MEDICAL EDUCATION IN INDIA : IN SEARCH OF RELEVANCE

A Sociological Inquiry into the Scheme of Reorientation of Medical Education (R.O.M.E.) as implemented in Selected Medical Colleges in Karnataka State

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C E R T I F I C A T E

Certified that the dissertation entitled "MEDICAL EDUCATION IN INDIA : IN SEARCH OF RELEVANCE - A Sociological Inquiry into the scheme of Reorientation of Medical Education (R.O.M.E.) as implemented in selected Medical Colleges in Karnataka State" submitted by Mr. Joseph Panackel is in partial fulfilment of six credits for the award of the degree of MASTER OF PHILOSOPHY of this University.

This dissertation has not been submitted for any other degree of this University or any other University and it is his own work.

We recommend that this dissertation be placed before the examiners for evaluation.

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A C K N O W L E D G E M E N T

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Joseph Panackel

List of Maps, Charts, Photographs, Tables and Appendix

ABBREVATIONS USED

1.	ROME	:	Re-orientation of of Medical Education
2.	P&SM	:	Department of Preventive & Social Medicine
3.	CM	:	Department of Community Medicine (same as P&SM)
4.	PHC	:	Primary Health Centre
5.	PHU	:	Primary Health Units
6.	MO	:	Medical Officer (of the PHC/PHU)
7.	LMO	:	Lady Medical Officer
8.	CHV	:	Community Health Volunteer
9.	IPP	:	India Population Project
10.	RHTC	:	Rural Health Training Centre
11.	DHO	:	District Health & Family Welfare Officer
12.	PGs	:	Postgraduate Medical students
13.	UGs	:	Undergraduate Medical students
14.	MPWs	:	Multi-purpose Health Workers
15.	BHWs	:	Basic Health Workers
16.	POL	:	Patrol, Oil and Lubricants
17.	ANM	:	Auxilliary Nurse Midwife
18.	BMC	:	Bangalore Medical College (Government)
19.	KMC	:	Karnataka (Government) Medical College, Hubli
20.	JJMMC	:	J.J.M. Medical College, Davangere
21.	JNMC	:	Jawaharlal Nehru Medical College, Belgaum
22.	ICDS	:	Integrated Child Development Service Scheme
23.	MCI	:	Medical Council of India
24.	IMA	:	Indian Medical Association
25.	IAAME	:	Indian Association for the Advancement of Medical Education
26.	IJME	:	Indian Journal of Medical Education
27.	UNICEF	:	United Nation International Childrens' Emergency Fund
28.	DPT	:	Diphtheria, Purtrusis and Tetanus (Triple Antigen)
29.	OPV	:	Oral Polio Vaccine
30.	CSM & CH	:	Centre of Social Medicine & Community Health,

31.	JNU	:	Jawaharlal Nehru University, New Delhi
32.	DGHS	:	Directorate General of Health Services (Delhi)
33.	MEC	:	Medical Education Cell at the DGHS, Delhi
34.	DME	:	Director of Medical Education (Karnataka)
35.	DHS	:	Director of Health Services (Karnataka)
36.	MCH	:	Maternal & Child Health Service

Preface

Medicine is fast undergoing change in its pattern, concomitant with advance in the field of natural and applied sciences. The impact of these changes on the Society has become a fertile field of study for social scientists. Although much has been accomplished in the field of medical education, rapid social changes and fast growing population in developing countries have thrown additional demands on the medical profession and indirectly on the planning of medical education. There is a persistant demand for more and better health services in greater quantity and increasing coverage.

In the last 38 years, medical education has undergone rapid growth and development in India and there has been a constant attempt to reorient the system, to prepare the undergraduates for his changing role in the community.

Medicine is a Social Science. Man is interested in health to the extent that it makes possible for him to achieve his primary needs. So the health needs have to be considered in the context of overall needs of the Society. The subject of medical education and health care delivery is as much a sociological challenge, as a medical one. Unfortunately, social sciences' consideration does not

seem to have exerted much influence on the formulation of policy and plans for developing a sound medical education system or for extending health services to large sections of the population.

In this dissertation the trends in medical education in India are reviewed with special reference to the scheme of Re-Orientation of Medical Education (ROME), this study is mainly from a sociological perspective. Two Government medical colleges and two private medical colleges in Karnataka State, were selected as the sample.

I do not claim that the present study is an exhaustive one. However, an attempt has been made to conduct an in-depth study of the implementation of ROME scheme in 4 medical colleges referred to above in Karnataka State more from a social science angle. It is my desire to present the facts from a first-hand experience that I gained from these colleges and their field practice areas as I could observe, see and perceive the (rather distorted) implementation of the scheme of ROME from a close quarters during my 3 month long field work in the districts of Bangalore, Chitradurga, Dharwad and Belgaum.

I wish to record that at no stage the officials at the Directorate of Medical Education or the College authorities refused access to any information or document during the course of my study. On the other hand, I have been given all cooperation, encouragement and necessary facilities for pursuing my research on this topic. The Government of Karnataka by a separate order accorded permission for my study and for this purpose allotted the two Government and two private medical colleges in four different districts of the State. The Govennment on their part also wrote to the Principals of these four medical colleges requesting them to make necessary arrangements for my research study.

It is my endeavour to present the facts as it is without any distortions, mis-interpretations and mis-judgements. However, if any inaccuracies have crept into this work, it is purely unintentional and by sheer inadvertence.

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CHAPTER - 1

Introduction

SECTION - A

The scientific and technological pace of medicine has experienced phenomenal growth in the past few decades. Yet, these advances in medical sciences have not reached the vast majority of people living in rural areas. At a time when health care is considered a right of every citizen, there are those who receive very inadequate care or none at all. For this reason, during the recent years the medical education in India has come in for a spate of criticism from the public, the politicians as well as from the medical educationists. The Government is earmarking a considerable amount of funds for medical education. The doctors trained at public expense do not like to go to villages or remote areas where eighty per cent of our population live. "The present day medical education in India has not only failed in delivering its objective but has failed miserably"[1]. "It is generally accepted that our medical education is neither need based nor relevant but is obsessed with disease, hospitals, specialization and sophistication"[2]. These are the reactions of some of our medical educationists, towards present day medical education in our country.

At the time of independence we had only 25 medical colleges and within three decades the number rose to 106. Thus the saga of modern medical education in our country is indeed a glorious one. One can take a (false) pride in its growth and development. It is a story of explosive expansion quantitatively even though the standards of excellence at all levels may have fallen short of expectation of all concerned.

When this realization purturbed the minds of early planners of medical education in the country, an attempt was made to put the medical education in the right track by establishing a department of Preventive & Social Medicine in each medical college. This was as early as in 1955. After two decades the planners realized the bitter truth that their earlier prescription was not all effective and they were in search of a better cure for the maladies of medical education. The new pill was found - in the form of Re-orientation of Medical Education (ROME) programme.

The ROME scheme is in operation since 1977. 106 medical colleges have been involved in the scheme and each medical college was supposed to have adopted three Primary Health Centres (PHCs) to start with, for the implementation of the scheme.

The overall objective of the ROME scheme was the involvement of medical college, i.e. faculties and students - both undergraduates and interns - in the community health activities with the object of providing (a) rural orientation to the faculties, students and the interns; (b) channelising the potentials of service and training components of a medical college to the rural community for improved health care and (c) ultimately such involvement of medical college with its faculties should spread up to the district through the existing health care delivery infrastructure.

"A good educational system should be sensitive to the social environment of the community, which it seeks to serve, and constantly adapt itself to changing requirements"[3]. It is from this angle the scheme of ROME is to be looked upon as an attempt to relate the system of medical education to the needs of the people at large.

Nine years after implementation of the scheme in 106 medical colleges in the country, our present study makes an attempt to portray a true picture of different aspects of the programme as implemented in the four selected medical colleges in Karnataka State. In order to obtain a composite view of the structure, organization of the programme and its impact on the beneficiaries the study tried to include all concerned to the programme as respondents.

Forcing lopsided developmental programmes on the people whose basic amenities for living are not adequately med and into a situation like this such scheme can lead to further deterioration of the quality of their socio-cultural development.

In this study on ROME scheme in medical colleges in Karnataka, the characteristics of this phenomenon will be focused upon as Karnataka is riddled with many problems covering different facets of medical education and rural health services.

We have attempted to analyse the subject on the following format, so as to understand the issues in a wider perspective and the factors exerting influence on the scheme of ROME.

Firstly, we have attempted to provide a brief overview of medical education by recapitulating and tracing the historical evolution and development of the system of medical education and the early medical education policies in the country, including the role of associations and organizations which have shaped the Indian medical education system to the present form viz., the Indian Association for the Advancement of Medical Education (IAAME) and the Medical Council of India (MCI). In the

next section we have made an effort to understand the objectives of medical education in India, and the need for reorientation. The subsequent section deals with the philosophy of reorientation and the actual objectives of the ROME scheme as laid down by the Government of India including a description of one of its major component - the 318 medules imported from U.K. at an enormous cost for providing rural health service in India as part of the scheme.

In Chapter 2, we reviewed with an inter-disciplinary perspective, some of the available literature on medical education in general and ROME scheme in particular giving a dimension of its historical growth and development. The available relevant literatures have been classified into Committee Reports, literature on a historical approach, social sciences approach and other related literatures.

Chapter 3 describes the methodology and design of the study.

Chapter 4 deals with the analysis, interpretation of the data. Here a number of case studies have been included from a sociological perspective.

In Chapter 5 we discuss some of the pertinent issues and problem areas which have come in the way of effective implementation of ROME. Chapter 6 covers the summary, conclusion and suggestions which are made based on the findings of the study.

SECTION - B

Development of Medical Education in India

The training of physicians and organisation of medical care in our country dates back to very ancient times, and these were usually founded in the proximity of religious institutions. Gradually, the training of physicians became more institutionalised and hospitals and other treatment centres became associated with the responsibility both for providing health services and also for the training of physicians. In Europe, during the period of Renaissance such institutions gradually assumed the character of the present day medical schools, and the training of health man-power became a part of educational process undertaken by the Universities.

Organised medical training in India was started in the 19th century. The first medical school was started in Calcutta in 1824 followed by one at Madras. Both the Ayurvedic and the Allopathic systems were taught in these schools for a decade after which they confined themselves to the Allopathic system.

In 1833, Lord William Bentick appointed a Committee to work out the principles on which medical education should be established in India. The Committee's recommendation

set the pattern for the development of medical colleges in India. Those were : (a) that all pupils be required to learn the principles and practice of medical science in strict accordance with mode adopted in Europe; (b) that instruction be given through English; (c) that the course should be for 4-6 years; (d) that the pupils be instructed in Anatomy, Surgery, Medicine and Pharmacy; (e) that the pupil witness the practice in various hospitals and dispensaries; and (f) that the public service be supplied with doctors from these institutions[4,5].

In 1835, the medical school in Calcutta was converted into a College and another medical college was started in Bombay in 1845. In 1846, a medical school was started in Hyderabad and in 1848 a school in Indore followed by many schools in different parts of the country. The army trained "hospital assistants" on a two-year course, who after qualifying, were employed in the army and some civil Governments. With the establishment of universities in various places, the medical colleges were affiliated to these universities. On similar lines medical colleges were established all over India. Soon new departments of Chemistry, Physiology, Midwifery, Ophthalmology, Medical Jurisprudence, Dentistry and Hygiene were established in addition to the existing

departments of Anatomy, Surgery, Medicine and Pharmacy. Later University affiliation was obtained, admission of women introduced and recognition received by the Royal College of London, Dublin and Edinburgh. These developments took place under the supervision of the General Medical Council of Great Britain.

The Medical Colleges at Madras, Bombay and Calcutta were taken over by the Universities which granted the LMS qualification for those who joined the course after matriculation examination and the MBBS qualification for those who joined the College after the intermediate examination. The MBBS degree was recognized by the General Medical Council of Great Britain as the standard of medical curriculae was in par with the one laid down by the Council[6].

Earlier, the Government also established medical schools to train subordinate medical staff, known as licentiates. By 1938 there were 27 medical schools, 9 of which were under private control. The medical schools had lower admission requirements and ran shorter courses than did the medical colleges and the licence holders were almost always restricted to the lower levels of the admission hierarchies. Unlike the college students, many of the pupils in the medical schools received stipends from public funds, and had entered a bond to work for the civil or military services after receiving their licences[7].

An act was passed in 1933, and Medical Council of India (MCI) was established to coordinate degree standards and to negotiate international recognition of degrees. The medical schools and licentiates were excluded from the purview of MCI.

At the time of independence, India inherited a system of medical education which had developed along British lines under the close supervision of the General Medical Council of Great Britain. The philosophy of medical care and education of health personnel had been focussed on high quality care of the individual patients. Therefore, the main challenge that faced medical educators, administrators and members of the medical profession was the re-orientation of the system to make it more relevant to the needs of our predominantly rural society.

The existing medical education system was meant to train doctors for work in large city hospitals modelled on the British and American patterns. Hence a departure from the conventional urban, hospital-based pattern of training to a community oriented system was becoming imperative.

Table 1

Health Services in Rural and Urban India

	Rural	Urban
Population	80%	20%
Doctors	20%	80%
Hospital Beds	17%	83%
Protected Water	4%	90%

Source : Sheila Zurbrigg (1984). Rakku's Story - Madras, George Joseph, p.83 - Quotes D. Banerji's "Social and Cultural Foundations of Health Service Systems of India", Inquiry/Supplement to Vol.XII, June 1975; also, Pocket Book of Health Statistics, 1980, GOI, p.70.

Table 8

Community Health Services

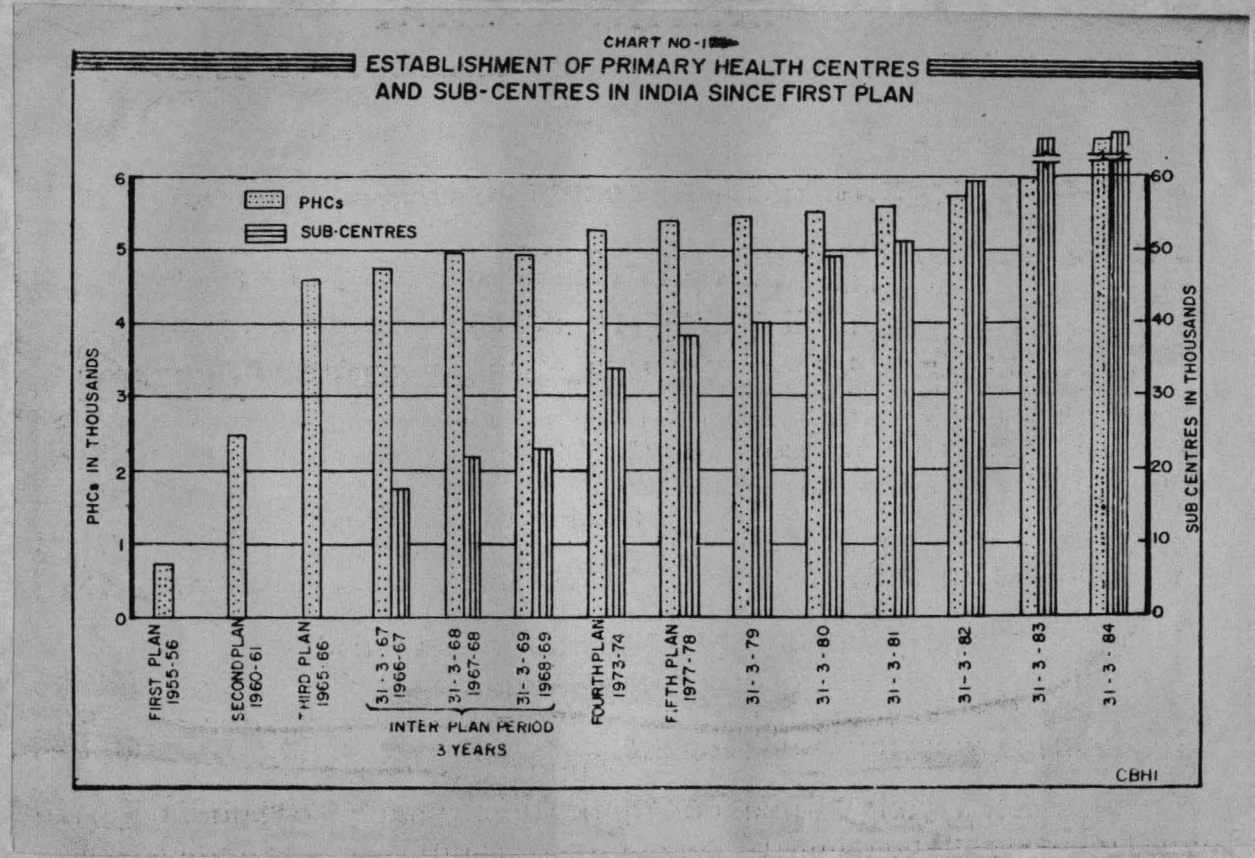
PHC's Sub-Centres in India since I Five Year Plan

	PHCs	Sub-Centres
First Plan	725	
Second Plan	2,565	
Third Plan	4,631	
Inter-Plan Period 3 Years	4,919	22,826
4th Five Year Plan	5,283	33,509
5th Five Year Plan	5,400	38,115
6th Five Year Plan	6,375	74,236
As on 31-3-1985 (Provisional)	7,250	83,000

Source : Hand Book of Health Statistics of India, 1985

Chart - 1

Rural Health Service



1. Establishment of PHCs & Sub-Centres since I Five Year Plan

SECTION - C

The Scenerio Today

The medical students continue to receive their training in large well equipped hospitals, where teaching is heavily loaded with study of disease and individual care, mainly within the hospital. "The specialist teachers are not familiar with the common conditions or facilities outside"[10,11]. Their undue dependence on sophisticated diagnostic and therapeutic aids are passed on to the medical students. Doctors have become estranged and alienated from the people by this. Teaching hospitals provide advanced care to those few who come to it, neglecting promotive and preventive services to the majority. "One of the saddest ironies of the medical education system in India is that the resources of the community are utilised to train doctors who are not suitable for providing services in rural areas where the vast majority of the people live and where the need is desparate"[12].

The working group on "Medical Education in relation to the country's changing needs"[13] states that the existing system of medical education which is based on curriculum and subjects as taught in the western countries, where too much emphasis is laid on curative medicine and too little on preventive and social medicine.

"Over emphasis of curative services, specialization and super-specialization and concentration on hospital services, gives the students the wrong notion that hospital care is the best"[14]. But the fact remains that it is very expensive (to the person, his family and to the country) and uncomfortable and inconvenient for the patient and family, neglecting their own living environment, where possible health care would have been most appropriate. The enormous investment on modern medical institutions in urban areas is quite out of proportion to the availability of medical aid to the bulk of people who do not live in urban areas (Table-2). Thus a paradox exists in that a time when medical knowledge and clinical capability and trained medical man-power are at an all time high, so also is the dissatisfaction with health care services - both quantitative and qualitative. It is real and widespread, and it comes from all quarters - Government, consumers, providers of care and those who pay for the care as third parties.

"In the context of the Directive Principles for State Policy of the Constitution of India and the political commitments, leaders of independent India unhesitatingly defined the social objective for medical education to ensure that medical and health services are available to the entire population of the country. Taking very

deliberately a socialistic attitude towards the health services, the aim was to make available health services particularly to those sections which had so far been ignored. All the documents of the Five Year Plans dutifully enunciated these social objectives of the medical education in India"[15].

Following these social objectives and on the basis of the recommendations and the deliberations of the National Health Education Conference of 1955, jointly organized by the Ministry of Health and Family Planning and the Medical Council of India, Departments of Preventive & Social Medicine were established in medical colleges to act as catalytic agents to bring about social orientation of medical education in India, by (a) giving a social perspective to health problems and health practices in the country (b) interacting with teachers of other disciplines to provide a social dimension to their teaching and (c) knitting together concepts and methods of the conventional "hygiene and public health" with those from other related medical disciplines to impart teaching of comprehensive health services to undergraduate and postgraduate students[16].

SECTION - D

Medical Council of India

While tracing the historical development of medical education in India, one will be convinced that the MCI had played a very crucial role in shaping the medical education to its present day status.

The Medical Council of India is the body which controls medical education in the country. Its recommendations give the basic regulations and requirements of the training programmes of medical courses.

This statutory body was created by an act of Central Legislature as early as 1933. Its two-fold responsibility is to maintain uniform minimum standards of university medical qualifications in India and to further the recognition of the qualifications outside India. "Efficiency at home and honour abroad" was the watchword. The important function of the medical education by the Council are : Uniform minimum standards of qualification in medicine; Uniform curriculum for under-graduate studies; Fixing standards regarding staff, buildings and equipment; prescribing qualifications for teachers; fixing the number of students and the standards for training and examinations of postgraduates; Inspection

of medical colleges and the examinations held; improving standards of both undergraduate and postgraduate education, improving the standards of teachers and stimulating research; plan medical man-power requirements; obtain recognition of Indian qualifications abroad on reciprocal basis.

Medical Council of India, from time to time has been recommending suitable modifications in the present system of medical education in order to increase community based training to the medical students. In 1977, MCI recommended that second clinical year medical students should be posted in the department of Preventive & Social Medicine for a period of one month, and on each day the posting should be atleast of 3 hours duration besides the revised rural internship for six months. This is termed as "community medicine posting". It is envisaged that the students should either be posted in health training centres, PHC - attached to the medical colleges or such postings should be given by visits to the field practice areas according to the facilities available.

Indian Association for Advancement of Medical Education

A study of the historical development of medical education would not be complete without a reference to the voluntary body which nurtured the growth of medical educatio in this country to a great extent.

For improving the quality of medical education in India, a voluntary association called the Indian Association for the Advancement of Medical Education (IAAME) was inaugurated in 1961 at Hyderabad by the Founder President Dr. A.L. Mudaliar. This Association during the last 25 years has been rendering yeoman service in this field. It has opened chapters or branches of the Association in most of the States publishing its own journal and holding annual conferences on important aspects of medical education. In 1962, the second conference focussed on the importance of social and preventive medicine in medical curriculum.

In consonance with the trends in the world medical education and on the recommendations made by the Medical Education Conference, convened by the Ministry of Health in 1955, the Association was founded in 1960. It was thought that such an Association could play a most valuable role if it were a voluntary association of teachers and non-official in character.

Although the Association had not been able to achieve some of its objectives it has served through its journal - Indian Journal of Medical Education (IJME) and annual conference to focus attention on some of the important issues in medical education especially the social aspects.

SECTION - E

The Objectives of Medical Education in India

The objectives of the medical education has to be to produce "basic doctors" and other health personnel according to the local needs of the community and the nation. In other words the purpose of medical education is to serve for the people, the best services the modern medicine can make available. "Social objectives determines the educational objectives of medical education in any country. Because of the difference in social objectives there are different educational objectives in different countries. Educational system in USA, UK, Western Europe, Soviet Union and East European countries, China, Latin America and African countries reflects the different social objectives. At one extreme, a social objective of medical education in a country can be to ensure that the educational system prepares physicians who are specially moulded to serve the requirement of the country"[17]. However, the Draft plan on National Medical Education Policy stresses the two fundamental objectives of medical education. They are : the development of the basic knowledge and the other the development of medical and allied man-power to provide the services.

The WHO in its inter-regional conference (1966) for establishment of Basic Principle for Medical Education in any developing countries laid down the following objectives : that every practitioner in a developing country should be as familiar as possible with all aspects and their implications, preventive and curative, of the prevalent medical problems of his country; that he should be competent to contribute effectively to their solution; that he should be so imbused with the principles of learning and skilled in the method, that he will be able to continue further education in medicine for the whole of his professional life. One most important objective of medical education is the training of an adequate number of para-clinical personnel to provide the supporting role to the doctors. Some medical educationists[18] have pointed out and added the latter which was one of the very important objectives of medical education which the WHO at that time perhaps over-looked.

Since the national needs are different in the developed and developing countries, the objective of medical education would be varied in these two contexts in training our future health man-power. "Medical Education should aim to give the student a comprehensive concept of man and his disease and to inculcate those habits of mind which will enable him to enter without handicap any one of

the fields of medical practice and research, be it medicine, surgery, psychiatry or public health"[19]. Creation of positive attitude towards the patient, family and community should be the foremost objectives of medical education.

SECTION - F

Need for Re-orientation

As seen earlier, adopted from Western countries, medical education in our country has mostly remained tradition bound and a carbon copy of that in the Western countries, instead of being developed according to the special health needs of the country. Without adoption of the concept of producing a good basic doctor, who is well conversant with the day to day health problems of the rural and urban communities and who can plan an effective role in the curative and preventive aspects of the national health problems, the medical education system is almost off the track today. There is a need to re-orient the system of medical education for achieving the above mentioned objectives.

Everyone seems to be in agreement that medical education has to be dynamic and it has to adopt itself not only to the new discoveries being made in the scientific and technical field, but also to the social realities.

The Ministry of Health and Family Planning, Government of India, seized with the problems facing the delivery of Health services identified certain areas in medical education and support man-power for attention. The main problems identified in the education and training were : Urban orientation of medical education, heavily based on curative methods and very little on preventive and promotional aspects; Lack of orientation of medical teachers to the needs of the country especially of the community in rural areas; Lack of integration of family welfare education in general medical education; Lack of proper training of medical students in the field of nutrition, family planning and M.C.H. services; Deprivation of services by qualified doctors to the rural communities.

The need for a change in the structure and emphasis on medical education to meet the changing requirement of the rural community was taken note of and the Ministry of Health and Family Planning appointed a top level Committee

called the Group on Medical and Support Manpower (Srivastav Committee) and the report of this group submitted to the Government in 1974. The recommendation of the group were duly processed by the sub-committee of the Ministry of Health and Family Planning and a concrete plan of action was drawn up which was adopted by the Third Joint Meeting of the Central Councils of Health and Family Planning in its resolution was later on ratified by the conference of Deans and Principals of Medical Colleges in India.

As a follow-up of these deliberations, the Government of India decided to implement the part 'C' of the plan of action namely, involvement of medical colleges in community health problems and re-orientation of medical education should be undertaken with celerity and promptitude by each of the concerned State Governments/ Union Territories, on time bound priority so that the much aspired social objectives underlying it can be achieved in the country to a considerable extent.

Initial proposal was to implement the programme in 25 selected medical colleges[20], later on the Ministry decided to implement the scheme in all 106 medical colleges which were recognised by the MCI (Plate No.1).

2—72 CBHI/ND/78

Map - 1 : Indicating 106 Medical Colleges where ROME programme has been implemented.

SECTION - G

The Philosophy of ROME

Apart from the recommendations of the Medical Education and Support Manpower (Srivastav) Committee, in May 1977, the 30th World Health Assembly decided that World Health Organization and the member-Governments should strive to provide to all the citizens of the world the kind of health and medical facilities which would enable them by the year 2000 to lead a socially and economically productive life. Towards this end, the International Conference on Primary Health Care which took place in September 1978 in Alma-Ata (U.S.S.R.) adopted a declaration emphasizing the importance of primary health care in order to fulfill the target of Health for All by the year 2000 A.D. Thus ROME programme received an additional impetus after Alma-Ata declaration.

As a signatory to the declaration and also to the South-East Asian Charter on Health, the Ministry of Health and Family Welfare set up a working group on "Health for all by 2000 A.D.", whose report is an important landmark, providing a blue-print for progress in this sector[21].

Government of India and Medical Council of India therefore have adopted a plan of reorientation of medical education in 1977 by involving each medical college in

adoption of three PHCs where undergraduate medical students would be posted for a period of one month and exposed to management of manifold community health problems and study the role of environmental, socio-economic and cultural factors in disease causation. For this purpose three PHCs in the area adjoining medical college were to be selected and residential facilities for the staff and students were to be provided so that the students can be posted for a period of one month at these centres to participate in the comprehensive health care delivery to the areas covered by these three PHCs.

The administrative and technical control of these three centres are to be vested with the medical colleges[22]. Thus a change in the structure of medical education to meet the changing requirements and to provide adequately for future needs, particularly of the rural community was envisaged. The graduate on completion of his studies must be able to manage on his own even if he has to work in a remote village with nominal facilities and inadequate technical and laboratory support. The young doctor should confidently tackle all the cases coming to him, including ordinary emergencies; plan for all the required preventive programmes and be able to spot out abnormalities which he cannot manage himself and refer them to hospitals which are better equipped and where such cases can be attended to.

The salient features of the scheme has been embodied in the recommendations of the MCI on undergraduate medical curriculum which makes it mandatory for each medical college to adhere to them. The implementation of the scheme, therefore, becomes statutorially necessary, as, otherwise, the medical college concerned will stand the risk of de-recognition by the MCI[23].

When MCI revised the curriculum of undergraduate medical education so as to incorporate the provision of the ROME scheme by providing for compulsory internship posting for the community health work for a minimum period of six months, this aspect of rural training has been emphasised[24].

SECTION - H

The Objectives of ROME Scheme

The objective of the scheme broadly is to reorient medical education by exposing the students and the faculty to the rural environment and to upgrade the quality of health care services in the rural and peripheral areas by providing meaningful referral service system linking the remotest peripheral health units with the colleges as well as the PHCs.

The medical college is also expected to accept the total responsibility for promotive, preventive and curative health care programmes of three PHCs (i.e. three Developmental Blocks) in the first phase and then to cover the entire district in a phased manner over a period of three to five years, by each of the 106 medical colleges. In each phase three PHCs will be attached to each of the medical colleges and ultimately they will be allotted nine PHCs[25] each to implement the scheme.

The three Mobile Clinics supplied by the Government of India under the programme will be utilised for providing the curative services in the rural areas and for training the undergraduate and interns (Photograph No.1). The Mobile Clinic will visit the rural areas attached to the PHC with students, interns and faculty on a pre-determined programme regularly after giving due publicity/information both to the PHC authorities and the community concerned[26].

The faculty will make use of the opportunity to demonstrate and teach the students and interns on diagnosis and management of common ailments in rural areas and guide the students in clinical skills and procedures.

PHOTOGRAPH - 1

3 Mobile Clinics (Medules) allotted to each of the 106 medical colleges which has become an integrated component of ROME scheme since 1979-80. The vehicles were fabricated by Bedford Company of U.K. The cost of each of this vehicle is Rs. 8 lakhs. The villagers have nicknamed these vehicles as "White Elephants" due to its unusual size.

In addition to clinical procedure and methods, the students will be involved in collection of baseline data of the concerned rural areas and actively participate in the health promotion and specific protective activities such as communicable diseases control, including immunization, maternal and child health care, family welfare services, health education, nutrition, counselling and rehabilitation, environmental sanitation etc.

Each medical college will evolve with the active involvement of district hospitals, taluk/tehsil hospitals, sub-divisional hospital and primary health centres, a well-knit referral service system. The PHC which are nearer to the medical colleges are supposed to be chosen for the success of such a referral system.

The staff of the medical colleges will be required to attend the district and taluk/tehsil sub-divisional hospitals by rotation for the purpose of improving the hospital services. The medical college will also extend cooperation in providing the peripheral units mainly with expertise and assistance in laboratory services, radiology services, clinical services, implementation of national programmes, control of communicable diseases, nutrition, maternal and child health services and family planning. By this scheme the resources of medical colleges, district hospitals and taluk/tehsil, sub-divisional hospitals and

PHCs will be pooled together in respect of manpower, transport, equipments, contingency grants etc., to evolve a well-knit referral system.

The programme also desired that a part of the training period of undergraduate students may be spent in district and taluk/tehsil, sub-divisional hospitals and PHCs. They have provided an annual posting of 8 weeks in rural areas during the undergraduate time-table.

The programme envisaged that the entire period of internship will be spent in suitably upgraded district hospitals, taluk/tehsil, sub-divisional hospitals and PHCs. Depending upon the availability of facilities at the district hospitals, the number of interns posted at the medical college hospital will be reduced.

The medical colleges were expected to collect baseline data about the health status of the community so as to enable them to evaluate the impact of the entry of the medical college periodically.

SECTION - I

Mobile Clinics and its role in ROME Scheme

One of the integral components of ROME scheme is the 318 Mobile Clinics imported from U.K. which were distributed among 106 medical colleges in the country. Mobile Clinics as a means for providing rural health services has its origin in Rajasthan. The Government of Rajasthan started a mobile surgical unit in 1955 to provide surgical facilities in Rural Rajasthan. By 1967 the unit developed into a 400 bed Mobile Hospitals fully equipped with operation theatre, laboratory, blood transfusion unit, x-ray van, dental unit and a generator. The mobile hospital could provide facilities for all types of general surgery, ophthalmic and dental surgery, and surgical sterilization. Included in the functions of these mobile units were immunization, health education and family planning advise. Interns from medical colleges in Rajasthan attended the camps organised by this mobile unit. The successful working of this scheme encouraged the Government of India to sanction smaller 50-bed training units to 21 medical colleges in 1970. It was hoped that these units could be used by senior members of the clinical staff to acquaint themselves with field problems in rural

areas and methods to provide specialist services in such situations[27,28]. The effectiveness of these units in the teaching programme is yet to be evaluated in a scientific manner.

Taking a cue from its success, the Government of India made an attempt to introduce this mobile clinic service through a new scheme called "Chittaranjan Multi-purpose Mobile Training-cum-service Hospital", during early 1970's. The objective of this programme was to orient the final year medical and nursing students and interns to the curative, preventive and promotive aspects of rural community health to enable them to practice in rural areas, and to render competent health and medical care and specialist and family planning services to the hitherto neglected rural population near their homes with the help of teachers from medical colleges working in this 50-bed tented hospitals[29]. During 1970's the MCI has prescribed three months stay in Rural Health Centres as a part of internship training. Since many of the medical colleges did not have their own field practice areas and if at all they have had, most of them were inadequately staffed. Moreover, with increasing number of students, they fall short of the commitments. In order to overcome these shortcomings the Government have decided to attach a 50-bedded Mobile Training-cum-service unit to all medical

colleges for giving training in comprehensive community medicine to undergraduate and interns in rural setting, while simultaneously providing comprehensive health care to the community[30].

Medical Education Committee Report[31] also recommended introduction of more mobile training-cum-service units popularly known as "Chittaranjam Mobile Hospitals" to be allotted to all medical colleges and senior teachers to provide specialist services in their respective field practice area.

Although very little is known about its efficacy, suitability, desirability and the cost benefit in rendering rural health services in our country, the scheme of Chittaranjan multi-purpose Mobile Training-cum-Service Hospital is in vogue in the field practice areas of different medical colleges including one at the Bangalore Medical College. Its success in certain parts of Rajasthan in delivering rural health services perhaps might have prompted the Government of India to procure 318 'Medules' fabricated by the Bedford Company of Great Britain at an enormous cost of 15.90 crores*.

SECTION - J

Medules under ROME Scheme

During the regime of Janata Government, when Shri. Raj Narain, was the Union Minister of Health during 1978, he showed a lot of enthusiasm on the British made mobile hospitals called "Medules". The Government of India procured 318 of them valued Rs.15.90 crores*[32] for India under a medical aid programme. The cost of each one of these mobile clinics is Rs.16.5 lakhs*. Each of the 106 medical colleges have been allotted 3 Mobile Clinics[33] to cover the areas of three PHCs already assigned to them. They are specially designed, highly sophisticated clinics capable of rendering a variety of general and specialised services. Each Mobile Clinic is designed and equipped to serve as a small hospital on wheels.

The clinics are of two types, namely, 4-wheel drive and 2-wheel drive[34]. 4-wheel drive mobile clinics which are comparatively smaller, are to meet the requirements of difficult terrains, whereas the 2-wheel drive large vehicles are meant for better moffussil roads of the villages[35].

The rural health service mobile clinics have three sections : Doctors consulting chamber, pharmacy dispensing window and operation theatre (Photograph 3 & 5). Each of the vehicle is equipped with water storage tanks examination couch, operating tables, sterilizer, refrigerator and anaesthetic equipment.

PHOTOGRAPH - 2

Specialists examinating patients under the extended tent of the Module.

PHOTOGRAPH - 3

Dental Surgery being conducted in the Operating room of the Medule.

PHOTOGRAPH - 4

A rural clinic run by the faculty from the Medical College

PHOTOGRAPH - 5

An ENT specialist examining a patient inside the consulting chamber of the Medule

PHOTOGRAPH - 6

Medule with the extended tents at a rural health camp. (The Mobile Clinic has provision for extended tent to both sides of the vehicle)

The anaesthetic equipment supplied in the clinic includes an E.M.P. apparatus, oxygen cylinders, essential resuscitative equipment, endotracheal tube of assorted sizes laryngoscope etc.

The mobile clinic is also equipped with four mid-wifery kits containing all the essential instruments for domicillary obstetric practice. The clinics have their own electrical generators and standby battery units. To enable to conduct operations in the night, operating lamps and half a dozen tube-lights have been provided. In addition to tubelights, which works on AC & DC currents, a number of exhaust and wall fans have been provided. It has also got extendable tents to both sides of the clinic (Photograph No. 2 & 6). The first batch of these mobile clinics were handed over to the Indian authorities at Bombay on 15th November, 1979.

According to the Ministry of Health, "No reorientation of medical education is achievable in practical terms, unless the medical students, along with the medical specialists and experts constituting the teaching faculties in the various medical colleges actually and directly deal with all aspects of immunization, detection and cure of disease, whether existing in a remote village or in the nearest urban slum. It is imperative that in the achievement of such

an objective, mass immunization, treatment of locally endemic diseases, maternal and child health services, carrying out minor surgical interventions including operations under the family welfare programme, prevention of blindness, school health programmes etc. are duly covered[36]. The mobile clinics, according to the authorities, can also be gainfully used for the screening and treatment of specially vulnerable population groups in backward areas, tribal belts and in pockets where outbreak of epidemics is threatened, if the communications and programme scheduling could be properly initated[37].

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CHAPTER - II

REVIEW OF LITERATURE

CHAPTER - II

REVIEW OF LITERATURE

SECTION-I

Medical Education in India - An over view

The major issues and perspectives which dominate the literature on medical education are mostly subscribed by medical educationists from within the profession who are invariably part of the system they examined. Though they have brought in their discussions certain amount of bias and lack of objectivity, by and large these literatures provide an over view to the system of medical education. Unfortunately our major handicap is that there is not much literature available on this specific programme of medical education, i.e. the Scheme of Reorientation of Medical Education. Though a few individual studies were conducted here and there, in most of them an epidemiological perspective was lacking, besides they could not be considered comprehensive or exhaustive on the subject.

SECTION - II

The Committee Reports on Medical Education

A. The Bhore Committee Report

The important document on medical education is in the form of a Committee report known as the Bhore Committee

report[1], this drew up a detailed health plan which subsequently became the frame work for national health policy after independence. Plans for the new rural health care system were innovative and bold, envisaging massive extension of primary, curative and preventive services. "Yet, in their essence they simply added a rural dimension to the curative physician - dominated, urban pattern of services which had developed over the previous century of British rule"[2]. The most regressive part of the report was their vehement argument for the abolition of licentiate in the name of high quality professional education keeping in pace with the standard laid down by the West. However, the positive side of the report was the recommendation for the establishment of a Preventive & Social Medicine Department in every teaching Institution and three months rural internship and the change suggested in the teaching curriculum of the medical course could be considered the first ever step towards social orientation.

B. Report of the Medical Education Committee

Another important document again in the form of a Committee Report on Medical Education (B.P. Patel) is the report of the Medical Education Committee[3] which made an attempt to define the 'basic doctor' and advocated certain measures that would encourage the doctors to go to villages.

Some of their recommendations especially in the area of improving the infrastructure at the PHCs and for the provision of adequate living and working accommodation for the doctors and the medical auxiliaries in the villages with modern sanitary facilities, in parts, can be considered as an emerging thinking. The prescription of minimum service in rural areas before crossing efficiency bar or grant of promotions and also the idea of granting special medical allowance for service in difficult areas, were based on practical wisdom. The Committee's recommendation on the admission policy on medical education that the University should evolve a common and uniform qualifying examination for entering the medical colleges was equally important. The involvement of senior teachers of the medical college to provide service facilities in respective rural field practice areas for providing reorientation of medical education for community health services is yet another welcome step. The thinking that reserving certain percentage of seats in medical colleges for candidates from other States would have definitely helped create a sense feeling of national integration. The most important point to be noted in its recommendation on the need for the entire gamut of medical profession (Professors, Elders and Leaders especially) is to undergo corresponding transformation in concern for health care in rural areas.

This report also, in part, showed certain progressive, innovative and emerging thinking in medical education, but certain recommendations like implementation of more Mobile Training-cum-Service Units (Chittaranjan Mobile Hospitals) to all medical colleges for rendering rural health care was not based on any scientific evaluation of the cost benefit or efficacy of such programmes. Though these mobile hospitals were successful in parts of rural Rajasthan due to its peculiar geographical situation, such a scheme may not be relevant if it is transplanted to the rest of the country for the conditions in other regions are different from that of rural Rajasthan.

C. Srivastava Committee Report

Yet another equally important and one of the recent Committee Reports on medical education is the report of the group on Medical Education and Support Man-power which is popularly known as the Srivastava Committee report of 1975[4]. The Committee analysed the contemporary medical education problem in a wider perspective and their recommendations turned out to be an important milestone and could possibly be considered the most innovative era in the new thinking of community orientation of medical education.

Though it may not be palatable to the people at the helm of affairs, the Committee strongly recommended to stop increase in the number of medical colleges and admissions. The Committee pleads for generating a national health man-power policy along scientific lines and advocates the evolvement of a national system of medicine by integrating modern and indigenous systems of medicine; to establish a medical and health education commission, besides training of interns in district/sub-division/ Taluk/Tehsil hospitals and not in the hospital of the medical college. Creation of referral service complex by the development of proper linkages between the PHC and higher level referral and service centres and involvement of the teachers of medical colleges in extending primary health care to the peripheral and remotest areas suggested by the Committee, are equally important.

These recommendations were landmarks in the history of medical education, more so by the reason that the committee considered the PHC as the nucleus of health care delivery system in the country and recognised the pivotal role of support man-power, i.e. the para-medical and health auxiliaries in delivering rural health care service.

The report condemned the metropolitical bias of health services which have deprived the rural areas of their basic facilities. The report advocated that the process need to be reversed and a programme of national health services is to be built with the community itself as the central point. The Committee opined that the over emphasis of provision of health services to professional staff is counter-productive. It makes a major shift for the creation of the large band of part-time, semi-professional, trained health auxiliaries in the community who have the advantage of accessibility and cultural kinness to act as a link between the community and the multi-purpose workers. To support them a highly competent, dedicated, easily-accessible referral system, for the minority of complicated cases which need specialist treatment is also envisaged. By and large the Committee has taken a comprehensive approach in its effort in providing relevance to the medical education in our country.

D. Report of the Working Group on 'Health for all - An alternate strategy

In the document on 'Health for all - an alternative stratefy[5] the report of the Working Group made recommendation for a sweeping change in the entire health service system including the medical education

in the country. The recommendations are radical and the report envisages the complete transformation of medical education and health service system based on the socio-economic political needs of the country. The document places greater emphasis on cultural, social and moral aspects of medical actions and purposes, and reiterates that there is no need to over emphasize high technology and the need for evolving similar technologies required for our villages and the medical training to be based on social, cultural and economic profile of people. The group believed that over education is counter productive and man and environment to be presented as a bio-cultural science in an inter-disciplinary holistic approach. It also mooted the health team concept, inclusion of social sciences and the structure of society in the curriculum apart from topics on health management - cost of effectiveness, logistics, personnel management etc., it emphasised the need for empathy with the people to reduce the over emphasis of postgraduation and integration of modern medicine with indigenous systems of medicine. Though the document has many lacunae, ~~in~~ ambiguity and lack of clarity of thought especially with regard to the practical implementation of the ideas discussed. However, it is an important document since it has come out from a Government organ and showed a change in their thinking on the contemporary issues in the health service and medical education system.

SECTION - III

Social Science Approach

Banerji (1977)[6] who traced the evolution of health service in India with a social science perspective gave a wider dimension to the subject. His appraoch was multi-dimensional and multi-disciplinary and he was able to present an overall picture of medical education, its growth, development, problems and its future. The health service system according to this analysis is shaped by two key political decisions of the new leadership after independence. A noteworthy feature of health service development in India according to Banerji is that throughout the past century and a half it has been influenced by two powerful forces which had been pulling it in different directions : the colonial approach which continues to be nurtured by the privileged classes after independence, pulling in one direction and the anti-colonial struggle, which later on took the form of a struggle for democratisation, pulling in another direction[7].

Banerji's analysis also identified the draw-backs of existing approach that instead of improving awareness and self-reliance has tended to enhance dependency and weakened the community's capacity to cope with its problem. The prevailing policy of training

health and medical personnel has resulted in the development of a cultural gap between the people and the personnel providing care. Therefore he called for a complete re-structuring of health services. "Inspite of all the radical declarations, however, no attempts were made to change the mentality that the senior members of the medical profession and teachers had inherited, nor were attempts made to open medical education to the poorer classes of society[8].

Banerji's analysis[9,10] on health service development in India is quite comprehensive, extensive and elaborate and the vital points, issues and its implications cannot be discussed in great detail in a paper like this. However, certain pertinent issues needs special attention. "Pretending to follow the recommendations of the Bhore Committee, soon after independence upgraded departments or Preventive & Social Medicine were created in Medical Colleges, at the instance of the Government and of the MCI, to act as spear-heads to bring about social orientation of medical education in India. However, as in the case of so many other ambitious and morally lofty Government programmes, concurrently it was also ensured that the very spirit of this programme is stifled, if not totally destroyed, by actively discouraging in various ways its actual implementation.

For instance, instead of mobilising the finest brains in the profession to bring about social orientation, most of the positions in the departments of Preventive & Social Medicine were filled by the discards, who were often found intellectually inadequate to get into the highly competitive and prestigious clinical disciplines, or even the para-clinical disciplines. This gave enough opportunities to the threatened foreign trained super specialists to ridicule the entire discipline of preventive and social medicine and bring it down almost to the bottom of the prestige hierarchy of disciplines in a medical college".

While analysing the social objectives, Banerji identified the objectives of the department of Preventive & Social Medicine, for which it was created in all medical colleges : to act as catalytic agents to bring about social orientation of medical education in India, by (a) giving a social perspective to health problems and health practices in the country; (b) interacting with teachers of other disciplines to provide a social dimension to their teaching and (c) knitting together concepts and methods of the conventional "hygiene and public health" with those from other related medical disciplines to impart teaching of comprehensive health services to undergraduate and postgraduate students[11].

While tracing the growth of medical education in the country he says "the phenomenal growth of medical colleges in the post-independence period has led to a gross dilution of standards in education. In addition there has been a culture of 'glorification of mediocrity'[12]. In the absence of adequate number of well qualified teachers all and sundry have been promoted to positions of leadership and important academic levels. These people not only lack the vision or the academic maturity, but have tended to form 'mutual admiration societies' around them to pad up their own complexes and limitations".

The spectrum of literature, Banerji produced is quite large during the last two decades and constitute a large chunk of material available in the country on medical education.

SECTION - IV

Studies on a Historical Perspective

Certain writers on medical education, like Jeffery (1979) have provided a historical perspective of the system of medical education in India in its search for relevance and this has provided us a deep insight into the evolution of the policies on medical education. Commenting on the early policy, he states "The idea that

only one type of medical education was relevant to Indian conditions, namely, as close approximation as possible to medical education in Britain, had finally established. Independent India has taken many decades to overcome the dead weight of this idea and it is still not clear that the battle for more 'appropriate' educational patterns have been won"[13]. He also mooted the idea that "the current conventional wisdom on medical education is that medical standards should be specific to the context in which they are to be used and the crucial members of the health team are those below the level of the full fledged doctors". He was highly critical of the policy on discontinuing licentiate training that "the cost must be cut according to cloth, and it must be seriously considered whether standard set on what is required in Great Britain or the rest of the Empire and world are necessarily or applicable here".

The article entitled "150 years of medical education - Rhetoric and relevance"[14], Ravi Narayan (1984) traces the history of medical education in a chronological order, right from ancient period to the present day and raises certain pertinent questions and issues the medical education in India faces today. He also critically examines the report of various committees on medical

education and health service with special emphasis on community health. While discussing the policy on medical education during Plan periods, he says "The Fifth Plan document stated that 'teaching in medical colleges still requires a radical change' and in parrot-like fashion it repeated the exhortation that 'the undergraduate medical education would have to be reoriented towards the needs of the country and emphasis would have to be placed on community care rather than hospital care". On the attitude of medical teachers and their orientation towards their profession and discipline, he says, that "Because of the professional vested interests in medicine, the medical profession has refused to accept the fact that all doctors cannot necessarily be good teachers. Educational science and pedagogy are important foundations on which medical curriculum should be organised whatever the content and relevance of the course. Teachers in medical colleges in India seldom join because of a love for the 'vocation of teaching'. A base in the medical college is helpful in the cut-throat competition of private practice apart from being itself a channel of referral to one's own private clinic. This is inspite of the fact that MCI recommends full-time non-practicing teachers. The remuneration offerred to medical teachers further compound this problem. It is only, as late as 1977, MCI has stated the need for teachers to undergo course in

pedagogy. However, even now this is not mandatory. What is worse is that all the recommendations for community and rural orentation have never included the single most relevant one for change, i.e. reorientation of the medical college faculty. When all of them have littleknowledge/sensitivity or skills to work with people in the community, how is it ever possible to bring about a social orientation in the environment of medical colleges"

A historical analysis of medical education in India right from Vedic period to colonial period and from colonial to the present day situation has been made by Thimmappaya[15] in a lengthy article giving vivid details of each stage which has passed through. This article add a new dimension to the knowledge of present day medical education in the context of its historical evolution. The author also examines the associations and organizations that have helped in shaping the medical education policies to the present day level like IAAME, MCI, IMA etc.

Yet another document by Ramamurthy[16] which appeared in a scientific journal and also in a popular magazine more or less in the same period, also analysed medical education from a historical perspective - its growth in different eras and also a critical evaluation

of the contemporary medical education has been made in the context of the objectives laid down for the medical education in India. "It is seen that amongst the medical profession itself, there is a fair amount of confusion about the aims and objectives of medical education. It will be a great step forward if the medical profession understands what it wants to produce at the end of the undergraduate medical education - a product that would best suit the needs of our country". The author (Ramamurthy) in introspection poses certain questions to the profession of which he is a member and expresses his serious doubts on its competence, credibility and relevance. "It is in this changed atmosphere with the public having creeping doubts about our competence and credibility, that we have today to face the challenges thrown upon by society. The question is - are we facing them boldly and reacting appropriately? or are we losing grip, allowing others to take over?"[17]

SECTION - V

Other Related Articles

One of the papers presented at the conference on Social Aspects on Medical Education in India by Madhavankutty[18] deals with development of new curriculum for delivery of health services in India. Besides it

traces the growth and development of medical education right from independence period and the various changes and modifications effected in the medical education policy in general and teaching curriculum in particular, including suggestions to develop a curriculum keeping in view the system of medical education required for the country. He makes a plea to include more of social sciences input in the curriculum.

The findings of a study conducted by Singh and others[19] in a medical college, to assess the view of the teachers on ROME programme, provided certain cues to the problem studied especially in the area of the perception of teachers and their response to ROME programme. According to the published data, the study revealed that only 36% of the teachers were optimistic about the ROME scheme and only a mere 8% favoured rural area for ROME training while others lingered with the present system. The study revealed a high degree of reluctance from the teachers to move into rural areas and 80% did not agree that the rural education would help in making the knowledge more comprehensive. 72% of the teachers, according to the study, were not keen in staying in villages for more than overnight.

Though the sample consisted of teachers from clinical and P&SM departments who had a minimum of three years experience in a particular medical college, the outcome is not isolated. It only reflects the general outlook of medical teachers demonstrates the difference between the precept and practice.

A vehiment plea was made by Hande[20] for creating a department of general practice. According to him what India needs today is large number of general practitioners and not specialists and super-specialists. He makes a strong plea for a greatest motivation of our young graduates towards general practice. "Any number of specialists, each deeply proficient in small area, cannot produce the needed changes in the face of India's health. On the other hand, well trained highly motivated dedicated general practitioners can be much more effective in this regard. That is why we want a basic doctor to be well versed in the components of P&SM, epidemiology, sociology, psychiatry, ability to diagnose medical, surgical and obstetric emergencies, mother and child care etc."

While suggesting alternatives in rural health care, Satyaprakash[21] has gone too far, and his suggestions undermined the establishment of health care institutions in the peripheral areas. "Numerous studies have shown

that small hospitals, for the same service, are uneconomical and it is better to provide free or cheap transport than to have small ineffectual medical care clinics. It may be remembered that more than medical aid, villagers need roads, schooling, clean water and various other essential amenities. In the absence of these amenities, posting of a doctor in an ill-equipped and inadequate centre will only mean loss of an expert and rendering him ineffective and frustrated"

While endorsing his view that the need for socio-economic development more than establishment of rural health care institutions in the peripheral areas, one might like to pose a question to him, that, should the millions of rural people wait patiently until such time a socio-economic development takes place in the country for meeting their basic health needs? Till then should people die in the villages for want of preventive and curative services? Though overall socio-economic developments should be an ideal or a desired goal, in the given situation in India, the same may not materialise in the immediate future due to many socio-political reasons. The villagers need something to fall back upon at least as crumbs in the form of a net work of primary health centres and sub-centres till then. One might accept his criticism that the conditions

of such institutions in the rural areas are far from satisfactory and as such they are under-utilised to a large extent.

In an article by Anand[22] exclusively on the newer born discipline, i.e. Department of P&SM and its role in orienting medical education to the needs of the country, he examines the development of the department in retrospect and analyses its objectives and the image it portraits to student community and also to the rest of the medical fraternity. The author (Anand) rightly concludes that the department even after its existence of 30 years, it looks as though its gestation period is not yet over.

A pertinent issue of primary health care and the role of medical college has been raised by Ramesher[23] who examines the medical technology of today in the context of principle laid down in the delivery of primary health care. A detailed analysis of the role, structure, function of P&SM department has also brought within the purview of analysis. He emphasizes inter-disciplinary and holistic approach in the problem of medical education facing today. To him the answer lies not in medical sciences but in the social sciences.

The deficiencies of the medical curriculum has been well discussed by Raghava Prasad[24] and the areas of lacunae are identified and he has presented a well thought out and a scientifically drawn syllabus giving the importance to social sciences.

The two articles on the experience of ROME programme in their respective colleges, Narasimhan and Agarwal[25,26] provide an insight into the problems faced during its actual implementation in these colleges. Both of them studied the role of PHC which occupies a central position in the ROME scheme. They have brought out the problem areas of the scheme, especially in terms of its logistics and administration of the programme. They point out the major hurdle in the implementation of ROME is that the PHCs are directly under the State and District health authorities and as such medical colleges or even the Directorate of Medical Education have no administrative control over them, which in turn has resulted in providing parallel services in the villagers by medical colleges as well as the PHCs.

Health services of a country and system of medical education are always inter-woven and the latter decides the quality of the former. To that extent the analysis of health service system in India : an expression

of socio-economic inequalities provides a valuable insight to the crux of the problem. Qadeer[27] makes a distinction between health and health service system in the very beginning and also critically examines the definition of health propounded by World Health Organization, besides making a comparison of medicine in Western and socialist countries. The inequalities within the system are identified and its distinct characteristics are enumerated. Though she makes only a passing reference to the system of medical education in our country, the analysis on the health service system in India is quite extensive.

Prabha Ramalingaswami's studies on medical education[28,29] examines certain vital issues on medical education. The study on the image of P&SM reveals that the speciality of P&SM does not enjoy an important place in student's preference. She identifies certain factors responsible for the un-popularity of the discipline of P&SM, like unattractive curriculum, the low status of the P&SM teachers in the medical set up and lack of monetary ratio and lack of practice etc.

"Rural training should be a well-planned, well coordinated and well supervised programmes to make this training useful to the students. The prevailing rural

training programme in most of the colleges leave much to be desired. The students do not develop a sense of commitment under these circumstances. The existing rural training programme in most of the colleges do not give the slightest suggestion of professional and academic growth for an young intern", she remarks.

Before concluding this section, we would also make an attempt to review draft plan of National Medical Education Policy which was circulated by the Ministry of Health & Family Welfare at the time of National Conference on "Medical and Health Education" organised at All India Institute of Medical Sciences (AIIMS), New Delhi, from 27th to 30th August, 1979[30]. According to draft document, the twin objectives of the national education policy are : the development of the basic knowledge and the other is the development of medical and allied manpower to provide the services. The document states that earlier attempts to develop an integrated system of medicine were not successful. Further, because of the fact that in the medical field both the public and the private sectors have been jointly operating, there has been inadequate manpower planning.

It focuss our attention on the fact that in the field of medical education, there has been a cultural dichotomy, coupled with parallel development of the various

systems of medicine. The modern medical system has, to a large extent, kept pace with the developments in the rest of the world. However, the type of education imparted, particularly at the undergraduate level, is heavily hospital oriented and has very little relevance to actual Indian situations. This makes a fresh graduate unsuitable to handle situations in the community and unable to appreciate the problem and dilemmas at that level. The indigenous (traditional) systems of medicine like Ayurveda, Unani, Siddha, Yoga, Neuropathy and Homeopathy, have after years of comparative neglect, started coming into their own. While there need be no attempt to forcibly integrate the modern medicine with the traditional systems of medicine, it is essential from the point of view of optimal utilization of national resources that each system should realise in the Indian conditions the limits as well as potentials of the other systems and draw inspiration from them. All the systems should support each other mutually.

The National Medical Education Policy seek to achieve the following : Quantitative and qualitative development of adequate trained health personnel of all categories; Development of programmes of training for different categories of health personnel; Development

of agencies for implementation of the educational programmes; Organization of an appropriate structure in order to bring about necessary modification in education depending upon the changing national needs; Development of a proper and adequate evaluation system for health professionals and health programmes.

There has to be a balance development of graduates and specialists of medicine (of all systems) as also of other health personnel like Dentists, Nurses, Technicians, Health Workers, Health Supervisors etc.

The draft plan also envisages the establishment of the Medical and Health Education Commission and compulsory rural service in an effort to spatially distribute medical and health personnel so as to provide suitable health coverage in rural areas. The document also calls for the need for continuing education.

Though the document is brief and inspite of the sweeping statements made, there was no concreate efforts to implement these ideals in practical terms even after 7 years after the documents was first circulated. The fate of the document itself is not known as to whether this Draft plan has been put into cold-storage , will all these ideals will ever take shape by actual implementation?

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CHAPTER - III

DESIGN OF THE STUDY
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RESEARCH METHEDOLOGY

CHAPTER - III

DESIGN OF THE STUDY

SECTION - I

A. Need for the Study

The type of Medical Education chosen in a country decides the quality of the health services in the sense that the former moulds medical personnel, required for the latter. In any problem oriented research a holistic approach is necessary and medical education is no exception. Though a number of studies have been carried out on Medical Education in general, only a very few studies have been undertaken in the area of re-orientation of medical education.

Despite the fact that the scheme of ROME was implemented as early as 1977, no comprehensive study was conducted till now to assess and evaluate the perception and the response of the parties concerned, i.e. the providers as well as the beneficiaries. Though the programme has been implemented for over nine years in 106 medical colleges in the country, at an enormous cost of several hundred crores of rupees its cost effectiveness and cost benefit is yet to be assessed. What required was epidemiological approach. Though some individual preventive & social medicine departments conducted a few evaluative studies for assessing their own programme of ROME in their college, no major multi-lateral study

covering a large sample was undertaken earlier. Hence there was an urgent need for such a study of ROME from a sociological perspective.

To realise the social objectives of the medical education, the Government created an upgraded department of P&SM in all the medical colleges in India, as early as 1955[1]. However, this department, for many reasons, could not fulfil this task satisfactorily and hence another attempt of giving relevance to the medical education was conceptualised in the scheme of ROME. It was the firm belief of the planners that the scheme of ROME would bring about an attitudinal change among the students and their teachers and it would cure many of the maladies of contemporary medical education, apart from extending the provision of health coverage in the peripheral areas. Hence it was imperative that the implementation of the scheme be brought for a comprehensive sociological study.

B. Objectives and Research Issues

Following the conceptual frame work that we have formulated in the preceeding chapters, the broad objective of the study is derived. That is to :

> examine whether the scheme of reorientation of medical education was successful in giving community orientation to the undergraduates and their teachers in providing health coverage to the rural communities

With this objectives in mind, an attempt is being made to study the following aspects :

1. To study as to what extent these medical colleges were able to implement the different components of the ROME programme ;

2. To evaluate whether they were able to achieve the objectives of ROME programme as envisaged, during the last nine years of its existence, i.e. orientation of medical students, interns and their teachers; the health coverage of the population in three development blocks; development of a sound referral system from the peripherry to the teaching hospital; in integration with PHC, Taluka and district hospitals; provision of specialists services at the peripheral areas etc.;

3. To study the perception and views of the students, teaching faculty; the Medical Officers (MOs) of the PHC and the community and their response to the programme ;

4. To examine the degree of involvement of the students, the faculty and the community and their participation in and response to the programme ;

5. To analyse the financial and other resources available to the institution in implementing the scheme ;

6. To identify the short-comings, areas of lacunae and problems faced by the colleges in implementing the scheme with regard to its conceptual, infrastructural, personnel, logistic, administrative and other problems, and to make suggestions to the concerned authorities based on the findings of the study.

SECTION - II

Data Collection

A. Type of data required for the study

Considering the major objectives of this study, it is necessary to collect wide-ranging information on the different aspects of the scheme and from different categories of respondents. The following data at objective and subjective levels are collected for this purpose :

(a) The socio-economic profile of the students ;

(b) The time allotted in the students' teaching curriculum for ROME programme and the actual period of exposure ;

(c) The type of service provided to the rural community ;

(d) The level and degree of teacher's involvement in the programme ;

(e) The involvement of clinical, para-clinical and pre-clinical departments other than P&SM in the programmes ;

(f) the reactions views and response of the students, interns and community on different aspects to this programme.

B. Methods of Data Collection

Considering the complexity and the inter-disciplinary nature of the problem, a variety of methods are employed to tap the fata. Research tools such as bibliographical studies, informal group interviews, discussions, case studies, observations, questionnaires and different types of interview schedule have been formulated for different categories of respondents.

1. Bibliographical studies : This includes :

(a) Published data from Government departments, viz. Ministry of Health & Family Welfare, Directorate General of Health Services and State Directorate of Medical Education on various aspects of ROME scheme ;

(b) Published study reports on the scheme by medical colleges and P&SM departments on various aspects of ROME scheme ;

(c) Articles published in the IJME on this subject.

2. Informal Group interviews & discussions

In order to get qualitative data regarding the effectiveness and impact of the scheme, informal group

interviews were conducted with some key informants such as informal leaders of the village belonging to all sections, school teachers, the undergraduate students, interns and doctors of the PHC. Informal group interviews and discussion yielded much more reliable data than the one obtained by questionnaire and interview schedules, especially regarding the community perception, their reactions and response to the programme. Informal group discussions also helped in identifying lacunae and problem areas in the effective implementation of the scheme.

3. Case Studies

For Social Scientists, especially for Sociologists, the case study method is a valuable technique for an inter-disciplinary social sciences research like this. On certain aspects of the problem studied, data has been collected by employing this method, especially from students, interns and PHC doctors.

4. Observational Method

The actual programme implementation at various medical colleges has been observed from close quarters as the researcher lived in the actual setting for a considerable period. The researcher also participated in some of the activities in the village along with the faculty from the

medical college such as the organisation of Mobile Clinics and specialist camps, immunization programmes, Health Education activities, conducting social surveys etc. These observations were recorded in a field diary.

5. Questionnaire

A detailed questionnaire was formulated covering the following aspects for administering the undergraduates and interns :

(a) General socio-economic profile of the undergraduate students ;

(b) The students involvement in the programme ;

(c) Their teachers' response to the scheme ;

(d) Their views on different aspects of ROME scheme, compulsory rural internship, compulsory rural service and also their orientation in future rural careers.

Many of the questions of the questionnaire are of the open-ended type, so as to enhance the reliability and validity of the data to be obtained.

6. Interview schedules

Four different types of interview schedules were formulated for purpose of administering to different categories of the respondents viz, the doctors of the PHC, clinical and P&SM teaching faculty, officials of Directorate

of Medical Education in Karnataka and Delhi and the members of the community.

C. Sample and Sampling

A sample of four medical colleges situated in four different districts were selected for this study out of the nine medical colleges where ROME programme has been implemented in the State of Karnataka.[2] The criteria for selection of the medical colleges were : two medical colleges in the private sector and two medical colleges run by the Government. The geographical distribution of the medical colleges were : one in the State Capital (Bangalore), the second medical college at a district headquarters (Belgaum), third one situated near a Municipal Town (Hubli) and the fourth one in a predominantly rural area (Davangare). At all the four medical colleges, there were facilities for postgraduate studies in most of the disciplines. While Government owned medical colleges selected students on the basis of merit, the other two private medical colleges admitted predominantly students on the basis of capitation fee paid, baring certain percentage of seats reserved for the Government merit pool. The four medical colleges selected were also affiliated to three different Universities.

The respondants selected for this study were (Table 9 & 10) :

(i) Final MBBS students of this four medical colleges;

(ii) The clinical and P&SM teaching faculty who were actually involved in implementing the programme;

(iii) The interns/house surgeons doing their 3 months[3] rural internship ;

(iv) The MOs of the 3 PHCs allotted to each of the medical colleges ;

(v) Community members as informal groups and

(vi) The Deputy Director and Director of Medical Education in the State and the Director In-Charge of the Medical Education Wing of the Directorate General of Health Services (DGHS), New Delhi.

Besides, the Principals of these colleges, were also interviewed at the end of the study in each of these medical colleges for the purpose of obtaining certain clafifications and his own view as a medical teacher. The selection of the respondents were based on the following criteria :

1. Medical Students

The entire medical students of the final year MBBS class were selected for the study. The questionnaire specifically formulated (Appendix 1) for them were administered in their class rooms and the absentees were followed up in the next three consecutive classes and remaining absentees who

TABLE - 9

SIZE OF THE SAMPLE

1.	Final year MBBS students	392
2.	Interns	90
3.	Medical Officers of the PHC	28
4.	Clinical Teachers	33
5.	PGSM Teachers	15
6.	Community Members/Groups	102

TABLE - 10

PROFILE OF THE SAMPLE

(Medical College-wise)

	BMC	JJMMC	KMC	JNMC	Total
1. No. of Final MBBS students covered	110	80	91	111	392
2. No. of Interns (Doing rural posting)	45	29	13	7	94
3. Clinical Teachers	7	12	4	10	33
4. P&SM Teachers	6	5	2	2	15
5. Medical Officers of the PHC	8	6	8	6	28
6. Community members/Groups	35	40	16	11	102

BMC - Bangalore Medical College (Government)
JJMMC - J.J.M. Medical College, Davangere (Private)
KMC - Karnataka Medical College, Hubli (Government)
JNMC - J.N. Medical College, Belgaum (Private)

were considered as habitual absentees and hence could not be covered.

2. Interns

This group of the sample constituted those who are presently doing their rural posting in different PHCs allotted to the medical colleges, and we have ensured a fair mix in the sample of interns of various stages of the training, i.e. beginners as well as those who were about to complete their rural training.

3. Medical Officers of the Primary Health Centres

Medical Officers of all the 12 PHCs allotted to these four medical colleges were also constituted as respondents under this category.

4. Teaching faculty of P&SM and Clinical Departments

While selecting respondents from thisgroup, care has been taken to include more of those who have been exposed to the programme and have been actively involved in its implementation. However, a small percentage of teaching faculty who have not been exposed were also interviewed to elicite their views on ROME programme.

5. Officials of the Directorate of Medical Education

From this category the top executives of the Directorate of Medical Education were included, i.e. the Director and Deputy Director of Medical Education from the State and the Director In-Charge of Medical Education at Directorate General of Health Services (DGHS), New Delhi. Also included in this category was the ROME Workshop Director at DGHS, New Delhi.

6. Members of the Community

Members of the rural community adopted by these medical colleges and who constitute the largest single beneficiary of the programme were covered by means of informal group interviews in selected villages, especially in their field practice areas of these medical colleges. This group consists of village leaders, school teachers, users and non-users of the services belonging to different caste/class groups.

SECTION - III

The Study

The study was conducted in two phases, the pilot study and the final study.

A. Pilot Study

Pilot study was conducted at the Bangalore Medical College during September-October, 1985. During

the pilot study, the questionnaire and interview schedules were pre-tested on a sample at Bangalore Medical College. The operational questions were identified and retained in the schedule after making necessary addition, alteration and modifications. It was realised that the questionnaire devised for the undergraduates may not be relevant if the students have not been exposed to ROME programme as prescribed by the MCI. They will not be able to comment upon the different aspects of the scheme or the suitability of Medules in rendering rural health services unless they are familiar with its equipments and facilities provided in it. Again the interview schedule formulated for interviewing the members of the community was found to be inappropriate as the majority of the patients who availed the services provided at the Mobile Clinic were women and children and they were not able to comment upon the quality of drugs or to identify the different types of medical personnel visiting their villages or the system of referrals under ROME scheme. Hence, this category of sample was modified to include villagers as groups (from different cast and class groups) andinformal group interviews were thought as a more appropriate devise toelicite their views on ROME programme.

B. <u>The Main Study</u>

The main study consists of administration of questionnaire and different interview schedules to various categories of the respondents in the four sample medical

colleges in Karnataka. Apart from this, other data collection techniques mentioned earlier are also used side by side. The researcher himself recorded the responses, baring the responses to the questionnaire, either at the time of the interview or immediately after the interview.

C. Procedure followed

In the case of medical students and interns, almost the entire group envisaged under the study could be covered, whereas in the case of teaching faculty, the sample was very selective so as to include the teachers who were actively involved in the programme. This is done on the assumption that only those who have been regularly attending the programme, will only be able to give a good feed-back as to the efficacy of the programme, the lacunae and problems faced at various stages and levels. Though it was planned to include only medical officers of the PHCs the investigator could collect data from a few MOS of the Primary Health Units (PHUs) who were involved in ROME programme. Informal groups interviews were conducted with elders of the villages and also with formal and informal leaders belonging to both caste and class groups. An indepth case study of certain PHCs/ villages, undergraduate students/interns and PHC doctors were conducted from a sociological perspective, whereby the social science input to the study has been enhanced.

D. Rationale behind the questionnaire and interview schedules

A questionnaire was thought ideal for obtaining responses from the undergraduate students and interns, since this can be administered to them as a group in a class room. Since the number of medical students to be covered for this study was quite large, no other tools would be suitable other than the questionnaire. While framing the questionnaire, care has been taken to elicite a comprehensive view from the undergraduates not only on medical education, but also about health services in general and individual faculty members, perception and response to rural programmes. Before administering the questionnaire the purpose of the study was explained to them. Since they are the beneficiaries of the programme, it was thought necessary to give due importance to the students' views and to provide them a chance to come out with their ideas on this scheme. They were encouraged to ask questions if they had any clarifications to seek. It is only after the students said they were ready toanswer the questions, this was administered. This helped in establishing rapport with the students and ensured the quality of the responses.

The interview schedules were formulated in such a way that it cross-checks the views expressed by other categories. The MOs of the PHCs were asked not only about ROME scheme but also about their living conditions and the

practical, administrative and other problems they faced in the rural situations. Wherever found necessary, additional data has been obtained from all the categories by probing questions and also by interviewing the Principals of medical colleges.

E. Field of Study

This study was conducted in four selected medical colleges of Karnataka State. Karnataka has the dubious distinction of having the largest number of medical colleges in the country, with majority of them in the private sector based on capitation.

The study was conducted during the period between September 1985 and February 1986 in two Government medical colleges and two private medical colleges in Karnataka State where the scheme of ROM[E] has been implemented[4]. The medical colleges selected were :

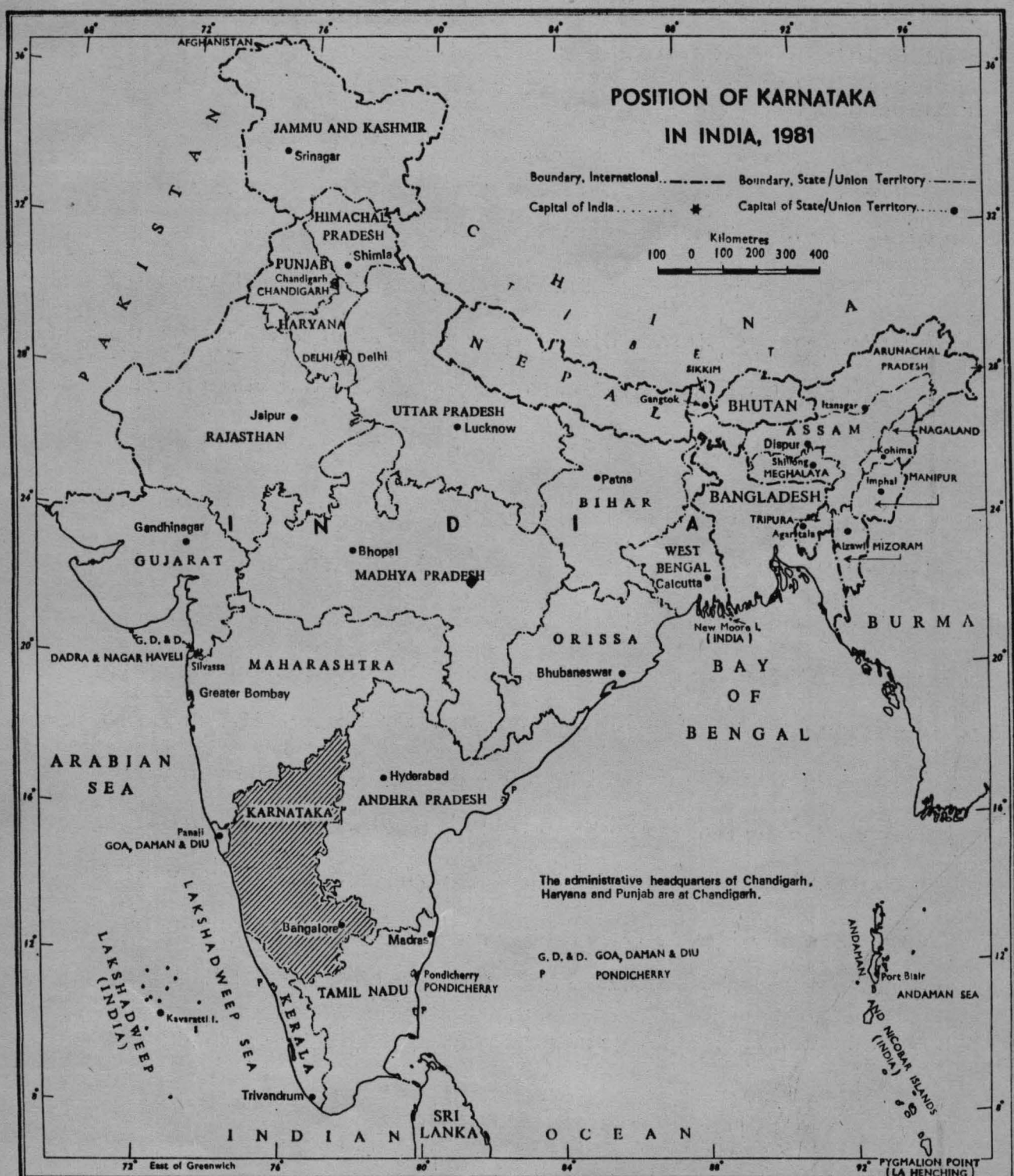
1. The Government Medical College, Bangalore (BMC)
2. The Government Medical College (Karnataka Medical College, Hubli (KMC)
3. J.J.M. Medical College, Davangare (JJMMC) (Private)
4. J.N. Medical College, Belgaum (JNMC), (Private)

F. Location

The prime consideration for selecting Karnataka as a field area was basically due to the fact that the State has largest number of medical colleges in the country and could be considered as leaders in medical education in that respect.

Here, out of the 19 medical colleges, only nine are recognised by the MCI. Hence, the re-orientation of medical education programme was officially implemented only in these nine medical colleges - four Government medical colleges of Bangalore, Mysore, Bellary and Hubli and 5 private medical colleges - St. John's Medical College, Bangalore; J.J.M. Medical College, Davangare; J.N. Medical College, Belgaum; Kasturba Medical College, Manipal; and Mangalore and M.R. Medical College, Gulbarga[5].

The sample chosen, i.e. the medical colleges were selected taking into account the nature of institution (undergraduate and postgraduate with or without education of other health profession) ownership (State and Private), size, admission criteria (merit and capitation), geographical locations (State capital/metropolis) district headquarters/town, tehsil or rural area. The four medical colleges selected are situated in four different districts (Bangalore, Dharwad, Chitradurga and Belgaum (Map 3 and Table-2) and they are affiliated to three different Universities (Bangalore, Mysore and Karnataka University, Dharwad).



Based upon Survey of India map with the permission of the Surveyor General of India.

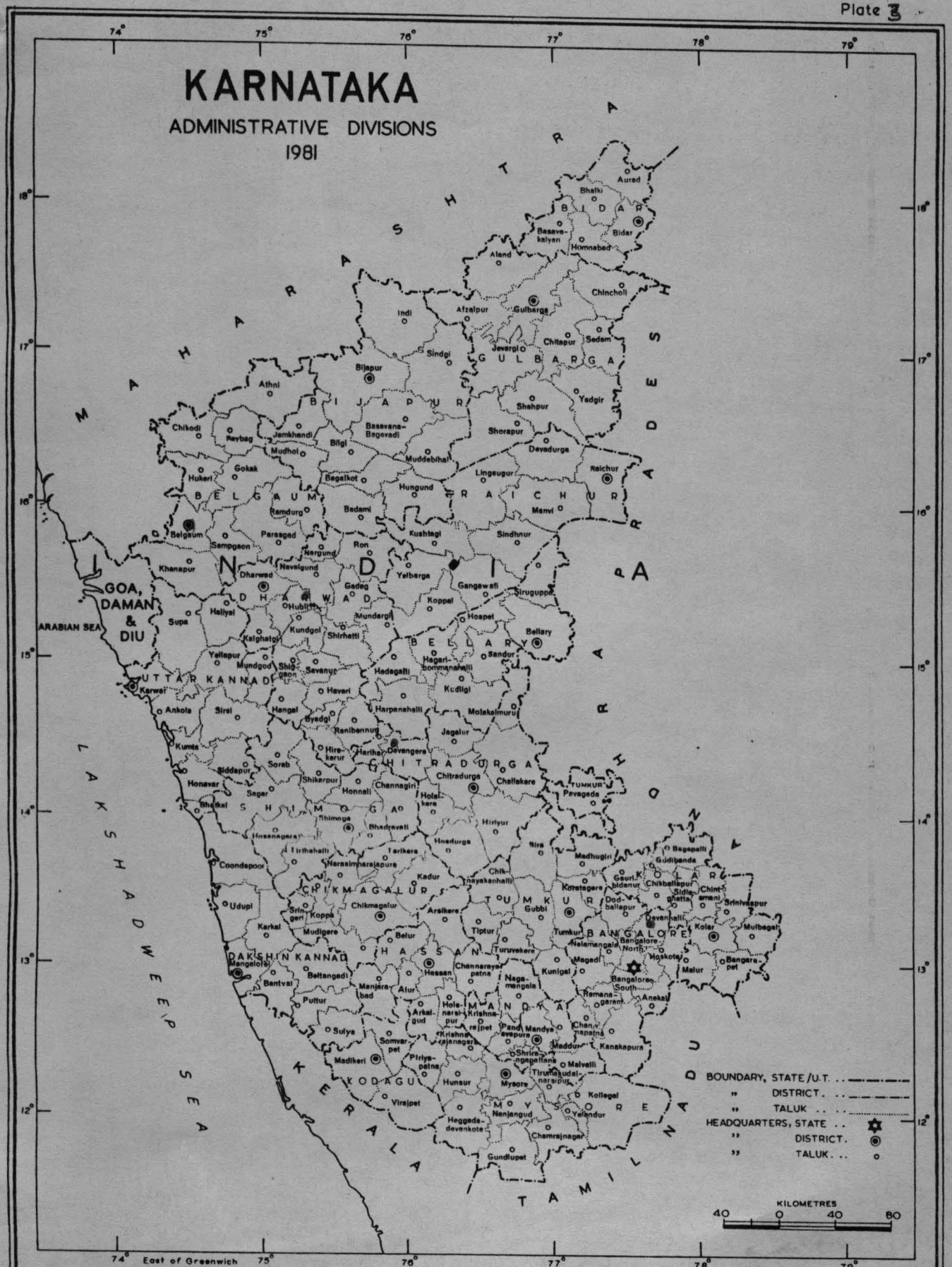
The boundary of Meghalaya shown on this map is as interpreted from the North-Eastern Areas (Reorganisation) Act, 1971, but has yet to be verified.

The territorial waters of India extend into the sea to a distance of twelve nautical miles measured from the appropriate

Map - 2 : Map of India - indicating the position of Karnataka State

Map - 3 : ● indicating location of sample medical colleges studied

Plate 3



Based upon Survey of India map with the permission of the Surveyor General of India.

The territorial waters of India extend into the sea to a distance of twelve nautical miles measured from the appropriate base line.

Table 7

Population and Literary Profile of the Sample Districts

STATE/DISTRICT	Total Rural Urban	Total Population			Literate and Educated Persons		
		Persons	Males	Females	Persons	Males	Females
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
BANGALORE DISTRICT	T	4,947,610	2,582,539	2,365,071	2,539,251	1,540,254	998,997
	R	1,754,394	900,579	853,815	552,645	384,575	168,070
	U	3,193,216	1,681,960	1,511,256	1,986,606	1,155,679	830,927
BELGAUM DISTRICT	T	2,980,440	1,523,311	1,457,129	1,092,059	741,130	350,929
	R	2,309,022	1,175,142	1,133,880	712,624	508,775	203,849
	U	671,418	348,169	323,249	379,435	232,355	147,080
CHITRADURGA DISTRICT	T	1,777,499	914,214	836,285	679,827	445,944	233,883
	R	1,359,756	694,778	664,978	445,218	304,613	140,605
	U	417,743	219,436	198,307	234,609	141,331	93,278
DHARWAD DISTRICT	T	2,945,487	1,511,688	1,433,799	1,247,691	819,967	427,724
	R	1,907,229	973,470	933,759	698,313	482,445	215,868
	U	1,038,258	538,218	500,040	549,378	337,522	211,856
KARNATAKA STATE	T	37,135,714	18,922,627	18,213,087	14,282,717	9,236,276	5,046,441
	R	26,406,108	13,352,400	13,053,708	8,197,913	5,616,633	2,581,280
	U	10,729,606	5,570,227	5,159,379	6,084,804	3,619,643	2,465,161

Source : Census of India-1981, Series-9, Paper 1 of 1983, page-6, Table 5.

SECTION - IV

A. The Karnataka Scene

The State of Karnataka apart from its rich cultural heritage, presents certain unique features. Though the State cannot claim the high literacy rate like one of her neighbours (Kerala), Karnataka can take (a false) pride in the number of medical, engineering, pharmacy, dental and teachers' training colleges, which is highest in terms of number in any Indian State. Till early January 1986, the total number of medical colleges sanctioned in the State stood at 19 and out of this, 15 medical colleges are in the private sector. Out of the 15 private medical colleges, 14 medical colleges are capitation fee-based (the capitation fees sometimes as high as six lakhs, though the Government has permitted private managements to receive only Rs.60,000 from Karnataka students and Rs.3.25 lakhs from non-Karnataka students.)

However, there was a general feeling that the standard of medical education has been diluted over the years in this State due to the mushrooming of the capitation based medical colleges.

The capitation fee menace has its origin in Karnataka. Way back in 1953, one could wangle a seat in a medical college for Rs.300/-. The demand for such seats

grew over the years and the State and politicians patronised several more such institutions.

In the history of medical education, if one goes back to the ~~recent~~ recent past, one will realise that Karnataka played the role of a villain, during 1974 when, due to the inadequate teaching, training and laboratory facilities in six medical colleges (including two Government medical colleges), the MCI de-recognised these colleges. As a consequence, the General Medical Council of Great Britain, de-recognised all Indian medical qualifications and the MCI retaliated by a reciprocal action.

Though prompt political pressure brought back the recognition, the colleges had to reduce its intake of undergraduate students drastically and to improve the clinical, laboratory and teaching facilities in part with the recommendations of the MCI.

B. <u>The Administrationof ROME programme in Karnataka</u>

The ROME scheme commences in the State when the Government by its special order allotted three PHCs to each of the four Government medical colleges and five private medical colleges in 1977, and in the second stage three mobile clinics were allotted to these medical colleges during 1980-81[6].

The scheme is a centrally sponsored one with a 50:50 basis between State and Central Government. The State authorities are supposed to provide expenditure of recurring nature for provision of additional faculty, drivers, steno-typist, drugs, POL, contingency etc.[7]

As per the initial pattern of central assistance, each medical college is eligible for one-time non-recurring grant-in-aid of Rs.4.79 lakhs for covering three development blocks under Phase I of the scheme[8]. Government of India's revised pattern[9] provided additional financial assistance to the tune of 9.60 lakhs to each of these medical colleges, i.e. 3.20 lakhs per PHC for covering additional structural costs, Rs.75,000 for procurring a Mini Bus, Rs.90,000 for the construction of three garrages for the Mobile Clinics. In all, additional financiel assistance of Rs.11.25 lakhs have been provided by the Centre during 1981-82. However, the amount released by the Government of Karnataka was in a different pattern.

In 1978-79 the Government of India released Rs.41.11 lakhs as central assistance for ROME programme and the Government of Karnataka released to each of the medical colleges a sum of Rs.1,25,000/- from the central assistance, towards construction of residential quarters (dormitory type for lady students) and Rs.30,000/- for

construction of seminar and lecture rooms etc. Further, Rs.45,000/- was ear-marked for addition to the faculty and Rs.18,500/- towards salary of Steno-typist and driver. additional recurring expenditure was provided for drugs, surgical equipments etc. to the tune of Rs.60,000/-. Under the non-recurring head, Rs.50,000/- was initially ear-marked for procuring a Mini Bus and Rs.45,000/- for making suitable alterations and additions to the PHC operation theatre and wards. A separate budget of Rs.54,000/- was made available for procuring furnitures and at least 100 books and other educational aids. Thus a total of Rs.4,97,500/- was allotted in the first phase of the programme to all medical colleges in the state, i.e. Rs.1,47,500/- per PHC[10]. However, this was later on revised and more funds were provided to meet the escalation of the cost under different heads. Under the new budget each medical college has been provided Rs.16.04 lakhs under recurring and non-recurring heads, which included Rs.75,000/- for procuring a Mini Bus for the purpose of transportation of the students and teaching faculty from medical college to PHC for conducting ROME programme. In the revised budget a sum of Rs.60,000/- has been made available for purchase of surgical equipments and instruments and Rs.5,000/- for purchase of necessary furniture and books. A sum of Rs.40,000/- has been ear-marked for addition to the faculty which included 4 drivers,

4 cleaner-cum-peons, 3 cooks and helpers, one Steno-typist besides addition to the P&SM faculty[11].

Though ROME scheme is a centrally sponsored scheme, the onus of implementation of the scheme rests with the concerned State Governments/UTs. All recurring and non-recurring expenditure over and above the central grant-in-aid for the scheme in the liability of the concerned State/UTs[12].

The Government constituted various coordination committees at the State, College and PHC level for both Government and private medical colleges for implementing ROME programme[13] and also decided that the MOs of the PHCs allotted for ROME programme will be designated as Honorary Lecturer in Community Medicine and the District Health & Family Welfare Officer (DHO) will be designated as Honorary Additional Professor in P&SM [14].

According to the decision taken in the meeting in which the Ministry of Health, the Officials of the Directorate of the Medical Education, the Deans/Principals of the medical colleges took part, the following conditions were laid down[15] apart from the conditions in the agreement entered into between Director of Medical Education and MCI[16] : POL charges to be borne by the management of the colleges; They have to attend to any repairs and replacements

at their cost; They have to maintain and keep the vehicle in road-worthy condition; Vehicles may be withdrawn by the Government any time if found necessary; The college managements shall pay the taxes, if any, due on the vehicle as well as the insurance which shall be comprehensive and keep the tax and insurance payments upto-date; A monthly report on its utilization and condition shall be sent to the DGHS and State Director of Medical Education by 10th of each month.

SECTION - V

PROFILE OF THE MEDICAL COLLEGES STUDIED

A. Bangalore Medical College (BMC)

The BMC was started in the year 1955 by a private organization, namely, the Mysore Medical Educational Society founded in 1954. It was taken over by the Government of Mysore[17] in 1957. The college was affiliated to the University of Mysore till November 1964. After the inception of Bangalore University, this medical college has been affiliated to Bangalore University.

The college has steadily grown in strength in terms of admission, staff, equipment and physical facilities. The intake capacity was initially 100 undergraduate students, which has grown later to 225 with postgraduate training

facilities in major pre-clinical, para-clinical and clinical disciplines. The intake was reduced to 175 after the MCI de-recognisation in 1974. The non-clinical departments are located in the college premises while the clinical ones are the four teaching hospitals, i.e. Victoria Hospital, Vani Vilas Women & Children Hospital and Minto Ophthalmic Hospitals in the adjacent campus and the Bowring & Lady Curzon Hospital situated in the Cantonment area. There are full fledged departments in all the major subjects and specialities.

The ROME scheme has been implemented since 1977 in this medical college. Prior to the implementation of ROME scheme, the college has taken up the Chittaranjan Multi-purpose Mobile-cum-service Hospital in the early 1970s and it is still continuing. Under the ROME scheme, the Government has allotted two more PHCs, namely, the PHC at Hesserghatta and the PHC at Kaduguntanahalli (K.G. Halli) besides their existing Rural Health Training Centre (RHTC) at Nelamangala on the Tumkur Road.

The three months rural internship training as per the Bangalore University syllabus is still practiced at these three PHCs in rotation for one month each.

Rural Health Training Centre at Nelamangala

This was the second rural health centre established by the BMC and developed as their field practice area for the purpose of providing rural training of undergraduates, para-medicals and auxiliary health personnels. The first being the PHC at Ramanagara which later on developed into Taluka hospital. The centre is situated about 24 kms away from Bangalore on the Tumkur Road (Bangalore-Pune National Highway).

The RHTC at Nelamangala has a 30 bed hospital and 5 medical officers (1 medical officer with postgraduate qualification exclusively for rural health training, 1 Medical Officer of Health (Administration), one Lady Medical Officer (LMO), one Medical Officer under Community Health Volunteer Scheme (CHV) and one dental surgeon are posted to this centre. The RHTC has hostels meant for boys and girls separately and another dormitory constructed under the ROME scheme. The college bus from BMC visits this centre twice a week with teaching faculty from clinical and P&SM departments and they make their onward trip from Nelamangala to a sub-centre village in the Mobile Clinic along with interns from the centre. Interns doing their three months rural posting spend their first month in Nelamangala and then move to Hesserghatta and at the 3rd month they are posted to K.G. Halli PHC.

The Mobile Clinic visits this centre twice a week and the modus operandi of the rural health service is to concentrate in a village for a month giving curative services and then move to another village in the second month. The RHTC at Nelamangala is directly under the administrative control of the Principal and Professor of P&SM department unlike the other two PHCs, which are directly under the District Health & Family Planning Officer (DHO) and the college has no administration control over these PHCs.

Hesserghatta PHC

This PHC is situated about 20 kms away from BMC on a deviation from Bangalore-Tumkur Road and in proximity to the Indo-Danish farm and Government of India's Institute of Horticultural Sciences. The PHC has three MOs sanctioned and at the time of the study, one post of MO sanctioned under Community Health Volunteers' scheme was found vacant. Though dormitory and garrages under ROME scheme had been completed these have not yet been handed over to the college/PHC authorities. Hence the interns doing their second month of rural posting commute every day from the City to the PHC. The clinical faculty from BMC visits the village twice a week in their college bus and from the PHC headquarters they go to interior

villagesin the Mobile Clinic. Here also the services are given to a village only for a period of one month.

Kaduguntanahalli PHC

This is the third PHC allotted under ROME programme to BMC, which is situated about 15 kms away from the college on the Tannery Road. Interns are posted for one month during their third month of rural posting. The mobile clinic operation is same as mentioned under other two PHCs. The dormitories and garrages under ROME scheme has not been completed. Hence the interns commute every day.

B. Karnataka Medical College, Hubli (KMC)

The KMC, Hubli, in Dharwad district was started in 1957, by the Government of Karnataka. The Government of India contributed a sum of Rs.1.50 crores towards the establishment of this College and a 600 bedded hospital. Consequently the MBBS course was started in 1960. The college has made steady progress since then and now it admits about 175 students and they have the facilities for postgraduation in most of the disciplines. The medical college is affiliated to Karnataka University, Dharwad.[18]

KMC has got a very good campus with its teaching block, college, hospital, O.P.D. block, hostels and staff residential block - all situated in one of the best laid out

campus in the State. Hubli-Dharwad are twin cities and the district headquarters is situated at Dharwad which is about 10 kms away from Hubli. KMC is situated about 4 kms away from Hubli Railway Station and480 km away from Bangalore.

ROME Programme

For the training of interns, one of the PHCs was developed into a Rural Health Training Centre (RHTC) - Kalghattgi, which since then has become their field practice area. Though ROME programme was implemented in 1977, and the PHCs of Kalghattgi, Alnawar and Kundogol, were allotted to KMC, the ROME programme has almost been abandoned since 1981, as the Government failed to provide adequate transport facilities for the teaching faculty and the students to go to the rural areas. The college bus has gone out of order during 1981, and has been condemned and surrendered to the Director of Medical Education in Bangalore. The college does not have any other vehicle except a 14 year old universal Jeep supplied by the UNICEF. The three Mobile Clinics given under ROME programme have been handed over to the concerned PHCs to operate it in their respective areas.

Internship Training

As against the three months rural internship programme in different Universities/Medical Colleges in

Karnataka, the interns of KMC are posted for only one month to the RSTC at Kalghattgi. The remaining two months they are rotated, 15 days at the postpartum centre (PPC) and 15 days at the Epidemiological Unit, where they assist the P&SM faculty in immunizing children with triple antigen and oral polio vaccine. Remaining one month they are posted to the Forensic Department to familiarise themselves with post-mortem procedures. This constitutes the three months rural internship of KMC.

Kalghattgi RHTC

Kalghattgi RHTC is situated 35 kms away from KMC on a little deviation from the Bangalore-Pune highway. PHC has got a good building including the facility of a telephone. There are four posts of MOs (MOH - 1; CHV MO - 1; LMO - 1 and additional MO for rural training - 1).

The dormitory and the garrage constructed under ROME programme have been handed over to the college/PHC authorities and the interns have occupied them. Interns assist the MOS in the routine OPD work in the PHC and apart from that they are not involved in any way in ROME programme as no specialists or faculty from P&SM visit this centre. Besides, the Mobile Clinic given to this PHC has gone out of order since over an year. According to the MO, they used to operate Mobile Clinics to three villages on alternate days with the MOs and staff of PHC along with the interns posted there.

Alnawar PHC

Alnawar PHC is almost 65 kms away from KMC on the Bangalore-Pune highway on its deviation to Panaji. Alnawar is a Municipal Town and also a railway junction on the Bangalore-Pune metre gauge to Dandeli and Panaji. The PHC is situated on a hill top on the side of a small river. All around Alnawar are the reserved forests and timber is the major industry and activity in this area. The total population of Alnawar is around 67,500 and there are four MOs posted to this PHC.(1 Administrative MO, 1 LMO, 1 under the CHV scheme and 1 under ICDS scheme). Two of the MOs are provided with residential quarters in the PHC campus and others commute from Dharwad every day.

The dormitory and garrages under ROME programme are ready to be handed over to the PHC authorities. The Mobile Clinic given to the PHC is used to visit certain sub-centre villages once in a week by the PHC staff during the afternoon hours.

Kundugol PHC

Kundugol is the third PHC allotted to KMC for implementing ROME scheme. This PHC is about 24 kms away from KMC on a 15 kms deviation from the Bangalore-Pune highway.

There are three MOs posted to this PHC and two of them have got postgraduate qualifications. Though quarters have been provided to all of them, only one MO lives in the campus due to the fact that the area where PHC is situated is one of the drought-hit areas of Karnataka and there is an acute shortage for drinking water. Though many bore-wells have been sunk (including two in the PHC campus) it was not successful. Due to this reason, although the dormitory and garrages under ROME scheme are completed the interns are not posted to this PHC. The Mobile Clinic allotted to this PHC has not been operating since 4 months as the vehicle has gone out of order.

C. Jagadguru Jayadeva Murugharajendra Medical College (JJMMC), Davangere

Location & Profile

Davangare Town is located 286 Kms from Bangalore on the Bangalore-Pune highway. It is a Taluk headquarters under Chitradurga District. Davangere is well connected by road (Bangalore-Pune highway) and rail (Bangalore-Miraj-meter guage line). The population is roughly 10,67,300 (Chitradurga - Table-2). The main agricultural crops are Bajra, Ragi, Rice, Cotton Seeds, Sulflower, Sugar-cane etc. In and around Davangere there are large number of industries, especially Sugar, Cotton mills. The Davangere Sugar Company and Davangare Cotton Mills are prominent among them. In the neighbouring taluk of Harihar, the Birla owned Harihar Poly Fibre is located.

Davangere has got a Medical, Engineering, Dental, Pharmacy and few Arts, Science and Commerce Colleges.

JJMMC was established in 1966 by the Bapuji Trust which runs a large number of educational institutions, in different parts of Davangare Taluk. This Trust is an off-shoot of Veerashiva sect (Lingayat Community). Though the Government has permitted the intake of undergraduates to a maximum of 125, the actual intake touched 209 last year and out of which 50% of the seats were filled by the Government under their merit quota.

The clinical facilities for teaching are provided at Chigateri General Hospital (C.G. Hospital) which is the Taluk headquarters hospital having 900 beds. The Bapuji Trust has established their own campus teaching hospital having 400-bed (Bapuji Hospital) with only pay-wards and no free beds. The C.G. Hospital is situated in close proximity to JJMMC campus. The college has a School of Nursing, a Pharmacy College and a Dental College within the same premises.

JJMMC is a capitation based medical college and the Government of Karnataka has permitted them to receive Rs.60,000/- from Karnataka students and Rs.3.5 lakhs from non-Karnataka students like other capitation based private medical colleges.

The C.G. Hospital has excellent clinical facilities and it is well-maintained unlike other Government Hospitals. Here the Assistant Surgeons and Civil Surgeons of the Government are working along with the clinical faculty of JJMMC. JJMMC is affiliated to Mysore University.

ROME scheme

Three PHCs have been allotted to JJMMC under ROME scheme, they are : the PHCs of Anaji, Siregere and Kodaganur (Plate 5 & 6). The college has received three Mobile Clinics (all 2-wheel drive models) during 79-80. Since the dormitory and garrages are not yet completed in the PHCs of Siregere and Kodaganur the Mobile Clinics menat for these PHCs are still stationed at the college premises and these vehicles have been made use of for conducting family planning camps. The third Mobile Clinic has been kept at the disposal of the Anaji PHC where the garrages have been constructed under ROME programme.

The college authorities have selected six villages - for ROME programme - two villages each from three of the PHCs allotted to them. The team of clinical faculty along with P&SM teachers visit these villages once a week in the College Bus and render essential curative services. The

Mobile Clinics are not put into use for ROME programme due to its high fuel consumption (less than 3 km/litre of diesel) and also due to the distance involved.

Internship Programme at JJMMC

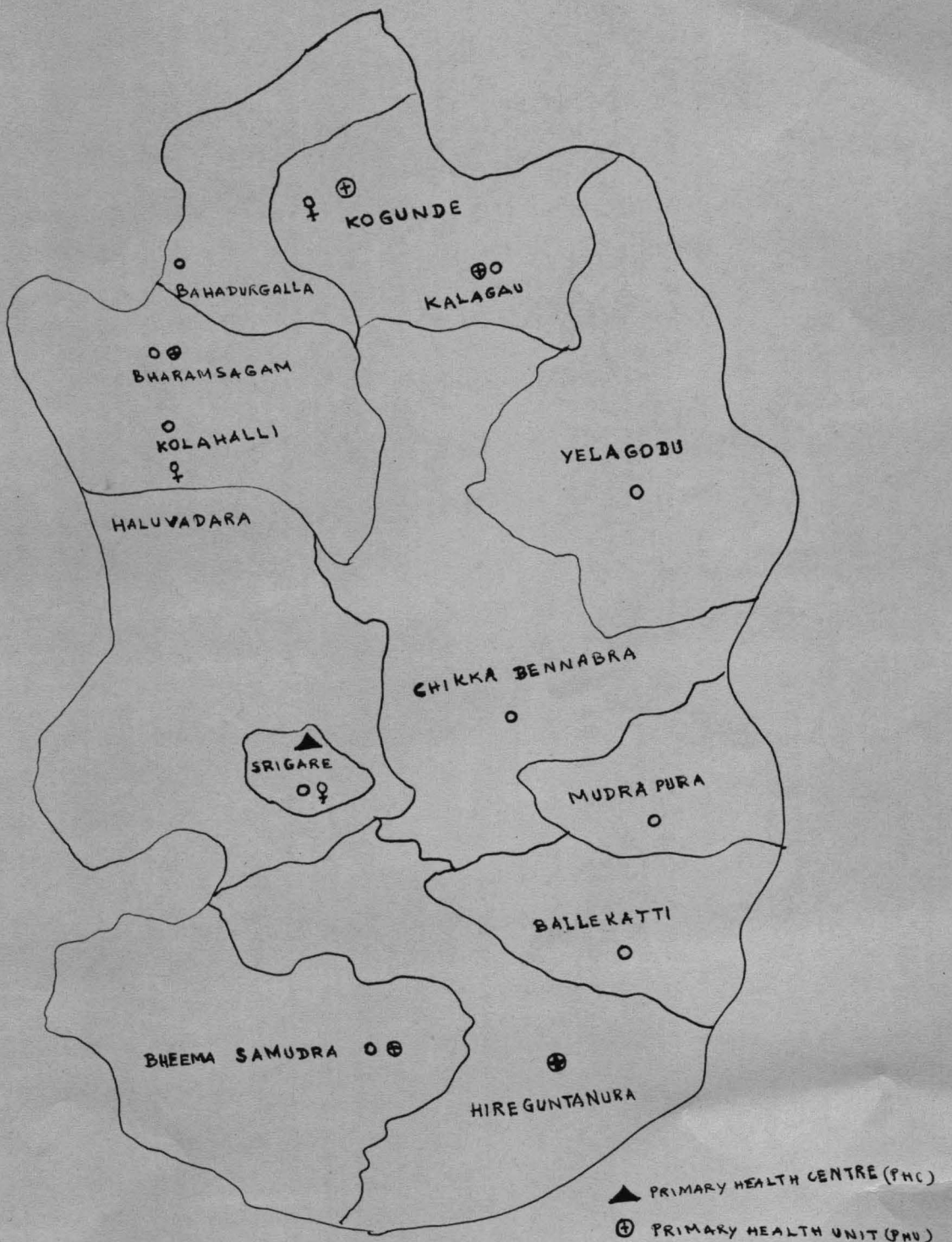
Since the dormitories are not completed in the two PHCs allotted to JJMMC, the interns do not live in the village during their three months rural posting. However, during all week days they join the ROME team and visit different villages. Their period of exposure is only from 8 a.m. to 12.30 p.m. (including the time taken for the travel).

Though three PHCs are alloted to JJMMC, the college authorities have no administrative control over the PHCs. Since there is no close liaison between the PHCs staff and college authorities the PHC staff are not involved in any manner in the implementation of ROME programme. The services provided by the college are almost parallel to that of PHC and there is no integration in their activities, within the PHC area.

The college authorities felt that the MOs of the PHCs are resisting the implementation of ROME and the posting of interns in their PHC area, as they fear that

Map - No.5

MAP OF PRIMARY HEALTH CENTRE, SRIGARE



it would affect their private practice. This situation has resulted in poor coordination and lack of proper communication between the college and the PHC. The clinical faculty visits six villages once a week along with students and interns (Honnuru, Anagodu, Deverbelekere, Dharamasagar, Mayakonde, Lokikere villages). The Siregere PHC is an upgraded PHC under IPP programme.

D. Jawaharlal Nehru Medical College (JNMC), Belgaum

The JNMC, Belgaum, is sponsored by the Karnataka Liberal Education Society, Belgaum[19] belonging to Veerashiva sect (Lingayat Community) which controls a large number of educational institutions in the district. In the City of Belgaum alone, the Society runs about 37 educational institutions of various nature.

As early as in 1957, the then Government of Bombay[20] contemplated for the starting of medical college in Belgaum. After the re-organization of the State on linguistic basis then Mysore Government permitted establishment of a medical college under the administration of the above Society in 1962 and consequently, the college started its first MBBS course from June 1964. The Government agreed to provide clinical facilities at the Government Civil Hospital (District Hospital), Belgaum. The college has

now facilities for postgraduation in selected disciplines and its own 450 bedded campus hospital is getting ready for commissioning. The medical college is affilitated to Karnataka University, Dharwad. The District Hospital have a bed strength of around 900. This college is also a capitation based medical college like JJMMC and both these colleges were de-recognised by MCI in 1974 along with four other colleges in the State, for lack of sufficient facilities for teaching as required under MCI regulations.

Belgaum City lies in the boarder of Maharashtra and it has assumed a lot of importance, at least in the political circle, as theboundary dispute for its inclusion, between the States of Karnataka and Maharashtra. While the Marati speaking residents of Belgaum would welcome its mergeh with Maharashtra, the Kannadigas would not budge to leave an inch of Belgaum to Maharashtra. There are constant clashes between the linguistic groups belonging to these categories and the Karnataka Government's recent language policy has aggrevated the boundary dispute further. This development has affected the growth of the Belgaum City and its economic development.

ROME Programme at JNMC

For the implementation of ROME scheme three PHCs have been allotted to JNMC. They are : Hirebagewadi, Uchagaon and Nandagad PHCs. During 1979-80, three Mobile

Clinics (all 2-wheel drive models) were allotted to this medical college and these vehicles have been kept under the administrative control of the District Surgeon. The Mobile Clinic team consisting mainly of postgraduates students and interns, visit three different villages under these three PHCs once a week. The villages are Sindolli, under Hirebagewadi PHC; Hannihal under Uchagaon PHC and Prabhunagar under Nandagad PHC. All the three Mobile Clinics are stationed at the college premises and out of the three vehicles allotted to them only one is made use of.

Internship Training

Interns of this college are not posted to any PHC for their rural posting. Out of their three months rural posting, for one month they join the Mobile Clinic team on alternate days during the morning hours. The remaining two months of the rural internship are spent at the Bijapur Civil Hospital which by no means can be considered as a rural hospital. According to the college authorities, this is done due to the lack of living facilities in the PHC areas as the dormitories under ROME programme are yet to be completed. In certain PHCs where dormitories are completed there is lack of necessary living facilities.

Hirebagewadi PHC

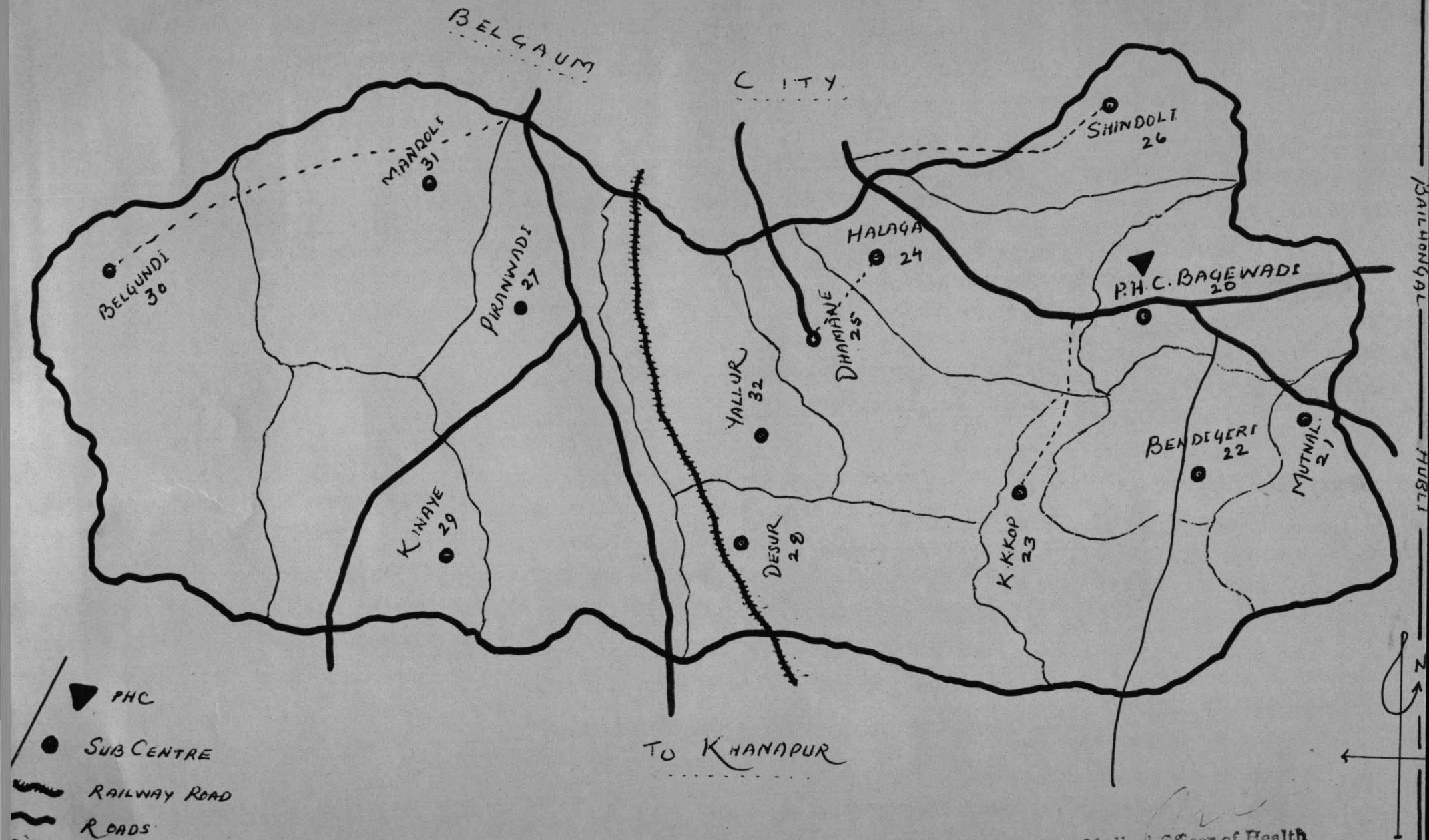
This PHC is situated on the Bangalore-Pune highway, 20 kms away from Belgaum City towards Bangalore (Plate No.6). The PHC has three MOs and two of them have been provided with residences in the premises. For the third MO (CH^{V} MO) quarters is being constructed under the India Population Project (IPP). One of the MO has a postgraduate Diploma in Clinical Pathology (DCP).

Dormitory and garrages had been constructed and handed over to the PHC authorities. The dormitory has got all the facilities like Kitchen, dining hall, seminar rooms. There is a bore-well with an attached hand-pump situated right in the campus which is said to have been dug by the previous MO by the Award money he received when he won a State Award of Rs.25,000/- for having exceeded the family planning target many times over the one fixed.

The PHC have been provided with two vehicles - one petrol jeep (UNICEF) and a Hindustan Diesel Trekker under IPP. It looks as though the main thrust among all programmes of the PHC, is family planning and the PHC has a continuous reputation of always exceeding the target fixed for them.

Map - No.6

MAP SHOWING THE AREA OF P.H.C. H. BAGEWADI.



Medical Officer of Health
Primary Health Centre

The college administrations' explanation for not posting interns to this PHC was not based on facts as there exist all necessary facilities for their stay and training.

Uchagaon PHC

This is the PHC which is nearest to the JNMC situated at a distance of 18 kms. The location of the PHC on a hill top with no water facilities and the land for the PHC was donated by the local Patils since this land cannot be used for any other purpose as it was a waste land with rocks and the Government accepted it for constructing PHC building here though the PHC area extends another 20 kms away from here and PHC headquarters situated in the extreme end of the area of its jurisdiction. There are supposed to be three MOs, 23 female health workers, 28 male health workers besides other usual para-medicals and auxiliaries. However, on the days of visit except a Pharmacist and a MO no one was found in the PHC. The PHC area looked desolate hardly with two or three patients in the OPD. Accordring to the MO the strength of the OPD normally is very thin as most of the people coming under the PHC go to other health centres since the PHC is situated in one corner of the area allotted to it. Another reason he cited is since Uchagaon village is very close to Belgaum City, people instead of coming here usually go directly to district hospital at Belgaum.

The population of the village is roughly around 1,47,000. The PHC has been provided with one patrol jeep and another diesel jeep (under IPP programme). The dormitory and garrages have been constructed here for ROME scheme, though no provision has been made for water supply.

Nandagad PHC - has been dealt separately (Refer case study of a Medical Officer of a PHC).

Field Practice areas of JNMC

Though three PHCs are allotted to JNMC for the implementation of ROME programme, they have not been able to take over this PHCs due to many reasons (distance from the college, lack of living facilites etc.). Therefore the medical college faculty and interns delivery some curative services in selected villages under these PHCs.

Hannihal is a tiny village very near to Belgaum airport, under Uchagaon PHC. The JNMC faculty - mainly consisting of PGs and interns, visit in the Mobile Clinic this village on every Saturdays. This village is also very near to the Belgaum Airforce Station. The distance from JNMC to this village is about 17 kms.

The second village selected for the ROME programme is Prabhunagar, a tiny sleepy village 25 kms away from JNMC

on the Khanapur Road (Road to Panaji) under Nandagad PHC. The patients' strength on the day of my visit was hardly 8. The reason attributed to this low response from the community was that it is situated on the side of the national highway and since they have access to go to Belgaum and get better care from there. Again Mobile Clinic visits this village only once a week, i.e. every Tuesday.

The third village selected for implementing ROME scheme is the Sindoli village under Hirebagewadi PHC which is only 13 kms away from JNMC. The team visits this village on every Thursday.

References & Notes

1. Banerji, D. (1978). Social orientation on medical education in India. Op. Cit.

2. Refer Plate 2 & 3.

3. Though MCI had recommended 6 months rural internship under ROME programme, all medical colleges in Karnataka are still having only 3 months internship.

4. The Government of Karnataka had accorded permission for conducting research on ROME programme in these 4 medical colleges - Vide Government Order No.PLN(2)/30/85-86, dated 14/10/1985 by the Director of Medical Education, Bangalore.

5. Government of Karnataka (1980). Letter No.MEP(2)/123/77-78 dated 2/4/1980 from Director of Medical Education.

6. Government of Karnataka (1981). MEP(2)/123/80-81, Circular from Director of Medical Education, dated 3/1/1981.

7. Government of India (1982). No.U/11011/10/81-ME, DGHS, ME (UG) Section, New Delhi, dated April 1982, addressed to Principals of all medical Colleges.

8. Government of India (1981). No.U/11011/10/80-ME (Policy), Ministry of Health & Family Welfare, Department of Health, New Delhi, dated 23/12/81 from the Jt. Secretary to Government of India to the Health Secretary of States/UTs.

9. Ibid.

10. Government of Karnataka (1981). No.MEP(2)/123/80-81 dated 10/1/1981 from Director of Medical Education.

11. Government of Karnataka (1982). Order No.HFW 65 MPS 82, Bangalore, dated 7/5/1982.

12. Government of India (1981). No.U/11011/10/80-ME (Policy). Op. Cit.

13. Government of Karnataka (1980). Order No.HFW 8 MPS 80, Bangalore, dated 1/8/1980.

14. Ibid.

15. Government of Karnataka (1980) - Minutes of the meeting held at the Chamber of the Health Minister on 2/11/1980 - No.MEP(2) 123/80-81, dated 22/11/80.

16. Government of Karnataka (1980) - Order No.AFW/253/MPS-80 dated 4/12/1980.

17. Karnataka was then known as Mysore State. The nomenclatures of the State was changed to Karnataka during 1971.

18. Dharwad District is also called Dharwar. Dharwar-Hubli are twin cities and all the administrative Offices are situated at Dharwad.

19. Karnataka Liberal Education Society was formerly known as the Karnataka Lingayat Educational Society - The nomenclature changed later on due to its caste overtones in its name.

20. Earlier to the linguistic re-organisation of the State, Belgaum was part of the erstwhile Bombay State.

CHAPTER - IV

PRESENTATION OF THE DATA, ANALYSIS AND INTERPRETATION INCLUDING 4 IN-DEPTH CASE STUDIES

CHAPTER - IV

Analysis and Interpretation of the Data

Our endeavour in this research study was to collect data from the concerned respondents to see as to what extent these medical colleges were able to implement different components of the programme, and whether they were able to achieve the objectives of the scheme as envisaged - primarily the attitudinal change in terms of motivation towards rural health care service on the part of the students, interns and their teachers and also to assess the nature of health coverage provided to the masses and the referral system developed as a result of the extension of health coverage in three PHC areas.

We have collected data for the first objective from the medical students, interns, teaching faculties and the doctors of the PHC to see whether these medical colleges were able to implement all the components of the scheme (Table Nos. 22-33).

Now with regard to the second part of the objective, i.e. to examine whether these exposure to the programmes has resulted in any corresponding benefit to the students, interns and their teachers in bringing about motivation or a favourable attitudinal change towards

community orientation . For this, we have relied solely on responses to certain questions. It is a limitation in our study that we could not assess their motivation and commitment to a future rural career, or community orientation on an 'affective level'. What we derive out of the data is merely at a 'cognitive level' response in terms of a few words in which they expressed their inclination. It need not reflect the actual orientation or lack of it. It is possible that by reasons of 'social-desirability' quite a large number of students have expressed their willingness to serve the rural masses after completion of their education. It is also possible if given a chance, they may not take up rural career at all and might look for better pastures. Thus an 'affective-level' orientation could not be assessed in this study. What we derived from the responses are basically the cognitive-level orientation (Table Nos. 18-22).

The perception and views of the students and interns on different aspects of the programme obtained are indicated in Table Nos.23-15 and also in the case study No.2.

The faculty participation and their response to the programme are represented in the Table Nos. 18, 19 & 26-30.

The PHC doctors' role in the programme, their involvement, views and responses are expressed in Table Nos. 31-33 and also in the case study No.3.

In order to obtain qualitative data on the subject we have also relied on a number of case studies from a sociological perspective, besided the data obtained from questionnaire and interview schedules. These in-depth case studies have been incorporated towards the end of this chapter.

The community's response to the programme and their views have also been presented in the form of a case study towards the end of this chapter (Case Study No.4).

To balance it, we have also obtained the views and the policy behind the different aspects on ROME scheme from the people on the other side of the fence - i.e. the sponsors of the programme. The views of the top executives of the Directorate of Medical Education at the State and Central level have been presented in a separate section.

A. Responses from the Undergraduates & Interns

First we have analysed the socio-economic background of the students, though it did not form an objective of the study. The purpose of this exercise is to cross check whether the degree of orientation the students possess could be correlated with their socio-economic background. In the absence of proper exposure

of students to the villages under ROME scheme in two Government medical colleges, whereby and large students from the middle and lower-middle socio-economic strata are predominant, we could not correlate the above subject. However, the socio-economic data was quite useful as to know the trends in medical college admissions and to check whether there is any shift in its class-bias.

The parents' occupation, annual income and education have been classified into four groups and used in our analysis of socio-economic background.

Socio-Economic background of the Undergraduates

One revealing finding (which is incidental to the study) is the predominence of female students in the Government medical colleges in the Capital and the urban background of students in both private and Government medical colleges, 56.4% and 73.97 % respectively (Table 11 & 12).

The data as presented in the Table 13 A, on the occupation of the parents also shatters one of the earlier myths that the students who take up medicine are predominently from elite class and higher socio-economic strata of the society. However, our findings is that the majority of the students in the Government medical colleges-over 50% belonged to middle or lower middle class even their parents' occupations varying from mason,

TABLE - 11

Sex Distribution of Undergraduates and Interns

		UNDERGRADUATES					INTERNS				
		Male	%	Female	%	Total	Male	%	Female	%	Total
1.	BMC	48	43.60	62	56.40	110	25	55.50	20	44.40	45
2.	KMC	57	62.63	34	37.36	91	8	61.53	5	38.47	13
3.	JJMMC	46	57.50	34	42.50	80	23	79.31	6	20.69	29
4.	JNMC	73	65.76	38	34.24	111	3	42.85	4	15.15	7

TABLE - 12

Rural-Urban Distribution of Undergraduates and Interns

	Undergraduates					Interns				
	Rural	%	Urban	%	Total	Rural	%	Urban	%	Total
1. BMC	9	8.20	101	91.80	110	9	20.0	36	80.00	45
2. KMC	26	28.57	65	71.43	91	4	30.76	9	69.24	13
3. JJMMC	28	35.00	52	65.10	80	11	37.93	18	62.07	29
4. JNMC	41	36.93	70	63.07	111	12	28.57	5	71.43	7

TABLE - 13 A

Socio-Economic Profile - Medical Students

PARENTS OCCUPATION	PRIVATE MEDICAL COLLEGES				GOVERNMENT MEDICAL COLLEGES			
	JJMMC	%	JMMC	%	BMC	%	KMC	%
Category - A	19	23.75	34	30.63	31	28.18	18	19.78
Category - B	35	43.75	42	37.83	29	26.36	27	29.67
Category - C	17	21.25	28	25.22	23	20.90	24	26.37
Category - D	1	1.25	6	5.48	25	22.72	16	17.58
No response	8	10.00	1	0.90	2	1.81	6	6.59
	80	100.00	111	100.00	110	100.00	91	

Category - A : Consists Professional groups like Doctors, Engineers, Scientists, Lawyers, Judges, Medical Teachers, College Teachers etc.

B : Company and Bank employees, Businessmen, Government/Defence Service, School Teachers etc.

C : Retired Government/Defence Officials, Clerica Cadres, Agriculturists, Para-medicals

D : Masons, Drivers, Housewives, Self-employed, Petty Businessmen, Class IV employees

weaver, tailor, attender, petty businessman, agriculturist, clerical cader etc. In terms of annual income of the parents around 35% are from the group earning below Rs.20,000/- (Table 14 A). The possible explanation for this curious finding could be the reservations made available at the Government medical Colleges and the quota of seats earmarked in the private medical college for the Government merit pool, for the ST/SC and economically weaker sections. With regard to their fathers' education only 30% belonged to the professional group (Table 15 A). A significant number of the students' fathers either illiterate or non-matrics (12.25 %). The matriculates are 22.75 % and the graduates percentage is 31.17 %. This trend even holds good in the case of mothers' educational background (Table 16 A).

Socio-Economic background of the interns

The data obtained from the interns on this subject was not different from the one obtained from the undergraduates. We find, a comparatively large number of lady interns in the Government medical colleges in the State Capital doing their rural internship than in private medical colleges. There is also a trend of large scale migration of students from other medical colleges of the state to the capital for purpose of internship training (47% - Table 11).

TABLE - 14 A

Socio-Economic Profile - Medical Students

PARENTS' ANNUAL INCOME	Private Medical College				Goverment Medical Colleges			
	JJMMC	%	JNMC	%	BMC	%	KMC	%
GROUP - A	14	17.50	11	9.90	8	7.27	3	3.29
GROUP - B	17	21.25	40	36.03	27	24.54	21	23.07
GROUP - C	21	26.25	33	29.72	26	23.63	30	32.96
GROUP - D	22	27.50	25	22.52	44	40.00	31	34.06
No Response	2	2.50	2	1.80	5	4.54	6	6.59
	80		111		110		91	

Group - A : Above Rs.50,000/-

Group - B : Between Rs.20,000-49,000/-

Group - C : Between Rs.10,000-19,000/-

Group - D : Less than Rs.10,000/-

TABLE - 15 A

Socio-Economic Profile of Undergraduates

PARENTS' LITERACY (FATHER'S EDUCATION)	Private Medical College				Government Medical Colleges			
	JJMMC	%	JNMC	%	BMC	%	KMC	%
Class - I	27	33.75	43	38.75	31	28.18	21	23.07
Class - II	23	28.75	24	21.62	37	33.63	28	30.76
Class - III	21	26.25	26	24.42	22	20.00	20	21.97
Class - IV	8	10.00	15	13.51	10	9.09	16	17.58
No Response	1	1.80	3	2.70	-	-	6	6.59

Class - I : Medical/Engineering/Law Degree/Doctorates/ MBAs etc.

Class - II : Degree holders/PGs in Arts, Science & Commerce

Class - III : Matrics, PUC

Class - IV : Illiterates, non-matrics

TABLE : 16 A

Socio-Economic Profile of Undergraduates

(contd...)

PARENTS' LITERACY (MOTHER'S EDUCATION)	Private Medical Colleges				Government Medical Colleges			
	JJMMC	%	JAMC	%	BMC	%	KMC	%
Class - I	4	5.00	7	6.30	12	10.90	2	2.19
Class - II	14	17.50	14	12.61	26	23.63	8	6.59
Class - III	39	48.75	50	45.04	48	36.36	35	38.46
Class - IV	19	23.75	37	33.33	21	19.09	36	39.56
No Response	4	5.00	3	2.70	3	2.72	9	9.89

Class - I : Medical/Engineering/Law Degree/PGs/Doctorates/ MPAs/IASs

Class - II : Degree holders/PGs in Arts, Science & Commerce

Class - III : Matrics, PUC

Class - IV : Illiterates, non-matrics

The background of the interns are predominently urban (72.3%). The occupation of their parents could be classified into mostly of middle class families (Table 14 B, 15 B & 16 B). This middle class bais was further established in their annual incomes. Majority of them belonged to the annual income bracket of less than Rs.20,000/- especially in Government medical colleges (60%). The children of the professional group were only 5% in the Government medical colleges, while their number significantly increased in the private medical colleges (21%). The educational qualification of the parents were predominantly non-graduates (55%) and significant percentage (27.8%) were non-matrics and illiterates.

Analysis of Students' and Interns' Responses

Out of 392 students examined by a questionnaire none of them were able to answer the first question, i.e. all the objectives of the ROME programme. This indicates that either the students were not briefed about the programme properly or it shows their own lack of interest in the programme.

In medical colleges where ROME programme has been implemented the students were enthusiastic especially in the initial stage. However, their period of exposure

TABLE - 13 B

Socio-Economic Profile - Interns

PARENTS' OCCUPATION	PRIVATE MEDICAL COLLEGES				GOVERNMENT MEDICAL COLLEGES			
	JJMMC	%	JNMC	%	BMC	%	KMC	%
Category - A	12	41.37	1	14.28	12	26.66	2	15.38
Category - B	5	17.24	4	57.14	12	26.66	7	53.84
Category - C	11	37.93	2	28.57	14	31.11	4	30.76
Category - D	1	3.44	-	-	5	11.11	-	-
No Response	-	-	-	-	2	5.0	-	-

Category - A. : Consists Professional groups like Doctors, Engineers, Scientists, Lawers, Judges, Medical Teachers, College Teachers etc.

B : Company and Bank Executives, Businessmen, Government/Defence Service, School Teachers

C : Retired Government/Defence Officials, Clerical Cadres, Agriculturists, Para-medicals

D : Masons, Drivers, Housewives, Self-employed, Petty Businessmen, Class IV employees

TABLE - 14 B

Socio-Economic Profile - Interns

PARENTS' ANNUAL INCOME	Private Medical Colleges				Government Medical Colleges			
	JJMMC	%	JNMC	%	BMC	%	KMC	%
GROUP - A	4	13.79	2	28.57	1	2.50	1	7.69
GROUP - B	10	34.48	3	42.85	11	27.50	4	30.76
GROUP - C	10	34.48	2	28.57	13	32.50	4	30.76
GROUP - D	4	13.79	-	-	18	40.00	3	23.07
No Response	1	3.44	-	-	2	4.4	1	7.69
	29		7		45		13	

Group - A : Above Rs.50,000/-

Group - B : Between Rs.20,000 - 49,000/-

Group - C : Between Rs.10,000 - 19,000/-

Group - D : Less than Rs.10,000/-

TABLE - 15 B

Socio-Economic Profile of Interns

PARENTS' LITERACY (FATHER'S EDUCATION)	Private Medical Colleges				Government Medical Colleges			
	JJMMC	%	JNMC	%	BMC	%	KMC	%
Class - I	10	34.48	1	14.28	10	22.22	3	23.07
Class - II	6	20.68	-	-	11	24.44	4	30.76
Class - III	7	24.13	3	42.85	10	22.22	3	23.07
Class - IV	6	20.68	3	42.85	11	24.44	3	23.07
No Response	-	-	-	-	3	6.60	-	-

Class - I : Medical/Engineering/Law Degree/PGs/Doctorates/ MBAs/IASs

Class - II : Degree holders/PGs in Arts, Science & Commerce

Class - III : Matrics, PUC

Class - IV : Illiterates, non-matrics

TABLE - 16 B

Socio-Economic Profile of Interns

(contd...)

PARENTS' LITERACY (MOTHER'S EDUCATION)	Private Medical Colleges				Government Medical Colleges			
	JJMMC	%	JMMC	%	BMC	%	KMC	%
Class - I	2	6.89	1	14.28	2	4.44	-	-
Class - II	3	10.34	-	-	5	11.11	-	-
Class - III	11	37.93	3	42.85	18	40.00	6	46.15
Class - IV	13	44.82	3	42.85	16	35.55	7	53.84
No Response	-	-	-	-	4	8.88	-	-

Class - I : Medical/Engineering/Law Degree/PGs/Doctorates/MBAs/IASs

Class - II : Degree holders/PGs in Arts, Science & Commerce

Class - III : Matrics, PUC

Class - IV : Illiterates, non-matrics

was confined to a bare minimum. Out of the 392 undergraduates examined by the questionnaire only 190 admitted to have ever gone to a rural area (48%). Those of the students visited village for a period less than one month (17.6%) and the total time spent in the village (including the time taken for the travel) is 2 hours (33%).

With regard to the students' views on the faculty involvement, maximum rating is given to P&SM department (32%) followed by department of Medicine (18%), Obst. & Gynae. (12.3%), Paediatrics (11%). The specialists involvement is maximum at the level of postgraduate students, if we can them specialists (48%)and interns(45%). Among the senior faculty, the involvement was more at the level of lecturers (38.4%) and Assistant Professors (20.5%) (Table 20).

Students Exposure to ROME Programme (Q. 2 & 3)

Table 17 provides the students' exposure to ROME programme, both in terms of time of exposure and the total period of exposure.

As we could see, in two Government medical colleges almost 95% of the students have not yet been exposed to ROME programme.

TABLE - 17

Medical Students Exposure to RCME Programme

A. Students Exposure/ Time	1 hr.	%	2 hr.	%	3 hr.	%	4 hr.	%	Not Exposed at all	%	No Response	%
BMC	2	1.8	8	7.2	1	0.90	-	-	90	81.8	9	8.1
KMC	5	5.5	1	1.1	2	2.22	1	1.0	68	74.7	3	3.3
JJMMC	8	10.0	50	62.5	28	35.00	4	5.0	-	-	-	-
JNMC	13	11.7	4	3.6	8	7.20	6	5.4	46	41.4	-	-

B. Period of Exposure	Once a week	Twice a week	Once in a fortnight	Once in a month	Once in 2 months	Once so far	Once whole month	Never	No Res.
BMC	-	-	-	-	-	15.45	-	72.7	11.8
KMC	3.29	3.29	3.29	-	-	-	-	81.3	8.7
JJMMC	32.50	1.25	7.5	2.5	1.25	2.5	50.00	1.25	-
JNMC	-	-	9.90	9.90	6.30	13.51	-	41.44	9.9

In the case of other two medical colleges where students have been exposed to rural training in a limited way, the period of exposure is barely 2-3 hours - including the time taken for the travel.

The students who were fortunate enough to get exposed to ROME programme, the response was that they could notspend sifficient time in the village so as to interact with the villagers and to develop raport with them. Since major part of the time is taken for the travel they could not spent more than an hour in the village and the faculty members and the students/eager to return to their Clinics. Hence they did not benefit much from these rural visits.

/ were

Out of the 392 students covered by the study, the majority of the students, i.e. the students belonging to two Government medical colleges had not even one exposure to ROME programme during their last four years of medical training. The percentage of students who had exposure to ROME programme is only 48%) while their time and period of exposure is about 2-3 hours for a month during the entire period of medical education (Table 17).

Key to Responses of Q. No.12 (Table 21)

A - Necessary

B - Unnecessary

C - Useful

D - Not very useful

E - Practicable

F - Impracticable

G - By reasons of social obligations

H - Unethical

The reactions of the undergraduates and interns were expressed on the above scale on three aspects of their role after completion of their MBBS examination, i.e. on the present three months rural internship, the proposed six months rural internship recommended under ROME scheme and two year rural service suggested for as a pre-requisite for postgraduate medical education.

Responses to these questions were considered as an indication, at least in the cognitive level, their community-orientation.

A higher percentage has indicated favourable attitude towards the existing three months' rural internship (both undergraduates and interns), while the relative scoring for the proposed six months' rural training under ROME scheme and rural service as a pre-requisite for postgraduate medical education was more on the scale expressing their dis-inclination and could be considered as lack of orientation. The majority of the students and interns in the four medical colleges expressed their views as "unnecessary", "not very useful", "impracticable" and even "unethical", on the last two subjects.

Q. No.8 (Table 22)

The students have been asked to score on two closed questions on rural teaching and training as to whether it is :

A. Relevant and useful

B. Not very useful

Their preference to rural training have been scored as under :

A. Rural teaching/training better than didactic class room teaching

B. Rural teaching/training better than hospital clinics

C. Rural teaching/training not better than didactic class room teaching

D. Rural teaching/training not better than hospital clinics.

With regard to the relevance of rural teaching and training, the students, interns have given very high rating giving their reasons. However, on a comparison with hospital clinics (Q. 9) the students did not consider rural teaching and training better than hospital clinics and they considered both are essential and complementary to each other.

Q. No.16 : Should the ROME programme be

A - restricted to a particular year of study ?

B - or shoud it be a continuous programme extending over the entire period of medical education.

TABLE - 18

Involvement of Clinical Departments
(Medical Students & Interns)

	Private Medical Colleges				Government Medical Colleges			
	JMMC		JNMC		BMC		KMC	
	UGs	Interns	UGs	Interns	UGs	Interns	UGs	Interns
Medicine	90.0	93.0	46.8	71.4	29.0	51.1	3.2	-
Surgery	41.2	51.0	9.9	14.2	13.5	44.4	-	-
Paediatrics	81.2	86.2	34.2	51.1	12.7	77.7	6.5	-
Obst. & Gynae.	32.5	17.3	17.1	71.4	11.8	71.1	3.2	-
Dermatology	58.7	51.7	28.8	57.1	4.5	51.1	-	-
E.N.T.	36.2	6.8	-	28.5	6.3	22.2	-	-
Eye	22.5	13.3	-	28.5	3.6	33.3	-	-
Orthopaedics	18.75	17.2	-	14.5	-	12.7	-	-
Dental	16.2	20.6	-	14.5	-	22.2	-	-
Psychiatry	-	-	-	-	-	-	-	-
Radiology	-	-	-	-	-	-	-	-
Urology	-	-	-	-	-	-	-	-
Neurology	-	-	-	-	-	-	-	-
Any other	-	-	-	-	-	-	-	-

TABLE - 19

Involvement of Pre & Para-Clinical Departments
IN ROME programme

(Responses from Undergraduates)

	Private Medical Colleges		Government Medical Colleges	
	JJMMC %	JNMC %	BMC %	KMC %
1. Anatomy	-	-	-	-
2. Physiology	-	-	-	-
3. Biochemistry	-	-	-	-
4. Pathology	-	-	3.6	1.09
5. Pharmacology	-	-	-	-
6. Microbiology	-	-	35.0	-
7. Forensic Medicine	-	-	2.7	23.0
8. Community Medicine	93.7	87.4	41.0	8.8
9. None of the above	93.7	87.4	45.0	76.9

As we could see in this table, the involvement of Pre & Para-clinical departments, other than P&SM in ROME programme is almost nil. This is contrary to the Government of India/MCI directive that the entire teaching community including those of Pre & Para-Clinical departments are expected to involve in the scheme in an appropriate integrated rural teaching for the undergraduates.

TABLE - 20

Involvement of Medical Personnel

(Designation-wise)

(Analysis of Undergraduates and Interns Responses)

	Private Medical Colleges				Government Medical Colleges			
	JMMC		JNMC		BMC		KMC	
	UGs %	Interns %	UGs %	Interns %	UGs %	Interns %	UGs %	Interns %
1. Professor	45.0	41.3	34	14.2	-	2.2	-	-
2. Associate Professor	43.7	55.1	40	42.8	-	6.6	-	-
3. Assistant Professor	38.75	62.0	28	28.5	-	44.4	-	-
4. Epidemiologist	-	-	-	-	-	-	-	-
5. Statistician	-	-	-	-	-	-	-	-
6. Lecturer	43.7	62.0	40	57.1	-	55.5	-	23.0
7. Registrars	-	-	-	-	-	-	-	-
8. Postgraduates	40.0	75.8	45	85.7	-	64.4	-	30.7
9. SHOs	12.5	-	-	-	-	-	-	-
10. Interns	32.5	96.5	40	85.7	-	100.0	-	100.0

TABLE - 21 A

Views on 3 months rural internship, 6 months rural internship and compulsory rural service

(Responses of Undergraduates & Interns)

		Private Medical Colleges				Government Medical Colleges			
		JJMMC		JMC		MMC		KMC	
		UGs	Interns	UGs	Interns	UGs	Inters	UGs	Interns
		%	%	%	%	%	%	%	%
Present 3 months compulsory internship training	A	32.5	20.5	18.7	28.5	31.18	28.8	30.2	17.5
	B	3.7	30.8	30.8	28.6	4.5	2.2	5.4	38.7
	C	32.5	15.6	20.0	14.2	18.1	44.4	18.7	18.3
	D	1.2	14.3	22.7	28.6	9.01	11.1	2.19	40.3
	E	18.7	10.0	14.2	-	21.0	6.6	16.5	13.6
	F	-	3.5	4.7	-	-	-	-	-
	G	-	-	-	-	-	-	1.09	-
	H	-	4.5	-	-	-	-	1.09	-

(For the key - A to H, Please refer page 125 & 126.)

TABLE - 21 B

Views on 3 months rural internship, 6 months rural internship and compulsory rural service

(Responses of Undergraduates & Interns)

Present 6 months compulsory rural internship under RCME Programme	Private Medical Colleges				Government Medical Colleges			
	JJMMC		JNMC		BMC		KMC	
	UGs %	Interns %	UGs %	Interns %	UGs %	Interns %	UGs %	Interns %
A	16.2	8.7	15.0	-	2.7	8.8	12.0	38.5
B	3.7	20.7	27.0	42.8	34.5	40.0	10.9	30.8
C	26.2	6.8	7.2	-	6.4	2.2	12.0	23.0
D	6.2	13.0	19.7	42.8	36.3	44.4	4.4	61.5
E	13.7	22.0	9.1	-	-	-	4.4	-
F	5.0	18.3	19.4	14.3	20.0	20.9	3.3	7.6
G	-	15.3	13.2	-	-	6.6	2.2	-
H	-	20.7	22.0	-	-	4.4	-	-

(For the key - A to H, please refer page 125 & 126)

TABLE - 21 C

Views on 3 months rural internship, 6 months rural internship and compulsory rural service (Responses of Undergraduates & Interns)

		Private Medical Colleges				Government Medical Colleges			
		JJMMC		JJMC		KMC		KMC	
		UGs %	Interns %	UGs %	Interns %	UGs %	Interns %	UGs %	Interns %
Rural service as a pre-requisite for P.G. Medical Education	A	2.5	3.4	9.0	-	2.7	15.5	17.5	15.4
	B	60.0	23.0	64.8	42.8	35.4	62.2	8.8	53.8
	C	2.5	-	36.0	-	3.6	20.0	8.8	7.6
	D	75.0	51.7	56.7	42.8	20.9	68.8	4.4	38.5
	E	3.7	-	1.8	-	-	4.4	8.8	15.4
	F	46.2	68.9	47.7	14.3	27.2	37.7	2.2	46.1
	G	12.5	17.2	11.7	-	3.6	33.3	-	38.5
	H	23.7	34.4	13.5	-	5.4	22.2	3.3	30.7

(Key given [A-H] in page No. 125 & 126.)

TABLE - 22

Response of the Undergraduates & Interns
(Relevance of Rural Teacing & Training)

		Private Medical Colleges				Government Medical Colleges			
		JJMMC		JNMC		BMC		KMC	
		UGs %	Interns %	UGs %	Interns %	UGs %	Interns %	UGs %	Interns %
Q.8	A	90.0	58.6	63.0	71.4	81.8	73.3	65.9	38.4
	B	6.2	27.5	33.3	28.6	14.5	22.2	32.9	61.5
Q.9.	A	76.2	62.0	71.2	21.4	79.0	80.0	56.0	46.1
	B	27.5	20.7	16.2	14.2	22.7	28.8	76.9	76.9
	C	22.5	20.7	27.0	28.5	20.0	17.7	24.1	46.1
	D	62.5	68.9	80.1	85.7	70.9	66.6	7.6	23.0

The students cited the following seasons for 8A - why the rural teaching is relevant and useful and why they prefer it better than didactic class room teaching ;
7B - gives the reasons why they do not prefer ROME teaching

Q.8A - Why :
1. More practical (87)
2. Better doctor-patient relationship (43)
3. Holistic view of disease (38)
4. Can see cases at their actual environment (33)
5. Better and more varied experiences (17)

( ) = n = frequency of responses.

8B. Why :
1. Faculty is not interested (45)
2. Very few cases (40)
3. No real teaching takes place during rural trips (38)
4. Too much time takes for the travel (31)
5. Frequent breakdown of vehicles (28)

TABLE L 23

Students/Interns views on RCME programme

Q. 16 A	2.7 %	Table No.23 provides the information with regard
Q. 16 B	81.6 %	to the nature of rural health care provided under RCME programme in their colleges whether it is primarily curative (74.7%) and only in a very small percentage has marked that it is a combination of preventive and promotive (10.2%) (Q.No. 17, A, B & C)
Q. 17 A	74.7 %	In this table, the students have indicated their
Q. 17 B	10.2 %	view whether the RCME programme should be a continuous
Q. 17 C	0.5 %	one extending through out the period of medical education (81.6%) or it should be restricted to a particular year of study (2.7%) (Q. 16 A & 16 B)

(Ref. page 136 for the full question)

TABLE - 23 A

Q.17	(i)	Adequate	-	10.71 %
		Inadequate	-	72.19%
	(ii)	Adequate	-	3.31 %
		Inadequate	-	55.60 %
	(iii)	Adequate	-	4.80 %
		Inadequate	-	58.67 %

(Ref. page 136)

The reason cited by the students for the inadequate curative, preventive and promotive health service provide as part of the ROME programme (Q. No.17 (i)-(iii) are (i) Lack of adequate transport availability, (ii) Irregular visits to the villages, (iii) Teachers are not committed to go and serve the villagers (iv) the villagers allotted are very far from the college, (v) non-operation of PHC staff and (vi) Inadequate drug and PCL budget etc.

The majority of the students, as indicated in Table-23 were of the view that it should be a continuous programme extending over the entire period of medical education.

Q. No.17 - indicates whether the ROME programme in their medical college is (Table 23) :

(a) primarily curative
(b) a combination of curative and preventive
(c) a combination of curative, preventive & promotive.

The majority of the students indicated that the ROME programme in their colleges is primarily curative (74.7%) and the smaller percentage (10.2%) indicated that it is a combination of preventive and curative.

Table 18 represents the students scoring in a preferential scale indicating various clinical departments' involvement in ROME programme.

The department of medicine especially in JJMMC has scored highest rating. This trend is also seen in other medical colleges followed by department of paediatrics. Third in the order is the department of

Dermatology and then Obstetrics & Gynaecology. This higher scoring for some department in ROME programme. The explanation for the JJMMC phenomenon is relatively simple, as the Professor of Medicine is the Co-ordinator of ROME, who according to many students and faculty, has a very different view on ROME scheme unlike other clinician who try to condemn the scheme. Earlier, the Professor of Paediatrics was the Co-ordinator at JJMMC.

TABLE - 24

ROME - Response of UGs/Interns

Benefits derived from ROME programme (Q. No.20)

The following nine statements were the most common occurred among the responses of UGs and interns with regard to the benefits they have derived from ROME exposure or might have derived if they were exposed to :

1. Can see the cases at their own environment (127)
2. Social etiology and epidemiology of disease (101)
3. Learn about social habits and customs of the rural people (76)
4. Cultural aspects and their role in diseases (65)
5. Resulted in better approach to the patient (53)
6. Came to know the facilities and living conditions in the village (50)

( ) = n - frequency of responses.

Table-24 - contd.....

7. Could modify the treatment based upon socio-economic status of the patients (35)
8. Study of diseases in its entirity (33)
9. Better understanding and interaction with the rural community (25)

With regard to Q. 21 of the questionnaire seeking their opinion on the suitability of the present Bedford Mobiles and its equipment in rendering rural health service in our country, most of the students were not able to comment upon this subject since they did not had sufficient exposure to the vehicle or access to it.

UGs and interns have given their suggestions to improve ROME programme, viz., (a) in the area of patient care in the village, (b) in the area of rural training of the undergraduate, (c) in the area of logistics and administration of the programme - in response to Q. No.22. These suggestionshave been presented in a table form (Table 25), in order or larger frequencies of occurrence.

TABLE - 25

Q. 22 (A) 1. Increased visits/stay in the village (149)
2. Improve the facilities at the PHC/Sub-Centre (98)

3. Better equipment, more drugs and duty conscious doctors (both at the PHC/College level) (76)
4. Improve road and communication facilities in the village (61)
5. Refular and good follow-up of cases (58)
6. A sound referral system (51)
7. Making aware of the programmes to the villages (50)
8. Participation of the villagers in the programme (39)
9. Implement all the programmes content of ROME properly (38)
10. Establish more health centres at the peripheral areas (13)

Q.22(B) 1. UGs should stay in the village with faculty of all departments (189)
2. Repeat exposure every year (153)
3. Adequate number of experienced, committed and motivated faculty (151)
4. More activities in the field-specific-tasks (147)
5. Involvement of all pre, para and clinical departments (117)
6. Allot more time to rural visits (105)
7. Exposure to different villages for varied experiences (103)

8. Decrease the number of intake in medical colleges (too large batch is difficult for rural training) (101)

9. Honest implementation of ROME scheme in all medical colleges (98)

10. Decrease the number of students in batches posted to village (10-15) (70)

Q.22 (C) 1. Dedicated, motivated and committed persons to coordinate at the college level, preferably on a voluntary basis. (72)

2. Bureaucratic delays should be cut down (53)

3. More funds - POL, drug budget to increase (40)

4. More vehicles - Metedor, Van etc - 3 each/college (40)

5. Additional personnel exclusively for the programme (Monitory/Supervision) (22)

6. Effective supervision by State Government & MCI (21)

( ) = n = frequency of response.

Interns' View on ROME Programme

There is a definite and striking contrast seen in the response obtained from the Government medical colleges and the private medical colleges in the State. As regards the students training provided at the Government medical

colleges, the one provided at the private medical colleges is comparatively better in terms of their rural exposure. However, this trend was reversed in the internship training. Here, the private medical colleges were lagging behind very much with not only regard to MCI regulations but also to the extent to which the Government medical colleges have implemented them.

Out of the two Government medical colleges, in one medical college interns are trained for three months in three different PHCs for a period of one month each and they get a total three months exposure. While in the other Government medical college, the total rural posting is only for one month and the remaining two months they are posted in the teaching hospitals and para-clinical departments.

In both private medical colleges, the interns are not posted to the PHC at all, in the sense that they do not live in the PHC area as required. The interns only accompany the ROME team to the villages in the morning hours.

The interns' views on the existing three months rural internship, the proposed six months rural internship and the rural service as a pre-requisite for P.G. medical education has been represented in Table 21. Here, what is more significant is that while they do not mind the

existing three months rural internship being continued, the proposed six months rural posting and rural service as a pre-requisite for P.G. medical education have been disliked by an overwhelming majority. In the preferential scale they have scored these two changes as 'unnecessary', 'not very useful', 'impracticable', 'unethical' etc.

SECTION - II

Responses from Clinical & P&SM Teachers

The responses obtained from 15 P&SM teachers and 35 clinical teachers have been represented in Table Nos. 26-30. (Appendix - XII).

On an individual analysis, there is a distinct contrast on views expressed by the P&SM teachers and the teachers of the clinical departments on ROME programme. The views expressed by the P&SM faculty by and large reflects a favourable attitude to the programme, the clinician do not seems to have a high opinion about the scheme.

Table 26 provides us the views of teachers on various issues in relation to ROME scheme, viz., the departmentsthat are involved in the rural training, the

TABLE - 26

Responses from P&SM & Clinical Faculty

(Pl. refer Page 142 & 144)

Q.1.	Yes	- 100%
	No	- -
Q.2.	Medicine	- 83.3%
	Surgery	- 20.8%
	Paediatrics	- 79.1%
	Obst. & Gynae.	- 45.8%
	ENT	- 37.5%
	Dermatology	- 87.0%
	Eye	- 37.5%
	P&SM	- 83.3%
Q.2B.	No	-100.0%
Q.3A.	Good	- 58.3%
	Not very useful	- 46.6%
Q.3B.	Yes	- 47.9%
	No	- 52.1%
Q.4.	Students are interested	52.1%
	Students are not interested	- 47.9%

(Pl. refer Appendix - III for the questions)

Q.4A.	Existing 3 months internship training	
	1. Necessary 2. Useful	95.8%
	3. Not very useful 4. Unnecessary	4.2%
Q.4B.	Proposed 6 months rural internship	
	1. Necessary 2. Useful	29.2%
	3. Not very useful 4. Unnecessary	70.8%
Q.4C.*	1. Necessary 2. Useful	29.2%
	3. Not very useful 4. Unnecessary	70.8%

* Compulsory Rural Services

adequacy of students exposure, the quality of rural teaching in comparison to usual class-room teaching and hospital clinics. This tables also represents their views on the internship programme and also the compulsory rural service.

While majority of the teachers have expressed very strongly against 6 months internship and compulsory rural service, they are quite favourable towards the existing 3 months rural internship.

Table 27 represents the views of the teachers as the appropriate period which they think the students are fit to be exposed to ROME and whether the exposure should be a continuous programme or it should be restricted to a particular year of the study. This table also gives their responses in terms of designation of the teachers involved in ROME scheme and also the average OPD strength at the rural clinics run by them.

Table 28 lucidifies the activities which the students are entrusted during ROME programme.

Table 29 throws light on the teachers' views on drug supply, the manner of coordination of ROME programme and their view on the possible impact of the programme.

Table 30 illustrates the teachers' view on the suitability and desirability of Medules and their suggestions to improve ROME programme.

TABLE - 27

Responses from P&SM & Clinical Faculty

(contd..)

Q.5.	Should the students be exposed to ROME programme before the beginning of their clinical years ?	
	Yes	- 12.5%
	No	- 87.5%
Q.5A.	Should the programme be a :	
	Restricted	- 12.5%
Q.5B.	Continuous	- 87.5%
Q.6A.	Categories of staff involved in Rural Health Service & Training	
	Professors	- 16.6%
	Associate Professors	- 8.3%
	Lecturers	- 31.2%
	PGs	- 58.3%
	Interns	- 62.5%
	PHC doctors	- 8.3%
Q.6B	Para-medicals (Not involved)	- 100.0%

7. Average OPD strength at rural clinics

1-5	-	-
5-10	-	27.0 %
10-15	-	37.5 %
15-20	-	50.0 %
20-25	-	12.5 %
25-30	-	29.1 %

TABLE - 28

Responses from P&SM & Clinical Faculty

(contd...)

Q.8. Whether surgical procedures are undertaken :

Yes : -

No : 100%

Q.9. Activities the students and interns entrusted with :

1. Assisting in OPD Registration (13)
2. Case Examinations (9)
3. Domicilliary visits (6)
4. Health Education (6)
5. Immunization (5)
6. School health (3)
7. Collection of baseline data (3)

Q.10A Preventive Activities : Immunization (4)
Environmental sanitation (3)

Q.10B Promotive activities : Health Education (3)
Nutrition Education (3)

( ) = n - Frequency of responses.

TABLE - 29

Responses from P&SM and Clinical Faculty

Q.11. Curative services at the Mobile Clinic

A. Adequate : -

B. Inadequate : 100 %

B(i) Reasons

1. Drug budget inadequate (41)
2. Choice of drug in the list does not meet actual requirement (19)
3. Date expired, nearing expiry drugs (17)
4. Not able to give full course of supply (17)
5. MOs of PHC does not supplement with his stock (9)

Q.12.A. Comments on Drug supply

1. Full course is not given (38)
2. All essential drugs are not available (30)
3. Date expired and useless drugs (30)
4. Drug budget inadequate (29)
5. No continuity of treatment (25)

Q.12.B. Role of P&SM department & ROME coordination

1. It should be a voluntary rotation among department (27)
2. Principal should be the Coordinator (10)
3. Existing system is okey (3)
4. P&SM Professor may be the Coordinator (3)
5. An external person may be the Coordinator (3)

Q.13. Can ROME make a meaningful contribution to PHC

Yes : 37.5% No : 31.2% Doubtful : 31.2%

( ) = n

TABLE - 30

Responses of the P&SM & Clinical Faculty

Q.14. Suitability of Medules

1. Too large a vehicle (40)
2. Spares & parts are not available (18)
3. Low mileage (17)
4. Not fit for Indian village roads (17)
5. Cost of the vehicle is too much (13)
6. Vehicle is not strong and sturdy (12)

Q.14A. 1. Yes : 16.6 %
2. No : -
3. Not useful : 83.3 %

Q.15 Suggestions to improve ROME Programme

(a) In the area of Patient Care in the villages

1. More Mini Buses to be given to the college (43)
2. Senior clinicians on a compulsory rotation (21)
3. Every day visit to the villages (15)
4. Provision of more drugs (14)
5. Full course of treatment (13)
6. Involvement of para-medicals and medical auxiliaries in the programme (6)

(b) In the area of students rural training

1. Students should stay in the village along with senior faculty from all departments (17)
2. Specific tasks allotted to students (16)
3. Repeat rural posting every year (15)
4. Involve PHC staff in rural training (7)
5. Suitable rural training curriculum (6)
6. Integrated teaching (3)

( ) = n

contd...

Table - 30 (contd...)

Q.15. (c)	In the area of logistics administration of the Programme	
	1. Increase POL charges	(22)
	2. Administration control of all the 3 PHCs	(20)
	3. Supervision by DME, DGHS & MCI	(9)
	4. Additional staff to be appointed for the programme	(3)
Q.16.	Yes : 83.3 %	
	( ) = n	

SECTION - III

Presentation of data obtained from PHC doctors

The responses obtained from the 28 medical officers of the PHC is of greater importance as the training of the students and interns were in fact within their dominion and they were expected to supervise their rural postings and training. The responses from 28 MOs from 12 PHCs attached to these 4 medical colleges obtained by an interview schedule (Appendix - II) revealed the following informations pertaining to ROME programme in particular and rural health service in general (Table 31-35).

The majority of the MOs do not belong to the village, town or district where the PHC is situated (82.1%) and a quite significant number of them are in the same PHC for more than 2 years.

In Table 31, the PHC doctors gives a clear picture of the students and interns postings to their PHCs. As presented in this table, no students are posted to their PHC, or do they stay in the PHC/village except in the case of BMC. According to the PHC doctors' response, the interns stay in the village vary from one month (7.1%) to 3 months (10.7%) while higher percentage (75%) of interns are not living in the PHC villages at all.

Table 32 portraits the activities which the interns are involved in the PHC during their rural posting. The second part of this table provides the information regarding specialists' involvement in rural health programme and frequency of their visit. It is quite evident from the data, that the introduction of Mobile Clinic service to the village, did not result in the additional services of Laboratory, X-ray, or surgical procedures as expected.

Table 33-35 lucidified the working of referral systems at the PHC level and also the PHC doctors views on the present 3 months internship, the proposed 6 months

rural posting and the rural service as a pre-requisite for PG medical education.

While majority of the PHC doctors are not favourable towards idea of enhanced period of rural internship, they have overwhelmingly supports the idea of compulsory rural service.

As response to Q.No.13, the PHC doctors have grasped the difficulties which they face in their day-to-day administration and their stay in the villages. As response to the question No.13(b), i.e. the factors responsible for the new graduates lack of interest in rural service, they have given the possible reasons which are represented in Table 34. This table also incorporates their comments on Medules with regards to its suitability.

Table No.35 throws light on the patients' response to curative services provided by the college through Mobile Clinics, and the benefits the PHC derived out of ROME programme. Majority of the PHC doctors (65.5%) as shown in this table, are not happy about the present style of curative services provided by the colleges in their PHC areas. All of them believe that the patients prefer PHCs to Mobile clinics as the former has continuity of treatment and also accessibility.

TABLE - 31

Responses of the PHC doctors

Q.1. Length of service in the same PHC

Less than 1 year	- 10.7%	2 years	- 50.0%
1 year	- 17.8%	More than 3 years	- 21.4%

Q.2. Whether belong to the same village/Taluka/District

Yes	- 17.8%	No	- 82%

Q.3. Involvement in the Teaching and Training of

UGs	Yes	- 14.28%	Interns	Yes	- 42.85%
	No	- 85.71%		No	- 57.14%

Q.3A. Interns - Maintenance of Attendance Register

I.	Yes	- 42.85%		No	- 57.14%
Students					
II.	Yes	- -		No	- 100%

Q.3B. Interns punctuality and Regularity in Attendance

1. Punctual	- 25%	Not punctual	- 75%

Q.4. Whether Dormitories & Garrages under RGNE has been constructed

Yes	- 32.1%	No	- 67.8%

Q.4A. Whether interns live in the village

Yes	- 17.8%	No	- 82.2%

Q.4B. Interns period of stay

No Rural posting	- 75.0%	2 months	- -
1 month	- 7.1%	3 months	- 10.7%

TABLE - 32

Responses from the PHC doctors

Q.4B. Whether UGs stay in the village

Yes - | No - 100%

Q.5. Time allotted for ROME scheme is

Adequate - 17.8% | Inadequate - 82.1%

Q.6. Activies of the Interns during rural posting

1. Assisting in the OPD (7)
2. MCH & ANC Clinics (4)
3. Health Education (3)
4. Domicilliary visits (1)
5. Under 5 Clinics (1)

Q.7. Frequency of Mobile Clinic visit to the village

Everyday - - | Once a week - 46.4%

Twice a week - 53.6%

Q.8. Specialists visit to the village

Everyday - - | Once a fortnight - -

Twice a week - 53.6% | Once a month - -

Once a week - 46.4%

Q.8A. Departments involved

Medicine -	71.4%	ENT -	17.8%
Surgery -	28.5%	Eye -	21.4%
Paediatrics -	67.8%	Dermatology -	46.2%
Obst. & Gynae -	28.5%		
PSM -	67.8%.		

Q.8B. Specialists involved

Professors -	7.1%	vLecturers -	32.1%
Assoc. Prof. -	7.1%	Postgraduates -	60.7%
Asst. Prof. -	25.0%		

( ) = n

contd...

Table 32 (contd....)

Q.9. Facilities provided at the Mobile Clinics

X-ray	Yes	-	Nil
	No	-	100%
Laboratory	Yes	-	Nil
	No	-	100%
Surgery	Yes	-	Nil
	No	-	100%

Q.10. Involvement of faculty from Pre & Para clinical Depts.

Yes	-	Nil	No	-	100%

TABLE - 33

Responses from the PHC doctors

Q.10A. Utility of Pre & Para-clinical faculty in ROME Training

Useful - 28.57% (Path., Micro., etc.)
Not useful - 71.40%

Q.11. Response of specialists on the referrels sent

Good - 75.0% Not very responsive - 25.0%

Q.11A. Referrels to :

Taluka	Yes	- Nil	District	Yes	- 100%
	No	- 100%		No	- Nil

Q.11B. Status of referrel system

Good	- 35.7%	Not satisfactory	- 21.4%
O.K.	- 17.8%	Not functioning at all	- 25.0%

Q.12A. Views on existing 3 months rural internship

Useful / Necessary - 92.8% UnNecessary - 7.1%

Q.12B. Proposed 6 months rural internship

Useful / Necessary	17.8%	Unnecessary	- 10.7%
		Impracticable	- 71.4%

Contd...

Table 33 (contd...)

Q.12C. Compulsory rural service

Useful Necessary	71.4%	Unnecessary Impracticable	- Nil - 28.5%

Q.13. Hardships and Problems of PHC doctors

1. Lack of sufficient quantity of drugs (27)
2. Vehicle to transport patients (23)
3. Interfere of local politicians (17)
4. Lack of living facilities at the village (15)
5. Shift of emphasis in other programmes and targets (8)
6. Wrong transfer policies (6)

( ) = n

TABLE - 34

Responses from the PHC doctors
(contd...)

Q.13B. The factors responsible for new graduates' lack of interest in rural service

1. Poor living conditions in the village (28)
2. Lack of facilities at the PHCs/PHUs (22)
3. Un-attractive salry and service conditions (18)
4. Corruption involved in the selection, ~~(15)~~ promotion and transfers (19)
5. Political interference in the day-to-day administration (9)
6. Family planning targets and dis-incentive for non-attainment of targets (8)
7. Lack of recreational facilities in the village (3)

Q.14. Whether present package of ROME will motivate students

Yes - 44.82% No - 35.71% Not sure - 17.85%

Q.15. Comments on Mobile Clinics/Curative service

1. Inadequate (20)
2. Not integrated and coordinated with PHC service (13)
3. No continuity and follow up of treatment (12)
4. Full course of drugs not given (11)
5. Frequency of visit very few (10)
6. Senior doctors and specialists are not participating (10)

( ) = n - frequency of responses.

Contd...

Table 34 (contdd..)

Q.15A.	Preventive Aspects of health				
	Yes	- 42.85%	No	-	57.14%
Q.16.	Drug supply to the PHC		To Mobile Clinic		
	Adequate	- 7.14%	Adequate	-	71.42%
	Inadequate	- 92.85%	Inadequate	-	28.57%

£££

TABLE - 35

Responses from the PHC doctors
(contd....)

Q.17.	Patients response to Mobile Clinic/ROME Rural Health Services				
	Good	- 32.14%	Satisfactory	-	65.51%
Q.17A.	Do the patients prefer PHC over Mobile Clinics				
	Yes	- 100%	No	-	Nil
Q.18.	Additional benefits the PHC derived out of ROME Programme				
	Drugs	- 25%	Specialist Services	}	75.0%
	Equipments	- 46.42%			
	Addl.Buildings	- 100%	Coverage of more areas	}	60.71%
	More referral facilities	} 50.0%			

contd...

Table 35 (contd...)

Q.18A. Whether ROME complement the service of the PHC

Yes - 46.42% No - 53.57%

Q.18B. Whether ROME scheme has been integrated with the PHC

Yes - 46.42% No - 53.57%

Q.19. Whether Medules are useful

Yes -- 25.00% No - 75.00%

Q.19B. Comments on Bedford Medules

Vehicle is too large } 75.00% Difficulty in maintenance & repair } + 89.38%

Low mileage - 89.28%

Vehicle is not very strong and sturdy - 10.71%
For Family Planning camps it is ideal - 60.71%
Not fit for rural work - 92.85%

Q.20. Suggestions to improve ROME Programme

(a) In the area of patient care

1. More and frequent visits by the specialists to the villages (19)
2. Periodical multi-disciplinary specialist camps (11)
3. Medical college should adopt few villages for intensive health care programme (8)
4. More ambulance to be provided to the PHC (8)
5. Increased drug budget to PHC (8)
6. More equipment and better buildings for PHCs, PHUs and sub-centres (8)

(contd...)

Table 35 (contd...)

Q.20. (b) In the area of students/interns training

1. Smaller batch of students should be posted (15)
2. The students should stay in the village for 15 days to 1 month with their teachers (9)
3. Good rural teaching and training curriculum (7)
4. More vehicles for transporting students. (6)

(c) In the area of logistics and administration of the Programme

1. More POL and drug budget (26)
2. Honorarium for PHC doctors and DMOs as honorary Lecturers (18)
3. Garrages and dormitories should be completed with all living facilities (9)

() = n

SECTION - IV

PHC -the Nucleus in ROME Programme

Along with the data obtained from the interview schedules used for interviewing PHC doctors, we have also obtained qualitative data by observation and informal group discussions. The data obtained by the latter method

found to be much more reliable for our purpose. To sum up, these findings are presented as under :

One is forcibly struck by the extreme contrast between the sophistication of the urban medical institutions and primitiveness, and poverty of health care facilities for the rural dwellers in our country. When the 20% of the urban population has all thebenefits of sophisticated institutions, the remaining 80% of the rural population has to fall back upon the PHCs and most of these PHCs and rural dispensaries are either ill-equipped or not equipped at all. The annual drug grant of Rs.10,000-15,000 may appear a big sum but considering for a population of one development block which is roughly around one lakh and taking into account their daily OPD attendance it would work about to a paltry sum of few paise per patient. The shortage of drugs, equipment, transport and other facilities make even the curative care provided at the PHCs sub-standard.

Transferring the administrative control of the PHC to the concerned medical college is an essential pre-requisite for the effective implementation of ROME scheme. According to P&SM faculty, there was a perceptible change in the attitude of PHC staff wherever the change over of control was effected. If the Government really means

business total control of the three PHCs allotted to each of the medical colleges, irrespective of their ownership, should be vested with the respective medical colleges, including financial control like budget, purchases etc.

The PHCs and its staff in the existing style of functioning are not groomed to suit the purpose of ROME training for many reasons. They are almost taken unawares to discharge these fresh duties. The staff of the PHC to which the mobile clinic is attached are expected to assist the faculty of medical college in their teaching-cum-service activities by coordinating and cooperating with them during the performance of their own duties.

The Government of Karnataka issued a separate order transferring the three PHCs completely under the administration control of these medical colleges[1]. However, the Director of Health & Family Welfare Services expressed certain doubts[2] regarding the practical problems involved in transfering the administrative control of the PHCs completely to the medical colleges, thereafter the Government went back in its earlier commitment[3] and Centres' direction to vest the complete administrative control of those three PHCs allotted to medical colleges for implementation of ROME programme has been ignored.

The Government of Karnataka had a second thought on this subject and felt that the scheme did not call for a transfer of administration control over the PHCs, to the medical colleges. Instead the Government suggested the constitution of coordination committees[4] and revised the Government order stating that the supervisory and other functions will now be exercised by the Director of Health & Family Welfare and the District Health & Family Welfare Officer as before and the status quo maintained.

It is learnt to have brought out in the college and regional levels coordination committee meetings that the PHCs are not opened at the scheduled time and the medical and para-medical faculty does not attend the PHC in time, as a result the concerned medical colleges are not able to implement ROME scheme in the manner envisaged by the Government[5].

The PHCs way of functioning has also come in the way of effective implementation of theprogramme. The general attitude of the PHC MOs and auxiliary staff is nothing but indifference to the programme and they consider that this programme is an additional burden to them without any extra benefit whatsoever.

Thus instead of being the nucleus of health and a first level rural referral structure, the PHCs has become merely an outpatient curative centre for the surrounding

villages and a Government agency to propagate and promote family planning . The head of the rural health team - the medical officer of the PHC has neither the training nor inclination to lead a health team or efficiently utilise para-medical workers. The MOs have therefore tried to transplant the urban-hospital methods of working to the PHC.

Most PHCs visited for the study lack full complement ofstaff and this may be because of poor accommodation facilities. When accommodation provided, other basic amenities will be lacking. But even those with a full complement staff function inadequately. Because most of the staff are not from the PHC area as pointed our in some earlier studies[6] a cultural barrier has arisen between the villager and the staff. This is especially true of the doctor who considers himself superior to the rest of the team because of his professional training. Consequently, villagers rarely avail of the PHC's in-patient facilities because of poor living conditions and lack of interest of the staff.

Apart from the cultural barrier between the people and PHC, there is professional barrier between the doctor and the other cadres of staff, and the "team" concept is yet to be taken root in the organisation and structure of PHC.

SECTION - V

PHC doctors' role in ROME programme

A Government order has been promulgated as early as in 1980[7] that the medical officer of the PHC where ROME programme has been implemented, will be designated as Honorary Lecturer in Community Medicine and the District Health & Family Welfare Officer will be designated as Honorary Additional Professor in Preventive & Social Medicine. However, the MOs of the PHCs brought under the present study not only been given this Honorary status but also they were not even aware ofsuch a decision. This clearly shows the communication gap between the apex of health administration and their peripheral units. If the proposed designation has been conferred on the MOs of the PHCs and District Health & Family Welfare Officer (DHO) they would have naturally shown some interest in the programme. More intriguing is the fact that in the said Government order, there was no mention of the amount of honorarium for these additional role as teachers to the medical students and interns. Even the concerned colleges were also not seem to have taken the order seriously, as there was no attempt to involve these honorary teachers in the regular P&SM teaching either in the college or in their field practice areas.

There are genuine difficulties which the MOs are faced with. The villagers are not so simple or gullible as one thinks. The village social structure and the power politics is much more complex than probably that of the cities. In such a situation his own survival there becomes difficult.

The PHC doctors' knowledge of community health, administration, communicable disease, hygiene and maternal and child health is at best theoretical, and in practice often inferior to that of the para-medical personnel whom he is supposed to guide and supervise.

For a meaningful implementation of ROME, there should be a complete coordination and cooperation between the PHC staff and medical college faculty. The teaching activity is shared by the PHC staff for which they must be suitable. Here the role of medical officer is very important. For PHC staff to be fully involved, the MO should be thoroughly motiveted and well trained to organise the teaching programme.

Unless the MO is trained in such activities he does not fit into the programme. He was till recently an essentially curative practitioner with hardly any training in community work. No training was provided for medical officer of the PHC, in any community health

programme either before placement or in service. This is the missing link in the plan that has to be supplied because he is designated as ex-officio lecturer of community medicine.

The MOs of the PHCs feel that since most of the PHCs are having postgraduate MOs, there is hardly any need for the specialists' visit. More-over PHCs doctors feel that if they refer the patient to visiting specialists, it would amount to their admitting incompetence in front of local population, which would be very damaging to their private practice. This has also come in the way of supporting whole-heartedly in the programme. However, there are others who think that the visit of the specialists would boost their own image and they need not have to refer the patient elsewhere. In any case, the MOs will be asked to provide the follow-up treatment of those cases seen by specialist and hence it would not affect their private practice in any matter.

SECTION - VI

The views of the Sponsors of the Programme

By interviewing the officials belong to the top hierarchy of the Directorate of Medical Education in Karnataka and the officials in-charge of Medical Education

Cell at the Directorate-General of Health Service at New Delhi, responses were obtained from them, especially on the policy and administration of the programme.

The Director and Deputy Director of Medical Education in Karnataka and the Director (E.M.R.) who is now in-charge of Medical Education Cell at DGHS, New Delhi were interviewed. The ROME Workshop-Director (DADG of Bureau of Planning, DGHS) was also interviewed. Interview revealed the following informations (Interview Schedule - Appendix - V).

The Government have allotted three PHCs each to nine medical colleges in Karnataka State and 106 medical colleges in the country. So also the case with the imported 'Medules'. There was no official information as to any medical college having refused to take three PHCs required under ROME scheme. According to the "Quarterly Report" sent to the Director of Medical Education and Directorate-General of Health Services all medical colleges are implementing ROME scheme and operating medules for rendering rural health services. The officials admitted that the educational component of the programme in many instances have been pushed to the background. However, they showed their helplessness in taking action against the erring college managements. There is no major change or modifications envisaged in ROME programme for the immediate future according to them.

The officials consider that the budget grant allocated under various heads are adequate, including the budget for drugs and POL. The officials rely only on the quarterly reports sent by the Principals of the College and they believe that the additional posts sanctioned under ROME scheme has been filled by the college managements and the programme has been implemented in all colleges.

To them, the choice of coordinators for the programme is entirely a college level decision. They did not consider that by changing P&SM Professor as Coordinator would improve the image of the programme.

They also believe that the referral system envisaged under the scheme linking PHCs, Taluka, District and teaching hospitals has been developed or the colleges are in the process of developing it. Preventive and curative services providedby the Mobile Clinics are also satisfactory according to them.

With regard to the delay in the reimbursement of the expenditure incurred by the managements of private medical colleges, the State authorities attributed it to the delay in auditing etc. by their finance department. To them there is not much of qualitative difference in the services provided by the medical colleges in Government, Private, Voluntary and Charitable Sector.

The officials are not fully satisfied with the implementation of the programme as many of the components are yet to be introduced in many medical colleges. One such area is the formation of the coordination committees and its periodical meetings.

They do not admit that Medules are used only for family planning camps but it is gemuinely used for ROME training also. They believe that the "Quarterly Reports" are based on facts and they do not consider the need for any surprise visits and they said they cannot venture into that area due to paucity of funds and personnel.

They think it is not feasible to involve the doctors from other systems of medicine in the programme and nor it is necessary to effect any major shift in its emphasis after the ROME workshop. The officials consider the Medules are suitable in rendering rural health service in India.

With regard to complementing to the service of the PHC, the officials at the State Medical Education Directorate said that since the PHCs are under the Director of Health Services (DHS) they are finding it difficult to integrate the services of the PHC with ROME. Though the State authorities passed an order for handing over the

administration control of the three PHCs to all the medical colleges, this had to be withdrawn in the wake of DHS's protest and on his report that such an arrangement is not feasible in Karnataka State. The DGHS officials also expressed their helplessness as health is a state subject.

The delay in handing over or completion of dormitories, garrages etc. under ROME programme is due to the fact that the State PWD had entrusted the work to private contractors. Since the PWD engineers are slow on the matter, it has taken almost 5-6 years to construct these buildings and in many instances these are yet to be completed.

The most important and revealing fact is that for these 318 Medules, the Government of India does not have any spares and the programme would come to a stand still very soon if spares are not procured from the manufacturer from Britain. With regard to the Mini bus sanctioned to all colleges under the programme for carrying the teachers and students to the villages from their college, the Government of India has sanctioned Rs.75,000/- per medical college. It was the failure of the State Government to procure these vehicles and give to the concerned medical colleges even after 5 years.

Many statements are made in defence of existing practices and the state of ROME programme implementation. Since ROME workshop has focussed on many issues in ROME implementation and the Government has accepted them and taking steps to streamline the programme.

However, the officials at both State and Central level admitted that the educational component (of undergraduates) has been given a very low priority if not ignored altogether what is taking place in the name of ROME is nothing but a rural OPD using Mobile Clinics.

SECTION - VII

Case Study - 1

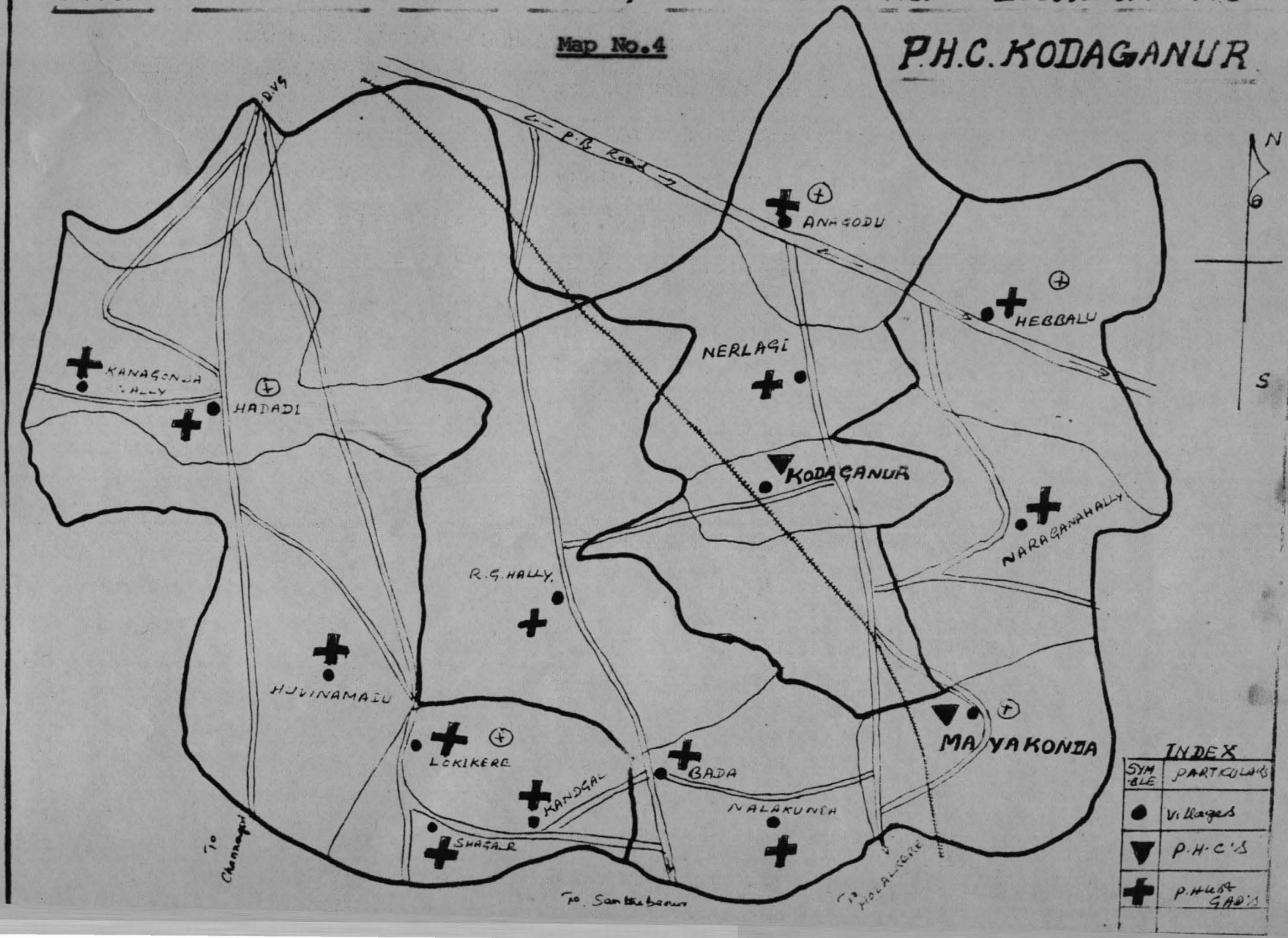
Profile of a PHC village - an indepth study

Among the 12 PHCs attached to the four medical colleges brought under the study, one PHC area was selected for an indepth study, so as to assess the impact of the scheme of Re-Orientation of Medical Education and the responses of the masses to this programme. The PHC at Kodaganur in Davangere Taluk of Chitradurga District was chosen for this purpose (Plate No.4). This PHC is one of the centres allotted to J.J.M.M.C., Davangere, for implementation of the ROME programme.

MAP SHOWING P.H.C. AREA, KODAGANUR & MEDICAL INSTITU...

Map No. 4

P.H.C. KODAGANUR



Davangere Taluk has two blocks each one having a primary health centre, namely, Kodaganur and Anaji. Kodaganur is situated 55 km away from the District Headquarters - Chitradurga. On the way to Davangere a deviation to Anagodu leads to the PHC, Kodaganur.

The PHC area is about 860 Sq.km., the population of the PHC area is 1,28,948 as per the 1981 census.. The density of the population is 150/sq. km. area. The PHC area is surrounded by PHC Siregere (which is also allotted to JJMMC) in the North, PHC Kerebilichi in the South, PHC Holalakere in East and on the West PHC Anaji (allotted to JJMMC).

The average rainfall in the area is 500 mm and the maximum temperature around 39° and minimum temperature is around 28°C.

Kodaganur is having railway accessibility directly to the State Capital, i.e. Bangalore, as the Bangalore-Miraj metre-gauge railway line passes through Kodaganur. The State Capital is at a distance of 306 km by rail. Motorable road is connected to Davangare through Anagodu and Government buses ply twice a day and as such the transport facilities are not satisfactory.

There are 119 villages attached to the PHC Kodaganur and there are three hoblies, namely, Mayakonda, Anagodu and Hadadi. A total of 32 villege Panchayats are working in the PHC areas of Kodaganur.

The main crops of the area are Jowar, Paddy, Ragi and Bajra and cash crops like cotton, sugar care and Groundnuts. There are series of water canals from Thungabhadra River which irrigates the paddy and sugar cane fields. The eucaliptus trees are grown in quite an extensive area under the garb of "Social Forestry" in which the Forest Department patronises to a large extent. This is inspite of the warning given by the Scientific Community of University of Agricultural Sciences in Bangalore that the large scale plantation of Eucalyptus can result in drought situations as the roots of the eucaliptus plant can go as deep as 40 ft. and drain out the under-ground water. The reason for Forest Departments over-enthusiasm is not far to find as the Birla owned Harihar Poly Fibres is situatedin the adjacent Taluk of Harihar on the banks of Thungabhadra river polluting the Bhadra water and the atmosphere there. The basic raw-material used for the manufacture of synthetic yarns and paper here is Eucalyptus and in Karnataka it looks as though the onus of providing a continuous supply of this raw-material is taken up by the forest department even at the cost of the public out-cry against such vandalism whereby the marginal of farmers who are proximate to the Eucalyptus plantation are the worst affected.

Again in this PHC area, there are reserved areas for growing toddy palms. The rationale behind this activity is higher revenues and for providing good quality toddy (a welfare measure indeed !).

There are many Mahila Mandal and Youth Clubs in the PHC area and according to the Medical Officer in the PHC, they fully cooperate in the Government programmes and also in the health services activities. According to him, the Kasturba Women & Child Centre is very active especially in motivating for family planning methods and also in conducting immunization programmes. This centre is situated in the headquarters of Kodaganur and they are also conducting occupational training for the women and also educate them on family planning methods.

Anganwadi Centres are also cooperating with the PHC in its activities like immunization to children under 0-6 years and supply of nutritional food, antenatal check-ups and health education. There are a total of 74 Anganwadi Centres and each one is manned by an Anganwadi Teacher (female) under the Integrated Child Development Services (I.C.D.S.) programme.

There are large number of educational institutions spread all over the PHC area. According to statistics available at the PHC, there are 150 primary schools, 32 middle schools and 6 high schools.

Out of the 119 villages under the PHC, 110 villages have been electrified.

The people are well exposed to the mass media. There are over 5000 radio sets, large number of T.V. sets (there is a low power T.V. Transmitter- a Satellite relay station installed at Davangere which is hardly about 30 kms away). Both English and Kannada news papers and periodicals are available in the village.

The major source of drinking water is the tube wells. Each of the villages has been fitted with tube well and in addition to it each A.N.M. Sub-centre is fitted with tube well either under India Population Project (IPP) funds or the health funds. This has, of course, resulted in drastically reducing the cases of gastroenteritis and other water borne infections, according to the MO of the PHC, since the chances of water contamination and pollution is ruled out in tube well technology. There are 20 A.N.M. sub-centres under the PHC control and 16 A.N.M. sub-centres under the direct administrative control of medical officers of the concerned PHUs. On an average each A.N.M. covers 3,000 population.

The A.N.M. sub-centres has been sanctioned are as follows : MCH sub-centres - 04; Family Planning Centres - 02; India Population Project - 09; Integrated Child Development - 04; Minimum Needs Programme - 01.

The predominant caste group is Hindus and majority of them belong to Veerashaiva sect (Lingayats). The majority of the education institutions in this area as well as in the Northern Karnataka belt are run by Educational Societies belonging to this sect, including JJMMC, Davangere and JNMC, Belgaum. Other major 'non-Hindu' caste group is Muslims which constitute only a microscopic minority. Within the village area, the Harijan colonies are well demarcated and usually found at the out-skirts of the village limites. These Harijan colonies have separate wells (either open wells or tube wells). Their occupation varies from agricultural casual labourers to cobblers, dhobis and such other menial jobs. Majority of them do not own land fit for cultivation. The Government Janata HousingScheme does not seem to have made a large scale entry here since most of this group still continues to live in mud huts with thatched roof.

ROME Programme in the village

The faculty from the JJMMC has chosen two villages in this PHC area for ROME programme. They do not visit the actual PHC headquarters, nor the Mobile Clinics are bought to the PHC. The dormitory and garrages constructed at this PHC though completed, have not been handed over to the college authorities. Hence the Mobile Clinic meant for Kodaganur PHC is still stationed at the JJM Hospital

at Davangere, and it has been made use of for conducting family planning camps. The JJMMC makes use of their college Bus (since Mobile Clinics are expensive to run such long distance considering the low mileage given by the Medules) and visit Mayakonta and Anagodu sub-centre villages of this PHC twice a week with the faculty from the department of Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics and Dermatology. Since there is no facility at the moment for posting the interns to the PHC the interns doing their rural posting join the Mobile Clinic team along with PG students. The service provided by the Mobile clinic team in these villages are almost parallel to that of the PHC and there is a lack of coordination and integration of service with the PHC. The health care provided by the college in the villages are predominantly curative with very little preventive and promotive activities. Even the curative services are not continuous or proper follow-up of the cases are given. The team also failed to involve the auxiliary and para-medical personnel of the PHC working in that area for preliminary screening and identification of cases for the specialists care. The drug supply also fall short of the normal requirements as the full course of the treatment are not normally given. Often patients are sent back after giving one or two days' dose with an advice to collect the remaining

from the PHC or to buy from outside medical shops. Domicilliary visit by students and interns are seldome done. The interaction between the village community and the students and faculty of the medical college is limited to a bare minimum. The community's response therefore to ROME programme was consequently not very good. The community consider this exercises only as part of students training and not really to help the villagers. Probably for this reason there is certain amount of indifference noticed from the part of community.

The PHC's main activity and thrust is in fulfilling the family planning targets fixed for them. The curative, preventive and promotive health care aspects takes a second place. The present couple team of MOs have made a mark in exceeding the family planning targets many folds. This is testified by the news paper clipping exhibited prominently at the PHC.

Case Study - 2

An indepth study of Interns and Medical Students

It was on a pleasant evening when after having dinner at the Anand Upper Mess of the Karnataka Medical College at Hubli, I noticed a group of young men discussing about their future prospects as doctors. The discussion interested me so much that I soon joined them. I was not unfamiliar to

them since for the last two weeks I have been in the midst of them - living in the campus and having my food from the same Anand Upper Mess." They were frank enough to express their experiences in the campus as students and some as interns. All of them had completed or completing their MBBS from Karnataka Medical College. Some of them are doing their internship which will be completed in a couple of months. Hence, they are all in the crucial stage of planning their career as doctors.

Ajay[8], one of the young doctors, was born in Mysore. His father was an employee with Life Insurance Corporation and hence kept on getting transfers very often. He had his education all over Karnataka State. Now for good they are all settled down in Bangalore. He belongs to a middle class Hindu family. He is one among the students passed out from KMC who has some inclination at least in a cognitive level towards a rural job and has been keeping in touch with many organizations involved in community health. He did his one month rural posting at Kalghattgi RHTC and the remaining two months of the three months rural internship he was posted , like all other interns of the KMC, to epidemiological unit, where he administered D.P.T. and oral polio vaccine to the children, for 15 days. Again another two weeks posting was given to him in the Postpartum centre of the Hospital where he was asked to give advice and motivate

eligible couples for contraception besides observing tubectomy and laproscopic camps. KMC hospital, he said, is one of the regional centres for laproscopic sterilization training centre in India. Then he was posted for one month to the Department of Forensic Medicine to see autopsy being done. Since the college authorities felt that as future MOs of the PHCs they should be well versed with the procedures of postmortem cases. This is how he spent his three months rural internship posting in KMC. He said he is yet to understand and realize the actual objectives of the P&SM department and its role in medical education. Our P&SM faculty, he said, never took classes during the entire period of MBBS course. "Our classes were entrusted to the PGs doing their MD and DPH courses in P&SM. After all, our P&SM faculty consists of only two persons - one Professor and one Lecturer", he commented.

At this point, other final year students also joined in the discussion and said that even the one Professor and the Lecturer, they have in their department, were too busy with a host of things other than academic. The varied interests and the consequent involvement of faculty are well indicated by the fact that as the Professor of the P&SM also the Warden of boys' hostel, Secretary of the College Cooperative Society, Member of the Canteen Committee and some religious Trusts, besides Chairman, Campus Ecology

Committee. "We were never taken out for any field visits nor for any rural programmes during this 4½ years of course period, on the ground that the college does not have a bus to transport us". The college Bus when gone out of order in 1981, was surrendered to the Directorate of Medical Education in Bangalore to be condemned. "We did not want to resort to what BMC students did in 1979. They burnt the obsolete College bus during their protest struggle against Government sanctioning more capitation fee-based medical colleges in the state. We were hopeful that the Government would replace the college bus soon. This proved wrong. In a way the BMC students were right", one commented. "Since they burnt the college bus, they got a new college bus immediately".

"To be honest, I do not know what this word 'ROME' stands for". Another intern said, "We, in our student days were never exposed to such programmes. Even during our one month rural internship at Kalghattgi RHTC, we were only running an OPD there, under no supervision of our teachers or MOs. All the doctors of the PHC have their own private practice and they are normally not available at the PHC, unless a local VIP turns up. Then the para-medical staff summons the doctor by a telephone call and he attends to the VIP only to return to his private clinic".

They were all furious about the present style of internship training. Though the rural internship may be of six months in other states, however, they felt even the one month rural posting of KMC is a meaningless exercise. Internship, they said, is a part of the training under the MBBS curriculum and the University confers the MBBS degree to them only after the 'successful completion' of this training and as such it is only reasonable to believe that we need to be trained under the supervision and guidance of some teachers and we cannot get trained ourselves. We need to be trained under the guidance of some teachers of the P&SM or the MO of the PHC and they are not bothered to come to the PHC. If this is the attitude of the people who are supposed to train us we do not find any purpose even in this one month posting and, we, no doubt consider this one month posting as a punishment of exile to a village, instead of considering this as a part of our training.

They all reiterated "we are interested in rural training and possibly in rural service, primarily due to our rural background. But are they prepared to train us ? Has a single Professorfrom the Clinical department of KMC ever come to Kalghattigi RHTC even once during our one month posting there ? - they asked. "We know that we are not fully equipped to meet the challenges of running a PHC,

OPD independently. Somehow we manage with 'SIMS & MIMS'. We know we are not doing a good job but in a given situation like this we cannot do better. Most of the essential drugs are not there in the PHC. We apprehend that there is large scale syphoning of drugs by the staff concerned. There is an acute demand for injections from the patients - a culture fostered by the successive MOs as a strategy to improve their private practice, and everyone in the village only wanted injections and not tablets or capsules. Injections, they think is the only effective medicine in Allopathy. Apart from running the OPD, the only other job we do is to assist organising family planning camps which seems to be the most important task given for the PHC.

The villagers know that we are only trainees and they do not consider us as full-fledged doctors. They have no faith in the treatment given by us. Many do not even bother to consult us and seeing us managing the OPD they turn away. It is sometimes very frustrating as well as humiliating. It is also a fact that we do admit that we do not have sufficient confidence in our clinical skill due to the insufficient and inadequate training we received".

Another student from the group pointed out the problem of language in medical education. According to him, a boy - however, brilliant he is, inspite of his high

percentage of marks, in the pre-university examination (and possibly obtained the medical seat on the merit quota), still if he had studied in the Kannada medium school or college and then switched overnight to English on a medical college that too Grey's Anatomy or Wright's Physiology, for months and years he finds himself unable to cope up with his language whereas the other group, who probably might have purchased the seat giving many lakhs (especially in private medical college having both quotas) but had the good fortune to have English Medium Education in a Public School, fair well in the MBBS theory and Viva-Voce Examination, mostly because of his fluency in English language and that sometimes becomes the criteria of his performance.

All of them said in one voice that they are prepared to take up rural service as their future career, since they do not have resources to start their own independent clinics. However, they said they are not in a position to pay the current market rate of Rs.40,000/- to 60,000/- for getting selected to the Government service. "We feel betrayed whenever our successive Health Ministers of our State makes a statement that the doctors are unwilling to go and serve in the villages". They said that "they all are prepared to go to any part of the State

or even outside, even to the remotest corner, if a decent job is provided without the 'mamool' of Rs.40,000/- to 60,000/-. Our parents have already spent quite a lot money for our education during this last 5½ years. It will be unfair on our part to demand another half a lakh or more for securing a Government job. Even if we are able to make up this amount by some means, what motivation and commitment will we have to serve the community? We, like others, will only be eager to make as much money as possible to make good the money paid, even at times resorting to foul means and corrupt practices, even at the cost of the suffering patients. When we give this half a lakh, we also sell out conscience also to them".

We often hear the accusation of corruption in the PHC, especially at the level of MOs, but in the present context, when they pay half a lakh as bribe to get a job, can one really expect a better service from them? Here, who is at fault? The corrupt bureaucracy or the PHC MOs?

"There are many thousands of doctors registered at the Employment Exchanges in Karnataka and waiting their turn for Government jobs. By no means, the Government of Karnataka can ever induct all of them to services. We have to look for other avenues. The source of migration

has also been plucked for good or bad. Then why should Government sanction medical colleges like primary schools in each and every towns in Karnataka. Not only the medical education is in search of relevance, we all are in search of relevance in this predicamental situation. We believe, it is our teachers who need, more than us, community-orientation. Once they are oriented and their mental out look changed, naturally the students will follow the suit".

Though their statements were loaded with emotion and certain amount of frustration, probably their reactions are not wholly unfounded. My observation and the data collected from other medical colleges only supported what they said and not a single statement contradicted.

Partly the reason lies in the fact that rapid mushrooming of medical colleges with the unavoidable influx of inexperienced teachers, lack of appreciation for the end-product needed, out-moded teaching methodology, lack of teacher training programmes and an ancient examination system - all contributed their might towards creation of a situation like this.

Case Study - 3

Case Study of PHC doctors

The three PHCs allotted to Jawaharlal Nehru Medical College at Belgaum are by no means near the medical college. The third PHC allotted to this medical college is at Nandagad, almost 65 to 70 kms away from the college on the way to Sirsi.

I boarded the Sirsi bound Bus in the morning and for the next 3 hours but travelled through the thick Government reserved forests of Khanapur Range, on a deviation from the road to Panaji. After about 8 kms from Khanapur was the Nandgad village. While getting down from the bus I could not believe that there is a village in that area since all round the village was nothing but thick forests and there were not much human habitation. The major occupation and economic activity of the area is timber industry. After walking about a kilo-metre from thebus stop, I reached the PHC of Nandgad.

Out of the three MOs there, one is a couple team (Administrative MO and LMO) who happened to be the graduates of JNMC. Once they finished the morning rush in the OPD, I could have a long chat with them and this led me to get bit of an insight into the problems which MOs in such remote areas are faced with. By no means, what these

doctors said was different from other MOs I met all other PHC in this State.

They said "we did not want to use the influence - political or otherwise, or money to get transferred to a better place and we are prepared to work in any part of Karnataka. 3 years ago we were working in Shimoga District in a remote village and this place seems better than the earlier one. Our only regret is that we are not able to provide good education to our children as there are no English Medium Schools around so we sent our children to Marathi or Kannada Medium schools[9].

The couple team seems to be very dedicated to the profession as also theyare very popular in that locality unlike some other PHCs I visited. I found the OPD strength quite good. Though both of them are young, their professional commitment and their attitudes towards patients looked impressive to me.

Nandgad is one of the drought-hit areas in Karnataka. There is a power shut down every day for 6 hours in the morning which affects the running of the PHC especially when minor surgical procedures are to be done.

The MOS at the Nandgad PHC said : "This area is also noted for KAYSNUR FOREST DISEASE (KFD) due to the migration of monkeys from the neighbouring districts of Shimoga and

Sirsi owing to the large scale deforestration in those districts. So also there were a number of cases of Japanese Encephalitis which is due to the increased pig farming in the boarder state of Goa which is not very far from Nandgad PHC area. The PHC has got good buildings and under the ROME Scheme a new operation theatre, garrage, seminar halls and dormitories have come up. Though they have not been handed over to the PHC authorities, the construction has been completed. This PHCs also come under the IPP and under this project additional quarters for the staff members have been built.

The MOs I met at all PHCs were quite frank while recounting their experiences in working in PHCs in the rural areas. They were highly critical about the Government's policy of transfer which is nothing but "pick and choose". It is not unusual to find MOs working continuously for 15 to 20 years in remotest villages whereas others who are near the power and politics will never be disturbed for decades from their comforts of city life. Again they will also be deputed for further training and will be chosen for promotions, they said, while the man without any influence is neglected in all these respects.

The MOs were of the view that if the Government was keen in making PHC available to the masses living in the rural and peripheral areas, then they should have provided

the basic infrastructure and living conditions for the doctors who has to live in villages. Many a time, their quarters, if it is constructed, are in dilapidated condition and without a sanitary latrine or drinking water facility. It will be too much to expect a doctor to live and serve in the villages in these conditions.

Theymade a comparison with the deputy Commissioner/ Tehsildars who have been provided best bungalows, vehicles and all amenities, who are in fact equivalent to them in cadre and designation. Unless facilities for the education of their wards and basic amenities for their stay are provided, doctors may not stey in the village though they might accept such postings. They were of the opinion that it would be unfair to generalise that all MOs of the PHCs are corrupt. Though there are a few black sheeps among them, by and large, the younger group of MOs have a sense of commitment and they do not indulge in such malpractices. According to them, the major causes for such incidents are the wide-spread corruption in recruitment, transfers, in-service training and promotion in the bureaucracy.

With regard to the introduction of ROME programme, they said they are in the midst of predicament because of the dual authority exercised over them. "Administratively the MOs of the PHC come under the direct supervisional control of the District Health and Family Welfare Officer (DHO) and in turn under the Director of Health Services (DHS)

However, under ROME a parallel line of authority has now been exercised by the Director of Medical Education through the Principals of Medical Colleges. Since we are bound to fulfil the targets set by the DHO especially on Family Welfare Programmes this additional task of training of students and interns poses a definite problem to us". Many MOs, they said, have taken a stand of ignoring the directives of the Director of Medical Education and Principals of the colleges, since the MO of a PHC is only answerable to the DHO who it seems is not very enthusiastic about ROME activities in most cases. He said, there is a definite communication gap between MOs of the PHC and the Directorate of Medical Education and they are not consulted even while constructing additional building or modifying existing structures within their own PHC campus". We do not even know that we have been appointed as Honorary Lectures of P&SM of these medical colleges".

"The family planning targets set for each of us sometimes burns our own fingers and we are bound to pay additional incentives to the acceptors in order to fulfil the target".

Though dormitory, garrages are constructed and there is water facility in the campus he was doubtful that medical college authorities will ever venture to post their students and interns to this PHC considering the distance involved and other resources and inputs required from their side.

Case Study - 4

The Role of Community in ROME Scheme

Though the benefit accrued to the community is incidental, they constitute the largest single category of beneficiary. Villagers in 318 developmental blocks/ PHCs attached to the 106 medical colleges, roughly constitute 3.18 crores of people who are supposed to be the beneficiaries to the scheme.

Our study reveals that 98% of them are not aware of the actual objectives, philosophy of ROME programme and their own role in it. What they have understood is only in terms of training programme for the "Doctor Makkalige" and "Chicka doctors" (doctor students and junior doctors).

They have not availed the services from the Mobile Clinics, as much as they wanted to. The reasons are many. Generally the Mobile Clinics visit to thir village is a once a week affair. Therefore they prefer to go to a local private practitioner or in his absence to PHC/PHU doctor whose services are availableat a nominal cost on a continuous basis.

They consider the medicines given at the Mobile Clinics are cheap and ineffective. Moreover, as one school teacher complained, normally they do not give medicines

for more than a day. The villagers are asked to go to the PHC doctor for the remaining days' dose. "Once we are there the PHC doctor chases us out stating he does not stock medicine for the Mobile Clinic doctors". Apparently there is a clash of ideas between the Mobile Clinic team and the PHC staff. In effect the villagers are made to run from pillar to post.

The students, interns and their teachers who come to the village to have a first hand experience of the rural environment - their housing, sanitation, hygiene and their health needs, refuse to come out of the Mobile Clinics. Practically no interaction takes place between them and the villagers. No health education, surveys or preventive or promotional health service worth its name is being carried out in most places.

People of the Hannihal village said"seeing this huge vehicle and the noise produced by its generator a large village crowd is attracted to the Mobile Clinic due to the curiosity and inquisitiveness. Most of the patients are women and children and most of them have only imaginary symptoms and their main purpose is to have a closer look at the vehicle. Since the Mobile clinic facility in this village is only once a week and the community has access to a private allopathic doctor within the village and also to

the PHU doctor at Sambar (5 kms away), most patients make use of facilities other than Mobile Clinic. Again their own PHC at Uchagaon which is situated 20 kms away from the village on the other end, is also ignored due to inaccessibility.

"At first we went there out of curiosity to know what this 'white elephant' is all about. We were greatly impressed by the inside of the Mobile Hospital, the roarding sound the Generator produced. Our childfen enjoyed most from their weekly visits. "Dodda doctors" (Senior Doctors) visit to the village is a rare event,often the student trainees (interns) only examine us", people of Hannilal village said.

The days of visit to the village is fixed according to the convenience of the college faculty. "If the visit was synchronised with the day of the village shandy (market) we would have greatly benefited from the Mobile Clinic as everybody takes a day off from the farm on the shandy day" said an old farmer.

Majority of the people who uses the services are women and children. Others cannot attend the clinic as they are busy in their farms.

The villagers were not aware their role in the programme more than that of mere recipients of the curative

services provided by these colleges. The villagers were not consulted nor their views obtained before fixing the days of visit to the village or given them representation in the various levels of co-ordination committees.

Thus all our tools of data collection - intensive observation, informal depth interviews, case studies, data obtained by questionnaire and different types of interview schedules revealed the rather distorted implementation of ROME scheme in the sample medical colleges studied.

Keeping the objectives of the study in view, certain parameters have been drawn up which would possibly indicate the students community orientation. Their response to certain questions were take as the criteria for deciding their community orientation. Since the majority of the students' response were on the negative side, we have concluded that the students' inclination towards rural health services is very low. This could be attributed to the teachers' this-inclination towards rural health services. The specific areas of deficiencies will be discussed in the next chapter.

References & Notes

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3. Govt. of Karnataka (1980). Letter No.MEP (2)/123/ 77-78 dated 2/4/1980 from the Director of Medical Education

4. Govt. of Karnataka (1980). Order No.HFW 8 MPS 80, Bangalore, dated 1/8/1980

5. Govt. of Karnataka (1980). G.O. No.HFW 8 MPS 80 dated 1/8/1980

6. Banerji, D. (1982). Poverty, Class and Health Culture. Prachi Prakashan

7. Govt. of Karnataka (1981). No.HFW 12 MPS 81 dated 13/2/1981

8. The name Ajay as given in page No.180 is not the real name of the intern interviews

9. Belgaum is the border district between Maharashtra and Karnataka and there are number of Marathi schools here as Marathi speaking people are predominant here.

CHAPTER - V

DISCUSSION

IMPLICATIONS OF THE STUDY

CHAPER - V

DISCUSSION

SECTION A

A society can make rapid progress if there is high relevance in its ideas and values, policies and practices and organizations and institutions. Whatever the efficiency of an enterprise or sophistication of a system, if its output serves only the private gain of a few then its social relevance is lost. On the other hand, the social relevance of a society can be deemed to be high when its economic, social and political ideologies, policies and instruments are oriented to meet the felt needs of the masses[1].

It is thirty eight years since India has attained her independence. During this period, there has been an explosive increase in medical education in our country (Chart - 3). This phenomenal growth can be compared favourably even with the more developed countries of the world. However, two cardinal factors have wiped out the apparent advantages of this commendable increase, i.e. inspite of the enormous growth rate of medical personnel, the benefits of the health care delivery system have not percolated to the periphery to the extent one would like and has not reached the grass root levels in our country (Table - 2). Therefore, the vast number of villagers are

Chart - 3

Medical Education in India

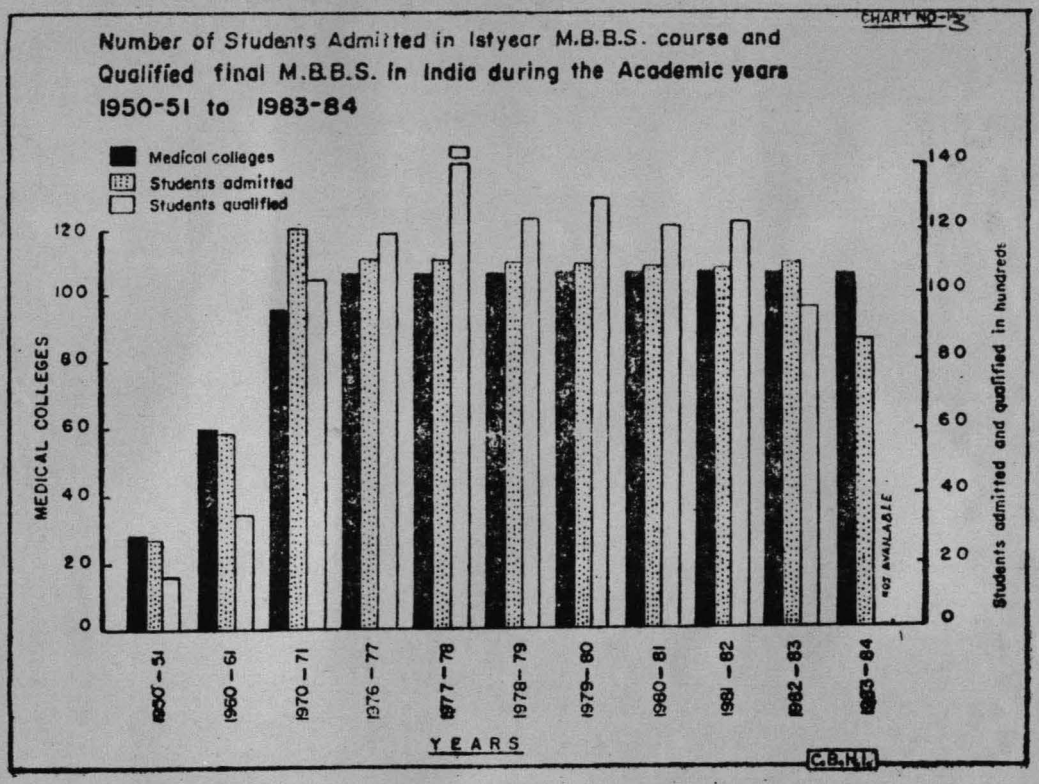

Table 3

Medical Education in India since Independence

Year	Total No. of Medical Colleges	No. of students	
		Admitted	Qualified
1947-48	24	1750	1051
1950-51	28	2675	1557
1960-61	60	5874	3387
1970-71	95	12029	10407
1980-81	106	10934*	12170**
1981-82	106	10749*	12278**
1982-83	106	11054*	9659**
1983-84	106	8521*	N.R.

* Data not received from one Medical College in 1980-81 and 6 Medical Colleges in 1981-82 and 1982-83 and 32 in 1983-84.

** Data awaited from 4 Medical Colleges in 1980-81 and 6 in 1981-82 and 22 in 1982-83.

N.R. = Not Received

Source : Medical Council of India

still without ostensible medical care. It has often been emphasized that the real India is in the villages and it is in this vital sector of our social fabric the poverty of health care delivery is acutely and keenly felt.

Today the majority of medical colleges (nearly 90%) in India are Government colleges funded by the revenues of our State Governments and Central Government. Without going into the statistical details of the exact quantum of money spent from public funds to produce a medical graduate, suffice it to state that quite a considerable amount is spent for the same. It is, therefore, imperative that the society shouldreceive the benefits of such a costly project. This can be done only if the system of medical education can produce doctors capable of, and willing to pay back to society the benefits that they have received in the shape ofhealth care service. For this we require well trained physicians, who are leaders of the medical team and who have the expertise of clinical and social skill apart from proper emotional mileau.

There is always a wide gap between the ideal and the practical. Medical education is expensive and the nearer it approaches the ideal the more expensive it becomes. Medical education has therefore to be related both to the resources that are available and to the needs of the country. It has to be cast within the framework of the general educational system in the country.

Any amount of time can be spent by going on an on at length about the pit-fall and lacunae in the programme of ROME as existing at present. But it would be more rewarding if we spend sometime to delineate some areas in which we are more concerned and separate the pertinent issues, and causitive factors for our discussions.

SECTION - B

Implementation of ROME - Has the Objectives Met ?

The scheme has essentially two components. One is the clinical teaching and training of the undergraduates, and interns in a rural set up and theother is making up the basic health care to the rural population especially those who are residing in remotest areas and those who cannot afford. Further, the services of the specialists are to be made available either by referrals or by active participation of the clinical specialities moving to the rural areas to the extent possible.

Now when we analyse the data collected, in the above context, we find that the programme has not made a conceptual entry even at the cognitive level to the undergraduates and their teachers, leave alone developing commitment, motivation or even a favourable attitude to community health. This is primarily because the college managements, especially the Government run colleges have

not yet made a sincere attempt to give a trial to the programme. The common excuse the Principals and Professors offered was that such 8 weeks posting under ROME scheme will upset the teaching programme of the students, especially the hospital clinics. Thus, by and large, the educational component in the programme has been pushed to the background (Table 17 & 20).

The training programme for the interns under ROME scheme is equally neglected. As against the MCI recommended 6 months rural posting, in most medical colleges, the posting is only for one month, except in one medical college where a three month programme is implemented. In most cases the faculty neither visits the PHC during their posting nor closely supervise their training. They have been left at the mercy of PHC MO who is equally ignorant about the philosophy, objectives and implications of ROME scheme and who is otherwise occupied with host of other activities. Hence the majority of the interns do not attend the PHC posting regularly and the absentees manage the situation through the proxys.

With regard to the second component providing health care coverage to rural population of three developmental blocks (three PHC areas) by the medical college, the study reveals that the service provided in a few villages by these colleges are essentially curative, with very little follow-up treatment.

The services are often parallel to that of the PHC and it has not been properly coordinated or integrated with the working of the PHC. Further, the modus operandi of the services provided is also far from satisfactory. For example in some instances the service is provided to a particular village for a period of one month only. Then the programme is shifted to another village and thus to return to the first village it would take minimum of 2 years. Hence the continuity of service is lost. There is hardly any domicilliary visit to the patients' home. The specialist services is nothing short of a glorified rural OPD conducted inside the Mobile clinics, mostly by PGs.

The first objective of our study is to find out as to what extent these medical colleges were able to implement different components of the ROME scheme. From the data collected, we arrived at the fact that the educational and training components in the programme have not been implemented in three medical colleges out of the four medical colleges studied. The second objective of our study is to evaluate whether these medical colleges were able to achieve the objectives of ROME scheme, i.e. the community orientation of UGs and their teachers and extending rural health to peripheral areas of the three PHCs allotted to them by creating referral complex linking

PHCs with Tehsil/Taluka, District and teaching hospitals. We have also seen that this objective has not also been successfully realized, except some rudimentary form of curative services which the colleges have been providing. Our third major objective is to examine as to what extent the rural communities have benefitted from these programmes, their role, perception, reactions and response to the programme. This we have discussed in the earlier chapter, in the form of a case study. Now the major task within our objectives is to identify the problem areas, lacunae and the difficulties in implementing the scheme. We shall discuss these under specific headings.

SECTION - C

The Principles of Primary Health in ROME Scheme

Let us begin this discussion in a conceptual level and consider the logistics of the scheme. WHO has defined primary health care as "essential care based on practical, scientifically sound and socially acceptable methodology made universally accessible to individual and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part, both of the country's health system of which it is a central function

and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with National Health System, bringing health care as close as possible to where people live and work, and constitute first element of a continuing health care process".

To crystalise, the primary health care has to be easily available, accessible and continuous andits success depends on three essential pre-requisites :

1. Multi-sectoral approach, co-ordinated factors with other development programmes ;

2. Community involvement -participation of people in planning, management and supporting the health care ;

3. Appropriate technology - scientifically sound techniques but financially feasible and operatable by less skilled at community level.

Now let us consider the ROME scheme in relation to the principles of primary health care, as this scheme is considered as a means to achieve the "Health for All by 2000 AD". The pertinent question at this stage is whether the ROME scheme was drawn up keeping this philosophy of primary health care at all.

Will the service provided under the scheme, in terms of easy availability, accessibility and continuity of health care, ever qualify to consider that it is based on primary health care principles? What are the components for multi-sectoral approach in ROME and what is the degree of community participation other than a mere recipient of of services from the providers? Though there are different co-ordination committees, at the level of PHC, College, Region, State and Nation and it is a hard fact that no community participation, not even of the slightest degree is incorporated in the programme either in the identification of problems or in planning, programming execution, management and support. Among the community health jargons, there is no other word as abused as community participation. Though it has become a cli che, many consider it fashionable to mention about community participation and we also see this in almost all documents on ROME. When we consider the philosophy of primary health care, it also means the social control of the technology, and use of appropriate technology, which in other words the subordination of technology to the people. The technology should be scientifically sound but financially viable and operatable by less skilled at community level. ROME programme can never boost to include within the frame work of any of the above principles. The 'Medules' come from Britain and they are not at all appropriate, taking into consideration the conditions of

our villages, and the rudimentary form of curative service provided to the community is not based on the felt needs of the community.

The second and the probably the most fundamental issue we could raise at this point is the very basis of the philosophy and objective of ROME. The ROME is primarily to reorient medical education by providing sufficient exposure to the students and the teachers in rural areas. Medical college is not a service organization. Its primary function is to impart medical education to the students. Therefore ROME naturally for them is only part of their teaching exercise and it is possible that they may not be concerned much beyond their prime consideration of teaching and training medical students. Here, when we talk about medical colleges, it includes private capitation based medical colleges run purely on a commercial basis. Hence, would it not be too much to expect that these medical colleges will provide health care coverage tothe population of three developmental blocks (roughly 3 lakhs) which is cheap, effective, accessible, easily available and on continual basis, considering the ill equipped departments they have in their colleges, and thaching faculty always precariously below the MCI guideline. Secondly, why should as a matter of ~~right~~ fact, the community look upon towards such private and Government medical colleges for provision of their primary

health care? Is it not yet another bureaucratic game of "passing the buck" by the Government to some one else whom they know that they cannot deliver the goods. Every citizen of India has a right to get medical and health facilities and this right has been embodied in our constitution too. Then why should the community look up to these ill-equipped medical colleges for their health needs which by no means is qualitatively satisfying. By the present scheme neither the community is benefitted from the poor quality services provided in a haphazard manner, nor the students are oriented by a few rural visits to watch a 'rural OPD'. Again, is it physically possible and practicable for any medical college to provide, within the given infrastructure of the college and taking into account additional inputs given from the scheme, to take up the onerous responsibility of health coverage of 3 lakh rural population except to provide a referral system as envisaged under this scheme. A via media would be to give freedom to the medical college to take up 2 or 3 remote sub-centre villages situated in the periphery of the PHC area and having roughly a population of 5000 each and to give intensive, preventive, promotive, curative and rehabilitative care until these centres are well-developed, for a period ranging from 3-5 years, and then the college can select three other sub-centres and concentrate there. This suggestion is based on the assumption that during this

3-5 years period, the Government will be able to establish health care infrastructure in these remote sub-centres by making it a PHU or by the input of sufficient numbers of health auxilliaries (CHV/MPW etc.)

Thus the community need not look forward to the haphazard services provided by the colleges which fall like crumbs. The responsibility of providing reasonably good health care facilities proximate to their villages should be the sole concern of the Government and not of a few medical colleg Deans or P&SM Professors, who stay in cities 60-70 kms away and make a 2 hour visit to the village once a week.

It was a great mistake on the part of the Government to allow the private capitation fees-based medical colleges to proliferate which are operated only with an eye on the big money involved. Taking advantage of the laxity of MCI, these colleges sprung up all over the state and now Government's plan of rural health care with medical colleges involvement has been thwarted. Neither they are able to hand over the administrative control of the three PHCs to them, possibly due to the dangers involved, nor they are in a position to withdraw from their commitment. In the bargain unwillingly or otherwise the community became the victims.

Choice of PHC's allotted for ROME Programme

During 1977, when the ROME scheme was launched, all the 106 medical colleges were allotted 3 PHCs for teaching, training the undergraduate students and interns and for providing health coverage to these three development blocks. While distributing these PHCs to the colleges, no thought has been given to allot PHCs which are proximate to the colleges for effective supervision and easy accessibility. There are PHCs allotted to colleges which are as far away as 70 kms from the colleges. In such a situation effective supervision by college authorities on interns and UGs training are bound to be affected. So also the specialists service provided to these villages. Almost 3 hours will take for travel one way alone and thus the faculty will get hardly an hour to spend in the village. Moreover, the fuel bill also goes mounting in such cases considering the fact that POL charges per vehicle is only Rs.500/- per month. If 3 PHCs allotted are in close proximity to the college, then it could have saved quite a lot of time, fuel bill, in addition this would have ensured an effective supervision and coordination of all programmes.

SECTION - D

Rural Internship Training Under ROME Scheme

Though the MCI recommended 6 months rural training out of the one year compulsory rotatory internship training, none of the medical colleges under study seems to have

implemented it for more than 3 months period. In two medical colleges interns are posted to rural centres only for one month, while in two other medical colleges, even during this one month's posting they do not reside in the PHC area as required. They merely join the ROME team on the days of visit. However, in one medical college, interns are posted to 3 different PHCs for a period of one month each on a rotation basis.

As it is, the interns training programme at the moment is a poorly arranged and ill-supervised. The rural internship programme, which was meant to familiarise medical students with rural health problems has come to be viewed as a necessary ritual. It is not uncommon for students to find ways of evading this stint, though they are there officially. Internship training is to be used to secure linkages between medical colleges and community by shifting such training programmes away from the medical colleges to selected PHCs, taluka hospitals and district hospitals. This has a two-fold objective, i.e. of training the students in an environment which he is likely to comfront in his actual life as a community physician and that of an emerging health care delivery services in the periphery as a result of the input of additional medical personnel in those regions from the teaching hospitals and the stimulus resulting there from.

Thus the rural internship programme which the students undergo under the supervision of the department of preventive

& Social Medicine is far from satisfactory. In most cases, the teachers are neither oriented to community nor to their own discipline, hence one cannot expect much from such teachers to impart rural orientation to the students. The prevailing rural training programme in most of the medical colleges leaves much to be desired and only meant for satisfying the MCI directives for the recognition of the colleges. The students do not develop a sense of commitment under these circumstances. Perhaps one of the areas where a radical change in the curriculum will be most effective is in the internment training programme.

Administration and Logistics of the Programme

Though the scheme was started as a centrally sponsored programme with 50:50 share with State Governments, it put a heavy financial burden on the medical colleges, especially on the private medical colleges. The Government of Karnataka clarified the policy[2] to the management of the private medical colleges that the cost of petrol, oil and lubricant charges in full in respect of the mobile clinics have to be met by the custodian of the vehicles - i.e. concerned colleges, and Government of Karnataka could reimburse this amountonly if the Government of India provides any assistance in this regard.

When one considers the genesis of the capitation based private medical colleges in Karnataka and the purpose of their existence, itis unrealistic to expect them to spend lakhs of rupees annually from their hands to run ROME programme in an effective manner as desired by the Government by meeting the expenditure on POL charges, repaires and maintenance charges of the vehicles given under the programme. Since their motives are clear, even if they take up rural health care under the threat of MCI's non-recognition, those attempts will be nothing short of a farce.

Finance and Budget Grant

Though a sum of Rs.10,000/- has been allotted per centre making a total of Rs.30,000/- for the 3 PHCs under a medical college for purchase of surgical equipments, in many cases either the budget granted lapsed or when procured, it is diverted for use in their own teaching hospitals. Similar was the fate of the budget grant of Rs.25,000/- sanctioned for furniture and books. Again, there is a provision of rural library at each of the PHCs under ROME programme. However, there were no such facilities existing in any of the PHC studied, obviously, either they have managed to get the budget lapsed or the books might have found its way to some other place.

Government's Apathy

Though Government of India has provided 41.11 lakhs during 1978-79 for ROME programme which includes provision for the purchase of a Mini Bus[3] as the 4th vehicle under the scheme which was meant for transporting faculty and the medical students from the college to the PHC areas. This has not been procured by the StateGovernment, though they received the Central assistance as early as 1979-80. The non-supply of Mini-bus was cited by most medical college Principals as the reason for not taking the students to the villages.

colleges skip their responsibility towards the rural community to accept the health coverage of three development blocks unlike the MCI recognised colleges. The decision of Karnataka Government to sanction several more capitation-based private medical colleges should logically spur the Union Health Ministry and MCI into action, but going by its track record one can safely predict that this will not disturb the Ministry's and naturally MCI's state of inertia, though both of them periodically threatens with a move to amend MCI Act. However, knowing the power of political lobbying for such private enterprises in this country one can safely presume that these threats may not materialise in the near future.

Despite a perceptible decline in the standard of medical education over the years, the Union Ministry of Health has neither formulated a national policy on medical education nor given the MCI enough powers to retrive the situation. As a result many ill-equipped medical institutions have sprung up in the state in recent years in contemptous dis-regard for the norms laid down by the MCI.

Medules

Government of India, imported 318 Medules, each costing Rs.8.5 lakhs[5] - 4 wheel drive smaller vehicle which is meant to manoeuvre difficult terrains and kutcha village

roads and hilly tracts another 2-wheel drive large vehicles meant for mofussil area where better roads are available. Deliberately or otherwise, we find all the 2-wheel drive large cehicles are dumped on to the private medical colleges and the 4-wheel drive smaller Medules were retained by the Government medical colleges in the State. Does this mean that the PHC areas allotted to private medical colleges have good roads and vice-versa. The private college authorities have now realised that 2-wheel drive large vehicle cannot manoeuvre the village roads in the PHC areas allotted to them. Such discrimination in alloting mobile clinics by the Government, whether deleberate or otherwise, was not in good taste. The authorities should have ensured a fair mix of vehicles of these two types so that college authorities could use them according to their discretion.

Since 1979-80 this Medules have become an integral part of ROME scheme and in many instances the faculty and students have understood ROME programme only in terms of Mobile clinics. In other words, the Mobile clinics have become synonymous with ROME scheme.

There has been mixed reaction to these clinics and some scepticism has been raised regarding their functional utility[6]. The utilisation of these clinics has varied from one institution to another depending on

different factors. There is, no doubt, an urgent need for evaluating the efficiency of the clinics to identify activities of optimal utility of total health care strategies for the rural areas, since the expenditure involved in procuring and maintaining these vehicles are enormous.

The Ministry of Health had given specific instruction that the Mobile clinics are not to be utilised for transportation nor should it be brought to the headquarters unnecessarily[7]. It should be stationed at the PHCs where separate garrages have been constructed. However, wherever the vehicles are put to use for ROME programme it is made to travel between the college to the village along with faculty and students.

When Government realized that mobile clinics given to medical colleges are not put into use, the DGHS expressed their desire to withdraw two of these mobile clinics from those medical colleges, where they have not been put to use properly[8,9] and to re-distribute the same. However, all medical college authorities painted a rosy picture on ROME implementation in their colleges and managed to retain all the three Medules, for conducting family planning and other camps or to keep it as a status symbol. Another reason for not returning these vehicles were that most of its expensive equipments have already found their way to their teaching hospitals.

The Medules have been fitted with heaters - a necessity in Britain but absurd in India - which made working conditions unbearable inside the vehicle. Inside these vehicles, there is no place for auxiliary personnel. The most important problem was its low-mileage - it merely runs less than 3 km/litre of diesel.

The vehicle is also not very strong, especially the interior furnishing, the shelves and pharmacy cup-boards given away within a few years of its use. When the most revealing fact comes out that these cup-boards have only a wood finish with sunmica/formica coating and inside it is filled with saw dust. An Indian Company could have fabricated a better, strong and sturdy vehicle which is suitable to Indian road condition for just half the cost. Even the two wheel drive vehicles are unable to negotiate interior village roads. These vehicles have also earned a nick-name "White Elephants" due to its unusual size (prpbably this name is appropriate not only because of the large size but also considering the expenditure involved in maintaing it).

"The scheme has not been successfuly implemented in most medical colleges. One of the reasons for this may be that the type of vehicle which was provided has not really done the job and on the contrary has brought ill-fame to the scheme".[10]

Now most of these hospitals on wheels given to these medical colleges are gathering dust and rust. Its doors are jammed, keys are lost and a lot of the expensive equipments has vanished mysteriously. The Government apart from the actual cost of Rs.8.5 lakhs and annual POL charges of Rs.6,000/- has to pay onyearly insurance premium of Rs.2,500/- on each of these medules.

As a newspaper reported[ii] "The spirit was willing but the flesh was weak and after sweating it out for a short while, the doctors gave up. And thus another grandiose but short sighted scheme hit the dust".

However, on an impartial view one would agree that Mobile Clinics can occupy an important and definite places in the planning of comprehensive health care for the rural areas, if its services are made available on a continuous basis and made accessible to all segments of population, particularly the vulnerable sections in the rural and peripheral areas. The domicillary surgical services through Mobile camps in most places have been well received.

SECTION - F

Rural Health Coverage Under ROME

With a weekly visit to an area, as practiced in some places and providing services continuously for a month and then shifting their services (in which case, it will

ultimately take 2-3 years to returns to the same village), there is no continuity or follow up of treatment given. Sugh programme probably would help the college management to paint a rosy picture to the DGHS authorities sitting in Delhi about the health coverage provided to the villages. However, to the villagers such a haphazardly organised programmes could not be of much help.

Even when weekly visits are provided by the medical colleges, it remains as a parallel services, as it is not integrated with the services provided by the PHC. In a few cases, the PHC authorities are not even aware when the faculty from medical college would visit their PHC villages. The much needed follow-up of the cases by the MOs of the PHC is not forth-coming.

By and large, the drug budget of Rs.15,000/- per Mobile clinic for a population covering a development block is by all means inadequate. Even if we are taking into consideration the PHC annual drug budget of Rs.10,000/- drug budget for the approximately one lakh population is a very meagre amount. One has to take into account the pilferage at various points and therefore the only a very small percentage of medicines goes to the people for whom it is meant for. A section of students accused the P&SM faculty for misappropriating ROME drug stock, while

some of the villagers think that the MOs indulge in misuse of drugs and other corrupt practices.

There was also wide spread discontent among the clinical faculty, interns and PGs as to the drugs supplied to the Mobile Clinics. Most of the drugs given are not useful in common practice and in some cases outdated drugs or drugs nearing expiry date were also found to be in use.

In most of the villages the drugs are given for one or two days only. The patients are expected to buy drugs for the remaining days. For many reasons - either due to non-availability or non-accessibility to a drug shop or non-affordability, this is seldom done.

Hence the scientifically trained specialists are doing more harm than good, especially while dispensing antibiotics for a day or two knowing that the patients cannot procure the remaining dose of such costly drugs. The college authorities pass the buck to PHC authorities stating that the PHC doctor is supposed to provide follow-up care and hence the patients can collect the remaining days' dose from the PHC. But in the actual situation where PHC having 7,500-10,000 annual drug budget for a lakh of population, can never afford to give those antibiotics prescribed by the Mobile Clinic team (very often in the PHC's list of drugs, such antibiotics are not included).

The Mobile clinic doctors spoke in defence of this practice of giving one day or two days dose of drugs. It is to "inculcate a sense of value to the villagers otherwise they will throw it off if the entire course is given to them".

One who has slightest knowledge about the village life will know that their sense of value of a villager is much higher than that of an average urbanite. This argument is nothing short of "rationalisation of an irrational action".

One of the objectives of ROME is to get the specialists deal with common ailments and train students to provide health care under rural conditions. Such being the case, will the posting of SHO, PGs and interns to Mobile Clinics in the place of clinical specialities, really help the students? Though they can help in the initial screening of patients and filter the cases for specialist care and student teaching, the PGs and interns should be under the guidance of their senior teachers. There is no involvement of para-medical workers in the Mobile clinics, so also essential lab, X-ray and surgical facilities.

The present complaint of insufficient clinical material at these posting arises out of poor coordination

with PHC personnel and consequent non-publicity of the specialist's arrival in a particular village on a given date. If the advance programme is sent to the PHC and the MO takes interest to send his BHWs of the area concerned and gives due publicity about the specialist arrival in advance, they would naturally make use of the facilities made available at their door steps.

The Role of CHVs in ROME Scheme

Though the Community Health Volunteers (CHVs) constitute the largest single health auxilliaries in India, i.e. one for every thousand population, their role and functions have not yet been defined inROME scheme nor their services have been integrated in the programme. As a result the services of millions of CHVs in the country remain unutilized in this vital sector, especially in preliminary screening and identifying of cases that require specialists attention, referrals from his village to the Mobile Clinic or through them to the teaching hospital. He could have been an useful link for the students and the faculties in establishing rapport with the village community and they could have made a successful entry to the village through him in solving the village health problems.

SECTION - G

Referrals

One of the important objective of ROME scheme was to create a viable "Referral Service Complex" linking PHCs, Taluka/Tehsil, District and Teaching Hospital of the college, at different levels so as to form a functional system having direct links with community around them. However, in the medical colleges under study, this concept is yet to take root. The cases seen at the villages, if they are serious enough to demand admission, such cases are brought to the teaching hospital, but once they are in, the situation is by no means better. The patient has to go through the usual bureaucratic hurdles to get himself admitted and the conditions of the hospital, quality of treatment, the drugs supply - all leave much to be desired.

Again the proposed 'Referral Service Complex' is short-circuited by linking the sub-centre village (where Mobile clinic is being operated) directly to the district hospitals or teaching hospitals of the college, by-passing the linkages in-between (i.e. intermediary links in the chain, like PHC, Taluka, Tehsil or sub-divisional hospitals) Whenever the PHC doctors refer cases, they also send them directly to the District hospital, by-passing the taluka hospital. Here again the teaching hospital of the medical college is ignored.

The scheme even after existence of almost a decade, is yet to develop a viable referral system linking all institutions in the hierarchy. So also it has not succeeded in providing the community an acceptable, reasonably good care to the referred patients. This is basically due to the fact that the scheme has not been integrated into the working of the PHC and its objective. As long as the present practice of conducting parallel service by PHCs and the medical college team is in prevalence, this idea of creating a viable 'referral service complex' may not materialise. Again under the scheme the Government has only visualized the development of infrastructure at the PHC, while at the other links (Taluka and sub-divisional hospitals) corresponding improvements are not envisaged.

Ambiguity in Government/MCI Directives

Students exposure

The Central Government/MCI directive is not clear in the following issues :

1. Batch(es) of students to be posted
2. Optimum number of students per mobile clinic
3. Duration of posting
4. Contents of the programme

Therefore the individual colleges interpreted the ROME scheme so as to suit to their convenience and implemented it in their own way. Again clarity lacking on the following matters :

1. Whether this suggested 8 weeks programme to be taken place during their pre-clinical or clinical years.

2. Whether this 8 weeks posting to be made at one stretch or in a staggered manner.

3. Repeat rural posting should be made in the following year or not.

4. How these postings can be effected without affecting their usual teaching curriculum and hospital clinics.

SECTION - H

Social Sciences input in ROME Programme

"Medical education if it is divorced from the study of humanities will tend to produce only a technician and not a physician endowed with the capacity to deal with human problems or with the sympathy and understanding necessary to win the confidence of the patients he treats[12]. The relationship between doctor and patient is first and last a very intimate human relationship the quality which is of the utmost importance to both. The more a medical man acquired for himself an understanding of human nature and of social relationships, the better does he equip himself for the wise use of his professional knowledge and experience for the benefit of his patients.

The expectations of the society that a medical graduate will be a scientist, a humanist, as well as a fellow citizen with a sense of responsibility to the community to offer his services whenever they are needed, will have to be fulfilled.

Successful practice of medicine depends not only on the clinical skill of the physician but also on his understanding of the psychological, cultural and social factors influencing the patients' response to treatment. It is therefore essential that the doctor should be familiar with the concept of social science as an important component of medical practice.

Subjects such as Economics, Demography, Sociology, Psychology and other social sciences should form an integral part of this package deal. It is only by evolving such a multifaceted approach to the study and understanding of the community's problems can the medical student and the doctor be made aware of the significant pivotal role he has to play in this dynamic endeavour, and not allow him to reduce himself into a technician with his technical know-how, ready to work in a piecemeal manner at certain vulnerable points.

The ROME programme should have been the most appropriate relm to introduce an increased input of social

sciences to the undergraduates which would have helped them to relate their professional skill to thepeople at large. Unfortunately, in the colleges brought under study, no such attempts seems to have been made in this direction. What was more distressing is the fact that ROME programme has been reduced into a conventional P&SM field visit and it has no way tried to improve the social science skill of the young graduates.

Faculty Position

The faculty position at many medical colleges is very precarious. In the Government run KMC at Hubli, the department of P&SM has a very pathetic condition with regard to teaching faculty. The department which conducts undergraduate and postgraduate courses (M.D.) and Diploma (DPH) is manned only by a Professor and a Lecturer. This is inspite of the specific recommendations made on these aspects of ROME at the 8th joint Conference of the Central Council of Health and the Central Family Welfare Council held in New Delhi on 18th-20th August 1982[13]. They have recommended that posting of requisite staff in the attached PHCs as well as in the P&SM and other participating departments of each medical colleges are to be ensured. The joint Conference also envisaged the establishment at the State level and in each medical college, of a standing machinery to review the implementation of the scheme every month and to forward progress reports regularly to the Ministry of Health & Family Welfare, however, this did not happen in most cases.

Medical Teachers in ROME training

One of the important factors for creating a frame of mind suitable for the practice of community health orientation is needed the attitude of medical teachers. If senior clinicians have an adverse attitude towards community health in general and on ROME programme in particular, then the students will naturally follow their lead to the detriment of the cause. The involvement ofthe faculty from clinical departments in the training of medical students in the community setting is an essential pre-requisite to achieve the desired results. As Banerji (1971)[14] points out "inspite of all the radicle declarations, however, no attempt has been made to change the mentality that the senior members of the medical profession and teachers had inherited, nor were attempts made to open medical profession to poor classes of the society".

Many of the medical teachers are on the job-for many reasons other than the aptitude or inclination for teaching. It will be too much to expect good teaching from such teachers. The selection of teachers in most of the medical colleges is made on many criteria of which academic attainment form only a very nominal part. In addition a good student need not necessarily be a good teacher. The major drawback of ROMEscheme is that the

faculty has not been groomed for this task. For the students orientation, it is necessary that their educators be oriented first.

As one medical teacher[15] comments "Because of the professional vested interests in medicine, the medical profession has refused to accept the fact that all doctors cannot necessarily be good teachers. Educational science and pedagogy are important functions on which medical curriculum should be organised, whatever the content and relevance of the course. Teachers in medical college in India seldom joins because of their love for the 'vocation of teaching'. A base in the medical college is helpful in the cut-throat competition of private practice apart from being itself a channel of referral to one's own private clinics. This is inspite of the fact that MCI recommends full-time non-practicing teachers. The remuneration offered to medical teachers further compound this problem. It is only as late as 1977 MCI has statedthe need for teachers to undergo a course in pedagogy. However, even now this is not mandatory".

This state of affairs has resulted in the clinicians generally developing quite an unfavourable attitude towards rural training of undergraduates and interns.

The Role of Preventive & Social Medicine in ROME Scheme

The programme has been coordinated under the responsibility of the department of P&SM in most medical colleges. This had led to some clinical faculties and interns to look upon this scheme as a programme of the department of P&SM.

The faculty drawn for the P&SM was mostly composed of those who in the early period came from the field and thereafter completed postgraduate studies to quality as teachers. They were considered out-siders to the academic world who get rapid promotions because of the vacancies that existed. Even today the faculty members in this department as one teacher stated 'continue' to be second class citizens'. The ranking is not so much as a result of lack of professional training. It is a part of mental block mostly attitudinal, which accepts the presence of community medicine departments in medical schools with reservations.

Secondly, it also needs to be noted that if the early teachers in the subject lacked academic competence, today they are handicapped with lack of adequate field experience. Either of the two situations prevent optimum growth and professional recognition. Since the P&SM pfofessors are the ROME Co-ordinators in most medical colleges, this affected the image of the programme in general and P&SM has a very poor image among the students and their own clinical freternity.

Thirdly, the student perception of the role of community medicine in their professional development is yet another important area. In most of the para and clinical departments students get fair mix of learning opportunities. In this learning experience, the teachers are active participants. On the other hand, the teachers in community medicine act through and with the cooperation of the staff in health centres. Very often the discussions in the classroom find little relevance in every day work experiences. In such a situation student is likely to get an impression (and very naturally) that community medicine is a concept that is to be talked about and discussed but it is not useful in day-to-day practice for it is vague and not very useful.

These amorphous concepts of Community Health taught to students do not tellwhat sort of economic and social prwesses are at work which produce huge differences in economic and social opportunities to different social groups, which have close bearing on the health statuses of the community[16]. In the teaching of community health it is often ignored that health should be seen in the context of over all socio-economic development of the community. However, those of the doctors who were inducted into as PHC medical officer, repented for not taking their P&SM classes seriously when they were students, as they

have now realised that what they practice now is 90% P&SM and other subjects which they thought as the best did not come to their rescue in the rural health practice.

Medical University

Many States, including Karnataka have been spinning the idea of establishing a medical University in this States in order to improve the standard of medical education and implement ROME scheme effectively. Even at the national level for sometime it has been debated whether such an orientation and development of relevant medical educationprogramme will be achieved better by setting up a Medical University for the entire country in contrast to the present system of affiliating medical colleges to the local general Universities. In the State of Karnataka the9 medical colleges (MCI recognised) are affiliated to 5 different Universities with slightly different curriculum, examination and semester systems.

Establishment of a Central Medical University will indeed bring about an uniformity throughout India in the system of medical education. The University will beable to enforce uniform admission requirments, curriculum and syllabus content, interns training, examination standards etc. Moreover, an all India merit basis admission to different medical colleges, irrespective of its geographical location, will now be possible, if such a plan is materialised.

Medical Council of India - Is it in deep slumber ?

The MCI, the highest technocratic body which had earlier undertaken the task of remodelling undergraduate medical education was unable to correct the prevailing problems in medical education, especially in Karnataka State.

"Even though the MCI has laid minimum standards formedical colleges including the qualification and experience of teachers it is a well-known fact that these standards have been followed in default rather than in acceptance. It would not be rash to state that if an objective evaluation were to be made of the 120 odd medical colleges using the so-called minimum requirements of the MCI, more than 50% of the colleges would have to be closed down immediately. This exercise would itself expose the complicity of MCI inspectors in the dilution of standards in the country[17].

Our present study only re-affirms the above statement. In most medical colleges, some of thepara and pre-clinical departments especially the department of P&SM exist only for the sake of MCI recognition with a skeletal staff. We find the Government often threatens stating that they are going to amend the MCI act to curb the mushrooming of capitation based medical colleges.[18]

Unfortunately the threat has not been materialised and more and more private capitation fee-based medical colleges have sprung up with the blessings of every successive Ministries.

All the unrecognised medical institutions owe their existence to theanomalies in the Indian Medical Council Act. Currently, a college is opened once the State Government gives its sanction. The Universities are almost taken for granted and university affiliation is given without much fuss. Several years hence the college authorities approach the Medical Council for recognition. The Council sends its inspection team and based on the report of the inspectors either grants or rejects recognition. Thus one can have an unrecognised medical college, whose students are awarded degrees recognised by the MCI. The MCI has found that colleges are not housed in proper buildings. Necessary equipments and laboraoty facilities are non-existant. Most of the colleges donot have attached hospitals and therefore the most important component of medical education - clinical training - is missing. Under the existing rules in Karnataka the Government can confer affiliation to a medical college directly over-ruling the University decision. In a given situation like this, how is Government going to hand over the responsibility of rural health care of 3 development blocks to these medical colleges ?

Literature on Medical Education

While reviewing the relevant literatures on medical education, it is found that the writers on medical education seems to be obsessed with undergraduate and postgraduate medical education and their discussion primarily confines to these two levels. However, when we consider the objectives of a medical college and its functions it is not only to produce medical graduates and postgraduates alone but it has also to meet the national health manpower requirements. When we consider the fact that the doctor is the leader of a health team, he is not the only important person. The para-medical and auxilliary health personnel play a pivotal position in providing comprehensive rural health care. Hence, training of an adequate number of para-medical personnel to provide the supportingrole to the doctors would be an important function of medical education, which should be given prime importance. However, their training provisions in these medical colleges have been largely ignored by many of the medical educationist (Table 4, 5, & 6 and also Chart No.2). These personnel need to be produced in a much greater proportion than that of the doctors. However, the paradox in our country is that though the undergraduate and Postgraduate medical education has developed manifold over the years, the training programme for the para-medicals and auxiliary medical personnel has not been given its due importance. There is a perceived felt need for these

Table 4

Para-Medical training facilities in India

S.No.	Description of the Course	No. of Institutions	Admission Capacity/ No. admitted
1.	Nurses General	324	7750
2.	Aux. Nurse Midwives	339	6006
3.	Midwives	276	7539
4.	Health Visitors	21	835
5.	Dental Hygienist	9	71
6.	Dental Mechanics/Technicians	8	54
7.	B.Sc. (Med. Lab./Technicians)	13	105
8.	Lab. Tech./Lab. Asstt.	78	1558
9.	Sanitary/Health/Malaria Inspector	30	3095
10.	Pharmacists	105	4063
11.	Radiographers	36	400
12.	X-Ray Technicians	22	209
13.	Operational Therapist Asstt	6	55
14.	Physiotherapist	7	146
15.	Occupational Therapist	5	121
16.	Speech Therapist	2	13
17.	Orthopist	2	12
18.	Optician & Refractionist	26	617
19.	Health Worker (Male) under M.P.W.	15	819
20.	Miscellaneous	27	721

Note :- Data in respect of S.No.5 to 20 relates to the period as on 1-1-1983

Source: Hand Book of Health Statistics of India, 1985 Page:50-51, Table 23

Table 5

Health Man-power Statistics : 1951-1984

(Doctors & Nurses)

Year	Doctors	Nurses
1951	61,840	16,550
1961	80,084	35,584
1971	1,51,129	80,620
1980	2,55,138	1,46,201
1981	2,68,712	1,50,399
1982	2,71,598	1,62,875
1983	2,84,265	1,64,421
1984	2,97,228	+

+ : Not available

Source : Medical/Dental/Nursing Council of India

Table 6

Rural Health Manpower Statistics-1984

Sl. No.	Category	No. sanctioned	In Position
1.	Doctors at P.H.C.	20115	18962
2.	Doctors at allopathic Dispensaries	7856	6849
3.	Doctors at ISM Dispensaries	3276	3142
4.	Health Workers (M)	75319	71968
5.	Pharmacists	20433	18640
6.	Lab. Technicians	6935	5973
7.	Block Extension Educators	4850	4494
8.	Health Supervisors (M)	23868	20451
9.	Nurses/Midwives	9394	8708

Source : Hand Book of Health Statistics of India, 1985 page-53, Table 25

Chart - 2

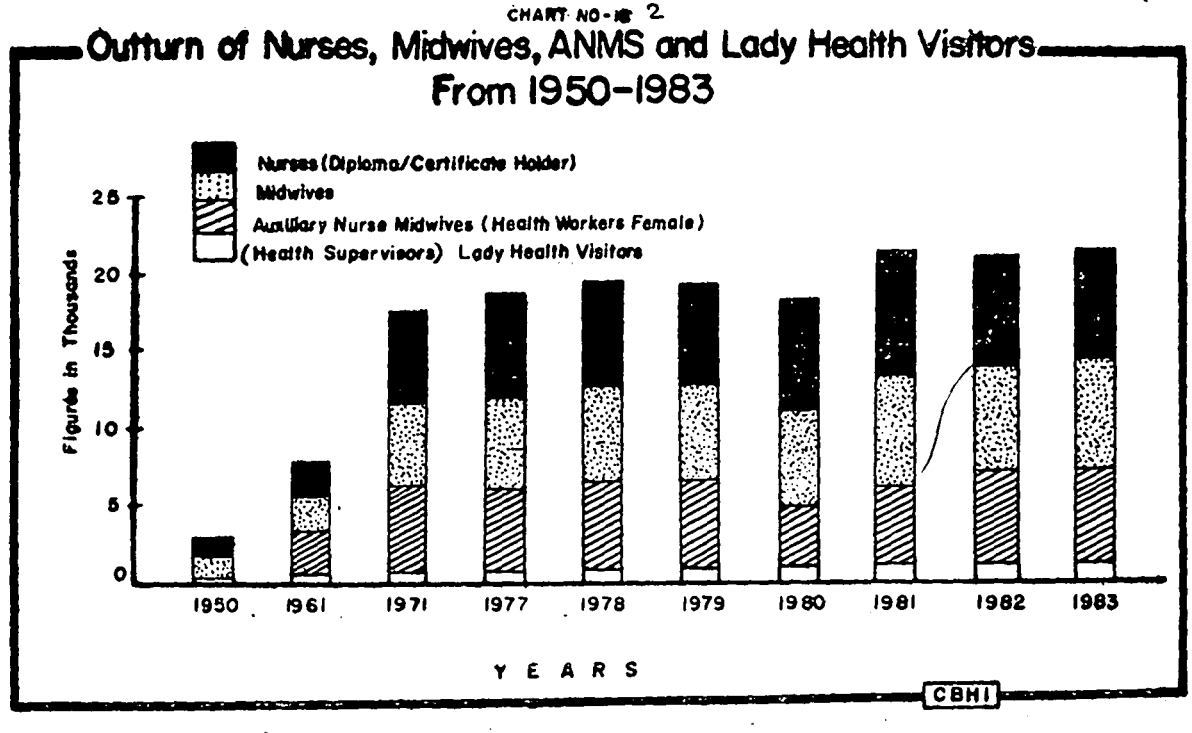
CHART NO - 2
Outturn of Nurses, Midwives, ANMS and Lady Health Visitors
From 1950-1983
Nurses (Diploma/Certificate Holder)
Midwives
Auxiliary Nurse Midwives (Health Workers Female)
(Health Supervisors) Lady Health Visitors
Figures in Thousands
25
20
15
10
5
0
1950
1961
1971
1977
1978
1979
1980
1981
1982
1983
Y E A R S
CBHI

categories of trained workers in the rural areas. However, the medical education literature seemed to be obsessed with only UG and PG medical education completely neglecting this vital area.

Coordination Committees

The Government has spelled out its policy with regard to the coordination committee meeting at various levels such as PHC, College, Regional (District), State and National (Appendix VI). The Government communication in this regard makes it clear that officers of the Government who do not attend this meetings will be treated as dereliction of duty on the part of the MOs, and are liable for immediate suspension and departmental enquiry. However, this has not happened in the actual practice. During the last one year even Directorate of Medical Education failed to convenue the state level meeting. The fate of the coordination committees at the level of college and PHC coordination committees at the level of college and PHCwere also not different. It at all convened, these meetings were poorly represented especially the DHO, and Government Officials and the deliberations of these meetings were not necessarily followed up with actions. In most cases, the DHO or his nominee has not shown much interest in involving himself in the college level meetings.

It is also interesting to note that though Government has worked out detailed plans on the constitution of various levels coordination committees ~~s~~ at the level of PHC, medical college, District, State level etc. in none of the committees, the actual beneficiary of the programme, i.e. community members were represented.

While the factors listed out in earlier sections have all contributed to stifile the programme, they are all basically symptomatic of one root cause, i.e. the total lack of community's participation in the programme. All manner of services and, programmes at all levels have been planned by people who have little, if any, knowledge of the rural areas or the villagers perceptions to health programmes. Their felt needs, wishes, views and ideas have never been consulted or respected and lack of their involvement has affected the programme to a great extent. Possibly, the centrallised bureaucratic approach now followed in the programme has dissuaded the community from involvement in the very programme aimed at their welfare. Whenever a programme fails there is often tendency to blame the community and we have scape-goat-mechanism by saying 'because people are ignorant and superstitious the programme did not make the desired impact'. The ROME programme is not an exception. We have heard this same theme in many variations many times. Either those who makes such statements are rash and careless or they betray serious gaps in their

knowledge of community perception. Programme implementation in rural setting is an extremely complex. Hence compromises are inevitable. But thecompromises should beminimum so as not to affect the basic objectives of the scheme. When DGHS or MCI formulate a rural health policy it is taken as granted that its optimum opinion represents all segments of the society. However, in practice they are sometimes do not find relevance to the masses..

This fact is clearly issustrated in our data too, presented in the preceeding chapter in the form of a case study (Case Study-4).

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CHAPTER - VI

CONCLUSION, SUMMERY, EPITOME OF FINDINGS SUGGESTIONS & POSTSCRIPT

SECTION - X

Conclusion

The findings of the study is no way encouraging. The Government itself is turned out to be the main culprit in not implementing the programme in a mode and spirit it was envisaged.

The vast majority of rural people, for whose benefit the programme was launched (besides UGs and Interns) were left out in planning as well as determining the goals, which were meant to cater to their needs. Neither has the community been encouraged to contribute to the programme nor their wishes are sought or respected. In fact, in the name of the new scheme, the trend has reversed - a total dependency on the medical profession has been promoted.

It has failed to motivate the students, even at a cognitive level towards rural orientation in relation to their future career. The attitudinal change expected from the teachers towards community orientation has some how worked in the opposite direction. Most of the clinicians reacted violently towards the programme and they maintained a perpetual hostility towards the scheme right from the beginning.

While the private medical colleges made some attempts to implement the scheme in their medical college those under the Government control, which are expected to set an example to others, have turned out to be the biggest defaulters in all respects. If the Government was earnest in implementing the scheme and a sincere effort was made, the programme would not have suffered to this extent. Even the Government's failure to release the Central assistance for purchase of a 'Mini Bus' to each of the medical colleges concerned has costed the programme very dearly. So also was the case when Government in a most retrograde and regressive step, decided to withdraw the G.O. on handing over the administrative control of the PHCs to the concerned medical colleges. The stand taken by the Government (DGHS & MCI included), by relying solely on the 'Quarterly Reports' sent by the Principals and not making its own effort to verify the facts with regard to programme implementation, has given a chance to the college managements to be lax on the issue. Government's inability to supervise, control and monitor the progress of the scheme has resulted in the scheme being neglected by all concerned. We believe that these measures adopted under the garb of RME to make the medical education in India responsive to social need far from progressive, they are merely cosmetic changes.

According to the original plan of the RCME programme, during the second phase which was supposed to commence after 5 years, the medical colleges were expected to take another set of 3 PHCs and ultimately the entire district was to be covered. However, this second phase did not at all materialise in any medical college. Even in the first set of 3 PHCs the programme is functioning at a highly unsatisfactory level. Thus the entire health coverage of district might remain as an 'utopia' or a distant dream in the given situation of this state.

RCME is a new concept, a novel philosophy and a strategy towards a specific and of giving relevance for medical education in India to be experimented in the settings of a medical college and practiced in their field practice areas, jointly by the entire gamut of teaching faculties with their full participation and support. However, by not showing patience to give it a fair trial the clinical teachers in most medical colleges threw the baby back to the lap of the PSM department to carry on its nurturing and they have taken the stand of a casual onlooker and sometime even becoming increasingly aggressive and hostile towards the programme. Whatever little the PSM department does, is undone by the remaining clinical departments in most cases. Most

clinicians have consider the implementation of RCME programme as the individual responsibility of P&SM faculty and they have nothing to contribute to it.

Equally responsible for the state of affair are the officials at the DGHS who provide the finance, but do not 'interfere' further in the matter and leave to the State Government to run it in their own way. The MCI should also share a larger part of the responsibility for the failure to take cognizance on those defaulting medical colleges for the gross violation of its directives, with regard to RCME implementation, especially in matters like students rural posting, rural internship training and for not having full complement of teachers in various departments.

All these factors have contributed their might to see that the programme is grounded before its take-off and the Government of India's share of Rs.17 crores spent on this scheme between 1977-85 did not benefit the beneficiaries much. "We all know that medical colleges as institutions are far too rigid and too bogged-down in quagmire of unhealthy values, wrong priorities and practices" Then it would be too much to expect them to give a new lead in the search for relevance.

The search for relevance is still within the four walls of the medical colleges and the truth to be found out is in the villages quite away from these.

SECTION - J

Summary

Re-orientation of medical education scheme was launched by the Government of India in 1977, to introduce community orientation of the medical students and their teachers based on the philosophy of making a medical college totally responsible, in a phased manner to provide health care to the entire population of the district in which it is located. Furthermore, it was envisaged that, along with the undergraduate students, the entire faculty will be involved in the shift towards community orientation. The entire period of internship training was proposed to be spent at the primary health centres, sub-divisional hospitals and district hospitals.

The present study covers the entire aspects concerning ROME - Final MBBS students of the 4 medical colleges, the interns doing their rural posting, the medical officers of the PHCs, allotted to these 4 medical colleges, the teaching faculty of the P&SM and clinical departments, the members of the rural communities who are also the beneficiaries of the scheme, the officials of the Director of Medical Education in the State and

DGHS at the Centre who sponsored the programme were also brought under the study as respondants to obtain a composite view on RCME. The study covered two Government and two private medical colleges in Karnataka State and their field practice areas.

The main objectives of the study were to examine to what extent these medical colleges were able to implement the different components of the scheme and whether they were able to realise the objectives of the programme during the last 9 years of its existance and to assess the perception, views and response of the parties concerned with the programme - i.e. medical students, interns, medical officers of the PHCs, village community and the sponsors. The study covered 392 medical students, 90 interns, 28 medical officers of the PHCs, 33 teaching faculty from clinical departments, 15 teachers of the P&SM departments, apart from over 100 members of the rural community and the top executives of the Directorate of Medical Education at State and Central level.

The study revealed, among other things that the students are not at all exposed to RCME programme as envisaged under the MCI regulation in two Government medical colleges. In that respect the private medical colleges were better, though their RCME programme has been hephazardly organised and there is not much of learning process, especially of social skills to the student.

With regard to the rural training programme of interns, no medical college have implemented the 6 months rural internship prescribed by the MCI. Only two medical colleges (one Government and one private) have implemented the 3 months rural training and in the other two medical colleges the rural posting is only for one month.

The teaching faculty's response to RCME scheme is equally dis-heartening. Even those medical colleges where the specialist go to a village, he conduct a rural OPD sitting inside the mobile clinics with the help of the PGs and interns hardly interacting to the village community. Again, hardly no teaching take place in the village by the clinical faculty.

Community has no role or say in the programme, except as the mere receipient of this rudimentary form of curative services.

The officials at the State and Central level and the MCI seem to be indifferent to the situation. There is no check over its implementation effectiveness, from the concerned Government departments.

The students and their teachers identify and perceive RCME programme in terms Mobile Clinics (Medules) and RCME programme has become synonymous with Mobile Clinics.

The real question posed at this state is how to transfer these otherwise good objectives and values into tangible reality ? Basically the ROME programme is a field programme and it has to be based in the community, taking family as a Unit. The teachers involved in the programme has to be well versed with socio-economic and cultural aspects of health and the practical realities in rural life. The teachers have to be aware of the problems ensuring community participation. This did not happen in the actual programme implementation in the colleges studied. The teachers were cut-off from the realities of rural life and their perception of rural life was quite different.

The philosophy of ROME essentially includes the task of making the curriculum to tailor to the defined objectives of health care delivery to the rural masses. Topple the existing priorities, divert the large segment of resources to neglected zone. Essential ingredient is a political commitment blanked by a major shift of priorities from well-served to the ill-served areas.

As we saw in the preceeding chapters that the expert committees one after another were recommending 'progressive changes' in medical education to make it more responsive to social needs. Atleast part of the problem could have been solved by implementing these progressive changes honestly and sincerely.

ROME stands for Re-orientation of Medical Education. However, we find that the educational component in the programme being completely neglected. What these medical colleges do under the garb of ROME, is nothing but running a glorified OPD at the village sitting inside the vehicle.

Thus the ROME scheme has failed, failed miserably, leaving many thousands of students many hundreds of interns millions of villagers all over India, in a state of confusion and disillutionment.

The medical education in India and its search for relevance has just begun and it is a long way to go before it can relate it to the people at large and the needs of the country.

SECTION - L

EPITOME OF FINDINGS

(1) In many cases the three PHCs allotted to medical colleges for implementing ROME programme are not in proximity to their colleges. Some of them are at a distance of 60-70 kms from the college. This has come in the way of the effective implementation of the scheme.

(2) The Government of Karnataka's decision not to hand over the administrative control of the PHCs allotted to the medical colleges has in effect resulted in a severe set back to the programme.

(3) The 'Mini Buses' meant for transporting students and the teachers to the village, which was sanctioned by Government of India in their 1979-80 budget and the State Government's failure to procure them has become a ready made excuse for the participating colleges for the non-implementation of the programme.

(4) There is hardly any communication between the PHC doctor and the Director of Medical Education or the Principal. Since the line of authority exercised over the PHC doctors is by DHS and DMO, this dual administration and lack of communication and accountability (to DME and Principal) has resulted in poor coordination of the programme at the PHC level).

(5) Though the Government of Karnataka has made an order conferring the PHC MO and DHO the status of a honorary Lecturer of P&SM and Visiting Professor of P&SM respectively, the communication has not reached many PHC doctors even after the lapse of 4 years. Again no honorarium was specified in the said G.O. Thus it

it did not work as an incentive to them for the additional responsibilities which they are expected to undertake.

(6) The choice of vehicle (Medule) for rendering rural health service especially in the interior parts of the country was not based on practical wisdom. Even the 4 wheel drive vehicles fail to negotiate 'kutcha' village roads. Therefore the 2-wheel drive large vehicles allotted to private medical colleges are almost useless except in mofussil areas.

(7) Most of the PHCs lack living facilities for the students, interns and their teachers for implementing ROME programme. The dormitories constructed at the PHCs in most cases have not yet been handed over. Wherever they are completed other facilities like water, essential furniture and personnel are lacking.

(8) The staff position in the teaching departments of the colleges in many cases are very precarious and they fall much below MCI requirement. The most dismal picture is that of P&SM department. Lack of full complement of staff has seriously affected the programme. Even additional staff sanctioned under ROME has not been filled up in most colleges.

(9) Since the image of the P&SM among their clinical fraternity is very low, the ROME programme has also suffered as the programme in most colleges are coordinated by Professors of P&SM.

(10) Lack of community participation and their non-inclusion in the different level of coordination committees have reduced the community to a state of passive recipient of their services with no say whatsoever in the programme.

(11) The MCI and Government directives are quite ambiguous and lack clarity especially with regard to students posting to RCME programme, such as number of students to be posted in a batch, their rural teaching curriculum, the year and period of the exposure etc.

(12) At the medical college level there is not enough response from the clinical teachers and generally the Principals of the college take casual view of the implementation of the programme (since he is also part of a clinical faculty in most cases). The participation by the entire teaching community of the college as envisaged is not forthcoming in any case.

(13). Though the Government has constituted various levels of coordination committees they are seldom convened and conducted seriously. From the Government side, in most cases the DMO who is supposed to attend the college and regional level meetings, has shown very little interest in these meetings.

(14) The idea of the RCME was that its programme would integrate with the services of the PHC and strengthen its activities. But in actual practice, it is nothing but providing parallel services in the PHC area without any integration or co-ordination between the two.

(15) The para-medical and auxiliary health personnel including the large band of CHVs are not involved in the programme, especially in case identification requiring specialist services and also interns rural training.

(16) Even where the ROME scheme has been implemented the teachers accompanying the students act in a typical preventive and social medicine way trying to dig soak pits and looking at privis, of course, little bit of immunisation with hardly any follow-up. A comprehensive and epidemiological approach is lacking in their activities.

(17) The referral system envisaged under the programme has not yet been fully developed. The existing system has short-circuited the intermediate links in the chain. By-passing Taluka/Tehsil hospitals, the cases are directly referred to district or teaching hospital of the college.

(18) In many cases the State Government has failed to release the Central Grant or the State's share in time. So also the reimbursement of expenditure incurred by the private medical college authorities.

(19) Supervision and monitoring of the programme is not done in an effective manner by the Directorate of Medical Education at the State level and the DGHS at the Central level.

(20) Laxity on the part of MCI in not taking stringent action onthe erring colleges (non-implementation of ROME, inadequate staff etc.) and their failure to conduct periodical inspection on this regard has resulted the college managements taking a very casual view on ROME.

(21) Among components of the ROME scheme there are no programmes aiming at socio-economic development of the community which could act as a lever for the overall development of the community including that of health.

(22) An epidemiological perspective was lacking in its entire approach.

(23) The drug and POL budget provided to the college is so meagre and no meaningful rural health service can be provided with Rs.15,000/- annual budget for drugs and Rs.3,000/- budget for POL charges for covering a PHC area having approximately one lakh population.

(24) At present half of the Medules supplied to the colleges are rotting in their garrages for want of spares(which was not imported along with the vehicles). Even the remaining vehicles will grind to a halt unless spares are procured from the manufacturers from U.K.

(25) Many of the rural health teams from the colleges find themsleves helpless to deal with extra medical dimensions of health care, which probably only a social scientist is more appropriate to handle. Since the medical team is not fully equipped with these social sciences skills, the programme could not make a real impact.

(26) In many instances the teams from the medical colleges were disappointed by the fact that no immediate perceptible change in the outlook of the villagers were forthcoming which affected their enthusiasm.

SECTION - M

Suggestions to Improve ROME Programme

Having spent Rs.17 crores of country's scarce resource on this scheme, the programme need to be salvaged out of the present crisis. From our analysis it is quite evident that the ROME scheme is practical and pragmatic and can be implemented in an effective manner, provided the senior clinical teachers show some attitudinel change towards the programme and MCI show their will to enforce the rule made by them.

We have identified some specific areas where, if some changes are effected, We are hopeful that the programme could be put back on the track.

Rural posting of the UGs may be for 15-20 days annually to begin with and repeat posting every year. The senior teachers in the departments of Medicine, Surgery, Obst. & Gynae., Paediatrics, Dermatology and P&SM may stay with students and interns on rotation. Faculty from ENT, Eye, Orthopaedics, Dental etc. could join the rural camp periodically.Even the faculty from pre & para-clinical departments,especially, Pathology, Microbiology, Bio-chemistry could join in an integrated teaching and also involve the students in providing clinical laboratory examinations in the PHC.

2. A well-drawn out rural teaching and training curriculum for UGs and interns ;

3. Coordination :
Under the present practice of making P&SM Professor as Co-ordinator of RCME has led to some clinical faculties and interns to look upon this scheme as a programme of P&SM department. We feel that the coordination should be the responsibility of the Dean of the College, who may appoint one of clinical Head, on a voluntary and rotation basis, as RCME Co-ordinator for a period of 2-3 years.

4. PHCS : The administrative control of the PHCs should be handed over to the concerned medical college (irrespective of Private or Government) as desired by the Government of India.

5. Transport : Besides the 3 Medules allotted to each of the medical colleges, 3 mini buses need to be procured for each of the medical college for transporting students and teachers to villages and the POL budget needs to be enhanced.

6. Faculty position : MCI must enforce the rule strictly with regard to faculty strength in teaching departments especially of P&SM department.

7. Additional Posts for RCME : All posts needs to be created at the College level (as teaching faculty in P&SM) of Social Scientists, Lecturers in Social Sciences, Programme Co-ordinators - with Social Science background, who would also support P&SM teaching.

8. Induct village leaders in all levels of coordination committees - PHC, College, Regional and State, and give them fair representation in these bodies

9. Monitoring of the programme implementation may be done both at State and Central level and periodically inspection by DHE, DGHS & MCI officials is a must.

10. An Epidemiological and long-term approach is to be emphasized in rural teaching and training linking the individual or family health problem with that of national health programme.

11. To identify and determine priority areas in RCME teaching, training and service

12. Streamline the referral system by connecting the missing links in the chain, i.e. Taluka, Tehsil and sub-divisional hospitals.

13. To include programmes of Socio-Economic development and integrate it with the scheme

14. There should be a more reliable feed-back mechanism from the PHC/College to the DME/DGHS unlike the present 'Quarterly Progress Reports'

15. Increased drug budget for PHC as well as Mobile Clinic services.

16. Government/MCI must curb the menance of capitation fee-based private medical colleges having insufficient infrastructure for teaching and training of students. MCI must ensure that its directives are followed meticulously by all the colleges and the erring colleges must be de-recognised. Government of India must deal with an iron hand on the unrecognised medical colleges existing in the country.

A POSTSCRIPT

FIRST WORKSHOP ON REORIENTATION OF MEDICAL EDUCATION

During the period of the study the Bureau of Planning, DGHS organised the first ever workshop on ROME scheme at Delhi from 28-31 August 1985.

Principals and Professors of P&SM of 105 Medical Colleges were invited to discuss the problems faced in the effective implementation of the scheme.

This Workshop was followed by another meeting of the Health Secretaries of the State from 27-28 Sept. 1985.

We have interviewed Dr. S.N. Bagchi, Director, Bureau of Planning, DGHS, who was also the Workshop Director, immediately after the Workshop and follow-up meeting.

Though the Workshop identified certain specific problems or bottlenecks faced by the colleges in effectively implementing the scheme, it has not achieved any thing great beyond documenting these areas of lacunae, bottlenecks and problems. The workshop was able to focuss the attention of the Government and the MCI on certain lapses from their side. This workshop made numerous suggestions for consideration by the Government for streamlining the programme. This apart, the workshop has not resulted in any radical change in the programme implementation.

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APPENDIX - I

STUDY ON RE-ORIENTATION OF MEDICAL EDUCATION (ROME)

(Questionnaire used for undergraduates and Interns posted to rural centres)

The data on this project is collected for the purpose of conducting social research on ROME programme, from selected Medical Colleges in India. The study will cover undergraduates, Interns, Medical Officers of the PHCs, members of the rural communities, officials of the Directorates of Medical Education (both in Karnataka and in Delhi) to obtain a composite view on ROME programme. The data collected is purely for research purposes and the responses of the individual will not be revealed to anybody under any circumstances. So kindly give your frank opinion.

Centre of Social Medicine & Community Health
Jawaharlal Nehru University
New Delhi - 110067

Joseph Panackel
Research Scholar

Medical College :

Name _____ Class _____ Sex M/F

Background Rural/Urban Parent's Occupation _____

Parent's Annual Income Rs. _____ Father's Education _____

Mother's Education _____

Home Address/Town _____

.....2/-

INSTRUCTION : Please mark ☐ if your answer happens to be any one of the given alternatives

1. What do you think the objectives of ROME programme are ?

2. How often are you taken to rural areas for ROME programme :

   once a week ☐ Once in a fortnight ☐ Once in a month ☐

   Once in two months ☐ Any other (Please specify ☐

3. On an average how much time do you spent at the villages on each visit (not including the time taken for the travel)

   One hour ☐ Two hours ☐ Three hours ☐

   Four hours ☐ One full day ☐

4. Do you stay in a village overnight (residential) as part of the ROME programme ? Yes/No

   If yes, what is the duration of your stay ? ☐ days

5. Is the time allotted per month to ROME programme adequate ?

   Adequate/Inadequate

   Why ?

6. What of these clinical depts. are involved in ROME programme training at the field practice areas :

   Medicine ☐ Surgery ☐ Paediatrics ☐ Obst. &

   Gynae ☐ Dermatology ☐ E.N.T. ☐ Eye ☐

   Orthopaedics ☐ Dental ☐ Psychiatry ☐

   Anaesthesiology ☐ Radiology ☐ Urology ☐

   Neurology ☐ Any other (Please specify) ☐

7. Which of these para-clinical departments are involved in ROME training programme at the field practice areas ?

   Anatomy ☐ Physiology ☐ Biochemistry ☐

   Pathology ☐ Pharmacology ☐ Microbiology ☐

   Forensic Medicine ☐ Community Medicine ☐

   None of the above ☐

....3/-

8. What do you feel about this 'out-of-class room' teaching under ROME programme (i.e. in the Mobile Clinic)

Relevant and useful ☐ Why ? ☐

Not very useful ☐ Why ? ☐

Any other (Please specify) ☐

9. Do you prefer such teaching in ROME programme better than

(a) didactic class room teaching ☐ Yes/No ☐ Why ?

(b) Hospital Clinics ☐ Yes/No ☐ Why ?

10. How do the faculty, in your opinion respond and react to ROME programme ? What is the general attitude of faculty from

DEPT. OF MEDICINE

Active involvement ☐
Co-operative ☐
Does it only because it is mandatory ☐
Indifferent ☐

DEPT. OF SURGERY

Active involvement ☐
Co-operative ☐
Does it only because it is mandatory ☐
Indifferent ☐

DEPT. OF OBST.& GYNAE.

Active involvement ☐
Co-operative ☐
Does it only because it is mandatory ☐
Indifferent ☐

DEPT. OF DERMATOLOGY

Active involvement ☐
Co-operative ☐
Does it only because it is mandatory ☐
Indifferent ☐

DEPT. OF PAEDIATRICS

Active involvement ☐
Co-operative ☐
Does it because it is mandatory ☐
Indifferent ☐

DEPT. OF COM.MED(PSM)

Active involvement ☐
Co-operative ☐
Does it only because it is mandatory ☐
Indifferent ☐

11. Which of these following categories of medical personnel does join you in your field trips ?

Professor ☐ Assoc. Prof. ☐ Reader/Asst. Prof. ☐

Statistician/Epidemiologist ☐ Lecturer/Tutors ☐

Registrars ☐ PGs ☐ SHOs ☐ Interns ☐

11a. Out of these categories, who are the commonest in your trips ?

1. 2.

3. 4.

12. What are your view on :

The present 3 months compulsory rural internship programme	Necessary ☐ Unnecessary ☐ Useful ☐ not very useful ☐ Practicable ☐ Impracticable ☐ by reasons of social obligation ☐ Unethical ☐
6 months rural Internship as recommended by Medical Council of India	Necessary ☐ Unnecessary ☐ Useful ☐ not very useful ☐ Practicable ☐ Impracticable ☐ by reasons of social obligation ☐ Unethical ☐
Rural service as a pre-requisite for postgraduate medical education	Necessary ☐ Unnecessary ☐ Useful ☐ not very useful ☐ Practicable ☐ Impracticable ☐ by reasons of social obligation ☐ Unethical ☐

13. Will you take up the career of a medical officer of a PHC (even if remote) if offered to you ? Yes/No

Please mention the reasons :

14. Do you think the present package of ROME programme can motivate students and interns for a future rural career ?

Yes/No

Why ?

15. Are you of the view that the students should be exposed to ROME programme before the beginning of their clinical years ?

Yes/No

Why ?

16. Should the ROME programme be :

(a) restricted to a particular year of study ? ☐

(b) a continuous programme extending over the entire period of medical education ☐

17. Do you think that the ROME programme in your medical college is :

(a) primarily curative ☐

(b) a combination of curative and preventive ☐

(c) a combination of curative, preventive & promotive ☐

Please comment on the :

(i) curative services Adequate/Inadequate

if inadequate, why ?

(ii) preventive health services Adequate/Inadequate

if inadequate, why ?

(iii) promotive health services Adequate/Inadequate

if inadequate, why ?

18. Do you think that the drugs supplied to ROME programme is :

(a) Adequate/Inadequate (b) Regular/irregular

Do you have any comment on the way in which the drugs are dispensed ?

19. What are the activities in which you are involved while you are posted to Mobile Clinics (ROME programme)

Collecting demographic data and baseline surveys ☐

Registration of O.P.	☐	Maternal health services	☐
Medical check ups	☐	Under 5 clinics	☐
Dressings and inj.	☐	Nutrition education	☐
Lab. investigation	☐	F.P. services & advice	☐
Dispensing drugs	☐	F.P. camps	☐
Immunization	☐	Assisting the physicians & Surgeons	☐
Health education	☐	Any other (Pl. specify)	☐

20. What are the benefits, you think, you have derived from the exposure to rural communities through ROME programme ? List them .

1.

2.

3.

4.

5.

6.

21. What is your opinion about the suitability of the present Bedford Mobiles and its equipment in rendering rural health service in our country ?

22. What are your suggestions to improve ROME programme ?

in the area of patients care in the villages

in the area of rural training of undergraduates

in the area of logistics & administration of the programme

APPENDIX - II

STUDY ON RE-ORIENTATION OF MEDICAL EDUCATION

INTERVIEW SCHEDULE

(To be used for M.Os of the PHCs)

PHC : _____ Name of the M.O. _____

No. of sub-centres ____ No. of M.Os sanctioned ____ Filled ____

Under _____ Medical College. P.G. Qual. of the

M.O. _____ If yes, the area of specialization _____

Where studied & No. of years of Experience _____ ____

No. of beds available at the PHC ____ Whether upgraded PHC Yes/No

Res. Qtrs. provided to the M.O. Yes/No

Presently staying at _____

---

1. How long have you been working in this PHC _____

2. Do you belong to this Village/Town or District Yes/No

3. Are you involved in teaching and training of Interns Yes/No
   and undergraduates Yes/No

3a. Do you maintain an attendance register for the interns Yes/No
   and the students posted to your PHC Yes/No

3b. Do you have any comments about the regularity and punctuality of interns posted here _____

4. Has the dormitory and garrage under the ROME programme been constructed here ? Yes/No

4a. Do the interns live in the village Yes/No
   If yes, what is the duration of their stay _____

4b. Do the students also live in the village as part of ROME programme Yes/No

5. Do you think that the time allotted to Interns in rural centres for ROME programme is adequate ? Adequate/Inadequate

6. During their postings to this PHC what are the activities do the interns undertake in the PHC/Village

   1. 2. 3. 4. 5.

7. How often the Mobile Clinics visit this PHC with clinical faculty and students from _____ Medical College _____

8. How often the specialists visits this village/PHC _____

8a. Which are the departments providing specialised services here

1. 2. 3. 4. 5. 6.

8b. What are the categories (designation) they belong to ?

9. Do they provide diagnostic facilities such as X-ray _____ Lab. investigations _____ Minor surgical procedures _____ in the Mobile Clinic

10. Do thestaff from para-clinical departments too visit PHC with the students ? Yes/No

10b. Do you think that they are of any use in rural training ?

11. What is the response of specialists at the Medical College Hospital on the referals sent from PHC ?

11a. Do you sent referals to the Taluk _____ and District Hospitals _____

11b. How is the referal system working ?

12. As a M.O. of the PHC what is your opinion about :

(a) Present 3 months compulsory internship :-

(b) Six months rural internship as recommended by MCI :-

(c) Rural service as a pre-requisite for P.G. Medical Education :-

13. What are the hardships and problems (administrative or otherwise) you have faced as a M.O. of the PHC ?

13a. According to you, what prevents the new graduates from taking up rural health services?

14. Do you think the present package of programmes under ROME will really motivate students to take up rural services ?

15. Do you have any comment about the adequacy and quality of curative service provided at the Mobile Clinics ?

15a. Do they undertake preventive and promotive health care ?

16. What is your comment on the supply of drugs (as to its adequacy) to PHC ? /Adequate/Inadeauate/ to Mob. clinics /adequate/Inadequa(

17. How do the patients react and response to the service provided at the Mobile Clinics ?

17a. Do they prefer PHC over Mobile Clinics when they fall sick ?

18. Have the PHC got any extra benefit from ROME programme, such as additional staff ☐ drugs ☐ equipments ☐ buildings ☐ beds ☐ or extending primary health to more remotest areas ☐

18a. Do they compliment the work of the PHC /Yes/No/

18b. Do you consider that the ROME programme has been well integrated into PHCs objectives and programmes /Yes/No/

19. Do you think that Mobile Clinics under ROME programme can provide a meaningful rural health services to the masses ? /Yes/No/
What is your opinion about the present Bedford Mobiles and its equipments in rendering rural health services in our country ?

20. What are your suggestions to improve ROME programme :

(a) in the area of patient care in the villages
(b) in the area of rural training of undergraduates
(c) in the area of administration & logistics of the programme

APPENDIX - III

STUDY ON RE-ORIENTATION OF MEDICAL EDUCATION (ROME)

INTERVIEW SCHEDULE

(to be used for P&SM and Clinical faculty)

[redacted] Medical College

Name [redacted] Designation [redacted]

Department [redacted] Full-time/part-time [redacted]

Length of service [redacted]

1. Do you think that the time allotted to students for ROME programme is adequate ?
   If not, how much time do you suggest ?

2. What are the other departments that join you in these out-reach programme ?

   Does the faculty from the para-clinical departments also attend the mobile clinics ?

3. What is your opinion as a teacher about this 'out of class room' teaching that is imparted to the students at rural centres and mobile clinics ?

   Do you prefer this kind of teaching over the usual class-room teaching and hospital clinics ?

4. As a teacher and as a clinical faculty what is your assessment of students/interns attitude to ROME programme ?

   What is your opinion about six months compulsory internship and rural service as a pre-requisite for P.G. medical education as recommended by M.C.I. as compared to the present three months posting ?

5. Do you agree with the view that the students should be exposed to ROME programme before the beginning of their clinical years ?

   Should this programme be restricted to a particular year of study or it should be a continuous programme extending over the entire period of medical education ?

6. Which are the categories of staff that joins for the field trips?

   Do para-medical workers too join in the team in the Mobile Clinics?

7. What is the average patient attendance at these clinics ?

To Surgery/Eye/ENT dept. ofeculty :

8. Do you undertake any surgical interventions at these clinics ?

9. What are the activities that students are entrusted during their posting to ROME programme ?

10. What are the preventive and promotive activities that you ask the students to do at these villages as part of the ROME programme

11. Do you think that the curative services provided at the Mobile clinics are adequate ? /Adequate/Inadequate/
If not, please testify the areas of lacuna and what remedial measures do you suggest ?

What are your comments on drug supply ?

11a. Do you have any comment on the way in which the drugs are dispensed ?

12. What is your opinion about the role of PSM department in ROME programme ?

Should the responsibility of coordinating ROME programme be vested in PSM department or it should be entrusted to a clinical or para-clinical department ?

13. Do you consider that ROME programme can make a meaningful contribution in the area of primary health care ?

14. Do you have any comments in the suitability of the present 'Bedford Mobiles' and its equipments/facilities for rendering rural health service in our country ?

14a. Will you stay in a village along with interns and students for a few days on rotation ?

15. What are your suggestions to improve ROME programme ?

in the area of patients
care in the villages

in the area of rural
training of undergraduates

in the area of logistics &
administration of the programme

16. Do you feel that the students are interested in this programme ? What is the general attitude of the students/interns to ROME programme and rural posting ?

APPENDIX - IV

STUDY ON RE-ORIENTATION OF MEDICAL EDUCATION (ROME)

INTERVIEW SCHEDULE

(to be used for interviewing patients/members of the community)

(to be translated into Kannada)

Name _____ Age ____ Sex ____ Caste _____

Occupation _____ Village _____ Income Rs. _____

Distance from residence to PHC/Sub-Centre _____ km

1. Have you visited mobile clinics earlier or are you visiting the first time ? Yes/No

2. How often mobile clinics and doctors from the Medical College visit your village ? _____ hs

   How long do they stay in the village _____

3. Are you getting the services from the specialists coming from the Medical College ?

4. Do the Mobile Clinic team conduct any multi-disciplinary specialist camp in this village ?

   Do you like to make use of the services of these specialists ?

5. Normally who examines you in the Mobile Clinics ?

   Med. students/Interns/SHOs/Lecturers/Senior Doctors

6. Do they provide facilities like X-ray ____ Blood ____ Urine ____ Sputum ____ examination and minor operations ____ in the Mobile clinic or you have been asked to do it outside ?

7. Do you get cured with the medicines given at the Mobile Clinics ? Do they give you medicine for the whole week or just for a day ?

8. Have you been asked to pay for the medicines given or laboratory investigations or operations done at the Mobile Clinic ?

9. Do you go to other Medical Practitioners when you fall sick ? In which of the Practitioners do you have more faith ? Mobile Clinic doctors/ doctors of the PHC/private allopathic practitioners/practitioners of indigenous system of medicine/ traditional village healers.

10. Are you satisfied with the service provided at the mobile clinic [redacted] and at the PHC [redacted]

11. Do the students visit your home and conduct surveys ?

Do they conduct any health education programme in your village ?

12. Do the students and interns live in your village ?

If so what is the duration of their stay ?

13. Do the doctors of the PHC live in the village or do they commute every day ?

14. Have you ever been referred to a Medical College Hospital or District Hospital ?

How did they looked after you at the Medical College Hospital/ District Hospital ?

Was the treatment free ?

15. <u>To Harijan patients only</u>

Do you think that the Harijans and poor people in the village are getting the same type of treatment as the high castes & rich ?

Whether any discriminationin the matter of examination, laboratory investigations, operation or supply of medicines ?

APPENDIX - V

STUDY ON RE-ORIENTATION OF MEDICAL EDUCATION

INTERVIEW SCHEDULE

(For interviewing the officials of Co-ordinating Agencies of ROME programme, i.e. Directorate of Medical Education, Bangalore and D.G.H.S., New Delhi)

Name of the Official : Designation :

Office of the :

1. How long have you been working in this department ?

2. What is your areas of specialization ?

3. Presently how many MedicalColleges in this Country/State have been allotted 3 Mobile Clinics each

   (a) Is there any incidents where a Medical College failed to take 3 PHCs as required under ROME programme ?

   (b) Was there any case wherein an unutilized mobile clinic being withdrawn from a medical college ?

4. Do all the medical colleges operate the mobile clinics regularly to PHC areas allotted to them ?

   (a) Did you receive any complaints on this context ?

5. If I say that the component of training and education in the programme has been completely neglected (undergraduate training) and the students are not adequately exposed (in certain cases, not even once during their entire period of medical education), will you deny it ?

   (a) What action/modification you plan to take on this score ?

6. What is your comments on the budgetary grant for ROME programme under different heads ?

   (a) Are you of the opinion that these are adequate ?

   (b) Have you received any complaints about short supply or delay in drug supply ?

   (c) Do you believe that the patients are getting full course of treatment (medicines) instead of one day day ?

   (d) Is there a need for increasing drug budget ?

7. Did all the medical colleges appoint the additional staff sanctioned under ROME programme ?

   (a) Do all the PHCs allotted to Medical Colleges have got the dormitory and garages constructed ?

8. Do you think that the first phase of the programme has been implemented effectively by all the Medical Colleges ?

   (a) Are you planning to allot the second set of PHCs as per the original programme of ROME ?

9. What is your assessment on the quality of services provide by the Mobile Clinic ?

   (a) Do you believe that there is a powerful lobbying against Mobile Clinic by the clinicians ?

10. What is your opinion about the role of PSM department as the coordinating department for ROME programme ?

    (a) Do you prefer a clinical department for coordination ?

    (b) Do you agree to the rotation of coordination job among various departments since the image of the PSM department among the medical fraternity is not very good ?

11. Are you satisfied with the working of the referral system from PHC to Medical College Hospitals/District Hospitals ?

12. Do all the medical colleges provide free lab. investigations, surgical facilities and drugs at the mobile clinics as well as cases referred to their respective hospitals ?

13. Is there any delay in the reimbursement of expenditure incurred by the medical collegesin implementing ROME programme ?

14. Have you noticed any qualitative difference in the service provided by Government medical colleges, private medical colleges and medical colleges run by voluntary organizations ?

15. Did all medical colleges receive one Matador Van/Mini Bus for the transportation of clinical faculty and students as part of the original ROME programme ?

    If not, why ?

16. Do all the medical colleges provide curative, preventive and promotive health care programmes in the villages ?

17. Do you think all the medical colleges have implemented all the important components of the ROME programme ?

(a) Are you satisfied with their performance ?

(b) Is there any over-emphasis (from State or Centre) of family planning, as made out by some critics ?

18. How about the functioning of various advisory committees proposed at a different levels ?

(a) What are your comments on their effectiveness ?

19. How you come across any incidence of mis-use of mobile clinics, equipments or drugs ?

(a) Do you consider the monthly report which the medical colleges sent to you reflect the actual situation ?

(b) Do you think a surprise visit to these colleges will yield better results ?

20. What is your opinion about the suitability of the present Bedford Mobile Clinics (Medules) for rendering rural health service In India, since many find the vehicle and its equipments useless and costly ?

21. Do you agree to the proposal that doctors from other systems of Medicine should also be involved in the ROME programme ?

(a) Do you have any such proposals ?

22. Is there a proposal for any drastic changes in ROME programme or shift in emphasis ?

(a) Did the workshop on ROME resulted effecting in any major changes in the programme ?

23. The Mobile Clinics under ROME programme are supposed to strengthen and compliment the work of PHC in providing primary health care in the rural parts. Has the ROME programme been well integrated into the objectives and activities of the PHC ?

24. In most medical colleges we find the dormitories and garrages constructed at the PHC compound are not occupied. Do you proposed to take any action on this matter ?

25. What are the facilities you have for the repair of these mobile clinics and its equipments ?

(a) Do you have sufficient spares ?

(b) How long the present stock of spares will last ?

26. Do you consider that after almost 9 years of launching ROME programme, it has benefited the undergraduate medical students in giving them the necessary orientation in their medical education ?

APPENDIX - VI

CONSTITUTION OF VARIOUS COORDINATION COMMITTEES

1. STATE LEVEL CO-ORDINATION COMMITTEE

(i)	Secretary to Government, Health & F.W. Department	- Chairman
(ii)	Director of Medical Education	- Member
(iii)	Director of Health & F.W. Services	- Member
(iv)	Deputy Director (Medical Education)	- Convenor

2. COLLEGE CO-ORDINATION COMMITTEE (GOVERNMENT MEDICAL COLLEGES)

(i)	Principal of the Medical College	- Chairman
(ii)	District Health & F.W. Officer	- Member
(iii)	One Professor each from Pre-clinical, Para-clinical and clinical sections (to be nominated by the Director of Medical Education)	- Members
(iv)	Professor of Preventive & Social Medicine	- Member-Secretary

3. COLLEGE CO-ORDINATION COMMITTEE (PRIVATE MEDICAL COLLEGES, EXCEPT ST. JOHN'S MEDICAL COLLEGE, BANGALORE)

(i)	District Surgeon and Superintendent of the teaching hospital	- Chairman
(ii)	Principal of the Medical College	- Co-Chairman
(iii)	District Health & F.W. Officer	- Member
(iv)	One Professor each from Pre-clinical, Para-clinical and clinical sections	- Members
(v)	Professor of Preventive and Social Medicine	- Member-Secretary

4. COLLEGE CO-ORDINATION COMMITTEE FOR ST. JOHN'S MEDICAL COLLEGE, BANGALORE

(i)	Divisional joint Director of Health, Bangalore Division	- Chairman
(ii)	Dean of the College	- Co-Chairman
(iii)	District Health & F.W. Officer	- Member
(iv)	One Professor each from pre-clinical, para-clinical and clinical sections	- Members
(v)	Professor of Preventive & Social Medicine	- Member-Secretary

5. PHC LEVEL CO-ORDINATION COMMITTEE (GOVERNMENT MEDICAL COLLEGES)

(i)	Professor of Preventive & Social Medicine	- Chairman
(ii)	District Health & F.W. Officer	- Member
(iii)	Block Development Officer	- Member
(iv)	One Asst. Professor each from clinical, para-clinical and pre-clinical sections (to be nominated by the Director of Medical Education)	- Members
(v)	Medical Officer of the PHC	- Member-Secretary

6. PHC LEVEL CO-ORDINATION COMMITTEE (PRIVATE MEDICAL COLLEGES)

(i)	District Health & F.W. Officer	- Chairman
(ii)	Professor of Preventive & Social Medicine	- Co-Chairman
(iii)	Block Development Officer	- Member
(iv)	One Asst. Professor each from clinical, para-clinical and pre-clinical sections	- Members
(v)	Medical Officer of the PHC	- Member-Secretary

Source : Government Order No.HFW 8 MPS 80, dated 1-8-1980, Government of Karnataka, Bangalore.