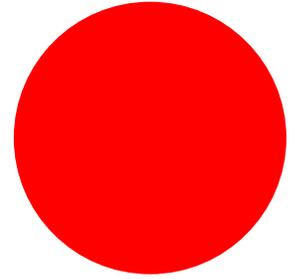


medico friend circle bulletin

99

MARCH 1984



WHY AN ALTERNATIVE MEDICAL EDUCATION IS NECESSARY

REPORTS OF THE THREE GROUP DISCUSSIONS AT THE TENTH M.F.C. ANNUAL MEET

Group A: Structure and Content of Pre-Clinical, Clinical and Para-Clinical Subjects

The group consisted of about 15 people of varying backgrounds — social workers, doctors, teachers, interns and medical students.

At the beginning of the Meet, We were given a set of questions prepared by Ashwin Patel, related to the topic to facilitate the discussion', and three main areas were identified from amongst them: (1) Process of formulation of curriculum. (2) Structure and contents of the curriculum. (3) Implementation and evaluation of the curriculum.

I. Process of Curriculum Formation: The discussion was initiated by pointing out that the curriculum formulated by the British did keep in view the job analysis of the doctor i.e. skills essential to serve the British Army and the local elite. The present curriculum is based on the British pattern but the job analysis has become blurred as a result of changes brought about in the curriculum and the health set-up. According to one view, there have been changes like addition of preventive and social medicine in rural internship to serve, at least on paper, the rural based PHCs. A superimposition of this on the existing British pattern has made the implicit job analysis hazy and confused. These changes may be in a wrong direction but their significance should not be overlooked. An opposite view contended that these changes are superficial and not fundamental, "only quantitative but not qualitative". Though the job analysis on paper has become hazy but as a determinant of curriculum content, it still remains the same! To serve the interests of the local elite. It was felt that the discussion could be better understood in the light of Ravi Narayan's article in the Bulletin

on "150 years of medical education". Proponents of both views agreed that the curriculum content is certainly not determined by the long term needs of the people.

Here it was suggested that if the curriculum is to serve the real needs of the people then certain guiding principles should be fixed at the national level but should have enough flexibility for covering regional variations and problems. This was countered by another view arguing that the present curriculum itself provided enough flexibility for such an exercise. It was even possible to formulate a people's need-oriented curriculum within the present structure only it required a meaningful and strong willed application. This was opposed by pointing to the inadequacies in the 'flexibility' of the present curriculum e.g. it cannot accommodate teaching of skills required for managing a small health centre, paramedic training or planning a 'health education programme At best, it provided for a possibility of laying stress on this or that problem included therein. Since the question of adding new skills and their teaching was raised, the students were asked to share their opinion. They felt that if the subjects taught had the right orientation, contents and methodology new subjects would not be burdensome to the students. However, a question was raised, as to why there should not be a minimum level of skills and knowledge laid down in the curriculum itself. That would reduce a lot of unnecessary teaching and learning giving more scope for new, more relevant topics. Presently, the curriculum gives an area to be studied which is vast, almost unlimited.

The opposing viewpoint argued that laying down a minimum would mean limiting the vision

and knowledge of an undergraduate who should be a first-rate physician. This was countered by the argument that limiting the horizons of the undergraduate does not mean a second grade doctor, it only means training a doctor better suited for the role envisaged' for a basic doctor and limiting the teaching only to areas relevant to performing such a role. It may also mean widening horizons in certain other areas like political economy of health and demography.

One participant felt that the student should be given some idea about indigenous systems of medicine because a doctor is often asked by patients about a certain therapy or drug or certain beliefs based on indigenous system and he/she does not have any idea about these. Two different views favouring the proposal emerged. One view argued that the basic principles should be taught so as to enable the doctor to understand and respect other systems of medicine. The other view favoured imparting of a limited awareness regarding:

- People's beliefs based on the indigenous system.
- Possible toxic effects of drugs used in these systems.

This equating of indigenous systems with people's beliefs was objected to, on the grounds that indigenous systems should be considered as proto-sciences with a rational body of knowledge and concepts having a potential of developing scientifically.

A totally differing view opposed any inclusion of indigenous systems at all because:

- a short course would be inadequate to understand even the basic principles;
- their concepts are so different from allopathic system that they would cause a lot of confusion.

It was important to develop a correct attitude towards these systems.

Ultimately, the group agreed that there was a clear need to impart some knowledge about these systems but there is no clarity about how much and what was to be taught because the efficacy of these systems is not properly understood.

The discussion on who is to form the curriculum was initiated by informing the group about how the curriculum is formulated at present. The group was told that it is a committee consisting of senior professors of various faculties of medical colleges that formulates the curriculum. This

system was found to be grossly defective by the group because:

- Such a committee does not and cannot reflect the real needs of the people, not being in living contact with the people nor being sensitive to their needs
- It is not directly involved with day-today teaching.
- The members are primarily clinicians not necessarily well versed with the science of education.

Thereafter, two divergent views emerged on a relevant alternative. One view opted for a curriculum planning committee consisting of elected representatives of student bodies, teachers, the University and of the people. It was argued that although a people's representative might not be able to contribute to the academic aspects of the curriculum but could certainly opine upon ethics, doctor-patient relationship etc. Similarly a student's representative would more meaningfully contribute to the methodological aspects. There was a suggestion for co-opting members from the non-governmental health sector involved with innovative health work and amongst the educationists.

Variants of this view suggested consultant with senior students and junior teachers before formulating the curriculum.

The opposing view proposed a committee consisting of (If concerned professionals working in, the field' in the non-Governmental sector because, they alone can reflect the needs of the people. This view objected to a representative body because they felt that the students and the teachers not only cannot reflect the people's needs but also at present they are, more concerned with their own interests.

These arguments were countered by the opponents by pointing out that first, the students and the teachers' orientation can be presumed to be pro-people if it is the alternative as envisaged in the "Prerequisites" that is being talked about and second, even if the existing situation is considered it can be argued that while the views of the students or the people's representatives might not reflect the real needs of the people, it does provide for the only opportunity for a Sincere people's' organisation or a pro-people student's body to make an impact.

II. Structure and Content of Pre-Clinical Clinical Paraclinical Subjects: To begin with, it was generally felt that the very terminology used in

this division is clinic-biased and reflects a lack of understanding of the concept of community medicine. It was conceded, though, that divisions are essential to ensure a smooth functioning but today they have become watertight compartments with little interaction which is undesirable because it interferes with a holistic understanding of health and disease. Except for a lone dissenting voice, generally the group felt that an integrated system wise teaching following a brief course in basic sciences would be better. It should include an early exposure to the actual health problems as encountered in wards and in community. By system wise teaching it was meant teaching the anatomy, physiology, pathology, medical and surgical conditions and interventions, pharmacology of the drugs of a particular system, all this with a predominance of community health orientation. Such a system was preferred because it provided an approach for an holistic understanding of the human body and its problems and it prevented medicine from becoming an academic exercise.

The dissenting viewpoint contended that the present system was better because in order to understand the pathology of one system' it was often necessary to know the anatomy and physiology of some other system/s as in the case of cardiovascular and respiratory systems. Similarly, drugs used in diseases of one system might have side effect on another system the physiology of which must be known in order to comprehend pharmacology.

But, it was argued, the integrated approach had other advantages like it avoided duplication of teaching the same facts of anatomy and physiology. Moreover, it was argued that the problem is not just that of interpreting pre-clinical and clinical subjects but more that of correlating constantly what was being taught throughout the period, and imparting to it a community centered orientation.

Two divergent views emerged on the question of time allocation and weeding out/adding of contents:

One view argued that the contents be strictly determined by the ultimate role that the doctor was going play. It would certainly mean curtailing of irrelevant aspects like rare health problems or those not amenable to simple interventions, along with their "Pre-clinical" aspects. Moreover, it would mean addition of new aspects and themes like demography, political economy of health or practical skills like reduction of Colle's fracture management of childhood tuberculosis etc.

The opposing view contended that nothing should be weeded out and the academic standards of the M.BBS course should not be compromised. The doctor should be trained to be a master clinician which requires a sound foundation in pre- clinical and clinical sciences. Also some aspects might seem to be irrelevant but they were essential to build up a scientific approach to a problem.

But, it was argued, what people needed was not a master clinician but a basic doctor who is expected to be a more relevant, better equipped "MBBS" doctor.

In the context of basic sciences the group felt that the contents relevant to the health and other problem that the basic doctor would tackle should be retained, the rest weeded out. But it was thought prudent reserve judgement regarding a specific theme as no correlation had been shown experimentally between the contents of basic sciences and the ultimate results.

Several factors contributing to more weightage being given to clinical sciences were identified. They were:

- *more* material incentives to its practitioners both in private as well as hospital practice.
- clinical practice is being more prestigious as a clinician can show a direct result in the form of immediate relief.
- Traditional belief that the doctor should be a clinician-healer.

Next, after clarifying its understanding of the terms fixed curriculum, clearly defined flexible core curriculum and free elective curriculum, the group felt that the present curriculum fitted into the first category. But, the group thought that in view of the previous discussion if one considered it as flexible enough then after reformulating the contents the structure of an alternative curriculum could remain the same.

But, a participant contended that a free elective curriculum gives the student an opportunity to explore various areas of his/her choice not necessarily with a view to specialise. A differing opinion argued that it may be relevant for developed societies as they offered a wide scope of productive activities after graduation but when we have a relatively fixed role in mind its relevance is lost. Moreover, making available facilities for a large number of elective courses would involve extra expenditure.

This view was countered by pointing out there was enough scope of offering electives even within the framework to suit the role envisaged by us. Over and above learning the fundamental aspects of areas like rural pediatrics, simple anesthesia, sociology, community diagnosis and demography etc., a student should be given an opportunity to upgrade his understanding/skills in those areas if he chooses to do so by offering them as electives. The group accepted this point unanimously but a few modifications were suggested.

One proposal was to allow the student to choose even conventional subjects like physiology, pathology, ophthalmology etc. as electives, but that the university/medical college should formulate special courses only for priority areas. A differing view proposed offering only the priority areas as electives as under the existing predominance of clinical medicine, such a choice would mean a rush for conventional areas like pediatrics.

Another suggestion that an incentive be offered to those opting for priority areas in the form of credit marks/priority for getting a job/post graduation in that department was opposed by pointing out that incentives kill initiative and students would be attracted to priority areas only for those credit marks. It also makes a mockery of the freedom in choosing a particular area. The suggestion that degree be not awarded till one elective course was completed was opposed on the same grounds.

After much deliberation regarding the time duration and the period when electives should be offered, the group came to the conclusion that it was desirable to have a fixed basic curriculum tailored to the needs of the role expected of the basic doctor with elective courses, provided that enough time to grasp the principles enhance the skills is allotted to the electives, preferably within the period of graduation and that there is a mechanism which prevents an undue rush in anyone area.

It was suggested that as an immediate demand at least those areas which are not at all included in the existing curriculum like political economy of health, community diagnosis etc. be offered as vacation electives so as to give a chance to a sensitive and interested student to achieve a better understanding of his/her *role*.

III. Evaluation and Implementation: The group felt that to ensure a correct and effective learning of the relevant contents a *relevant* methodology also needs to be *developed*. As another group was already discussing this theme, it was not discussed further.

The group felt that the concepts of secondary and tertiary levels of health care need to be clarified. It was suggested that they be seen as levels of health care according to the sophistication of 'knowledge and equipment required'. The group felt that there is a need to give at least a general idea of what forms other levels of health care. Since the basic doctor is expected to be equipped for primary level care only, special training would be necessary for him/her to work at secondary /tertiary levels.

The group thought that the reasons for non-implementation of so-called progressive changes in the curriculum were different at the level of policy makers and at the level of health activists like MFC. For the former it cannot be said that there is a lack of will or imaginative minds or lack of knowledge because the will, and knowledge and the imagination are manifested when it comes to making of and implementing of policies in the interest of elite classes. It is true that due to active resistance the health bureaucracy and the technocracy, new pro-people proposals of various committees go unimplemented.

At the level of health activists where the will to change is present often inability to *innovate* or a lack of knowledge and skills do come in the way of effective implementation.

Actually, both these reflect the undemocratic culture generated by our society. Activists too *have* no initiative no self confidence to innovate. The entrenched bureaucracy and the technocracy has no interest in having a dialogue with the actual implementors, field workers and the people at large. The group felt that this was true sometime *even* for the health activists. It was suggested that at least they should try to overcome this stranglehold *over* their thoughts and actions and strike at the problem lying at the very root of the social structure.

— Dhruv Mankad

Group 8: Content and structure of community medicine

This was the largest of the three groups. Most of the non-medical participants of the meet opted for this group and so, the discussion rightly focused more on the socio-economic aspect of community health. The complex interaction of socially conscious medical students, doctors, sociologists etc. led to a *very* lengthy but intensive discussion which helped in developing further understanding of relationship between socio-eco

nomic order and health. Time was insufficient *and even after* an additional session many issues could not be discussed.

The first question that was posed by the participants was: "What is community medicine?" One participant felt that in one of the background papers biomedical intervention is emphasised more and so we should make more efforts to find out other forms of interventions. After discussion, two suggestions were made: (1) in community medicine, we do not make mere medical diagnosis of the disease e.g. when we see a case of tuberculosis, we also try to find out from where that person is coming, to which socio-economic section of the population he/she belongs, what are the conditions of that section which makes them more prone to that disease etc., Treatment also is not curative treatment of the individual patient but community treatment. (2) It is not sufficient to talk in terms of diseases only, but social illnesses like market exploitation should also be included. It was agreed that such social illness impinge upon health disorders in society and need to be included but while keeping the focus on the health issues. Here the participants added that in certain disorders like mental problems, the social forces are primarily responsible for those disorders and so they should be given greater emphasis.

While responding to the question whether community medicine or PSM needed a separate department, the participants agreed that irrespective of the fact whether there is a separate department or not, PSM teaching should be integrated with the teaching of other subjects. In this context, a discussion on hospital and community came up. One suggestion was that hospital and community should not be counterposed. Many of us counterpose them as we separate secondary and tertiary aspects of health care from primary health care. Present day medicos remember more of secondary and tertiary aspects of health care while primary health care is usually forgotten or neglected. If we take them as an integrated whole, then we realise that hospital is nothing but an extension of the community. It was pointed out that if doctors are to make community diagnosis, they must understand what society is. This point led to the discussion on what we mean by the community. It was agreed that community is not a homogenous entity but there are many divisions/ differences within it.

On this a question, was raised: Why call it community medicine and not social medicine? The latter would explain the nature of the community we are dealing with in India. two viewpoints were put forward: (1) One was that the word community, medicine better explains the type of approach we are taking up and at the same time we should keep in mind the divisions within the community (2) Another view was that the word community has a connotation of community and so sometimes the understanding of the divisions within community gets blurred. On the other hand, if the word 'social' is used, it will better explain the differences and inherent conflicts in the society. This discussion was not continued further as it was understood that both viewpoints agreed on the content of our understanding of 'community' and 'society'.

At this point one participant argued that it is not enough to say that community is divided within itself but we should also recognise that the tools of community health have been developed in a particular social structure and so, they are not *value* free.

It was agreed that we should know how such tools have been developed but some participants felt that they were not so *value* loaded that they should be altogether discarded. Merely because some people have misused and are misusing them they do not become invalid. On the other hand the very same tools can be utilised by the exploited masses to fight against the system itself.

In response some participants argued that it was not a question of use and misuse or validity of the tools but the need to understand that in every tool there are some ideological constructions which are inherent and which should be exposed. Thus, it is not sufficient to say that community medicine should recognise divisions and conflicts in the society but to question the ideological substructure of the tools of community medicine. It was agreed that tools are value loaded and they have limitations, but are these limitations inherent? Here, the example of the stethoscope was given and argued that it is used for the same purpose for all. Others argued that this is not necessarily so. A hoe used for tilling land is used by children as a toy. Some participants contested two points made in one of the background papers. These were: (1) We do not have relevant, useful and durable knowledge of disease in the community, and, (2) we must consciously develop abilities and competence in the methods of community health. It was suggested that examples should be given to

prove that these tools are so value loaded that they cannot be used at all.

In response, the example of psychometric methods was given. It was argued the psychometric methods of measuring human behaviour mystify the social reality. The very act of quantifying human behaviour makes the psychometric methods biased.

Some participants further suggested that concepts historically develop in socio-political system and therefore, concepts have an ideological substructure. This ideological substructure should be made explicit and exposed. We should use these tools remaining conscious of their ideological substructure and inherent limitations; only thus, can better tools or concepts be evolved. Since participants agreed to disagree this debate was stopped at this point and the group went on to discuss other points.

Next, the content of preventive and social medicine was taken up for discussion. Park's text- book on PSM was taken as a case study. Participants made the following comments: (1) Park's textbook is a useful book as it discusses certain aspects like epidemiology. But there are certain weaknesses also. For example, agent, host and environment are given equal importance which is actually incorrect. (2) The book has failed in motivating students. Also students have no chance to put into practice what they learn. In response to this comment some participants said that motivation does not come from the book alone. (3) Areas of limitations in this book were mentioned but were not discussed in detail. One such area that was mentioned was occupational health. Here it was stated that the role of social conflict is more or less ignored in Park's textbook. (4) One participant said that Park has formalised what is going on in the medical system. Park's book is in some ways a dictionary from which you cannot understand the dynamics of the disease process in society. In brief, Park is only helping the medical students to pass the examination. (5) In the section on social sciences, sickness is defined as an individual's attempt to escape from the society. The doctor's role is seen as persuading the individual to go back to society. (6) Theory of social science is explained as definitions of various terms. As any other science, there are various theories in social sciences and they cannot be reduced to mere definition of terms. (7) The book perpetrates the idea of blaming the patient for his/her ill-health.

The content of teaching of pre-clinical sciences was reviewed by the participants. In preclinical teaching almost everything in anatomy biochemistry etc. are taught without explaining their significance in *community health*. Everything is given equal emphasis, but actually, in the Community we come across more problems to extremities and not head and neck.

The next question was: What leads to tension between basic science and clinical sciences? Is this tension real?

It was felt that basic sciences should be understood in the context of the problems in the community. For good community health work knowledge of basic sciences is required. Only this will help us to know what type of distortions have taken place in actual practice e.g. when we advise people to prepare oral rehydration fluid from the substances available in the community we can know the distortions, if any, in the actual oral rehydration theory if our knowledge of basic sciences is good. Therefore, it was suggested that the tension between basic sciences and clinical sciences is apparent and not real.

The next question was: How are the priority problems being dealt within PSM teaching and text books? Some participants pointed out that poverty, inequality, exploitation etc. are priority problems of society. Against this it was argued that since the doctor is involved in health work, the social problems should be explained through the medical priorities in the community. It was suggested that since our basic assumption is necessity of social change, it should also be integrated as priority in the teaching. We should think of the priorities of people and not of doctors. People's education also plays an important role in removing ignorance and that in turn helps in improving health standards. An example of improvement in nutrition status of children through health education of mothers was given.

On the point of setting priorities, some participants felt that who sets the priorities is important. If the priorities are set by the people themselves then they may be different from our own concepts of priorities.

Due to lack of time it was not possible to discuss many other issues. The group did not come out with any recommendations or concrete conclusions as clarification of the issues involved was given central importance.

— Amar Jesani

Group C: Changing the methodology of training in Medical schools

Change in methodology could be discussed from two stand points. One, with the long term perspective of it being part of a wider movement for alternate structures in all aspects of life; two critical intervention in the existing medical education in order to accelerate the process of the emergence of socially conscious and concerned health personnel.

The group felt that at present, in the absence of a wider political movement, it was essential to think of ways of intervening in the present system.

Before the discussion on the actual methodology, a few points were made:

- Change in methodology cannot be seen in isolation from the other aspects of medical education i.e. selection of students, curriculum etc.
- It was agreed that change in methodology will have to be discussed in the context of wider social, political and economic forces within the society which maintain the present distortions in medical education. For instance we would have to discuss changes in medical education in the context of changing the whole educational system which deliberately perpetuates a set of values. However, the limitations of doing so was realized by the group and it was agreed to focus the discussion on what could be done to influence the on-going medical education keeping the constraints in view.

An attempt was made by the participants to list the qualities expected in a socially conscious health personnel. He/She should

- be able to see a patient as a human being rather than a diseased entity.
- have an understanding of the socio-economic political roots of the disease.
- be able to understand society and its dynamics and be able to initiate change.
- be able to work as member of a team and assume leadership if necessary.
- be able to function effectively and find solutions to problems with whatever resources available using his/her ingenuity innovativeness and initiative.
- be able to have an insight into the non-material rewards which are more satisfying in the long run.

- be able to face challenges, frustrations which will be a part of Community Health work and be willing to undergo a certain amount of emotional isolation.
- be equipped with knowledge and skills related to health care, training of other health personnel and basic research.

It was emphasized that we were not trying to train health personnel to fit into the existing health care system rather, it was hoped that the new health personnel would be instrumental in changing the direction and structure of health care system to meet our peoples' needs.

The group felt that at present the health personnel involved with basic health care are given low status due to the general illusion that the skill and knowledge required to perform this function is "basic". In reality, such a health person has to be much more competent and capable than his/her colleagues working in institutions which have an array of infrastructure facilities and support.

The qualities enumerated above, triggered off a discussion on the selection process of the medical student which is inherently biased against the emergence of a socially conscious medico.

The pros and cons of selecting students from rural-urban background, age of entry into medical school, block wise or selection by Panchayat were discussed. For instance, some participants felt that there should no upper age limit while some others felt the younger the student, the easier it is to 'mould' him or her. Others felt that the students should enter medical college after they have experienced some social reality. The group moved on to discussing the values inherent in present methodology which prevent students' from becoming sensitive to realities.

The present methodology

- perpetuates a hierarchical structure
- actively discourages questioning
- gives the doctor a superiority complex about his/her knowledge
- discourages innovation and self-learning.

SPECIAL 100TH ISSUE

The April issue of the Bulletin will be the 100th issue. We plan to bring out a special double issue (100-101) which will feature excerpts of earlier issues, reviews and reports of the ten years of MFC and a. trip down memory lane!

An effective methodology would therefore be one that can counter the above values and inculcate a different set of values into the training programme.

Same suggestions made by the participants were:

1. Introduce field visits soon after the students are admitted for the programme. In this context the present method of students "looking after" 2-3 families was criticised. The rural internship too was felt to be inadequate as it is introduced too late in the programme. The duration is short and neither the students nor the teachers are interested enough to carry out this activity sincerely.

2. Problem-solving methods should be used more often.

3. Participatory method of teaching should become the norm.

4. Some participants felt that the mother tongue should be made the medium of instruction but this point was not discussed any further.

5. The training should be conducted in rural areas but it was emphasized that it is not enough to merely locate the building in a rural area.

FORM IV

(See Rule 8)

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ANANT PHADKE
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Rather, the whole cultural milieu of the medical college/hostel needs to be changed.

A few questions were raised about the role of the teacher since they are the ones who would have a major role to play:

— Is it possible to train the present teachers to use a different methodology?

— If this were not possible where does one find new teachers?

These questions were not resolved. At this point another question was posed as to 'where such a training could take place. Should a new institution be set up or should the already available facilities in both Government and voluntary sector be used?

It was felt that the existing voluntary agencies are not readily equipped in terms of knowledge and competence to train medical students. There is very often a contradiction between the ideology that is preached and that actually implemented. The unfortunate thing about voluntary agencies is that having reached a level of complacency they actively discourage questions regarding their incompetency, incapability and lack of political will. Further they are overburdened with their day to day activities and training of medical graduates will not form a priority with them.

However it could be worthwhile if voluntary agencies collaborate with medical colleges in imparting a different kind of training to medical students. The exposure to a voluntary agency could start early in student life. A minimum of three months would be necessary. The student should be exposed to voluntary agencies based in both rural and urban areas as well as those operating under different ideological framework. The ideological bias inherent in the activities of voluntary agencies might influence the student adversely and therefore the student should be exposed to different voluntary agencies and be encouraged to question the activities themselves. The role of the trainer was re-emphasized as this would play an important part in developing the critical faculty of the student. Some participants feared that this exposure might be viewed as an imposition on the students. It was pointed out that the present educational system itself is an imposition.

A question was raised as to whether the energies be focused upon trainers students or planners. Medical students are often operating under economic constraints but the past experience of working with medical students has shown that even though the students do not take up community

(Continued on page 12)

REPORT OF THE X GENERAL BODY MEETING

We, 90 participants who had come to CINI, Calcutta, for the MFC Annual Meet from different parts of India had now been together for almost two days. After the discussion on the theme "Why an alternative medical education is necessary?" was over we continued the plenary session after dinner and I requested those participants who had come to the MFC-meet for the first time to tell us what they felt about the experience of this meet. Since there were many such participants we were quite keen to know their reaction. I was a little tense when I asked this question since at all earlier MFC-meets there had always been a section of participants who had been thoroughly dissatisfied with the MFC-meet and had reacted negatively about MFC; and went away from us. In recent years, we have been systematically trying to understand why this happens and improve our method of organizing Annual Meet, clarifying the aim.....etc.; but something would go wrong somewhere and there would always be some participants who got quite disappointed and alienated. But this time to our pleasant surprise all new comers said that they were happy to be here and would like to come back. Some of them made some concrete positive suggestions about how future meets could be organized in a better way.

None of us was totally satisfied with the discussions. By its very nature, it is very difficult to have a very good, indepth discussion, leading to definite conclusions in a group comprising of individuals coming from different perspectives, regions, traditions, levels. But against all these odds all participants felt that it was definitely worthwhile coming all the way to a remote place to discuss and equally important, to meet people from different backgrounds. This feeling testifies to the success of the X Annual MFC Meet, It was the best MFC Annual Meet I have attended. (I have not attended the earliest Annual Meets). Though there is a lot of scope for improvement in our efforts: we seem to have found a definite direction along which we need to improve upon.

The report of the discussions on the theme has been published elsewhere in this issue. I would restrict myself to the report of the important decisions of the Annual General Body meeting.

Accounts

The accounts for the period 6th January, 1982 (the date of registration of MFC as a Trust) to 31st March, 1983 have finally been prepared.

audited and the Audit-report has been submitted to the Charity Commissioner. The Auditor has advised us to change the accounting year to 1st September to 31st August since the General Body Meeting has to be convened within first 6 months after the accounting year ends. A resolution to this effect was unanimously passed in the General Body. The audited accounts for the period of 31st March to 31st August, 1983 are being prepared. From the next annual meet onwards budget and accounts would be presented for the period — 1st September to 31st August. For this year Anant presented unaudited accounts for the period January '83 to December '84. These accounts were unanimously approved.

Accounts of "Health-Care — which way to go."

We had printed 2,100 copies.

	Rs. P.
539 copies sold by VHAI	5,390.00
125 copies — complimentary	—
578 copies sold by MFC-members	5,780.00
216 copies remaining with MFC- members and friends for sale. :	
571 copies in balance with VHAI Office	
71 copies in balance with MFC Office	
<hr/>	
2100 TOTAL	TOTAL Rs. 11.170.00
	Less
i) VHAI Commission (10%)	539.00
ii) Postage incurred by VHAI	1.218.35
	BALANCE Rs. 9.412.65
<hr/>	

MFC Office has probably spent about Rs. 200 on postage for this book. But this expenditure was included in the general office-expenses. Moreover, postage has been recovered in most cases from the buyers. VHAI is our chief distributor and stockiest for this book and they have mailed bulk copies to MFC-members and also complimentary copies abroad. Hence they had to spend so much on the postage.

We have thus Rs. 9.400/- On hand from the sale of 1017 copies. We have a reserve surplus of about Rs. 4,000/- from our general accounts. We can therefore decide to go for the production of our third anthology. The list of the articles to be included in the third anthology has already been more or less finalised. Press-copy, cover-page, lay-out, cartoons.... etc. should all be ready by

June-end at the latest. Specific responsibilities were given to different individuals for the preparation of the press-copy. By June-end, we should sell majority of the remaining copies of "Healthcare....." so that lack of money- would not delay the publication of the third anthology. All members, friends are requested to help in the sale of these remaining copies. The publication Officer of V.H.A.I. has informed us that they are ready to print and distribute our coming anthology. We are extremely thankful to him for this help.

Articles for Newspapers

The Centre for Science & Environment (CSE) had offered to make a series out of the articles written by MFC-members on mutually agreed topics and to get published in; the newspapers. In the last Annual Meet a scheme was drawn up to prepare such a series. But the progress has been very slow; partly because of lack of a competent editor. Mohan Rao was to do this job, but there is no response from him for last six months. Satyamala agreed to find out whether Mohan Rao is still interested. Otherwise she would do the editing.

Centenary Issue of 'M.F.C.-Bulletin'

The April '84 issue of MFC Bulletin would be the 100th issue. Ashwin Patel (the first editor of MFC Bulletin) add Ashok Bhargav (The first Convenor of MFC) would write a leading article on 10 years' of M.F.C. Anant Phadke (as outgoing Convenor) is to write about the role of MFC in today's situation and in immediate future. Ravi Narayan (as coming Convenor and Editor) would write a comment on the contents of the MFC Bulletin during these 10 years. Mira Sadgopal would categories the articles published in these 10 years according to different themes and this list would be published as a supplement to the Centenary issue.

Drug Issue

It was decided that MFC would continue to be a part of the coordinated effort on a national level to oppose the irrational production, marketing and use of drugs in India and to have a rational drug policy.

Vincent Panikulangara had filed a writ petition in the Supreme Court regarding the ban of the import, manufacture, sale and distribution of drugs identified as hazardous and/or irrational by the Drugs Consultative Committee (D.C.C.). Now he has filed a further petition to amend and add to the original petition. This has been done in the wake

of the Govt. of India notification of 23rd July, 1983 banning 22 categories of drugs. In the new petition, Vincent has drawn the attention of the court to the lacunae of this order like certain categories recommended by DCC to be banned are not included in the present order of the Government of India. The drug company's lobby is fighting hard to mobilize forces against this petition. It is necessary that socially conscious organisations of medicos, Peoples Science Movement Groups, Consumer Organizations. _ .etc. should become a party to Vincent's writ. After a lot of discussion it was decided that members of MFC should not hesitate to go on behalf of MFC as experts or even as party to Vincent's writ whichever would be more useful. Anil Patel and later Sathyamala offered to go on behalf of MFC. Since Satyamala is in Delhi, probably it will be more convenient if she would represent MFC. MFC is not expected to take up financial responsibility in this case. The idea is to help in whatever way we can.

Next Core Group/Executive Committee Meet

This would take place at Sevagram (Near Wardha) from 27th to 29th July, 1984. Ulhas Jajoo has offered to host it. We would discuss the issue of social aspects of tuberculosis especially of the intervention of the private medical profession different social organizations and the Government's National Tuberculosis Control Programme. This discussion would be done as a preparation for the discussion on the same issue at the 11th Annual Meet of MFC. After this discussion, important organizational matters would also be discussed as usual.

Visit to CINI

Before the General Body Meeting, we had a three-hour session with Dr. Samir Choudhury, Director of Child-in-Need Institute and his colleagues. MFC bulletin had carried an article on CINI two years back. Samir Choudhary therefore, restricted himself to how CINI evolved, how it grew and what are the present programmes. He read an evaluation report by a Government body. Since it was a Sunday, many of their routine activities could not be seen but they took us round their hospital and Nutrition Rehabilitation Centre. It was perceived that at each step, CINI has tried to organize its interventions in an appropriate manner. For example, they discourage seeing those cases at the hospital which can be adequately dealt with by their Community Health Worker in the village itself; their NTR has tried to use local

food-stuff and they have tried to demystify medical technology.

After coming back from this visit, we assembled again to ask more questions. Gopi, their "management expert" answered a number of questions about their non-medical work. We wished we had more time to have an indepth discussion on the problems that confront such innovative attempts. Since Samir Choudhary was quite willing to share their problems, weaknesses, we could have gained a lot by discussing some of the knotty problems that have evaded a solution. But unfortunately, time was running out and we had to postpone such a discussion for a future date. Mira Sadgopal thanked Samir Choudhary and his colleagues for their warm hospitality. CINI had agreed to host the meet even though all of them were to be very busy in their preparation for their Foundation-day ceremony on 1st February. CINI not only made arrangements for stay and food, but Samir Choudhary called a couple of meetings of MFC Sympathisers in and around Calcutta to involve more persons and make this meet a success. All the arrangements were painstakingly made; we were all quite comfortable and enjoyed our stay at CINI. MFC has been able to survive and grow because of such love and help.

Change in Convenorship

Anant Phadke had been wanting to step down from Convenorship since last year because he had been convener for three years. (M.F.C. has a tradition of shifting the Convenorship every 2-3 years.)

Ravi Narayan has been kind enough (especially to Anant Phadke) to agree to become the Convener. The Convener's Office will shift to his place from last week of March 1984.

From 1st April 1984 all correspondence to the convener may please be made to Ravi Narayan. His new Address is:

Ravi Narayan, 326, 5th Main; 1st Block, Koramangala, BANGALORE-560034. (Tel. 565484)

Change in Editorship

Ravi will also take over Editorship in coming few months once he gets his Convener's Office settled. Kamala Java Rao has agreed to help out till and to the extent is necessary.

The printing of the Bulletin may also shift to Bangalore in due course. Ravi, Thelma together would manage these responsibilities with the help of friends in Bangalore.

New Executive Committee

As per the constitution of M.F.C., the term to E.C. expires after two years. Since Dilip Joshi, Ulhas Jajoo, Dhruv Mankad have completed their two years, they stepped down. Anant Phadke, Amar Jesani, Amar Singh Azad were elected for a new term. Satyamala, Kartik Nanavati, Mira Sadgopal, Lalit Khanra would continue their term for their second year. Ravi Narayan would be the Convener.

Editorial Committee

It was decided that it's desirable to prepare a short note meant for persons who want to write for the MFC-Bulletin. It would indicate what type of articles, in what style, for what purpose would be suitable for MFC-Bulletin... etc. Kamala Jaya Rao would prepare it and it would be finalized in the next E.C. Meet at Sevagram from 27th to 29th July, 1984.

Drug Action Network Meet

Since a number of persons from different parts of India had come together for MFC-meet and since some of them were active in the "drugs issue." also, on 30th January '84, a meeting was organized of those who were interested in participating in the co-ordinated effort at the national level to oppose the irrational production, marketing and use of drugs in India and to replace it with a rational drug policy. Mira Shiva of Voluntary Health Association of India had taken initiative in organizing this meet.

Some friends from Calcutta had specially come for this meeting - representatives of Federation of Medical Representatives Association of India, Health Service Association, Health and

Society Group, Low-cost-project ... etc. This was not, however a full-fledged meeting of all those involved in the "drugs-issue", and hence the purpose was limited: to take a review of the happenings during the last one year (after the All India People's Science Movements' Conference at Trivandrum in February, 1983), to discuss any urgent action-programme that has to be taken up in the coming few months and to plan for the full-fledged, and in-depth yet action-oriented Drug-Workshop in this year.

Mira Shiva gave a brief account of happiness during last year. (Those interested in details of recent news may write to her for a copy of the Drug Action Network Newsletter - first two issues; C/o VHAI, C-14, Community Centre, S.D .A., New Delhi-11 0 016.) The All India Cam-

campaign could not be launched as vigorously as we wanted to, partly because of lack of proper co-ordinator and communication amongst the action groups. However, the visit of Zafarullah Chowdhury to Pune, Bombay, Trivandrum, Bangalore, New Delhi and Baroda was a result of a coordinated effort of planning his programme. His tour proved a tremendous success and a real galvanizing event which forced many groups into a co-ordinated action-programme. Mira Shiva emphatically pointed out that things are however moving very rapidly in an undesirable direction at the National Drug Policy level and unless we respond to these moves with equal efficiency, we would be left nowhere. She therefore stressed the need for a definite co-ordination committee. Two current issues were discussed during this meeting. The first one, of the writ petition of Vincent Panikulangara, has been reported elsewhere in this issue. The second one concerns the Govt.'s reported move to treat the foreign drug companies as Indian if they dilute the foreign equity to 40%. This move would remove all restrictions on foreign companies and would give a clear chit to them to produce whatever they want and to sell inessential drugs at whatever price they choose. After a lot of discussion it was decided that our stand would be - these companies must dilute the foreign-equity but should not be treated at par with Indian companies. Even with 40% equity, foreign interests can and would very well control all the management of these companies it would take much more co-ordination and understanding amongst us to plan and carry out action-programmes based on such stands. How exactly to do such co-ordinated campaign would be discussed in depth at the two-day workshop to be held on 30th and 31st July '84 at Sevagram, Wardha after the MFC Core group meeting. All action groups would discuss in detail the action programme -agenda of this workshop amongst themselves before coming to this workshop. Since a lot of home-work intra-group discussion needs to take place before we can launch an effective action-programme and an organization for it (if this can't be avoided), this workshop cannot be held in coming couple of months. July-end seem-

Editorial Committee:

**Anant Phadke
Padma Prakash
Ravi Narayan
Shirish Datar
Ulhas Jajoo
Editor
Kamala Jayarao**

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ed to be the most convenient, most appropriate time for this workshop considering the availability of different representatives, traveling arrangements ... etc. The tentative agenda for this workshop was formulated as follows - (1) Criteria for rational drug-policy; (2) Graded essential drug-list; (3) A list containing all brands of the drugs mentioned by their generic name by the Govt. of India in its ban-order in July '83; (4) Over-the-counter drugs; (5) Pricing of drugs; and (6) Whether acid if yes, how to form an Organization/committee for coordinating this campaign.

Those who want to participate in this nationwide-action-programme and hence this workshop may write to Mira Shiva to get the details of this agenda (and its rationale) and other details.

— Anant Phadke

(Continued from page 8)

health work, a different exposure helps them to be "better" doctors, (better in terms of rational therapeutics, sensitivity etc.). Teachers who are already thinking differently should be contacted and drawn into a common pool. The innovations they could make would give the necessary feedback for further analysis and innovation. But it was pointed out that in order to be effective it is essential that the alternate medical education should be as forceful (based on concrete facts and scientific evidence) as the conventional medical curriculum. This is all the more important as these two divergent types of medical education perpetuating diametrically opposite values are going to exist side-by-side for some time to come.

There were also suggestions regarding the production of 'kits' for medical students and organising distance teaching, (correspondence course) for students.

An important area of the methodology of evaluating the student's performance was not discussed due to lack of time.

Sathyamala Lalit Khanra & Indu Kapoor.