Come to Mental Health in C.O.M.E.

S. Farooq (Department of Psychiatry, Lady Reading Hospital, Peshawar.)

"We pledge ourselves and call on others to join us in an organized and sustained programme to alter the character of medical education so that it truly meets the needs of the society in which it is situated" The Edinburgh Declaration[1].

This pledge from the Edinburgh Conference on medical education is bound to be overlooked by our medical elite which has been trained and practicing in a system that has been out dated long ago. This system of medical education based on a traditional UK model of early 60's is due for a complete overhaul[2]. A group of medical educationists from the U.K identified major deficiencies in this system succinctly long ago, in following words: "We believe that the British medical education is failing in two respects: firstly, in the extent to which it equips doctors with capacity to think critically for themselves; and secondly, in the degree to which it inculcates a broad, holistic and sensitive outlook towards the health of both individuals and communities[3].

Realization of these and other deficiencies has resulted in a major change in medical education in the UK and in many other countries. A remarkable transformation is the attempt to prepare its students not only for the usual responsibilities of a doctor to the individual patient but also for the responsibilities towards the community as a whole. Community Oriented Medical Education (C.O.M.E.) aims to prepare the students for this role. In C.O.M.E. a trainee has the opportunity to get training in the community, realizing and acquiring first hand knowledge of the needs of the community besides learning how to avail of the resources found in a community. It is encouraging to note that an initiative was taken in the nineties to start C.O.M.E. programme in Pakistan. One medical college in each province was selected for this purpose. C.O.M.E. has already been described by various authors[4,5] and need not be discussed here.

It argued that mental health should also become an integral part of successful C.O.M.E. programme. At the outset I must explain that this is not a plea of a psychiatrist who wants a lion's share for his subject, a usual scene in the curriculum development. Psychiatry has to play a much wider role than merely to provide mental health training in C.O.M.E. as is discussed below. It must be realized that mental health is bound to form the core component of any programme for C.O.M.E. as mental health problems are one of the commonest disorders presenting in a community. This is evident in the extensive literature available on psychiatric morbidity in community. Most recently a World Bank report has highlighted the burden of psychiatric morbidity. The World Bank Development Report (W.B.D.R)[6], has tried to quantify the burden of the disease on the economy of developing countries. This report, for the first time, used the Disability Adjusted Life Years (DALYS) for calculating the burden of the disease. Prior to this, mortality figures were mainly used which obviously failed to find any impact of psychiatric disorders as these do not cause any substantial mortality. A rather unexpected fmding, according to the Report, was that mental illness was 5th amongst the top 10 causes of burden of disease on the developing countries' economies[6]. Furthermore when the data was analysed according to the age and diagnosis, it transpires that depression was fifth for females and 7th for males in the most productive age group (15-44 years). A

follow up report in 1996 concluded that depression is set to become the leading cause of burden on the economies of developing countries by the year 2020[7]. This report should not be a surprise for any health professional who knows that about one in five persons suffers from a mental disorder in one year. From the viewpoint of C.O.M.E., the most important fact is that, since most of the morbidity occurs in the community, it can and should be treated in the community.

A more compelling reason to include the mental health in the C.O.M.E. is not related to the mental health care provision directly. It relates to the other skills required in this new approach. As can be expected of any new approach in medical education in the present times, the trainees are not only trained in the traditional roles of diagnosing and treating the medical conditions and treatment of specific disorders. They are also expected to bring the sympathetic outlook towards the care of their patients while being conscious of their social responsibilities related to the community. Elaborating these skills, a recent General Medical Council, U.K. report recommends that "students have to listen to patients attentively and to look at them with the intensity of trained observers and to communicate well with patients relatives, and other health professionals. They must also learn to prevent and treat common disorders to keep accurate records, to handle common emergencies and also about rehabilitation[8]".

It is thus evident that the word "treat" has been used only once, all others skills require observation, careful listening and a holistic approach towards the patient. These skills though required in any clinical setting are essential in any community oriented medical education programme.

Indeed, it can be argued that C.O.M.E. when properly implemented will again focus on clinical skills of listening and observation which at present is being ignored in a training confined to high-tech tertiary care centers consisting of what Godfrey[9] has aptly described as plethora of superficial visits to every speciality". The approach in C.O.M.E. is entirely different. It focuses not only on the symptomatic management of individual patients but also takes into account the broader family and social problems related to that particular problem as it occurs in a community. While describing their experience of medical education in the community in Nigeria, Hamilton and Ogunbode describe the experience of community posting for medical students as "In a study of malnutrition, the basic work might be a systematic survey of weight for age. But individual teams might choose to study in addition the social issues relating to each malnourished child beliefs and practices about weaning, breast feeding, and child spacing, the acceptance and practice of a nutrition chime and the price and choice of food as it relates to season, poverty and custom[10]".

Anyone familiar with the training and practice in psychiatry will realize that the mental health component of C.O.M.E. will indeed play an important role in helping the medical students to acquire the skills we have just discussed. Psychiatry is one of the medical disciplines which still retains the holistic approach as it has been relatively lagging behind the other specialties in the technical onslaught that has taken away the humanistic element from the doctor- patient relationship.

Moreover, psychiatric training can also help to bring this humanistics and holistic approach in medical training in general. Unfortunately, however, this does not seem possible in the traditional curriculum being followed in the present undergraduate medical education. One can hope that the educationists implementing the C.O.M.E. will

be more receptive to the new ideas that psychiatry can offer. The administrators of C.O.M.E. will have to look towards psychiatry for this new role, not merely in the role of just another specialty. It will augur well for the students, the teachers and the community.

References

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