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# MEDICAL EDUCATION

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## Can teachers cross continents? Experiences in Sri Lanka

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**SUMMARY.** We describe our experience of planning and running a workshop in Sri Lanka to prepare doctors for teaching a postgraduate diploma in general practice. We explore whether British models of education for general practice are applicable in other cultures and put forward a check-list of questions which teachers of general practice who are invited to work abroad should ask themselves.

### Introduction

FOR a variety of reasons, general practice appears to be undergoing a worldwide renaissance. Different factors have promoted this development in each country, but nearly all have established colleges or academies of general or family practice. The Royal College of General Practitioners is widely considered to have pioneered this work and opportunities now arise for British doctors to visit other countries in some sort of advisory capacity. These considerations made us feel that our own recent experiences might be of some help to those who find themselves in a similar position and that our conclusions are relevant to all those who teach outside their own immediate environment.

As we boarded our separate jets for the journey to the East, the question "Can teachers cross continents?" was uppermost in our minds. We had been invited by the British Council to co-resource a 'Teach the Teachers' Seminar at the Postgraduate Institute of Medicine in Colombo, Sri Lanka. If the answer to the question was "no", then we would have three weeks of gentle relaxation amongst the splendours of a tropical island lapped by the waters of the Indian Ocean. If the answer was "yes", then we just might be the catalysts to

revolutionize primary care in this Third World country.

Sri Lanka is a relatively small island off the tip of India. The mainly Buddhist Sinhalese are the largest group in the population of 14,000,000, but there are significant numbers of Tamils (usually of the Hindu faith) as well as Muslims and Burghers. On most economic indices, Sri Lanka compares badly with Europe but better than India, Pakistan and Bangladesh. To the traditional exporting industries of tea, coconuts and rubber, a rapidly expanding tourist trade has now been added. Whilst the people are poor, the enormous problems of scale that are found in India do not seem to exist.

### Medicine in Sri Lanka

The government considers its main aim in the health field is to provide a curative and preventive medical service covering the whole island and free to the patient at the point of delivery. There are small, medium and large hospitals as well as 102 preventive health districts, each of which is the responsibility of a Medical Officer of Health. In addition to the 3,000 to 4,000 government-employed doctors, there are approximately 800 private general practitioners, working mainly in urban areas, 1,000 auxiliary medical practitioners (the Sri Lankan equivalent of the bare-foot doctor) and no fewer than 19,000 ayurvedic practitioners. Only about a third of this last group go through the official College of Ayurveda, the remainder being self-appointed practitioners of this ancient art. Ayurveda is an indigenous health care system with a lot of sound common sense (recommending personal hygiene, clean water and effective sanitation) mixed with Hindu philosophy and herbal medicine.

All the doctors, whether in private or public, curative or preventive medicine, seem to work remarkably hard. This is a personal observation. The only major research

(Simeonov, 1975) concentrated on the people offering health care rather than what they were doing, and there are almost no records kept in either hospital or general practice (Sivagnanasundram and Samarawickrana, 1979).

Public health doctors can refer patients to the hospital outpatient department, where they take their chance with those who have come of their own accord. General practitioners can refer either to the hospital outpatient department, where initial contacts are always with junior doctors who are untrained in primary care but who can refer patients to their specialist seniors, or to specialists in their private practice. As patients do not register with a private general practitioner, it is very difficult to provide further evidence concerning the real health of the community. The Simeonov Report (1975) was sponsored by The World Health Organization but, in spite of spending some three years' hard work, a large team was unable to produce any figures for the diseases seen in primary care.

### The visit

Just where do British general practitioners fit into this picture? Early in 1979 one of us (M.A.V.) went to Sri Lanka, having received a Nottingham Medico-Chirurgical Society Travelling Fellowship. The purpose of the grant was to investigate the possibilities of an exchange between the Nottingham Vocational Training Scheme and Sri Lanka. By an accident of timing, this visit proved to be the catalyst whereby general practice and the University of Colombo began to get together. Both sides were then highly suspicious of each other, and the sort of unhelpful, unproven, anecdotal comments made both by general practitioners and by hospital doctors about each other were very similar to those often heard in Britain 10 or 15 years ago.

A frequent question asked by Sri Lankan general practitioners was "If we are allowed to teach, how do we do it?" In response to this, the visitor wrote an educational programme for the development of general practice in Sri Lanka. Some time later, we received an invitation to co-resource a week's workshop which was to prepare general practitioners for teaching a postgraduate diploma course. However, there was no account of what had happened between the original report and this invitation. This information slowly filtered through in response to our urgent requests, but it was not until the night before the seminar was due to begin that a full medical, educational and political explanation was offered.

### Some questions

We were so surprised by these and other aspects of our trip, that in retrospect we have formulated a number of questions for those brave enough to accept invitations to teach in a culture different from their own. Although

primarily designed for those teaching overseas, we feel that all involved in medical education of any type would benefit from considering these questions.

#### *Question 1. Why has the invitation come?*

This must be answered in terms of the medical, political and economic background to the invitation. Inevitably, the answer is a complicated one, but in our case it involved a quite significant change of attitude by the government and a decision that all types of specialist training must take place in Sri Lanka. Having just allowed their own hospital specialists to go private on a part-time basis, the attitude to private general practice was bound to change. While no visitor can expect to be involved in these initial decisions, he or she must be aware of such policies in order to make the course relevant.

#### *Question 2. What are the recipients' wants and are they the same as their needs?*

It was very obvious to us at an early stage in our preparation that our friends in Sri Lanka had adopted the Churchillian concept "Give us the tools and we will finish the job". They wanted to know how to teach undergraduate/postgraduate/continuing education for general practice and how to write an examination. They wanted to be told and expected us to come with a blueprint that they would simply go through one stage at a time.

1. The wants of the learners in any teaching/learning process are usually simplistic and inappropriate.
2. If it is true that all learning must be related to needs, then learners must be helped to understand and define their needs.

#### *Question 3. Why have we been invited rather than anybody else?*

It is probable that many people are invited for the same reasons as ourselves, namely one of us was known already. It may seem a rather simple question but, until it is answered, one cannot progress to a potentially much more important area. Personal knowledge does not ensure that the guest has the necessary knowledge and skills: it may be that he or she is just less threatening. It would be easy for the visitor to get out of his or her depth.

#### *Question 4. Are we the people who can deliver the goods?*

This is the crunch question. No-one who is in the teaching and learning business should take too great a step outside their own perception of their skills. This does not necessarily mean that one must do only what has been done before or cover ground with which one is personally familiar. If the latter was to be the case, we should both certainly have declined the invitation. Both

of us, in an honest but realistic way, believed that, although the task was difficult, we could perform it as well as most.

*Question 5. What preparation is needed?*

Prepare thoroughly but with flexibility. By D-Day minus four weeks, we had to make some sort of statement for our own benefit as to what we expected to do when we arrived in Sri Lanka. We realized at the time that we did not know exactly what was expected of us. However, we wanted to set out what we considered was possible, bounded by the constraints within which we were acting. This is almost certainly what anybody does who becomes involved in teaching, whether in his or her own culture or another. We prepared a statement for our own guidance and also for prior circulation to course participants. Whilst the details of this document are not relevant here, there are a number of key phrases which have more than local significance. The trap which teachers often fall into (whether in Nottingham, Manchester or Sri Lanka) is to assume that they know precisely what should be done in any particular field by those listening to the dissertation. This is the "You should do . . ." syndrome, and is inappropriate for any teacher anywhere and is certainly not a technique which should be used by those attempting to teach across a culture barrier. The next phrase down the line of authoritarianism is "You could do . . .". We felt that this was still inappropriate, as it would lead to a theoretical provision of options which in practice would still give the recipients no choice at all. The phrase which best described our approach to the whole symposium was "Could you do . . .?" or "Do you think it would work if . . .?". Adopting this philosophy, we wrote a basic aim for each of our five teaching sessions.

*Question 6. What methods will be appropriate? Will they be acceptable?*

People learn best by doing things. Whoever the expert is and wherever he or she comes from, one of the big dangers is to assume that a package deal can be handed by the expert to the learner. This is particularly true when so-called experts from rich Western countries go to the different atmosphere and attitudes of poorer ones. We could not assume that the model of general practice which is appropriate in the United Kingdom could be transferred wholesale to Sri Lanka, even though, as it happens, there are many similarities: the problems of winning the respect and support of colleagues in other specialties and of methods of internal organization are similar to those faced by the British general practitioner of 25 years ago.

*Question 7. How reliable is our information?*

Never believe everything you hear. Because a respected member of a small group says something authoritatively in discussion, it does not necessarily mean it is true. There were occasions when we were informed that every

general practitioner in Sri Lanka was fully practising all the constituent parts of the Leeuwenhorst job definition. It seems likely that this is not true for any country in the world, let alone Sri Lanka.

*Question 8. Can you teach by example as well as by precept?*

Medical teaching in the United Kingdom at both post-graduate and undergraduate level has always relied heavily on imitation. (The taught wish to emulate the teacher and not only do what he or she says, but copy what is done and the way it is done.) This may not work if the culture gap between teacher and taught is too wide. We concentrated our verbal and group skills on defining the teaching task, establishing objectives, choosing content and using different methods. We tried hard to set tacit examples by preparing circulated materials beforehand, by using visual aids, by being punctual and by being concerned about the physical comfort (seating, lighting and ventilation) of our learners.

### The seminars

We found out the answers to questions 1, 2, 6 and 7 only the night before the seven-day seminar started. It became clear that our hosts had in mind two objectives for the seminar: to convince the specialists and academics that general practitioners could and should teach, and to teach the general practitioners present about small group teaching. These somewhat conflicting objectives were particularly difficult to achieve because the group was to be twice the size we had been led to expect, and was to be seeded with possibly hostile academics. The latter would not be there throughout, and so join in any growing group identity and trust, but would attend one session each.

For each of the five sessions, we decided in advance what we hoped to achieve and circulated at the start of the meeting a brief, jargon-free statement of intent. Each of the two groups (containing about 16 to 20 general practitioners and 3 to 4 university staff) was led by one of us and elected a reporter. At the end of the afternoon, the two leaders and the two reporters got together to discuss what had happened. The two leaders then wrote a summary which stated what each group had been doing and set out some suggestions for the next stage of development. This was photocopied for distribution at the next session. By the end of the week, a whole sheaf of reports was available for transmission to a variety of sponsoring bodies.

### Conclusions

As long as teachers are prepared to teach by helping a group of learners to reach a defined goal, rather than by trying to provide a blueprint, then the skills developed in one country can be applied in any other. Exactly the same stages have to be gone through with a group of

# The

**M&B May&Baker**

## Diagnostic Quiz

The answers to the August quiz are as follows:

1. What is this condition?

**Black hairy tongue.**

2. What is its pathogenesis?

**A form of candidiasis.**

3. With which drugs is it most commonly associated?

**Broad spectrum antimicrobials, especially tetracyclines.**

The winner of a £100 British Airways travel voucher is Dr Stephen Plumb of Rochdale, Lancashire.

### A SURVEY OF PRIMARY CARE IN LONDON

Occasional Paper 16

General practice in inner cities has emerged as a topic of immense concern to patients, the profession and government but, although there are many anecdotes, prejudices and rumours, hitherto there has been a great shortage of facts.

*A Survey of Primary Care in London, Occasional Paper 16*, is the report of a working party led by Dr Brian Jarman, which gives more facts than have ever been assembled before about the medical problems in London and the characteristics of the doctors who work there. A particularly valuable feature is the number of comparisons with Outer London and England and Wales.

This is likely to become a classic reference for all those interested in the problems of primary care in big cities.

*A Survey of Primary Care in London, Occasional Paper 16*, is available now, price £4.00 including postage, from the Publications Sales Department of the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Payment should be made with order.

general practitioners in Colombo as in Nottingham (the needs of the patient, the responsibility of the doctor, the scope of medicine and disease and the educational needs of the doctor). The footnote to this story is really an open-ended question—what effect have we had on the development of health care in Sri Lanka? General practitioners have undoubtedly become more enthusiastic about developing their knowledge and skills and about practising of their art. Hospital doctors and academics have also become more aware of the role of general practice. In immediate terms the groups of doctors who had prepared what they had hoped was a total teaching programme for a diploma in family medicine realized that they had done little more than produce a list of topic headings. A fair and not necessarily impartial conclusion would be that, for the first time, general practice in Sri Lanka (and the emergent College of General Practitioners) had begun to define the stages through which they would have to go in order to improve the care of their patients and, in so doing, change the standing of family medicine in Sri Lanka. The enthusiasm and affection with which we were showered could well have distorted our assessment of what had been achieved. Our host quoted Caesar in Britain: "Veni, Vidi, Vici", but we were moved to think that there has been little but Roman ruins in England for many years.

#### References

- Simeonov, L. A. (1975). *Better Health for Sri Lanka*. New Delhi: World Health Organization Regional Office.
- Sivagnanasundram, C. & Samarawickrama, G. P. (1979). Study of 132 general practitioners in Sri Lanka. *Sri Lanka Family Physician*, 1, 59-64.

### Withdrawal of benzodiazepines

Forty patients (out of 86 who were eligible for the trial—46 refused to take part) seen in general practice and psychiatric outpatient clinics who had taken lorazepam or diazepam alone in regular dosage for a mean period of 3.6 years had their benzodiazepine replaced by propranolol (60-120 mg/day) or placebo for two weeks under double-blind conditions. Depending on the criteria for the definition of an abstinence syndrome, 27 to 45 per cent of the patients had withdrawal symptoms during the study. Propranolol did not affect the drop-out rate or the incidence of withdrawal symptoms, but significantly reduced their severity in patients completing the study. The percentage fall in serum levels of desmethyldiazepam in patients who experienced withdrawal symptoms after stopping diazepam was significantly greater than in patients with no withdrawal symptoms.

Source: Tyrer, P., Rutherford, D. & Hugget, T. (1981). Benzodiazepine withdrawal symptoms and propranolol. *Lancet*, 1, 520-522.