TEACHING AND TRAINING PROGRAMS IN DEVELOPING COUNTRIES

ORIGINAL ARTICLE

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ABSTRACT

Abstract

KEYWORDS: Oncology, Training Programs, Developing Countries

INTRODUCTION

Turkey is a typical example of a developing country. Its healthcare resources are limited, the infrastructure is relatively underdeveloped, the trained personnel for health service are underpowered and the demand for improvement is apparent. On the other hand, because of increased communication with developed world either through direct travelling to Western Europe and USA or via internet; the Turkish people are asking for better services. The effort toward improvement naturally also involves need of improvement in upbringing of doctors which causes to question the validity and adequacy of current teaching and training programs for doctors. The search on improving the current standards should focus on three aspects. Improvements on all three aspects would make Turkish Medical training programs more competitive and productive toward increasingly demanding

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healthcare environment. These four aspects are uniqueness, thorough cooperation, synchronizations and teaching teachers.

Four Requirements of a Successful Teaching and Training Program:

1. UNIQUENESS

An important mandate for a program to be successful is to have a strong local flair. Importing a program from a developed country such as USA or England and then trying to adapt it to the everyday realities of a developing country would take more time and energy than creating a local program from scratch. Of course the initial task of starting a unique program requires a thorough search to find out the needs of the particular country. This brings the second aspect of a successful and workable program through cooperation.

2. THOROUGH COOPERATION

Of course a successful program will need input from the program directors and all othe experienced senior faculty of that particular country but a “sine qua non” of a successful program also needs the involvement of all parties that will be functioning in the program. Especially the doctors who are currently or recently have been in the receiving end of the program should be actively involved in the decision making process of the program. But the involvement should not be limited to recent or current trainees, the nurses, patients and the policy-makers including the specialty and subspecialty societies are all an integral part of a program and they should have a strong role in implementation of the rules and requirements of a program just as well. This approach will increase the chance of adaptation to the new rules and regulations of a program which maybe demanding at first. Making of a unique program should not be interpreted as total ignorance to the experience of others who went through a similar process and the search for that experience certainly should include the experiences of program makers in developed countries as well. This approach will bring the third requirement of a successful program the synchronization.

3. SYNCHRONIZATION

This refers to fine tuning of a program at all levels. For instance sending personnel to developed world to understand the basics of a successful program implementation or inviting faculty who are involved in implementation or running of such programs there may be one aspect of synchronization process. This approach may help overcome one of the main obstacles of building a program in developing world,that is lack of adequate number of people who has time and expertise of program building and running. Another benefit of inviting outside experts is to use their prestige and wisdom to overcome the resistance from senior faculty who would be likely to resist to the changes and insisting on “traditional ways to continue. A common resistance points would be that “such approaches have been thought and tried by themselves in the past but it did not work”. These experts may also use their influence on “ironing-out” the minor issues that may prevent the consensus. Collaborative efforts of initiating and running short programs together with the developed world societies may also increase the experience of local administrators. But the synchronization efforts should not be limited to synchronize the program with the developed world only, implementation of the program in different geographic locations will help to reveal the shortcomings of the program and the adaptation process to these difficulties will make the program stronger and more adaptive to the demands of localizations with different levels of advancements. These adptations will also help to standardize the program for wider groups and locaitons. If the need is to develop a program that will serve in different countries than it is imperative to try it in at least some of these countries initially.

4. TEACHING TEACHERS:

Convincing the teachers, especially the senior faculty that they need to go through some courses and tests to adapt to the new order is a must but on the other hand may be one of the main obstacles of implementing a contemporary program. Various techniques including using prestigious experts or “sugar-coating” may be used together to convince the senior faculty to “pitch in”.

CONCLUSION

The changes in medicine and demands of society and the policy-makers requires adaptiation of the teaching and training programs to oversee their ways and means. These changes are inevitable and adapting to these needs would be sooner the better. Although most of the doctors in the developing world who are assigned to these jobs are mere clini-

cians and do not have any particular training expertise in these works, they have to assign more time and energy in their day to day practice if they want to successfully fulfill their roles as educators. On many occasions the faculty assigned to these tasks already have some experience and training in the developed world which may help them to overcome the difficulties of this work by using the expertise they gained through functioning in that part of the world.