Chapter 10
Skill Training Process in Medicine Through Distance Mode

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ABSTRACT

Skill training can take place whereever trainer, trainee and clinical material is present. In a residential training, all the pedagogic steps of pedagogy are implemented in the same institution. In distance mode, each level of pedagogy is linked to separate settings to provide flexibility, and thus provides an alternate model to residential mode of medical education. While cognitive domain can be taken care by the Distance education institutions, the psycho-motor domain can be taken care through a integrated network of the tertiary level, secondary level and the primary level health set up in a sequential manner. Thus, every health institution of a nation and the clinical learning materials available in those settings can be utilised to impart medical education. Similar principle can be followed for imparting surgical training through distance mode. Skill training in medical education is a very sensitive issue. Its implementation through ODL mode needs conviction and a lot of expertise.

INTRODUCTION

Healthy productive life is the goal of every individual. Therefore to have a good health care delivery system, every nation needs to have adequately trained health manpower. As health training deals with lives, the training has to be carried out with utmost care and sensitiveness. This demands not only careful planning of the training

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process but also its execution to ensure quality training and a quality product. This could be one of the reasons for the long duration of training in the conventional mode of medical education across the globe.

Why Distance Mode?

As per Global Health Observatory (GHO) data, about 44% of WHO member states report to have less than 1 physician per thousand population. Only 5 of the 49 countries categorized as low-income economies by the World Bank meet the minimum threshold of 23 doctors, nurses and midwives per 10,000 population that was established by WHO as necessary to deliver essential maternal and child health services.(1) World health statistics, 2015 mentions India to have the density of physicians at 0.7 per thousand population and that of nurses at 1.7 per thousand population (2) This shows the task ahead for every nation in meeting the trained health manpower need to achieve the goal of 'health for all' vis-a-vis the sustainable developmental goals of 2030. While the developing nations need the trained health manpower the most, these are the nations who are not able to carry out training either due to lack of sufficient health infrastructure or the non availability of qualified trainers. Therefore, to address the global challenge of filling up the gap in availability of trained medical personnel, alternate training strategy to provide adequately skilled personnel is of paramount importance.

Distance education has evolved with time and technology. It should not be viewed with the stigma and deficiencies of correspondence courses. Distance education is essentially a mass education. According to Otto peter, it is an industrialized form of teaching and learning. But, there is a provision of human element to guarantee the 'continuity of concern for students learning at a distance'(3). The peer group interaction, immediate feedback, solving learner problem, etc are examples of this human element. Therefore, providing quality skill training in distance education is as realistic an event as that of class room teaching. There can be arrangement for skill demonstration and hands-on practice for sufficient duration as per the need for a specific skill. It is the type of skill that should decide the duration of human element. Indeed, the distance education stigma can be removed if we look the transaction as a blended learning approach and call it Open and Digitalized Learning.

Medical Education

Practice of medicine is both an art and science. Traditionally, medical education is imparted as a residential mode of training. There are various systems of medicine