CHAPTER 8

Practice in Attending the Sick

THE IMPORTANCE OF A SOLID BASE IN CURATIVE SKILLS

As we discussed in Chapter 3, ability to attend the sick is one of the most important skills a community health worker can learn. This is because:

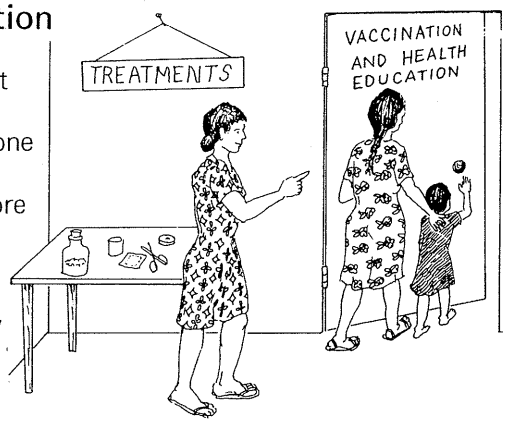
- Curative medicine answers a strong felt need. Most people show far more interest in curing their ills than in preventing them—at least at first.
- A health worker who is an effective healer will win people's confidence and cooperation more readily—even for preventive measures.
- Early, safe, low-cost treatment by people in their own homes is an essential part of prevention. It keeps many minor problems from becoming severe.
- Attending the sick provides a key opportunity for health education that relates to the family's immediate problems and concerns. (See the discussion below.)
- Only when health workers are well versed in curative medicine, including its risks and limitations, can they help people overcome common misunderstandings about modern medicine. (Training health workers only in 'prevention' can actually lead to greater misuse, overuse, and *mystification** of medicine!)

Appropriate curative medicine is a key part of prevention.

Treatment as a door to prevention

Many health workers have found that the 'clinical consultation', or occasion when a sick person seeks treatment, is one of the best opportunities to talk about preventive measures. Some find this more effective than organized health talks in small groups because . . .

- it is more immediate and personal,
- the sick person and her family are very much concerned with the illness in question, and
- many people come for treatment who might not come to health talks.



CURATIVE MEDICINE—
A DOORWAY TO PREVENTION

*Mystification: Making something seem magical or supernatural, beyond the understanding of ordinary people.

A health worker who can diagnose and treat, or help others to diagnose and treat many of their own health problems, has many more opportunities for health education.

Starting with what people want—then helping them explore what they need

The clinical consultation, or 'patient visit', offers an excellent opportunity for health education. It is a chance to talk about the causes, diagnosis, treatment, and prevention of the person's illness or injury.

However, when using the clinical consultation as a starting point for health education, it is wise to take certain precautions.

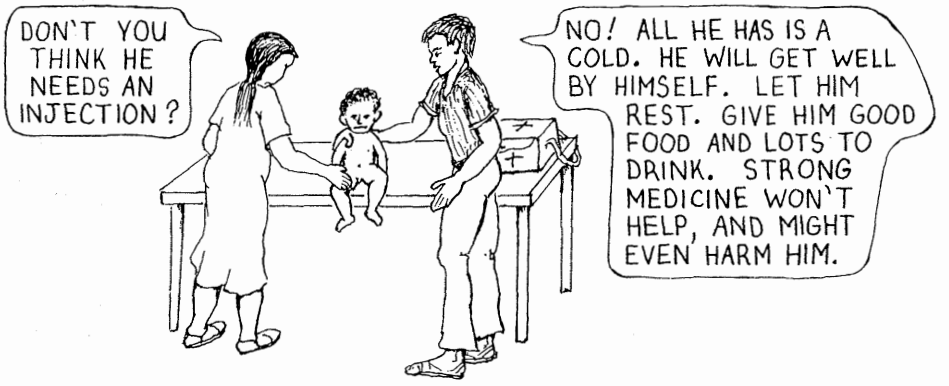
If you want people's good will and cooperation:

First **start with what people want** (their immediate or FELT needs).

Then help them to better understand and meet their underlying, long-term needs (REAL needs).

TREATMENT FIRST — THEN PREVENTION

Sometimes people ask for treatment that is harmful, wasteful, or based on misunderstanding. If this happens, try to help them understand the situation and accept a more appropriate treatment. (See Chapter 18.)



If medicines are not needed, take time to explain why.

LEARNING WHAT TO DO FOR THE SICK AND INJURED

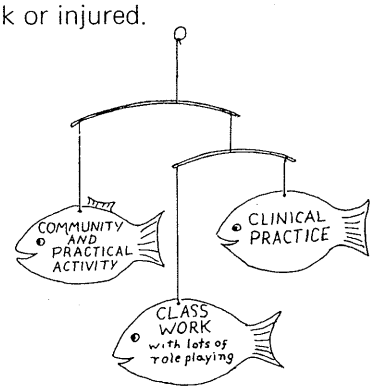
Learning what to do for sick or injured people can be approached in a combination of ways:

- in the **classroom**—through study, reading, and discussion.
- through **role plays** (usually also in the classroom). Different illnesses are acted out, and students take turns diagnosing, treating, and giving advice.
- through **actual practice** in diagnosing, treating, advising, and caring for sick persons and their families.

The first two ways (classroom and role plays) are covered in Parts Two and Three of this book. In this chapter we will consider mostly the third way—which involves working directly with persons who are sick or injured.

Direct experience through 'clinical practice' is one of the most important parts of health worker training. It needs to be balanced with classroom learning and activities in the community. But be sure to allow plenty of time for clinical practice: perhaps 1½ to 2 hours a day. In addition, try to be flexible and interrupt class when there is a chance for students to observe and help treat emergencies or other important illnesses.

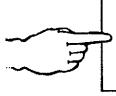
To follow are some ideas and suggestions that may help clinical practice during training to be more effective.



A GOOD BALANCE FOR A HEALTHY 'SCHOOL'

Clinical instructors

In some ways it is best for health workers-in-training to get clinical practice with experienced community health workers rather than with doctors. In any case, it is important that the clinical instructor be a person who makes clear his own limitations. He or she needs to set an example by referring sick persons with difficult or confusing problems to those who are more highly trained or specialized.



Usually it is better for health workers to gain clinical experience under the guidance of persons who practice at a level similar to that of the health workers in their communities.

It also helps if the clinical instructors are the same persons who work with the health workers in the rest of the training program. This way, classroom learning and community activities can be better related to clinical experience. **Classwork becomes more meaningful when it relates to real persons and problems recently seen in the clinic or community.**

The place and level (hospital, health center, or home)

The term 'clinical practice', as we use it, does not mean only activity in a clinic or health center. It includes visiting sick persons in their homes.

Many programs have found that health workers do not need a special, separate 'health post'. They can work well in their own homes, or by visiting the homes of the sick. The home is a more relaxed place for a consultation and puts the health worker and the sick person on more equal terms. It provides a more appropriate setting for talking about preventive measures. And it helps to 'demystify' or take the magic out of medical care.

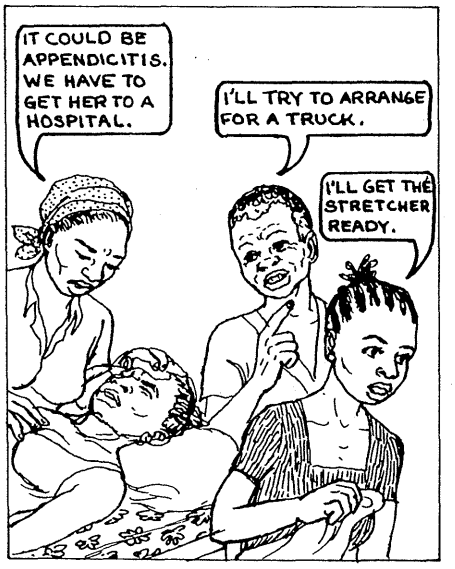
There is, however, one big advantage to having students gain at least part of their clinical experience in a community clinic or health center. It gives them a chance to see a wider variety of health problems and to gain repeated experience in handling the more common problems.

But there are also some disadvantages to clinical practice in a large clinic or hospital:

- The staffs of large centers or hospitals tend to be **less flexible,** less able to arrange active, appropriate learning for health workers.
- Care tends to be **less personal** and more hurried. Staff may not have time to treat either patients or health workers as persons. Health workers may learn more bossy, less friendly attitudes and habits.
- Often **costly equipment** is used that will not be available in health posts.
- Students may take part in difficult diagnoses or treatments of problems that they would normally need to refer to a health center. This can lead to **confusion and temptation to go beyond their limits.**

LESS APPROPRIATE

MORE APPROPRIATE



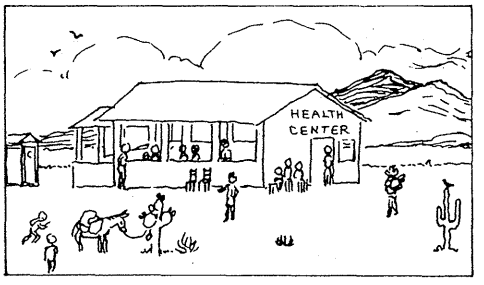
As much as possible, health workers should gain clinical experience in a situation similar to that in their own communities.

Generally it is wiser for health workers to gain clinical experience in a small community health center. Here things are more personal and more flexible. The staff, the sick and their families, and the health workers have more chance to learn about each other—not just as 'problems' and 'problem solvers', but as fellow human beings. They can all begin to care for and about each other.

In a small rural clinic, however, there may not be a wide enough range of problems for health workers to gain adequate experience.

Ideally, perhaps, students should have a chance to learn in both a small, unhurried village setting, and in a health center large and busy enough so that they can see a broad range of problems and persons.

A community-based program in Nuevo Leon, Mexico *(Tierra y Libertad),* has managed to do this. Training is based in a small village. But the students take turns spending time in a busy community health center in a poor neighborhood in the nearby city of Monterrey.



Classroom preparation

It is a good idea to begin clinical practice early in the course. So classroom preparation for this also needs to begin early. Classes might include:

- **clinical ethics** (relating to the sick as persons, not 'patients')
- **basic teaching and communicating skills** to help in understanding needs and explaining things clearly to a sick person and his family
- **how to examine a sick person** (see *Where There Is No Doctor,* Ch. 3)
- **how to take care of a sick person** (see *WTND,* Ch. 4)
- **practice in using record sheets** (see Ch. 22)
- **solving problems step by step** (scientific method, Ch. 17)
- **diagnosis, treatment, and prevention of common illnesses and injuries** (based on local needs and resources)
- **proper use and measurement of medicines** (see *WTND,* Ch. 5, 6, 7, and 8)
- **preventive measures** for specific health problems

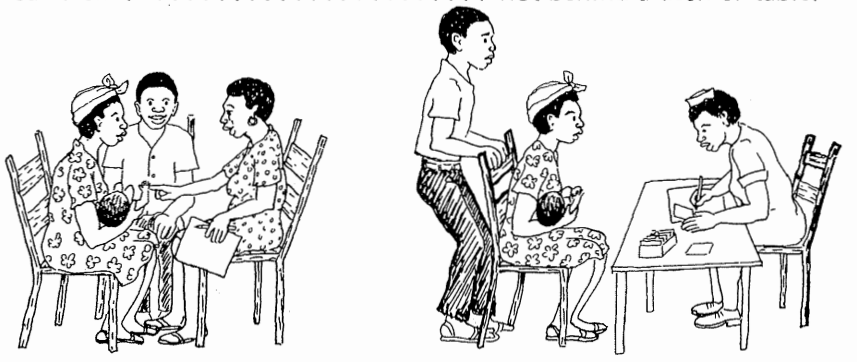
In classroom study of these subjects, the closer the learning situation can be to the real-life situation, the better. Through role plays and sociodramas, students can practice all the above skills in a lifelike way. A **checklist,** or list of review questions, can be used to evaluate how well the students do (see page **8**-10).

ADVISING HEALTH WORKERS ABOUT 'CLINICAL ETHICS'

Before health workers begin clinical practice, it is a good idea to spend some time discussing guidelines for relating to the sick. These guidelines should be followed by the instructors, too, as they set the example for the health workers-in-training. You may want to include these points:*

Treat sick persons and their families as your friends and equals, not as 'patients' or 'cases'. For example:

- Make sure there are places for everyone to sit.
- Dress as they do, instead of wearing a uniform.
- Sit near them . . . . . not behind a desk or table.



- Use simple, clear language people understand (avoid big medical terms).
- Ask about family and friends, not just about the health problem. Take interest in the life and ideas of the sick person and his family.
- Do not let record keeping interfere with communicating. Do not write while the person is talking.
- Respect people's traditions and beliefs.
- Learn how to listen. Be sympathetic to people's hopes and fears.

First serve those whose needs are greatest. When many persons are waiting to be seen, try to notice those who are especially sick or need immediate attention. Very sick persons need to be seen first. They should not have to 'wait their turn'.

If other workers at the training center (and people in the villages) can learn to recognize signs of serious illness, they can help to make sure that those who need attention immediately are seen first.

*These guidelines are from a mimeographed sheet written by Project Piaxtla staff for village health worker trainees in Ajoya, Mexico.

Respect the confidence and privacy of the sick person. Do not discuss someone's health problems outside the clinic or classroom. This is especially important in a small village where gossip is a main form of entertainment.

If someone asks you, "What is wrong with Maria?" consider answering, "I'm sorry, I can't discuss a person's private problems except with members of the immediate family." This way, people will learn that they can trust you. They will then be willing to see you about problems they do not want others to know about.

Be honest with the sick person and his family—but also be kind. Sometimes when a person is very ill or dying, or has a frightening disease like leprosy or cancer, you may not be sure whether to tell him and his family the truth. But often both the sick person and his family already suspect the worst, and suffer because they try to hide their fears from each other. Each situation needs to be approached individually. But as a general rule, it is wise to **be as truthful as possible . . .** but in a way that is gentle and kind.

Help the sick person gain a better understanding of his illness. Explain the physical examination, diagnosis, causes of the illness, treatment, and prevention in clear, simple terms. Use your books or show pictures to help explain things. Help people take informed responsibility for their problems. Never use your knowledge of healing as a form of power over other people.

Use medicines only when needed, and help people understand why it is important to limit their use. In about 80% of illnesses, a person will get well without medical treatment.

On the average, a clinic should aim at giving medicines to only about half of the persons who come for treatment. But make every effort to see that those who go away without medicine are content with the advice or treatment given. One of the most important aspects of health education is to help people realize that **it is healthier, safer, and cheaper to manage many illnesses without medicines.** (See Ch. 18.)

Recognize your limits, and admit when you don't know something. No matter at what level a health worker is trained, there will be certain illnesses or problems she cannot diagnose or treat. This may be because the problem is not treatable, or because she lacks the skill, knowledge, medicine, or equipment to treat it. In any case, it is important that the health worker admit her limitations. When necessary, she should refer the sick person to where he is more likely to receive the attention he needs.

Also, when you have doubts or are unsure of how to do something, do not pretend to know. Admit your doubts and ask for assistance. This is as important for instructors as for students.

KNOW YOUR LIMITS

THE ART OF ASKING QUESTIONS

Sometimes a sick person will tell you what he thinks you want to hear, in hopes that you will treat him better if you are pleased with his answers.

Help students to be aware of this problem. Try to make sure that they ask questions carefully and get correct answers. They may have to ask about the same thing more than once. But have them take care not to insult the sick person by seeming to doubt his answers.

Usually it is a good idea to avoid asking questions that lead the person to answer in a certain way. For example, look at these questions and answers:

A leading question . . .

. . . supplies the answer you expect.

A more open question . . .

. . . gets a truer answer.

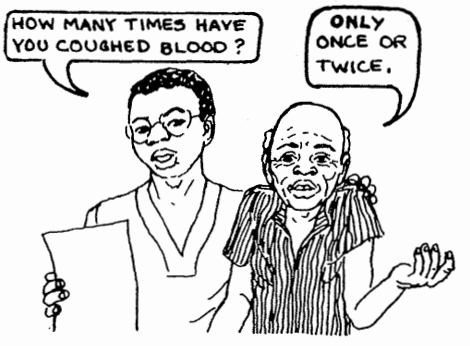
In either case, the health worker will need to ask more questions in order to understand how and when the problem began.

A more open question is not always better. Often a sick person will be afraid to admit that he has signs of a disease such as tuberculosis or leprosy. These diseases are especially feared because many people still believe that they cannot be cured. In a case like this, a leading question will sometimes get a more revealing answer.

A more open question . . .

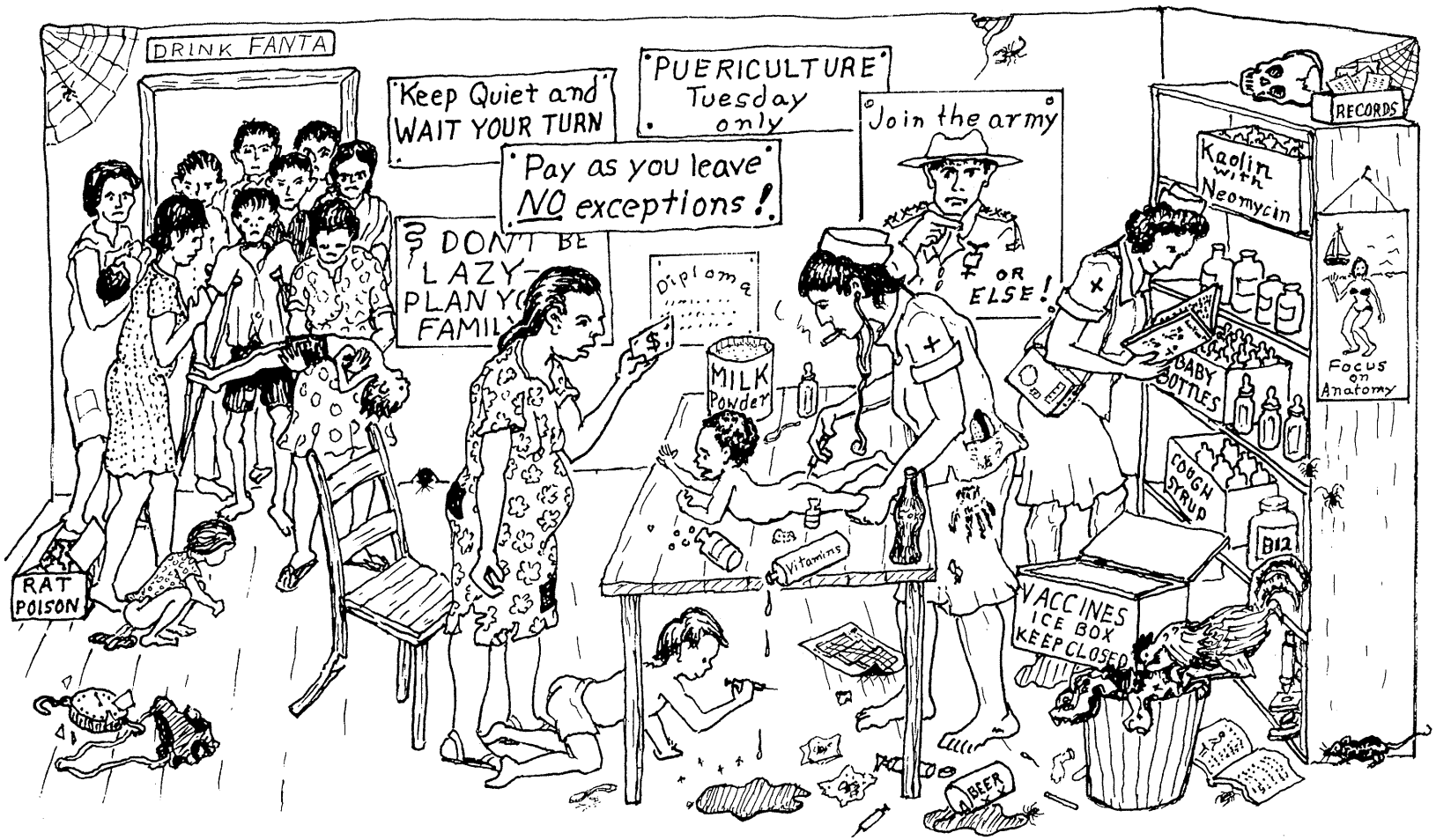
. . . got a misleading answer because of the person's fear.

A leading question . . .



. . . got him to admit the truth.

Classroom role plays can help students practice asking appropriate questions—in a way that does not offend.



Ask your health workers how many faults they can find in the clinic shown here. (We find more than 50.) What improvements do they suggest?

SAMPLE CHECKLIST FOR EVALUATING A CONSULTATION

Note: This self-evaluation checklist is a sample, intended for raising questions as well as for evaluation. You do not have to read it in detail as you read through this chapter. Refer to it later if you need to.

PERSONAL APPROACH AND ATTITUDE–
Did you . . .
___attend the person promptly? Or did he have to wait long?
___spot at once if the person was very sick, and if so, see him ahead of others?
___invite the mother or relative to take part in the consultation (if appropriate)?
___ask the sick person and family members to sit down, and make them feel at ease?
___sit close to them, not behind a desk or table?
___ask questions and take the time to listen to personal and family concerns? Were you really interested in the 'patient' as a person?
___touch children and show warmth?

MEDICAL HISTORY
___**Observation:** Did you look for and see obvious signs of illness early in the consultation?

For example:
- general appearance and health (weight, posture, relaxed, nervous, depressed, etc.)
- skin color (normal, pale, yellow, blue)
- eyes (color of whites, pupil size, etc.)
- breathing (sounds, rate, effort, sucking in of skin behind collar bone)
- bulging veins, scars, sores
- specific signs of illness

History (questioning the sick person): Did you . . .
___take an adequate history **before** starting the physical examination?
___ask appropriate questions in a sensible order?

For example:
- What bothers you most **right now?**
- **When** and **how** did this begin?
- What **other problems** do you have?
- When were you last completely well?

___follow up with other searching questions?

For example, if a child has diarrhea:
- When did the problem begin?
- How many stools a day?
- What does the stool look like? (blood? mucus? etc.)
- Has the child vomited? Urinated?
- Has the child been drinking liquids? What? How much? How often?
- Does he eat? What? How often?
- Possible related illnesses? (earache, tonsils, polio, malaria, etc.)

Did you find out about the following, if necessary?
___Details of the problem–signs, dates, etc.?
___If others in the family or community suffer from the same problem?
___The person's living situation, if it might help with diagnosis, treatment, or prevention?
___What medicines or treatments have already been tried? And with what results?

PHYSICAL EXAMINATION Did you . . .
___conduct the physical exam in a sensible order?
___do what is least disturbing first?

For example, listening to a child's lungs before looking in his ears or throat.

___take precautions to make the exam as little disturbing as possible?

For example:
- Explain tests and procedures ahead of time (what you are going to do and why).
- Warm a cold stethoscope by rubbing the bell before examining a child.
- Have the mother remove the child's clothes and hold him on her lap.
- Avoid unnecessary tests.

___make sure enough clothing was removed to allow adequate examination?
___repeat doubtful or difficult examinations 2 or 3 times?
___do all necessary steps of the physical examination, and leave out those not needed for the particular problem?

DIAGNOSIS Did you . . .
___use a systematic approach to problem solving?
___consider different possible causes?
___ask questions or make tests to decide which cause was most likely and which were not?

For example, the test for rebound pain when appendicitis is suspected (***WTND,*** p. 95).

___if you made a diagnosis, did you consider it to be the probable cause of the problem? (Or did you feel absolutely certain–a very risky position to take?)
___make a sensible decision about what to do?

For example if you could not obtain enough information to make a diagnosis, did you:
- Send the person for lab tests.
- Send him to a doctor you trust.
- If it could be done safely, treat the problem according to the most likely diagnosis.

___make good use of available resources for helping make the diagnosis? (books, instruments, people)
___As nearly as can be told, did you make the right diagnosis?

TREATMENT AND MANAGEMENT

Sensible use of medicines or alternatives:
Did you . . .

___use no medicines if they were not needed?

> At least 50% of health problems are best managed without medicines.

___if medicines were not needed, help the person understand why the problem is best managed without them?
___use appropriate non-medicinal treatments?
___use only medicines that were needed?

> Use only 1, or at most 2, medicines. If 3 or more medicines are given at one time, people often cannot remember how to use all of them properly.

___ask if the person is allergic to any medicines?
___before giving a woman medicine, ask if she was pregnant? Give only medicines that are safe for the child in the womb.

___use the correct dosage of medicines?
___measure or count the medication (pills)?
___write for the person the name of the medicine, its use, the dosage and the person's name, in clear simple form (or in picture code if illiterate)?
___explain the medicine and dosage clearly and simply, and have the person repeat it?
___do your best to make sure the person will take the medicine correctly?

> For example, have him take the first dose at once, especially if it is a single-dose medication (like some worm medicines).

___avoid injections, except when absolutely necessary?
___consider the cost of different possible medications, and choose the cheapest one likely to do the job adequately?
___emphasize the importance of taking the medicine as directed and for the time necessary?
___give advice about risks and precautions?

Traditional medicines and beliefs: Did you . . .

___use traditional medicines or healing methods, if appropriate?
___explain about diet and other traditional concerns people have when taking medicines?
___explain things in such a way as to respect and build upon people's traditions and beliefs, rather than reject them?
___**Follow-up:** Did you make arrangements for follow-up, if necessary?

Referral: Did you . . .

___recognize your limitations, if the problem was beyond your ability to diagnose and treat?
___openly explain your limits and help arrange for the person to receive care elsewhere (hospital or clinic)?

HEALTH EDUCATION AND PREVENTION

Communication about the health problem:
Did you . . .

___discuss with the sick person and his family: the illness, its causes, and its prevention?
___use simple, clear language, and local words?
___include the child, as well as the mother when discussing the health problem and its prevention?
___use books, teaching aids, examples, or stories to make points clearer?

Prevention:

___Did you place enough emphasis on prevention?
___Were the preventive measures you suggested clearly related to the problem in question?
___Did you consider the feelings and concerns of the sick person and his family?

> For example, did you talk about prevention only after providing for treatment?

___Did you try to make sure that the preventive measures you suggested would be followed?

> For example, in case of typhoid, did you:
> - Offer to visit the home and plan with neighbors to help construct a latrine?
> - Help the family make a water filter or a rain water collecting system.

___Did you do your best to share your knowledge and show there is nothing magic or secret about your medical abilities? Or did you look things up secretly (or not at all) in order to give the impression that you 'know it all'?

USE OF BOOKS Did you . . .

___make good use of your reference book(s) during the consultation?
___openly look things up in the book while with the sick person and his family?
___show the sick person or a parent the sections or pictures in the book that explain the problem?
___double check dosage or other information by looking it up, even if you were fairly sure?

RECORDS Did you . . .

___write a record of the consultation?

> - Name, age, date, etc.
> - Health history and what you found in physical exam—in enough detail for another health worker to understand.
> - Possible alternatives for diagnosis.
> - Tests and information in order to rule out or confirm possible causes.
> - Conclusion (most probable diagnosis).
> - Care and treatment (or decision to refer).
> - Preventive advice given.

___record the information so that it is **clear** and **well organized?**
___record the information in a way that did not disturb your conversation with the sick person?
___fill out any other necessary forms?

ROLE OF THE INSTRUCTOR IN THE CLINICAL SITUATION

The role of the clinical instructor—whether an experienced health worker, a doctor, or someone else—is of key importance. The instructor needs to do far more than question, examine, and treat the patient while the students watch. It is up to her to balance consultation with education. She needs to look for every opportunity to help the students learn, yet be sensitive to the needs and feelings of the sick person and her family.

Teaching assistants: In the early stages of clinical learning, it is especially helpful if, apart from the instructor who conducts the consultation, a second instructor or experienced health worker is present. This teaching assistant quietly guides the observing students in where to look in their books and how to record information in the 'patient report' forms. This way, the consultation proceeds with little interruption, yet the students receive individual help and answers to their questions. The teaching assistant can also quietly ask the students questions that lead them to asking the right questions themselves.

Involving the sick person and her family as helpers: Sick persons sometimes feel angry about having students observe or take part in their clinical consultation. They may feel they are being used, without having any choice in the matter. Unfortunately, this is often true.

You can often transform this situation by looking at the sick person as a ***person,*** not as a patient. To do this:

- Explain to the sick person and her family about the training course, and the need for health workers to gain experience in order to serve their communities better. Then ask if they are willing to help teach the student health workers about the problem.
- Respect the decision of those who say no. Do not try to pressure or shame them into saying yes.
- Keep the student group small—usually not more than 3 or 4.
- Include the sick person and any family members in the discussion of the problem. Make sure that details of the physical examination, diagnosis, treatment, and prevention are discussed clearly and simply.

If the sick person is involved in this way, you will be surprised how often she will end up feeling good about the consultation and the presence of the students. Several times we have seen persons thank the group warmly and say:

If the person's illness is an especially common one, and not embarrassing to her, she may not mind if other people waiting for consultation also hear about its signs, causes, prevention, and treatment. They may even have helpful ideas or experiences to contribute.

STAGES OF CLINICAL LEARNING

The role students take in clinical consultations depends on a number of factors. But generally they are given more responsibility as their training progresses.

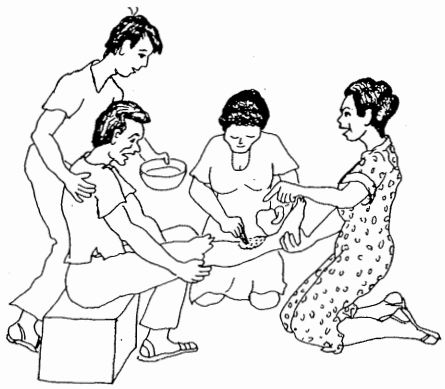
At first students may be mainly observers, staying in the background and saying little. As they gain more knowledge and experience, they usually take an increasingly active role (and the instructor a less active one). By the end of the training program, students should be able to take charge of the consultations. The instructor stays very much in the background, participating only when her advice is asked or when students forget an important step or make an error.

STAGE 1:

Instructor takes the lead; students observe.

STAGE 2:

Instructor still leads, but students take increasing responsibility.



STAGE 3:

Students conduct the consultation; instructor observes.

STAGE 4:

Students in charge: instructor absent but on call if needed.

POSSIBLE STAGES IN CLINICAL PRACTICE

STAGE 1:

(about 1-2 weeks)

Instructors take the lead;

students observe.

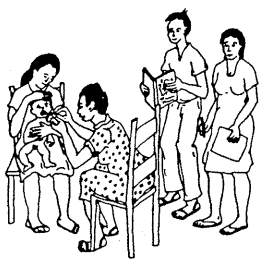
What health workers can do

- mostly observe
- look up the problem in their books and try to figure it out
- ask instructor some questions (but with care not to disturb the sick person)
- practice filling out record sheets about the sick person

What instructor can do

During the consultations:

- ask the sick person or family if students may observe
- conduct the consultation
- explain steps of history taking, physical exam, diagnosis, and treatment to both the sick person and the students (with care not to disturb the sick person)
- ask occasional questions of the students to help them think things through
- be sure information gathered is clear enough for students to fill out record sheets properly
- discuss appropriate preventive measures with the sick person (or family)



- ask instructor questions and comment on what they saw and learned
- practice on each other any physical exam skills used
- review how consultation was carried out

After the consultations:

- discuss important points of the consultation and the health problem, pointing out what was typical and what was not typical
- review student record sheets and compare with her own
- demonstrate and help students practice relevant tests and physical exam skills
- make sure students understand the inter-relationship and importance of each part of the consultation (observation, history, physical exam, tests, diagnosis, management and/or treatment, prevention, education)
- discuss with students their doubts, abilities, limits, and how they could best handle a similar problem when they confront it in their villages (what to do or not do; if and when to refer)

STAGE 2:

(2-3 weeks)

Instructor still leads;

but students take a more responsible role.

What health workers can do

- help take history
- perform parts of the physical exam that they have already studied and practiced
- fill out record sheets
- use their books to diagnose and determine treatment (with help from instructor)
- help with simple curative measures
- give preventive advice or read preventive measures from their books for the sick person (or family)

What instructor can do

During the consultations:

- let students take the lead in history taking and examination when problems appear to be those with which they have experience, but be quick to step in when they need help
- make suggestions and ask questions to help students remember to make the right tests, interpret results correctly, and ask the sick person appropriate questions
- make sure the sick person and family feel comfortable with the consultation process
- take over when necessary
- make sure students use their books well and explain things to the sick person
- if necessary, repeat tests or physical exam to check if students did things right
- review treatment (medicine, dosage, etc.) and advice given by students
- be sure students give preventive advice, in a friendly way

After the consultations:

- as in STAGE 1, but by now students can also take turns leading the review discussions and asking each other questions

FOR HEALTH WORKERS-IN-TRAINING*

STAGE 3:

(about 2-3 weeks)

Students conduct the consultation;

instructor observes.

As much as possible, the situation should be like that in which health workers will later work—except that the instructor is nearby.

What health workers can do | **What instructor can do**

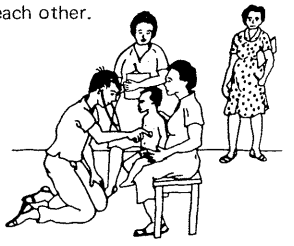
During the consultations:

- conduct the entire consultation
- use books as much as possible, and ask for suggestions or help from instructor only (but always) when unsure of what to ask or do
- together with the sick person (or family) make the decision about how to handle the sick person's problem; whether to instruct the person on treatment or refer him to a clinic or hospital

- be present as an observer. If possible, remain silent throughout the entire consultation, taking notes on points to discuss after the consultation.
- take an active part only when the health workers make an error that might result in harm or inadequate treatment
- when necessary, help health workers gain the person's confidence by agreeing with their conclusions or approving of their methods

After the consultations:

- similar to STAGE 1, except that the health workers take more responsibility for the review, evaluation, and questioning of each other.



- review the handling of the consultation: comment specifically on the strong and weak points, and what might have been done better
- encourage health workers to evaluate each other's handling of the consultation and to review each other's records for clarity, accuracy, and completeness

STAGE 4:

(about 1-2 weeks)

Students completely in charge;

instructor absent, but on call.

What health workers and instructor can do

During the consultations:

Similar to STAGE 3. This time, however, the instructor is not only silent, but absent, although on call when needed. In this way, by the end of the training period the clinical consultation is quite similar to the actual situation of a health worker at work in his village or community. He assumes much of the same responsibility. Although the instructor is on call if needed, by the end of the course the decision making is completely up to the health worker trainee.

After the consultations:

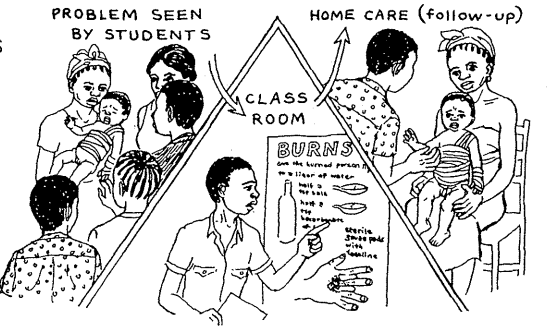
After the consultation is completed, the instructor can review the record sheets and discuss them with the health workers. This, too, is similar to what will happen when the instructor (or 'supervisor') visits the health workers' villages to help them review their records and 'trouble shoot' problems.

*Timing suggestions are for a two-month course.

ADAPTING CLASSWORK TO PROBLEMS SEEN IN THE CLINIC OR HOME

If the course plan is flexible, instructors can schedule classes about specific illnesses or problems that students have just seen in the clinic or community.

Suppose that one day a badly burned child is seen by the students in the clinic. If class discussion that same day covers burns (their causes, prevention, and treatment), the students are likely to take great interest. Then follow this with more classes on burns, as well as follow-up care and home visits to the burned child, until he is completely well.



Students learn better when classes relate to problems they have just faced in real life. Such unplanned classes can cover the subject matter for the first time. Or if the subject has already been covered, they can serve as review.

This kind of flexibility in scheduling classes is of great value. But it can create difficulties with planning and coordination. It is much easier to do with a small learning group at the village level.

FOLLOWING THE CLINICAL CONSULTATION

In order to take full advantage of the consultation as a learning experience and still keep classes more or less on schedule, a special period can be planned for discussing problems seen in clinical practice. Some programs allow a half hour or an hour for this each day, immediately after the consultations.

In these sessions, students describe to the rest of the group a problem they have just seen that day in clinical practice. They review the consultation process and the instructor helps emphasize the most important points to be learned. This review can be done mostly in the form of questions and answers. In the early stages, the instructors may take the lead. Later in the course they can encourage the students to summarize what they have learned and to question and evaluate each other.

Remember the importance of clinical skills:

The confidence that villagers have in their health worker depends greatly on his ability to treat their most common and serious illnesses. For this reason it is essential that the training course provide a solid base for curative skills and clinical experience. With this training, and good support from the program and the community, the health worker can help his people meet their felt needs for curative care. Then he will be more able to help people recognize the underlying causes of ill health and work toward effective prevention.