ARTICLE

What rural doctors want: a qualitative study in Chhattisgarh state

KABIR SHEIKH, SHINJINI MONDAL, PRATIBHA PATANWAR, BABITA RAJKUMARI, T. SUNDARARAMAN

Abstract

The importance of addressing concerns of rural health worker welfare in order to improve their performance and retention is widely acknowledged; yet there is little empirical research on the needs of rural health professionals. We report findings from a qualitative research study in rural Chhattisgarh, involving in-depth interviews with 37 practitioners and data analysis using the "framework" approach. Participants' expressions of their needs encompassed a range of reforms and improvements, including better salaries and job security, more rational posting and promotion procedures, and facility improvements. Opportunities for need-based skills training and better housing also emerged as key needs, as did better schools, assurance of personal security, and recognition and appreciation of their services by the administration. Increased investment in rural infrastructure and training, graded packages of benefits for rural doctors, and governance reforms to improve the internal accountability of government health services emerge as recommendations from the study.

Introduction

The shortage of health workers in rural areas is a global problem, but its effects are particularly harsh in developing countries (1,2). In India, shortages of qualified rural health personnel severely constrain the health system's ability to deliver services to rural populations. Government estimates indicate that currently, 18% of primary health centres are without a doctor, about 38% do not have a laboratory technician and 16% lack a pharmacist (3). Specialist allopathic doctors are particularly in short supply in the public sector, with 52% of the sanctioned posts of specialists at sub-district hospitals lying vacant (3). High health worker absenteeism in government facilities has further compounded the problem of access to quality care (4).The failures of publicly provided health services have also resulted in the majority of rural households receiving care from providers with little or no formal qualification, with detriment to their health (5,6).

State governments have adopted varying strategies to resolve issues of access to quality healthcare in the villages. Lately, attention has been drawn to the importance of the welfare and needs of those serving in rural areas, to improving their experience, and promoting greater motivation and likelihood of retention. A global review of approaches to health workforce retention in developing countries variously identifies factors such as financial reward, better resources and infrastructure, and opportunities for career development as being instrumental in the retention of health workers (7). A few studies have identified familial and personal needs, such as guaranteed employment for spouses, education of children and safety issues, as contributing factors towards the recruitment and retention of doctors in rural practice (8). Ebueh and Campbell (9) reported that financial incentives, better working conditions, social support systems and opportunities for career development were all crucial motivators for rural practitioners. Butterworth et al. (10) similarly drew attention to the significance of career progression and in-service professional education opportunities, apart from monetary benefits. "Soft" factors, such as a positive and appreciative environment, have also been observed to play a role in the effectiveness and retention of health staff in rural areas (11). Systematic reviews on the subject have highlighted these manifold factors and the complex interplay between them, and suggest careful consideration of essential local and contextual factors to develop appropriate workforce strategies (12,13).

Clearly, a better understanding of rural practitioners' requirements is a basic prerequisite to developing policies to improve the performance and effectiveness of rural health services and aid in health worker retention. Yet, the research in this area from India is very limited and there is a significant gap in knowledge. This article attempts to address this gap through an exploration of rural doctors' perspectives of their specific requirements while in rural service.

Methodology

This qualitative research study was conducted in the state of Chhattisgarh in central India. The study had diverse objectives, focused on understanding the experiences and decisions of rural government doctors. It also explored why some doctors remain in rural service. One objective of the study is addressed

Authors: **Public Health Foundation of India** Delhi NCR, Plot No. 47, Sector 44, Institutional Area, Gurgaon 122 002, INDIA – Kabir Sheikh (kabir.sheikh@phfi.org), Senior Research Scientist; Shinjini Mondal (corresponding author – shinjini.mondal@phfi.org), Research Associate; Pratibha Patanwar, Independent consultant; **Indian Institute of Public Health, Delhi,** Plot No. 47, Sector 44, Institutional Area Gurgaon – 122 002 INDIA; Babita Rajkumari (babitark@gmail.com), Former Senior Lecturer; School of Health Systems Studies; **Tata Institute of Social Sciences**, Purav Marg, Deonar, Mumbai 400 088 INDIA – T Sundararaman (t.sundararaman@tiss.edu) Professor and Dean, School of Health System Studies.

To cite: Sheikh K, Mondal S, Patanwar P, Rajkumari B, Sundararaman T. What rural doctors want: a qualitative study in Chhattisgarh state. *Indian J Med Ethics*. 2016 Jul-Sep: 1(3)NS:138-44.

in this paper – to understand the perspectives of rural doctors in government service with respect to their requirements which, if met, would improve their experience of rural service.

Two teams of two researchers each conducted in-depth interviews with rural government practitioners between July and September 2009. All the researchers (one male and three female) were trained in qualitative research, with a minimum of a Master's level qualification in public health or social work. All interviews were conducted privately in the participants' respective places of work – usually clinics or government offices. It was often a challenge to ensure the privacy of participants, since superiors and colleagues frequently desired to be in the room at the time of the interview.

The medical background of one of the researchers frequently served to break the ice with the medically qualified participants. The researchers were often exhorted by participants to take up their manifold personal and professional concerns in policy circles. It was a challenge for the researchers to manage these expectations and to convince participants that the publication of the study was the most appropriate means available to the researchers to highlight the participants' circumstances.

Essential criteria for the selection of study participants were: recognised medical qualification, and service either in a "non-remote" rural area for more than five years or in a "remote" rural area (as defined by official government norms) for more than one year. Government records were used to identify all the doctors fulfilling the essential criteria in eight districts. Participants for the first round of interviews were identified purposefully from this list of eligible practitioners. Maximum variability principles were applied in this selection to ensure representation of both women and men doctors, those trained in allopathic (western or modern) as well as Indian systems of medicine and homoeopathy – collectively categorised as AYUSH, in both categories of employment (ie regular and contractual), and across different geographical locations within the state (which would not have been possible through random selection), to allow for greater thematic breadth in the responses (14).

Following 37 interviews in eight districts, preliminary listing and analysis of emergent themes revealed that no new themes were being generated in the latter interviews, and fieldwork was concluded considering principles of data saturation. All 37 practitioners consented to participation prior to being interviewed. In-depth interviews were conducted in Hindi and recorded on a digital media device with the permission of the participants (15). Topic guides were used to conduct the interviews, and interviews were guided by probes. All recordings were transcribed and then translated into English text by the same team of researchers, on a computer-based word processing programme.

The same team of researchers who conducted the fieldwork and transcribed and translated the text also analysed the data and authored the study report and subsequent publications. For organising data from transcripts of interviews, the "framework" approach of qualitative analysis for applied policy research was applied (16). "Framework" combines the deductive and inductive approaches of analysis, and involves developing a thematic framework consisting of *a priori* and emergent thematic codes, followed by application of the thematic framework to the data. The steps in the framework approach as followed by the research team are enlisted as follows:

- Familiarisation with raw data
- Identifying a thematic framework, based on predetermined objectives, and themes emerging from respondent narratives
- Indexing – by applying the thematic framework systematically to the data
- Charting – rearranging the data into distilled summaries of views and experiences
- Mapping and interpretation – using the charts to locate concepts, phenomena, typologies, and associations between themes.

Practitioners' perspectives of their specific requirements whilst in rural service were extracted from the narrative accounts and classified thematically. Initially, two researchers coded the data separately using the thematic framework, following which their analyses were compared and revisited to improve the reliability of interpretations of the data (17). While extracting themes and coding the data, we maintained an emphasis on extracting underlying implications and meanings that respondents ascribe to their experiences, rather than their overtly stated views and rhetoric. The thematically categorised findings are written up and are presented.

Ethical precautions

Prior to interviews, participants were informed of the objectives of the study, following which verbal consent was obtained by the researcher(s) who conducted the interview. In each case, a signed and witnessed statement of the person taking consent, indicating that s/he had explained the context, purpose, procedures and risks involved and taken free and informed consent, was provided to the study participant, with a copy also retained by the researcher. Recordings and digital data were stored in encrypted format with restricted access. Care has been taken to ensure anonymity of all individuals quoted in this article. Ethics review was undertaken and clearance obtained from the institutional ethics committee of the Public Health Foundation of India.

Results

Study setting and profile of participants

The study area, the state of Chhattisgarh, is located in the central region of India. The state has an area of 135,191 sq. km. and a population of 25.5 million (18). Forty-four percent of the land is forested and is home to tribes, which constitute one-third of the population. The physical inability to ensure outreach services to forested areas, coupled with the poor

economic status of the tribal majority, has constrained efforts to improve health and health service indicators in the state. Chhattisgarh has an inadequate health workforce. According to the *Bulletin of Rural Health Statistics* in India, 2005, the doctor-to-population ratio is 1:3100. Government practitioners were often the sole qualified healthcare providers in the rural areas that were the setting for the study. The formal private healthcare sector was largely absent, although there were several unqualified private providers operating in rural areas. Table1 presents profiles of the 37 participants in the study, on the basis of different characteristics.

Table 1. Profile of study participants

		Selection (n=37)
Sex	Male	33 *(89%)*
	Female	4 *(11%)*
Employment status	Regular	25 *(68%)*
	Contractual	12 *(32%)*
System of medicine	Western or modern (allopathic)	31 *(84%)*
	Indian systems and homoeopathy (AYUSH)	6 *(16%)*
Years of service	1–5	12 *(32%)*
	>5	25 *(67%)*

Working in adversity

The practitioners were confronted with a complex range of adverse circumstances and phenomena that influenced their professional and personal lives. Basic working conditions were compromised in many instances, and several respondents reported having to cope with shortages of water, electricity, space and supplies.

> *There was an epidemic of gastroenteritis here – everyone was in the same condition and we did not have space. There is no hospital building, and all this (existing facility) is old-style, like in the monsoons it leaks. When there are too many patients, we have problems as to where to keep them – so everything was filled with vomit and faeces. But we treated them*. (Allopathic doctor, regular, 24 years in rural and remote areas, male)

Problems in travelling to poorly accessible field outposts were frequently reported. Problems with residential facilities were widely reported, with doctors being forced to take up private accommodation or live in poorly maintained or inadequate government facilities. Several respondents reported incurring personal expenses to address local healthcare needs.

> *I have to look after two places…so if I have gone there and they call me for something important, then I have to run here –it's about 20 kms – I go by (motor)bike. (Interviewer: and the money for petrol? does the government give money?) R: we go on our own. Otherwise we would not be able to do it*. (Allopathic doctor, regular, 8 years in remote area, male)

There were also several accounts of doctors, nurses and support staff working overtime, sharing duties and sometimes dividing their time across two or more facilities in different locations to overcome personnel shortages. Practitioners routinely experienced late payment of salaries, and inability to obtain promotions or transfers to other locations.

> *I have been working here for 16 years. If we go by government norms then after five years of duty in a tribal area I should have been transferred to another less remote place- but all these things are not possible. I don't want to blame the government but this is a fact that without making a lot of personal efforts, there will be no transfer.* (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

Problems of access and communication were particularly marked in more remote areas. Long separations from families, a common consequence of being located in remote and inaccessible areas, were often a cause of distress. A few doctors indicated disturbances in spousal relations and estrangements, consequent to the problem of separation.

> *We are living 600-700 kms away from our family and relatives. Government gives us 18 days casual leave only (in a year). If something good or bad happens in our family then… if you travel 600 km it will take three days to go and three days to come. And I will stay for at least two to three days. So out of 18 days, 10 days are gone like this.* (AYUSH doctor, contractual, six years in remote area, male)

Erosion of professional skills and confidence was a commonly reported problem, as often attributed by respondents to others of their acquaintance, as to themselves. Frequently this was linked to limitations of resources (clinical facilities and equipment) to practise a high standard of medicine, and the lack of opportunity for further academic development.

Doctors in contractual employment reported a distinct set of concerns, related to insecurities of employment and a widespread perception of their inferiority in relation to regular doctors. Problems of separation from families were reported more frequently by contractual doctors, who had less choice in determining their locations, and limited permitted leave of absence. Clearly, contractual doctors were affected more severely by concerns of job insecurity and poorly supportive working and administrative relationships than doctors in regular employment.

> *In contract service you can't think much - November will come now, then we will come to know if this service will remain or not. If there is a permanent service then a person thinks about the future also - what will one do or not do. But in a contract job - I have one daughter - you can't plan whether you will have a service or not, or will be able to afford a second child or not. You never know what the future holds.* (AYUSH doctor, contractual, two-and-a-half years in remote area, male)

Finally, the threat of civil strife is pervasive in many parts of interior Chhattisgarh. A number of doctors said that they were generally permitted to stay and practise in insurgent-dominated areas and rarely subjected to direct personal harm. However, they were often restricted in their movements by the fear of being caught in, or left stranded by, incidents of violent conflict. Several respondents cited instances of armed

individuals taking possession of large quantities of medical supplies and medicines for their own use; and some of being roused from their homes and taken at gunpoint to treat the ill and injured.

Expressed needs: job and compensation

Remarkably few doctors in regular employment (2/25) expressed dissatisfaction with their current salaries. Among contractual doctors, higher pay scales were a frequently expressed need, with a majority of them claiming that their compensation and the terms of their contracts were unfair. A number of respondents reported how their salaries had not been increased to match the rising prices of commodities and services.

> *They are giving me 15,000 per month, which is nothing. When I joined here, rice was Rs 11 per kg. Now, how can you manage in 15,000? When we used to go to Raipur the fare was Rs 50, today it is Rs 350 and our salary is the same. Our economic condition has been disturbed badly - today if our children fall ill what will we do in Rs 15,000? Salary is not good.* (AYUSH doctor, contractual, six years in remote area, male)

Contractual doctors gave prime importance to the assurance of a regular job, highlighting the need for job security to ensure continuity in rural practice. Many of them had joined their current contractual positions on the basis of assurance or expectation that the contractual position would be converted to a regular position after a period of time. The uncertainties of contract employment were magnified in the case of AYUSH doctors, since there are no regular jobs earmarked for non-allopathic practitioners.

> *I want to see myself progressing, but because it is in the hands of God, I don't know if it will happen or not. I feel there can be some progress if we stick here but here, it might also happen that we leave and go. My Mrs (wife) stays outside, children and all live outside, so sometimes I think, "Leave it, just for 15,000 rupees...," but because I see some possibilities, I think that in a year or two I might get regular. Then I can bring my Mrs here.* (AYUSH doctor, contractual, three years in remote area, male)

Several respondents highlighted the need for more transparent and rational procedures for promotion and transfer.

> *I have been working here for 16 years. If we go by government norms, then after five years of duty in a tribal area I should have been transferred to another less remote place – but all these things are not possible. I don't want to blame the government but it is a fact that without making a lot of personal efforts, there will be no transfer.* (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

A number of participants expressed the need for government responsiveness to their preferences for postings, and a transparent process for reviewing their preferences.

Expressed needs: professional support and training

Several essential requirements for an effective rural practice were highlighted by participants, such as well-equipped facilities and improvements in the workplace. Deficient human resources, apart from the problems they create from a planner's perspective, ultimately have a great impact on the working lives of the providers who continue to work in underserved areas. The need to address shortages in personnel by filling existing vacancies was voiced by a majority (32/37) of respondents.

> *There is X-Ray but the technician is not there so it is not operational… The workload has also increased, with me and (a colleague) what has happened that I have to look after an entire PHC and a CHC. (The colleague) has two PHCs - (names of PHCs). Because of the workload I feel unsure. I think that if I get one helping hand then I will be able to do it.* (Allopathic doctor, regular, four years in remote area, female)

It was also stated widely that improving the quality and regularity of medical supplies and providing better workplace infrastructure would improve working conditions and enhance professional satisfaction.

> *There is shortage of materials, and it is of very bad quality. We get only one-tenth of the required materials for everything. IV fluid – whether I talk to the CMO, the collector, or give in writing – whatever fluid comes lasts only a week… Ladies come and lie down in the labour room – the rubber sheet is never changed. Fifty deliveries take place on the same sheet. For the past 20 years, I keep hearing this – there is no delivery table, no syringe, no stand or drip, no pads or cotton. If we use one suction tube for one child, we should not be using the same for all the delivered babies. If someone is dying of pain, we should not use used syringes. They give 50 gloves for the month, that too unsterilised, and one has to wash it every time and then use it. There are no blood banks. There is just one in the district which has four bottles of blood. If we don't give blood then patients die every day. At CHC level if blood is not given, then many patients will die. Do write all of this down – if something will happen by your writing it, then do write it.* (Allopathic doctor and specialist, regular, 20 years in rural and remote areas, male)

> *When we are doing caesarean section, most of the things we have to arrange (purchase) on our own. As such government is not able to supply all the things to the peripheries like the drugs and equipment – there are many things that we have to order personally.* (Allopathic doctor and specialist, regular, four years in rural area, female)

> *Being a BMO, I should be getting a vehicle to work on field, only then will I be able to cover whole field of 70,000 people-vehicle, diesel, driver, these are petty things that should not need to be said. But, even to do that I have to make lots of efforts and despite those I haven't received them. I have to use my own vehicle and spend on my own petrol and diesel to do fieldwork.* (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

Another key demand across all the respondents was for greater opportunity for training and skill development such as refresher courses, opportunities for specialisation and trainings in relevant areas. There was emphasis on the need for clinical skill development, especially in areas that they dealt with daily. Many also took an interest in undertaking outreach work, and in implementing national public health programmes in the community. Others claimed particular interests and skills, (eye care, infectious diseases, surgery, obstetrics, health administration, etc.) which they wished to develop further by means of training and higher education. They felt that this would help in an effective rural practice.

> *If the government can get the doctors who are posted in the peripheries to polish their skills once in a year or so… a refresher course – we must be given a chance to do something like that. So that even we are benefited and we do not forget whatever we have studied.* (Allopathic doctor and specialist, regular, four years in rural area, female)

> *Many a time, we are in the field and the condition is such that we feel we don't have enough skills. Especially in surgery and obstetrics – we want to treat, but we don't have the authorisation. So it would be good to get some training. From the beginning, I have had an interest in surgery, but even if we want to do it, we are unable to – so this is the only thing left.* (Allopathic doctor, regular, 18 years in rural and remote areas, male)

Expressed needs: personal and social support

A need expressed by a majority of participants (27/37) was the availability of good quality education for their children. Availability of good schools was frequently cited as a crucial factor in their decisions to stay on or leave.

> *It is the main reason – if a doctor joins here then there is no facility for water and electricity, there are no doctors' quarters, but the biggest problem is that they can't give their children even primary education. So according to the times, his children will lag behind. So because of this, nobody wants to join here. At block level at least there should be a school for children – from there, doctors can go daily to their PHCs. This way, there will be more doctors for rural service.* (Allopathic doctor and specialist, regular, eight years in rural and remote areas, male)

The need for better living and housing arrangements was commonly reported across all categories of respondents. Costs of repairs in dilapidated housing were often borne personally, and sharing of living quarters was commonplace. Some respondents complained about the indignity of living accommodations that they felt did not befit their professional status. A specific need for guaranteeing personal security also emerged from doctors in violence-afflicted areas, especially from female participants.

> *Give a few amenities to the doctors. They should make quarters for doctors, not like a primary school master – there are many who are living in rented houses. To bathe, they are going outside to the river. So all this is not right. If you are constructing a PHC somewhere, then along with that, you should make quarters a little away from the common people. All these accommodations are not so good – repairs are often needed, and we have to do it ourselves. The government only provides the wall and the roof. If anything has to be improved, we have to do it.* (Allopathic doctor, regular, 18 years in rural and remote areas, male)

Many doctors perceived a general lack of appreciation and recognition of contributions from the administration. Doctors' frustrations with the anonymity of working in remote areas and the lack of appreciation and recognition of their contributions were expressed eloquently by this Block Medical Officer:

> *(Doctors) working in good places like AIIMS and Safdarjung (tertiary hospitals in Delhi), their work gets highlighted. We learn that some doctor has received Padmashri (national civilian award). I am saying some bitter things. I am working here; if I die in a blast or my hand gets fractured, then I am not going to get any Padmashri. We are not getting those garlands, those flowers or gold medals. We are only serving the patients. If I am satisfied at that level, then it's fine. Otherwise, if I am going to tax my brains by being unsatisfied, then nobody is going to lose but me. We understand everything, experience it, but cannot say it. Who do we say it to? Would I say all this to the poor tribals who themselves don't understand much? Would I say this to those corrupt administrators?* (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

Evidently, personal and social needs included both tangible elements such as the availability of education and housing, and also softer aspects such as due recognition of services and even public acclaim.

Table 2. Major requirements described by rural doctors

Job and compensation
Assurance of job security (contractual employees)
Better salaries (contractual employees)
Professional support
Improved workplace arrangements and resources
Needs-specific training and skill development
More rational promotions and transfers
Recognition and appreciation of services
Personal support
Good schools for children
Better housing
Assurance of personal security

Discussion and conclusion

No employer can afford to neglect the welfare of its employees, and India's government health services are no exception. Ensuring a health workforce delivering quality services in rural areas requires close attention to their professional, social

and personal needs. The narratives of the rural practitioners demonstrate the multifaceted nature of their needs, which cannot be addressed through narrowly conceptualised strategies, but necessitate robust and holistic policy reforms, with a distinct focus on their overall well-being. Such a holistic approach must involve tangible reforms in the shape of improved resource flows and governance arrangements, but also must consider "soft" interventions that can help raise the acceptability of employment in rural health services, as well as improve the image of government health services among rural communities.

The findings of this study are of a subjective nature but highlight specific systematic enhancements, which may aid in improving the quality of experiences of the public health workforce, and ultimately its performance and effectiveness. Firstly, while the need for an absolute increase in pay-scales did not emerge as a strong theme among this selection of respondents (except for contractual doctors), the issue of economic returns cannot be considered insignificant. However, as the global literature reflects, it is important to balance financial incentives with institutional reforms that provide other advantages and a conducive working environment (19,20).

Such institutional reforms (10) include improved workplace arrangements and resources, needs-specific training and skill development, more rational promotions and transfers, and assurance of job security and personal security. There is a crying need for better working conditions for health workers,– including better infrastructure, medicines and equipment. Nurturing doctors' professional interests and ambitions, and stemming the erosion of professional skills is another critical step in addressing the needs of providers and strengthening the quality of services.

Also very significantly, doctors, like other public service employees, seek and need accountability and respect from their employers. Rational and transparent procedures for placement, transfer, promotion and regularisation of contractual jobs can all play a role in making rural government service a more attractive proposition. Finally, the goal of greater retention may well be served if authorities were to accord formal recognition and reward for services under difficult conditions to health workers with appropriate credentials and histories of rural service.

***Competing interests**: None*

***Funding**: This study was funded by the Global Health Workforce Alliance, WHO; the National Health Systems Resource Centre, Government of India; and the State Health Resource Centre, Government of Chhattisgarh.*

***Ethical approval**: Ethical clearance for the study was received from the Public Health Foundation of India institutional review committee and the WHO Research Ethics Review Committee.*

Statement of submission of very similar work, with reference to the previous submission

We have published a paper from the same research study, entitled "Location and vocation: why some government doctors stay on in rural Chhattisgarh, India". (Sheikh K, Rajkumari B, Jain K, Rao K, Patanwar P, Gupta G, Antony KR, Sundararaman T. Location and vocation: why some government doctors stay on in rural Chhattisgarh, India. International Health. 2012;4(3):192–9.)

This paper will be complementary to the previous publication, and addresses a different question. The previous article focused on explanations for why some doctors remained in rural practice, for which we explored underlying themes in their narratives that explained their behaviour. Conversely, this paper focuses on doctors' needs whilst in rural practice, and draws directly from their narratives to report their stated views and perceptions. The paper is built from a distinct set of thematic codes used in the study, and there is no overlap between the data presented in the two papers.

References

1. World Health Organization. The World Health Report 2006 – working together for health. Geneva: WHO; 2006.
2. Chen L, Evans T, Anand S, Boufford JI, Brown H, Chowdhury M, Cueto M, Dare L, Dussault G, Elzinga G, Fee E, Habte D, Hanvoravongchai P, Jacobs M, Kurowski C, Michael S, Pablos-Mendez A, Sewankambo N, Solimano G, Stilwell B, de Waal A, Wibulpolprasert S.Human resources for health: overcoming the crisis. *Lancet.* 2004;364(9449):1984–90.
3. Government of India. Bulletin on Rural Health Statistics 2008, Ministry of Health and Family Welfare, Government of India; 2009.
4. Hammer J, Aiyar Y, Samji S. Understanding government failure in public health services. *Econ Pol Wkly.* 2007;42(40)**:**4049–58.
5. World Health Organization. Not enough here... too many there– Health workforce in India. New Delhi: World Health Organization, Country Office for India; 2007.
6. Banerjee A, Deaton A, Duflo E. Health, health care, and economic development: wealth, health, and health services in rural Rajasthan. *Am* 2004;94(2):326–330.
7. Willis-Shattuck M, Bidwell P, Thomas S, Wyness L, Blaauw D, Ditlopo P. Motivation and retention of health workers in developing countries: a systematic review. *BMC Health Serv Res.* 2008;8:247. doi: 10.1186/1472-6963-8-247.
8. Rourke J. How can medical schools contribute to the education, recruitment and retention of rural physicians in their region? *Bull World Health Organ.* 2010;88(5):395–6. doi: 10.2471/BLT.09.073072.
9. Ebueh OM,Campbell PC. Attraction and retention of qualified health workers to rural areas in Nigeria: a case study of four LGAs in Ogun State, Nigeria. *Rural Remote Health.* 2011;11(1):1515. Epub2011 Feb 10.PMID: 21314213.
10. Butterworth K, Hayes B, Neupane B. Retention of general practitioners in rural Nepal: a qualitative study. *Aust J Rural Health.* 2008;16(4):201–6. doi: 10.1111/j.1440-1584.2008.00976.x.
11. Chhea C, Warren N, Manderson L. Health worker effectiveness and retention in rural Cambodia. *Rural Remote Health.* 2010;10(3):1391. Epub 2010 Jul 29.
12. Dieleman M, Zwanikken P, Gerretsen B, Kane S. *Realist review and synthesis of retention studies for health workers in rural and remote areas*. Geneva, Switzerland: World Health Organization; 2011.
13. Henderson LN, Tulloch J. Incentives for retaining and motivating health workers in Pacific and Asian countries. *Hum Resour Health.* 2008;6:18. doi: 10.1186/1478-4491-6-18.
14. Silverman D. *Qualitative research: theory, method and practice*. London: Sage; 2004.
15. Grbich C. *Qualitative research in health? an introduction*. London: Sage; 1999.
16. Ritchie J, Spencer L. Qualitative data analysis for applied policy research.

In: Burgess RG, Bryman A, (eds). *Analyzing qualitative data*. London and New York: Routledge; 1994: pp.173–94.
17. Mays N, Pope C. Quality in qualitative research. In: Pope C, Mays N(eds). *Qualitative research in health care*. London: BMJ Books; 1999:pp.82–102.
18. Chhattisgarh Population Census data 2011[cited 2015 Dec 15]. Available from: http://www.census2011.co.in/census/state/chhattisgarh.html
19. Mathauer I, Imhoff I. Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Hum Resour Health*. 2006;4:24.
20. Dieleman M, Cuong PV, Anh LV, Martineau T. Identifying factors for job motivation of rural health workers in North Viet Nam. *Hum Resour Health*. 2003;1(1):10.

Personal experience narratives by students: a teaching–learning tool in bioethics

RADHIKA PANDYA, RADHA SHUKLA, ALPA P GOR, BARNA GANGULY

Abstract

The principles of bioethics have been identified as important requirements for training basic medical doctors. Till now, various modalities have been used for teaching bioethics, such as lectures, followed by a small case-based discussion, case vignettes or debates among students. For effective teaching–learning of bioethics, it is necessary to integrate theory and practice rather than merely teach theoretical constructs without helping the students translate those constructs into practice. Classroom teaching can focus on the theoretical knowledge of professional relationships, patient–doctor relationships, issues at the beginning and end of life, reproductive technologies, etc. However, a better learning environment can be created through an experience-based approach to complement lectures and facilitate successful teaching. Engaging students in reflective dialogue with their peers would allow them to refine their ideas with respect to learning ethics. It can help in the development both of the cognitive and affective domains of the teaching of bioethics. Real-life narratives by the interns, when used as case or situation analysis models for a particular ethical issue, can enhance other students' insight and give them a moral boost. Doing this can change the classroom atmosphere, enhance motivation, improve the students' aptitude and improve their attitude towards learning bioethics. Involving the students in this manner can prove to be a sustainable way of achieving the goal of deep reflective learning of bioethics and can serve as a new technique for maintaining the interest of students as well as teachers.

Introduction

Doctors and health professionals are frequently confronted with ethical dilemmas during their practice. Though bioethics has been recognised as a priority subject in medical education over the past five decades (1–4), Indian medical curricula do not clearly address how to deal with ethical issues.

The objectives of teaching medical ethics should be to (i) enable students to better understand the implications of ethics in all aspects of their profession, (ii) prepare students to develop the ability to identify underlying ethical issues and problems in regular medical practice, and (iii) equip them to consider alternatives under the given circumstances and make decisions based on acceptable moral concepts and traditional practices. To achieve the broad goal of developing common morality among students, the teaching of bioethics is a continuous and consistent process during undergraduate medical education and beyond.

Classroom teaching of bioethics can focus on professional relationships, the patient–doctor relationship, and issues from the beginning to the end of life. It should also deal with values, ethical concepts and principles. Lectures have long been the standard method of communicating information. This mode of teaching, however, has been strongly criticised as it is associated with a lack of student participation and a loss of interest. Medical education literature supports both case studies and classroom exercises as effective methods of delivery, and these appear to be useful supplements to lectures and discussions (5). Active learning techniques allow students to participate through critical thinking and problem-solving, which are instilled through "instructional activities involving students in doing things and thinking about what they are doing" (6). Therapeutic recreation educators may be keen to consider using a wider variety of teaching methods. For effective teaching–learning of bioethics, it is necessary to integrate theory and practice, rather than merely teach theoretical constructs to students without helping them translate those constructs into practice (7).

Kirkpatrick (8) suggested that using stories for teaching could promote knowledge and values, besides being appealing and enjoyable. In his article, "Telling stories", R. Ganzei (9) stated: " .... Stories help us make sense of the world and give structure and order to our everyday lives. They tell us what is important and what is not, and give us a way to connect people's individual experiences to those of others, as well as to universal truths. Indeed, stories are yet another way we put a

Authors: **Pramukhswami Medical College**, Sojitra Road, Karamsad, Anand, Gujarat 388 325, INDIA – Radhika H Pandya (itsradhs@gmail.com), Intern; Radha Shukla (shuklaradha9021@gmail.com) Intern; Alpa P Gor (alpapg@charutarhealth.org) Associate Professor, Department of Pharmacology; Barna Ganguly (corresponding author - barnaganguly@rediffmail.com), Professor and Head, Department of Pharmacology.

To cite: Pandya R, Shukla R, Gor AP, Ganguly B. Students' personal experience narratives by students: a teaching tool in bioethics. *Indian J Med Ethics*. 2016 Jul-Sep;1(3) NS: 144-7.