



MAKING A DIFFERENCE

An Interview of Rogayah Binti Ja'afar

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How did you get involved in medicine?

As a child, I dreamed of becoming a nurse. I also enjoyed teaching and thought about being a graduate teacher. I never imagined doing medicine. My father's



aspiration was for one of his children to take up medicine. He had been a juvenile diabetic and had heart problems. I think it was his health situation that prompted him to talk to me a lot about the possibility of going to medical school. My mother was very encouraging, but not in an obvious way.

I'm the youngest of eight siblings, and I was the last to enter boarding school. I managed to get the grades to go into medicine, so I did. Two of my uncles were physicians. I think that I'm the first woman in the family who went into medicine. I spent some years as a practicing doctor and then went into academic life, so now I have married two of my interests: medicine and teaching.

Where did you go to medical school?

I went to the University of Cairo in Egypt. At that time the best students in Malaysia got to do medicine overseas. Before my time, students were sent to Australia and the UK because we were a commonwealth country and had a university system that was similar to theirs. But the year before I started school there was a sudden hike in fees in medical schools in these countries, so the government sent us to Egypt.

The Gulf War was just ending, and there was some instability in the Middle East. My mother was a bit upset. My father said to go ahead and that he would be praying for me.

Both of my parents passed away while I was in Egypt. I wonder what it would have been like for them to see me graduate from medical school.

That's very sad. But they did see you successfully on your way.

That's right.

How many years were you in Egypt?

The University of Cairo has a five-year medical program. But I did a prematriculation course, so in all I was in Cairo for six years. That's a long time. I grew up very fast. I learned about accommodating to people and to a new culture. I had to look out for my own flat and cook. Those things are all done for you back home, and you tend to take them for granted.

What did you do after completing medical school?

I returned to Malaysia and worked for a year as an intern and three years as a government doctor in the Health Ministry. I was posted to a few general and district hospitals around the country. I met my husband along the way. He is a graduate of the first medical school in our country. He's one year my senior, career-wise, as a doctor.

There was a great shortage of doctors in the country. It was too costly to have

two new doctors posted to one hospital. Two months after we were married we were separated when my husband was posted to a northern state. That was quite a burden in terms of family life. After our first child was born, we decided we should have a stable home together. That was one of the reasons we both chose to join a university. Also, I had a lot of interest in teaching.

How old was Universiti Sains Malaysia when you and your husband joined the faculty?

Our medical school was commissioned in 1979 and took its first batch of students in 1981. We joined the school in 1983.

This was the first innovative medical school in our country, trying to make a difference. The two older schools were more conservative and were trying to train doctors to move into specialties. Our founding dean had a vision of more community-oriented doctors who would go into primary care. Even if our graduates went into a specialty, the dean felt that they would be community-minded in their practice. This was a great vision, but it was another thing to make the vision a reality.

I was interested in pursuing further studies in pediatrics. My dean wanted me to study medical education because our school was struggling with the concepts of PBL and community orientation, and he wanted to get the department of medical education started.

Consequently, my husband and I both did masters degrees in Australia at the same time. I did a masters in medical education at the University of New South Wales from 1984 to 1986. My husband did a masters in public health at the University of Sydney.

I had made a deal with my dean that when I returned home I would work in the pediatric department. I didn't get to do that though because establishing a department of medical education, starting faculty development activities, and trying to monitor a new medical curriculum took all of my energy and time. I was very young. I dreaded the days when we had to call everyone to the table to look at problems and strategies. Some faculty members who questioned our approach would say, "We've been teaching for 35 years. Why are we doing this?"

Those were difficult years. Now we've produced 16 batches of students and have a good record in terms of our graduates' performance. Now our dean tells faculty members, "You either subscribe to this philosophy or you won't be part of our faculty." In the early years we could not have that luxury. We were short of staff, so we had to get people on board and then convince them as we went along.

Being young made it difficult for you to help long-time faculty members make changes in what they were doing. Did you face any special challenges because you are a woman?

I think that being a woman can be good because my role calls for being

persuasive. We try not to impose on people but rather to show by modeling. I think it's easier for women to do that. Personality is also a factor. Being a medical educator doesn't just involve your knowledge but also how you put those ideas across to people. You need to get people to join with you. I think those qualities and that role is easier for a woman than for a man.

Do these thoughts lead you to any suggestions to readers who want to bring about change?

One of the principles in developing partnerships or bringing about change is the notion that you need to listen to people before you voice your ideas. Some people say that's the reason that God created us with two ears and one mouth. My experience is that if you just go and tell people what to do, they will turn around and say, "It's so easy for you to say."

Often when we want to make changes at our school we put the burden on ourselves to actually start that process. We do pilot and demonstration projects and evaluate these projects. When a project works, and the students say that they like what we're doing, then the faculty will listen and know that the change is possible. It takes longer this way. It would be easier to write a letter to the dean saying, "Please direct heads of departments to start this initiative," and have the dean twist people's arms. But I find that if we have struggled with the new initiative ourselves, the faculty will be much more willing to listen to us. If the faculty feels that we are part of the team and are making the change together with them, they are more likely to make and sustain changes.

For example, if we want to encourage an innovation, such as making contract learning part of our community and family case study program, we not only have to run faculty development activities dealing with contract learning and the role of the supervisor, we also have to be one of the supervisors. That way when people talk to us about their problems, we can appreciate their problems because we've dealt with them and have gone through the same process. We talk on the same wavelength

What other challenges do you face?

I get frustrated. I think we have run more than 200 faculty development activities. Faculty members attend the activities and get good at teaching. Then they leave our school. We have very rapid turnover of academic staff. We're in a rural state and do not have an ideal situation in terms of facilities and amenities for families. We have a lot of expatriate staff, and, until very recently, we didn't have international schools up to secondary level. So a lot of people just stayed until their children were 12 and then moved on. That means we need to do the faculty development activities over and over again. That tires you and ties you down quite a bit. But I think we have to maintain and sustain the faculty

development program if we want to sustain the momentum of innovation. If we don't do that, then the students will start to complain and the new faculty will be uncertain of their role in PBL

You need not only to orient new staff, you need to refresh the older staff regarding new educational approaches. Sometimes it's easier to orient the new ones because they are open to new ideas. The new postgraduates are very eager to convey the knowledge they have just developed and welcome our assistance in the teaching and learning process. Sometimes it is difficult to convince the established teachers, who believe that what they are doing is the best and only thing to do. We struggle with these issues over and over again.

What role does the community play in your curriculum?

We developed a collaborative model with the community and the local government in an effort to improve the quality of life of the people. This model developed from the feedback and dissatisfaction of our students. In most other medical schools, I believe, changes come primarily from the top. In our school it's more of a bottom-up, grassroots model. The change agents are the medical students.

From the beginning we actually did have a community-oriented program. We were more community-based than the other two Malaysian medical schools. We developed packages of increasing difficulty and got students to implement them in the community. The packages were structured and faculty-driven. The students, however, came back and said, "We did a lot of work. We implemented the packages. We used a lot of community resources. We stayed in community members' homes. We interviewed them. We took their blood samples. But we don't really know what the people need. They shared everything with us, but we don't have anything to give back to them." After a while, the students felt that the community was an experimental laboratory for them to work in. They didn't see the long-term impact of their involvement in the community.

The students met with me because I'm very much involved in evaluating the programs of the medical school. We discussed how we could make this better. The students wanted to look at the broader activities of the community because they didn't think that doing health screening and education was really going to impact on people's lives. They said there were many more urgent issues in the community. We developed a proposal, but it was initially turned down because the medical school thought our group, which was made up of students and a few faculty members, was a hyper, crazy group. The faculty told me, "We aren't producing a jack of all trades. We are producing doctors, and doctors have to confine themselves to medical screening and management."

Our group adopted the most disadvantaged subdistrict in our rural state. We started by asking the people what they were concerned about in the community. They said they were concerned about the water supply. The students were happy because they felt that water was a health issue. It turned out that it was the color

of the water that bothered the people. The people did have some concern that some of their children had diarrhea. But the mothers were concerned that they couldn't keep their children's uniforms white. And they said, "The rice doesn't look right because it's not white. And the utensils are brown most of the time." So students learned what matters most to communities.

The community was also unhappy because it hadn't rained and their crops weren't doing well. So the students saw that there was a need to help with irrigation. We worked in partnership with the community in getting a good water supply. The students provided the logistics. For example, they figured out how many houses could be supplied by each water tank. The students also mobilized the community. They got the Ministry of Health team to provide the basic hardware for the construction of the tanks. One of the community members donated a small piece of land to put up one water tank, so he became the custodian of that tank. The community subsequently constructed four water tanks with the help of our medical students and the Ministry of Health team. Now when we bring visitors to the community, the first thing that the local people do is show them their clear water. They are very proud of it.

We had worked together with the community and gained their trust, so when the students finally organized a health screening and medical camp, 97% of the population came out. This was a record for our medical school in terms of a community response to a university initiative. By midday there weren't enough prescription slips or drugs because there were so many people.

There have also been failures. The students were very successful with the water project, so they were motivated to go on to other things. They wanted to get some business cooperatives underway so they could increase the economic status of the community and ensure that the youth are occupied with some good work and not smoking. Many of the people in the community are tobacco farmers. The middlemen who buy tobacco from the village give free cigarette boxes to everybody, so even very young children get addicted to smoking. The students' new project was to try to get farmers to shift from raising tobacco to chicken rearing. They weren't successful though because you don't get the same kind of money and free cigarettes from chicken rearing.

The water project attracted the attention of a few NGOs (nongovernmental organizations). The family planning agency and the Lion's Club had activities with the community. Then the Canadian International Development Agency (CIDA) heard about the water project and offered us some money to help build a community hall. The medical school handled the logistics. The community was responsible for mobilizing the people and building the hall. We promised CIDA that the hall would be completed in nine months. It ended up taking three years and seven months.

The water project worked better because the community wasn't given money. When money starts coming into a community, people don't seem as motivated to work with you. They anticipate that everything will be done for them. Along with the students we learned that the community members have their own time

frame and target. And they have to think of their own livelihoods. In this community, the people first and foremost are fishermen. Then tobacco growers. Building a community hall is optional.

The students and I were frustrated with the delay. We were tempted to take over or get a contractor to do it. But we learned that we can't push people. If we had taken over, then they wouldn't have felt ownership of the hall. Now the hall is open. Many activities take place there, including a monthly clinic for mothers and children. In the past, people in the community had to travel 8 1/2 kilometers to the nearest health clinic.

When did you get involved with the Network?

The first time I came to a Network meeting was 1989 in the Netherlands. This conference was different than other medical education conferences that I had attended. The atmosphere was friendly. Everyone was able to speak their mind and share their experiences, however small or insignificant. Now I come every year that I can get funds. I've been on the executive committee for four years and will end my term at this meeting.

At meetings, there's ample opportunity to network. I meet new friends and old friends. There's always something new to share. You get a challenge from a keynote speaker or a poster and then try the new ideas back home. Then you can come back to the next meeting and present what you have done.

Sometimes in this work you feel so lonely. At a meeting like this you realize that there are other people facing the same problems. You're not alone. Attending meetings helps bring back your sanity and keeps you at peace with yourself and the community.