

Humanities in education of doctors

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Medical education lasts five and half years', requires acquisition of a vast body of knowledge and frequent assessments and end course examinations. In addition, the course requires that students spend sizeable amount of time in hospitals and communities. Medical students are under a lot of stress to conform to the views of the teachers when it comes to factual information and style of dealing with patients and their relatives. The majority of medical students these days are not content with an undergraduate degree as they perceive it does not give them enough credibility, and undergo postgraduate courses which requires as least three or four additional years of sustained study and practice. Under these circumstances, it is not surprising that medical students and specialists in training do not have much time or inclination to read and reflect about material from other disciplines. Does it matter that the doctors don't read much from literature, politics, history or psychology?

Recently one of our colleagues had published a book (a compilation of his articles about peoples' movement II)¹. The preface to the book was written by a politician known for his intellectuality. In the preface he commented that doctors are pushed by market forces towards excessive acquisition beyond their needs. As a result, doctors cannot find the time for other more personal pursuits such as reflection and literature. Constant attention to their own field can also inflate the self-importance of doctors by making them think that they are responsible for the saving of many lives, while making them oblivious to how their activities may be indirectly causing a negative impact upon the health of the larger community. The writer then commends the writer of the book for awareness of important topics beyond medicine and writing about them.

It thus seems that society expects doctors to possess social and political awareness that goes beyond their particular field of expertise. Doctors are looked up in society as important opinion leaders; people listen to them, even politicians like to have doctors' support to gain support for their cause.

A busy and conscientious doctor who usually does not even have much time to read from his own

subject and specialty, cannot be expected to do much reading to keep abreast of current political and social developments. Moreover, medical education also does not prepare one to read and appreciate matter from other subjects.

In addition to providing doctors with a broader awareness of the world that society seems to demand of them, wide reading provides direct benefits to the aspiring doctor. A recent study showed significant correlation between premedical grades in the English language and cognitive performance in medical schools.²

If one were to undertake a review of the expectations that people have from physicians, care, compassion and availability would come at the top of the list. It is being increasingly commented that the type of education we provide in medical schools is not adequate to produce such a doctor³.

Newer requirements of a "global physician" that can "think globally and act locally" have identified certain competences in a physician: professionalism, commitment to ethical values, critical reasoning skills and communication skills in addition to a sound foundation in science, population health and clinical skills. Again the current curriculum and the teaching learning experiences offered to medical students are found lacking to achieve the goal of producing a compassionate, caring, ethical doctor who can reflect on what s/he reads or sees.

We have borrowed the model of medical education from the western world; therefore, it would be pertinent to take note of what is happening in those countries. In USA, by the time medical students begin their studies they have already completed a four year undergraduate course with substantial study of the liberal arts. These students are therefore more mature at the time of joining the medical schools. Their awareness and understanding of philosophical, social and historical aspects is of a higher order compared to younger students who have completed only 12 years of schooling with an emphasis only on science subjects.

In UK and other European countries, medical students are given courses in liberal arts with a list of required reading.

A course in history of medicine in a Canadian medical school had the following goals:

to raise awareness of history (and the humanities as a whole) as a research discipline that can enrich understanding of the present, and to instil a sense of scepticism with regard to the 'dogma' of the rest of the curriculum. The purpose of learning experiences offered to the students was to provide them with a conceptual tool for learning about medicine⁴. Newer approaches in teaching-learning that stress self directed problem based learning are being tried and these are expected to free students of unnecessary rote learning. The Calgary curriculum called the Medical Skills Programme has expected that "with repetition, the diagnostic aspects of the clinical presentation require less emphasis, enabling other aspects of the programme, e.g., communication, informatics, ethics and culture to receive increasing emphasis".⁵

Are these worthwhile goals in the education of doctors in our country? What do the students think about it? What opinions do the faculty members or teachers of medical colleges have on this subject?

Society is getting increasingly complex. Awareness and understanding of social issues, ethnic variation and geopolitical realities is becoming more and more relevant to the way we practice. Medical education can't simply remain confined to imparting of "scientific" knowledge and skills. People demand a more rounded and complete person as their care taker, confidante and physician. In such circumstances, it is essential to begin discussion on humanistic subjects and methods that can be added to the curricula in order to raise doctors' competence and awareness, while simultaneously scrutinizing the current curricula for what is redundant and should be removed.

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Editorial

Effective medical education

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We are quite familiar with the words "Learning by mistakes", but it should not be implied always. Alternatively, the one time strongman of Germany *Bismarck* said, "only a fool learns from experience, the trick is to learn from the experience of others". Many important lessons in medical education are not well conveyed by lectures, books, and electronic media including goal setting, work ethic, patient interaction, consultation and coping with uncertainty and failure. Learning is not merely the memorization of facts, but also the adoption – often subconscious- of attitudes and approaches to daily work. One of the crucial components of

learning is emulation, which can be constructive or destructive. Constructive emulation occurs when learners function more effectively and efficiently as a result of the attitudes and approaches they adopt from senior colleagues or teachers and environment. One goal of medical education should be to increase opportunities for constructive emulation and decrease the probability of its destructive counterpart. Education leaders need to consider not only what learners are being taught, but also by whom and with what effect. One way of enhancing educator's effectiveness as role models is to strengthen their

understanding of this vital but frequently overlooked aspect of education.¹

Programmes in the medical education provide learners with both formal and informal curricula. Elements of the formal curriculum include stated learning objectives, reading assignments, and the material represented on examinations. Elements of the informal curriculum include learner's observations of how they speak and act. Medical students learn many of their more important lessons from residents, and junior residents learn from senior residents as well as faculties. In short, some of the most influential models for this learning are not identified members of the teaching faculty. Educators of medicine should give importance and spend as much time attending to their informal curriculum as their formal curriculum so that learner's experiences in both areas serve the programme's overall goals.

Learners who think they already know everything are unlikely to benefit substantially from working side by side with good role models. Such situations make it important to provide learners the opportunities to recognize what they do not know and to appreciate its importance. A crucial component of learner effectiveness is clarity about goals. Many students are not necessarily unmotivated or unintelligent. They simply do not know what they want to gain from their experience in the medical field.

As a result, they fail to recognize and capitalize on opportunities to learn. So education can do learners a service by helping them assume an active role in setting learning objectives and by helping them structure their experience in a way that promotes achievement.

For medical students and residents to become excellent physicians or surgeons, they must learn to regulate their conduct not only according to how others reward or punish them, but also based on their own internal moral compass. To help learners attend to and accurately perceive good habits of conduct, educational programmes should validate good habits by incorporating them into the formal curriculum.

Learners must appreciate that ethical conduct constitutes just as important a learning objective as lesion detection and differential diagnosis. Including parameters in algorithms for evaluation of medical students and residents is vital. When done well, it validates the importance of conduct, provides appropriate reinforcement, and helps to foster the development of positive internal goals and standards. The goals are challenging. Medical education is neither doctrinaire nor static. It changes with time. Lots of overall effort is essential to improve the system of medical education. It is not the number of students, or faculties or infrastructure or the visit of the monitoring council members that indicate the standard of the quality of medical education. There should be systematic and productive effort from all the sectors of the medical education system, that include motivation and preparedness of the faculties, students, education materials, organization, effective monitoring system, habits of reviewing the positive as well as negative facts and achievements.

References

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