From the Editor's Desk

Our Medical Colleges: A Reflection On The Past, Present and Future.

"The medical student's present education is badly fragmented because his professors are not teaching him clinical medicine as should be taught – mainly because they themselves are not usually clinical doctors" **Dr. J. Knowles.**

"Medical Professors poorer and less experienced in the art of healing – producing doctors in their deficient image" **-Dr. John Knowles,** General Director of Massachusetts General Hospital

"The Goals of medical schools are, in a sense, a three-legged stool in which teaching, research and patient care form the necessary support. Unfortunately, recently most modern medical school have had a hypertrophy (overgrowth) of the research leg, stimulated by the trophic effect of the over-abundant sums of money in the form of research grants…. The full-time clinical professor has become primarily a research professor whose chief claim to fame is his 'grantsmanship" and whose hallmark is ***'publish or perish'*** ". Some professors are fundamentally lacking interest in teaching clinical medicine to medical students." **Willis E Brown,** University of Arkansas Medical Center.

People accomplish what their communities honour. **- Plato**

Martin L Gross[1] In his book entitled: **"The Doctors: A Penetrating Analysis of The American Physician and His Practice of Medicine"** raised many issues concerning training of the American medical doctor. Do the points of concern raised in this book apply to our medical colleges today? In his book, Gross referred to the observation made by Dr. John Knowles, General Director of the Massachusetts General Hospital, a major teaching institution of the Harvard Medical School that "the medical student's education was badly fragmented because his professors were not teaching him clinical medicine as it should be taught – mainly because they themselves were not usually clinical doctors". According to Dr**.** Knowles "The medical students were complaining that the professors were no longer professing. '*Why' they ask, 'can't they teach them medicine?*' Was it possible they had abdicated their responsibility of teaching and proper patient care to concentrate on research, where the rewards were?"

According to Dr. Knowles "they (the Professors) claim they can do both teaching and research. According to him, when you have a Clinical Department of a medical school headed by a research man, what is likely to result is a sad situation for the clinical teaching of medicine in the medical schools becomes "spotty at best, fragmented, uneven, discontinuous, and haphazard." Other critics believe that the vocation of medical teaching is atrophying; research-conscious professors have made teaching future doctors a real sideline.

Brown of the University of Arkansas Medical Center believes that "The Goals of medical schools are, in a sense, a three-legged stool in which teaching, research and patient care form the necessary support. Unfortunately, recently most modern medical school have had a hypertrophy (overgrowth) of the research leg, stimulated by the trophic effect of the over-abundant sums of money in the form of research grants…. The full-time clinical professor has become primarily a research professor whose chief claim to fame is his 'grantsmanship" and whose hallmark is **'publish or perish'**. Some professors are fundamentally lacking interest in teaching clinical medicine to medical students."

Gross[1] referred to the assertion of Dr. Clinton L Compere, former President of the American Academy of Orthopedic Surgeons, who showed concern about "the consistent downgrading of the professor whose greatest commitment is teaching medical students rather than research. He was "seriously disturbed" by the trend of appointments and promotions at medical schools, most of which go to researchers rather than clinical doctors. He felt that many medical schools were placing undue and unwise emphasis on basic medical research, whether good or bad. He adds "'***How many papers have you published during the past couple of years?'*** is usually the number one weighted question for an applicant for an academic position."

Promotion and tenure processes commonly examine faculty progress as summative events. Materials describing the candidate's achievements in publication, grants and standing in national and international academic community have been central to a successful review, for research faculty, these have been have been more or less appropriate and certainly historically consistent. For clinical departments in a college of medicine, these same guidelines are no longer appropriate given their focus on clinical activities versus attention to

research and publication. As academic faculty, clinicians are expected to maintain the same high national and international profiles as their research colleagues. In addition, they must teach and perform clinical work. This seems clearly unfair. Other avenues such as teaching should be considered that allow clinician a path to promotion. Recognizing the inherent problem of this practice, in 1996, the University of Illinois at Chicago College of Medicine (UICCOM) established a process, which seeks a process that supports clinical teachers' teaching activities as a basis for tenure and promotion[2].

Academic promotion based on research background rather than medical skills and sophistication should not become a burlesque of the original concept. We know it is unreasonable to expect satisfactory performance in someone who is not interested in what he is doing. A researcher with minimal interest in teaching and clinical activities will not efficiently impart clinical skills to the medical students. To him, teaching becomes a tax that is levied, not the opportunity that is relished.

Educating medical students is an important responsibility of surgical residents and undoubtedly get involved in teaching in our medical schools. Clinical clerks on a surgical service receive between 19% and 40% of their teaching from resdents3. However surgical residents typically receive formal assistance or training in teaching and learning, and therefore the extent and quality of their teaching tends to be variable. They lack experience as well which they would otherwise refer to.

Policy Analysis in Medical Education

Education policy analysis is a formal discipline that has not been widely used in medical education. A review of literature shows that the lack of analysis "tools" results in an approach to educational policy analysis and/or development that may be fragmented and unorganized4. Education policy decisions in medical schools about such crucial topics as governance structure, curricular objectives and revision and student assessment methods should not be based on goal ambiguity and implicit, rarely-stated policy assumptions. Reid5 advocates a structured approach to educational policy analysis, which is geared toward curricular issues. He states that five crucial arrears must be considered in developing educational/curricular policies: teachers, learners, the "educational milieu" (or environment), subject matter and "curriculum-making" (i.e., educational decision –making processes). He laments the "intrusion of interests outside the professional world of education" into educational policy development, stating that such intrusion has led to "approaches [which] stress top-down control and short-term goals" rather than sound educational policies.

Lately, a number of medical schools in our region have been undergoing metamorphosis. That curricular reviews should take place from time should not be questioned. However, serious consideration should be given before introducing new programmes and abandoning teaching programmes / curricula that have stood the test of time. Where necessary pilot studies should be done first before their full implementation. It is important that Curriculum revision should aim at not increasing but reducing the amount of theoretical sciences while strengthening the teaching of clinical medicine.

The clinical curriculum – basically Osler's "learning by the hospital bedside" – has unfortunately been adversely affected by the new research stress. Dr. Osler's use of the hospital beds provides a better setting for teaching scientific medicine than other alternatives and therefore should be stressed. Luckily, our medical students have free access to the general patients unlike in the developed countries where students hardly have limited access to the patients. In revising the curricula, more time for clinical rotation (Clerkship) rather than reduction should be the rule if we are to maintain high clinical and professional standards.

To supplement on the skills medical students acquire from their clerkship in their clinical rotations in surgery, all medical students should go through Essential Surgical Skills courses. The benefits of the ESS courses can no longer be questioned. Appreciation goes to Dr. Ronald Lett, President of the Canadian Network for International Surgery (CNIS) for introducing ESS courses in the medical schools East and Central Africa. Administrators in our medical colleges should support efforts departments of surgery to establish ESS laboratories.

Medical education policy makers in our medical colleges often find themselves operating in a vacuum operating within a "policy vacuum", due to a lack of information upon which a given policy may be analyzed. It is highly recommended that they should familiarize themselves with the paper by Dr. David W Musick [4].

As new programmes are introduced, deans in our medical colleges should answer the following questions about their undergraduate medical students:

1. Is the young doctor being trained for medical combat anywhere he is posted after internship?
2. Is he/she prepared for the excursion into the real world of rural medical practice where there are no seniors or consultants to advise and where the diseases may be challenging but usually not dramatic or academically interesting?
3. Is he/she well prepared to handle all surgical, medical, paediatric, obstetric and gynaecological emergencies that may come any time even at the middle of the night?
4. Is he/she learning all the essential surgical skills that he should know to be able to handle all emergencies once qualified such as gangrenous obstructed inguinal hernia, tension pneumothorax, obstructed labour, ruptured ectopic pregnancy, laryngo-tracheal bronchitis causing complete airway obstruction and diabetic coma?
5. Is the student taught how to patiently sit and listen to an old woman who gives a litany of complaints?

Much of the criticism of our medical colleges is appropriately directed at the research domination of the institutions, the result of a near-religious force that makes other education goals crumble. According to Plato, **'People Accomplish What Their Communities Honour'** and by implication what meets their immediate demands. The rural communities expect the medical colleges to produce for them highly skilled, compassionate, ethical and understanding doctor that they can confidently go to when sick.

The importance of research is not doubted, but its present context in the medical schools at the expense of devoted clinical teaching and patient care, in countries already overburdened by communicable diseases, poverty and ignorance is under vicious debate. But that change in the medical schools and the medical profession as a whole is essential can hardly be debated. The results of its metamorphosis will undoubtedly be the creative compromise of many concerned minds.

Those directly involved in administration of our medical colleges are meanwhile called upon to listen to all opinions of thought including those that are differing with theirs. This is particularly crucial when they introduce new programmes that greatly may greatly affect the methods of clinical teaching.

The contemporary reforms in training of the medical students must spring from all the stakeholders including all clinicians involved in teaching as well as the medical students themselves. The medical education policy makers in the region should introduce appointment and promotion and tenure policies that favour doctors committed to teaching and clinical work. **That is how our medical colleges will be able to produce tomorrow's doctors that will become the 'healers' the public once assumed the doctors were.**

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