Opening up the debate on medical education in South Africa

"*Gentlemen – it may not have escaped your professional observation that there are only two classes of mankind in the world – doctors and patients. Speaking as a patient I should say the average patient looks at the average doctor very much as a non- combatant (in war time) looks upon the troops fighting on his behalf. The more trained men there are between his body and the enemy the better. But what sort of education and training do these men and women need?"*

Rudyard Kipling 1908 [1]

In 1993 the General Medical Council produced its seminal publication Tomorrow's Doctors [2], and by drawing attention to the changing demands of health care delivery, described the consequent need to change medical education. The ever-expanding demands on health care, added to an exponential growth in the knowledge base of medicine, lead to an expectation that the doctors of the 21st century must equip themselves to assimilate and apply this ever-increasing knowledge to the practice of their profession.

Realistically it is not possible for the doctor to be the "*fount of all knowledge*" but if the public were asked what they want of a doctor it is possible that the answer given would be that they require a depth of knowledge, an acquisition of skills and an attitude that is appropriate and apt for that patient at that particular time.

There exists therefore an analogy between the dynamic requirements of the medical practitioner, ready to rapidly react to the changing world of the individual patient, and the expanding and demanding world of medical education, which is undergoing constant revision; the aim to produce a " viable product" suitable to deal with the changing world of health care. But how do we deal with and balance these two dynamic inferences in everyday practice?

One way is by changing medical education, both at undergraduate and postgraduate levels. The majority of health care providers will be aware of the changes that have occurred in undergraduate medical and health sciences education. The change from the lecture dominated environment of proudly accumulating masses of factual information, and competency being measured by the ability to regurgitate this information during an oft-false situation, has occurred. In its place has appeared small group, integrated discovery learning, encapsulating evidence-based enquiry in the real setting of situational learning. A new cadre of medical teachers have appeared, who although institutionalised through often ad hoc training are now becoming rapidly conglomerate through an increasing body of accredited national and international associations.[3,4,5]

But what of the outcomes, and what influences are these changes bringing? The primary customer of medical education is often the learner, with its effects focused upon students and interns, not patients.[6] Medical educational research occasionally, but not always to a significantly greater amount, demonstrates effects upon communities, patients and employment. [7,8] However if we are to take note of Bertrand Russell, who quoted

"We have, in fact, two kinds of morality side by side: one which we preach and do not practise, and another which we practise but seldom preach" [9],

we have to recognise and create opportunity for medical education to inform postgraduate life.

If we believe that the outcome of most medical schools in South Africa is to

" produce a doctor who will provide high quality service both to the individual and the community; who will continue to learn and develop professionally throughout his or her career; who will assess personal performance regularly and seek continually to improve the service provided by research and development – and all of that occurring within the context of the team approach and suitably applied to a South African environment"

we should be able to observe, evaluate and apply educational principles to our everyday working environment.

As we move into a climate of Family Medicine development, with the proposed expansion of Departments of Family Medicine and the roll-out of vocational training schemes the principles of medical education, indeed adult education, take on new meanings.

In a new series of short articles starting in this issue, we aim to describe some of the principles used in medical education and, by encouraging debate, explore how they can be used to enhance everyday working activity. We hope that in this era of life long learning, we can explain why we need to change; why we need to keep up to date professionally in both clinical and educational arenas; why those who are teaching should be recognised as professionals and acquire a teaching qualification and why we all should find out more about new teaching methodologies and approaches to facilitating learning.

Trevor Gibbs
David Brigden
Derek Hellenberg

References

1. Rudyard Kipling in an address to the medical staff of the Middlesex Hospital. 1908
2. General Medical Council. *Tomorrows Doctors: Recommendations on Undergraduate Medical Education.* London: GMC; 1993
3. Gibbs T J. Medical Education: will we ever get it right? *South African Medical Journal.* 2002; 92 8 609-610
4. Gibbs T J. Medical Education in South Africa. *The Network, Towards Unity for Health* 2003; 22/2 page 31
5. Kent A, Gibbs T. Health Science in South Africa. *Medical Education.* 2004; 38. 121-122
6. Shea JA. Mind the gap: some reasons why medical education research is different from health services research. *Medical Education.* 2001; 35:319-320
7. Kuo AA. Community- based Education: is the effort worth it? *Medical Education.* 2001; 35: 315-316
8. Howe A, Ives G. Does community based experience alter career performance? *Medical Education.* 2001; 35: 391-397
9. Bertrand Russell. *Sceptical Essays* 1928