

Some gaps in the medical curriculum at UCT

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Curriculum vitae

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Summary

Because we teach students too much about their patients' behaviour and too little about their own behaviour, there are some major gaps in our teaching at the University of Cape Town. We omit these topics because, as a group, we doctors are not much given to self-analysis and prefer to see ourselves as clear thinking problem solvers. Student interns respond avidly when these subjects are raised suggesting that there is a real need to address these issues with them.

Teaching primary care to student interns at UCT has shown me that we omit some important topics from the medical curriculum. If we do teach these topics, they don't register with the interns, because the interns respond so avidly when the subjects are raised. These subjects, which concern the interns' response to stressful clinical situations, have been well documented by others in primary care,^{2,3,4} and are usually issues for postgraduates while we address them with undergraduates. Because we are not much given to self-analysis, we teach students too much about their patients' behaviour and too little about their own.¹ These subjects do not necessarily warrant courses in the curriculum, but could be examined in a six-year curriculum.

THE GAPS

1. Sexual attraction in the consulting room

Student interns may not be prepared for feeling attracted to a patient. Such arousal induces guilt and embarrassment and inhibits the student in examining the patient confidently which can lead to the patient becoming embarrassed. This anxiety is reduced when students accept that their responses are natural and predictable. This subject was well treated in a recent AMA publication.⁵ Students must understand the distinction between being attracted and acting on that attraction.

I am not referring here to the seductive patient; an altogether different problem which it would be preferable for the intern not to encounter without due preparation.

What is right in a ward may be wrong and unhelpful in primary care

2. Doubt and error in medicine

Student interns find the uncertainty of work in primary care confusing because much of their training rightly prepares them to work towards a precise organic diagnosis. Primary care, however, comprises undifferentiated problems where a precise diagnosis is often not possible and is sometimes undesirable where it is possible.

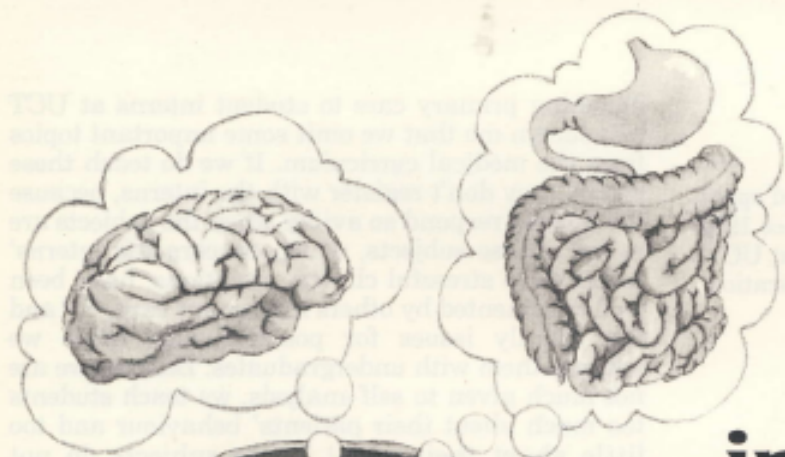
Students see this as imprecise medicine, suitable for the inferior mind and often feel guilty about their inability to do what their training has so successfully trained them to do. They need to learn when an open-ended response is right and that such a

response does not denote inability, or negligence. This uncertainty generates anxiety which both the tutor and the student must address.

Students must know how to deal with error; how to review a patient's course so as to detect errors in diagnosis, prognosis and management. Error is part of life and medicine.

They need to cope with being wrong and to learn how to include the patient in detecting and correcting error. Students are much less anxious when they can cope with error. They find that they can manage, that patients do recover, that most illness in primary care is self-limiting and that coping with error is part of the practice of good medicine. Students are reassured to find that they can rely on their training in medicine - an accurate history and a careful examination will deal with most problems most patients present with, most of the time.

Error in medicine raises issues other than anxiety in student interns, such as: litigation; our need to be right; error as culpable rather than as a fact of life. Students need guidance here and must be helped to accept the inevitability of error, a subject which has been well examined by McIntyre and Popper.⁶



**Are you
in two minds
about the
anxious
abdomen?**

3. The urge to refer all patients in pain or bleeding

Pain and bleeding are such cardinal signals of major malaise that students understandably, out of inexperience, fear and anxiety almost instinctively wish to refer patients. This instinct is reinforced by didactic teaching about emergencies in the wards, because, of course there are patients who do need immediate referral. Most patients bleeding or in pain can be managed without referral however. The first requirement is that the intern assess the problem from a careful history and examination before deciding whether or not to refer. Student interns need careful guidance here until they realise that their initial response was not necessarily in their patient's best interest. This requires that the intern be sufficiently responsible for the patient without the ensuing anxiety being too much for the student.

Some students assume responsibility beyond their competence to an extent that is not in their patients' best interests either; this too must be checked.

4. The defensive use of investigations

Student interns have a defensive attitude to investigations and often want to investigate patients

extensively. They take their hospital experience as a model, unaware that what is right in the ward may be wrong, wasteful and unhelpful in the clinic. We teach them to select investigations which will benefit the patient. Students become selective in their use of investigations once they learn to decide

Students often feel guilty if they cannot give a precise organic diagnosis

whether or not a specific investigation will assist in the management of a particular patient. The crime of 'missing something' weighs heavily with them until they learn that they can see their patients again and detect what has been missed.

5. Strategies for keeping up to date

AN Whitehead aptly observed that 'knowledge does not keep any better than fish'. Students know that their knowledge has a half-life of five years but do not know how to keep up to date. They are dismayed to find that their hard-won insight is soon out of date. Students are usually familiar with

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TREATS CAUSE AND CONSEQUENCE IN THE ANXIOUS ABDOMEN.

Modern Medicine and the SA Journal of CME. They are less familiar with the BMJ, for example, and its superb teaching sections such as the review articles and the ABC series which are models of educational clarity, brevity and conciseness. Students must be able to critically assess published in-

Error is part of life and part of medicine; we need to learn how to deal with it

formation; to some extent their teaching in epidemiology and statistics equips for this.

6. The stresses of medicine and the doctor's personal life

We don't teach students much about the stresses that their work will place on their personal lives. Students know about the long hours away from home and family but are not aware of the problems accompanying this separation. Problems like: being drained and fatigued on reaching home with little to give to their family, and believing that this is the natural order of things when, from the protesting family's perspective, it is far from natural.

Do students need to know the risks of the profession? Risks such as resorting to alcohol or drugs to solve problems which can be most taxing early in the doctor's career. Surely there is time in a six year training to examine these issues with students? Students give these matters much thought and welcome an opportunity to review the implications of a career in medicine.⁷ Small group work would have a place here.

7. Manipulation by the drug companies

Student interns seem to believe that apple pie in the tea room at a day hospital means that there is such a thing as a free lunch. They do not know that, as a

Knowledge does not keep any better than fish!

profession, we are best understood by those with a financial interest in our co-operation, and least understood by ourselves. We think we operate on cold clear logic but the drug companies know that we operate on an emotional basis we are often unaware of.⁸ They know too that we can be bought with a bottle of wine, a crayfish and toy for our desk. On a lesser scale, cake at tea time is the way in to promoting the drugs. We are unaware of how thoroughly reps are trained to manipulate us. They

always defer to us as right even when we are wrong, because they are trained never to contradict us. Students given stethoscopes when they are short of funds will unconsciously favour the donor company when it comes to prescribing its products later.

There may be nothing wrong with this and students will have to decide for themselves. Before they can do so, however, they will need to know that we are subjected to very sophisticated subtle and effective marketing strategies where it is easy for us to be flattered into believing that we are really rather god-like.

Students should understand the medical marketplace and recognise when they are being manipulated into behaviour which is not in their patients' interests. Student interns must know that there is no such thing as a free lunch - whether or not to have the lunch is their decision.

Conclusions

These problems, germane to primary care, concern the doctor's personal reactions to difficult situations, some of which are unique to medicine.

Hard won insight and facts are soon out of date!

They generate anxiety and guilt in student interns which can impede the students' development into fully functioning professionals. We should put these matters before students and help them to work through their attitudes to these problems. They need to know something of themselves, yet, in the text for a course in human behaviour now given at UCT,⁹ I could find no reference to the doctor's understanding of his own behaviour.

As student interns assume responsibility for their patients they need to deal with their responses and to incorporate them into their development as professionals. With this incorporation comes the emergence of a confidence based on 'internalised' experience.

Our students have a vast theoretical knowledge which only becomes fully useful when the student has the necessary judgement for its wise application. Some understanding of self is essential for the student to develop this judgement, an understanding which could readily be fostered in the six years they spend with us.

We need then to counsel students in these matters. Just as we teach students to counsel patients to deal with their life problems, so we need to counsel student interns in how to deal with their own professional life problems,¹⁰ those of becoming a confident and effective health professional.

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