

THE NEED FOR CHANGE IN MEDICAL EDUCATION

We have much to be modest about in medical education, despite countless publications, conferences, and a great deal of hard work. Advances in medical science, outstripping advances in medical education, are piling up masses of detail that paralyze our present curricula. Medical school programs, long, unimaginative, and overcrowded, tolerate and encourage mediocrity. Small wonder then that many bright college students find other branches of science or other professions more attractive.

Most of us entered medicine with enormous enthusiasm for learning how to care for sick people, and all of us were dulled by two years of pre-clinical work. Most of our students probably come to medical school for much the same reason. Why then must we blunt their enthusiasm and kill their spirits with a year, or more likely two years, of lectures and laboratories that pay little more than lip service to clinical correlations?

Since medical knowledge obviously will continue to grow, and since the capacity of our crania will just as obviously not keep pace, we must accept the fact that none of us is now, nor will we ever train, the "complete physician." We will do well to graduate a student who can become a good house officer, viz., an adaptable student who may enter his specialty training with some idea of how to learn for himself, how to read and think critically, and how to obtain information from a patient. Only a paragon of students is able to survive a curriculum clogged by vast quantities of unrelated facts, and emerge untouched by mediocrity. These factual details we can afford to leave in books, which is where most faculty members have long since left them anyway, after discovering that they lead to mental constipation or worse. The requirements for becoming a good house officer are not great: the guidance of general principles, a limited number of facts and skills, and much

free time in which to think about them. Our present medical schools do not provide such programs.

How then can our present curricula be altered to provide programs marked by excellence? Perhaps this can best be accomplished by profiting from the students' initial enthusiasm for patient care; in other words, by giving them the chance to live medicine and absorb it through patient-centered teaching. From the day they enter medical school, they could spend a third of their time in the classroom, a third on the wards, and a third in research, or, like warty bliggens, for contemplation of "the moon and wheeling constellations." Such teaching would have to be done according to organ systems, rather than by departments, and would require active participation in all years by members of all departments. But, who knows? Under such a program, a student might discover that the basic sciences do have some connection with patient diagnosis and care. He might retain his curiosity and independence of thought, and even achieve a sense of proportion.

A perusal of medical school catalogues shows that most schools now use four years to obtain 33 months of actual instruction. Simultaneous basic science-clinical teaching might make it possible to obtain the same 33 months of instruction in a three-year period. Furthermore, by encouraging independent study, such a teaching program undoubtedly would better prepare a student for his specialty training. Our present medical schools are no longer really medical schools, anyway, but are pre-medical schools. It is during the long years of postgraduate training that a man learns his clinical skills.

The key to tomorrow's medical practice lies, not in the development of better clinical artisans, but in the development of clinicians who can interpret disease through application of the basic sciences. A medical curriculum at a graduate student level, based on patient-centered teaching with strong and continuous basic science correlation, could provide such clinician-scientists.