Editorial

MEDICAL EDUCATION SERIES Part II

Medical Education Reform: What Is the Goal?

In recent years, medical education has become a topic of general interest. The proliferation of newspaper and magazine articles, television commentaries, and books devoted to the subject reflects the increased attention focused on medical education by state and federal government officials, business and labor leaders, and the general public. The number of special meetings and conferences convened by medical educators, professional organizations and societies, and various foundations to discuss some aspect of medical education attests to the fact that the interest of those outside the profession has not gone unnoticed by those within the medical education community.

Because of the role of medicine in our society, the general public has a legitimate interest in the way physicians are educated. The scrutiny of medical education by those outside the profession can serve a valuable function by stimulating medical educators to review carefully the existing approaches to the education of physicians. Public scrutiny, however, can also pose a risk. Fearing the consequences of public discontent, medical educators may rush to alter the medical school curriculum in response to ill-founded concerns about medical education. Thus, a note of caution is in order.

To place this issue in perspective, we should recognize that the concerns about medical education expressed by members of the general public seem to arise from what they perceive to be wrong with medical care in the United States—primarily that it is too costly, too impersonal, too technologically oriented, and, at least for some segments of the population, too inaccessible. The general public would like to believe that these deficiencies might be corrected if physicians were educated differently. Before medical education is changed substantively in an attempt to respond to these concerns, however, serious thought should be given to whether alterations in the educational process would eliminate the problems that concern the general public.

My own view is that such an approach is unlikely to produce the desired changes. Admittedly, medical care is costly and technologically oriented—and these factors are, at least in part, related. I also concede that the inappropriate use of technology contributes to the excessive cost of medical care. Recent studies that have shown substantial variations in the patterns of medical practice across the United States and extensive use of technologically advanced invasive procedures have suggested that better physician education would decrease the cost of medical care by decreasing the excessive use of technologic procedures. Although this premise may be sound, the inappropriate use of technology is primarily caused by a failure to educate practicing physicians about the proper applications of technologic approaches in their practice and the inability to monitor their patterns of practice. This situation can be attributed, at least in part, to the lack of an adequate technology-assessment program in the United States. This problem is unrelated to formal medical education and hence provides no rational basis for changing the medical school curriculum.

Similarly, the inaccessibility of medical care for some individuals and population groups in our society cannot be solved by reforming medical education. Unless our society agrees to provide health insurance for all citizens, medical

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care will not be universally accessible. Physicians do need a better understanding of this issue in order to become more effective advocates for the underserved. Nevertheless, the medical profession—including the medical education community—is not responsible for solving this problem. Until those responsible are held accountable for their inaction, no effective solution will be forthcoming.

Thus, although I admit that medical care is too costly, too technologically oriented, and inaccessible to some individuals in our society, none of these problems seems to be a valid reason for making substantive changes in medical education. As a medical educator, I am most concerned that the public perceives that medical care is too impersonal. This is a serious issue because it suggests that physicians are not sufficiently caring. To the degree that physicians are perceived to lack a caring attitude, concerns about the cost and technologic orientation of medical care will be exaggerated by patients and become embedded in the public opinion of the medical profession. More importantly, patients and their families will not feel as secure or confident as they should about the medical care that they receive. Can medical schools do a better job of ensuring that future physicians will be more caring? This question leads directly to two other questions. Can more caring applicants be selected for entry into medical school? Can reform of medical education produce more caring physicians?

There is little reason to believe that any educational program can make an uncaring person more caring. I doubt, however, that the perception that physicians are uncaring derives from the fact that students accepted to medical school are basically uncaring persons. If any truth exists in this contention, we must alter our admissions policies in an attempt to avoid the selection of such students. Alternatively, I suggest that the primary problem is that physicians have not been taught to be fully appreciative of the psychosocial dimensions of a patient's illness and therefore may not project an image of compassion. I believe that something can be done about this deficiency during the medical education process but that major changes in the method of educating physicians are unnecessary.

In my opinion, the best way to begin to prepare young men and women to become caring physicians is to overcome the urge to tamper with the curriculum and to concentrate our efforts on the years before entry into medical school. In this regard, I believe that students should enter medical school with a better foundation in certain of the social and behavioral sciences and with a deeper appreciation of humanistic values. This prior preparation is important for several reasons. First, insufficient time is available in medical school to explore these subjects in depth. Of necessity, the medical school curriculum must focus on information most appropriate to the practice of medicine, and the scientific data base is vast.

Second, if students must meet these requirements before acceptance into medical school, the process of identifying which students will most likely become caring physicians may be facilitated. Academically qualified applicants who do not possess the attitudes and values thought to characterize a caring physician might not be selected, whereas those who are less qualified academically but who demonstrate the appropriate attitudes and values might be chosen. Furthermore, during their study of social and behavioral sciences, some students might come to the conclusion that they do not want to devote their lives to the care of patients and will pursue other careers. Consequently, those students who are most likely to become caring physicians would be admitted to medical school.

To ensure that students have an adequate foundation in the social and behavioral sciences, medical schools should change their requirements for admission. Each of the current science requirements should be carefully analyzed relative to its applicability to the functioning of a physician, and a balance should be created between the physical and biologic sciences on the one hand and the social and behavioral sciences on the other. Lower division survey courses in the social and behavioral sciences should not fulfill the requirements for admission. Medical students should have a deeper understanding of

these subjects. Perhaps a minor course of studies in the social and behavioral sciences should be required, or the concept of enriched majors could be adopted for this purpose. Medical school educators need to work with undergraduate educators to develop innovative curricula that will accomplish these goals for students interested in attending medical school.

Although implementation of changes in undergraduate requirements would be helpful, such a step would not be the total answer to enhancing the caring attitudes of those intending to become physicians. A formal education in the social and behavioral sciences and the humanities is insufficient for molding an individual's attitudes and values. Recently, in a report entitled "Clinical Education and the Doctor of Tomorrow," a panel of medical educators recommended that a period of community service be required at some time during the education of physicians. As a member of that panel, I concur with that recommendation. The experience of providing service to fellow human beings is directly relevant to the work of a physician. If the community service experience occurred before application to medical school, admissions committees might have further insights about candidates for medical school that would yield a more compassionate group of potential physicians.

A community service experience before entry into medical school might serve another purpose as well. Most medical schools offer preceptor-type experiences that expose students to many social issues relevant to medicine. In addition, clinical clerkships based in city and county hospitals offer an excellent opportunity for students to begin to appreciate some of the problems faced by the poor in our society. Students who have participated in prior community service projects might be better equipped to learn from these experiences and more likely to take a greater interest in learning how these important social issues affect their patients rather than simply focusing on the specific disease that prompted the visit to the hospital or ambulatory clinic.

In summary, I will restate my message more broadly. As medical educators, we should always be receptive to suggestions about changes in the methods of educating physicians, but we must keep in mind that our goal is to produce caring and competent physicians who are imbued with a commitment to lifelong learning and who have an appreciation of the role of physicians and the medical profession in society. We should not change medical education under the false premise that somehow the changes we introduce will substantially decrease the cost of medical care, make care less technologically oriented, result in major improvements in the access to medical care for the underserved, or any other ill-founded expectation. Furthermore, in considering how to improve the process of educating physicians, we should analyze the entire continuum of general education from the undergraduate through the postgraduate years. I have focused on the premedical experience because I believe we tend to overlook those valuable years that could be instrumental in the better preparation of students for their more formal medical education. Additional changes in the medical school curriculum per se might be addressed by other contributors to this series on medical education.

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