Need for Alternative Medical Education in South Africa

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Medical education was introduced in South Africa in 1922 and has since produced many eminent doctors. But today the universities are not producing doctors appropriately trained either for current needs or more disturbingly, for a post-apartheid future. There is an urgent need to radically transform the medical course and curriculum. (Reprinted from Critical Health, *1988)*

DOCTORS first completed their medical education in the University of Cape Town in 1922. The early medical teachers brought their curriculum with them, mainly from the United Kingdom. They produced many first rate doctors and in the decades since, many graduates have attained international acclaim. There have been a number of intra-university curriculum reviews but these have tended to add more and more to an already overfull course. In 1985, the South African Association for Medical Education (SAAME) held a national review of medical education in South Africa, but very few of the recommendations have had any effect on our medical schools. Our universities are neither producing graduates appropriate to the needs of our country at present nor, more disturbingly, for the post-apartheid future. This paper sets out some of the reasons why we urgently need alternative medical education to help solve the serious health care problems in this country, remembering that it will be six years after the new curriculum is established before the first graduates appear.

Maldistribution of Health Services

Doctors tend to practice in the kind of environment where they are taught and so it is understandable that they find their security in city practice, either in this country or overseas. It is true that it will take more than a changed education to entice doctors to practice holistic medicine in the neglected parts of our country, but if we don't change the education we provide, no amount of structural change in the health service will bring about improved health care for the people of South Africa. Doctors need to be trained in the context of where their services are needed most.

Not only does maldistribution operate geographically but also in the emphasis on specialities. For example, many specialist obstetricians with a minimum of twelve years of training spend the bulk of their time doing normal deliveries for extra-ordinarily high fees while primary health care for the poor is seriously neglected.

The major portion of clinical teaching is provided in referral, high-technology teaching hospitals, where the bulk of the country's health budget is spent. This gives students a view of health care that suggests that doctors only deal with rarities and that sophisticated monitoring systems and laboratory investigations are not only indispensable, but immediately available.

The teaching hospital glorifies high-technology curative medicine and surgery and gives limited consideration to preventive and promotive health. Role models have a major influence on the development of a medical student's approach to medical practice, and with the emphasis given to curative medicine and the down-playing of preventive and promotive care, it is little wonder that the same pattern persists in succeeding generations.

There is a need for a medical faculty to develop expertise in the various specialities but this does not promote the most appropriate basis for medical education. It has engendered unhealthy competitiveness for curriculum time, space and status. Each department advances its own course for survival sake and as a result produces a curriculum more suited to specialists in the discipline. Such structures are not suited for the undergraduate education of a 'core' doctors. Instead, there is a need for strong central departments of medical education that co-ordinate cross-discipline, integrated programmes of problem-based learning.

Medical students who graduate from our medical schools have every right to presume that health care is dependent primarily, or even exclusively, on doctors. Their doctor teachers in the hospital are on top of the pile and project other health workers as auxiliaries. Medical students are seldom introduced to other health workers, let alone train with them. Again it is understandable that our graduates have little experience of working in teams and that our country's health service is, in the words of David Werner (author of the book *Where There is No Doctor*) community oppressive rather than community supportive. Doctors are expected to have all the knowledge and wisdom and are not shown how to consult the communities they are meant to serve. They have been trained to be consultants before they learn to consult and to direct before they have learnt to serve.

The tenets of western medical practice are taught as if no other belief and practices have any place in a country with such a multiplicity of cultures. Our very failures should alert us to the need to examine others' successes and to incorporate them into new learning opportunities for our students. A salutary research study conducted in Zimbabwe needs to be heeded by our medical educators. Groups of 100 rural and 100 urban women (many of whom were university graduates) were asked where they would wish to be delivered of their next baby and who they would like as their attendant. The majority in both groups wanted the safety of hospital or maternity clinic but 100 percent of the rural and 90 percent of the urban woman preferred to have a traditional birth attendant (TBA) with them during their labour. Few doctors even

recognise that the overwhelming majority of women on this continent are delivered by TBAs. Instead they write off such patients as 'unbooked' or 'defaulters'. We interpret compliance as meaning taking the host of tablets we prescribe, in spite of the fact that we never explained what they were for. We also forget that our patients have an entirely different world view that informs their understanding of the aetiology and therefore treatment of illness.

Not only do we compartmentalise within our medical faculties, but we isolate the medical schools from all other faculties in the university. How can we expect students to accept other disciplines such as agriculture, economics, sociology and education as being important, if not more important, than medicine in providing health and wholeness of care? We even call one of our schools a Medical University, which is not only a contradiction in terms, but more evidence of our failure to understand what holistic health care is all about. The consequences are a country that can boast the first heart transplant while within walking distance of the particular hospital involved, there are townships with no piped water. The need for a multi-disciplinary approach to teaching extends beyond the compartmentalised medical school to cross the academic barriers in the university. It is only when engineers and agriculturists link with sociologists and physicians in formulating new curricula that the ill-health caused by factors related to each of these disciplines will be addressed. It all seems so obvious, but until we are brave enough to create new educational structures, our students will retreat into their academic enclaves instead of becoming the new pioneers of health care in Southern Africa.

This is not the language of our medical teachers. We are the privileged ones and we are comfortable with our elitist positions and the status quo and bureaucracy that protects our academic safety. Few of us have experienced the oppressive effects of apartheid, the major cause of poverty and ill-health in the midst of this land of great wealth. Without this experience, our teachers are unable to interpret the effects of state systems on community and individual health, and therefore demand that politics and health care be kept in separate compartments.

In spite of the fact that many of our students come from the oppressed communities, their awareness and understanding is not encouraged by the majority of their teachers, and the only oasis in the midst of a year of non-contextualised teaching is the annual Students Conference, at which academic staff are conspicuous by their absence.

The Medical Course

This statement hardly needs elaborating, yet we are all guilty of adding every new discovery to the curriculum, without taking anything out. Each new discovery should remind us that much of the content in today's curriculum will be out of date by the time our students are in practice and our volumes of content will not prepare them for the demands of the new century. We subscribe to 'Health for All by the year 2000' but are not equipping graduates to meet that challenge. Rather than multiplying content we need to provide students with problem-solving skills, for it is that they will be called on to do whether at the community or the individual patient level. Problem-solving will ensure a multi-disciplinary approach to medical education and will equip students to absorb and apply new knowledge as it becomes available. It will also ensure that each subject discipline is dealt with according to its merits, the merit of the solution to common life-saving problems in the first instance, and later, any other problem that may present itself. Students progress when they know how to explore knowledge rather than just memorise it.

We manage to drain every atom of motivation and enthusiasm that students bring with them by our layered curricula, which in the first three years can only suggest to students that life is filled with laboratories, cadavers and specimens in bottles. How much more exciting it is to see a small group of first year students deciding on the anatomy, physiology, pathology etc that they need to explore and learn to enable them to solve a particular clinical problem. By the end of a course of suitably chosen problem-solving studies they will have not only learnt the principles and content of each subject in the curriculum but they will see how it all fits together in helping them solve the problems. Experience with such curricula has shown that students have to be restrained from over-studying rather than driven through the early years of boredom.

Medical schools are not entirely to blame for suppressing the natural spirit of adventure and exploration. The rot sets in at junior schools. Children, left to themselves, are experiential, self-directed learners until the schools get hold of them. From then on the teacher takes control, and presumes that all children learn at the same pace. Consequently they are regimented into large classrooms, told to keep quiet and listen to the teacher. The only difference at medical school is that the classes are many times larger and the teachers do not even hold an education diploma. My only surprise has been the rapidity with which fourth year university rote learners respond to the liberating experience of changing from an emphasis on whole-class lectures to the fun of problem-solving in small groups. We have shown that it works at that late stage of the curriculum, so why not start that way from the first year of the medical course?

Of all countries in the world today, South Africa in particular needs a liberated educational system. Not only is this the most appropriate way to learn but it equips people to seek after truth and justice in every sphere of their lives.

This outline of the need for alternative medical education in South Africa must point us in the direction of community-based, community-oriented, integrated, problem-solving education as the solution to our needs.