By Jin Yao

Medical Education: One student's grouses, and his attempts at constructive criticism

"'Problem-based' and 'self-directed' learning seem to be the buzzwords amongst educationists..."

It's that time of the year again, brightly-coloured flowers burst into bloom, lovely little birds flit from treetop to treetop before breaking out into the lilting melodies of spring, and a young man's fancy turns to love.

Wait, scrap that – wrong scenario. *Ahem*

It's that time of the year again, when final-year medical students (a state of being which some of the rather more experienced alumni may not be able to recollect altogether clearly) across the nation prick up their ears, sit up a little straighter, dust off the ol' faithful copies of *Harrison's* and *Bailey & Love,* and start asking that million-dollar question: "*Eh Ah Kau*, MBBS *chu simi* topic ah?

The following represents one humble medical student's valiant attempt to provide, once and for all, an answer to this perplexing enigma.

Method: (since they tell us that a proper reporting of methodology is the basis for scientific peer appraisal) Careful and meticulous analysis of collective past experiences with the system, otherwise known as 'sitting round a table and talking cock over beer' in the real world, and 'retrospective observational study' to us intellectually superior men of Science.

As far back as I can remember (which is, really, only a couple of years), the gist of exams under the **'new and improved system'** (emphasis mine) has been either one or the other of:

"WE DON'T TEACH IT, SO WE'LL TEST IT"

'Problem-based' and 'self-directed' learning seem to be the buzzwords amongst educationists in the upper echelons of academia these days, so much so that, believe it or not, we have not received any formal teaching on chemical

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Jin Yao is a final-year medical student, struggling to strike a balance between his desire to have his opinions heard, and the fear of not being taken seriously – or being taken far to seriously.

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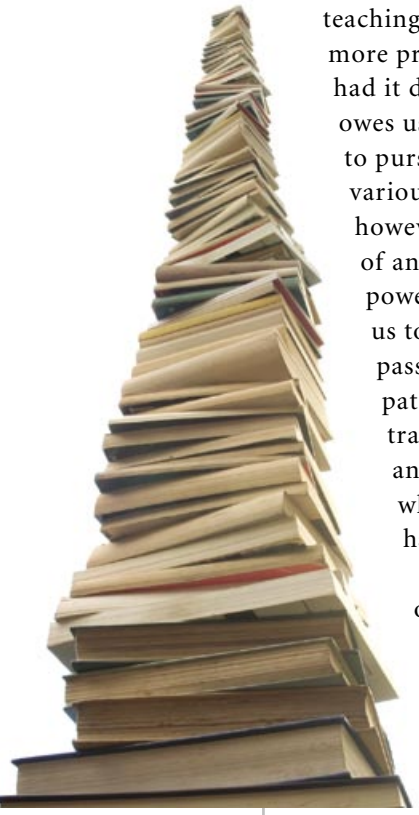
pathology and the interpretation of lab results, and topics that used to be taught in three to five lectures are sometimes now only allocated a single hour-long slot in the curriculum.

Now, don't get me wrong. I am perhaps the strongest proponent for fewer lectures and more time to dedicate to the slaking of our unquenchable thirst for ~~leisure, girls in string bikinis~~, knowledge and wisdom, but surely, there is a tad too many things that have been left to us to discover on our own.

As it is, barely half of the 'must see must know' topics in our clinical curriculum receive any coverage in formal teaching sessions, and neither do certain essential practical subjects (fluid replacement, interpretation of lab results and prescribing/dosing being the most obvious examples that immediately spring to mind). If you were lucky to be posted to a hospital where supplementary lectures were given on the topic, or if you got a tutor who bothered to go through the nitty-gritty of practical management with you, then well and good, but an alarming number (probably even a majority) have arrived at the halfway mark of final-year M5 without the slightest clue as to how to go about these mundane matters.

And, at least in my humble opinion, the education of medical students should not, as it is, be left to fate and/or chance. Certainly, a certain degree of due diligence and responsibility for one's own learning must be exercised, but surely the University and teaching staff in particular must also fulfill a more proactive role. So very often, we have had it drummed into our heads that no one owes us an education, and that we will have to pursue learning and knowledge in all their various guises on our own. After a while, however, that comes to smack somewhat of an abdication of responsibility by the powers that be. If you do not owe it to us to ensure that we know enough to pass our exams, surely you owe it to the patients to ensure that we are adequately trained to provide quality healthcare, and to yourselves, since you are the ones who will be working with us, hand-in-hand, in the wards.



Another rationale for the emphasis on 'self-directed' learning is the 'explosion of knowledge' as 'medical knowledge and advances continue at a breathless pace', and I believe that no one in his/her right mind would dispute the fact that doctors need to make conscious and deliberate efforts to keep abreast of medical developments. However, the sheer volume of unprocessed information out there can get pretty overwhelming, especially for a lowly medical student, struggling to remember that PID means different things in orthopaedics and O&G. Time to collate information from three different textbooks and browse through several review papers and a randomised double-blind control trial? Please, some of us barely have time to eat and sleep, with defaecation demoted from the ranks of 'necessity' to 'luxury'.

In fact, it is in view of this very overwhelming deluge of information that students need a little more guidance, not less. We should be told or shown specifically what we need to know – the essentials on which to base any further learning. By all means, leave us to pursue knowledge and learning, but first, teach us what we need to know.

After all, even McMaster University, the pioneers of problem-based learning, have realised that they need to incorporate didactic teaching into the syllabus.

"WE CAN'T TEACH IT, SO WE'LL TEST IT"

Under the new examination format, final-year students have to sit for what is termed a 'communication skills OSCE' in mid-January, ostensibly designed to assess students' communication skills as well as awareness of ethical issues.

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First off, I wish to state that I've always thought that communication skills, empathy and a basic respect for ethical considerations form the foundation for a rewarding doctor-patient relationship.

But (and you just knew there was going to be a 'but', didn't you?) here's the rub: you just can't assess these things in an examination situation. Of course, you can try to, you can pretend that you are, but when push comes to shove, the bare

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fact of the matter is that a 10-station OSCE does nothing to replicate the real-life scenarios that we'll be facing in the real world.

Can I really feel empathy, knowing full well that the person sitting across me is not in fact the relative of a terminally-ill grandmother, but merely someone pretending to the relative of a terminally-ill old woman? And more to the point: is someone who performs well during the OSCE someone who is better than the rest at feeling and showing empathy and concern, or is he/she really just someone who knows better how to put on a big show for the examiners and is, consequently, someone who will be more likely to talk the talk but not walk the walk later on in life?

Yet another example of this obsessive-compulsive urge to assess and quantify everything is the ethics case write-up that each student must complete and submit by the middle of Year 5. Personally, I fail to see how being able to write an adequately informative and analytical report be equated with being an ethical person, and if this correlation was never meant to be made, then what was the point of the whole exercise in the first place? To add on to our burgeoning workload? One certainly hopes not.

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"WHAT CAN BE DONE" *AKA* "THE WAY FORWARD"

In the spirit of constructive criticism, and also because I do want to graduate, avoid litigation and being blacklisted, so that I can get a traineeship, here's my two cents' worth (in reality worth a lot less than two cents) on what can and should be done to improve the system that we have now.

Put the money where the mouth is. Happily, I have actually noticed assessments becoming more and more clinically-based, a rather good example being the recently-concluded Paediatrics OSCEs. The upcoming revamped Student Internship Programme sounds promising, but judgment must be reserved till its implementation can be adequately appraised.

The next step would be to ensure that this is carried over to the subsequent theoretical and clinical parts of the exams. More importantly, ensure that instead of being taught how to present a long case, or how to look polished for the short cases, the emphasis on clinical-year ward work be shifted to the practicalities of day-to-day approach and management of the patients.

From experience, an excellent way to do this is to have students shadow a member of the team; someone senior enough to be able to adequately impart experiences and knowledge to his/her protégés, yet young enough to be able to connect on a more personal level and, above all, be genuinely interested in and committed to teaching.

It's not impossible to find someone like that, as my experience while rotating through general surgery proved. The problem, of course, lies in finding enough such people to carry the collective burden of upping the quality of medical education for future generations.

In short, test us on what we should know, and teach us what we need to know.

Also, just as there are limits to the curative and restorative powers of modern Medicine, so too are there limits to what exams and tests can assess. The traditional 'soft' skills of Medicine: communication, empathy, professionalism and compassion, are no doubt important, even essential, but teaching should be left to role-modelling through ongoing observation of mentors in real-life day-to-day scenarios, and assessment should be left to those most meticulous of judges – our patients and colleagues. ■

"WHILE SOME OF THE IDEAS IN THIS ARTICLE ARE REASONABLE AND RELEVANT, THE ARTICLE SUGGESTS THAT SINGAPORE MEDICAL STUDENTS ARE UNABLE TO ENJOY THE THRILL OF DISCOVERING FACTS FOR THEMSELVES AND STILL NEED TO BE SPOON-FED. PERHAPS WE HAVE TO WAIT FOR THE GRADUATE MEDICAL SCHOOL TO GET STUDENTS WHO ARE EXCITED ABOUT LEARNING NOT FOR THE SAKE OF EXAMS BUT FOR KNOWLEDGE, SO THAT THEY CAN BE BETTER DOCTORS FOR THEIR PATIENTS."

SMA News reviewer, a senior medical educationist and Associate Professor, NUS Faculty of Medicine