



## SA MEDICAL EDUCATION 'CHAOTIC' – PRICE



Professor Max Price, Dean of the Faculty of Health Sciences at Wits University.

South African medical education was 'chaotic and unsystematic', the assessment of students did not stand up to stringent clinical testing standards and teachers merely hoped that their charges would see an adequate cross-section of patients.

Professor Max Price, Dean of the Faculty of Health Sciences at the University of the Witwatersrand, said this while delivering the keynote address at the inaugural meeting of the South African Association of Health Educationalists last month.

While most senior medical academics were 'very satisfied' with the clinical skills of doctors they had trained, South Africa's system was being seriously challenged by top educationalists. Most local clinical exams involved only one or two patients.

'Any statistician will tell you that that's too small a sample to do a reliable test - they say how do you know that the people who pass aren't just lucky?'

Price cited the case of a university in the UK about two years ago when the Dean was sued by a patient after it was found that a young doctor he was responsible for having trained was negligent and incompetent.

He said most local teaching relied on apprenticeship and was 'rather random'.

'You hope that over three years of clinical training the student will encounter patients with a particular condition and to have learnt about that condition - but there's no record or log book such as in obstetrics (with deliveries), for example'.

The criticism was not just that student exposure to patients was unsystematic and abysmally monitored, but perhaps more importantly, that there was no attempt to standardise a country-wide approach.

Different teaching methods across the country confused students and very often they learnt vital skills, such as how to take blood, put up a drip or perform a lumbar puncture from their peers without ever being examined on them.

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Price said that in spite of all these criticisms, 'the world and our government tell us we're producing good clinicians'. The truth was possibly that most medical students were self-driven and did well 'in spite of the gaps in the curriculum'.

However, so many being good did not mean that a 'significant number don't fall through the cracks and are bad,' he stressed.

Price emphasised that even though aspirant doctors filled many gaps during their internship, medical schools 'should be worried about that'.

One positive sign was that the Medical and Dental Professions Board (MDPB) was beginning to remove accreditation from hospitals not providing adequate supervision to interns - a system introduced two years ago that was beginning to bear fruit.

Price said the MDPB had undertaken to address written complaints from interns about problem hospitals within a month.

Board members could inspect the hospital and transfer the intern elsewhere if they felt it was seriously compromising his or her skills acquisition.

Universities were developing skills laboratories and sharing videos and information technology, with many now buying mannequins so students could at least learn how to put up a drip.

On curriculum reform, Price said the most important objective of the unprecedented workshop was 'for each of us to learn what the other is doing,' particularly as graduates of the new curriculum were now coming through in numbers. What he found interesting was that 'we're using the same terms to describe different things'.

Different universities' goals and outcomes were similar but they reached them in divergent ways.

He questioned to what extent clinical studies were being integrated into basic science but commended the different campuses for using small-group learning models which enabled teachers to 'evaluate whether anything is being compromised'.

On information technology, Price said universities needed to shift from focusing 'on who's got the best X-ray database or CD-Rom and begin sharing these expensive resources'.

Wits had raised R1.5 million to distribute among other medical faculties for resource development, on condition



that these were freely shared. R800 000 had just been allocated to the University of Cape Town to develop a CD-Rom on clinical skills training.

A committee, with representatives from each university, decided on the grants and was currently accepting applications.

Information technology was fundamentally changing teaching methodology. Price questioned the continued need for 'wet labs' and said three-dimensional computing virtually did away with the need for anatomical dissection.

On AIDS, Price said he believed the workshop emphasis was inappropriate. 'We should be addressing ways of using

the HIV theme... to hang many other issues on'.

Besides microbiology and virology, the pandemic provided a unique vehicle for health education and promotion, counselling and doctor-patient communication skills.

One could look at the social economic determinants of health (poverty, nutrition and education - all of which were dramatically illuminated by HIV/AIDS).

Other subjects the pandemic impacted were bio-ethics, public policy and resource allocation.

'I was hoping we'd get a shift from looking at AIDS as something that virologists and clinicians and



A speaker addresses the inaugural meeting of the South African Association of Health Educationalists held at the Colleges of Medicine in Rondebosch last month.

Picture: Chris Bateman

pharmacologists teach, to an integrating framework within which we teach all these other things,' he told the SAMJ.

Chris Bateman

## The South African Medical Journal

### 100 years ago

The Rev. Albert Maggs, a missionary then in charge of the St. Luke's Station, was medical attendant in ordinary to the whole of the countryside thereabouts. He was sent for one day to see a young boy who had been gored by an ox. He found a gash two or three inches long in the abdominal wall and a good deal of bowel protruding. One loop of this bowel had a gash in it extending through about half of the circumference. Mr. Maggs at once told the relatives that the patient must die, and confined his efforts to cleansing the parts and giving opium. Even a qualified surgeon could, in those days have done little more. Some three months afterwards he had occasion to visit the kraal, and, to his astonishment, recognised his former patient running about alive and well. On inquiry he was informed that, as the white 'umlungu' could do nothing, the parents had sent for a native doctor of note, who had effected a cure. The doctor first went to the river and selected some reeds. He picked out one which appeared to fit nicely into the lumen of the gut, just distending it. He then stripped off the hard outer rind, leaving a cylinder of sufficient tenacity to hold the walls of the gut apart, and yet not too tenacious to resist disintegration in a few days. He cut this down to about four inches in length, and soaked it for a short time in some solution prepared from herbs, the composition of which he would not disclose. After carefully cleansing the parts with the same solution, the doctor inserted the reed into the lumen of the gut, and sewed up the gash over it with threads taken from the ligamentum nuchae of an ox, which threads he always kept ready for surgical purposes. The wound in the abdominal wall was stitched up with the same material. The boy was put to bed, and given some soothing draughts, and recovered. It certainly seems as if this indigenous doctor had grasped intuitively the sound leading principles of abdominal surgery.

### 50 years ago

It is true that 50 years ago death at birth was ten times as great as today. On the other hand, fifty years ago the Country Doctor was loved and idolized, while today millions would vote for socialized medicine.

It is true that seventy years ago death from cholera, smallpox, syphilis, scarlet fever and typhoid took its thousands every year, while today such death is rare.

It is true that medical aid has developed so fast since 1900; that life expectancy has jumped from 40 to more than 67 years - people live 60 per cent longer and 60 per cent faster than they did fifty years ago. But it also is true that fifty years ago the doctor was the confidant of everyone in town, the arbiter of disputes, the adviser on matters social and economic. Today the doctor can better care for his patients, but the public feels that he cares less for them as individuals. Now WHY has the Medical Profession, which has performed such astonishing services, become the target of charges of selfishness and greediness, and of charges that the doctor places the dollar before his patient? I believe I can bring to mind some reasons for this feeling of suspicion on the part of the public. Let's check up on ourselves. . . to see how WE are doing. We may not like what we find, but it's time we looked ourselves in the face. I believe in spite of astounding advances in medicine you'll find what I found - that we have fewer friends in a world that desperately wants to be friends with us. I believe you'll find that the public is reacting unfavourably to the profession which sincerely wants to serve it.

*John H Kleinheksel, President, Alumni Association of the Mayo Foundation, Rochester Minn., USA. Presidential Address to the Medical Association of South Africa.*