ARTICLES

Restructuring medical education

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Abstract

This article explores instances of dysfunctional behaviour in resident doctors and examines the causes. It looks at the cultural competency training procedures for doctors in some institutions. There is a need for greater competency and diversity training of resident doctors. Counselling services also must be in place for addressing stress issues of doctors. These are important attributes looked for by WHO for accreditation.

Resident doctors in public hospitals are frequently in the news for the wrong reasons. For example, when a doctor told the daughter of a woman who had just died that a post mortem examination was required, she got agitated and allegedly slapped the doctor. Or when an irate husband of a parturient woman, who gave birth to a stillborn, attacked two female residents.

At least seven such incidents of assaults on doctors were reported in Mumbai between June 2005 and March 2006, all in public hospitals (1). The doctors struck work. The Maharashtra government responded by enacting an ordinance guaranteeing their safety. Resident doctors in public hospitals will now be classified as public servants; anyone assaulting them would be held without bail (2).

Numerous other cases have been reported where the issue is frustration and a lack of stress management training, or a lack of discretion and cultural diversity training, or a lack of communication and listening skills. A few examples:

- A resident doctor was found dead in his room. He was newly married, could not acquire suitable residential quarters, and took antidepressants. Many young resident doctors remain in dire need of decent quarters. Many have managed to adapt and ignore their needs.
- A junior doctor went away from the campus without telling anyone. She had been reprimanded for a lapse in duty. Worried senior colleagues and teachers called her parents and informed the administration. The matter ended when she reached home after a few hours.
- A resident doctor aged 27 dropped dead in the midst of his postgraduate exams. He was apparently healthy, a promising student, and due to be married a few days later.
- A patient's husband lodged a complaint with the administration of a hospital that the patient was intimidated and verbally abused, and the nursing staff made communal remarks. The junior doctors in question were reprimanded and the action taken was reported.
- A junior doctor got angry with a patient for not following instructions, and allegedly used inappropriate words. The patient's husband complained to the seniors of the unit. On questioning the doctor apologised to the patient and her husband.

Missing aspects of medical training

In the midst of other pressing matters in our public health system, such issues are often given secondary importance. The evaluation of non-cognitive criteria and professionalism in medical students has not received the same attention as the evaluation of other aspects of clinical competency, knowledge, and skill. Due to this failure, students or junior doctors misinterpret, undervalue, or fail to notice subtle feedback (3).

Medical students are expected to be sensitised to the social and ethical issues in medical research and patient care (4). Unfortunately, with the current spacing of subjects and the frequent examinations that undergraduates must prepare for, they spend more time in the libraries and less time with patients and in clinical training. During residency, the student does not get hands-on cultural competency training.

Stress and emotional disturbances are an integral part of students' lives, especially in fields like medicine, where trauma, disease, ill health and death are daily features. About 73 per cent students admitted to being stressed in a medical college study in Mumbai (4).

Centralised admissions keep many young doctors are away from their parents and they are unable to seek emotional support from the family. The stress often manifests in substance abuse, suicide, and irrational behaviour. Physicians have a higher rate of depression than non-physicians, and depression is an important risk factor for suicide. Among female physicians, the risk may be exacerbated by sexual harassment. When they become suicidal, physicians generally choose effective suicide methods (5).

In a recent survey of 13,500 college students in the US, nearly 45 per cent reported being so depressed that they had difficulty functioning, and 94 per cent reported feeling

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overwhelmed by everything they had to do (6).

Counsellors recognise that the person most likely to notice mood changes in a student's behaviour is a family member. In residency training senior colleagues and teachers should be alert to warning signals such as depression, trauma, substance abuse and anxiety. Counselling services with assured confidentiality should be in place in all institutions. Are our postgraduate teachers and guides equipped with the skills to detect aberrant behaviour and take appropriate measures?

An estimated 15 per cent of physicians, worldwide, will be impaired at some point in their careers. Impairment means not just making incorrect diagnoses or the failure to treat appropriately; it may include not acknowledging the patients' psychological needs, dehumanised care, inappropriate treatment, or over involvement in care (3).

Making curricula more comprehensive

Although efforts have been made, our medical education system must more comprehensively revise its methodology to include greater diversity training in postgraduate teaching, and start stress management training for postgraduates. It must also ensure and publicise the availability of counsellors, build a system to receive feedback from patients at discharge to build patients' confidence in the health system, and periodically evaluate social competency while assessing a student.

The World Health Organisation's South East Asian Region report on health ethics in six SEAR countries (India, Bangladesh, Indonesia, Sri Lanka, Myanmar, and Nepal) says that all have ethics curricula. In India, Bangladesh, Myanmar and Nepal, it is taught as part of medical jurisprudence. Indonesia encourages the faculty to teach humanities in medicine to students (7). Ethics as a subject is included in the MBBS undergraduate forensic science curriculum in Indian medical students. The Kasturba Medical College, Manipal, and the Christian Medical College, Vellore, have a case study based programme for lawyers and experts in the field.

The St John's Medical College, Bangalore, has a department of medical ethics with four faculty members. Their teaching programme for medical ethics extends from undergraduate training to internship and residency by clinical case-oriented sessions. Since 1992 this college has also conducted monthly "clinico-ethical" conferences. In each session, interns and residents present a case with ethical issues to the faculty and audience. Topics such as truth and confidentiality, life support, transplantation, respect for life, drug promotion and prescription and patient-doctor relationship are discussed (7).

Students' sensitisation has also been undertaken at the Seth GS Medical College and KEM hospital in Mumbai. Called "Shidori", the student-teacher preceptor programme is conducted on entering medical college, at the beginning of clinical terms, and during internship. It covers group dynamics, study skills and communication skills. Shidori-2 is conducted for second level MBBS students and includes training in bedside manners, and communication and coping skills. Shidori-3 is for interns and includes the relationship between medical representative and the doctor, rational drug prescribing, rational diagnostics, doctor-patient communication, time management and assertive behaviour (4).

In the UK, a training called PROCEED (Professionals Responding to Cancer and Ethnic Diversity) was developed in response to growing concern about inequalities in health care experienced by patients with different ethnic and cultural backgrounds (8). Some trainers in the US department of health have focused on common cultural and demographic misconceptions of diverse ethnic populations, as well as their values and health beliefs (9).

Eligibility for accreditation requires quality education imparted to future doctors. Quality may be defined by its "fitness for purpose", "meeting the expectations of the consumer or user" and "satisfaction of client". The requirements of stakeholders must be considered. In medical education, the stakeholders include patients and communities (10). Medical courses should produce graduates who will perform at a high level in the changing roles the community requires of its medical practitioners. They should have a flexible approach and commitment to a lifetime of continuing medical education.

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