Personal View

Why Do We Teach the Way We Teach?

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Medical practitioners often believe that their clinical judgement is based on research and logical reasoning. This is probably true of many specialities. Medical education is an exception where tradition and 'intuitions' appear to play a greater role in its practice. A study of how our curriculum originated provides some evidence for this view.

The first medical school opened in Colombo in 1870 and the curriculum was probably based on curricula of British Medical Schools which were implementing the recommendations made by the General Medical Council in UK in 1867[1]. Since inception, content and subjects have progressively been added to the curriculam and students are now overloaded with an unprecedented volume of knowledge[2]. Integration of such knowledge or coordination between departments have received scant attention. However, despite a teaching programme which is minimally integrated, students are expected to develop an integrated and holistic approach towards patient care.

The tradition of teaching preclinical subjects for two years, before exposing students to clinical subjects or patients is continued in the belief that normal structure and function must be taught before the abnormal. The origin of this belief may be Flexner — scientist turned medical educationist — who in 1909 stated 'the first two years should be totally consumed with laboratory sciences[3]. His views are now being challenged and newer integrated methods of education are coming to the forefront. Thus learning in the context of a clinical or health care problem is practised in certain medical schools eg. problem based learning, while others use a system of modules where subjects are integrated around systems (eg. cardiovascular system) or important topics (eg. growth and development).

Our educational methods lay emphasis on teaching rather than student learning. Didactic lectures where teachers attempt to teach large audiences is favoured to small group learning or tutorial based learning. In the latter, students are expected solve problems or learn topics on their own, with guidance by the tutor. Such learning situations increase the motivation of students to learn and enhance their communicative, and problem solving skills[3]. Regretably even bedside clinical teaching, instead of being an exercise in clinical problem solving, gravitates towards a formal lecture by the teacher on a disease, in the presence of a patient.

Evaluations used in the medical schools in Sri Lanka emphasise end-of-course (or terminal) evaluation rather than in-

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course (continuous) evaluation. For example, nearly three years of arduous clinical work is assessed by one final examination lasting a few hours. The stress on the students and inefficiency of this method of evaluation is obvious. Examinations continue to consist of components like viva voce, essay questions and clinical examinations which are often unreliable and subjective. Unfortunately (for the students), more reliable and objective methods of evaluation (eg. Multiple Choice Questions and Objective Structured Clinical Evaluations to evaluate knowledge and clinical skills respectively) are used only by a minority of departments.

A natural response to such criticism aimed at the traditional system of medical education is the question "how did such a 'bad' system produce so many good doctors?". This argument is flawed because it is often based on a selected sample of good performers (with no control group), who may have excelled irrespective of the method of education. The existing system of medical education is therefore an uncontrolled experiment being conducted on unsuspecting students! On the contrary, the newer developments in education are based on scientific research in adult learning, psychology of memory and cognitive sciences and appear to be superior to the traditional system at least in student motivation, encouraging self study and problem formulation[3 5].

In my opinion it is the duty of medical teachers to be receptive to developments in medical education. Universities in Sri Lanka should encourage teacher training and constant review of teaching methods and curricula. Our methods of scientific inquiry should include research on improving learning or teaching methods. An appropriate starting point in such an endeavour to improve standards of medical education in Sri Lanka may be to ask ourselves the question "Why do we teach the way we teach?".

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