

EDITORIAL : VAN DIE REDAKSIE

MEDICAL EDUCATION

'The proper study of mankind is man' POPE, *Essay on Man*

Sickness and bereavement are the most penetratingly personal afflictions of man. They often go hand in hand. To help him in his distress, suffering Man calls on his family doctor. George Bernard Shaw in a pungent verbal cartoon said of Faith, that '... the public has transferred it from God to the General Medical Council'. Like all cartoonists, in whatever medium, he points his moral by exaggeration, but makes it clear that a doctor's purpose in life is to provide all the human aid available to restore a sick person to health.

In accepting this task the doctor must bear the full responsibility for the exercise of that degree of skill in diagnosis and treatment which is proper to a general practitioner. When this requires him to call for specialist and expert aid, he will do so, and probably the more obscure the illness, the more complicated the ancillary investigations and the more numerous the specialist consultants, the more does the patient trust his family doctor's skill, commonsense, and friendship. 'Doctors' do not treat 'illness'. A doctor treats a sick person in his or her indivisible physical, mental and spiritual individuality, and in a particular environment.

The education of a student to this position is, and must remain, the primary purpose of every phase of medical education at all times from the first professional to the highest postgraduate examination in general medicine, and even to the latest refresher course.

The emphasis laid at different times on different subjects in the curriculum will vary, because the entity of man-in-his-environment changes, and even the very effects of disease-producing agents upon man change from generation to generation. What remains more constant is that physical, mental and spiritual unit which constitutes the person. There is a great tendency today to forget this entity—not only its rights and privileges, but also its limitations and obligations—and to think about it in general terms, attempting to force it to fit preconceived patterns of environment. Because Osler equated pathology with practice, there is no need to assume that practice is merely—or even mostly—applied chemical pathology, bacteriology, detailed anatomy, physiology, or even pathology. That draws the staple of his analogy finer than the thread of commonsense. He must have been far too great a clinician for that. Man is not a strange-shaped bag of bones sustaining a variety of glands in a solution of electrolytes, any more than, in any sense, he lives by bread alone.

Most teachers agree that the curriculum may not be lengthened. Many favour attempts to shorten it. All agree that the doctor's approach to his patient is largely conditioned by it. Therefore all fear lest it fail to form in him the habit of independent thought, reasoning from a care-

ful history and a careful clinical examination to a differential diagnosis. No doubt we should all be aware that this failure may result from the habit of scurrying for succour to the biochemists, radiologists, and histologists, shooting off a blunderbuss of specimens and requests *en route*, hoping to strike the bull of the diagnostic target. The ideal is probably to educate the student to a knowledge of the scope of the help offered by such specialists in the 'basic' sciences, and their clinical counterparts, of how to choose and use their services, and of how to coordinate their findings and assistance in an eclectic manner at the bedside guided by his clinical uncertainty. Medicine at the bedside does not demand a weighty knowledge supported by deep but narrow pylons of learning. A wider and shallower foundation may well support a more effective structure. Undue preoccupation with what Pickering called the 'fascination of the machine, the fragmentation of knowledge, and the tyranny of jargon', may cost a student the development of his clinical soul.

To solve the problem of improving the curriculum will need critical self-appraisal by all teachers, clinical and non-clinical. There will have to be pruning of non-essentials, and a willingness to refrain from requiring an unnecessarily high standard of knowledge about rarer and less widely useful aspects of their subjects.

When the student enters his clinical training for the first time he should receive several exemplary lessons in the art of history-taking and clinical examination. It might be best for him to see and hear the most senior staff members being consulted by a patient from the first word to the construction of a differential diagnosis. First impressions usually go deepest and last longest.

Group practice and group research are increasingly common today, and they may point the way to the next step. In this stage a student group would see a selected patient presented by a postgraduate doctor to a physician and a surgeon, for example, for demonstration of physical examination, discussion of a differential diagnosis, and the steps to be taken to establish a diagnosis in view of the experienced assessment of the probabilities by these consultants. Later on the same group—patient, students and doctors—would meet members of the departments of medical chemistry, radiology, pathology, and even physiology, to evaluate their various findings and opinions into terms of diagnosis and treatment. Later the whole group should meet again. Reports of procedures could be received, and progress could be discussed, together with the criteria, both clinical and laboratory, by which it is being assessed.

The organization of such symposia might require the full-time services of an organizer of much ability and not a little tact. He might act as chairman of the meetings.

The time required might be obtained by sharing between two or more departments one or two of those weekly clinics which are often filled by rather repetitive teaching, and which are given by every member of each department. The 'basic' scientists who have worked so hard in the lecture-room and the laboratory in the pre-clinical years might welcome the chance of influencing the development of their ex-students in their clinical years. Moreover, many clinicians' estimation of the value of the work done by these, our colleagues, might be increased.

Such methods would provide a great opportunity for the improvement in scope, and the integration of methods of teaching throughout the curriculum. Sharing rather than

sacrificing of allotted periods of instruction would be called for, but, especially at first, this should not be difficult. There are well over 120 weeks of clinical instruction in the clinical years. It should not be too difficult to run a pilot scheme, in the first instance, dealing with about 30 subjects in the three major specialities, selected as being of major clinical importance, reasonable frequency of incidence, and recognized difficulty in diagnosis.

Whatever variations are effected in the curriculum will be most happily achieved if both the haves and the have-nots remember at all times to do-as-you-would-be-done-by. Academic wheels also turn full circle.

BESTRALINGSGEVARE

Soos lede van die mediese profesie weet, bestaan daar alreeds 'n geruime tyd lank bedenkinge in verantwoordelike kringe oor moontlike gevare vir die publiek wat kan spruit uit die diagnostiese, terapeutiese of kommersiële gebruik van röntgenstrale of ander ioniserende strale wat nog nie deur wetgewing beheer word nie. Daar is die gevoel dat baie persone elke dag blootgestel word aan bestralingsgevale sonder dat hulle ten volle daarvan bewus is, en daar is ook by sommige kenners ernstige bedenkinge oor die moontlike misbruik van bestraling.

Om hierdie hele saak op 'n bevredigende voet te plaas, is daar, soos bekend, onlangs 'n Kommissie van Onderzoek, onder voorsitterskap van prof. S. F. Oosthuizen, deur die Regering aangestel. Ter algemene inligting wil ons graag hier die opdrag van dié kommissie herhaal: Die opdrag is naamlik om ondersoek in te stel en verslag te doen oor:

1. Die gevaar vir die gesondheid van persone wat blootgestel word aan röntgen- of enige ander ioniserende strale wat nog nie deur wetgewing beheer word nie, en die gebruike en misbruike van sodanige straling;

2. die hoeveelheid straling waaraan individue in verskillende hoedanighede blootgestel word;

3. die verwante gesondheids- en ander gevare waaraan pasiënte, personeel, en die algemene publiek blootgestel word;

4. die onderskeie toelaatbare stralingsdosisse; en
5. enige aanverwante aangeleentheid wat deur die Kommissie nodig geag mag word.

Die opdrag is verder ook om aanbeveling te maak:

1. Of die gebruik van alle tipes röntgenstrale aan statutêre beheer onderworpe gemaak moet word, met inagneming van bestaande wetgewing in verband met die beheer van radioaktiewe isotope;

2. oor wetgewing in dié verband, wat deur die Kommissie noodsaaklik geag mag word;

3. oor die moontlike opleiding van persone in die gebruik van en beskerming teen röntgenstrale; en

4. oor navorsing wat op hierdie gebied nodig geag mag word.

Ons het onlangs in ons Briewerubriek 'n versoek van die Voorsitter van hierdie Kommissie geplaas waarin hy meedeel dat die Kommissie op sy jongste vergadering besluit het dat 'n skrywe aan die Mediese Vereniging van Suid-Afrika gerig word met die doel om die geneeskundige beroep te herinner aan die werksaamhede van die Kommissie wat uit die aard van die saak die belange van die geneeskundige beroep baie nou raak, en dat die verskillende belanghebbende groepe van die Vereniging vriendelik uitgenooi word om so gou doenlik enige sienswyse wat hulle in dié verband mag inhou, aan die Kommissie voor te lê.

Langs hierdie weg wil ons ook graag 'n beroep doen op alle belanghebbende persone en instansies, binne en buite die profesie, om alle moontlike hulp aan die Kommissie te bied, sodat die lede van die Kommissie in staat kan wees om hierdie belangrike taak op 'n verantwoordelike manier te voltooi.