

A (CONSTRUCTIVE) CRITICISM OF MEDICAL CURRICULA

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As I was informed by a very wise man, “there are two sorts of critics, the Destroyer and the Builder”. The “Destroyer” does just that, tears things down, leaves nothing, whereas the “Builder” replaces or rebuilds, constructively. I abhor the former “Negative Nellies” and intend this critique to be, not only constructive, but also achievable.

The King of Hearts advised Alice (or was it the White Rabbit?) to “Start at the beginning”, but I have corrupted this to “begin at the end” viz: what do you want from your medical course and how well will you be equipped or trained when you graduate.

I am not sure if my era’s “Toti-Potential Cell” is today’s “Stem Cell”, but I feel today’s analogous graduate would want what we all wanted back then – to be trained in all spheres to be competent and confident for the “most common things that occur most commonly”. Unfortunately, this is also the most commonly ignored axiom. And in this first few years, whether you recoil from the great unwashed and later flee to research, pathology or radiology and never have to see a live patient again, you will have to see them now, and the medical curricula should provide adequate training.

I am sure the various medical schools attempt to do so, but the politics and funding gets in the way. The politics sees each professor or department fighting for kudos, while the funding limits employing the best teachers.

When I did Anatomy, it was taught by a professor who was so incompetent he was never registered as a medical practitioner, despite graduating. He expanded his empire to 18 months and was the cause of the greatest number of failures in our six-year course. I remember in one practical exam, there was a horizontally transected heart across the atria with a dirty, faded piece of red cotton going up one of the arteries on the Aortic Arch. The specimen was swathed in formalin-drenched rags making breathing difficult (let alone dangerous) and viewing almost impossible.

I straightened up and laughed such that the demonstrator, a good bloke with his FRACS asked “What’s up?” to which I replied, “This is bloody ridiculous. Only we and Michael De Bakey will ever see this”. De Bakey was then the world’s leading heart surgeon in Texas (and I doubt if even he ever saw this in any event).

Yet, this “Prefesser” as I now call them, the incompetent ones that is, never knew or showed us where to inject the gluteus maximus, so as to avoid the sciatic nerve. He simply didn’t know. (The sad result of this was that I did see a permanent foot drop caused by such a mistake).

And this brings me to my first constructive suggestion: as much as possible, all subjects should be taught by clinicians – even anatomy.

My father used to say that anatomy, physiology and histo-pathology “were the fundamental tripod on which medicine was based” and, while I agree, these should be taught by clinicians to avoid spending incredible hours smoking drums and dissecting frogs to record a muscle’s “refractory period” and such. I am sure this is not done today, but I am equally sure it has been replaced by an equally not very useful substitute.

In my practice, I frequently examine exercise physiologists and it is stimulating to discuss their tests, which, without having done a great deal of post-degree cardiology, I could not. Surely a medical graduate should know as much as they?

The “circus movement” hypothesis of the electrical conduction of the heart has now been replaced by “egg-beater” recordings from multiple sensors inserted into the atria. Atrial fibrillation is now an epidemic in those over 60 years of age, yet when I talk with medical students or most GPs, this is not known. But it is the most common preventable cause of strokes.

I do not know how pharmacology is taught now, but I do know that drug companies hide any detrimental trials in their amoral pursuit of profits. I still have a pack of Vioxx, which caused some 140,000 deaths before Merck was forced to remove it. We were taught that, as doctors, we knew more than the drug reps, but series after series of studies show how doctors are ‘influenced’ by drug reps to prescribe their new wonder drug, such as Vioxx.

Surely, there should be some pharmacology lectures to alert you to the chicanery of some drug companies, and where best to access the best information.

Recently I examined the new Head of Emergency at one of our teaching hospitals and I asked her who had “taught her suturing” and, like me, she had to confess she “had learned it on the job”.

I was appointed to a Sydney teaching hospital, which then had probably the busiest of casualty departments (now, of course as we Americanise, called “Emergency”) staffed by M.Ds, and while the alcoholics healed up beautifully, I was concerned about doing the best job possible on the faces of pretty young women who had gone through their windscreens. And so, I approached the plastic surgeons, who were wraith-like creatures we never saw, and asked them for a tute. Back came the answer “Why?” and it never happened.

There are obviously different motives and drives for each of us to do medicine and for me, money was not one of them. That is not to say that as a great neurologist observed “a doctor’s income should be commensurate with his/her qualifications and responsibilities”. Judges are meant to be paid enough such that they are not tempted by bribes and what this eminent physician meant was, not that we should expect the latest German luxury vehicle, exotic holidays and a great wine cellar, but that like the judges, we should be paid adequately, which, I would define as an income that does provide for private school fees and a good, not exorbitant, lifestyle.

Unfortunately, times have changed and what I didn’t realise, when I was shocked at the plastic surgeons’ rebuttal, was that I was witnessing the formal start of medicine as a high-income career.

And this is a problem. These high-income doctors simply don’t, given their lifestyles, have the time to teach undergraduates for free. I am not “holier-than-thou”, here as I was asked to lecture and did so for a year at considerable inconvenience and financial loss – especially when the “Medical School”, all of whom were on salaries paid for out of my taxes, then pointed out how impoverished they were and what a noble gesture it would be if I donated

my promised remittance to them, which I did, but I never went back. I simply couldn't afford to.

Now my income was pathetic compared to a high-rolling "Plastic" and that is why they don't teach. I dare not tell you what a plastic surgeon earns in a morning, but they all have the latest German luxury cars, or two or three, at least those I know.

Surely, there are enough skilled "Stitchers" to show every medical student how to best suture. I was so disgusted at the general standard I even wrote a book on surgery to pass on a few hints, but this does not replace actual practice. Now, GPs pay to be taught how to suture by the various skin cancer institutions. What then are the undergraduate courses taking your money for if you can't even do subcuticular suturing or an A to T Flap?

The skin is the body's largest organ. Not a day goes past without a patient asking, "What is this?" whilst pointing to a rash or skin lesion. Yet, throughout the world, dermatology is not taught well. Again, I think this is the "Plastics Syndrome" – they can't afford the time, but I also think they do like to keep skin as their own province.

When I was asked to lecture, the dean was a great bloke, but I don't think he had ever seen a live patient and he gave me a sheaf of lecture notes to deliver on "lead poisoning". I actually knew a great deal about this having been taught by the acknowledged world expert (Brian Emmerson), and examined on it by the Royal College of Physicians of London, but for undergraduates, this was ridiculous. So, even before the movie, I taught the students how to make paper-planes from these turgid notes and we launched them from the upper story of the Medical School. I then taught them 'How to dress,' (one student was in a boiler suit and no shoes) and 'How to write a prescription'. They did not even know that Rx was the Latin abbreviation for a 'recipe'. The "Dressing" was not an affectation; studies, let alone common sense, have shown that patients feel more confident if the "doctor looks like a doctor" (and I offered to buy the barefoot boy a pair of shoes). Anyway, we progressed along these practical lines and I was rewarded by them telling my wife "they were the best series of lectures they had ever had." This, I hasten to add is not chest-beating, but a tragic condemnation of the dross they had previously been served up. There was nothing new or world shattering in my lectures, just worldly-wise every day practical experience.

And so we pass to my hobby horse(s)- Preventive Medicine and Nutrition.

I had been appointed to the world's first Coronary Care Unit, and as cardiovascular disease is our greatest killer, I figured I should learn something about it. Framingham had just started and since 1968 I have done my lipids almost yearly and watched as my very bright, or brighter than me, colleagues died, disabled or demented such that, at our 50th reunion I was the only one of this group left standing (the psychiatrist, of course, had committed suicide, but of the others, the Captain of Rugby no less had died from heart disease, the two GPs and the "Orthopod" were either in a foetal position incontinent of urine and faeces to just being vague as the amyloid and tau bodies obliterated their axons).

In 1974, when I was in Edinburgh, one of the doyens of British cardiology (Michael Oliver) told me, he thought there were few, if any, tests that were any good for prevention. He was then right, but I thought and think otherwise. I realised it was early days, and by accumulating my lipid, MBA (Multiple Biochemistry Panel) and haematology profile, the

next decades may shine some light as to whether any were actually of help. And it seems they were.

Most illnesses can be prevented yet there seems to be little or no undergraduate training on this. Let me run this past you again in another way: the greatest good we can practically do as medical practitioners is not being taught by the dotards of academe.

In a pang of conscience, I wrote to the Dean of my alma mater a few years ago, to point this out and he replied how a “Government Department,” that neither I, nor any of my colleagues, have ever heard about, “was doing a great job”.

Pigs arse.

We are in the midst of the epidemic of the “Diseases of Affluence”: obesity, hyperlipidaemia, cardiovascular disease, type 2 diabetes and their sequelae of osteoarthritis, depression, cancer et al. with probably 40 to 90% being preventable! And at no or very little cost!

I watch with horror as these lumbering, prematurely aged patients on about ten drugs try to get up on my examination couch, let alone roll over.

“It’s no fun getting old, Doctor” they admonish me, “wait till you’re my age” and so I look and see they are ten years younger than I.

At medical conferences, I also watch with horror as my colleagues descend like locusts on the wedges and blobs of saturated fats and sugars presented as the most delicious and obviously irresistible morning- and afternoon-tea snacks, only to be supplemented at lunch and dinner by deep fried excess-on-excess. Even at a cardiology meeting the pudding was almost pure sugar! The only good nutrition I’ve had at a conference was at a business one.

Why? What is going on?

When I did medicine, and I can’t see that it’s changed, medical students were the acknowledged intellectual elite of the University, and yet we have surrendered nutrition to the dieticians. This is not only absurd, but bad medicine. No wonder we have an epidemic of these “Diseases of Affluence.” As medical practitioners we have abrogated our responsibility to inform our patients how and what to eat, because our universities have abrogated their responsibility to teach this essential *medical* subject.

The other outstanding omission, as I see, from medical curricula, are those illnesses or medical events unique to the location of each particular medical school. Here in Queensland we have the highest incidence and prevalence in the world of melanoma, skin cancer and brown snake bites...yet these are not taught.

Elsewhere, I would think chill-blains and ski-injuries and such should similarly be included if the medical school is located in such an area.

Almost finally, I had great teachers. You must fight, as I did, to seek them out. You should also try for an appointment at the best teaching hospitals. When I “had” to write my books, it was the result of visiting a number of general practices, where it dawned on me that not only were they chronically underfunded, but also that the GPs had also not been exposed to the best teaching units and standards.

And finally, after your exposure to living patients, you then have to choose a career. Most, I assume, will be driven by their interests (and there was an hilarious algorithm in the BMJ to this effect), but it would be remiss of me not to alert you as to choices.

World-wide general practice is being unmercifully screwed, as it is the only way governments can contain costs, so as the bureaucracy clones expands exponentially, along with its red tape, GP remuneration and prestige falls.

The next problem is litigation. It is open season on doctors and any clinician is vulnerable to any zany making a complaint. Even for the stupidest and most unreasonable complaint the clinician has to “fully explain” such that, a patient from interstate who walked in and demanded an operation then complained when my colleague couldn’t do it there and then, caused my colleague to suffer a heart attack from the stress and retire prematurely.

The great problem is that medicine has spawned an increasing retinue of camp-followers who “seek power without responsibility (the prerogative of the harlot for centuries)”. The lawyers, the insurance companies, the ombudsmen, the post-graduate training schemes, the colleges, “Uncle Tom Cobly and all”, all of whom keep shovelling it back to the doctor, while they dream up yet more paper-work and accept no responsibility. It all seems so “reasonable”, but rather than freeing up the doctor to spend more time with the patient, they impose more and more training demands, auditing and now we are even told we must “reflect” on how we may improve.

I can only wonder at these bureaucrat doctors who justify their existence with such imposts. They are akin to “Kentucky Colonels”, who could buy their commission, but “never went to war”.

Maybe it is they who should “reflect”.

And finally, I pass on two aphorisms from my father and another from one of my teachers:

1. Be very proud of medicine, there are only two real emergencies in the world – war and medicine.
2. Gentility is the best anaesthetic.
3. The sun should never set on pus.