

# MEDICAL EDUCATION IN MALTA – PRESENT TRENDS AND FUTURE GOALS

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## INTRODUCTION

Formal medical education in Malta began in December 1676 with the establishment of a School of Anatomy and Surgery by Grand Master Nicholas Cottoner. Its first director was Dr. Joseph Zammit, who besides being the chief physician of five successive Grandmasters was also a priest and a member of the Order of St. John. It was not until 1771 that a Faculty of Medicine was established in the University incorporating the School of Anatomy and Surgery, thereby enabling Maltese students to study both surgery and medicine locally. Previously, students aspiring to become physicians had to obtain their training and qualifications overseas.

Over the past three hundred years our medical school has generally managed to maintain the high standards and to fulfil the ideals for which it was founded. Maltese society has benefited in no mean way from its medical school. In the XVth report of the Royal University of Malta Commission under the chairmanship of Professor R. Dahrendorf, our medical school came in for some very favourable comments. The Faculty of Medicine was described as 'the most progressive and closely concerned with the life of the community'. Whilst this is most reassuring to the medical faculty in particular, and to Maltese society in general, there should not be any room for complacency.

I would like to emphasize that the views expressed in this article are entirely my personal ones. I hold no brief to speak for my department, my faculty or the university bodies of which I form part. It is not my intention to write a comprehensive report on the subject; I would however like to raise and discuss a number of points, some of which may well prove to be controversial, in the hope of provoking further thought and perhaps some possible future action.

## TEACHING

Medical education is often accused of being generally somewhat traditional in its approach to both methods of teaching and to curriculum content. Here in Malta, the Faculty of Medicine has proved

to be conscious of the need for change in the curriculum so that new branches of knowledge may find their place in it and so that students may be better equipped to meet the contemporary and future needs of society. It is widely recognised that a curriculum which is overburdened with purely factual data, sometimes presented in an unrelated form, that must be committed to memory, is a poor preparation for the acquisition and development of scientific habits of thought. The archaic process of learning, remembering and reproducing of largely undigested, unabsorbed and disjointed facts from books or notes should be shelved once and for all. The major purpose of a basic medical course may be said to be to provide practice in the critical evaluation of evidence with which students are presented. It is of vital importance that students should be encouraged in all possible ways to develop the ability to think for themselves. Only in this way may one hope that they will become safe and competent doctors. Unfortunately the indiscriminate regurgitation of data, often straight from the lecturer's notes, is still a common phenomenon in examinations. Perhaps the blame for this should not be placed entirely at the student's door.

I think that a closer look at present methods of teaching is warranted. There are two extreme patterns of education in medicine, the so-called 'block' and 'integrated' systems. The former is the traditional system in which various subjects are taught either sequentially or in parallel. In the integrated system subjects are taught in an integrated fashion and individual topics are dealt with coherently by teachers from more than one department. Full integration would imply that teachers from every department will in principle be concerned with teaching at all levels and entitled to participate in it. Three major advantages of this system immediately spring to mind. There is an avoidance of unnecessary repetition in teaching which is not only educationally harmful but may add considerably to expense. The student is also discouraged from compartmentalising his knowledge and is encouraged to bring one discipline to bear on problems arising from another. In the integrated teaching system it is also easier to alter courses in the light of experience, since teaching time would be allocated to topics rather than to departments represented by academic administrative units. Departments have been largely autonomous and have been regarded as 'owning' both space and time on the curriculum. This has often prevented or delayed the discarding from the curriculum of material that is no longer strictly necessary for the

basic training of doctors. Departments must be prepared to give up consciously some of this autonomy. At all levels students must be encouraged to integrate their knowledge. One must admit that there will always be limits to the degree of integration that is practicable. In such a system each teacher must be fully and continuously aware of the instruction given to each student and this will require a high staff-student ratio. More co-ordination of teaching, although falling short of full integration is perhaps the most feasible for local conditions. Such a recommendation for a co-ordinated planning of all stages of medical education has again been made this year in the Report of the Committee of Inquiry into the Medical Profession (Merrison Report) referring to medical education in the United Kingdom. A wellcome first step in this direction has been taken this year by a number of clinical departments but more remains to be done.

As new topics and areas of studies are introduced into the undergraduate curriculum one must be prepared to prune continuously the traditional material if the student's burden is not to become impossible. Communication between teacher and student remains the very essence of the educational process in medical education as in every other field. Students are now more than ever intimately concerned with the organisation of their own medical schools. Obviously a system such as that prevailing at Uppsala where feed-back between students and teachers is actively encouraged could prove to be of immense value. Whatever the pattern of teaching that is finally adopted – fully integrated, co-ordinated or block – it is important that aspects of clinical medicine be introduced in the early stages of a medical student's course. Carefully organised clinical demonstrations can admirably illustrate and supplement aspects of the pre-clinical sciences. This has been the policy followed by the Department of Physiology and Biochemistry for the past ten years. The bridge between the pre-clinical sciences and clinical subjects must be further strengthened and broadened allowing for a two-way flow of participation, to enable it to take a heavier load, especially now that the faculty is committed to annual entry. We will thus make sure that we will not be running the risk already present in some countries of producing medical biologists instead of clinical doctors.

#### GENERAL PRACTICE APPRENTICESHIPS

In 1967, following the recommendations of the General Medical

Council, training in general practice was accepted as an integral part of the curriculum for all medical students in the United Kingdom. Although initially the recommendations do not appear to have been immediately and satisfactorily implemented in all medical schools (Pearson *et al.*, 1968), student attachments in general practice now form regular part of the general training of British medical students (Bryne, 1973). Most of these attachments are held sometime in the final two years. The Carnegie Commission, in 1970, also recommended that medical education and health care should be more closely linked and interrelated.

By far the largest proportion of doctors in any country are general practitioners. It would therefore seem a sound idea to train our students with general practice in mind. Up to the present, emphasis in teaching is still largely on hospital medicine. Both the university and government health authorities lately appear to have become increasingly aware of the need for change. For the first time, last October, the Faculty of Medicine co-opted a general practitioner to form part of the faculty board. This is certainly a step in the right direction. But perhaps even more important, following the recommendations of the Dahrendorf Commission, is the imminent establishment of a Department of Community Medicine. Such a department should serve to establish and forge links between the various hospital clinical departments and medical practitioners involved in community health care, besides carrying out epidemiological research.

One hopes that the establishment and organisation of general practice attachments for our medical students will be high on the priority list of the new Department of Community Medicine. Students will then be able to observe a spectrum of medicine which is different from that normally seen in hospitals. They will not only be given the opportunity to study diseases which rarely reach hospital but will also be able to see the early stages and first symptoms of those that do. Furthermore, students will be able to follow patients when they leave hospital and return to the community. Ideally these attachments should allow students to follow a planned though flexible teaching programme with emphasis on the personal, emotional and psychological aspects of family medicine over a period of four to six weeks. General practitioners involved in such a scheme should be carefully selected to ensure that they will be able to devote at least two full sessions each week to teaching. During such a general practice attachment the student

should be able to acquire first hand knowledge of all aspects of community care and be able to observe, from close range, general practice as a possible vocational opportunity for himself. It has been established that in Britain medical students look upon exposure to general practice as a useful contribution to their medical education. (Dean, 1971).

#### CONTINUING EDUCATION

Little more than a decade ago continuing education was a new term just coming into use in the more developed countries. It can now be claimed that the term has become common parlance. As early as 1900, William Osler, an outstanding clinician and teacher whose contributions to medicine have earned him a place amongst the truly great physicians of all time, understood and felt the need for continued learning. Writing in the *Lancet*, he stated, 'If the licence to practise meant the completion of his education how sad it would be for the practitioner, how distressing to his patients'. Continuing education in medicine involves the provision of learning facilities through which a medical practitioner may keep abreast of the advances in knowledge, development of skills and the ever changing attitudes which are intimately related to his field of practice. It has been defined as an education in which learning often occurs of necessity borne of the problems of medical practice (De Crow, 1969).

It was only in 1959 following the Second World Conference on Medical Education that widespread recognition was afforded to the importance of continuing medical education (Clegg, 1961). Since then many countries have shown a great deal of interest (Nakamoto and Verner, 1972) and it has been generally recognised that perhaps even more than in any other field, there can be no terminal point in learning in medicine. The mushrooming volume of knowledge in medical care poses an ever increasing challenge to medical education. I believe that continuing medical education is evolving to be the principal means of meeting this challenge.

The need for continuing medical education in Malta has been acutely felt and increasingly recognized over the past few years. The local branch of the British Medical Association has been organising yearly refresher courses for general practitioners in an attempt to satisfy some of this need. The number of postgraduate lectures delivered every year both by local and foreign lecturers at our Medical School also helps in keeping doctors aware of the ad-

vances and developments that are continuously taking place. However, I feel, that something more ought to be done to put continuing medical education in Malta on a more permanent and better organised footing. It can perhaps be readily appreciated that there can be no better start made than at an undergraduate level by inculcating the student not only with a continuing desire to learn but also, and this is perhaps even more important, with an ability to do so. Encouraging the student, from early on in his medical education, to look things up for himself and to involve him in small research topics will in the end, prove to be a most rewarding exercise.

The responsibility of providing continuing educational activities ultimately lies with the University, the medical profession and the government, through the Department of Health. Continuing medical education must be a partnership in which general practitioners, medical societies, hospitals, medical school and government participate (Sodeman, 1969). It is important in drawing up plans for continuing medical education to ensure that any courses provided are readily accessible. A great deal of thought has to be given and co-operation sought between the various bodies concerned to make sure that courses take place during such a time when busy doctors will be able to attend. It is perhaps in this respect that the Department of Health can make a most valid contribution by releasing doctors in its employment for short courses as well as arranging locums for general practitioners wishing to avail themselves of any courses organised by the Medical School together with the medical societies. I think that the Medical School should actively pursue a policy of organising continuing medical education which present undergraduate students and qualified practitioners will be able to follow. Continuing medical education should be an integral component of our health care system.

#### CONCLUSION

The clear identification of the skills which students should and must acquire in order to be able to meet the ever-growing demands of medical care will continue to constitute an important challenge to our medical curriculum designers. In various countries medical schools are increasingly carrying out a number of studies of all aspects of medical education, including criteria for admission, educational methods, student attitudes and aptitudes, as well as examinations and other forms of assessment. It is now generally

recognised that considerable expertise in educational methodology is required for the critical evaluation and planning of a medical curriculum as well as for its final implementation. A problem in medical education presently facing a number of medical schools abroad is the low level of staff-student communication. Whilst it can be stated that in Malta the problem is not so acute, the size of our medical school is such as to allow the almost complete elimination of such a problem, resulting in a better exploitation of the capabilities of both groups. Ideally medical educational programmes should be planned to respond sensitively to feed-back from a number of sources including the students, their teachers, as well as the health authorities.

Ministries of health all over the world, are now expecting medical schools to devote increasing attention to continuing postgraduate training, to social research and to provide expert advice to government, besides fulfilling their more traditional functions of teaching and research (WHO report, 1975). This necessarily calls for a much closer co-operation between the health authorities on one hand and the medical school administration on the other. Such co-operation has to a certain extent been always present in Malta. The mechanism for maintaining the necessary relations between the local medical education system and health services will perhaps be further strengthened and developed once the new Department of Community Medicine has been firmly established.

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