# EDITORIAL: "IT BEARS REPEATING..."

There can be no argument with the fact that one of the most outstanding characteristics of medicine in 1967 is rapidity of change. The facts of change are the offspring of an impressive post-war expansion in medical research and have become the daily challenge of both medical practitioners and educators. Education, in particular, appears at present to be floundering under the deluge of this "new knowledge". Panic, dismay, and finally experimentation have gripped medical educators, with the cry that today's students must be educated to be tomorrow's doctors. The concept of continuing change in medicine and its basic sciences is essential in planning a medical curriculum with foresight and originality.

However, all too frequently it is forgotten that what is *not* changing is the setting in which medicine is practiced: - the patient, the responsibility of the physician to the patient, and the patient-physician rapport. Amidst all the new hypotheses and theories, this, the cardinal duty of the physician, is overlooked, and training is dedicated to producing scientists, not humanists. Not that medicine is an art alone! Medicine is indeed a "happy blend of both science and art" and this theme no longer sparks discussion.

I do not propose to solve any of the current problems in medical education; my only purpose is to suggest that the aforementioned "cardinal duty" of the physician be kept in mind as the solutions are attempted and to suggest that at times, educators need a gentle prodding in this regard. The patient - that is to say, human nature - is not changing, despite the ebb and flow of medical science about him. To be sure, today's patient reads *Time* and *Reader's Digest* and has a much broader medical vocabulary than the patient of 30 years ago, but as an individual, is he really that much different, despite his sophistication? The successful practitioner, general or specialist, must be enough of a scientist to attain a basic understanding of the particular disease mechanism which the patient displays and to decide on an adequate program of management. Yet he must be enough of a humanist to respect this patient as an individual and to achieve some understanding of his manner of thinking no matter what his place in society.

It is fine to recognize that the five-year survival rate for malignant gastric ulcer is 40%, but it is more essential to realize that the course in this individual patient will be distinctly coloured by his attitudes towards his pathophysiology, and that the foundations of these attitudes will be laid down in the physician's initial attempt to explain the nature of the problem to the patient. Even in a less grim situation, the prognosis frequently depends on the ability of the doctor to create an awareness in the patient of his own responsibility in following the regimen prescribed.

All this can only be accomplished when the patient sees his doctor as an individual who is vitally interested in him as a person and in his well-being. Of course, doctors cannot be explicitly taught to be such individuals, to be humanists. Is this a valid discussion, then or merely so much nebulous philosophy? Does it bear any relation to current trends in medical education? Emphatically, yes! This is a most integral part of medical education.

Lectures, labs and seminars will produce a scientist, but the essential touch of humanism must come from elsewhere. First of all, there must be a source deep within the student himself. Unless there is a small measure of "love of fellow man" in the individual who has chosen for himself a medical career, he is destined to some degree of failure as a practitioner. Unfortunately, this quality often lies dormant, so there must be, in the second place, learning of the art by example. All too many clinicians *talk* of "cases", "the patient", so that the student *sees* a "52-year old white male in no apparent distress". This is necessary on the chart, but unquestionably poor at the bedside.

The approach to the patient must be discussed at length with the student - slanted not so much towards the importance of every question in Hutchison's suggested functional

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inquiry, but towards the importance of establishing a comfortable rapport with the patient. So called "bedside manner" will be simply a reflection of the student's own personality, but a little guidance based on experience may be invaluable in bridging an awkward gap as the student realizes his position at the bedside. Furthermore, the approach to difficult and uncooperative patients must be discussed in detail.

The demands of the scientific approach should be relaxed somewhat at the bedside. It is of utmost importance that the student see his patient as an individual first, and as a myocardial infarct second. The student should be allowed to be a sympathetic listener and to gain experience in patient-doctor relationships. The student should be encouraged to learn and to respect his patient's attitude toward his illness and toward life. And, most important, the student should rarely see humanistic shortcomings in his clinical teachers.

Perhaps this is idealistic. Perhaps this entire discussion is not justified.. However, the teaching of medicine, both as a science, and as an art, is the current responsibility of medical educators. Dalhousie is by no means shirking its responsibility, but it is most definitely time for serious introspection into the adequacy of the teaching program with respect to the second aspect of that responsibility.

D.M.

*Criticism is the principal need of our day; and for this, knowledge, experience, and calm are requisite.*

Theodor Billroth (1829 - 1894)


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