Editorial

When is Time to Change?

James Ware
Medical Education Centre, Faculty of Medicine, Kuwait University, Kuwait

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After almost thirty years of existence the Faculty of Medicine at Kuwait University has undertaken a reform of their undergraduate medical curriculum and now has a modern, case-based, problem based learning (PBL) medical program being rolled out. Without the usual external drivers of change, it usually takes far more inner resolve to achieve this successfully. In the UK, it was the General Medical Council (GMC), responsible for educational and professional standards, which forced through curricular reform according to their blueprint described in *"Tomorrow's Doctors"*[1]. In the US, similar initiatives have taken place and almost three-quarters of medical schools have adopted some form of PBL strategy.

However, this round of curricular reform has been far more challenging than those that came before. The changes have come at a time when educational institutions increasingly are being held accountable for their activities, usually through the process of accreditation. But the Faculty of Medicine, Kuwait University, is achieving change without either a powerful external driver or a process of accreditation that could be used to shape and support change. With discipline based educational ownership being passed to a central Faculty Administration there are all the ingredients for conflict. Some say this is just a painful generational change from the traditional to the modernists, who espouse openness and debate and reject isolationalism and intransigence. This openness is often forgotten by the reformers whose haste leaves little time to inform and articulate their vision for reform. All reformers shall be both informed and prepared to inform, otherwise dissent is inevitable. Students too, have often been forgotten, becoming the foot soldiers on the battlefield. This is wrong, and their contributions are also an essential ingredient for successful reform.

What's so wrong with the traditional medical curriculum that it needs fixing? First and foremost, it is overloaded with non-essential content that has accumulated like the barnacles on an un-scrubbed ship, gleaming on the topsides yet almost unseaworthy below the surface, unseen by those who choose not to look. We know how little is retained from a lecture delivery, and yet the traditional curricula has thousands of them. Medical knowledge and practice almost completely changes every ten to fifteen years, and soon will have an even shorter shelf life, and yet we have not prepared our new doctors to cope with this change. Deficiencies have been seen, debated and discussed endlessly, often progressing no further. Curricular reform is a time to address all these issues.

First, Howard Barrows started a new medical program in the late sixties with his vision for developing the skills of clinical reasoning through a process called PBL[2]. Then, came Ron Harden, a true modernist, who showed the starting point of reform with his SPICES model[3] in the early eighties. What was common to both these pioneers was the centrality of the student learning process. Considerable attention was being paid to two facets of the process, what the product should actually be and how adult learners would get there. All this change has created other problems that still wait to be fully addressed. For example, secondary school education was unprepared to meet these new challenges and often just continued to turn out students for traditional teacher centred tertiary education. Kuwait may be temporarily stuck in this groove. But the voices of the consumers are powerful ones and must be listened to.

Kuwait University's Faculty of Medicine is now introducing modern educational philosophies and strategies and should be supported: their new curriculum is fully integrated, employs case-based PBL, has a skills-program and early clinical exposure, has introduced modern and validated assessment techniques and uses a stringent quality control

Address correspondence to:
Professor James Ware, Director of Medical Education, Faculty of Medicine, Health Sciences Centre, Kuwait University, PO Box 24923, Safat 13110, Kuwait. Tel: 4986407, Fax: +965 5318454, (M): 7854153, E-mail: jamesw@hsc.edu.kw

process, right from the lecture hall to the examining process. But there is more, tomorrow's doctors shall be able technologists and computer literate. As part of the Faculty vision, the curriculum will soon be fully supported by an Electronic Learning Project: this is an electronic curriculum that allows students to plan their learning according to their study style and pace. The web-based delivery platform incorporates a framework of learning objectives and theme outcomes comprehensively linked to all the study resources provided both by the teaching staff as well as selected sites on the internet. Theoretically, a medical student from Kuwait can continue their studies with full support and access to all the usual learning materials while visiting family in the US.

So why are there any detractors? There are probably two major concerns: the first is that graduates from these modern programs are not as well equipped academically as their predecessors and the second is that many universities have not kept pace with the structural changes that a modern curriculum has on the activities of many Faculty staff. Many universities just continue the same outdated mantra about teaching hours for tenure, without first seeking to find out whether this form of appraisal is still valid. The answer to the first concern is that there is no evidence that exam results are prejudiced and many examples abound[4-7]. Interestingly, those who are the detractors were trained in traditional curricula and judge graduate results from new curricula the same way they were themselves judged, the whole thing becoming an outdated self-fulfilling prophecy. The very reason for the reform of medical training was to produce a different sort of doctor, not clones of an earlier time. Universities with any pretention to modernity should be informed about changing teaching methods and the developments taking place in their institutions. While at the same time it has been found that the single greatest mistake made by most champions of change is that insufficient time and attention has been paid to communicating their vision and plans to the stakeholders.

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