

Can Medical Education in Libya Learn from the British Experience?

Salamat A¹ and Byrne A²

¹ Department of Haematology, ABM Trust University Hospitals, Swansea

² Department of Anaesthesia, Swansea Medical school Swansea UK

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Despite recent reforms and developments in Medical Education worldwide, a recent commentator described a significant decline in the quality of Libyan Medical Education, due to the lack of curricular reform and leadership [1], which is evidenced by a failure rate of over 50% in some exams [2]. Although this may simply be a reflection of the assessment process used, such failure rates must entail a huge waste of valuable resources for both students and schools. Our aim in this paper is to highlight some of the reforms that have taken place within Medical Education in the United Kingdom and question whether such reforms could be effective in Libya.

In the UK Medical Education has, in the past, consisted of two years of basic science lectures in a university, followed by three years ward based training in large hospitals. While the Quality Assurance Agency for Higher Education in the UK has ensured that universities attain basic educational standards by a system of regular audit and reporting, studies have shown graduates to lack the practical skills necessary to become effective doctors [3]. Perhaps more importantly, medical schools have also been accused of failing to prevent those unsuitable for medical practice gaining entry to the medical profession [4].

The General Medical Council (GMC) has sought to address these problems in its statutory role of ensuring the quality of Medical Education through regular inspections and the publication of guidance: 'Tomorrow's Doctors' [5]. The first edition in 2003 was a breakthrough in that it specifically instructed Medical Schools to reduce their teaching and assessment of factual information and to increase their teaching of more generic clinical skills such as communication. It also

encouraged methods of self-directed learning. However, it is important to note that the GMC has never determined how medical schools should achieve these aims but has chosen to inspect schools and to provide them with support and advice where required. As a result, there are some UK medical schools whose curriculum largely follows the traditional pattern and some who have adopted new active learning methods. The majority now use a variety of techniques [6-7].

Behind this variety is perhaps a much more uniform pattern of progress. Firstly, there is widespread recognition that the separation of basic science and clinical teaching and the separation of teaching into subject specialist 'blocks' actively encourages students to learn superficial facts that are soon forgotten. All schools have sought to integrate teaching both vertically (basic – clinical) and horizontally (across subjects). Many have also

adopted a spiral curriculum where students repeatedly rotate through a variety of subjects with gradually increasing levels of complexity and challenge [8-10].

Secondly, the recognition that doctors who perform badly in clinical practice often have entirely adequate levels of knowledge and clinical skill, which has led to the addition of teaching and assessment in areas such as communication skills, ethics, psychology and professionalism [11-12].

Thirdly, the rapidly changing nature of medical knowledge has led to the adoption of Problem Based Learning (PBL) in many UK schools. This has recognised that by the time students qualify, much of the information imparted to them during their training is already out of date. It aims to produce students that are able to recognise their own learning needs and keep their own knowledge up to date through self directed study [13].

Despite this, it is now increasingly recognised that PBL has failed to produce the educational benefits that it originally promised. While it has undoubtedly improved the confidence and learning skills of doctors, there is little evidence that this translates into more effective practice [14-15]. However disappointing this may be, it has clearly demonstrated that much 'accepted wisdom' in Medical Education is wrong. For example, lectures are not an effective teaching method; students do not need to know the basic sciences before learning clinical methods; doctors are not necessarily good teachers; blocks of clinical attachments are often ineffective [16].

Although consensus within education is always difficult, there is perhaps recognition now that the educational methods employed are not the main determinant of success. The key features of effective education are a clear vision of the qualities of the Doctor [17-18] followed by effective 'alignment' of learning outcomes, teaching and assessments [19].

Problems arise when these elements are 'misaligned'. For example, if students are given Learning Outcomes as accumulation of facts and taught in lectures, it should be no surprise that they are unable to interact effectively with patients. If we concentrate on communication skills and patient centred care, we can expect students to lack essential scientific facts.

Above all, the whole process must have a clear vision shared by all those leading the teaching process. This is no easy matter as while any one doctor will have a clear idea of what makes a good doctor, there is generally no overall consensus. Cancer specialists emphasise the genetics of oncogenes and mutation, surgeons; a

knowledge of anatomy, psychiatrists; communication skills and anaesthetists; resuscitation skills. Students cannot achieve the highest levels in all these areas and if individual departments are left to set standards, students are left confused and often fail to achieve any useful outcomes.

The solution to the problems within the Libyan Medical Educational system is therefore unlikely to be provided by changing teaching methods. The responses of students and teachers to educational change are difficult to predict. Students will tend to revert to the learning methods to which they have been accustomed to and teachers will tend to revert to the teaching methods used in their own training. Any attempts to change these methods are met by suspicion and hostility and change can only be led by enthusiastic brave individuals. Further, those aware of these issues must work together with colleagues across departments and schools to provide leadership that rises above the traditional inter department/speciality divisions.

The recent LJM editorial [1] proposed an ambitious action plan to modernise the Libyan Medical Educational system to provide a clear signal for change although its proposals will require considerable personal and political determination to put into practice. While this paper argues against the idea that there is a single solution to the problems of Medical Education, there is much to learn from each other. While we are unlikely to find a simple solution to our problems in any other school, we can learn valuable lessons about what works and what doesn't.

In conclusion, effective education is about the alignment of desired outcome, teaching and assessment. The often heard debates about how much time should be spent on subject x versus subject y, lectures versus PBL, or essays versus multiple choice questions are distractions. We need to think clearly about what sort of doctors we want to produce. We need to consider the often complex processes of teaching and assessment and be aware of how they shape our students.

The danger comes from those who believe that the answers are simple. That, "the students must work harder", or "I just need more teaching time" or "if we could just change the timetable". Education is a complex process and where change is made it should be after a review of best practice elsewhere and linked to an evaluation of the results of those changes.

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