# The issue of medical education

The theme - medical education - necessarily implies in the recovery of the main trends influencing education models of the medical profession in the Twentieth Century. At the end of the Nineteenth Century and the beginning of the Twentieth Century, Medical Education was submitted to a change still challenged in our days. At the time the need to assess the conditions of Medical Education in the USA and Canada emerged. An assessment by the American educator Abraham Flexner of the Medical Education in the United States and Canada was published by the Carnegie Foundation in 1910, known as the Flexner report. Flexner stated that medical schools just sprouted everywhere: there were even one year courses, no acceptance criteria for applicants, clinical work performed without scientific background, teaching was lacking in equipment and laboratories, and professors had no control over university hospitals. Medical education was *"... a private adventure, proprietary in spirit and in object"* without scientific basis.

This report had such a strong political, institutional and social repercussion that it reached beyond the limits of Medicine and resulted in the closing and mergers of schools and elimination of vacancies. Discrimination in the medical profession grew deeper as doctors became professionals belonging to the high and upper-middle classes; medical schools for Negroes were closed and the numbers of Negro students enrolled in the remaining schools were significantly reduced.

Flexner's proposal was: *"... the definition of admission standards and the lengthening of medical education to four years; the introduction of laboratory based teaching, the encouragement of full-time teaching; the creation of a basic cycle and the expansion of clinical education, specially in hospitals, the linking of medical schools to universities, the emphasis on biologic research as a way to overcome an empirical approach in medical education, the linking of research to teaching and the control of professional exercise through the introduction of professional regulation."* These guidelines are still the core of medical education and practice but subject to criticism.

This model also known as scientific medicine brought about substantial change in the concept of the "object" of medical practice and consequently changed the doctor and patient relationship. Humans seen as people involved in the therapeutic process, respected in their dignity, will, freedom and reason, became subjects of study, technology consumers, individuals treated as the objects of of study like in Physics, or Botany. Doctors' training followed a biomedical model, reducing humans to their biologic bodies. There were changes in the doctor-patient relationship in which doctors began to be considered mere service providers.

Concurrently this trend was followed by others - preventive medicine, integrated medicine, community medicine, linkage established between teaching and clinical practice. Movements with different orientations also originated in the USA throughout the Twentieth Century. Preventive Medicine had the stronger impact on medical education in the attempt to introduce preventive medicine through medical practice, in addition to the proposal of again valuing the relationship between social and collective health and the course of disease.

To Arouca *"Prevention dilemma: contribution to the understanding and criticism of preventive medicine",* preventive medicine stemmed from three sources : hygiene awareness in the Nineteenth Century, capitalism and liberalism, the discussion involving medical care costs in the United States in the 30's and in the 40's of the Twentieth Century and the reconsideration of medical responsibility concerning medical education. Each source assessed the previous one and amplified the role of doctors, associating the medical professional education background to the accumulation of knowledge provided by other sciences revealing the value of community, family and the perception of human beings as a whole.

The practical result of this movement was the pervasive implementation of preventive medicine in medical schools, but with a shortcoming: the disciplines of this department, a fundamental department to the development of coherent medical practice, with a more complete view of the individual, the perception of the individual considering the completeness of biological, psychological and social aspects of human beings, are superficial in the medical curricula and do not disrupt the prevailing biological model or achieve the introduction of concrete changes in the content or orientation of medical practice. The movement requires from medical schools a professional education that will consider the complexity of human beings because an oversimplification between medical thought and behavior does not take into account the context of life as a whole.

In 1970, the PAHO (Pan American Health Association) coordinated by Juan César Garcia enhances two basic issues of medical education: the first is the technological explosion effect in developed countries and the second is the need to improve the health conditions to ensue economic development in developing countries.

The need to control technology related costs and the multiplicity of specializations in the USA resulted in the movement of community medicine as a social policy with the aim of providing healthcare to low income social groups excluded from medical assistance. This movement spread throughout Latin America in the 70's with the support of international health agencies oriented to populations' needs. In the process of adjusting the scope of medical services with the growing costs of medical assistance there has been the recognition of an excessively technological approach in healthcare practices when the epidemiological evidences pointing towards the higher rates of common diseases in the population are considered. At this time, medical schools emphasizing specialty oriented education are not aware of the demand for general practioners or family doctors.

In Brazil in the last two decades medical schools have been accused by civil society of not qualifying professionals to meet the needs of the population. Therefore, it is necessary to recover, however if timidly, historical moments of medical education, to avoid the generalization implying that changing curricula, reformulating medical courses would be enough to change medical education.

Feuwerker, 1998, quoting Nunes, 1989 and Schraiber, 1989, stated that although the process of distinguishing between practice and medical education defines a scenario where practice is more prevailing than education, agrees with the recognition of the need of a certain autonomy for medical education. Therefore, medical education and medical practice changes proposals are part of the movement of population healthcare changes.

In this context, implementing curricular changes in medical school presented by ABEM, CINAEEM and UNIDA network, to encourage discussion of the Curricular Guidelines published in November 2002 by the Ministry of Education and Culture, to review academic administration in Medical Courses, are part of a historical process, which will certainly retrieve and update the social role of doctors in modern times, the social role of medical courses and of the university in itself.

Quoting Simões Barbosa, the world in transformation requires that education prepare men and women providing them with a moral and ethical conscience capable of valuing education as a transformation tool. This implies in the recognition that education should be seen as a social and pedagogy as being instrumental.

Professor Elza Maria Neffa Vieira de Castro feels that a university capable of meeting new demands for knowledge, amplifying its role in society, must create the conditions so that all participants understand the cultural, social, political and economic realities of the country.

Cristovam Buarque feels that what ensues the feeling of quality loss is the inability of the academy to respond to the expectations of society. When in crisis, society creates different problems, in such an overwhelming speed, that the University is unable to respond. In summary, the present crisis requires the formulation of new issues, whilst the University remains dedicated to old ones. However, community is aware of this constraint: it is not satisfied and defines loss of quality as loss of function.

At last, when mentioning education it would be impossible not to refer to the superb work of Professor Paulo Freire with whom I learned that the process of learning is the dynamics between a person (a being with concepts, habits, history and unique thoughts and behavior) and an object (with specific characteristics) learned and intermediated by another person who is unique as well.

With another important educator, Professor Arroyo I learned that we as doctors need to learn that through healthcare a minority of society succeeds in extending life, but the people in general must struggle to become free. Life should carry the sense of human dignity, of freedom and justice. Therefore education must seek to rescue humanity stricken by hunger and unemployment, without falling into the romantic trap of unknowing groups striving towards popular education.

Professor Arroyo states that to create an individual it is required that pedagogy reclaims the dimension of the body. An important message he conveys to medical professors is that both education and health are somewhere, and this somewhere is not restricted to the body, but extend to the word - capable of changing, values, conscience and habits, interacting conditions creating the relationships and experience exchange that educate men and women.

Emília Pessoa Perez
Coordinator of the Medical Course
Federal University of Pernambuco