Train For What?

... might as well just make a living

by A/Prof Lee Kheng Hock, President, 25th Council, College of Family Physicians Singapore

You can lead a horse to water but you can't make it drink. So goes an old saying. I think many teachers like me feel the same way when we are faced with students who are not interested to learn. This saying is not entirely true. You can make the horse drink if you try. You can try putting the horse on a boat. Bring it to the deepest part of the river and push it overboard. As it desperately swims to shore and presumably gets through the ordeal alive, it would most likely have drank a few mouthfuls of water. Many of us had been victims of this style of teaching. There is a more humane and equally effective way. That is to feed the horse with lots of salted vegetables before bringing it to the water. Creating a reason to drink and a thirst for knowledge is important.

Many years ago when I was still working as a solo GP in my own practice, I signed up to join the first batch of FCFP(S) by assessment after completing my MMed (FM), I was thirsting for more knowledge. I knew there was more to family medicine than what I had learned. There were many detractors who planted doubts. I remember a kind senior colleague who was one of the pioneers of the College leadership. When he heard about this program he quipped,

"You know, we are all over-trained for what we are allowed to do… You sure you want to do this?" There was no cynicism or malice in his voice, just disappointment at the sorry state of family medicine as it was practiced then.

One of my seniors in medical school was even more direct. He had built up a thriving private practice and I did locum sessions for him back then. When he learned that I was signing up to study family medicine, he had this to say,

"Train so hard for what? You don't know how to practice family medicine meh? I tell you it is all very easy." He proceeded to give me tips on how to be a successful GP. He did it with all earnestness to help me to be successful. One of the so-called tips he gave me was to add chlorpheniramine syrup to cough mixtures.

A/Prof Lee Kheng Hock addresses the guests and graduands of Convocation 2015

"Some of these young locums are very bad. They don't even know how to treat simple cough and cold. I am teaching you these things that I had learned because you are my friend. When a patient comes to see you for cough, he won't get well if you just give him cough mixture. If he don't get well quickly, he won't return to you again. The cough is caused by flu, right? So you must include flu medicine in the treatment even though he might not have a runny nose."

The really sad thing was that he was not joking. He honestly believed that he had superior clinical knowledge of family medicine and this was the reason why he had been so successful as a GP. More than anything else, his advice strengthened my resolve to further my training and perhaps one day change things for the better.

Many years had passed and now I find myself on this side of the table. I realized that much of medical education is about thinking of ways to make the proverbial horse imbibe from the fountain of knowledge. One nasty way to do this is to create high stakes examinations. A whole mountain of pseudoscience had emerged out of this. In the United States, an education-industrial complex had emerged that is similar to the military-industrial complex.[1]

I remember helping Prof Goh Lee Gan set questions for the MMed (FM) exams in the days when he was the Chief Examiner. He used to jokingly refer to what we did as inventing instruments of torture. It was a funny way to look at it but there were indeed some similarities. We were basically trying to extract information under duress from the hapless victims, to determine the truth of their claim that they had trained diligently and had attained the levels of competency that we expect. Of course we know Prof Goh to be a compassionate man and many of us had survived the torture of exams thanks to his mercy and kindness. In the really bad old days in the 60s and 70s when dinosaurs ruled the medical assessment world, things were really bad. Back then, setting exams is like concocting a potion that is designed to be lethal to about 49% of the subjects. If it was not toxic enough and there were too many survivors at the end of the ordeal, people from the other specialties will snigger and make snide remarks about the lack of rigor of the exams and that the discipline was not intellectually demanding.

Thankfully now, things have changed and become more scientific. There are lots of theories about learning and assessment. It is all about precision and psychometrics. People wax lyrical over validity and reliability. Apart from the fancy mathematics and rigorous committee meetings, the outcome of the massively complex and expensive exercise had largely remained the same. Examinations are still very painful for the subjects. There are still those who pass and some others who fail. Those of us at the receiving end, and who have to work with the product of the process will also report that little had changed. We still get to work with roughly the same proportion of competent and incompetent junior doctors who made it through the process. There may be recall bias but professionalism seems to be on the decline despite the organization of mandatory ethics courses. To be fair, it might be a sign of the times but many

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suspected that this might be contributed by the depersonalization of medical education. Teachers are contracted to teach with their contribution expressed in fractions of their worth as lifeless time equivalents. Their teaching output is reduced to digits generated by feedback forms. There is no relationship, no mentors and no role models. We are all digitized equivalents of one another. One silver lining about depersonalization is that examiners no longer need to feel responsible or guilty when candidates fail. The claim is that everything is objective and the examiners did not have a chance to exercise their judgment beyond ticking the boxes. Another interesting difference is that, the casualties of the exams are dead for good with no possibility of being resuscitated by the wisdom of compassionate exam boards. A good change from the perspective of the candidate is that the mantra of examinations had changed for the better. The new mantra is that if too many candidates die during the process of torture, it means that your training program is no good. It is not the student's fault, it is now usually the teacher's fault. Therefore one should dial down the toxicity of the stuff. This puts a damper on the killer instincts of the examiners. The downside is that some of the undead may come back as zombies.

Another casualty of the mechanization of medical education is the dilution and eventual demise of clinical examinations. In recent times, education reformists have been raising alarm about the negative impact of standardized tests on learning.[2] Ironically, medical educationists have "re-discovered" standardized testing and pursuing it as if it is the proverbial invention of sliced bread. There are many avid advocators of the use of standardized patients, a logical extension of the standardized tests. Real patients with real clinical problems are too complex to be standardized. The logistics of organizing clinical examinations with real patients can be very daunting. This is why many so-called advanced countries have given up on using real patients in clinical exams. It is often claimed that this is because real patients cannot be standardized so therefore the exams are not objective and results are not reliable. (To the credit of our MMed (FM) Exam Committee, they did hold their ground and kept the clinical examinations with a mixture of real and standardized patients.)

I remember in one of many committee meetings, we had an argument over how important it is to ensure that FM candidates are able to pick up real clinical signs such as an enlarged liver in the exams. One of the members who advocated for completely doing away with the use of real patients argued vehemently. "How often in real life does a family doctor examine and discover an enlarged liver?" Another chipped in that exams must simulate real life and the day-to-day consultations that happened in our consult rooms. This carried the implication that those who insist on higher standards using clinical exams with real patients are somehow impractical and unreal. Real life in family medicine can be over rated.

We know how bad the practice environment in real life can be for family doctors. Conscientious and well trained family doctors are often forced to practice 6-min consults and manage patients within protocols that are more administrative than evidence based. They have to wriggle their care plans within the narrow confines of the approved menu of tests and medicine. Beyond that, he or she is forced to refer ASAP to either the specialists or the emergency department.

The problem with this line of argument is that it perpetuates the status quo and concedes that what we are doing now is the best possible practice in family medicine. With this line of thinking, whatever standards that we have now will not change and will probably degenerate with time. We will then truly become cough and cold doctors or the mail man who delivers for the real doctors in the hospitals. The leaders of our fraternity must ask ourselves tough questions. "Is this the best that I can do as a family physician? Is this the best kind of primary care for my patient? More importantly, are your patients receiving the best primary care that Singapore can afford to give them?"

I think the answer is clearly "no" to all. Mahatma Gandhi once said, "Life is an aspiration. Its mission is to strive after perfection, which is self-realization. The ideal must not be lowered because of our weaknesses or imperfections."

We must not train to remain in our present imperfections. From the first MCGP exams that our College conducted in 1972 to the latest FCFP(S) exams conducted in July this year we had stayed true to our vision of improving standards through training and preparing young doctors for a better future in family medicine. We must not let our training and assessment systems falter under the influence of faddish ideas in medical education which is presently obsessed with standardized testing. We must train for a better future. A future where family doctors are given the necessary resources to do our work. Where practice conditions are compatible with our vision of good primary care. Where we are recognized for our special competencies and given the recognition that is due to us, nothing more and nothing less.

This is what we should be training for.

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[1] *Picciano AG. Spring J. The Great American Education-Industrial Complex: Ideology, Technology, and Profit (Sociocultural, Political, and Historical Studies in Education). Published by Routledge 2013. New York, NY.*

[2] *Robinson K. Aronica L. How schools kill creativity: Forget standardized tests, here's how we really engage our kids. Test makers rake in bucks, students and teachers chafe under the strain. Here's a better way forward for everyone. http://www.salon.com/2015/04/26/how_schools_kill_creativity_forget_standardized_tests_heres_how_we_really_engage_our_kids/*

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