Medical curricula for the next millenium: responding to diversity

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Résumé

LES ATTENTES DE LA SOCIÉTÉ À L'ÉGARD DES MÉDECINS ÉVOLUENT, et ces changements sont à l'origine de nouvelles méthodes de recherche et d'éducation en médecine. Le concept classique de l'homme blanc de 70 kg comme sujet de recherche ou patient normatif n'est plus toléré. On s'attend maintenant à ce que les chercheurs incluent des femmes dans leurs populations d'étude et à ce que les médecins aient reçu une formation qui les sensibilise aux questions spécifiques aux sexes et aux cultures. Ces changements d'attitude se traduisent dans les lignes directrices de réforme des programmes d'études que présentent dans ce numéro le Dr Barbara Zelek et ses collègues (page 1297). L'auteur affirme que le modèle de la pratique fondée sur la réflexion de Schön peut aussi fournir un modèle conceptuel utile pour la réforme des programmes d'études.

In our diverse society, physicians are expected to provide competent care to patients of either sex and of any sexual orientation, people with disabilities, members of visible minorities and economically disadvantaged people — to name but a few groups. This places an enormous responsibility on medical educators to provide training that will sensitize future practitioners to the needs of all patients.

Traditional medical curricula present the 70-kg white male as the norm, implying that being female is somehow aberrant.[1] Several years ago, when the University of Ottawa undertook the task of upgrading and enhancing its medical curriculum, one of the criteria used to judge the existing curriculum was sensitivity to gender issues and freedom from bias on the basis of gender. Particularly telling was the assessment by second- to fourth-year students that "sexist attitudes and comments prevail[ed] in the classroom."[2]

Women have also been underrepresented or excluded from study populations in medical research, making it impossible to conclude whether a treatment that is helpful for men is also helpful for women. Studies of heart disease in women illustrate this problem. A review of primary prevention strategies for coronary artery disease (CAD) in women found that insufficient data were available to support the conclusion that interventions such as lowering serum lipid levels, maintaining normoglycemia, avoiding obesity or giving low-dose acetylsalicylic acid therapy reduced the risk of CAD in women.[3] On the other hand, these strategies had been studied widely and conclusively in men. In view of the fact that the main cause of death among women over age 60 is CAD, how can the exclusion of women from trials of CAD prevention be justified?

Another review, which examined the evaluation of chest pain in women, described difficulties encountered in history-taking. Although atypical chest pain is considered to be more common in women than in men and ischemia presents with a different pattern of pain in women than in men, "a woman with an exaggeratedly emotional presentation style is often perceived to have a far lower likelihood of coronary heart disease than a woman with an identical history and a businesslike affect."[4] CAD is thus an extremely serious medical problem that presents in a much more cryptic manner in women than in men, is studied much less in women and, if not presented to a physician in a "businesslike" manner, has a higher likelihood of being ignored or discounted.

Since the beginning of the 1990s we have progressed from the realization that

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"The time has come for a new medical 'specialization': women's health"[5] to an acceptance of women's health as "core" material in undergraduate and postgraduate medical curricula. Accompanying this shift is an increased emphasis on the societal context of illness and health, and a recognition that "curricula that focus primarily on the biologic causes of illness may limit students' awareness of the social determinants of health."[2] We should not forget that one of these determinants is the way in which medical professionals view women. The manner in which women are referred to in medical presentations and the questions they are asked in the course of history-taking often devalues "being female" in subtle and sometimes not so subtle ways. A classic example is the question "Do you work or are you a housewife?" Another underlying problem is the inherent power imbalance of the physician–patient relationship, which results from "the power conferred upon physicians in our society as a result of their knowledge, professional status and social position."[3] This imbalance exists in the case of both male and female patients but, for many social and cultural reasons, is especially apparent in the treatment of women.

The influx of women into medicine has helped to highlight the needs of women as patients. Although being female does not automatically make one sensitive to gender issues, it makes it more likely that, by virtue of sharing the same physiology and experiencing similar social stereotyping and indoctrination as other women, one will have a heightened understanding of their needs and concerns.

Medical school is a "learning moment" that spans 4 years. From there we are dispersed like seeds into various specialty areas. Educators in family medicine frequently debate how areas of knowledge can be prioritized such that what is most significant is presented as the main course in the curriculum and the rest as gravy — if time allows. The result has been to de-emphasize issues that affect women and other groups that do not fit the norm of the 70-kg white male. What could be more central than dealing competently with the needs of over 50% of the population? Is it ever too early to teach students how to respond to the diversity of their patients?

In this issue (page 1297) Barbara Zelek and colleagues build on the work of the Women's Health Interschool Curriculum Committee of Ontario, which has established a theoretical framework for curriculum reform, and of the University of Ottawa's assessment of its medical curriculum,[6] which evaluated "all its instructional procedures, materials, settings as well as the content" with respect to "patient care, history taking, physical examination, problem identification, treatments and therapies."[7] They begin with a statement of goals and objectives for medical education and describe some of the shortcomings of traditional medical curricula. They continue by outlining clear and specific guidelines for transforming a traditional medical curriculum into one that in its content, language and process is sensitive to gender issues. Finally, they touch on a key element in medical education: the messages that educators transmit subconsciously, unintentionally and continuously as they interact with students. They ask educators to be aware of the power of acting as role models with respect to gender sensitivity.

It has been suggested that the educational models of the past will not be adequate to meet the needs of a society that demands a very high level of expertise of its medical practitioners. The move to "problem-based learning" seems to be an improvement on the past in that it prepares students "to collect and appraise information critically."[8] However, we must now integrate features such as gender sensitivity and cultural awareness into the educational process. One model that could potentially provide a conceptual framework for such reform is Donald Schön's model of reflective practice, which combines the science of medicine (the zone of mastery) with the art of medicine (a zone characterized by uniqueness, conflict and ambiguity).[8–10] It reflects on how practitioners think as they work. That which is implicit and unconscious becomes explicit and conscious. Such a model allows movement from an attitude in which there is only one "right way" for a patient to be.

Perhaps the norm of the 70-kg white male was so attractive because the world of the "total" patient is so overwhelming in scope. As Crandall writes,[8] the advantage of Schön's model is that it

> acknowledges and legitimizes the ubiquitous nature of uncertainty. It makes uncertainty, uniqueness, and surprise a positive part of medical practice, instead of something to dread. It blends the science of medicine with the physician's clinical acumen — a function of his or her repertoire of experiences — to weave the tapestries that frame and solve medical problems.

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