EDITORIAL

Medical education: Knowledge, skills and attitude

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Blooms' taxonomy is a time honoured component of medical education. It comprises of 6 levels, but the fundamental 3 elements of the triangle of education are Knowledge, skills and attitude.

Much is written about the Knowledge and skills but very little about the third dimension of medical education called attitude i.e. ethics.

Medical knowledge and skills were transferred through long associations between the master and the pupil, since almost the times of Galen and Hippocrates. A process of osmosis, percolation and absorption enabled the pupil to become a teacher in his time. Besides, he also acquired the basic bed side manners such as greeting the patient, listening to him attentively, and offering the best advice to help him. Any Good Samaritan would be expected to do the same albeit the physician has the privilege of being a Hakim, the wise one.

The life was peaceful and the profession did not have to face many formidable challenges .The doctor knew it best .The paternalistic approach worked well. It was a time of mutual trust and understanding. However, with the explosion of knowledge and advancement of technology, the physician is now exposed to an ever growing myriad of ethical dilemmas; particularly so in a multicultural society like Britain. Internet and the search engines have educated the beneficiary as much as the benefactor.

Formal teaching of medical ethics in the UK is a relatively new phenomenon. Universities are actively engaged in identifying the relevant teaching material as indeed the appropriate tools. An essential component of the GMC's document called Tomorrow's Doctor has now gained its due place.

Patients from different cultural backgrounds expect to be dealt with in conformity with their norms and practices. Social Anthropology is a fascinating subject. It's impact on daily life of a colourful society are visible in all spheres of life. The debate of morality being universal or relative is fascinating. But that is for another time.

There are many examples of the impact of diverse culture on bioethics.

In today's clinical practice an English man, a Welsh , a Scot or an Irish likes to know every fact personally, about the problem, plan of treatment, risks and complications ,alternate therapies etc. He alone makes an informed decision on all matters of his illness. A South East Asian patient, on the other hand often reverts to the family patriarch.

The Afro-Caribbean communities on the other hand are very different compared to the British Asians. They are a self assured, strong willed and independent people. They almost always take matters in their own hands. The Polish , the Latvians, the Serbs, and many Eastern Europeans who now constitute a formidable portion of patients, have very different values; not only deep rooted in Christian ethics, but also strongly embedded in their rich cultural heritage .

There is a great diversity amongst the Far Easterns. For instance the Malaysians living in London, Liverpool, New Castle etc. Those of the Indian stock would leave all decisions to the patriarch, the Chinese make all decisions at the masculine level, and most ethnic Malays would leave the matters to the home maker. The Phillipinoes tend to be very polite, soft spoken and independent decision makers. In contrast, the Somalis have a rather aggressive approach in demanding the best. Even for an ordinary headache or an abrasion on a finger they want at least a scan! In a world of falling resources, the principle of distributive justice may indeed face a challenge.

When it comes to the question of confidentiality, we are not supposed to reveal the patient's findings to anyone; not even to the spouse. And yet more often than not when an Asian elderly, who may have a serious illness, walks into the clinic, the situation is typical of its culture. He is often preceded by a close relative, insisting on being informed first, pleading not to break the bad news to the patient to prevent a crisis. Perhaps many consequestionalists may like this approach. It has a few merits. Beneficence and Non-maleficence take

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precedence over Autonomy in such situations.

Surrogate consent is often the standard practice in most Asian communities such as the Indians, Pakistanis and the Bengalis.

Suffice it to say that there are lots of challenges that one may face in day to day's work, and there are mighty few guidelines available to deal with multiethnic patient population. The standard guidelines published by the authorities from time to time are invaluable in providing the essential information and advice in most matters; but are they tailor made to suit all cultures and all patients coming from different back grounds? Probably not.

The answer lies in laying more emphasis upon formal teaching of medical ethics in the medical schools. And that applies to all nations as a vast bulk of doctors come from distant lands.

Theoretical knowledge of normative principles through brief introductory didactic lectures may be supplemented with real or simulated scenarios of multicultural ethical dilemmas in the skill labs, outpatient clinics or a teaching environment. In the clinical years it could be a lot easier, particularly in the major city hospitals, who have a fair share of multiethnic patient population. Clinical workshops, symposia and seminars could be the other forms of tools of learning at both preclinical and clinical levels. In the contemporary practice of integrated teaching it is much easier any way.

Some workers believe that 'to contribute usefully to contemporary debates, ethicists need to better address the multiethnic, multifaith character of contemporary social settings.[1] They need to recognise the existence of a plurality of 'communities, of interpretation' and 'local moral worlds'.[2]

The first generation immigrants from the subcontinent, Africa and elsewhere who came to Britain as a labour force after the second war, are now senior citizens and form a bulk of patients, presenting with a variety of medical conditions at the family practices. The second generation though thoroughly British, still maintain their ties with the former home country, through marriages, social visits, or religious activities. The third generation however, is loosing a connection with their parents and the home countries due to a multitude of reasons. They are facing an identity crisis. Perhaps a major reason of evil forces engulfing them to serve their cause; in return rewarding them an identity. Nature abhors vacuums. Good or evil, some force will fill in the void. How apt is the writing of Iqbal... paiwnda reh shajar sey umeed e bahar rakh'.

It is a fact that 'for many of those who trace their origins from other than a European lineage it is clear and distressing at times, that the NHS has found it difficult to adapt to the needs of minority groups'.[3] Rapid advances in knowledge and the lack of awareness of the religious, and cultural values as well as their specific ways of life or rituals of death, are posing different kinds of challenges.

Regrettably the answers may not be found in the books on medical ethics[4] or by following the philosophy of the books or the standards of Good Clinical Practice only. They are undoubtedly invaluable in laying down the foundation, but the building must be built thereupon through practical experiences. Such an exposure should be given to the medical students quite early in life. Infact decision making in many matters of life and death may require at least the basic working knowledge, if not more, of the faiths and beliefs, rituals and practices of the community that a doctor serves.

Since the British National Health Service was designed to cater to the needs of a homogenous population, it should not be surprising to note, that some of the themes considered as norms may not be suitable in many a patient with a different background. Thus 'central to discussions concerning ethics, and medical ethics in particular, there must lay an understanding and an appreciation of the beliefs, perspectives, and conceptual frameworks used by our patients'.[5]

The 1991 Census revealed that almost six percent of the UK population classified themselves as belonging to a minority ethnic group.[6] The previous edition of book called' The life in the UK' mandatory for any one applying for naturalisation quotes the figure at 9.2%. The Daily Guardian published a news item on 8April 2008, quoting the former home secretary Jacqui Smith on her visit to Islamabad that the Whitehall believed that the Muslim population in Britain stood at 3.3 % or 2 million mark.

Garter and Sheikh[7] in a paper highlighted the principles and practices observed by the Muslims, who in fact form a sizeable component of the United Kingdom. They pointed out that 'A minimum level of cultural awareness is a necessary prerequisite for the delivery of care that is culturally sensitive'. They have highlighted some of the fundamental issues such as genetic manipulation, assisted conception, adoption, prenatal screening, abortion, end of life issues, organ donations, and many other ethical questions, in the light of relevant religious beliefs and scriptures.

Many national and international groups and societies like the Imamia Medics International (www.imimmedics.org) hold regular meetings in different cities like London,

Birmingham, Manchester and Edinburgh to brainstorm on burning issues facing the Muslim diaspora of various cultural backgrounds. Likewise religious channels like the Hidayat TV and others hold symposia and panel discussions to educate the audience on contemporary bioethical issues.

Obviously the concept of 'identity' is of crucial importance. The burning issues are 'Authenticity' and Integrity'. What authenticity entails is a responsibility to live our lives in accordance with the values that constitute our unique cultural perspective. People also need to retain their integrity as a group. They must uphold the shared values that unite them.[8] In a colourful society of today's Britain, an Asian, an African and a European can all maintain their authenticity without compromising the integrity as a member of the British nation. And that is true for North America, Canada, Australia and the Middle and the Far East. The world is indeed a global village.

It is obvious that in a multicultural, multi- faith, pluralistic society, religion, customs, norms and values determine both the genuineness and the authenticity of one's perspective. The delicate and subtle matters of bioethical dilemmas facing the Indo-Muslim and Arab diaspora in the West are progressively increasing as the populations grow with time. Some of these issues and possible solutions are discussed in this guest editor's book.[9]

UK is currently facing an acute shortage of primary physicians. Some authorities have estimated that at least 10,000 family doctors may be needed in the next 5 years. It certainly opens the gates for the young Pakistani doctors looking to find a place in the NHS. It may be worthwhile for such aspirants to prepare themselves accordingly. Medical ethics is one such field which they must learn as both the MLEs and the PLABs duly concentrate on moral and ethical issues. It is about time it should be taught as a regular subject in the curriculum.

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