

## Undergraduate Medical education in Nepal: Need for Change

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*'As we all were rumbling around the clinical ward during a clinical posting, then there came a doctor who was senior to us to take the clinical discussion session. Honestly speaking, that was few years back, I cannot remember much. But what I remember is, we were unable to answer the questions asked. The teacher was very angry, shouted at us, and humiliated literally. This created fear and a loop hole for demotivation was seeded then. This humiliation, now I analyse as 'bullying' and 'disempowering' at the same time.'*

The medical education can not be described without undermining how a good teaching is perceived. How would you define a good teaching? I ask myself. I do not have the correct answer. But I know what the incorrect answer is. Logically speaking, it is not the delivery of formal medical education within a dominant hierarchical culture.

James<sup>1</sup> as he reviewed the book<sup>2</sup> points the fallacy within the medical education as a disconnection between the mission statement of the institution itself and the medical curricula of the formal medical education system. Next is exclusion of moral development, advocacy<sup>1</sup>, leadership development and stereotypical hierarchy within the system. These issues however can be implicated as submerged portion of iceberg phenomenon, where the tip is attributed to the infrastructure, health reform policy and content of the curricula itself which has been diverting its attention towards itself and making the submerged issues unexplored and unarticulated. Lempp and Seale<sup>3</sup> have critiqued this unarticulated and unexplored issues as the hidden aspects of the curriculum and refers them as the hidden curriculum which is one of the striking though intangible factor affecting the professional development and medical education.

### UNDERGRADUATE MEDICAL STUDENTS: PASSIVE BENEFICIARIES OF HIGHLY FUNCTIONAL MEDICAL SYSTEM

The medical education which has been targeted to the medical students is more or less controlled by the 'top down' approach such that the medical students become mere passive beneficiaries without a voice. What a medical student faces during his/her training has

been going unnoticed, despite the fact, that humiliation and bullying within the medical schools has been forbidden in Nepal as in the world. Conversely, these issues are least disregarded because these are direct influences of hierarchy, frequently goes unarticulated and is less often talked about. However intangible it seems, the effect is dramatic often creating a cycle of low commitment among both the junior and the senior medical professionals. Therefore, a question strikes again! Can medical institution in Nepal afford to continue undergraduate medical education within the same organisational framework? Where the climate of super specialisation and postgraduate teaching has been a great investment for the medical industry, can we really afford medical students to be just passive beneficiaries of the so called competent undergraduate's education system?

### AFTERMATH OF HIERARCHICAL DISHARMONY

Much has been discussed in the literature about the humiliation involved in the medical teaching sessions. But has there been any transformation within us? Taking an example, junior medical staff, interns or residents face the stress and humiliation when they can not answer a question. It has become a universal phenomenon and a naturalised truth. But the aftermath of repeated humiliation could be disempowering. Contradicting the notion where education should ideally be an empowering tool, such humiliation disempowers younger medical professionals. Alternatively, it promotes the transmission of the humiliating and the dominant culture among the emerging professional, the then juniors, interns and residents. This would allow them to employ the same authority and power and thus, disempower the next generation creating a vicious cycle.

### UNDERGRADUATE EDUCATION IN NEPAL: A LOOPHOLE IN THE DEMAND OF THE CHANGE

During the past few years, literature to promote and to implement the reform within the medical curriculum

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has been seen<sup>4,7</sup>. But none reflects the unarticulated and hidden aspects of the medical system that needs reform. With the dramatic increase in the number of medical schools and colleges from late 70s when the first medical teaching school was established, outcry for the reform to provide quality education has been started.

Marahatta SB<sup>6</sup> highlights that the tools that were adopted 'yesterday' for medical education needs a replacement with new curricular innovations. However, it has not been clearly stated within the literature of Nepal, that the reform is required within the organisation's dominant culture. Neither has it grabbed the researcher's attention which may be due to the diverted attention to the medical and the clinical research and lesser to the hidden agendas as hierarchy and humiliation within the medical education.

## THE WAY FORWARD

Empowering medical students and meeting the demand of medical professionals who are well equipped professionally to treat patients of diverse needs have been the frontline goal of the medical education since ages. To this end, we have become quite a successful but on the other hand, rethinking and reframing organisational culture within the medical education system has been the critical demand of the modern era. Curriculum as Karki<sup>7</sup> postulates is the important guiding principles to direct the undergraduate training program, which at present, is variable from university to university within our country. The evaluation system varies on the same time. But the need for the uniform and standardised

evaluation system and uniform core curriculum is the need of the present era. The medical curricula should incorporate ethical teaching and should include moral and leadership development as well. The culture of the mutual trust has to be planted between the seniors and the juniors. Besides this, the medical institution should be reformed in terms of power decentralisation with advent of bottom up approaches. This means, the voice of even the juniors should be heard and should be considered, rather being 'target' of seniors and being frequently 'humiliated'. The need for structured clinical teaching, clinical rotations and internship is a priori as much as the reform is needed. The responsible institution should take the accountability of the organisation such that power of one does not overshadow other. This entails adoption of capacity building strategy i.e., 'partnership' where the seniors act as a facilitator rather than power controller thereby enabling the young professionals to empower themselves.

The current disarray in the medical education shall supervene if the concerned authority like Ministry of Health and Population, Nepal Medical Council, respective universities and institutions, and other relevant stakeholders do not adapt to the changing needs of the medical graduates of Nepal, who are at the moment the passive beneficiaries only. Therefore, when a culture of active and systematic learning process is established, it would ripple its effect by developing a socially responsible medical professional and not just the stereotyped medical professional.

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