

**BHA-FPX4002 Assessment 2: Changes in Medical Education**

Student Name

Program Name or Degree Name (e.g., Bachelor of Science in Psychology), University

COURSE XXX: Title of Course

Instructor Name

Month XX, 2024

NURSINGGLANCE.COM

## **Changes in Medical Education**

Health is dynamic. The developments in medical education reflect this nature of health. As technology advances, educators and medical schools bring in changes to help adapt to the continuum of technological development. The structure of medical education is bound to change as science seeks to find answers to the societal tribulations that erupt during different periods (Buja, 2019). All these are aimed at improving the quality of care for the patients. The purpose of this paper is to discuss the changing scope of medical education, the impact of these changes, and the importance of understanding the history of medicine as a discipline.

### **The Changing Scope of Medical Education**

The first medical school in the US was established in Philadelphia in the year 1765, followed by several universities such as Harvard, Dartmouth, and King's College, all founded before 1800. Before this period, the training of doctors and other health practitioners was informal through apprenticeship. The training was unregulated, with no formal syllabus for the trainees and no prerequisites for admission into the medical course. Regulatory bodies such as the American Medical Association, formed in 1876, were set up to streamline both training and aspects of medical practice, such as licensure of doctors. Medical training continued to advance following Flexner's recommendations, which prompted the inclusion of previously independent medical schools in existing universities to allow trainees to obtain knowledge in other health-related fields (Young & Kroth, 2018). This report was a huge stepping stone to modern medical training by strengthening the relationship between biological science and medicine and formalizing licensure. Training has expanded from rudimentary training to well-established undergraduate studies, postgraduate studies, and fellowship programs in different faculties.

Technology is not only a stepping stone in patient management but also a golden charm in medical training. Changed societal perceptions of patient security and the need for quality care have continued to reduce the training in the skills of actual patients. This prompts the use of human patient simulators. Technology also facilitates distance learning when needed, as was witnessed during the peak of the COVID-19 pandemic. Technology has enhanced the acquisition of knowledge and decision-making and allowed medical trainees to train on rare cases that are not commonly encountered. Cultures have had a significant impact on medical training. The appreciation of cultural diversity has propagated the development of a new concept in care: cultural competency. This has spurred the addition of courses like communication skills in the medical training curriculum.

#### **Apprenticeship Model vs. Academic Model**

The apprenticeship model of learning model in medicine is credited to William Stewart. It is often described as the “see one, do one, teach one” study model. This model, however old, has not been done away with. The new academic model comprises an evidence-based standard of training. It depends on the idea that teaching causes learning and that improved learning culminates good patient outcomes (Biesta & van Braak, 2020). When learning depends on people with more experience to impart knowledge and skills, there is bound to be a variance in different individuals' styles of performing medical procedures. This variation may pose a danger to patients. The modern academic evidence-based teaching model is directed at reducing these variations and improving patient outcomes (Nabavi, 2021). The apprenticeship model has several benefits, including early incorporation of medical trainees into the field, amassing practical knowledge and skills, and progressive professional growth, which is initially observatory and later independent (Young & Kroth, 2018). This model of study allows trainees to greatly

improve interpersonal communication skills as they become acquainted with the day-to-day processes (Nabavi, 2021). In a critical study of the two models, an integrated teaching model confers higher effectiveness in delivering knowledge and instilling skills.

### **Analysis of Evolution and Impact**

Apprenticeship was a major training method even at the inception of medical schools. The question of patient safety from inexperienced clinicians was a propagating factor in integrating other teaching models, such as competency-based evaluation systems and high-fidelity simulations deemed safer. Evolution into the medical model has arguably relegated medical training to a closed and casual system with minimal subjectification, professional socialization, and qualification in the essence of limited skills and understanding concepts (Biesta & van Braak, 2020). This evolution has also culminated in improved patient outcomes and satisfaction. Patient safety has improved due to the protection of the patients from being handled by healthcare practitioners who do not possess adequate skills.

### **Importance of Understanding the History of Medicine**

In medicine, a lot of things can go wrong. History gives us a critical perspective in viewing trends in health care and accurately predicting outcomes and management of cases, even with limited knowledge. It also provides a perspective on the direction of growth in the medical field. A good example would be coronavirus outbreaks; the first occurred in China in 2002, where 774 people died; in Saudi Arabia in 2012, there was a MERS-Cov outbreak where 891 people died, with a 35% fatality rate (World Health Organization, 2022). Studying the trends and histories of these virus outbreaks portrayed these viruses as highly infectious with a high fatality rate. Experimental knowledge of the treatments during these outbreaks was also available in history. When there was an outbreak of COVID-19 in 2019, this existing information was used

to advise the general population on self-care tips like minimizing physical contact with others and keeping social distance.

### **Conclusion**

Growth in the medical field is inevitable. Technological advancements have spurred this growth. The scope of medical education has been changing continuously from an initial rudimentary, unorganized system and apprenticeship to adopting a well-organized academic model. There is still a need to build a medical education model that provides quality care to patients during the training of medics and, at the same time, provides an avenue for the instillation of clinical, professional, and cultural competency skills to trainees.

NURSINGLANCE.COM

## References

- Biesta, G. J. J., & van Braak, M. (2020). Beyond the medical model: Thinking differently about medical education and medical education research. *Teaching and Learning in Medicine*, 1–8. <https://doi.org/10.1080/10401334.2020.1798240>
- Buja, L. M. (2019). Medical education today: All that glitters is not gold. *BMC Medical Education*, 19(1). <https://doi.org/10.1186/s12909-019-1535-9>
- Nabavi, N. (2021). The apprenticeship model would better prepare medical students for practice, says RCP. *BMJ*, n65. <https://doi.org/10.1136/bmj.n65>
- World Health Organization. (2022, April 7). *Disease Outbreak News; Middle East respiratory syndrome coronavirus (MERS-CoV) – Saudi Arabia*. Who.Int. <https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON363>
- Young, K. M., & Kroth, P. J. (2018). *Sultz & Young's Health Care USA: Understanding its Organization and Delivery* (9th ed.). Jones & Bartlett Learning.