

Changes in Medical Education

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Rapid changes in medical education have become mandatory to cope with the multi-dimensional needs of modern times. Such adaptation urges to equip the learners with the necessary skills and expertise to ensure quality medical services. Undoubtedly, early medical education in the country was of subsided standards due to insufficient facilities (Young & Kroth, 2018). However, huge development has evolved with time regarding the quality and standards of medical education. All such changes have left impeccable prints to improve the education quality of current medical student slots around the county. The current document owes the purpose of addressing such changes in medical education that resulted in modern magnificent progress in far and large of the health system. Hence, this paper will explore the evolution regarding changing scope and analysis of executed changes by comparing apprenticeship and education models of medical education. In addition, it will also elaborate on the importance of medical history education and how its understanding promises improvements in medical education in the approaching times.

The Changing Scope of Medical Education

Before pacing into 1800, medical education was started in the United States with four medical schools. The University of Pennsylvania was the first one in 1765. After that, King's College, Harvard, and Dartmouth were founded in 1767, 1782, and 1797 respectively. After 1800, history witnesses that the four schools sprout into seventy-three in total numbers around the country having unregulated teaching and training features. In 1876, the American Medical Association was promulgated to regulate medical education in the county. The association enacted various laws to regulate medical education with compulsory four-year degrees and training in the field for practice as a physician (Swenson, 2021).

However, medical schools were first under the apprenticeship system but later, the formal and systematic teaching system replaced it. In mid of the mid-19th century, the medical education curriculum was formulated with the introduction of eight eight-month courses along with various subjects, including human anatomy, chemistry, theory and practice of medicine and surgery, therapeutics, medical jurisprudence, pharmacy, etc.

Moreover, a hospital internship program after graduation was introduced and in the 1920s, it became mandatory for all medical students. This transformation also included laboratory maintenance along with clinical practice which resulted in high-quality medical education. Another change was three internship patterns, i.e., straight one, in medicine and surgery in the field, rotating internships required the students to move to different clinics while mixed one was the amalgamation of these two.

Meanwhile, these transformations were meant to cope with the needs of advanced times and for that purpose, the system of academics and internships was considered a gateway to improve medical education. Further, medical education has to face acute challenges concerning specializations. To pace with this challenge, the 'residency system' comprised over several years was adopted as a mixture of internships and research experience. The academic residency experience was introduced first time at John Hopkins Hospital (Swenson, 2021). Such advancements have replaced some traditional and informal ways to produce a doctor in the country.

Hence, present-day medical education has deep roots in the evolutionary process comprised over centuries. Compared to 1800 medical education, the current programs are rigorous, comprehensive, and dynamic and according to contemporary needs. In alliance with all the necessary skills and expertise, modern medical education requires a medical student to be dedicated, disciplined, and sacrificing in a personal capacity (Pories, et al., 2019).

Apprenticeship Model vs. Academic Model

Description and Comparison of Both Models

Both models provide professional enrichment to shape the medical education standards for producing potential students. The apprenticeship model advocated direct involvement in clinics without formal medical education in classrooms. This model ensures the hands-on practice of medical students and considers classroom education as a waste of time. The apprenticeship system has no regulations in 1800 but was used to organize the guidance clinches from seniors to juniors till 1960 (Rassie, 2017). However, in current times such a model has lost its applicability in the modern medical education system compared to the past practice. Contrary to the apprenticeship model, the academic model builds structural education with lectures and learning outcomes in the form of assessment and practical experience as well. It involves a regular and dynamic curriculum with rigorous practical experience and research. From the nineteenth century to date, this model is evolving in a continuous stream and the future will transform into more development.

Analysis of Evolution and Impact

Though apprenticeship and academic models of medical education are usually considered opposing to each other, they have evolutionary similarities in shaping medical students to become good physicians or surgeons. Over a long time, they have combined to emerge as the contemporary practice of medical education, i.e., the combination of both classroom knowledge and clinical experience. Their combined impact has paved the way for high-quality care of the patient community in modern times and their legacy will improve in the future.

Importance of Understanding the History of Medicine

Revisiting and understating medical history urge students to know how scientific inventions and medical theory have resulted in the immense care of patients. It is also a building block and huge paradigm of medical education to know medical history for well encountering the issues of life. So, it helps the doctor community to relinquish the repetition of mistakes. For example, in 1800, there was no proper sterilization ethics, and surgeons were not entitled to proper hand-washing aspects. The usage of protective barriers like gloves and gowns etc., was not adopted during operation proceedings. However, Florence Nightingale advocated and tried hard to introduce hygiene guidelines to prevent infection and contamination till the late 1850s (Newsom, 2003). Hence, it is very significant to understand medical history to avoid any mistakes during practice in modern days.

Conclusion

Lastly, it can be inferred from the above discussion that medical education has undergone tremendous advancements over time. The integrated application of modern techniques and discoveries has paced medical science to a brand of progression. In this context, today's medicine owes its advancements to innovators who played a pivotal role. Similarly, the evolution of learning methods has enabled students to diversify their skills and approaches. Medicine has shielded the long passages with successes and relearning from failures. As per the recorded history, it can also be predicted that the future perspectives of medical education will see rapid changes toward glory by utilizing the current technologies and systems.

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