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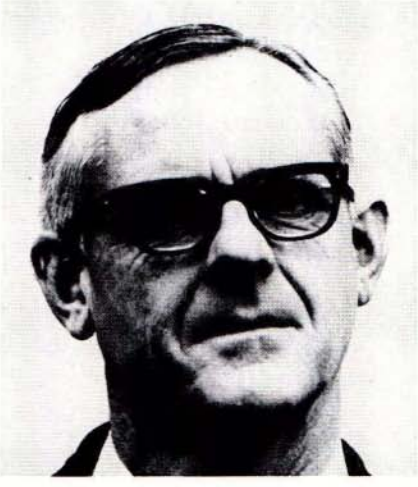
The medical education that began in Otago in the 1860's was founded on the Edinburgh tradition with its thorough grounding in the basic sciences followed by a sound training in clinical diagnosis. For over 90 years, the Otago School remained the national center of medical teaching, until the Auckland School was established in 1967. Its curriculum has followed British patterns and, until 1965, changes and advances were slow and never radical.

However, following both British and American trends, major changes have been made in the last five years. The resultant turmoil is continuing with shifts of emphasis in both the preclinical and clinical stages of the course.

New basic knowledge has accumulated rapidly, especially in the fields of biochemistry, electronmicroscopy and investigative medicine, while the proliferation of new specialties and specialists over the last 15 years has been staggering. These changes have led to an undesirable disintegration of the broad fields of medicine, perhaps inevitable because of the complexities involved.

Medical educators hold diverse views about the purposes of medical education. Nearly all are specialists and each feels obliged to teach the facts that he thinks medical students should know about his specialty. Some set out to train the student to think and learn for himself. Very few indeed feel any re-



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sponsibility to discuss the philosophy of medical practice. The teacher who does step outside the boundaries of his own subject to discuss philosophical topics will soon run into criticism because his own attitudes toward life will inevitably come to the fore.

Specialism Grows

The course curriculum in the modern medical school is bogged down by the complex nature of current scientific knowledge as multiplying information is crammed into a course that remains the same length it has been for half a century. The new information is being taught by more and more specialists who communicate with each other less and less about broad principles. Therefore, medicine is becoming increasingly a technological discipline.

There is nothing philosophical or moralistic in the course content of the basic subjects of anatomy, physiology, pathology, medicine and surgery. There is no time for philosophy anyway, unless extracurricular opportunities for such discussions exist. In any event, these are likely to be limited and poorly attended.

Opportunities for teachers to introduce certain issues with philosophical significance do exist in the disciplines of psychiatry, preventive and social medicine, forensic medicine, and obstetrics and gynecology. In certain matters, the doctor has clear duties to the law that he must observe in spite of his own personal attitudes. He is also under the influence of that vague code of behavior known as medical ethics, and he has precise responsibilities to the General Medical Council under the terms of his registration.

Instruction in the law of medicine and medical ethics is minimal in the modern curriculum as the pressure of more and more specialized new knowledge is imposed on the timetable. The teacher with the most opportunity to incorporate a philosophy of medicine into his teaching program is the psychiatrist, and it seems that the modern academic in this field is applying himself to this function with enthusiasm and dedication. A new trend in this regard is the appearance of behavioral science in our preclinical curriculum. A statement from the Otago Medical School referred to it as: "A multidisciplinary course aimed at furthering an understanding of man in a developmental family, social and psychological context."

Philosophy Neglected

There is no doubt that a doctor needs to have a concept of the nature of man if he is to adopt attitudes his community can appreciate and if he is to understand the reaction of his patients to stresses and advise them wisely. But how many doctors give this any particular thought or study? The medical student at Otago is exposed to this important issue only by the psychiatrists, and there is a school of thought here that is uniformly anti-

Christian and humanistic in its approach.

The average New Zealand student, coming to medical school after a strictly secular education, is unlikely to have strong religious or moral feelings about human behavior. His selection for the course is based on academic performance alone. To such a student, the eloquent humanistic philosopher preaching a gospel of expediency as the ideal criterion for action in stressful situations brings a breath of fresh air in a curriculum otherwise devoted to scientific knowledge divorced entirely from the important notion that both doctors and patients are human beings and not just rather bright animals. As a result, when he graduates the young doctor will find that the notions of human behavior he has learned conflict in no way with those found in *Playboy* magazine and the world of entertainment.

As far as the treatment of organic disease is concerned, he will perform with credit, as expected of a New Zealand graduate. As a general practitioner, psychiatrist or gynecologist, however, he will find himself concerned with matters that have come to be included in medical practice only in very recent times.

For instance, the general practitioner and psychiatrist are consulted about problems formerly the concern of the minister of religion. Marriage guidance, economic stresses, delinquency, the housing shortage and unwanted pregnancies are some of the problems that come the doctor's way because of the decline of religion in New Zealand society. He deals with them according to his own idea of them, in some cases based on attitudes gained from sources outside his medical training as well as within it.

Permissiveness Advanced

In general, the medical profession has supported the public's demand for tranquilizers, contraceptive pills, sterilization and abortion — all for non-medical reasons — thus joining in with the advance of permissive and materialistic thought. No doubt euthanasia and forced family limitation will soon follow. The Christian doctor who feels there is an interrelationship between his medicine, his religion and his morals looks aghast at the current situation, especially when he sees the radical changes in attitude that have occurred in the last 20 years.

What can be done? In my view it should not be the function of a medical dean or any medical teacher to include in his official teaching or administrative responsibility the inculcation of a rigid philosophy of medical practice. On the other hand, the deans should be concerned if a teacher uses his position to force a particular philosophy on his students and should ensure that a balanced presentation is preserved. Official status should be given to medico-moral issues. Abortion, contraception, sterilization, euthanasia, human experimentation, artificial insemination, aspects of organ

transplantation, attitudes toward the incurable and the dying, aspects of drug therapy and pain relief are all examples of medico-moral issues not included in our medical course.

It is expected that a society's doctors will follow the moral and ethical standards of that society. This seems to be the case in New Zealand where doctors prescribe enormous quantities of drugs to combat and ease the stresses of life and generally adopt a liberal attitude toward therapeutic abortion, vasectomy, tubal ligation and free contraception. In all of these instances, the patient usually suggests the treatment and the doctor acquiesces. It is commonly said of a doctor who refuses to comply that he is imposing his moral attitudes on the patient; the reverse is never suggested.

Typical Attitudes

In an abortion discussion recently, my opponent, a general practitioner, said that he never allowed his moral opinion to interfere with his medical opinion when considering a case for abortion. This doctor and many of his colleagues believe that the general practitioner and his patient should decide the abortion issue and that even the gynecologist should not be allowed an opinion in cases he is expected to abort. This is typical of the climate of modern society and of modern medicine.

The new world of medicine is strongly in favor of the zero population band wagon, and the average doctor is more deeply concerned about pollution of the environment than about the degrading and dehumanizing effects of the new morality. The only chance we have to reverse the trend is to return to basic practical Christianity so that young men and women entering medicine will appreciate the origin, integrity, dignity and ultimate destiny of those they will serve as practicing physicians.

Religion must be restored to the state school curriculum. The churches alone are unlikely to be successful in any counter-revolution. In fact, a disturbing number of clergymen have given up the fight and joined the lax, unprincipled and expedient philosophy of the modern age. Every thoughtful Christian must speak out emphatically whenever the opportunity comes his way, and medical school teachers have an important role to play.

"All that it needs for evil to triumph is for good men to do nothing," has been said before — but it is surely appropriate to the trends we see in modern medicine.