Making tomorrow's doctors better prescribers

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Deans of medical schools, and those responsible for deciding the teaching programmes for undergraduate medical students, are invariably suspicious of curricular proposals by specialist societies. They assume a self-serving motivation intended to enhance the power and image of the discipline. They say to themselves 'they would say that wouldn't they?'.

However, medical schools ignoring the proposals [1] published in this issue of the Journal will do so to the detriment of future generations of patients. For there is abundant evidence that today's doctors are, generally, poor prescribers; and unless there is concerted action, tomorrow's doctors will be even worse. The current shortcomings have been clearly documented by health professionals [2, 3] and the Audit Commission [4]. Also, to add insult to injury, British doctors are amongst the slowest in the developing world to adopt effective new treatments [5],

It has been inferred [1, 6] that British doctors' deficiencies as prescribers are the result of the General Medical Council's ill-judged attempt at curricular revision in 1993 [7]. This, I believe, is too harsh. Our failure to train young doctors in safe, effective and cost-effective prescribing goes back much further, and probably has more to do with our professional culture than with recent pronouncements by the General Medical Council.

Curiously, during the 19th century, most UK medical schools had established chairs of either material medica or therapeutics. In the early years of the 20th century most (except those in Scotland) of these posts disappeared. Why? I attribute it to William Osler. Osler was, unquestionably, the greatest and most influential teacher of his era. He was, though, scathing about the therapeutics of his day:

'One of the first duties of the physician is to educate the masses not to take medicines'.

'The young physician starts life with 20 drugs for each disease, and the old physician ends life with one drug for 20 diseases'.

His caustic remarks are understandable. A hundred years ago, despite the availability of large numbers of both extemporaneous and proprietary products, he recognized that few had any useful beneficial effects; and that many were downright dangerous. His emphasis on teaching the basic principles of bed-side clinical diagnosis was appropriate for the time, and his disdain for therapeutics was rational, but the advances in pharmacotherapy that have occurred over the past 50 years have not been paralleled by an appropriate educational commitment; and Osler's antipathy to therapeutics as an essential component of medical education still resonates with the General Medical Council's Education Committee, deans of medical schools, and curricular designers. As a consequence, patients have not reaped the benefits that modern pharmacology could provide for them.

The Society's proposals [1] now offer curriculum planners and teachers in UK medical schools clear advice on the delivery and assessment of teaching in clinical pharmacology and therapeutics. The proposals emphasize the need for leadership and describe the necessary content in unequivocal terms. I applaud the emphasis it gives for medical schools to create a 'student formulary', although I wonder whether we all need to keep re-inventing the wheel. Perhaps we could pool our resources and idiosyncrasies to establish a 'national student formulary'?

Nevertheless, if UK medical schools pay heed to the Society's core curriculum, tomorrow's doctors and tomorrow's patients will reap real benefits.

References

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