

Correspondence

Commentary: Education at the Faculty of Medicine

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In his article entitled *Neoliberalism Within Psychology Higher Education in Indonesia: A Critical Analysis* (*Anima Indonesian Psychological Journal*, 32(1), 1-11), the author, Teguh Wijaya Mulya, using a broad, in-depth, and philosophical view, has claimed in the conclusion section that (cited as follows): *“In contrast to medical schools that usually approach humans as a collection of interconnected organs that may or may not function properly, psychology (c)laims to engage with humans as humans”*. I would like to comment on this statement.

I think that the statement is based on impressions and not on research. However, the author is not the only one who has this impression. I heard similar comments made by some people, scientists, educators as well as medical doctors. They have used different words, but the main idea is the same or meaning somewhat like: doctors nowadays are more commodity oriented than community oriented. Where does the impression come from? It may emerge from a personal experience and/or a family member's or friend's encounter with an individual doctor. I must admit that there are such doctors. But this is not an experience involving medical schools or the Faculty of Medicine as an institution. But, then, the assumption may well be that doctors of course obtained this from their education. I doubt that the Faculty of Medicine has deliberately encouraged this attitude, as stated by the author earlier: *“...medical schools that usually approach humans as a collection of interconnected organs....”* If there are such doctors, not many of them (based on my experiences), then it should be ascribed to their own personal attitude, expressed consciously or unconsciously in their behavior towards patients. Furthermore, if there are doctors with this attitude, would it not be more appropriate to say that this is the result or side effect of neoliberalism as discussed by the author? It is very possible that a few lecturers, including those from the Faculty of Medicine, have been influenced

by neoliberalism and then in turn, they influence their students. I think there is no single cause, but for sure the Faculty of Medicine does not deliberately design a curriculum with such a purpose. This learning issue is in the affective domain of learning and its cause is multifactorial.

A doctor's competencies, the knowledge of basic medical sciences, their clinical knowledge and clinical skills are determined by his/her medical school's competency based curriculum and by what and how he/she has been doing during his/her life long learning experience. As said before, the attitude and behaviour of medical students are usually influenced by a large number of factors. There are influences coming from inside the faculty (still manageable), but there are also factors from outside the faculty (unmanageable). Another important factor is the *hidden curriculum* (this is the attitude and behavior of lecturers concerning ethics, disciplines, and manners, as well as their soft skills) which is also having a strong influence. Although the hidden curriculum is an internal factor of the faculty, it is difficult to manage. At the end, a doctor's performance, as a human being, as a member of society and also as member of a medical team, the way he/she works as a doctor, is determined not only by his/her medical technical competencies (which are also important), but more by his/her soft skills, ethics, disciplines, and manners. Up to now, it is difficult for the Faculty of Medicine to create effective (and efficient) learning experiences in order to develop these types of skills and attitudes, because of the many factors influencing them. In particular, the issue is how to design learning experiences that could lead to permanent changes in the affective domain of learning (in terms of soft skills, ethics, disciplines and manners) and which also are not easily influenced by negative factors from the outside world that are contrary to the medical profession. In this case, maybe we need advice from educational psychology.

The medical profession itself is making continuing efforts in designing a “better” curriculum for graduating “better” doctors. For example, the Indonesian Medical Council or KKI (*Konsil Kedokteran Indonesia*) has developed the Competency Standard for Indonesian Doctors or SKDI (*Standar Kompetensi Dokter Indonesia*) in 2006, revised in 2012, and in 2017, the third edition of this competency standard would be processed. The SKDI clearly indicates that the competency *areas* (definitions are included) of Indonesian doctors are arranged in the following order:

1. Noble professionalism
2. Self-awareness and self-development
3. Effective communication
4. Information management
5. Scientific medical knowledge
6. Clinical skills
7. Health-issue management

According to John Alexander (cited in Ryadi, 2015), the goals of education are:

1. To help a person learn to think.
2. To help a person understand himself as an individual.
3. To help a person understand the society of which he or she is a part.
4. To help a person understand the environment in which she or he as an individual and society as groups live.
5. To help a person enjoy that understanding.
6. To help a person make wise decisions.
7. To help a person implement those wise decisions.
8. To help one earn a living.

According to the International Commission on Education for the 21st Century of UNESCO (United Nations Educational, Scientific and Cultural Organization), after holding a conference with the theme “Learning: The Treasure Within” in Sydney in 1996, education is defined as:

- **Learning to know:** to help learners to become competent in critical and systematic thinking as to understand the reality of self, others and the world.
- **Learning to do:** to help learners in problem solving.
- **Learning to be:** to help learners to become authentic human beings, holding on principles, and not easily becoming frustrated by self interest and environmental pressures.

- **Learning to live together:** to help learners to become aware and understand that to develop unity not by denying differences, but by respecting each other’s differences and uniqueness (loving, caring and forming each other).

Later added:

- **Learning to learn:** to incite learners to practice lifelong learning and be able to learn from each life experience.
- **Learning to love:** to help learners to be able to love oneself, other human beings and the Creator.

According to Schillebeeckx (cited in Ryadi, 2015), a humanistic doctor is:

- Able to find meaning and self.
- Aware and able to develop existing potencies.
- Able to control existing drives.
- Able to form conscience.
- Able to develop appreciation and able to express feelings and thoughts honestly and rightly.

Advances in science and technology can not be stopped. The horizon of technology is the *possibilities*. But there is *no* neutral technology, a tool can be used in all directions, for the goodness or destruction of humankind. What is good for humankind, is good, what destroys humankind is wrong. In order to determine this, we need the elaboration and guidance of morals and bioethics, because the horizon of morals and bioethics is the *goal*. Therefore, the UNESCO Bioethics Chair has strongly advised the inclusion of bioethics in the curriculum of schools of life sciences, such as biology, psychology, medicine, nursing, and so forth (The head office of *UNESCO Asia-Pacific Bioethics Network, Indonesian Unit* is at the Faculty of Medicine, Airlangga University and the current chairperson is Dr. Siti Pariani, dr, MSc.).

Although in lectures and discussions with medical students I often stressed that a patient is not a mass of cells and a group of organs abiding to biochemical, physiological, and pharmacological laws, but he/she is *a bio-psycho-socio-cultural-spiritual being, like the doctor him/herself also is*, I have to acknowledge that a doctor’s performance is influenced by many factors. As stated earlier, the problem is how can we provide learning experiences making changes in their affective domain and becoming more “resilient” in dealing with the negative influences of the outside world, including the rapid biotechnological development that seems to

be running out of control? Educational psychology states that small group discussion is the most effective learning method in producing changes in the affective domain. For moral development, I use Lawrence Kohlberg's theory of moral development and his method of moral dilemma discussions. Doing so pushing the participants through *personal ethical reasoning* to a higher level of moral development, so they can take *greater personal responsibility* for their ethical decisions, and not only referring to other sources, as if those sources are also responsible for their decisions (Maramis, 2009; Maramis, 2015).

If educational institutions are not cautious, then their goals might change from emphasizing wisdom to emphasizing wealth, and values, priorities, and focuses will also be declining (Berman, 2015). If this is the case, then during the learning process (as well as practices), educators and students, who previously started learning and practicing with their heart, brain, and hands, gradually are going to use their brain and hands only, and finally, only their hands. They will be performing like robots. They will become robotic doctors and see patients as a conglomerate of cells and organs only.

We, at the Faculty of Medicine, Widya Mandala Catholic University Surabaya, are very aware of this issue. Thus, all undergraduate students of Widya Mandala Catholic University Surabaya have to collect 100 points of student activities or PK2 (Poin Kegiatan Kemahasiswaan), extracullicular, during their study for developing their soft skills, before they are allowed to graduate. Particularly for medical students of Widya Mandala Catholic University Surabaya, in addition to 100 PK2, they have to pass 14 credit points of humanities courses (out of 148 credit points in the curriculum). They should also collect 70 points of medical student activities or PK3 (Poin Kegiatan Kemahasiswaan Kedokteran) that consists of Moral Dilemma Discussions (DDM, Diskusi Dilema Moral, groups of 10 students and each group with one facilitator) held once a week, 10 times each semester, and lectures on ethics with specific topics held twice each semester, both from semester 1 to semester 7 (Maramis, 2015). For students in clinical training (co-assistants or junior doctors), who work full-time in a hospital for two years during their professional training, they have to collect 50 PKDM (Poin Kegiatan Dokter Muda) or Activity Points of Junior Doctor, with the purpose

of developing soft skills, ethics or ethical reasoning skills, disciplines, and good manners, as well as medical professionalism (see appendix). Our slogan is:

Graduates of the Faculty of Medicine of WMCUS
are:
Professional doctors,
with spirituality and moral integrity,
And excellent soft skills,
Who serve with ethics, discipline, good manners,
and
Love

Surabaya, October 2016

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Appendix

Foundation of Competencies of Physicians (Modification of SKDI)

