

## Editorial

## Educating Tomorrow's Doctors

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Most worthy medical schools undertake curriculum review and reform from time to time. It often begins with enthusiasm but soon reveals difficult, unresolved questions. Among the most fundamental: What is the single most important attribute tomorrow's doctors must have? Defining this is not just an academic exercise; it shapes the doctors we train and, ultimately, the future of the profession itself.

The answer is not straightforward. The list of contenders is long and has shifted over time. Knowledge, of course, is essential; doctors are no longer barber-surgeons. Critical thinking and the ability to apply the scientific method help doctors guide patients through a landscape crowded with misinformation. Clinical competence, too, is vital, as are the clinical communication skills that are proven to result in better patient outcomes. In the UK, different attributes have risen and receded like tides: lifelong learning, reflective practice, patient care, and, more recently, kindness. In an increasingly interconnected world, diversity, cultural competence, and an international perspective have become essential attributes. Meanwhile, in Western healthcare systems, the increasing marketisation of care has placed the most vulnerable at greater risk, making patient advocacy and public health once again essential skills for doctors.

All these qualities are important, and all should be cultivated - but without a single, defining priority, curriculum design risks becoming a spinning top, expending enormous energy yet making little real

progress. An extensive list of desirable attributes may look impressive in a curriculum document, but without a clear guiding principle, it offers no real direction. A singular focus does not diminish the importance of other attributes; rather, it provides a framework for how they should be applied in practice. Choosing the most important attribute for tomorrow's doctors requires looking ahead and also looking back. Today's graduates will still be practicing in 50 years, and the changes their predecessors have faced offer a glimpse of what lies ahead.

In the last fifty years, ultrasound, CT, and MRI have shifted from research tools to routine investigations; laparoscopic surgery and interventional radiology have appeared and then revolutionised treatment; and our understanding of viruses and viral disease has developed exponentially. As late as 1985, an early description of HIV ('slims disease') in *The Lancet* reassured doctors that 'there is no clear evidence to implicate other possible means of transmission, such as ... re-used injection needles'.<sup>1</sup> Today, this seems unthinkable, yet at the time, it reflected mainstream thought.

Beyond scientific advances, the very role of the doctor has shifted. The internet and mobile data have decentralised medical knowledge, eroding the traditional model of the doctor as the sole authority. The profession has had to redefine itself, not just in response to new discoveries, but in response to changing societal expectations. Future doctors will face even greater shifts - some predictable, others currently unimaginable. Fixed knowledge cannot sustain a lifetime of practice; medical education must prepare graduates to navigate and lead in a landscape of relentless change.

Medical revolutions are inevitable, often unfolding with remarkable speed. When germ theory replaced miasma theory, entire generations of physicians had

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to abandon their fundamental understanding of health and disease. By 1880, the idea of infectious agents remained contested, yet within 30 years, it had reshaped medical science, practice, and education entirely. If current foundational knowledge is overturned just as swiftly in the future, will graduates be ready to adapt, or will they resist, as many did in previous revolutions?

In terms of attributes, then, above all, graduates need to be prepared for profound levels of change during their working lifetimes. Above all, they must be lifelong learners. On this issue, Osler stated that “More clearly than any other, the physician should illustrate the truth of Plato's saying-that education is a life-long process”.<sup>2</sup> Whilst widely and consistently accepted in postgraduate training, lifelong learning is often neglected in undergraduate education - precisely where it must begin.<sup>3</sup> Once central to medical education, lifelong learning has steadily slipped down the list of priorities, eclipsed by immediate, competency-based objectives. This shift reflects a broader problem: a growing preoccupation with measuring the measurable, rather than fostering the habits of intellectual curiosity that sustain a doctor's learning for life. Encouraging students to become lifelong learners is not easy. It involves teaching them how to learn (study skills) and teaching them how to actively manage their learning (metacognition). There are extensively researched and validated methods to do this, however these alone are not enough.

Beyond skills and strategies, medical teachers must also inculcate in students the understanding that knowledge is not fixed, but fluid, and that knowledge is not held by the school and passed down to its students, but rather that it is constructed as the learners make sense of what they learn and what they experience. Unfortunately, most students join university with a simple binary view of truth, and the route to intellectual maturity is challenging and only completed by some.<sup>4</sup> If a student graduates believing that they need a teacher to learn, or graduate unable to deal with uncertainty, they will never become lifelong learners.

Paulo Freire critiqued the 'banking model' of education, where “knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing” (p 72).<sup>5</sup> He argued that this approach not only stifles critical thinking but is also a means through which power is maintained, reinforcing the idea that knowledge

belongs to those in authority rather than being co-created through dialogue and experience. Traditional medical education has long operated under this model, where expertise is something delivered rather than questioned.

If medical education is to produce lifelong learners, how we teach is just as important as what we teach. Each time a definitive answer is given without acknowledging uncertainty, each time authority is asserted without inviting questioning, and each time debate or dissent is discouraged, the idea is reinforced that knowledge is fixed and learning is passive. We, the educators of tomorrow's doctors, face a challenge not merely to model a different way of thinking, but to believe in it. Preparing doctors for a lifetime of learning requires more than accepting uncertainty; it must be valued. Questioning must not only be permitted but encouraged, and adaptability must not only be taught but embodied in everything we do.

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