THE ASIA-PACIFIC SCHOLAR
MEDICAL AND HEALTH PROFESSIONS EDUCATION

INNOVATIONS AND INSIGHTS

Check for updates

Submitted: 31 January 2024
Accepted: 3 September 2024
Published online: 7 January, TAPS 2025, 10(1), 56-58
https://doi.org/10.29060/TAPS.2025-10-1/PV3239

Compulsory lecture attendance: A poison or antidote?

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I. INTRODUCTION

Contemporary undergraduate medical education is increasingly emphasising the cultivation of student ownership and autonomy, entrusting learners with the responsibility to take charge of their own studies. Across Asian countries, high school graduates embark on their medical education journey at the age of 19 to 20 years, stepping into the realm of adulthood and assuming accountability for their academic pursuits. As the landscape of medical education undergoes transformative shifts propelled by technological advancements and evolving pedagogical approaches, one enduring tradition faces scrutiny: the imposition of compulsory lecture attendance.

Intriguingly, amid the broader trend toward fostering student autonomy, some Asian medical schools grapple with concerns about low lecture attendance. Rather than embracing the prevailing ethos of adult learning, these institutions respond by adopting autocratic measures to enforce mandatory attendance. This perplexing approach begs the question: Why, in an era of educational evolution and empowerment, do certain medical schools resort to rigid mandates to address the issue of diminished lecture participation?

This article does not engage in a debate about the efficacy of lectures; instead, it delves into the heart of the matter — the compulsory attendance. Considering medical teachers' dissatisfaction with students' lecture attendance rates, it becomes imperative to explore the underlying frustrations that lead institutions toward autocratic measures. What lies at the core of this apparent contradiction between the shift toward learner autonomy and the persistence of compulsory lecture attendance?

II. THE FRUSTRATIONS AND OUR ARGUMENTS

1. Some medical teachers may argue that frustration lies in the association between lecture attendance and academic performance.

Our arguments are as follows. First, research data show a mixture of supporting and opposing evidence (Doggrell, 2020b). Second, if this association holds true, it implies that high-achieving students should be afforded the freedom to forego lectures. Alternatively, medical students who acquire lecture content from other media, such as recorded lectures or online resources (e.g. YouTube videos), and offline resources (e.g. reference books) should also have the freedom to skip lectures. Third, it appears more rational to correlate academic performance with students' active engagement during lectures rather than their mere physical attendance. Students who attend lectures to avoid punishment may be reluctant to become involved. Despite their outward presence, if these students remain preoccupied with internet-connected devices, does their mere attendance satisfy the expectations of medical teachers? The scenario becomes even more poignant when considering the time medical teachers spend managing students who are not engaged in lectures. This time could otherwise have been meaningfully invested in students genuinely seeking to absorb and engage with the lecture content.

2. Some medical teachers contend that the crux of the frustration lies within professionalism, positing that attending lectures is an integral aspect of student professionalism.

Our arguments are as follows. First, a systematic review discussing unprofessional behaviours among medical students does not identify lecture attendance as a dimension of professionalism (mak-Van der Vossen et al., 2017). Second, even if one were to categorise lecture absenteeism as unprofessional, the AMEE Guide No. 61, titled "Integrating professionalism into the curriculum", does not advocate for compulsory attendance as a prescribed professional solution (O'Sullivan et al., 2012).

Some medical teachers draw parallels by likening student absenteeism to the unacceptable conduct of on-duty medical practitioners. However, this analogy lacks validity. The execution of medical duties by practitioners necessitates a specific venue, such as a clinic, and adherence to fixed working hours. In contrast, medical students can fulfil their learning responsibilities at any time and from any location, exemplified by the ability to engage with recorded lectures. For the analogy to be valid, lectures must be proven irreplaceable in delivering certain medical content.

3. Some medical teachers contend that their frustration lies in low lecture attendance, adversely affecting their morale for teaching (Emahiser et al., 2021).

Our arguments are as follows. First, although low attendance can be upsetting and disappointing, medical teachers should not request compulsory attendance to appease their emotional and moral demands. While commenting on student absenteeism as unprofessional, do these teachers, in turn, project a more professional image by demanding mandatory attendance? Second, the variability in audience size for different lectures or lecturers warrants the teachers' self-reflections on their teaching methods (Emahiser et al., 2021). Third, there is perhaps no downside to the teaching styles employed by medical teachers; however, some medical students have preferences for different learning methods (Emahiser et al., 2021). Alternatively, the characteristics of Generation Z learners, marked by a limited attention span and a preference for online learning environments, may not align with the assumptions underlying compulsory lectures. Mandating attendance presupposes a one-size-fits-all approach, and debatably, lectures might not be the panacea for optimal academic performance among medical students.

4. Some medical teachers may argue that the frustration stems from the perception that many Asian high school leavers are not mature enough to make decisions.

Our central argument posits that, irrespective of the potential benefits of lectures, they should not be mandated. How can medical students cultivate maturity if they are not afforded the opportunity to exercise decision-making in the first place? It is ironic that, while Asian medical schools try to promote adult learning principles into their curriculum, they endorse paternalism in conditioning student behaviours. Our stance is not a discouragement of lecture attendance; rather, we oppose the imposition of paternalism in moulding the physicians of tomorrow.

III. OUR PROPOSALS

1. To address the challenge of low lecture attendance, our proposal for medical teachers is to reconsider the delivery method of lectures. Let us acknowledge the need for our teaching methods to evolve in response to technological advancements and the distinctive learning preferences of Generation Z. Following is an actual reason for absence - "I don't consider the lecturer adds to the material given on the PowerPoints" and a reason for attending – "It allows for interaction with course staff and/or students" (Doggrell, 2020a). Thus, it becomes imperative for medical institutions to train educators with interactive strategies (e.g., inquiry activities) that complement lectures and motivate students to actively participate in the learning process. Consequently, faculty development programs that are in line with evolving learning science and the changing needs of learners are deemed necessary.

Next, we should reconsider the emotional need to see students physically. Theoretical and empirical evidence suggests that recorded lectures work effectively, as students can pause and play the recordings, which enables them to learn at their own pace. Medical teachers must accept that, with the tremendous amount of available teaching and learning materials online, attending lectures is no longer the sole source of knowledge. Considering flexible attendance policies that accommodate students' individual needs and recognising the importance of adapting to evolving educational practices and preferences are equally essential.

2. For medical students, our suggestion is to foster ownership and autonomy in their studies, predicated on an understanding of the potential repercussions on their academic performance. Medical students should be empowered to make informed choices, cognisant that each choice carries consequences. This approach aligns with the principles observed in medicine, where patients retain the autonomy to continue or discontinue treatment at their own risk. If adult learning is deemed fundamental to the future medical curriculum, Asian medical teachers ought to relinquish paternalistic tendencies.

This shift does not imply a cessation of support for student learning. Instead, we shift to help students "learning to learn", for instance, to promote the understanding of (including but not limited to) andragogy and self-regulated learning. It may not be the lecture attendance that some low-achieving medical students have missed; rather, it could be the cultivation of appropriate mindsets about learning, including aspects like time management and motivation.

IV. CONCLUSION

In conclusion, our scrutiny of compulsory lecture attendance reveals that it neither serves as a panacea for academic performance nor aligns seamlessly with the principles of professionalism or the preferred learning styles of Generation Z. Rather than acting as an antidote, the imposition of compulsory attendance manifests as a form of paternalism within Asian medical schools. This paternalistic approach, rather than nurturing, acts as a toxic element for aspiring medical professionals, hindering the cultivation of autonomy and adult learning principles in the trajectory of futuristic medical education. To remedy this issue, delivery method of lectures should consider state-of-the-art learning science, matched with the changing needs of students.

Notes on Contributors

Chan Choong Foong conceptualised and designed the work, and drafted the manuscript. Mohamad Nabil Mohd Noor conceptualised and designed the work, and drafted the manuscript. Galvin Sim Siang Lin interpreted the findings from past studies for the work, and revised the manuscript critically. All authors have read and approved the submitted manuscript.

Funding

The authors did not receive support from any organisation for the submitted work.

Declaration of Interest

The author declares that there is no conflict of interest.

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