Academic Medicine: What Does an Outsider Have to Offer?

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One of the many problems of academic medicine is its detachment from actual health problems of the population. Family medicine has a potential of bridging this gap. The paper describes the positive experience from introducing family medicine as a new academic discipline to the medical school in Slovenia. Its introduction was of benefit to family medicine, which has received recognition and has experienced a rapid academic growth. Medical academic establishment has benefited by being exposed to new ideas in research and education. The key to success was the fact that the academic world accepted a newcomer to its midst and that the newcomer managed to integrate its principles into the rules of the academic environment. The next step in this process is to apply some of the positive experiences of the family medicine department to the curriculum reform of the entire faculty.

Key words: curriculum; education, medical; faculty, medical; physicians, family; Slovenia

The dispute over academic medicine is largely based on the supposition that academic medicine is concerned with purity of science and research and detached from everyday practice (1). Therefore it fails to serve the public good and lacks global perspective. Academics live in ivory towers, concerned with problems that do not reflect reality. They pursue their own interests, which appears to be a greater problem in poorer countries (2). There is a failure to translate basic discoveries into benefits for patients (3). A lot of criticism is related to various shortcomings in medical education, which is supposedly outdated (4).

A closer look at the academic world shows a grim picture: the numbers of academics are inadequate and career paths for well-trained medical academics are not very well defined or supported (5). The dinosaurs that inhabit the ivory towers have created an environment that is unpopular among the young and the bright (6) and, although it may still be interesting from the outside, the environment is not appealing: there is no air-conditioner and the air quality is very poor.

Clearly a change is necessary. The only way is to adapt, but also to maintain the core values and determine the positive effects of academism. Addressing this issue is difficult and different strategies should be used. The experience of introducing family medicine in Slovenia is perhaps an interesting example of how outsiders to the academic world can help in solving some of the problems of academic medicine.

Improving Air Quality by Opening the Windows

Outside the ivory towers of medicine there are stakeholders that aspire to join the academic world, as to be one of academic disciplines is still a sign of recognition and prestige. A typical example of such a discipline is family medicine. The trend of introducing family medicine as an academic subject is universal (7). In Slovenia, introduction of family medicine teaching was slow and the department was created only in 1994, after a long period of scepticism from the university. The Department introduced innovative teaching methods by applying principles of modern education and engaging the best general practitioners as teachers (8). By introducing teaching that was very different from the teaching at other departments, we became a very popular subject.

The start was a modest attempt of introducing a new subject, with an emphasis on the integration of clinical knowledge and teaching communication skills in the last year of medical school. But this new initiative was a useful challenge for the young and bright physicians working in family medicine, who have wanted to contribute to this development and have been appointed (mostly voluntary) assistants at the Department. Although the formal number of people employed by the faculty has not changed over the years, the growth of the Department in the last decade showed that it was a success: the number of lecturers (ie, professors and senior lecturers) has increased threefold and the number of instructors eightfold. But
the most important contribution probably was that about 15% of all physicians in general practice took part in teaching students as voluntary preceptors.

But the Department itself also contributed to the University: it was a source of new ideas in research by, for example, introducing qualitative research methods and raising new research questions that would be more relevant to the needs of the population. Also, the number of new masters degree students taking family medicine as the subject for their theses has risen to about ten every year from previous years where there was one student every five years.

Next Step: Taking the Dinosaur for a Walk

The academic world needs to get in touch with reality. The leaders of universities are well aware of these challenges, but they need people that would demonstrate that the new ideas are here to induce changes, usually in a form of a curriculum reform. Over the last 10 years, the Department has demonstrated to the Ljubljana faculty that modern teaching can work in our country as well. Therefore, the decision of the Faculty to introduce a curriculum reform was not that difficult (9).

Lessons Learnt

In the last ten years, we have learnt the following lessons and some of them are direct answers to Tugwell’s editorial.

1) There is no “academic health care”. Obligations in research and training are part of any good quality health care. With the democratization of training, these two have become an integral part of every physician’s tasks. The title “academic” actually means “higher quality”. Introducing everyday practitioners to the academia benefits both: the practitioners receive recognition and the academics get new ideas and resources to conduct research and teaching.

2) Methods of teaching in medical schools are often inadequate, based on previous experience of teachers. Introducing new teaching techniques is very important, but needs to be done with rigor. Departments of family medicine often serve as models of modern approaches to teaching, merely because it is easier for them to introduce new approaches.

3) Hospitals are the wrong place to train doctors. This teaching environment largely belongs to the past, unless the aim is to teach about exotic cases. Because of that, the trend today is to introduce community-based teaching and teaching in primary care, which more clearly reflects reality (7). Family medicine has a potential to overcome this problem by using practitioners who regularly meet common health problems in practice. But this is by far insufficient. Teaching should include addressing the challenges that tomorrow’s doctors are going to face when they start practicing medicine. Therefore, we need to put more importance to teaching about new technologies that are here already. Future doctors will certainly not communicate only on a person-to-person level. Internet, e-mail, mobile phones, SMS messaging, virtual reality, and other technical innovations are still not addressed by the medical curricula, even by those claiming to be innovative. These are the challenges of teaching communication skills of tomorrow. If family medicine has contributed to the medical curriculum by introducing communication skills training, it should also adapt to these changes.

4) Introduction of changes brings new problems. The newly established departments can soon become members of the same establishment, sharing the same problems. Involving practicing physicians in education is a reward by itself on a short run, but it may also lead to their increased workload and potential for burnout (10).

Conclusion

Family medicine is a discipline that has the potential of bringing new ideas and approaches to academic medicine by introducing “real medicine” into the curriculum, raising new research questions, and introducing new research methodologies. Most of this, paradoxically, does not require vast investments of resources, but the willingness to adapt and to accept that academic medicine is defined by innovation and acceptance of new ideas that come from various sources.

References


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