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A tale of two cultures, of mentors and scholars

A new partnership of clinicians and academics is needed to train young physicians and encourage them to take up neglected disciplines and practice in nonurban communities.

ABSTRACT: Abraham Flexner's seminal report on medical education in 1910 unintentionally divided the teaching community of our university medical schools into two cultures, a dominant scholarly culture and a less powerful culture of practitioners. Despite this, the practitioners are the essential role models and mentors for medical trainees, without whom there would be no doctors. As scientific information has burgeoned, the university scholars have undervalued mentors and mentoring, one reason for the dearth of doctors. Many more mentors will be needed throughout the province if the medical school expansion is to reverse this shortage, but it will only happen if we all accept the pivotal role of mentors and mentoring and ensure the process is adequately funded. If we succeed, the public will get the service it so urgently needs, the divide between the cultures will melt away, and everyone will gain.

Society gave our universities the exclusive authority to train doctors more than a century ago. We are now short of doctors and the shortage is getting worse. Why is this? The reasons are complex, and although government is ultimately responsible, being the source of funds, our university medical schools are also partly to blame. Despite their responsibility for medical education, medical schools have became preoccupied with cutting-edge research at the expense of education, and in doing so they have undervalued and failed to support clinical mentors and mentoring, the essential tools for training doctors. Furthermore, this mind-set has made them increasingly remote from clinical practice and hence slow to recognize and respond to the medical needs of the community at large.

How could this have happened? An unintended and, until recently, unrecognized paradox was introduced to medical education in 1910 with Abraham Flexner's report on medical education in the United States and Canada.[1,2] Flexner's report was solicited by the Carnegie Foundation because many medical schools had been slow to incorporate the new scientific knowledge then accruing and there was considerable public dissatisfaction with the results of medical education. A key recommendation of his report was that medical school teaching should henceforth be the preserve of salaried physician scholars trained in the laboratory and engaged in research. The universities applauded and, with the support of the Rockefeller General Education Board, added an idea of their own: "that physicians not trained in the laboratory must disappear" from the medical school.[3] Both recommendations were widely implemented; and while Flexner's brought a valuable infusion of science to medical education, the universities' requirement created two cultures within the profession—an all-powerful Scholarly Culture in the university, a culture in complete control of medical education, and a Clinical Practitioners' Culture of service to patients and communities, a culture largely excluded from teaching and mentoring and with little influence in the medical school.

The scholars, full-time salaried university appointees, soon found that teaching cut into their laboratory time and so they welcomed the clinicians' return to the medical school to volunteer their time as teachers and mentors

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to the students. Not surprisingly, the scholars, appointed for their academic prowess, saw themselves as superior to the clinicians, appointed to carry out the necessary but (in the scholars' view) less exacting chore of teaching.[4]

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The scholars kept control of the funding and structure of medical education, and do so to this day. Despite the fact that most students are destined for a career in clinical practice, the scholars are still unwilling to share control of medical education with the clinical practitioners.

The use of clinical practitioners as mentors and role models, if not as policymakers, became established over the years and in British Columbia they are given the courtesy title of "clinical faculty," one that carries little weight since most of them are excluded from decision making in the medical school and enjoy few of the benefits bestowed on their salaried colleagues.

Furthermore, having no representation in the university, they have a second-class status within our system of medical education and, if only in this regard, within society, where most other workers are protected from the arbitrary acts of those with power over them.

However indifferently treated, clinical faculty have become the engine of medical education and outnumber the salaried scholars by four to one, a number that has been increasing as the medical school expands. Most of the scholars, although entrusted with medical education, are not appointed primarily as educators. Rather than being hired for their experience as clinical practitioners, they are hired for their past record and future potential as researchers, something both they and the university value over education.[5] With the important exception of some active clinician scholars, many of whom are handsomely subsidized (although to what extent is unknown), the majority of salaried faculty have little experience of, or interest in, the daily routine of medical practice outside the university and so cannot prepare students for this type of clinical career.

Herein lies the paradox. Control of the university medical school, and hence the training of doctors, is in the hands of those who, however distinguished, are seldom involved in the daily practice of medicine. Meanwhile, clinical faculty, who spend their lives caring for patients and are responsible for an increasing proportion of physician training, remain subservient to these scholars and are expected to do the bidding of the medical school, which seldom consults them and appears indifferent to initiatives for change that they, the clinical faculty, have proposed. Perpetuation of this hierarchical system is one reason for the university's sluggish response to the worsening shortage of doctors, a crisis that has loomed for years.

How has this system, which excludes clinical faculty from the councils of medical school policy, contributed to the shortage of doctors? Firstly, by putting a high premium on scholarly activities and being uninvolved in the wider practice of medicine, the university medical school has been relatively insensitive to the developing shortage of doctors. This is why in 1991 their protests were too feeble to prevent adoption of Barer and Stoddart's disastrous recommendation that medical school enrollment be cut by 10%.[6] Many were to blame, but our university medical schools, remote from clinical practice despite their responsibility for medical education, failed to realize the danger and so were as guilty as any for failing to avert it.

Secondly, and for similar reasons, the university medical school has failed to understand the mix of doctors needed to provide comprehensive medical service throughout the province. We are fortunate to have competent subspecialists to mentor those students who choose a subspecialty career, but those who have worked in the community know there is also an urgent need for generalists in family medicine, internal medicine, and general surgery because it is neither practical nor cost-effective to have subspecialists for every body system in each community. With an aging population of patients, many with multiple problems, the only way to coordinate care is with well-trained generalists. The atmosphere in our medical schools, where research is king and scholars rule, does not encourage and may even discourage a generalist career. Generalists are seen as an inferior breed, an attitude that students cannot fail to absorb.

If we are to encourage generalists, how should they be trained? As special-

ists proliferate, generalists in downtown teaching hospitals are increasingly bypassed and no longer attend the range of problems they once did. As a consequence, their ability to act as role models to those destined for community practice is hampered. Furthermore, downtown hospitals are no longer ideal sites for the training of generalist physicians, with their emphasis on tertiary care and a patient mix on the general wards that sees substance abuse, placement, and other chronic problems predominating. This is unlike the variety trainees will meet in practice, where most patients are investigated, diagnosed, and treated in physicians' offices, and only admitted to hospital, and then briefly, for specific reasons. There are few opportunities in our teaching hospitals for trainees to experience the nature of practice outside. Knowing little of it, and lacking appropriate mentors, why *would* a student consider a generalist career?

The place to train and attract prospective generalists is in the communities where generalists thrive, using experienced practitioners as mentors. We must expand the medical school beyond its traditional borders to include those community physicians able and willing to mentor and to teach.

One of the most damaging results of relegating clinical faculty to the wings has been the astonishing assumption that these irreplaceable mentors, who will be needed in increasing numbers as the medical school expands, will be able, let alone willing, to accept ever-increasing mentoring responsibilities without adequate funding and facilities as their clinical workloads increase, waiting lists lengthen, and overheads rise.[7] When budgeting for expansion, the medical school failed to consider the expenses and loss of income of clinical practitioners who mentor well, and included a piffling sum for their contribution—a lack of foresight and a failure to respond to changing circumstances as great as the one that prompted Flexner's recommendations so long ago.

So what is to be done? Recognize the paradox in medical education, jettison the obsolete and insulting relationship of a privileged elite attempting to control an increasingly disgruntled and overburdened workforce, bring clinical faculty mentors to centre stage (their rightful place in medical education), and ensure that there are adequate resources for them to do the job. Medical education has been subsidized for decades by volunteers, and like all subsidized systems, it is inefficient and in danger of collapse—an impending disaster for which the worsening shortage of doctors is ample warning. That the training of doctors, a function so vital to society, should depend on this archaic system is absurd.

A radical change in thinking is urgently needed.[8] The two cultures must form a new relationship based on partnership, equality, and respect. While continuing to support the highest level of scholarship within the scholarly ranks, we must also give priority to setting up a province-wide system of credible clinical faculty mentors to attract young doctors to those neglected disciplines and communities that have suffered under the present regime. How best such a system of mentors might function, be accountable, and produce results remains to be seen, but clinical faculty, with advice from educational experts, are more likely to determine this than any number of remote soothsayers ensconced in ivory towers. Above all, tangible resources, not muscle, must be mobilized to make this work. If we fail to produce the doctors needed, all those cash-hungry activities the medical school has sunk resources into won't be worth a bag of nails. If we succeed, however, we will free up the scholars' time and could well enhance their achievements, something as essential to a world-class medical school as good mentoring.

The university may see this as a loss of power but, on the contrary, such a partnership of equals would extend the university's influence and prestige, enhance the medical school's ability to train doctors and increase its academic prowess, and (hence) allow it finally to discharge its obligations to the society that pays so dearly for its existence.

Competing interests

None declared.

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