

Social Accountability of Canadian Medical Schools: The Factor of Complexity

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To the outside observer medical schools and their affiliated institutions form highly complex organizations whose structure and functions are difficult to understand. The question arises as to whether medical schools and their partners are truly complex or whether academic medicine has not done a very good job of explaining exactly how academic health sciences centres work. In the treatise that follows I will try and make the case that medical schools are indeed more complex than other parts of universities, including other professional schools, and I also hope to disentangle some of the complicated relationships.

Perhaps the most fundamental difference between schools of medicine and other professional schools is the tripartite function of medical schools with engagement in teaching, research and clinical care. In general, faculty in other professional schools who are full-time university employees engage in teaching and research but do not practice their profession as an intrinsic part of their university appointment but do so, rather, as private consultants acting outside the formal university structure. For example, a full-time law professor would not, in general, carry on a busy professional practice while holding the university appointment. In these faculties, and to some extent in medicine as well, involvement of the practicing profession comes through part-time appointments. The difference in medicine is that all full-time clinical faculty engage in clinical practice as a major part of their daily activity. It may be overstating the case somewhat to say that full-time clinical faculty in medicine are the only professional faculty who actually “profess” their calling. That medical schools are structured the way they are is because most of us believe that to impart clinical art and science the teacher must be actively engaged in his or her own clinical practice. While some people don’t like the term “apprentice” profession there is nevertheless a substantial element of what might be called apprenticeship in the education of physicians.

The consequences of this medical school organization are very substantial. It means that virtually all clinical faculty have two distinct but interlinked appointments, one in the university as a professor and the other in the hospital or clinic as an attending or consultant physician. Unlike many institutions in the United States, hospitals and clinical care facilities in Canada are under a totally separate governance structure from universities and medical schools and thus the clinician finds him or herself reporting to two masters through two independent structures. Not surprisingly, this arrangement has implications for remuneration, promotion, tenure, deployment and discipline. An individual physician presenting for the first time to be appointed to a medical school has to have that appointment vetted through the faculty, its appointments committee and then sent to the university board of regents or trustees for approval. The academic and clinical appointments are usually interdependent. The clinical appointment requires appropriate licensure and approval by a division and/or department within a health care institution

and eventually by the board of trustees of that institution. The loss of one appointment may well put the other in jeopardy.

Clearly there is opportunity for disagreement between the two (or more) sponsoring institutions as to how such an individual's time may be best spent, for example, in research and teaching versus clinical care. Such disagreements are generally dealt with through a joint management committee guided by a formal affiliation agreement. Given these arrangements it would not be surprising to learn that the financing of academic medicine is fairly complex both at a macro level as well as at an individual level. For any given clinical faculty member sources of funding for personal support include university "hard money", university "soft money" (internal awards), external awards (e.g., Canada Research Chairs) and clinical practice, to name some. Over the years groups of clinicians found it advantageous to form practice associations in which clinical earnings were pooled and redistributed according to certain pre-agreed upon formulae. This permitted a cardiology group, for example, to hire research-oriented cardiologists who may not generate substantial billings but nevertheless were able to "survive" through redistribution of their colleagues' earnings. In some faculties there was a single practice plan for the entire full-time faculty. A further refinement was the introduction of the alternative payment plan in which clinical faculty do not actually bill the government directly for their clinical services but are compensated based on their ability to deliver on a pre-agreed upon set of objectives. The government provides a block grant to the department or faculty. This scheme permits appropriate compensation to be given for teaching, research and administration and not just patient care.

As government support for post-secondary education has diminished, faculties of medicine have become more and more dependent on clinical earnings to balance their ledgers. This clearly has implications for associated healthcare organizations such as teaching hospitals which usually carry some or all of the infrastructure costs for these same university physicians who are working within their institutions. In addition to waiving office overhead, hospitals may supply secretaries, laboratory space and also contribute directly to clinicians' earnings. While most, if not all, faculties and schools in a university obtain moneys from a variety of sources, for the most part the bulk of faculty salaries (which is the biggest single expense in any faculty) comes through the grant to the university. In faculties of medicine this is by and large no longer the case and the actual contribution to the medical school through the university for faculty salaries may be quite small or, for some faculty, non-existent. This in itself gives rise to interesting dynamics as faculty appreciate just how and where their bread is buttered. While 20 to 30 years ago the distinction between part-time and full-time faculty was fairly clear cut, this distinction is no longer so obvious.

The 20th century saw an explosion in biomedical research, much of it carried out in faculties of medicine but also in affiliated research institutes which, like affiliated hospitals, may have a separate board of trustees, a separate appointments mechanism and may compensate faculty directly for their contributions. Thus a clinical faculty member may have an academic appointment in the faculty of medicine, a clinical appointment in

an affiliated teaching hospital and a research appointment in an affiliated research institution.

The fact that medical schools are inextricably linked to the healthcare system is a distinguishing feature of these professional schools compared with others. An area where this plays out is in the field of postgraduate medical education. Collectively there are in 2003-2004 some 7800 students enrolled in faculties of medicine as so-called undergraduate students. In reality most medical students already have a baccalaureate degree or the equivalent thereof. Once they complete the MD program they are obliged to undertake residency training, in family medicine or in one of the more than 60 specialties. In 2003-04 there are more than 9400 post-MD trainees registered as university students through our medical schools. What is different about this category of student is the dual nature of their responsibility. Although they are registered university students they are also employed by the provincial governments through one of the healthcare authorities or teaching hospitals in recognition of the fact that they contribute a great deal of service to the healthcare system. Furthermore, they are critical in their roles as supervisors and evaluators of medical students. Faculties of medicine also have students proceeding to advanced degrees at the masters and doctoral levels but the postgraduate MD trainee represents a unique category that is not seen in other faculties or schools.

Finally, medical education has changed dramatically over the past two to three decades. The course structure so familiar in most schools and faculties has largely disappeared in medical school to be supplanted by a vertically and horizontally integrated curriculum which is not quite seamless but much less course-based than previously. The emphasis currently is on a student-centered approach with a push toward self-directed learning, small-group instruction, early clinical exposure and case-based and problem-based curricula. About half the MD program is spent in a clinical clerkship, not in a classroom. Furthermore, the sites for clinical instruction and experience have changed significantly over the past couple of decades. Traditionally, large inner-city teaching hospitals were the major venue for clinical education but changes in patient profiles and acuity of illness have made the so-called tertiary care centre much less suitable for undergraduate medical education. The clinical clerkship experience has become decentralized and “distributed” into community hospitals, clinics and practitioners’ offices all of which may be located some considerable distance from the “mother ship”. The establishment of these extensive networks also requires that community-based faculty are enlisted as teachers and evaluators of medical students.

How does all this play out in the area of social accountability of medical schools? It is clear that schools set their own missions and goals and that not surprisingly these differ across the country. Furthermore, schools are situated in communities with very different healthcare issues and priorities. Nevertheless, all are focused on the importance and interrelationships of the missions of education, research and clinical care. However, from the foregoing it is clear that there are many centrifugal forces pulling and tugging at faculties and particularly at individual faculty members. Thus the university, the healthcare organization, the research institute and the community may all have somewhat

or very different priorities, each of which has to be accommodated by the faculty member. The inaugural Partners' Forum, held in conjunction with the 2004 annual meeting of ACCM, is an attempt to establish an enduring national venue in which the healthcare needs of Canadians can be articulated, prioritized and acted upon by those whose influence in their respective sectors is such that concerted action is both feasible and is undertaken. Perhaps an appreciation of academic medicine's complexity will help move this endeavour forward.

Additional Reading:

1. Parboosingh, J. et al. CMAJ. April 1, 2003; 168(7) 852-3. Medical schools' social contract: more than just education and research.
2. Leinster, S. J.R. Soc Med. 2004; 97: 3-5. Medical Schools: Are we paying for education or for technical training?