SOME THOUGHTS ON THE CHANGING FACE OF ACADEMIC MEDICINE

These are difficult times for academics in general, and particularly so for those in medical faculties everywhere. Most of us arrived at the medical school for various reasons - narcissistic, altruistic, or perhaps even sheer "somatic destiny". And we strive (or at least try) to bring order to the system we are in, and seek for opportunities to give what we did not receive or better than we did. After all, most of us are surely concerned about our chosen discipline, and anxious that certifiable incompetence does not lead our departments and institutions.

It is convenient to think that our duties are perched on a tripod, the legs of which support the functions of teaching, research and service. Sometimes one wonders if that tripod seems to be toppling, the legs overstretched, and the aspirations it embodies eclipsed by the harsh realities of life.

As academics, our original and abiding purpose has been to be guardians of the knowledge base, and to teach it in theory and practice. The task of physicianship remains an overriding obligation to relieve suffering, to enhance the patient's ability to heal himself, and to allow for the collaborative synergy to drive the healing process. We utilize the best of science, sense and sensitivity, confident in the knowledge that in our formative years we have seen the worst; but that we have learned to hope for the best.

However, these are trying times to be an academic leader. Escalating health care costs, hard economic times, health care cost constraints and the emergence of managed care as an important factor in the health care equation has thrown the entirety of medicine, governance of ourselves and our interfaces with society in disarray.

The essential clash of value systems may be illustrated by the shifting focuses in the way we conduct our daily businesses, as the challenges and concerns of a Medical Center become intertwined with the ideals of a medical school - a business vs. an academic environment; a top-down, flexible and fast response vs. a bottoms up, reiterative, often slow, consensus based style of governance; output as measured in dollars vs. publications; organizational success dictated by budget, the bottom line, and patient and employee satisfaction vs. faculty bibliography and inflow research dollars. These problems are global, and the fate of teaching hospitals in the US and UK are testimony; many of these ravenous monoliths face the tide of mismanaged care and have become fragmented by competitive health care institutions.

It is clear than, that if we are not vigilant, academic medicine could become an increasingly depersonalized, bureaucratized, fragmented and increasingly commercialized practice.

Medical faculties have generally been well tolerated within universities. Thankfully or not, society and government has always had an investment in our profession. Universities have been the seat of quiet reflection, whereas professions combine both reflection and action. That delicate tension between medical knowledge and its practical application indeed provides much of the attraction of a medical career. One vital role of academic leaders and chairs in medicine is to mediate these tensions between the pure sciences and the messy clinical sciences, the practitioners and artisans of medicine and the clinician-investigators, between education and vocational training. For the University, this brings overheads plus risks and abstract business concerns that seek to distract from the "goals of the mind".

These complexities have also inflicted the research leg of the tripod. The modern day researcher has to contend with animal and human ethics committees, local and national research review boards. He has to be mindful of miscalculating statistics, guard against inadvertent plagiarism, trust computer printouts of complex clinical research, and strive for multidisciplinary direction and commercial fruit at the end of the line for a project to be ensured longevity. Marrying these with a truckload of faculty responsibilities and achieving good annula performance reviews is a thrilling challenge, but .. it is a challenge.

The net result of this has been that some of the best teachers, physicians and researchers now actively seek different arrangements than that

available in academe to pursue their essential purpose. Perhaps the independent research institute, or one situated within the university, or sometimes private enterprise companies, some of which our brightest investigators start and in which they invest in, as a far more effective way to achieve their goals of pursuing knowledge gain. The proliferation of multi disciplinary approaches to patient care and research (the neurosciences and biotechnology leap immediately to mind), have resulted in clinicians budding off into groupings of experts in the community, or has resulted in them signing up with for-profit hospitals essentially in the search for more congenial locales to support scientifically tutored medical practice.

So what is to be done ?

It is probably not enough to say that our work in the Faculty is a costly but necessary and cost-effective national resource. It may be timely to bring the full direct and indirect costs of medical education out into the open, to grapple with issues such as how much a research bed costs, or for the need for equipment and the funding for research education. Biomedical research remains an enthralling adventure, and were it not for the sheer excitement and fun that it offers, and the stimulus afforded by students, there would have been far more exits from the system than we've already had. The real monopoly of medical schools is the free flow of undergraduate and postgraduate personnel. We must harness this resource and model the services needed for their education. I have always believed that it is an effort to avoid the anti-innovative thrusts that are ingrained in the system, often involuntarily, developed as a result of sheer convenience from the symbiosis between "the system" and overworked academic and general staff.

The hearts of public policy and academic medicine must meet soon and it is my hope that they find each other in complete collusion. Public policy must find the enormous good that is offered by deliberative, scientifically tutored medicine in the context of the doctor/ patient relationship. I know of no other institution that exemplifies better the complex missions of society than the medical school and its idealistic tripod of goals.

It has been a tremendous privilege for me to be in the extraordinary company of colleagues in academic medicine. And so it can be for our students is we practice what is indeed academic about academic medicine.

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