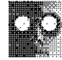
Begin with Ethics. The Rest Will Follow.



COMMENTARY

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**"So when we ask, 'What is medicine?'
I would begin with 'Medicine is ethical.' The rest then follows."**
– Alfred I. Tauber, *Confessions of a Medicine Man* (1999)

ABSTRACT

Solutions to some of the challenges facing Academic Health Sciences Centres (AHSC) might be found in expanding their mandate from the traditional tripartite definition – teaching, research and patient care – to include an equally important fourth mandate – responsibility to the community. Indeed, it could be argued that the current movement towards community-based teaching will exert such funding and organizational pressure on AHSCs that fundamental change will be forced upon them.

Osler vs. Flexner

When the Flexner Report came out in 1910 it was no surprise that it met with substantial opposition, particularly since it represented, at least in health education, a culmination of the logical positivist movement of the previous century. After all, its supporters argued, the only true manner to see the world was through the proven (and provable) lens of cold, laboratory science – the training of physicians should be no exception. In fact, with the proliferation of all sorts of bizarre health theories leading to more or less accredited and licensed "healers" of various persuasions occurring in the United States

around the turn of the century, there were good arguments for grounding medicine firmly in the laboratory. A new entity, the Academic Health Sciences Centre (AHSC), was to be the laboratory-based flagship of the new scientific medical practitioner of the 20th century. The AHSC was also to be the chosen accredited location for much of this training, particularly in postgraduate studies. The university would adapt and cooperate.

Opposition to the Flexner Report was predictable, the premises of many counter-arguments still being found today in the "alternative medicine" movements of the 21st century, and all in some way espousing belief systems other than the dry tenets of the logical positivists. What is less well known is that many prominent clinicians of the day also adamantly opposed the Flexner Report, among them Osler at Johns Hopkins and Peabody at Harvard. Osler, a pragmatist if there ever was one, vigorously objected to the vector in medicine being drawn from the laboratory directly to the bedside, at the expense of clinical expertise. Of course, these clinicians lost the battle, seeing some of the world's most prestigious AHSCs grow in their backyards (Tauber 1992).

The resulting 90 years have led to the situation (at least in Canada) described so cogently by Lozon and Fox in their lead paper. To one working at the coal face of medicine, in the dark and the dust but counting on the clear light of academic wisdom to shine dimly through once in a while, the concept of the AHSC being laid bare causes an almost reflexive urge to shield the eyes. The remainder of my comments will be given peeking through parted fingers with the occasional prayer to Osler and Peabody.

The bibliography shows many agreeing with Lozon and Fox that research, teaching and patient care are the three mandates of the AHSCs. Responsibility to the community, what Lozon and Fox call "regionalization," is relegated to the role of a challenge, not a fourth goal in itself. Herein lies the problem from a "field" perspective. I would suggest that solutions to some difficulties of the AHSC could more easily be found were community "service" given a formal role, equal to the other three stated goals in importance. At the risk of academic lynching, I will also argue that this cannot be easily done unless postgraduate training of healthcare professionals is removed from the university's responsibility and given to the AHSCs, although the university should still support this teaching system in many ways with its own funding.

If more of the same, with some tinkering, as Lozon and Fox seem to argue, is the only managerially realistic way of proceeding, this is certainly because there are no other coherent possibilities open to those struggling to keep the apparatus going. Life in the AHSC and the university may be so complicated that this is indeed the case, but some provincial governments are now thinking along "community service" lines, if the recent announcement of a "Northern Ontario Medical School" is any indication. How such a medical school will even meet accreditation criteria under the present Canadian training system is a moot point, but the idea of community service is the primary reason given for such an institution. Furthermore, it could be argued that the "community-based teaching" movement now appearing in

Canada will exert such funding and organizational pressure on the training system that fundamental change will be forced on the university-AHSC relation. It might therefore be managerially canny for the AHSC CEO to at least consider the arguments for adding a formal fourth mandate, particularly if this mandate can provide some clothing to our disrobed and distressed AHSC.

Protection Money?

Let us first look at the research goal of the AHSC. Most academic physicians working in AHSCs spend considerable effort seeking "protected" time. Protected from what? Why, from patients or teaching, of course. This is Osler's nightmare come to pass, where the system not only favours research at the expense of clinical and teaching duties, but actually makes advancement within that system solely dependent on research accomplishments. The rules for associateship (tenure) or achieving full professorship, with all the (debatable according to some) prestige, pension plans and advantages, until relatively recently were exactly the same academic rules in the Faculty of Medicine as those in, say, the Faculty of Arts. An assistant professor in the Department of Surgery, for the sake of promotion and tenure, was advanced according to standards identical to a member of the Department of Physics or Fine Arts. Promotion was judged solely on the research output of the candidate – "publish or perish." Teaching or practical skills, while informally having some influence, were not part of the formal criteria for promotion. These academic standards, which, to be fair, vary from university to university, have been set for centuries for the very good reasons of ensuring the university's independence from political manipulation while preserving the individual professor's long-term ability to further human knowledge. Although the situation has changed today, the embers of this research determinism still fuel the world of postgraduate medical training. This fundamental problem lies at the root of many of today's "town-gown" tensions.

The problem, of course, is that an academic system seems a poor way to prepare for what is essentially a trade, and I submit that the general public, along with the governments spending the public's money, look to physicians far more for their practical skills than their ability to advance human understanding – although both are important, of course. AHSCs are then left in the difficult situation where many of their teaching staff strive to maximize or isolate their research interests. There is considerable pressure on the AHSC to assure smooth functioning of the essentially academic nature of the institution above all other considerations. The recent $48 million plan to stabilize research funds in the Toronto Sick Children's Hospital is an example of how innovative solutions can qualm certain fears in this direction, at the expense, some say, of a measure of academic freedom. The reality, though, is that there will still be sick children needing care and trainees needing to learn how to do this.

Those Who Can't ...?

Some universities have tried to meet the AHSCs need for teaching by disposing of tenure or by appointing "clinical" professorships – physicians excelling in administration, patient care and/or teaching can be recognized with almost every advantage

shared by predominately research colleagues. Lozon and Fox refer to the difficulties in paying these brave souls, where pooling the fee for service payments can lead to bitter confrontation with those seeking "protected time," and where governments question why they must not only pay for professors but then also find money for others to do the teaching. The vexing challenges of quantifying medical teaching hours and then giving them a value compound the difficulty.

The concept of clinical professorships is not always well received by other faculties within a university. While the Department of Fine Arts cannot easily accord full university professorial status to, say, art gallery owners, the Department of Surgery can point to the huge difference in teaching hours needed to turn out a surgeon versus an art historian. Of course, as they are wont, the trainees also complain about academic "irrelevance," particularly about the "sink or swim" learning theory that is celebrated in AHSCs whenever there is no planned or funded teaching.

Another pressure mounting on the teaching mandate of the universities is community-based teaching, where the bulk of at least the postgraduate training of a physician is assumed by practitioners working outside of the AHSC. Family medicine leads the way, but similar arguments are made for community-based teaching of the increasingly rare community general surgeons, internists and psychiatrists. All reasoning for this type of teaching is essentially non-academic – the preference in community-based teaching is more to practical training principles, with an added dash of "meeting the community's needs" thrown in – although research of certain kinds does lend itself to this type of learning. Inevitably, the challenge is to construct a teaching system integrated enough with universities and AHSCs to allow for accredited teaching (without a research function), but autonomous enough to realistically meet the community's needs, all the while still validating (and paying) the teachers. Once again, governments question the need for financing a separate teaching structure, even as universities and AHSCs struggle to accommodate non-academic staff into their storied halls and deepest rituals. This being said, governments are naturally receptive to pitches involving community needs, as Lozon and Fox no doubt know.

Last, all this teaching must be accredited, an essentially incestuous process according to some, the "sine qua non" according to others, but nevertheless a challenge to the university or the community, particularly if the funding for teaching is precarious. For community-based teaching to succeed, the accrediting colleges must also be capable of practical vision – a lamentably elusive quality, at least to date, given the fragmentary pressures and academic bias generated within the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

Who Cares …?

Patient care in AHSCs, even as it pushes the CEO to find funds for increasingly sophisticated diagnostic and treatment modalities (the needs for which are as often as not dictated by research agendas), is greeted with some ambivalence by the community. While we at the coal face are grateful for clinical and diagnostic advances that make our patients' lives easier, it is

becoming apparent that many "advances" evolve into clinical standards of care impossible to attain outside of academic centres. Our patients must travel to the AHSC to receive what is deemed "adequate" care. This might be satisfactory for Belgium or Great Britain, but travel in a country with Canada's geography has repercussions not found in more densely populated nations. This type of clinical imperialism raises questions similar to those raised about cultural imperialism. Stratospheric standards of care and sub-specialization are two among many reasons the cost of healthcare is rising disproportionately to the actual health of the population, as, again, governments know. These esoteric standards of care might be tempered by a community service mandate, or at least not allowed to develop in an unrealistic and costly academic vacuum.

Yet another threat to patient care in AHSCs – the ethics of research on humans in the guise of good medicine – is an awakening giant these days. A well-described community service mandate would help guide the debate within AHSCs.

Last, if most professors must do research, who is caring for the patients? Perhaps it is best not to ask. But Osler and Peabody might approve of research and undergraduate training being assigned primarily to the university while clinical care and postgraduate teaching were the purview of the AHSC. Clinical care and teaching are closely linked. If community service became a formal mandate of the AHSC, with a commensurate budget, these essential functions could regain their former importance – perhaps without too much stress on the public purse.

Diamonds in the Rough?

How would the beleaguered AHSC respond were it obliged to make community service a goal equal to research, teaching and patient care? One senses from Lozon and Fox that this might just be the straw that breaks the camel's back. Were St. Michael's Hospital in Toronto given total responsibility for the area of Northern Ontario from, say, Dryden to the Manitoba border and north to Hudson's Bay, even massive funding could not save the day. The AHSC is an integral part of Canada's training, accrediting and licensing system – arguably the best medical system in the world for producing qualified physicians. This system, polished but under-valued jewel that it is, has always had trouble dealing with the realities of rural medical practice, which makes up 30% of Canada's far-flung population, usually relying on the "trickle-down" effect of supply side economics to meet rural staffing and clinical needs. John Kenneth Galbraith once made the comment that supply side economics made as much sense as a farmer trying to plant crops by feeding his horses oats and turning them loose onto the plowed fields. Rural healthcare, even more beyond the pale in these days of shortage of oats, is slowly organizing, examining itself, formally characterizing its needs and means, and formulating closely reasoned policies (see, for example, Iglesias et al. 1998). Forcing AHSCs onto our fields is not in the cards, particularly not alone or without proper clothing.

The rural healthcare system has done a good job with scarce resources over decades in an under the table sort of way, relying on a foundation of broadly skilled generalists working on constantly fluctu-

ating levels of primary and secondary and often tertiary care. This foundation supports the three pillars of rural healthcare – surgery, anaesthesia and obstetrics – these specialized services being provided by an almost equal mix of certified specialists, international medical graduates and Canadian generalists with defined specialty skill sets. Our problem is not the absence of AHSCs but rather the essential fragility of the system, where local loss of any one of the pillars, or minor crumbling of the foundation, leads to inevitable and quick collapse of the entire local rural healthcare system for anything other than triage and public health (Hutten-Czapski 2001). The 1999 Barer/Stoddart brief eloquently shows how limited are the options open to provinces trying to solve the rural healthcare problem. Regionalization and telemedicine (except for teleradiology) are blunt tools to say the least – unproven and many already causing damage to rural healthcare. Canada's geography and demo-graphics demand that the entire Canadian training system – universities, accrediting colleges, licensing bodies, and, yes, AHSCs – help us validate the historically proven, but rapidly failing, rural health system already present – to support it rather than sweeping it under the carpet. There is considerable work to do. Current "primary care reform" ventures that rely on urban concepts of restricting the generalist to primary care will spell the end of significant rural healthcare. On the other end of the spectrum, our national training system and AHSCs tend to laud sub-specialization and cannot easily accommodate the concept of the "jack of all trades."

However, were this polished jewel that is our training system to return to Osler and Peabody's initial concerns about the Flexner Report, redrawing the vector of care from the clinician to the bedside, there might be some hope. One should start from the philosophical premise that science is not the be all and end all (although a valuable adjunct), that medicine is about treating patients, that the patient-doctor relationship is a therapeutic one that can be taught, and that "medicine is ethical." The rest will follow. In fact, the AHSC might lead, if given the mandate, clinical care being so closely linked to teaching, and might do so more easily than the universities' essentially academic structure will allow.

"Money Doesn't Talk, It Swears" (Dylan ©1966)

Lozon and Fox point, somewhat longingly perhaps, to the relationships many American AHSCs are developing with the primary care systems in their regions. They call for an increased federal role in coordinating academic planning and funding. The Society of Rural Physicians of Canada (SRPC) is also calling for federal involvement in rural healthcare issues by providing recurrent stable funding of about $300 million per year for a National Rural Health Strategy. So, not to make too fine a point, this is about money.

Some AHSCs and all universities could, if they wished, retreat to the domains of research and tertiary care, simplifying their funding and staffing lines in pursuing their paths of excellence, innovation and special expertise. The universities could maintain undergraduate teaching since this contains much basic science.

If we assume both the desirability of a return to clinical postgraduate teaching

and also the inevitability of community-based teaching, then other AHSCs could join the SRPC in working for a funded National Rural Health Strategy, developing a plan for teaching and community service that might be attractive to government funders, particularly if this plan can model a "primary care reform" movement of far greater efficiency than currently proposed models, where generalists function on all levels of care both in rural and urban areas. For such a venture to work, the following prerequisites seem necessary:

1. The AHSCs must have their research funding secured. Not to minimize the difficulties, but with the creation of the CIHR and the new payment plans, they seem well on the way.

2. Teaching budgets must be rationalized and standardized in consultation with all the stakeholders at all layers of the system, preferably from a single provincial payer.

3. AHSCs could be given responsibility for postgraduate teaching (and to a certain extent, clinical care) for a defined geographic region, with a budget commensurate to the task. The universities would provide academic infrastructure and coordination with the national accrediting bodies.

4. A recurrent federal budget would provide the seed money for piloting various models of such teaching, clinical care and standards, all with close involvement and leadership of AHSCs.

5. This budget would be pioneered in rural Canada first, as part of a National Rural Health Strategy, because the need in rural areas is greater and the current system simpler and more efficient. It would eventually be applicable to the rest of Canada in conjunction with primary care reform initiatives.

6. The various national bodies in our medical system – accrediting (College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada), universities (Association of Canadian Medical Colleges), licensing (Federation of Medical Licensing Authorities of Canada), professional (Canadian Medical Association, Society of Rural Physicians of Canada), the Medical Council of Canada, as well as representation from medical administrations and AHSCs – would provide policy building and coordination in a federally funded "Rural Medical Forum."

7. The provincial health bureaucracies would be represented in an "Advisory Committee on Rural Health" that interacts with the Rural Medical Forum and advises the federal/provincial/territorial Ministers of Health on a national rural health strategy.

It must seem forward for rural physicians to offer clothing to our bared AHSCs. Usually, with a tug of the forelock, we lie down in the mud to keep the way dry. And yet, if the result is an improved teaching system with a renewed and efficient clinical approach, and the added bonus of a practical "primary care" system, Osler and Peabody may still be able to claim victory over Flexner.

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