



MAKING A DIFFERENCE

An Interview of Dr. John D. Hamilton



This is an abridged, edited version of an interview of Dr. John Hamilton conducted in October, 1999 at the annual meeting of the Network, in Linköping, Sweden. Dr. Hamilton is Professor of Medicine and formerly Dean of the Faculty of Medicine and Health Sciences at the University of Newcastle, Australia.

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Would you be willing to talk about how you got into medicine and medical education?

I went to medical school in 1955 at Middlesex Hospital in London. I had never been away from home. We had no university background in our family and no medical background.

I think I was attracted partly through reading books about medical missionar-

ies written by an Australian, which is, of course, interesting because we ended up in Australia. I was also very interested in biological science, and I probably had a generally goodwill-to-mankind approach to life.

In 1962 I wanted something to do on a wider scale, so for two years I worked as medical officer to St. Francis Hospital in Zambia, then Northern Rhodesia. That was a particularly important experience. Very intense, quite challenging. Without that I would not have been able later to help set up the medical school in Nigeria.

I remember a very important day. I had been working predominantly in the hospital and regularly going out to the other hospitals roundabout, but I had never stopped and looked at all the circumstances of any of the villages. Towards the end of my stay, I arranged to visit a village where I examined every child. When I did this I realized that many of them were less well than they could have been, but not ill enough to make the three-hour walk to the hospital.

What was especially interesting was listening to what people told me about the illnesses. Measles had just been through. They described how the spirit of the measles had come into the village through this old lady that they brought forward. She had her head shaved and had gone through ceremonies to cleanse her of this spirit. Hearing this I realized that unless you understand the way the people look at things, you will not really address the issues in terms that might be acceptable to them. Years later when we were to set up the medical school in Nigeria, my experience that morning led to my conviction that students needed to spend some time living in villages.

On my return from Zambia, I went into reverse culture shock at Hammer-smith, then St. Bartholomew's Hospital, where my work included some bench-top and clinical research.

In 1969 I was asked if I would like to be part of the new medical school in Canada at McMaster University, and I found myself into medical education. On the clinical front I was head of gastroenterology. On the education side, without ever claiming to be an educationist, I found myself taking up such roles as chairman at the selection committee and then chairman of the curriculum committee.

What are some of the innovations that you and your colleagues were involved with at McMaster?

In the curriculum, the small group tutorials and the discussions of topics and problems gradually emerged into a format that later become known as problem-based learning. I cannot remember it being called that in the first few years.

We studied the outcomes of the admission process, and we introduced a safe and credible selection process that included looking at more than just the candidates' academic marks and not requiring candidates to have a science background. It all seemed to be very experimental and perhaps revolutionary.

On the community side there was a good link with the health

service, using community hospitals until we built our own McMaster Medical Center. There was not a great deal of experience for students in the community, other than in general practice. There was a strong epidemiological population health perspective out of which, in part, came the Rockefeller Foundation initiatives to bring public health and clinical medicine together.

That's how I found myself in medical education. I went to McMaster newly married. My wife, Alison, and I had been at the same medical school in London. When we met again after several years, she had gone into obstetrics and was also planning to go to Canada, so we went together. Alison had a practice. Our children, Susan and William, were born in Canada.

What was your next adventure?

In 1978 after nine years at McMaster, we felt we had contributed what we could. We looked for a next step, preferably to a developing country where the children could see a different world. An old acquaintance, Eldryd Parry, was then Dean of the new Ilorin Medical School in Nigeria. He wanted it to be a community-based, community-oriented school. We visited, and I then went there as professor of medicine and chairman of the curriculum committee.

We started the school with one room and villages. We sent the students out to the villages for the first month of the curriculum. (Later we decided it was better to wait until their sixth month.) The students learned about the community by living in it. They presented the findings of their studies first to the village and then to the class. After being in the community, the students' commitment to medicine was very strong.

This community-based education and service approach (COBES) became a model that a lot of other schools in Africa and elsewhere have used. Ilorin was not the only place that was developing this model. But I think Ilorin was very early in defining that particular approach of not just looking at health and disease, but looking at the whole social surround. Getting to know the villages in their own right. Going at different times in successive years to see the effects of seasons.

We got basic scientists to go out and work with the students in villages. Not everybody was pleased about that, but some found that being in the villages helped them reorient the way they taught the basic sciences. Some lived in the village for a month and acted as tutors and mentors.

To assist the students and their tutors, we sent out teams of experts to visit each village in turn. The teams might include an epidemiologist, statistician, and parasitologist. It depended on the topic of the rotation.

We did epidemiological studies on nutrition, disability, blindness, and a whole range of issues that became the topics for the students' learning. This is one of the best examples of problem-based learning, though we never gave it that label.

After Nigeria I worked for a period as a public health specialist at the World

Bank. John Evans, a very fine leader and the first dean of McMaster, was setting up the Population, Health and Nutrition Department of the World Bank. Being at that agency gave me experience with big international programs.

Soon after arriving in Washington, DC, David Maddison, the very good foundation dean in Newcastle, died suddenly. The school was looking for somebody who had similar educational experiences and ideas and contacted me. After lots of midnight phone calls and exhausting decision-making, we decided to move again.

Moving from the US to Newcastle, Australia wasn't trivial. You were again moving from continent to continent.

Yes, those were big moves. Next time we're running our lives we won't move quite so often. It gives you a new challenge, but it does take time to pick up your momentum.

Anyway, we moved. As Alison had done in Nigeria, she settled into these difficult circumstances well and so did the kids.

Newcastle already had a well-established program that was to lead to a lot of changes in medical education in Australia. But the school was still in its early years, having only graduated one class. The curriculum was based on the principles of integration, problem-based learning, community focus, and community orientation in term of population health, epidemiology, biostatistics, and social sciences. Many students were placed in rural areas.

At first, I think the school was seen as a bit of a curiosity, even though a government report had proposed the creation of a new school so that the mode of medical education in Australia could be changed. The report indicated that a new school was needed because the existing schools did not have the capacity to change. It's an interesting comment, because now, 20 years down the line, the other schools are changing a great deal.

At the time, the selection of students in the existing schools was dominated by school grades. Little attention was paid to social issues, either in the selection of students or in the curriculum. Very little attention was given to public health or general practice.

The public was in favor of a new medical school. The academic medical establishment was divided. Many people thought it was important to start rethinking education, but many thought that the new school was going to be anti-academic, anti-research—a barefoot doctoring type of thing. But it isn't. It's academically very challenging and it requires a solid faculty base of epidemiology and public health, a strong academic infrastructure, and strong research.

Soon after getting to Newcastle, I was also asked to set up the Accreditation Committee for the new Australian Medical Council. Previously, the British General Medical Council (GMC) had overseen and accredited Australian schools, but only to ensure that they produced doctors who were safe to practice in Great Britain. The GMC approved the Newcastle program, but we

didn't fit their model. So having the Dean of Newcastle in charge of creating the new Australian accrediting system was probably a bit of a surprise.

I didn't push the Newcastle line. We had a good committee with a wide range of opinions. I felt the GMC had given away much of its influence by no longer visiting schools. We wanted the accreditation visits to include consultations and an exchange of ideas. We felt that if academics looked at each other's medical schools, they could see new ideas in practice and explore new possibilities for medical education.

Queensland was the first school that we visited. Everybody assumed that its accreditation would be a rubber stamp. In fact, there were a number of problems that had not been addressed for a long time. After a week at Queensland, we gave the school a five-year rather than a 10-year accreditation.

Everything hit every fan over that. Luckily, I had to attend a meeting elsewhere, so I got on a plane and vanished. Queensland rallied though, and two years later we were able to give the school full accreditation.

Successively, each school was visited. Beforehand there was always a thorough internal review, so we developed quite good documentation of medical education in Australia. Our aim was to help strengthen medical education and help each medical school do what it was trying to do. We didn't prescribe from on high. We were interested in student opinions, so we always had long discussions alone with the students. On the last day of the visit we gave feedback to the school, so there was a sense of immediacy.

Newcastle was the last school to be visited. (By then I had moved off the committee.) We held our breath wondering whether the biter would now be bit. But we got a very positive appraisal, for the curriculum, for the student opinions and for our contribution to change in Australia.

Later a formal appraisal within the state of New South Wales confirmed our graduates' excellent communication skills and empathy with their patients. The appraisal also indicated that our graduates tackled clinical problems effectively and organized their own learning—all skills that we had been at pains to develop.

People were realizing that we were producing good doctors. A manager in one of the Sydney teaching hospitals said his institution preferred Newcastle graduates as interns.

What kind of impact was the program at Newcastle having on the other Australian medical schools?

People began to realize the need for a relook at medical education. More attention needed to be given to helping students develop communication skills, and, perhaps, personal qualities were not given enough attention in the selection process.

The AMC rewrote its guidelines, commending independence of learning. Problem-based learning was commended, but not required. Back in Britain the

General Medical Council looked at our Australian experience and realized that they needed to be much more active.

Now in Australia, three of the schools—the University of Sydney, the University of Queensland, and Flinders University—have gone to a fully integrated problem-based learning curriculum modeled after ours, with a similar selection process, particularly in the interview. These three schools now take only students who have completed a first degree, whereas we still take a mixture of school leavers and graduates. Other schools have changed their selection criteria and are finding much better outcomes, much more motivated students. So there's diversity.

Newcastle was one of the early innovative programs, and it has been known for its innovations over the years. What would you recommend to our readers about ways to sustain that growth and openness to change? It's a big challenge, because you become an orthodox in your own unorthodoxy. Inevitably, as time goes on, some of the ways become a bit wearied, and you've got to rethink what you're doing. You've got to make sure that you do what you're doing well, but not become overly defensive of it, if time has moved on.

I think you need to listen to students and keep on getting feedback. You need to do an appraisal of your own program. If you are putting an emphasis on community, you've got to have research programs that give you information about community needs and bring that information back into the curriculum. You need to bring young faculty into positions of responsibility. We have no hierarchical system because we did not have traditional departments, although there is now a restructuring, along the lines of departments.

I think one does need a systematic review and a full rethinking of the curriculum. Otherwise there's a danger in getting so used to your own program that you chug along with it and you improve bits and pieces, but you don't stand right back and consider whether you should reform completely. That's what the three schools that I mentioned have done, although rather closely following our model.

What other lessons have you learned?

I've been very impressed with the way the people at New Mexico realized that they were not addressing their environment. Through their community-oriented, problem-based track, they did address it. Then the whole school addressed it. But they didn't stop there. They introduced this community orientation into the postgraduate years, so now the principles pervade all the training. That notion of continually expanding the scope of what you're doing has been a very good model.

But it's no good saying, "We'll buy problem-based learning and wind it up and it'll just run on its own." At New Mexico the dynamism and creativity of

people like Art [Arthur Kaufman], Stewart [Mennin], and Scott [Obenshain] puts the energy into it.

What happens when these leaders move on?

At New Mexico there's a well-planned program for developing the leadership skills of young faculty members. Getting funding for these extra dimensions is a very important part of a deanship.

Through the Network and WHO, I've learned that it is in the developing countries where some of the really creative things are to be found. Recently for WHO I reviewed Universiti Sains Malaysia. Some of the best community experiences are embedded in that school's curriculum. The students are delighted. You can see that they realize that medicine is not just a technical, clinical thing. Medicine is involved with all the issues of life.

Some of the interprofessional things that have been done in the Americas and South Africa, partly with Kellogg funding, have been good models for other countries. It's a pity how little some of those programs are known broadly. The Network is a good organization for giving visibility to these models. But perhaps the reach of the Network is limited to its own membership.

Any other recommendations for people in the Network?

Staff and students must go and see things for themselves: live in the community, listen to patients, see the health service in action, study it in action. You've got to inquire of it and learn from it. Perhaps Network meetings should occur more in and with communities. This would require very difficult logistics.

We found that the students living in the villages in Nigeria came to the most astonishing insights just by listening to villagers talk about their life stories or their beliefs and why they did this and didn't do that.

What about the role of the Network as we face the new millennium?

It would be a good idea for the Network to have an occasional extension of its sphere of interest. The Network started with innovations and problem-based learning. Then the community side developed. We've been talking about health services in terms of cooperation. Now I think it's time to be studying health services as an organizational system with its own properties. That was the theme of my keynote address this year (Hamilton, 2000). Until you understand that, you don't understand the environment in which you work.

Also, the question comes up: should the Network continue to be largely global or should it be more regional, giving people a better opportunity to go to meetings and interact with each other? There are cases to be made on both sides. If you become regional, you run the danger of becoming insular and the central things can get lost. But this option does need to be looked at.

We need to involve other people. It's a pity that some of the developed countries aren't more involved. There are lots of new things developing in Britain, and many of the American centers have got very good things going on. They are present in the Network, but not as widely as might be useful. We need also to learn directly from other sectors that have relevance to health. The presentation from the forestry manager about conflict on land use at New Mexico last year was a good example.

In a recent editorial (Hamilton, 1999) you talked about the concept of a deeper inner journey. Would you be willing to reflect on the key experiences in your own journey?

I'm not a psychoanalytic person, but I think you need to be aware of the direction that you're going and reflect on it. I find it often very helpful to reflect with colleagues on the good things and the bad things and so on. It's helpful to reflect, interpret, and get feedback on issues that otherwise are transient experiences.

This is very important for students and graduates. They often get tangled up in bad outcomes as a result of a clinical error. But there may be little reflection and little opportunity to learn from what happened. As an undergraduate, one needs to start a pattern of reflecting, and you need to have peers and colleagues with whom to reflect. This needs to be a cultural norm in medical schools and in health service. Some health professional programs are now protecting time for reflection, but this is not happening enough yet in medicine.

My experience working in Africa was extremely focusing and gave me one of the most secure lines in my life's career. By that I mean a reference point for career and priorities. When things went wrong, it was painful. But there were also rewarding times. I think that working with people in that way focuses your attention on the needs of the people you're with, rather than your career needs. You see life through the eyes of the other person. And that's really at the core of community experience for students.

I would normally think of myself as a fairly conservative person. But when I stand outside, I reflect that I seem to have found myself caught up in unusual things.

Yes, indeed. And we all thank you for your many contributions.

References

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