



POSITION PAPER

Curriculum Change and Strategies, Past and Present: Why Is It Taking So Long?

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ABSTRACT *For the last 30 years or more the old war songs of medical education (community orientation, active learning, etc.) have been repeatedly ventilated in meeting after meeting, article after article. But of the present 1642 medical schools on the planet, only about 100 members of The Network and a few other have put these principles into practice, more or less. Obstacles and constraints are known. Is it the system, or the leadership, or the university culture, or the accreditation rules, or all of the above that are responsible for this lack of progress? Still, some overcame the obstacles, some removed the constraints. It would be useful to be better informed about HOW it was done. I suggest that Education for Health: Change in Learning & Practice (EfH) should present more articles explaining HOW successful schools managed to DO IT or WHY they were NOT able to DO IT.*

KEYWORDS *Change strategies, obstacles, constraints, medical education, curriculum.*

Some time ago the Editor-in-Chief of EfH (H. Jason) suggested themes to stimulate the presentation of possible pro and con discussions among eventual authors. Three of those themes attracted my attention:

- Health professions students must first have an early exposure to clinical experiences.
- The case against lecturing: active learning is the key.
- Students must be involved in shaping their learning.

I liked those titles. They sounded to me like the right choices.

But I wondered why the “right choices” (the *old war songs* that were ventilated repeatedly in meeting after meeting, article after article, for the last

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30 years or more) still needed to be defended or explained in EfH. Why haven't these beaten-to-death messages not been translated into more concrete, widespread action by now? Why have they not been implemented more often?

There are about 100 schools that are full members of The Network.¹ Their degree of implementation of the *war songs* is widely variable. As a generalization, I would say, based on over 25 years' experience as a former senior WHO staff member, responsible for human resources development and observing the international scene, that the northern Network schools are strongly PBL-focused and the southern ones are more community-oriented.

Education for Health, the professional journal of The Network (and EfH's predecessor publication, *The Annals of Community-Oriented Medical Education*), has been reporting these innovative medical schools' efforts. But I feel that what is lacking and that I would like to read more often in EfH is HOW these schools managed to DO IT while so many of the 1500 other schools continue to snore happily along. Or, I would like to learn WHY some schools did not undertake such changes.

We had an informal exchange of ideas among the members of EfH's Editorial Board. One suggestion I made was that teachers are not required to have formal training in Teaching & Learning. Steve Abrahamson reacted quickly, saying,

You are right ... but not quite right! I think we know that a big part of the answer to "why" is that the SYSTEM is at fault. It's not the faculty. Not at all! Faculty are behaving quite appropriately in response to the system. Imagine: we hire a "teacher" and reward him or her for research and/or bringing in money or fame by publishing or for seeing patients or by performing cutting-edge procedures (no pun intended), etc.!!!! We hire TEACHERS and then penalize them if they spend time on preparation for teaching. It is almost as if their careers depend on their NOT spending time and effort on education. And, when we criticize the system, we risk being ejected from the system.

I felt that Steve was right ...but not quite right! There are, unfortunately, many other reasons.

The articles in EfH are NOT "just saying the same stuff again and again". But most articles are not sufficiently focused on "change strategies". Even if they describe the "right actions", I wish they would explain HOW they managed to DO it or WHY they were prevented from doing it. I would be interested, also, in hearing from them what were the "obstacles and constraints"² that prevented them from putting the themes of the *old war songs* into practice.

Let us look at some obstacles that come to mind.

The Leadership of Medical Schools

Faculty members, like other decision-making groups, are organized in a somewhat hierarchical structure. This basic structure dates back to the way universities were organized in the Middle Ages in Europe. It is neither a typical military hierarchy (although traditional uniforms are used on ceremonial occasions) nor a typical business management ladder (in spite of the fact that enormous economic factors are typically involved). The boss (Dean, Director, etc.) is usually elected for a limited period (sometimes down for as few as two years), very often because he/she is perceived as someone who is not going to make waves. His “political platform”, when explicit (which happens rarely), is usually politically correct and sufficiently vague. He has almost never had any formal training in management. He is often near the age of retirement, has an office that is understaffed, and inherits rules and regulations that are beyond his control. Although he may honestly wish to achieve something valuable that future generation will remember, he is typically kept from accomplishing much at all.

The Organizational Values and Culture of the Teaching Staff

A few years ago, I had an occasion to report on what teachers thought about medical curricula (Guilbert, 1998). They said they were “aware of the importance of a community orientation but that such an explicit orientation might provoke considerable resistance among teachers of the basic sciences whose main idea is to cover their discipline, however relevant or not the details might be to the practice of medicine”. In relation to the explicit formulation of learning objectives, they felt that “it could be considered as a limitation of academic freedom”. Others said, “The teaching staff does not feel the need to elaborate (prepare a professional profile) and, in the tradition of Humboldt, are more concerned with the quest for new knowledge”. In relation to a learner-centred approach they said that “the teacher is the one who knows best what he should teach”. The students “have not reached the level of maturity nor the level of experience to judge; this will lead to a depreciation of the education”. Interestingly, they also said that “the absence of training of teachers in educational science is considered by the university hierarchy to be an important constraint”. But at the same time they indicate that “we know those who most need training, but they are those more strongly opposed to it”. And no remedial action is taken. So what are the chances for diminishing the use of the world-wide most common teaching method, the straight lecture, when students, infected by their teachers, who are suffering from a bad case of *coveritis* (Guilbert, 1995), say “What bothers me, in this PBL reform, is the idea that it might leave holes in my knowledge”?

An Over-interpretation of the Historical Flexner Report by Governing Bodies, Teachers, Etc.

This over-quoted, famous Flexner Report (1910) is often used as an excuse for keeping the arbitrary and unfortunate gap separating the medical curriculum into two phases (the so-called pre-clinical and clinical phases). This gap has a negative impact on any efforts made towards a holistic approach that has relevance for a population's high priority health needs. A consequence is that in most schools students are forced to study along a discipline-based curriculum, separated from the meaningful context that could be provided by working in a professional milieu.

The Role of Accrediting Bodies in Forcing Approaches of Doubtful Relevance to Population Health Needs

The detrimental effect of the pre-clinical/clinical gap is increased by a subsequent separation of certifying examinations (such as Part 1 and Part 2 of the US Medical Licensing Examinations in that country). Students rapidly forget most of the pre-clinical stuff instead of being given an incentive, through exams, to use it in order to solve real practice problems for the benefit of patients.

The Failure of Medical Education to Recognize the Importance of Organizational Research

My own 35 years of a fair degree of intimacy with what is published in the field of medical education leads me to accept this statement as true. Organizational research (a study of THE SYSTEM) is very poorly represented in most of our mainstream publications, as if we did not care about it, or did not know how to cope with it. Such research would help us translate our educational research findings into reality.

Are These Issues Really International?

I would not be surprised if some of my North American colleagues would defend the view that "we have taken meaningful steps in a number of cases". This might be true for Network members and some others, but even if all the schools in the US and Canada had made meaningful, positive curricular changes, these schools, in total, represent less than 10% of all the world's medical schools.³

On the other hand, I was told that these obstacles and constraints "are all very North American in direction and perhaps we need a broader view of the

international scene since our readership is international". So, I expect that the readers from parts of the world other than North America will indicate to what extent they have observed similar situations or not.

But over 20 international years of observation and experience with WHO have led me to see that there is a closer intellectual relationship between a professor of biochemistry from Ibadan University (Nigeria) and his counterpart from London (UK) than between this same Nigerian professor and the population of Nigeria living in tetanus-infested gutters under the windows of his lab. A Riyadh (Saudi Arabia) medical school's structure is about the same as one in Liverpool. Everywhere research is the way to make a career and clinical work to make money. Explicit interest in medical education is a slow form of professional suicide nearly everywhere.

So, most likely, it is an international "multifaceted disease". Through many centuries, the noble and elitist concept of what a university is has continued to have a world-wide impact.

What Can Be Suggested about How to Overcome Obstacles and What Resources Are Needed?

I hope that we can have answers to this question coming from various schools. I would like to read HOW they managed to DO IT in spite of the obstacles mentioned above and many other obstacles that I did not mention. Or WHY they were NOT able to DO IT.

In order that we might obtain more of this kind of information, should a condition for acceptance of curricular articles in EfH always be that they must include paragraph(s) stating hypotheses about WHY it is that the author's proposals, views, etc. have been or have not yet been implemented? Then, in each issue, the editor could list the TOP 10 "good and bad" WHYs of the previous issue. And we could all then try to find ways to get things moving.

Notes

1. The Network: Community Partnerships for Health through Innovative Education, Service, and Research. The Network is a non-governmental organization, founded in 1979, comprised of some 240 Full and Associate members educational institutions. EfH is the scholarly journal of this organization.
2. "Constraints" are "fixed factors (social, political, cultural, financial, technical, etc.) imposed by the environment which cannot be removed, and which influence the achievement of objectives". "Obstacles" are "impediments that must be overcome to achieve objectives". In contrast to

constraints, obstacles can be removed, bypassed or overcome. From the Glossary of a Report of a WHO Working Group, Therapeutic Patient Education, WHO/EURO, Copenhagen, 1998.

3. A total of 141 US and 16 Canadian schools, out of a total of 1642, listed in the World Directory of medical schools (2000).

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