ORIGINAL ARTICLE ON MEDICAL EDUCATION

TITLE

***THE WISDOM LOST IN KNOWLEDGE*: FACULTY'S VIEWS ABOUT THE MEDICAL EDUCATIONISTS**

SHORT TITLE

FACULTY'S VIEWS ABOUT MEDICAL EDUCATIONISTS

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ABSTRACT

BACKGROUND: Some change in medical education maybe driven by self-interest of educationists. Some of us may have become 'too blinded by science of medical education'. In the process, the trainers are often alienated and feel some animosity towards the well-meaning, but aggressive medical educationists; this is even more relevant in developing countries.

The objective of this study was to explore the views of teaching medical faculty about their medical educationists (MEs).

METHODS: This was a mixed method study. Thirty members of teaching faculty, 10 each from three different medical colleges in Pakistan participated in this study. A 25 item questionnaire was administered. This was followed by an in-depth discussion with each cohort. The qualitative data of survey and discussion was analyzed to identify the main themes and subthemes. The transcripts were then analyzed thematically and analyses were integrated in the final interpretation phase to draw conclusions.

RESULTS: Besides all the good points highlighted, a number of negative themes emerged: MEs in their zeal sometimes lose sight of the practical problems; some are quite aggressive in their approach; often make the faculty feel that whatever they are doing is wrong or outdated; may hide behind jargon; recommendations are not practical or according to resources. At times it feels that MEs are trying to project themselves more than the medical education.

CONCLUSIONS: MEs need a little introspection, about their approach. The educational concepts being propagated should be tailored to needs and facilities. They must be practical, and implemented with unusual sagacity, employing true leadership skills; thus avoiding any alienation that medical faculty may feel.

PRACTICE POINTS

- Some medical educationists may be too aggressive in their approach. This may alienate the teaching faculty, viewing educationists being driven by self-interest.
- It is important to know what the teaching faculty of medical colleges feel about their well-meaning educationists.
- The faculty felt that at times some educationists are too overbearing, hide behind jargon, offer advice which is not practical and trying to project themselves more.
- Before embarking on any faculty development program we must shed this new perceived image of a medical educationist.

INTRODUCTION

When Flexner (1910) published his seminal work in the field of medical education a century ago, it opened up a whole new specialty. With the advent of medical education, a new breed of specialists – the medical educationists (MEs) – appeared on the scene. New departments of medical education were established in almost all medical institutes of the world. These were mostly staffed by medical doctors who, being medical teachers themselves either trained, obtained degrees or simply started working in the field of medical education. Flexner, although not a medical doctor himself, but a pure educationist created fertile ground for change and debate among health professionals about the necessary reform in the way medicine is taught; a debate which is now entering into the second century (Eva 2011). Even in a developing country like Pakistan, the Pakistan Medical and Dental Council made it mandatory for all medical schools to have a Department of Medical Education (DME) (PMDC 2008).

The College of Physicians and Surgeons of Pakistan (CPSP) established one of the earliest DMEs in 1979. It was designated a "WHO Collaborating Centre for Training and Research in Educational Development of Health Personnel" for the Eastern Mediterranean Region in 1996. Initially most of the MEs were trained abroad or at CPSP. There were only a small number of qualified MEs to begin with. But with the start of a Masters level program at CPSP, and later some other local Universities, the number of new MEs has steadily increased. Trainers and supervisors at home and abroad are having more and more exposure to this new genre of 'teachers of teachers'. With the advent of dedicated DMEs in medical colleges, the MEs there, whether part time or full time, are involved in faculty development at their institutes. Their main emphasis has been to train

our traditional faculty in the newer concepts of educational principles, instructional strategies, assessment techniques and curricular change. Some have been more than passionate about it. The faculty, at times driven hard by the MEs, complains about the ways in which they are being indoctrinated into this new field. Usually the experienced senior faculty members, who are traditionalists at heart, give scathing feedback about the MEs themselves; unfortunately some of it may even be valid.

To bring about a real change in the field of medical education, it is important for the MEs to be aware of this critique. A little introspection and with appropriate change in approach this often perceived threatened attitude of MEs may be channeled in a more fruitful way. Some say that the change in medical education maybe driven by 'self-interest amongst educators'; some may have become 'too blinded by the science of medical education' (Dornan 2011). In the process, the trainers are often alienated and may feel some animosity towards the well-meaning, but aggressive medical educationists. Although armed with extensive ***knowledge*** of health professions educational philosophy, a lot of ***wisdom*** has to be exercised. The objective of this study was to have an insight into what the faculty's views are about the medical educationists themselves, hoping to sensitize the MEs themselves to their strengths and shortcomings, eventually improving their effectiveness as change agents.

METHODS

This study was conducted at the Department of Medical Education, Army Medical College, Rawalpindi, from January 2012 to March 2012. Approval from the Institutional Review and Ethical Committee was obtained.

It was a Mixed Methods study using Qualitative exploratory survey followed by structured group discussion using a sequential exploratory design (Creswell 2003). The study was conducted in three phases.

In the first phase three medical colleges of Northern Pakistan were selected: an Army (Army Medical College, Rawalpindi), a public (Punjab Medical College, Faisalabad) and a private (Shifa College of Medicine, Islamabad). Ten faculty members from each medical college were chosen, with 5 each randomly selected from clinical and non-clinical departments. These 30 faculty members had mixed seniorities (assistant, associate and professors). After explaining the purpose of the study and obtaining their consent a 25 item questionnaire (Table 1) was administered. It consisted of mostly open ended questions grouped under 5 themes regarding their personal views and experiences about MEs they had interacted with (general, MEs attributes, attitudes, expectations from their MEs, expected functions *and a final question!*). The questionnaire was distributed to each cohort of 10, at a time.

Following completion of the questionnaire they were invited to a focus group discussion, as the second phase of the study. The group was thanked for their participation and the objectives of the study were explained further and any queries answered. The author acted as facilitator and the group of 10 participants further discussed the themes in the

questionnaire explaining their viewpoints more frankly and quoted their own experiences to justify their answers, a method similar to triangulation (Creswell 2003). Each point was summarized after its discussion, and individual opinions finalized. The discussion continued till no new points were raised. The session was audio taped and transcribed later for accuracy and tabulation of results.

When all the three groups had been interviewed the results were cumulated for the final phase of the study. The first step of analysis was 'familiarization' with the data (Raibee 2004). Further steps of analysis were done starting with a framework, indexing, mapping and finally interpretation of the main themes (Pope et al. 2000).

The result of the compiled data from all three steps was consolidated and checked with transcripts to find any inaccuracies and finally summarized into results, using thematic template analysis (King 2004).

RESULTS

Thirty faculty members, 10 each from three different medical colleges participated in the study. There were 22 males and 8 females, half each from clinical and non-clinical departments, consisting of 5 professors, 11 associate and 14 assistant professors.

The questionnaire had five main themes (Table 1), which were later discussed in a group fashion. Following is the summary of the content analysis of the five themes:

Theme A: General

1. Have you been exposed to a trained medical educationist (MEs)?
2. Do you think there should be medical education and MEs?
3. Give an overview of MEs general strengths and weaknesses.

All the faculty members (30/30; 100%) had been exposed to MEs, mostly through the trainee and supervisor's workshops held by CPSP or during faculty development educational activities of the employing institute's DMEs. All (30/30; 100%) agreed to the need for DME and MEs. The responses to the general strengths and weaknesses were interesting. Some of them are given below:

- Strengths:
  - ***Impressive communication, facilitation and teaching skills of MEs***
  - ***Focused, good orators, confident***
  - ***Passion and dedication***
  - ***Seemed to enjoy their work***
- Weaknesses:

- ***Sometimes not let others speak***
- ***Opinions not sought, not paid attention to the questions asked***
- ***Often have a set agenda and stick to it only***
- ***Deflect questions, rarely admit to gaps in their knowledge***
- ***Often get different answers from different MEs;***

Theme B: Personal Attributes

4. How do you rate them as a person, generally?
5. As facilitators and teachers?
6. Should they be full time or part time?
7. If part time, do you think clinical teachers are better MEs or non-clinical teachers?
8. What are the advantages or disadvantages of having clinical or basic sciences part time MEs?

To the Q4, most of the responses were positive (23/30; 77% - *decent, sober, dedicated*). There were 5 negatives (*self-centered, vain, over-bearing*). To the question regarding rating them as facilitators or teachers the responses were almost all (29/30; 97%) complimentary:

- ***Most are well groomed***
- ***Pleasure to listen to; make things easy***
- ***Passion and energy for their work***

The next three questions were about whether the MEs should be full-time or part-time. These questions were framed keeping in mind that presently most of the DMEs in

medical institutes of Pakistan are run by part-time MEs, whether from clinical or basic science disciplines. The general impression carried is that the part-time MEs may not have enough time. Consequently, full-time dedicated MEs may help run the DMEs in a more organized fashion. However, 70% (21/30) said that part-time MEs are better, even if full time and qualified MEs were available; and to our surprise 17 out of these 21 (81%) wanted them to be from the clinical side (remember 50% of the surveyed faculty was from basic sciences). The advantages argued were:

- ***Patient contact gives them better insight into faculty's problems***
- ***Would not become pure MEs, like their pure 'bosses'***
- ***Don't want them to become mere 'pen-pushers'***
- ***Full-time MEs may become concerned about security of their job and thus may not have the same commitment and dedication as part-time MEs who do this out of personal interest, voluntarily***

Theme C: Attitudes of MEs

9. Do you ever feel that MEs think that the present teachers are not up to mark?
10. Do they ever treat you as ignorant?
11. What do you think they need to improve in their attitude?
12. Do they have empathy towards your problems?
13. Do they offer practical recommendations or advice?
14. What they offer, does it interfere with your personal style of teaching?

Over the years the feedbacks from medical teachers attending the compulsory supervisory workshops of CPSP, about some of the MEs' attitudes have not been very satisfactory; for example they have used expressions like 'intimidating', 'aggressive' and in some cases, according to faculty's perception, somewhat 'degrading' (CPSP Feedback Report 2006-11). This theme was generated to address this issue.

In answer to Q9 and Q10, 26/30 (87%) respondents felt that at times some MEs gave the impression that the already working faculty is not up to the mark and often treat them as totally ignorant of educational philosophies, in spite of the fact that many of them are quite experienced. In response to what the MEs need to improve (Q11), some of the answers were:

- ***Listen to what we have to say also***
- ***Address our problems***
- ***Not belittle us, and give weightage to our experience***
- ***Their theoretical knowledge from medical education books may not be valid here***

However, nearly half (16/30; 53%) did think they were empathetic towards their problems as teachers. Majority thought that the advice and strategies propagated were not practical (21/30; 70%). Also nearly half thought (16/30; 53%) that too rigid guidelines may interfere in their personal style of teaching.

Theme D: Expectations from MEs

15. What are your expectations of MEs?
16. How do they not fulfill these expectations?

17. Do you think they have insight into your problems as both teachers and service providers?
18. What is it that they do right?
19. What needs improvement?

Following on the theme A, where nearly all thought that MEs are a good addition to the medical institutes, their expectations were also very high, which the MEs would obviously have to meet. Some of them were:

- ***More advice on how to teach better***
- ***Understand our problems***
- ***Give practical advice***
- ***Not tout the administration's line, only***

As to why they are not meeting these expectations, some responses were:

- ***Maybe worried about their jobs!***
- ***Cannot translate theory into practical advice***
- ***Not in touch with the realities on ground***

Nearly two-thirds of the faculty (21/30; 70%) thought that MEs being themselves part of the faculty have an insight into their problems, and have many qualities:

- ***Teaching style worth learning***
- ***Their enthusiasm***
- ***Where do they find time to do all this?***

But some areas needed improvement (Q19), like:

- ***Less jargon***

- ***Stop trying to impress***
- ***Not think they are all-knowing***
- ***Be good role models***
- ***Have to act as good leaders to motivate***

Theme E: Functions

20. Have you learned anything from MEs?
21. After a session, are things clearer or more confused?
22. What are the areas they should be concentrating on in medical education?
23. What do the MEs need to improve in their approach about this new area?
24. Are they merely trying to forward the administration's policy or are really interested in medical education?

In this last theme the functions of MEs were explored. Almost all of faculty (26/30; 87%) thought that they definitely learned from the MEs. But unfortunately nearly half (13/30; 43%) thought they were sometimes more confused after a session; something not very flattering for a trained ME! To a query about the important areas to be concentrated upon and how approach this new subject, the answers were (Q22 and Q23):

- ***Improving curriculum***
- ***Do more faculty training***
- ***Be more available***
- ***Modernizing Assessment***
- ***Try to convey their viewpoints***

- ***Listen to us***
- ***Convince bosses we have to do our jobs also***
- ***Not think we are idiots***

Are they merely agents of the administration? Many faculty members think that MEs do everything to further the ideas of the administration and do not truly have the interest of improving medical education. Unfortunately the majority (**16/30; 53%)** said yes.

A very important final question ended the questionnaire, which was not part of the theme but summarized the whole (***Q25. Is medical education better or worse since when you were a medical student yourself?***). An overwhelming 28/30, 93% faculty members thought it was *better now*.

A summary of survey results is given in Table 1.

DISCUSSION

This was a study of personal views held by the faculty about the medical educationists (MEs); these MEs were involved in faculty development and imparting new educational philosophies to the teachers at their undergraduate medical schools. To our knowledge, this is the first study to know what the faculty thinks about the MEs in general, their personal attributes and attitudes as perceived by them, their expected functions and expectations from them. This collective wisdom of the faculty may help MEs embark on a journey of self exploration and introspection, lest we get carried away.

Maddison (1978), one of the most astute educationists from Australia asked a very important question, 'What's wrong with medical education? Flexner (1910) had asked the same question more than half a century before that and thus set in motion events which has laid the foundation of modern, evidence based medical educational philosophy. Maddison (1978) argued what many among the faculty often say (or at least think!), that there cannot be much wrong with the system which has produced a good doctor like them. He agreed many of the problems were created by shortage of money, shallow policies and often commitment to extreme and untested views. But he also felt that a great many of the problems were created by medical educationist themselves, propagating some unequivocally disastrous programmes and views in the field of medical education.

With increased public expectations relating to healthcare, societal demands for accountability, need to incorporate educational developments in teaching/learning process and to train more doctors within existing resources were some of the reasons that led to development of DMEs in medical schools throughout the world, and hence the medical educationist (Davis et al. 2005). As the expectations of those involved in the change process are important in the successful achievement of change, faculty's views about these agents of change (MEs) are important too; hence striving to improve their modus operandi and not be carried away with their own scholarship (Gale & Grant 1997). It is essential that the MEs and faculty work in harmony and are on the same grid. This may save them from facing an unsympathetic audience, who at times may get lost in jargon.

Discussing the results of this survey the answer to final question (Q25- Table 1) is important. Dornan et al (2011) in a special article celebrating the centenary of Flexner report asked the question as to what should be the goals of medical education for the next century. The question could be if there was a role of medical education in the next century? In our survey an overwhelming 93% of faculty thought that medical education was much better now than when they were students; hence medical education is here to stay, and so are MEs. The Theme A (Q1-3) of the questionnaire further emphasizes this aspect, with 100% of the faculty of all three medical schools having been exposed to MEs and 100% agreeing to their usefulness and presence. Giving an overview of general strengths of MEs the faculty appreciated their facilitation and oration skills and their passion. But more importantly the weaknesses like not listening to the opinions, deflecting questions, sticking to fixed agendas etc are worth considering. Are they related to one or two odd MEs? Or is it a weakness which is pervading the 'all knowing' MEs of today? Hence the need for introspection.

Over the years when MEs have to wear the hat of 'teachers of teachers' there is a danger of them developing a personality, which may become peculiar to their role. Something like a typical drill sergeant in the army. Theme B (Q4-8) explored such perceived attributes of MEs as a 'tribe'. Seventy-seven percent (23/30) thought they were sober and dedicated, but 17% used words like over-bearing, self-centered and vain. Although this small number can be attributed to one or two specific MEs that the reporting faculty was exposed to, but still a malady to shy away from. Many of the MEs in the world are eminent specialists in their own field and out of sheer love and passion for education as well as the traditional role of doctors as teachers, assumed the role of MEs. This debate

whether the MEs should be part time or full time occasionally takes place at various forums. Many feel that MEs should be full time, as part time fully practicing doctors may not have enough time. About 70% (21/30) of faculty felt that they should be part time by design; and 81% of this mixed faculty from basic and clinical sciences felt that they should be from clinical side. The arguments that came up during discussion following administration of the questionnaire emphasized the importance of patient contact of MEs, not become 'pure' MEs and mere 'pen-pushers'. This justifies the argument of Dornan et al (2011) of humanizing medical education, which may entail patient interaction. This may also prevent them from becoming, what Gordon (2011) calls 'hypochondriac educationist' (more and more preoccupied with less and less significant educational questions). Another argument given by faculty about part time MEs is that they work as MEs because they want to and not only taking it as a mere job, or trying to hang on to one.

Theme C (Q9-14) explored the attitudes of MEs towards the faculty. This theme was important because of the anecdotal comments of the faculty about MEs. This needed substantiation. More than 87% faculty felt (Q9-11) that the MEs who they came in contact during workshops or medical educational activities treated them as if they were totally ignorant of any concept of medical teaching. The post-questionnaire discussion also openly brought out the feeling among faculty that the MEs thought that whatever the faculty was doing so far was probably all archaic and needed to change everything. Fifty-three percent thought that what was taught interfered in their personal style of teaching (Q14), which somehow needed to be married with the evidence based educational philosophies. This attitude of MEs, perceived or otherwise, is a dangerous trend creeping

among the MEs. It seems to be contradictory to the tenants of facilitation, something aggressively propagated by MEs themselves.

The advice offered by faculty to rectify this misdemeanor was to listen and address what they had to say. Many of them were experienced teachers, and wanted their opinions to be taken seriously, and not just be mere recipients of what is given in the books, without giving due consideration for its practical implementation. Only 53% thought that MEs had any empathy for their problems as both teachers and care-givers (Q12). A lot has been written about the waning empathy in medical students as they progress through medical school (Sherman et al 2005; Chen et al 2012). Maybe there is a need to enhance 'medical educationist empathy' also. The only silver lining in this theme was Q13, where 70% felt that many of their suggestions could be implementable.

Theme D (Q15-19) was logically generated to know what the faculty's expectations were from the MEs. These are not very different from what students expect of their teachers: caring, motivation and character (Jehangiri et al. 2013). This indeed is what we have to work upon. Some of the main expectations (Q15) were related to learning more skills to teach better, which was expected. However they also expected their problems to be understood and given practical advice. Many were cynical about the real reasons for bringing a change in the system, feeling that MEs were merely trying to further the agenda of administrators who wanted this change, not for the sake of education, but for other motives. In the discussions following the questionnaire administration the reasons given were mainly about the mistrust of the faculty for the change the MEs were trying to sell, not purely for educational reasons. This is a point which needs to be clarified methodically by all MEs. They also felt that the MEs were not in touch with the realities

on ground and unable to give practical advice. Q18 and 19 asked about what the faculty felt was being done well. Most were impressed by the enthusiasm and teaching styles of MEs, and the dedication with which they found time to fulfill this extra commitment, in case of part time MEs. When asked about the improvements needed, the main emphasis was laid upon being good role models and translating theory into practice, without relying on jargon and exercising good educational leadership.

The last Theme E (Q20-24) further elaborated the functions of the MEs. Although 87% admitted they always learned something (Q20), but 43% still came out confused from a session (Q21). The next two questions further addressed what was discussed in the previous theme. Q24 confirmed the suspicion the faculty had about the employers using MEs to further their own agendas (53%).

For any ME this feedback can be an eye-opener. Most of the lot is dedicated and well-meaning but they may become over zealous in their approach. These points have to be taken seriously. Only by gaining the trust of the faculty can a change be brought about. Hence the need for leadership and astuteness. Most of the faculty was highly appreciative of the work being done, and many would love to have the same facilitation and teaching skills. Few areas which need attention can be attributed to lack of experience and becoming 'blinded by science' (Dornan 2011). Lastly, the final question with a thumping 93% approving the present medical education, a hundred years after Flexner, is something to be proud of. There is still a long way to go and most of the work maybe has to be done at personal level, than at a higher scientific level. The wisdom has to be sifted carefully from the knowledge.

CONCLUSION

Medical education has come a long way in course of the last 100 years. MEs are a spirited group of people who have gone where no man has gone before. The benefits, of course, lie in the production of quality young, critically thinking doctors in modern medical schools. This has been brought about by conceptualizing the new strategies and approaches, conveying them to the faculty and medical teachers and hence implementation of new programs. But over the years, driven by sheer force of conviction, the MEs come across as hard task masters, without empathy and at times over-bearing. It is time that MEs should reflect on their approach. The educational concepts being propagated should be tailored to needs and facilities. They must be practical, and implemented with unusual sagacity, employing true leadership skills.

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No funding was sought for this study, and there is no conflict of interest.

NOTES ON CONTRIBUTOR

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Table 1. The 25 item questionnaire and summary of results.

QUESTIONNAIRE REGARDING MEDICAL EDUCATIONISTS (MEs)

THEMES	QUESTIONS	RESPONSES
Theme A: General	1. Have you been exposed to trained medical educationists (MEs)?	Yes: 30/30; 100%
	2. Do you think there should be medical education and educationists (MEs)?	Yes: 30/30; 100%
	3. Give an overview of MEs general strengths and weaknesses.	**Strengths**: *Impressive communication skills, facilitation skills, teaching skills of MEs* *Focused, good orators, confident* *Passion and dedication* *Seemed to enjoy their work* **Weaknesses:** *Sometimes not let others speak* *Opinions not sought, not paid attention to the questions asked* *Often have a set agenda and stick to it only* *Deflect questions, rarely admit to gaps in their knowledge* *Often get different answers from different MEs;*
Theme B: Personal Attributes	4. How do you rate them as a person, generally?	Positive (23/30; 77% - *decent, sober, dedicated*). Negative (5/30; 17% - *self-centered, vain, over-bearing*)
	5. As facilitators and teachers?	Complimentary; 29/30;97% *Most are well groomed* *Pleasure to listen to; make things easy* *Passion and energy for their work*
	6. Should they be full time or part time?	Part time: 21/30; 70%
	7. If part time, do you think clinical teachers are better MEs	Clinical: 17/21; 81%

	or Basic science teachers? 8. What are the advantages or disadvantages of having clinical or basic sciences part time MEs?	Advantages argued were: *Patient contact gives them better insight into faculty's problems* *Would not become pure MEs, like their pure 'bosses'* *Don't want them to become mere 'pen-pushers'* *Full-time MEs may become concerned about security of their job* *Part-time MEs work due to personal motivation*
Theme C: Attitudes of MEs	9. Do you ever feel that MEs think that the present teachers are not up to mark? 10. Do they ever treat you as ignorant? 11. What do you think they need to improve in their attitude? 12. Do they have empathy towards your problems? 13. Do they offer practical recommendations or advice? 14. What they offer, does it interfere with your personal style of teaching?	Yes: 26/30, 87% Yes: 26/30, 87% (At times some MEs gave impression that the is not up to the mark and often treat them as totally ignorant; Need to improve: *Listen to what we have to say also* *Address our problems* *Not belittle us, and give weightage to our experience* *Their theoretical knowledge from medical education book may not be valid here* Yes: 16/30; 53% Yes: 21/30; 70%. Yes: 16/30; 53%; *Too rigid* *Interfere in our personal style of teaching.*
	15. What are your expectations of MEs?	Expectations: *More advice on how to teach better* *Understand our problems* *Give practical advice* *Not tout the administrations*

Theme D: Expectations from MEs		*line, only*
	16. How do they not fulfill these expectations?	Why not meeting these expectations: *Maybe worried about their jobs!* *Cannot translate theory into practical advice* *Not in touch with the realities on ground*
	17. Do you think they have insight into your problems?	Yes: 21/30; 70%;
	18. What is it that they do right?	*Teaching style worth learning* *Their enthusiasm* *Where do they find time to do all this?*
	19. What needs improvement?	Improvements: *Less jargon* *Stop trying to impress* *Not think they are all-knowing* *Be good role models* *Have to act as good leaders to motivate*
Theme E: Functions	20. Have you learned anything from MEs?	Yes: 26/30; 87%
	21. After a session, are things clearer or more confused?	More Confused 13/30; 43%
	22. What are the areas they should be concentrating on in med education?	*Improving curriculum* *Do more faculty training* *Be more available* *Modernizing Assessment*
	23. What do the MEs need to improve in their approach?	Improvements: *Try to convey their viewpoints* *Listen to us too* *Convince bosses we have to do our jobs also* *Not think we are idiots*
	24. Are they merely forwarding the administration's policy or really interested in medical education?	Administrations' Viewpoint: **16/30; 53%**
Final Question!	25. Is medical education better or worse since when you were a medical student yourself?	Better: 28/31; 93%

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