The Politics of Medical Curriculum Accreditation: Thoughts, Not Facts?

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ABSTRACT

The medical profession needs to adapt to the socio-political challenges of the 21st century. These have been described as the ‘Health Society’. Medical professionalism, however, is characterised by conservative values that are perpetuated by the professional attributes of autonomy, authority, and state-sanctioned altruism. The medical education enterprise is a replication and continuation of these values, sanctioned by its accreditation agencies. The Australian Medical Council through its accreditation standards only sanctions the formal curriculum. The status quo, however, is maintained by social, cultural and political parameters enmeshed in the informal and hidden curricula. By not addressing informal and hidden value constructs that maintain elitist medical arrogance the accreditation agency fails to uphold its remit. This paper explores the philosophical and empirical bases of these phenomena and illustrates them by means of a case study. Medical education and its sanctioning structure and agency are confirmed as forceful political enterprises. We conclude that explicit review of the informal and hidden curriculum is a feasible and necessary prerequisite for medical education reform and change.

Keywords: Accreditation, Australia, Curriculum, Medical Education, Political Analysis

INTRODUCTION

Is accreditation of medical education a commendable technical quality assurance effort, or a superficial political exercise to maintain the power base of the medical profession? The stated purpose of accreditation efforts in medical education is quality assurance for the public good (Karle, 2008). In fact, on reading World Federation for Medical Education documents and quite possibly the constitutional papers of all accrediting agencies around the world, accreditation is a lofty affair wholly grounded in sound social and philosophical commitments to human well-being and advancement. This is, of course, exactly how the medical profession (and for that matter, every profession apart from, possibly, theoretical astrophysics) wants to be seen, and how most health bureaucracies, industries, and consumer groups prefer to see the induction of new members into the sanctum of medical professionalism.

There is, however, a darker side to medical curriculum accreditation. This perspective relates to the creation, maintenance and protection of power and dominance of a privileged elite. This medical dominance, in terms of educational
development, may well start formally with the blessing Medical Schools receive from their accrediting agencies.

In this article we will review the nature and attributes of the medical profession, the functions and agencies it deploys to maintain its socio-economic privileges (autonomy, authority, and state-sanctioned ‘altruism’ – Freidson, 1970), the construction and role of medical knowledge in formal, informal, and hidden curricula, and the rhetorical efforts that accreditation agencies unleash to maintain the status quo. Having thus constructed a political discourse of medical education accreditation we will conclude this piece with a narrative case study, illustrating these issues in one particular Australian accreditation exercise.

Medical Profession: Medical Dominance

In medieval European times, and in many other cultures throughout history, we have witnessed what seems to be a natural drive to organize and distinguish classes, groups, castes, ethnicities, and trades. The trades, in their European contexts, were organized in Guilds. Such Guilds maintained strict access rules, licensure, set tariffs and prices, and enforced a hierarchic system for necessary qualifications. Guilds were conservative associations aiming to maintain the status quo and exacting control over trade qualifications; their purpose was never innovation, market responsiveness or transparency (Ogilvie, 2008) and the Guild system has been blamed for significant social and economic stagnation due to a strict class-exclusive market limitation (as Adam Smith in The Wealth of Nations noted’).

In the European medieval social stratification surgeons, recognised as craftsmen, organised themselves into surgeons’ guilds (or, if there were insufficient numbers of individuals, they joined the Guild of Blacksmiths, Sigerist, 1935). Physicians, on the other hand, emerged from more philosophical approaches to the human lot, whether they were interpreting dreams (Hippocrates) or seeking life balance (Ayur Veda). In the European university tradition (which emerged between the 10th and 12th centuries AD, founding a tradition that currently pervades global perspectives on tertiary education and scholarly development) those physicians trained in a strictly regulated system of peer assessment in institutional arrangements that were governed by higher powers, be they city administrations or sovereigns (e.g., the Holy Roman Emperor). The system included studies of logic (i.e., humanities) and medicine, followed by internships under the guidance of experienced practicing teachers. Each training stage culminated in examinations, and the license that ensued enabled medical practitioners to move between city-states (Sigerist, 1935).

Licensure and accreditation are different aspects of the same phenomenon: they set behavioural, academic and practical standards for the carrying out of medical diagnosis and intervention. Licensure relates to the legitimization of individual practice, whereas accreditation sets and enforces standards for institutional training arrangements. As Porter (1997, p.287) explains: “Medicine today is organized through structures that grant the profession considerable autonomy under state protection, while claiming to protect the public from malpractice and quackery.”

Throughout modern—post-enlightenment—history two options for accreditation have been competing, and preferences for one or the other seem to be grounded in the social construction of either medicine as a public good, or medicine as a form of healing entrepreneurship. There have been two possible accreditation strategies as a result of the discourses around these perspectives, both within state driven statutory codification of the legal conditions to call oneself a medical practitioner (e.g., through Health Acts). One accreditation strategy, and apparently the most dominant one in the Anglo-Saxon world, devolves the authority to regulate medical education to the profession itself. The other one, culturally perhaps better described as ‘European Continental’, assigns accreditation responsibility to state bodies (which then, in turn, are predominantly filled with medical academics, sometimes supplemented with members from legal and engineering professions,
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