



ISSN: 1697-090X

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Rev Electron Biomed / Electron J Biomed 2014;3:7-10.

Editorial:

REFLECTIONS ON MODELS FOR MEDICAL TRAINING AND PRACTICE. INNOVATION OR RENEWAL?

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Context and questions

Based on well-regarded but simultaneously polemic standpoints from medical and non-medical subjects two antithetic models of medical training and practice have been established: the hegemonic (dominant or biomedical) model and the innovative bio-psycho-social paradigm¹.

Consequently, all the supposedly negative aspects were assigned to the dominant model whereas all the theoretically positive ones were attributed to the alternative model which in addition to looking more appealing and understandable provides a sort of epic feeling to its followers, neutralizing simultaneously any reformist

attitude.

Beyond its original strengths, this perception, however, leads to mandatory questions when enriching debates for guiding toward feasible positions are intended.

Initially, one of those questions may be whether these two rigid paradigms, facing what is allegedly unfavorable (i.e: not necessary) with that idealistically beneficial to be achieved (i.e: advisable), reflect reality as in fact is.

In this regard, and as happened in Argentina, the question arises on how to classify those teachers, researchers and practicing physicians who often adhere to several features related with the alternative model even working in a hegemonic model sphere of activity. A frequent argument is that these deal with minority or inexistent cases. If so, this has to be reliably appraised.

Conversely, if long lasting Argentinean curricular experiences based on the alternative model are considered², the question emerging is how to incorporate physicians trained in that framework in an Argentinean health care system where the dominant model is still prevailing.

Further doubts and reflections

While personal behavior is built previously to accessing to medical schools, these institutions provide knowledge, attitudes, habits, values and skills apt to produce behavioral changes for good. However, it becomes doubtful that the medical career may solely change those well-intentioned persons committed with the alternative model and, of course, to those who, despite looking fanaticized with the new model, actually pursue economic advantages into the still prevailing traditional model.

The qualitative leap leading to the alternative paradigm may carry from allegedly unfavorable characteristics to others, theoretically better but critically not appraised, as yet. It follows that every potentially surmounting proposal does not have to be imperfectly implemented since, if it fails, may shatter something desirable and gradually suitable to be achieved.

The abovementioned reflections do not imply ignoring, that unfavorable features in medical training and practice do not have to be improved. It only points out that, when pursuing it, the medical career does not modify *ad integrum* the former student behaviors. Consequently, other questions may be listed without intending to exhaust the issue:

1. How dispensable and advisable are the respective hegemonic and alternative models?
2. Is the health care system determinant for the medical formation?

3. If so, would the health care system have to establish the most convenient model to be adopted by medical schools?

4. In the same sense and in case that the health care system reveals unsatisfactory for community needs, would it have to be formerly changed? Is it possible that an initial change in medical formation may diachronically improve the health care system at last?

5. Rescuing the more valid aspects of currently considered unsatisfactory and outdated model and hybridizing it with the more promising features of the new trends, is it possible to structure an intermediate model? In this regard, examples of curricular hybridization already exist as reported by Nanda et al.^{3/SUP>}


6. Furthermore, if in accordance with it intermediate improving variations in both systems (health care and medical career) simultaneously are implemented, may they converge satisfactorily as times goes by?

7. Understanding the epochal changes, the scientific-technological advances and the needs of changes in medical training and practice, it remains unsolved some complementary and related questions: Why outstanding professionals, trained in the so called dominant paradigm, firmly discard its redeemable features and accept proposals critically not appraised? What underlies in this Copernican twist, this all-or-nothing strategy, this ignorance of evolutionary hybrid options and this disdain towards their own medical training? Do firm convictions lead them to overcome still pending questions about this issue? May be snobbism? Political, economical or academic advantages, perhaps? Or other altruistic or egoistic not yet clarified reasons?

Summing up, enough questions and doubts still remain for adopting hasty radical decisions. It does not mean to be indecisive or courageous, to confuse efficiency with irresponsibility and transformation with adventure. Rather, it means to be faithful with our condition of Homo sapiens sapiens; in other words, acting more rational than emotional or even from a neuroscientific standpoint: *focusing our behavior more in the prefrontal cortex than in the limbic system in general and in the cerebral amygdala in particular, however good its interconnections are.*

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