EDITORIAL

Medical education in Colombia

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Unquestionably, there have been significant quantitative changes in medical education during the last fifteen years. As a result, these relevant fluctuations have forewarned about a likely deterioration of the quality of medical education in our country. As an illustration, the domestic supply of medical programs in recent years has increased by just over one hundred fifty percent from 21 in 1992 to 59 in 2011. The regional supply in some cases has multiplied even more.

Nevertheless, it is relevant to state that changes in medical education do not occur spontaneously but in concordance to a policy directed at not only opening markets, but also including all social sectors, in this case, with particular regard of Law 100 1993 and Act 30 of 1992. The first law established a Social Security System, with a health component that aims universal coverage in a few years, and the second law regulates (deregulates?) higher education and provides the legal conditions that facilitated the growth of medical schools and all disciplines in general.

However, beyond the significant quantitative changes that have occurred in the supply of medical programs, we must say that the country has been instituting a number of instruments to assure quality (both: general in regard to higher education, and specific to health) that have influenced the training of doctors. Moreover, they attempt to remedy both situations that arose as a result of such laws: the lack of regulation to new programs and the declining relation teaching- service.

The High Quality Accreditation by the National Council for Accreditation (CNA) is undoubtedly a very important instrument for the promotion and recognition of the quality of medical schools. In Colombia, 21 schools have been accredited by one, for two or three times. As a matter of fact, there has been a significant effort that makes visible the quality minded schools. ASCOFAME has actively participated in the accompaniment of this process in medicine faculties as well as the CNA, and its statutes promote a compulsory affiliation or enrollment of these schools to it.

The process however raises some concerns that should be explored:

What about those schools that fail to be accredited? This is otherwise a puzzle. The accreditation decision is public, but when the accreditation is denied the result is unknown. Would it be useful as a mechanism of social control and responsibility that the Ministry of Education informs about the negative aspects that led to an accreditation denial? Does the fact that the accreditation process is voluntary means that negative results cannot be made public? What about those who, without any justification (such as developing international accreditation processes) do not want to be credited? If the accreditation process was made mandatory, the question that arises is: whether the ceiling becomes floor, must you create a new ceiling?

The legitimacy and importance of the enhancing process is clear, but it cannot be allowed that only those institutions that enlarge quality programs will be the only ones linked to a quality process. It is necessary that quality processes have greater coverage and provide mechanisms to encourage the involvement of all programs in the country, as well as social sanctions that make that those who are not involved in quality processes cannot remained in force.

Nevertheless, the quality of medical education does not depend exclusively on the university. Educational projects that are enlarged in the university are developed to a great extent in hospitals which accomplish teaching service agreements. Despite attempts to regulate this relationship, the model does not allow effective interaction between the parties for the benefit of doctor's training so far.

The coexistence of several medical programs (therefore educational projects) on the same stage of practice gives as a result that the service institution is in charge of the educational project. These institutions happen not to have an instruction project developed, and they often do not have a structure that allows them to manage the medical instruction. As a result, the university loses the possibility of monitoring and evaluating teaching processes as well

as controlling the academic development of training programs.

The effort that is made by the education sector to have accredited and good quality programs is undermined with an educational project that dies in an institution where multiple service training institutions converge. Additionally, these teaching service institutions have little progress in the accreditation process of quality in relation to health care and service.

The issue of teaching service requires strong political will in many industries in order to be properly resolved. The law 1438 of 2011 that amends Act 100 of 1993 shows some ways to solve the problem, which we hope will materialize in adequate regulations.

Two additional issues deserve special attention in the multiplicity of variables that affect the quality of a future doctor's performance: medical education and teaching skills regarding the vocational profile that is sought to achieve in the school syllabus.

Since the 60s, last century, the principals of teaching education claimed that it was not enough to be a good doctor but to be a good teacher of medicine, a situation that is becoming more evident. In the last five years, we have insisted on students' skills but little on teachers' skills.

In addition to the mastery of content that teachers must have, they must be trained to understand the processes of teaching and learning, to use existing methodologies in a proper way, including ICT, to make an ethical approach to learning situations, to set an effective communication with students and colleagues, to work in teams, among others.

Medical schools must ensure the competence of their teachers, not only in the classrooms of the faculty but also in practice settings. The mere linkage of a physician to a hospital with which they have teaching service agreement may not be enough to become teachers. That is why and regarding the new circumstances, it is necessary to improve the teaching ability of teachers, to improve their own abilities, with clear concepts of expanding their pedagogical understanding as well as overcoming resistance to changes that have involved new paradigms in medical education, in addition to the conditions of employment.

They must commit to ensuring better care practices especially in schools. The concept of leadership cannot miss, especially when the medical teacher holds the title of educator. In fact, this position requires a critical, personal and institutional support for the development of the individual as a teacher, who along with the institution ensures the provision of permanent education

The institution must provide regardless of the contractual status of its paying a real learning environment, based on work. This aspect is indeed where medical education has had its true development, the articulation of networks and systems of organization and culture that still remain as the core in the educational process. This digest involves mentoring and support for the teacher and the student.

It is therefore necessary to maintain a permanent stimulus for teaching work.

Finally, the profile of training medical students in the country deserves a reflection not so much in terms of quality but the very needs of the system.

Some universities, in their autonomy and their right, have explicitly stated that they want to train doctors to specialize and others do so implicitly. Many schools report that the profile of its graduates is family health, community health, primary care oriented however trends toward medical specialization, the type of teachers' training and practice scenarios do not achieve this purpose. The training of medical students in highly complex scenarios, in addition to worsening the situation of teaching service, it generates an inefficient use of this resource, besides, it is not conducive to the student's vision as a general practitioner and it gives as a result a continuous copycat effect of the model of the specialist.

therwise, it is necessary to establish the right balance of what is intended by the general medical training. Of course, the future doctor must be a professional capable of implementing activities related to promotion and prevention. Nonetheless, the competences characterize doctors are: diagnosis and treatment with a component of knowledge about epidemiological transition as we have in Colombia. Our doctor not only has to know about infectious diseases and deficiencies, but must be trained in chronic and degenerative diseases as well as trauma and violence. In genera terms, this confluence of conditions has allowed us to have a competent physician in the national and international scene.

The doctor's training must be committed to social responsibility. We believe we can disagree with the system but medical education and the provision of services should be geared to the needs of the population, without excluding

the research and analysis processes during professional life. Moreover, medical instruction must teach even learn to unlearn, as it is required by a science governed by biological principles under high and low variability.

It is not possible to talk about the future of medicine without linking it to education of its individuals as a priority, the medical, research and adaptation to the diverse and different models of care. Medical education must necessarily go beyond learning. Thus, health reforms, the expansion of scientific knowledge, must necessarily open a permanent discussion about professional needs. It is impossible to separate the search for the best medical possible education from the best care and attention to patients.