Chris Roberts, Faculty of Medicine

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trelling an atypical pathway into academic life has characterised a surprising number of teaching colleagues profiled in Synergy. Chris Roberts, musings on ‘just how much I hated the first two years at the university’, not only had ‘no real standing of being an academic’ but was completely put off by his negative experience of medical school in the UK. Focused on job prospects, he had graduated, completed his vocational training and gone into general practice. It was only when somebody asked him: ‘Would you like to teach some medical students?’ that he could re-engage with the structures of teaching and learning that had proven so dispiriting in his student days.

Influenced by the works of Roger Neighbour, Chris moved from teaching students to tutoring in professional development programs for GPs. These programs were traditional in format: ‘We called ourselves the ‘manchur bunch’,’ we’d turn up at didactic lectures, get some points, and consider ourselves educated. Chris became a fully-funded GP trainer, ran the local GP training scheme and soon after, began to sense his real calling: ‘I was getting to my mid thirties and thinking, I would really like to go into the academic side of things. I decided to take a year out of practice and do a Masters. The education component of the course was the bit I enjoyed most. So then I made a huge decision - for the family as well - I gave up my full time practice (earning lots and lots of money) to pursue a career in academia.

Changing fields necessitated a change in hemisphere, after Chris applied successfully to the University of Sydney for the job of Director of what was then the Office of Teaching and Learning in the Faculty of Medicine. ‘Launching into his vision of how he would change the way the Graduate Medical Program (GMP) was taught, Chris was set straight by the Dean: ‘All very interesting, but I don’t want you to do that. I want you to write on educational research; that’s the direction we are going’.

Chris found a complex array of forces at work: light educational research; few researchers; a world famous - but ageing - medical program; and - fortuitously - ‘a group of people who had got fed up with this fossilisation in the Faculty of Medicine’. Working with them, Chris developed a new direction and set up the Centre for Innovation in Health Professional Education and Research (CIPHER) to support quality teaching, but also to become a leading health education and development group, with a focus on ‘the three areas where we already had an international reputation: professionalism and patient safety, the scholarship of teaching and learning; and interprofessionalism’.

Chris’s group recently attracted nearly $2 million dollars through the federally funded Cancer Education Project. ‘At the same time we started promoting the research culture, and got people in the Masters thinking more about getting into research. Some of these things started to show results with an increase in PhD registrations and in our Scholarship Index.’ At the level of teaching and learning practice, Chris set up a learning outcomes data base ‘articulating both what educators think and what the faculty think about learning outcomes, written so they are actually aligned with assessment’. Those learning outcomes mean reviewing teaching and learning material, revealing that: ‘Our third year lectures bore no clear relationship to the learning outcomes. They seemed to be a random selection of what the lecturers thought best’. So we tightened the lecture outlines and educated lecturers about what they should be lecturing.

Chris’s work embraces other areas of health, complete with inter-disciplinary tensions. ‘We get a lot of reports about marginalisation of dental students, even verbal abuse, and this went right up to the Dean, so we developed a project where we did shared problem-based learning from which the denists were previously excluded. We wanted to improve the experience of dental students, give them more respect’.

‘Do students actually gain from these things? We feel they do, but it is a slow process. Medicine does reasonably well in the CEQ, but we are stubbornly stuck in some areas. We’ll be looking at how our new curriculum affects CEQ results. I think the major issue is what people are expected to learn. The curriculum is supposed to be problem-based. But people still wanted to do disciplinary teaching. For a conservative Faculty, it was an extraordinary revolution that they shocked out a traditional six year learning course and instituted problem-based learning. For Chris, it is interesting that ten years on, ‘the very people who were supposed to change have become stuck in their ways and do not want any tinkering with the course. The revision favours a return to traditional tenes, particularly in anatomy and assessment, but is creative in the area of professional development, patient safety and clinical education’.

Many interlinked challenges face Chris: How to get quality teaching and learning into the clinical contexts where most of the formative teaching and learning happens, with the patients? How to support that learning with new technologies, with interactive media? How to streamline procedures which we don’t want to practice on patients? How to get people to use ePortfolios? ‘I think we have 1000 students and 2000 teachers, many of them not actually paid. So how do we reward and develop those people, and promote the scholarship of teaching and learning so people are considered academic and innovative?’ Another tricky area - and one on which Chris has done important research of his own - is admission procedures: ‘Given the lottery conditions we operate under, how do we select the type of doctor that you and I and our families would want to see? We shouldn’t have to decide between brilliance and values - how do we ensure that non-cognitive characteristics are given equal credence in the admission procedures?’

On diversity issues, Chris’s personal commitment to equity and fairness has sometimes meant frustration: ‘Nowhere in the University has a project suffered more from the restructuring than in the Indigenous area. As a Faculty we were about to recommend senior appointments; promote outreach, support and retention; and make everything more culturally sensitive around Aboriginal and Torres Strait Islander issues… but that didn’t happen. To keep things going the Faculty appointed a senior lecturer in Indigenous Medical Education providing support to our Indigenous students and promoting recruitment’. Encouragingly, however, all the medical schools in Australia and New Zealand have now set up standards each school has to reach in its own curriculum, ensuring an institutional obligation to reach those standards in order to get accredited. Students are also a reason for optimism: ‘Students are the great impromptu agents of change, and whilst we have been stuck in committees they have run some really interesting activities themselves’.

Australia, says Chris, needs rural medical students to become rural doctors: ‘We try to make sure they have a positive, well-supported rural clinical experience - both metropolitan… education, with 45 to 60 international students, mostly from Canada - but also from Europe, South East Asia, all over’. Throughout our chat, Chris articulated a view of stereotyping which extended beyond ethnic or cultural difference. His comments made it clear that disciplinary and professional boundaries can be equally difficult to surmount. Speaking, for example, of his work on interprofessionalism - the idea of doctors and nurses and allied health professionals working together as a team - he noted that it is sometimes difficult to overcome the negative stereotypes held by various groups. Chris and his colleagues (Jill Thistlewaite and Charlotte Rees, respectively) are currently involved in innovative research projects which could impact directly on how medical education happens. ‘In traditional medical education there is a triad of people - the clinical tutor, the patient and the student - and the typical interaction is that the patient is passive and the tutor transmits knowledge and principles. But we are looking at it as a three way dialogue where the patient can learn more from the patients. Patients know how they would like to be treated and how they want to participate, and if there are more likely to be engaging in the teaching and not be retained as a sort of convenient body. We’ve also been looking at research on the students themselves, and whether, or how they are happy with their bodies being used for medical education. As you can imagine, there are some cross cultural issues in that area’.

‘We are very interested in collaborations within and beyond the University, to learn from each discipline, and approach common problems of teaching and learning. We’d like to see our members in earnest discussions with other academics around projects of mutual interest’.

A/Professor Chris Roberts is Associate Dean (Education) in the Faculty of Medicine, and Director of the Faculty’s Centre for Innovation in Professional Health Education and Research (CIPHER). Chris can be contacted at: croberts@med.usyd.edu.au

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