Commentary: Funding will make you free

John C Alcolado

Academic freedom does not exist and has probably always been a myth. Wright and Wedge raise several important issues regarding the autonomy of clinical academics but, perhaps wisely, are careful not to provide a clear definition of “freedom.”¹ Freedom is not just an absence of physical restraint but also the lack of psychological compulsion. The central issue is the extent to which institutions and society are willing to tolerate some degree of freedom (or self indulgence) by academic physicians.

In the United Kingdom, we are already reigned in by the General Medical Council; its booklet on standards in medical research sets boundaries to what we may or may not do.² Failure to heed its advice could result in the ultimate sanction of removing our freedom to practise medicine at all. Our freedom to perform clinical studies is further limited by the local research ethical committees. Even if their approval is obtained, individual NHS trusts may veto projects by refusing permission via their research and development committees. Just because I want to do a study and it is ethical, that doesn't mean my hospital has to make the facilities available. The presence of clinicians, academics, ethics specialists, lay members, patients, and perhaps representatives of the pharmaceutical industry on these committees may provide the balance required to resolve the disputes envisaged by Wright and Wedge.

Although we would all agree that resolution of conflicts between our university and clinical roles should occur in a forum that acknowledges the primacy of patient's welfare, the key question is: who ultimately decides what is in the best interest of patients? Currently everyone looks at it from a different perspective. The university is motivated by research income and the next research assessment exercise; the individual academic is motivated by the desire to succeed; the local research ethical committee

tries to make a moral judgment; and the hospital has to consider whether the research will benefit the institution in a climate where “balancing the books” and reducing length of stay are paramount. All of these would say they have the patient's best interest at heart—but how easy would it be to limit a clinician's academic freedom with some spurious concern about patients' welfare?

Yale University may promulgate the “right to think the unthinkable, discuss the unmentionable, and challenge the unchallengeable,” but I have no right to expect funding or resources to help confirm my hypothesis. If I cannot find funding, my academic freedom is but a vapour. Although I have recourse to the mass media and the internet, I have no real freedom to have my ideas published in mainstream medical journals. I recently submitted a hypothesis article to the *Lancet* that was rejected by the editor without external peer review. Is this an infringement of my academic freedom?

Ideally, individual workers and dissidents should not only have the freedom to voice their opinions but also have some resources (financial or clinical, or both) to help them challenge orthodoxy. Society has to empower individuals to exercise their freedom. In clinical science it is funding, not truth, that will make you free. Minority academic views have always had to struggle. Galileo had to contend with the Vatican; today some of us will be urged to recant at the altar of big business and the research funding bodies.

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1 Wright JG, Wedge JH. Clinicians and patients' welfare: where does academic freedom fit in? *BMJ* 2004;329:795-6.

2 Research: the role and responsibilities of doctors. London: General Medical Council. 2002. www.gmc-uk.org/standards/research.htm (accessed 20 Sep 2004).

A memorable patient

Beating the test

An 89 year old woman with dementia is currently being managed in the community with six monthly visits from the community elderly mental health nurse and intensive family support. She is vivacious and intelligent and still regularly attempts the *Daily Telegraph* crossword, having previously held a prestigious position in the City of London. Her short term memory has recently deteriorated, and she depends on her diary for keeping appointments and knowing people's contact details.

We were therefore surprised to learn that she regularly receives high marks in the Folstein mini-mental state examination, which she completes during the visits from the mental health nurse. We were determined to discover the reason for this apparent anomaly.

It became clear that at the end of every visit by the nurse, while making the appointment for the next visit, the patient would record the correct answers to the mini-mental test in her diary.

Just before the nurse's next arrival, she would read in her diary that she should “revise for test” and would learn the answers by heart, hence earning high marks. Several hours later, she would be unable to recall the questions or answers, but she would have the date of the next test and the required answers already written in her diary.

This case highlights two important lessons. Firstly, that objective tests form only one part of a clinical evaluation—along with history, examination, instinct, and experience. Secondly, it is a charming example of strength of personality and forethought overcoming adversity.

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