A LETTER FROM

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Divided We Stand

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– Written by Adam Meakins, United Kingdom

Despite significant advances in modern healthcare – which have undoubtedly improved the lives of many patients – there exists an ever-present threat to further developments that needs to be acknowledged and addressed. This is the wide and persistent divisions between healthcare academics and clinicians to fully understand and appreciate each other, which is limiting purposeful and meaningful collaboration. This ongoing divide is arguably one of the biggest factors that impedes the progression and translation of any new advances in healthcare, with delays of up to 17 years being reported before research is routinely used in clinical practice[1].

The academic/clinician divide can be attributed to a number of factors; the first is that these two groups tend to have very different personalities, ambitions and goals, both personally and professionally. The academic individual often tends to be analytical and calculated, driven and focused on publications and qualifications. The clinician tends to be more empathetic and caring, driven and focused on people and their problems. The academic also tends to work with populations and pathology, whereas the clinician works with individuals and disability. These different personalities, goals and drives – although not mutually exclusive – do make collaboration and agreement between clinicians and academics difficult.

Another key barrier that contributes to the academic/clinician divide is an often archaic, dogmatic, hierarchical system that traditionally places academics at the top and clinicians as subordinates. This can, at times, make it challenging and daunting for clinicians to question, discuss and debate with academics openly, freely and confidently. This hierarchy can also be attributed to some academics' over inflated self-perceptions of their own standing and position within the profession due to the effort and intensity they have under gone to achieve their qualifications[2].

This can make some academics susceptible to eminence-based thinking – quick to rebuke, rebuff and reject potential new ideas and thoughts from others without fair consideration. These factors can soon lead to stagnation, lethargy and general inertia, with clinicians and junior academics too fearful or demoralised to challenge senior academics' work and ideas. The situation is simultaneously worsened by academics viewing clinicians with disdain, as lazy or lacking interest or understanding in research due to their lack of questioning or translation into practice.

A further key factor contributing to the academic/clinician divide is that they often don't speak the same language. Differences in terminology, acronyms and jargon exist on both sides making it hard at times for one to understand the other. For example, academics tend to discuss pathology and treatments in terms of statistical prevalence, incidence and treatments and assessments in terms of probability and reliability. Unfortunately many clinicians do not understand these terms well, which can make it frustrating and exasperating for academics to get their message across to clinicians as to why something is or is not effective[3].

Adding to this communication barrier is the disparity in understanding of the basic scientific principles that academics

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and clinicians have. Unfortunately many clinicians have poor understanding of the fundamentals of scientific investigation and processes, and tend to be unaware that their day-to-day observations and clinical expertise are prone to many cognitive biases and error. Many clinicians convince themselves that a treatment is effective when academics prove otherwise. This can and does cause resentment and friction between the groups and lead to further divisions.

All these barriers in hierarchy, language, terminology, communication and basic scientific knowledge means communication and collaboration between academics and clinicians will always be challenging, but they are not insurmountable. First, clinicians must be better taught the basic scientific principles and have a better understanding of statistics and cognitive biases. And academics need to work harder in reducing the hierarchical barriers and make themselves more approachable and willing to accept constructive criticism and challenges of their work by clinicians.

Finally, both academics and clinicians need to recognise and embrace the many different ways of knowledge translation and acquisition that are now freely available. Gone are the days of only being able to learn in a lecture hall or classroom when new research could only be read once a month via a printed journal. In today's world information is only a click away.

With the expansion of digital resources such as the internet, social media, hyperlinks, downloads, RSS subscriptions, keyword searches, blogs, vlogs, infographics, webinars etc, there are almost an unlimited number of possibilities to share, promote and disseminate information and just as many ways to connect, collaborate and work to close the divide that separates academics and clinicians.

The phrase 'united we stand, divided we fall' has long been used to inspire unity and collaboration. It is based on the belief that if individuals with similar goals work on their own instead of as a team they are doomed to fail. Unfortunately this prediction could become a reality in healthcare if we don't work harder to acknowledge and address the divisions in our profession.

It is without doubt that academics and clinicians have the same goal – to help patients. But to do this we need to better understand and respect each other's strengths and weaknesses, we need to work harder to overcome the barriers and prejudices that stand in our way and ultimately, we need to stand united.

Further reading

1. *Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. J R Soc Med; 104:510-520.*
2. *Aronson E, Mills J. The effect of severity of initiation on liking for a group. The Journal of Abnormal and Social Psychology 1959; 59:177-181.*
3. *Fernandez-Moure JS. Lost in translation: the gap in scientific advancements and clinical application. Front Bioeng Biotechnol 2016; 4:43.*

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