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A Grounded Approach to Clinical Academics in Low Middle Income Countries

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ABSTRACT

PhDs for clinical academics in low middle income countries (LMICs), such as Fiji, balances between research and clinical expertise. While PhDs enhance academic prestige, this paper argues that prioritizing super-specialization over mandatory PhD requirements better addresses LMIC healthcare needs, where specialist shortages are acute.

KEYWORDS

• Superspecialisation • PhD • LMIC • Healthcare • Postgraduate medical education • Research • Clinical expertise

An ideal medical education system should integrate research and clinical expertise, as both complement each other. However, policymakers must determine the right balance between these two paths. While ministries of health focus on providing comprehensive healthcare, universities aim for academic prestige, often pushing for faculty members to obtain PhDs. This creates a conflict, as requiring PhDs from clinical faculty may undermine their ability to deliver effective patient care.

PhD is a research-intensive qualification that requires years of study, potentially reducing the time clinicians spend honing their practical skills, which is more needed for developing nations. While research strengthens academic institutions and contributes to medical knowledge, an overemphasis on PhDs could

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result in fewer clinically competent doctors. The core responsibility of medical professionals is patient care and expecting all academic clinicians to pursue PhDs risks compromising this fundamental mission.

BACKGROUND

Health disparities across economies have been highlighted yet again by the COVID pandemic and calls for a rationalized global approach to changing needs in health care. The global economic disparities, resource availabilities, climate change and changing health demographics need a relook at medical education needs for different nations. PhD is most common in the academic domain, although it is a burdening and stressful process.[1] With 2 medical universities and lack of clinical super specialization studies in Fiji we do have to question on the rationale need for PhD graduates in the nation versus the need for more clinical based postgraduate studies to fulfill the nations health needs.

The usability of PhD graduates for research purposes is also questionable for LMICs given the low priority given to research funding by governments and reliance on external funding sources which meant shift of research agendas toward donor driven priorities, which may not align with the most urgent local needs.[2] No thematic differences existed between how LMIC and HIC trainees defined Decolonising Global Health (i.e., actively eliminating power imbalances; prioritizing local needs; promoting local leadership; providing equitable opportunities; and ensuring programs are culturally appropriate)[3], hence a PHD does not seem to make a difference in the thematic and pragmatic though process of an advanced medical trainee.

Candidates themselves don't think it adds much generic value to their practice but rather extremely specific study-oriented value which may-not be of much use in LMICs where funding and Human Resources are scarce to distribute for research purposes.[4] The average duration of PHD could be 3.6 years and 75.9 % full time students reflects loss of essential expert workforce which for a developing nation could affect health delivery services drastically.[1] Stakeholders should integrate doctors with specialization qualifications into the rural health systems in LMICs.[3] Overall, a PhD is not superior in terms of financial benefits, but it is the driving factor behind the high rates of candidates pursuing a PhD.[5] Though limited by a small sample size, findings highlight the need for better integrated institutional and programmatic supports for MD-PhD students, especially during PhD training. MD-PhD physicians had a lower lifetime earning potential than MD physicians in the same specialty; there was an inverse relationship between earning potential and research effort in different specialties, with MD-PhD physicians in high-earning specialties tending to spend less time on research; and despite this, MD-PhD physicians in academia were more likely to choose clinical fields that allow more time for research.[6]

In developing nations medical staff face challenges in funding the cost of a PhD and have difficulties in completing the program due to the staff shortages and excess clinical workload.[7] Despite these challenges and even after reaching a PhD, medical staff attrition rates are highest amongst PhD graduates who may be well suited for greener pastures than continuing in their LMIC after reaching a PhD.[8] Only half of the PhD candidates choose to pursue a faculty path.[9] A considerable proportion of medical doctors has no active research output after obtaining a PhD degree in radiology, and this should be considered when relying on PhD programs to replenish the academic workforce.[10]

MD-PhD programs are a powerful tool for developing nations but to pursue an 8-year study program is loss of essential workforce for developing nations. Also, this may not be feasible in developing nations as the funding for and capacity for research are limited.[11] Even developed nations struggle to implement rigorous mentorship during the PhD programs though limited by a small sample size, findings highlight the need for better integrated institutional and programmatic supports for MD-PhD students, especially during PhD training.[12] A review has highlighted the importance of LMIC/HIC collaborations for developing Clinical education programs for LMICs rather than investing in PhD programs for medical professional in LMIC which may not be possible.[13] Clinical research self-efficacy was correlated with the amount of clinical research training and specific clinical research tasks, which may inform curriculum development for a variety of clinical and translational research training programs.[14]

The geographical distribution of specialists clearly influences fair service delivery and specialization is accelerating in LMIC, with a growing proportion of doctors organizing their careers around specialist training. Policy initiatives are underway in LMICs to increase access to specialists in rural health facilities and improve referral systems[15] rather than focusing on PhD.

The Priority: Super-Specialisation Over PhD Research

To become a clinician is a demanding, multi-year process. Clinicians already dedicate years to obtain undergraduate and postgraduate medical degrees, followed by supervised hands-on training before getting a vocational registration to practice in a particular discipline. In resource-limited countries like Fiji and other Pacific Island nations, the focus should be on developing competent clinical specialists rather than producing PhD holders with limited practical expertise.

Encouraging super-specialisation offers multiple benefits such as super-specialists bring advanced expertise to patient management, enhancing healthcare delivery and patient outcomes. General specialists and students benefit from exposure to highly specialised knowledge. As clinicians deepen their expertise, they develop a natural curiosity that may lead them to pursue research and PhDs voluntarily, rather than through institutional mandates. Forcing clinicians into PhD programmes undermines self-motivation and risks diminishing their engagement with both research and clinical practice. The decision to pursue a PhD should stem from personal interest, in an organic manner.

The Risks of Enforcing PhD Requirements

Some argue that since Fiji's Master of Medicine (MMed) programme lasts four years, clinicians could simply extend their studies by another two years to obtain a PhD. However, this overlooks the realities of medical training that include a typical medical eight years of undergraduate and postgraduate study, followed by mandatory service and then further specialisation. Doctors must undergo supervised training in divisional hospitals to gain practical experience even after specialization education before practising independently. Extending this process for a PhD could derail their clinical development during junior consultant training post master's graduation. Clinicians not only need hands on training, but equally important is to deal with crucial clinical situation where they develop capabilities to take vital decision independently. Prioritising research over clinical training could lead to underqualified practitioners making crucial errors in critical patient care related decisions.

Acquiring a PhD after clinical training could make a doctor out of touch with real-world patient care, as theoretical research cannot substitute for hands-on experience. To quote Sir William Osler: *"To study disease without books is to sail an uncharted sea, while to study books without patients is to not go to sea at all."*

The Need for Super-Specialists in Fiji and the Pacific

Fiji and other Pacific Island countries face severe shortages of medical specialists. The absence of qualified radiologists and anatomists highlights an urgent need for clinical expertise. Encouraging super-specialisation addresses healthcare needs directly, reducing the necessity for patients to seek treatment abroad. For instance, the availability of cardiac stents and 2 locally trained interventional cardiologists has saved countless lives and financial resources by enabling local treatment.

While research based policymaking has its place, it must be approached pragmatically. Low and middle-income countries (LMICs) lack the facilities and funding for large-scale medical research, making it impractical to prioritise PhD programmes over clinical development.

Practical Considerations for Medical Education

A comparison between postgraduate clinical degrees and PhDs highlights the value of prioritising clinical training:

Advantages of Postgraduate Clinical Degrees (e.g., MMed, MD, MS)

Clinicians with postgraduate degrees have superior real-world experience than PhD holders in terms on clinical exposure. Experienced practitioners provide more interactive and practical learning experiences. Clinical specialists align with the immediate healthcare demands of Fiji and the Pacific and this expertise is more beneficial to healthcare in LMICs than theoretical research.

Advantages of PhDs

PhD holders excel in scientific inquiry and critical thinking, which may not correspond to the most urgent healthcare priorities currently facing LMICs. PhDs improve university rankings and accreditation, and research-focused faculty members provide depth in academic subjects. For medical education, postgraduate clinical degrees should take precedence over PhDs. PhD holders are valuable in pure sciences and research focused disciplines, but patient care requires hands-on expertise rather than purely academic training.

Recommendations for a Balanced Approach

The Fiji National University (FNU) and the Ministry of Health (MOH) must collaborate to decide the right balance between PhD qualifications and clinical training. The current policy requiring 30% of faculty to hold PhDs by 2026 is unrealistic and counterproductive. Instead, a gradual transition over 5 years must be implemented to allow for a gradual transition, enrollment, and completion of a PhD. Prioritizing clinical specialisation is necessary to fill critical vacancies in essential disciplines such as anatomy, radiology, pathology, interventional cardiology, nephrology, and pediatric intensive care.

Ensure equal career progression for both clinicians with extensive experience and PhD holders and formally recognize clinical Superspecialist on par to PhD when considering promotions. To encourage PhD pathways that encourage growth of local healthcare research priorities rather than abstract academic topics. Once key clinical specialist positions are filled up then clinicians should be supported in pursuing research pathways with workplaces providing protected time (e.g., seven days per month) for those interested in research. In addition, offer competitive salaries, candidate focused research priorities, healthy workplace leave entitlements and incentives to encourage participation in continuing medical education (CME).

CONCLUSION

A Contextualized Approach to Medical Education

Fiji and Pacific Island nations require a balanced, integrative model that fosters research without compromising clinical ability. While PhDs are valuable, their role in medical education must be carefully considered. The primary focus should be on strengthening the healthcare workforce through specialisation rather than prioritising academic prestige.

A blanket PhD requirement for medical faculty is misguided and potentially harmful. Instead, institutions should support clinicians in pursuing super-specialization, allowing them to enhance both their practical skills and research engagement organically. A more measured approach, where clinical experience and research coexist harmoniously, will serve both the university and the healthcare system more effectively.

REFERENCES

1. Damba F.U., Mtshali N.G., Chimbari M.J. Barriers and facilitators of translating doctoral research findings into policy: The case of a selected health sciences school in a South African university. Heliyon. 2024 Sep; e37314.
2. Agyepong I.A., Barasa E., Sheikh K., Lehmann U., Gilson L., Dahoui Y., *et al.* Health policy and systems research capacity development to support maternal, new-born, child and adolescent health in West and Central Africa. Ghana Med J. 2022 Sep 1; 56(3): 3–12.
3. DeCamp M., Matandika L., Chinula L., Cañari-Casaño J.L., Davis C.H., Anderson E., *et al.* Decolonizing Global Health Research: Perspectives from US and International Global Health Trainees. Ann Glob Health. 2023 Feb 6; 89(1): 9.
4. Anttila H., Lindblom-Ylänne S., Lonka K., Pyhältö K. The Added Value of a PhD in Medicine - PhD Students' Perceptions of Acquired Competences. International Journal of Higher Education. 2015; 4(2).
5. Marini G., Henseke G. Is a PhD worth more than a Master's in the UK labour market? The role of specialisation and managerial position. Studies in Higher Education. 2023; 48(10): 1538–50.
6. Physicians Cientist Development. 2024; Available from: https://doi.org/10.1172/jci.
7. Larsson E., Mawkin M., Taylor-Robinson S.D., Harrington P., Gondwe H., Watson C., *et al.* Implementing Innovative Approaches to Healthcare in a Lower-Middle Income

Country: Perspectives from Malawi. Int J Gen Med. 2020 Dec; Volume 13: 1723–30.

8. Mie N., Htun M., Reyer J.A., Yamamoto E., Yoshida Y., Hamajima N. Trends in attrition among medical teaching staff at universities. Vol. 78, Nagoya J. Med. Sci. 2016.

9. Andriole D.A., Jeffe D.B. Predictors of full-time faculty appointment among MD-PhD program graduates: A national cohort study. Med Educ Online. 2016; 21(1).

10. Yakar D., Kwee T.C. Research Output by Medical Doctors after PhD Graduation in Radiology: 17-Year Experience from the Netherlands. Acad Radiol. 2021; 28(6).

11. Ashour L., Schoumann-Alkhatib A., Alshawabkeh A., Alsouri M., Sawalmeh M., Hatamleh H., *et al.* Highlighting the Need for MD-PhD Programs in Developing Countries. Avicenna J Med. 2023 Apr; 13(02): 065–7.

12. Chakraverty D., Jeffe D.B., Dabney K.P., Tai R.H. Exploring reasons that U.S. MD-PHD students enter and leave their dual-degree programs. International Journal of Doctoral Studies. 2020; 15: 461–83.

13. Hill E., Gurbutt D., Makuloluwa T., Gordon M., Georgiou R., Roddam H., *et al.* Collaborative healthcare education programmes for continuing professional education in low and middle-income countries: A Best Evidence Medical Education (BEME) systematic review. BEME Guide No. 65. Med Teach. 2021; 43(11): 1228–41.

14. Sebastian M., Robinson M.A., Dumeny L., Dyson K.A., Fantone J.C., McCormack W.T., *et al.* Training methods that improve MD–PhD student self-efficacy for clinical research skills. J Clin Transl Sci. 2019 Dec; 3(6): 316–24.

15. Sriram V., Bennett S. Strengthening medical specialisation policy in low-income and middle-income countries. BMJ Glob Health. 2020 Feb 11; 5(2).