Challenges in medical education—what the doctor ordered?

It is hard to imagine a greater range of challenges than those currently facing the providers, purchasers, and consumers of medical education—a clear case of multipathology, with several vital systems facing the prospect of becoming overwhelmed. How will our patient, “medical education”, as an undergraduate (“paediatric”), postgraduate (“mediatric”) or in its continuous professional development (“geriatric”) state, respond? Will the two billion pounds the NHS spends annually on medical education—what the doctor ordered?—be sufficient to pay for treatment?

From its earliest days, our patient has had two guardians, the NHS and the universities, looking after its welfare, and protecting its interests. These guardians have been and are continuing to work on their relationship. The General Medical Council and the royal colleges set the standards by which the guardians are judged. Both the guardians and standards organisations are being challenged. This is not simply as a result of the increased political demand for accountability and transparency, but is part of the bigger picture being reflected in policy and evident in documents from The New NHS Modern. Dependable, through to A Health Service of all the Talents. This proposes radical changes, including that postgraduate deaneries coalesce with regional health authority boundaries, and the royal colleges participate more closely with others in workforce planning initiatives to establish wider consultation for the accreditation and location of training places. It is also proposed that funding formulas for specialist registrar posts should become more flexible, reflecting the needs of service delivery and learning opportunity. The availability of high quality clinical training posts for the service areas that need them is a priority. Historic precedence will give way to carefully planned allocation of resources to meet workforce demands, to be driven by population needs and care pathways. Thus the relationship between service delivery and training posts is made explicit . . . those who pay the piper? It is not legally possible for the royal colleges alone to determine where and when permission for training posts is made explicit. Historic precedence will give way to carefully planned allocation of resources to meet workforce demands, to be driven by population needs and care pathways. Thus the relationship between service delivery and training posts is made explicit . . . those who pay the piper? It is also proposed that funding formulas for specialist registrar posts should become more flexible, reflecting the needs of service delivery and learning opportunity. The availability of high quality clinical training posts for the service areas that need them is a priority. Historic precedence will give way to carefully planned allocation of resources to meet workforce demands, to be driven by population needs and care pathways. Thus the relationship between service delivery and training posts is made explicit . . . those who pay the piper? It is not legally possible for the royal colleges alone to determine where and when permission for training posts is given or withdrawn.

The need for collaboration and expedient use of resources is clear. The proposed, integrated National Workforce Development Board will have ultimate responsibility for education and training. Care Group Workforce Development Boards will become responsible for service developments and any skill mix changes necessary for future service delivery. These will also be multidisciplinary, including managers, professional bodies and trade unions, as well as patient and consumer organisations. However, there are potential problems in this model. The elderly patient, with coronary heart disease, diabetes, and “age” looks as if they will be the responsibility of at least three care boards, a result possibly of the way in which the realities of caring for the whole patient are still not yet fully understood. The education and training agenda could be similarly disadvantaged, with the educational resources going to parts, which do not produce a whole. The emerging vision of a multidisciplinary team based approach to care has strong face validity. However it can only be brought about through a change in culture and practice, allied to changes in management, resource allocation, and objectives for education and training. Its realisation will be dependent upon the development of effective new grades and types of staff, clinical and technical: a further educational challenge. Who teaches the teachers and who assesses effectiveness?

Changes in the management of education have already been mentioned; they are coupled with proposals to alter the resources. At postgraduate level the proposal to merge the Service Increment For Training (SIFT), the Medical And Dental Educational Levy (MADEL), and the Non-Medical Educational Training (NMET) budgets is a strategic decision that is likely to be welcomed, even if its sufficiency is challenged. But money, even in the universities, is not the only issue. At undergraduate or professional training levels, doctors, nurses, health care professionals, and managers are educated separately, but in the real world have to work in teams. At work, allocation of time and responsibilities can make it difficult to organise and protect time for education, both for individuals but especially for teams. This is true for both primary and secondary care. Clinical governance, revalidation, care pathways, health improvement plans, and a range of performance indicators are explicit reasons for increasing the coordination of postgraduate education and continuing professional development (CPD) both within and between the primary and secondary care sectors.

Changes to the reward systems for continuing medical education/CPD, and reaccreditation, are still unclear. There should be an agreed “exchange rate” for educational activities that would satisfy a range of accrediting agencies such as the national boards for nurses, or national vocational training awards for administrative and managerial staff. Historic cultural and tribal patterns will need to be disentangled, and traditional routes into the profes-
sional groups revised, to deliver the proposed integrated education and training for the new clinical teams. Advantage should be taken of the emerging consensus of credit accumulation and transfer. Examples of good practice exist, such as the new schools of postgraduate medicine, where it has been possible to identify needs and access resources to introduce award bearing, and CPD courses that bring together a wide range of health care professionals.

However, there are other challenges that need to be taken into account alongside the on-going need for updating, research activities, and reflection on practice that constitute the existing educational agenda. The capture, processing, and use of information has become a major clinical issue impacting on everything from record keeping to performance management. Clinical governance is the policy framework, which brings a great many of these issues together. It has brought a huge educational agenda, requiring ways of managing information, and performance, in a process of continuous improvement and transparent risk management. Creating a safe learning environment, one of the fundamental principles of adult learning, will, in some teams, some specialties, some hospitals, take time.

Without that prerequisite, the disclosure and sharing necessary for a “learning team” to engage in “dialogue”, in order to improve practice, is unlikely to occur. Similarly, the need to become efficient managers of information is a challenge for all of us. Evidence based medicine has changed the way we learn and develop our practice. Health informatics will present us with a similar quantum leap in how we think about patient care and improvement in service delivery. Will this become a core subject for all prospective doctors? Will the NHS be able to afford the necessary investment in hardware, software, time, and human resources to develop the essential infrastructure support, and educate the workforce to make best use of it? Will the professions ever have explicit standards in record keeping and communication, which will enable automatic processing of information in electronic form by machines either within or between professions? Integrated systems require standards that can be integrated, these standards involve clinical as well as technological subjects. Health care professionals need to share and understand these skill areas if they are to trust the use of such data to improve their care of individuals or to improve their services and, as is intended, make each clinical hour more effective. Excellent progress has already been made but more is needed.

Medical education faces a dilemma with the current information explosion and knowledge volume challenges; should it increasingly specialise or will it maintain a broad base? We are currently educating and training through an increasingly steep pyramid, with specialisation and subspecialisation through the training grades, but is this meeting the needs of patients in the optimum way? The demographic time bomb is going off, with greater numbers of “young old” and “old old” with multiple pathology an increasing factor. The doctors we are currently training are apparently not being taught to manage the majority of patients who are making use of the health services, if we are to believe the press reports. Equally doctors entering the workforce from overseas sometimes have little experience of the complex pathology found in the elderly. This “re-visioning” of the NHS towards a “customer oriented” service (A Milburn, Radio 4, 9 May 2000) requires a medical workforce which can think and do (technologists), and suggests that we may need to consider whether some subspecialisations may be better served by those that can do (technicians) under the supervision of the technologist. Time is what the doctor ordered, sometimes time to rest in order to be able to learn, sometimes time to think about what is needed to be learnt, and sometimes time to work together on learning together.

Lifelong learning is with us. Evidence of learning and benefits to practice, rather than a certificate of attendance, are likely to be required, in order to justify time and resources spent on CPD activities. There is a necessary tension between wanting to encourage voluntary self direction of learning and ensuring that the workforce is adequately equipped to deliver the services that are required. Career change and redirection will be available, again, hopefully reflecting a voluntary process—but what if service demands change: will CPD or retraining be an alternative to redundancy? And, how can this be seen as a positive and empowering choice to make, rather than a consequence of failure or poor performance? Cultural change at the heart of the medical education system might be needed. With the multidisciplinary team, and the learning team, we need all team members to take responsibility and to be valued for the essential contribution they make to the welfare of the patient and the delivery of the service.

Providers of medical education include both the NHS and higher education. In higher education the focus for discussion is on the (undergraduate) medical schools, whereas (postgraduate) medical schools and broader university based departments are playing an important and increasingly large part in medical education. However, the medical schools report an ever increasing difficulty in recruiting clinical academics, despite the settlement that brought pay scales back in to line with hospital posts. The relative devaluing of clinical research in the research assessment exercise, with its subsequent loss of funding, and the increasing demands for good quality teaching, have placed huge stress on staff in existing medical schools. The recent Committee of Vice-Chancellors’ and Principals’ paper indicates a desire for the higher education sector to be a full partner in the developments proposed for the NHS, and any attempts to improve the effectiveness of the funding and relationships between these organisations should be welcomed.

One of the most problematic aspects of the current system of medical education is the gap between knowing and doing, between competence and performance; between ticking a “done that” box and gaining insight, understanding, and an ability to apply knowledge using appropriate skills, with a professional, caring attitude. Portfolio or log-books can be designed to support this aspect of professional development, and some do, but practical developments are needed in this area. Realists might argue that the performance competence gap is a manifestation of pressure of work. Our doctor is certain to have ordered time: time for individual education and development, time to explore the important field of informatics, time to review service delivery and develop new multidisciplinary teams, time to give adequate, or even generous, support to the doctors in training posts, and time to reflect on what we have achieved ourselves. A further prescription might be to ensure that we are able to act as a positive role model to colleagues and training doctors; to enjoy our work and to feel we are making a contribution to our profession and the health of the nation.

For many of the challenges described above, the value of the outcome will lie in the “how” of what is done, as much as in the “what”. Embattled, entrenched clinicians might not want new challenges. Technological developments will assist, eventually, but also challenge as they change the practice of medicine, and the doctor-patient relationship. The skills needed in a good doctor will still include listen-
ing, communicating, thinking, doing, and caring. The context in which they take place is changing through increased partnership with patients and greater reliance on colleagues within the team. The team that learns together performs better...? It certainly will be better placed to deliver our patient good care, using all our talents...just what the doctor ordered.

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Medical anniversary
Robert Seymour Bridges, 23 October 1844

Robert Seymour Bridges (1844–1930) was born at Walmer and educated at Eton, Corpus Christi College Oxford and St Bartholomew’s, qualifying in medicine in 1874. He was elected physician to the Northern General Hospital (1876) and to the Hospital for Sick Children, Great Ormond Street (1877). After an attack of pneumonia (1881) he deserted medicine for poetry, became poet laureate (1913), and produced The Testament of Beauty (1929). He died on 21 April 1930 at Boar’s Hill, Oxford.—D G James