The uncertain future of medical education

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In the aftermath of *Liberating the NHS*: Developing the Healthcare Workforce and the Browne Report on *Securing a Sustainable Future for Higher Education in England,* the parallel worlds of regional postgraduate deaneries, universities, and medical schools seem set to converge. All three provide a crucial focus for improving patient care, universities through research, teaching and social engagement; medical schools by preparing undergraduates to enter the profession; and deaneries by developing graduates into independent, career-grade doctors. There are already obvious cross-over points between them, such as medical schools' clinical placements for undergraduates, which utilise deanery Local Education Providers [LEPs] in hospitals and GP Practices; and Master's degrees provided by universities as an elective part of individual doctors' postgraduate medical education [PGME]. Since the cost of maintaining three separate organisational bases to work towards the same purpose no longer seems affordable., and the aim is to improve quality and drive the level of central funding for educational down, our question is, how might they collaborate to form a new community of practice; why haven't they done so already; and what are the implications of the proposed changes, including the level of unintended risks to the future of medical education?

Historic barriers to collaboration

To take the second part of our question first, beneath their surface similarities, the three entities are historically different. Western universities, referencing themselves to Plato's Academy and Aristotle's Lyceum, began in the UK in the twelfth and thirteenth centuries, with the foundation of Oxford and Cambridge. Medical schools, however, developed from charitable hospitals and learned societies: their genesis was in real-life clinical practice. So, England's first medical school, the London Hospital Medical College, founded in 1785, developed from professional practice at St Bartholomew's Hospital, founded in 1123, at the same time but quite separately from Oxford and Cambridge universities. Even the development of scientific medicine, from Jenner onwards, took place at one remove from the new Victorian civic universities: at Newcastle on Tyne, for example, a College of Medicine was established in 1834 in connection with the University of Durham, founded in 1832, but was not incorporated into the new, larger, independent Newcastle University structure until 1963. Nine hundred years of different cultural development separate universities and medical schools, so that even today, most medical schools seem to be hosted by, rather than incorporated into, their universities.

Deaneries were founded within the NHS, and heralded by the Goodenough Report, which called for 'each university to depute a person to undertake the organisation and general supervision of the postgraduate arrangements' for medical education (Goodenough, 1944). In 1968, a Royal Commission called for a network of postgraduate medical centres at local level, overseen strategically by a national Central Council operating through regional committees (Todd 1968), while the Merrison Inquiry emphasised the need for robust and effective management of PGME, as part of medicine's professional self-regulation (Merrison 1975).These aims were achieved finally in 2009, when the Postgraduate Medical Education Board [PMETB] was merged with the GMC to form a single, independent, national body, responsible for quality assuring the whole of PGME. Concurrently, Deaneries entered new partnership arrangements with the medical Royal Colleges, to implement the requirements of the Calman Report (DH 1993) and *Modernising Medical Careers* (DH 2004), while organisationally, deaneries became part of Strategic Health Authorities in 2002 (HMSO 2002).

The parliamentary separation, which places universities and medical schools in the Department for Business, Innovation and Skills [BIS] and deaneries in the Department of Health [DH], reflects these different histories. Universities, medical schools and deaneries have different affiliations, networks of influence, roles and responsibilities, and these legitimate differences can stimulate creativity and diversity. However, they have also produced some costly idiosyncrasies, especially in the still-developing relationship between universities and medical schools. For example, unlike every other part of the UK university system, medical schools do not have a uniform system for awarding first degrees: some award first, second, or third class honours degrees and some do not. So, while other UK graduates have their expectations set for them by the grade of their first degree, medical graduates do not, since they enter their PGME as an undifferentiated group. This means both that individuals may have quite unrealistic expectations, and that the public purse pays for an expensive, time-consuming selection process for deaneries to admit medical graduates to the first year of their postgraduate education. At a national level, DH appears to be footing the bill for BIS inefficiencies.

Underlying these historical and organisational differences, and presenting a real danger to patient safety, lies a deeper philosophical separation, between praxis and the Academy. As Stanley (1990) points out, the 'tradition of the academic mode' is to separate people from knowledge of their own experience and to re-locate knowledge in the Academy. This is done by focussing 'on propositional knowledge, or "knowing that", as the paradigm of knowing', so that '"knowing how," or skilled activity, is consistently subordinated' (Alcoff and Potter 1993, 11). Praxis, the knowledge that arises from practice, that is co-constructed through inter-subjective relationships between doctors and patients, and is held communally, is inferior in the eyes of the Academy. Yet it is precisely praxis that comprises professionalism, the 'psychosocial and humanistic qualities such as caring, empathy, humility and compassion, social responsibility and sensitivity to people's culture and belief' (MMC 2010) which lie at the heart of a patient-centred NHS. Without it, there is no professional judgement, no contextualised understanding of the personal, complex, problematic needs of individual patients,that is the only real guarantee of patient safety.

The philosophical differences are embedded in organisational differences, but there are signs of change at national level. Funding for undergraduate placements in NHS Trusts, the so-called Service Increment For Training [SIFT] used to be routed from DH to Medical Schools, who would then disburse it to NHS Trusts, often using the NHS Trust associated with the Medical School as their agent. This labyrinthine process is now being replaced by direct payments from DH to NHS Trusts, with the funding following the footfall of students, and reflecting the organisational needs of LEPs, their doctors, and their patients.

Collaborating in medical education

To return to the first question, how might new communities of practice emerge for medical education? A starting point, perhaps, is to reconceptualise the relationships between universities, medical schools, and deaneries. Medical schools are now part of a larger, wider academic body than just medicine, with huge opportunities for drawing on its broader intellectual community. It is true that they have been outside the defining changes that affected higher education marketplaces in the 1990s - the stimulus to commercial diversification provided by the PICKUP scheme (Duke 1992) and the creation of the 'new universities' by the Further and Higher Education Act (1992). However, new requirements by the GMC for Educational Supervisors to be clinical teacher educated and accredited (ref), a new focus on Leadership for Clinicians (ref), and the emergence of Medical Humanities as a substantive discipline (ref) all open the way for medical schools to collaborate with relevant specialist departments in their own universities.

This does not mean that universities should take over the function of deaneries, that the Academy should seek to subordinate praxis still further. Universities are locuses of academic qualification, while deaneries facilitate professional accreditation; universities have an effective 'travel to teach' distance of either about thirty miles or globally, while deaneries must operate across a large region

but within its boundaries; and while deaneries, as NHS organisations, are indemnified against the legal and financial risks inherent in workplace-based learning, universities as private organisations are not. Nor does it mean that deaneries and universities should treat each other as cash-points and convenience stores, with deaneries expecting universities to provide any kind of course at the drop of a hat, and universities stalking deaneries to fund their favourite projects.

It is important to note that the United kingdom is relatively unique in combining work place learning and working in PGME, as part of a conducive, decentralised learning environment. In other countries medical training is more centralised. A new kind of partnership is required, in which praxis and the Academy, clinicians and academics, come together to develop new ways of improving medical education and increasing patient safety. Many deaneries have already made steps in that direction, by employing non-clinical specialists in education, or leadership, or careers, to create new processes and programmes for learners within their region. Some deaneries have developed academic infrastructures in their LEPs, to manage recruitment, retention, progression and completion for postgraduate medical education, so that they operate on lines that are strikingly familiar to universities [KSS 2010]. These are clear directions towards ending the binary divide between undergraduate and postgraduate medical education, towards opening up a 'third space' that draws together praxis and the Academy, and towards respecting and drawing on the best contributions of the best practitioners and academics. An opportunity is present to transform medical education, to create a new, broader, integrated community, where workplace based learning and classroom based learning count equally in the curriculum, and where non-clinical academics complement the clinical expertise of their colleagues with their own subject specialism. Of course, this will require creativity as well as good-will, since whatever is produced must be clinically appropriate, educationally effective, financially efficient and being evidence based for improving patient care.

Who should lead improvements?

Who, then, should take the lead in transforming medical education for the new NHS? In due course, universities will be very significant players, since they are the only bodies that can award academic qualifications and they have unique academic expertise. But at the moment, they have a big agenda for bringing medical schools into the mainstream of their organisations locally and into the UK qualifications structure nationally. At the same time, each university will need a considerable amount of time to understand their new financial equations post-Browne: medical schools are not necessarily the most profitable departments to run, and finding cost-effectiveness for their present role will be a complex calculation. As well, their spheres of influence are both too local and too global, and their business is too competitive, to make universities credible leaders for regional change. The medical Royal Colleges, which draw from the expertise of both LEPs and universities, clearly have a large agenda ahead of them to review and implement their new National Curricula, to be fit for purpose, for their role is highly specialist and national - they are the senior curriculum authority for PGME. They have a lineage as old as the ancient universities and like them, are organised as chartered, private institutions, with their regional NHS role carried out through their partnership with deaneries, in a relationship which has been very successful in stimulating growth and change at NHS LEP level.

Since the inception of the NHS, deaneries have been a constant unit of management for change. In the process, their identity has changed equally rapidly, from being part of universities eighteen years ago, to becoming part of NHS Regional Offices, then absorbed into Workforce Development Confederations, and latterly, SHAs. In the process, as 'lean organisations', they have made partnerships with every other part of the national, regional and local infrastructure for medical education, operating impartially across their regions and collaboratively across regions. Their main weakness, of course, is their limited financial power, unable to carry funding across from one year to another, without capital assets, tasked as uniprofessional organisations and highly vulnerable to the turbulence of frequent financial change. However, these are weaknesses that have been

addressed positively in other areas of the NHS, in the creation of Foundation Trusts, and so they are clearly not insuperable.

Collaboration at Kent, Surrey, and Sussex Deanery

Deaneries provide a 'third space' between universities and medical Royal Colleges, between national responsible bodies and local patient care. For example, at KSS we have formal Partnership Agreements with several universities, to enhance the professional accreditation of PGME by engaging with academic and research agendas. We have structured ourselves deliberately to provide a system of Local Academic Boards [LABs] and Local Faculty Groups [LFGs] in each of our LEPs, operating to professional processes and standards and regulated by Graduate Education and Assessment Regulations [GEAR]. This provides a robust system of management, regulated by Contract, through Directors of Medical Education [DMEs] who chair the LAB for their LEP. it also gives us a vibrant motivational structure for Specialty development, through our Heads of Speciality School, joint appointments of KSS and the appropriate medical Royal College, who relate directly to the College Tutors leading each LFG at local level. We also have a cadre of senior academic staff seconded , as Assistant Deans Education, directly to advise on our strategic development and operational partnerships. In these ways, we seek to resolve the two worlds of praxis and the Academy, by drawing together the best of each, as a hybrid, matrixed 'learning organisation'. It is a partnership of this kind, built on a deep, mutual concern for better patient care, that we believe the new medical education will require to retain the best of its tradition and to unite it with a new talent, fit for the twenty-first century: affordable, attractive and academically rigorous.

The new consultation paper envisions devolving education and workforce planning to Local Health Providers. It emphasises skills and training for the whole workforce to deliver cost effective patient care. However, there is no mention of the necessary requirement for development of various professionals, including medical professionals, to act as change agents and risk assessors in delivering complex patient care. Furthermore, there is currently very little expertise in the organisation of education at Local Health Providers. We believe these omissions will carry an unintended high level of risks for preparing the next generation of professionals, including doctors, as critical, creative and thoughtful practitioners who endlessly strive to develop their practice and who are therefore lifelong learners (de Cossart, L and Fish, D (2005).

It is wholly appropriate to review education for professionals and all the workforce, in partnership with Local Health Providers, and we believe this should include service development planning, with integrated financial and workforce planning, as part of a medium to long term strategy. However, we urge policy makers to assess the level of risk for patients' safety and cost benefit of the proposed organisational changes before its implementation.

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