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Citation for final published version:

Browne, Julie 2014. Medical educators: the other 'lost tribe' is coming home. *Excellence in Medical Education* 5 (1) , pp. 19-22.

Publishers page: <https://www.medicaleducators.org/write/MediaManage...>

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Medical educators: the other 'lost tribe' is coming home

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Competing interests: none

The author affirms that this is original work and not under consideration for publication elsewhere.

Acknowledgements: The author would like to thank Professor Derek Gallen for his comments on an earlier draft of this paper.

Word count 1928

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In the eight years of its short existence the Academy of Medical Educators has already survived through two Governments, the London Olympics, the Queen's Diamond Jubilee, droughts, storms, floods and a global banking crisis: and even though it is not yet into double figures, it can at least claim the honour of being older than both Twitter and Prince George.

Since 2006, the Academy has racked up five different office moves, three Presidents, six annual conferences, five Calman Lectures, well over a hundred workshops, seminars and educational meetings - though we haven't actually been counting-, five issues of its journal *Excellence in Medical Education*, and over 1,000 applicants for Membership and Fellowship through its Recognition Scheme. Despite all these internal changes it has never swerved from its fundamental vision, which is to work for the improvement of patient care through fostering and promoting excellence in medical education.

Like all young and aspiring organisations the Academy has set itself some very ambitious targets, and in so doing it has achieved a great deal. As a consequence of the rapid pace of change and development, it has also had its ups and downs, particularly in terms of its finances and infrastructure: but we believe it has got over what Jane Austen calls the 'most trying age'(1). The Academy is in good shape to face the challenges of the future.

It will need to be.

In the last two decades there have been a number of seismic upheavals in the way that medical education is organised, regulated and structured both at postgraduate and undergraduate level in the UK, and most importantly, in the way that it is perceived and understood. The pace of change looks set to continue and the Academy's members will inevitably be on the front line, so let us consider what has been going on and where we are going next.

Medical education is in a period of upheaval that arguably began in, or about, 1993, the year that the first edition of *Tomorrow's Doctors* was published (2) and the year the Calman Report on postgraduate training emerged (3). In the final decades of the 20th century, a number of key figures drew attention to the poor state of postgraduate training in the UK. Notably Calman (3) and Donaldson (4) called for the introduction of more structure into specialty training designed to sweep away the old 'lost tribes' of Pre-registration House Officers and Senior House Officer, of whom it was said: "nobody knows what they do in hospitals or has a clear idea what skills they should be learning. Nobody is responsible for them and they suffer from having a poor career structure and inadequate training" (5).

Organisational responses to the problems caused by poor career structures and haphazard approaches to training began to appear across all organisations involved in postgraduate medical education: the General Medical Council (GMC)(6), the Royal Colleges, the National Health Service (NHS)through the Department of Health, the Deaneries and a wide array of other stakeholders all

responded to the need for reform with a number of initiatives that explicitly aimed to improve the conditions for doctors in training. There was a new emphasis on curricula and standards, underpinned by quality assurance frameworks to ensure that all parties understood what was expected. Some of these structural changes have had an enormous impact: the Foundation Programme was introduced in 2005 and the Modernising Medical Careers specialty training programme came into existence in 2007, clearing the way for smoother and swifter progress towards completion of training (CCT), offering a broader range of experience and training to assist in career selection and progress, and making explicit expectations of what junior doctors need to learn and be assessed upon in order to pass through the various stages in their training. The merger of the Postgraduate Medical Education and Training Board and the GMC in 2010 to create a single regulator, the introduction of the GMC's Quality Assurance of Basic Medical Education (QABME) process in 2010, the continued restructuring of local health authorities and trusts, changes to national employment contracts and the way the NHS itself is structured and funded have caused ripples – and occasionally tidal waves - throughout medical education at all levels.

If medical trainees were getting a raw deal out of the UK's medical education system during the last two decades of the 20th century, however, so were their supervisors and trainers. It was not explicit to anyone, let alone to the teachers themselves, what students were expected to learn, or how, or when, or to what standard. Organisational, structural and professional support for trainees was emerging rapidly in the wake of the Calman, Walport and Tooke reports (3, 7, 8); but support for trainers lagged far behind. Most clinicians were teaching largely without training, resources, support or recognition for the extraordinary work they were doing in spite of the many challenges they faced. Things were perhaps better in general practice, where the Royal College of General Practitioners had traditionally laid emphasis on standards for GP training; and in undergraduate medical education some teachers were able to benefit from traditional university support structures. But even among these groups, things were challenging to say the least.

In undergraduate education in particular, many highly experienced clinical and medical teachers found themselves totally unprepared for the radical changes to medical, dental and veterinary school curricula that were happening everywhere (6). These changes followed decades of government-backed calls for reform (9), which culminated in the 1993 publication of the GMC's influential new guidance, *Tomorrow's Doctors* (2). Several sacred cows had been slaughtered along the way, including the idea that undergraduate students did not need to see patients for the first two years of their education. New technologies were changing clinical practice, and teaching and training programmes had to respond. There was an increased emphasis on educating students in professional skills such as self-directed learning, clinical reasoning and team working and a corresponding reduction of the burden of factual knowledge. Such curricula required a different style of teaching from the time-honoured 'teacher knows best, so don't answer back' model. Medical educators throughout the United Kingdom were increasingly being required to teach new material and new skills in new ways - but for most, professional development opportunities and institutional support, let alone a clearly defined career path, were sadly lacking (6).

That said, medical educators are an energetic and committed – not to say idealistic – group; and throughout this period there was an explosion in the numbers of people undertaking postgraduate education qualifications, involving themselves in research, evaluation, conferences and other scholarly activity to update and share their skills and knowledge, and pushing at many organisational

and institutional doors to bring about change and improvement. Many of these became leaders and managers of medical education, and were in their turn able to advocate for better support for their teaching peers.

Despite a huge amount of work at personal and institutional level, by the time the Academy of Medical Educators was launched in 2006, it was clear that medical educators as a profession had not benefitted from the same national focus on organisational, personal, professional and career support that they were being expected to deliver for their students and trainees. To this extent they, too, were a lost tribe.

So it's time for a quick reminder about why the Academy was set up. Its aims, which have not changed since its inception and are enshrined in its Articles of Association, are "to advance medical education for the public benefit by:

1. the development of a curriculum and qualification system;
2. undertaking research for the continuing development of professional medical education; and
3. the promotion and dissemination of best practice in medical education (10)."

Before the Academy could even start to develop a curriculum and qualification system for medical educators, of course, we had to find out who the medical educators were, what they did, and what training and support they received to do it. This information was surprisingly difficult to obtain, reflecting the fact that many medical teachers at the time were heavily involved in education within their hospitals and trusts, but working without recognition, training or support. At the same time the Academy undertook a Department of Health-funded project in 2008 (11) aimed at establishing more specific data regarding the educational and clinical supervision workforce in secondary care, and again there was very little hard evidence available. As a result of these and other projects, we now have a situation in the UK where the huge size and skills mix of the medical education workforce in the UK, and the immense contribution it makes to safeguarding and improving patient care, are actually starting to be recognised and appreciated in organisational terms.

One of the most important tools for recognising and appreciating the role of the medical educator is a set of clear standards for medical educators, agreed by the profession itself and also by regulators, patients and the public. The Academy is proud of its work in developing its *Professional Standards for Medical Educators* (12), a document that was 18 months in the making but which has gained considerable currency and influence in the six years since its publication and is now adopted nationally and internationally as a definitive statement of what medical educators at all levels, clinical and non-clinical, should know, believe and do. Moreover, thanks to the behind-the-scenes work the Academy has done among the UK regulators, we have the beginnings of a national recognition and approval scheme for educational and clinical supervisors in secondary care and for those who supervise the progress of medical students in clinical settings and on placements.

These initiatives have had knock-on effects: the Academy's *Professional Standards* are finding their way into job advertisements and role specifications; they are proving a valuable tool for appraisals and revalidation; courses for medical educators are increasingly being mapped against them; and for the first time, all medical educators have an authoritative and rigorously designed resource to help them plan their continuing professional development, a framework against which they can report

and reflect on their progress, and a formal scheme within which they can submit their portfolio for recognition and feedback from their peers in medical education.

All of these projects have been accompanied by the steady, day-to-day work that the Academy does through its volunteer members: accrediting courses; recognising and celebrating excellent medical educators through its affiliate programmes and annual prizes; supporting organisations to develop their teaching faculty; creating and enhancing links and partnerships both in the UK and internationally; promoting and developing research and evidence in medical education; mentoring, advising and encouraging its members; arranging conferences, workshops and networking opportunities; developing educational resources and a quarterly journal; and all the other things that a small-to-medium size membership organisation would be expected to do on a very restricted budget.

But in terms of influence, the Academy punches well above its weight, and we will continue our drive to embed the *Professional Standards* further into medical, dental and veterinary training – and more importantly, to assert the predominance of our claim that good patient care is critically dependent on high standards of medical education. In the past, the old idea that ‘those who can’t, teach,’ led to a patronising and casual view of medical education and the role of the clinical teacher, with damaging effects to all: thanks to the efforts of the Academy and the increasing professionalization of medical education, such ideas have begun to look not only silly, but dangerous. Medical education is at last coming out of the wilderness.

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