MEDICAL ACADEMIC REPRESENTATIVES

Conference discusses problems of medical teaching

Academic element "sadly lacking" in specialist training

The BMA's conference season started on 11 June with the Conference of Medical Academic Representatives. In the chair was Dr George Mitchell, from the Department of Materia Medica and Pharmacology at the Welsh National School of Medicine.

The guest speaker was Professor W I N Kessel, who spoke about teaching standards in medical education. In his view—a personal one he emphasised—the academic element in the future training of specialists was sadly lacking. The fault lay with the university academic departments. There was something ludicrous, Professor Kessel said, about a professor of medicine spending endless time teaching students how to examine the spleen when they might never do so, yet not to pay sufficient attention to the future training of the practitioner's own specialty.

Emphasising that teaching standards were not a matter for the General Medical Council, Professor Kessel, who is dean of postgraduate medical studies, University of Manchester, and a member of the education committee of the General Medical Council, said that the GMC was entitled, however, to visit medical schools to satisfy itself about the sufficiency of the instruction given. The education committee's subcommittee on examination returns, of which he was chairman, received information each year about the number of students who failed and those whose tuition period had had to be extended. The subcommittee had recently asked about difficulties that medical schools might experience in maintaining standards. It had received information about the effects of cuts on some of the newer subjects, particularly in general practice, but for the most part medical schools had reported that although research had declined standards of medical education had not.

Professor Kessel said that he personally had three criticisms to make. One was the lack of university type education in university medical education; the second was the distortion in the balance between academic elements and the apprenticeship element in student training; and the third was the error in regarding teachers' standards as an important factor in medical education.

As to the absence of university type education he said that the change from boys and girls to prototype housemen was a change despite education rather than because of it. The students were not stretched by the course; only at examination time, and he knew of no other faculty where this was the case. There was no problem solving in medicine; there was not even much debate. Nothing difficult was put in their way except the absorption of facts. He put the blame for that on the preclinical course. He was not criticising preclinical staff who carried on manfully despite, in his view, the failure of the other members of the staff in medical faculties to support them.

Turning to the academic/apprenticeship balance, Professor Kessel said that medical education grew up with a complete split between the two. A student did his or her academic study and then some clinical study. For some time there had been a mix of practical apprenticeship and university theory.

The chairman of the conference, Dr George Mitchell from the Welsh National School of Medicine.

The modus vivendi between the hospital and the university side had grown up and worked reasonably well until the past 10 or 15 years. Academic teaching units had grown up in hospitals but the academic influence had been weakened by the increase in student numbers and had led in part to the creation of new teaching hospitals and in part to an increasing use of non-teaching hospitals. The academic/apprenticeship balance was also breaking down because the teachers now found themselves with much more clinical work.

Teaching standards, Professor Kessel said, would be much improved by concentrating on teaching. Those who pressed for an increase in teaching skills and an increase in the selection of academics did not understand university education properly. But even in the university the concentration had to be on learning and not on teaching.

Professor Kessel said that he would like to see a return to more clinical science. There was a need to select the teachers because they were scientists and research workers. Where students were not in contact with that they became merely fact gatherers. Skills in teaching existed and, to some extent, could be taught. Skills in communication were required. Students modelled themselves on their teachers, and in medicine they were being taught by people who were doing what they wanted to do. Some teachers were good in the lecture theatre and some were superb on an individual basis. The teaching standards fell because there was too little education being offered to the good students. It left them unstretched but worn out—able to be doctors now and to practise medicine when they qualified, but because of the lack of understanding of the principles of medicine they would be unable to adapt to the changes that would occur during their working life.

University cuts

In 1983 the monitoring body on the effects of university cuts on medical and dental faculties had reviewed the effects of the cuts in 1981-2 and in April 1984 it had looked at the updated picture for 1982-3. The chairman of the monitoring body, Professor Peter Quilliam, reported that the surveys had shown that because of reductions in their numbers medical staffs in medical schools and university hospitals were having to devote so much more time to care of NHS patients that a severe erosion of the time available for their personal medical research was now occurring, and there was a substantial reduction in the teaching contribution that could be made by medical teachers to preclinical and clinical dental courses where medical schools were associated with dental schools. That was detrimental to the instruction of dental undergraduates in the medical aspects of dentistry.

The cuts for dentistry had been above average despite the University Grants Committee's desire that they should be below average, because of previous manpower problems and lack of research opportunity in the university dental field. The remaining dental lecturers had to carry increasing patient care and teaching loads, and thus had less time for scholarship and research. Professor Quilliam said that he made no apology for stating the dental problems so starkly. Medical academics should look carefully at them for they showed how a disastrous scenario could develop despite the statement from Sir Edward Parkes, the then chairman of the University Grants Committee, in his letter of 1 July 1981 that "the University Grants Committee has for some time been concerned at the generally low level of research in dental schools which it believes is in part due to inadequate funding. Although it is not yet possible to improve this situation, the committee has based its grant distribution on a less than average cut in the resources available to dentistry."

Those words on dentistry had been preceded by the following: "The committee regrets that it is no longer able to include in grant funds, to enable universities to offer to clinical medicine, the protection which it has hitherto enjoyed in relation to the general decline in resources." This, Professor Quilliam said, must serve as a lesson to medical academics and a dire warning of what might be in store for medicine

with the pressures by non-medical disciplines on university resources.

Returning to the trends, Professor Quilliam said the greatest loss of clinical academic staff was in the age group 30 to 34, ranging between 24% to 16% of the total. It was from among those university teachers that future academic leaders normally emerged. The University Hospitals Association's survey quantified a net reduction of 105 lecturer and 42 senior lecturer posts, or 13%, during 1981-3.

The "new blood" posts had been few in number and were being made too slowly, though they were greatly beneficial to recipient departments. More "new blood" posts were needed across the board in medical faculties, where the losses of clinical academic staff due to the cuts had bitten more deeply and more quickly than in non-medical university fields.

The survey showed that technicians' posts were still being lost at a considerable rate, though less than in 1981-2. The cumulative loss of 118 over the academic years 1981-3 was so large that it had seriously eroded the infrastructure on which medical research was based.

It was undesirable that the numbers of consultants in university hospitals should be reduced pro rata with reductions in the numbers of hospital beds because that could disproportionately and seriously impair the standards of care of the NHS patients, disadvantage teaching, and reduce or abolish research time for clinical academic and NHS university hospital staff.

The pre-eminence of British medicine was closely related to the vigour and breadth of medical research, hitherto so characteristic of British university hospitals. The BMA surveys on the effect of the cuts on university medical research over the academic years 1981-3 showed that the cuts had been detrimental to the medical research base—namely, the well found laboratory and clinical research facilities—and to research in medical departments hitherto possible within the frame of University Grants Committee funding of preclinical and clinical departments in the medical faculties. The monitoring body considered that that research had already suffered severely, and the effect of further cuts threatened a further and steep decline in the future unless steps were taken to reverse that trend.

MASC chairman's report

Professor J P Payne, from the Research Department of Anaesthetics, Royal College of Surgeons, chairs the medical academic staff committee, and he reported that the year's activities had been essentially a matter of standing still without losing ground. The Secretary of State for Education and Science had been looking for every conceivable way to save money and medical academic and research staff were on the receiving end.

Referring to the question of tenure, Professor Payne said that one of the complications was that in universities generally a lecturer was in a tenured post, whereas in medical schools a lecturer was in a training post. There was pressure on medical schools to rewrite contracts in which the tenure would no longer be held by new occupants of the post.

The medical academic staff committee had been asked to debate the future of higher education and to look at staffing arrangements and staff/student ratios. There had been discussions with the Medical Research Council on the arrangements for salaries and the right to the same provision that was available in some medical schools for domiciliary visits, etc. Little had been achieved so far and one of the problems was that there was not a unanimous view in the committee that academic staff should be allowed to do private practice for personal gain. The practice varied from school to school and from department to department. It was more likely that some improvement would be achieved in terms of rounding up salaries.

In many hospitals auditors had moved in to look at how money was being spent. The chairman of the Central Committee for Hospital Medical Services, Dr Maurice Burrows, had asked consultants who did private practice to ensure that the rules were strictly obeyed (12 May, p 1472). So far as academic staff were concerned if income from private practice went to research funds there was an obligation to inform the hospital and their colleagues. If these rules were not followed there was a risk of being criticised by the auditors.

Professor Payne is deputy chairman of the clinical academic staff salaries committee and he reported that if the recommendations of the review body were implemented for clinical academic staff they would receive an increase of 4·63% over the year. When the BMA's representatives had met the Secretary of State for Social Services on 7 June the position of academic staff had been put to him and he had undertaken to use his good offices to ensure the translation of the NHS award to clinical academic staff salary scales. A meeting had already been arranged with the Committee of Vice Chancellors and Principals to see that similar increases were implemented for academic staff.

Preclinical staff remuneration

The chairman of the working party on negotiating rights of medically qualified preclinical staff, Dr David Bowsher, reported that the working party had met representatives of the Association of University Teachers in November. Although the latter had not agreed to surrender its negotiating rights for medically qualified preclinical staff it had said that it was happy to work with the BMA and had suggested a joint approach to the Committee of Vice chancellors and Principals. It was agreed that as a basis for negotiation the document on clinical teaching allowances, which had been produced in 1980, should be used. The allowances should be awarded for longer than a year at a time, which was the original decision, and they should be superannuable.

Dr Bowsher said that there were several anomalies, and it would be helpful if his working party knew exactly how many medically and dentally qualified preclinical staff did hospital sessions and took responsibility for patients, and who taught in the clinical context.

The conference . . .

- supported the medical academic staff committee in its fight for broad comparability in terms and conditions of service between NHS and academic medical staff.
- instructed the medical academic staff committee to arrange a joint working party consisting of the committee and associate members to review the impact of potential and actual university cuts on the education of future doctors.
- deplored the reduction in funds for medical research.
- demanded urgent action to implement BMA policy to reduce medical student intake to 1979 levels.
- called for an immediate end to the policy of "freezing" vacancies in medical academic posts which had a service component.
- expressed support for the medical academic staff committee in its continuing efforts to win negotiating rights in respect of preclinical academic staff and thus achieve an appropriate salary scale for this underpaid branch of the profession.
- asked the BMA council to consider the suggestion that medically qualified preclinical teachers should be allowed to negotiate for separate salaries (compared to non-medically qualified teachers).
- was concerned at the failure of most medical schools to include teaching on the medical effects of nuclear weapons in their undergraduate curricula, the examination syllabus, and postgraduate training programmes.
- recommended that the BMA should investigate claims that in some countries doctors were cooperating in the use of torture.
- rejected a request that the board of science and education should undertake a review of teaching methods but believed that medical teachers should be taught to teach.
- regretted the lack of action by the Secretary of State for Education and Science to improve grants to clinical students and requested the council to press the Secretary of State for action.
- called for the BMA's active participation in providing more career guidance at medical school level.
- instructed the council to ensure that clinical freedom and responsibility and standards of patient care were safeguarded under any new management arrangements in the NHS.
- asked for medical students to be included in the NHS Injuries Benefit Scheme.