Analysis and comment

Medical education

Challenges of training doctors in the new English NHS

Linda Hutchinson

Current health service reforms in England aim to create services that are more patient responsive. Will changes in the design and delivery of services be at the expense of medical education and training?

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The health service in England is undergoing fundamental changes. Three principles emerge from recent policy documents: patient led culture, mixing of skills, and plurality of providers.[1 2] Each of these separately presents a challenge to medical education, and together they present an even greater one. Medical and lay press carry stories of reported threats to doctors' education and training from some of the initiatives.[3–6] This article examines the challenges.

Challenges to current system

The centralist arrangements of the NHS have allowed universal adoption of changes and improvements to medical training. Although health policy is now devolved to the four UK countries, medical education is mostly considered a UK-wide activity. However, the health service in England is creating a new context, increasingly different from the other three administrations, making common approaches more challenging. Within England, the established framework for education and training of doctors will need to be adapted for the new environment. The box summarises the main initiatives that will affect education.

Patient led services

A truly patient led health service requires a major cultural change. Moving from a paternalistic care service to one that is centred around information, advice, and guidance with a choice of procedural services is going to be challenging. Many staff will easily embrace the shift in emphasis, but for others it will be harder. Medical education could take a lead in producing doctors who are prepared for a health service characterised by choice and personalised care. The question is whether we have a critical mass of clinical leaders in both education and service who can be the role models for future generations. The early signs seem encouraging, with the Royal College of Physicians of London, the BMA, and others debating and publishing on the need for change in the future medical workforce.[8 9]

Patients will need to be more involved in education as well as in development of services. There is scope for more use of patient representation on boards and much greater input from patients in teaching and assessment. Regulators have an important role here. The newly created Postgraduate Medical Education and Training Board (PMETB) sets out the principles for assessment in postgraduate medical education. These helpfully include a mandate to have lay input into development and delivery of assessments.[10]

Simple messages in assessment also need attention. A multiple choice question that currently asks, "Which of the following treatments would you choose for this patient?" should be reworded as, "Which of the following treatments would you discuss as options with the patient?"

Breaking down barriers between professions

Doctors see devolving care to other professionals as a threat,[6] yet it is proceeding to a greater or lesser extent in several countries. The process is often seen as a cost saving measure, but it has accelerated even in the past few years of financial and workforce growth in England. Several initiatives are claimed to allow doctors to concentrate on more complex cases, which

Summary of healthcare reforms in England[7]

Payment by results—Previous hospital funding was through block payments, based on historical budgets with some changes from individual negotiations by commissioners. In future payments will be by national tariff for each activity adjusted for case mix

Plurality of providers—Voluntary sector, private sector, and not for profit organisations are being encouraged to compete for service contracts. For example, independent sector treatment centres provide diagnostic and elective surgical services to NHS patients

Foundation trusts—Decision making in these trusts is legally transferred from central government to local organisations and communities so they are more responsive to local people. They have greater financial freedoms than previous trusts and less central performance management

Patient choice—Patients will get more choice about how, when, and where they receive treatment. They must currently be offered at least four options for providers of elective care once their general practitioner has decided that a referral is required

Skill mix—Staff are trained to take on extended and expanded roles to cut waiting times or improve work flow. Typically nurses or others take on tasks previously done by doctors, such as endoscopy or specific surgical procedures. There are also new administrative and assistant roles working under supervision with a professional, such as radiographer assistants and midwifery assistants

raises the question of how doctors are to train for that role without experiencing simple cases first. Clearly students and trainees will need to spend more time with or substituting for staff other than doctors during their undergraduate and postgraduate training.[11] Similarly, there will be a move, already established in some universities, postgraduate deaneries, and trusts, to create faculty who are truly multiprofessional and thus able to teach students of all healthcare professions. Patient led health care and team working are not separate courses; they should both be embedded at every stage and in every part of training.

But there is another concern about substitution of doctors. Doctors have held a privileged place in society predicated on a societal need for functions that only doctors could perform: prescribing, certification of death, surgery, decisions about treatments, etc. If those functions are now done by other staff members who have not gone through the obligatory and expensive 5500 hours of university education (as laid down by European law) and subsequent structured postgraduate training, questions may be asked about the validity of the stringency and inflexibility of the undergraduate and postgraduate medical regulations. It has always seemed incongruous that the brightest of school leavers, spending five or more years in the most expensive of higher education courses,[12] are still not "job ready" for several years.

Will the success of extended and expanded roles of other health professionals lead to a re-examination of training for doctors? Mechanisms common in other professions—modular degrees, part time courses, top-up training—could be adopted to widen access and allow medical students to function earlier, and follow flexible career pathways.

Plurality and autonomy of providers

Plurality is the policy that causes most concern to educators, who have been able to arrange training placements for medical students and trainee doctors with relative ease. The NHS in England will move from a delivery to a commissioning service; the NHS logo will signify quality rather than an employer.[1] Traditional education and training arrangements will be challenged by the existence of multiple providers from statutory, independent, or voluntary sectors and the establishment of clinical networks and social enterprises. How do we ensure continuation of the collectiveness and collaboration that has allowed rotations of medical student and trainee doctors through appropriate learning environments?

A precedent already exists of placing students and trainees with general practice (semi- independent) and hospices (charitable), and there are encouraging developments in the independent sector. Concerns about the effect of independent sector treatment centres on surgical and anaesthetic training have resulted in the next phase of centres having education commitments in their contracts. However, the grounds for these concerns need to be verified. A recent check on trainees' logbook records showed no fall in experience for trainees at an NHS unit close to an independent sector treatment centre (Clair du Boulay, personal communication).

Foundation trusts also have to provide education within the legal framework. The Health and Social Care (Community Health and Standards) Act 2003 obliges foundation trusts to provide education and training as part of their "goods and services." It is up to the commissioning bodies, the primary care trusts, and the authorisation process to ensure that contracts are explicit yet flexible enough to allow for collaborative approaches to ensuring the future workforce.

Commissioning

The move to plurality of providers and payment by results means we urgently need to review funding for educational activities. Education commissioning and provision in England is currently paid through the multiprofessional education training budget. In 2005-6 this was £3.9bn (€5.8bn, $7.4bn) and funded, for instance, preregistration and post registration courses for nurses and allied health professions, trainee doctors' salaries, and service providers that take medical students on placement. The budget is acknowledged to be distributed inequitably across institutions and professional groups,[13] but any major changes have been avoided for fear of destabilising local health economies. We now need a funding system that is fit for purpose—one that rewards activity rather than history and is coherent with government policies. Can we find that elusive formula that provides proportional incentives for providing work based experience and learning for all healthcare students and trainees?

Educators' response

The landscape in the English health system will be very different in 2008. Medical education and training, both in content and in the context of delivery, will be

affected. So what do medical educators at undergraduate and postgraduate level need to be doing now?

In essence we need a reality check on purpose and practicalities.

- Do curriculums and assessments truly reflect the type of doctor the public will expect in future years?
- Are we role modelling patient engagement and using the patient voice throughout our educational structures?
- Have we embedded patient autonomy and team working in all aspects of training programmes?
- Have we checked our documentation for the subtle messages?
- Are we using the whole healthcare team and patients as teachers?
- Are we influencing and changing the incentives for placements to meet new financial systems and the plural provider market?
- Do we have enough flexibility to future proof for technological advances, demographic changes, and new government policies?

Ensuring the health service has the right capabilities and capacity is everybody's business. Medical education and training prepare doctors for their future roles, and their leaders must have a vision of those roles and an understanding of their context. The changes occurring in England are not unique. Patient pressure for choice, diversity of healthcare providers, and extended roles of other staff are realities in many countries. The lessons learnt here about maintaining and strengthening medical education will be applicable elsewhere.

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Summary box

Changes in English health services will affect medical education and training

Medical education has an important role in shifting to a truly patient led culture

Moving some roles to other healthcare professionals will require review of medical students' and doctors' training

Appropriate contracts, reimbursements, and regulation are needed to facilitate training across multiple service providers

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Commentary: Dutch perspective

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The health service in England is experiencing a revolution.[1] Dutch health care is also changing but less dramatically than in England. Medical educators can embrace this challenge as an opportunity to improve medical education and training.

Dutch changes

The eight Dutch faculties of medicine have successfully completed the transition from traditional, teacher centred education to student centred approaches. It is important to recognise the similarities and interconnectedness between student centred teachers and patient centred doctors. If health care becomes more patient centred, it creates numerous opportunities for teaching.

Research into undergraduate clinical training has shown that observation of students during rotations is rare or non-existent. Supervision needs improvement.[2] Contracts with hospitals where students undertake clinical training now include settlements about payment for educational services commensurate with the quantity and quality of supervision. Clinical teachers are also offered staff development courses.

Postgraduate specialist training is the remit of the professional societies. They have a statutory obligation to design training plans and introduce new types of assessment, such as portfolios and the mini-clinical examination exercise (mini-CEX), a snapshot of doctor-patient interaction. These measures aim to strengthen the effectiveness of postgraduate training and coincide with the ongoing debate about shortening medical education.