A Festschrift for Professor Dame Barbara Clayton

'Postgraduate Medical Education Now'

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Those of us who love the old stories, will delight in remembering, or hearing for the first time, the story of Unn, the Deep-Minded, from the Icelandic Viking sagas. Unn, a woman of strength and substance, who owned and captained a Viking ocean-going cargo ship, was one of the first settlers in Iceland. Her crew was twenty strong, all free men, for she kept no slaves, all lusty lookalikes of Kirk Douglas and Ernest Borgnine, proud, violent men, with names like hawk-beak, timber-quaker, skull-gasher, iron-ribs, serpent-tongue, wolf-howl, whale-might. All knelt before, followed and obeyed Unn the Deep-Minded, as she established her settlement in west Iceland, as authoritative a family head as any male settler, holding sway over the community and dispensing land to her kinsmen, other settlers and, remarkable for its time, slaves whom she freed. In a period of huge political turbulence, Unn established a centre of order, of civilisation, and of calm, welcoming guests to her hall with delight and generosity, enjoying deeply the pleasures of debate and fine thought.

Of course, Unn and her saga, the Laxdael Saga, written both by women and about women, comes to mind to me as I think of Dame Barbara. The abiding image I have of her is as the Chair at SCOPME, sitting at the head of a table of feisty doctors or determined dentists, who to me, a newly-arrived visitor from a far country, had all the terrifying aspect of berserkers, shape-shifters, and werewolves. I was entranced to see the way in which Dame Barbara chaired: setting up, by her very manner – by her sense of presence, really – a set of expectations, an implicit anticipation that of course, people would discuss sensibly, and moderately, that they would be considerate of the needs of others, ready to make reasonable concessions to ensure harmony with the rest of the community. She exemplified in her very being, the need to consider carefully what best might be done in the service of the learner and their patient, enacting as she did so SCOPME's understanding of education as a fundamentally ethical activity. Deep-minded indeed, in her central concern to enable everyone to perform the key task of education, that of bringing their moral unconscious into consciousness.

The Iceland in which Unn landed deserved its name: bleak, empty vistas of stone, frozen landscapes, scaldingly hot springs, volcanoes grumbling below the ground like dissatisfied gods threatening inescapable devastation. The relationship between Royal Colleges and Postgraduate Deaneries [deaneries] in 1993 could not be better described. Fifty percent of the funding for PRHOs and SHOs salaries had just been given to deaneries, outraging some hasty-tempered members of some Royal Colleges –you know who they were – and to a meek educationist like myself, it was as if Asgard itself was on fire, as though Thor and Odin were at war with each other, dealing lightning bolts and mighty hammer blows, as though Ragnarok, the end of the gods, was at hand. Through the slashing of swords and the biting blows of battle-axes came Dame Barbara's *leitmotif*, leading SCOPME in a Ride of the Valkyries,

like Brunhilde and her gentle shieldmaidens, regenerating fallen heroes in the quiet meeting rooms of a Valhalla that was set next to Regent's Park.

What would those heroes – some of whom I see sat before me today – make of the landscape of postgraduate medical education [PGME] now? Well, much of what SCOPME advocated under Dame Barbara's leadership is still current today, and what is more, in a much more developed, progressed form: assessment, mentoring, multiprofessional working and learning, 'training the trainers', to mention a few. The reports produced in these areas were often pioneering and formative, providing an authoritative baseline for development. They were unique products, since SCOPME provided a unique service, independent of all other bodies and their vested interests, concerned to bring together a range of views on a particular subject, and to identify the principles and practices that they held in common. In the lifetime of Unn the Deep-Minded, the landscape of Iceland was transformed by new farmlands, lovely slopes of new-mown hay and golden corn, hardy sheep and strong cattle. In much the same way, Dame Barbara and SCOPME transformed the landscape of PGME, causing new shoots to grow, new ideas to take fruit, and seeding new practice.

What, then, of postgraduate medical education now?

In the aftermaths of the White Paper *Liberating the NHS* and of the Browne Report on *Securing a Sustainable Future for Higher Education in England,* the parallel worlds of PGME, 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 postgraduate medical education 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 benefit from the work of postgraduate medical education in hospitals and GP Practices; and Master's degrees provided by universities as an elective part of individual doctors' curriculum. 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 down the level of central funding for education, the questions are, how might we collaborate to form a new community of practice; and why haven't we done so already?

To take the second part of our question first, beneath their surface similarities, these 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.

Postgraduate medical deaneries were founded within the NHS, and heralded by the Goodenough Report in 1944, which called for 'each university to depute a person to undertake the organisation and general supervision of the postgraduate arrangements' for medical education.[1] In 1968, a Royal Commission called for a network of postgraduate medical centres at local level,[2] while the Merrison Inquiry emphasised the need for robust and effective management of PGME, as part of medicine's professional self-regulation.[3] 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[4] and *Modernising Medical Careers*.[5]

The medical Royal Colleges, which are largely staffed by, and draw from, the expertise of both postgraduate medical education and universities, clearly have a large agenda ahead of them to review and implement their new National Curricula, 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 - the Royal College of Physicians received its royal charter in 1518 - 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 Local Education Provider [LEP] level. They represent a model of partnership which perhaps shows the way for the future, with each body bringing to the table its distinctive contribution, to create a new whole, which could easily be much greater than the sum of its parts.

However, these potential riches are not so easy to come at. Guarding them, like a kind of Fafnir-dragon (to return to our Viking theme), and presenting a real danger to patient safety, lies a deep philosophical separation, between praxis and the Academy. As Stanley 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.[6] 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'.[7] 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'[8] that lie at the heart of a patient-centred NHS. Without it, there is no professional judgment, no contextualised understanding of the personal, complex, problematic needs of individual patients, that is the only real guarantee of patient safety.

To return to the first question, then, how might new communities of practice emerge for medical education? A starting point, perhaps, is to reconceptualise the relationships between universities, medical schools, medical royal colleges, 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. New requirements by the GMC for Educational Supervisors to be clinical teacher educated and accredited, a new focus on Leadership for Clinicians, and the emergence of Medical Humanities as a substantive discipline all open the way for

medical schools to collaborate with relevant specialist departments in their own universities.

This does not mean that universities and their medical schools should take over the function of deaneries and royal colleges, that the Academy should seek to subordinate praxis still further. Universities are locuses of academic qualification, while deaneries and royal colleges 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 royal colleges have a distinctively national role. Finally, unlike all of the other bodies, deaneries, as NHS organisations, are indemnified against the legal and financial risks inherent in workplace-based learning.

Nor is it easy to import models of best practice. 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 quite new kind of partnership is required within the UK, therefore, 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 and royal colleges 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 PGME, so that they operate on lines that are strikingly familiar to universities.[9] 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 the best 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 maintain a clear focus on improving patient care.

Now, in postgraduate medical education, therefore, we need to nurture the seeds sown by Dame Barbara and SCOPME, to grow new, hybrid, partnership organisations. Built on a deep, mutual concern for better patient care, it is partnerships of this kind, that the new postgraduate 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.

Where shall we find a national locus for this debate? We have a wealth of specialist national bodies operating in postgraduate medical education – GMC, AMROC, COPMED, AMA, NACT, MMC, UKFPO, MEE, to mention a few – but no table around which they sit, outside the constraints of hierarchy and politicised relationships. Now, more than ever, with our modern Iceland bankrupt and its restless financial gods raining volcanic ash on European commercial airlines, we need an Unn the Deep-Minded, to bring together the various bodies, each carrying their own distinctive contribution, each willing to make reasonable concessions to their own agenda in the interest of a shared concern for patient safety, each separate but joined in a common

purpose. And let us not forget the reliance that Unn placed on her wisest adviser, Njal, so important that he merited a whole saga to himself, of whom it was said:

> He was so skilled in law that no one was considered his equal. He was a wise and prescient man. His advice was sound and benevolent, and always turned out well for those who followed it. He was a gentle man of great integrity; he remembered the past and discerned the future, and solved the problems of any man who came to him for help.

I think we can all recognise the identity of SCOPME's Njal, and I am sure we all owe a debt to his abilities.

So, we need an Unn, and we need a Njal, and most of all, we need SCOPME back again, for another tour of duty, to help us reforge postgraduate medical education, retaining all the values which Professor Dame Barbara Clayton so ably represented – integrity, compassion, academic rigour, practical common-sense, simple honesty, sensible kindness – so that as we honour the past, we may also herald the future.

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[1] Ministry of Health and Department of Health for Scotland. 1944. *Report of an Inter-Departmental Committee on Medical Schools*. [Goodenough Committee]. London: HMSO.

[2] Royal Commission on Medical Education. 1968. *Report 1965-68*. [Todd Committee]. Command 3569. London: HMSO

[3] Committee of Inquiry into the Regulation of the Medical Profession. 1975. *Report*. [Merrison Committee]. Command 6018. London: HMSO.

[4] Department of Health (1993) *Hospital Doctors: training for the future. The Report of the Working Group on Specialist Medical Training*. [Caiman Report]. London: HMSO.

[5] Department of Health (2004) *Modernising Medical Careers - The next steps: The future shape of Foundation, Specialist and General Practice Training Programmes.* London: HMSO.

[6] Stanley L. *Femnist Praxis.* London: Routledge.

[7] Alcoff L, and Potter E, eds. 1993. 'When feminisms intersect epistemology.' *Feminist Epistemologies.* London: Routledge, p. 11.

[8] Modernising Medical Careers (MMC). 2010. *A Reference Guide for Postgraduate Specialty Training in the UK: The Gold Guide.* 4th edition. London: NHS.

[9] KSS Education Department. 2010. *GEAR: Graduate Education and Assessment Regulations*. 3rd edition. London: KSS.