Resisting the tick box culture:

refocusing medical education and training

The recommendations of David Greenaway's Shape of Training review have provided a welcome opportunity to reconsider our current approach to the preparation of doctors for independent practice.[1] In our view, the time has come to progress from the prevailing outcomes-focused system, which we believe does not reward the autonomous learning necessary for developing as an adaptable professional,[2] towards an approach that explicitly acknowledges the breadth, richness, and scholarship of medical education and practice.

THE CHALLENGE: MOVING BEYOND THE COMPETENCY TICK BOX

The challenge is to offer a vision of medical education where there is a synergy between competency and education in its broadest sense; between acquiring the knowledge and learning the tasks of doctoring and learning to 'be' a doctor. In general practice, as with any other specialty, we must reach out and engage teachers, trainers, and learners to think differently in order to shift the culture of medical education to one where achieving competencies is only one part of the education process. Drawing on the vast education literature, medical education must be redesigned explicitly to support and reward the development of both professional identity[3] and the life-long and self-regulated learning skills required to underpin life-time professional practice.[4] Let us also be realistic and acknowledge that this progression must be achievable in modern target- and outcome-focused healthcare environments, where empowerment to teach and learn can often be limited by the system itself.

While it is clear that the GMC is already addressing how to raise the profile of professional identity throughout the continuum of medical education,[5] what we add to the debate is a way of conceptualising the goals, some practical techniques for delivering these goals, and some ideas of how goal achievement can be assessed.

FROM COMPETENCY TO PROFESSIONAL PRACTICE

First, we conceptualise the issue. Our common interest in this area stemmed from recognition that a competency-based framework, while having some advantages (particularly for the regulators), does not recognise that being a doctor is much more than the sum of the individual parts performed.[6] Instead, professional medical practice is about interpretive practice,[7] which is an advancement of the educational toolkit that was described by evidence-based medicine (EBM).[8] EBM has been invaluable in developing skills and competencies related to biomedical practice. However, it is insufficient, and perhaps particularly so in primary care, to support the full range of professional medical practice.[9] Interpretive practice, on the other hand, describes the capacity to move beyond protocol care to offer a critical interpretation of a person's illness with experience based on multiple sources of knowledge (including medical evidence, but also the patient's story and the doctor's experiential knowledge and professional value system). Thus, interpretive practice includes the ability to judge both the trustworthiness of the information and the decision which comes from that judgement.[7]

Interpretive practice depends on a sound knowledge of the evidence for biomedical practice but it also requires the capacity to generate new knowledge: a personalised account of health and healthcare need. As such it is akin to the skills of scholarship: of discovering data, integrating ideas based on a clear analytical framework, to generate new meaning, and so judge the trustworthiness of the knowledge production process.[10] Doctors working from this model must have the self-regulatory skills to identify and address their learning needs effectively, and the attitude that to do so is core to being an adaptive professional.

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DESCRIBING A NEW VISION

Second, how to achieve the vision of supporting doctors working within this model of interpretive practice? This depends on professional identity and life-long learning, and the competencies required to achieve and maintain the associated skills and attitudes (scholarship), shifting from the periphery to the centre of training. The focus of training must change — from competency and outcome only — to competencies as stepping stones along the pathway of developing as a professional. To achieve this, the approach to professional development and practice that is to do with an interpretive way of working must be explicit and visible by offering a model against which professionals can compare their practice, both in terms of delivering ('doing') person-centred medicine, and of 'being' an autonomous, responsible practitioner

To achieve this depends on both the learning (training) environment and the individual.[11] Drawing from Billett's[11] extensive research on vocational workplace learning, we propose that the medical education system has to move away from the current tick box culture to one where education and learning are institutional and personal priorities. In other words, the focus must be on the learning, not the record of a learning episode. Why is this change to the system/learning environment critical? First, learning experiences in any workplace are structured towards sustaining practice. What practice should be sustained is shaped by social and cultural need.[12] If the need is for competency-

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based practice, then that is what is shaped. In our view, this is exactly what we see with trainees under Modernising Medical Careers. Learners are offered certain types of participatory activities and guidance, and rush to ensure that they have achieved (or appear to have achieved) all the necessary competencies, particularly at the end of an attachment or rotation, potentially to the detriment of developing more broadly as a practitioner.

SUPPORTING NEW SKILLS, ATTITUDES, AND CONFIDENCE

This also illustrates the second critical factor: learners are not passive. Rather they are agents in their own development, electing to engage with whichever workplace activities they see as important.[11] So, if the medical education and training system values simple competency-based outcomes above all, these are what students and trainees will focus on. On the other hand, if the system values rich learning of the norms, values, and practices to shape and sustain interpretive practice, and structures activities, interactions, guidance, and judgements about performance throughout the continuum of medical school, training, and professional development accordingly, then these will be important to learners throughout professional life. The culture within which this development takes place will beneficially provide a stable set of values within which to learn, and where education and learning are prioritised. The system has to support the processes of socialisation that promote particular norms and behaviours.[13] This requires creating dedicated space within curricula to enable engagement; specific support for the development of skills, attitudes, and confidence in interpretive practice; and feedback that supports and sustains the socialisation processes.

SUSTAINING CHANGE THROUGH FEEDBACK

Finally, how can we measure the impact of a change in culture from competency-based practice to interpretive practice on indicators such as patient outcomes and safety? The relationship between education and the quality of health care is never straightforward[14] and we believe there is a clear need for those delivering educational practice to work more closely with academic colleagues to identify, test out, and translate into practice ways of working and thinking. For example, quality indicators (QIs) are already used in the UK to judge quality of, and improvements in, education[1,5] and care (Health Education England's [HEE] QIs for the five high-level domains of the Education Outcomes Framework [EOF]). However, these are not a 'quick and dirty' measurement. They must be developed systematically, to ensure transparency and high-quality standards. They must be relevant to the selected problem and field of application, feasible, valid, reliable, understandable, able to evidence change in behaviour, achievable, and measurable. Achieving good QIs and other ways of measuring the impact of training and learning on patient outcomes and safety is only feasible if those at the coalface of medical education delivery and governance work in partnership with those researching medical education. With careful thought and development, such tools may provide metrics of achievement towards the goals outlined in this article.

Recent high-level UK reports[15] have highlighted the need for an educated, engaged workforce providing health care in the UK. This has to be realised in policy that prioritises educational quality within funding streams. Translating the principles of changing the culture of medical education and training proposed in this piece into practical tools would allow their effectiveness to be tested in the real world, to demonstrate value and lead change. Only by bringing together education, research, and clinical practice can we stimulate innovation and improvement, and hence achieve necessary culture change in medical education.

ADDRESS FOR CORRESPONDENCE

Jennifer Cleland

Division of Medical and Dental Education, University of Aberdeen, Polwarth Building, Foresterhill, Aberdeen, AB25 2AZ, UK.

E-mail: jen.clelandf@abdn.ac.uk

Jennifer Cleland,
John Simpson Chair of Medical Education, Division of Medical and Dental Education, University of Aberdeen, Aberdeen.

Joanne Reeve,
NIHR Clinician Scientist in Primary Care, Health Services Research, University of Liverpool, Liverpool.

Joe Rosenthal,
Senior Lecturer in General Practice, Research Department of Primary Care & Population Health, UCL, London.

Peter Johnston,
Associate Postgraduate Dean, NHS Education for Scotland (NES), Scotland Deanery, Aberdeen, Aberdeen.

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