The future of medical education in the UK

Medical education is always changing but the next 5 to 10 years are likely to see an increased pace of change as we face financial pressures in both educational and health systems. Every change and challenge presents an opportunity, and we must ensure that we use any forced changes to develop our aspirations for the future of medical education.

Despite promises of protection of health funding, the financial constraints on the UK economy will affect the health service as health inflation outstrips resources. Higher education is already feeling the effects of funding reductions, and medical education is likely to be squeezed from both sides. It is crucial that medical educators demonstrate the quality and value of graduates, and show that 5 to 6 years of expensive education for young people in the highest academic bracket produces a workforce of considerable and unique value.

There is a continuing move for more health care to be delivered in the community, requiring more qualified doctors working in that area. This will lead to an increase in the proportion of graduates training for general practice (planned for at least half of the medical workforce[1]) and a shift in the working pattern for secondary care specialists. We must ensure that we are training graduates to meet these needs.

EDUCATION IN THE COMMUNITY

Although medical education tends to follow changes in clinical practice and NHS organisation, we must predict these more precisely to avoid too many students chasing too few jobs in smaller specialties such as surgery. The career aspirations of students change during training and after graduation, and are affected by their experiences and by the role models they encounter. If more graduates are needed to work in general practice and in community facilities, then students need to experience these environments early and throughout their undergraduate training. An essential element of this will be facilities for education in the community.

Where new community facilities and organisations, such as polyclinics and consortia, are developed, educators must be involved in planning educational resources in terms of space, room design, staff time, and social environments for multiprofessional training. If education gets proper representation in the planning then the development of larger units for delivery of community health could have great possibilities for teaching. Students will be at the place where most health education and delivery takes place, and the scale will allow some economies around facilities and student–teacher ratios.

APPRENTICESHIP MODEL

Within secondary and tertiary care, working lives have changed with the European Union Working Time Directive, consultant contracts and job plans, and increased front-line involvement of consultants. The coalescence or disruption of clinical firms means that apprenticeship attachments cannot work as they did, making it difficult for students to link easily to specific trainee doctors.

It is important not to abandon the apprenticeship element, as students need to learn the skills of team working and handover in these bigger teams, as these new ways of working will be even more integral to their future working patterns. Similarly, the apprenticeship model of general practice teaching has great advantages and should remain an important element of training.

GLOBAL PERSPECTIVE

Changes in the working practices and culture of the NHS through globalisation and environmental, social, and economic crises put a great responsibility on medical educationalists to prepare young doctors and strengthen their resilience and resolve to face these challenges. Developments in medical technology and a focus on prevention and health promotion will mean that ethical considerations and a global perspective will be essential.

CAREER PROGRESSION

More structured assessment of trainee doctors, multiprofessional training, and revalidation mean that the demands of teaching and assessment have increased. Most postgraduate trainers are also undergraduate tutors. There is a danger that undergraduates could suffer as the career progression requirements of trainees take priority.

Training must be seen as a continuum with graduation as just a step on the ladder. The move of the Postgraduate Medical Education Training Board into the General Medical Council (GMC) may help in this coordinated thinking, with joined up curricula and a planned progression in assessment using similar tools. The clear identification and audit of teaching time for undergraduates within job plans will help to protect undergraduate and postgraduate teaching.

TOMORROW'S DOCTORS

The GMC sets the pace and direction for undergraduate programmes and its latest version of *Tomorrow's Doctors*[2] was published in late 2009. This details a more prescriptive approach on outcomes and a closer monitoring of medical schools, without moving to a common national assessment. There is a danger that undergraduate assessment becomes more a record of competency than understanding and a broad education. While bridging the undergraduate–postgraduate gap, it is important to retain the university element of medical education and ensure this enhances the graduate trainee

programme, rather than move to a tick-box and competency model.

Tomorrow's Doctors deals with the newly prioritised elements of patient safety and professionalism which will need to be addressed. While the emphasis on patient safety will require the demonstration of competencies and the involvement of patients, the development and assessment of professionalism will allow some wider thought on behaviour and reflection.

UPCOMING CHALLENGES

The financial situation and a belief that we may be training too many doctors may well produce pressure to reduce medical student numbers. This would decrease educational income to the medical schools affected, which would put further pressure on the organisation of education and increase the tension between education and research. Any changes in medical student numbers take up to 8 to 10 years to feed through to trained doctor numbers, and the move towards a more senior or consultant-delivered service would not be compatible with a reduction in numbers.

Clinicians are likely to have increased pressure on commitments to clinical delivery, research, and administration. We need to make best use of all possible teachers and remove any idea that only doctors can teach medical students. We will need to protect time for broader involvement in the organisation and research of education, as well as delivery, and find ways to value teaching in the academic environment, including ensuring that medical education has a strong career structure.[3]

With the focus on patient-led medical services, patients may well come with increased expectations of a consultant-delivered service with fewer educational opportunities for students competing with trainee doctors. We need to emphasise the importance of teaching and training as a key to maintenance of a health service for the future. Students themselves are likely to be faced with higher tuition fees, raising their expectations of teaching, while the total education budget for universities declines despite their increased fees.

So the main priorities for undergraduate medical education over the next 5 to 10 years will be the delivery of the new *Tomorrow's Doctors*, the change in the pattern of medical education to meet the health service changes, and the maintenance of education in a climate of reducing costs with increased expectations from other trainees, the public, and students. It will be essential that the profile of education is increased and that this is seen as the responsibility of all managers, health workers, patients, and students themselves.

P John Rees,
Dean of Undergraduate Education,
King's College London School of Medicine,
London.

Anne E Stephenson,
Director of Community Education,
King's College London School of Medicine,
London.

Provenance
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ADDRESS FOR CORRESPONDENCE

John Rees
Sherman Education Centre,
4th Floor Southwark Wing,
Guy's Hospital, London, SE1 8RT.
E-mail: john.rees@kcl.ac.uk