Widening the horizons of medical education

edited by Mary Seabrook, Paul Booton & Tyrrell Evans

Department of General Practice & Primary Care ■ King's College School of Medicine & Dentistry

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A report on the issues involved in moving medical education into the community

Edited by Mary Seabrook, Paul Booton and Tyrrell Evans

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■ Summary

The project

The Innovation in Medical Education project, based in the Department of General Practice & Primary Care, King's College School of Medicine & Dentistry, aimed to explore the implications of a substantial move of medical education into the community. The main areas covered were:

- interviews with a wide range of interest groups or 'stakeholders'
- interviews with GPs to determine how their involvement might be maximised
- the development of appropriate teaching and learning materials.

A national conference was held mid-way through the project to present the interim findings and test out whether they were applicable at a national level.

Details of the background, rationale and methodology appear in Chapter 1, together with an overview of the main findings.

At a practical level, both the discussions with stakeholders and our experience in running the King's Medical Firm in the Community led us to consider the process of establishing and running community-based learning. Chapter 2 presents a guide to some of the opportunities, issues and problems we encountered. A report of the development of appropriate learning materials for use in community teaching is also included.

The issues raised by students, patients, GPs, the primary health care team, complementary practitioners, and health care purchasers and providers are summarised in the reports in Chapter 4, together with a summary of the national conference. Issues concerning finance and accountability in medical education were raised and additional work undertaken to clarify the current situation. This identified major needs for change which will require addressing at a national level. This work appears in Chapter 3.

Key issues are summarised in a box at the start of each section, and the major issues and questions to arise overall are highlighted overleaf.

Major issues

An enormous range of issues was raised, out of which a number of consistent themes emerged:

- A dialogue with the community: How do we engage the stakeholders?
- The 'real' work of doctors: Are we training doctors for what they actually do?
- Doing it differently: The same old curriculum or a whole new beginning?
- Different values and priorities: How can community education reflect these?
- Unused opportunities: Can we tap the enthusiasm and skills in the community?
- The patient as teacher: Can patients be active partners?
- Team players: Are doctors, trained with and by other doctors, ready to join the multidisciplinary team?
- Flexibility: Are we creative enough to involve a range of teachers?
- Maintaining cohesion and identity: How can we avoid fragmentation?
- The practicalities: Can we make a community-based curriculum work?
- Funding: Must the funding drive the curriculum or can the curriculum lead the way?
- Accountability: Who is the customer and who sets and monitors standards?
- What sort of a doctor? At the root of it all, what kind of a doctor are we trying to create and who should say?

Acknowledgements

The project Steering Group and Commission members are:

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Abbreviations

ASME	Association for the Study of Medical Education
CBME	Community-based medical education
CELC	City and East London Confederation for Medicine & Dentistry
CMO	Chief Medical Officer
DfE	Department for Education
DoH	Department of Health
FHSA	Family Health Services Authority
FTE	Full-time equivalent
GMC	General Medical Council
GMSC	General Medical Service Committee
GP	General practitioner
HEFC	Higher Education Funding Council
HO	House Officer
IT	Information Technology
KCSMD	King's College School of Medicine & Dentistry
KMFC	King's Medical Firm in the Community
OSCE	Objective Structured Clinical Examination
RHA	Regional Health Authority
SCOPME	Standing Committee on Postgraduate Medical Education
SELHA	South-East London Health Authority
SETRHA	South-East Thames Regional Health Authority
SGUMDER	Steering Group on Undergraduate Medical and Dental Education and Research
SIFTR	Service Increment for Teaching and Research
UMDS	United Medical and Dental School of Guy's and St Thomas's

■ 1 The Innovation in Medical Education project

1.1 Introduction, aims and methodology

Paul Booton, Mary Seabrook

Background and rationale

The changing pattern of medical care in the United Kingdom over a number of years has led to a decrease in reliance on hospitals as the point of provision of care and a corresponding increase in care in the community. This shift has accelerated in recent years, acknowledging the importance and centrality of a primary care led service. The reasons have been technical, in that medical technology has decreased the need for long patient stays; philosophical, in assuming that patients prefer to be cared for out of hospital; and political and economic, relating to the high costs of inpatient care.

At the same time, there has been only limited change in undergraduate medical education, with students continuing to meet patients predominantly in a hospital setting. A wide-ranging debate is now under way about the nature of medical education, part of which concerns the issue of where medical students will learn and the potential role of the community. The reasons for considering a more community-based approach to medical education are summarised in section 2.1.

Traditionally, medical school curricula have been defined by their senior members on the 'doctor knows best' principle. There are major pressures to move away from this concept and towards a community-defined curriculum which will be responsive to the needs of the local population rather than the perceived needs of the school itself. This philosophical change in approach has been defined as 'community-oriented medical education'.[1] As part of the process, there is an interim need to develop learning programmes, techniques and attitudes which are appropriate to a community setting. In this document we refer to this process of development which involves a change in both practice and philosophy under the general term of 'community-based medical education' (CBME).

Local experience: the King's Medical Firm in the Community

In 1991, a major initiative to teach mainstream curricular subjects from a community rather than a hospital base was launched at the medical school of King's College, London. This arose from local plans to develop a more community-oriented and based teaching hospital (the King's 2000 plan[2]). In

1989, agreement was reached that an experimental firm in general (internal) medicine would be developed in local general practices to run alongside the existing general practice firms. The following year, a lecturer was appointed to lead it and the first students attended at the beginning of 1991. The firm has run continuously since then, and its size has approximately doubled in that time to one third of the annual intake of about 100 students. The King's Medical Firm in the Community (KMFC) was unique in that it was the first time that a major medical specialty had been taught in a general practice setting.

While this experience has been invaluable in discovering more about the potential for community-based education, it has also revealed a number of problems and difficulties to be overcome before such a scheme could become widely applicable. Despite enormous interest in this work from other schools and a wide recognition of the reasons for expanding CBME, there are still only a few schools that have embarked on significant moves in this direction.

Project aims

We felt that there was a need to explore the implications of a major move of medical education into the community. A grant was obtained from the King's Fund, and the Innovation in Medical Education project was established, running from August 1992 to May 1994. The aims for the project were:

- to explore the implications of a move into the community for all those involved within the teaching boundaries of one medical school, and use the findings to generate guidelines which would be appropriate at a national level.
- to investigate GPs' attitudes towards, and reasons for wanting to become involved in, undergraduate medical education. To explore GPs' objectives in teaching and develop practical ways in which these could be met, with due regard to the pressures of time and space in the community setting.
- to develop inquisitive, student-centred learning methods suitable to a community setting. These methods should be self-directed and holistic, embrace the thinking of both science and relevant humanities, make good use of community assets unavailable in hospital, and integrate clinical work with basic scientific ideas.

Research process and methodology

We believed that our aims would best be achieved by a detailed, focused study of one medical school's teaching catchment area, investigating the relationships and processes which could facilitate or impede change. From this information, we would then create a blueprint for change locally and draw out national implications.

At the core of the work, a Commission of inquiry was formed to gather information from all those players with an interest or potential involvement in

medical education. The members of the Commission were chosen to represent a broad spectrum of decision makers within the local medical community, together with a member of the King's Fund Centre to set the national context.

The Commission started by mapping all the individuals, groups or organisations that could be affected by, or have an interest in, any increase in community-based education. It then undertook to formulate questions, collect evidence from the various players and, based on the answers obtained, plan further investigations. Since it would not be possible to research every area in detail, a number were selected as priorities and investigated by Commission members. In addition, a researcher was employed to explore practice and community staff perspectives, and three students were recruited to investigate students' attitudes.

Non-probability sampling and qualitative research methods were chosen to gain an adequate depth of insight into the local situation. The methods used included questionnaire surveys, individual interviews, focus group discussions, key informant interviews and literature searches. Further details of the methods used are given under the individual reports in Chapter 4.

Two experienced GP tutors were appointed to carry out specific pieces of research. The first investigated GPs' attitudes towards teaching by conducting in-depth interviews, the report of which appears in section 4.4. The second examined teaching methods suitable for practices and developed structured learning packs for students. The account of this work appears in section 2.5.

National conference

At the half-way stage in the project, a national conference was convened at the King's Fund Centre to promulgate the work of the group and to open a debate on these developments more widely across the country. It aimed to determine the relevance of our local work to the country as a whole. The findings and outcomes of the conference form part of this final report.

1.2 Overview of the results and their implications

Mary Seabrook

Engaging the stakeholders

One of the most useful aspects of the project was the opportunity it gave us to talk to key local figures in the health service (i.e. managers in local and regional health authorities, local health care purchasers and providers). This was the first time that members of the medical school had made a systematic effort to discuss issues in medical education with these organisations, and it proved an educational experience for both sides.

As significant as the opinions of the discussants were their changed expectations as a result of the discussion. Some came with the view that they had little to contribute and no reason to be involved, but left with an understanding of the importance of the involvement of their sector in medical education. The opening part of the discussions, where we described the project and explained to the 'interviewees' where they fitted in, sometimes took considerable time, but was important in this process. We found that the meetings helped us to clarify roles and responsibilities, explore likely future developments in both health care and education and discuss the possible implications. Both parties were able to gain a better understanding of the other's aims and constraints and, by the end of the session, could identify areas of potential future collaboration.

Other groups, including patients, primary and community health care professionals and complementary practitioners were also both surprised and pleased to be included in discussions about the future of undergraduate medical education. Many expressed a wish to be better informed about developments and hoped to be further involved in the future.

Summaries of each series of meetings are given in Chapter 4.

Telling is selling

The process of engaging these groups in discussion, in itself, created a great deal of interest in and enthusiasm for our work. Even some groups who were initially opposed to the prospect of more CBME, such as students, became much more positive when encouraged to think through all the issues and implications. This highlights the need for medical schools to communicate more widely within the local community and engage the support of local stakeholders for potential developments. We believe that our discussions have already had benefits for the medical school in terms of raising the profile of medical education and initiating/improving relationships with those who can facilitate its development.

The community is more than general practice

At the start of the project, we imagined that CBME would require a much larger commitment from GPs, and efforts were directed at identifying how this could be achieved. Our research showed that many GPs would like to do more teaching, and that increasing flexibility through changes in its structure and organisation could facilitate greater involvement. Even given optimal conditions though, there is limited scope for expansion with current service pressures, especially since the introduction of the new contract in 1990 and the progressive transfer of services from the hospital to the community.

The enthusiasm of other groups to be involved in teaching, however, was enormous and suggests that widening our horizons in terms of who can and should teach will provide the extra human resources required. General practice

and community trust staff and complementary practitioners are all very interested, and have a positive contribution to make in terms of the particular skills and expertise they can offer.

There is also a huge potential for patients to play a more active role in teaching students in the community. Our concerns were that patients might be more assertive in declining to see students on their 'home territory', but it soon became evident that they thoroughly supported the idea of becoming more involved in helping students learn.

Losing control – or gaining consensus?

Talking to this wide range of interest groups demonstrated that a community-based programme would involve allowing a greater number of people than at present to have input into educational decision making (for example, about the curriculum). Everyone involved in a community-based course needs to be able to contribute ideas and set priorities, and the challenge would be to gain consensus while maintaining cohesion and identity. To some schools, this may seem a frightening prospect – it is certainly less 'cosy' than the current hospital-based courses. However, it would be a way of bringing education into the 'real world' and developing a curriculum which focuses on the real needs and concerns of health care practitioners and patients.

If the curriculum were to be taught primarily outside the hospital, a different kind of organisational control would also need to emerge. In the hospital, the medical school is able to exert tight control over all aspects of the educational process – in theory, at least. The prospect of teaching in the community raises all sorts of cries about the potential for disorganisation, fragmentation and poor standards. These issues certainly need to be addressed, but critics of community-based education tend to assume that the present system does not have any problems. In fact, there is little training for teachers and limited monitoring of standards in current teaching hospital practice. The demand for standards in the community which are not present in the hospital is often due to fear of change. The students in our study certainly confirmed that standards were of equal concern in either location.

Maintaining cohesion without the bricks

With any such dispersion of teaching, it would be essential to provide practical and personal support for the teachers and an overall co-ordination and integration for the students. Teachers in the community agreed that well-organised programmes with clearly defined objectives would be required. They would want to know the students' likely level of attainment and understand how their contribution fitted into the whole course. Training in teaching and ongoing staff development would be required. Opportunities to meet with other teachers and feed back problems and ideas to the medical school would help to integrate the components and develop a cohesive course.

Students were particularly worried about the potential loss of identity in a community-based course. There would need to be opportunities for small and large group sessions as well as more individual work, and students would need a tutor to ensure that they received a balanced, integrated programme. The organisation would need to minimise the time and expense incurred in travelling.

More sophisticated methods of communication would be necessary, which would require investment in the infrastructure, such as improved computer/information technology/fax/electronic mail links as well as extra administrative and support personnel.

Not a transfer but a reinvention

The need to allow a new curriculum to emerge from the community is a central finding of this project. Potential community teachers (both GPs and others) are not interested in chunks of the hospital-defined curriculum being 'dumped' in the community. They want to help students learn in a way that reflects the ethos and practice of primary health care. This is seen as an opportunity to move away from the disease and specialty-based hospital environment and to centre on the needs of the patient. Community staff do not feel that this makes their teaching 'soft'. They appreciate the need for students to acquire scientific knowledge and feel that this should be taught in context, along with the appropriate skills and attitudes. Students' perceptions of the real task of doctors are crucial to their motivation to learn, and it is important to acknowledge and spell out the differences as well as the similarities in approach between hospital and community.

The educational methods used in hospitals likewise could not be simply transferred to the community. Teachers would need to develop programmes and methods which are suitable to their working environment. In particular, these should allow teachers flexibility so that they can find creative ways to balance service and teaching commitments.

Who is the customer?

Neither we, nor others we talked to, were clear about who the customer for medical education is. Is it the student (who chooses the medical school)? Or the patient (as end user)? Or the health care provider unit (which will employ the student when qualified)? Or the health care purchaser (who will purchase from the provider)? Or the Government (who is paying)?

It is important to identify who the customer is because otherwise medical schools do not know whom to ask for feedback on whether they have provided a satisfactory service. The confusion over this issue means that medical schools currently have no recognised 'feedback loop' and therefore little accountability. Usually, organisations are responsible to their funders, but in medical education the financial and educational decision-making structures are separate.

We found that an examination of the current structures helped us to understand some of the problems and propose solutions. A particular problem in the context of this report is that the money to support the additional service costs caused by medical education was originally designed for hospital teaching and is difficult to transfer to the community. These areas are addressed in detail in Chapter 3.

Given that some of these problems can only be solved at a national level, it is important not to feel that nothing can be done until this happens. Creative solutions can be found, and a successful pilot scheme will focus attention on facilitating further CBME. The practical issues involved are addressed in Chapter 2, using the experience of the King's Medical Firm in the Community.

References

1. Hamad B. Community oriented medical education: what is it? *Medical Education* 1991; 25:16–22.
2. Camberwell Health Authority. *Service Changes 1988/9–1991/2. A consultation document.* London: CHA, 1991.

2 Developing local community teaching

Paul Booton, Jeremy Gray, Roger Higgs, Mary Seabrook, Penny Shaw, Anne Stephenson

This section discusses the practicalities of setting up community-based teaching.

Key points

- Reasons for introducing community-based medical education
- The need for medical school support, both practical and philosophical
- Building trust and communication between the hospital and the community
- Finding funds for new schemes
- Involving community teachers in developing their own curriculum, teaching and assessment methods
- Training and supporting teachers
- Addressing students' concerns of identity, safety, time and cost
- Organisation, administration and communication between the medical school, students and community-based teachers

2.1 Gaining medical school support

Despite a great deal of discussion about community-based medical education (CBME) and the establishment of a number of pilot schemes, there is still considerably more theory than practice. The reasons for this include the need to rethink community-based health care services to create a climate in which teaching can develop, and the lack of local expertise of the would-be developers. This section looks at the process of establishing a scheme locally and draws extensively on our experience of setting up the King's Medical Firm in the Community (KMFC). It aims to give practical guidance to others wishing to develop similar schemes, and to draw out issues that may need to be addressed, including likely pitfalls.

What forms can CBME take?

A wide variey of schemes have been instituted which essentially fall into six possible models (see Box 1). The differences between them are in their location and their objectives. These may involve:

- replacing teaching traditionally carried out in a hospital setting;
- allowing students to explore a greater breadth of the natural history of illness than a hospital view allows;
- allowing students to explore the social aspects of illness for the patient and carers;

- allowing students to develop an understanding of the community in which they work;
- allowing students to explore public health issues.

McCrorie, Lefford & Perrin's survey of community-based teaching[1] illustrates the diversity of schemes currently in operation.

Box 1: Models of community-based medical education

1. General practice as a specialty: General practice has traditionally been used to teach general practice as a 'specialty'. Students are attached in various ways to observe the range of issues dealt with in general practice and how primary care operates. The setting lends itself to areas such as communication skills, ethics and clinical reasoning.

2. Longitudinal student attachment: The student is expected to relate to a patient or family for a relatively long period of time, 3–12 months typically. Some schemes follow patients suffering from a chronic illness, others follow a family over a period of time, or a pregnant woman through pregnancy and birth. Students are expected to learn about the patient's condition, life, social context, relationships, etc. They may or may not be required to carry out a formal medical clerking.

3. General practice as a base to explore traditional disciplines: Potentially, general practice has far more to offer than the 'specialty' firm. It can act as a resource from which students can explore both medical and non-medical areas, allowing them to meet patients and have access to a tutor to help them make sense of the experience. Two very different approaches are provided by the KMFC,[2] which uses a general practice setting to teach general medicine as a specialty, and the Cambridge community-based scheme,[3] which aims to teach the whole of medicine as it presents in general practice, without reference to the traditional disciplinary divisions.

Cont.

4. The wider community as a learning experience: Medical students tend to come from a limited range of social backgrounds, often very different from those of their patients. Finding ways of bringing students into contact with their patients in a non-medical setting can help them to explore and confront these differences. Such a scheme can be based in existing community institutions. In the CELC Community Module,[4] tutors are drawn from a wide variety of local community groups and institutions and help students to explore areas of the community to which they would otherwise be unlikely to have access. This type of placement helps students to explore areas beyond the boundaries of the traditional curriculum, and thus represents a broadening of, rather than a substitute for, the traditional curriculum.

5. Outreach clinics: Increasingly, outpatient care is moving into community settings and the role of existing community-based clinics is being extended. Specialties such as paediatrics and psychiatry are making particular moves in this direction. As a resource for students, this area has increasing potential but remains underexplored and underutilised. Successful models of outpatient teaching could probably be adapted to this setting. It will be important, however, to take advantage of the increasing community- and patient-centred orientation of these clinics if their full potential as a teaching resource is to be exploited.

6. Primary care centres: The King's Fund report[5] and the Tomlinson report[6] envisage the development of primary care centres which will contain a variety of services, such as physiotherapy, occupational therapy and inpatient services for those who require nursing care without the need for high-tech hospital services. A model for this is the Lambeth Community Care Centre. The potential for this type of centre as a learning resource for medical students has yet to be explored.

Why introduce CBME?

Community-based medical education is not an end in itself; all medical education should start with a view of the needs of the doctors it is training, informed by the needs of the patients that they will serve and the provider units within which they will work. Reasons for developing CBME are rehearsed in Box 2.

Box 2: Reasons for introducing community-based medical education

At its simplest, CBME merely implies a change in location of medical teaching. As such, it has a limited amount to offer, suggesting that the same subjects will be taught in the same way but in a different location. CBME perceived in this way does, however, have practical attractions. The change in the philosophy of care of recent years means that far more care takes place at home and far less in hospital. The practical corollary of this is the huge reduction in hospital beds that has occurred. British medical education has relied extensively on students learning medicine through meeting patients. Teaching hospitals now face considerable and increasing difficulties in finding adequate numbers of patients for their students to see. At this level, CBME offers an opportunity to correct this imbalance.

At a less mundane level, moving to a community base offers a chance to redress the loss of diversity of medical experience. In hospitals, not only are students limited by the numbers of patients they can see, but the nature of their encounters has also changed. Patients spend substantially less time in hospital. As a result, students only see patients at one phase of their illness, usually when they are at their most ill and are thus least able to help the students. The community offers the opportunity to give students a broader view of the nature and natural history of illness. In hospital, this view has always been somewhat restricted,[7] but now more than ever. Thus CBME can be viewed as an opportunity to recoup the losses wrought by the change in service provision.

At another level, CBME can contribute in ways which conventional medical education has not been able to offer. Students meeting patients in the community can explore concepts surrounding the practical effects of illness, and emotional and ethical issues relating to the meaning of health and illness in the context of patients' homes, families and work.

A further argument relates to the way doctors already work and will increasingly work in the future. For many years, we have been training doctors almost exclusively in hospital, about half of whom will eventually work in the community. The other half who will continue to work in hospital will need to relate to community medical structures, often with the most perfunctory experience of them.

What are the barriers to implementing CBME?

The barriers to moving medical education into the community are not merely logistical, but involve changes in the balance of power, status and resources. These include:

- the changed importance of hospital and community doctors in providing undergraduate medical education;
- the loss of role for hospital teachers;
- the loss of money to hospital teachers if finance follows students;
- the threat to status for hospital doctors;
- the need for a different ownership of the curriculum.

How can these barriers be overcome?

The creation of CBME schemes should be part of the development of a vision of medical education for, and preferably by, the whole medical school. This will not occur instantly: it will often start with a lone voice that sees the potential and promotes the idea in the school. The support of an influential member of the school who will champion the cause is useful in giving prestige to the ideas and increasing the opportunities for them to be heard. He or she can influence or quieten doubters and bring the discussion to influential areas of the medical school. Appropriate representation of community scheme developers on the relevant school committees is important both to show that the school values the work and to give correct information about the progress of the scheme.

At present, there is often a chasm between the hospital and the community based on a mutual ignorance of each other's activities, which allows a climate of suspicion and distrust to persist. Activities enabling the two sides to meet together in non-confrontational situations are an effective way of beginning to break down the barriers and form bridges across the divide. 'Teaching Teachers' workshops at KCSMD, and the inclusion of community- and hospital-based teachers on an equal basis in discussions of the new curriculum are two examples (see Box 3).

Providing the school with an opportunity to meet successful innovators in the field can give staff a taste of the possibilities. Launching pilot schemes gives the school first-hand experience, and allows an informed debate to occur. Securing funding, at least in part, from the school is helpful in solidifying its commitment (see Box 4).

How can funding be secured?

The issue of funding is key to the development of community-based education, particularly in the new market atmosphere of the NHS. The financial structures supporting medical education were designed for hospital-based teaching and cannot easily be transferred into the community. (A detailed examination of these issues is made in Chapter 3.)

Box 3: Orienting King's College towards the community

In 1990, the hospital produced the King's 2000 plan, a scheme to develop the teaching hospital in a more community-oriented direction. Roger Higgs, Professor of General Practice & Primary Care, used this as a platform to promote long-standing ideas about the increased role of the community in teaching mainstream medical specialties. An agreement was reached to develop a pilot firm to teach general medicine in a general practice setting, funded out of hospital and school funds. The work was supported and promoted actively by Adrian Eddleston, Dean of the Medical School, who linked his own teaching to the new community firm.

The success of the firm converted doubters (which included some GP teachers!) to concepts of CBME. Staff development workshops ('Teaching Teachers') were set up to improve teaching skills and attracted participants from both community and hospital, who had an opportunity to work together and get to know each other.

Paul Booton, a GP with an interest in medical education, was appointed as Curriculum Sub-Dean in overall charge of the undergraduate education programme of the clinical school. As the school moves to develop a new curriculum, community- and hospital-based teachers are involved on an equal basis.

Higher Education Funding Council (HEFC) money is limited because of the small number of academic staff in most departments of general practice. The huge majority of GP teachers are within service posts, giving little scope for knock-for-knock arrangements to operate (which requires a rough balance of service and academic appointments). There is no equivalent to the Service Increment for Teaching & Research (SIFTR) for community-based teachers. Direct support is provided in sessional payments from the FHSA which, at current levels, are little more than notional.

Options for funding are limited but include:

- local arrangements to make SIFTR available to CBME projects;
- direct support and pump-priming initiatives from medical school funds;
- support from grant-making bodies;
- negotiations with FHSAs to allow either pilot funding for projects or a more liberal interpretation of existing regulations!

Arguments need to be established which address the needs of each funding source, and a constructive dialogue developed and maintained.

For the future, progress in funding could quickly be made by increasing existing FHSA allowances. At King's, we are exploring the development of teaching agreements which describe a contract between the practice, the medical school and the FHSA. These will clarify the needs and expectations of all sides and inform future funding decisions. At present, there is no formal mechanism to provide undergraduate teaching space in general practice, although FHSAs may exercise discretion to allow for this. A summary of the work on teaching agreements is included in Appendix 1.

Box 4: Resourcing the KMFC

The initiative to develop CBME at King's was agreed by both hospital and medical school as a key area which they wished to spearhead. A clinical lecturer was appointed, funded equally between the hospital and the school. A budget was established from the medical school to take on the costs of developing and pump-priming the scheme. This supported a half-time administrator, gave funding support to GP tutors to set up their practices, made a contribution towards re-equipping practice libraries, and provided support to tutors to allow them to attend development meetings.

The established scheme attracted SIFTR monies (through a locally agreed arrangement) and central medical school funding (mainly HEFC), which supports the continuation of the scheme.

Tutors claim from the school and from the FHSA for sessional payments for their agreed teaching, each source contributing the equivalent of one session per week (paid at the equivalent locum rates).

2.2 Organisation within the medical school

How should the programme be designed?

The usual rules about curriculum change apply: one cannot design the scheme from the centre and then hope that those who will have to implement it will be enthusiastic. Community tutors need to be involved in the process from the earliest possible point; give them a voice, time, resources and responsibility and allow them to approach the process of change with all their creative energy. The benefits in terms of producing a more imaginative change and ensuring

that the tutors are committed to the scheme from the outset are considerable. Nevertheless, there is a tension between the need for central control and the importance of genuine involvement at a grass-root level. On the one hand is the danger of creating a scheme centrally that the teachers will not implement and, on the other, the danger of creating a scheme co-operatively that is not supported or funded by the school. Ideally, both processes should go ahead in parallel with cross-representation where possible.

How can community teachers be found?

Moving teaching into the community means that the teaching network increases many fold, both in geographical area and in complexity. The exposure that this gives the student to the large and multi-faceted resources of primary health care is a key strength. Whatever model is adopted, it is unlikely that schools will be starting from scratch. Existing links can be developed and strengthened, and out of these new ones will begin to emerge.

Within general practice, almost all schools have a department of general practice and an undergraduate teaching programme based around it. There is a considerable respect for teaching in general practice and a well-developed skills base, much of which originated in the many excellent postgraduate training schemes and has continued in schemes to give undergraduates experience of general practice. Increasing the amount of teaching from the general practice base, strengthening its position within the school or extending it in different directions from the traditional model can all be built on the existing foundations, drawing on the strengths brought by a body of well-trained, enthusiastic local teachers.

There will be an increasing need to look to the whole primary care team as the teaching base, both to satisfy the human resourcing requirements of any scheme and more importantly to take forward a multidisciplinary approach to medical education. Recruiting to schemes based outside existing medical structures may be more problematic. Links may have to be made *de novo* and with a disparate group of tutors. The CELC Community Module shows how successfully this may be achieved.

What support do teachers need?

For any educational programme to prosper, supporting and training the teachers is essential. Training would include: teaching methodology, proper briefing on the curriculum to understand how their teaching fits in with the overall learning objectives of the school, and clear information and written materials from the centre. There is now a welcome emphasis on the need to train medical teachers, challenging the previous assumptions that teaching 'just happened'.

We found at the outset of our scheme that many tutors expressed a fear that they would not be capable of doing the job. Deeper investigation revealed not a lack of ability but rather of confidence. It is worth noting that any scheme

which seeks to change the traditional power relationships and hierarchies in medical teaching will need to confront issues of confidence in the new teachers and the perceived loss of status in the old ones.

Teachers need personal and practical support to cope with the extra burden imposed by teaching, including ready access to help and advice from the centre and contact with other tutor colleagues. The opportunity to discuss problems and offer mutual support is particularly important for community-based tutors who are likely to be relatively isolated, compared with their hospital colleagues.

Teachers must feel that their efforts are valued by the medical school and that they can contribute to discussions on the curriculum. Interdepartmental rivalries with 'friendly' abuse of each other's teaching can be particularly destructive across the hospital–community divide, and make this an area which will require sensitive handling. As part of the school, community teachers should be aware of, and take part in, setting the learning objectives and assessing students, and their teaching should be appraised on the same basis as other firms.

What about a teaching 'contract'?

The project to develop model teaching agreements between the practice and the school (see Appendix 1) will, we believe, be important to the future of CBME. At present, teaching is an additional activity in the practices, often arranged, and locum cover provided, informally. Considerable effort and strain can be incurred through such an approach. The development of a contractual basis between practice and centre, while committing practices to certain standards, will allow them to incorporate teaching into their financial plans, operational activity and attitudinal orientation. The school will be assured of a supply of properly trained teachers working in practices appropriately set up for their educational role.

How can students be encouraged to value their community learning?

The historical tensions between hospital and community may give rise to the perception on the part of students that taking part in a community-based attachment is inherently inferior to a hospital one. Establishing a culture within the school and its teachers that values the community component helps to ameliorate this conflict. However, old prejudices run deep, and it is likely to be years before the concept of equality of community and hospital is a reality. It is therefore helpful to spend time at the beginning of the attachment exploring students' concerns and correcting misapprehensions.

What is expected of students?

After a consideration of students' expectations and needs, it may be helpful to formalise arrangements in a learning contract, which essentially sets out what the tutor and the student each undertake to do. This is a standard educational device, but may be particularly helpful in a community learning situation in reassuring both the students about what they can expect to learn and the tutor of the students' commitment.

What are the potential problems for students?

Safety

Community attachments may bring students into potential safety problems. While students are regarded as adults, it is worth considering whether they are being put in situations of particular risk. Potential areas of concern include students visiting patients on their own or travelling in high-risk housing estates. Simple measures such as working in pairs or avoiding travel after dark may alleviate such problems. This issue was of particular concern to students at our national conference and a number of solutions were proposed (see section 4.8).

Isolation

Students may feel isolated and miss the cameraderie of their colleagues if working away from them for significant periods of time. Designing the attachment so that it allows them to meet together during the week, or to work in pairs or groups can ameliorate these feelings. The KMFC has not found this to be a particular problem, but students have said on occasion that although not a problem for them it might be for others. The attachment has the students in pairs for some or all of every week; they also meet with the rest of their year for lectures and with the rest of the firm for a number of sessions each week.

Travel

Declining student grants make any additional costs particularly unwelcome to students. Students live across a wide area, and so some attachments may be particularly difficult for individual students to reach. We let students organise among themselves to which practices they will be attached, providing information about availability of public transport to help them make the choice. For those students who receive a grant, a sum is included for travelling. Medical students have a special dispensation whereby they may claim for travel costs above this limit if that travel is to an attachment which is a required part of the course. This is of no benefit to students who receive no maintenance award. In the present economic climate, it is unlikely that this situation will improve.

What are the administrative needs?

Success in keeping together a disparate band of students with an equally disparate band of tutors depends on the central administration of the scheme. Responsibility for this will usually lie between the academic directing the scheme and its administrator.

The administrator acts as the link between students, community teaching centres, the department and the medical school. The administrator should be aware of developments and/or difficulties on all fronts and should be able to anticipate and, possibly, avoid problems. If problems do arise, the administrator will probably be the first point of contact.

The administrative needs of a community medical programme will include tutor liaison, tutor allocation and payment, provision of student materials, organisation of assessments and evaluations, and record-keeping (see Box 5). Good communications are essential and we have found a direct telephone line, and ansaphone (used judiciously) and a fax to be essential.

To ensure that community teachers are not seen as a different or lesser breed, they should be on the same mailing lists as other school teachers, invited to school meetings on the same basis as other school teachers and encouraged to participate. Awareness at an administrative level can greatly facilitate this process.

Box 5: Administration of the KMFC

Finding tutors

There is a 'pool' of KMFC tutors from which each firm's group of active tutors is taken. We try to plan tutor allocation at least six months ahead. This is a considerable improvement in terms of forward planning for both us and the tutors, compared with the early days of the firm when we used to recruit firm by firm. Inevitably, there needs to be fine adjustment near to the start of each firm, and tutors are asked to confirm their availability by telephone or at a tutors' group meeting.

Organising payment

At the beginning of the firm, the medical school is invoiced on behalf of each tutor. A signed FHSA claim form is sent out with the course material to allow the practice to claim this component of their fees. We are currently trying to negotiate an agreed standard rate per firm with the FHSA to streamline the claims procedure.

Cont.

Timetabling

This is cyclical, although surprisingly few firms are precisely the same in terms of timetabling. There are one-off medical school events or examinations which interrupt the regular pattern, as well as extra sessions we organise within the firm itself – for example, an afternoon of special gastro-enterology teaching was recently arranged at a practice. This emphasises the importance of good communication between the firm and the school.

Course material

Course material is contained within the firm booklet, which comprises some 30 pages of information, timetables, self-assessment sheets, advice on appropriate study methods and a firm-evaluation questionnaire. All of these are constantly reviewed and updated. Books are printed and bound for the start of every new firm – one for each student and tutor involved.

In any firm, there will be unforeseen changes to its regular running, and these have to be notified to the students as quickly as possible. Experience shows that it is best to send a clear (preferably brightly coloured and in large print) notice to each student by first-class post, or to telephone each of them at home.

The end-of-firm examination

An objective structured clinical examination (OSCE) takes place in the penultimate week of the firm at one of the larger participating practices. It is essential to ensure that there are sufficient examiners booked for the day. Early liaison with the practice staff responsible is required so that suitable patients can be organised to attend the examination and sufficient rooms found for the exercise. Sets of examiner's checklists are produced, together with written questions, marksheets and room schedules – it is helpful to maintain a 'bank' of appropriate information and material on computer. The administrator attends the examination and looks after the logistics – lunch for the examiners, patient hospitality, timekeeping, question papers distribution and collection. Without well-thought-out administrative procedures, the OSCE could be a nightmare; once they are in place, however, it is enormous fun.

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Student liaison/welfare

Not strictly speaking an administrator's role, but often thrust upon one in circumstances that leave little choice. First-year clinical medical students – especially early in the year – are often disoriented or suffer crises of confidence. Problems of all kinds emerge, and it is usually the administrator, as the person who is always there, who deals with them. With the right attitude, this can be a job-enhancing experience rather than a nuisance.

The KMFC tutors' group

The group meets every 6–8 weeks in the evening at a practice to discuss the running of the firm, problems with students, plus new developments and methods of teaching. These meetings are minuted, and agendas and accompanying papers distributed with letters of invitation well in advance of each meeting.

2.3 Organising teaching in the community

How much time is required for teaching?

Non-medical teachers are used to the concept of preparation time. Doctors teaching in hospital have patients 'frozen' in bed and are expected to be able to teach 'on spec'. However, it is a mistake to assume that because some teaching can be carried out at so little cost it all can. Allowing preparation time for teaching when the reverse is the norm requires a mental adjustment on the part of both tutor and colleagues.

What preparation is involved?

Preparation for teaching sessions will involve a number of areas:

- *The content:* Tutors must decide what knowledge, skills and attitudes they aim to teach in any session. This should be informed by the needs of their students, which they will have elucidated previously. We should challenge the assumption that a doctor should know and be able to teach anything. Generalists will often need to review the material about which they intend to teach.

- *The process:* Too much medical teaching is purely didactic. As we move to more student-centred models, teachers will expect to consider the *process* of their teaching method just as much as the *content* of what is taught. Choosing active-learning methods will encourage better learning in the students. (See Box 6.)
- *The space:* A suitable room and equipment should be arranged.
- *The patients:* Arrangements will need to be made with the patients who are to help in the teaching. (See Box 7.)
- *The practice staff:* Teaching activities will frequently impinge on the work of other practice staff with whom arrangements will need to be made.

How can tutors manage the workload?

Practices use locum cover or share teaching between the partners as a way of coping with the workload. While locums provide immediate cover, they are unsatisfactory in the longer term. A solution to this might involve partners reducing their surgery commitments or appointing extra staff either to teach or to take on the service commitments. Although this might appear the ideal solution, it is difficult to realise with the present limited funding for general practice teaching.

In some practices, each partner takes it in turn to teach in place of one surgery. In a large practice, the extra load on individual partners is small and they are able to maintain near-normal surgery commitments. However, students experience a succession of tutors, and in order to cope with the lack of continuity one partner acts as teaching co-ordinator and holds regular supervisions with the students.

Most small- and medium-sized practices share teaching between partners and use locum cover. Some surgeries designate one or more doctors to take on the responsibility for teaching, while others switch between teams of teachers on alternate firms.

How can space for students be found within the practice?

At present, we are obliged to make do with whatever space a practice can provide. However, if there is no space dedicated for student use, this can leave tutors feeling that the students are 'hanging round their feet' all the time, which is a cause of stress.

Box 6: Teaching methods used on a community-based medical firm

Clinical exposure

- observing surgeries
- on-call experience
- attachment to other primary health care team members
- outreach clinics.

Opportunistic learning

- topic related (e.g. skills, patient-led teaching)
- learning by doing
- one-to-one teaching, especially problem solving, clinical reasoning
- random encounters.

Planned encounters

- patient clerking
- home visits
- role adopting (e.g. supervised health promotion clinic, explaining management to patients)
- skills development (e.g. blood pressure, urine analysis).

Self-directed learning

- reading (preparatory, on-site, follow-up after seeing patient)
- projects on self-selected topics
- problem-based learning.

Guided learning

- structured independent learning packs
- individual tutorials
- video/computer learning
- small-group teaching
- case studies.

Learning from tutor feedback on:

- student presentations of patients
- clinical (systems) examinations by students
- formal student assessments (OSCEs)
- observing paired student presenting patient history or examining in front of tutor.

Ideally, students will have a place where they can work alone. Practices with a dedicated library might consider opening it to the students for this purpose. This gives the student the opportunity for private study and to work on projects and presentations. For clinical work, an examination room with a couch and two chairs allows the student to see patients while the GP tutor is otherwise occupied.

Although we would like to see these as minimum space requirements, to do so would effectively debar 70 per cent of our teaching practices. There is a considerable problem locally in finding sufficient space for normal service provision. This is due in part to the inadequacy of allowances on the cost rent scheme for London building costs, the difficulty of identifying appropriate sites and the increased demands on community services over the last few years. We are pressing for a change in regulations that would allow provision of undergraduate teaching space to be included in practice buildings.

Box 7: Organising patients for the KMFC

Getting patients involved

In the KMFC, we encourage active student involvement with patients selected to show specific problems. We therefore mainly use a planned encounter approach, so either patients are asked to attend the surgery specifically to see students or the student goes to the patient's home. The patients concerned need to be contacted and the situation explained to them in advance. A reminder is given nearer the time. Patients may also be asked to combine a visit to the surgery for their own needs (e.g. for a follow-up appointment, to pick up a letter, for venesection) with a teaching appointment, which may justify them spending a little time away from work if necessary.

Patients do not have the same expectation to be involved in teaching as they would in a teaching hospital, and their agreement has to be negotiated. Those who have had embarrassing or humiliating experiences of teaching in the past will be understandably reluctant to take part again, and in the general practice setting may feel much more confident about refusing. However, the experience of meeting an individual student, maybe at the patient's home, is different. Most patients, having once experienced teaching on the firm, are delighted to take part time and again. Being involved in teaching is often seen by patients as an opportunity to give something back in return for their care and to contribute to the training of a doctor.

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Patients who are unemployed or retired are especially able, and often very willing, to help in this way. Being involved in teaching also gives patients an opportunity to have their care reviewed in more detail than is normally possible, and to find out more about their condition – these advantages can usefully be spelled out, not only to patients, but to potential tutors too.

A threat to the smooth running of the system occurs when a student fails to attend a session for which a patient has attended specially. The discourtesy to the patient is obvious and, because of a number of similar incidents, some patients have quite reasonably refused to take further part in the teaching programme. The student's responsibility in this regard is stressed at the outset of the firm, and we insist that students who break appointments with a patient contact him or her to explain and apologise. This helps demonstrate to the patient that it was the student's, and not the practice's, fault. It may retrieve a patient who would otherwise be lost to teaching and, importantly, it obliges the student to confront professional attitudes and values.

Building up a patient data bank

Most of the patients seen on the firm are those with chronic conditions whose attendance can be planned. To facilitate this, tutors build up a patient database in the weeks prior to the start of the firm, usually asking patients for their help opportunistically as they appear in surgery. This may be a simple notebook divided into systems to jot down patients' details as they are seen during routine surgeries, when the issue of seeing students can be raised with the patient. This data bank is useful for finding patients for examinations and also as a way of reviewing what pathologies are unrepresented. A patient who may be consulting on one condition may have another medical condition that is suitable for teaching. The search facilities of the practice computer can be used to find patients with specific problems, but patients found in this way need to be approached sensitively; patient recruitment by insurance sales representatives' style 'cold calling' is not entirely desirable. Using a diary on the desk to book patients seen in surgery straight into a future teaching session is probably the most efficient way. Use of the practice computer enables this information to be shared among all teachers in the practice.

What teaching and learning methods should be used?

A variety of different teaching methods can be employed depending on the educational objectives, the student's stage of learning, availability of staff and resources and the tutor's own training and experience of teaching (see Box 6).

Students particularly enjoy learning when they are involved in practical activities rather than simply observing. Tutors and tutors' groups may develop their own ideas and preferences, and can learn a great deal from each other.

In the KMFC, the majority of patient contacts are via planned encounters whereby the tutor arranges for the patient to come to the surgery to meet the student, or for the student to go to the patient's home. This enables students to see a planned range of conditions or to focus on areas where they need to become more proficient.

We have found that there is little value for KMFC students in attending ordinary surgeries, but modifications to the surgery pattern can be useful. Slow-booked surgeries allow time to discuss problems as they arise. While these are unsorted, many can be used to discuss medical issues. These opportunities are improved further if there is an examination room where the student can take a patient with an interesting story to explore it at his or her own pace. Some tutors arrange to use certain surgeries for a review of patients with medical problems. This gives a 'guaranteed' general medical content and enables the students to see clinical decision making in action.

Whatever approach is used, we place an emphasis on the tutor devoting some time to watching the student take a history or make an examination, so that the student's developing clinical skills are both honed and assessed.

A series of structured learning packs are also used which are undertaken independently by students and followed up with a tutorial (see section 2.5).

How can other members of the primary health care team be involved?

Students' experiences are enriched if the experience of other members of the primary health care team can be incorporated into their learning.

Some practice staff see teaching as an add-on activity that the doctor is fitting in and not therefore part of their job to become involved. If teaching were to become a more integral part of the GP's routine, then teaching support could be included in the staff's job descriptions and staff may enjoy being involved in educating the new doctors. Certainly, contact with non-medical staff in positions of responsibility is a valuable educational aspect in preparing doctors to work in multidisciplinary teams in the community.

There is much work to be done apart from the teaching, such as introducing students to staff, welcoming the students and patients each day when they arrive, finding somewhere for them to work with and without the patients, organising replacement patients if one cancels, delivering students to patients' homes if they do not have their own transport (see Box 7). Delegation of some of these tasks would be appropriate, but since teaching medical students is still a new phenomenon, all these tasks are still being done by the GP. Patients seem to respond, at least initially, only to a request from their GP to attend, but recurrent patterns may allow the practice manager or a receptionist to get involved.

2.4 Monitoring and measuring

How should students be assessed?

Methods of assessment will drive student learning. If the assessment is confined to testing the acquisition of facts, then that is what the students will learn. Thus it is important that the objectives and priorities of a community-based attachment are reflected in the assessment. Like the curriculum and teaching methods, methods of assessment appropriate to the community will need to be devised and refined by community teachers and educationalists.

How should the programme be evaluated?

Evaluation is an essential part of any educational programme, nowhere more important than in innovative projects. It is essential to know whether the agreed objectives are being met on the attachment as a whole and how individual tutors or practices are coping. Both tutors and students should be encouraged to evaluate the scheme as they experience it, as well as in more formally designed evaluation projects.

We have built in a variety of formal and informal procedures on the King's scheme which may be appropriate in other situations (see Box 8).

Box 8: Evaluation of KMFC

- The students meet as a group with the firm director every week for a tutorial. This routinely begins by reviewing the previous week's activities.
- The tutors meet bi-monthly. Part of the meeting is devoted to current problems and concerns.
- The students complete an evaluation sheet at the end of each firm. This was developed for the firm, but is now standardised across all medical school firms.
- The students take part in an end-of-firm examination. Consistently poor results in one area may indicate a failure of the educational process at that point.

2.5 The development of structured learning packs for undergraduates

Helen Graham, Mary Seabrook

This section describes the development of structured learning materials for GP tutors to use with medical students.

Key points

Structured learning packs:

- complement the teaching of clinical medicine in the community to undergraduates
- offer students opportunities for guided independent learning
- aim to develop in students the ability to evaluate information and personal observations in a critical way
- offer GP tutors flexibility in their teaching programme
- improve students' motivation to learn if they are given an active role in the learning environment.

Recent recommendations on the future of medical education emphasise the need for a different approach to the teaching of students, with a shift of clinical teaching away from the hospital bedside to outpatients and the community.[8,9,10] Proposals include giving students more opportunities for self-directed learning in preparation for the continuing learning required throughout their professional life. A range of innovative learning methods, developed in medical schools, include computer-aided learning packages,[11,12] project work, distance-learning workbooks[13] and video vignettes on clinical topics.

In self-directed learning, the student is the main driving force behind an open educational process in which he or she determines the material, content and depth of the topic studied.[14] This encourages a sense of curiosity and exploration of knowledge, rather than the passive acquisition of facts associated with conventional teaching. Self-directed learning, however, may at first appear to students to lack direction and purpose. Weaning students from traditional teaching to open learning requires guidance and supervision to facilitate a change in attitude.[15,16]

The KMFC was introduced in 1991 for first-year clinical students. It involves teaching mainstream medicine primarily from a general practice perspective.[17,18] Students are attached to general practice tutors individually or in pairs, with teaching co-ordinated around a major clinical system for each of the eight weeks of the firm. With the move of a traditional clinical subject to a new environment, the Department of General Practice & Primary Care decided

to review the appropriateness of existing teaching methods and to assess the opportunities for self-directed learning.

Feedback from the firm suggested that the intensity of the one-to-one tutor–student relationship was stressful. The competing commitments of student teaching and service provision were also a source of conflict for tutors. Students had difficulty processing information and needed time for reflection and discovery.

Self-directed learning seemed an attractive solution. Tutors, however, were concerned that students may be insufficiently motivated to take full responsibility for their learning. Structured learning materials with follow-up tutorials would offer an intermediate stage in the move towards independent learning.

We set out to explore the opportunities for structured learning within the firm and to develop appropriate learning materials.

Developing the packs

Setting up the study

A general practice tutor was appointed in September 1992 for one session a week over 12 months to design structured learning materials suitable for the community medicine firm. Educational and design support for the study was provided by the project co-ordinator. The initial period involved background reading, discussion with medical, educational and social research colleagues, and involvement in the medical school's curriculum review. The project steering group met regularly and agreed guiding principles for the packs (see Fig. 2.1).

The materials should:

- Relate to the main objectives of the clinical teaching programme.
- Use contextual learning with patients in their clinical and social settings.
- Encourage students to make sense of their clinical experiences.
- Use relevant resources in general practice and the community.
- Develop students' problem-solving skills.
- Be student-centred (adjusted to students' learning needs and interests).
- Be based on clinical concepts rather than specific diseases.
- Be acceptable to GP tutors, acknowledging the constraints of space and time within general practice.
- Offer flexibility for tutors and students in a range of settings.
- Avoid reliance on technical equipment such as video-recorders.

Fig. 2.1 Principles for the development of structured learning materials

Identifying potential themes for learning

Themes for learning were identified by feedback from two sources:

- questionnaires from students and tutors who had completed the firm
- discussions with GP tutors and students currently undertaking the firm.

The questionnaires identified the strengths and difficulties of the learning processes. Reported strengths included: a wealth of material from a wide range of clinical conditions; the one-to-one contact with patients and tutors; regular student presentations and discussion of clerked patients; and insight into patients' perspectives of health and illness. Reported difficulties included: processing information from patients' histories and notes; understanding the logic of diagnosis; inadequate textbook coverage of community issues; appreciating the relevance of patients' occupations, lifestyles and activities of daily living to clinical management; the lack of self-confidence when visiting and communicating with patients at home; and reduced learning in passive situations, such as 'sitting in' on surgeries and clinics.

Discussions with tutors and students highlighted a preference for information gathering by discovery and tutorials which helped to interpret students' observations. The students described a gap between clinical experience and the explanation of that experience, which tutors agreed was important to address.

Using this information, a range of topics were identified. Working with two firms of students attached to one of the authors' general practice, exercises were designed and redesigned using action research methods.[19] Initially, short exercises were based on the system of the week. Most of these fell into one of five categories:

1 Diagnosis and management of patients
2 The home environment
3 Chronic illness and rehabilitation
4 Health beliefs and illness behaviour
5 Lifestyle and illness prevention.

Each exercise was tested by students and its suitability for further development evaluated. Some proved unsuitable – for example, an audit of a chronic care clinic was too complicated for students lacking previous knowledge of the audit process, and a patient mobility observation exercise in the waiting room made students feel obtrusive. Other exercises worked well – for example, carrying out a functional assessment on a disabled patient at home. One exercise from each area was selected for further development.

The draft packs

The exercises tested by students were developed by the authors into structured packs involving a series of tasks. Practical and theoretical information required to understand concepts and acquire skills was integrated into the exercises. The draft packs included:

- guidance notes for tutors – how and when to use the packs.
- guidance notes for students – the aims and objectives of the packs.
- an introduction and background information on the selected topic.
- practical exercises (e.g. surveys, interviews, reading patients' notes).
- questions designed to aid interpretation, relate previous learning to the information gained and plan patient management.

Piloting the packs

Tutors from a range of teaching practices were asked to introduce the packs to students on successive firms and to record their own and their students' comments. This feedback was used to improve the content and style of the packs – for example, revising and expanding parts of introductions which were unclear; illustrating generalised statements with examples; giving an estimated time for completion; and providing fuller notes for tutors, including a summary of resources required. An additional section was added to the end of each pack asking students to reflect upon their work, identify areas requiring further learning and suggest ways of achieving this.

Photocopies of packs completed by students were used to inform improvements in the design and spacing of the exercises. The format of all the packs was standardised. A summary sheet detailing the aims, exercises, timing and resources of the packs was produced (see Fig. 2.2). This final stage completed a process which had extended over six terms (see Fig. 2.3).

Discussion

This work has highlighted a range of opportunities for independent learning within general practice. It has shown how areas which are inadequately covered in textbooks can be approached through active learning, with tutor time devoted to discussion of the problems and issues which arise. Thus, structured learning packs can complement one-to-one teaching to provide an enriched learning experience for students and flexibility for tutors.

The ability to motivate students is crucial to the success of the packs. It was essential to pitch the materials at the right level for students. By focusing on students' learning processes, we identified the clinical concepts which they found most difficult. These areas were often taken for granted in textbooks or glossed over by tutors – for example, the process of making a diagnosis from the plethora of information gained from clerking patients and reading clinical records.

Title	*Objectives*	*Activity*	*Resources required*	*Estimated time*
Towards a diagnosis	To make a clinical diagnosis	Taking a history, forming hypotheses, planning further investigations, reading patients' notes and making a diagnosis	Patient with multiple problems and clinical notes	2 hours
Symptoms in the population	To investigate patients' beliefs about their symptoms, ways of coping and factors influencing the decision to seek medical help	Designing a questionnaire, gathering and analysing information from patients	About ten people. Privacy for interviewing	2 hours
Writing a referral letter	To achieve effective communication of clinical information to a health professional	Writing a referral letter, using patient information	Patient seen previously	1 hour
Health promotion and disease information	To explore the potential of patient education	Identifying and advising on risk factors for ill health. Use of patient education materials	Health promotion session. Patient education leaflets	2–3 hours
Living with disability	To understand the problems of people with chronic disease	Home visit to patient with chronic disease. Undertaking a functional assessment	Patient with chronic disease at home	2 hours

Fig. 2.2 Structured learning packs

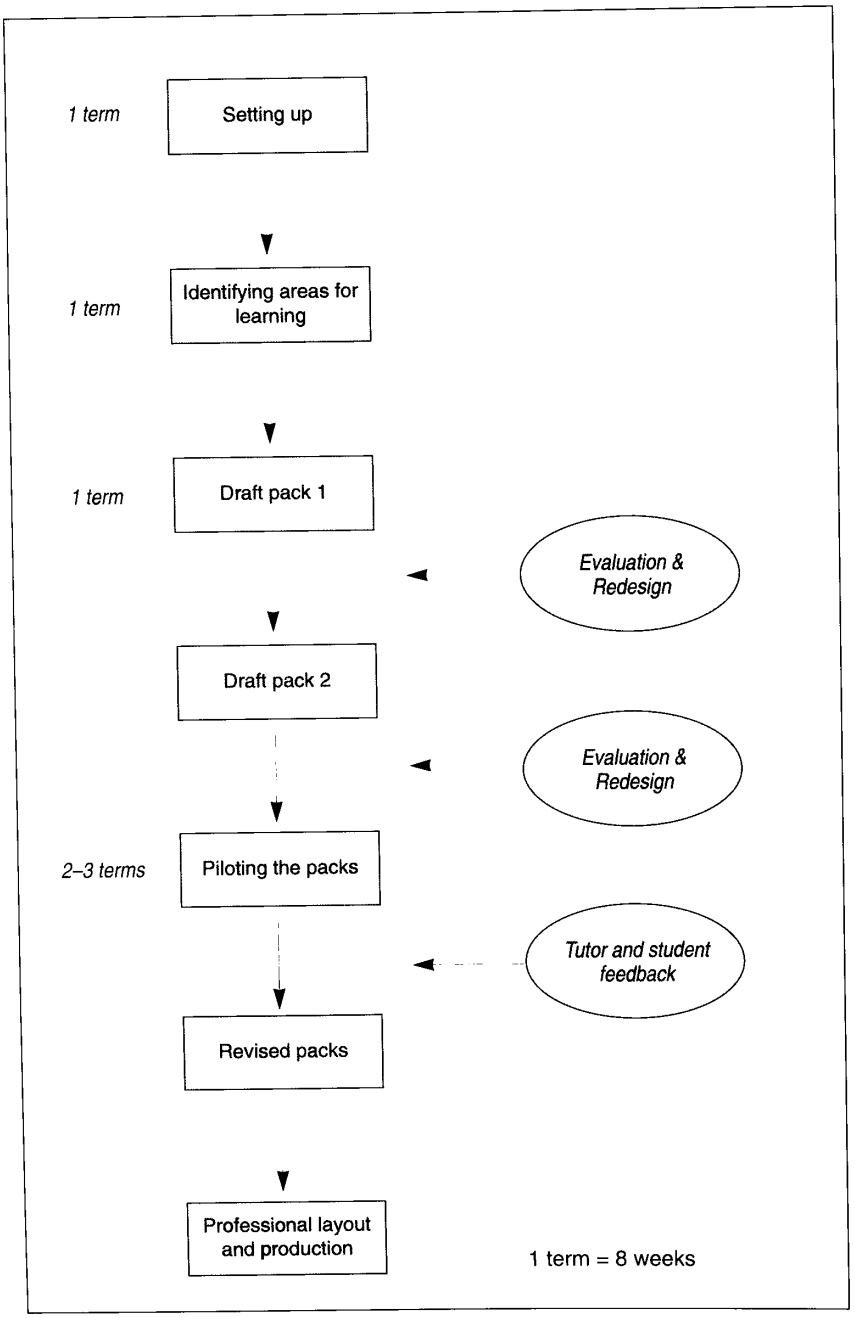

Fig. 2.3 Stages in the development of structured learning packs for medical students

To inexperienced students the information appears undifferentiated and confusing. By prompting them to work through a series of steps in which they are required to order the information, students adopt a more logical approach to making a diagnosis.

Most students found the exercises enjoyable, although two who completed the symptom survey pack considered it would have been more time-effective to obtain the information from a textbook. Doubt was expressed by tutors that this reading would have been done, and the students would not have benefited from the experience of conducting short interviews.

A defined task which involves obtaining information from a patient or member of the primary health care team makes the exercise more purposeful for students. Students particularly enjoyed tasks which fulfilled a genuine practice need, such as writing a referral letter; providing patients with appropriate health education material, and the functional assessment of an elderly patient at home, which fulfils the requirements of the over-75 health check.

The packs were considered to offer greater versatility if they were designed to work in a range of clinical situations, rather than being disease- or patient-specific. The exercise on symptoms and illness behaviour, for example, can be used for any common symptom from any clinical system such as headaches in neurology or constipation in gastro-enterology. This should enable the packs to be used in other clinical departments.

The flexibility in timetabling provided by the packs was appreciated by tutors. An unexpected finding was that tutors could spend as long dealing with the enquiries prompted by the exercises as with face-to-face teaching. They observed, however, that the teaching was at a different level. Students were reflecting on and interpreting clinical material gained from their own observations, and relating this to their previous learning. It prompted deeper discussion about concepts, practical issues and further concerns and proved more intellectually satisfying than learning by conventional methods. This 'elaborated approach' to learning has been found to facilitate subsequent retrieval and use of the knowledge gained.[20]

The GMC recommendations for medical education[21] propose a move towards 'learning through curiosity, the exploration of knowledge and the critical evaluation of evidence to ensure a capacity for self-education'. The structured learning packs illustrate one way in which teaching methods in general practice can be adapted to fulfil these recommendations.

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3 National issues around medical education

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Key points

- Financial and educational structures in medical education
- Disparity between structures for financial and educational accountability
- Division of funding responsibility between the Department of Health and the Department for Education
- Influences and mechanisms for quality assessment in medical education
- Functioning and limitations of SIFTR mechanism
- Effects of NHS reforms on medical education
- Exploration of alternative models

The education of medical students has received much criticism in recent years, and change is widely acknowledged to be overdue.[1] Indeed, many medical schools have already implemented or are planning major changes, encouraged by the recommendations of the General Medical Council (GMC)[2] and the interest of the Chief Medical Officer (CMO). These initiatives focus primarily on the curriculum and teaching methods. Less publicised have been the anomalies of the funding system and the inherent lack of accountability of medical schools. These became apparent during discussions with local health care providers and commissioners as part of our work to explore the implications of a move of medical education into the community. We all felt that there was a lack of clarity both about who the 'customer' is and about the educational and financial relationships involved. This prompted us to explore these relationships further, looking in particular at how the educational and financial structures relate to each other.

This chapter reviews the financial and educational structures of the current system, identifies the problems and proposes a new structure to address them. Three possible models are outlined.

3.1 The financial structures

The Department of Health and the Department for Education

The current funding system is very complex, with money flowing through two major routes to support medical education (see Fig. 3.1).

These two routes emanate from the Department for Education (DfE) and the Department of Health (DoH). The DfE finances educational provision at medical schools through the Higher Education Funding Council (HEFC). The DoH provides money to offset the extra service costs incurred by health care provider units through their involvement in teaching and research (the Service Increment for Teaching & Research (SIFTR)). The DfE and the DoH are linked through the Steering Group on Undergraduate Medical & Dental Education & Research (SGUMDER), chaired by the Permanent Secretary at the DoH.

The complexity inherent in funding medical education through two separate ministries is a weakness of the system.[3] Back in 1987, the University Grants Committee (UGC) (now the HEFC) report[4] noted that neither the DfE nor the DoH were 'in a position to take full responsibility for the funding of medical education'. It considered the options of either responsibility passing entirely to the DoH, or the UGC funding the pre-clinical years of the course with the DoH funding the clinical ones. It concluded that the 'prevailing opinion' was that objections to either course of action outweighed the potential advantages. It recommended greater consultation between medical schools and health authorities and improved mechanisms for joint policy development. This is part of SGUMDER's terms of reference and may or may not happen at a local level.

HEFC funding

The funding process starts with Medical Manpower Planning at the DoH, which determines the number of funded places that should be available for medical students. (These figures are calculated assuming 100 per cent course completion and entry into medical practice.)

The HEFC then sets guide prices, i.e. the amount paid for teaching each student, for both pre-clinical and clinical students. It also determines the number of students who will be given funded places at each medical school. Recently, provincial medical schools have been invited to bid for the number of places that they wish to provide. The money is passed to medical schools, either directly or via the local university.

In the past, there has been little attempt by the HEFC to examine the quality of the schools or the students they are funding. Recently, it has initiated audit procedures to look at the administrative aspects of universities and it has now started to assess the quality of education in some subjects.

The method to be used for medicine is unclear, but if a satisfactory technique can be found, it is conceivable that schools will receive teaching ratings in the same way in which they now receive research ratings (upon which their research funding depends).

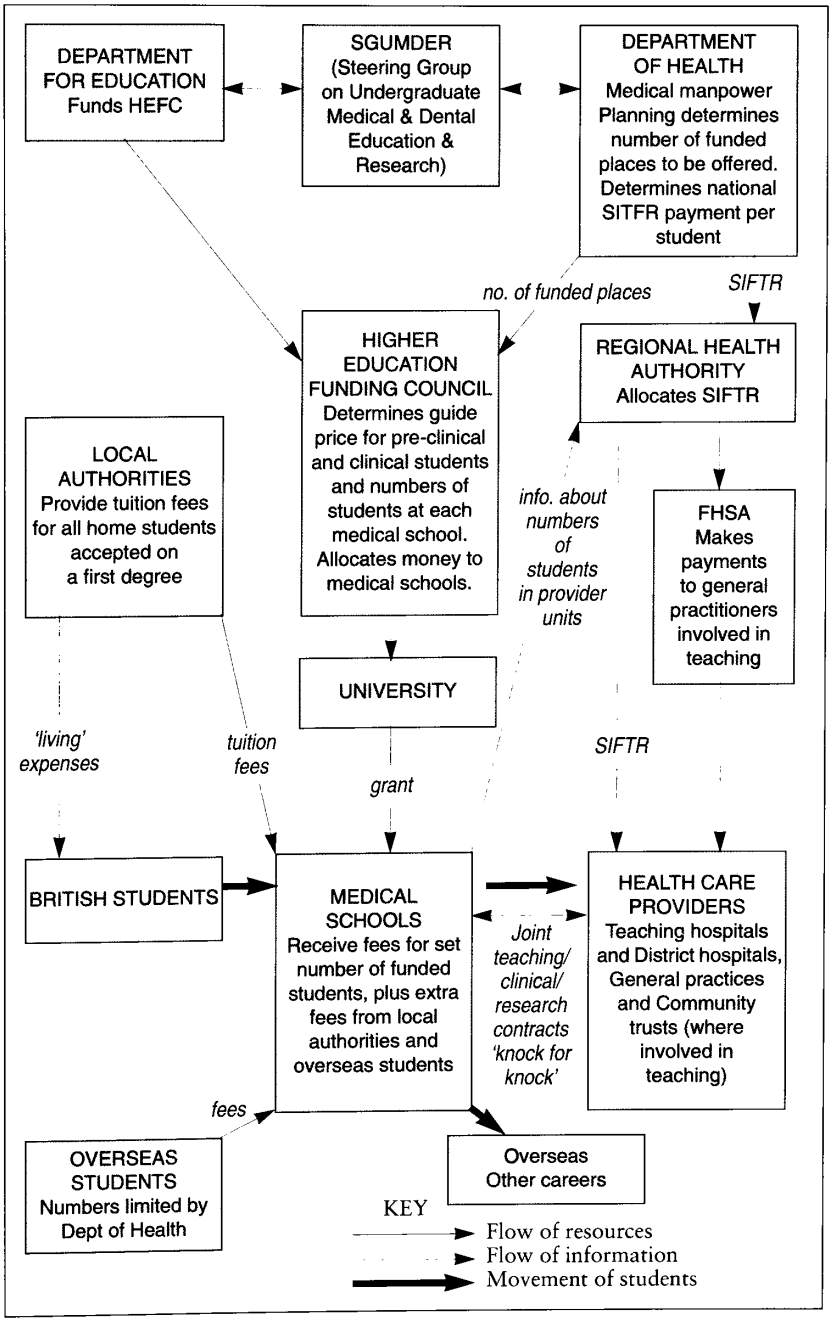

Fig. 3.1 Financial structures of medical education

The Service Increment for Teaching & Research

The DoH sets the national SIFTR payment per student. This is transmitted through the RHAs to teaching hospitals and is intended to cover the excess service costs incurred in teaching and research. For the university teaching hospitals, it is a substantial figure, amounting to approximately 13–15 per cent of their income, which they have discretion to allocate. In some areas, district hospitals which take more than five students also receive SIFTR payments, although these are lower than those of the teaching hospitals as they are intended to cover variable costs only (i.e. costs which increase directly with the number of students with no allowance for infrastructure).

Historically, SIFTR was developed because of an imbalance in the costs of service provision in teaching hospitals when compared to non-teaching hospitals. It was designed to compensate health authorities which contained teaching hospitals for the extra expenses involved and, since the NHS reforms, has been seen as a mechanism for ensuring that teaching hospitals are on a 'level playing field' with non-teaching hospitals in terms of price competition. It is often assumed that SIFTR was calculated to cover certain defined costs; in reality, it is based on a rough-and-ready proxy for the higher service costs which teaching and research are assumed to generate. Thus it supports service costs irrespective of either the amount or quality of teaching and research, which is frustrating for those trying to bring about improvements in medical education.

This situation is coming under increased scrutiny as the recent changes in legislation have emphasised the separation between the medical school (as an arm of the university) and the hospital (as a health care provider). The Government has stated that the costs of training NHS staff will 'need in future to be met in such a way that hospitals which carry out significant amounts of training and research are not placed at a price disadvantage or advantage'.[5] The introduction of the internal health care market has encouraged a precise identification of costs, and services that are not cost-effective may not survive.[6] This has forced medical schools to start finding ways to identify SIFTR use. King's College School of Medicine & Dentistry, for example, has recently introduced a system which allocates SIFTR to individual departments according to proxy measures of teaching and research load and estimates of excess costs[7] based on recommendations made by SGUMDER.[8] This process may lead to improved targeting of the money to support education[9] and could have several beneficial effects. It could, for example, give added value and status to teaching and facilitate dedicated time and a career structure for teaching. Teachers would be clearer about exactly what time commitment and standards were required, and this would reduce the conflict between service and teaching demands. The present situation where only research is assessed and funded directly means that education has tended to be seen as less important.

While local arrangements may make allocation of SIFTR more rational within the teaching hospital, they offer little opportunity for educational

change outside its walls, an important example being the issue of transferring teaching into the community. When the SIFTR system was established, it was taken for granted that undergraduate education would take place in secondary care, and the scheme was thus aimed entirely at hospital provision, and teaching hospital provision at that. The present transfer of services to primary care and the recognition that hospitals are becoming too highly specialised and technical to retain their near monopoly on student education have led to general agreement that there needs to be an increased focus on community-based education. Education needs to follow the patient, and the Government has a stated aim to give increased emphasis to teaching in general practice and the community.[10] It is difficult, however, to see how this might be achieved with a funding system that is available to only one sector of the potential educational community. If the curriculum is to take advantage of the new opportunities afforded by the community, a more flexible funding mechanism will be required.

'Knock for knock'

Traditionally, teaching hospitals and medical schools have been mutually interdependent. This relationship is formalised into the 'knock-for-knock' arrangement, whereby it is assumed that the contribution made by academics to clinical (service) work is equivalent to that made by NHS staff to teaching and research. The UGC report of 1987[11] (and the SGUMDER report of 1990[12]) recommended the retention of this arrangement. While recognising the difficulty of assessing value for money in such a system, the report considered that any attempt to allocate costs in detail would be burdensome and arbitrary. However, in 1990, the Government's Working Paper[13] stated that the principle of cross-charging in this respect would be 'wholly consistent with the overall thrust of the Government's proposals'. It is considered by many to be unlikely that, in the longer term, 'knock for knock' will survive the changes in the NHS. While it continues, though, it further contributes to the difficulties of developing a rational and accountable way of funding teaching, since, as with SIFTR, it is only applicable in the teaching hospitals where a rough balance of academics and non-academics exists. In district hospitals, community facilities and general practice, there is little opportunity for such an arrangement.

Other sources of funding

Service money. Due to the complexity of the system and the difficulty of identifying SIFTR use, service money may contribute to education, especially in community teaching where SIFTR is unavailable.

Research money. Soft funding is another source of money which contributes to the overall picture, particularly in hospitals.

Local authorities. Medical schools obtain money from local authorities, which are obliged to pay tuition fees for all home students who have not previously had a grant for a degree course.

Overseas students. Overseas students, funded privately or by their governments bring in further money. The number of overseas students allowed per medical school is defined by the DoH.

Payments to GP teachers. Recent changes to the financial arrangements for general practice have allowed GP teachers to claim a small fee for undergraduate teaching from the FHSA, paid on a sessional basis. While this is a welcome initiative, the sum involved does not in any way represent actual teaching costs.

Summary of problems with the financial structure

- The separation of responsibility for funding between the two ministries of Health and Education.
- The design of SIFTR which does not allow for transfer into teaching locations outside the hospital system.
- The inability of SIFTR to respond to a market-based health care system.
- The integration of SIFTR money into teaching hospital service provision, which makes it hard to identify.
- The difficulty of calculating 'excess costs' caused by teaching and research and therefore of knowing whether SIFTR covers them.
- The lack of integrated quality control mechanisms.
- The lack of funding directly related to teaching quantity and quality, which causes conflict between service and teaching responsibilities, and low status for teaching activity compared with research.

3.2 The educational structures

Medical schools have a close but variable relationship with their parent university. While being bound by the statutes and regulations governing the whole university, they essentially control their own affairs. Individual medical schools have direct responsibility for defining the syllabus they teach and the teaching methods they use, and for setting appropriate qualifying examinations. They employ the senior teachers, organise the teaching and supply the necessary resources for students, such as library facilities and accommodation.

There are both national and local influences on an individual school (see Fig. 3.2). The two principal national bodies are the GMC and the HEFC. Most recently, they have been joined by the DoH through the personal initiative of Kenneth Calman, the Chief Medical Officer, in pressing for change.

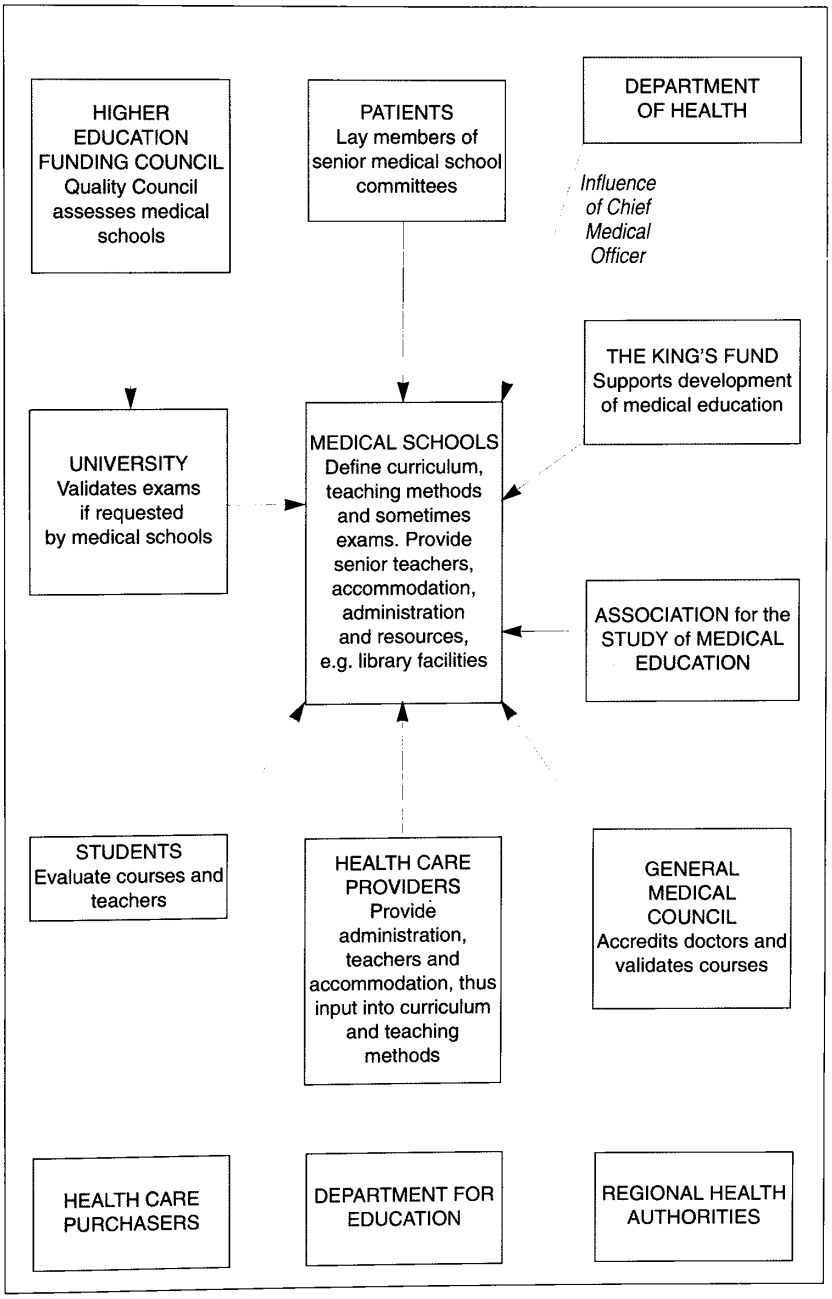

Fig. 3.2 Influences on educational decision making in undergraduate medical education

The Higher Education Funding Council

For most medical schools, the relationship with their major funding body, the HEFC, is a critical one. The medical sub-committee of the HEFC has overseen the implementation of the Goodenough[14] and Todd[15] reports, which began the process of integrating medical schools into universities, expanding their facilities and establishing new medical schools. More recently, as a result of the Tomlinson Report[16] and the Government's response,[17] further amalgamations and integrations of medical schools onto multifaculty campuses have been proposed.

The HEFC has recently established a quality council, the HEQC, to assess higher education and make recommendations for improvement. It has begun what is proposed to be periodic inspections of universities, including their medical schools. In the first forays, the HEQC has been particularly concerned with the administrative processes of schools. It is next embarking on an audit of teaching quality, but, unlike the GMC, it has not tried to influence issues of content or educational method. Reports of the visits are available for inspection by the public, although this is not widely publicised.[18]

The GMC

Through its education committee, the GMC has ultimate responsibility for the standard of medical education.[19,20] It has the power to inspect medical schools to investigate whether they provide appropriate education and to inspect their qualifying examinations. If it finds these examinations unacceptable, it has the power to recommend to the Privy Council that recognition be withdrawn. In practice, this 'all or none' response has limited the GMC's power or, at any rate, its inclination to act: its powers to withdraw recognition of courses have never been used (except in one rather unusual case), despite widespread acknowledgement of deficiencies in current medical education.[21] Possibly, it needs a greater range of sanctions or a greater will to see that its recommendations are implemented.

The GMC has made regular comments about the *content* of the curriculum in the form of approximately decennially produced recommendations on undergraduate medical education. Until 1980, these took the form of a prescribed mix of specialty attachments which the GMC considered appropriate for an undergraduate to follow. Since then, it has looked at the mix of attitudes, skills and knowledge that an undergraduate should have acquired on qualification with recommendations about the *educational process* to achieve these, rather than an insistence on any blend of attachments. The GMC expressed disappointment that its 1980 recommendations[22] produced little action and, to encourage curriculum reform, published its 1990 recommendations as a discussion paper,[23] followed by a series of visits to individual schools and, by the release of its final report,[24] much debate and change had been stimulated.

The Department of Health

It is perhaps surprising that despite its major role in determining student numbers and funding for undergraduate medical education, the DoH has in the past had little influence on the educational content of undergraduate training. However, the present CMO in the DoH, Kenneth Calman, who has exerted considerable influence on postgraduate training, is now promoting change on the undergraduate side by offering pump-priming money for curriculum change to each medical school in the UK. He holds a regular academic forum with wide-ranging membership. In doing so, he has supported the GMC's recommendations both practically and philosophically.

Other national influences

A number of pressure groups have sought to influence the direction of medical education. These may be medical (such as dermatologists striving to improve the recognition of malignant melanoma), patient groups (such as the various myalgic encephalomyopathy support groups) or a combination of these (such as the British Diabetic Association and Action on Smoking and Health (ASH)).

Educational researchers voice their findings through journals and meetings (such as the Association for the Study of Medical Education (ASME)), and certain groups (notably the King's Fund Centre) are actively involved in supporting the development of medical education.[25]

The Royal Colleges have little involvement in undergraduate educational work, although the Royal College of General Practitioners was active in promoting more teaching in general practice in its earlier days. They are generally more active in providing postgraduate education.

Local influences

Locally, the influences on medical schools are more diffuse and variable.

Teaching hospitals. The principal relationship is perhaps with the teaching hospitals with which medical schools are historically inextricably combined. They provide the facilities for the great majority of patient-based teaching. They also supply a large number of clinical teachers; within a teaching hospital something like two-thirds of the teaching will be provided by NHS-employed medical staff, supported indirectly through 'knock for knock' and SIFTR arrangements. Their influence on the medical school is considerable and, because of the symbiotic relationship between the two, operates both directly and indirectly.

Perhaps the greatest influence at a local level is exerted by the individual departments and their chiefs. Medical schools are mainly structured as collections of specialty departments in which most of the power resides. Their heads are the key representatives on the school committees and, since most curricula are departmentally based, they provide the syllabus and the teachers.

The GMC guidelines, which before 1980 prescribed the undergraduate curriculum in terms of the amount of time spent within each specialty, enhanced this power. While the GMC has moved away from this approach, various local schemes which allocate SIFTR monies in proportion to teaching load encourage departments to increase their teaching commitment. Safeguards may be needed (and are in place at King's) to ensure an appropriate balance of teaching within the curriculum.

District hospitals and general practice. The need to provide extra educational experience for students has taken teaching to district hospitals and, most recently, to general practice and community clinics. Outside teaching hospitals, most teaching has been carried out through interest and good will, although recently some local schemes have made relatively small quantities of money available through SIFTR. Initially, these outside health care providers had little influence on the school, acting somewhat as subcontractors. However, they are increasingly seen as partners and their influence within the school is increasing.

Local people. Local people are frequently lay members of senior medical school committees, but are local 'worthies', rather than representatives of patients or of the local community. Their influence is, accordingly, individual.

Students. There is a general recognition that students need to be involved in their own education; the amount and reality of this recognition vary widely between schools.

Who should be influencing the curriculum?

As health needs change – for example, with an ageing and multicultural population, the development of new medicines, and new diseases such as HIV – so the training of doctors must change. New technologies and information systems and the increase in management responsibilities mean that new skills must be acquired and the curriculum needs to change accordingly. Such changes illustrate the need for students to acquire lifelong learning skills to enable them to cope with an uncertain future, rather than a body of knowledge which is going out of date from the moment they first learn it.

Both medical students and their teachers believe that the teaching methods used and the content of the curriculum in undergraduate training are inappropriate,[26,27] yet change has been slow in occurring. The various teaching specialties within the hospitals guard their teaching time fiercely. Despite the fact that teaching is considered less important than research in career terms, it does bring in SIFTR money and adds status to a department. Thus changing the curriculum implies a power shift which is difficult to bring about. The end result is a curriculum which has not been updated to reflect changes in health care provision, leaving doctors inadequately trained for their new responsibilities.

The need for change has been acknowledged by the GMC in its recent recommendations on undergraduate medical education[28] and a structure which is capable of addressing these issues is clearly essential.

Figure 3.2 illustrates the number of different bodies that currently influence medical education. Most do not have the power to force change and some key groups are unrepresented. In addition, the disparity between the financial structure and the educational one means that those with influence over medical education have no control over the allocation of funds, and those who pay have no power to influence the 'product'.

A comprehensive list of groups that should influence medical education would include the stakeholders, purchasers and consumers of medical education, that is students wishing to be trained, professional colleagues, such as nurses and physiotherapists with whom new doctors will have to form teams, employers of doctors in the form of health care purchasers and providers, and patients who are the end-users of the system.

The involvement of health care purchasers and providers (as potential employers) would help to ensure relevance. The UGC under Lord Croham[29] in 1987 recommended that medical schools should consult their relevant health authorities before submitting their academic and financial plans. These recommendations, however, have not been widely implemented, and health care purchasers do not normally have an opportunity to influence medical school plans. Involving these groups on relevant committees at a national level would help to ensure that medical schools do not lag behind current health care practice.

Summary of problems with the educational structure

- Lack of consensus about who should determine and influence the content and method of medical education.
- Lack of clarity as to who constitutes the purchasers/stakeholders/consumers in medical education.
- Overlap of roles of GMC, HEQC and, most recently, the CMO.
- Lack of financial power for those governing the curriculum.

3.3 Finding solutions

What do we need from a new system?

- A mechanism to determine educational needs and match resources to them.
- The alignment of finance and accountability, preferably under a single body.
- Greater quality control with mechanisms to force change where necessary.
- Broader input into curriculum planning.
- A structure which can adapt to changing patterns of health care.
- Reduced conflict between clinical and teaching roles.
- The development of a more flexible form of funding.

Recommendations

We propose a new structure in which educational and financial accountability are linked (see Fig. 3.3). It is based on the premise that all undergraduate medical education should be financed through the DfE. This would include the money currently distributed as SIFTR.

The basis of SIFTR is that it offsets the extra service costs which teaching and research cause. In our view, the distinction between direct and indirect teaching costs is unhelpful and serves only to confuse the system. Extra service costs caused by teaching are costs of education and not health, and should therefore be channelled through the education system and to health care providers via the medical school. This is the usual way in which any service is bought – for example, the fee for a computer course includes not only the direct costs of the teacher's time, but also a proportion to cover the capital investment in computers and buildings, the rent, administration, etc. In the new structure, the DfE would keep its link with the DoH through SGUMDER, which would remain responsible for manpower planning, and assume responsibility for the co-ordination between undergraduate medical education (DfE) and postgraduate education (DoH). The money to fund undergraduate medical education would be channelled down through the HEFC, which would be responsible for monitoring its use.

Any major changes in funding, such as those proposed, would obviously need to be implemented in a controlled way with transitional arrangements to ensure that current teaching hospitals were not put at a disadvantage in the short term.

Implications for medical schools

Medical schools would gain direct control over SIFTR money and accountability for how it was spent. They would have greater flexibility in how they organised teaching and would be able to purchase education for students from appropriate bodies, including hospitals and a variety of community institutions. Thus they would be able to initiate changes more easily.

Medical schools would remain providers of education but with sub-contracting capacity. Thus the school would provide the overall co-ordination, some teaching, and student and teacher support systems, and would contract out modules of the curriculum to be taught within health care provider units. Contracts would be agreed, either on a negotiated or competitive basis, which would clarify the expectations and commitments of both sides. Teaching would become an explicit and separately funded part of staff contracts, which should help to reduce the conflict between service and teaching demands. Medical schools would monitor standards more closely, making use of student feedback and making changes where necessary.

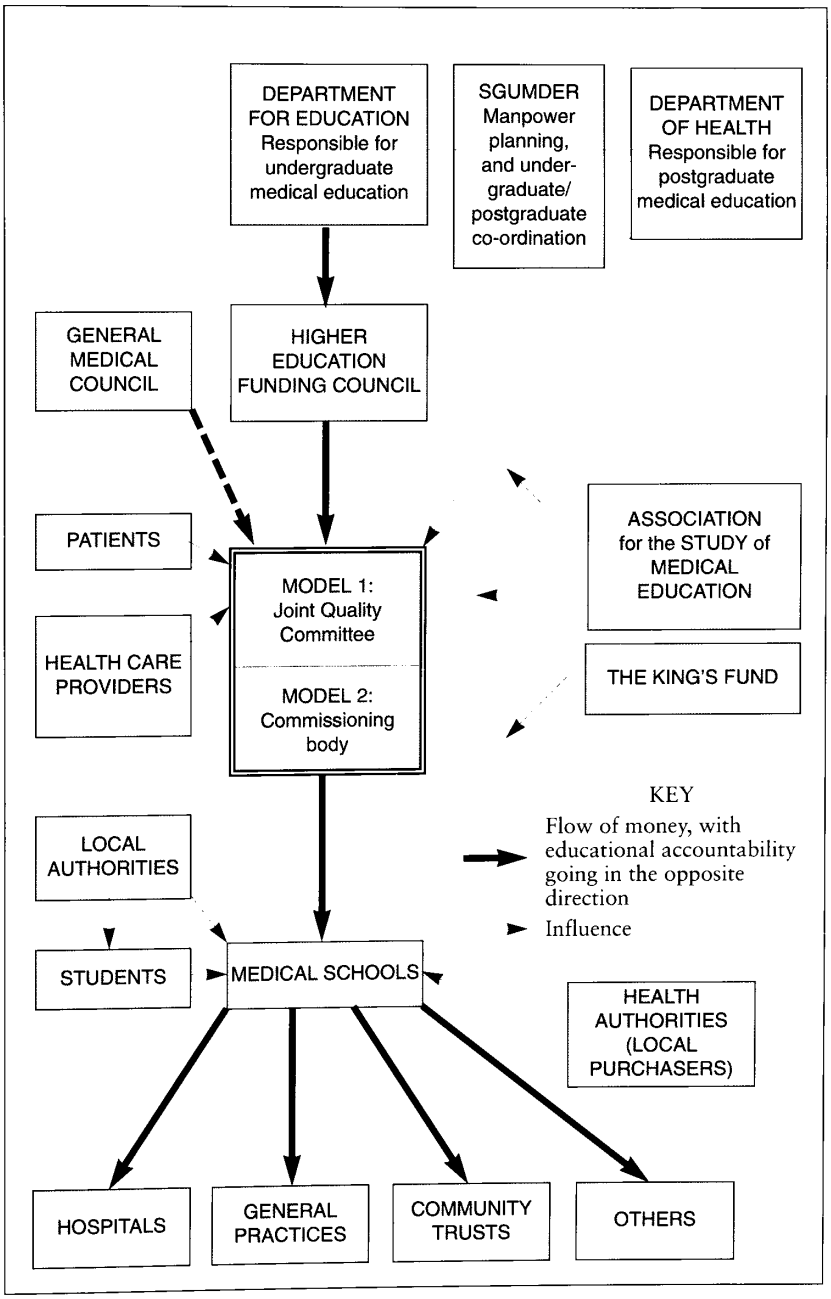

Fig. 3.3 Proposal for a new model of medical education linking financial and educational accountability

Medical schools would provide teaching health care providers with an appropriate level of funding. These costs can never be precisely calculated, but any formula should include:

- an allowance covering specific student costs based on numbers of students and teaching time;
- an environment subsidy to support infrastructure (capital and human resources), and an appropriate level of service which allows time for the thought and reflection necessary to achieve high-quality teaching and research.

This change in control, administration and financing to give medical education independence from other demands, such as service and research, has been recognised as crucial in creating a curriculum more responsive to students' needs.[30]

Implications for teaching health care providers

In this structure, health care providers that wished to be involved in teaching, would take the needs of teaching into account when considering capital expenditure. When planning building work, for example, extra space for teaching might be included. This would be an investment as part of the organisation's business plan, with the expenditure to be recouped over the medium term with income from the medical school for teaching. (Hospitals can currently apply for funding under 'Standard Teaching Additions'; in general practice, it is not so clearly defined but at the discretion of FHSAs.)

Potential models

Within the structure indicated, we propose three possible models which differ at the mid-level between the DfE and the medical schools.

Model 1: The Joint Quality Committee

The HEFC and the GMC have some power over medical schools but have not proved to be effective in bringing about change. We propose a new joint body, the Joint Quality Committee (JQC), which would combine the HEFC's power to control the money and GMC's power to recognise courses. The JQC would be responsible for deciding 'what sort of doctor' will be needed in the future. It would therefore need to represent the customers of the service, a concept which is not clear in medical education. At one level, the health care providers are the customers in that they 'buy' the qualified students to work for them. One step removed but influential are the purchasers, who are expected to act in the interests of the patients who are the consumers of the service. It would seem reasonable that health care providers, purchasers and patients should all be represented on the JQC, although we suggest that the purchasers' primary involvement should be at a local level where they might have an interest in facilitating medical education (see below). The DoH could be represented by the CMO.

The JQC would have the authority to make recommendations and the power to implement them, since it would control the money. Schools could be visited regularly to inspect the education provided, the accounts and management systems. There would also be the potential for a greater range of responses to schools which were underperforming – for example, they may be given extra money to fund specific improvements or their allocation of students might be decreased.

The advantages of this model are that it could be implemented fairly easily by combining existing bodies and powers and should ensure good-quality standards. It would improve accountability and would act in a supportive way, by investing in change. The disadvantages are that it may not bring about change as quickly as needed and traditional vested interests may be retained.

Model 2: The purchaser/provider model

In this model, there is a clear separation between the purchasing and providing of medical undergraduate education. There would be a medical education commissioning body at both national and local levels. The national group would be responsible for defining the principles, the key methods of learning and the curriculum. It could have common membership with the relevant parts of the GMC, the HEFC, and have health care purchaser and patient representatives. It would control all the money available for undergraduate medical education and would determine how many places for students it wished to buy from any local commissioning group.

The local medical education commission might be based at regional office level. It would purchase medical education from local providers, aiming to deliver the highest quality at the optimal price. Contracts for teaching would need to be for a realistic length of time to allow the effective use of accommodation built for teaching purposes. There would need to be a decision about who set the examinations, depending on who defined the curriculum.

The advantages of this model are clear. The separation of purchaser and provider avoids vested interests and could drive change forward more easily. The local purchasing would allow provision based on local needs and facilities, as well as the transfer of educational activity and the necessary funds from medical schools to other settings (e.g. general practice or other university faculties and units). It is possible that education commissioners may wish to purchase changes in service to enable education to develop, as well as health authorities wishing to purchase education to facilitate service developments.

The potential disadvantages are similar to those apparent in the recent health care changes. A change in culture would be required which might result in low morale among medical school teachers, particularly if there is little preparation or consultation. There is the potential to lose professional good will, particularly if price is seen to become more important than quality. There will be increased expenditure on administration and competitive activities like marketing, and the potential closure of some schools.

Model 3: The 'student as purchaser' model

In this model, the student is the purchaser, and the number of places at any medical school would be determined by the school's capacity and by the number of students who elected to go there. Popular schools would thus gradually increase their

capacity, while unpopular ones may attract too few students and would eventually cease to function (a model similar to that operating in the primary and secondary school system).

The advantages of this model are that it would bring about change in a more controlled way and would ensure that schools with a good reputation for meeting students' needs would be likely to survive. In this model, the HEFC and GMC would retain their current roles and thus disruption would be avoided. The disadvantages are that students may not be in the best position to judge the quality of medical schools and which are most likely to prepare them well for the future. It would be hard to impose quality standards other than those dictated by the student's wishes. Expenditure on competitive activities like marketing would increase.

Other influences

In all models, there would be an important link between medical schools and local commissioning bodies (the new local health authorities and GP fundholders). Local purchasers would have an interest in facilitating medical education as they would hope that their purchasers could recruit high-quality staff from local schools, especially in areas where recruitment is difficult. They would provide information to medical schools on their purchasing intentions so that medical schools could ensure that they were purchasing education from the most appropriate place. This link could also bring about greater co-ordination between postgraduate and undergraduate education. Recent research has shown that within the London Implementation Zone there are over a hundred educational and training projects commissioned by FHSAs.[31] These generally have little input from educational authorities. If a new education commissioning body was to be set up, there would be the potential for joint commissioning in this area.

In all these models, ASME and the King's Fund would remain independent. They would be free to carry out their own research projects and development work and influence the various parts of the system as they do at present.

Related issues

A number of related issues have arisen which we have not explored in detail, including:

- **link with postgraduate education**: should undergraduate and postgraduate education be jointly commissioned?
- **nurses and professions allied to medicine**: should one body be responsible for the entirety of education for all health care professionals?
- **research**: should education and research be jointly funded as at present? Should they be seen as inseparable?

Final remarks

The models are in the early stage of development but are included here as topics for debate. It is clear that the inherent structural problems in medical education need to be addressed, and there are many issues involved in this complex organisation. We have had some initial ideas but clearly much more work needs to be undertaken to clarify the potential benefits and disadvantages of the various models.

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4 Views of the stakeholders in medical education

4.1 The stakeholders in CBME

There are a wide range of people with an interest in how medical students are taught and in a potential shift of learning to community settings. Figure 4.1 identifies some of those who might want a say.

General practices & community health services	***Family Health Services Authority***
General Practitioners	Medical Director
GP trainees, assistants & locums	General Manager
Managers and administrators	Planning, e.g. capital projects
Practice Nurses	Finance
Health Visitors	Nurse advisers
District Nurses	Consumer directorate
Receptionists	
Counsellors	
Therapists	
Medical school & academia	***Authorities, political & professional bodies***
Specialist departments (e.g. Medicine, Surgery)	Department of Health
Department of General Practice	Department for Education
Administration	Regional Health Authorities
Library	University Funding Council
Finance	General Medical Council
Public Health	British Medical Association
Deanery	Local Medical Committees
Curriculum Committee	The King's Fund
Students – pre-clinical and clinical	Royal College of General Practitioners
	Medical Defence Union
	Royal College of Nursing
	Association of University Departments of General Practice
	Association of Medical Secretaries, Practice Administrators and Receptionists
	National student groups
Other health care and community service providers	***Users and community groups***
Hospital managers	Voluntary organisations
Hospital teaching departments	Self-help groups
House officers	Carers
Social Services	'Friends of ...'
Housing	Relatives
DHS/Benefits	Patients/teaching patients/patient groups
Employment	Minority groups
Chemists, Opticians	Community Health Councils

Fig. 4.1 The stakeholders in community-based medical education

It was not possible to consult all the groups listed, so we selected a number of them to investigate. These included:

- students
- patients
- general practitioners
- community and primary health care professionals
- complementary practitioners
- health care purchasers and providers
- a group of people with an interest in medical education who attended a national conference.

The reports of our findings appear in the following pages.

4.2 Students' attitudes towards increased community-based teaching

Tagore Charles, Sahar Hassan, Rosie Scott

Key points

- Potential threat to student identity
- The need to keep up to date with health care changes, but also reluctance to break with tradition
- Teaching quality issues: specialist's expertise versus generalist's overview
- Concern over lack of resources in the community
- Concern that extra travel required will be time-consuming and expensive

This section explores students' views regarding the proposed increase in medical education in the community. Our objectives were:

- to explore KCSMD medical students' attitudes and fears
- to propose solutions to problems and issues identified.

The debate

In order to assess students' views, it was decided that a debate would be an effective and enjoyable option. The motion chosen for the debate was:

> ***'That it is both desirable and practical that the bulk of medical education should be taught in the community'.***

The motion proposed that 'the bulk' of medical education should be taught in the community as opposed to a less extreme scenario so that we could assess the full spectrum of implications and fears students may have. The speakers chosen to stand 'for' or 'against' were clinical medical students who believed strongly in the arguments 'for' or 'against' community-based teaching. Students from all years were invited to attend by striking poster advertisements. These were placed both at the pre-clinical (Strand) site and the clinical (Denmark Hill) site where the debate was held, and personal invitations were sent by post to third- and fourth-year clinical students. In addition, questionnaires were distributed to the students present to provide quantitative assessment of students' views, and to assess any change in students' opinion after they had been made more aware of the implications raised by the speakers. (See Fig. 4.2.)

We initially compiled all the information and distributed it for comment to five students who had attended the debate and a further three who had not; their comments are included in this report.

'That it is both desirable and practical that the bulk of medical education should be taught in the community'.

No. of students who voted	28	
Medical students	27	
Dental students	1	

Seven of the students who attended had done an eight-week medical firm based in the community. Four of these voted for and three against the motion.

Year of students present	1st	0
	2nd	0
	3rd	10
	4th	17
	5th	1
Votes	At start of debate	At end of debate
For	6	11
Against	13	16
Abstain	9	1

Fig. 4.2 Quantitative assessment

The results

We have included most of the issues raised under four main headings:

- student identity
- role of medical education
- teaching standards
- travel.

Student identity

Student identity is thought to be an important aspect of life at medical school, particularly at King's, which is part of the University of London. It is achieved by working alongside fellow students in familiar surroundings and seems to be largely dictated by tradition. By shifting the bulk of medical education into the community, it is thought that this student identity will be lost. There are concerns that medical students will become increasingly isolated and out of touch with their peers, with an accompanying decrease in student morale. With a reduction of the time spent at the hospital, there will be a loss of status and a decrease in the sense of community, belonging and history which students experience from being part of King's College Hospital. It was felt that this would result in fewer applicants and a higher drop-out rate.

There would be less opportunity for students to work in groups and learn from each other. Extra-curricular activities including team sports would be more difficult to organise among the scattered distribution of medical students and there would be a consequent decrease in communication.

However, arguments against the apparent detrimental loss of student identity were that the patient is more important than 'convenience' for a student; teaching would still take place in the hospital; and teaching in the community could still take place in firms and with a team of professional workers.

The role of medical education

Students were agreed that medical training should be designed to produce 'good doctors' at the end of the course. The precise nature of the 'good doctor' is not clear-cut, particularly in the light of recent government changes which have resulted in increased emphasis on primary health care and the introduction of GP fundholders. Medical students are only at the beginning of a life-long education. Their aim is to gain basic clinical knowledge to enable them to choose their specialties while being aware of all available services. They are not training to be community workers and hence need to find a balance between all the specialties.

Many students felt that although the current system is not perfect, it would be a set-back if more teaching were to move to the community.

> ***'We can't afford to create a disaster by moving from a system that produces reasonably good doctors to one which does not produce any good doctors.'***

There were fears and reservations about the long-term implications and the effect on career aspirations. CBME was thought inadequate to prepare medical students for finals. Students were particularly concerned that they should be competent for their role as house officers, which was considered their primary

goal. Another fear was the fact that medical students would be the first generation to be taught in the community and they would be looked down upon when competing for jobs by 'old boy' consultants taught by the conventional methods.

Other students highlighted the changing nature of medicine, with an increasing emphasis on primary care in the community. Disease patterns are also changing, with decreases in infectious diseases treated in hospital and increases in chronic conditions which are managed in the community. The students concluded that training should reflect the changing role of the doctor.

> ***'We need to open our minds and look towards the future of medicine. If we resist, we will end up stuck in a stagnating institution for another 50 years and people will be saying "why was nothing done?" and we will be left completely unsuitable for the jobs that we will be doing in the future.'***

The following advantages and disadvantages of more community education were highlighted:

The protected environment. In hospital, students have the back-up of other staff and investigations. In the community, they are exposed to real-life situations and not protected by the 'cosy' environment of the hospital. A reassessment of students' role may be needed for successful interactions with patients on their own territory, and students may have to be more imaginative.

The 'whole person' approach. General practitioners were seen to concentrate on holistic medicine, treating patients as a whole, unlike hospital specialisation. Doctors should be taught from the outset how to deal with a patient as an individual, and not as a pigeon-holed disease.

The team approach. The community is an excellent environment to see the health care team in action. Learning to work with occupational therapists, physiotherapists, community psychiatric nurses and district nurses, will make students very effective doctors working as part of a co-ordinated team.

Research. A shift to the community could have a detrimental effect on research, undermining the scientific basis of medical practice if decreased funding of teaching hospitals results from such a move. Thus students may not see some scientific methods of research, although they may be exposed to different types of research which usually take place in the community.

Teaching standards

Teaching standards were a paramount cause for concern and discussion during the presentations and ensuing debate. The discussion addressed the fundamental question of whether hospital- and community-based teaching were comparable in their effectiveness to teach present-day medical students to be competent, caring and confident house officers and future doctors, regardless of

their eventual chosen specialty. Concerns were expressed about the quantity and quality of medical teaching in both settings, and more specifically focused on differences in patient availability, time commitments to teaching, and the precise nature of teaching and teaching facilities.

Time. Experience on GP firms showed that GPs had little time for students when they sat in on a morning's surgery of consecutive six-minute consultations, and even less for the more extensive teaching of system examinations and essential general medicine.

It was however recognised that teaching in hospital could also be restricted by time, although in some circumstances a member of a consultant's junior staff could take on the teaching session responsibility.

Quantity of patients and acute medicine available. The number of patients available to be seen by a student studying in the community was discussed. There were concerns that there would be insufficient patients with, for example, a particular heart murmur, whereas in hospital there would be a high concentration of such patients in a single cardiac clinic or ward round, i.e. ill people go to hospital and hence there is a greater concentration of clinical material. Additionally, hospital patients would be seen in association with their hospital results to date (e.g. X rays, ECGs and drug charts).

Opportunities for the teaching of acute medicine (e.g. cardiac arrest) in the community were thought to be minimal and hence a serious cause for concern considering the necessity of such knowledge during the house officer year. Acute and emergency medicine teaching in hospital is far superior in terms of quantity, investigations and management. Allied to this is the perceived deficit of interesting or stimulating medicine in the community – excessive cough/cold presentations compared with the obvious/dramatic presentation of acute renal failure seen in a hospital setting.

Generalist versus specialist teaching. Quality of the teaching in terms of accuracy and breadth was a topic of the debate. It was thought that GPs' knowledge might be outdated and they may be less competent at teaching accurately even some common conditions. For example, diabetes would be better taught by a diabetes specialist in a hospital than a GP. This prompts the question 'why settle for second best in teaching'?

In favour of teaching in the community was the recognition that some hospital teaching was too high-powered and specialist, with an excessive factual content aimed more towards postgraduates than medical students. The possibilities of one-to-one teaching, gaining a holistic view of the patient and hence a broadened outlook, and the fact that common conditions occur in the community were recognised.

It was considered that in both community and hospital settings, increased teaching by other health professionals would be positive.

Facilities. A major argument against CBME was the criticism that it lacked many of the facilities present in a hospital environment and instead of holistic medicine in the community it was better to have the whole of medicine around

the medical student. In addition, basic equipment in everyday use at a hospital is conspicuously absent in a general practice (e.g. ECG monitoring equipment).

Travel

Community teaching was seen by the majority as time-consuming and expensive and was particularly of concern considering increasing student poverty. However, 'the community' does not necessarily imply far-flung corners of London and hence these problems can be minimised.

Solutions

A number of ideas were suggested by students as to how teaching in the community could be carried out effectively, and potential problems overcome. These ideas are presented according to the issues they address, using the same headings as in the previous section.

Student identity

- Medical school turned into campus site, with larger library and other facilities for students to use if not at GP practice.
- Friday afternoon seminars to discuss activities of the week, bringing students together.
- Lectures in clinical topics at medical school.
- Morale-boosting events (e.g. discos).
- Students not to spend their entire time at a single GP practice.
- Structure of firm of students to be carried through to the community.

The role of medical education

- Need to define aims and objectives of medical school – house officer versus good doctor – a lot of confusion as to what we are working to achieve.
- Talks arranged with house officers and other doctors about what they feel is important about being a doctor.

Teaching standards

- It was recognised that the hospital has many assets and facilities to teach students. It is also clear that whether or not the bulk of or more medical teaching is shifted into the community, improvements in the hospital-based model should be made to take full advantage of what it could offer to students during the time they spend there.
- Consultants and other hospital doctors interested in teaching should play a greater role in this and be paid for doing so.
- Only GPs interested in teaching should take part – these should have reduced patient lists and be paid accordingly.

- Teaching courses for doctors consisting of regular updating seminars following an initial intensive teaching course.
- Use SIFTR money to improve teaching facilities.
- Regular feedback between student and doctor throughout the firm, so improvement on both sides can be made.
- Learning/study packs could be used by hospital doctors to ensure that medical students are taught about all aspects of a disease process and that facilities (e.g. X rays, ECGs) are used.
- Resources should be increased in the community (e.g. teaching rooms, computer availability, locums to cover GPs if necessary to free practice GPs for teaching purposes).
- Co-ordinate timetable with good communication, especially as regards activities which are cancelled.
- Provide assurance that the examination systems will be tailored according to the revised teaching emphasis and location.

Travel

- Organise a minibus service to transport students to general practices.
- Encourage GPs and consultants to give lifts to students.
- Gather information to match GPs' surgeries with students' addresses to provide convenient travel and utilise student transport (e.g. bikes, cars).
- Students can choose practices near to their residence.
- If in pairs/threes, students in one practice can arrange it so that one has a car and is willing to transport the other two.
- Subsidise student travel (e.g. travel cards, cycle allowance, petrol allowance).

Conclusion

Most students felt that it was unacceptable that the bulk of medical education should take place in the community. Most realise that a greater role for the community is necessary. Although the results obtained from the debate were very informative and interesting, the numbers of students who attended were a small proportion of the clinical years and were those perhaps who already had strong views about this controversial issue. They may also be the ones who will do well whatever the system.

The debate highlighted the need for education and information for the medical student. Many opinions expressed were based on misinformation or no information and general distrust of change. Students are very poorly informed about the future of medical education and what exactly community-based education stands for. For medical education to work, any changes should be preceded by comprehensive discussion and information. This should not just be aimed at future medical students but at today's students who see the course from

the receiving end. Present medical students are also a major advertisement for the course, since prospective students talk to them for the most up-to-date information.

4.3 Issues and implications of CBME for patients and patient organisations

Mary Seabrook & Tyrrell Evans

Key points

- Positive wish by patients and carers to be involved in teaching medical students
- Need for students to be aware of patients' concerns and vice versa
- Importance to patients of doctors' attitudes, communication skills and long-term relationship
- Guidelines on the use of patients for teaching purposes

A number of community-based learning approaches have been tried in various parts of the country, mostly based either in non-clinical community venues or in general practice.[1] Although these have been well documented, little information on the views of or effects on patients has been forthcoming.

The project Steering Group considered that finding sufficient patients willing to be seen in general practice may be more difficult than in hospital. This was because patients were likely to feel more able to say 'no' when they were on their home territory compared with when they were in hospital. We set out to explore patients' experiences, attitudes and thoughts about basing more student learning in primary care, and what they felt would be important for students to learn there.

Methods

A range of methods were used:

- discussions were carried out with a local patients' and a local carers' group, with about ten participants each. These were informal, wide-ranging discussions based around a topic sheet.
- individual interviews were carried out with a convenience sample of ten patients, using a semi-structured questionnaire.

- questionnaires and/or invitations to contribute in writing were sent to individuals and to voluntary organisations representing patients' interests. Six replies were received.
- a literature search was conducted.

The results of the local research were analysed and compared with the information from the literature search.

The results

The patients interviewed ranged from those who had never come across students to those who had taken part in student examinations and been involved in assessing students' performance. Many had seen students either in general practice or in the hospital.

The results of the research are summarised under three headings: (a) patients' attitudes to students; (b) priority learning areas; (c) potential for patient's involvement in medical education as teachers.

(a) Patients' attitudes to students

In general, attitudes towards students in our study were overwhelmingly positive. Similarly, King *et al.*[2] in a study of geriatric patients in Liverpool found that over 95 per cent of elderly people questioned had positive attitudes towards students. Pittman & Barr[3] in a study in the USA found that 42 per cent of patients indicated a definite desire or preference for seeing a medical student, 44 per cent were indifferent as to whether they saw a member of the faculty or of the student body, while only 14 per cent of patients preferred not to see a student.

In our discussions, patients gave a number of reasons for their positive attitude. Some felt that they had a duty to help the community and to help educate the next generation of doctors. They felt it was important for students to learn on real people not 'dummies' and to learn by doing and not just watching. One patient commented, 'Experience teaches wisdom.' Some found it interesting to see the students' approach and different attitudes, and felt that they learnt more about their condition from the discussion between doctor and student.

Many people enjoyed the extra time and attention that having a student gave them, and thought that it ensured a thorough check-up. One patient said:

> ***'When the doctor has a student there she always explains things really well, but when she's on her own she just gives me a prescription and tries to get me out of the door.'***

Patients felt that home visits were good for morale, and a long-term attachment could have a therapeutic value. It could be valuable for patients to have

someone to talk to from outside their normal range of contacts, and would help them to feel that they had something to contribute. It would also give students an opportunity to develop relationships with patients. They would learn about how being ill affected the patient's daily life and about social and cultural aspects of life in the community.

Research by Mayo-Smith *et al.*[4] in the USA into the motivations of patients to participate in a physical diagnosis course also found that patients had mostly altruistic motives for taking part. Wanting to help the students and to benefit future patients were rated most highly, above possible benefits to themselves, either medically or from talking to someone. The study also measured students' and faculty members' perceptions of how the patients had felt. Both groups consistently rated the favourable motivations too low and the unfavourable ones too high, and perceived the overall experience to be more unpleasant and inconvenient for the patients than it actually was.

Concerns. In our local research, patients were concerned to ensure that they were given a choice as to whether or not to have a student in the consultation. Some patients had had bad experiences in hospitals where they had been subjected to examination in front of large groups of students without warning. Others had been asked for their permission but had been feeling too ill to be able to think about it. In general practice, patients wanted advance warning about students' presence and an option to decline.

Most patients would accept a student in any situation, but some would not want students present in an emergency or if their consultation was on a personal matter. This might include pregnancy or marital problems. Most women were reticent about students being around when undressing or internal examinations were involved, although some would not object to a female student at these times. This is borne out by King *et al.*[5] who found that the minority of patients who were reluctant to be involved in clinical teaching were mostly women who were embarrassed at being examined. Some patients in our study were also concerned that the student might be embarrassed at these times.

Patients felt that students needed to be made aware of their worries and concerns and vice versa. More than one student could be off-putting and make the patient feel that they were being 'tested'. Students who appeared bored or uninterested in the patient were offensive, and if they visited a patient at home, students should be diplomatic. Some patients expressed concern that students might be used instead of doctors, thus giving patients a second-class service.

Patients thought that longer appointments may be needed as students tended to need more time. However, Pittman & Barr[6] found that the additional time taken by the student in performing relatively routine clinical tasks is viewed by the patient more often as a positive, rather than a negative, feature.

A set of guidelines based on the comments made have been developed and are included in the appendix to this section, on p. 65.

(b) Priority learning areas

Patients were asked what they considered important for students to learn about, and whether they would be interested in being involved in teaching.

The areas of learning mentioned most frequently as important concerned the attitudes of doctors and communication. It was seen as particularly important for the doctor to be non-patronising and non-judgemental, to show an interest in the patient, to ask the 'right questions' in the 'right way', and to listen and take notice of what the patient has to say. The doctor should make eye contact with, and be at the same eye level as, the patient (particularly for those in bed or in a wheelchair). A caring attitude is important, particularly when the patient is going through a bad time and needs a friend, and the level of respect for the patient should not diminish as the patient gets older. The continuity of the relationship between patient and doctor is highly valued.

Patients want the doctor to explain their problems in clear, everyday language and to be reassuring. They want to be told the truth and do not want doctors to regard the carer (paid or unpaid) as more mentally competent than the patient. Doctors need to assess how much information anyone can take at one time and to tell the truth in a kindly way. Doctors need to give full information about the side-effects of drugs that they prescribe and to involve the patient in choices when there are alternatives. If they do not know something, they should say so. It is important for the doctor to accept that someone with a long-term condition is an expert in their own management.

Carers want to be involved and there was a suggestion for a 'carer's transfer note'. Doctors need to link with and work alongside community and self-help groups. Students should be encouraged to listen and learn from all types of experts, not just doctors.

(c) Patients as teachers

Input into professional training is increasingly on the agenda for patient and voluntary groups.

MIND has an official policy to seek input from mental health service users into all basic professional training and post-qualifying training.[7] They say that training should be well planned and integrated into the rest of the course (not just a one-off) and properly funded. They aim for trainers representing a range of perspectives.

The National Eczema Society has recently produced a discussion document entitled *Using patients in the education of health care professionals*. It outlines a number of educational methods suitable for patient involvement and gives guidelines for organisers. The paper stresses the need for patients to give informed consent and to be properly briefed. It also recommends that the number of students be kept to a minimum.

The National Asthma Campaign has held a workshop for doctors to examine the issue of effective communication with asthma patients. They found that patients were initially very nervous but became more assertive

during the workshop and felt they had a lot to offer in feedback about effective communication. Patients also felt a desire to be more involved at policy level, not just as practice material. The Campaign is now considering a project to enable medical students to learn more about asthma.

In the USA, the use of patients as teachers is considerably more developed than in the UK. Stillman *et al.*[8] describes how patients have been trained to use their own bodies as teaching material and to act as patient, teacher and evaluator of physical diagnosis skills.

Discussion

The research demonstrated the need to consider patients' views when planning and implementing community-based teaching, as their co-operation will be essential to its success. The small number of relevant articles found in an extensive literature search demonstrates that this is an under-researched area, perhaps because it has never been seen as a potential problem in hospitals.

Health care managers and doctors we interviewed in a parallel study were unsure as to whether patients would be willing to participate and felt that there might need to be a 'marketing' effort to persuade them. In fact, patients were very positive about seeing students. They are, however, in a better position to decline when at home than in hospital. Thus GP tutors will need to ensure that patients' experiences with students in general practice are positive, unlike the traumatic experiences some have undergone in hospital. Respect for the individual patient's wishes will need to take a higher priority and their concerns will need to be addressed.

There are certain constraints which may be problematic for medical schools and GP tutors. Most female patients did not want students to be present during 'personal' consultations, which may give students little chance to practise some of the most difficult consultations both for them and patients. Most patients were also reluctant to see more than one student at a time. While one student per patient is usual in general practice at the moment, it may be difficult to sustain if there is to be a substantial increase in community teaching.

Many patients felt that they would be more willing to be involved if they knew more about medical education. Individuals, particularly younger patients did not feel they had anything they could teach students, but older patients and groups felt they did have something to offer. Clearly, there is potential for patients to become involved as teachers and/or assessors of students. Patients have clear views about what is important for students to learn and if they became more involved in teaching, they would want to contribute towards curriculum decisions.

One advantage of the community is that GPs have well-developed relationships with patients who may be able to work with students over a long period. Their role could extend beyond that of simply providing a patient's perspective and examination material to teaching skills, imparting factual

information and assessment. For example, patients with chronic illnesses, who also develop teaching skills, could become a useful resource for the GP tutor. Thus patients could take a more active role in teaching than heretofore. As with any other group, training and support would be required and payment, or at least expenses, would need to be considered. Patients may be more difficult to access in the community but their potential for involvement may be greater.

Appendix: Guidelines for the use of patients for teaching purposes in general practice

- **Obtain informed consent from the patient**
  Co-operation needs to be requested in a way that allows the patient to say 'no'. It may be difficult for some patients to decline when the student is actually present. A good time to ask is when the patient telephones or calls in to arrange an appointment. A further check could be made by the receptionist or doctor when the patient arrives for the consultation.

- **Use the term 'student doctor' rather than 'medical student'**
  Patients are not always familiar with the term 'medical student'. One study found that 29 per cent of 'alert' elderly patients did not know that a medical student was going to be a doctor.[9]

- **Introduce the student to the patient by name or ensure that the student introduces him/herself**

- **Keep to one student per patient**
  In hospitals, some patients have been subjected to 'being taught on' in front of large groups of students. In general practice, this is not normally the case, and one student is the general rule. Most patients are happy with one student but may find more unacceptable. In some cases (eg. home visits where the doctor is not present or project work in the waiting room), two students could work together.

- **Sit the student within eyeshot of the patient**
  Patients may feel uncomfortable if the student can see them but they cannot see the student. The student should also be at the same eye level as the patient.

- **Brief the patient**
  If patients are asked to come into the practice specifically to see the student they should be appropriately briefed. This would include explaining to the patient what the student is learning, why it would be useful for the student to see them and what form the meeting will take (e.g. talking only, physical examination). They should also be given an idea of how long the session will last.

Contributors of information

Paxton Green Health Centre Carers' Group
Wells Park Road Reminiscence Group
National Asthma Campaign
National Eczema Society
MIND
British Diabetic Association
Individual patients

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4.4 GPs' attitudes towards CBME

Brian Fine

Key points

- There is considerable enthusiasm among GPs for teaching medical students in the community
- GPs will need protected time for teaching which must be adequately funded
- GPs will also need resources, training and support for themselves and their practices
- Curriculum must be based in the ethos of primary care and teaching methods must fit with general practice approach
- New courses must have flexibility and be divisible into modules to allow variable commitment by GPs

General practitioners have been involved in medical education since the 1950s. Until 1991, this work had generally involved GPs teaching students the principles and practice of general practice. More recently, a number of GPs, notably Nigel Oswald in Cambridge,[1] have been arguing that more of the undergraduate curriculum could, and indeed should, be based in the community and there is a growing acceptance of this idea[2] for a number of reasons (see section 2.1).

The GP tutors involved in teaching on the KMFC (see section 2) were fired by great enthusiasm and worked hard to overcome the initial problems. After one year, despite apprehensions in the medical school, the firm achieved considerable success, and is now an established part of the medical school programme. This led tutors to consider whether the increased level and range of GP teaching activity could be more extensively undertaken.

My view was that the personal gains and losses for GPs as teachers, and the fears and concerns of non-teaching GPs, would be important in determining the viability of increased GP teaching. I set out to investigate the constraints upon GPs' involvement in teaching, and to identify interventions that would bring about a significant increase in their teaching.

There are few published data on the attitudes and motivating factors of GPs towards undergraduate teaching. A survey of physicians involved in continuing medical education of doctors in Illinois suggested that personal factors were likely to be of importance.[3] Highly rated factors included: 'enjoyment of teaching', 'keeping current in a field of expertise', 'interaction with professional colleagues', 'keeping up to date on patient care', 'recognition among peers and colleagues' and 'increased feelings of self-esteem or satisfaction'. This study was specifically concerned with postgraduate education and did not look at GPs, non-teaching doctors, or negative factors that prevent or 'demotivate' doctors from teaching.

Methods

GPs working in south-east London were selected for interview. The doctors came from a wide spectrum of backgrounds in terms of gender, age, experience in general practice, size of practice, place of training, country of origin, teaching experience (including some with no teaching experience) and part-time as well as full-time GPs (see Fig. 4.3).

In-depth interviews were undertaken with 17 GPs, who were given information on the project and the purpose of the study. Although these numbers are insufficient for statistical analysis, some very clear and widely held opinions did emerge.

Gender:	Male: 7	Female: 10	
Age:	Overall range:	34–59	
Distribution:	30–39	5	
	40–49	7	
	50–59	5	
Year qualified:	Overall range:	1957–84	
No. of years in practice:	Overall range:	4–22	
0–5	1		
6–10	7		
11–15	4		
16–20	3		
21–25	2		
Place of qualification:	UK	14	
	Outside UK	3	
Number of partners in practice:	Overall range:	1–7	
1 partner : 2		5 partners : 2	
2 partners : 4		6 partners : 1	
3 partners : 5		7 partners : 1	
4 partners : 2			
Full-time GPs: 12		Part-time GPs: 5	
Previous teaching experience:		None/minimal	2
		Some	11
		Extensive	4

Fig. 4.3 Demographic information about the interviewees

The interviews were semi-structured and aimed to identify the GPs' views on the items shown in Fig. 4.4. Interviews were tape-recorded, apart from one interviewee who refused permission, when handwritten notes were taken. The interviews were subsequently analysed.

Contacts were made with a number of GPs who declined to be interviewed. Most of these had no known background of involvement in teaching. The results of the study are therefore biased towards the views of those GPs who have done some teaching.

Feedback from members of the Innovation in Medical Education project Steering Group, other researchers, individual GPs and participants at a national conference held at the King's Fund Centre in November 1993, were all helpful in developing the approach to this work.

- Why do some GPs teach medical students and others not?
- Many GPs have a very clear idea of what they wish or do not wish to teach. What determines these views?
- What do GPs feel they get out of teaching?
- What are the negative or problem areas of teaching for those GPs who teach?
- Are there limits to the amount of time that GPs can or will devote to teaching, and what are the determinants of this?
- How can medical schools respond to these needs?
- What changes might produce an increase in the amount and scope of teaching that GPs undertake?
- Which models of CBME would best fit the patterns of work and life of GPs?
- Is it feasible for GPs to play a major role in more extensive and wide-ranging CBME?

Fig. 4.4 Investigation of the needs of GPs as tutors

The results

The outcomes of the interviews are presented in categories in the order of frequency with which they were mentioned by GPs. Items in bold type were mentioned by more than half of the interviewees.

The needs of individual GPs as tutors

What motivates GPs to teach?

There was a diverse range of reasons for GPs enjoying or wishing to be involved in teaching. Some related to intellectual and learning needs, whereas others were more concerned with satisfying emotional needs such as self-esteem.

1. **Having an interest in the process of learning and education.**
2. **Seeing teaching as giving value or worth to their work as GPs.**
3. **Seeing teaching as part of personal learning and development.**
4. **Enjoyment of the personal aspects of the teacher–student relationship.**
5. Enjoyment of teaching itself.
6. Seeing teaching as a natural part of general practice.
7. Having a special interest in a particular area of the curriculum or in aspects of the teaching process.

'I like thinking about how to devise a process that successfully addresses the sorts of issues that I'm trying to look at with the student.'

'Preparing for teaching helps me to think about my own ideas and sort my own ideas out a bit.'

'[Teaching is best] when I come out of it feeling expanded either in terms of my knowledge of the patient or of that situation.'

'Teaching students expanded my daily life, giving me a broader area of interest and more variety in my daily life.'

'I really get my biggest reward in the feedback from the student.'

What factors currently limit GP teaching?

A number of factors cause problems for GPs with their current teaching activities. However, by far the single most important problem was insufficient time for teaching while maintaining service needs and personal or family commitments.

1. **Lack of time.**
2. Philosophical and educational issues (e.g. poorly motivated students).
3. Training issues and support needs.
4. Curriculum issues – both content and process.

' Teaching is a luxury I haven't got time for'.

'There comes a time when your life is full and you have to call a halt.'

What factors would limit increased teaching in the future?

1. **Lack of time and/or financial implications.**
2. **Curriculum issues – both content and process.**
3. **Problems for practices with an increased teaching role.**
4. Philosophical and educational issues (e.g. the need to fit in with a general practice approach to health/illness).
5. Concerns about adverse effects on patient care.
6. Inadequate premises for more teaching activity.
7. Training issues and support needs for GP tutors.

Again, the biggest single concern was lack of time, often linked to the resource or financial aspects. There were major concerns regarding the effects of more teaching on the administrative workload and on the interpersonal relationships within the practice.

Many GPs were concerned about further decreasing the time available for patients, particularly a worry for part-time (predominantly female) GPs, and about possible adverse effects on the doctor–patient relationship.

In addition, many GPs had concerns about curricular issues (e.g. possible excessive emphasis on knowledge teaching), as well as deficiencies in their own knowledge. Some GPs only wished to teach areas directly related to GP-based management of patients.

'If I had more time, and if I had secretarial help to find the patients and make sure they were there, then it would be enjoyable.'

'I'd like some proper financial recognition. I think that would show a respect for the job that the teacher is expected to do.'

'My biggest worry is lack of time and money. I have to be able to afford to recruit someone, not just occasional locums, who will come in regularly and the patients get to know, so that I can have time to teach.'

'To do more teaching something else has to be given up.'

'The dilemma for all of us is energy, interest, time and responsibility, and they all need to be taken account of.'

'The technical side of what happens to patients in hospital is something I don't know enough about in order to teach it.'

'I would only like to teach those areas which I am interested in.'

'There are some things I don't feel competent to teach.'

'My interest is teaching "process", I'm not so interested in teaching "content".'

'Isolation and lack of support would turn me off, and actually are dangerous.'

'Another problem is space. Here we are in our new building and already it's too small.'

Possible responses of medical schools to the needs of doctors

What would help GPs do more teaching?

There are a number of changes needed in the way in which medicine is taught for GPs to consider more extensive teaching, both in quantity and range.

1. **Increased personal and practical support.**
2. **Increased help with the administration of teaching.**
3. Increased flexibility in the teaching timetable.
4. More appropriate teaching methods for general practice.
5. More appropriate premises for teaching in the community.

Which models of CBME will attract GPs?

A number of possible models for future CBME programmes were considered which attempt to meet the needs of GPs and so encourage active involvement. Ultimately, two models were developed, which were discussed in detail:

- *The Academic Teaching Practice Model* envisages funding practices at competitive rates to provide protected time for agreed teaching activities. A teaching agreement would provide both security for the GPs and details of the teaching commitment. This funding would facilitate the provision of high-quality teaching, satisfying the needs of teachers, without impairing service delivery or income. The money might be used to reduce patient-list sizes, or perhaps to take on new partners or assistants to teach or to help with the service workload. There was a high level of interest and enthusiasm for this model. Although the numbers are insufficient for statistical purposes, 81 per cent of the GPs expressed 'definite interest' in this model.
- *The Chocolate Box Model* envisages a process of agreeing a teaching/ learning curriculum for students, and then dividing it up into sensible teaching modules of varying sizes. These modules would be offered to teachers, including GP tutors and other appropriate people, to teach according to their interests, expertise and availability. The commitment would be defined in a teaching agreement. This model would have the advantage of allowing GP tutors to make a variable commitment, according to their individual situations and might therefore be attractive to a much larger number of GPs. However, it would require significant organisational and administrative input to ensure continuity of the experience for the student. A co-ordinator would be required to ensure that students receive a complete, integrated set of modules.

Of the interviewees, 59 per cent were very interested in this model; a further 12 per cent said that they would not need this model as they would be interested in a complete package.

How many GPs might take on more teaching?

Of the GPs interviewed, 19 per cent said that, under optimal conditions, they would definitely wish to do more teaching, with a further 31 per cent saying they might possibly get involved. This suggests that about half of all GPs might potentially become further involved in CBME.

Discussion and conclusions

This study looked in depth at the attitudes and views of a relatively small number of GPs towards a possible large-scale move of teaching into the community. Despite the diversity of aspirations and approaches among the GPs

interviewed, there was a convergence of views with respect to medical education, often related to external pressures. Some clear conclusions can be drawn.

- There is real interest for teaching among many GPs. This is based upon factors such as:
  - an enjoyment or interest in the process of learning;
  - seeing teaching as being intimately connected with personal learning and development;
  - seeing teaching as a way of giving value to one's work;
  - enjoying personal aspects of the teacher–student relationship;
  - seeing teaching as a natural part of general practice.

- The major areas of concern or difficulty are:
  - a lack of time and financial resources for teaching while attempting to maintain service and personal commitments – this was an almost universally expressed difficulty;
  - philosophical and educational issues, such as a desire only to be involved in teaching that relates to the work of general practice, and that the teaching style should match the approach of general practice rather than that of specialist care;
  - concerns about the training and support needs of GPs as tutors in a wider and more extensive curriculum;
  - concerns about the impact of more teaching on practices, staff and relationships within practices;
  - concerns about the impact of more teaching on the quality of patient care.

If teaching programmes and curricula can be designed to address the above issues, it should be possible to tap into the natural enthusiasm of many GPs to be further involved in teaching. For such a shift to take place it will be necessary to recruit, train and support larger numbers of GPs than are currently involved in teaching, and persuade them to spend more time teaching a wider range of subjects. The basic requirements that will have to be incorporated into any model of CBME are shown in Fig. 4.5.

Although these requirements for widespread, active involvement of GPs in CBME programmes may seem extensive, they should be achievable. If a medical school is serious about changing the pattern of medical education along these lines, which is consistent with the GMC guidance on undergraduate medical education,[4] they must allocate adequate resources and time to planning such a course.

Resources

- Adequate funding to cover the costs of the time involved in teaching, planning, preparation and training, as well as to provide a measure of reward for tutors.
- Availability of appropriate resources for teaching, including learning packs and videos.
- Practice premises development as necessary, including effective communication/IT links.

Curriculum

- The content of the curriculum to be specified and planned with the active involvement of GP tutors.
- The curriculum to be sensitive to the GP approach to medicine and health.
- The needs of patients and views of the public on the desired qualities of doctors should influence the curriculum.

Teaching structure and process

- Teaching methods appropriate to a general practice approach.
- Teaching programme divisible into modules of variable size to encourage participation of GPs with other commitments.
- Setting appropriate and achievable standards for teaching.
- A contract or agreement for teaching between GP, medical school and FHSA clearly describing the commitments and responsibilities of all involved, including the duration of the agreement.
- A tutor or co-ordinator to ensure that students receive a complete and balanced programme, and to help them explore their individual learning needs.

Support and training

- Support structures for GP tutors, including peer group and individual support mechanisms.
- Educational support and training for GP tutors, including help with teaching methods.
- Educational support for students to encourage a more mature approach to learning, with more assessment, feedback and self-direction.

Fig. 4.5 Basic requirements for CBME programmes

If there is to be a real shift of medical education into the community, we will have to rethink the undergraduate curriculum. It is highly unlikely that directly transplanting traditional hospital medical school teaching patterns into the community will work. This presents hospital doctors, GPs, scientists and academics with an opportunity to consider the role of doctors and medicine in our society.

Clearly, with more teaching taking place in the community, this debate must be joined by all those in society who will be affected by such a change, not least other health professionals and the general public.

Unlike hospital-based teaching, neither the teachers (GPs as opposed to hospital doctors) nor the patients (at home as opposed to in hospital) are a captive audience, and there is a greater potential for failure if the course is not properly planned and set up. However, as new models of teaching are explored, the opportunity arises for all those involved to contribute to the debate about what sort of doctors we want in our society, and where we hope medical practice will move over the years ahead.

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4.5 The implications for community health services and the primary health care team

Maggie Jee

Key points

- Enthusiasm for extending medical education in the community and pleasure in being consulted
- A strong desire that better communication, understanding and trust should develop with a new generation of community-trained doctors
- The need for adequate resourcing
- The need for proper organisation and structuring in terms of what is to be taught, how and by whom
- Specialist skills which the various health professionals could teach

This report considers the views of community health professionals towards:

- training medical students in the community
- the sort of doctor community health professionals would like to see being trained, and with whom they would like to work
- what their professions could contribute to the teaching of medical students

- the overall implications of extending medical education into the community.

Methods

Community health services

Contacts were made with West Lambeth and Optimum Community Health Trusts and local general practices. Discussions took place between November 1993 and February 1994. Contacts were also made in West Lambeth Community Care with the Child Health Directorate, Mental Health, Well-Woman Services and Community Midwifery.

The discussion groups were based on a topic discussion sheet sent out in advance. This also served as a questionnaire that could be circulated to staff who were unable to attend discussion groups. Discussion groups were held with:

13 health visitors (2 groups)
6 district nurses (2 groups)
8 therapists (including Heads of Department of Speech and Language Therapy, Physiotherapy, Chiropody, Child Psychiatry, Art Therapy, Occupational Therapy, plus Head of Library Services and Principal Pharmacist)
9 practice nurses
6 receptionists
7 practice managers.

Questionnaires were returned from three neighbourhood bases in West Lambeth Community Care, which expressed the views of a further ten health visitors. One questionnaire was returned from the Department of Speech and Language Therapy, which summarised the views of 12 therapists; one was returned from a chiropodist, and two from physiotherapists. Comments were also received from the Royal Pharmaceutical Society of Great Britain which had been contacted by the principal pharmacist.

Total community health professionals consulted	
Community health professionals interviewed	54
Questionnaires returned	8
Respondents' views incorporated in questionnaires	26

Outcomes

There was a strong convergence of views between the different groups of health professionals in several key areas. They all expressed:

- great enthusiasm for extending medical education into the community and pleasure in being consulted;
- concern that any further extension of medical education into the community should be adequately resourced;
- an awareness of the practical difficulties that might inhibit progress;
- concern that medical education in the community should be properly organised and structured in terms of what is to be taught, how and by whom;
- a strong desire that what was described as a 'barrier' between doctors and other health professionals would be broken down as a result of collaboration over training; and that better communication, understanding and trust would develop with the new generation of community-trained doctors.

Attitudes towards training medical students in the community

All groups expressed enthusiasm that medical training should be extended in the community, and emphasised their eagerness to make a contribution. They looked on it as an opportunity that would bring benefits for everyone: students, community health staff and patients.

Benefits to students. Medical students would meet patients in their normal surroundings, and where most medical consultations take place. This would help students, especially those intending to develop hospital careers, to appreciate social, economic and environmental factors in health status and health care.

District nurses and therapists pointed out that patients were a tremendous resource because 'every single disease and condition you can think of is managed in the community'. Health visitors added that medical students would benefit from being able to follow a patient/family through several developmental stages. All groups commented that because patients in the community are not a 'captive audience' as in hospitals, students would learn to appreciate them in different ways. Student doctors would have the opportunity to relate to patients as persons rather than as 'conditions', and would also learn how to develop long-term relationships with them.

Students would learn to collaborate in a multidisciplinary team with other community health professionals. They would understand the roles of the different health professionals and see how they complement each other. They would also learn how different teams (e.g. for elderly people or mental health) work together, and how specialist roles (e.g. MacMillan nurse or counsellor) are integrated within an overall framework.

Some community health professionals felt that there would be benefits for the social and emotional development of medical students too, as they were more likely to be 'treated as human beings' in community settings. Students could be helped to acknowledge and deal with their own vulnerability, rather than denying their own feelings and attempting to become 'superhuman', as may happen under the pressure of hospital settings.

Benefits to patients. District nurses thought that many socially isolated patients would love to have a medical student attached to them. They would relish the opportunity to have their case history taken again and to spend time going through it with a student doctor. It would also make them feel they were still valuable members of society.

Benefits to community health professionals. Community health professionals would benefit in the long term because of the better interpersonal and professional understanding that would develop between doctors and other health care workers. Multidisciplinary team working and the idea of 'partnership' could be built in from the beginning, and barriers between doctors and other health professionals would be lessened. Most groups, but therapists in particular, considered they would receive more appropriate referrals from community-trained doctors.

Opinions were divided as to whether community health professionals could expect medical students to reduce their workload by providing another pair of hands, or even, on long placements, by eventually managing a small caseload.

What sort of doctor?

There was considerable consensus on this among all groups, and no real surprises in the points that were made. The *degree* of unanimity between the different groups of health workers is perhaps more surprising than what they actually said. All groups felt that their opinions reflected their experiences of working with today's general practitioners and hospital doctors.

Lurking quite near the surface for most community health professionals and emerging eventually in all discussions was the issue of the barrier that exists between doctors and other health professionals. Sometimes this was expressed as a problem stemming largely from doctors' attitudes. Most health professionals were also ready to admit that it was equally a problem of their own attitudes and ways of behaving towards doctors. Community health professionals were frank in their discussion of this issue:

> ***'This is a very tricky one. Some GPs behave badly, but even with the kindest of GPs the barrier is there.'***
>
> ***'They may not intend to, but some of them make you feel inferior. They are better educated, but it can also be a class issue, and possibly a race/ethnic and gender issue.'***

This perceived status difference leads some health professionals to feel subordinate to doctors and to behave deferentially towards them. It lies behind some of the points that were made about the kind of doctor with whom health professionals would like to work, and it is partly responsible for the reluctance of some to be involved in the assessment of student doctors. However, several

health professionals felt a responsibility to help develop the qualities they would like to see in a doctor, rather than, as one put it, 'moaning from the sidelines'.

Community health professionals would like medical students and future doctors:

- to have excellent interpersonal and communication skills, including the capacity to listen and respond appropriately;
- to know and understand what other health professionals do;
- to respect the roles and skills of other health professionals and to value their professional opinions;
- to recognise that other health professionals may have skills and a knowledge base that doctors may not possess;
- to be able to work in a multidisciplinary team or in partnership with other health professionals;
- to have an holistic approach to patient care;
- to have excellent clinical and diagnostic skills;
- to be very knowledgeable about *normal* human development;
- to know about the impact and management of lifestyle and environmental factors in relation to health;
- to be aware of and know how to access relevant non-medical agencies and services in the community.

In the case of doctors planning a career in hospital medicine, community staff would like them to remember and apply what they have learnt in the community and especially to transfer patients back to community care appropriately.

What should medical students be taught? What can community health professionals contribute?

All groups felt they could make an important contribution to the teaching of doctors.

Jobs and roles. Community health professionals believed that they had a part to play primarily in teaching about their own role and how community health services, or general practice, are organised. This could include team-work skills, hospital discharge planning and support, and management skills.

Social skills. All groups thought they could contribute to teaching social skills, such as communication, negotiation, counselling of patients and families, awareness of confidentiality, and gender and race issues.

Environmental education. Community health professionals could help medical students to understand the realities of how patients manage in different social circumstances and environments, and how treatments might have to be adapted accordingly.

Change and development in the NHS. Several groups considered that, given the recent extent and pace of change, students should be taught the basic principles and organisational implications of the purchaser/provider split, general practice fundholding, and other changes in the NHS. Although some community health staff thought they could teach aspects of this, the overall view was that it should be done by practitioners/experts from relevant agencies.

Specialist skills. The different professions also felt they could offer specific skills, including some clinical skills. These are detailed in Fig. 4.6. All thought they could assist in placing medical students with appropriate patients.

Profession	Skills
Health visitors	Health education, group work skills, human development.
District nurses	Terminal care and pain control, HIV and AIDS care, management of chronic conditions and disabilities, assessment of elderly people, use of technological aids in the home.
Therapists	Guidance on appropriate referrals, assessing and working with people with disabilities.
Pharmacists	Function and potential of community pharmacy in relation to the public, general practitioners and other community health professionals.
Practice nurses	Health education, basic clinical procedures (injections, blood tests), well-woman procedures (smears, breast examination), management of asthma and diabetes, communication skills.
Receptionists	Communication skills, handling difficult patients, patients' attitudes, issues of confidentiality, summarising patients' notes.
Practice managers	The same as receptionists, plus overall co-ordination of general practice, including budget and personnel management, links with FHSAs and other agencies in the community.

Fig. 4.6 Specialist skills which health professionals could teach.

Curriculum development. Each group considered that they would like to play a part in curriculum development, and were concerned that this should not just

be tokenism. They felt that the involvement of their respective professional organisations would add weight to their contribution. Trust staff also thought that their own training and development departments could offer some courses off the peg (e.g. multidisciplinary courses, such as child protection), and might be interested in devising specialist courses. It was felt that courses should be tried out and refined in practice, rather than aiming for perfection before starting.

The overall implications

All groups were adamant that for any such venture to be successful it would have to be properly resourced and organised. This would help to dispel any notion that training in the community was a soft option, or 'not where the real training takes place'.

Problems. Respondents were concerned to point out that general practices and community health settings are already inundated with students. Each professional group trains its own trainees, as well as coming into contact with GP trainees and medical students from several medical schools on various forms of existing 'community placement'.

A potentially large increase in the numbers of medical students in the community raised the following general concerns:

- community health professionals, willing as they are to work with medical students, would not want to compromise the teaching of their own students.
- the demands on community services are increasing continuously and health professionals were concerned about the additional impact of the closure of a major hospital in the area.
- at what point would saturation be reached and potential benefits lost? Health professionals wondered whether sufficient staff and placements could be found in community and general practice settings, given the problems of inner-city practices (e.g. lack of space and run-down premises, large numbers of single-handed and elderly GPs), and the difficulty of securing high-quality locum staff. Community services staff from both trusts were particularly concerned to maintain the highest quality of services and corporate identity in the newly competitive market, and unwilling to rely on agency staff other than for short-term cover.
- would sufficient patients be found to match increased demands? Patients would have to be given choice and already some placements can be difficult to find (e.g. for male students with female patients). Health professionals also felt that if students were attached to a greater number of patients it could possibly inhibit the development of their own professional relationship with patients.

Although all groups said that they currently welcomed students and found teaching them both stimulating and challenging, they also said that students could be an enormous strain. The main sources of strain are as follows (the last three points apply to medical students in particular):

- students require time and attention so the health professional's basic work takes longer to complete, but there is usually no reduction in workload. In general, the less the students know, the more time they take up.
- many community health professionals work in confined spaces and there is little room for students.
- students sometimes turn up with no warning.
- neither student nor health professional may be clear about what the student is expected to do and achieve.
- the health professional may have no information about the students' stage in their training nor their existing knowledge.
- some students come with negative attitudes towards working in the community: they see it as a 'soft option' and 'can't be bothered'.
- some come with dismissive or arrogant attitudes towards community health staff.
- receptionists in particular felt that the skills required for their work were not fully appreciated. For example, students would be allocated to them for a morning and, with no preparation, be expected to handle confidential and difficult telephone calls from patients.

Some possible solutions. Several suggestions were made as to how these issues could be addressed and obstacles overcome so that all parties would benefit from medical training in the community.

- Courses should be structured with clear course goals, and these learning objectives should be made known to staff and students. There should be specific objectives for the course block being taught by each professional group. Each student should have a 'learning contract'. Training should be hands-on, rather than 'hands behind the back'.
- Appropriate contracts should be drawn up with community services and/or general practices which allow for proper resourcing and organisation. This should include allowances for locums (possibly as permanent extra staff to avoid reliance on agency staff), provision of adequate library facilities and teaching aids, insurance, etc. To encourage the placing of students, there should be some financial incentive, not just the covering of costs. The set-up year would need additional resourcing.
- Students should be allocated to teams, not individuals.

- If there are to be placements with community services trusts, there should be an overall community co-ordinator for each student, such as a community services neighbourhood, patch or locality manager, who would be in an excellent position to co-ordinate placements in various community settings.
- In general practice placements, the co-ordinating function could be taken on by the practice manager, with relevant inputs from community services neighbourhood or patch managers.
- Views on the optimum length of placement in either location varied between three and six months for community services, and between six months and a year in general practice.
- Both community services and general practice staff would want to have a choice as to the students they took on, particularly for long placements.
- To ease communication there should be a straightforward mechanism for linking students, medical school and community. This should probably be a particular person attached to the medical school.
- Community staff should be able to volunteer to teach medical students. Volunteers should all be appropriately qualified and experienced, and further/specific training should be open to them to take on this role.
- There should be back-up support for community trainers in the form of supervision, meetings with other trainers, and regular liaison/feedback with the medical school.
- Views about assessment differed, although all agreed that assessment of medical students should be straightforward and not too time-consuming. Some community staff felt cautious about assessing medical students, partly because of feelings of inferiority, partly because they thought (as is now becoming common practice in nursing and allied professions) that doctors should be assessed by doctors. Others felt more comfortable about assessing medical students, and would see it as their responsibility to assess the block/section of the course that they had taught. There was support for collaborative assessment with, for example, a GP.
- There was felt to be a role for mentorship as part of review or appraisal.
- It was suggested that a student-held record or assessment book in which all participating trainers contributed, as well as the student, could help to structure the course and hold together what could otherwise be disparate assessments.

4.6 The implications of greater CBME for complementary practitioners

Anne Stephenson

Key points

- Key qualities for doctors are to be healers, communicators and people of high professional standards.
- The community is exactly the right setting in which to teach medical students
- Complementary practitioners see themselves as having a role in teaching students, for example in areas of preventive medicine, emotional and psychological aspects of disease and communication

A small study sampled, opportunistically, the views of nine complementary practitioners as to what they saw as the important foci for medical education. The sample included: an assistant for people with physical disabilities, two counsellors, a family therapist, a hypnotherapist/psychotherapist, a massage practitioner/therapist, two oriental medicine practitioners and an osteopath.

A written questionnaire was completed. Although the sample was small the answers were comprehensive and certainly appeared to outline and agree on a philosophy for an integrated medical education system.

This shortened report considers the views of the sampled complementary practitioners on:

- the sort of western doctor they would like to see being trained
- the training of doctors in the community
- their profession's contribution to western medical training
- the implications of community-based learning.

What sort of doctor?

Basically, a doctor should be:

- *a healer*
- *a communicator*
- *a person of high professional standards.*

See Fig. 4.7 for details of the knowledge, skills and attitudes required.

What about training doctors in the community?

All thought this to be exactly the right place. The community has many resources, including teachers, and much can be taught of great relevance to a

doctor's task. As to who could teach, the answer ranged from formally trained teachers, workers in the field, professionals, experienced and qualified personnel, those with a deep understanding of the human condition through to 'all sorts of people, including patients and ordinary people' and 'as wide a range of people as possible'. See Fig. 4.8 for more details.

Attitude	- sensitivity of manner - friendly attitude - ability to create rapport - ability to listen - awareness of own attitudes - ability to stay with patient's emotional pain - holistic approach.
Skills	- assessment skills - intuition - responding skills - accurate diagnostic ability - treatment skills - realistic prognostication - ability to impart information.
Knowledge of	- relationship of individual to large systems (e.g. family) and smaller systems (e.g. organs) - highly significant relationship between aetiology, course, outcomes of disease and interactions between systems - life-cycle issues, transitions - preventive techniques - complementary therapies.

Fig. 4.7 What sort of doctor?

What could/should complementary practitioners contribute to medical training?

All were keen to contribute and participate and felt very strongly that they had important information to share with and impart to students. The teaching methods they envisaged using reflected the methods in use in the present medical education system (see Fig. 4.9).

What are the implications of community-based training?

Most could not be sure until teachers' objectives were set. Payment of teachers was seen to be the most expensive resource required, with other resources (e.g. venues) seen as available and relatively inexpensive.

What can be taught?

- Preventive medicine/education (including diet, posture, breathing, fitness, relaxation, massage, listening)
- Disease in its widest sense and its relationship to the individual, family, workplace, neighbourhood, lifestyle, ethnicity, culture and time
- Emotional and psychological aspects of disease
- Communication, co-operation, counselling
- Flexibility in approach
- Caring
- Perspectives and roles of other health care professionals in and out of the NHS

Resources available

- Community institutions
- Complementary medical practices
- Primary care teams
- GP practices
- Groups of patients
- Patients in their homes
- People of all ages, cultures, creeds, experiences

Fig. 4.8 Training in the community

- One-to-one with tutor
- Large groups/small groups
- Practice-based workshops
- Treating patients under supervision
- Seminars
- Working alongside primary care workers
- Use of patient feedback
- Use of video and role-play

Fig. 4.9 Possible teaching methods

Summary

The ideas and visions that came from complementary practitioners suggest that they would be a most interesting and useful group to reapproach in the development of a new medical curriculum. Their strength comes both from their particular knowledge of people, systems, health and disease and from their perspectives, energy and experiences which have, in many cases, placed them outside the more institutionalised western medical model of health care.

'Students should be taught to respond to human suffering rather than a set of symptoms. Teaching methods must reflect the need for regaining the confidence of people in western medicine – that there is enough time for them to articulate their condition, that the doctor is really listening.'

'Students should be kept closely in touch with the people to develop their feeling of personal responsibility. A devotional attitude towards others is rare, but working towards this would create a cohesion within the community so that real caring could develop.'

'Competition (which hinders the growth of community-based education) by its nature asserts that we are all separate from one another, sending the community in diverse directions so that cohesion cannot take place. To facilitate growth we need a real foundation which is based on engendering unity – not political unity (which is a minute part) – but social and spiritual unity.'

4.7. The issues for health care purchasers and providers of an increase in CBME

Tyrrell Evans, Mary Seabrook & Steering Group

Key points

- Teaching leads to higher-quality services
- Purchasers have no funds to support teaching
- Increased workloads make teaching more difficult to fit in and do well
- Community trusts offer new opportunities for teaching
- Purchasers and providers should be involved in curriculum planning
- SIFTR is not transferable and a new funding system is required for community-based teaching
- Teaching contracts would clarify expectations on both sides and give recognition to teachers

Aim

To explore the issues and implications of greater community-based education for health care purchasers and providers.

Method

Discussions were held with key personnel from:

South-East London Health Authority
Lambeth Southwark & Lewisham FHSA
Optimum Health Services (Community Trust)
Local GP Fundholding Group
King's Healthcare (King's College Hospital & Dulwich Hospital)
South-East Thames RHA
Policy Consultant to South-East Thames RHA.

Discussions were based on a sheet of questions sent to the interviewees in advance of the meeting. These covered five main areas:

- current roles and responsibilities in medical education
- anticipated future developments in health care and education
- capacity and resources
- bodies to influence
- acceptability of community-based education to patients.

A sample sheet is included in the appendix to this section, on p. 92.

Results

Health care providers

Advantages of teaching. Providers feel that they have a lot to offer to students educationally. They also perceive benefits in having students around, as they believe that teaching and research activities lead to a questioning ethos which has a direct and positive impact on the quality of service provided. Teaching also adds to the status of the health care provider (whether a hospital, community trust or general practice) and helps the organisation to become a 'centre of excellence'.

GP fundholders feel that their commitment towards teaching has not changed as a result of becoming fundholders, although they are more aware of the costs. The new GP contract, however, has had a great impact on teaching because of the additional workload and service pressure on all GPs, irrespective of their fundholding status.

Difficulties of teaching. Teaching may result in additional strain on already busy doctors. This is particularly difficult in deprived areas where the consultation rate is high. Teachers need to perceive personal rewards for their teaching, such as greater promotion prospects which are currently lacking,

particularly in hospitals. There is currently a lack of recognition for teachers both in terms of status and funding.

Teaching requires additional administrative work which is not adequately covered even in hospitals where SIFTR payments are available and not at all in practices. Space is a particular problem in inner cities, where many practices are in overcrowded premises. Current local planning regulations restrict premises development as they do not allow residential property to be converted to health care premises which are classed as business use. This highlights the need for social, educational and health policy to be co-ordinated.

Health care purchasers

Purchasers are not funded to contribute towards medical education. In discussions about their purchasing decisions, the initial reaction was that a provider's teaching status was irrelevant to these decisions unless it resulted in higher prices. On reflection, it was accepted that teaching did generally lead to higher quality services, both in the long term (when the students become doctors) and in the short term (through the effects of teaching on the teachers). Purchasers also accepted that in areas like South-East London where recruitment is difficult, they may have an interest in promoting teaching in order to encourage students to remain in the area after qualification.

The move towards CBME

There is general agreement that education needs to follow the patient and that a greater emphasis on community-based education is therefore appropriate. Secondary care is becoming a progressively smaller part of total health care, and as hospitals become more specialised, it is harder to provide relevant experience for students. Community trusts are seen as having great potential for teaching, providing new opportunities for students – for example, to learn about groups of people not reached through general practice or hospitals, such as the homeless and refugees.

There is no agreement on the best model for achieving a shift of teaching into the community (e.g. whether by a hospital outreach programme or through a contracting model). There is a danger of education becoming fragmented and isolated in the community.

Curriculum issues

It is acknowledged that the current curriculum is out of date and needs to be broadened and updated to reflect the reality of today's doctors' working lives. The current pace of change and the difficulty in forecasting future patterns of service provision make curriculum decisions particularly difficult. It is a paradox that students need to be prepared for the health care of the future, yet educational change always lags behind service change. The medical school needs to produce doctors who are able to respond to unforeseen challenges and new patterns of disease.

At present, there is no feedback system whereby the medical school receives information from employers (health care providers) on how satisfactorily it is preparing students for their future roles. One way in which this could be achieved is through involving health care purchasers and providers in the medical school's curriculum planning.

Financial implications

There would be major financial implications for hospitals if a substantial amount of teaching were to be transferred to the community. Teaching hospitals receive a service increment for teaching and research (SIFTR) payment to cover the additional costs required to support teaching and research. At King's Healthcare NHS Trust, this accounts for about 15 per cent of income. However, this money is very much integrated and 'fixed' in service provision, and it is felt that only about 15 per cent of SIFTR would be transferable if the teaching were provided elsewhere. This is the amount of SIFTR transferred to district general hospitals that undertake teaching of students on behalf of the university teaching hospital. A new form of funding would appear to be required. Both hospitals and community providers will need to be clear about any additional costs caused by teaching and obtain funding to cover them. These financial issues have come under scrutiny since the introduction of the internal market, as purchasers are not funded to support teaching activity.

There is concern that the marketplace will lead to a fragmentation of research, 'short-termism' and a lack of overall ownership of the development of medicine and the health service. It is also possible that the focus on population health needs may change the emphasis in a positive way from the 'high-tech, leading edge' type of research to 'mass' problems, such as asthma or mental illness.

Teaching organisation

There is a move towards developing teaching agreements or contracts whereby medical schools allocate funds for specific teaching services. This would allow a greater variety of providers to bid for teaching and could be one way to encourage community-based teaching. It would make teachers more accountable and give them greater recognition. General practices would welcome such an arrangement as it would clarify expectations on both sides.

Acceptability to patients

The purchasers and providers felt that, while patients in the community were less ill and therefore more likely to be able to cope with seeing students, they may also feel more able to decline on their home territory. It may be necessary to market the idea of students in a way that will encourage patients to accept them.

Influence
The following groups were felt to be important to influence:

- London Implementation Group
- Regional health authorities
- Standing Committee on Postgraduate Medical Education (SCOPME)
- Steering Group on Undergraduate Medical and Dental Education and Research (SGUMDER)
- Local health authority directors of public health.

The RHAs will be undergoing considerable change in the next two years when they will first merge and then undergo a change in role as they become regional offices. Their discretion in the allocation of SIFTR is likely to be reduced but their input into central policy making will increase.

Further work

The issues raised by purchasers and providers have both local and national implications. At King's a number of steps are under way to address the issues raised (see below).

Local developments

SIFTR money. A system has been developed to allocate SIFTR to individual departments (see section 3.1). Over five years the school will move to a level playing field between units by covering the excess costs caused by teaching.
Development of teaching agreements. Local practices and members of the Department of General Practice & Primary Care are involved in a pilot study to set up teaching agreements. This will involve negotiation between the Department, the practices and the FHSA. (See Appendix 1.)
Communication with health care trusts. A Medical Schools Liaison Group has been set up by UMDS and King's (whose medical schools will merge) with major providers of teaching and research (local hospital and community trusts). The initial remit of the group is to share common problems.

National implications
Some issues, in particular problems with the financial and educational structures underpinning undergraduate medical education, require a national solution. Following this series of interviews, further work was undertaken to examine this area and the results appear in Chapter 3.

Appendix: Innovation in Medical Education Project – areas for discussion with SETRHA

Current role

What are your roles and responsibilities in the education of medical students?
What relationship do you have with the medical schools locally?
How do you assess the effects of undergraduate medical teaching within the health care provider units in your area?
What is your opinion of the move towards greater community-based teaching of medical students?

Future

How do you see health care purchasing developing in the future and how might this affect undergraduate medical education?
How do you see the relationships between the purchasers and providers of medical student education (i.e. the medical schools, SELHA/GP fundholders, hospital and community trusts and general practices) – now and in the future?
How would you like them to develop?
How could these relationships affect:

- the development of the curriculum?
- secondary to primary care transfer/substitution?

Capacity and resources

How do you view the current level and method of allocation of SIFTR?
How do you envisage it developing in the future?
What are the implications for health care purchasers and providers of a significant transfer of medical student teaching to the community in terms of planning and resources, with particular reference to:

- finance – is there a need for a general practice SIFTR?
- space/buildings
- personnel
- administrative help
- training and support for teachers?

Influence

Who do you feel should be influenced in order to enable this shift to occur?
Who are you able to influence?

Patients

Do you believe patients/local people will support this change?

4.8 A national view: the 'Widening the Horizons of Medical Education' conference

A national conference was held at the King's Fund Centre on 10 November 1993 to disseminate the interim results of our research, and to stimulate debate. It was attended by over 80 people from medical schools, hospitals and community groups from all over the UK and a few from overseas. The day was divided into presentations by project team members and group discussion sessions. During the group discussion, participants were asked to address the following questions:

(1) What are the opportunities offered by a move to more community-based education for your particular interest group?
(2) What are the difficulties, constraints and challenges faced by this group/these groups?
(3) What strategies might assist in developing community-based education (e.g. curriculum, teaching methods, resources)?
(4) Are there potential solutions to some of the challenges identified?

The groups recorded their ideas on flipcharts which were subsequently collated to form the report below. A list of participants is given in Appendix 2.

Summary of group discussions on CBME

(1) Opportunities

To access a rich variety of learning experiences
Increasingly the community is where most people are
Greater variety of learning experiences
See different types of illnesses, particularly common ones
Greater range of conditions and locations
Progression of disease within context of person's life
Exposure for students who choose to stay in hospital practice
Opportunity to follow through (in longer courses)
The 'real world'

To enable patients to contribute more
Easier for patients to relate to student in their own environment
Not so ill, more comfortable on their territory
More time spent on patients
Improve patient care

Start from what the patient needs
Students seeing 'patients' as people
Educational materials (produced for patients/adapted for students/teachers)
Increase patient : student ratio
Use patients as a verbal textbook
Hear personal views
Patients as partners
Opportunities for student–patient contact outside clerking relationship
Opportunity for patient feedback

To broaden the curriculum and change the emphasis
Reassessing the whole curriculum and assessment process
Better grasp of diseases and problems, chronicity, self-management
Understanding the influence of home and family
Learning different vocabulary among community workers
Importance of prevention
Way of updating curriculum – more in touch with what's happening
More diverse perspectives
Experience of dilemmas, choices, uncertainty, complexity
Opportunity to experience the diversity of health care
Linking undergraduate teaching into longer approach to learning through a lifelong medical career
Insight into non-clinical aspects, business, teams

To develop a different ethos
Different role-models and attitudes
The importance of seeing the patient in context
A holistic view
Seeing the illness as an episode of someone's life with a before and after
Realisation that much care takes place within the family, especially for children
'Myth busting' – challenging assumptions and values
Enabling the student to confront and rethink attitudes/perspectives
Reshaping notion of diagnosis
Patient and student focus in community, doctor focus in hospital

To introduce different teaching and learning styles
More personal teaching on a one-to-one basis with the student
More student-centred
Less threatening
Protected time for teaching
More informal, opportunity for self-disclosure
Can develop spirit of enquiry
Tutors can try a variety of teaching styles
Opportunity for joint teaching (GPs/hospital consultants)

Mentoring
To set standards for teaching and teachers
To evaluate the learning processes which are most appropriate for community setting

To use a wide range of teachers
'Experts' in the community
Opportunity for GPs to develop and learn
To utilise GPs' excellent diagnostic skills
GPs' generalist skills particularly appropriate to needs of undergraduates
Patients as teachers
Complementary therapists
Voluntary organisations
Volunteers
How far could students help each other?
To improve standards of practice

To value the multidisciplinary nature of health care
To demonstrate good teamworking
To see different people's perspectives – patient, carers, family
Multidisciplinary education with nurses, physios, etc.

(2) Challenges and constraints

Great diversity
What to choose
Random nature of exposure
Tension between clarity and variety
Community large, unstructured, diverse
Constructive integration and balance

Funding
For teaching
Extra administration
Teacher training
Patients as teachers
Materials

Management and administration
Lack of integration of care
The current structure of general practice
How to manage 'dispersed service', logistics
Adequacy of funding
Integration/co-ordination

Accommodation
Selection/access to patients, need good range, age, race
Importance but costs of one-to-one relationship
Who do we recruit? Some do not want development
Timetabling

Negative attitudes/resistance to change
Convincing students that this teaching is valuable and comparative to consultant teaching in hospital
No student-centred education in schools
Stigma
Elitism of professions, rather than meetings of experts
New language (e.g. use of term 'community' negatively as 'non-hospital')
Converting the unconverted
Vested interests of hospital teachers – need to forget the past
Divisions/prejudices between general practice, hospital and students
Potential divisions between GPs and hospital

Standards of teaching
Minimum standards definable?
Traditional teaching based on goodwill and non-accountability.
Need for more professional and structured approach
How to teach the teachers
Resources needed for teaching teachers
Quality of records

Students' issues
Physical safety of students (violence, sexual/racial harrassment, dangerous buildings, difficult or unsuspected situations) in both hospital and community
Harassment from colleagues as well as patients
Different risks for students in the community
Supporting students
Accommodation of students in peripheral attachments
Travel costs
Student co-operation

Patients' issues
Patients' good will
Confidentiality (e.g. of records)
Patient exploitation
Recompensing patients
Motivation
Seeing patients as equal partners and not as objects
Need good range (e.g. age, race, level of communication)

Teachers' issues
GPs/practices taking on too much
Awareness/respect.
How do we approach our learning/teaching?
Giving teachers protected time
Funding and resources
Support for teachers other than GPs
Recognition and valuing of teaching
Recognition by medical schools, status of teachers
Insecurity of new teachers, lack of confidence
Needing to provide emotional support for students
Needing to learn about new teaching methods
Difficulties of 'professional patient' with an axe to grind

Curriculum issues
Vision (informs the rest)
Letting the curriculum evolve rather than be prescribed by medical school
How we deal with demand for scientific base
Lack of clarity of aims and evaluation
Constructs for which we do not have language – need to develop
All aspects need rethinking
Materials development
Evaluation of innovations
Assessment procedures
Final exams must reflect changes in curriculum (GMC must sanction this)
Legitimising contributions by medical schools

(3) and (4) Strategies and solutions

Developing staff
Adequate finance to support teachers (including primary health care team members)
Compulsory teaching of teachers incorporating student feedback
Teaching training and follow-through, looking at both content and process
Tutors need to learn to use a variey of teaching methods
Need specific teaching on assessment skills – tutors and students
Sitting 'in' on each other
Videoing teaching sessions
Making teaching learner-centred
Setting goals for teachers (modest and clear)
Link person–staff development in hospital and community
Access informal social support groups
Allowing tutors to function within own self-perceived limitations
Mutual support groups for teaching ('teaching the teachers')

Horizontal links with consultant colleagues
Use vocational training network to train teachers
Administrative support and costs
Supervision of teachers (as with trainers), formative, summative?
Measuring behavioural changes
Identification of skills within teachers and their practices
Non-teaching partners – approach
Encourage all community staff to take teaching courses and staff development
Accreditation (e.g. diplomas, National Vocational Qualifications)
Accreditation/recognition for 'non-doctor' teachers
Good education for hospital doctors as well as community doctors

Teaching strategy
Where are our students from? Academically/intellectually
Variability, potential, preconceptions
What skills do students have when they arrive?
Valuing existing experiences/skills (e.g. family contact programmes)
Importance of contracts including skills, determining what is needed
Define practice standards, including premises
Multidisciplinary involvement – bring constituency in (breaking boundaries)
Packages of educational materials for teachers and students
Tutor representativeness (e.g. sex, race)
Evaluation of original aims, feedback to purchasers

Valuing teaching and teachers
PGEA recognition
Raise GP fee
Value on teaching initiatives, not just research
Rewards (widest sense) for teachers, status
Merit awards
Reaccreditation of teachers
Raising profile of teaching in GP
Develop methodology for evaluating teaching
Convince health commissions that 'teaching' improves patient care – produce evidence that this is the case

Ensuring quality of teaching
Staff development (see separate section)
Reaccreditation as teacher is in itself a quality measure
Patient involvement in quality control of tutors/support staff (i.e. non-medical people involved)
Developing student feedback mechanisms
Need to compromise on quality when large scale?
Identify local strengths

Model of postgraduate training in GP applied to undergraduate teaching?
Check out that model is working, evaluation of aims
Setting aims
Standards – minimum, acceptable, ideal
Standard settings – department, patients
Premises/practice standards
Teaching contract
Define levels of contracts (e.g. basic, intermediate, advanced)
Medical school criteria for teaching standards (monitor student evaluation)
Stipulate protected time
Standards for teaching medicine
Using evaluation forms to raise standards
Reflecting a seamless service

Improving the curriculum

Process
Broader involvement of curricular planning
Ownership of the curriculum by those who teach it
Tutor involvement in course design
Input from newly qualified doctors
Get students to define their curriculum – have some say
Clearly define doctors of the future
Clarify what we mean – aims of community teaching
Define community core curriculum – be explicit about core subjects – clinical skills, communication, etc.
Define detailed structured syllabus (aims and objectives)
Define electives: – broader curriculum, options
– project work for voluntary sector
Relate exam to curriculum changes
Links with humanities
Long-term strategy – introduce to students at beginning of course
Joint training with other disciplines (e.g. joint research projects)

Content
Community attachment
– support for attachment
– integrated into rest of curriculum
– importance within curriculum
– assessment, valuing by other teachers
– preventing marginalisation of new learning schemes
Self-defence training
Retain a lot of old ideas – conventional, traditional
Include medical/scientific research exposure

What is community – what are health needs – epidemiological input?
Ethics committee – set up structure and process
Student's exposure to professional standards
Reflect community needs in practice

Improving accommodation and resources
Central teaching – educational centres (community education centres)
Cost-rent subsidy
On-site education facility
Access to learning resources (e.g. library/computers)
Library Support Officer – link with GP tutors
Loan or purchase of videos and other out-of-pocket expenses
Appropriate learning materials for self-directed learning
Rewrite textbooks

Involving patients
Patients' payments/rewards (plus actors if used)
Develop clear strategy for 'use' of patients in teaching process
Should it be the patients who 'teach attitudes'?
Involvement in teaching, in design of course, in feedback to students
Use patient registers in practices
Careful teacher's vetting of patients
Flexibility of approach (e.g. log books, portfolios, follow patient/family)

Managing the change
Forget the past
Redundancy payments for hospital lecturers
Research views/attitudes community health staff
Ongoing method of consultation

Administration
Local versus national blueprint
Key organisers (department, community)
Whole practice in centres
Develop appropriate IT
Take community into hospital
Use students to teach students
Teaching contracts for reasonable period of time (e.g. 5–10 years)
Learning contracts
Monitoring network (educational) national and international
Register of student attendance
Unify partners of general practice
GP representation on faculty of medicine
Involvement of local medical committees

Team approach/joint responsibility (e.g. geriatrics, terminal care, primary care and secondary care, multidisciplinary)

Safety of students

Give students adequate background information about the area they will be working in, while trying not to reinforce prejudices or fears (e.g. about inner-city areas)
Alarm (e.g. buzzer), mobile phone
Assertiveness training
Training in personal safety (recognising danger signs), how to deal with and defuse difficult situations, practical hints and guidelines (e.g. go in pairs if possible, not leaving one student alone in the surgery)
Self-defence training
Take students' complaints seriously – process for reporting back and action to be included in course literature
Take information from community nursing training, police, Suzi Lamplugh Trust.
Include this training in introductory module (include both general practice and hospital situations)
Educate patients (e.g. statements about not tolerating harassment in patients, brochure, pre-admission information).

Calculating costs

What strategy should be used for setting up, costing and contracts?
– GMSC (involvement)
– Shifting resources (e.g. prescribing costs, fundholding)
– GPs should offer assessed costings
– Contracts
Who do we pay? (e.g. patients)
Explore financial implications – get this right, possible models to pilot
Payment – item of service – capitation
Unit costs: – opportunity costs (e.g. locum, clinical assistant)
– professional fee
– SIFTR/no. of students x FTEs
Separation of teaching and service work for costing
Local admin support costs
'Costing' the attachment
Value for money
Formula – based on locum fee or lump sum?

The conference demonstrated the many common opportunities and problems in introducing more community-based teaching. Participants valued being able to share their ideas and experiences and work towards solutions.

APPENDICES

■ Appendix 1

Developing NHS support for general practices involved in teaching undergraduate medical students

This appendix is a brief summary of a discussion paper prepared by an informal FHSA working group for South-East Thames RHA's Regional University Liaison Committee SIFTR Group. The members of the group were:

Ms Rosemary Crafts, Policy Consultant
Mr Ron Crapper, Director of Finance, Lambeth, Southwark and Lewisham FHSA
Dr Tyrrell Evans, Senior Lecturer, Department of General Practice and Primary Care, KCSMD
Professor Roger Higgs, Department of General Practice and Primary Care, KCSMD
Dr Andrew Harris, Director of Clinical Policy and Research, Lambeth, Southwark and Lewisham FHSA.

The group's initial suggestions were for an adequate and appropriate financial allowance for general practices involved in teaching, and for the development of service agreements for teaching between the teaching general practice, the FHSA and the medical school. We believe that there are clear benefits to the NHS, not least in the raising of general practice standards, from the increased involvement of general practice in teaching medical students.

The NHS must recognise that mainstream undergraduate medical teaching can only occur in general practice if properly resourced.

Teaching allowances for practices approved for teaching

The teaching allowance must reflect that the key issue is the time of the general practitioner. Involvement in teaching will result in some loss of income (fewer patients seen, fewer items of service claims), additional practice staff and primary health care team time costs, accommodation and administrative costs.

We recommend a teaching allowance per session allied to GP locum costs. All teaching sessions and preparatory sessions should be counted as exclusively teaching sessions. There should be no restriction on how the allowance is used, except that appropriate payments should be made to members of the primary health care team outside the practice who participate in the teaching. The entitlement to the allowance (including the number of qualifying sessions) should form part of our proposed teaching agreement.

We believe it is imperative to encourage 'teaching and academic general practice' in the face of competing opportunities for the GPs' time which bring financial rewards. We also wish to sustain an academic and questioning orientation in which general practice as a major resource for research should be nurtured.

We recommend that the current interim scheme to fund additional posts in general practices where service pressures compromise teaching activity should be put on a permanent footing.

Allowances to practices with salaried academics

We believe that the GP contract has created significant additional financial pressures on practices with salaried academics, because there is now an even greater disparity between the average net GP remuneration and the clinical lecturer scale.

We therefore recommend a two-part allowance: a basic academic allowance as well as access to the teaching allowance for practices approved for teaching (except that qualifying sessions would be limited to sessions at the practice with students and directly involving patients). For part-time salaried academics and university general practices the allowances would be set pro rata.

Developing teaching agreements

The proposal to develop teaching agreements aimed to open a dialogue between the teaching general practice, the medical school and the FHSA.

The objective of the teaching agreement is to define with each individual practice:

- what teaching the practice is able to offer
- how the teaching will be done
- what resources the practice would need to do the teaching
- the payments that will be given for that work.

Clarity about the teaching and all that is involved deserves emphasis at this stage of the development of teaching in general practice. The teaching agreements are not intended to be prescriptive decided prospectively, but rather developmental, fitting in with the practice's own agenda.

From the medical school's perspective, the development of these agreements will give them a confidence that teaching requirements are understood and deliverable, and teaching curricula can be based accordingly.

This process will ensure that FHSAs fully understand the teaching commitment being offered and thus the package of support needed.

It is this dialogue that is important, with the purpose of the teaching agreement to focus that discussion.

Benefits which may occur for the NHS from teaching agreements

It may create a process and capacity for the commissioning of teaching and training to address anticipated and actual service changes, especially substitution from the secondary to primary care sector.

It may promote the earlier adoption of successful innovations from peers by 'pump priming', thus enabling more rapid introduction and evaluation of new service models.

The establishment of teaching and training as an appropriate professional practice may help avoid inappropriate referrals and admissions, and promote appropriate usage of secondary and community sectors. Thus a mechanism is created for education which should result in reduced waiting lists and better developed primary care.

It brings together the public health/population focus of commissioners with the individual patient/doctor focus, which is the core of general practice. By introducing clinical policies, health strategies and needs assessment into practice teaching, this creates an opportunity to influence the thinking of future general practitioners, while extending their responsibilities.

There is rapidly achievable improvement in the quality of general practice provided by practices that are involved in teaching students.

Medical students are made aware of the roles, responsibilities and value of the primary health care team.

There is an opportunity to ensure complementarity, and avoid conflict between teaching and service needs.

Piloting the teaching agreements

The development of teaching agreements is now being piloted and tested with six South London practices by an extended group of the originators of this paper, based at the Department of General Practice and Primary Care at King's College School of Medicine & Dentistry. This work has been funded by South-East Thames RHA.

Appendix 2
Widening the Horizons of Medical Education

10 November 1993 – Conference Participants

Mrs J Allan	Undergraduate Administrator, University of Glasgow
Dr Roger Barton	Reader in Medicine, University of Newcastle
Dr Anita Berlin	Lecturer in General Practice, St Mary's Hospital Medical School
Dr Len Biran	Senior Lecturer in General Practice, Department of General Practice, St James' Hospital, Leeds
Dr David Bird	General Practitioner, Tutor, Bristol & St Mary's Medical Schools
Dr Mitch Blair	Dept of Child Health, University of Nottingham
Ms Gerry Blache	Director, South London Education & Development Unit for Primary Care, King's College School of Medicine
Dr David Blane	Lecturer in Sociology Applied to Medicine & General Practice, Academic Dept of Psychiatry, Charing Cross & Westminster Medical School
Dr Josef Bohm	Deputy Principal, Anglo-European College of Chiropractice
Ms Mairead Boohan	Lecturer in Medical Education, Department of General Practice, University of Belfast
Ms L Bullard-Cawthorne	Medical Education Development Officer, National Forum for Coronary Heart Disease Prevention
Dr Peter Campion	Senior Lecturer in General Practice, Department of General Practice, University of Liverpool
Mr Gwyn Carney	Student Enterprise Officer, London Hospital Medical School at QMW
Ms Shiao-yng Chan	Student, Cambridge Community-Based Course
Ms Gillian Clack	Research & Development Officer, King's College School of Medicine & Dentistry
Dr Mike Cooper	Academic Developments Co-ordinator, University of Greenwich
Dr Chris Drinkwater	Senior Lecturer in Primary Care, University of Newcastle
Professor Charles Engel	Medical Education Unit, University College, London
Dr Philip Evans	Faculty of Medicine, University of Liverpool
Ms Linda Finn	Education Officer, British Diabetic Association
Professor Tony Firth	Director, Medical Education Unit, St Mary's Hospital Medical School
Professor George Freeman	Professor of General Practice, Charing Cross & Westminster Medical School
Mrs Christine Hay	Education Officer, National Eczema Society

Dr Eric Gambrill	Deputy Regional Adviser in General Practice, University of Surrey
Dr Iain Grom	General Practitioner, Blantyre Health Centre, Glasgow
Dr Andrew Gellert	General Practitioner, London NW10
Mr Roger Haugh	Dept of Health, NHS Management Executive
Professor Sean Hilton	Head of the Department of General Practice, St George's Hospital Medical School, London
Ms Dianne Hinds	Educationalist, Cambridge Community-Based Course
Dr J V Howard	Associate Adviser in General Practice, SW Thames Region, University of Surrey
Ms Maggie Jee	Researcher, Innovation in Medical Education project, King's College School of Medicine & Dentistry
Dr Steve Jones	Clinical Lecturer in General Practice, Cambridge University
Ms Diana Kelly	Patients as Partners, Dept of Epidemiology & Medical Statistics, London Hospital Medical School at QMW
Professor Brian Kliger	Principal, Anglo-European College of Chiropractic
Mr Wilfried Kunstmann	Faculty of Medicine, University of Witten/Herdecke, Germany
Dr Cindy Lam	Head, General Practice Unit, University of Hong Kong
Ms Mary Lawson	Research Associate, Academic Dept of Public Health, St Mary's Hospital Medical School
Dr Francis Lefford	Senior Lecturer, Department of Anatomy, University College, London
Dr Colin Leonard	Senior Lecturer, Charing Cross & Westminster Medical School
Dr R M Lewkonia	Office of Medical Education, University of Calgary
Dr John Loakes	Associate Adviser in General Practice (Wessex Region)
Dr M N Marshall	General Practitioner/Research Fellow, University of Exeter
Ms Helena McNally	Faculty of Medicine, University of Belfast
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Mrs Helen Pearson	Medical Education, University of Leicester
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Dr David Percy	Wessex Regional Health Authority
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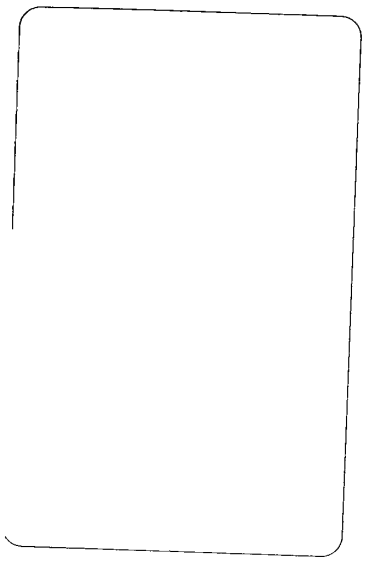

Over the past few years, the pattern of health care in the UK has been changing. Today, care is increasingly provided in the community setting. However, for the majority of their time, medical students are still taught in the hospital.

The General Medical Council has recommended changes to the way in which doctors are taught. It wants to see students given a greater range of experience of primary care and community health services. Yet, how could such moves be brought about, and what would the implications of such changes be for all those involved?

This well-researched report, the result of a two-year project, sets out to answer these questions and includes:

- guidelines for setting up community-based teaching, based on the experience of the King's College Medical Firm in the Community
- details of the various stakeholders' views on increased community-based medical education and its implications for them
- an analysis of the funding and accountability of medical education at a national level.

Essential reading for medical students and teachers, this book will also be of interest to patients, general and complementary practitioners, primary and community health care workers, purchasers and providers, and statutory authorities.

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