Aims and Scope
The Academy of Medical Educators (AoME) was established in 2006. The main aspiration of the AoME is to improve clinical care through teaching excellence. *Excellence in Medical Education* has been designed with this aspiration in mind. The first five issues will focus on the AoME Professional Standards with invited expert reviews. Future issues will be based on specific educational themes with invitations to submit articles with a peer review process.

*Excellence in Medical Education* has been designed for the active and busy medical, dental and veterinary teacher. The aim is to highlight important educational topics, discuss challenging and controversial issues and stimulate debate. The series embraces 21st Century medical education with expert reviews, interviews and specialist articles. The series will provide an inspirational and thought provoking journey into the exciting field of medical education. We welcome articles and reviews for future issues so if you would like to contribute or comment please contact the Editor, Dr Vimmi Passi, at: vpassi@aol.com

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# Contents

**Welcome from the Editor** ........................................................................................................... 4

1.  The AoME Professional Standards.......................................................................................... 5

2.  Professional Standards – Domain Five: Educational management and leadership.................. 6

3.  Worthwhile Education: A Vision for Educational Leadership............................................... 7

4.  Is it time for transformational change in medical education – but how can it be achieved?.......................................................... 11

5.  Cost-effective remediation........................................................................................................ 15


7.  Medical Education – a Dean’s journey.................................................................................. 28

8.  Interview with the President.................................................................................................... 30
Welcome from the Editor

Dr Vimmi Passi,
Editor of Excellence in Medical Education

Following the success of the first three issues, I am very pleased to welcome you to the forth issue of Excellence in Medical Education, an exciting new educational product for the members of the Academy of Medical Educators (AoME). This series embraces 21st century medical education with expert reviews, interviews and specialist articles. It also provides an inspirational and thought provoking insight into the exciting field of medical education.

It has been an exciting year for the Academy and the AoME Education Committee has been leading in many national and international events. We led an exciting symposium at ASME AGM on Assessment in Medical Education and also held a successful workshop in AMEE in Prague on Developing a Caring Culture in Healthcare. In addition, many AoME Recognising Teaching Excellence Workshops have been held throughout the UK. We are very much looking forward to welcoming you all to our Annual Academic Conference-Shaping the Future Medical Workforce in London on October 23rd 2013.

In this issue of Excellence in Medical Education, we focus on AoME Professional Standards Domain Five, Educational Leadership and Management. There has been an explosion of interest in educational leadership over the past decade with some excellent books and journal issues highlighting the key aspects of leadership and management. We were therefore keen to produce a unique publication and this issue explores some varied, exciting topics on leadership and management, written by experts in the field.

This Issue begins with an overview of Domain Five of the AoME Professional Standards which focuses on educational leadership, management and governance. This then leads to four thought provoking articles highlighting some exciting themes in medical education: The articles effectively describe a new vision for educational leadership in postgraduate medical education; explore transformational change; highlight the importance of cost effective remediation and embrace leadership in ecological healthcare. We aspire that these topics will stimulate debate among educators both nationally and internationally.

The final two articles highlight the professional journeys of two Academy Leaders. It is a great privilege to include both these articles in this issue and I believe these journeys will inspire the future generation of medical educators. Professor Derek Gallen, Chair of the AoME Membership Committee describes an exciting insight into his academic career leading to his current role of Postgraduate Dean of Wales. The final article is a truly inspiring interview with the President of the Academy, Professor Sean Hilton. I would also like to take this opportunity on behalf of the Academy Executive and Council to sincerely thank Professor Hilton for his enthusiasm, support and excellent leadership over the past three years as our President.

Excellence in Medical Education has been an exciting new venture and I would like to thank all of our expert authors for their thought provoking and fascinating articles. It has been a great pleasure working with you all. We welcome articles and reviews for future issues, so if you would like to contribute or comment, please contact me at vpassi@aol.com.
1. The AoME Professional Standards

The Academy of Medical Educators (AoME) is a charitable organisation developed to advance medical education for the benefit of the public through:

A. The development of a curriculum and qualification system;
B. Undertaking research for the continuing development of medical education; and
C. The promotion and dissemination of best practice in medical education.

In order to achieve these objectives, the AoME’s Professional Standards have been produced. These Standards have been designed to provide the basis upon which a curriculum for medical educators can be developed. They act as a framework against which professional progression as an educator can be planned and measured. The Standards are a tool designed to assist medical educators to work towards excellence.

To be engaged in effective and appropriate professional development is an integral part of Membership and Fellowship of the AoME. The Standards aim to help clarify the professional characteristics that should be maintained and built on for the variety of roles undertaken by medical educators. The Professional Standards are divided into themes and each theme provides details of the knowledge, understanding and practice that underpin the roles of those involved in medical education.

The Standards may be used by organisations to identify the skills and competencies required of those who undertake or fulfil an educational role. Organisations may also use the Standards to develop and offer a framework for training and continuing professional development in support of medical education. The Standards could be considered when setting objectives in performance and appraisal and used for assessing the performance of individuals within organisations.

The Professional Standards are divided into core values of medical educators and five domains.
2. Professional Standards – Domain Five: Educational management and leadership

<table>
<thead>
<tr>
<th>Element</th>
<th>Standard Level 1</th>
<th>Standard Level 2</th>
<th>Standard Level 3</th>
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<tbody>
<tr>
<td><strong>Education management</strong></td>
<td>5.1.1 Manages personal educational time and resources effectively</td>
<td>5.2.1 Manages educational programmes and resources, including individuals and financial resources at a local level</td>
<td>5.3.1 Manages educational programmes and resources, including individuals and financial resources beyond the local level</td>
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<td></td>
<td>5.1.2 Achieves intended educational outcomes by meeting the learning needs of individuals</td>
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<td><strong>Educational leadership</strong></td>
<td>5.1.3 Understands role in local education</td>
<td>5.2.2 Leads educational projects or programmes locally</td>
<td>5.3.2 Advanced ability to communicate, lead, develop, integrate and formulate a wide range of educational interventions and programmes</td>
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<td>5.2.3 Supports the educational development of others within a local team, faculty or department</td>
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<td>5.3.3 Impacts upon medical education beyond immediate geographical locus</td>
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<td>5.3.4 Contributes to educational policy and development at a national level</td>
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<td></td>
<td></td>
<td></td>
<td>5.3.5 Successfully discharges senior roles in medical education</td>
</tr>
<tr>
<td><strong>Educational governance</strong></td>
<td>5.1.4 Understands the roles of statutory and other regulatory bodies in the provision and quality assurance of medical education</td>
<td>5.2.4 Is involved in the provision and quality assurance of medical education</td>
<td>5.3.6 Is involved in the development of effective educational standards or governance frameworks</td>
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3. Worthwhile Education: A vision for Educational Leadership

Professor Linda de Cossart and Professor Della Fish

Summary

This article offers a definition of educational leadership as appropriate for postgraduate medical education, indicates what we mean by this, why it is important and how it can promote worthwhile education. It argues that educational leadership involves far more than educational management and, to be of quality, requires an understanding of education as a practice, educational vision, courage, and expertise.

Introduction

We offer here a new vision of educational leadership in postgraduate medical education (PGME) and contrast this with educational management in PGME.

We thus challenge current ideas that seem to conflate the two in ways we find unhelpful. Some detail is also offered about the educational vision that we believe should shape the practice of PGME. Although this paper is focused on the responsibilities of educational leadership as engaged in by experienced clinical and medical practitioners, we are aware of the very important role of others in the field including education centre managers.

The thinking that we share here arises from our experience in and critique of current practice and is informed by our view of the importance of what is involved in ‘worthwhile education’ for postgraduate doctors.1

Educational leadership: vision, capability and expertise

We believe that leadership in PGME should be about having the vision, capability and expertise in the practice of education to lead from the front the enterprise of developing postgraduate doctors educationally.

We believe that the vision for PGME should encompass a new emphasis on the ontological aspects of education which is about developing human flourishing, (self knowledge, a sense of identity and an awareness of what it is to be a doctor), in addition to attending to the necessary but not sufficient epistemological aspects (the technical expertise in skill and medical knowledge).

We see the capability and expertise of educational leaders in PGME as intellectual, moral and practical. This means that firstly they both fully understand and appreciate ways of engaging in the practice of education so that junior doctors are better facilitated to learn, and so that what they learn is emancipatory. Secondly, they are committed to the importance of the teacher paying the learner moral and intellectual attention (which means knowing each learner and attending appropriately to their crucially differing wants and needs).2 Thirdly they are able successfully to engage in the actual practice of education (as opposed to ‘delivering training’) — to enrich juniors’ medical and human understanding, expand their insights and deepen their thoughts and feelings, all of which are so influential in their clinical decisions and professional judgements.3,4,5 We see this as a proper recognition of the nature of worthwhile educational practice, where importance is given to nurturing the human flourishing of the learning doctor so that they will be able to bring intelligent kindness to their patients.6

Such educational leaders will also have a firm hold on the arguments for education. Training imposes ways of thinking and acting on those who cannot or will not either think or decide for themselves, or commit to a moral view of healthcare practice. This makes the trained, someone else’s agents. Education, by contrast, develops personal vision, thoughtful engagement, and requires individual commitment to personal practice which is based on a moral awareness. This enables the educated to be the responsible and principled agents of their own conduct within the ethical parameters of healthcare practice.7

For these reasons, leaders in postgraduate medical education should have the courage to argue for replacing training, (which is concerned only with inculcating change in the trainee’s behaviour, so that they adopt, but do not own and personalise the ideas and standards imposed upon them), by engaging instead in the kind of worthwhile education we have characterised above. As educational leaders they will need to address the risks of a mind set that sees doctors as part of the ‘workforce’ (as opposed to members of a profession).8 This view assumes that all members of the NHS are there to be to be ‘shaped’ by ‘the delivery of’, or ‘trained in’, skills and behaviours, as opposed to developing expertise and attending to how they conduct themselves as driven by their own personal and professional values.

Training is seen as necessary in order to make people ‘perform’ in ways that conform to the NHS values of ‘behaving with respect and dignity and showing...
Excellence in Medical Education

compassion’, whereas medical education should, we would argue, address the need of doctors to understand their own identity as a person and a professional in order to ‘live’ their values and be true to themselves — in addition, of course, to having the vital skills and knowledge that are part of being a doctor.

In short, we see leaders in medical education as those who not only understand and can articulate what is involved in worthwhile education (including assessment), but who are actually able to engage practically as teachers with learners in ways that are very different from the inappropriate and inadequate processes (driven by a tick-box mentality) that are currently offered to many postgraduate doctors. We further argue that in the light of the Francis Report and all the recent fiascos in medical practice, we should all recognize that the central concern of PGME is to develop doctors whose aspiration is to place the patient at the centre of their practice, and to serve them not only with expert technical skill, but also with moral understanding, knowledge, humanity and humility.

Leadership as a capacity exercised at all levels

We see leadership generally as a capacity that is exercised by people at all levels in an institution (in this case, in the NHS generally and in their own immediate place of work particularly). Leaders are those who pose difficult questions and demand change from those they work with. They meet the technical challenges about processes and are imaginative and adaptive about issues. Above all, they value personal relationships and understand that they need to require others to grapple with difficult issues. By definition we would argue that this means that all successful teachers, wherever they are in the system, are inevitably leaders, because being good teachers means working to these core principles.

Educational management: requiring different expertise and understanding

By contrast to this, we see educational management as providing the very important supporting structures and organisation for this PGME enterprise but not as engaging expertly in educational practice. This kind of leadership certainly involves understanding the complexity and subtlety of worthwhile education and the arguments for it (as opposed to those for the quick-fix promise of the crassly simplistic and superficial nature of training). It also requires having the political expertise and knowledge of the systems to negotiate sympathetic but robust structures and mechanisms to give PGME appropriate status, time and space to achieve its ends. Thus, it attends to the more technical aspects of the provision of PGME and the systems of regulation (exams and competency testing). Whilst this is important, it does not of itself work at the real heart of a doctors’ professional development, but rather facilitates those who do.

Leading forward worthwhile postgraduate medical education

On this argument, then, educational leadership in PGME, requires all who are involved in teaching postgraduate doctors, to be immersed in the philosophy and values espoused across the centuries in the commonly agreed principles and practices of teaching and learning, which we have come to call worthwhile education in the moral mode of practice.

By ‘flourishing as learners’ we mean that the human being the doctor is grows in capability, confidence and effectiveness as a member of the medical profession through the practice of sound education offered, in practice, in the healthcare organisation in which they work. Such flourishing should lead to a maturing practitioner ready to take on the full responsibilities of being a member of the medical profession, including caring for patients, researching their practice to improve it, teaching the next generation of practitioners and being able to account intelligently and honestly, for their professional life.

Such flourishing may not be measurable but is certainly appreciable by patients and all those who work and live closely with young professionals being educated in this way. Appreciation of this has been seen in an evaluation of a course offering education in the moral mode of practice. It is our experience that when young doctors (and their teachers) are offered professional development which values attending to the ontological aspects of their development (attending to their being a professional) as well as ensuring their acquisition of relevant empirical knowledge, they each become a happier, more confident and more capable professional. This ontological element, which was probably tacit in the ‘old fashioned’ education and training, is
completely missing from most specialty curricula currently regulating PGME. There is a growing theoretical literature supporting the importance of it.\textsuperscript{14,15}

We believe that it is more than time for all associated with AoME, all directors of medical education and all who actually teach practising doctors in their clinical settings to address these matters and aspire to become proactive in developing these educational leadership attributes. Our patients are calling for this. We will fail our most precious resources — our medical graduates — if we do not respond.
References


4. It is time for transformational change in medical education. But how can it be achieved?

Dr John Sandars

A recent commentary of a special issue of *Academic Medicine* considered that transformational change in the way that medical education is provided was essential if twenty-first century healthcare needs are to be effectively addressed.\(^1\) This is no ordinary challenge for medical educators since transformational change is when ‘an epiphanic or apocalyptic event’ has been provoked.\(^2\)

Transformational change can be considered to have occurred when there is ‘a shift in the business culture of an organization resulting from a change in the underlying strategy and processes that the organisation has used in the past.’\(^3\) In the context of medical education, what does this mean for educational leadership and management? I will illustrate the essential aspects of both transformational change and the leadership required to achieve transformational change by using the implementation of curricula to improve patient safety, a current major priority in healthcare.

The work of Argyris and Schon on single-loop and double-loop learning in organisations can provide useful insights into some of the conditions required for transformational change.\(^4\) Single–loop learning occurs when an event triggers a need to change and a simple, almost knee-jerk, solution to deal with the event is quickly selected. For example, the curriculum may not include patient safety, as recommended by the General Medical Council (GMC), and the chosen response by the medical educator is to introduce a couple of lectures by a consultant surgeon or anaesthetist on the principles of patient safety and the use of checklists to avoid error. This approach is concerned with ‘doing things right’. However, double-loop learning requires a more questioning approach to inform change. In double–loop learning, it is essential to develop insight into why something should be different. In contrast to single–loop learning, this approach is concerned with ‘doing the right things’. For example, the stimulus to include patient safety in the curriculum may be the result of one of the inquiries into poor healthcare, such as the recent *Francis Report*. A fundamental change in the curriculum is likely to be required if medical educators are to effectively respond to the recommendations of the *Francis Report*, with the aim of achieving the changes that are required for safer healthcare in the organisation. The new curriculum will need to consider not only an overview of the importance of organisational culture in patient safety, with its emphasis on individual and collective attitudes to patient safety, but also provide time to explore the personal and organisational implications of taking responsibility and whistleblowing. This change will require implementing learning opportunities that can challenge beliefs, not only for the learners but also for their tutors.

Double-loop is not enough to ensure that transformational change will occur in an organisation. Triple-loop learning is essential for transformational change since it concentrates on the core values of the organisation, including how these values are expressed in the main processes that characterise the organisation.\(^5\) It is only by challenging and changing how these values are expressed, that the culture of an organisation can achieve change. The importance of triple-loop learning in medical education can be illustrated in the following two examples.

- **Kneebone** has challenged the philosophy of simplification in simulation, with an argument that procedural skills should not be disembodied from their clinical context and that simplification of a complex process can interfere with deep understanding.\(^6\) He recommends that complexity should be reintroduced in simulation, where learning from mistakes can occur without direct impact on patient safety.
- **Aron** and Hendrick creatively use the analogy of the various filters that act as barriers to prevent patient safety incidents to highlight the contribution of the range of different factors that need to be carefully considered if transformational change in medical education to improve patient safety is to be achieved.\(^7\)

The range of core processes that contribute to medical education have to challenged, such as the admission criteria, the teaching methods, the approach to assessment and the early identification of un-professional behaviour. Developing tutors who are aware of their own responses to witnessing un-professional behaviours and understanding the response of the medical school or postgraduate institution are also essential aspects of medical education that can contribute to improved patient safety.

Transformational change requires triple-loop learning that is concerned with ‘why should we be doing it that way?’. The main aspects to be considered and challenged are the influences on the present way of ‘doing things’, especially the policy directives that dictate the curriculum and how an organisation responds to these directives.
The curriculum is mainly determined by external bodies, such as the GMC with its statements of expected outcomes in *Tomorrows Doctors* or the Curriculum Statements in the GP Curriculum of the Royal College of General Practitioners. However, the meaning and intent of these statements require critical discussion by medical educators who are expected to implement and make changes in the way that they craft the learning experience.

The essential aspect of achieving transformational change is to recognise that diversity of opinion exists in an organisation, understand why there is diversity and to achieve a working consensus that is expressed as the culture of the organisation. Implementing systemic cultural organisational change for transformation requires transformational leadership, with a ‘hearts and minds’ approach that involves all members of the organisation.

This diversity leadership and management approach recognises the importance of diversity in the values of each member in regard to the curriculum. These values may come from fundamental philosophical beliefs (such as the autonomy of individual learners), from previous experiences as a teacher or learner (such as preference for didactic presentations), or from a perception of the ‘best evidence’ (such as systematic reviews on a particular educational method). The values may also come from an acceptance of policy directives, especially when the medical educator feels powerless in calling into question the apparent wisdom of these policies. The style of transformational leadership is in contrast to instructional leadership, with a ‘command and control’ approach to implementing change. Although the leader may espouse a more participatory approach, it is essential to be critical and explore the extent to which the beliefs of the leader about the conditions required for change are congruent with their actions.

At the core of transformational change is a critical and participatory process. This critical aspect recognises the importance of challenging values and the participatory aspect recognises an active and collaborative approach that involves all individuals of an organisation. There are several possible methods for this process of change, but action research has the potential to achieve sustainable and transformational change in complex education organizational systems, including the introduction of new teaching interventions and curriculum development. Action research has been widely used in many educational contexts as an effective approach to achieve transformational change, but a recent literature review identified few studies that have used this approach in medical education.

Action research in organisations can be performed in different ways, but there are some common features. A partnership between all participants is a key feature, along with a dynamic approach that has clear cycles of problem identification, planning, action and evaluation. The results of each phase will iteratively inform the next stage.

An essential aspect is the evaluation phase since it is within this phase that mutual critical reflection considers the underlying beliefs and assumptions that are held by the members of the organisation. A collaborative discussion of how these individual and collective beliefs influence the values of the organisation, stimulates a redefinition of the problem and the proposed intervention. This is the phase when the essential double-loop and triple-loop learning can take place.

An important aspect of action research is that it recognises that it is often only through implementing an initial intervention that underlying problems in the organisation begin to surface and become apparent to the participants. For example, the impact of an intensive training intervention on handwashing technique may be significantly reduced when students observe lack of attention to the technique by healthcare professionals during their clinical placements. This finding may stimulate awareness of the difficulties of making clinical colleagues aware of what students have been taught and how they are expected to perform. However, this finding could highlight the fragile cracks in the current relationship between the medical school and the local healthcare providers. In this circumstance, it is unlikely that transformational change will occur in the curriculum unless there is action to address the relationship.

The recent literature review provided an insight into how action research has been used for curriculum development and implementation in medical education. Most studies appear to have only considered action research as an approach to participatory change management with the use of one or two cycles and with little critical reflection that can inform the refinement of further interventions in subsequent cycles. This limited approach to action research reduces the potential value of action research to medical
education, especially when transformational change is the aim.

Transformational leadership for transformational change requires a more dispersed leadership model that is not prescribed by roles and the status-driven hierarchical features that are typical of many organisations. The focus of the transformational leader has to be the individual within the organisation and is concerned with raising awareness of the existence of problematic issues and then facilitating double-loop and triple-loop learning. This style of leadership is highly principled, with a focus to ensure that the ‘right’ decisions will produce the desired impact. Principled leaders are not only aware of their own beliefs and values, but hold onto their principles during the difficult times of transition that occur in any change process. The essential leadership skills are challenge and support. Challenge within a supportive environment creates an opportunity to identify and confront the underlying beliefs, both individual and collective, that influence all actions.

Transformational change is not only a medical education leadership activity but is also about the scholarship of medical education. The aim of scholarship of teaching and learning can be simply stated as making transparent the process by which the educator has made learning possible. This transparency should reveal the influence of underlying beliefs, principles and values, as well as how the influence of these factors have been modified to produce the learning experience.

Implementing and embedding transformational change in medical education is a challenge to all educators, but it is essential if the aspirations of medical education on future healthcare are to be fully realised. Leading and managing the process of transformational change highlights the importance of participatory approaches that have a clear focus on creating challenging, yet supportive, environments. Nobody has said that achieving organisational change will be easy, but it is more likely to occur if there is better understanding of the process by which organisations can change.
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5. Cost-effective remediation

Dr David Mendel, Dr Kieran Walsh, Dr Julia Whiteman

Abstract

Remediation was the focus of a recent Department of Health steering group report1, which adopted a definition of remediation as: the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling to more formal supervised programmes of remediation or rehabilitation. There is a small but growing evidence base on what is likely to constitute effective remediation. However the costs of remediation are difficult to define – they depend largely on the remediation programme that is required by an individual healthcare professional. And by its nature remediation needs to be tailored to an individual's requirements to have a good chance of success. Relatively little is known about what may constitute cost-effective remediation for healthcare professionals. There is little original research on which to base conclusions but we can draw some guidelines from first principles. An early holistic assessment, coupled with specialist and targeted services, has the potential to reduce costs both through avoiding long suspensions and through targeting remediation interventions towards identified needs in individuals most likely to benefit.

Introduction

Remediation of doctors whose performance has fallen below an acceptable standard is important. It is also important that screening processes to identify such doctors and remediation services to help them are both effective and cost-efficient. In these times of financial stringency those responsible for managing concerns about fitness to practise of the small, but growing, minority of doctors whose performance has failed to meet the expectations of patients, colleagues, commissioners and regulators, may ask how favourable outcomes can be achieved with the least expenditure.

As strengthened medical appraisal and revalidation are introduced across the UK there is likely to be a further increase in the number of practitioners for whom remediation is considered appropriate. All doctors with licences to practise are now required to demonstrate that they are participating in a process of periodic review (appraisal) and working within a governed system. They therefore now relate to the Responsible Officer (RO) of the organisation or ‘Designated Body’ through which they maintain their connection to the General Medical Council (GMC) for revalidation purposes. The RO for a Designated Body has a wide-ranging role set down in legislation. The RO legislation makes it a duty for ROs to ensure that doctors are appropriately trained and supported in the range of roles they fulfill across the scope of their practice and that remediation is available to address any causes for concern.

(revalidation is the process in the UK whereby doctors will maintain their registration by showing that they are up to date and fit to practise; in other countries it is called maintenance of certification or maintenance of registration).

For the purposes of this paper we are exploring cost-effective remediation for doctors outside of training grades who have performance problems and, although there is no doubt a human cost to be paid by doctors undergoing remediation, in this article when we mention costs, we mean financial cost. Whilst knowledge of what makes effective medical education has advanced2,3 we know relatively little of what educational interventions are the most cost-effective and the research that does exist to date is often of low methodological quality.4 Sandars5 suggests the challenge in measuring the cost-effectiveness of education lies in both identifying the true costs of educational interventions and agreeing on expected benefits that are appropriate to the wide variety of interested stakeholders. In this paper we will examine in detail a number of points. We will look at;

- How best to screen for doctors who need remediation
- What is likely to be effective remediation?
- How best to identify the costs of remediation including
  - The cost of screening and assessment PLUS
  - The cost of remediation itself PLUS
  - The cost of time away from work for remediation PLUS
  - The cost of assessment of the effectiveness of remediation MINUS
  - The cost of failure of remediation or of not doing anything
    - How best to provide cost-effective remediation
    - What conclusions can be drawn?)
How best to screen and then assess doctors who need remediation

Assessment programmes that identify poor performance operate at three levels:

1) Screening whole populations of doctors e.g. appraisal, revalidation, recertification.
2) Targeting “at risk” groups e.g. older doctors, isolated practitioners.
3) Assessing individuals whose performance has given rise to concern e.g. through complaints or other governance processes.6

If we are considering the effectiveness of remediation, the process used to identify underperforming doctors is arguably relevant. Firstly, it should be analysed in relation to its own effectiveness and secondly it is likely to influence the numbers and characteristics of the doctors with remedial needs that are identified.

Studies on screening of practising doctors, as in Canada,7,10 may give a more realistic estimate of the prevalence of dyscompetence than complaints to regulators, and is judged by Williams11 as likely to be somewhere between six and 12%. The latter figure, applied to the approximately 175,000 doctors in the UK, would give a figure of 21,000 doctors requiring remediation, a costly and daunting prospect. UK studies to date, however, have given far lower figures. Bahrami and Evans’ survey of UK Deanery involvement with underperforming GPs over a two-year period found that the numbers included comprised only 0.0016% of the workforce (in the UK deaneries are responsible for the commissioning, management and delivery of postgraduate medical education).12 Taylor’s survey of doctors thought to be under-performing in another deanery found a variety of methods used for identification and very small numbers of doctors being referred to under-performance procedures, but larger numbers of doctors suspected as needing help with performance through a variety of sources including targets, practice inspections, pharmaceutical advisor input and other quality assessment systems.13 Another scheme for identifying and supporting under-performing GPs estimated a prevalence of 1-2%.14 These studies, however, are not recent and the effect of strengthened medical appraisal, revalidation and increased performance monitoring by commissioners can be predicted to increase the numbers of doctors identified as under-performing.

This emphasises the need to understand the extent to which the characteristics of the population of doctors identified as needing remediation depends on the methodology used – for instance, does the very small percentage of doctors identified by the regulator through complaints differ from those referred by commissioners or through screening by appraisal and revalidation? If we focus on competence and leave aside issues of health and behaviour, we may question whether some practitioners have ever achieved today’s standards of competence, and if they have come to attention because standards and expectations have changed rather than because of any change in their performance. This implies that capacity and capability may need consideration before offering remediation to practitioners who have not, and who arguably never had, the competency base for completing modern specialty training.

The impact of health on doctor’s performance has received relatively few publications15 but it is estimated that up to 15% of doctors will be impaired at some stage in their careers. Gibson, Kartsounis and Kopelman16 point out that assessment of cognition is complex and multifaceted. A quick questionnaire able to assess higher functions for doctors in this context does not exist. Specialist occupation health assessment is needed, backed up by neuropsychiatry and neuropsychology where necessary.

What is likely to be effective remediation

So, having identified doctors with performance difficulties, what are the most effective elements in the black box of successful remediation? Rather than concentrating solely on knowledge and skills gaps it is likely that a model that looks at the ‘biopsychosocial functioning of the physician as a whole’ will be more effective: a failing physician may have a number of problems, for example, they may have fallen behind in their clinical knowledge as well as being depressed or anxious or lacking motivation.17 In light, external as well as internal factors may contribute to a doctor failing to practise to an acceptable standard, so effective remediation should at the very least look at external factors and, where appropriate, attempt to modify them. The evidence suggests that remediation will be most effective when it starts off by using a number of tools to discover and delineate deficiencies and then enables tailored and individualised education, supervised practice with regular feedback and finally re-assessment at the end.18
Although much work remains to be done, there is already a small but growing body of evidence of what is effective remediation and there is some evidence that remediation can help doctors improve their performance. However, the evidence is not overwhelming. For example, Hanna et al reported on five moderate to severely dyscompetent doctors given a three-year individualised remediation programme including a variety of state of the art educational interventions, which have been shown to be successful elsewhere in CME, and found that only one improved whilst three actually deteriorated. Hauer et al's thematic review found only four studies of remediation in practising doctors which met their inclusion criteria, all from Canada, and none measured outcomes at the highest level of Kirkpatrick's hierarchy, improvement in outcomes for patients, but three were able to demonstrate positive changes in behaviour.

Many doctors referred for remediation feel angry, or feel that they have not received justice from assessing authorities and some of them who have had to try to function in unacceptable workplace environments will have a degree of justification. For these reasons remediation should ideally be delivered by a body that is independent of the assessing authority. Remediation should be flexible and supportive and must take adequate account of a doctor's motivation to change. Arguably, gaining insight and engaging in the process is the most crucial step in achieving successful remediation and the skills required to help doctors achieve this step will be difficult to cost. Finally, when the intensive period of remediation is over the doctor and their supervisor must put long-term plans in place to continue to maintain their new level of competence.

### How best to identify the costs of remediation

To work out the costs of remediation we must identify

- The cost of screening and assessment PLUS
- The cost of remediation itself PLUS
- The cost of time away from work for remediation PLUS
- The cost of assessment of the effectiveness of remediation MINUS
- The cost of failure of remediation or of not doing anything

### The cost of screening and assessment

The cost of screening and assessment must be taken into account in the first instance. Here international comparison offers some starting points. Finucane et al.'s survey of assessment programmes in Canada, Australia, New Zealand and the UK for 2001 noted that the UK GMC carried out the highest number of level 3 assessments, (on individuals whose performance has given rise to concern), at 160, costing £3.7m (equivalent to US $5.9m), had the largest budget, and covered the largest number of doctors at 200,000. All assessments were carried out by regulators backed by legislation, some deliberately at arms length from licensing authorities. Only one had received a legal challenge when surveyed but most had an appeals mechanism. Funding for level 1 assessments was generally through licensing authorities via annual membership fees, whilst level 3 funding was generally on a cost-recovery basis paid all, or in large part, by the doctor under investigation. Costs included administrative and support staff as well as practising physician assessors. Budgets were hard to compare, as there were different sizes and scopes of programmes. Level 1 constitutes low stakes screening whilst level 3 is high stakes and assessments must be rigorous. Assessment tools varied widely and involved a trade-off between reliability and validity on the one hand and cost and acceptability on the other. Case discussion, doctor interview, notes review, use of standardised/simulated patients, and direct observation were the most popular means of assessment.

### The cost of remediation itself

Having identified doctors with performance difficulties, the next challenge is to work out the costs of providing effective remediation. This is not straightforward as most doctors in difficulty have complex needs which encompass both individual and context-related issues. Context is increasingly recognised as important and Cox et al suggest the term ‘remediation’ may indeed be viewed as inappropriate or unhelpful when used in relation to factors that are not necessarily the fault of an individual. They suggest the following issues commonly apply: individual (internal) factors including physical health, psychological health, personality and attitudes, education, training and CPD, and work-associated (external) factors – including climate and culture, team working, leadership, workload, sleep and shift work.
Remediation interventions to address these issues typically consist of workplace support e.g. mentorship and supervision, retraining e.g. in a training practice with a trainer who supervises practice and learning, and support outside service provision e.g. for practitioners who have been suspended by the GMC. Typical direct current costs for these interventions at the London Deanery Professional Support Unit are £700 for four sessions of mentoring and £500 for two hours of face-to-face educational supervision. Coaching in language skills and learning behaviours are additional costs that may be applicable in some cases. For retraining on the Induction and Refresher scheme, led by the GP National Recruitment Office, the minimum cost is to cover the trainer's allowance – £7645 per annum. There is considerable variation in the level of any salary paid to the GP from zero, through to the minimum wage, to £20,000 per annum.

Indirect costs include administrative costs within Deaneries, providers and regulators which are currently centrally funded and free at the point of need. As these bodies become self-financing through charges at the point of use, the costs will become more obvious. Hidden costs include GMC registration fees and medical defence subscriptions, both of which have risen steadily to support the increasing activity around doctors’ performance.

The cost of time away from work for remediation
Remediation is also likely to result in loss of income for the doctors concerned, through suspension, reducing working hours to allow time for remediation, or through difficulty obtaining employment due to restrictions by, and known involvement with, the regulator. Locums or staff replacement costs must also be borne and can be considerable depending on the duration of remediation and the salary of the replacement.

The cost of assessment of the effectiveness of remediation
The UK National Clinical Assessment Service (NCAS) has emphasised assessments based on overall ‘fitness for purpose’, and includes the team and workplace context as well as a full range of individual characteristics and attributes. The costs of assessments need to be worked out from all the individual elements of the assessment that the doctor undergoes.

However, passing an assessment, which could be considered as demonstrating learning and behaviour changes at a specific end point, does not necessarily ensure continuing changes in practice or improved health outcomes for patients.

The cost of failure of remediation or of not doing anything
Whilst a return to practice will be the desired outcome for most doctors with performance deficiencies, for a minority a career change or retirement may be in the best interests of all concerned. This may be regarded as an unsuccessful remediation but may be seen by many as a successful outcome for an individual doctor.

When looking at the cost of any service we should also look at the cost of not having such a service and in this case not having a remediation service could result in many years of continuing useful contribution to the health service being lost if the practitioner leaves prematurely. Equally there is potentially the cost arising from legal challenges when the service fails to provide expected support through remediation to a struggling practitioner.

How best to provide cost-effective remediation
There are very few studies on cost-effectiveness in medical education and none on cost-effective remediation. There is a need for more studies to find more cost-efficient means of identifying doctors who need remediation and also to discover more cost-efficient approaches for remediation itself. This research could follow the Medical Research Council’s guidelines for complex interventions.

However, if we work from first principles and start to put together the elements of remediation that are most effective and least expensive then this could result in progress. We have seen that an early holistic assessment, coupled with a specialist health service for doctors, has the potential to reduce costs both through avoiding long suspensions and through targeting remediation interventions towards the individuals most likely to benefit and the specific areas of their performance that need development.
Assessments that predict the likely success of remediation may improve overall cost-effectiveness by focusing resources on individuals with the highest chance of a favourable response. Insight and capacity to change may be important in this respect and cognitive impairment may be present in a significant minority of doctors with performance difficulties and explain the failure to improve with remediation.

It is likely that making a full assessment early in the process of remediation, which looks at the individual doctor’s profile including health, personality and cognition as well as their team and work context will improve cost-effectiveness by allowing limited resources to be targeted towards those doctors most likely to benefit and in a manner that is sharply focused on their needs. Analysis of the first 50 cases managed by the National Clinical Assessment Service (NCAS) in the UK found performance problems in 80% of cases and behavioural difficulties in nearly all (47 cases) including problems with communication and work with colleagues. Fourteen doctors had cognitive, physical or mental health problems. It is likely that applying generic CPD interventions to retrain these individuals will be doomed to failure unless these more complex problems are also addressed.

The NHS Practitioner Health Programme in London provides a comprehensive specialist primary and secondary care service to doctors. In the first 12 months of operation 184 doctors were seen, 62% had mental health problems, 36% addiction problems and 2% physical problems alone. Initial cost-benefit analysis suggested that the service was safer and cheaper than traditional ways of dealing with sick doctors and dentists which ‘often involve long periods of time off sick on full pay with associated management and locum costs for their organisation.’ Whether remediation includes treatment of an underlying health issue that has caused a performance problem, or starts once the health problem is rectified to a level compatible with practice and then continues in parallel as necessary, needs to be considered.

A report on the effectiveness of the NCAS (NCAS) in the UK suggested that reducing long-term exclusions from work of doctors through suspension was a key area for cost saving. Each long term exclusion cost in the region of £140,000 and the numbers of long term exclusions had halved since NCAS took responsibility for advising the NHS. Cost savings included locum cover, management time, legal costs, compensation claimed by doctors, reduced staff turnover, and the costs of training a replacement doctor.

And there are other factors to be taken into consideration. Medical education that results in doctors that are fit to practice is expensive – no matter what raw materials you are working on. However, at its best, a successful remediation could get a failing doctor back on his feet and contributing usefully to the health service after six to 18 months. By contrast it takes at least 10 years to take a school leaver and convert them into a GP. The cost of training a doctor from medical school entry to full registration has been estimated at between £200K and £250K, this does not include postgraduate education.

When looking at the cost-effectiveness of any service we should also look at the cost of not having such a service. If we make a financial comparison with the cost of training a new doctor, it will need to take into account the success rate and the average number of years’ service that would follow after successful remediation, compared with a doctor at the start of their career. There is evidence that increasing age is associated with performance issues and therefore length of service after remediation may be limited in some cases. A further relevant factor is whether you should include screening and assessment in the estimation of costs, or include only the cost of remedial training itself. Arguably assessments that allow resources for retraining to be targeted at those most likely to benefit will increase overall cost-effectiveness. Where the cut-off point lies in defining performance deficiencies in the first place is also relevant.

Conclusions

In summary, there is much work to be done before we have definitive answers to a range of questions on cost-effective remediation. Such questions include: how do we make remediation more cost-effective? Will cost-effective remediation mean cut backs elsewhere? Will concentrating too much on cost affect the quality of learning provided? Is early intervention more cost effective than late intervention? And lastly and importantly, how will studies into the cost-effectiveness of remediation come about?

It is an old adage that you sometimes have to invest in the short term to save in the long term and this may be
particularly true of this subject. There is surely a case for a strategy of investment in studies of remediation and its cost and effectiveness now in order to have an evidence base that could save money in five years time. But whatever the arguments this is an issue that will not go away. With many countries toughening up their system of ongoing registration for doctors, the number of doctors being referred for remediation is likely to rise rather than fall and in times of budgetary restraint the question will inevitably arise – who should pay: the individual or the institution or both? Many would argue that both should make a contribution, not least as both will then have made financial investment in making remediation work.

Main messages:

• The costs of remediation are difficult to define – they depend largely on the remediation programme that is required by an individual healthcare professional.

• An early holistic assessment, coupled with a specialist and targeted services, has the potential to reduce costs both through avoiding long suspensions and through targeting remediation interventions towards individuals most likely to benefit and the specific areas of their performance that need development.

Current research questions:

• What screening tool that identifies doctors in difficulty will be the most sensitive and specific and at the same time be cost-efficient?

• What individual components within a remediation intervention are likely to be most cost-effective?

• Is early intervention in remediation more cost-effective than late intervention?
References


Human lifestyles have produced unprecedented changes to global and local ecosystems and a burgeoning epidemic of chronic illness. With climate change purported to be ‘the biggest global health threat of the 21st century’, high-carbon healthcare systems are undermining the building blocks that sustain human health, through high-resource consumption, emissions and waste, and a lack of preventive focus.

The 2008 Climate Change Act tasks the Secretary of State with the duty to ensure reduction in the UK’s net carbon account by at least 80% by 2050 (compared to the 1990 baseline carbon emissions). In line with government targets, the NHS is also committed to reduce its carbon footprint by 80% by 2050. This is already starting to change the way medicine is practised.

Ecological health systems

Rather than overwhelming healthcare systems, current ecological and health challenges present opportunities to refresh healthcare services and, moreover, medical education. There is a growing body of evidence that reducing greenhouse gas emissions and waste can confer health ‘co-benefits’; actions to protect the environment can also protect public health. For example, promoting or taking up active transport instead of private motor vehicles reduce fuel consumption and emissions. Meanwhile, increased physical activity and time spent in green spaces during walk or cycling brings multiple physical and mental health benefits.

Ecological health systems will benefit patients too. The NHS is responsible for a quarter of England’s public sector carbon emissions. The largest part (59%) of the NHS carbon footprint comes from the procurement of goods and services, of which pharmaceuticals contribute 37%. An ecological health system could focus more on prevention of disease, minimise unnecessary investigations and treatment (e.g. repeat investigations or investigations that will not change management), support patients to manage their own care closer to home, and use lower carbon technologies and practices (e.g. telephone consultations instead of home visits, where appropriate). These measures could minimise discomfort and cost (e.g. of travel) for patients, save health service funds and reduce environmental resource consumption and waste.

Educational leadership

Medical educators in the UK occupy an unusually privileged position. In the UK, support to introduce teaching on the ‘greening’ of medicine comes both from legislation at the national level (UK Climate Change Act) and from an NHS policy framework (NHS Carbon Reduction Strategy, 2009). The Royal Colleges have issued position statements encouraging teaching on the links between health, healthcare and climate change. The Higher Education Funding Council for England (HEFCE) and the Higher Education Authority have asked universities to include sustainability and carbon reduction concepts in curriculum and practice (and there will be financial penalties for not doing so). Finally, students, drawn to the medical profession by concern for fairness and social justice, have themselves been instrumental in pushing both global health and sustainable healthcare curricula (see Medsin’s Healthy Planet website www.healthyplanetuk.weebly.com). From policy drivers to student demand, the field is ripe for educational leadership.

Just as yesterday’s doctors led the campaigns against smoking by example and advocacy, tomorrow’s doctors can lead by example: living active, low-carbon lifestyles; informing patients; and transforming a wasteful, consumptive and incoherent health service into a sustainable health system.

Medical schools have a vital role to play in preparing students to address the predicted impact of environmental change on the health and wellbeing of the populations they serve. Why have some medical schools not yet taken this on?

Key educational challenges

With many subjects competing for time in undergraduate curricula, finding space for what seems to be a new, add-on, or faddish topic can be difficult. Although uncertainties remain about the specifics of future health scenarios, a stream of new research is emerging to identify effective strategies for rolling out sustainable clinical practice and ecological public health. Innovative service-based projects, such as the Green Nephrology programme, are being evaluated. We know that the adaptations required of lifestyles and social systems offer public health gains, and clear evidence exists about the health benefits of eating less red meat, using active transport and insulating homes, for
example. Extensive research has been carried out in the social sciences on effective approaches to communicating health and sustainability messages.

Such research can underpin development of new curricula. Furthermore, there are links between ecological perspective on health and other key curriculum topics. We need to develop effective educational strategies to inculcate these concepts into teaching, in keeping with recommendations from professional bodies and the World Health Organisation.

A further challenge is that new topics require resourcing, and many schools lack faculties with the confidence to address these topics. Experience in medical schools that are teaching an ecological perspective has shown that educators do not require an in-depth knowledge of climate science; indeed students need only understand the core underlying principles and how they relate to practice, not details. As the body of medical knowledge expands, competent practice increasingly involves knowing where to find information and guidelines, rather than learning by rote.

Finally, in some schools, teaching about the social determinants of health is given low priority, indicating an apathy about ‘upstream thinking’ generally. Some are persuaded by ‘moral offset’ – the notion that healthcare providers already contribute significantly to society and are therefore exempted from further demands. What we know, however, is that environmental challenges to health are here to stay and set to grow, especially without strong individual and policy action. There are many reasons why health professionals have a key role to play in addressing apathy towards ecological harms to health; not least the scale of the local and global health impacts resulting from resource-intensive practices, and the significant impact of the NHS (both as a proportion of the UK carbon footprint and as an exemplar of good practice).

The Sustainable Health Education Network

Medical education is evolving in tandem with the health service to meet these challenges. In 2009, the Sustainable Healthcare Education network (SHE) brought together educationalists, clinicians and students to share experiences, strategies and materials for teaching on the links between health and sustainability. SHE has developed teams in eight medical schools across the UK. SHE teams are incorporating sustainability concepts into core teaching and assessment (including in Bristol, East Anglia and Leeds) and student selected components (including in Cambridge, Sheffield and York). Many more schools deliver teaching as part of global health or public health.

The ultimate challenge is to integrate a sustainability perspective across the curriculum. A broader understanding of the links between health and the environment is likely to encourage a preventive focus to healthcare and the use of fewer technical interventions. SHE network members working in general practice, public health and global health have developed several schemas for clarity of curricular purpose and content in this area (see Box 1), are working with the General Medical Council to develop links between sustainability and core medical curricula in line with Tomorrow’s Doctors 2009. They will be conducting a national consultation on their proposals in 2013.
Conclusion

For any educator looking to incorporate sustainability into teaching at their medical school, we make three suggestions. First, forge connections with others by joining the SHE network – harnessing student enthusiasm can help overcome logistical challenges. Medical students are often passionate advocates for more teaching on environmental sustainability. The student organisation Medsin has a Healthy Planet project (see above) with members across the country helping to design student selected components, scheduling additional lectures and lobbying course directors for core teaching.

Secondly, find opportunities to incorporate sustainability into your own subject area. No area of medicine is untouched by the effects of ecosystem change, and the Centre for Sustainable Healthcare provides useful resources to explore links between your specialty and sustainability.16 Resources to support the delivery of lectures, small group teaching, and student selected components and can be found at: http://sustainablehealthcare.org.uk/sustainable-healthcare-education

Thirdly, work towards realistic goals. An initial goal might be to establish one core lecture (during induction or public health modules) and one SSC on sustainability and healthcare. SSC’s are an excellent way for educators to develop confidence in teaching and inspire the most engaged students. For example, Bristol enables learning through debate, discussion and interactive demonstrations (such as pushing a car up a hill to illustrate the embodied energy of fossil fuels). In East Anglia and Sheffield students

Box 1: Priority learning outcomes in sustainable healthcare education, from Sustainable Healthcare Education network curriculum development working group.15
make ‘Dragon’s Den’ pitches for practice change to address the ‘triple bottom line’ of people, planet and profit (or care, carbon and cost).

Sustainable healthcare education – like sustainable healthcare and ecological public health – is fast-evolving. The new challenges of the 21st century offer opportunities for new approaches to medical education and research to identify their impacts. Reconciling the (sometimes unnecessarily) carbon-costly consequences of current medical practice and the need for social and environmental responsibility is both an ethical and a practical challenge. Such challenges will touch all areas of medical practice, and medical educators increasingly have the opportunity to contribute to the teaching, research and policy development that will enable tomorrow's doctors to locate their own position and role in promoting healthy, sustainable people and populations.
References:


7. Medical Education – a Dean’s journey

Professor Derek Gallen

‘Where do you want to be in five years’ time?’ This was a question at my interview for a GP Principal Post in 1988. It was a very common question at the time and still has some currency even now. Frankly, I think the timeline is too long with the changing face of the NHS and, indeed, medical education. However, I knew exactly what I wanted to do in five years’ time and that was to be a GP Trainer. At the time, in the Oxford Deanery, you could not become a GP Trainer unless you had been a Principal for five years. That timeline is something I would go on to change, but more of that later.

I had always wanted to be involved in education and teaching, though I can’t really give a coherent answer as to why as it was to go on and take my career in a very different direction. I went on the GP Trainer course in the Oxford region when I had been a Principal for four years to ensure I could start training at the five year rule. The course involved three modules, spread throughout the year, each of 3 days. It taught us how to prepare to become a GP Trainer and also some of the skills and theories of teaching, but the product at the time was not quality assured, there were no assignments to be marked and in essence other than the fact that your Practice itself might not be ready for training, there was no failure rate.

Our Practice was already a Training Practice and so it was no surprise after the visit from the external assessors, I was deemed fit to be able to have my first trainee. The year was 1993 and I had taken over a training role in the Practice as the then Trainer had gone on to be the Local Course Organiser. Over the new few years I trained six registrars, which was a great experience and one I enjoyed enormously. At least half of those have gone on to become trainers themselves either at postgraduate or undergraduate level.

The Royal College of General Practitioners introduced a Fellowship by Assessment, a new method of being awarded Fellowship of the Royal College, whereby you produced evidence of your clinical ability and the Practice’s high standards of clinical care. This was quite an involved process and took the best part of two years to complete the documentation and make some of the Practice protocols more robust. It is a very reflective process and fundamentally allows you to look at the way you organise clinical care. It sat very well within the standards that are required for anyone undertaking training of GP registrars and I felt the roles dovetailed very nicely together. Again, we had a visit from external assessors and one of the partners and I undertook the Fellowship. The assessors looked at our videos of consultations and went through all the documentation we provided and thankfully decided we had met the standard; the year was 1996. The system of fellowship has now changed within the Royal College and, in fact, there are only just over 300 GP’s who have obtained a fellowship via this route. It was expensive and time-consuming for the College and so they streamlined the process further. It did make the practice a better training environment as we reflected on service delivery and quality standards.

A vacancy came up in 1997 for a GP tutor for Northamptonshire and I duly applied. The essence of the job was to provide educational opportunities for all the GPs within the area to allow them to get their educational allowance which comprised of 30 hours education per year. I threw myself energetically into the job, sending questionnaires to all the GPs, asking them what form of continuing professional development (CPD) they would like to see put on at the Local Postgraduate Centre and then duly responded by putting on over 150 hours per year. The job had many elements in as much as you had to put on a mixed programme, invite speakers. However I can honestly say my CPD has never been more up-to-date and I did get to meet some excellent speakers and presenters. It also gave me experience of the role so that in the future I would know exactly what my GP tutors had to do. It is important to know what jobs entail as I do believe you should not ask people to to work that you would not be prepared to do yourself.

A further educational job came along in 1997 when Oxford Brookes University advertised two Senior Lecturer posts. Oxford Brookes actually trains all the health professionals excepting doctors and this was their first foray into having any doctor representation at the University. My job was to help out with the lectures in certain modules throughout the year, which mainly involved me in the new Nurse prescribing initiative. I also lectured on ethics. This was a very interesting job, as it gave me a better understanding of how unpopular medics are in the wider health professional community. I heard many stories of how allied professions were treated over the years by doctors. It would often...
Excellence in Medical Education

I explain the reception I got when lecturing to a group of 80 health professionals. Clearly an integrated team working ethos had not arrived in the NHS at that time.

I resigned from that role after two years to take up a post as the GP Advisor in the Oxford Deanery in 1999. This involved me overseeing the education opportunities for all GPs within the county of Northamptonshire and inputting to the educational strategy for General Practice training within the Oxford Deanery. I was delighted to be appointed to this role and truly felt that I would remain in this post for quite some time. However, as with several of my previous appointments it is about being in the right place at the right time and a great deal of luck. I applied for, and became, the GP Director in the Oxford area in 2001. It was at that time I started changing the GP Trainer criteria. This was to ensure that the course was to certificate level quality assured by Oxford Brookes University and that no one in the future could be a GP Trainer in the Oxford region without attaining the Certificate in Post Graduate Medical Education. I was warned off this path by many people, including my fellow GP Advisors. However, when we introduced it in 2002, the course was oversubscribed. Since then, it has continued to develop successfully at the Oxford Deanery.

In 2003, I was appointed dean of the Leicester, Northampton and Rutland deanery. This would, in essence, bring me back to the county I live in, Northamptonshire, which in a previous reconfiguration had been lost to the Oxford Deanery. So, 10 years after becoming a GP Trainer I became the Postgraduate Dean for Leicester, Northamptonshire and Rutland. I wouldn’t say this was the career path that I had planned, because I was only really firm about one thing, and that was to become a GP Trainer. The rest, like so many things in life, just evolved. However, that’s just a very small part of the story. What is much more important to me, along the way, were the people I got to work with (remember you work with people, they don’t work for you). My path was certainly smoothed by the talent around me, suffice to say that three of them are now Postgraduate Deans. One, in particular, a non-doctor, my Practice Manager, went on to be awarded Honorary Fellowship of the Royal College of General Practitioners and became the GP Director of the Oxford Deanery. A real success story.

During the 10 years between 1993 and 2003, I was committed to developing my skills as an educator and undertook a Master’s in Medical Education. This is a distance learning degree from Dundee University, which I felt was very important to do in terms of ‘walking the walk’ and not just ‘talking the talk’. I also co-authored 4 books and published several papers on education and training. I started going to educational conferences and presenting papers and workshops and certainly enjoyed seeing new cities and meeting up with many people across the UK who had a like-minded interest in medical education.

So, while this story (to get to the dean role) really stops in 2003, clearly I have not been idle in the last decade. What I have learnt is that there is no end-point in terms of jobs that you can ever say that ‘you’ve arrived’. Each new job is a new beginning and brings with it its’ own challenges.

If I could summarise, the last 10 years, I would say this. I joined the MMC Team in 2004; changed Dean jobs to go to Wales in 2006; formed the UK FPO in 2007; was a Founder Member of the Academy in Medical Educators; became Chair of COPMeD in 2012 and wrote another book.

The profile of Medical Educators and Educational Supervisors is rising and that has got to be very positive for the profession as a whole and for patient safety. The privilege of my journey has unquestionably been the people I have worked with and being able to serve those who appointed me to various positions across the years. The hope is always that you look back and think you have made some small difference and helped others along the way to roles in medical education.
8. Interview with the President.

Professor Sean Hilton – President of AoME.

Who influenced you most?

It would be difficult to pick one name from a long list of people who have been very influential across my career: my first Dean at medical school as a mentor; my boss in Paediatrics for devotion to patients and the NHS; my partners in general practice; Paul Freeling, my boss and mentor in academic General Practice; Sir Robert Boyd for leadership; David Leach, Paul Batalden and Ronald Epstein for values in medical education. They are all people I have tried to emulate in some way. However, if pushed to choose one person, I would say Sir Donald Irvine for his integrity and unflinching commitment to improving standards for patient care.

Please describe your current roles

I retired from St. George’s, University of London, in 2012, after 25 years there as a clinical academic; and I retired from General Practice in 2010 after 30 years as a partner in General Practice.

Since then, the true-ism of feeling busier after retirement than before it has applied. I have a fascinating and challenging role as Dean of Clinical Education for the St. George’s/University of Nicosia School – Cyprus’s first Medical School. This involves a good deal of travel to Cyprus, Israel and the USA, although much of the work is co-ordination from home.

My term as President of the Academy comes to an end at our next AGM, but has kept me busy, not always in ways that I had foreseen.

I have a role as a GMC Associate in medical education quality assurance. I am team leader for the new school visiting team to Swansea Medical College. We have been visiting regularly since 2008, and will continue for a further year until their first graduates are in FY1 positions. For the last six years I have chaired the Steering Committee for the RCGP’s Essential Knowledge Update programme. This has proven to be a highly successful CPD offering for the College. Locally, I am a Trustee of the Princess Alice Hospice, an inspirational provider of palliative care.

Professor Sean Hilton is the elected President of the Academy of Medical Educators. He is an academic general practitioner, and recently retired from his post as Deputy-Principal at St George’s. He was formerly Dean of Undergraduate Medicine (1997-2002), and was responsible for the introduction of new curricula for five-year (1996) and four-year (2000) MBBS courses. Professor Hilton served as a non-executive member of the St George’s Healthcare Trust Board for 8 years and is a past member of the Council and Executive of the Association for Study of Medical Education (ASME). He is particularly interested in personal and professional development for medical students, and was a member of the Royal College of Physicians’ Working Party on Medical Professionalism 2003-5.
Please describe the defining moments of your career

There have been plenty of these as well, and they tend to be linked with the people who influenced me most, but I’d say it’s possible to plump for five.

Getting into medical school was the first. I was the only pupil from my grammar school post-war to do so, and none of us had much idea of how to do it. It took me two attempts at A levels, and an act of faith in me by the aforementioned first Dean to secure my time as a student.

Pathology to General Practice. I went through that stage that we now recognise so well in medical students, of initial idealism turning to anxiety about how to survive in the system. I pursued a route into training for pathology, before re-discovering the reason I had been so eager to get into medical school in the first place.

When I had re-trained for general practice, I was very lucky that my practice – in other words my partnership - was committed to research and education as integral parts of service provision, and gave me every support in developing these myself.

Paul Freeling – meeting him led to academic general practice as a next step in my career. He was an exceptional person, and a great writer and thinker about general practice, and I was very lucky to work with him for 15 years.

Shortly after I succeeded Paul as Professor of General Practice at St. George’s, I was appointed Chair of the Curriculum Committee, charged with implementing a 1993 Tomorrow’s Doctors curriculum. This was a major project over six years that involved me more broadly in medical education than was the case with my previous experience of GP education.

In 2002, after five years as Dean of Undergraduate Medicine I was granted a sabbatical, and had the opportunity to put some scholarship into my growing interest in the development of professionalism. It enabled me to meet some very impressive people, including: David Leach, Ronald Epstein, Scott Obenshain, Stewart Mennin, Hank Slotnick in the USA, and David Prideaux and Richard Hays in Australia. This has led to an enduring interest in professionalism for me through the latter part of my career.

Looking back at these defining moments, there seems to be a common thread, and yet, aside from the first one, all of these opportunities arose by fortune and circumstance rather than careful forethought.

What are the challenges for medical educators in the UK?

To address the gap between our rhetoric and reality. We have to build evidence to demonstrate that higher standards in education and training enhance patient care, rather than compete alongside it or simply co-exist.

The present focus on standards for clinical trainers and the educational environment is good news for us at AoME, but it comes against a background of pressure on service and resources that risks harming education and training as we have seen too often in the past.

With the shattering outcomes of the Francis Report on Mid-Staffordshire Hospital still fresh in our minds, and the recommendations of Donald Berwick’s subsequent report, I believe it’s clear that education and training is part of the solution rather than an added strain on a very stretched service. Berwick’s first recommendation is that the NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning and adds that quality and patient safety sciences should permeate lifelong learning for all healthcare professionals.

This patient-centred discourse is set to dominate medical education for the coming years, and whilst there are many desirable outcomes to be sought from it, there are also perils to which we must be alert. Aligning educational and patient outcomes will be a challenge, but will bring two huge benefits.

The first is more obvious – it will bring genuine patient centredness to our education demonstrable patient benefits are amongst the outcomes. The second is that it addresses one of the weaknesses of the current competency and outcomes approach. Virtually all of our outcomes are focused on the individual, whether their knowledge, skills or reflective ability, and yet we all emphasise the importance of multidisciplinary team working and interprofessional learning. Patient outcomes are achieved by multiprofessional units, teams and departments. Good outcomes result from effective interprofessional practice, and any educational environment should be judged, at least in part, on the quality of the patient outcomes that it provides.
What are the most important values for medical educators?

Well, of course, I have to say that the core values of the Academy are the most important. We summarise these as QRIS:

- Quality and safety of patient care (Q)
- Respect for patients, public, learners and colleagues (R)
- Integrity (in pursuit of our educational aims) (I)
- Scholarship (S)

Out of respect, integrity and scholarship, I hope, come openness and humility.

What are your aspirations for the AoME?

I have recently come back from the excellent International Association for Medical Education (AMEE) conference in Prague – a reminder that there are literally hundreds of organisations involved in Medical Education around the world. There are many differences between them, but many shared aims and objectives. It is important for AoME to have a relevant and appropriate place in medical education in the UK and internationally. This requires the blending of distinctiveness with shared visions. If we have no distinctiveness we have no reason to continue.

We have committed ourselves to standards and values for medical educators whereby we judge ourselves on improvements in patient care – short and longer term – as outcomes. This is our charitable aim and on an annual basis we have to demonstrate that what we do is in pursuit of that aim.

The Academy must show leadership in demonstrating the link between better education and better patient care. This is not straightforward (although the positive evidence on effective teamwork and interprofessional working is building) and this is why we have to work collaboratively with a range of organisations.

Globalisation, regardless of whether or not the UK has a referendum on leaving the EU, has arrived and is here to stay. The Academy needs to look internationally as well as at the UK. It is striking how much interest is expressed in our standards at international meetings. This is good work that AoME can be proud of and I would like to see us strengthening international links – we have made a promising start.

Finally, and linked to the above, AoME has started a process of moving towards being an Academy for all healthcare educators. Currently, our statutes limit us to membership of all those involved in medical, dental or veterinary education. Revalidation for doctors (and therefore for doctors who are also educators) is a strong focus of our activity at present. However, but within a few years we anticipate revalidation in some form for all healthcare professionals, and it is my personal view that within that sort of time frame we should become the academy for healthcare educators. The AoME Council for 2014 will take this debate forward and also seek the views of our membership.
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