AE

An Introduction

THE EDUCATIONAL LANDSCAPE

ANAESTHETISTS as EDUCATORS

The Royal College of Anaesthetists

Aims

The aim of this chapter is to give a brief history of formal postgraduate medical education in the UK from its inception in the 1950s to more recent changes, including modernising medical careers (MMC) and the overarching influence and direction of the GMC. In relation to Anaesthesia, the important governing bodies and their functions will be outlined including a reference to the educational roles within the specialty.

Intended learning outcomes

By the end of this chapter you should have a better understanding of:

1. The history and development of the structures and processes relating to Postgraduate Medical Education (PGME) in the UK (TM_HK_13).

2. The roles and responsibilities of educational agencies involved in educational quality assurance and governance (TM_HK_13).

3. The roles and responsibilities of educational agencies involved as competent authorities relating to PGME in general and anaesthesia in particular (TM_IK_09).

4. The formal responsibilities of clinical trainers (TM_HK_01) including the roles and responsibilities of Clinical and Educational Supervisors (TM_HK_07).

Activity

The interaction between the different governing bodies can appear intricate and complex.

Basic – Consider your role and position within the world of clinical education. Write down as many governing or influencing bodies that you know of on a blank piece of paper.

Intermediate – Ask yourself 'why are so many governing or influencing bodies involved in Postgraduate Medical Education (PGME)?' In relation to the above task, now try to draw connections between each body.

Higher – In reference to the diagram you are starting to construct from the above two tasks, consider the various roles or functions that each body might have. Try to list at least 3 of these roles under each heading or organisation title.

A short history of Postgraduate Medical Education (PGME) UK

The aim of Postgraduate Medical Education and Training in the UK has always been to develop high quality, skilled, caring professionals at the point of completion of a programme of training. As time has moved on, healthcare has become more complex, the standards of care more rigorous and the expectations of patients and public more demanding. In addition, the need for increasing formalisation of structure and process is evident along with the level of external scrutiny, quality assurance and regulation.

The 1950's

The **Medical Act 1950** (DoH 1950) formalised the requirement for PGME. It introduced a mandatory pre-registration year after graduation, the 'house year'.

The **Medical Act 1956** (DoH 1956) ensured that the General Medical Council (GMC), via its Education Committee, took statutory responsibility for medical education in the UK. Up until this point postgraduate education had still been left very much to the profession on a hospital/location basis and was predicated on an apprenticeship model.

The 1960's

The **Christchurch conference** (Williams 1985) was attended by all the major medical agencies, including the Colleges, Deaneries and UK Department of Health (DoH). They formally recognised all posts, from senior house officer (SHO) to senior registrar (SR), as training positions and directed that all National Health Service (NHS) hospitals should provide facilities for the continuing education of trainees.

The conference recognised the need for the coordination of training, through Postgraduate Training Committees, chaired by postgraduate Deans appointed by the faculty of a regional University. They also urged all consultants to recognise their responsibilities for training junior medical staff and students.

The 1970's

The GMC was given specific responsibilities, through its Education Committee, to oversee all phases of Postgraduate Medical Education. There were concerns with the pre-registration year and although many recommendations were made, most were never taken up. For instance, one proposal recommended replacing the House Officer year with a 2-year period of Graduate Clinical Training, with a corresponding reduction in length of the undergraduate course (See 'Unfinished Business' in the reference section for a modern day comparison).

The Medical Act 1978 (Kandiyali 1978) underlined the need for PGME by officially ending the notion that graduating doctors were omni-competent and instantly fit for independent practice.

The 1980's

The 1980 Education Committee of the GMC (GMC 1980) emphasised the need for *on-going learning* in its statement on the purpose of undergraduate training:

> '…to provide all doctors by the time of full registration with the knowledge, skills and attitudes which will provide a firm basis for future vocational training'.
>
> (GMC 1983)

Edinburgh Declaration

1988 saw the World Federation for Medical Education (WFME) call for a profound reorientation of the whole of medical education.
It set out 12 principles, see text box.

The 12 principles of the Edinburgh Declaration (WFME 1988)**:**

1. Relevant clinical settings.
2. A curriculum based on national health needs.
3. Emphasis on disease prevention and health promotion.
4. *Lifelong active learning.*
5. *Competency based learning.*
6. *Teachers trained as educators.*
7. Integration of science with clinical practice.
8. Selection of entrants for non-cognitive as well as intellectual attributes.
9. Coordination of medical education with health care services.
10. Balanced production of different types of doctor.
11. Multi-professional learning.
12. Continuing medical education.

Task

Think about the 'principles' that underpin medical education today.

- If you had to draw up *generic educational principles* what would they be?
- How do you think they might differ from those defined in the 1980s?

The 1990's - The Calman Era

In 1993, a summit entitled '**The Changing Medical Profession'** was held in Edinburgh bringing together leaders in medical education from around the world (WFME 1994). Underpinning this conference were the growing criticisms directed at the health care sector, the doctor as a professional, and at the medical educational system that produced them.

The summit recognised that although widely adopted in theory, implementation of the principles outlined in the Edinburgh Declaration of 1988 remained incomplete. The central notion that medical education should be viewed as a *continuum* remained imperative. A strategy was proposed to bring about the necessary changes in the structures, relationships, processes and outcomes of medical education to meet the changing face of medicine.

The most dramatic change to PGME was driven by the perceived inequality between the training UK doctors receive in comparison to their European Union (EU) counterparts. In fact, the UK actually demanded higher standards of training necessary for eligibility to the specialist registers.

The Chief Medical Officer (CMO) Sir Kenneth Calman chaired a working party to advise on the action necessary to bring the UK in line with EU law. They produced the report '*Hospital Doctors: training for the future*' now universally referred to as the '*Calman Report*' (Calman 1993) (See Figure 1).

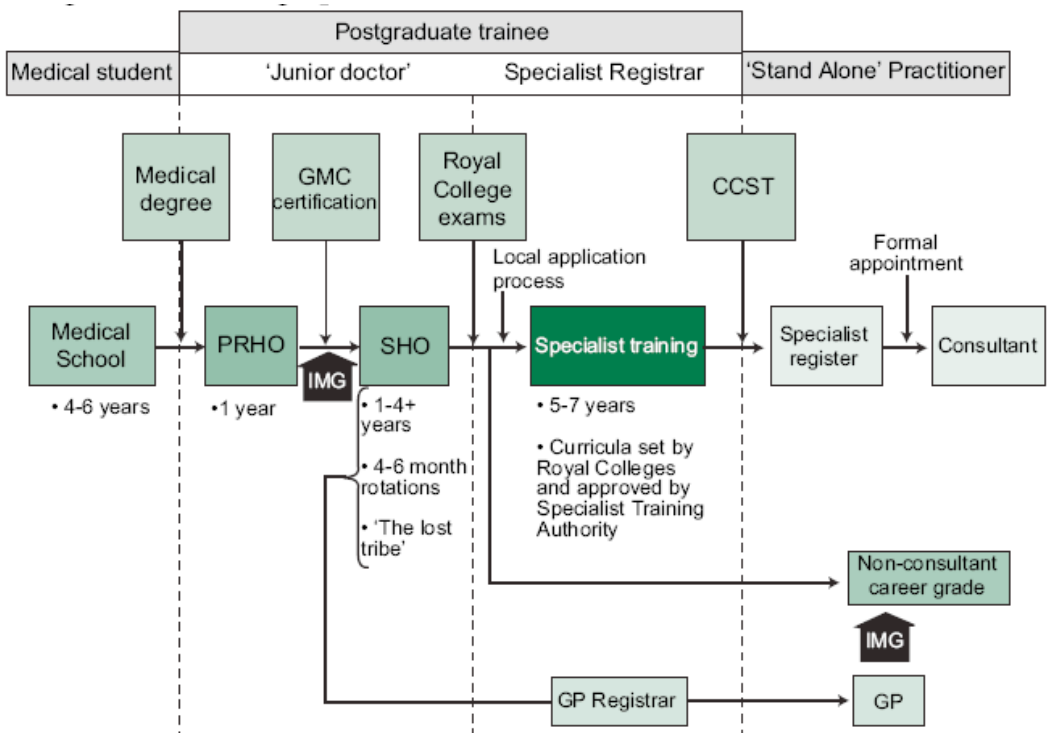


Figure 1: outlines the changes implemented following publication of the Calman report.

Summary: '*Hospital Doctors: training for the future*'

Restructuring of specialist training programs:

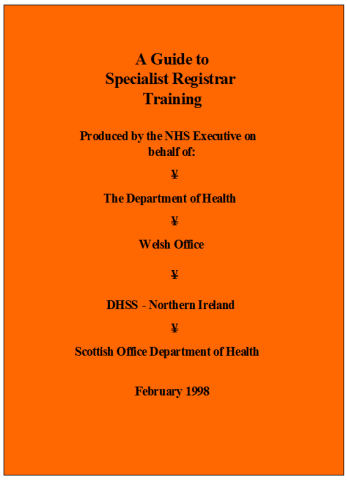
- Registrar & senior registrar grades combined - specialist registrar (SpR).
- Reduction in the length of training – 7yrs total.
- Defined starting and finishing points to training.
- Royal Colleges to provide structured curricula and specify the standards to be achieved in the delivery of training.

Certificate of Completion of Specialist training (CCST):

- Awarded by the GMC on advice from the appropriate College.
- Completion of training program to standard compatible with independent practice.
- Eligible for appointment to a consultant post.

All trainees appointed to a **Calman Programme** studied under a generic guide to training 'The Orange Guide' (DoH 1998). This book outlined all generic aspects of **SpR** training for all specialties. Each specialty then had their own specific requirements listed in the specialty curricula.

At the same time as changes to the structure of PGME were taking place, the Government tried to tackle the manpower issues. In 1993 the Joint Planning Advisory Committee accepted recommendations to develop a numbering system for trainees, programmes and posts within the NHS. From this point each trainee was given a **'National Training Number'** (NTN) (DoH 1998).



The Orange Guide

Principal features of a **NTN** were to:

- Provide each trainee with a personal, regional and specialty specific number.
- Enable central coordination and monitoring.
- Allow tracking of trainees' progress.
- Offer interchange of data between deaneries.

The 2000's - Competency based training

In 2003 competency based training was introduced across all specialties. It was felt that training should be based on the acquisition of competencies i.e. *knowledge, skills* and *attitudes* identified for each stage of training. Once all the appropriate competencies had been attained, the trainee could be signed off for a Certificate of Completion of Specialist Training (CCST). Training would be no longer be time based.

Every specialty had to produce a curriculum that was assessed by the GMC. The RCoA produced a curriculum detailing the modules to be completed, the competencies required for each and how trainees should go about achieving them.

Task

Think about the current RCoA curriculum:

- What constitutes a curriculum?
- What do you think is the difference between a curriculum and the syllabus contained within it?

Modernising Medical Careers (MMC)

The NHS Plan (DoH 2000), published in 2000, included a commitment to 'modernise the Senior House Officer (SHO) grade'. This was in response to the widely held view that there were many problems with the training at SHO level. These problems included: no clear educational or career pathways, no defined educational goals, no limit to time spent in the grade and a lack of distinction between service and training.

MMC was launched in February 2003 by the four UK health departments, after a report by the Chief Medical Officer called '*Unfinished Business*' (Donaldson 2002). A new system of recruitment and training was introduced. The first recruitment to the Foundation Years (FY) programme took place in 2005 and recruitment to Specialty Training (ST) first happened in 2007. It extended to all specialties, affecting all grades.

One of the intended benefits of Modernising Medical Careers (MMC) was to ensure a transparent and efficient career path for doctors. Trainees would exit Foundation training, gain a NTN in a Specialty Training Programme by competitive interview and then train for 7 years to become a consultant. This was to be seamless or 'run-through' training, (see Fig 2).

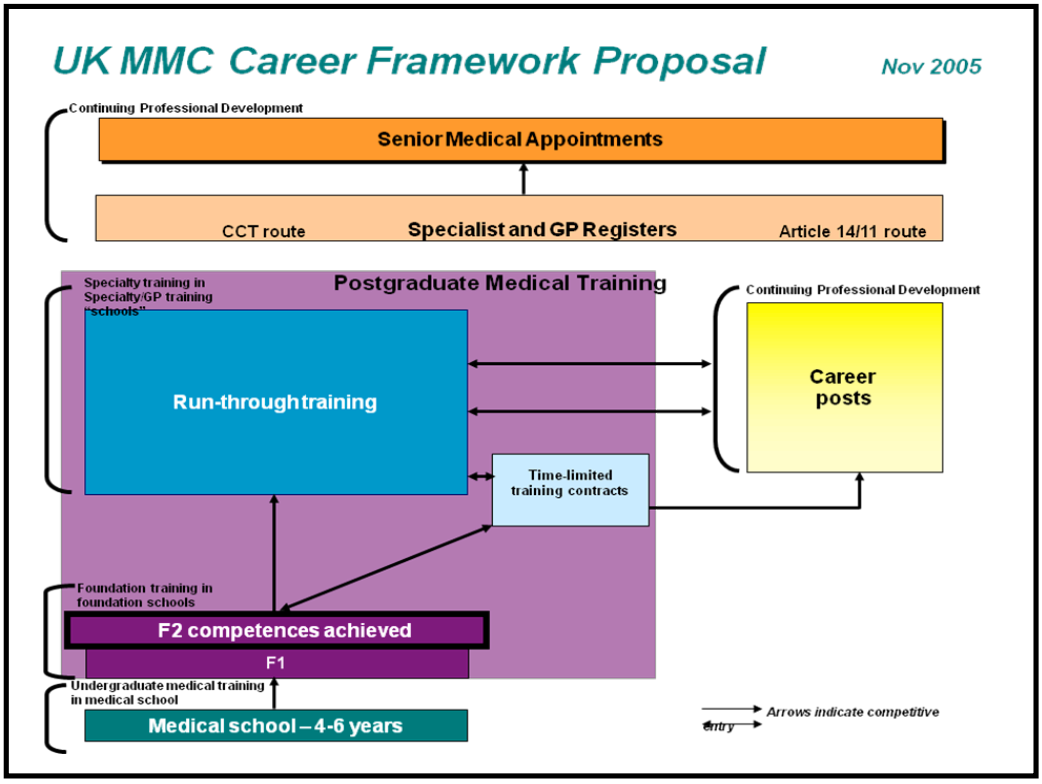
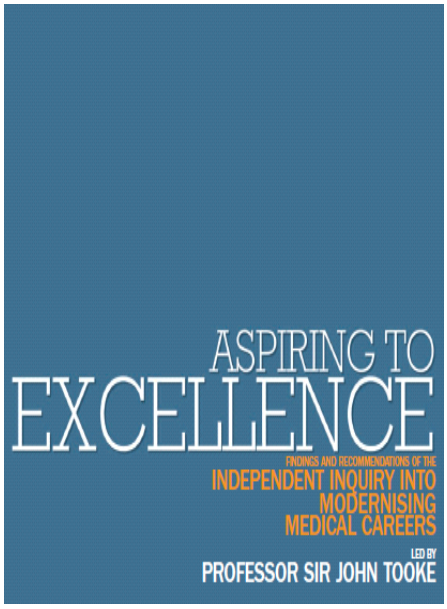


Figure 2: Framework for MMC career pathways.



Recruitment

Because of the failure of the Medical Training Application System (MTAS), used for recruitment in 2007 and the demands of the medical profession for a review of the new training system, an inquiry was undertaken resulting in the Tooke Report (Tooke 2007). This was a very detailed report that made a total of 45 recommendations.

As a result of the Tooke Report recommendations, many specialties including anaesthesia 'uncoupled' their training programmes. This essentially meant that there would be 2 years 'core training' (CT) equivalent to 2 years SHO training, followed by 5 years specialty training. Further information can be found at www.mmc.nhs.uk.

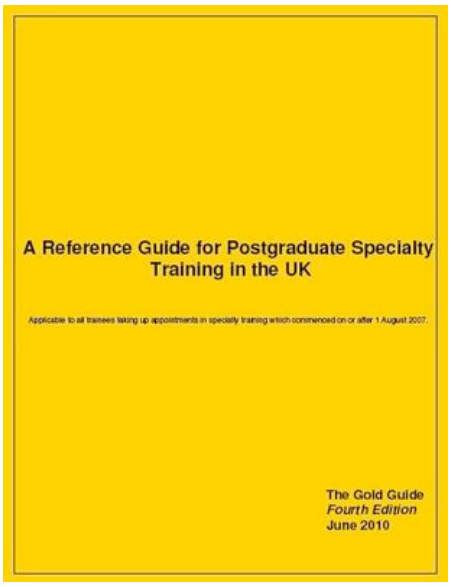
Task

The Tooke Report was published after the perceived failures of MTAS.

- What are your thoughts on the problems with the MTAS recruitment process?
- Read the Executive Summary and Final Recommendations of the Tooke Report.
- Do you think these recommendations have been addressed?

Gold Guide

All trainees, appointed from 2007 onwards, trained under the 'Generic Guide to Specialist Training' - the 'Gold Guide' (MMC 2010). This document was originally produced in 2007 for MMC and detailed the rules for all aspects of specialty training. There have since been several revisions including the addition of a Core Training supplement in 2008. The 2010 Gold Guide now governs all training in all specialties for all trainees appointed from 2007 and replaces all previous guides.



Educational Infrastructure: Roles and responsibility

Each Anaesthetic department has a training capacity related to patient population, trainer availability and services provided, dictated and sanctioned by the College.

A trainee belongs to a Training Programme, which might be part of a **School** or an **Academy of Anaesthesia**. The School or Academy is part of a Deanery. The Deanery funds 40hrs of a trainee's salary. The trainee is also employed to work in a hospital by the Trust (Eng) or Board (Scot), which pays for the *service* part of a trainee's job.

Trusts or Boards have a **Service Level Agreement** (SLA) with the Deanery to provide education and training that meets the standards laid down by the GMC. In some areas Trusts/Boards will have trainees from more than one Programme, School or Deanery.

Sessional Supervisior - All consultant anaesthetists who have trainees attached to them in any clinical area are Sessional Supervisors. They have direct responsibility for what that trainee does in the workplace while they are supervising them.

Named Clinical Supervisor - A trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement.

Named Educational Supervisor - A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee's Educational Agreement.

All trainees should have an Educational Supervisor but this can work slightly differently between Schools. Some trainees may have a different Educational Supervisor every time they move Trusts or Health Board, others may have one Educational Supervisor throughout a stage or indeed throughout their entire Training Programme.

Educational Supervisors are responsible to several people including the College Tutor for the department, the Training Programme Director (TPD) and the Director of Medical Education (DME) in the Trust.

College Tutor - has overall responsibility for the education of trainees in the department, to ensure training happens, teaching occurs, assessments and appraisals are done and to sort any problems that may arise. The College Tutor is answerable to the College via the Regional Advisor. They are also responsible to the Deanery via the TPD and to the Trust via the DME.

Director of Medical Education (DME) - is responsible for the education of all trainees within their Trust and they oversee the running of Postgraduate Medical Education centres in each hospital. They are also responsible for the undergraduate students while they are doing clinical attachments in the Trust.

Training Programme Director (TPD) - has overall responsibility for the Training Programme, which is part of a School of Anaesthesia or Academy of Anaesthesia. Their role is to ensure the Training Programme is recruited to, runs to appropriate standards and provides the appropriate training to fulfil the RCoA curriculum. They also have responsibility for the Annual Review of Competency Progression (ARCP).

Governing bodies in medical education

A. Regulators

General Medical Council

The GMC has always overseen undergraduate training and the registration of doctors. It has also taken charge of the revalidation of doctors. It was felt that undergraduate and postgraduate training needed to be more 'joined up'. The GMC now has 3 boards: Undergraduate, Postgraduate and Continued Practice. The GMC has produced a strategy for the future of medical education (GMC 2012) and it has released new documents relevant to postgraduate training (GMC 2012):

- The Trainee Doctor.
- Standards for Curricula and Assessment Systems.
- Quality Improvement Framework.

Postgraduate Medical Education and Training Board (PMETB)

PMETB was set up as an independent statutory regulatory body in 2005 by an act of parliament (GMC 2009). It replaced the Specialist Training Authority (STA), which used to oversee medical education. Both were independent from the Colleges. The purpose of PMETB was to approve all training posts, specialist training curricula and assessments, quality assure and evaluate the management of postgraduate training and certify doctors for the specialist registers. PMETB was absorbed into the GMC on 1st April 2010 to produce one body looking after the continuum of undergraduate and postgraduate medical education and on-going maintenance of certification.

NHS Education for Scotland (NES)

NES are a special health board responsible for supporting NHS services in Scotland by developing and delivering education and training for those who work in NHSScotland. NES designs, commissions, quality assures and delivers Postgraduate Medical Education in Scotland.

Medical Education England (MME)

MME was set up in 2009 (MEE 2009) as an independent body to oversee medical education and training on a *national* level and also bring a coherent professional voice on matters relating to medical education and training. MME advised the Department of Health on how to address the multiple deficiencies identified by the Tooke report and they now provide professional advice on policy issues and workforce planning. MEE is accountable for England issues only. NHS Education Scotland (NES) provides education and training support for Scotland.

Health Education England (HEE)

Health Education England is a new national leadership organisation that will be responsible for the delivery of excellent healthcare and health improvement to patients and the public of England, by ensuring that our workforce has the right numbers, skills, values and behaviours, at the right time and in the right place. It will have five functions:

- Provide national leadership on planning and developing the healthcare and public health workforce
- Promote high quality education and training that is responsive to the changing needs of patients and local communities, including responsibility for ensuring the effective delivery of important national functions such as medical trainee recruitment
- Ensure security of supply, of the health and public health workforce
- Appoint and support the development of Local Education and Training Boards (LETBs)
- Ensure that investments made in education and training are transparent, fair and efficient, and achieve good value for money.

Deanery

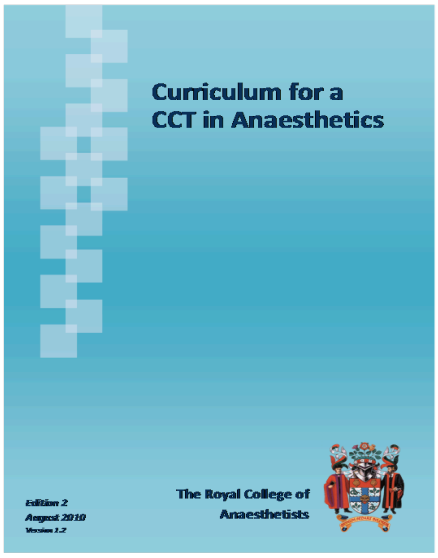
Currently each Deanery holds the budget and is also responsible for commissioning training from the Local Education Providers (Trusts or Health Boards). They are responsible for the National Training Numbers and manage the recruitment process. Deaneries are in charge of quality management and do annual quality assurance visits to Trusts. Each Deanery is set up slightly differently but usually has a Postgraduate Dean, a Deputy and a variety of Associate Deans. Their specific roles may vary from Deanery to Deanery.

B. Competent Authority

The Royal College of Anaesthetists (RCoA)

The College is responsible for the development of the curriculum (RCoA 2010) and ensures that this complies with the GMC's 'Domains of Good Medical Practice' (GMC 2010). The syllabus,

within the curriculum, lays out the *knowledge, skills* and *attitudes* that have to be attained at each stage of training to obtain a CCST. Every part of the curriculum can be assessed using examinations or workplace based assessments. The College sets the standards for these assessments. It also sets the specialty specific standards for training, by which Trusts and Training Programmes are judged. The College works with Postgraduate Deaneries to ensure that the curriculum is delivered locally.



The RCoA 2010 Curriculum contains the syllabus and describes how to achieve the competencies laid out within it.

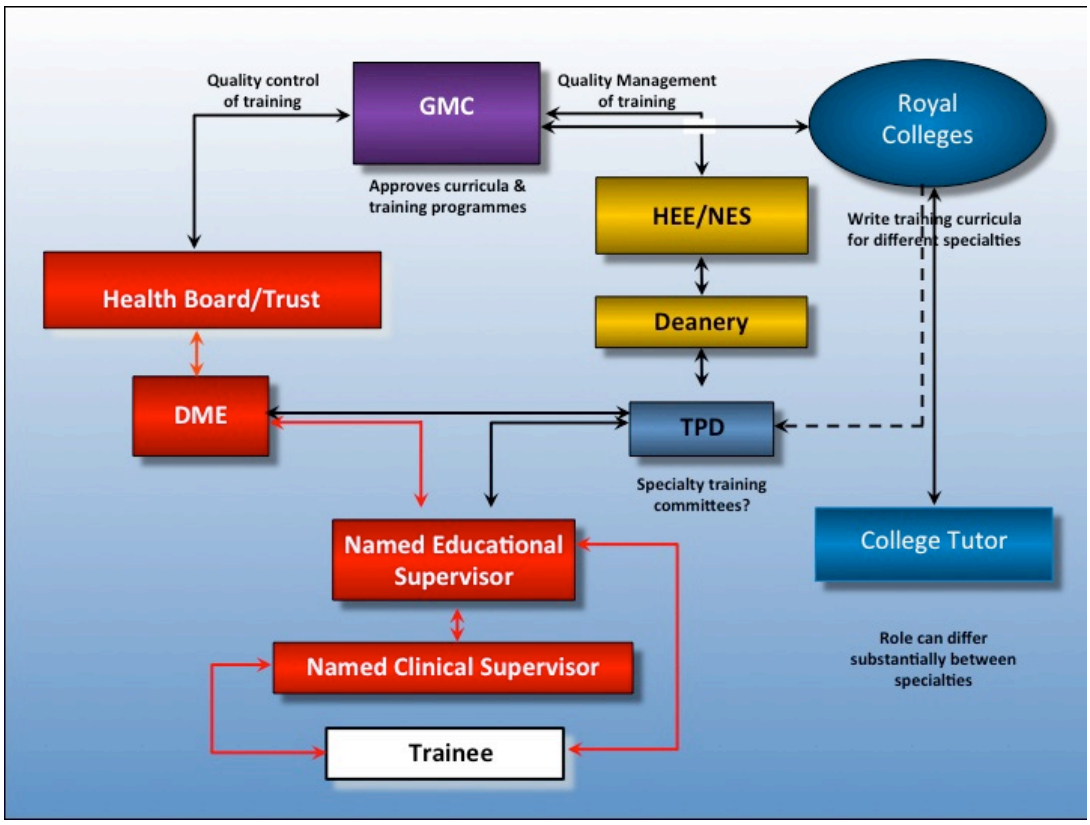
Reflection

Take a look at the 'Standards of Training' set out in The Trainee Doctor. How does your current training module match these standards?

How the College interfaces with the GMC and other agencies

The GMC approves all training posts using specialist advice provided by the College. The GMC quality assures and evaluates the management of postgraduate training and if there are problems, will seek the advice of the College and their expertise.

The college writes the syllabus and the assessments of competency, which then have to be approved by the GMC. Before a trainee can gain their CCST, they must apply to the College for approval of their training. The College then approves the training as fulfilling the requirements for the CCST and makes a recommendation to the GMC that the trainee be placed on the specialist register. A trainee has to have a CCT and be on the specialist register before they can take up a substantive consultant post.



Quality in PGME

The GMC has produced a document called 'Quality Improvement Framework' (QIF) (GMC 2010). This sets out how the GMC will quality assure (QA) medical education and training in the UK. The QIF was guided by 5 principles: Proportionality, Accountability, Consistency, Transparency and Targeting. It is believed that by coordinating quality assurance at all stages of training, the GMC will be in a better position to generate a comprehensive picture of medical education across the UK. There are three levels of quality activity: quality assurance, quality management and quality control.

Quality assurance (QA) is based on the GMC's statutory remit. It is the overarching activity under which both Quality Management and Quality Control sit. It includes all the policies, standards, systems and processes that are in place to maintain and improve the quality of medical education and training in the UK.

Quality management (QM) is the responsibility of medical schools and postgraduate Deaneries. It refers to the processes through which these bodies ensure that the training their medical students and trainee doctors receive from their Local Education Provider (LEP) meets the GMC's standards.

Quality control (QC) is, in turn, the responsibility of LEPs. They must ensure that the education they are providing meets local, national and professional standards.

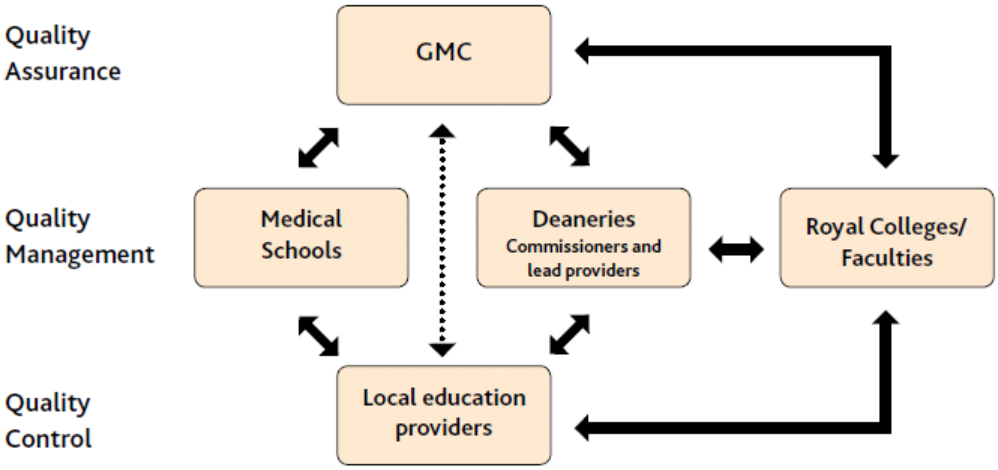


Figure 3: demonstrates how the different levels of QA, QM, QC relate to each other.

The future

There will be major changes in the way healthcare is commissioned. The Strategic Healthcare Authorities are being disbanded in favour of Commissioning Clusters. At present it is not known whether the Deaneries will continue in their present form and who they will be responsible to. It is likely that Medical Education England will become part of Health Education England (HEE) with a similar remit but looking after the wider healthcare workforce not just the medical workforce.

Key thoughts

The structure of medical education and training in the UK is in a state of constant evolution. At times it can appear confusing, but it is important to know a little about the origins, current roles and responsibilities and the future developments of key educational agencies. It is also useful to understand how you as a teacher and learner fit into the current framework and where best to find key information relevant to your current situation.

Evidence of progression

Basic level

- Look at one of the websites listed in the bibliography. Go to the 'documents and policies' section and *click* on one that interests you. Read the executive summary pages and try to reflect on how it might impact on your day-to-day teaching and learning.

Intermediate level

- Identify a consultant in your department who has a key educational role. Discuss his or her responsibilities within the department and how this fits in with the Deanery and College.

Higher level

- Write a reflective piece (200 words) on how the relevant bodies *quality* assure medical education. As clinicians, what is our role in this process?

Further reading

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RCoA 2010 Syllabus Key

TM_IK_09 Explains the roles and responsibilities of educational agencies involved in postgraduate medical education.

TM_HK_01 Understands the formal responsibilities of clinical trainers.

TM_HK_07 Explains the roles and responsibilities of Clinical and Educational Supervisors and Consultant/SAS trainers.

TM_HK_13 Explains the roles and responsibilities of educational agencies involved in educational commissioning and governance including, but not exclusively: the GMC, the DoH, Deaneries, Colleges and NHS Education Commissioners.