Jeopardising a Hippocratic tradition

What's needed in medical education are new and big ideas, coupled with a dose of investment

In the 18th century, doctors had no particular qualifications and their education was gained as an apprentice to a master. Maybe this wasn't such a bad idea — students today find themselves increasingly on the fringe of a system that has lost its enthusiasm for imparting wisdom to its young people, despite this imperative being enshrined in the Hippocratic Oath. The UK's General Medical Council still has high expectations of medical schools: early contact with patients; patient-centred communication skills; courses rich in ethics, culture and ethnicity; and more training taking place in the community. It champions curricula that produce caring, knowledgeable, confident and competent medical graduates who have a broad understanding of health and disease in individuals, their families and society.

But in the UK today there seems to be a growing gap between aspiration and action: the universities, the National Health Service (NHS) and the government don't seem to support the laudable goals of the General Medical Council. While it is often difficult to measure the success of medical education, there is only so much neglect it can tolerate — squeeze it too hard and standards will drop.

In both the UK and Australia, governments want more doctors trained, but the strategies do not extend much beyond numbers and throughput. There is money for new places in medical schools — in the UK, Labour has invested substantially in the NHS in recent years, and the number of students accepted in medical schools has increased from about 4800 in 1999 to almost 7000 in 2003.[1] This has been achieved by increasing the size of existing schools and by establishing new ones, such as the University of East Anglia and the Peninsula Medical School in south-west England. Additional sites for medical training have been created in association with existing schools (eg, Durham with Newcastle, Derby with Nottingham). But there is a dwindling pool of both clinical and pre-clinical academics to teach the eager new recruits.

Teaching seems to be moving off the mental map for doctors working in a health service that, they feel, has pushed them to the edge. The human side of medicine is what makes working in the NHS tolerable; it can be rewarding to spend time with patients and students without the need to race back to the lab to inject some more rats or write another grant application. Good relationships and appreciation of effort can help too — many consultants and general practitioners feel they are in exile within the NHS, doing cut-down versions of the jobs for which they trained. Teaching does not fare well in such an environment. We have new contracts for consultants and GPs that encourage careful tallying of hours worked and quality targets met. Many find this "policing" approach demoralising; it is only through professionalism, goodwill and belief in its value that teaching will flourish.

Juggling clinical work, research and teaching is difficult enough. But when teaching lacks mechanisms equivalent to those that identify and reward excellence in practice and research, it is relegated to a distant third place. Disturbingly, emphasising teaching over research in their portfolio can be professionally life-threatening for academics. While two-thirds of the income of medical schools reflects the numbers of students they teach, the remainder is determined by scores in the Research Assessment Exercise (RAE).[2] Several research-intensive medical schools approached the 2001 RAE by a thorough purge of dedicated teachers in order to boost the institution's average rating for excellence in research. Despite being obliged, almost immediately, to rehire limited numbers of teachers to meet their education responsibilities, some of these same medical schools are already sharpening their knives for more academic cutbacks in the run-up to the 2008 RAE. The less ruthless medical schools emerged from the 2001 RAE with financial penalties and have since cast staff adrift more slowly.

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Nevertheless, it's possible that this obsession with research-based income will implode. Sooner or later the General Medical Council will decide that things have reached such a point of neglect that medical education needs dedicated investment — not just in buildings, but in teachers and medical courses. In the meantime, the next generation of medical academics and teachers is shrinking. To train all the extra students in the system, the UK probably needs about 1000 more clinical academic posts by 2006.[3] This won't happen while the new NHS contracts attach financial rewards to service in preference to teaching.

These problems are not unique to the UK. Australian medical schools face similar pressures, and teaching often comes out second best. The spirit of curriculum reform has led to more graduate entry, more problem-based learning, and now strategies to get medical graduates into rural and remote Australia. Yet, Australia is also short of graduates, and recent increases in medical student numbers will only partially redress the short-sighted cutbacks of the early 1990s. One hopes the Australian Health Workforce Advisory Committee's push for a more integrated approach to workforce planning will produce a commitment not only to boost numbers, but to ensure appropriate funding of courses to maintain the high reputation of Australian medical graduates.

Governments are becoming increasingly hard-nosed about the money they invest in training medical students, and there is a burgeoning international transfer market. Australian medical graduates are an attractive product in this global marketplace. Governments want their graduates to stay. The Scottish Executive, for example, questions why it should educate so many English students when they are inclined to return "south of the border" on graduation. This market mentality needs a few more rules; there needs to be an international commitment to high standards and agreements to maintain investment locally rather than trying to poach quality graduates trained at some other country's expense.

Despite the difficulties, there are some impressive developments in undergraduate education in the UK. The new medical schools are alive with enthusiasm and energy,[4] and are pursuing models of

medical education that build on previous innovation, such as Australia's Newcastle model. Nevertheless, what's needed in medical education are new and big ideas, coupled with a dose of investment. Where are the current icons in medical education? In the past the likes of Abraham Flexner argued passionately for practical and interactive education, while James Mackenzie introduced the novel concept of teaching by general practitioners. Without passionate and committed teachers, medicine will decline. Then, any number of state-of-the-art laboratories, industrial partnerships, novel genes and science parks won't be able to rescue it.

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