

# Clinical Tutor

Newsletter of the National Association of Clinical Tutors

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## CHAIRMAN'S MESSAGE

*I hope the sun is blazing upon you in some quiet backwater as you read this. If so, you are probably not in the UK, judging by the weather in the first part of the summer!*

*I was pleased to see so many of you at the 5<sup>th</sup> Joint Conference in Bournemouth on July 10<sup>th</sup> – 12<sup>th</sup>. Those of you who did not manage to get there missed an important event. However, all is not lost! Highlights are available in this newsletter.*

*An account of the conference with slides will also be posted on the web – we expect this to be on the 5<sup>th</sup> Joint Conference website – <http://www.wessex.org.uk/medical/confer>*

*The NACT Annual General Meeting and NACT Council were both held in Bournemouth. Summarised accounts will be available on the NACT website soon.*

*The COPMeD Working Party on Education and the EU Working-Time Directive (EUWTD) is (still) due to publish a report soon, which will help Clinical Tutors assist their College and Specialty Tutors refocus on learning. Watch out for that on the COPMeD website, perhaps, at [www.copmed.org.uk](http://www.copmed.org.uk).*

*The pilots for SHO RITAs during 2001-2 have been largely successful and are continuing in the Deaneries where they have been developed. Before the complete RITA process can be implemented as intended, from July 2002, it ought to be properly funded. COPMeD is working on this. The process must be based on evidence about SHOs' performance. A separate COPMeD sub-group has developed a matrix tool for generic assessment of SHOs (based on the GMC's Good Medical Practice, with College-derived specialty-specific parts), but is not yet ready to publish its conclusions.*

*You may recall that NACT contributed comments on the Medical Education Standards Board (MESB) consultation document. The Board is*

now the Postgraduate Medical Education and Training Board (PMETB), with some changes from the consultation document, but still no mention of Clinical Tutors or NACT, which I regard as a missed opportunity to recognise and involve our association.

*My visits to Deaneries around the UK have started again. My presentation at these discusses 'What Can NACT Do for You?'. I recently attended meetings of Northern Deanery and Oxford Deanery Clinical Tutors. Both were most welcoming and hospitable and I greatly enjoyed the camaraderie and exchanges with fellow Clinical Tutors. Ask your Deanery Representative to invite me if he/she has not already done so!*

*All members of NACT should receive emails from the Chairman. These are cascaded via NACT Deanery Representatives. (If you have not received these messages, see trouble-shooting guide opposite). Via the cascade you should have heard about: –*

- *COPMeD meetings I have attended in April, June and July on NACT's behalf. I circulated my précised versions of the proceedings of all these by email to NACT Officers and Deanery Reps, within two days. I asked Deanery reps to cascade these to PGCTs and APGCTs in their Deaneries;*
- *Information about conversion of Trust Doctor posts to GP SHO posts recently.*

*If you would like to contact me personally, I would be pleased to receive emails or phone-calls. I wish you all a good summer break. I know that Clinical Tutors with their increasing workload, induction and ongoing responsibilities, will all deserve it. What is more, with the work (both old and new) that will be arriving on your desks in the autumn, you will need it!*

*Best wishes*

*Alistair*

I, too, enjoyed the delights of Bournemouth, or at least, its International Conference Centre, beach, and Pavilion. The Wessex team did a great job making us all welcome, and not only did they manage to make the arrangements foolproof, they almost managed to make them doctor-proof, too!

Frank Smith led very much from the front. He introduced us to the conference, he took down on the digital display board the final workshop bullet points, he bade us farewell at the end. Perhaps most impressively of all, he bravely led the dancing to the band after the conference dinner. Some of us thought they might play to an empty floor throughout, but Frank's example catalysed some very energetic endeavours.

There were excellent displays in the main hall – posters (including an interesting account of a consultant mentoring scheme in the north-east), trade stands and sister organisations' stands, as well as the DNUK cyber café (see account later). There was ample opportunity to meet old friends and make new ones – it was good to be able to take the CMO to one side after his presentation and let him know what was what! He was able to confirm that he hadn't been offended by the direct questions received during the Q&A session.

The civic reception was held in the main hall. The mayor's deputy tried hard to make us welcome, but some delegates seemed to be working harder at the networking than being guests, and so not all of the speech was easily heard. Luckily, the Wessex welcome included two days of glorious sunshine, although the onshore breeze tended to temper the temperature. One brave group held their first workshop outside. It almost looked tempting from inside, but then again we didn't need two people to prevent the flip chart from flipping. On balance, we decided not to venture out until after the workshop! The weather stayed mild enough for some of the West Midlands deanery team to go paddling after supper – I understand it's called team building...

Well, I gather the SHO review is imminent. I always assumed that imminent meant occurring in the very near future, rather than the increasingly frequently encountered sense of at some unspecified time that suits someone else. It's interesting how the meanings of words can evolve more rapidly than you might expect, a sort of philological shift, on the background of the more gradual drift to which we can perhaps more easily accommodate.

I thought one of the most provocative suggestions generated by the workshops in the conference was the suggestion of an NSF for education. Now that would be an organisational shift, indeed!

Enjoy your summer (don't worry too much about whether to put things on hold lest the SHO review is suddenly released just before you go away!!). Four weeks of no school run or school run traffic, and political torpor...

Bye for now

Kit

## **CT's – ARE YOU BEING SERVED?**

**Do you get COPMeD meeting notes?**

**Do you get feedback from NACT Council meetings and the AGM?**

**Do you know who your Deanery Rep is?**

Amongst the benefits of NACT membership is the delivery of information via the cascade system to your Deanery rep and thence to you.

- If you are not receiving information in this way, contact your rep.
- If you do not know who this is, see the list on the back page.
- If you are still having problems, email our office at [office@nact.org.uk](mailto:office@nact.org.uk)

## **5<sup>th</sup> Joint Conference July 2002**



### **Introduction**

The latest of these 3 yearly major events in postgraduate medical education was held at Bournemouth. The 11 constituent organisations had put together an excellent program with the overall subtitle of "Can you risk not doing it?" We were hosted by Dr Frank Smith (Director of PG GP education in Wessex) and his team, who put much effort into making sure that the 270+ delegates had an excellent experience.

Between the presentations, we were divided into heterogeneous groups of about 12 for three workshops. The first was to reflect on where things were at the moment educationally, the second on where we wanted to be, and the third on how we might get there. The organisational challenge of this logistical nightmare was coped with magnificently and some useful views and ideas were generated and collated as a result. As one would hope at such a gathering, much useful networking occurred.

### **Quote of the Conference**

The simplest way to understand the difference between education and training is to think of how you would like your teenage daughter to learn about sex...

Claire du Boulay

## Setting the Scene

Mr Nigel Crisp  
Chief Executive, NHS

*Reporter – Dr Alistair Thomson*

Nigel Crisp opened the conference with a challenge to delegates – to try to get outside the ‘comfort zone’. He described the changes in the NHS and society that make it impossible to stay still. The implications for education are numerous. Changes to education itself – undergraduate, postgraduate and continuing; the new structures in the NHS – PCTs, SHAs and the PMETB; and the change in patients – iller patients with more complex constellations of diseases and their complications as medicine becomes more effective, but also better education and specifically knowledge about disease.

He mentioned some of the changes in more detail – such as the SHO Modernisation, the New Deal and the EU Working Time Directive, together with the NHS’s strategic alliance with the Higher Education Funding Council for England (HEFCE) and conceded that the effect of these could not be foreseen.

Moving outside the ‘comfort zone’ would not be a challenge to be accepted or rejected, so much as a necessity in our lives in medical education.

## Academic Theory of Learning Organisations

*Mr Stuart Marples  
Chief Executive  
Institute of Health Care Management*

Stuart Marples started with a quotation – “The most successful corporations of the 1990s will be something called a learning organization – a consummately adaptive enterprise; an organization ... which facilitates the learning of all its members and continuously transforms itself” He summarized such an entity as: a) an organisation and b) one that learns.

He then defined Senge’s 7 “learning disabilities”:

- I am my position
- the enemy is out there
- the illusion of taking charge – in fact much apparent activity can be simply reacting to events
- the fixation on events  
discrete short term events often grab the attention, especially of the media, but slow gradual processes are more important threats nowadays.

- the parable of the boiled frog  
a frog will jump out of the pot when put into hot water, but if put into cold water which is then gradually heated up, apparently it becomes increasingly drowsy before it dies (*don’t try this one at home, folks!*).
- the delusion of learning from experience.  
Our own experience is the most powerful learning influence, but we rarely see the ultimate outcome of our actions (how many trainees have you seen ten years later?)
- the myth of the management team  
The collection of “savvy & experienced managers” who represent the organization may actually be fighting for turf and avoiding personal adverse outcomes thus tending to dilute decisions, opting for compromise and bland outcomes. When was the last time we saw someone promoted for raising awkward questions about the system?

How do we become a true learning organization? It needs a learning approach to strategy, participative policy making, “informating” (i.e. implementing IT) as well as automating the system, formative accounting and control and internal exchange re expectations. Members with outside contacts act as scanners for the organisation and feed back to the organisation. There should be resources for self development available to all in the organization.

He defined the characteristics of such an organization as including benefits to employers: more responsive to change, increased emphasis on quality, reduced dependency on outside labour and increased morale, better industrial relations, and improved whole systems outcomes. There would be an impact on training: increased multi-disciplinary training, a re-evaluation of the importance of knowledge, and opportunities available to all. The impact of training should be judged against corporate rather than individual goals. Education becomes a central not a peripheral activity, and employers become training providers.

The benefits to employees include the ability to influence their own life, personal expansion and consistent, understandable goals.

He ended with a photograph of a 94yr old man from a Swahili village on the edge of the Indian Ocean. He had proved adaptable with 6 different jobs over his lifetime. As a young fisherman using a line he would bring boatloads of fish back at the end of the day, compared with current fishers who bring few back despite using nets & technology. This man had demonstrated life long learning.

## Lessons from Outside Medicine

*Mrs Jennifer Tippin  
General Manager Flight Training  
British Airways)*

Mrs Tippin gave us a review of BA's approach to training, which over the years had been informed by a number of disasters. She posed the rhetorical question "Why do we need to get it right?" and answered it "Because the safety of hundreds depended on it".

She mentioned some plane crashes in the 90's where the captain had taken erroneous decisions, and the crew had felt unable to question them. None were caused by external or freak circumstances or technical failure, but by poor teamwork. NASA research suggested that individual captains had too much to be responsible for with 70% of accidents being due to human factors and behavioural issues. Whilst these lessons were learnt in North America, with the introduction of a training system called cabin resource management, it took Kegworth to make UK airlines realise & accept that these approaches were necessary. The problem in the Kegworth air disaster was that one of the plane's two engines caught fire. Just as he was about to deal with it, air traffic control then requested the plane reduce speed and the captain shut down the wrong engine – he was flying a new plane version with which he wasn't familiar. The air accident investigator identified poor training and communication were responsible. She pointed out that the chain of command was not necessarily the chain of communication. The important points were to focus on the situation at hand, the environment, and to use one's initiative.

Communication is the key to effective team working. It is made effective by using all available knowledge, skills and resources, as well as being facilitated by assertiveness. For this, team members must value their own integrity and recognize their own needs, as well as those of others. Health (physical, psychological & emotional) is important – tiredness can have severe consequences.

The aim of CRM is to work as team "to keep small incidents as small incidents". Despite 9/11, 2001 was the safest year worldwide since the 1980s.

BA have done work on team-building courses with Bart's A&E department. This includes such techniques as putting the team in a Boeing simulator with a manual, and then challenged to land at Heathrow airport. Apparently, people then start communicating together pretty well and pretty quickly!

## Getting Better at Getting Better

*Prof. Sir Liam Donaldson  
Chief Medical Officer*



Professor Donaldson gave us an analysis of the natural history of the NHS since its inception. He started with a Punch cartoon illustrating the medics of the day as roman gladiators who were saying to the government (as the emperor) "Ave Caesar, morituri te salutant." (Hail Caesar; those who are about to die salute you). This represented the pessimistic attitudes of the professions of the day. He described a number of phases in the development of the NHS:

- 1948 universal coverage and health for all
- 1950s therapeutic optimism and drugs for all ills
- 1970s dawn of cost containment & structural reform second thoughts
- 1990s rise of quality, standards & the consumer
- 21<sup>st</sup> cent. the drive for modernisation

He then summarised some of the changes in demography, life expectation and disease patterns. Some of his messages included, don't forget public health as a vital discipline, more infrastructure was needed (and quickly), and both quality and safety were now major issues in the NHS. He implored us not to be put off by the term "modernisation" but to be aware of the issues arising in the workforce as a result of the changes in population structure. The questions generated failed to unsettle him, he answered with the consummate skill of the practised politician.

## Implications for workforce development confederations

*Ms Barbara Walsh  
CE, NorthTrent WDC*

The context of current workforce development ideas was based in the Workforce of all the Talents document which built on the training and education consortia, shifting the balance of power. The WDCs were working with Strategic Health Authorities to develop a national program.

Ms Walsh identified 3 key success criteria:

- inclusivity (of a wide variety of players)
- delivery (workforce [esp. consultant] numbers)
- playing a part nationally with lead people from each WDC identified nationally for the various specialties.

She pointed out that WDCs appeared at times scary to teaching hospitals & universities, the professions, and on a bad day, the whole workforce, because they insist that the patient is at the centre of things and also ask difficult questions.

She felt optimistic that the new arrangements would result in systems that could deliver the necessary products.

## The New Generation Project

*Dr Debra Humphris  
Director NGP  
University of Southampton*

Because of the changing workforce numbers, new ways of looking at training health care workers were needed. Southampton had developed an approach in association with the University of Portsmouth whose integrated faculty from the schools of nursing, social science, midwifery, pharmacy, radiography, etc had conventionally trained 7 different types of health care workers. This project was aimed at producing more generic training to allow individuals to decide later which end point they wanted.

In the background to all this was chapter 25 of the Kennedy report which highlighted the importance of education, and in particular the need to start learning about interprofessional working early (i.e. before qualifying) and also the need to learn to work in teams which was not an innate trait.

She quoted the CAIPE definition from 1997 of interdisciplinary learning – 2 or more professions learning from and about each other to improve collaboration and quality of care. She contrasted this with multiprofessional education where learning side by side of different professionals occurred (“bulk teaching”) without the different people learning from each other.

In order to deliver this interprofessional (IP) learning, it was necessary to define a common learning programme and also to work out how can we put doors in walls between programmes? This would allow, for example, a trainee OT to change during the course to become a social worker at qualification.

The workforce supply chain needed widening to allow greater access of entry. Different approaches

are needed to attract people into health care careers. For example the [www.barbie.com](http://www.barbie.com) website shows Barbie’s career page – unfortunately she doesn’t have paediatrician as an aspiration!

She described the organisational structures including an external reference group of 12 “big brainers” to future-scope the workforce.

She saw this project as an extraordinary opportunity to reform curricula & prepare for different futures. It was important systematically to build an evidence base, this would take a 10-12 year cohort study. There was a much greater emphasis on working in teams. Students had to be able to “walk the talk”.

## New Health Worker: Physicians’ assistants (*What’s in a Name?*)

Sue Crane  
School of PG Medicine, University of Portsmouth

Different models of non-medically qualified individuals acting as support staff for doctors have been described around the world in different settings. These ranged from the very highly trained US physicians’ assistants with significant skills and autonomy, through the medical assistant known in the Royal Navy who is able to take sole charge of a ship’s company without a doctor present, to combat medical technicians in the army who have no qualifications recognized outside the forces.

The medical technician is a new type of non-registered worker who can carry out a defined range of technical interventions and report the results as normal or abnormal (and referring the latter for medical review). They have a patient-centred focus, working with patients and relatives as well as being part of team. They are multi-skilled (not generic) workers who are functionally environmentally independent.

A foundation degree has been established whose key features are employment-related higher education, quality academic learning built in to curriculum with training too. Key skills include IT, communications, application of number, and improving one’s own learning & performance. Progression to an honours degree can occur within 1.3 academic years.

The FdSc (foundation degree in science) in applied medical technology uses work-based learning in clinical placements underpinned by basic science knowledge, and skills lab training.

A wide entry profile exists from access courses, the armed forces, NHS employees. The entry requirement is a level 3 qualification or equivalent, e.g. 1 A-level, an NVQ level 3, etc.

The aims include improving the recruitment and retention of staff, raising staff morale, facilitating getting “two feet on the skills escalator”, delivering consistency in care (“1 stop shop” worker instead of several carers seeing to the patient), giving doctors quality time with patients, and contributing to meeting the EWTD on juniors’ hours. This is a relatively “quick fix” part solution (taking 2 years full time or 3 years part time) not a cure-all.

She felt that it was important to find a job title which was acceptable to both doctors and the post-holders themselves, stressing the basically clinical nature of the work involved.

## An NHS Trust Education Directorate

*Dr Linda Hutchinson  
Director of Education & Workforce Planning  
University Hospital Lewisham*

Linda is a paediatrician at Lewisham Hospital where a number of changes over the past 7 years led up to the formation of an academic directorate whose role evolved to bring together all education, training and development activities. The director’s role takes 50% of Linda’s time leaving the other half for clinical duties. She was appointed from a field of 4 applicants – the others were all nurses

The directorate has 5 sub-groups including nursing & allied health professionals’ education, resuscitation training, and also training & management development.

Linda’s own role includes simply being an extra pair of hands within the education sphere, but she provides added value in a strategic role with horizon-scanning, checking for duplication of effort within the organisation, being a single point of contact within the system, and not least, being a single person responsible and accountable for strategy, business planning and managing changes relating to MPET.

In the future are planned the development of educational facilities, learning accounts, clinical placements, generic and mandatory training, and CPD.

## Workshops 1 & 2 – a synopsis

### 1. “Where are we now?”

As at the last Joint Conference, a synthesis of the first day’s workshops with the above title was undertaken that evening by Dr Liz Paice, Dean Director, London Deanery. She presented the summary of the

discussions on the Thursday morning, claiming that it had been an enjoyable and interesting task, and identifying a number of recurring themes.

### Time

Educating within increasingly pressured time constraints, with the EWTD & shifts limiting trainees, and waiting list pressures etc. bearing on trainers. The result was too little time for reflection (alone or in teams) and appraisal, assessment and programme evaluation all were needing time allocated. “*The best way to fatten the pig is not to constantly weigh it*”.

### Money

PGMDE continues to run largely on good will. PGMDE monies are still used at times to support the service and/or /other professions. Will there be new funding for new initiatives (remember Calman was planned to be “resource neutral”!)? Money should accompany new developments.

### Multi-professional learning

Is this a dogma, a mantra or the way forward? We wait with interest. PGMDEs and libraries are multi-professional, but with little extra investment. There are anxieties about the impact of MPL on resources for medical & dental education. Are the expectations of skill mix realistic? “Stewardesses do not have to fly the plane”!

There are often multiprofessional audiences at lectures, and it is increasingly common for undergraduates to learn in this way. Also, MP team learning is commoner and we know that learning can be qualitatively enhanced by MP context, e.g.: risk management, time management, and communication. It certainly helps to put people in others’ shoes, developing self awareness and awareness of others.

### Spreading good practice

Examples of these were confidential error reporting (eg prescribing errors, xray reporting errors), websites & e-learning, PRHO prizes, trust based education advisors, a unified education centre, & trust training dept. MP generic training programmes, skills labs, simulators, and actors all helped to improve learning. Hi-fidelity anaesthetic simulators (where learning comes from suspended disbelief, and the human interactions were videoed then analysed) helped to teach conflict management and leadership change analysis.

### Organisational change

Mergers of trusts, multi-site working, new medical schools, reconfigured deanery boundaries, disappearance of ROs and emergence of WDCs, StHAs and the PMTEB all seemed to be too much, too fast, and possibly too complex.

## **Workforce development confederations**

Threat or opportunity? There is the potential for finding solutions, though, and “bringing together activities and initiatives. Excellent initiatives usually involved nurses. We should be levelling up, not down.

### **Is education yet truly a core business?**

Trainees don't always turn up and trainers have other priorities. Education is barely acknowledged in the new consultant contract. Strategic plans & PFIs tend to leave education out. “Has any CE been sacked for providing poor education?”!

### **How can we prove we add value?**

Education audits, trainee satisfaction surveys, outcomes, patient satisfaction surveys all have their place. Comparisons between deaneries and with other countries are all reasonable tools. “Prove it or lose it”

### **How to move out of our comfort zone**

Learn to live with (though not necessarily loving) complexity. “For every complex problem there's a simple solution (& it's wrong!). We need to forge new partnerships across boundaries, remembering that all change is not necessarily improvement, though there's no improvement without change. “The future is not set” (from Terminator 2)

## **2. Where do we want to go?**

Claire du Boulay had the unenviable task of following Liz Paice's tour de force, but apparently effortlessly managed to do so. The range of vision was enormous, from the sublime to the ridiculous, and could be grouped under the following headings:

### **Service & workforce**

Working patterns will look very diff (post EWTD and with service networks & new healthcare settings). Better educated patients (“consumers”) will put patient safety increasingly high up the agenda. Care will be much more outcomes-focused (both in service and education) and there will be new types of workers, with significantly more women – flexible working and diversity will have to flourish.

### **Multi-professional education (MPEd)**

This should result in levelling up not down, and managers will include equality of access to CPD for all staff. The value of workplace learning will be at a premium (with clinical placements being the key to health learning), generic placements will become common, as will better monitoring; all this will break down professional barriers.

### **Education will be core business for trusts**

Or goals won't be achieved. This will demand commitment at board level. E&T directorates will have a director team consisting of MP educators & learning

facilitators. Education & skills centres for all staff, with rolling training days will be the norm

### **Teachers & learners**

Should be valued & rewarded appropriately. Clinical education should be professionalized, having an explicit career structure and defined progress. There should be protected sessions (perhaps easier with the new contract?). Teachers will have to teach well – if the quality is not maintained, a cycle of abuse would be likely. The suggestion of mandatory qualification was made, and the need for good role models reinforced. Remember, doctors need not do all the teaching.

### **Trainees**

Need to be responsible for their own learning and thus start life long learning. They should have some ownership of their education. Learners needed to be educated and trained to be able to be adaptable and not just fit for current purpose. They also needed to respect others' roles, learning in teams might help.

### **Patients, safety & outcomes**

Better informed “consumers” and more patient choice had changed the landscape. Educated patients should be harnessed as educators and learning would happen in a wider variety of settings.

### **Safety**

Education would be increasingly driven by risk management, resulting in more skills labs and simulators, nationally agreed generic core components and competency-based assessment procedures.

### **IT**

Access to IT & e-learning in all clinical areas and the development of national materials needed to be funded & rolled out (e.g. fire, infection control etc). Learners could do it in their own time, using contact time for communication skills, interprofessional learning & feedback

### **Resources**

We must stop making do – “get real about what it costs”. Protected funding streams, commissioners ready to listen to those on the ground are needed – WDCs are scary – not yet proven bodies. Perhaps 5-10% of the NHS budget should go on E&T

### **Leadership**

This must influence our top policy makers – perhaps a role for PGDs? Local education collaboratives (with all professionals, not just doctors) are needed to influence the WDCs. Perhaps multiprofessional deaneries? There should be a critical mass of educationalists in each patch

### **Joined up thinking**

Stop reinventing wheels – share good practices. Service & education should be planned together, not just having reactive educational units tacked on. WDCs and StHAs

could work together better. Joint monitoring visits perhaps the PMETB will help this? Colleges and deaneries might co-operate in helping trusts develop effective local education strategies, generic learning materials could be developed nationally and evidence-based education needs to be developed. Perhaps an NSF for medical education standards & targets should be published?

Ideally education and training would be viewed as a core requirement for a quality service. On a personal level, we should care for ourselves & each other first, to keep us fit to care for the patients.

## The future: informed speculation and possible implications

*Dr Richard Smith  
Editor, BMJ*

The meeting reached its climax with the BMJ's Richard Smith looking into possible futures for medicine and medical education. He described conventional education as "Stalinistic learning" and then pointed out some of the dangers of looking to the future. As Sam Goldwyn said, "I never make predictions, especially about the future". Richard pointed out that the renowned Lord Kelvin predicted, among other things, that radio had no future, x-rays would prove to be a hoax, and heavier than air machines would not work. Other widely touted, but wrong, predictions included the leisure society, the paperless office, the death of the novel and the end of communism. Equally, no-one predicted the rapid and universal spread of the Internet or the tragedy of September 11. He emphasised that we should learn to not to try to make predictions, but rather to attach probabilities to possibilities. Other traps for the unwary were: simple extrapolation, only thinking of one possible future, and people consistently overestimated the effect of short term changes and underestimated the effects of long term changes (see Stuart Marples' contribution above).

He gave us some insights into different ways of looking at the future – don't try to predict it, but rather prepare for it. Think of possible drivers, then use those to generate different scenarios. Imagine say 3 plausible but different scenarios, then extrapolate back. Such drivers might be the Internet, the IT age, globalisation, cost containment, increasingly sophisticated consumers, the "24/7" society, science and technology (especially molecular biology), ethics, and the environment

Using such methods, three possible futures for health care had been devised (the so-called Madingley scenarios). They were given neutral descriptive names of three metals:

### a) *Titanium*

a highly IT-based system, with a global market, little governmental control, huge choice, a suspicion of government-sponsored services, and many "truths".

### b) *Iron*

a top-down highly regulated system, overwhelmed by information. This makes people turn to trusted

institutions (e.g. the NHS). Experts would be important, information standardised, and the public interest more important than privacy.

### c) *Wood*

a world where reaction against technology has occurred, legislation restricts innovation, and privacy is valued. Internet access is limited and there are no mobile phones!

Pictures of future health care were perhaps disturbing. More developed countries' health care systems seemed to be tending towards the North American model of a three tier service: fee for service system for the rich, an M&S-style managed care system for the middle classes, and a safety net service for the poor.

The old (i.e. that which we were trained for) and the new worlds were very different. Many examples of the differences were given: the individual vs the team, on top vs part of the complete organisation, long hours vs "want a life with the family", patients before family, professional freedom vs accountability, expert opinion as the source of know vs systematic reviews, semi-mystical clinical skills vs managed & audited care, most knowledge in the head vs IT tools, lip service to keeping up to date vs CPD, essential medical care assumed to be beneficial vs assessing the good/harm balance, doctor as master over patient and pupil vs partnership, doctor smartest vs patient much smarter.

We were told about Professor Christian Koeck from Witten who was reinventing medical education in his medical faculty. His approach was to discard the old model of medical students studying natural sciences, then applying them to solve people's problems. His rationale was that doctors aren't scientists and people are not machines but "complex adaptive systems" (as are families, social groups, and nurse/doctor interactions). Such systems need technical and adaptive skills

Major problems were faced by doctors, especially where either the patient's problem or the problem's solution was not clear (as so often happens in clinical medicine, and complex systems management). He posed the rhetorical question "Would you prefer that a medical student knew all about clinical governance, or hypertension in pregnancy?" When he actually took a show of hands on it, the audience was firmly divided!

Smith finished up by quoting David Pencheon who said that the three most important words in education were "I don't know". We should celebrate ignorance, not hide it, in Smith's view.

"If you aren't confused, you don't understand what's going on" as Jack Welch CEO of General Electric said.

### The 5<sup>th</sup> Joint Conference NACT "Richard Smith" caption competition



What is Richard Smith (editor BMJ, left) saying to Richard Smith (NACT Hon Treasurer, right)?  
Email or post answers to the NACT office

# WEBLINE NEWS

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[www.Doctors.net.uk](http://www.Doctors.net.uk)

**The Joint Conference Cybercafe News**

Doctors.net.uk were delighted to provide a cybercafe for all delegates at the recent PGMDE conference in Bournemouth – 10-12<sup>th</sup> July 2002. All delegates enjoyed free access to Internet and email throughout the conference and many also took advantage of the opportunity to participate in workshops led by Dr Rebecca Small, Head of Education at Doctors.net.uk with valuable support from Helen Bingham and colleagues from the National Librarians Network. The workshops covered 2 topics, "Introduction to the Internet" and "Online Education" and provided an excellent opportunity for educators to explore the use of online information and learning for the medical and dental professions.

The Department of Health publication "Working Together-Learning Together" states that all NHS organisations should have developed a local five year e-learning strategy and capability by December 2002. The national vision for e-learning in the NHS is to enable staff to access learning opportunities at times and places that best fit in with their lifestyle. This means 24 hr access to knowledge and learning resources 365 days per year from places that are most convenient for individuals and groups with the technical support structure to ensure this happens. That's the challenge..!

Dr Tim Ringrose  
Medical Director  
Doctors.net.uk

Doctors.net.uk provides online education services to NHS Trusts and Professional groups

All you need to do to register is go to [www.doctors.net.uk](http://www.doctors.net.uk) with your GMC number handy and click on the new members 'join' button. The Doctors.net.uk helpdesk, which has recently won a Daily Telegraph/ Energis award for excellent service, is available to answer questions every weekday 9am to 7pm, so you won't be left stranded. We look forward to welcoming you to Doctors.net.uk.

If you require more information, please email Neil Bacon: [neil@mess.doctors.org.uk](mailto:neil@mess.doctors.org.uk)

## PUBLICATIONS OF INTEREST

### ABPI

Clinical Tutors might like to look at the following documents:

- A Code of Practice for the Pharmaceutical Industry 1998 – *Prescription medicines code of practice authority.*
- The Seven Values of Medicines – *report on the economic value of medicines. Reports are now available on; Asthma; Bowel & Breast Cancer; Epilepsy; Hepatitis C; Kidney Failure; HIV & AIDS.*
- Target Rheumatoid Arthritis/Target Parkinson's – *brief monographs on current use and possible future medicines for these diseases.*
- Patient Progress – *The story of advances in medicines for the NHS*
- An A –Z of British Medicines Research – *An accessible, easy to use survey of current research by the Pharmaceutical Industry operating in the UK.*
- Reporting of Suspected Adverse drug Reactions – *the role of the medical representative.*
- The Pharmaceutical Industry: Careers for Graduates – *A review of all aspects of work of the Pharmaceutical Industry and the wide career opportunities for those with degrees; including medical qualifications.*

For a fuller list of APBI Publications and price list contact the Publication Dept., ABPI, 12 Whitehall, London SW1A 2DY. Tel: 020 7930 3477 Ext.1466. Fax: 020 7747 1411

### MEDICAL FORUM

#### Bringing Career Guidance to all Juniors

Medical Forum runs a number of one and half day workshops for juniors.

#### Career Guidance Techniques

These workshops for Clinical Tutors are also available.

For more information please contact:  
Dr Sonia Hutton-Taylor, Director, Medical Forum  
phone 07000 790173 fax 07020 933964.

Alternatively, you can obtain a leaflet from:

[medicalforum-info@autoresponder.freeyellow.com](mailto:medicalforum-info@autoresponder.freeyellow.com)

Or visit Medical Forum at:

[http://fast.to/medical\\_forum](http://fast.to/medical_forum)

### POSTGRADUATE MEDICAL JOURNAL

Information on subscribing to the *Postgraduate Medical Journal* can be obtained from:

BMJ Publishing Group  
Journal Marketing Dept  
PO Box 299

# NACT COURSE LISTINGS 2002

## Effective Clinical Tutors Course

Parts 1, 2 & 3.

(Clinical Tutors should attend *all three* within 1 year of appointment)

### ECT Part 1

“Essential Skills For Clinical Tutors”

*October 8–10 2002 Nottingham  
March 25–27 2003 Farnborough  
October 14–16 2003 Banbury*

### ECT Part 2

“Making use of Assessment in Education & Clinical Governance” Course

*27th September 2002  
8th April, 17th September,  
4th November 2003*

### ECT Part 3

Counselling Skills (including Appraisal) Workshops

26th September, 3rd October 2002  
9th April, 18th September,  
5th November 2003

Novartis Foundation,  
41 Portland Place, London

# NACT 2002

## NACT OFFICERS

Chairman: Dr APJ Thomson  
Vice Chair: Dr A Blair  
Hon Secretary: Dr A Long  
Hon Assist Sec: Vacant  
Hon Treasurer: Mr R Smith

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## NACT OFFICE

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Web: [www.nact.org.uk](http://www.nact.org.uk)

*We need to know the Postgraduate Centre email address and the Clinical Tutor's email address. (This may change with successive clinical tutors). Please send an email from each of these addresses to the NACT email address so that we amend our database.*

# **FUTURE NACT MEETINGS**

Please pencil these dates into your diary (or enter them into your PDA...)

## **Spring Meetings**

2003 – 8/9 May 2003, Inverness

2004 – Trent Deanery

## **Winter Meetings**

2002 – November 29<sup>th</sup> – RCP

2003 – November 28<sup>th</sup>– RCP Joint with NAMEM

Please visit our website

<http://www.nact.org.uk>