

# Clinical Tutor

Newsletter of the National Association of Clinical Tutors

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## CHAIRMAN'S MESSAGE

I hope you have all returned refreshed from your summer break. If my analysis is right, you will need to be! This letter gives some recent news from the postgraduate medical education arena.

Since the last newsletter, I have visited the meeting of Clinical Tutors in Wessex. Elsewhere in *Clinical Tutor*, you will find accounts of my attendance at the NAPMECA meeting and the AMEE 2001 conference attendance, as well as NACT's involvement in other meetings and the final excerpts of the NACT Spring Meeting in Swansea. These illustrate NACT's

continuing involvement at the cutting edge of medical education.

On the business side, I have attended the COPMeD meetings in July and September on NACT's behalf. Attending COPMeD as an observer on behalf of NACT has given me useful insights and up-to-date information. I summarise the proceedings for the NACT Officers, usually circulating my version within a week of the meeting. I would be willing to consider circulating my summary further afield by email. I envisage that potentially it would be useful at least to Deanery representatives and maybe to all PGCTs. If you are interested in this proposal, please let your Deanery rep, or me, know. I shall have the issue discussed at Council.

In the last newsletter, I outlined COPMeD's priorities for the coming year: modernisation of the SHO grade; introduction of a national system of assessment of training grade doctors and the implementation of the RITA process; training of a cohort of assessors for the RITA process in each Deanery; preliminary work with Workforce Development Confederations on training capacity in primary care and higher specialist training; and workforce planning to solve the flexible hours funding crisis and the implementation of the EU working time directive. Most of these are still unsolved, which is not surprising considering the size of the problems. But there have also been new issues coming on to the agenda, which have made these main agenda items drop down the priority ladder.

New initiatives include the NHS aim to expand the medical workforce. Recruitment from Europe or further afield seems fraught with problems, not least that the targeted countries may be short of doctors and that educational standards and attainment of the trainees within a different medical environment may be different. Promotion of existing non-consultant career grades, even if their qualifications and skills

make this possible, then leaves a gap in the medical workforce at those grades, instead of consultant level. The expansion of the medical workforce must come from undergraduate level and even the expansion currently underway seems to be in danger of providing a workforce that is only 'standing still' in terms of manpower capacity, once hours-of-work, gender mix and other factors are taken into account.

This autumn the NHS is contemplating the reduction in juniors' hours to 48 per week and the inevitable introduction of full shift systems in most departments. Meanwhile length of training is not increasing. This is providing a heavy irony for some former flexible trainees, who worked 56 hours a week during their flexible training and were unable to shorten their training despite consultant vacancies in their specialty. All this seems dangerously political for NACT; but the educational implications of an expanded workforce, who work fewer hours, but train for the same number of years, combined with pressure to get doctors through the system, are considerable. At present, NACT and ASME are exploring a joint conference together for early Spring 2002, to examine some of these educational issues.

In my last newsletter, I mentioned the need for trainee documentation. I mention it again here because I believe the national introduction of the SHO RITA process is going to create a major need for clear documentation of the progress of the 'Lost Tribe', as they were dubbed in a report in the last decade. Documents needed for the SHO RITA process will include at a minimum: agreed educational objectives for the post (ideally as part of a formative appraisal); a review of objectives attained at the end of the post; assessment for trainee's progress by supervising consultants - and other staff with whom they work; and, crucially for the trainee with difficulties, evidence of these problems. This latter requirement will be vital, if we are to advise trainees about their problems at the RITA: trainees will wish to challenge any criticism. Critical incident forms will become a vital part of the educational process and, if a pattern emerges, these may become evidence of problems. Hopefully, Deaneries will address these documents from the top down, but this can be a slow process. Educational supervisors - and PGCTs - who have not collected this evidence may end up in the invidious position of seeing a trainee move on to the next post, without being able to pass on with them vital information for the next educational supervisor. Clinical governance issues will then potentially be undermined. These issues are not well recognised by PGCTs and even less so by most

educational supervisors. I have no doubt I shall return to this topic.

Since the last newsletter, my own hospital has been visited by CHI, the Commission for Health Improvement. (The report may be published on the web at [www.chi](http://www.chi). around the time this newsletter appears). I have put together some thoughts about this elsewhere in *Clinical Tutor*.

Last words! Please join the NACT interactive forum on the [Doctors.Net.UK](http://Doctors.Net.UK) web site. Consider joining the Institute of Learning and Teaching (ILT): 'grandfather' membership application time has recently been extended to May 2002. Also in 2002, on 10th to 12th July, the 5th Joint Conference on Postgraduate Medical Education will be held in Bournemouth. This is essential for all PGCTs and Associates.

I hope to see you at the NACT Winter Meeting on Friday 30th November.

Alistair

## Editor's Column

Another edition of our organ is at last compiled for your enlightenment and delectation. As you will see, our hard-working Chairman has produced most of the content. He has maintained the high activity (and productivity!) with which he started, and carries on the tradition which his equally enthusiastic predecessors have bequeathed him! The other Officers (and of course Jane Litherland) also constitute a formidably active team. I mention this only to remind you that, as with everything in life, few of the best things that happen do so just by chance!

As you will know if you have read previous editorials, I enjoy reading old medical textbooks. The less charitable of my colleagues suspect that these are the only publications which I employ. A certain William Buchan outraged many of his physician colleagues in Edinburgh when he wrote in 1772 a book for the layperson

about medicine. It is called Domestic Medicine. His take on EBM in it is quite salutary:

*"I have not troubled the Reader with an useless parade of quotations from different authors; but have nevertheless made use of their observations where my own were either defective, or totally wanting ... Several other foreign physicians of note have written on nearly the same plan ... but as these gentlemen's productions have never come to my hand, I can say nothing concerning them".*

I wish I could feel so sanguine about the things that I know I don't know! A century later (1876) Dr P M Latham is quoted in his "Collected Works" as saying:

*[These lectures] do not pretend to teach the clinical student any single thing peremptorily or dogmatically, but only to furnish him with certain aids and assistances by which he may be better able to teach himself.*

Communication skills - we all know how important this area is. Lorraine Noble, Lecturer in Communication Skills at UCL, gave an excellent account of teaching communication skills at the NACT Spring Meeting in Swansea. I am delighted to report that she has agreed to provide a précis of her presentation for the next edition of the Newsletter. I think it will be well worth the wait! On the learning front, we all know that one learns much more from mistakes than from success. Put another way, "Good judgement comes from experience - usually experience which was the result of poor judgement". Perhaps this is epitomised in the Bristol story which is, after all, an acknowledged seed in the genesis of revalidation. Much fascinating reflection on the events in Bristol is to be found on the relevant web site. For more information see Weblines News.

Incidentally, if you feel that revalidation will never work, do bear in mind that with sufficient thrust, pigs fly just fine!

I am keeping in contact with the BMA's Refugee Doctors Liaison Group. You may not be aware that guidelines for refugee doctors' clinical attachments are now available. PGCTs obviously may be closely involved with such initiatives, so you might like to check the document on the BMA web site, in the International section [www.bma.org.uk/public/intl.nsf](http://www.bma.org.uk/public/intl.nsf). I will take this opportunity to remind you that the BMA has set up a voluntary database for refugee doctors. This is intended to allow a needs analysis, as well as allowing the development of co-ordinated resources for this vulnerable but potentially valuable minority within our profession.

Thinking of difficult political issues, I cannot help but recall the world-changing atrocities in North America, recently. Many if not most will have reflected on life and some of its more impenetrable facets. I happen to belong to an email group which includes a physician who was among the many waiting outside St Vincent's Hospital in New York, waiting for those thousands of casualties that never came. He described the frustration at being ready but not needed, and the apocalyptic nature of the scenes he saw just down the street. I am sure that we can all still recall that sympathy we felt at the time for our fellow humans *in extremis*. Let us hope that our species' apparently inexhaustible ability to overcome insuperable odds (which we see all too often in the NHS in general, and medical education in particular) will continue to come to our rescue.

Bye for now

Kit Byatt

## Meeting with AMEE

### Association for Medical Education in Europe Conference 2001

*Dr Alistair Thomson, Chairman NACT*

In 1910 Flexner asked why it was assumed that, if a person was a doctor, that person could also teach. This question is one that is engaging us still. But the AMEE conference this year went further and took as its theme 'Medical Education and Standards at a Time of Change'. The theme of global standards in medical education was explored in plenary sessions, large group sessions and small groups. Simple and sensible though this aim of certain core standards sounds, we heard that there was major opposition to the concept only two or three years ago.

Other running themes in medical education were not neglected. Best Evidence Medical Education (BEME) was reviewed, though it was suggested this should be renamed Better Evidence Medical Education! The three short communications sessions had 13 concurrent subjects, including ones on Postgraduate Medical Education, Multidisciplinary Education and two on CPD. There were two afternoons of workshops - with choices of 12 and 13 respectively and a spoken poster session with 12 simultaneous themes. In addition, for the real die-hards, there were 7 pre-conference workshops, including one that started 2 days before the conference proper!

With over 700 participants from over 50 countries there were numerous viewpoints to be heard.

Other NACT Officers there were Andrew Long, Honorary Secretary and Richard Smith, Assistant Secretary. Together with Jane Litherland, NACT's Executive Manager, we had an 'Officers' mini-meeting', (which we often refer to as a 'mini-Officers' Meeting' - a linguistic construction that has me imagining vertically-challenged Officers). Andrew Long and I helped our former NACT Chairman Kwee Matheson with the Directors of Medical Education Group's workshop 'Risk Management in Education'. This was well-attended with many learning points illustrated by anecdotes. Two particular THMs (take-home messages) are, firstly, that clinical incidents have a valuable educational use, though they may turn into documentary evidence, if a doctor's

competence is challenged; and, secondly, the corollary, is that educational supervisors should keep careful records of contacts with trainees. A resume of this workshop is to be found on the web site.

Without exaggeration or hubris, the United Kingdom is in the vanguard of countries who are tackling many of the issues of standards in education. Documents from the GMC, which set the standards for much of Lifelong Learning, courses from our Colleges and many initiatives from other UK bodies contributing to Medical Education were cited as examples of a high quality of educational practice. This is valuable feedback to UK practitioners, but also acted as a challenge to develop further.

On the lighter side, there was a reception in the 'Rotes Rathaus' - the Red Town Hall, so-called because of its red brick facade, but also, more recently, because it was on the Communist side of the wall. The coach tour took us past Checkpoint Charlie, the Brandenburg Gate and the Norman Foster-renovated Reichstag; and an evening cruise on the canals showed us Berlin from a different perspective. The metaphor is obvious. Berlin, like UK medical education, is a city in transition for the last decade. The amount of new building does not always seem coordinated.

There were few NACT members at this year's AMEE. Yet there were topics to interest everybody. Next year's conference is in Lisbon, Portugal from 29th August-1st September 2002. I recommend it to you. If you are in doubt, review the contents of the 2001 Conference website at [www.amee.org](http://www.amee.org), which has lecture texts, slides and other materials from this year's proceedings; however, these can only be a pale reflection of the value of the meeting, because they miss out the interplay, the questions and the discussion. The only way to judge is to see for yourself.

*My gratitude to GlaxoSmithKline and Roche, who contributed financial support to my trip. I was granted overseas professional leave (as opposed to study leave) by Mid-Cheshire Hospitals NHS Trust, with financial support for the conference fee and some subsistence costs. My thanks to my colleagues, who provided ward cover during my absence.*

## NAPMECA Conference Cardiff, 5-6<sup>th</sup> July

*Dr Alistair Thomson, Chairman NACT*

As Chairman of NACT, I was invited to the NAPMECA Spring Conference in Cardiff in July. So, while the rest of the country was sweltering in a heat wave, I travelled into progressively duller weather. There had been a tropical storm in the city only the day before with power cuts and flash floods. So we were lucky it was only overcast in this pleasant metropolitan city!

The opening speaker in the section on 'Appraisal - Threat or Opportunity' was Jane Hutt, AM (Assembly Member), who discussed plans for appraisal of career grade staff and the links with revalidation. This will have an impact on doctors, but it is not clear how much individual PGMCs will be involved. It is perhaps more likely that PGCMs and their PGMCs will be called upon to provide training for appraisers and information (or should one call it training?) for appraisees.

There followed a double-act on appraisal and assessment by Dr Melanie Jones, Postgraduate Organiser (PGO, i.e. Welsh for PGCT) and Mrs Shelagh Jones, Deputy Chief Executive, both from Bridgend, who outlined how junior staff had been appraised. The introduction of an appraisal system for doctors in training, with training for the appraisers, documentation, etc has taken nearly 10 years in Bridgend. The COPMeD document 'SHO Training: Tackling the Issues, Raising the Standards' was produced after Wales had begun, though it remains an important source. So does the SCOPME study on 'Appraisal for Doctors and Dentists in Training'. In Bridgend, there are 84 trainees, with 24 Educational Supervisors, including 7 College Tutors. Educational Supervisors needed training, which has been provided by management at Bridgend, not centrally in Cardiff. That training is now provided with actors substituting for trainees, which provides a consistent and skilled source of expertise. Appraisals occur at 1 month, 3 months, and 6 months. Participation in appraisal earns juniors reimbursement of study leave costs, though there are still problems within recalcitrant trainees. Other demands on consultant time are the greatest problem faced by appraisers. The discussion showed that appraisal systems differ markedly

between deaneries. There are also problems around confidentiality of appraisal, its relationship to assessment and performance management and issues of the honesty in the system. It seems to me that there will have to be some uniformity, if the national RITA system for SHOs is to produce comparable data across Deaneries.

Mr Richard Mills, former PGO, gave his perception of consultants' views on appraisal, which range from 'wild enthusiasm' to 'kicking and screaming'. In an analogy using theatrical terms, the variety of plot-lines, stage managers and script writers were summarised. The spectrum of threat that includes NICE, CHI, NCAA and the medico-legal industry does not sit well with the concept of the 'no-blame' culture, within which framework appraisal could best exist. His review of writing on the subject reveals confusion, again mainly between appraisal and assessment. His views of the potential for training for appraisal were entertaining but pessimistic, but not as critical as his summary of the proposed arrangements for the paperwork and for the session itself. He predicted that it might not work unless more time is spent and work undertaken before appraisals for consultants are implemented. The PGCM audience enjoyed this talk enormously.

Dr Amanda Kirby, GP, then spoke about learning how to do appraisal. She showed the web site [www.appraisalskills.com](http://www.appraisalskills.com) to the audience. She also discussed how to learn about appraisal through experience. Most doctors undertaking appraisal want confidentiality, continuity, constructive dialogue, and attention to life issues as well as professional skills. Quality of appraisal is highly dependent on the appraiser.

Unlike the previous speaker, who suggested that appraisal might rapidly become extinct once its problems become apparent in practice, Dr Kirby drew the parallel with industry, where performance appraisal has been happening for over 30 years, and predicted that appraisal in some form would soon become an essential tool in the NHS.

The final talk of the afternoon was 'A Scot's perception of 6 months in the Welsh Assembly' by Dr Gladys Tinker, Consultant Geriatrician and Associate Medical Director of Medical Education and Training at Cardiff Hospitals NHS Trust (and another former PGO). Dr Tinker drew a number of parallels between her 6 months and the average SHO's stay in a Trust, emphasising the importance

of first impressions, the environment, the culture, jargon and structure of the organisation. All of these need constant review in a Trust if they are to be put across in an induction programme so as to be helpful to new junior staff in a hospital. She gave a number of insights into the workings of the Welsh Government and her perception of the issues that are important to civil servants.

One tip she gave to increase feedback and evaluation is to ask members of an audience to complete 'post-it' notes and stick them on a door as they leave. This gives considerably more feedback than the standard methods. Another tip is that, if one is submitting a bid for funding from an organisation, to use that organisation's own past publications as referenced documents - and a thesaurus. Overall, she conveyed a sense of having met the challenge of becoming enabled to narrow the gap between the government of a country and clinical work at the coal-face.

The next day the morning session opened with 'Past Imperatives in Postgraduate Education' by Dr Rhid Dowdle, Consultant Physician, Royal Glamorgan and PGO. He used a series of classical and modern paintings in a witty and erudite presentation. He reviewed postgraduate medical education (PGME) since the end of the 1980s, encompassing the major changes brought about by the implementation of Working Paper 10. Despite these changes, medicine is the only profession that does not employ professional teachers. Identifying time and money as the two main barriers to provision of PGME, he compared wealth of countries such as France (#4 in wealth but #1 in quality of healthcare) to the UK (#5 in wealth, #25 in quality of healthcare) and led the audience to the conclusion that you get what you pay for.

Dr Ieuan Davies, Specialist Registrar and BMA representative for Wales, then spoke about 'Finding the way back', which, *pace* the title, was a resume of the views of junior doctors about medical education. After a review of the career structure and the activities which have to be undertaken on the way to their career posts, he discussed the changes in legislation - particularly the EU Working Time Directive - and the difficulties this will pose for the delivery of organised PGME. This will be a tremendous problem for PGMCs to solve. This was a refreshing, well-focused view of the problems and some of the solutions. His THM (see earlier!) is that service is the educational opportunity.

In the Open Forum the NAPMECA website was demonstrated - [www.napmecca.org](http://www.napmecca.org). This links with the NACT website [www.nact.org](http://www.nact.org) and is worth perusal by PGCTs. In particular, it has a useful map, with the name and details of each Deanery's PGMCs and a click brings up a link to each PGMC's email.

I was particularly impressed with attendance at the conference, which attracted over 100 delegates from the 280 members of NAPMECA. Given that there are the same number of PGMC managers as there are PGCTs, this is a higher proportion of hospitals represented than at NACT meetings. How can this be? Factors that might increase PGCM's attendance at these meetings, in comparison to PGCTs' at our own meetings, include more time available to PGCMs, a longer time in post, continuity in medical education and an interest in what other Deaneries are doing that is not met by other contacts in the same way as consultants. On the other hand, PGCMs are busy people, whose PGMC cannot do without them for long, especially in the last month of the SHO posts in their hospital. Certainly their programme was good and relevant to the day to day business of PGCMs and the areas of future responsibility, though there was a call for more workshops next time. For me, this confirms that NACT's strategy for future meetings - which is similar to the above - may be correctly targeted to maximise attendance.

It was a well-run professional meeting - as one would expect from NAPMECA. The speakers were all of high calibre and the sessions were well chaired - by PGOs. A final memory of the meeting was the little touches: Welsh scones at tea-time, Danish at coffee time and a bottle of Welsh wine for the speakers. Look out for (some of) these at the next NACT meeting too!

### **Afterword**

NAPMECA have voted to change the name of the organisation from December 2001 to NAMEM - the National Association of Medical Education Managers. The criteria for membership of the association have not changed, however. NACT and NAMEM will doubtless continue to collaborate and hold joint meetings together and I, as your Chairman, welcome this.

I am most grateful to NAPMECA for a most stimulating conference and their hospitality in Cardiff.

# CHI - Visit or Visitation?

*Dr Alistair Thomson, Postgraduate Clinical Tutor,  
Mid-Cheshire Hospitals NHS Trust, Crewe*

CHI visited my base hospital this summer. There were aspects of this visit which will interest Postgraduate Clinical Tutors and Directors of Medical Education. CHI were particularly interested in the way the hospital was run and the structure and effectiveness of clinical governance. Because education is a vital part of clinical governance, (I hope you all sit on your CG Committees?), the PGCT gets heavily involved.

Firstly, CHI required a large amount of documentation. On the postgraduate front, this included records of all education taking place and copies of all hospital recognition visits from the last five years. I found my PGMC annual report particularly useful. (If you do not compile one, start now).

I kept my own copies of all material that the PGMC had sent to CHI. This was valuable when I was asked to meet the CHI information-gathering team off site. CHI met 'stakeholders', patients, users of the service away from the hospital premises so as to gain frank information about the organisation. I was one of only a few hospital personnel asked to attend.

The hospital documentation and data need checking. Our hospital data contained a glaring inaccuracy in the mortality data, which was at first treated as an accurate piece of information and an excuse was offered. Closer examination of the tables revealed that it was a misprint, not a problem. Do make sure that you check the data your hospital submits.

CHI selects 3 areas for an in depth review. Supposedly these are selected to be one area

where practice is deemed to be good and two areas where problems exist. As you can imagine there is a lot of jockeying for position within the hospital - or, rather, a desire not to be in position. CHI, however, make the final choice and are guided by their exploratory interviews.

The week when the CHI team itself visited, the slots where they required a meeting were cleared - there is little room for choice and fixed sessions may need to go. The CHI team will need to see the PGMC and educational areas. They will accept other guides, such as the PGMC manager, for this tour, but my advice is to conduct it yourself if you can. The CHI team also required a separate hour with the PGCT in that week. Take your documentation and be prepared to be frank. There is not much the team will not know by now.

As Director of Medical Education I was asked to the feedback meeting. This was a long afternoon, when each area visited is commented upon and the insights gained into the other areas of the hospital are exposed. The clinical governance mechanism is the focus of their report in many ways, in that this demonstrates how it all fits together. Points out of 4 are awarded. CHI see the exercise as educational.

The CHI team then compile their report over the next weeks and send this to senior management. The report has to be answered within a week, with new information, supported by evidence and documentation. I was originally asked to view the report at this stage, but was away most of the week at AMEE. Although I arranged to view it on email, it was not sent; I think this reflects the pressure of time that the hospital found it faced.

As I write, we await the final report. It is at this stage that heads can roll. A debriefing session in the hospital can be useful, especially if you are faced by another visit soon - e.g. Clinical Negligence Scheme for Trusts, College, etc. And even if none of these is expected in the near future, remember CHI itself will be visiting again in 4 years' time. Good luck!

# WEBLINE NEWS

The Bristol Inquiry report was published on 18 July, and might be deemed to be passé now. However, if you have not read it there is a lot of thought provoking stuff, especially in the (198) recommendations. These alone occupy pages 433-461! For example, the idea of Distinction Awards for junior staff (recommendation #44). Suggestions about Trust Board members' appointment (#49), induction (#52), training (#54) and mentorship (#55) are redolent of where PGME was some 15 (plus?) years ago. Mention is also made about competencies, generic skills, and multiprofessional learning(#57-64). Six key aspects of non-clinical education, training and CPD were highlighted:

- Communication skills
- NHS organization and care management
- Developing teamwork
- Shared learning across boundaries
- Clinical audit & reflective practice
- Leadership

Medical school selection processes and curriculum design are also addressed (#75-80) as are PGME and the eagerly [?, Ed]awaited MESB (#81-84).

All in all, much food for thought, and possibly even an extra lever in the process of change management?

The report is available at [www.bristol-inquiry.org.uk](http://www.bristol-inquiry.org.uk) and the Secretary of State's statement is at [www.doh.gov.uk/bristolinquiryresponse/index.htm](http://www.doh.gov.uk/bristolinquiryresponse/index.htm)

On a minority note, there is a small but select group of medical folk who use Psion personal organizers in their professional life (yes, I do know that they are not being made any more!). I am involved with the "Psions for Healthcare" egroup, whose aim is to share information about these useful tools (or silly gadgets, depending on your point of view!). If any other enthusiasts out there are interested in joining, you can do so from [www.jiscmail.ac.uk/lists/](http://www.jiscmail.ac.uk/lists/) and search for Psion. Don't worry about being overwhelmed by messages; there is not a massive traffic, perhaps one mailing per week or so. I look forward to sharing experiences with you!

Finally, we are still encouraging PGCTs to try out [www.doctors.net.uk](http://www.doctors.net.uk) - you simply need your GMC number handy and then click on the new members 'join' button on the entrance page.

NACT continues to build links with DNUK since there is much of mutual benefit. We see IT as an important resource in CPD, and DNUK sees information access as a valuable resource which they can offer their members. We are planning to bring you some articles about how to make the best of your IT resources, in collaboration with DNUK. Watch this space next issue for more details!

# What Do They Do? COPMeD

*Professor Peter Hill  
Chairman*

The Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD) is a forum in which its members can meet to discuss current issues, share best practice and agree a consistent and equitable approach to the management and delivery of high quality education for doctors and dentists in all deaneries.

As well as every postgraduate dean from the four territories, COPMeD and the Postgraduate Dean for the Armed Services, membership include the chairs of the sister general practice and dental organisations (the Conference of General Practice Education Directors - COGPED; the Conference of Postgraduate Dental Deans - COPDEND). There are also a number of observers, including the Chair of the National Association of Clinical Tutors, the Chair of the Flexible Training Sub-Group, the Chief Executive of the Scottish Council for Postgraduate Medical and Dental Education, and a representative of the NHS Executive.

COPMeD acts as a focal point for contact between the Postgraduate Medical Deans and many other organisations, including the Medical Royal Colleges and the Academy, the General Medical Council, the Specialist Training Authority and the various Joint Committees for Higher Specialist Training, and particularly with the NHS Executive and the Department of Health. COPMeD also supports the development of excellence in postgraduate medical education through its relationships and work with universities, promoting high quality research and supporting the development of the seamless continuum from undergraduate, through postgraduate to continuing education, as part of lifelong learning.

More details of all this, our terms of reference and publications are contained on our web site ([www.copmed.org.uk](http://www.copmed.org.uk)) where there are also useful links to related sites.

## Erratum

Re GP Training

*The editor writes:*

*I received a letter from Dr David Sowden, Postgraduate Dean for the Mid Trent Deanery clarifying an error which arose in the article about Theo Joannides' communication skills assessment project. The final sentence on page 4 was inaccurate. I reproduce the body of David's letter in full, since it makes very clear the issues involved:*

The report on Theo Joannides work suggests that Summative Assessment is part of the MRCGP- this is not the case.

The MRCGP is the Collegiate exam for the RGCP that is currently undertaken by approximately 70-75% of GP Registrars as they complete their vocational training and remains an entirely voluntary exam. Summative Assessment is an exam required by law to exit vocational training for General Practice.

A simulated surgery can be used by GP Registrars to complete the consultation assessment element of Summative Assessment in the same way as they can use videotape of consultations.

In the MRCGP exam simulated surgery is only available to those who have a legitimate objection to video taping consultations – the main reason being those of an Islamic faith who for religious reasons cannot consent to the representation of the human form as occurs on a video tape.

The important point is that Summative Assessment and the MRCGP are separate exams one compulsory and one voluntary and the only linkage between the two is that certain elements if passed at MRCGP can be treated as equivalent passes for Summative Assessment but not vice versa.

## Pertinent Anagrams

**Is homomorphism enforcement vital?**

*Working towards uniformity*

**The informal commonership motives.**

*Off the record - lowest common denominator*

**Non-chemist, or of evil metamorphism!**

*The wily haematologist*

**Feverish lemon promotion mismatch**

*The Peter Principle?*

**The servomechanism promotion film**

*Oiling the cogs...*

**Mechanism to impoverishment floor**

*Lift to bargain basement!*

**I'm the mammoth's conversion profile**

*Evolution works?*

## PUBLICATIONS OF INTEREST

### MEDICAL FORUM

[Http://www.medicalforum.com](http://www.medicalforum.com)

07000 790173

Special "tutors only" section will be available by password access

To obtain password – email [tutor@medicalforum.com](mailto:tutor@medicalforum.com)

### Postgraduate Medical Journal

Information on subscribing available from:

BMJ Publishing Group  
Journal Marketing Dept  
PO Box 299

## COURSE LISTINGS

### NACT

#### Effective Clinical Tutors Course

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

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### ECT Part 1

"Essential Skills For Clinical Tutors"

*March 12-14 2002 Farnborough*

*October 8-10 2002 Nottingham*

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### ECT Part 2

"Making use of Assessment in Education & Clinical Governance" Courses

*26<sup>th</sup> April & 27<sup>th</sup> September 2002*

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### ECT Part 3

Counselling Skills  
(including Appraisal) Workshops

*25<sup>th</sup> April & 26<sup>th</sup> September 2002*

*at: Novartis Foundation,*

*41 Portland Place, London*

Pertinent Anagrams

*Commission for Health Improvement*

# **NACT AUTUMN 2001**

## **COUNCIL MEMBERS**

TBA	London
TBA	Kent Surrey & Sussex
Dr J Day	Anglia & Oxford (Anglia)
Dr G Luzzi	Anglia & Oxford (Oxford)
Dr C du Boulay	South & West (Wessex)
Dr J Lowes	South & West (Sth Wstn)
Dr P Brown	Nthn & Yorkshire (Yorks.)
Dr R W G Prescott	Nthn & Yorkshire (North'n)
Dr M Serlin	North West (West)
Dr I Brett	North West (East)
Dr PC Taylor	NorthTrent
Dr C Bowman	Mid Trent
Dr D A Sagar	South Trent
Dr C Campbell	West Midlands
Dr F Morris	Wales
Dr K McHardy	Scotland
Mr G Orr	Scotland
Dr J McKnight	Scotland
Dr B Reid	Scotland
Dr P Burnside	Northern Ireland

## **FUTURE NACT MEETINGS**

### **Spring Meetings**

2002 – none – Joint Conference  
(Bournemouth 10-12 July) instead

2003 – 8/9 May 2003, Inverness

### **Winter Meetings**

2001 – November 30<sup>th</sup>- RSM

2002 – November 29<sup>th</sup> – RCP

## **CALL FOR ABSTRACTS**

### **NACT WINTER MEETING 2001**

*Do you have any initiatives,  
projects, research or  
insurmountable problems you  
wish to share with like-minded,  
non-threatening colleagues?*

*If so, please submit an abstract (title and up  
to 200 words) describing your topic to the  
NACT Office. We plan to hold some 15  
minute sessions during the Winter Meeting  
for these to be presented*

If in doubt about whether to send something in,  
either do anyway or contact one of the officers to  
discuss it?

***Closing date Friday  
19 October 2001***

## **NACT OFFICE**

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Email: [office@nact.org.uk](mailto:office@nact.org.uk)

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

Mrs Jane Litherland Executive Manager

## **STOP PRESS**

### **NACT Wyeth Travel Fellowship 2002**

This is your last chance to apply to the  
NACT Office – the closing date is 31 October

# Clinical Tutor

*Newsletter of the National Association of Clinical Tutors*

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