affected. So what do medical educators at undergraduate and postgraduate level need to be doing now?

In essence we need a reality check on purpose and practicalities.

- Do curriculums and assessments truly reflect the type of doctor the public will expect in future years?
- Are we role modelling patient engagement and using the patient voice throughout our educational structures?
- Have we embedded patient autonomy and team working in all aspects of training programmes?
- Have we checked our documentation for the subtle messages?
- Are we using the whole healthcare team and patients as teachers?
- Are we influencing and changing the incentives for placements to meet new financial systems and the plural provider market?
- Do we have enough flexibility to future proof for technological advances, demographic changes, and new government policies?

Ensuring the health service has the right capabilities and capacity is everybody's business. Medical education and training prepare doctors for their future roles, and their leaders must have a vision of those roles and an understanding of their context. The changes occurring in England are not unique. Patient pressure for choice, diversity of healthcare providers, and extended roles of other staff are realities in many countries. The lessons learnt here about maintaining and strengthening medical education will be applicable elsewhere.

Contributors and sources: LH has specific remit for workforce, education, and training issues in the Office of the Strategic Health Authorities, including the support and management of collective working of postgraduate medical deans and GP directors of education. The views expressed here are not necessarily those of the office or the strategic health authorities.

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Commentary: Dutch perspective

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The health service in England is experiencing a revolution.¹ Dutch health care is also changing but less dramatically than in England. Medical educators can embrace this challenge as an opportunity to improve medical education and training.

Dutch changes

The eight Dutch faculties of medicine have successfully completed the transition from traditional, teacher centred education to student centred approaches. It is important to recognise the similarities and interconnectedness between student centred teachers and patient centred doctors. If health care becomes more patient centred, it creates numerous opportunities for teaching.

Summary box

Changes in English health services will affect medical education and training

Medical education has an important role in shifting to a truly patient led culture

Moving some roles to other healthcare professionals will require review of medical students' and doctors' training

Appropriate contracts, reimbursements, and regulation are needed to facilitate training across multiple service providers

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Research into undergraduate clinical training has shown that observation of students during rotations is rare or non-existent. Supervision needs improvement.² Contracts with hospitals where students undertake clinical training now include settlements about payment for educational services commensurate with the quantity and quality of supervision. Clinical teachers are also offered staff development courses.

Postgraduate specialist training is the remit of the professional societies. They have a statutory obligation to design training plans and introduce new types of assessment, such as portfolios and the mini-clinical examination exercise (mini-CEX), a snapshot of doctor-patient interaction. These measures aim to strengthen the effectiveness of postgraduate training and coincide with the ongoing debate about shortening medical education.

New and extended roles and functions in health care are being created, such as physician assistant and nurse practitioner. These changes are expected to create new ways of sharing work and more flexible education and training, as advocated by Hutchinson.¹

Making the most of change

As medical educators, we would be wise to seize the opportunities offered by changes in health care to improve the quality of learning in the workplace. Commitment in the workplace is crucial for successful improvement. Clinical teachers have a pivotal role in education and training. Dornan showed that clinicians will dissociate from educational innovations, despite their essentially positive attitude, when educators fail to attend to their concerns and neglect to secure their support.³ Clinicians' support should not be taken for granted, given the pressure exerted on them by hospitals and universities to deliver more services and research. Evidently, a prerequisite for good medical education is a workable balance between the competing demands made on clinical teachers. Transparent funding for education and a climate that fosters

educational activities through material and immaterial rewards are important steps in this direction.

As educators we need to support the teachers in their environment. The workplace is a complex environment characterised by manifold interactions. We should enlist the support of other professionals and work with them as a team to ensure that our students are appropriately prepared to take on their professional responsibilities. We might look to clinical governance and learn how to make good use of the associations between quality of service to patients and quality of education and training. Last, but not least, we should focus more of our research efforts on change processes to seek evidence of effective mechanisms of change—to improve and convince.

Competing interests: None declared.

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Commentary: Australian perspective

J Jill Gordon

Hutchinson explores the likely educational impact of changes in health service design and delivery on the part of the NHS in England.¹ In Australia, we envy the way in which centralist arrangements in the UK help to disseminate improvements to services and training.² Here, funding is split between the Commonwealth and the states and between the public and private sectors. Despite the differences, however, many similar concerns and problems prevail.

Rather than a patient led environment, Australia is still working toward one that is more patient centred. Patient centred care is embedded in the national patient safety framework developed under the auspices of the Australian Council for Quality and Safety in Health Care.³ It is designed to address the educational needs of managers, clinicians, and support staff at all levels. Ensuring its dissemination remains the biggest challenge.

Patient participation

Many of the most interesting changes in patient led teaching have been in undergraduate education. At the University of Sydney, for example, students are taught by young people with diabetes, intravenous drug users, carers, transplant recipients, and many others. As part of their assessment in evidence based medicine, students are required to ask patients whether their information needs have been met in a way that is acceptable and helpful. There are many other examples. The new graduate entry programmes necessarily enrol older students, and 20-25% of students admitted during the first five years at the University of Sydney had a first degree in a health profession such as

nursing or physiotherapy. In practical terms, this has meant that one or two students in each problem based learning group could contribute from first hand experience of other careers.

Fewer changes have occurred at postgraduate level, and nothing to match the UK plans for lay input in the development and delivery of assessments.¹ New South Wales has established an Institute for Medical Education and Training,² a body similar to the Postgraduate Medical Education and Training Board, creating an opportunity to adopt this idea, if it proves to be more than a token.

Plurality

As in the UK, attempts to mix skills have met resistance in Australia.⁴ New South Wales has only 65 nurse practitioners, but some educational initiatives may increase this number, especially in rural areas.⁵ Role substitution undoubtedly needs serious attention, but the diagnosis and management of complex illnesses, as opposed to routine care, require a well grounded understanding of disease mechanisms. This point is easy to gloss over to avoid the charge of elitism.

Having experienced the headaches of negotiating student and trainee placements and ensuring quality of teaching in multiple sites, I predict a full blown migraine for those responsible for dealing with "a plurality of providers." Negotiations for placements consume precious time and create friction as medical schools try to accommodate increased student numbers. Particularly in the for-profit sector, careful monitoring (another time consuming activity) is

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