Education in Clinical Pharmacology and Therapeutics in a changing world

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There is a widely held view that the pace of change in Higher Education, particularly in the health care sector, has never been as rapid as it is at present. Of course this is the view of every generation and only history will be able to say whether a particular vintage was correct in their belief. By the time this edition of the journal hits people's desks we will have read the conclusions of the Dearing Committee on Higher Education (published on July 17th) and the Richards review of Academic Medicine. No doubt each of these will result in further changes to the way we work.

However let us keep our thoughts more focussed on the field of Clinical Pharmacology and Therapeutics (CPT) where the education process has produced changes, but also I feel benefits as well. There have been perhaps two main stimuli to this process. Firstly in the postgraduate field the UK Government was close to being taken to infraction proceedings by the European Court for its lack of action over postgraduate medical education. It was clear that the system in place in the early 1990s did not conform to European Law and rapid action was needed to bring the length of specialist training in the UK down to the European expectation. The resulting 'Calman' report is having far reaching effects and Clinical Pharmacology and Therapeutics, like other medical sub-specialties, is among the last of the clinical disciplines to introduce the new Specialist Registrar (SpR) grade. The transition phase should have been completed by March 31st although a few teething problems still exist.

The benefits are considerable. Firstly a new link has been made with the pharmaceutical industry who have part funded the eight new SpR posts in CPT that were established in 1996/97 with further posts being developed in 1997/98. Secondly, the Joint Committee on Higher Medical Training, through its Specialist Advisory Committee in CPT, finalised in December 1996 a new curriculum for specialist training in CPT defining both the obligatory and recommended experience that a trainee in CPT should have [1]. Thus the obligatory experience for specialist trainees in CPT has to cover the broad areas of Drug Action in Man, Clinical Pharmacokinetics, Statistics and Experimental Design, Evaluation of the Scientific Literature, Drug and Therapeutic Committees, the use of Drug Formularies and Communication and Educational Skills.

Thirdly the changes to specialist training have been coupled with changes to SHO training where the Royal College of Physicians now has a recommended curriculum for Senior House Officer training in medicine [2]. These changes are coupled with continuing determined efforts by Postgraduate Medical Deans to guarantee protected training time for all junior doctors and to insist on proper supervision

by consultants who have received training in how to teach.

However these changes to the postgraduate scene are arguably dwarfed by the changes to undergraduate medical training. The General Medical Council has been making critical comments about undergraduate medical training at regular intervals for at least the last 50 years. However its 1993 report entitled 'Tomorrow's Doctors' [3] has at last landed on fertile soil and many medical schools are well advanced in their development of new undergraduate curricula. We should be aiming to produce an educational system in medicine that provides a seamless service from the undergraduate stage, through postgraduate training and then into continuing medical education. At the least the first two steps are slowly coming together.

The new undergraduate curricula are following a number of principles; the encouragement of student learning rather than didactic teaching, the attempt to define a 'Core Curriculum' with student choice to follow more selected options, the greater involvement of the community and the increased emphasis on attitudes and skills. These approaches have produced integrated curricula which in some schools have followed a 'problem orientated approach' and in two schools (Glasgow and Liverpool) the introduction of the problem based learning (PBL) system. Inevitably concerns have been expressed that this approach will lead to a devaluation of traditional values in CPT education and may produce graduates who are not well versed in the science and art of Therapeutics [4]. This feeling is not unique to CPT but has been felt by other disciplines that have taught throughout a traditional course of medicine such as pathology and related studies.

Such fears are probably not justified as judged by a recent study from the Netherlands [5] but nevertheless these concerns have stimulated a number of actions to improve the situation. Firstly there is a report elsewhere in this volume of a recent study to develop a core curriculum in CPT [6]. This was conducted by the Delphi technique [7] whereby a consensus can rapidly be reached by a group dealing with a complicated problem. The Core Curriculum is itself described in a parallel report on page 171 [8] and shows some similarities to the core curriculum in CPT developed in the USA and reported by Nierenberg in 1990 [9]. However the latter core curriculum is predominantly knowledge based and it is nice to see that the new UK curriculum defines three areas; core knowledge, core skills, and core attitudes and this is very much in keeping with the approach suggested by the General Medical Council's document [3].

In order to see such a core curriculum in action Lloyd Jones and her colleagues [10] have described how such a curriculum was developed for the Liverpool problem based curriculum. There are many similarities between the two core curricula described but this is not surprising given the

source material and the personalities involved. It is however clear that the core principles of CPT can be made to fit into a PBL curriculum in a meaningful way and without causing too much dissent on the way. It will now be important for such courses to be properly evaluated so that we can be certain that tomorrow's graduates will be functioning as well, if not better than today's.

It is to be hoped that these curricular innovations will be carried through from the final year of the undergraduate course into the pre-registration house officer year. It is this year that is now most in need of educational attention as judged by the postgraduate deans and the General Medical Council. The recent decision to fund 100% of the salary of the PRHO year from the MADEL levy after April 1997 is indicative of the central desire to make this year essentially a learning experience. One can only hope that this does not discourage its participants from continuing with a career in medicine as is certainly happening today. It will be fascinating to revisit these reforms in 5 years time when the first graduates of these new courses will have completed their PRHO year.

References

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