Governance of academic medicine should be with public trustees

EDITOR—Many of the problems arising in academic medicine are due to the divergence of academic goals and the values of society. Academic institutions are not currently governed in a way that fosters a strong and healthy alliance with government and the population at large, and there is a failure to support satisfactorily the public interest against vested and other competing interests.¹

We suggest that a good first step is to turn over the governance of academic medicine to public trustees with protected authority. Public trustees must ensure that the three familiar goals of research, teaching, and patient care are supplemented by the unsung fourth goal of community service. Moreover, trustees have the right to insist that most of the research and teaching programmes in academic medicine be placed in the context of the health needs of the entire population.

It is also time to reform the governance of medical schools. We suggest that it fosters tunnel vision for the dean when the executive committee of the medical school is composed primarily of department chairpeople whose main responsibility is the welfare of individual departments, not the mission of the school as a whole. We advocate instead an executive committee comprising senior faculty and public representatives, while excluding department heads.

If academic medicine exists to promote the public interest, is it not time to grant patients and the public at large a controlling interest in setting priorities and overseeing operations?

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Competing interests: None declared.

¹ Lewis IJ, Sheps CG. The sick citadel: the American academic medical center and the public interest. Cambridge, MA: Oelgeschlager, Gunn and Hain, 1983:241.

Academic medicine has pitfalls for junior researchers

EDITOR—We share Clark and Smith's concerns about the decline of academic medicine.¹ New entrants must be both attracted and retained.² In March 2004 delegates

attending a regional meeting of the Society for Academic Primary Care in Bristol were invited to take part in a workshop to discuss the problems facing junior researchers. Twenty four participants identified problems with, and offered some solutions to, issues of supervision, career structure, and funding.

The relationship between supervisor and researcher was seen as important. Conflict may arise when the supervisor is also the "boss" and mentor. Some academic departments have dealt with this by dividing these roles between different people. The relationship between supervisor and researcher may also benefit from clinicians and non-clinicians supervising their own kind.

Employment on short term contracts was thought to hamper project planning and career development seriously. Together with an absence of educational funding and conflicting personal or professional commitments, this made obtaining a higher degree more difficult. Clinicians were concerned that schemes such as the academic general practitioner registrar scheme may encourage young doctors into research too prematurely. A lack of career structure and means of progression were particular concerns to non-clinical researchers.

Researchers said they were caught in a "Catch 22" situation, in which it is hard to get funding without a proposal, and hard to put together a proposal without funding. Non-clinical researchers thought that their incomes did not rise in accordance with their experience and value to the institution. To acknowledge the experience of non-doctoral research associates, one institution had introduced a "technical" grade post. For clinicians, the concern was the comparatively poor pay of academic work compared with clinical pay.

Many of these are familiar complaints in research,² but we think they are particularly important to junior researchers. If the reported decline in academic medicine is to be reversed, we think junior researchers in particular need nurturing and support.

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Competing interests: All the authors are junior researchers.

¹ Clark J, Smith R. BMJ Publishing Group to launch an international campaign to promote academic medicine. *BMJ* 2003;327:1001-2.

² Bell J. Resuscitating clinical research in the United Kingdom. *BMJ* 2003;327:1041-3.

Reform of undergraduate medical teaching in the United Kingdom

Evidence base for problem based learning is growing

EDITOR—Williams and Lau's criticism of the recent reforms in medical education is dismaying.¹ Everyone involved in undergraduate medical education in the United Kingdom wants to produce doctors who are "fit for purpose." This requires flexible learners with the core knowledge to practise safely as preregistration house officers and to build on during postgraduate training. They also need relevant skills in communicating and working with other health professionals and patients, as well as in making ethically and clinically sound decisions.

Evidence suggests that preregistration house officers have felt deficient in some of these skills.² New medical curriculums seek to remedy these deficiencies as well as identify, and enable better learning of, core knowledge.

Three established UK medical schools (Manchester, Liverpool, and Glasgow) have almost 26 years of combined experience of problem based learning. The decision to adopt problem based learning was not taken lightly as such major curricular change entails substantial investment in time and effort. They were, however, convinced by the compelling theoretical basis in the psychology of learning (which is largely missing from traditional methods of teaching) and the experiences of other problem based learning schools in Europe, North America, and Australia.³

Although problem based learning is an example of student centred learning, it does not necessarily equate with student directed learning.⁴ In problem based learning, knowledge content can be tightly structured by faculty by means of carefully written "problems," supporting clinical and laboratory sessions, and appropriate assessments. The content of curriculums is documented

and can be reviewed for relevance and balance, instead of being left to the vagaries of individual departments.

It is difficult to see how a UK evidence base for problem based learning could have been generated without some schools having the courage to try something different. Arguably, more is known about the process and outcomes of these new curriculums than was ever known about previous traditional courses.

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Competing interests: JM is a product of a traditional curriculum but was involved in developing, and is now deputy head of, an undergraduate medical school that has a problem based learning curriculum.

- 1 Williams G, Lau A. Reform of undergraduate medical teaching in the United Kingdom: a triumph of evangelism over common sense. *BMJ* 2004;329:92-4. (10 July.)
- 2 Jones A, McArdle PJ, O'Neill P. Perceptions of how well graduates are prepared for the role of pre-registration house officer: a comparison of outcomes from a traditional and an integrated PBL curriculum. *Med Educ* 2002;36:16-25.
- 3 Norman GR, Schmidt HG. The psychological basis of problem-based learning: a review of the literature. *Acad Med* 1992;67:557-65.
- 4 Schmidt H. Assumptions underlying self-directed learning may be false. *Med Educ* 2000;34:243-5.

*The long version of this letter (<http://bmj.bmjjournals.com/cgi/eletters/329/7457/92#67271>) was originally accepted as a commentary to go with the article by Williams and Lau but was inadvertently not published with it.

Unfunded reform always ends in reaction

EDITOR—Williams and Lau seem to have overlooked an important factor common to all attempts to make education more effective by making it more humane and less industrialised.¹ Humane educational methods are always far more labour intensive and always require higher teacher to pupil ratios.

I visited Albuquerque medical school in the 1980s in its first years of introducing problem based learning, modelled on experience at Case Western Reserve and McMaster. The programme was then experimental, with educational results compared in two cohorts, one continuing the traditional didactic programme. Problem based learning won hands down on all counts, including popularity with students—so much so that the experiment had to end because so few wanted to stay in the traditional programme.

Watching problem based learning in action, I was struck by the huge new demands placed on one to one tutoring and on far more imaginative teaching, which made it impossible to rely on teaching routines and material changing little from one year to the next. Problem based learning would demand a huge expansion in staff and per capita costs.

Problem based learning for medical students resembles the teaching methods applied throughout Wales and in most parts of England from the late 1960s, which were eventually enormously successful compared with past methods of more didactic teaching. In 1970 nearly half of all children left school without qualifications; by 2000 this had fallen to 10%. In the early 1960s only 10% of

children went on to any kind of higher education, but by 2000 this reached nearly 40%.²

These new, more humane, more pupil oriented methods required much higher teacher to pupil ratios, and per capita funding, at levels comparable with those in private sector education. These they never received. The result has been a reactionary counterattack ignoring all these advances, and blaming differences between public and private education on progressive teaching methods based on evidence rather than gut beliefs, instead of the parsimony of a state still serving minority interests.

Williams and Lau present a plausible warning against any trust in magical effects of problem based learning compared with rote learning, with an underlying assumption that teacher to pupil ratios and per capita funding are bound to fall. The key issue is not how students are taught, but how they learn. That has an inescapable material base in sufficient university funding from the nation as a whole through taxation—the growing social product devoted to growing social purposes. There is no alternative.

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Competing interests: None declared.

- 1 Williams G, Lau A. Reform of undergraduate medical teaching in the United Kingdom: a triumph of evangelism over common sense. *BMJ* 2004;329:92-4. (10 July.)
- 2 Tomlinson S. Quoted by Benn M. Where one size fits all. *Guardian* 2004 July 23.

Students are too many to be assessed individually in general hospitals

EDITOR—I share Williams and Lau's misgivings about changes in medical education and agree that *Tomorrow's Doctors* is a depressingly bland document.¹

Like most non-teaching hospitals in the United Kingdom, this hospital has seen a huge increase in the number of medical students, who spend between two and eight weeks on our medical firm. The two week stints are too short for us to get to know the students well, and such a short time may coincide with the absence of a crucial team member. We have students from both Oxford and Leicester, and without stereotyping either medical school, the Oxford students seem to have more freedom to fill in their perceived gaps in knowledge and experience.

My grouse about the teaching is the paperwork it generates. After an hour long tutorial with a group of eight new students, I am expected to fill in a detailed questionnaire about the performance of each participant. I have no objection to the students giving feedback on my performance and invite this at the end of the session. But vice versa is madness. When we protest, we are told that it is a requirement of the General Medical Council.

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- 1 Williams G, Lau A. Reform of undergraduate medical teaching in the United Kingdom: a triumph of evangelism over common sense. *BMJ* 2004;329:92-4. (10 July.)

"Problem based learning" v "traditional" is a false debate

EDITOR—Williams and Lau debate the reform of undergraduate medical teaching.¹ The most important issue in medical education is not whether problem based learning is a weaker approach than "traditional" learning but whether medical sciences are viewed as a body of facts to be crammed in a crude fashion or as a conceptual framework for understanding human health and disease. Quality in medical education can be assured only by understanding this essential point.

The traditional strategy does have certain weaknesses. Why provide students with overwhelming lists of detail if they lack the intellectual skills necessary to apply these appropriately? No one can emerge from a medical degree having achieved a comprehensive knowledge of the basic sciences: biochemical and genetic knowledge is expanding faster than anyone can retain it. Why try to force students to achieve impossible ends?

This reality means that the material presented to students must be carefully selected—by focusing the learning on a clinical problem, problem based learning may have a role in performing this function.

Anecdotes show, however, that during group sessions students too often do not identify and learn what is needed to tackle the case presented properly. Problem based learning therefore fosters incomplete styles of learning. The authors correctly identify—crucially—that the suitability of such an approach to UK school leavers is in doubt; it probably requires a maturity that the recently reformed A levels may not provide. It is ultimately only as good as the groups who undertake it and the "scaffolding" that facilitators provide.

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Competing interests: None declared.

- 1 Williams G, Lau A. Reform of undergraduate medical teaching in the United Kingdom: a triumph of evangelism over common sense. *BMJ* 2004;329:92-4. (10 July.)

Evangelism triumphs over common sense for ophthalmology

EDITOR—In the same issue as Williams and Lau describe the reform of undergraduate medical teaching as a triumph of evangelism over common sense,¹ on page 80, the photographs showing narrowed and normal retinal arteriolar diameter are the wrong way round.² Five days later on bmj.com no one else seems to have noticed [though a correction was published a month later³].

This is a sad reflection on the inability of non-specialist medical practitioners to distinguish between a retinal arteriole and a retinal venule any more, the result of the lack of undergraduate medical training in ophthalmology. Another triumph of evangelism.

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- 1 Williams G, Lau A. Reform of undergraduate medical teaching in the United Kingdom: a triumph of evangelism over common sense. *BMJ* 2004;329:92-4. (10 July.)
- 2 Wong TY, Shankar A, Klein R, Klein BE, Hubbard LD. Prospective cohort study of retinal vessel diameters and risk of hypertension. *BMJ* 2004;329:79-82. (10 July.)
- 3 Correction. Prospective cohort study of retinal vessel diameters and risk of hypertension. *BMJ* 2004;329:384. (14 August.)

Summary of responses

EDITOR—No clear consensus emerges on whether problem based learning is a good thing in the many responses to Williams and Lau's education and debate article.¹

Among those in favour, US based associate professor Will Beachey finds that students who have learnt with this technique are not disadvantaged and argues that many people might be jealous that these students experience less intimidating education tactics than they did themselves.

Traditional courses do not need to be protected so carefully and any nostalgia is misplaced, writes Norman Bofft, a medical student from Australia, while Peter McCrorie and colleagues from London's St George's Hospital Medical School provide their own course as an example of a successful application of problem based learning. Thuli and Andrew Whitehouse, a medical student and a consultant physician, ask for the public as consumers of health care to be the judge of what kind of teaching works best.

Problem based learning may be more appropriate for postgraduate than undergraduate teaching as it provides more knowledge and fewer facts, argues Brian Rambihar, a general practitioner from Preston. For him, the main argument, which bears out the pragmatism of a primary care doctor, is what doctors do is more important than what doctors know.

Problems with appropriate assessment of new teaching methods are also brought into the debate. Kayvan Shokrollahi, a trust surgeon in Oxford, finds that the key to successful medical training is to state explicitly to students or trainees what they need to know and provide the means for them to achieve these skills and knowledge. Jorge Zimbron, medical student in London, argues that the information retained after whatever teaching has been offered depends on the quality of the teacher, not on the way the teaching is delivered.

Among the detractors, radiologist Patrick Xavier equates problem based learning with deskilling. And Richard Heatley, consultant physician in Leeds, praises Williams and Lau for pointing out that the reform of medical teaching has achieved nothing other than being different, illustrating his argument with lots of examples.

A possible solution to the teaching dilemma may be evidence based learning or evidence based teaching. But undergraduate teaching should not be used as a political pawn, argues Umesh Prabhu, consultant paediatrician in Bury, adding that tomorrow's doctors must be better than today's doctors at both clinical and non-clinical

skills in the quest to be "good doctors." Undergraduate teaching has not achieved this objective, so reform is necessary.

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Competing interests: None declared.

- 1 Electronic responses. Reform of undergraduate medical teaching in the United Kingdom: a triumph of evangelism over common sense. *bmj.com* 2004. <http://bmj.bmjournals.com/cgi/eletters/329/7457/92> (accessed 3 Aug 2004).

Ethics: entitlement may benefit disadvantaged patients and students alike

EDITOR—Jagsi and Lehmann extrapolate three major areas of research ethics to medical education but could have added entitlement, using the ideas of Rawls, to benefit disadvantaged people.^{1 2}

All fourth year medical students at this medical school see a patient with intellectual disability, and they not infrequently question the validity of that patient's consent to be interviewed. A person with mild or moderate intellectual impairment can usually give informed consent to student contact, but this does take extra time and effort. People with severe intellectual disability usually cannot.

We therefore notify in advance the patient's carers, community team, and general practitioner of the proposed student's visit, any of whom can prevent the visit if they consider it may be harmful. We also point out that we offer to the patient with intellectual disability an extra benefit in the form of a supervised, student led, physical health check that he or she otherwise might not have had, and a biopsychosocial assessment that is often unblinkered and innovative. Such benefits to potentially disadvantaged people may well be happening in other areas of medical education but may not have been recorded.

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Competing interests: None declared.

- 1 Jagsi R, Lehmann LS. The ethics of medical education. *BMJ* 2004;329:332-4. (7 August.)
- 2 Rawls J. *A theory of justice*. Cambridge, MA: Harvard University Press, 1971.

Measuring participation in UK medical schools

More insight is needed

EDITOR—In their article on medical school admissions Seyan et al pay no attention to the three major determinants of academic aptitude for any career—IQ, EQ (emotional quotient), and education.¹ Testing for aptitude for a career as broad as medicine is challenging, but certainly an adequate IQ as well as an adequate EQ (in my view almost more important), is necessary.

They give no data on the ethnic and sex distribution of these variables in applicants. Neither is any attention paid to the distribution of those who have had an education to the standard required for medicine. Medical schools can hardly be expected to make up for a poor education.

The claim in the title that the article deals with sex is not fulfilled. It is mentioned only in the second half of one paragraph which, in view of the major effect it has on lifetime working hours per doctor qualifying, is not doing it justice. Is not our goal to produce more doctor-hours of the highest standard possible, irrespective of a person's race, sex, or origin? If applicants are not coming forward for selection in an even distribution, that is an educational problem at school level. The real test of discrimination would be the acceptance to medical school of "academically apt" applicants. It would be most unfortunate if the standardised admission ratio as published were to be accepted as politically correct and therefore desirable.

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Competing interests: None declared.

- 1 Seyan K, Greenhalgh T, Dorling D. The standardised admission ratio for measuring widening participation in medical schools: analysis of UK medical school admissions by ethnicity, socio-economic status, and sex. *BMJ* 2004;328:1545-6. (26 June.)

Social class data are problematic to interpret

EDITOR—Seyan et al use the standardised admissions ratio to measure widening participation in medical schools.¹ This ratio is difficult to interpret, although it is an interesting concept. The validity of the measure of social class as used by the University and Colleges Admissions Service (UCAS) is poor.

UCAS uses brief, typically one word, students' descriptions of parental occupation to assign social class (wwwucas.ac.uk/figures/enq/index.html). This process is unlikely to be an unbiased, reliable, or valid indicator of the subtleties of class,² particularly for 17 year olds with little idea of parental jobs and for ambiguous terms such as "manager"—of a small rural petrol station or a multinational oil company? The uninterpretable numerator of standardised admissions ratios is exacerbated by a denominator derived from entirely different data (www.statistics.gov.uk).

Standardised admission ratios cannot reach a value of unity. Post-1945 Britain has very much been meritocratic, with interclass mobility driven by intelligence,^{3 4} which predicts examination results (and hence university entrance), making it unsurprising that higher classes predominate in universities. Standardised admission ratios are unlikely ever to reach a utopian value of unity. Selection entirely based on intelligence would mean that 14%, 35%, 41%, 8%, and 2% of medical students would be from classes I to V with standardised admission ratios of 2.25, 1.18, 0.97, 0.48, and 0.30; social class I is still 7.7 times that of class V.⁵

Proportions of UK medical students in social classes I, II, III, and IV and V, from 1956 to 2001 compared with population proportions for 1961 and 2001 (see <http://bmj.bmjournals.com/cgi/eletters/328/7455/1545#64772> for data sources)

A longer view shows little systematic change in social class of UK medical students over half a century (figure). The standardised admission ratios for social class I dropped from 12.3 in 1956 to 6.76 in 2001, but only because social class I is now twice as common in the population.

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- 1 Seyan K, Greenhalgh T, Dorling D. The standardised admission ratio for measuring widening participation in medical schools: analysis of UK medical school admissions by ethnicity, socio-economic status, and sex. *BMJ* 2004;328:1545-6. (26 June.)
- 2 Rose D, Pevalin DJ. *The national statistics socio-economic classification: unifying official and sociological approaches to the conceptualisation and measurement of social class*. Colchester: University of Essex, 2001. (ISER working papers, paper 2001-4.)
- 3 Halsey AH, Heath AF, Ridge JM. *Origins and destinations: family, class and education in modern Britain*. Oxford: Clarendon Press, 1980.
- 4 Nettle D. Intelligence and class mobility in the British population. *Br J Psychol* 2003;94:551-61.
- 5 McManus IC. The social class of medical students. *Med Educ* 1982;16:72-5.

Authors' reply

EDITOR—In a 600 word short report it was not possible to provide a detailed analysis of medical school admissions data. Such analyses are provided in the articles referenced in the report.

Our purpose was to share a tool that we developed to analyse admissions by ethnic group, sex, and social class by using publicly available data and offering some illustrative worked examples. The standardised admission ratio could of course be used alongside other measures (such as the biomedical admissions test (BMAT), A level performance, school deprivation index, etc) to test systematically the speculative hypotheses which the above authors have raised, and thereby throw light rather than heat on the widening debate on participation.

This work began as a medical student's project—perhaps another student might like to pick up the challenge?

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Competing interests: None declared.

Emphasise burns prevention in developing countries

EDITOR—Ahuja et al highlight factors associated with high risk of burns injuries.¹ In our experience in Nigeria, additional factors include perennial fuel scarcity, adulterated kerosene, erratic power supply, and local traditional practices such as hot water baths for mothers immediately after childbirth and the treatment of convulsions in children with fire.

As a result of fuel shortages, petrol is stored in homes and carried in overcrowded vehicles. Therefore, although most burns injuries occur in the home, burns after road traffic injuries are on the increase. Although management is based on standard principles, hospitals are ill equipped with staff and support facilities. Physiotherapy is often assisted by patients' relatives. Delays in hospital presentation are common. Ambulance and prehospital services are non-existent. The vulnerable groups are women and children and young men with petrol burns.

The emphasis should therefore be on prevention, by advocating change from harmful cultural practices. This needs to be done with care and sensitivity. The radio has the greatest reach for this, with tips on prevention and first aid treatment aired in the local language. Similar tips in school lessons and antenatal clinic talks will create awareness among children and pregnant women. Market days provide opportunities for public enlightenment and education at village market squares. Collaborative initiatives that help train staff in burns management will be very useful. Measures such as electrification as recommended by the World Health Organization² require sustained pressure on governments that have the resources to re-order their priorities.

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1 Ahuja RB, Bhattacharya S. Burns in the developing world and burn disasters. *BMJ* 2004;329:447-9. (21 August)

2 World Health Organization. *Burns*. www.who.int/violence_injury_prevention/unintentional_injuries/burns/burns2/en/print.html (accessed 21 Aug 2004).

Screening research papers by reading abstracts

Idea seems reasonable

EDITOR—Groves and Abbasi propose screening research papers by reading the abstract.¹ Submitting an abstract is the usual practice for paper acceptance at scientific meetings, so this proposal seems reasonable.

The question is, will the *BMJ* allow authors simply to submit an abstract for screening and then invite them to submit

the full paper for consideration if the paper gets past this hurdle? This will concentrate the minds of the authors and will avoid some of the problems with abstracts that the editorial lists.

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Competing interests: None declared.

1 Groves T, Abbasi K. Screening research papers by reading abstracts. *BMJ* 2004;329:470-1. (28 August.)

Just how rapid is "eternal" review?

EDITOR—As a freelance medical writer and editor, I am always fascinated by what catches the editor's eye and what drives decisions about whether a manuscript will be published or will perish. I thank Groves and Abbasi for confirming my suspicion that editors start the same place we readers do—with the abstract.¹ Given the number of articles that make it into publication but fail to catch the reader's attention in the abstract, I shudder to think what the *BMJ*'s daily duty editors must read if 15% to 25% of the articles don't make it past that first brief review of the abstract.

But what really tickled me was the typo that read, "Daily duty editors...can reject manuscripts, send them for eternal review, or pass them to colleagues..." I suspect that "eternal" review is selected for those papers that are neither suitable for external review nor clearly destined for rejection but instead must spend an eternity in review while their authors wait anxiously, forever awaiting a reply from the journal.

I presume this letter has the ideal combination—its observation is correct, but it displays blatant disrespect for the editor—necessary to be selected for eternal review, rather than rapid review or immediate rejection. If I were in the *BMJ*'s shoes, however, I think I'd opt for the latter.

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Competing interests: None declared.

1 Groves T, Abbasi K. Screening research papers by reading abstracts. *BMJ* 2004;329:470-1. (28 August.)

Review may be eternal but rejection is swift

EDITOR—I hope that "eternal review" used in this editorial by Groves and Abbasi was a typo and did not refer to a Kafka-esque process of articles circulating around the postal service (or internet) ad infinitum.¹

I am pleased to say that this is not an accurate description of the review process for papers I have been involved in that have been submitted to the *BMJ*. These were rejected swiftly and efficiently.

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Competing interests: None declared.

1 Groves T, Abbasi K. Screening research papers by reading abstracts. *BMJ* 2004;329:470-1. (28 August.)