

Letters to a Young Doctor

Postgraduate education

PHILIP RHODES

It is well to have some understanding of the organisation of postgraduate education in medicine so that you may use the system to the best advantage. If you know how it works and who does what in it you can usually find the right person to help you.

There is much overlap among various bodies in graduate medical education. This must be borne in mind in the following description, which has to be more clearcut than in fact is the case. Even if you do not get to the right part of the organisation at first you will usually find that those in it will direct you to the best place for answers to your questions. Sometimes you may run up against an awkward, unhelpful bureaucrat, but in general those who are in the organisation prefer to be as useful to its "consumers" as they can. They know that they are there to serve the doctors who call on them, so they try to provide a service within the resources available to them.

National and regional

Essentially there are "national" and "regional" organisations. The national ones mainly set standards and prescribe the curricula and experience necessary for higher diplomas and accreditation. These are mainly the royal colleges and their faculties. The regional organisations mainly provide resources for educational activities. The concept that I prefer—to try to epitomise the system—is that of regional schools of graduate medicine preparing their students for the examinations and requirements of the "external" national bodies. This envisages all the doctors in a particular region as members of a school of graduate medicine. The members are sometimes teachers and sometimes students (though all should be students all the time) and sometimes they are junior and sometimes senior, with all grades in between. All are concerned more or less with educating themselves and others, just as much as they are concerned with service, research, and administration. These four activities are inseparable and intertwined in the functions of all doctors, whatever they are doing, and are mixed in different proportions for each individual.

The benefit of the idea of the school of graduate medicine is that it crystallises the notion of the importance of education in the National Health Service and for it. Although it is difficult to prove, it is probably a well founded belief that educated and trained doctors who are kept up to date will provide a better service for patients than those who allow their education to grind to a halt. In any subject based on science and technology perhaps the matter does not need proof. Many activities in life have to be accepted a priori, and this may be one of them. In any case

it seems that education is here to stay and has been at work since the days of Plato about 2500 years ago. Without education of succeeding generations civilisation and its scientific and technological accompaniments would disintegrate. In our own lifetimes this is unlikely to change.

The general pattern is that the university (or universities) in an NHS region is responsible for providing graduate medical education. In this function the postgraduate dean is the university's chief officer, and the body to whom he is accountable is the regional postgraduate medical education committee (RPMEC). This consists of people from the university, from the regional consultants, from the teaching hospital (undergraduate) consultants, and from the administration of the NHS. All of these regional committees also include representation from the junior doctors of the region. This is the body finally responsible for all educational activities going on in the region.

The RPMEC is comparable with the academic board of a medical school or the faculty of medicine in a university. It cannot know all that goes on in its name throughout the region, but it directs policy and is a final court of appeal on all matters concerning graduate medical education. The committee is accountable to the faculty of medicine of the university and also to the regional health authority. In its own spheres of activity, however, it is relatively autonomous and tends to report its deliberations only to its superior bodies when necessary. The postgraduate dean is the chief officer and he carries out most of the day to day functions. In this he is comparable with the dean of an undergraduate school or faculty and thus may or may not be chairman of his parent body.

Undergraduates and graduates

A major difference between the postgraduate dean and the undergraduate dean is that the former has an extensive remit stretching right across his region. It is much easier to envisage and encompass an undergraduate school or any other university faculty, because it can be largely identified with certain buildings and staff. In some senses the graduate school is a medical university without walls, made up of all its members in a looser configuration than the undergraduate school or faculty. Moreover, the grades of student in an undergraduate school are easier to identify than in the graduate school. Undergraduates move steadily on from one year to another, and in a year all are at roughly similar stages of progress.

Graduates in medicine, however, range from preregistration house officer to consultant and principal in general practice, through various grades of senior house officer, registrars, senior registrars, associate specialists, hospital practitioners, and trainees in general practice. They range roughly from 25 to 65 years in age, and each has different needs and wants in education. Moreover, they are in many, different specialties—50 to 60 of them—each with its own educational programmes. There are many more graduates than undergraduates—60 000 to 70 000 as

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compared with about 20 000—and they are students for many more years than the five or six of the undergraduate period.

Advising the regional postgraduate medical education committee are subcommittees in each branch of medicine. The variety of these differs from region to region. Nevertheless, there are always groups providing advice on educational matters in their disciplines whether they are set up formally or not. One of the more important ones is that for general practice, since it represents almost half the doctors in any region. These subcommittees represent similar interests to those of the regional postgraduate medical education committee and include members from regional consultants, teaching hospital consultants, university departments, and junior doctors. Those that take their duties seriously review the posts in their disciplines throughout the region to see that they are providing satisfactory experience, and they also review and advise registrars in post on their careers. This is in addition to advice obtainable as it should be from consultants and others with whom the junior doctor is working.

Subcommittees in many disciplines advise the regional health authority on matters of service. Often these also take on an educational role in advising the regional committee and the postgraduate dean. This saves the time of members of the subcommittees and prevents duplication of effort. In addition, it draws constant attention to the relations between education and service. This must ever be in mind for everyone. At the very least standards of education and training set standards of care.

The boundary between determination of policy and executive action to be based on it is often impossible to determine. A decision, however, always needs someone identified to see that it is carried into effect. For the regional postgraduate medical education committee this is nearly always the postgraduate dean, though by virtue of his position he is also a major determiner of policy, and this is true of all officers, subject only to the oversight of and discussion by their parent committees. Obviously the postgraduate dean needs helpers throughout his region by the nature of the task to be performed.

The key figures are clinical tutors selected for each NHS district. An important thing to know is that each clinical tutor is appointed by the regional university. He is really an assistant dean. He is chosen from among doctors working in a particular district so he is an NHS employee, but in his function as a clinical tutor he is employed by the university to carry out its functions. This makes a reality of the concept that the provider of educational resources in the region is the university. This, in fact, is a little tenuous since virtually all the finance for graduate education comes from the NHS. Nevertheless, although the NHS pays, it has in effect delegated education to bodies external to itself—the universities. This gives a degree of independence to the

educational arm so that it shall not always be subservient to the needs of service, which might happen if the NHS ran its own educational activities. The distinction may be a fine one but may be valuable nevertheless.

Reconciling the needs of the service with educating doctors is not always easy. Often the same people are concerned with service and education, but it is valuable and helpful to give formal recognition to education.

Postgraduate centre

The clinical tutor is given charge of the postgraduate medical centre in his district, which has a centre administrator, a librarian, and other staff. These show the unusual and harmonious relation between the university and the NHS, since the centre is provided by the district health authority, which pays the administrator and other staff and is responsible for cleaning, heating, lighting, and other maintenance. It is a remarkable union and shows the value that the NHS places on graduate medical education.

Supporting and helping the clinical tutor are many doctors with a special interest in education. Tutors in, for example, psychiatry, surgery, medicine, and general practice are often specially appointed either by the university or the colleges or faculties or by local arrangement. These all help to arrange programmes and lectures in the centre and they may conduct tutorials for groups of junior doctors. They are in effect a form of miniature faculty in each district. They do the work often unpaid, though the clinical tutor is paid a small honorarium by the university that is reimbursed from NHS funds—another example of the value the NHS places on graduate medical education, and the relative independence of its educational arm.

The junior doctor's main sources of careers advice are in his district and include his own consultants or principals or both and the clinical tutor or the specialty tutors. All can and should be used. They are in contact with regional and national bodies on whom they can call when their own knowledge runs out. The libraries are sources of information on careers and can provide addresses and people to contact. The libraries are parts of networks on which they can draw at regional and national levels. It is up to you to look after yourself and your own interests and act or not according to the advice you seek. But all the mechanisms and the people and the systems are there to help you if only you will call them into play.

In the next article I shall discuss how postgraduate education is organised for general practitioners.

A 55 year old joiner has frequent nose bleeds and some symptoms of perennial rhinitis. What is the risk of his developing nasopharyngeal carcinoma, and are there any screening tests for this condition for people in at risk occupations?

Frequent nose bleeds and perennial rhinitis do not indicate that a patient has nasopharyngeal carcinoma, and nasopharyngeal carcinoma is not common in joiners. A more common carcinoma of the nose that does occur is adenocarcinoma of the maxillary antrum. There are no screen tests that are of any value, but these patients ought to be examined by an ear, nose, and throat surgeon, and perhaps an x ray examination of sinuses would be of value.—J D K DAWES, reader in otolaryngology, University of Newcastle upon Tyne.

What should a general practitioner do when faced with a dead patient in the patient's own home when the body might possibly be used for organ transplantation?

The circumstances in which this might occur must be quite rare, but the difficulties would be practical rather than legal. For organs

such as kidneys to be transplanted the potential donor must be brain stem dead—that is, without spontaneous respiration and therefore being maintained on mechanical ventilation but with a beating heart up to the time of removal of the organ. This is unlikely to be sustained in domestic circumstances by means of emergency resuscitation, and therefore the donor would have to be rushed to hospital for maintenance in an intensive care unit until a suitable recipient was found and tissue matching procedures were completed. So long as the provisions of the Human Tissue Act 1961 were carried out—that is, either antemortem permission from the patient such as a valid donor card or, more usually, the permission of the near relatives—then these procedures could legally be carried out. As the likelihood of a domestic “death” being dealt with in this way seems slight, the other alternative would be to offer for transplantation tissues that do not require the continuance of cardiac function and respiratory support until the moment of removal. As cadaver vascular grafts are now rarely used, the most likely donation would be of corneas, which may be taken up to six hours after death. The nearest department of ophthalmic surgery should be contacted for the details of this procedure.—B KNIGHT, professor of forensic pathology, Cardiff.