



## *How do medical schools differ and does it matter?*

### Transcript of webinar:

Time Code	
00:01:13	<p>DEREK</p> <p>Hello everybody I'm just giving you another minute. People are still registering online so I'm just pausing for a second to let a few more get online before we start. Thank you.</p>
00:02:29	<p>DEREK</p> <p>Ok, welcome to the ASMEBITESIZE series. Today we've got another interesting lineup for you. We're going to be discussing two papers. But first I've got to do some housekeeping. So, this session will run for 45 minutes and we will keep quite strictly to time. We do hope to take questions at some stage after the speakers have finished but if we run out of time, we are thinking of doing an adjunct to this later on in the ASMEBITESIZE series. If you wish to ask a question please use the chat field. This feature is available by clicking on the chat button either at the bottom or the top of the screen depending on what computer you're using. If we don't get time to answer all questions, we will provide a document after the webinar with any questions we were unable to address. The comments field is available for you to contribute to conversation. We may invite some participants to expand on their comments by asking their permission to make their audio and video live. Please respond via the chat feed that you are happy for us to add you as a temporary panellist to join the discussion and expand on your comments. This webinar is being recorded and a video will be made available on the ASME website along with the Q&amp;A document. If you have any technical problems, we ask you to make ASME aware by emailing <a href="mailto:events@asme.org.uk">events@asme.org.uk</a> rather than adding to the comments field. Thank you. So today we are going to be discussing two papers. The shortened version of the titles of these two papers are one: 'The Analysis of Teaching of Medical Schools Survey' and the second paper: 'Exploring UK medical school differences'. I have on the panel with me today Oliver Devine who's an MB/PhD student at UCL, Chris McManus who I'm sure many of you do know has been, probably born at UCL he's been there that long, and of course John Cookson who is the Three Counties Medical School Lead for Worcester who are bidding for a new medical school. I'll come back to John later. But first if I could ask Chris to kick off?</p>
00:05:04	<p>CHRIS</p> <p>Ok, thank you very much indeed. I need to share my screen which is always the high-stress part of these sessions and with luck, now I hope you can all see that. Can my panellists nod? Yes. Ok, the big question we're interested in here, and I just want to do a quick overview of where this all came from, is how medical schools differ and then does it matter? And in a sense, we know they all differ, you know, whenever you get two medical students together from different schools, they'll say what's different about their experiences, but does it matter? So, what we want to do is we want to look at that. I'm going to give a little bit of background just to set some of the academic context and then we're going to talk very briefly indeed about the two studies. The</p>

papers are very long and we can't possibly summarize it all but we'll try and give you a sense of what these papers are about. One's called AToMS that's the one that's looking at the teaching in medical schools and the other's called MedDifs, the differences between medical schools. Ok, all of this really goes back I suppose to the Tooke Report back in 2008. Do you remember the debacle on Modernising Medical Careers? Tooke enquired into it and in the appendix to that report they said we need answers to some fundamental questions and I think that's absolutely right. How does an individual student from one institution compare with another from a different institution? Where should that student be ranked nationally, and remember this was in the context of applying for foundation, and which medical school students are best prepared for the foundation years and crucially what makes the difference? Now at much the same time in 2008 we also published a paper using the MRCP exam results where we discovered that there were large differences between medical schools, graduates of different medical schools, on the performance to the three parts of MRCP. So, these two things were beginning to come together. A few years later, 2014, the GMC put out this report called 'Be Prepared, Are New Doctors Safe to Practice?' Slightly scary title. But they asked a number of questions and made some statements. They said there are substantial variations between medical schools, particularly actually in relation to specialisation of the graduates and they weren't sure if this was desirable or not. And they were talking particularly about some medical schools producing more GPs than others. And they said on the one hand it might reflect competition for places and so on, but on the other hand they said those schools producing large numbers of GPs are helping to express a key area of concern in medical staffing, and may be more valuable to the NHS. A couple of years after that Ian Cumming who was then Chair of Health Education England came out with a wonderfully controversial statement where he simply said it's not rocket science, if the curriculum is teaching mental health and general practice you get a much higher percentage of graduates who work in that area in the future. As always when something's said not to be rocket science it often transpires it's more complicated than it seems but this really stimulated us in the work we were doing. The College of Psychiatry interestingly followed down that same route saying if you put mental health at the heart of the curriculum, you'll encourage more medical students to specialise in psychiatry. And then quite interestingly the president backtracked slightly and said well actually the data is rather limited on that one. Finally, Oliver and I started working together on another paper back in 2015 we published this one. This was mainly Oliver and Andy's work, I got involved in the stats side. But there they were looking at medical schools and how they differ in the type of assessment they give in the exams and just to summarize to give a sense of it, what you can see here, and I don't know if you can see my cursor or not, but you can see the amount of assessment across a course varies dramatically across medical schools and also medical schools are using different types of assessment. So, that was a precursor to the present study. So, let's just briefly look at the two studies. I'll introduce AToMS and then Oliver's going to talk a bit more about it, then I'll come back to MedDifs. These are the two studies, they've each got their rather fancy coloured logos and you can see they've got long titles and they've got very long lists of authors. If we want to know what they're about the opening lines actually summarize it quite well. The AToMS survey starts; medical schools teach that much is obvious but what subjects they teach, what ways they teach and how much they teach each subject is very unclear. There's very little information on teaching. And the second paper starts out; medical schools differ, but whether those differences matter is a separate issue. The other thing to say about these papers is - I've highlighted it here - the large number of authors involved. And I

	<p>think this is a key feature of these papers, they're very unusual in that sense from medical education papers and these all come back to Oliver and he set up what's called the Medical Student Investigator's Collaborative, MSICo, and that was the underpinning for doing this sort of research. We couldn't have done it on our own I think it's fair to say. Ok at this point Oliver is going to take over and talk about AToMS and I think Oliver can request to control the screen. This is the most high-tech part of the whole thing. Let's see if it works.</p>
00:10:54	<p>OLIVER</p> <p>That should work. Yes, I think is that advancing. Yes, it is. Ok so thanks Chris. And thanks Derek and ASME for organising this and inviting me to say a few words about this paper. So, the first paper as Chris already said is called AToMS and that sort of, we came up with this sort of fancy backronym which is Analysis of Teaching of Medical Schools. And what this goes back to is in 2013 I'd finished pre-clinical medicine in Keele, I transferred to Birmingham to do an intercalated degree and then I'd moved to UCL to start the MB/PhD so I had this very sort of movement from north to south across the country and I'd experienced teaching at three different medical schools that are quite different. So Keele of course being this sort of quite well-established PBL course off the back of the previous Manchester course, Birmingham and UCL being considerably more traditional. So, I found Chris' 2008 paper on the differences in MRCP and I'd been thinking for quite some time, how much does this difference in medical school teaching really matter? Is it going to affect me? As a student am I going to have a different experience as a foundation doctor? Am I going to be a better or a worse doctor? And so, to find Chris' 2008 paper showing such differences in MRCP I was a little worried to tell you the truth. And I thought well surely we can figure out what influences post-graduate performance? And we kind of came up with these three things; assessment, teaching and the learning culture of a school which may contribute to postgraduate performance. And the low-hanging fruit because it was really the easiest thing to quantify was assessment. So, we went for assessment first and that was the paper that Chris just spoke about where we showed there were big differences between medical schools and it does seem to influence post-graduate performance, or at least contribute to the variance in post-graduate performance. So, after we finished assessment, we thought well teaching is probably the next easiest thing to go after. You know, if you want to go and quantify a culture, I'd say that's actually quite a challenging thing to do, so teaching was the next step if we want to explain some of the variance in post-graduate performance. So, we went and tried to measure that. So, what did we measure? We wanted to know what was taught at the medical schools, we wanted to know how it's taught and we wanted to know sort of how much teaching takes place on each particular topic. So, we identified 28 medical schools with established A100 courses so that's your sort of standard five- or six-year medical course in the UK that most applicants will be applying to. We had to exclude Plymouth and Exeter because they were in the middle of a divorce at that particular time and things were not quite complete with their new courses. There were a couple of newer schools that again didn't have a sort of established course. And we submitted FOI requests, Freedom of Information requests, for the full and, I would stress complex, timetables for each of the courses for the 2014-2015 academic year. Now FOI is one way of getting information. Two schools did refuse, one school excluded from our analysis because basically we couldn't get the data analysed quickly enough and we ended up with 25 schools with a detailed data that we could put forward for analysis. So, we recruited as part of this MSICo group that Chris just spoke about three to ten medical students from each school and those students were then going to look at their</p>

own timetables that they would be familiar with and code it according to a standardised proforma. And so, to give some idea of how long a project like this takes, we started this in 2016 not long after the assessment paper, we started on teaching and the actual recruitment of students at medical schools to do the data analysis took us just under a year. At the same time, we were putting in freedom of information requests to collect the timetable data from the medical schools with various levels of success and that was definitely a process that we chipped away at it over the space of a good 12 months. We then had enough data to send it out to the students to do the timetable coding, which again took about a year, and then we sort of cogitated over the data for quite a while and mercifully had a relatively short peer review period and of course we published. Now what I would say is when we finished this we had 47,258 teaching events which is actually rather a lot, and that's across 25 schools, and when we're talking about teaching events we're talking about the smallest indivisible raw unit of teaching and we're measuring that in hours. So, each event we classified according to format. So, for example, is it a lecture? Is it PBL? Is it a ward round? Is it a supervised teaching event or is it the kind of teaching event where a student goes off to a ward, they're instructed to go off to a ward and just do some learning, which does happen relatively frequently. We then classified each event according to the content of that teaching. So, is it anatomy, is it physiology, is it biochemistry, cardiology, orthopaedics? You know we did actually try and manage to remember every possible clinical topic and specialty and a few did get through the gap in our sort of pre-emptive planning. So, we established the start time and the finish time for every teaching event and the duration. So, this allows us to then plot this. So, on the x axis we're looking at each medical school we have in our analysis and on the y axis we're showing the total number of hours of teaching. So, you can see that the vast majority of schools are sort of creeping up above this 5,500 hours which is actually the minimum amount of teaching stipulated by the Medical Act 1983. And that's quite reassuring isn't it? That most medical schools teach what they are required to do by law. But what you will note is in red we're including self-regulated learning. So, actually a lot of the teaching that takes place at medical schools, if you take out the self-regulated learning there are some schools that start to just drop down below that sort of critical line. Now you get an impression that there is a significant amount of variance which is also quite important. What this table, and it is an extremely complicated overview and don't pay a great deal of attention to it, but what I'm trying to illustrate here is you have all the different methods of teaching and the content types of teaching, so is it anatomy dissection, practical PBL and then biochemistry, anatomy etc., and we have the schools across the top. And the red boxes are indicating where there is rather a large amount of a particular teaching and the blue boxes are indicating where there's rather a small amount. So, if you for example took PBL and went across you'd see blue boxes, blue boxes and you know we get to these red boxes and it just so happens that unsurprisingly yes these are the PBL schools that teach a rather large amount of PBL. So, we can pull a lot out of this data and I would say go and read the papers because we've done a lot of sub-analyses but what we want to focus on today is really this PBL versus non-PBL. So, this is a factor analysis and if we start out by looking on the left we're showing how different teaching types and topics cluster according to how traditional a course is, which is kind of a measure of how much PBL they have, and how structured a course is which is kind of a measure of how much unsupervised teaching students undertake. So, what you can see is that there are certain clusters that start to emerge so you have your PBL teaching kind of clustering with your GP teaching here on the left and then you've got clusters of biochemistry lectures and neural behaviour and

	<p>physiology on the right. And so, you start to see that there may be some sort of natural clustering of these schools. And if you plot onto the same factor analysis the individual medical schools you see that there is a division. And these colours that we're showing the blue and black, they are not colours that we have invented, these are how schools self-identify whether they self-identify as PBL schools over here with slightly more PBL unsurprisingly and a slightly more structured course, or here on the right with the traditional schools. So, there is this natural tendency to divide across PBL/non-PBL lines. And to just to pull out some headline points on what we found with regard to differences between PBL and non-PBL schools again unsurprisingly they have a lot of PBL, 12 times as much PBL. When we say a non-PBL school we're not saying they don't do any because actually the vast majority of schools do some. However, a true PBL school is doing in the order of hundreds of hours of PBL across the course, whereas your sort of traditional school is doing somewhere in the region of 10 hours. They have twice as much early clinical experience at PBL schools, they have about 60% of the pre-clinical teaching as a traditional school and only 70% of the lectures of a traditional school and of course as shown by the factor analysis [brief technical interruption]. So, 70% of the lectures of a non-PBL school and 50% more GP which goes back to the factor analysis. But overall a very similar amount of teaching and then the next thing that we asked you know you see these differences across this very clear PBL/non-PBL divide and you have to ask the question does that matter? And that then naturally leads on to the next paper which is MedDifs that Chris is now going to speak about.</p>
00:21:29	<p>CHRIS          Ok, thanks very much Oliver. This is going to be a very selective look at just a few aspects of the MedDifs study. You can see from the title we're looking at institutional histories, selection, teaching styles, everything you can think of and we wanted to see how medical schools differ. We did look at PBL because it's such a major division within UK medical education. We had slightly more schools this time because we had more data from those that weren't in the AToMS study. We had 11 PBL and 18 non-PBL. We then tried to get as many measures as we could and this was data that was in the public domain in some sense, so we could find it. And Oliver talked about the culture, we tried to summarise some of that and you can see, this is just a list of the measures, we can look at their history. Medical schools are described by their history in many ways. What influences their curriculum how they select their students and remember much of the time that's self-selection, what do we know about teaching, learning and assessment and the AToMS data are in there. How satisfied are they? We had data from the national students' survey. How did they do on the foundation scores, the EPM &amp; the SJT? We had data from the National Training Study, survey, on how they felt about the F1 performance. We knew quite a few things about the choice of the specialty training, in particular GPs. We had quite a lot of data on post-graduate exams, either pass/fail or in many cases more finely grained detail than that. And we also knew differences in fitness to practice issues coming from the GMC. So, we had rather a lot of stuff. We can't possibly talk about it all here. We do in the paper and you can go off and look at that. Let's just think though on those 50 measures what are the differences between PBL and non-PBL schools? And down the side here you'll see the 50 measures we're talking about and across here we've got the non-PBL, and here we've got the PBL schools. We did some significance tests and only the ones in bold are significant, let's just pull those out and in fact of those when you do <input type="text"/> for any correction only four of them end up as significant, five of them. One of them is that they tend to be more traditional, that's not surprising as Oliver would say PBL schools do more PBL. There are other interesting differences though, the PBL schools have</p>

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lower entry grades on average than the non-PBL schools and that's liable to affect other things. When you come down here the PBL schools actually do less well, the graduates of the PBL schools do less well on post-graduate exams. And that applies in particular to one exam, the applied knowledge test of MRCGP. So, they're doing less well on that exam. But then they have got lower entry grades. And finally, if we look at ARCP we can find out whether they've got problems not in exams because exams have been talked about here and the PBL schools actually have higher rates of problems with non-exam conduct issues. So, there's a number of interesting differences here. Now, we can look in detail at this I'm only going to show you the flavour of it you know, there's much too much here, but down the side we've got all the 50 measures and across the top we've got the same 50 measures. I mean this is a correlogram. We can look at how these correlate with one another and we spend a lot of time in the paper unpacking what on earth is going on here. There are two big questions we want to look at and I'm actually only going to look at the first one here and that's this question that was brought up by health education England. Is it rocket science that if you teach more general practice more people go into that speciality? So, let's just have a look at that. Here I've pulled out all the specialties now, I've reorganised that table before so we've got fewer measures and so for instance in general practice we've got history of producing GPs in school, how much GP is taught, how many people go into trainees in general practice, and then performance in the MRCGP exams. And we've tried to do the same thing there and also psychiatry, anaesthetics, O&G, internal medicine and surgery. Now we're really interested in these little bits of the table and here I've just highlighted the row to do with teaching. Ignore the GPs for the moment but the most striking thing is that actually in all the other specialties it doesn't matter how much more or less teaching you do in it; it has no relation to anything else. So that's actually quite an important issue. What about the GPs? Well when we look at them what we see is that the more GP is taught in a medical school, the more people become trainees in general practice so that's good, that's what you'd expect. The issue though is these two red boxes here, these are negative correlations, in other words the more teaching you do in general practice the less well people do on the MRCGP exams. Now that may sound a bit unlikely so let me show you in a bit more detail. What we've got here is a graph, here's the amount of GP teaching and you can see there's some schools with nearly 700 hours, there are other schools with just over 100 hours. The schools are indicated, the yellow boxes by the way indicates that they're problem-based learning schools. This is the percentage of their graduates going on to become trainees in general practice and I think there's no doubt about the strength of that correlation. And you can see that the yellow boxes are more up this end because the PBL schools are teaching more general practice. The tricky one to understand though is this one. Because now we've got the same measure of teaching hours in general practice but now, we've got performance on the MRCGP's applied knowledge test and the relationship is clearly downwards. Interestingly there are two outliers Oxford and Cambridge. Oxford doesn't actually teach very much GP but it has by far the best performance of any university, any medical school on the GPs exams. Cambridge teaches more but it also does better. But you'll also see that there are other schools which aren't PBL which don't do much teaching which are actually doing quite well on the exams and so on. And by the way we can do the same thing for the clinical skills assessment so this isn't just book knowledge. Oxford still comes out way up the top here. Just briefly, what about psychiatry? Because of course we saw that quote from the college of psychiatrists earlier. Well there's the scattergram for the amount of teaching of psychiatry. There's the number of psychiatry trainees and the lines show

	<p>that there is simply no relationship really. You can compare Oxford and Cambridge here; they have much the same teaching of psychiatry. Oxford produces loads of psychiatrists; Cambridge hardly produces any. But there's no relationship here really. We could go on and ask about other questions, this one is so complicated I'm not going to talk about it. I can only say go off and read the paper. But at that point I think that's enough to give you a sense of what we were trying to do. I want to thank you for the opportunity to describe it, I also have to thank our huge number of co-authors. This really is an interesting collaborative project. Which I don't believe we could have done without having a method like this and I think that's quite exciting and interesting. Thank you.</p>
00:29:37	<p>DEREK Yes, thank you very much indeed for those two presentations. We've had one comment from Sheffield questioning whether it should be classified as a PBL or not but I don't think we want to go into that at the moment. I'd like to turn now to Professor John Cookson who has a long history of involvement in medical schools. Setting up the Hull/York medical school, the Warwick medical school, he is currently lead for the Worcester and also set up a medical school in Botswana. What are your reflections John on someone with that extensive involvement in medical schools both curricula wise and PBL versus non-PBL?</p>
00:30:32	<p>JOHN Well it was all very interesting. I like papers that overturn perceived wisdom and this one certainly did that. And as I put it, it distorted several sacred cows, things that we've accepted as being de rigueur for a long time in medical schools. But what would a Dean or somebody running a medical school do with this information? It really depends on what you want but if you want your students to do well in post-graduate exams then it's clear that there's an academic spine that runs through all this and wherever you are if you do well academically, you do well. And you do well in what we would think would be non-academic areas. So, there's something there about the person I think or the relationship between academic and non-academic. So, what you would do if you were thinking about widening participation which of course we all do, by all means do that but don't at the same time lower your entry criteria because if you do you'll do less well in post-graduate exams and probably, when it comes about, the MLA. And of course, if medical schools are then put in some sort of league table, as they will, and perhaps quite rightly, then if you're the top well, and if you're the bottom it's another issue. And that gives rise to problems because most of the evidence seems to suggest that medical schools don't do much actually. Their influence is comparatively slight perhaps compared with the type of people who come in. Both in terms of academia and in terms of personality and what they want, their career goals. So, by far the biggest selection is the student. We don't select them they select us. And what we do with them after that makes comparatively little difference particularly when we try to train people, or educate them for particular areas like general practice or psychiatry. So, I think the dean in your school has got some hard thinking to do about they actually want and the limitations that are imposed. And if you wanted to try and do something different, more GP for example, it would be difficult to do to create such a large amount of extra general practice to actually make a difference. So, I think the end result is that medical schools are different but they're probably different in their own way of themselves, their entire of themselves. If you try and impose some change it may on the one hand not work but on the other hand it might create quite unintended consequences which would be detrimental. So, I think the whole thing, these two papers do need a lot of study and a lot more work done, and a lot more thinking about</p>

	<p>them. And it's going to be interesting to see what comes out. One issue proposed in the paper is to, and I just see it's come up on a chat box, is to allocate students randomly to medical schools. And that's basically the only way you're going to do it to get the product the same at the end. Well, do we want to go there? Well, over to you. Thanks.</p>
00:34:24	<p>DEREK Thank you very much for that. I can see Chris is a very fast typer there and has already been clearing out some of the questions that we have. I've got just one to kick off with before we hopefully get some more online. Both to Oliver and Chris, you know having gone through this paper and whatever, and I know John has mentioned the MLA which is allegedly the great leveller coming forward, but that's another BITESIZE I think to discuss all of that, what major changes do you think are needed to, if you like, level the field or give patients the confidence that 50% at one medical school is 50% at another and therefore to use the pilot analogy you've passed and you are safe?</p>
00:35:22	<p>CHRIS Oliver do you want to start?</p>
00:35:24	<p>OLIVER Yeah, I mean I think the UK MLA is actually the solution to that problem if you want to have reasonable, comparable, quantifiable measurements on performance. The question of whether or not you're measuring something useful with the MLA-ers is a whole separate issue. But you know having gone through the process of these two papers what I would say is that we've learnt that we still need more information and more information can only come through being able to perform these kinds of large quantitative studies. And I think Chris has mentioned a couple of times that actually being able to perform trials in medical education is probably the most important part of understanding exactly what the outcomes are in the long term for doctors. And moving to a place of being able to do real sort of randomised and controlled trials in medical education is what I would like to see happen, a sort of macro-level thing that I would like to see happen next.</p>
00:36:30	<p>CHRIS I can only agree entirely with that. I think there are other ways of doing it as well though. And better data too is part of it. You know one of the issues for instance with the MLA we don't really know how schools differ. But actually, we've had the SJT in finalists and we've also got the PSA, the Prescribing Skills Assessment, in finalists. Those data aren't in the public domain but I assure you they look extremely similar to the other results; those are the exactly the same ordering of medical schools. So, I've got no doubt that MLA will end up doing the same thing. If we want to change one thing actually here what we need is better data. And that's the hard bit to get. And I think UKMED, the UK Medical Education Database is about to transform all of this, I'm heavily involved in it so I have an interest here, but there is data which previously was not around. And what we've done in our MedDifs paper is to put together stuff which was floating around independently and we've really fixed it together and then added in the AToMS data as well, but I think that needs to be done much more systematically. Evidence, evidence, evidence probably is what we need.</p>
00:37:44	<p>DEREK On this point about better data of course we've had a comment that you may have already seen there which was the decision to use an FOI as a method of collecting the data and whether you'd have got better information and better quality by using a less aggressive approach was the comment. Is there anything to say about that?</p>

00:38:08	CHRIS Two medical schools didn't play ball anyway.
00:38:11	OLIVER Yeah I mean what I would say to that is we went through the approach of speaking directly to medical schools directly for the assessment paper that we did in 2015 and yes you can get it, it was already a difficult process to get this through FOI but from our experience with assessment it was very hard to get schools to consent to hand over information about what assessment they do. In terms of the completeness of the data through the FOI approach actually it was perfectly complete. There was very little holding back of information and 26 out of 28 was pretty good in our book and I think the other two actually were eventually compelled to hand the data over but it was just too late to include in the study. As for whether it's an aggressive approach or not, I mean yeah you can make the argument that it seems aggressive but equally you can counter that by saying these are publicly funded, by and large publicly funded institutions and the data should be released anyway, it's not commercially sensitive data.
00:39:22	JOHN Yeah and the Information Commissioner censured both of those medical schools for not providing what should be in the public domain I think. So, there's nothing secret about this and there's very little benefit to be gained by it. You know we hear about league tables but actually medical schools are probably the very last institutions no longer to be involved in league tables. Primary schools, secondary schools, universities, cardiovascular surgeons and so on, they're all in league tables. And it's not clear to me why medical schools should be exempt from that. The GMC publishes league tables on performance on post-graduate medical school exams for every medical school in the country, they're on their website and they say the Medical Act requires them to do that. They can't put out anonymised data. So, I think there's a sense here in which it is the last bastion of not putting out data.
00:40:21	DEREK Thank you. I've got a question here from the audience as it were, so is achievement in post-graduate specialty exams what we are aiming for as a mark of success?
00:40:33	CHRIS I'll come in on that one because the answer is clearly not, or rather clearly not as the only criterion of post-graduate success. But doctors who fail their exams and are not very good at their specialties are probably not what the public wants or desires and therefore if we want excellence in clinical care then part of that is knowing the knowledge. Yes, we'd love to know about how well they communicate, and all sort of other things about them the trouble is there's simply no data out there. If people believe those other aspects of being a doctor are important then they need to get out there and tell us how the doctors vary and we can then work out how that relates to other things. But yeah so measure, measure, measure. Same principle.
00:41:19	JOHN It is part of a much wider problem which is how do we assess the non-assessable? We count what we can count but what we can count doesn't always count. What counts we can't count. And it runs through the whole of medical education and probably much wider too. So, if we had some methods, we might do better on it. But people will look at what's visible and what's visible is success in post-graduate exams, and make their own judgements.
00:41:51	CHRIS

	I think that's right but I think, you know, I started teaching communication skills in a medical school in London in the 1980's. We've been teaching it now for 30 years. We assess it in OSCLs, we assess it in post-graduate exams and what we haven't done here is to partial that out but if we feel it's important, we can describe when it goes wrong then, you know, I'm a psychologist, we measure the unmeasurable. That's our job and I feel we ought to be able to get measures for those sorts of things.
00:42:24	DEREK Another question here; how do we consider this information with the development of private medical schools in the UK?
00:42:36	CHRIS I think we ought to be able to do the same thing with private schools as we do with public schools, public funded schools. I think in so far as the private medical schools will add to the 'n' and possibly increase the variance, from a research point of view they can only help us understand what's going on in a better way. They may be more variable; they may do things differently that's their privilege in a way and we can then decide whether or not it gives better or worse outcomes.
00:43:09	DEREK Just an add-on to that Chris really and part of what I've been thinking about private medical schools is that many of them seem to have a greater focus on education, teaching, training because they don't have necessarily the emphasis on the academic research element. Now without going into the 'you should be learning in an academic environment argument' - another ASME BITESIZE I suggest - if you have league tables I would fully expect the private medical schools to be right up there at the top in terms of the educational components, satisfaction or whatever. Is that your view?
00:43:51	CHRIS I think it's more than possible but I think it's a bit like the National Student Survey measures; high satisfaction scores in these data actually relate to poorer performance at post-graduate exams. So, there's a sense in which they may want to try and teach better, they may be doing it but it may not actually be having its outcome. That may also reflect differences in intake, different people will go to private schools for various reasons. And teasing it all apart is actually quite hard.
00:44:27	DEREK Ok we're absolutely running out of time. I would like just to give the last word to John who's right in the midst of developing a new medical school at Worcester as to whether these papers will change or alter your thinking or direction that you're planning for the next couple of years?
00:44:53	JOHN Right, well we are commissioned to produce more GPs and more psychiatrists. We know how to produce more GPs; we don't know how to produce more psychiatrists except by selecting people who want to become psychiatrists. If anybody knows how to do that then I would be most interested to hear from them. As for the future well to be controversial I think that things should stay as they are because if the schools are different and different in their own way and they do things well in their own way that's something to be valued. If you try and make everybody the same by the MLA or whatever then we may throw out the babies with the bath water. That would be my thought.
00:45:48	DEREK Well I'm sure if anyone from Medical School Council is in the audience then they'd be very happy to hear those final few words John, thank you. I know there's been lots

ASMEBITESIZE

John Cookson, Oliver Devine, Derek Gallen and Chris McManus,

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	<p>more questions and we will find a way of answering those for you. I think we are going to do a further ASMEBITESIZE on this topic and it maybe we will hone down on certain aspects of the two papers so that we can have a more in-depth discussion again and use this technically if you like as an introduction to the subject. So, we will get back to you with regard to that. I really would like to thank the panellists for their papers and input to today and also, my backroom staff in the office at ASME for producing this. As I've said this is just one of several please look at the ASME website we are doing these regularly. We're hoping for at least one a week between now and January which is quite a tall order but we're going to give it our best shot just so to keep in contact with the membership and keep medical education to the forefront. Thank you all very much indeed.</p>
00:47:06	<b>ENDS</b>