

Expanding the English medical schools: The politics of knowledge control

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Since 1997 there have been two concerted attempts to expand the number of medical school students in England: by increasing the size of existing medical schools, and by creating new medical schools. These initiatives have been a direct result of government policy, although policy implementation was delegated to the state apparatus. They also led to a struggle between higher education interests and the General Medical Council for knowledge control. The aim of this article is to offer an analytical framework for this conflict, and to draw attention to consequent shifts in university governance and the epistemological framing of higher education.

Keywords: policy control; policy implementation; university decision-making; curriculum; pedagogical change

Introduction

This article examines the foundation of the 'new' medical schools in England since 1997, when the Medical Workforce Standing Advisory Committee (MWSAC) first recommended the expansion of the number of medical students. In particular it will analyse the struggle to control the curriculum of the medical schools: what should be taught, and how it should be taught and examined.

One of the central purposes of the university is to determine what counts as high-status knowledge (cf. Hirst and Peters, 1970; Tapper and Salter, 1992). But as the universities have performed that purpose, they have often responded to the demands of well-organized bodies, especially professional associations, representing the concerns of particular societal interests. The university's academic training helps to secure status and respectability for the profession, while the university is likely to gain financial rewards, societal regard, and political credit (Rothblatt, 1968). In England the ties between the medical profession and the universities have been particularly strong over time, with both the General Medical Council (GMC) and the British Medical Association (BMA) taking a keen interest in the work of the medical schools (Salter, 2001; Salter, 2004; Irvine, 2006). Universities provide a broad-based academic course, albeit containing some specialized professional requirements, which is then followed by a period of specialized training before the trainee can be certified as a qualified professional practitioner. The question that arises is: would the new – post-1997 – medical schools follow this model?

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The aim of this article is to examine the relationships between government, the state and quasi-state, the universities, and the GMC in the struggle to restructure the curriculum of medical students. It will be argued that it is primarily in the context of founding new medical schools that the harbingers of change in the character of medical education have emerged, and attention will be drawn to consequent shifts in university governance and the epistemological framing of higher education.

Expanding medical education: Government, state, and quasi-state in action

Any government-driven policy decisions are underwritten by continuing powerful political pressures. In Britain there is continuous pressure on governments to be seen to be improving the nation's overall standard of health care (note, for example, that all the political parties paid considerable attention to the funding of the NHS in the 2015 general election). The MWSAC was founded by the government in 1992 to provide advice on what the size of the medical workforce should be and how it should be trained (Maynard and Walker, 1993). The main recommendation of the MWSAC's third report, published in 1997, was to propose an increase of 1,000 per annum in the student intake of the English medical schools and, following the publication of the *NHS Plan* in 2000, this number was to be augmented by an additional 1,000 students. The 1997 Report made some very precise recommendations: to lessen the reliance on medical personnel who were not British citizens, to recruit doctors from a more diverse range of social backgrounds, and to ensure that the regional inequalities in the distribution of medical personnel was lessened, which was hopefully to be achieved by founding new medical schools in regions with fewer doctors (MWSAC, 1997: 13–14).

The financial costs of most health-care initiatives mean that they invariably require government support to bring them to fruition. In its three initial reports, the MWSAC pointed to a more routinized approach to managing the size of the medical workforce, arguing that its augmentation should be determined by agreed criteria and that expansion should follow the dictates of those criteria rather than being driven politically (although presumably there would be a political input into determining the criteria that triggered expansion, and all governments would be wary of the potential financial burden of meeting inbuilt expanding obligations).

Governments took the responsibility for funding these two initiatives to expand the number of medical students, but responsibility for policy implementation was delegated to different parts of the state apparatus and to quasi-state organizations. The Department of Health and the Higher Education Funding Council for England (HEFCE) were given the responsibility for implementing the policy, which followed a parallel course on both occasions. In 1997 they met to form a Joint Implementation Group (JIG), which was composed of 'the great and the good' drawn respectively from the fields of medicine (the Chief Medical Officer, the Chairman of the Joint Medical Advisory Committee, the Chair of the General Medical Council's Education Committee, and the NHS Director of Research and Development), and higher education (HEFCE's Chief Executive and its Director for Institutions). Obviously, on the university side other key negotiators who would also be drawn into the equation would be personnel who would help to determine either increased student numbers at established medical schools or the founding of a new medical school.

A decision-making process was created that appeared to offer something to all the interested parties. For government there was the implementation of a popular policy initiative, while for the Department of Health there would be more trained doctors that should enable it to fulfil more competently its responsibilities for meeting the nation's health-care needs. For so long subject to cuts in public funding, some universities now faced the pleasing prospect of

increased resources for some targeted expansion. At the heart of the policy implementation process was the Joint Implementation Group (JIG) composed of leading figures drawn from the fields of higher education and health, which enabled the government to maintain a respectable distance from the process. The JIG, composed of an elite group of personnel, was sufficiently well-connected to receive inputs from all the leading figures and organizations in the fields of medicine and higher education. JIG represented a form of insider-governance with direct links to both the higher education and medical establishments. It was *par excellence* an example of corporate governance in operation, in which policy was driven forward by the interaction of government, the state apparatus, and the dominant organized interests (cf. Castells, 2012).

The Joint Implementation Group pursued a broadly similar implementation process following both the 1997 MWSAC Report and the *NHS Plan* in 2000. The individual personnel were different but the represented posts remained the same. It is almost as if a temporary, *ad hoc* quasi-state organization was created to undertake the important but specialized policy implementation tasks of increasing medical student numbers in existing medical schools and of determining which universities would have new medical schools. On each occasion JIG had 1,000 additional medical places to distribute. The existing medical schools were invited to request additional numbers, which subsequently had to be approved by JIG. However, there was always the intention of allocating some of these additional places to new medical schools. Given the comparative shortage of doctors in some parts of the country, it was hoped that the foundation of a new medical school in particular areas would help to alleviate this. (For a comprehensive overview of the distribution of medical school student numbers, see the Health and Education National Strategic Exchange, 2012.) It was also anticipated that the new medical schools would be more academically innovative and hopefully recruit students from a wider range of social backgrounds.

As a result, seven new medical schools were established, taking one of three forms:

1. A new medical school located at a single university with no prior experience of running a medical school. Only the University of East Anglia falls into this category.
2. A new medical school located on two campuses with neither university having the experience of previously running a medical school. There are three examples: Plymouth and Exeter (the Peninsula Medical School), founded in 2000; Brighton and Sussex, founded in 2004; and Hull and York, founded in 2012.
3. A university with an existing medical school cooperating with another university that was embracing medical education for the first time. These were Manchester and Keele, Leicester and Warwick, and Newcastle and Durham.

It is interesting to note that several of the new medical schools were based in universities founded in the 1960s. The Universities of Warwick, East Anglia, Sussex, and York now have medical schools. Besides the need to meet the shortfall of medical personnel in their vicinities, there are two other possible explanations. Firstly, these were ambitious universities with aspirations to join the prestigious research-intensive Russell Group of British universities, and having a medical school could be seen as a *sine qua non* of Russell Group membership (of the original Russell Group members only the London School of Economics did not have a medical school). Both Warwick and York (with new medical schools) are now members. Secondly, if there was a desire to modify the content of a medical degree, then there was a certain rationale in establishing new medical schools in universities that were already seen as being committed to promoting new ways of organizing knowledge, and embracing more vocationally focused disciplines (Beloff, 1968). But, just as the foundation of the new universities was attacked as being an expensive way to expand English higher education (Carswell, 1985), it would have been less expensive to have located

all the expansion of medical student numbers in those universities with established medical schools. The geographically uneven spread of medical personnel would then have needed to have been tackled in other ways – even perhaps through a centralized allocation of trained medical personnel.

Regulating medical schools

Salter (2001) has broken down the regulation of the medical workforce into three areas of interactive concern: research, education, and performance. Each area is subject to three forms of regulation: standard setting, monitoring/evaluation, and intervention (Salter, 2001: 872). Later he argued that, 'When measured in terms of the sheer quantity of institutions, roles, procedures and networks involved, *education* is the most complex and impenetrable of the three regulatory arenas (Salter, 2004: 99). The Joint Implementation Group claimed that it had resolved the education issue by stating that in making its decisions it would be guided by the extent to which universities making bids for additional medical student numbers were prepared to adhere to the framework and principles that had been established by the General Medical Council (GMC).

In its publication *Tomorrow's Doctors*, which had been periodically revised by the General Medical Council since the appearance of the first edition in 1993, the continuing control of the curriculum of the medical schools by the GMC was apparently reaffirmed. So, although medical education was organized by the universities, the form it took would, at least, be steered by the GMC through *Tomorrow's Doctors*. However, it would be impossible to see the GMC as applying a straitjacket:

It is for each medical school to design its own curriculum to suit its own circumstances, consistent with *Tomorrow's Doctors*. Both curriculum design and delivery must take into account modern educational theory and current research.

(General Medical Council, 2009: para. 92)

In spite of this apparent flexibility (we may well ask the question of what modern educational theory would not permit), students still have to meet defined outcomes: 'the overall curriculum must allow students to reach the outcomes specified in the first part of *Tomorrow's Doctors*', and 'medical schools must demonstrate the way in which these outcomes are met' (General Medical Council, 2009: para. 93). Therefore, it is more a question of permitting different ways of reaching *well-defined* goals rather than a debate about the possibility of varying the goals. It appears that the GMC was more intent on controlling the goals and content of the curriculum and less concerned with pedagogy narrowly defined, although even a cursory understanding of educational theory would convey the realization that these are not easily separable ends.

The extent of the potential conflict between the GMC and the universities is well-illustrated by the 2001 HEFCE report entitled *Increasing Medical Student Numbers in England* (HEFCE, 2001). In effect, HEFCE makes a number of implicit negative observations on *Tomorrow's Doctors* (see HEFCE, 2001: Annex C, 9–10):

1. the burden of factual information imposed on students in undergraduate medical education should be substantially reduced
2. learning through curiosity, the exploration of knowledge, and the critical evaluation of evidence should be promoted and should ensure a capacity for self-education
3. clinical teaching should adapt to changing patterns in health care and should provide experience of primary care and of community medical services, as well as of hospital-based services

4. systems of assessment should be adapted to the new style curriculum, should encourage appropriate learning skills, and should reduce emphasis on the uncritical acquisition of facts
5. the design, implementation, and continuing review of curricula demand the establishment of effective supervisory structures, with interdisciplinary membership and adequate representation of junior staff and students.

The HEFCE critique is directed essentially at the pedagogy implicit in *Tomorrow's Doctors*, and clearly claims that it is outdated and is unlikely to result in appropriately trained medics. While the knowledge that students need to acquire may be deemed appropriate, the learning process is far from adequate. The impression is created that the interests representing higher education are intent on reshaping the curricula – both what is to be learnt and how it is to be taught – of the medical schools.

The evidence is suggestive of a power struggle within the Joint Implementation Group between the medical and higher education interests. The MWSAC's 1997 Report concurred that *Tomorrow's Doctors* should form the basis of the curricula of the new medical schools but the JIG, which was appointed as a consequence of the *NHS Plan* (2000), stated that when it came to establishing new medical schools it would take into account, 'regional priorities, innovation, quality, graduate entry, widening participation and value for money' (HEFCE, 2001: 2). HEFCE also claimed that these aims were more pronounced than in the previous round of expansion 'with clear effort made to modernise curricula to take account of the NHS Plan and to move towards widening access and incorporating elements of multi-professionalism' (HEFCE, 2001: 5). HEFCE made particular reference to the new medical schools as being in the vanguard of change in this second round of expansion:

Because the establishment of a new medical school represents a major challenge for any university, especially when undertaken without partnership with an existing medical school, JIG considered these bids particularly carefully. The joint bids from the Universities of Hull and York, and the Universities of Brighton and Sussex, were felt to be innovative and soundly based.

(HEFCE, 2001: 5)

The continuing tension in the field of medical education is illustrated perfectly by the subsequent termination of some of the joint university agreements. The joint medical schools at Leicester and Warwick, along with Exeter and Plymouth, now follow separate paths. Moreover, and not surprisingly, the individual medical schools like to portray their distinctive characteristics. For example, the University of East Anglia sees itself as offering, 'a five year integrated programme to attract both graduate and mature students', and places particular stress 'on the recruitment of women' (University of East Anglia Medical School, 2015). The Peninsula Medical School claims that, 'it offers the right environment to support the way doctors are trained in line with the General Medical Council's guidance, *Tomorrow's Doctors*' (Peninsula Medical School, 2015). The medical school at Brighton and Sussex refers to its incorporation 'of the social sciences and bio-molecular science' (Brighton and Sussex Medical School, 2015). So, while the GMC may stress the common ingredients of a medical education, it is evident that the individual schools are advertising the distinctiveness of what they have to offer.

For some years now, undoubtedly partly in response to this greater fragmentation of the medical curriculum, the Education Committee of the GMC has been undertaking consultations about the possibility of introducing a national examination for those seeking to practise as doctors. The need to pass a national examination could be a precondition for graduation and provisional registration (General Medical Council, 2014). In the words of the GMC's Chair this would in effect be a licence to practise, although no formal decision has yet been taken regarding

this proposal (Stephenson, 2015: 2). In an elaboration of his personal support for the proposal Stephenson has argued:

The development of UK assessments will enable universities to produce doctors who are heterogeneous, adaptable and flexible. They can be educated in different ways, bringing in school-leavers and graduates, they will use practice-based learning and more traditional approaches, some will have more emphasis on care in the community, others will devote more time to 'high-tech' interventions. But I think that the public would like to be reassured that in terms of core knowledge, skills and competencies, all doctors meet the same standards.

(Stephenson, 2015: 2)

Stephenson makes these claims in a letter to *Times Higher Education* in response to an article entitled 'Medical education in a critical condition' (Cookson, 2015), which argued that a national examination would lessen the control of the universities over their curricula and, moreover, could result in a less demanding curriculum for the student. What can be said with greater certainty is that the curricula of the medical schools, like so many other fields of professional study (for example, law and engineering), were never controlled by the university alone but in conjunction with the relevant professional associations. The major variation in curricula is that between the traditionally taught curriculum and problem-based learning (PBL), with the latter associated in particular with some of the new medical schools. Certainly there is continuing pressure from the medical profession against the latter, although ultimately the form the curricula assume may be more determined by student choice, and the market position of the medical school.

Of course a national examination, one overseen by the GMC, would at the very least exert a strong influence over the curricula of the medical schools because those of their students who wished to become doctors would have to pass that examination, and would naturally assume that by following the medical school curricula they were being trained to pass it. Of course, medical schools may offer courses that do not expect their students to become doctors or have students who do not see themselves as trainee doctors. Such possible outcomes would raise the hypothetical question of what then is the purpose of a medical school education. It would also lead governments to wonder why resources that were supposedly being used to fulfil a politically desirable goal – that is the training of more doctors – were not being employed for that purpose to the extent that they could be by the medical schools.

If medical schools are first and foremost about the training of doctors, then it is evident that the GMC will have a key role in shaping their training, if only because it is the body that is formally charged with licensing them to practise. Therefore, regarding the content of their curricula the universities have no choice but to seek an accommodation with the GMC. Of course, while there can be flexibility with respect to pedagogy, with respect to curricula content, unless the GMC is prepared to assume a purposeful self-denial role, then it has the right to establish requirements that the university has to accommodate. Alternatively, either the GMC fails to fulfil its responsibilities or the medical schools do not train doctors, which would raise the question of what are their purposes. However, for both the medical interests and the universities there is enough at stake to persuade them to reach mutually acceptable accommodations.

The incorporation of medical education within the university does not give rise to a radically different conundrum from the incorporation of other disciplines, although there are important differences in terms of the relative authority and status of the organized interests, the intensity of the societal gaze, and the role that government and state may have to play. It is fair to say that in recent years the medical interests have been somewhat on the defensive vis-à-vis the university, given the political desire to increase the number of medics, to widen the social base of recruitment into the medical profession, and the GMC's recognition of the limitation of its own prior guidelines on medical training. But thanks ultimately to its control over professional

recruitment, the GMC retains the authority to determine what a medical education should be, and sooner or later the universities will have to come to terms with this.

All three components of Salter's regulatory regime – standard setting, monitoring/evaluation, and intervention – have come into play, with varying degrees of intensity, in recent years. Increasingly, standard setting became the primary concern of higher education as new programmes and pedagogies emerged. Monitoring/evaluation continued to be shared, with the universities assuming responsibility for evaluating academic performance while the GMC still monitored who should have the right to be registered as a medical practitioner. In effect, an uneasy truce has becalmed the relationship between the two sets of interests as we have awaited the GMC's interventionist move to introduce a national qualifying examination for the registration of doctors, which is likely to have an impact on the degree programmes of the medical schools – both in terms of their appeal to students and the purposes the schools are meant to serve. This is intervention with a sharp edge.

Conclusion

While the new medical schools and the increase in the number of medical students is a direct result of government policy, the policy implementation process has been controlled by state and quasi-state institutions. For the universities the initiative represented an opportunity to undergo some expansion after a period of at best consolidation. The constraint was that they did not have complete control over the curricula of their medical schools. However, because the medical interests were on the defensive, in part due to pressure from the government and the state, the universities succeeded in augmenting their authority. Now, though, the GMC, through its intention of imposing a national examination to determine the registration of doctors, is in the process of attempting to reassert its authority. It is possible that flexibility with respect to aspects of pedagogy – especially approaches to teaching and learning combined with an acceptance of variations in examination modes – will enable the medical and higher education interests to arrive at an acceptable compromise.

What both the higher education and medical interests need to recognize is that ultimately their authority is dependent upon government and the state: the willingness of governments to sustain prerogatives (such as the right to award degrees or register doctors), and of the state apparatus acting to achieve mutually agreeable compromises. However, all parties have a vested interest in sustaining a working accord. No government would find it easy to define what the shape of a medical education should be, and it has to set in motion the state apparatus to bring the dominant interests together in order to determine what that shape should be.

In certain respects medical schools may be formally part of a university ('in the university') but not necessarily 'of the university'. The degree of integration will depend on a number of factors. Where is the medical school located physically? Does it have its own site or is it based on the main university campus? The content of the medical school's degree programmes will impact upon the level of academic cooperation, which could be reinforced by research proposals that cut across faculty boundaries. Such integration is likely to vary from university to university but medical schools should enhance a university's income and augment its wider prestige, especially if its faculty are research-active. Over time, therefore, there is no reason why universities and medical schools should not form a symbiotic relationship, even if the binding criteria are essentially pragmatic. The medical school moves steadily from being 'in the university' to being 'of the university'.

Implications

The implications of the decision to expand medical student numbers are still unfolding. The GMC still has to resolve the question of how the registration of doctors should be determined. Whether or not to implement a national examination, the form it is likely to take, its impact upon the curricula of the medical schools, and its implications for those universities with medical schools, are all issues that are in the process of being decided. As we have noted, even the stability of some of the newly formed joint medical schools is problematic. What is not in doubt is the continuing significance of medical education for the future of the university. It represents a vital area of professional knowledge that has been incorporated in higher education for a considerable period of time and its presence is likely to grow.

Medical education is important because it links the university to vital societal concerns and interests and directly to government and the state. The university is increasingly about the pursuit of professional concerns as much as, if not more than, the pursuit of academic goals. An important segment of the future identity of the university will be determined by how it incorporates medical education. We have already seen that there is an interesting story to tell with respect to the wider policymaking process. What remains to be done is to explore how that worked out with respect to individual institutions in order to assess its impact upon the character of British higher education at large. Will government and state work to sustain the independence of the university, partly in order to better ensure the fulfilment of their own policy goals, or will they side with the powerful societal interests because that seems to be the politically easiest path to take? Indeed there is much at stake.

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