

Entering a new culture – the challenges of working in medical education a personal perspective from an outsider

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My transition from a community development worker in an inner-city area working with local communities (address issues of deprivation and disadvantage) to the role of a lecturer in a prestigious medical school, (leading a community-based module) was challenging. It had all the characteristics of entering a new culture. I had to learn a new language, foster new relationships, negotiate new ‘rules of engagement’, interpret acceptable forms of behaviour and communication. But perhaps the hardest challenge was to gain acceptance for what I had to offer and counter perceptions that I represented a threat to the status quo.

Preamble

This paper has been written at the request of Yoko Watanabe¹⁾, who invited me to describe my involvement in medical education. I feel self-conscious in publishing my experience, but I hope it will offer insight that will assist others following a similar path.

The narrative that follows is a subjective, personal account of my ‘rite of passage’ into medical education through to my current engagement in the field in which I reflect upon events and offer a perspective that may resonate with others who have ventured into the challenging ‘world’ of medical education from outside the field.

Reflective practice has long be considered to be a core component of professional work in all disciplines. Schön’s (1995) work has been highly influential and many have built upon his work. Reflection is becoming integrated into our professional practice and is shifting from an individual to an organisational pursuit (Boud et al 2006). While this is a personal account, my reflective approach seeks to examine my role in the context of professional and organisational cultures.

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ARRIVAL - welcome, rejection or toleration

Acculturation

‘Acculturation’ is a term adopted by Berry (2005) which I consider to be highly applicable to my experience of entering the field of medical education, which may be shared by others who do not have a medical background. Berry defines the term:

‘Acculturation’ is the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members.’ (2005:698).

He highlights the differential in power between the ‘host culture’ and those who choose to ‘settle’ in a new country. Berry states such newcomers are faced with two key ‘issues’: the first is the degree to which they choose to maintain their own ‘heritage, culture and identity’ and their relative preference to participate in the ‘new culture’. He suggests that people adopt one of four primary strategies: integration, assimilation, separation or marginalisation. These reflect the degree of inclusion or exclusion that takes place and on whose terms. The ‘choice’ of strategy is determined by the ‘openness’ of the ‘dominant group’.

While Berry has developed his model from an analysis of opposing political cultures and has applied it to the experience of people settling in a new land, I consider his model to be applicable to my experience of introducing a community-perspective within the undergraduate curriculum of a medical school in the UK in the 1990s.

Bringing a Community Development Perspective

My background is in community development. Before I joined a medical school in 1990 I worked in an area of London that had high indices of deprivation. It was a vibrant, ethnically diverse community committed to improving the quality of life in the area. My role was to support the community to secure the resources to effect changes that they determined.

I had been appointed by the medical school to lead a new community-based component of the undergraduate curriculum, the Community Module. The timing and conditions associated with my ‘arrival’ were significant. The module had already been created as an integral feature of the undergraduate medical and dental curriculum. A series of consultations with local community organisations had already taken place and there was now some urgency to employ someone to shape and co-ordinate its implementation.

It required the invitation from a doctor within the Medical School to facilitate my introduction to medical education. It was his judgement that my knowledge and experience

would enable him to deliver a programme for which he was responsible. So, entry into the medical ‘world’ required a recognition of a need and the realisation that it could not be met from within the institution: a new perspective with different skills was required to address a ‘problem’.

I had significant discretion over the delivery of the module. I brought to the role my experience as a community development worker with all its associated values and principles of challenging discrimination, increasing social justice, facilitating collective action and adopting an empowering approach that uses the strengths of the local community to effect change. Fostering a reflective practice is also at the core of community development work, encouraging an experiential and participatory approach to learning. Obviously these values are not unique to community development, but underpinned my approach to my new role in the medical school.

It was often the application of these values in an unfamiliar environment that triggered the ‘culture-conflict’ and ‘acculturative stress’ that Berry refers to in his analysis of ‘intercultural interactions’.

An Itinerant Irritant

When entering a new culture, the passage is eased if one’s arrival is in response to an invitation, but this offers no guarantee of welcome or acceptance by members of the ‘host culture’. From the outset I felt marked out as an outsider: as ‘non-medical’, a ‘non-scientist’. This assigned ‘identity’ could not be changed, I could only hope to win acceptance by demonstrating that I offered something of value to my ‘hosts’. This was difficult because I had been appointed to lead a new module within a radically changed curriculum that had unsettled many people within the medical school.

As a new component, the ‘Community Module’ was regarded as a threat by some to traditional medical teaching. It was seen as ‘soft’ and taking time away from the core ‘hard’ basic medical sciences of anatomy, physiology, pharmacology and pathology.

The Community Module (Wykurz 1997) had a component in each of the first two years of the undergraduate curriculum for three hundred medical and dental students. The logistics of implementing the module were challenging, requiring the recruitment of tutors from not-for profit organisations in addition to health personal working in community settings across the East End of London. Some ‘colleagues’ doubted the feasibility of delivering the module and I was advised to cancel the programme rather than risk its collapse. I was given the clear impression that the introduction of the community module was resented by some and that they were waiting to seize on any short-comings to challenge the legitimacy of its inclusion in the medical curriculum.

Undaunted by the lack of encouragement by some, I worked with allies within both the community and health sectors to ensure the success of the module. Tutors planned a programme of activities in Year 1 that introduced students to local community issues that would impact on the health of the community and in Year 2 students had the opportunity to work in small groups on projects proposed by tutors, e.g. preparing a leaflet on HIV/AIDS for young people with moderate learning difficulties; dental care for children with haemophilia; the needs of Somali refugees (Wykurz 1997).

ESTABLISHING IDENTITY AND ROLE

– Integration or Assimilation

Berry makes the distinction between an ‘assimilation’ strategy where the individual loses their ‘heritage culture’ and becomes absorbed into the ‘dominant society’ and ‘integration’ where personal ‘cultural integrity’ is maintained while establishing positive relationships with members of the host community. My ‘entry’ into the ‘medical world’ required constant vigilance, keeping a balance between asserting the values of a community-based approach and being accepted as a colleague within the world of the medical school. This tension is well illustrated by a discussion at a course committee meeting when timetabling was discussed:

Asserting Principles

I was concerned that many of the sessions for the Community Module had been timetabled on a Friday afternoon. Obviously, not a popular slot in the curriculum so I acknowledged it would be reasonable for the module to have its fair share of such sessions. Nonetheless, I argued that if the intention of the module was to introduce students to the local community then this would include both the Jewish and Islamic communities for whom Friday was a day of worship. If a disproportionate number of sessions were timetabled on a Friday this would deny the participation of organisations from these communities in the module with a consequent loss of learning opportunities with these communities for the students.

The response that I received from the Chair of the committee was, “...*but it’s Poets’ Day.*” Colleagues laughed. I was confused. I did not understand the point. There appeared to be an ‘in-joke’ shared by members of the group, from which I was excluded. Nonetheless, I reasserted my point. After the meeting I queried the comment and was advised that ‘POETS day’ was an acronym for ‘push-off early tomorrow’s Saturday’. This incident symbolised the stark difference in values, priorities and culture. The issue I had raised had been trivialised and dismissed with a joke. The reaction was also indicative that for the Chair to address the issue would have implications for the timetabling of other modules. This risked challenging an established order and arrangement between these elements of the curriculum, the status of the individuals who led the modules and their departments.

Organisational Culture

On reflection, my comment appeared to have implications for whatever arrangements had been negotiated between departments that preceded my arrival. The faculty had already experienced major change in adopting a radical new curriculum which had required significant readjustments that were still in the process of settling down.

Perhaps it is in the very nature of higher education that courses become personalised and associated with those who lead them, so a course becomes ‘my’ or ‘your’ course. Consequently, there is a risk that the overall goals of the curriculum become subjugated under discussions over the delivery and timetabling of individual elements, determined not by educational principles, but by the power-dynamics between individuals, disciplines/specialisms and departments.

Posner (1992) highlights both the political and organisational context of curriculum development. He refers to how the organisation of a curriculum “serves some people’s interests at the expense of others: that is, some people stand to benefit and others suffer from it.” He goes on to say:

“The fact that the curriculum must fit into the organisation of an institution exerts a strong influence on the curriculum’s organisation. In particular, the departmental structure of schools increases the compartmentalization of knowledge; the stronger the departments, the stronger the compartmentalization.” (1992:143)

As the new curriculum rolled out it emerged that lecturers were enlisting the support of students to challenge the legitimacy of the community module as an integral component of the medical curriculum. It was reported to me by students that they had been told in their lectures that the reason why a lecturer could not complete all that that had wished to convey was because the time allocated had been curtailed to make room for the Community Module. The fact that new principles of teaching had been introduced to reduce the length of lectures from an hour to forty-five minutes, did not dissuade some from scape-goating the new module.

The Community Module was seen by some as taking time out of the curriculum and resources from the teaching budget. This appears to have triggered or reinforced criticism of the Community Module by some students who believed that it was taking them away from core subjects. Rather than seeing a community-orientation to the curriculum as being an essential dimension of medicine it was being marginalised to exclusion.

Friends and Enemies

In addition to a personal commitment to creating a quality learning experience for the

students I felt under pressure to ensure that the module was well-organised and gave no cause for criticism of its design or implementation. It was no small task to organise a community-based programme for three hundred students across the East End of London in both the first and second year of the curriculum. Its success was determined by the commitment of individuals and organisations willing to host groups of students throughout this ethnically diverse and dynamic part of London. I felt acute pressure that I and the module could not risk failure.

As I negotiated my way through the terrain of my new 'place of settlement' I slowly became conscious of the presence of 'opponents' and 'allies' – necessitating an assessment of those who sought to undermine the relevance of a community-based component in the curriculum and those who would advocate for its inclusion and support its contribution to medical education.

The inclusion of a community-based and community-oriented component in the curriculum required the support and intervention of those with power and influence over the curriculum (and crucially the budget) who had a long-term vision for a radical new undergraduate curriculum and the desire to prepare a new generation of doctors for the demands of their role. Without the support for the module and my approach from my Head of Department and the Dean of the Medical School I could not have sustained the work I had been appointed to deliver. However, this did not guarantee support for the module from staff or students.

As a 'non-medic' I had no status in the eyes of the medical students, so when promoting the importance of a community-perspective to them I invited medical consultants to a lecture to make the connection between the learning experience the module offered and its relevance to medical practice.

Many of my colleagues were 'basic scientists'. I was not a 'basic scientist'. I did not share their language or experience. The context of radical curriculum change in which the community module was introduced did not endear me to my new colleagues. I consider that the reactions I received were less to do with 'who' I was than 'what' I represented. What I slowly came to realise was that this group also felt 'segregated'. They had once been part of a medical school and had now been transferred to a new setting and building and were coping with the changes of status and dislocation, limiting their capacity to welcome a stranger with whom they had no affinity.

With hindsight it might have been wise to invest more time in exploring ways of developing constructive relationships with my new colleagues, but the 'cultural barriers' appeared too great. I was dependent upon those within the 'host community' to facilitate relationships with new colleagues. In his model of acculturation Berry refers to the role played by the 'dominant group' in the acculturation process. He uses the term 'segregation'

to describe the separation of a new group by the dominant group. In general, this is how I consider my work was contained. The quality of the delivery of the module was not challenged, but it remained a separate component without an explicit relationship to other elements of the curriculum.

GETTING TO KNOW THE CULTURE – Listening and Learning

I had arrived at the medical school without any knowledge of that ‘community’ and its ‘culture’. I had no experience of the milieu, language or norms of behaviour. I was initially dependent upon my Head of Department, who although knowledgeable in his field and shared the ‘culture’ of medicine as a doctor, was not from the UK, so he too was negotiating his way in a new environment, but from a different perspective. Nonetheless, his authority and support was key to enabling me to fulfil my role and remit.

Owens (2001) refers to the distinctive nature of educational institutions and cites Tagiuri’s four dimensions of ‘organisational climate’ of which one is ‘culture’, composed of the values, beliefs systems, norms and ‘ways of thinking’. As I entered the culture of the medical school I faced the challenge of discovering its culture while managing the tension between those elements I was prepared to accept and those I did not.

Discovering Disciplines and Divisions

Arriving in a new culture I did what all strangers do, I asked questions. Questions to clarify direction and familiarise myself with custom and practice. What I had been asked to introduce into the curriculum was new, different. People did not have answers to my questions that would facilitate the embedding of a community-oriented component into the curriculum. However, my enquiries soon revealed that I was not engaging with a homogeneous entity, but like all communities it was subdivided into interest groups, in this case represented by disciplines and specialties each with their own territorial claims, borders and boundaries. My exploration revealed positions of power, influence, insecurity and vulnerability which helped me ‘map’ the terrain through which I would have to find my own path.

Pursuing a Passion

In the absence of an obvious reference point I drew upon my training and experience as a community development worker, but my perspective was of someone wanting to promote a particular perspective and encourage the medical profession to deepen their understanding of the needs and concerns of the local community and work in partnership with community organisations.

I wanted medical students to meet members of the local community as ‘people’ not

‘patients’, to shift the power dynamics to encourage a position of mutual respect of each other’s knowledge. I wanted the students to meet people in the context of where they lived to appreciate health and illness in the context of a community setting rather than a hospital or GP practice where they would traditionally meet ‘patients’. Again seeking to shift the power-dynamic from the ‘domain’ of the doctor to that of the person seeking access to medical expertise.

I was passionate about what I wanted the medical students to learn, but I either made assumptions of who they were, or ignored where they were from, their hopes and expectations and what motivated them to learn. With hindsight, my commitment to a purpose, coupled with insecurity and lack of familiarity with a new environment led me to adopt an approach that gave insufficient attention to the context within which I was asked to introduce a community-based approach to learning. I had failed to adopt and apply a basic tenet of education (and community development): to respond to ‘where the learner is rather than where I would like them to be’.

I wanted the medical students to develop an understanding of ‘community’ in the sense that I was familiar, whether this be a neighbourhood or ethnic group. I wanted to challenge what I had discovered to be the use of the term ‘community’ in medical parlance, which tended to describe the *location* of services, ‘in the community’, as distinct from those delivered in a hospital setting, with an implied difference in status. I remember dismissing a student’s description of medical students as a community, because it did not match what I wanted the student to learn, when I could have built upon this perception instead.

Understanding the Learner

What I failed to appreciate was the desperate desire of medical students to be regarded as aspiring doctors. They had worked hard to secure high grades, to enter medical school and they brought with them a desire to learn the knowledge and skills to be an effective doctor to diagnose, treat and heal people who were ill and injured. They had been inspired by doctors they had met and often television programmes and films: doctors were people who could make a difference, they could save life. But when they arrived at medical school they found themselves in huge lecture theatres and laboratories far removed from patients.

Nonetheless, they could understand the logic of learning anatomy and physiology, but what had the Community Module got to offer? As one student stated on an evaluation form, “I am training to be an MD [medical doctor] not a social worker!” A dental student echoed the sentiment, “I’m still not sure how housing affects people’s teeth.” I later gave the latter statement to a professor of public health dentistry as a the topic for a introductory lecture for the module in a subsequent year.

Practice in Context

I also adopted the student's comment as the title for an article about the module (Wykurz 1994). A student kindly contributed the insights she had gained from her experience of the module which is indicative of the fact that many students grasped its purpose and the value of the process:

“It seems rather inadequate to pick up a textbook and read it to get an impression of the issues facing a local community and its people. In order to get a real understanding you have to ‘get into their shoes and walk around’ ...

It has given me the opportunity to meet the patients I will be treating in my clinical years and to see that a patient is not just a case of asthma or bronchitis, but rather that his condition has been brought upon or aggravated because of the damp and squalor in which he lives; because he sleeps five to a room; because he must lose a whole day's pay to visit out-patients; because he must take his seven year old son to hospital to act as an interpreter.” (Salima Beg in Wykurz 1994:16)

Reviewing what Motivates Learning

However, not all the students saw the value of ‘getting into the community's shoes’. Other approaches needed to be explored to encourage medical students to see and appreciate individuals in a more holistic context. I recognised that they wanted to meet people as ‘patients’ and that this was the way to motivate their learning about the context of medical practice. This led to the development of a new initiative, ‘Patients as Partners’ (Kelly 1997) which required funding from outside the medical school to initiate and sustain the programme. It provided medical students with the opportunity to learn directly from patients, meeting them on a one-to-one basis to develop an understanding of what is important to their patient-partner's health and wellbeing. But what was crucial to the programme was the principle and process. Describing the programme, Kelly states:

“It challenges the traditional passive role of patients in medical education by enabling them to be active facilitators of learning. It also seeks to foster relationships between future doctors and patients based on mutual respect for each other's expertise.” (1997:149)

This new component was offered both as an option within the Community Module and in a later phase of the curriculum. Its introduction also provided another valued resource – a new colleague to lead the programme who shared a community development perspective. I now had a ‘fellow traveller’ with whom to share my journey in a ‘foreign land’, someone with whom I could discuss ideas, strategies and problems associated with the introduction of a community-oriented approach to medical education - a valued collaboration that still

continues.

In a later role commissioned by the NHS²⁾ Executive to evaluate a national programme to foster closer collaboration between medical schools and NHS organisations I was introduced to an impressive programme that adopted a different approach from the Community Module to appreciate the context within which patients on low incomes had to live. The course was led by a doctor and explicitly focused on ill-health (Lennox & Petersen, 1998). It was located on an inner-city estate in Leicester and was designed to enable students to ‘gain a richer understanding of the individual patient’. It encouraged medical students to place ‘the causes and prognosis of illness’ in the context of economic and environmental factors.

This programme was demonstrably effective in creating a learning environment for medical students to understand the factors that contribute to inequalities in health through meetings with people as ‘patients’ in their own homes, on their territory. While the programme did not elevate the patient or community representatives to the status of ‘teacher’ it was an inspiring course, offering an example of how medical students like to learn in a community setting. It was a well-crafted and led by a doctor with a passion for her subject and the skill to create a format that would motivate the students to learn.

FINDING SUPPORT – joining networks

A settler in another land quickly seeks out people with whom they share a common culture. I was no exception. On arrival I was already aware that the medical school had appointed medical educationalists. While they had been instrumental in introducing radical changes in the curriculum we did not share a common background or approach to education. Their approach focused more on the contribution of psychometric tests and educational measurement to course design and assessment, while my educational interest placed a higher value of the benefits of experiential learning (Kolb, 1984) and the liberating and transformative quality of education advanced by Freire (2000) which also underpinned my approach to community development.

The medical school was spread over three sites and the medical education unit was a train journey away. However, another community worker had been appointed in an educational role, but she too was based at this other site, so opportunities for mutual support were limited.

International Links

To my surprise and enduring satisfaction, I discovered that my greatest source of support to help me endure the ‘acculturative stress’ of my new situation and sustain my work within

2) NHS – National Health Service in the United Kingdom

the medical school lay not only outside the institution, but also outside the country. The University of Maastricht was and still is, regarded as an innovator in medical education. It was while attending one of their ‘summer schools’ in 1991 that I was introduced to problem-based learning (PBL) which Maastricht had pioneered in the undergraduate curriculum.

I also discovered ‘The Network: Towards Unity for Health’ (TUFH), an international organisation of academic health professions institutions and organizations promoting equity in health through community-oriented education, research and service (The Network, 2010). To discover an organisation that shared concerns and goals that were at the core of my work, and had an international reach was liberating I soon became a regular participant of their conferences and valued the camaraderie of people with whom I could talk the same ‘language’ and most of them were doctors!

Berry’s model does not refer to the strength people gain through association with international networks, but these offer a powerful source of support in a ‘new land’. For me this was a pivotal source of support that sustained me throughout my work to promote a community-oriented and community-based approach to medical education.

My association with Maastricht led me to take a Masters in Health Professions Education where I learnt with and from doctors in a stimulating and creative learning environment. I was beginning to find a niche and ‘home’ in this ‘foreign land’ of medical education that valued my application of community development principles. While I could enjoy an affinity with doctors abroad, changes at my institution in the UK indicated that it was time to move on.

RELINQUISHING TERRITORY - departure

The Community Module had, in part, been designed in response to a call from community organisations to take on an active role in teaching medical students (Wykurz 1997). Both the module and Patients as Partners had facilitated closer links between the medical school as an institution and local community organisations in the East-End of London. These two community-based and community-oriented initiatives had enabled representatives of the local community to cross the threshold of the medical school and work with them as partners.

Territorial Interests

By 1996 reduction in government funding for the non-for-profit sector significantly reduced the capacity of local organisations to support the Community Module. This coincided with an expansion of the Department of General Practice & Primary Care in the medical school and its growing ambition to secure a proportion of the undergraduate curriculum. The Community Module became a prime a focus of attention. I had been considering moving on

for sometime, so when an invitation came to return to my professional roots and lead a postgraduate programme in community development, I left to embark on a new journey which coincided with the merger of the department within which I had been located.

The Community Module was rapidly superseded by a programme introduced by the Department of General Practice and Primary Care who had claimed the territory I had left behind. This reflected the shift in status of primary care within the delivery of health services, with the UK government promoting a primary care-led NHS, shifting the power-base for the delivery of healthcare away from secondary and tertiary care.

Disempowering Practice

Within the new programme the base for learning had moved from community organisations to GP practices. Community representatives were still involved, but were now seen as a resource that could be distributed across the area which led to tutors from community organisations being assigned to GP practices outside their neighbourhood. In one instance a tutor with experience and expertise of working with the Bengali community was asked to partner a GP tutor in an area serving the Hasidic Jewish community. Consequently, by being removing them from their local context, the value of the tutor's knowledge and expertise was diminished when working with a GP tutor in an area with which they were unfamiliar to support the medical students to learn about the local community.

Soon after my departure little evidence of my work remained. It was as if the land I had cultivated had been ploughed under and planted with a different crop.

LIVING IN TWO CULTURES – life after the Community Module

After leaving the medical school I returned to community development, but now leading a masters course. Nonetheless, I retained my association with the medical world. Not only were several of my colleagues in this new institution doctors, but my role included working with a GP practice to develop a patient-partnership group and other community initiatives (Wykurz 2006).

My earlier association with Maastricht University led to an invitation from the Maastricht University Centre for International Co-operation for the Development of Education (MUNDO) to facilitate a five day workshop for the Medical School of the Ahfad University for Women in the Sudan, supporting them to review their community-oriented medical curriculum. It was a privilege to work with such a committed faculty who were prepared to work with their students and colleagues from other medical schools in their country to review their curriculum. I was also invited to review papers for The Network's publication 'Education for Health'. My involvement with an international network had sustained my participation in the field of

medical education that I had not anticipated.

From my new university position I also undertook evaluation projects that straddled the world of medicine and community development and was asked to write an editorial for the journal 'Medical Education' on patient involvement in medical education (Wykurz 1999). This in turn led to an invitation to write an article for the student BMJ (Wykurz 2000). I chose to write a provocative piece which prompted an intriguing response from a person who described himself as 'a former medical student' who had participated in the Community Module. He recognised my name, and took the opportunity to criticise the module and my approach rather than comment on the article.

Promoting patients as teachers

The distance from the medical school created the space and opportunity to embark on a piece of collaborative writing with my former colleague who had led the Patients as Partners programme. We wanted to investigate the role of patients as teachers in medical education and highlight the value of their contribution to medical education. We wanted to bring to the attention of doctors that patients had expertise and experience that was not generally being used to their potential. Traditionally, patients had a passive role in medical education and we wished to reveal examples where they had been invited to take on an active teaching role.

We wished to maximise the impact of our message, so carefully chose a publication to ensure that it would reach our intended audience: the medical profession. The prestigious status of the British Medical Journal (BMJ) made it the ideal vehicle for the article. We carefully crafted the article to ensure it complied with rigorous academic standards and then took some pride in our success as two community development workers in getting our article published in a medical journal (Wykurz & Kelly, 2002). Our work had been accepted by the world of medicine.

However, our self-satisfaction was punctured by a reply to our article from a 'user representative' (Blennerhasset, 2002), someone who as a patient represented the people we considered could play the active role in medical education for which we were advocating. However, her criticism was scathing:

"The patient teachers are still to be simply vehicles for practising upon - the only difference being that now they can give marks out of 10."

Her remarks prompted personal reflection on its implications. In the context of Berry's model, despite my perception of having secured respect for the community development principles I had brought with me into medical education, had I now reached a state of 'assimilation' rather than 'integration'?

Influencing Practice

Despite the soul-searching prompted by the response to our BMJ article, the paper proved to be a resource and a spur for many who shared our desire to elevate and support the role of patients as teachers in medical education. This interest has gathered momentum over recent years. The British Medical Association have recently published a discussion paper that examines the role of patients in medical education (BMA 2008). It is satisfying to see that it includes a substantial section on 'Active patient involvement: patient centred learning'. The section includes a significant reference to the paper Kelly and I wrote which is perhaps indicative of the value our contribution has made to the importance of involving patients as teachers and the influence 'outsiders' can have in medical education.

Renewing Associations

Following the publication of the BMJ article my involvement in medical education remained dormant for a few years while I concentrated on the community development course I led. However, the department which I was eventually asked to lead supported a 'teaching the teachers' course for doctors and nurses working in primary care settings. I became its liaison tutor, acting as the link between the university and the course. I quickly developed respect for the quality and rigor of the programme led by an interprofessional team that included doctors, nurses and later another colleague with a community development background. They had a strong commitment to the principles of adult education and high standards of teaching and assessment.

In 2005 I attended a conference in Vancouver, 'Where's the Patients' Voice in Health Professions Education' organised by a colleague who had also worked at the medical school where I can begun my journey into medical education, but who had now moved to Canada. The conference was a positive and powerful event, celebrating patient involvement in medical education. Its aims were "to explore practice, innovation and theory that embeds the patient/client voice in health professional education; to empower patients; to enrich and enlighten practice." It represented a reinforcement of my personal, professional and international links with this important field. On my return to the UK my enthusiasm for the conference was greeted by a comment from a colleague, "It seems like you felt more at home at the conference than you do here."

Enhancing Clinical Teaching

Her remark was prescient. It was not long before I left the university, adopted a freelance career and within a year took on a role with the London Deanery to support consultants to develop their teaching skills. The programme, ECTOR (Enhancing Clinical Teaching through Observation and Reflection) was inspired by a well-established programme of an adjoining

deanery (Robinson, undated). ECTOR offers a resource to consultants across the whole range of specialties providing an opportunity to consultants to explore their teaching with the support of an 'Education Facilitator' who can share their experience and expertise in education.

During the pilot phase of the programme, key values and principles were identified that underpin the relationship between the Education Facilitator and the consultant as teacher. The Education Facilitator is expected to:

- Prioritise the needs of the consultant in their teaching role
- 'Do no harm' – act with compassion, counter anxiety, emphasise strengths
- Promote a participatory, experiential, reflective and transformative approach to learning
- Encourage a relationship of mutual respect and reciprocal learning through dialogue
- Facilitate a process of co-creating new learning
- Challenge without being judgemental
- Maintain confidentiality of information

It is no coincidence that the phrase 'do no harm' echoes a fundamental principle of medical practice and in this case is applied to the relationship between the Educational Facilitator and the consultant in their teaching role.

Encouraging Reflection on Teaching and Learning

Participation in the programme gives the consultant the opportunity to have their teaching observed on three separate occasions, each followed by a discussion with their EF who writes up notes of the discussion and initiates a reflective dialogue with the consultant about their teaching. This culminates in an 'overview document' prepared by the consultant who is expected to synthesise what they have learnt over the period. A consultant summed up the process and value of what he gained from the experience of participating in the ECTOR programme:

"I entered the programme with an open mind expecting that someone would give me some insight into my teaching and help me develop my teaching skills ... you have taken me through my path of learning and practice teaching, have made me answer my own questions and have facilitated my learning of how I teach and how I can improve my teaching skills. You have not given me information or advice, but have directed me through a process of self-learning and reflection."

I consider it a privilege to observe the teaching of doctors who are committed to serving their patients and facilitating the learning of trainees and medical students. To observe how skilfully some doctors weave their dual responsibilities can be impressive. The quality of teaching observed is often high, sometimes demonstrating an intuitive grasp of core educational

principles which blend personal commitment with the adoption of positive traits from clinical teachers they have respected during their own clinical training.

Affirming the Patient as Teacher

Much of my current work now straddles the two ‘worlds’ and cultures of medicine and community development. I move between them and occasionally they overlap. During the writing of this article I received an email from a consultant haematologist who I am supporting within the ECTOR programme, she was briefing me on the next teaching session that she wanted me to observe. She was planning a session for a group of medical students with one of her patients and had invited the patient to state what she wanted to tell the students.

In response to the points the patient listed, the consultant affirmed the importance of what she planned to say and the significance of her role as a teacher,

“Each statement is valuable and has an important message to convey to doctors-in-training. These are precisely the aspects of communication that are difficult to teach students; much more powerful to hear it from a patient. It is all about the impact on you and your family.” (Consultant Haematologist)³⁾

The consultant’s desire to invite a patient to collaborate with her in the teaching of the medical students and attribute such value to her role is perhaps indicative of an increasing desire of doctors across specialties to recognise the experience and expertise of patients as teachers. (see Lefroy, J, 2008, for another example).

VISITOR OR CITIZEN? – concluding comments

I am one of many people who work in the world of medical education in the UK who do not come from a medical or health background. My journey may be indicative of the challenges and opportunities that others have also experienced in the transition from a peripheral position on the ‘borders’ of medicine, to a place where the values I hold are in harmony with others within the medical profession who wish to effect change through working in partnership.

The lessons I have learnt are that a commitment to values and tenacity of purpose can win through and have influence, but effectiveness and sustainability are dependent upon understanding the culture, analysing where power lies, identifying allies, seeking opportunities and linking into supportive networks.

3) Personal communication included with the consent of the consultant.

Over time doctors have become trusted colleagues, sources of inspiration on educational matters and friends. Once accepted into the world of medical education as a respected colleague there is always the risk of co-option and collusion. There is a risk that the longer our sojourn in the ‘medical world’, we begin to ‘learn the language’ and accept the norms of our new culture which may compromise our willingness to challenge. By being ‘outside’ the medical profession our position may give us a vantage point where we can utilise our independent perspective and ability to challenge and effect change when undertaken within a relationship of trust and mutual respect with a commitment to positive outcomes for patients.

I am not of the medical profession, so I do not expect to be accepted as a ‘citizen’ of that world with its associated ‘rights and responsibilities’. I consider myself more than a ‘visitor’ and will no doubt be seen at times as an ‘itinerant irritant’. I have struggled to find a term that describes an intermediate state that might apply to my position. The UK’s Border Agency are responsible for considering applications for permission to enter or stay in the country. They have the power to confer the status of ‘discretionary leave to remain’ on those who are allowed to stay as long as certain circumstances apply.

My identity pass to enter the London Deanery has a neck band on which the word ‘Temporary’ is repeated along its length. Symbolic perhaps of my status within medical education. But I am content with such a position for it enables me to sustain a critical distance and perhaps reduces the risk of losing such a perspective through ‘assimilation’. However, while my status is temporary, I hope the work to elevate the status of patients as teachers and build closer collaboration with communities in facilitating the learning of doctors throughout their education will endure.

Since I first became involved in medical education it is evident that an increasing number of doctors have taken an interest in education, joining courses at a variety of levels from e-learning modules to masters degrees. The Association for the Study of Medical Education is run by doctors and healthcare educationalists and its membership continues to grow. Numerous books have been written on teaching and training of doctors, some as a collaboration between educationalists and doctors (e.g. Fish & de Cossart, 2007).

I hope that medical education will always be a place that welcomes ‘outsiders’ who offer creative ideas and a constructively critical perspective. If my experience is anything to go by the relationship can be enriching for all involved, prompting new insights for doctors and for those from outside the field of medicine.

A tenet of community development is to always ask the questions: *For what purpose?*
For whose benefit?

In the field of medical education what all who are involved need to keep at the forefront

of our work is the primary aim of the endeavour which is to support doctors to sustain and improve the health and quality of life of individuals and communities through an empowering process. In that we can all share a common purpose.

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