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Editorial

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Clinical medicine is currently under the spotlight in many countries. Governments and the public are beginning to raise questions about competence to practice (sometimes referred to as "fitness for purpose") particularly in the light of several well publicised cases of incompetence and failure to act, such as in the case in the UK of the Bristol paediatric cardiac surgeons [1,2]. With health care reforms on many government agendas, and a general dissatisfaction with education and training, the time is opportune to examine the state of professional education, at both undergraduate and postgraduate levels. Practitioners often comment on the perceived lack of skills of newly graduated pharmacists; academics regularly criticise practitioners for their lack of scientific appreciation and application in the workplace. This tension between academia and practitioners in the "real world" is not new, but then again, neither has it gone away. In the *milieu* of increased government and public scrutiny, however, we must start to honestly examine the relationships between teaching, research, pharmaceutical practice (of all types) and public expectations. It is counterproductive for each sector to blame the other for perceived failings, and neither can the profession as a whole ignore societal and governmental shifts in expectations and health care culture.

The emergence of clinical governance as a concept to address the shortcomings of professional accountability in medicine has some lessons for education. Clinical governance is defined as "a framework through which… organisations are accountable for continuously improving the quality of their (health) services and safeguarding high standards of health care by creating an environment in which excellence in clinical care will flourish" [3]. Linked with the concept of evidence-based medicine, this philosophy is designed to inculcate lifelong habits of learning and continuous development in health care professionals. Governments and professional bodies are actively seeking ways in which this philosophy can be incorporated into health services systems and professional codes of conduct, with the legitimate intention of improving standards of practice and public confidence in those who are charged with looking after the health of populations. It is not difficult to see the importance of education and training as a foundation for governance and competence to practice.

Perhaps it is also time we started to think about a similar concept for the education and training of young professionals, from within the higher education system. Educational Governance could be defined as a framework through

which higher education institutions are accountable for continuously improving the quality of education provision and promoting high standards of teaching by creating a climate in which excellence in learning is the norm. Perhaps it is also time to examine more closely the "professionalisation" of teachers within our profession, and to emphasise the growing, and unavoidable, need to inculcate lifelong learning habits in pharmacy undergraduates. Educational governance, as a concept, can only flourish if there is an evidence base, of course. Evidence, research and the reporting of best practice in education has been growing slowly over the last decade, but now is the time to promote these concepts as a vital and necessary part of higher education provision, including the provision of continuing education, continuous professional development and training within the profession. It is time to set an agenda for evidence-based education.

Pharmacy Education would welcome views and further discussion on these issues.

References

[1] *Br. Med. J.* **323** (2001), 125.
[2] www.bristol_inquiry.org.uk/ (accessed 23 July 2001).
[3] Department of Health, HM Government, UK (www.doh.gov.uk/pricare/clingov.htm accessed 23rd July 2001.)