To consider

Generic Professional Capabilities

Issue

1. This paper summarises current work aimed at reinforcing professionalism in postgraduate specialty training curricula. Our focus has been on the skills which are generic to all specialties and integral to good clinical care, rather than the technical specialty elements which are already well defined in curricula.

2. As members will know, the issues have been explored in the independent Shape of Training Review which reported on 29 October 2013.

3. Thinking has also been informed by the earlier exploratory discussions that we held through informal fora in 2012, and reflected in the report at Annex A.

Recommendations

4. The Education and Training Advisory Board is invited to:

   a. note the background to and direction of travel with this work

   b. consider the questions at paragraph 21.
Generic Professional Capabilities

Issue

Context

5 The *Education Strategy 2011-2013*, makes the commitment that:

‘In 2011, we will begin to consider the scope for setting out generic outcomes for postgraduate training (for example, key components of the Good Medical Practice framework for appraisal and assessment such as leadership, communicate effectively, establish and maintain partnerships with patients, share information with other healthcare professionals for safe and effective patient care, put into effect systems to protect patients and improve care and apply knowledge and experience to practice).’

6 The commitment in the strategy was against the background of Lord Patel’s review of the future regulation of medical education, published in 2010, which argued that we should take a more outcomes-based approach to postgraduate training. This echoed the position taken by the former Postgraduate Medical Education and Training Board in its Future Doctors review published in 2009, which also recommended the establishment of generic curriculum themes covering professional skills and behaviours.

7 Although curricula were strengthened in 2010 with the incorporation of the Medical Leadership Competency Framework and elements of the Academy of Medical Royal Colleges Common Competency Framework for Doctors (CCFD), the coverage of professional elements is variable.

Coverage in the Shape of Training Review

8 Recommendation 6 in the Shape of Training report, states that:

*Appropriate organisations must introduce a generic capabilities framework for curricula and placements for postgraduate training based on Good Medical Practice that includes, for example, communication, leadership, quality improvement and safety.*

9 The report argues that medical education goes beyond learning the technical aspects of medicine. It is fundamentally about becoming a dedicated doctor who will need to respond to increasing numbers of patients with complex health needs in different settings.

10 In order to respond to these challenges, the report stresses that future postgraduate curricula will need to articulate the generic professional capabilities that all doctors should possess or be able to develop. These include some fundamental areas of practice including the need to communicate effectively, empathise, lead, follow and be diligent and conscientious.
The report also highlighted that embedding a professional framework (defined by Good Medical Practice) into medical education and training, will reinforce key aspects of good care

**Our discussions with key interests**

The report at Annex A reflects the earlier discussions held in 2012 with key interests as part of a series of informal fora to explore ideas on possible ways forward.

The Forum supported the view that we should identify generic themes – though they suggested that we express these as ‘generic professional capabilities’ rather than ‘generic outcomes’ - for incorporation in all specialty curricula and building on the Academy’s existing CCFD.

The Forum looked at a range of issues including:

a the formation of professional identity

b the critical professional behaviours expected of all doctors

c the alignment of language across the different stages of education

d how curricula can be better used to describe the culture and environment for learning

e the need to ensure that generic themes are sufficiently flexible to be contextualised to the needs of different specialties

f the wider policy context for change e.g. Human Factors.

**How we are taking the work forward**

We expect the work on generic professional capabilities to be taken forward as part of the response to the Shape of Training Review. In this context, any decisions about fundamental changes to the structure and content of curricula will be made in full consultation with key interests including the Medical Royal Colleges, faculties, deans and Health Education England, and bodies in the other three countries.

In the meantime, we have been undertaking some scoping work with the Academy of Medical Royal Colleges to see what the generic themes might look like and how they align to Good Medical Practice.

Once we have developed a broad outline, we will – with the Academy - establish a small informal group of key interests to test the themes, think through the implications for assessment and the level of specificity required in certain areas e.g leadership, ethics.
18 We will then bring this back to key interests in early 2014 as part of the wider discussions on the Shape of Training Review.

19 So far, the scoping work has identified three categories which may help to describe the professional capabilities which are generic to all specialties:

a  non-clinical professional knowledge, skills and behaviour eg, leadership, communication, breaking bad news

b  clinical skills which underpin good care eg, diagnosis, prescribing, referral

c  understanding the structures, environment and culture in which service and education and training takes place e.g. governance structures, relationship with other professional groups.

20 We shall also be looking at the implications for other parts of the education continuum including the generic themes which run through all stages and whether language can be better aligned.

Questions

21 It would be helpful to have the Board's views on the following high level questions about the scope of generic professional capabilities:

a  What are the key professional capabilities that all clinicians should be able to demonstrate, regardless of specialty, at the point of CCT?

b  How prescriptive should the GMC be in setting generic professional capabilities as outcomes?

c  What challenges does this approach pose for assessment?

22 How might our approach to generic professional capabilities translate to other professional groups?
Supporting information

What equality and diversity considerations relate to this issue

23 A full equality analysis has been prepared on generic professional capabilities.

If you have any questions about this paper please contact: Mark Dexter, Head of Policy - Education, mdexter1@gmc-uk.org, 020 7189 5321
Report of discussions - Generic outcomes for postgraduate specialty training

Purpose of this paper

1. This paper summarises current thinking on the scope for developing generic outcomes in postgraduate medical specialty training.

2. The paper reflects the discussions held, over the last 12 months, at the Postgraduate Board and meetings of the informal Discussion Forum set up to seek and test ideas on possible approaches.

3. The Discussion Forum met three times between July and December 2012 and followed some initial exploratory think-tank-style seminars held with key interests. The list of those who participated in the Forum is at Appendix A.

4. Reflected in the paper is contextual information including:

   a. The relevance of generic outcomes to wider policy initiatives, for example Shape of Training, Better Training, Better Care, the Educational Outcomes Framework.

   b. Implications for the four countries of the UK.

   c. References to published studies.

   d. The overview of postgraduate specialty curricula undertaken by Zircadian Consulting.

   e. Comparisons - ‘Map’ of non-clinical requirements across a range of different systems.

   f. Implications for the GMC’s curricula approval process.
Background

5 The Education Strategy 2011-2013\(^1\), makes the commitment that:

\[\text{In 2011, we will begin to consider the scope for setting out generic outcomes for postgraduate training (for example, key components of the Good Medical Practice framework for appraisal and assessment such as leadership, communicate effectively, establish and maintain partnerships with patients, share information with other healthcare professionals for safe and effective patient care, put into effect systems to protect patients and improve care and apply knowledge and experience to practice).}\]

6 To set this in context, for postgraduate specialist medical education and training there are some 65 medical specialties and 36 sub-specialties each with curricula approved by the GMC. These are delivered in over 100 approved training programmes.

7 Over the last six years, there has been a shift towards a more standardised approach to the requirements for all specialty curricula. The Standards for Curricula and Assessment Systems\(^2\), originally introduced in 2006, were a step forward in bringing greater consistency to the design and expectations for curricula delivery.

8 Also in 2009/10, when curricula were reviewed, the opportunity was taken to incorporate some non-clinical elements considered relevant to trainees in all specialties as preparation for their future roles as consultants or GPs (after the award of a Certificate of Completion of Training). Recommended by colleges and faculties and approved by the GMC, the new elements reflected the helpful guidance in the Medical Leadership Competency Framework\(^3\) and also the Common Competences Framework for Doctors\(^4\) – covered later in this paper.

Why consider a generic outcomes based approach to specialty training?

9 The general trend for an outcomes-based approach to training has been highlighted in a number of reports including Lord Patel's review of the future

\(^1\) Education Strategy 2011-2013, GMC, 2010


\(^2\) Standards for curricula and assessment systems, GMC, 2010

www.gmc-uk.org/Standards_for_Curricula_Assessment_Systems.pdf_31300458.pdf

\(^3\) Medical Leadership Competency Framework, Academy of Medical Royal Colleges, 2010

www.leadershipacademy.nhs.uk/discover/leadership-framework/

\(^4\) Common Competences Framework – Academy of Medical Royal Colleges, 2009

regulation of medical education\textsuperscript{5} published in 2010 and the Future Doctors review\textsuperscript{6} undertaken by the former Postgraduate Medical Education and Training Board.

The standards for undergraduate medical education in \textit{Tomorrow’s Doctors}\textsuperscript{7} already adopt a dual standards and outcomes-based approach. More recently, outcomes have been specified for Foundation Year 2 doctors in the revised \textit{Foundation Programme Curriculum}\textsuperscript{8}.

The postgraduate specialty and sub-specialty curricula approved by the GMC contain both the clinical requirements of each specialty and, as described earlier, some non-technical elements. Unlike \textit{Tomorrow’s Doctors}, there are no generic outcomes for postgraduate training set out in \textit{The Trainee Doctor}\textsuperscript{9}.

The Forum agreed that the development of generic outcomes should help encourage and facilitate a culture of improvement. There needed to be a better articulation of the relationship between expectations for ensuring minimum standards and striving for excellence, particularly in the context of professional behaviours and practice.

\textbf{Key questions}

This raises some key questions:

\begin{itemize}
  \item[a] Is there a body of non-technical knowledge, skills and behaviours which is generic to all specialties and therefore postgraduate training?
  \item[b] If so, what are the generic themes and how should we define them?
  \item[c] To what extent do specialty curricula already contain generic themes?
\end{itemize}

\textsuperscript{5} Lord Patel's review of the future regulation of medical education, GMC, 2010 \url{www.gmc-uk.org/4___Appendix_B___Outcome_of_Consultation_on_the_Review_of_the_Future_Regulation_of_Medical_Education_and_Training.pdf_31275463.pdf}

\textsuperscript{6} Educating Tomorrow's Doctors, PMETB, 2008 \url{www.gmc-uk.org/Educating_Tomorrows_Doctors_working_group_report_20080620_v1.pdf_30375087.pdf}

\textsuperscript{7} Tomorrow's Doctors, GMC, 2009 \url{http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors_2009.asp}

\textsuperscript{8} Foundation Programme Curriculum, UKFPO, 2012 \url{www.foundationprogramme.nhs.uk/pages/home/curriculum-and-assessment/curriculum2012}

\textsuperscript{9} The Trainee Doctor, GMC, 2011 \url{www.gmc-uk.org/Trainee_Doctor.pdf_39274940.pdf}
General principles

14 Initial consideration by the Postgraduate Board and subsequently the Discussion Forum indicated general support for the concept of generic outcomes. The discussions highlighted a number of issues and principles which it was felt should inform and guide any developmental work. These are briefly covered below.

What we mean by generic outcomes and how this links to professional practice

15 It was noted that generic outcomes had effectively been adopted as a working title for this project. The Discussion Forum’s starting point was to consider how the concept could best be described.

16 The Forum agreed that many of the qualities of good educators, leaders and clinicians could be characterised as core capabilities. The ability to communicate effectively, empathise, lead, be diligent and conscientious, could be included in the list of capabilities that trainees must possess or be expected to develop. These illustrate the kinds of knowledge, skills and behaviours which are complementary to doctors’ clinical skills but which, crucially, are integral to their professional practice. Arguably, these can apply to any profession.

17 The Forum agreed that the work on generic outcomes provides an opportunity to more clearly express the following:

a "Professional practice", (setting it apart from other modern uses of similar terminology, where there has perhaps been a devaluation of term "professional")

b That professionalism is fundamental and includes things which are givens - critical behaviours.

c Examples of behaviours which are considered unacceptable.

18 The Forum argued that work is needed to develop a consensus on and instil the values of professionalism across the sector.

19 Against this background, the Forum recognised that development of the generic outcomes concept should take account of and be aligned to the principles of Good Medical Practice10.

10 Good Medical Practice, GMC, 2006 revised 2009
www.gmc-uk.org/guidance/good_medical_practice.asp
The Forum reflected that with the increasing emphasis on competency based training over the last decade, the current curricula for postgraduate training had narrowed in scope.

Competency may not in fact be a helpful term. To some extent it perpetuates the notion of a minimum standards culture without aspirations for excellence. Simply knowing how to undertake a medical procedure and tick the competency box is not enough. Knowing when not to take action and how to take things forward when guidelines and protocols do not cover the situation is equally important. This comes with experience and is part of the process of developing as a professional.

In this sense, curricula have effectively become syllabi, listing competences and procedures which must be completed, with very little describing the process, culture and environment for learning or the requirements for professional practice.

The latter was considered by the Forum to be critically important to the delivery of curricula and ultimately producing fit-for-service doctors. The environment and culture of learning was described in terms of the three Cs: community (valued by organisation) collegiality (valued professionally) criticality (the ability to express opinion in interests of service improvement and patient safety).

It was felt that the current system had lost sight of the importance of valuing the professional nature of doctors. This is particularly important to their development and self-esteem both during the formation of an individual’s professional identity and throughout their career.

The Forum considered that the generic outcomes project would provide a good opportunity to address what it sees as deficiencies in the structure of current curricula in respect of both the non-clinical skills and the process of learning, taking account of the three Cs.

There was broad agreement that generic outcomes should be seen in the context of spiral and longitudinal learning and not in isolation from the other stages of the education continuum.

Therefore, any developmental work would need to ensure a coherent relationship not only with the principles of Good Medical Practice, but also the standards and outcomes for undergraduate and Foundation training - ensuring a common language as far as possible - continuing professional development and revalidation.
To better understand the nomenclature used to describe aspects of the education and training environment, the Forum noted the GMC’s glossary which provides some definitions of associated terminology. This is at Appendix B.

Relevance to other policy initiatives

There was broad agreement that the generic outcomes project was mutually relevant to other workstreams currently underway, including:

a **Shape of training review**\(^{11}\): - Chaired by Professor David Greenaway and sponsored by the GMC and others, the debate about how ‘we’ achieve a more appropriate balance between doctors with generalist and specialist skills is relevant to generic outcomes.

b **Better Training, Better Care**: Led by Health Education England, the project is examining how the system can enable the delivery of the key recommendations from the reports by Sir John Temple’s *Time for Training* and Professor John Collins’ *Foundation for Excellence*.

c **The Education Outcomes Framework**: This is being led by the Department of Health (England) and is relevant to generic outcomes in the context of its goals for excellent education, NHS values and behaviours and an adaptable and flexible workforce.

d **Promoting professionalism and excellence in Scottish Medicine**: Led by the Scottish Government in 2008, this work looked at – among many other areas – the development of team and partnership based working practices.

e **Human Factors**: The work being led by the National Quality Board on Clinical Human Factors is also relevant. In an interim report published in March 2012 titled *Human Factors*\(^{12}\), human factors are described as:

> …enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings.

\(^{11}\) Shape of training review [www.shapeoftraining.co.uk/](http://www.shapeoftraining.co.uk/)

The Forum agreed that principles around handover and continuity of care are generic professional capabilities which apply equally to airline pilots as they do to clinicians.

f **Technology Enhanced Learning:** Also originating from the Department of Health (England) and of potential relevance is its *Framework for Technology Enhanced Learning* \(^{13}\). The Framework aims to establish an effective communication network; share evidence on patient safety, quality of care and professional excellence; and encourage and support scholarly development. The Association for Simulated Practice in Healthcare (ASPiH) and the Higher Education Academy (HEA) are leading a development project across the UK to promote dissemination of existing good practice, multidisciplinary working and commitment to quality improvement.

g **Involving junior doctors in quality improvement:** In September 2011, the Health Foundation published an *Evidence scan: Involving junior doctors in quality improvement* \(^{14}\). The document summarises some published literature about the involvement of junior doctors in quality improvement in the UK and internationally. The scan found that the three most common approaches to engaging junior doctors in quality improvement include:

- formal training;
- quality improvement projects and initiatives led by junior doctors;
- projects designed by others to improve the quality of care provided by junior doctors.

Factors that may help or hinder the degree to which junior doctors are involved in quality improvement include:

- transitions to new roles;
- organisational culture;
- support and supervision;
- working conditions and hours;
- ongoing learning opportunities.

\(^{13}\) Framework for Technology Enhanced Learning, DH(E), 2011

\(^{14}\) Evidence scan: Involving junior doctors in quality improvement, The Health Foundation, 2011
Is there a body of non-technical knowledge, skills and behaviours which is applicable to all specialties?

30 Underlined by developments such as the *Consensus Statement on the Role of the Doctor*[^15] and the King’s Fund report *On Being a Doctor*[^16] there appears to be an appetite across the sector for the development of a body of non-clinical skills. To illustrate, the consensus statement argues that:

- All healthcare professionals require a set of generic attributes to merit the trust of patients that underpins the therapeutic relationship. These qualities include good communication skills, the ability to work as part of a team, non-judgemental behaviour, empathy and integrity.

- [there is a] need to select those with the appropriate attributes for training....All doctors must be demonstrably committed to reflective practice, monitoring their contribution and working continually to improve their own and their team’s performance.

- The doctor must possess the ability to work effectively as a member of a healthcare team recognising and respecting the skills and attributes of other professions and of patients.

31 The Forum agreed that within a multi-professional context, some 75% of standards are broadly common across healthcare professions.

If so, what are the generic themes and how should we define them?

32 In considering the scope of generic themes, the Forum reviewed various literature about professional practice as it applies to medicine. This is summarised at Appendix C with some reflections noted below.

*Formation of professional identity*

33 In relation to the familiar charge made that medical training is now a tick-box culture, focusing mainly on the technical aspects of individual specialties, Iona Heath argues that:

[^15]: Consensus statement on the role of the doctor, AoMRC and others
[^16]: On Being a Doctor, King's Fund, 2004
there is an unexamined assumption that the list of required competencies will add up to everything that society expects of doctors, but the faltering confidence of young doctors, undertaking their first professional roles, makes this look questionable.  

34 The study by Irby, Cooke and O’Brien suggests that medical education goes beyond learning the technical aspects of medicine; it is fundamentally about becoming a dedicated physician. Therefore, the professional identity formation of physicians - meaning the development of their professional values, actions, and aspirations - should be a major focus of medical education.

35 Their argument is that formation of the professional identity of the physician includes the integration of three themes:

a the process of becoming a professional through expanding one’s knowledge, understanding, and skilful performance;

b through engagement with other members of the profession, particularly more experienced others;

c and by deepening one’s commitment to the values and dispositions of the profession into habits of the mind and heart.

36 These arguments are in line with the paper by Dr Ian Curran which picks up the theme of capability mentioned earlier. He views capability as fundamental to professional practice.

In addition to professions being defined by their unique knowledge and technical base, professionals are also defined in terms of a core set of associated values, beliefs and behaviours… and complex behaviours provide professionals with a capability to integrate knowledge, technical ability and complex personal and inter-personal behaviour.

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www.bmj.com/content/345/bmj.e4549


19 Curran, I., ‘Professionals need capabilities beyond simple competencies’, Clinical Tutor (Newsletter of the NACT UK) October 2007, Vol 12 No. 4 p10-12

20 Physicians Compact, Virginia Mason Medical Centre, 2001
The Forum agreed that the development of personal identity, with a demonstrable commitment to beliefs and behaviours, is equally important. Trainers should be more explicit about this.

Patients’ perspective

The Forum reflected on patient expectations of clinicians. The Medical Education England’s Shape of training workshop - *Responsiveness to patients and the public* held in January 2011 – highlighted that, in addition to expecting clinically competent staff treating them, the two things that matter most to patients are communication and compassion. Communication should be understood not just in the context of a narrow set of skills but in terms of the nature of the doctor as a professional.

The alignment between personal and organisational cultures/values is also referred to in the *Virginia Mason Medical Centre’s document, Physicians compact.*

The book entitled *Intelligent kindness*\(^{21}\) also helpfully underlines the knowledge and skills required of doctors to function as both technicians and professionals with an understanding of and empathy for their patients’ circumstances.

Also, in the Values documentation produced by Health Education England\(^{22}\), there is specific reference to the need for a compassionate and flexible workforce.

Against this background, the Forum felt that the current system neither fosters the professional or personal aspects. In examining the scope for change, consideration should be given to empowering trainees.

To what extent do specialty curricula already contain generic themes?

*The overview of postgraduate specialty curricula undertaken by Zircadian.*

The Postgraduate Board and the Forum noted the review of postgraduate specialty curricula which had been undertaken by Zircadian Consulting in 2010.

Zircadian’s brief was to provide an overview of the content, common aspects and variability of existing specialty curricula and to make recommendations on how generic elements could be incorporated into specialty, including core,

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\(^{22}\) *Introducing Health Education England*, HEE, 2012

curricula. In doing so, Zircadian also looked at specialty and Foundation curricula to see where elements were common to both stages of training.

45 In addition to the review of curricula, interviews were held to test opinion with key stakeholders, including senior figures in postgraduate medical education, a selection of trainees and newly qualified Consultants and GP’s.

46 Although Zircadian concluded that good progress had been made in integrating leadership and some elements common to all specialty curricula, it was considered that the coverage of other non-clinical skills which might be applicable to all specialties pre-CCT, was variable.

47 The results of Zircadian’s interviews and their recommendations on the way forward are contained in Appendix D. This includes a list of the generic themes where there appears to be broad agreement by key interests who were interviewed on the areas considered most important. The Forum’s views very much accord with Zircadian’s findings and recommendations.

Assessment and review

48 The identification of generic outcomes, core capabilities or aspects of competence will inevitably pose the question of how these should be assessed. This is an area which will need a considerable amount of work.

49 Formative assessment would support the development of trainee doctors in these regards. Summative assessment would enable the trainees to demonstrate that they have successfully completed a stage of training and can properly proceed across a transition point.

50 More specific outcomes shared across specialties could be assessed through existing tools. The Royal colleges and faculties would be able to identify validated tools have been used to support and summatively assess performance for these aspects of professional activity. As highlighted earlier, any developments must avoid creating a reductionist approach by simply adding generic skills to an existing list of competences which are required. This would not be helpful.

51 It might be more problematic to identify effective mechanisms to assess wider aspects of competence or capability. That difficulty would be consistent with the challenge to assess professionalism in early stages of education and training. Nevertheless, specific tools or mechanism could be identified, which might be linked to approaches found useful for the revalidation of practising doctors as well as the fitness to practise or ‘conscientious’ of medical students.

52 Performance in respect of the generic outcomes or core capabilities is likely to develop throughout an individual’s education and training (and beyond the completion of formal training). It may not therefore be appropriate to seek
approaches that allow a particular outcome or capability to be ‘ticked off’ at some point in a training programme, requiring no further development or assessment. As in the Common Competences Framework, the definition of level descriptors for broad areas may be as important as the identification of specific aspects of knowledge, skill and behaviour. This will also pose the question of how a variety of pieces of evidence can best be considered to reach a defensible global and longitudinal evaluation of an individual in respect of the wider aspects of competence or capability. While this sort of process may not be strictly regarded as a form of assessment, it should be key in determining whether or not trainees should be able to progress between stages of training.

53 It will be important to consider whether the identification of generic outcomes or core capabilities should be associated with a move towards a more standardised approach to the assessment and review of these aspects of professional performance. It might be possible for example to identify interesting or good practice in assessment tools, both formative and assessment, and also in approaches to reviewing a range of evidence to reach conclusions about an individual’s suitability to pass a significant transition point in their training. Research may be helpful in this area.

‘Map’ of non-clinical requirements in different systems

54 In thinking about the areas which could feature in any future model of generic capabilities and outcomes, the Forum considered a ‘map’ showing the non-clinical requirements applicable to different systems. This is at Appendix E.

55 The map includes the Academy’s Common Competences Framework. The Framework was developed to identify the common competences that should be acquired by doctors in core and specialty training.

56 The common competences for all trainee doctors are based on the four domains of the Framework for appraisal and revalidation, derived from Good Medical Practice (GMP). The Framework is ordered into four domains which cover the spectrum of medical practice:

- Domain 1 - Knowledge, skills and performance
- Domain 2 - Safety and quality
- Domain 3 - Communication, partnership and teamwork
- Domain 4 - Maintaining trust

23 The Good Medical Practice Framework for appraisal and revalidation, GMC, 2011
www.gmc-uk.org/GMP_framework_for_appraisal_and_revalidation.pdf_41326960.pdf
The map also includes a column which shows common themes highlighted as priorities by those interviewed by Zircadian as part of its review.

How the work can be taken forward in 2013

In acknowledging the progress made over the last three years with the integration of common elements in curricula – particularly the Academy’s Medical Leadership Competency Framework and the Common Competences Framework for Doctors (CCFD) – the Forum considered how the GMC might develop a framework which builds on these developments.

Possible approaches could involve the following:

a  Role of the GMC – to develop and consult on:

 i  Overriding principles - under the overarching outcome of ‘formation of professional identity’.

 ii  High level learning outcomes - consider how generic themes can be expressed and be assessed as outcomes.

 iii  Consider how the emerging thinking on generic outcomes should be fed into and be informed by internal and external policy workstreams e.g. Shape of Training, Human Factors.

 iv  Assess the implications for the GMC’s curriculum approval process.

 v  Consider further research – including evaluation of outcomes of implementation of initiatives (as currently being done for Supervised Learning events in the Foundation Programme) and literature on good practice.

b  Role of the Academy - to develop in association with the GMC, colleges and others a further development of the CCFD. Key considerations would be:

 i  A revised CCFD should include additional areas not covered in the current edition.

 ii  It would need to take into account the undergraduate and Foundation stages of training to ensure a common language and core capability areas.

 iii  Development should take account of the process adopted for establishing the content of the Foundation Programme Curriculum.

 iv  Further development of the level descriptors, range of instruments for evaluation and assessment.
v Ensuring that the appropriate links are made to the recognition and approval of trainers, environments for learning (possibly with more detail about culture, role modelling, etc).

vi A recognition that the GMC would need to approve the generic professional elements for inclusion in specialty curricula.

c Development of an engagement plan and subsequent communication strategy. This is relevant to sections a and b above. Key considerations would be:

i Involve all key interests from across the medical education and training continuum - ensuring connections are made between the undergraduate and postgraduate sectors.

ii Ensure engagement with other key interests: Departments of Health, MSC, Colleges/faculties, COPMeD/COGPeD, PG Deans, medical schools, NHS Employers including some of its constituents, trainees, students, patient/lay Groups, HEE, NES, NI MTDA, the Wales Deanery, NACT.

iii Ensure that engagement and subsequent communications are applied UK-wide.
Appendix A
Discussion Forum

Scope of work

1 The development of generic outcomes will be influenced by other key workstreams including the review of Good Medical Practice, Shape of Training and, later, the review of education standards.

2 Within this context, the Discussion Forum reviewed the following themes:

   a What do we mean by generic outcomes?
   b Are there skills which all clinicians should possess, regardless of specialty, at the point of CCT?
   c If so, what are they and how do they align to expectations of professional practice?
   d Are there exemplars of good practice we can draw from?
   e How can we express these as outcome requirements?
   f How can we effectively measure the themes as part of quality assurance?
   g As part of a process of spiral learning, what elements should run through all curricula – from undergraduate, through foundation to core and specialty.

Participation

3 The Discussion Forum was facilitated by Dr John Jenkins, member of the GMC Council and chair of the Postgraduate Board.

4 Those invited to participate include the following:

   a The Academy of Medical Royal Colleges (Alastair Henderson & Manjula Das)
   b The Conference of Postgraduate Medical Deans (Derek Gallen)
   c MSC (Ian Curran)
   d NHS Education Scotland (Stewart Irvine)
   e The Faculty of Medical Leadership and Management (Peter Spurgeon)
   f NHS Employers (Bill McMillan)
   g The Academy of Medical Royal Colleges Trainees’ Group (Rajat Chowdhury)
The BMA (Tim Yates from the BMA Junior Doctors Committee)

A CEO of an NHS foundation hospital trust (Sue James)

A Medical Director (Peter Hockey)

A postgraduate medical trainee (Toby Hillman)

A curriculum expert (Colin Coles)

An assessment expert (Winnie Wade)

A trainer (Andrew Jeffrey)

A lay representative (Sally Malin)
Appendix B

Extracts - GMC glossary for regulation of medical education and training

Curriculum

A statement of the intended aims and objectives, content, experiences, outcomes and processes of a programme or course, including a description of the structure and expected methods of learning, teaching, feedback and supervision. The curriculum should set out what learning outcomes the learner will achieve.

Outcomes

Areas or aspects of knowledge skill or behaviour to be acquired through a period of education or training.

Competence/competencies

A holistic understanding of practice and an all-round ability to carry it out under ideal circumstances. Competence must be distinguished from the competencies assessed in contemporary testing programmes. It rests on an integrated deep structure of understanding and involves subtleties of sensitivity, imagination, wisdom, judgement and moral awareness that are the mark of a wise doctor. A successful conceptualisation of competence would show how specific competencies are integrated at a higher level.

For ‘competence standard’ see Standards.

Competence standard

A competence standard in relation to the Equality Act is an academic, medical, or other standard applied by or on behalf of an education provider for the purpose of determining whether or not a person has a particular level of competence or ability. Competence standards apply to all parts of a course including entry and must be reviewed from a disability discrimination perspective. Reasonable adjustments do not have to be made to competence standards but they do have to be made to the way that the standards are assessed or performed.

Knowledge, skills and behaviours (covered in the professionalism definition)

Professionalism denotes a set of values comprising statutory professional obligations, formally agreed codes of conduct, and the informal expectations of patients, colleagues and the wider society in which the professional works. Key values include acting in the patients’ best interest and maintaining the standards of competence and knowledge expected of members of highly trained professions. These standards will include ethical elements such as integrity, probity, accountability, duty and honour. In addition to medical knowledge and skills, medical professionals should
present psychosocial and humanistic qualities such as caring, empathy, humility and compassion, social responsibility and sensitivity to people’s culture and beliefs.

Syllabus

A syllabus is a list, or some other kind of summary description, of course contents; or topics that might be tested in examinations. In modern medical education, a detailed curriculum is the document of choice and the syllabus would not be regarded as an adequate substitute for a curriculum, although one might be included as an appendix.
Appendix C i

Extracts from published studies

1 Professional practice and the formation of professional identity

*Calls for Reform of Medical Education by the Carnegie Foundation for the advancement of teaching: 1910 and 2010 – Irby, Cooke and O’Brien.*

- Medical education goes beyond learning medicine; it is fundamentally about becoming a dedicated physician. Therefore, the professional identity formation of physicians—meaning the development of their professional values, actions, and aspirations—should be a major focus of medical education. Formation of the professional identity of the physician includes the integration of our other three themes.

- *Formation*, a term borrowed from our colleagues in the study of clergy, involves the process of becoming a professional through expanding one’s knowledge, understanding, and skilful performance; through engagement with other members of the profession, particularly more experienced others; and by deepening one’s commitment to the values and dispositions of the profession into habits of the mind and heart.

- Arnold and Stern suggest that one’s development as a medical professional has two elements.

  a The first is demonstrating mastery in three foundational areas—clinical knowledge and competence in medicine, communication skills, and understanding the ethical and legal responsibilities of a physician.

  b In addition to these foundational areas, there are aspirations: goals that are striven for but never achieved, as one can always improve. These include excellence, humanism, accountability, and altruism.

- While physicians and learners of medicine still require intelligence, industry, compassion, integrity, and fidelity as they did in Flexner’s day, and while we argue that the themes of individualization and standardization,

24 journals.lww.com/academicmedicine/Fulltext/2010/02000/Calls_for_Reform_of_Medical_Education_by_the.18.aspx


integration, habits of inquiry and improvement, and professional formation as a physician are continuous from Flexner’s work to ours, sweeping changes in the practice of medicine have radically transformed what physicians must know and be capable of doing today.

- At the same time, insights from the learning sciences help us recognize that many features of contemporary undergraduate and graduate medical education do not support the development of the capacities we desire and society needs in our physicians.

**Educating physicians: A call for reform of medical school and residency**

- Professional identity formation – development of professional values, actions and aspirations – should be a major focus of medical education.

- It should build on an essential foundation of clinical competence, communication and interpersonal skills, and ethical and legal understanding, and extend to aspirational goals in performance excellence, accountability, humanism and altruism.

- Successful performance of patient care activities requires solid preparation in medical school and residency as well as lifelong growth and advancement beyond competence.

- Furnishing a learning experience that properly represents the dynamic and situated nature of physicians’ work will require a perspective that recognises the importance of physicians’ capability beyond formal scientific knowledge as well as vigorous management of curricular content and appropriate sequencing of learning challenges.

- Learning experiences must be organised in ways that are developmentally appropriate and occur in the company of effective teachers and role models. Opportunities for regular practice using knowledge and skills in similar, but not identical, scenarios coupled with focused feedback on performance is most effective for improving learner’s efficiency and accuracy in many activities.

- An educational programme has failed to achieve a key part of its mission if it produces physicians who perform routine work skilfully but rarely see new possibilities or greater complexity in their daily practice.

- The public needs more from medicine than competent performance. It is suggested that three key aspects are self-awareness, inter-personal relationships and acculturation are required.
The aspiration to do better, coupled with commitment and a sense of personal responsibility, will drive knowledge seeking and enhanced procedural proficiency, not only in training but over a lifetime. Moreover, because relief of suffering, not merely prevention or mitigation of illness, is a key goal of medicine, our physicians’ concern for their patients’ experience as human beings and their ability to empathise will grow in parallel.

Recommendations (not the complete list) include:

- Establish common competency domains across the undergraduate, postgraduate and continuing professional development continuum, with appropriate developmental benchmarks for learners.
- Individualise learning within and across levels, allowing flexibility in approach to learning and offering opportunities to pursue areas of interest beyond core learning outcomes.
- Promote learners’ ability to work collaboratively with other health professionals to effectively deliver patient care in complex situations.
- Engage learners in challenging problems and knowledge-building endeavours.
- Support leaner and teacher relationships that advance the highest values of the profession.
- Create collaborative learning and practice environments committed to excellence and continuous improvement.

2 Professionals need capabilities beyond simple competencies - Beyond competence the value of capability, Ian Curran

- Capability is fundamental to professional practice and only acknowledged to a limited extent in the Gold Guide and specialty training frameworks – the emphasis being more heavily focused on competencies.
- Professions are defined by their unique knowledge and technical base. Professionals, those within a profession, are also defined in terms of a core set of associated values, beliefs and behaviours. These complex professional behaviours provide professionals with a capability to integrate knowledge, technical ability and complex personal and inter-personal behaviour. These produce useful outcomes for patients.

27 Clinical Tutor (Newsletter of the NACT UK) October 2007, Vol 12 No. 4 p10-12
• The technical orientate competences or competencies by themselves do not make individuals professionally competent as they are become less useful in the context of training in professional practice. Part of the difficulty with competences or competencies is that there is an implicit obligation, requirement of any competency based system that the competence or competency can be defined. This is acceptable if the system requires technicians to perform repetitive, limited or contained tasks with little variability in the process or outcome. This approach may not always be so productive or applicable particularly in the context of higher-order, non-technical skills such as professional skills or behaviours. The military has always valued capability over competence – perhaps this is because they need to be adaptable in often the most unforgiving and hostile environments.

• The concept of developing capability as an educational goal or concept has a lot to offer professional training. In the same way that competencies are defined and restrictive, so capabilities are fluid and flexible. Competencies are also largely retrospective or static. Capabilities however give a degree of future flexibility. It is the fluid personal qualities that allow professionals to adapt their practice to deal with the infinite complexity and variability of the real world.

• We need competencies, but let's aim higher and produce capable, competent, professional doctors, not simply medical technicians.

3 In praise of young doctors - Iona Heath ²⁸

• Problems begin early, as the structure of education invites teenagers to think that all that matters in the making of a good doctor is an understanding of science. Science is, of course, necessary, but it is never enough in a profession that seeks to understand and alleviate the huge diversity of human suffering.

• At university, the emphasis on science and the linear reasoning of cause and effect persist, leaving little room for the exploration of doubt and the nurturing of that probing scepticism necessary to explore the gaps in the current state of scientific explanation. Students are encouraged to record their reflections but are seldom invited to question the fundamental assumptions about the nature of science and medicine. And, for students in England, there is the additional burden of huge amounts of debt not faced by previous generations, as a result of the policy on student loans.

• Clinical education seems to be based almost entirely on the acquisition of competencies—small aliquots of skill that can be practised, measured, and certified. As Della Fish and Linda de Cossart pointed out in their 2007 book Developing the Wise Doctor ²⁹, this is all about epistemology (what the

²⁸ BMJ 2012; 345:e4549  www.bmj.com/content/345/bmj.e4549

potential doctor knows), and almost no attention is given to ontology (who he or she is). There is an unexamined assumption that the list of required competencies will add up to everything that society expects of doctors, but the faltering confidence of young doctors, undertaking their first professional roles, makes this look questionable. Medical ethics seems to be too often taught on the basis of the four principles popularised by Beauchamp and Childress30, so that even ethics risks being reduced to a series of boxes to tick. Again this is epistemology triumphing over the more arduous but infinitely more worthwhile ontological approach that would be grounded in the ethics of virtue and could do so much more to nurture the known aspirations of students entering medical school.

4 Virginia Mason Medical Centre - Physicians compact

- In the US, the Virginia Mason Medical Centre had described a compact between management and professionals to drive forward what management expect and what professionals can expect from the organisation they work for - see Appendix C ii.

- In this country we prepare our undergraduate trainees to understand the concepts of Good Medical Practice but it was argued at the Forum that perhaps we do not prepare them quite well enough to be an employee.

Virginia Mason Medical Centre Physician Compact

Organisation

Foster Excellence
- Recruit and train superior physicians and staff
- Support career development and professional satisfaction
- Acknowledge contributions to patient care and the organisation
- Create opportunities to participate in or support research

Listen and Communicate
- Share information regarding strategic intent, organisational priorities and business decisions
- Offer opportunities for constructive dialogue
- Provide regular, written evaluation and feedback

Educate
- Support and facilitate teaching (GME and CME)
- Provide information and tools necessary to improve practice

Reward
- Provide clear compensation with internal and market consistency, aligned with organisational goals
- Create an environment that supports teams and individuals

Lead
- Manage and lead the organisation with integrity and accountability

Physician

Focus on patients
- Practice state of the art quality medicine
- Encourage patient involvement in care and treatment decisions
- Achieve and maintain optimal patient access
- Insist on seamless service

Collaborate on Care Delivery
- Include staff, physicians and management on team
- Treat all members with respect
- Demonstrate the highest levels of ethical and professional conduct
- Behave in a manner consistent with group goals
- Participate in or support teaching

Listen and Communicate
- Communicate clinical information in a clear timely manner
- Request information and the resources needed to provide care consistent with VM goals
- Provide and accept feedback

Take Ownership
- Implement VM-accepted clinical standards of care
- Participate in and support group decisions
- Focus on the economic aspects of our practice

Change
- Embrace innovation and continuous improvement
- Participate in necessary organisational change
Appendix D

Findings and recommendations from Zircadian consulting’s overview of postgraduate curricula

1. Throughout the review the relative importance of the generic themes already contained in the Common Competency Framework for Doctors (CCFD) and the Medical Competency Leadership Curriculum (MLCF) were discussed.

2. A list of the generic competences considered to be most important by the various interviewees was formed. This is not an exhaustive list, rather a summary of the main themes raised during the interviews, and includes some of the themes that are already contained in the CCFD or MLC.

3. In addition to the general professional skills, the list also covers some of the generic clinical skills considered important by interviewees.

Generic Clinical Skills:

- Management of the acutely ill patient;
- Chronic disease management and the management of co-morbidities;
- Safe prescribing;
- Promoting patient decision making and patient self-care; and
- Dealing with psychological problems/difficult patients/difficult family members.

Management:

- Quality and safety of care – personal and professional responsibilities;
- The concept of Quality, Improvement, Productivity and Prevention (QUIPP) and its practical application in the NHS;
- Understand how different health systems operate and function;
- Understanding systems based care – the bigger picture of healthcare, team working, liaison with other sectors, quality improvement, advocate for individual patient and populations as a whole;
- Budget management: service cost and efficiency;
- Change management;
- Clinical governance;
- Revalidation;
• Chairing meetings;
• NHS structure;
• Project management; and
• Managing people and supporting self-development in others.

Patient Safety Agenda:
• Research and evidence based practice – how to find and use the clinical evidence base to promote safe practice;
• Learning from ‘near misses’;
• Documentation;
• Safe prescribing;
• Audit;
• Patient-centred care and negotiation of risk; and
• Child protection and safeguarding/vulnerable adults.

Leadership:
• Theories of different types of leadership, including ‘shared’ leadership and an understanding of ‘followership’;
• Implementing change;
• Critical evaluation of a service;
• Healthcare as a business and learning to take responsibility to be head of the service;
• Service development/ service improvement;
• Crisis leadership; and
• Engaging the patients and public.

Communication:
• Communication and team working;
• Inter-professional communication;
• Patient communication;
• Dealing with conflict and negotiation skills;
• Active listening; and
• Team working.

Personal behaviour:

• Ethics and professional practice;
• Understanding of how to influence others: Neuro-linguistic programming (NLP) and Emotional Intelligence (EI);
• Knowing oneself – personality profiling;
• Management of work/life balance;
• Professional conduct and probity;
• Prioritisation;
• Decision making in difficult situations;
• Time management;
• Responsibility for Continuous Professional Development (CPD);
• Responsibility for life-long self-directed adult learning – setting objectives, finding learning opportunities, developing skills;
• Learning to be a teacher and trainer;
• Learning to be a mentor and a coach;
• Presentation skills; and
• Career management – flexible/portfolio career development.

Recommendations

3. Zircadian made the following recommendations:

Recommendation 1: This project has highlighted the variance in the style of inclusion of the generic competences from the CCFD and the MLC in the curricula. The GMC may wish to engage individual Royal Colleges, particularly where this independent review has been unable to identify elements of the CCFD and MLC in curricula, to identify how they have included the competences and, where revisions are required assist and advise the Royal Colleges in making these revisions.

Recommendation 2: The GMC should continue to advise the Royal Colleges that at least a basic level for each generic competency (as listed in the CCFD and MLC) is included within every curriculum and that this inclusion should be quality assured with curriculum reviews. Quality assurance of these curricula, in terms of inclusion of
the generic competences, can now be facilitated by the database tool developed during this project. Consequently future versions of curricula may now be more easily assessed.

**Recommendation 3:** The GMC may wish to undertake a project to investigate how the CCFD and the MLC could be further developed into one document for use by all the Royal Colleges in producing their curricula. This would serve to collate all the generic competences including leadership, whilst also avoiding duplication. In addition the language used to describe these competences could be rationalised to allow for greater understanding by the profession – trainees and trainers alike. As an alternative option the GMC could ask the Royal Colleges to map the generic competences in their curricula to the CCFD and the MLC (if this has not already been done).

**Recommendation 4:** The GMC may wish to undertake a project to further review the assessment methods currently used by the Royal Colleges in order to clarify how the generic competences can most effectively be assessed. Interpersonal skills are an example of competences which would benefit from a review of assessment methods. The current work taking place within the Royal Colleges and other stakeholders regarding assessment methods for generic skills should be investigated and shared.

**Recommendation 5:** The GMC should encourage the Royal Colleges to present their curricula in a concise and user-friendly fashion. Indeed we would recommend further development by all the Royal Colleges of web-based curricula that link to the assessments and e-portfolio.

**Recommendation 6:** The GMC should promote the importance of the role of key stakeholders involved in medical education to ensure that generic competences are comprehensively included in all curricula.

**Recommendation 7:** The GMC should ensure that all the generic competences, including leadership skills, are incorporated into the curricula from undergraduate to post certification. These skills can be approached in a spiral fashion and re-visited at progressively more advanced and complex stages. In order to successfully achieve this there must be considerable co-operation between undergraduate and postgraduate medical education stakeholders.

**Recommendation 8:** The GMC may wish to undertake a project in association with key stakeholders to develop more detailed and specific level descriptors for the generic competences at each transition stage (undergraduate/postgraduate, foundation/core, core/specialty, specialty/post CCT) to help support these transition periods.

**Recommendation 9:** The GMC could host a symposium for key stakeholders to discuss the generic competences, the language used to describe them and the format to best present and describe them in curricula.
**Recommendation 10:** In order to clarify the end-point of training, in terms of common competences and leadership skills the GMC may wish to undertake a project to develop a specific guidance document that defines the outcomes of postgraduate medical education in terms of these generic competences—‘Tomorrow’s Senior Doctor’.

**Recommendation 11:** The GMC may wish to request that the Royal Colleges make further consideration regarding trainers in terms of how they are selected and how they may be further supported to deliver training and support to trainees in developing generic competences.

**Recommendation 12:** The GMC may wish to engage with the Royal Colleges to produce supplements to their curricula which will contain additional information and examples of how to achieve the generic competences in the work-place e.g. ‘Guide to service improvement projects and how to do them’.
## Appendix E

### Mapping of generic outcomes

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<td>Evidence and guidelines</td>
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<td>Teaching and training</td>
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<td><strong>Personal attitudes and behaviour</strong></td>
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<td>Personal behaviour</td>
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<td><strong>Management and leadership</strong></td>
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<td><strong>FPC additional areas</strong></td>
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<td>CCFD</td>
<td>FPC</td>
<td>MLCF</td>
<td>MLC</td>
<td>AMC</td>
<td>CanMEDS</td>
<td>Zircadian</td>
<td>Linked to GMP?</td>
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<td>Risks of fatigue, ill health and stress (to self)</td>
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**CCFD**

We have used the competences listed in the AoMRC’s [Common Competences Framework for Doctors](#) (CCFD) as a comparison as it is designed to identify the common competences that should be acquired by doctors in core and specialty training in the UK.

**FPC**

The CCFD and [Foundation Programme Curriculum](#) (FPC) are quite similar in structure and content – the FPC was used to help compile the CCFD list. There are some differences as the FPC is set at foundation level.

**MLCF**

The [Medical Leadership Competency Framework](#) (MLCF), developed jointly by the AoMRC and NHS Institution for Innovation and Improvement, focuses specifically on the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

- It is mainly about team working, leadership and planning skills, there is little on clinical skills.
- It also gives examples of meeting the competences at the level of undergraduate, postgraduate and continuing practice, which is a different approach to the CCFD and FPC. It also applies to dental surgeons.

**MLC**

The [Medical Leadership Curriculum](#) (MLC), also developed jointly by the AoMRC and NHS Institution for Innovation and Improvement, is based on and developed from the MLCF. The competences are the same in the MLCF, but the focus is on the knowledge, skills, attitudes and behaviours to be formally achieved and consolidated as the doctor progresses through postgraduate training. It was designed to be integrated into the different specialty curricula.

**AMC**

- The [Australian Medical Council](#) (AMC) is consulting on a draft standards framework for intern training (equivalent to foundation year 1). The table refers
to this document – draft Intern Global Outcome Statements. The consultation closes on 17 December 2012. It is structured as four domains, which are very similar to the outcomes for graduates in *Tomorrow’s Doctors*.

**CanMEDS**

*CanMEDS 2005 Physician Competency Framework* is produced by the Royal College of Physicians and Surgeons of Canada (RCPSC). The competences are for trainees and practising doctors. The competences are organised into seven roles: Medical expert; Communicator; Collaborator; Manager; Health advocate; Scholar; and Professional.

**Zircadian**

The *Zircadian research report* produced in Feb 2011 looked through all 95 specialty and sub-specialty curricula and interviewed key stakeholders to define the generic outcomes of postgraduate training – the commonalities and generic competences (clinical and non-clinical) – that should be incorporated into all specialty curricula. The approved curricula already contain generic competences drawn from the CCFD and the MLC. One of the project phases consisted of interviewing senior representatives from the AoMRC, COPMeD and UKFPO, and with trainees/newly qualified consultants and GPs – they were asked what generic competences they considered to be most important. The table indicates the result.

**Linked to GMP?**

The *GMP Framework for appraisal and revalidation* is based on the current version of *Good Medical Practice* (GMP). The draft GMP 2012 sent out for consultation earlier this year is also structured around the same four domains:

- Domain 1 - Knowledge, skills and performance
- Domain 2 - Safety and quality
- Domain 3 - Communication, partnership and teamwork
- Domain 4 - Maintaining trust

We have indicated which domains each competency relates to in the table. The revised version of GMP is due to be published early in 2013.