Modernising
The New Doctor

GMC Consultation on the
Review of PRHO Training
Contents

Introduction A3

Summary of Consultation Issues A5

The Consultation Process A5

Section 1 A7
  Background to the PRHO Review

Section 2 A9
  The Key Issues
  Outcomes A9
  The period of PRHO training A9
  Three months in medicine and three months in surgery? A13
  The nature of the assessment used to determine whether the outcomes A14
  have been met
  Responsibility for the PRHO Year A15
  Issues relating to the health and conduct of PRHOs A16
  Legislation A17
  Quality assurance A18
  Transition A18

Section 3 A19
  Equality and Diversity Implications

Section 4 A20
  List of Questions

Appendix 1 A20
  The New Doctor

Appendix 2 A20
  Legislation Proposals
Introduction

1. The GMC’s main objective in exercising its functions is to protect, promote and maintain the health and safety of the public. The GMC’s Education Committee has the general function of promoting high standards of medical education and co-ordinating all stages of medical education.

2. The GMC’s Education Committee has a specific statutory duty to determine the patterns of experience which may be recognised as suitable for general clinical training for the purposes of the practice of the medical profession leading to full registration. This means that the Committee is responsible for deciding what PRHOs should do, and where and for how long they should do it, before PRHOs can be granted full registration.

3. The current edition of The New Doctor sets out our recommendations for PRHO training. It was published in April 1997. These recommendations set out what the GMC expects of UK graduates before they are granted full registration. The recommendations are framed within an experience-based legislative structure.

4. In April 2002, the Education Committee began a major review of the PRHO year. Proposals resulting from this review are set out in this document.

5. In August 2002 the Department of Health in England published Unfinished Business. In February 2003 the four UK Health Ministers launched Modernising Medical Careers. Both documents foresaw the establishment of a two year Foundation Programme that incorporated the PRHO year and the first year following full registration.

6. We have worked closely with all four Departments of Health to ensure the effective parallel development of the new edition of The New Doctor and the introduction of Foundation Programme envisaged by Modernising Medical Careers.

7. We are also conducting a wider review on routes to registration and the introduction of licences to practise. The proposals in this paper are consistent with the ideas emerging from this wider review.

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1 Section 5(2)(c) of the Medical Act 1983
8. Some of the issues that we are consulting on require a change to the current legislative framework. We have an opportunity to pursue this during 2004. For this reason, we are proposing changes to the legislation now. These changes will not prejudice any of the issues in the consultation. The changes will allow the Education Committee to be more responsive to change. The changes will ensure that the Education Committee remains accountable.

9. We have illustrated in relevant sections where changes in the law might be required. These are set out in more detail in *Modernising Legislative Policy – Principles for Change* at Appendix 2.
Summary of Consultation Issues

10. There are nine main areas on which we would appreciate your views. These are:

   a. Outcomes – nature, content and measurability.
   b. The period of PRHO training.
   c. Whether we should retain the requirement that all PRHOs spend at least three months in medicine and three months in surgery.
   d. The nature of the assessment to be used to determine whether the outcomes have been met.
   e. Responsibility for the PRHO year.
   f. Issues relating to the health and conduct of PRHOs.
   g. Legislation.
   h. Quality assurance.
   i. Transition.

The Consultation Process

11. This paper is published on our website. It has also been sent to a number of different organisations including:

   • Consumer bodies and patient organisations.
   • Groups representing students, doctors in training and doctors generally.
   • UK Higher Education Institutions.
   • Postgraduate deaneries.
   • Other health professional bodies.
   • UK Health Departments.
   • NHS employers.
   • Professional bodies and associations.
   • Academy of Medical Royal Colleges.

12. Individuals and organisations are invited to submit comments on any of the issues covered in this paper. Your comments are requested by 30 April 2004. They should be sent to:
Fiona Browne
Policy Advisor
Education and Development
General Medical Council
178 Great Portland Street
London
W1W 5JE

Tel: 020 7344 3967
Fax: 020 7915 3599

Email: TND@gmc-uk.org
SECTION 1

Background to the PRHO Review

13. The current PRHO training framework is experience-based. PRHOs are required to spend 12 months in house officer posts approved by their University. At least three months must be spent in a surgical house officer post and at least three months must be spent in a medical house officer post.4

14. In 1993, we moved to an outcomes-based approach in our recommendations on undergraduate training - *Tomorrow’s Doctors*. This move has been successful. It has enabled and encouraged diversity in the way that undergraduate medicine is approached.

15. We have confined our requirements to the outcomes that need to be demonstrated by students. The detailed design of the curriculum and the way in which students are assessed has been left, subject to quality assurance arrangements from the GMC, to the medical schools to develop.

16. By enabling diversity, the medical schools have been able to be innovative in the design of their curricula, delivery and assessment.

17. We would like to introduce a similar system for PRHO training. Rather than specify periods of experience or lists of tasks in which a PRHO should be trained, we would like to define the outcomes that a PRHO must demonstrate.

18. We accept that a move from an experience-based system to one that concentrates on outcomes may not be straightforward. But we believe that it will provide greater flexibility and more opportunity for innovation.

Goals and Principles

19. In undertaking the review of PRHO training, our goals have included:

   a. Ensuring that there is an educational continuum between undergraduate medical education, the Foundation Programme and postgraduate medical training.

   b. Identifying the added value of PRHO training to a medical graduate.

   c. Applying modern educational principles to PRHO training.

20. Our principles have been:

   a. The GMC’s main objective, set by the Medical Act, is to protect, promote and maintain the health and safety of the public.

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4 Sections 10(2) and 10(3) of the Medical Act 1983 and The Medical Act (Certificates of Experience) Regulations 1999
b. The GMC should provide a clear set of outcomes to be met by medical graduates before being granted full registration.

c. A new legislative framework is necessary to enable the Education Committee to respond quickly and effectively when change is required.

d. Those bodies involved in PRHO training must be given the freedom to design effective and innovative training programmes which meet the outcomes set out in *The New Doctor*.

e. The GMC should provide a platform at full registration that the Foundation Programme can build upon.

f. A system of quality enhancement is necessary to ensure that PRHO training is effective and to provide a mechanism to allow the aspirations of contemporary society to be met and good practice to be disseminated and fed into improved standards.

**Questions**

*Q1 Are our goals and principles appropriate to our review?*

*Q2 What goals and principles have we not included?*
SECTION 2

The Key Issues

Outcomes

21. We believe that there is general support for a proposed move in PRHO training from an experience-based model to an outcomes-based one. Such a move:

a. Would allow us to reflect current educational principles.

b. Would allow us to widen access to medicine for doctors with disabilities by specifying outcomes that are necessary for modern practice rather than types of experience that are frequently useful.

c. Would allow the Education Committee to determine what doctors must actively demonstrate rather than a more passive approach determining what posts PRHOs should occupy, and for how long, and directing what a PRHO should learn whilst in those posts.

22. The outcomes we propose are set out in the draft version of The New Doctor set out at Appendix 1.

Questions

Q3 Do you endorse a move from an experience-based model to an outcomes-based model?

Q4 Are the outcomes required for The New Doctor (Appendix 1) appropriate and measurable?

The period of PRHO training

23. The current period of PRHO training is specified as one year. The move to an outcomes-based approach means we need to examine whether this period remains appropriate.

What is the purpose of a period of PRHO training?

24. PRHO training enables a medical graduate to consolidate knowledge, skills and attitudes learned as an undergraduate. It also provides an opportunity to develop and demonstrate knowledge, skills and attitudes expected from a fully registered doctor.

25. We are also bound by European legislation which requires, amongst other things, that for the purposes of full registration, doctors must have

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5 Schedule 1 to The Medical Act 1983 (Certificates of Experience) Regulations 1999
undertaken a six year course or 5500 hours of theoretical and practical instruction. Our legislative framework currently assumes that the PRHO year is part of this period of training.

26. There are four options for the period of provisional registration. These are:

   a. No period of provisional registration.
   b. Minimum period of one year.
   c. Minimum period of two years.
   d. None of the above – full registration should be granted when outcomes are achieved.

27. There is a related question: should we be able to set a maximum period of provisional registration?

No period of provisional registration

28. Some have argued that we should simply abolish the PRHO year. Medical graduates would be able to move straight to full registration. This would enable them to commence specialist training immediately and function as fully registered doctors with the attendant rights and privileges.

29. Our PRHO review group considered the effect of the European Directive. Currently our legislation is drafted on the assumption that a PRHO year is required to fulfil our obligations under the Directive. The Directive requires that basic medical training consists of six years or 5500 hours of theoretical and practical instruction.\(^6\) We think that it is theoretically possible for the Directive’s requirements to be met solely at undergraduate level.\(^7\) We recognise that further work may be required in this area to ensure that all undergraduate medical courses met this requirement.

30. We have considered carefully the purpose of the PRHO year. In particular, we have concluded that PRHO training enables a medical graduate to consolidate knowledge, skills and attitudes learned as an undergraduate. It provides space and an opportunity to demonstrate knowledge, skills and attitudes expected from a fully registered doctor in the workplace before being given the responsibility of a fully registered doctor. During this time, other doctors will be aware that PRHOs are putting their knowledge, skills and

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attitudes into practice for the first time. They will take this into account when delegating duties to PRHOs in accordance with Good Medical Practice.\(^8\)

31. We do not think that removing the PRHO period altogether would provide adequate safeguards to patients. Indeed, this conclusion was reached in our wider consultation on the Review of the Routes to Registration.

Minimum period of one year

32. The benefits of a fixed minimum period of PRHO training would relate to certainty in the delivery of service. We recognise that although primarily providing training posts, PRHO training is delivered in a work based environment. Patient safety demands that posts be filled as far as possible for a fixed period of time to enable replacements to be planned and to ensure continuity in the care of patients.\(^9\)

33. A minimum period of one year would enable the educational supervisor sufficient time to make and collate a robust assessment of consistent performance in the workplace with its attendant demands during PRHO training whilst preparing PRHOs for practice as fully registered doctors.

34. The Foundation Programme is two years. A move to full registration part way through the Foundation Programme would enable a further consolidation period with all the rights and privileges of full registration gained in a well rounded environment which could in due course count towards specialist training.

Minimum period of two years – coterminous with the duration of the Foundation Programme

35. This option would be the easiest to administer. It would reduce the number of assessments required. It would require a summative assessment at the end of the Foundation Programme and would combine determination for full registration with eligibility for basic specialist training.

36. However, this option would delay full registration for a further year. There is no evidence to suggest that the majority of PRHOs require longer than a year of PRHO training. It would also remove the advantage of having a progressive change to full registration part way through the programme.

37. The Department of Health has indicated that: ‘The Postgraduate Medical Education and Training Board (PMETB) will in due course be able to assess whether the training in the post-registration sections of Foundation Programmes can be counted towards completion of general practice or

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\(^8\) General Medical Council, Good Medical Practice, paragraph 46 which states: ‘…When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy provided…’.

\(^9\) Our publication, Good Medical Practice, reflects this principle. At paragraph 41 it states: ‘You must take up any post, including a locum post, you have formally accepted unless the employer has had adequate time to make other arrangements.’
specialist training programmes and, hence, the award of a Certificate of Completion of Training (CCT).\(^{10}\) This would not be an option if full registration did not occur until the end of the Foundation Programme.

None of the above – full registration should be granted when the PRHO achieves all the outcomes set out in *The New Doctor*.

38. This is the most educationally appropriate option. It recognises the reality that some PRHOs will be able to demonstrate the specified outcomes more quickly than others.

39. Nevertheless, in practice, this option might be difficult to manage as jobs may be left vacant at different times. This could impact on patient safety as there would be no continuity of care for patients.

A maximum period of provisional registration

40. The Education Committee do not currently have a power to set a maximum period of registration. In our *Modernising Legislative Policy – Principles for Change* at Appendix 2 we suggest that the Education Committee should have a discretionary power to be able to set a maximum period on provisional registration.

41. This might take two forms. First, a period could be set from the date of graduation within which all outcomes must be met. Second, a period could be set starting at the commencement of PRHO training within which all outcomes must be met.

42. There are advantages to this proposal. It would ensure that the knowledge, skills and attitudes learned as an undergraduate would be reinforced and would be put into practice before they become out of date. It would also provide a flexible mechanism enabling the point of full registration to be between the end of the first and the end of the second year of the Foundation Programme. In this sense, it would ensure that the grant of full registration is closely related to ability to take on this responsibility. It would also enable us to ensure that doctors without the ability to proceed to full registration would lose their entitlement to provisional registration after a period of time.

43. However, we recognise that without careful checks and balances, doctors who were unable to work full time, perhaps through sickness, or due to care arrangements, could be significantly disadvantaged.

44. In order to combat these potential difficulties, we favour a model which would enable those responsible for assessing PRHO training to make a recommendation to us to extend the period of provisional registration. Along

\(^{10}\) See the FAQ section of the *Modernising Medical Careers* website at http://www.mmc.nhs.uk/faq.asp#10 See also European Directive 93/16 Article 3l at http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=EN&numdoc=31993L0016&model=guichelt
with this power would be the responsibility to ensure that PRHOs who were not able to demonstrate the required knowledge, skills and attitudes, despite appropriate support, would not be allowed to proceed to full registration.

45. We have indicated that we neither favour a move straight from graduation to full registration nor a provisional registration period of two years. We think that the period of PRHO training should rest on the time when the outcomes are achieved. To make this practicable however it may make sense to give an indication of a year as the minimum period in which it will take place.

46. We propose to change the Medical Act 1983 to allow the Education Committee to make regulations specifying the maximum and minimum periods of PRHO training.

Questions

Q5 Should there be a period of PRHO training? Why?
Q6 How long should the period of PRHO training be?
Q7 Should there be a power to impose a maximum period of provisional registration?

Three months in medicine and three months in surgery?

47. The current legislative framework is experience-based. It requires PRHOs to spend at least three months in a medicine post and at least three months in a surgery post.\(^{11}\) It is also possible to spend a maximum of four months in a general practice placement.

48. Moving to an outcomes-based framework will require an assessment of how the outcomes have been demonstrated. This means that we may not need to determine where and how those outcomes should be met.

49. Removing the experience requirements would enable those responsible for delivery of PRHO training to have the flexibility to design broad based programmes whilst still delivering the outcomes expected at the completion of PRHO training set out in *The New Doctor*. This could lead to innovations and improvements in the way that PRHO training is delivered which could ultimately be reflected in better patient care. Removing experience requirements would remove some unnecessary barriers to medical practice for doctors with disabilities. For example, PRHOs may be able to satisfy the outcomes but not be able to complete satisfactorily a period of three months in surgery.

\(^{11}\) Section 10(3)(a) of the Medical Act 1983 and Rule 2 of The Medical Act 1983 (Experience before Full Registration) Regulations 1999
50. Nevertheless, an important part of being a PRHO however will still relate to the experience obtained in different aspects of medicine. We believe that this needs to be achieved through the definition of appropriate outcomes. Rather than requiring practice in branches of medical practice, we think it might be better to require practice using particular types of knowledge and skills. For example, it could be helpful to require PRHOs to have experience of emergency medicine and of treating the acutely ill, rather than specifying so many months in medicine or surgery.

51. Our proposals for a more responsive and less rigid legislative framework suggest that the requirement for us to prescribe which branches of medicine a PRHO must undertake be removed. It should be replaced with a discretionary power to prescribe such branches of medicine. This would enable us to respond effectively to the results of this consultation in this area. We also suggest that the Education Committee have the power to make recommendations with respect to the nature, content and standard of PRHO training. This will enable us to facilitate all strategic changes discussed in this section.

**Questions**

**Q8. Should we move away from requiring practice based on experience of specified branches of medicine towards practice using specified knowledge, skills, attitudes and behaviours?**

*The nature of the assessment used to determine whether the outcomes have been met.*

52. Movement to an outcomes-based model requires robust and reliable assessment to ensure that those outcomes are met by PRHOs in the workplace. This is important educationally and also because successful completion of the PRHO year will result in the grant of full registration.

53. There are three broad ways of doing this:

a. Through a UK wide exam (perhaps an extension of the PLAB test).

b. Through in-training assessment. This would enable those responsible for training to design and implement their own assessment schemes which would be subject to quality assurance by the GMC. This is analogous to the successful system in place in respect of undergraduate training.

c. A hybrid model using in-training assessment for all PRHOs subject to quality assurance by the GMC combined with a UK-wide
exam for any PRHOs who do not demonstrate through their in-training assessment that they have met the outcomes of training.

54. The advantages of using an examination are simplicity and consistency between UK and overseas registrants. However, this may not assess the ability of a PRHO to deliver on a daily basis in the working environment.¹²

55. The advantages of using in-training assessment is the idea that this can more easily assess professional attributes and do so over a period of time. While it may be more difficult to demonstrate consistent standards amongst PRHOs, collaboration between those responsible for work based assessment would enable them to demonstrate consistency whilst still delivering appropriate assessment methods.

56. This third model is a hybrid. It was conceived as an answer providing an effective screening mechanism for PRHOs who are not fit or able to deliver the standards expected for full registration.

57. Our preference is for a model that clarifies responsibility for designing and making assessments which would take place locally, subject to the quality assurance of the GMC. We do not underestimate the challenges of delivering a system of this sort. But we also do not underestimate the advantages of a system in respect of innovation and diversity.

Questions

Q9 What is the purpose of assessment during PRHO training?

Q10 What is the best model for assessment of PRHOs to demonstrate that they can put into practice the knowledge, skills, attitudes and behaviours learned as an undergraduate and during the PRHO period?

Responsibility for the PRHO year

58. The Medical Act specifies that responsibility for managing the PRHO year rests with the universities.¹³ In practice, many of the universities have delegated the operation of this to postgraduate deans. This has resulted in some statutory and organisational confusion. We want to resolve this confusion to make statutory and organisational responsibilities clear. There are a number of ways in which this could be achieved:

59. The current position could be confirmed. The universities would retain responsibilities. This may require some legislative tidying in order to remove certain anomalies (such as that which leaves unclear the universities’ legal responsibilities with respect to PRHOs, who are not formally their students). The advantage of this approach is that universities should be able to tailor

¹² In 2002, 44% of new registrants obtained their medical degree overseas, 42% of new registrants obtained their medical degree in the United Kingdom and 14% of new registrants obtained their degree within the EEA. GMC, Medical Register
¹³ Section 10(3) of the Medical Act 1983
PRHO training to that provided by their medical school in undergraduate medical education, thereby retaining an educational continuum. On the other hand, differences in the use of assessment tools and documentation between one university and another could create difficulties for educational supervisors who have to supervise PRHOs from several medical schools.

60. Alternatively, responsibility could be removed from the universities and passed to the postgraduate deans. Already universities commonly delegate their responsibility for the PRHO year to postgraduate deans. Nevertheless, there would be significant resource issues to resolve. We would also need to ensure that the postgraduate deans had sufficient powers to enable them to carry out this responsibility.

61. We could operate a mixed economy whereby different organisations are approved by the GMC to be suitable deliverers and assessors of PRHO experience. These organisations would be listed in legislation individually. This is analogous to the position for undergraduate training.

62. The European Directive requires that basic medical training, which must consist of six years or 5500 hours of theoretical and practical instruction, must be under the supervision of a university. This means that we must be sure that the requirements of the Directive can be delivered at undergraduate level before being able to change the current position. We know that this is theoretically possible, but recognise that this might not be delivered in practice at the moment.

63. We believe that whatever body is responsible for PRHO training, it is important that:
   a. They are clearly responsible and accountable for doing so.
   b. They have adequate resources and determination to design and deliver quality training.

Questions

Q11 Which organisation should be responsible for PRHO training and how should that responsibility be defined?

Q12 If the organisation you recommend was given responsibility for PRHO training, what would the resource implications be?

Issues relating to the health and conduct of PRHOs

64. Currently, if PRHOs are by reason of lasting physical disability prevented from embarking on or completing prescribed experience requirements, such as three months medicine and three months surgery, they

must make an application to the Council for a direction as to the experience that must be undertaken by the PRHO. If these experience-based requirements are abolished, there will be no need for PRHOs with a disability to make an application to the Council. Our position could be that provided PRHOs meet the outcomes set out in *The New Doctor*, they will be able to complete PRHO training. There would be no need to make a separate application to us for approval.

65. This position would enable those with responsibility for training to be responsible for developing the ways in which PRHOs with disabilities can meet the outcomes.

**Questions**

Q13 Do you support the principle that provided PRHOs can meet the outcomes set out in ‘The New Doctor’, there is no requirement for the General Medical Council to approve training programmes for PRHOs with disabilities? Why?

Q14 Is the section on PRHO health and conduct in the attached draft of ‘The New Doctor’ at paragraphs 76 to 94 helpful and appropriate?

**Legislation**

66. Our PRHO review has shown that the legislative framework for PRHO training is restrictive and slow to change. Much of the detail is contained in the Medical Act 1983. We have touched on this issue throughout this paper. More detailed proposals are attached at Appendix 2 dealing with our proposed changes to legislation. These changes do not in any way prejudice the issues that we are consulting on in this paper. On the contrary, the legislative changes proposed would allow us to respond more effectively to the responses received to our consultation. They would also allow the Education Committee to be more responsive to change, when this is required in the future.

**Questions**

Q15 Do you support the principles that underpin our legislative framework set out in paragraph 15 of ‘Modernising Legislative Policy – Principles for Change’ at Appendix 2?

Q16 Do you think that the issue of responsibility should be set out in primary legislation (as it is now) or should it be something that the Education Committee can make regulations on?
Quality assurance

67. We recognise that we will need to ensure that we put in place robust quality assurance mechanisms to ensure that processes are in place to ensure that PRHOs meet the outcomes set out in *The New Doctor*. We recognise that further work will be required in this area when we have decided on the major strategic issues set out in this paper. We will consult further on the quality assurance and quality enhancement processes that we develop.

Transition

68. We also recognise that a move to an outcomes-based approach would require a period of transition. Time would be needed to design PRHO training in the context of the Foundation Programme. Time would be needed to design effective assessment methods to ensure that outcomes are met. During this time it may be necessary to retain the experience-based framework.

69. We propose, therefore, that the transition period would be a period of three years. Those responsible for delivering PRHO training are already designing and piloting Foundation Programmes along with appropriate assessment mechanisms. To facilitate this process, we have shared the new version of *The New Doctor* with these groups in draft.

70. We propose to work to the following timetable:

a. Summer 2004 – Department of Health publishing consultation document on new Section 60 Order effecting proposed legislative changes.


d. 2006 – conclusion of transition period – activating new legislation to give effect to a new framework.

Questions

Q17 If a change to an outcomes-based approach is confirmed, how long would a transition period need to be?
SECTION 3

Equality and Diversity Implications

71. There are equality and diversity issues arising from the proposed recommendations resulting from our primary objective to protect the health and safety of the public.

72. Individuals from all sectors of society should be encouraged and supported to enter and to complete medical training. We have sought to include the core outcomes that are expected from a doctor who has completed PRHO training. We are consulting on the removal of process requirements that may disproportionately affect PRHOs with disabilities.

73. *The New Doctor* requires that those responsible for recruiting to PRHO training put in place valid, reliable, open, objective and fair selection procedures to make sure that they recruit the candidates regardless of ethnicity, socio-economic background, culture or disability.

74. In developing PRHO training, we will seek to identify opportunities for universities and their NHS partners to widen participation and to provide all candidates with the support and encouragement they need. We will consider whether there are any specific equality and diversity issues that should be addressed in the new guidance and in the quality assurance arrangements that we put in place to support its implementation.

75. In our informal discussions, we have sent our draft to equality and diversity experts and organisations. We have sought to include patient and public groups. We have consulted with interprofessional organisations as well as medical professional organisations and service interests. We hope to consider their comments in detail and have offered to meet to gain a clear understanding of implications for all those interested in PRHO training.

**Questions**

**Q18** Do the proposals described in this paper meet our commitment to equality and diversity?

**Q19** Do the proposals in the draft of *The New Doctor* meet our commitment to equality and diversity?

**Q20** If not, what other steps might we take to achieve this?

**Q21** Are there groups for whom these proposals would have an adverse effect?
SECTION 4

List of Questions

Goals and principles

Q1 Are our goals and principles appropriate to our review?
Q2 What goals or principles have we not included?

Outcomes

Q3 Do you endorse a move from an experience-based model to an outcomes-based model?
Q4 Are the outcomes required for The New Doctor (Appendix 1) appropriate and measurable?

The period of PRHO training

Q5 Should there be a period of PRHO training? Why?
Q6 How long should the period of PRHO training be?
Q7 Should there be a power to impose a maximum period of provisional registration?

Three months in medicine and three months in surgery?

Q8 Should we move away from requiring practice based on experience of specified branches of medicine towards practice using specified knowledge, skills, attitudes and behaviours?

The nature of the assessment used to determine whether the outcomes have been met.

Q9 What is the purpose of assessment during PRHO training?
Q10 What is the best model for assessment of PRHOs to demonstrate that they can put into practice the knowledge, skills, attitudes and behaviours learned as an undergraduate and during the PRHO period?

Responsibility for the PRHO year

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Q12 If the organisation you recommend was given responsibility for PRHO training, what would the resource implications be?
Issues relating to the health and conduct of PRHOs

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Q16 Do you think that the issue of responsibility should be set out in primary legislation (as it is now) or should it be something that the Education Committee can make regulations on?

Transition

Q17 If a change to an outcomes-based approach is confirmed, how long would a transition period need to be?

Equality implications

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Q20 If not, what other steps might we take to achieve this?

Q21 Are there groups for whom these proposals would have an adverse effect?