5 – Outcome of Consultation on Review of *Tomorrow's Doctors* – Annex C

Impact Assessment: Review of *Tomorrow's Doctors*

1. A draft impact assessment was included in the documents published for the consultation on the 2009 edition of *Tomorrow's Doctors*. This version reflects the response to the consultation.

2. This version refers to the 'July 2009' draft of *Tomorrow's Doctors*, the text to be considered by the Council of the GMC on 8 July 2009.

Step 1 – Define the problem or opportunity

3. The General Medical Council's role in regulating medical education is defined by the Medical Act 1983 (as amended).

4. This states at Section 5 that we have the 'general function of promoting high standards of medical education and co-ordinating all stages of medical education'. In particular, we:

> 'determine the extent of the knowledge and skill which is to be required for the granting of primary United Kingdom qualifications and secure that the instruction given in or under the direction of bodies or combinations of bodies in the United Kingdom to persons studying for such qualifications is sufficient to equip them with knowledge and skill of that extent' (S. 5(2)(a))
>
> 'determine the standard of proficiency which is to be required from candidates at qualifying examinations and secure the maintenance of that standard' (S.5(2)(b))

5. The 'extent of the knowledge and skill' and the 'standard of proficiency' are set out in GMC documents, in a series now known as *Tomorrow's Doctors*. *Tomorrow's Doctors* was last published in 2003. Since then, several developments and new sources of information and analysis have led to the review of *Tomorrow's Doctors* with the intention of publishing a new edition in 2009.

6. The GMC ensures that the standards in *Tomorrow's Doctors* are met through its Quality Assurance of Basic Medical Education (QABME) which reviews medical schools and leads to the publication of reports on their compliance with the standards.

7. This impact assessment is focused on the main themes for the review of *Tomorrow's Doctors* with potentially significant impact:

a. Prescribing and patient exposure.

b. Professionalism and leadership.

c. Assessment.

d. Quality management.

e. Student Selected Components.

8. The impact assessment ends with sections on equality and diversity and on privacy considerations.

9. In considering our approach, we have faced a choice between:

a. Doing nothing – keeping the 2003 edition of *Tomorrow's Doctors* in force.

b. Introducing amendments to the text of the 2003 edition.

c. Preparing a new edition, building on the foundation of previous editions but informed by recent developments and information.

d. Pursuing other options such as a national examination near the start of medical practice, a UK-wide register of medical students and a strategy fully to engage students in professional and regulatory matters.

10. In considering this choice, we have been mindful of the major developments in medical education and training and in health care since the 2003 edition was drafted as well as the information and analysis that have emerged in this period. This context has effectively ruled out doing nothing and has cast severe doubt on the adequacy of amending the 2003 edition. We have looked carefully into the options of a national examination and a student register but are not actively pursuing these currently. However, the GMC, with support from PMETB, has commissioned a review of the regulation of medical education and training in the light of the forthcoming merger of PMETB with the GMC. The outcomes of that review, which is being led by Lord Naren Patel, will inform regulatory policy going forward. In the meantime, we have concluded that a student engagement strategy is important and hope that such a strategy, sitting alongside a new edition of *Tomorrow's Doctors,* will help to address the current concerns particularly about the consistency of assessment and students' commitment to professional values.

Step 2 – Identify the desired outcome

11. The GMC's educational functions, and in particular the review of *Tomorrow's Doctors*, contribute to the achievement of the GMC's main objective as defined by the Medical Act 1983: 'to protect, promote and maintain the health and safety of the public'.

12. The GMC's Business Plan sets out its current activity in light of that main objective. Key Aim One of the GMC's 2009 Business Plan is: 'To develop, promote and assure the quality of all aspects of basic medical education in the UK up to the point of full registration'. More specifically, we undertook to: 'Consult on and publish a fully revised edition of *Tomorrow's Doctors*, setting out the standards, knowledge, skills, and behaviours required of medical graduates and the standards required of UK medical schools'.

13. The desired outcome was defined as an edition of *Tomorrow's Doctors* published in 2009 which:

a. Contributes to the effective regulation of medical schools without avoidable burden or restriction on innovation and diversity.

b. Is fit for purpose in the changing context of medical education and healthcare.

c. Meets the needs and responds to the aspirations of the NHS and other employers of doctors and providers of health care.

d. Meets the needs and responds to the aspirations of patients and the public.

e. Is consistent with other GMC guidance including the revised editions of *Good Medical Practice* (2006) and *The New Doctor* (2007); and with standards issued by PMETB for specialist training.

f. Takes account of different landscapes from all four countries of the UK – England, Northern Ireland, Scotland and Wales.

g. Promotes equality and values diversity and human rights.

h. Underlines and reinforces the continuum of medical education and training.

i. Correctly defines outcomes necessary to be fit to practise and to be prepared for practice and Foundation Programme training.

j. Provides a solid foundation for the GMC's Quality Assurance of Basic Medical Education.

Step 3 – Analyse the Anticipated Impact

Issue 1: Prescribing and patient exposure

14. Errors in prescribing are potentially dangerous to patients. In addition to the direct impact on the patients' health, prescribing errors contribute to financial costs borne by the NHS, for example in relation to handling complaints and compensation claims and providing medical attention that would otherwise be unnecessary. In so far as prescribing errors are, or are perceived to be, due to shortcomings in undergraduate medical education including placements, they may also lead to an increased need for postgraduate medical training in prescribing to make up for these alleged shortcomings.

15. The GMC commissioned from the University of Manchester a literature review on the prevalence and incidence of prescribing errors. The team found:

> 'Prescribing errors were usually intercepted and reported by pharmacists before they caused harm (process errors) although 3% of studies reported adverse drugs events (outcome errors) and 14% of studies reported both process and outcome errors. Definitions varied widely and were often specific to the study rather than derived from prior consensus or research.' [1]

16. The research team also completed a systematic review on the causes of prescribing errors.[2]

17. The GMC then asked the research team to identify studies that linked prescribing error to medical education and training. They found four studies and concluded:

> 'There is little empirical evidence concerning the impact of educational interventions on prescribing errors in hospitals. Even when such evidence exists, education was usually part of a complex intervention including decision support and/or a quality improvement initiative. In the field of CPD, decision support has been shown to be more effective than education so we have to conclude that the value of 'just in time' education is unproven.' [3]

18. The team's empirical research into the prevalence and causes of prescribing errors, also commissioned by the GMC, is under way at the time of writing.

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[1] Penny J Lewis, Tim Dornan, David Taylor, Mary P Tully, Val Wass, Darren M Ashcroft. *The prevalence and incidence of prescribing errors: Systematic Review,* 2008

[2] Mary P Tully, Darren M Ashcroft, Tim Dornan, Penny J Lewis, David Taylor, Val Wass. *The causes of and factors associated with prescribing errors: Systematic Review, 2008.*

[3] Penny Lewis and Tim Dornan (for the EQUIP project team: Darren Ashcroft, Tim Dornan, Heather Heathfield, Penny Lewis, Jon Miles, David Taylor, Mary Patricia Tully and Val Wass), *What evidence is there that educational interventions reduce the risk of prescribing errors?*, 2008

19. It appears that there is a prevalence of prescribing error across doctors' careers, rather than solely among recent graduates. Analysis of the causes of prescribing error has not demonstrated a strong, specific link to factors in undergraduate medical education.

20. Nevertheless, the research commissioned by the GMC into the purposes of *Tomorrow's Doctors* found that educational supervisors 'express deep concern about the knowledge base of new trainees particularly in relation to basic sciences, anatomy, pharmacology and prescribing. They now sometimes have to teach content that in former times they could assume'. National figures also believe that the pendulum in undergraduate medical education has swung too far away from pharmacology and prescribing.[4]

21. Consistent findings emerged from the research commissioned by the GMC from Newcastle University, comparing the preparedness of graduates from Newcastle, Warwick and Glasgow universities:

> 'There was a consistent thread, from primary sample data throughout the year, and from triangulation data, of under-preparedness for prescribing. Weaknesses were identified both in the pharmacological knowledge underpinning prescribing, and the practical elements of calculating dosage, writing up scripts, drug sheets, etc. While there was some feeling from triangulating data that F1s were prepared for prescribing, pharmacists did identify severe gaps. Prescribing was also the main area of practice in which errors were reported by respondents, indicating a significant potential risk.'[5]

22. Prescribing has also emerged as an issue in the research commissioned by the GMC from Professor Trudie Roberts and colleagues at the University of Leeds on exploring doctors' transitions to new levels of medical responsibility. This project is in progress at the time of writing.

23. The QABME reviews of medical schools report concerns about the extent and the effectiveness of patient contact and placements, which could contribute to poor prescribing skills:

> a. Some schools do not provide students with sufficient patient contact in their early years of study. This challenge is common among those schools where there is a clear divide between pre-clinical and clinical years.
>
> b. Schools' relationships with their local health service providers pose a variety of challenges. These challenges include communication between the schools and the health service providers, ensuring a high standard of teaching quality through quality assurance mechanisms and ensuring teaching staff are aware of the curriculum and cover the appropriate parts of it.

[4] Janet Grant and Trudie Roberts, with Mairead Maxted, Dr Katharine Boursicot, Katrina Chambers, Sue Kilminster and Joanne Marshall, *An investigation of the explicit and implicit purposes in Tomorrow's Doctors and an analysis of the impact of possible environmental changes on the knowledge, skills, attitudes and behaviours required of medical graduates,* 2007

[5] Jan Illing, Gill Morrow, Charlotte Kergon, Bryan Burford, John Spencer, Ed Peile, Carol Davies, Beate Baldauf, Maggie Allen, Neil Johnson, Jill Morrison, Margaret Donaldson, Margaret Whitelaw, Max Field, *How prepared are medical graduates to begin practice? A comparison of three diverse UK medical schools*, 2008

24. In the consultation, Skills for Health carried out semi-structured interviews with 230 NHS staff across the UK. Interviewees were keen to say that some junior doctors are excellent and some respondents thought that standards were generally improving. The message from many NHS respondents was, however, that junior doctors are generally not meeting the needs and expectations of the current NHS. The main areas which were said to cause difficulties are lack of confidence and competence in clinical-decision making, clinical procedures and prescribing in practical situations, lack of understanding of the NHS and how it works, and standards of professionalism which are below those generally expected of NHS employees. In particular:

> 'Difficulties with prescribing were the most commonly mentioned way in which junior doctors are not meeting the needs of the current NHS. Some aspect of prescribing was mentioned by 65% [of] respondents. Some respondents recorded very real concern at the current standard of prescribing by junior doctors and the consequent level of risk to patients.'

25. It is worth noting however that the research commissioned by the GMC on the purposes of *Tomorrow's Doctors* suggested that concerns should not be attributed to the text of the 2003 edition:

> '*Tomorrow's Doctors* is clear in its advice about drugs and prescribing. Schools' response to this, as described in their curriculum documents, is somewhat muted. Inspectors' guidance does not, in general, pick up this point. There is considerable concern amongst students and postgraduate supervisors about prescribing skills and knowledge in new doctors which must be attributed to interpretation of *Tomorrow's Doctors* rather than following its advice systematically.'[6]

26. The July 2009 draft of *Tomorrow's Doctors* reflects the conclusions of the research commissioned by the GMC on the preparedness of graduates:

> 'The conclusion is that undergraduates' preparedness to begin Foundation Programme will be improved by having more experiential learning in clinical practice in their undergraduate programme. To do this the providers who host placements need to encourage the development of a learning culture in which all staff contribute to the development of new doctors as an explicit part of day-to-day working.'[7]

[6] Janet Grant and Trudie Roberts, with Mairead Maxted, Dr Katharine Boursicot, Katrina Chambers, Sue Kilminster and Joanne Marshall, *An investigation of the explicit and implicit purposes in Tomorrow's Doctors and an analysis of the impact of possible environmental changes on the knowledge, skills, attitudes and behaviours required of medical graduates*, 2007.

[7] Jan Illing, Gill Morrow, Charlotte Kergon, Bryan Burford, John Spencer, Ed Peile, Carol Davies, Beate Baldauf, Maggie Allen, Neil Johnson, Jill Morrison, Margaret Donaldson, Margaret Whitelaw, Max Field, *How prepared are medical graduates to begin practice? A comparison of three diverse UK medical schools*, 2008

27. Replacing the provisions of the 2003 *Tomorrow's Doctors* with the text in the July 2009 draft might require changes in the curricula at some medical schools. We have not quality assured schools against the standards proposed and cannot offer an estimate of the costs required to comply with the proposed text. If change is required, transitional costs might be occurred; and the changed curriculum may be more expensive than current arrangements on a recurring basis.

28. In particular some schools might need to secure more direct clinical contact between their students and patients. Placements might need to be more effectively supervised to improve students' prescribing skills. Developments along these lines would have resource implications for the NHS and/or the medical schools. Without effective supervision of students' contribution to prescribing decisions, there could be adverse consequences for patients' health and financial consequences related to complaints, compensation claims and further medical treatment. It should be noted that the preparedness research concluded, in relation to prescribing, that 'risks to patient safety are reduced, but not removed, by checks from other clinicians and pharmacists'.

29. The benefits of the revised standards could exceed the costs. The revised standards could lead to reduced prescribing errors, which in turn could impact favourably on the risk to patients and the resulting costs to the NHS and to postgraduate training. The cost of extending student contact with patients, and improving the supervision and educational focus of that contact, is potentially significant. This cost may however be required in any case, irrespective of changes in the text of *Tomorrow's Doctors*.

30. In the consultation, many respondents said that implementing the proposed requirements on prescribing and patient exposure would require increased supervision of medical students and training of staff involved in supervision. Others suggested practical steps involving more assessments in prescribing, more teaching and supervision by pharmacists and pharmacologists, and more detail in curricula on prescribing. Many said increased Health Service funding would be required. The Medical Schools Council said:

> 'We consider that the major impact will stem from the implementation of greater patient exposure. The introduction of Student Assistantships is likely to have significant resource implications – particularly in relation to their assessment. Therefore the impact will depend on the final decision about the range of skills that will need to be routinely tested.'

31. One respondent suggested that primary care settings could be useful in the delivery of all the areas discussed in the impact assessment:

> ‘The impact assessment needs to take account of the time needed for effective teaching and financial implication for backfill of clinical sessions that have been reduced or cancelled for teaching to take place. Clinical environments often lack suitable teaching spaces. Although the student feedback shows that teaching in Primary Care is liked by the students and effective as a learning environment there has been very little investment in creating dedicated teaching spaces in Primary Care, i.e. an additional consulting room for students…Key resource implications are GPs and other health care professionals willing to teach and teaching space.’

32. In general, respondents to the Skills for Health survey were positive about the proposals in the consultation draft of *Tomorrow’s Doctors* and felt that these should produce doctors that meet the needs of the NHS if implemented across the UK. Strong doubts were, however, expressed about the extent to which it will be implemented in practice.

33. Our view, based on research and endorsed by the consultation, is that enhanced clinical experience for medical students will help to improve the prescribing and practical skills of UK graduates. There are undoubtedly challenges for the medical schools and the providers of placements in meeting the requirements proposed in the July 2009 draft. However, the consultation demonstrated that the medical schools and the NHS acknowledge that these challenges need to be addressed. We will continue to work closely with the medical schools and the NHS to monitor implementation and ensure that the requirements are met within a realistic timescale.

Issue 2 – Professionalism and leadership

34. It is difficult to assess the costs and benefits in relation to students’ awareness and confidence regarding issues involving professionalism and leadership. Maintaining the 2003 guidance to medical schools would allow the impact of other initiatives associated with professionalism and student engagement to be studied and considered. But there is a widespread perception that it would be advantageous to address the issues of professionalism and leadership more thoroughly in undergraduate curricula. The NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges have jointly defined competences relating to leadership for various stages of medical education and training including undergraduate education. The Royal College of Physicians of London and the King’s Fund have published reports on professionalism. The importance of student engagement with regulatory and ethical issues has been recognised in the debate about student registration.

35. We do not expect significant costs to be incurred by the proposals in the July 2009 draft although some modification to curricula may be required. The text has a section explicitly devoted to the doctor as a professional and is intended to promote understanding of professional and regulatory issues among UK graduates. We believe that the benefits of the proposed text outweigh any transitional costs incurred by the need to redesign curricula.

36. Leaving aside the review of *Tomorrow's Doctors,* the cost of a student engagement strategy to promote professionalism depends of course on its remit and the sum of its component parts. A set of proposals were considered by the General Medical Council in September 2007 which were costed at around £134,000 in addition to recurring annual costs of £125,000. The Council noted that the resource implications of enhancing existing engagement mechanisms were potentially significant. The Council was assured that all proposals taken forward would be subject to scrutiny under normal approval processes.

37. While the need to amend the text in *Tomorrow's Doctors* could be reduced by an effective engagement strategy, and the need to take forward specific engagement proposals could be reduced by new standards, the GMC could aim to enhance professionalism among new graduates using both approaches together.

38. We believe that the benefits of a cost-effective student engagement strategy would outweigh the costs. We intend to develop our current initiatives alongside the publication of the revised *Tomorrow's Doctors.* We intend, among other things, to continue to work with the King's Fund and the Royal College of Physicians to promote student interest in professionalism as a key concept.

39. Student registration is a further option for promoting professionalism among medical students that has been investigated by the GMC and others. The Chief Medical Officer for England recommended: 'Administration of a system of student registration would have modest costs, to be borne by the General Medical Council itself.' These were estimated at approximately £1 million per year. That would imply a cost of £29 per student. It is not clear how this estimate was determined.[8]

40. A key benefit is that student registration would make it easier to secure consistency in how medical schools consider students' fitness to practise and it would help ensure a good fit between decisions made locally about students and made by the GMC about graduates seeking provisional registration.

41. However, medical schools should be unambiguously responsible for ensuring that medical graduates are fit to practise and they are better placed than the GMC to respond appropriately and speedily to concerns about their students. Student registration would compromise the autonomy of medical schools and should be pursued only if we are confident that other steps will not achieve the objectives sought. Student registration would not be proportionate or targeted.

[8] Initial Regulatory Impact Assessment to Chief Medical Officer report, *Good Doctors, Safer Patients,* Department of Health, 2006

42. We are not persuaded that the potential advantages of student registration outweigh the potential disadvantages. The GMC intends, in light of the review of the regulation of medical education led by Lord Naren Patel, to review the strength of the case for student registration and the availability of alternative additional steps to enhance student engagement with professional values and regulation. Commenting on the section on professionalism in the consultation draft, a Royal College said: 'If there is not to be a system of student registration then this section…is critical to continued good medical practice'.

43. In response to a consultation question about practical steps that would be necessary to implement the proposals on leadership and team-working, respondents suggested:

a. More teaching about the multi-professional team and within the multi-professional team.

b. Increased small group teaching and associated assessment.

c. Use of simulated environments.

d. Teaching and assessment by behavioural scientists and psychologists.

e. Monitoring of student adherence to GMC guidelines on professionalism and fitness to practise.

44. We have also noted relevant publications during the consultation period. In particular the 2008 Annual Report of the Chief Medical Officer for England referred the potential of simulation for developing practical skills and team-work.

45. The July 2009 draft is intended to underline the importance of team-working, leadership and respect for and understanding of one's colleagues. The draft leaves reasonable flexibility to medical schools in terms of curricular delivery while stressing the importance of effective clinical experience and referring to the educational potential of simulation.

Issue 3 – Assessment

46. Medical schools demonstrate a variety of approaches to assessment, even in relation to the finals and summative assessments that lead to graduation.

47. Professor Peter McCrorie and Katharine Boursicot have surveyed medical schools and reported: 'There is an extensive range of assessment processes in place at UK medical schools, ranging from portfolios to formal written and clinical examinations of the OSCE-type. It is difficult to compare the equivalence of standards of graduates because of the use of such a wide range of assessment tools, of variable pedagogic rigour.'[9]

[9] Peter McCrorie and Katharine Boursicot, *Variety in Medical School Graduating Examinations: is it tenable?, 2008*

48. This variety creates scope for development and avoids the creation of 'identikit' doctors. It also reflects current uncertainty about how best to combine the various assessment tools to reach a summative conclusion about an individual's fitness to practise.

49. However, the variety in approaches to assessment also leads to concern about differences in the level of knowledge, skill and proficiency achieved by UK graduates. This could undermine the confidence in medical education of service providers and patients and members of the public. And it creates costs in relation to training in the Foundation Programme and in the NHS which would not apply if new graduates had a skill set that was more predictable and uniform.

50. Furthermore, the GMC's quality assurance reports have repeatedly expressed concern about aspects of assessment at some medical schools:

a. Many schools have difficulty ensuring that the number and type of assessments are appropriate. Particular areas of difficulty include ensuring that: there are not too many assessments; assessments test the objectives of the course; and assessments test integrated knowledge.

b. Several schools are challenged with providing timely and formative feedback to their students after assessments.

c. A small number of schools lack clarity and consistency when awarding distinctions and honours.

d. A few schools are not sufficiently or adequately using standard setting methods.

e. Many schools are challenged with providing good and ongoing training to their examiners.

51. It is possible that the diversity in approaches and the shortcomings at some schools relate in part to the high-level nature of the guidance on assessment contained in the 2003 edition of *Tomorrow's Doctors*. In addition, the high-level guidance may lead QABME visiting teams to take a variety of approaches when considering assessment arrangements, which could create uncertainty and cost at the medical schools under review.

52. The GMC has considered the option of introducing a national examination for UK graduates. A national examination could have a number of benefits in relation to demonstrating the preparedness of graduates; consistency in assessment outcomes; confidence in undergraduate education; efficiency gains; and fairness in recruitment to the Foundation Programme.

53. As an indication of the cost of a national examination we can note that the charges for the GMC's PLAB examination for International Medical Graduates are intended to cover costs but not to make a profit for the GMC. The charge for Part 1, the written examination, is £145. If that is used as an estimate for the cost of a written examination for UK students, to be taken by 8000 graduates a year, the total cost would be in the region of £1.2 million pa. The charge for Part 2, an Objective Structured Clinical Examination (OSCE), is £430. So a national examination comprised of the equivalent of Part 1 and Part 2 would cost around £4.6 million pa to deliver to 8000 graduates.

54. There would be other disadvantages resulting from the introduction of a national examination. These could include a contraction in the diversity of curricula that might result and students becoming overly focused on success in the examination rather than developing fitness to practise more broadly.

55. It is difficult to reach a firm conclusion. While notional financial costs for a model similar to PLAB can be identified, other costs and benefits are more intangible and less easy to quantify, and there are a range of potential models that could be explored further. It is likely that consideration of the advantages and disadvantages of a national examination will continue, both within and beyond the review of the regulation of medical education led by Lord Patel.

56. However, this is not truly an alternative to revising *Tomorrow's Doctors*: even if a national examination were introduced, it is likely that medical schools would need to assess their own students in light of standards issued by the GMC.

57. Many respondents to the consultation said that implementing new assessment systems in line with the draft would incur financial costs. Respondents suggested various practical steps:

a. Streamlining assessments so they were both cost-effective and robust.

b. Introducing mandatory workplace-based assessments in line with postgraduate training.

c. Improving local quality control mechanisms so that outcomes from assessments could be better analysed and used for development.

d. Establishing a national clinical examination.

e. Introducing a common bank of assessments to be used by all medical schools.

f. Sharing and implementing best practice in assessment through assessment experts, assessment committees to 'research, formulate and implement best practice in medical education assessment' and a 'national assessment network' where leads in each school are supported to build and exchange expertise.

58. The July 2009 draft text is more specific than the relevant paragraphs in the 2003 edition, which should help to tackle poor practice and encourage more consistency without creating unnecessary regulatory constraint.

Issue 4 – Quality management

59. As the 2003 edition of *Tomorrow's Doctors* says little about the quality management systems at medical schools, QABME reviews have operated without detailed explicit standards laid by the GMC. There is a risk that this gap in the regulatory framework creates room for avoidable variation in the approach of QABME Visitors, creating uncertainty at medical schools.

60. No benefits have been identified from continuing with the current gap in the regulatory framework, except for avoiding some transitional compliance costs that may be implied by the proposed standards.

61. The regulatory gap needs to be addressed. The consultation draft was intended to establish clear standards for quality management to provide a basis for QABME reviews and the development of medical school systems. The level of detail and precision in the standards was intended to avoid unnecessary regulatory burden and compliance costs.

62. Respondents to the consultation said that financial costs would be incurred in implementing quality management and control systems. One pointed out that any externally imposed changes would need to be consistent with the universities' quality procedures. Several respondents identified challenges in getting meaningful feedback from patients.

63. Respondents suggested establishing a QA group to consider and implement the new standards and that the GMC could identify model quality management systems. Other comments included:

> 'The School is concerned that there appears to be a requirement for very detailed Service Level Agreements with each placement provider. If this is the case this will involve significant workload demands, potentially requiring additional resource.'

> ‘This area of the document is disappointingly thin. We think that there is much to commend the framework advanced by the Postgraduate Medical Education and Training Board underpinned by their Quality Framework, Generic Standards for Training, Standards for Deaneries and Standards for Curricula and Assessment Systems. These have led to postgraduate deaneries, medical royal colleges and local education providers… working together to develop and implement standards of quality management (at deanery level) and quality control (at local education provider level). It is very apparent that the organisations and individuals involved in delivering postgraduate medical education and training overlap enormously with those involved in delivering undergraduate medical education and training and it would seem to us that there is considerable benefit to be gained from ensuring integration between the processes for quality assuring undergraduate education and training and those for ensuring quality in postgraduate education and training.’

64. The requirements in the July 2009 text address the regulatory gap that has been identified, for example in the relationship between medical schools and the providers of clinical placements. Following publication of *Tomorrow’s Doctors*, the GMC will review the quality assurance mechanisms that it should apply in the context of the merger of PMETB with the GMC from 2010.

Issue 5 - Student Selected Components

65. The 2003 edition of *Tomorrow’s Doctors* states at paragraph 38:

> ‘The curriculum must have a core and student-selected components (SSCs). The core curriculum must take up most curricular time. We expect that in a standard five-year curriculum between 25% and 33% would normally be available for SSCs.’

66. The research commissioned by the GMC on the purposes of *Tomorrow’s Doctors* found that the introduction of Student Selected Components (SSCs) had taken time away from core learning. Among medical school teachers, ‘SSCs are generally regarded as taking up too much curriculum time at the expense of core content’. And among educational supervisors and nurses, ‘SSCs are causing concern even at Foundation level…’[10]

67. The perception, if not reality, that SSCs compromise delivery of a curricular core led medical schools to attempt to include under this heading elements of curricula that did not effectively reflect selection by students or the purposes intended for SSCs as set out in the 2003 edition. This in turn led to discussions and tensions between medical schools and QABME Visitors.

[10] Janet Grant and Trudie Roberts, with Mairead Maxted, Dr Katharine Boursicot, Katrina Chambers, Sue Kilminster and Joanne Marshall, *An investigation of the explicit and implicit purposes in Tomorrow’s Doctors and an analysis of the impact of possible environmental changes on the knowledge, skills, attitudes and behaviours required of medical graduates,* 2007

68. QABME reports indicate that many schools are challenged by SSCs in one way or another. The most common challenge is ensuring there is adequate scope in the choice of SSCs. Other common challenges include making the course objectives clear and ensuring the appropriate amount of time in the curriculum is spent on SSCs. Quality assuring content, monitoring SSCs and assessment are also common challenges.

69. The consultation text of *Tomorrow's Doctors* referred to the importance of SSCs but did not propose a quantitative minimum. The draft impact assessment identified a risk that medical schools would significantly reduce their commitment to SSCs with a negative impact on the development of students' research skills, learning skills, interests beyond the curricular core, ability to present findings and consideration of career paths (aims set out in *Tomorrow's Doctors* (2003), paragraph 40). However, the consultation text was intended to allow medical schools and QABME visitors to focus on substantive issues regarding student centredness and educational gain, rather than terminological debates around a quantitative requirement.

70. Respondents to the consultation did not identify significant financial costs from the proposed requirements although it was recognised that some reorganisation would be necessary.

71. In light of the response to the consultation, the text was amended so that the July 2009 draft introduces a requirement that SSCs take up at least 10% of the curriculum.

72. We consider that the July 2009 text carries potential benefits and opportunities outweighing potential costs and risks, particularly given the need to focus on the quality rather than overly ambitious standards for the quantity of SSCs.

Equality and diversity, including disability

73. There is considerable evidence of inequalities in health and in access to healthcare services. It is less clear how far these inequalities result from shortcomings in medical education.

74. Some minority ethnic groups are well-represented among medical students but some including African-Caribbeans are not. Women are well-represented. The socio-economic background of students remains largely professional and middle-class.

75. The approach taken in the July 2009 draft involves setting out a wide range of competences and also the specification of some competences at a more detailed level than in previous editions of *Tomorrow's Doctors*. Having carefully considered the requirements for training after graduation, and thoroughly considered a wide range of perspectives, the Review Group drew up a list of proposed competences and the GMC agreed to consult on whether the list was appropriate. The list has been amended in light of the consultation.

76. The proposed outcomes may have various impacts:

a. Specifying competences for all students may impact on some ethnic groups, for example due to association with cultural or religious attitudes.

b. Disabled individuals wishing to become students may be affected by the determination of a more specific list of clinical skills, which could be problematic for some groups.

c. Specifying competences for all students may impact on some religious groups.

d. A heightened emphasis on professionalism in relation to student fitness to practise could impact on the career opportunities of groups who are disproportionately likely to have had previous contact with the legal system.

e. The outcomes should help to ensure that graduates do not discriminate in their patient care or among colleagues and that they allocate resources according to patients' capacity to benefit.

77. The pursuit of training involving more clinical contact could impact on groups with particular external commitments, for example regarding children and other dependants.

78. The proposed standards for delivery underline that medical schools need to be non-discriminatory and open in their admissions and arrangements for student support.

79. Some of the current competencies outlined in *Tomorrow's Doctors* may pose restrictions on some students with disabilities to qualify as medical practitioners.

80. The GMC and partners have already provided detailed guidance to medical schools on encouraging disabled students.[11] This sets out a range of aspects of support to applicants and current students, including possible reasonable adjustments, to allow disabled individuals to achieve the competences itemised in *Tomorrow's Doctors.*

81. The available statistics may not accurately reflect the number of medical students with disabilities or how this number has changed over time. This is because many either do not identify as being disabled or choose not to declare.

[11] General Medical Council and others, *Gateways to the Professions. Advising medical schools: encouraging disabled students*, 2008

82. In 2004, the BMA reported:

> ‘Data indicate that medical schools receive few applications from students with disabilities. However, these figures may not be accurate. Of those medical students with disabilities, dyslexia is by far the most common disability. There are also many examples of students with mobility, hearing or visual difficulties successfully completing medical degrees’.[12]

83. In 2008, the *Gateways* guidance reported:

> ‘Although about 19 per cent of people of working age in the United Kingdom are disabled, fewer than seven per cent of students in higher education are disabled; and in 2004/5 only three per cent of students in medicine and dentistry declared a disability. The number of students declaring a disability is rising and the increase in declared disabled students is also much greater than the general increase in student numbers (68 per cent as opposed to 14 per cent). However, this might be due to a change in the declaration rates rather than an increase in the actual number of disabled students.’

84. The July 2009 text includes a list of practical procedures that is more detailed than the equivalent list in the 2003 edition although shorter than the list issued for consultation. While we would expect that generally medical schools already require competence in these procedures as a condition of graduation, it is possible that the more specific list will make it more difficult or even impossible for some individuals to graduate.

85. In addition, the new list may entail transitional and recurring costs for any medical schools that do not already teach and assess students in some of these areas of competence.

86. The July 2009 text is intended to provide more clarity on the outcomes required at graduation and certainty for individuals considering medical careers, while maintaining the GMC’s commitment to supporting disabled students.

87. If the GMC made the outcomes required for graduation less specific, this could create a lack of clarity and consistency among the requirements of medical schools. In addition, a lack of clarity or specificity in the outcomes required could create risks to patient safety and/or complexities and costs for the organisations employing and training doctors after they graduate. Any change to medical school curricula may entail transitional costs. Our view is that the potential costs from making outcomes less specific in relation to clarity, consistency, patient safety and fit with entry to the Foundation Programme would outweigh any potential gain in career options for a small number of disabled people.

[12] British Medical Association Board of Medical Education, *Demography of medical schools - a discussion paper*, 2004

88. The consultation asked whether the draft impact assessment was an adequate representation of the impact the guidance would have in relation to equality and diversity. 56% agreed, 6% disagreed and 38% were not sure. Categories of respondents varied in their support: 79% of doctors and 80% of medical schools agreed but only 20% of NHS organizations, 60% being unsure. Respondents suggested the draft had missed out evidence on equalities in health and access to healthcare services and had not covered all the equalities strands required by legislation.

89. The consultation also asked whether the consultation draft would pose any difficulties or barriers for particular communities or groups. 27% said yes, 46% said no and 28% were not sure. The view that it would not pose difficulties or barriers was adopted by 40% of postgraduate medical institutions, 42% of doctors, 50% of medical schools, 66% of medical students and 69% of medical educators.

90. Some respondents identified difficulties or barriers for disabled people although many of them said the outcomes required were necessary. One said: 'the impact assessment considers there is a risk and I agree that over-prescription with respect to outcomes may require the provision of some discretion for disabled students - especially if their career intentions are to enter a [specialty] such as psychiatry or public health where some practical skills are not required'. One respondent called for an opt-out facility 'where a specific disability can be compensated for on an individual basis without affecting patient care and safety or imposing unfair burden on others'. A member of the public stressed: 'Need to make sure people with mental health problems not excluded providing that their condition doesn't prevent them from achieving [the same] competency as anyone else'.

91. A smaller group of respondents identified difficulties or barriers for people with certain religious beliefs. One medical school commented: 'The revised draft does pose some problems, particularly for students who can't comply with the expectations of behaviour and performance of the document. A[n] … example would be students observing certain religious practices for example some male Moslem students may feel unable to touch or examine female patients (this is a fairly extreme example, as most Moslems would not feel this way and would agree that they need to conform to the host nations' practices and behaviours).'

92. The consultation asked: 'Should changes be made to address these difficulties or barriers, and if so, what?' 81% said changes should be made although many said patient safety and clinical standards should take priority. Several called for reasonable adjustments compatible with the needs of employers. An NHS body said: 'There should be a clear statement of the requirements of a doctor and examples of the level of adjustment that may be made, provided that patient safety is not compromised. This would need to be agreed with the NHS employers.' One respondent called for a wide-ranging review:

‘Firstly the GMC with others need to define the role of the doctor and define what EVERY doctor must be able to do. This defines the person specification that every applicant and graduate needs to fit UNLESS there is an adjustment to the job description for those with disabilities or other barriers to practice. Following this there needs to be consultation on the level of independence required of every doctor for every task. In other words can we adapt the job description for those with difficulties? This is a complex question and would require input from Trust Management, the national Departments of Health, GMC, ethicists and others. Once it has been agreed what level of assistance can/should be offered to practising doctors (and students) this would define the reasonable adjustments that can be made to any of the learning outcomes in *Tomorrow's Doctors*. An adapted job description with reasonable adjustments for some may raise the question of why others will fail to graduate if they do not demonstrate competence in these areas: clear guidance will be required.’

93. Several respondents to the consultation commented that medical schools would need to continue to work with their university disabilities co-ordinators and services on reasonable adjustments for disabled students in line with the more detailed practical procedures list in the revised *Tomorrow’s Doctors*. One respondent commented that ongoing training in equality and diversity for staff and students would be required. One respondent suggested that ‘the relative responsibilities of the medical school and FY1 employer need to be clarified, including governance, exchange of data and resource issues’.

94. We have also noted that in his Annual Report for 2008, the Chief Medical Officer for England looked to the medical profession to take an active lead on race and equality concerns.

95. The GMC has placed a high priority on considering the implications of the proposed outcomes for individuals with disabilities who wish to pursue medical schools. We are confident that the competences set out are consistent with the requirements of the disability discrimination legislation. In the July 2009 text, we have stressed equality and diversity in curricular outcomes and in relation to the composition of the student body. However, there remain important issues to address in relation to disability in the medical profession and the profession’s role in achieving equality and diversity in the services which it provides.

Privacy

96. The main aspects of the revision relevant to privacy are:

a. Encouraging student involvement in patient care, requiring patients’ consent and effective arrangements for sharing information about students’ progress between medical schools and NHS/other providers of placements.

b. Encouraging the sharing of information about students’ areas of relative weakness between medical schools and the Foundation Programme.

c. Collecting and using information about students' disabilities in line with the *Gateways* guidance published by the GMC and other organisations.[13]

d. Collecting and using information about students' fitness to practise in line with the student fitness to practise guidance published by the GMC and the Medical Schools Council.[14]

97. Detailed arrangements would need to be determined locally by medical schools, placement providers and the Foundation Programme.

98. In the consultation, 73% agreed with the proposals in the draft as they related to collecting and using personal information, 2% disagreed and 24% were not sure. Many said the proposals were necessary to protect patient safety. This was particularly with regard to sharing information about students' progress between medical schools and providers of placements and sharing information on students' weaknesses between medical schools and the Foundation Programme.

99. Several respondents agreed with the proposals but commented that it was important for students to be aware of the collection and sharing of information about them in all but the most exceptional circumstances. Respondents also commented that information about students should be kept confidentially and securely.

100. The consultation also asked whether the draft included appropriate detail on collecting and using personal information. 66% said there was appropriate detail, 1% said too much, 11% said too little and 22% were not sure. There were some calls for further guidance particularly about aspects of sharing information about individual students with the Foundation Programme:

> 'When it would be reasonable to hand on information about students and in what format… [if] explicit consent required to pass on information to the Foundation Programme… [if it is] permissible to tell tutors the assessment results of the students in their group, to help them triangulate their own assessments with other and to give them feedback on their teaching.'
>
> '…For example, it is stated that "doctors should not pass on information without the student's permission, unless the risk to patients is so serious that it outweighs the risk to the student's rights to privacy". Some guidance about the level of risk would be helpful.'
>
> 'There was agreement that the School would not wish to prejudice any student by this process of sharing information. However, there was also recognition of the benefit of ensuring some students receive an appropriate level of support following graduation. It was suggested that this may be addressed through an appraisal process at the end of year 5 prior to graduation.'

[13] General Medical Council and others, *Gateways to the Professions. Advising medical schools: encouraging disabled students*, 2008
[14] General Medical Council and Medical Schools Council, *Medical students: professional behaviour and student fitness to practise*, 2007

‘At the moment the new graduate is said to be in control of this but the schools also seem to have responsibilities. This needs to be clarified.’

101. The consultation also asked whether respondents believed that medical schools and other education providers had documented governance arrangements to ensure that personal information would be properly collect and used. 34% said yes, 13% no and 53% were not sure. Generally this may suggest that many respondents did not feel in a position to comment. One respondent said: ‘It is highly likely that individual institutions have good and documented governance arrangements relating to the use of personal information within their own organisations. This becomes less certain when boundaries between institutions and particularly between institutions and regulatory bodies are encountered.’

102. There was an encouraging general level of support for the proposals in relating to collecting and using personal information, acknowledging that the uses envisaged were appropriate in light of patient safety. The paragraph in the July 2009 draft of *Tomorrow’s Doctors* on transferring information to the Foundation Programme has been redrafted to make it more clear and to ensure a good fit with developing practical arrangements.

Conclusion

103. 45% of respondents to the consultation thought that in the draft impact assessment we had correctly identified the aspects of the proposals likely to have the greatest impact on medical schools, the NHS and other bodies. 20% disagreed and 35% were not sure.

104. Respondents suggested various themes that they felt should have been covered in the impact assessment, or covered in more depth, including:

a. Patient safety.

b. The European Working Time Directive.

c. Structures, funding and policies within service providers.

d. Financial resources within medical schools.

105. Clearly these themes relate largely to factors other than *Tomorrow’s Doctors* which impact on undergraduate education and which will constrain and shape the implementation of the proposals.

106. Generally, the consultation response indicated a perception that the proposals would have financial impacts in relation to teaching, supervision on clinical placements and assessment. The impacts on equality and diversity and on privacy have been widely seen as appropriate and justified.

107. Our intent is that the investment involved will result in better prepared graduates, reduced burden for the bodies that subsequently employ and train them, and improved standards of care for their patients.