General Medical Council Education Committee

Final Report

Strategic Options for Undergraduate Medical Education

Consultation

June 2006
# Contents

- Executive Summary ................................................................. 3
- Introduction .................................................................................. 5
  - Approach to the strategic options consultation ......................... 5
  - Streams of the consultation ...................................................... 6
  - Consultation processes ............................................................. 7
- Consultation outcomes ............................................................... 9
- National Assessment ................................................................. 9
- Student Fitness to Practise ......................................................... 13
- Admissions .................................................................................. 16
- Tomorrow’s Doctors ................................................................. 17
- Themes for the undergraduate curriculum .................................. 18
  - Interprofessional learning ......................................................... 18
  - Patient-centredness ................................................................. 19
  - Learner-centredness ............................................................... 19
  - Equality and diversity ............................................................. 19
  - Permanence of change ............................................................ 20
- Summary of outcomes and next steps ........................................ 20
- Annex A – Qualitative report on the outcomes ........................... 22
Executive Summary

1. The General Medical Council (GMC) undertook a facilitative consultation from 1 July 2005 to 31 October 2005 on the strategic options for undergraduate medical education. We asked for feedback on how the GMC could ensure patient safety and improve the quality of the UK undergraduate medical education system. The consultation focused on:

   a. Whether or not we should develop a national assessment.

   b. Whether or not we should introduce a student register.

   c. Whether or not the principles in Tomorrow’s Doctors are appropriate in relation to patient-centredness, interprofessional learning, learner-centredness, equal and diversity and the permanence of change.

2. This report sets out the general themes and opinions that emerged from these three streams of the consultation. A qualitative analysis of the written responses is in Annex A.

3. In general, there was support for developing a more robust assessment system in the UK. Points raised include:

   - The majority of respondents identified concerns about the need for consistency in outcomes between medical schools and between students.

   - The majority of respondents supported developing a more in-depth approach to assessment in our Quality Assurance in Basic Medical Education (QABME) processes.

   - There was a call for a more robust external examiner system.

   - The majority of respondents would support a shared questions bank or assessment tools applied to all medical schools.

   - There was some support for a national assessment because it would facilitate more consistent marking against standards. However, most respondents raised concerns over a loss of diversity and flexibility in medical education.

   - There was a general opinion that more evidence was necessary before any large-scale changes were undertaken.
4. In general, there was support for developing more consistency in student fitness to practise in the UK. Points raised include:

- A large majority of respondents identified risk in the current student fitness to practise arrangements. They were concerned about a lack of consistency in how decisions are made within and between medical schools.

- A vast majority supported guidance by the GMC on student fitness to practise that would help local arrangements develop more robust and informed procedures.

- There was some support for a student register because it would track students and develop consistency in outcomes as well as protect the public.

- However most respondents indicated that medical schools must retain their responsibility over the fitness of students. They advocated a national framework under which local arrangements operated.

5. We asked for some initial feedback on *Tomorrow’s Doctors*. Points raised included:

- A concern that the balance between basic science and non-technical knowledge and skills in the guidance should be reconsidered.

- The majority of respondents supported generic standards and outcomes in *Tomorrow’s Doctors*.

6. We also consulted on some underlying themes in the undergraduate curriculum. Points raised included:

- The majority of respondents thought interprofessional learning had to take place in practical situations.

- There was support for a move towards doctor/patient partnerships, but these skills had to be learned through experience.

- The majority of respondents supported a generic curriculum and suggested the guidance addressed the needs of students.

- Most felt that equality and diversity were not being implemented properly in the curriculum with support for more explicit teaching.

- There was strong support to educate students to deal with the uncertainty both in clinical practice and within the changing Health Service.
Introduction

7. The General Medical Council (GMC) is the regulatory body for the medical profession in the United Kingdom. One of the functions of the GMC’s statutory Education Committee is to promote high standards in medical education. The Committee maintains the quality of medical education by issuing guidance on the outcomes required for medical graduates and trainees as well as quality assuring educational providers against these outcomes. Within this context, the Education Committee continuously reviews its functions as the regulator of undergraduate medical education and the training of doctors in their first year after graduation.

8. In 2002, we published a revised edition of Tomorrow’s Doctors, our recommendations on undergraduate medical education. A section on student fitness to practise was incorporated in 2003. During 2003-4 a system for the Quality Assurance of Basic Medical Education (QABME) was piloted at three UK medical schools and is now being rolled out to the other schools. During 2004 we engaged in a major consultation on our guidance for the PRHO year and a revised version of The New Doctor was published in 2005 to cover the period up to 2007. During 2004 we also issued guidance on Continuing Professional Development for the first time.

9. Continuing to lead in medical education, the Education Committee decided in April 2005 to consult on the three strategic areas of student fitness to practise, national assessment and guidance on undergraduate medical curricula.

Approach to the strategic options consultation

10. On 9 May 2005, the Education Committee held an international conference, ‘From Here to Where?’ It considered the future of medical education and highlighted some of the drivers that may impact on medicine in the future. The conference looked at the extent to which medical education needs to recognise and reflect change. Leading figures in medicine and medical education from around the world addressed the conference, including the four UK Chief Medical Officers and Dame Janet Smith. Over 200 people participated in this event.

11. The formal consultation on Strategic Options for Undergraduate Medical Education ran from 1 July 2005 to 31 October 2005. We held several meetings and discussions with key players, including patient groups, students, educationalists and people working with the Health Service. We also organised five public seminars in Belfast, Cardiff, Edinburgh, London and Manchester. Patient groups, students, medical school staff and people in the medical profession were invited to these seminars. GMC Members participated in the consultation through a Council seminar in September 2005. We also piloted a student debate and showcased the consultation at the GMC student day on 26 October 2005.
12. The purpose of the consultation was to facilitate debate about how the GMC could ensure patient safety and improve the quality of the UK undergraduate medical education system. The consultation focused on arguments for developing a national examination, developing a register for medical students, and how the undergraduate guidance, *Tomorrow’s Doctors*, should embed principles associated with patient-centredness, learner-centredness, interprofessional learning, equality and diversity as well as the permanence of change.

13. The consultation document set out a range of arguments on the advantages and disadvantages of a national assessment and a student register. We suggested other possible options that might achieve reforms without extensive restructuring of medical education in the UK. We also asked respondents to comment on possible influences on medical education and medical practice and the extent to which they should impact on *Tomorrow’s Doctors*. The consultation document is available upon request or on our website http://www.gmc-uk.org/education/index.asp

*Streams of the consultation*

14. ‘Student fitness to practise’ in this sense relates to students whose conduct or health raises questions about their fitness to practise as doctors. Until the 1990s few medical schools had a robust mechanism for removing from a course students who were academically able but about whom there were fitness to practise concerns. Instead, the medical schools relied on the generic university-wide disciplinary procedures. These did not necessarily relate to the professional standards set out by the GMC in *Good Medical Practice*. Pressure from the Council of Heads of Medical Schools based on legal advice resulted in all medical schools introducing fitness to practise panels. However, universities with medical schools vary considerably in statute and regulation. For this reason among others, there may be significant inconsistency between fitness to practise panels in universities. This is a potential risk and will in addition raise difficulties when the GMC starts to require UK graduates to demonstrate that their fitness to practise is not impaired before they are granted provisional registration.

15. Alongside variation in fitness to practise procedures, the 27 medical schools in the United Kingdom make their own arrangements for assessing students and thereby determining whether they should be granted a Primary Medical Qualification. They will vary for example in their reliance on ‘finals’ as opposed to assessment throughout the undergraduate course. They will vary in their emphasis on particular aspects of knowledge and skills. The assessment arrangements need nevertheless to be consistent with the outcomes set by the Education Committee in *Tomorrow’s Doctors*. Consistency with these outcomes is demonstrated through the Committee’s mechanism of Quality Assurance of Basic Medical Education (QABME). At the same time, UK universities have a system of external examiners who oversee the examination process. And several universities share examination questions. Nevertheless, medical schools continue to vary in their approaches to assessment and there may be scope for more consistency without inappropriately compromising the independence of universities.
16. *Tomorrow’s Doctors* was last published in 2003. We need to ensure that the
guidance, including the outcomes, remains up to date and appropriate.
Representations are frequently made to the Education Committee suggesting ways
in which the guidance could be changed. A new edition is scheduled for 2008.

**Consultation processes**

17. We had over 150 written responses to the consultation. Over 150 people
attended regional seminars in Belfast, Cardiff, Edinburgh, London and Manchester.
We also met with more than 30 key stakeholders to discuss aspects of the
consultation.

18. The responses to the consultation have been collated and analysed in three
groups (depending upon whether they emerged from the meetings, or the seminars,
or the formal written responses received). The general categories of respondents in
all streams of the consultation were:

- Medical educators – Individuals
- Doctors - Individuals
- Medical Schools - Institutions
- Doctors’ representative groups/Royal Colleges including the BMA, CoPMED
- Health Service/Departments of Health
- Students/PRHOs
- Patient groups
- GMC lay members/associates
- Postgraduate Deaneries
- Equality and Diversity Groups
- Members of public
- Other: regulators, MPs, healthcare professionals

19. Analysis of the responses is based on general trends or opinions, but caution
must be taken in extrapolating the information too broadly. We received only a small
number of responses from some groups.

Meetings with stakeholders

20. An important aspect of this consultation was to encourage key stakeholders to
participate and respond to this consultation. We met with a number of people who
considered the implications of the three consultation areas. Some of the people we
met included:

- Association for the Study of Medical Education
- BMA Junior Doctors Committee
- BMA Medical Students Committee
Chair of the BMA Board of Medical Education
Chair of the BMA Council and new Chair of the BMA Medical Students Committee
Conference of Postgraduate Medical Education Deans
Council of Heads of Medical Schools
Council for Healthcare Regulatory Excellence
Disability Rights Commission
Equal Opportunities Commission
Gay and Lesbian Association of Doctors and Dentists
GMC Committees and Council
Mencap
Modernising Medical Careers
MPs and members of the House of Lords
National Association for Patient Participation
National Association of Clinical Tutors
NHS Confederation – Wales
NHS Education for Scotland
Occupational Health Smart Card group
Other healthcare regulators – cross regulatory meeting
Patients’ Forum
Picker Institute (Europe)
Royal College of Nursing

21. In general, participants in these meetings suggested that it was useful to debate potential changes in medical education and how they might impact on patient care and the medical profession.

22. There was a wide range of comments and opinions from the participants that raised common themes and topics, which have formed part of the outcomes of the consultation. These positions suggest a general support for some kind of change in the current medical education system in relation to assessment and student fitness to practise. Although there was polarisation of opinion on whether or not there should be structural reform by the GMC that would lead to a national examination or a
student register. There was also support of review of Tomorrow’s Doctors and a discussion on whether or not it has struck the right balance between clinical knowledge and skills and non-technical knowledge and skills.

Seminars

23. We also organised five public seminars in Belfast, Cardiff, Edinburgh, London and Manchester. Over 150 people attended these events including patient groups, students, medical school staff and people in the medical profession. Minutes of the meetings are available upon request or on our website http://www.gmc-uk.org/education/index.asp

Written responses to the consultation

24. Although the consultation questions were not intended to function as a psychometrically validated questionnaire, several of the questions did ask for information in the form of closed (yes/no) questions or a scale of options. These closed questions were then explained or expanded on in open-ended questions. The closed questions were designed to get an overview of the range of opinions to inform our next steps. This acts as a quick snapshot of the environment in which the consultation operated.

25. We commissioned an external researcher to undertake a qualitative analysis of the consultation responses.

26. 96 of the written responses we received addressed the specific questions identified in the consultation. A further 59 responses provide comments in a letter or essay format (and did not necessarily cover the questions set out in the consultation).

27. All the responses have been considered and integrated into the qualitative report (attached at Annex A or available on our website http://www.gmc-uk.org/education/index.asp).

Consultation outcomes

National assessment

28. The responses to the consultation did not indicate a clear consensus on the question of a national assessment.
Key meetings

29. In general, participants in the stakeholder meetings found merit in tightening up the undergraduate assessment system. There was support for a more formal external examiner system and a more in-depth approach to assessment by QABME. There was praise for the diversity in medical schools and concern that a national assessment would jeopardise this important aspect of UK medical education. Many respondents suggested that more evidence was needed before any large policy changes were implemented. Some participants supported embedding common assessments into finals at all medical schools, but medical schools would still be expected to examine students over and above these common elements. Participants also raised concerns about ranking medical students and schools. In general, this was approached with caution and many felt it would not lead to better patient safety.

Seminars

30. Some of the main themes and arguments about national assessment that emerged from the seminars are set out below:

a. There was support for reform to the current system on the ground that it did not adequately demonstrate that students where achieving a common minimum threshold.

b. There was no strong evidence presented about whether or not medical students were achieving the skills, knowledge and attitudes to become competent doctors.

c. There was support for a variety of assessment methods because it was necessary to capture all components of competence.

d. Some reported concerns that a national examination would lead to students and medical schools working towards the exam, rather than the wider knowledge and skills needed for a good doctor.

e. There was agreement that the external examiner system should be quality assured and more regulated. There was strong support for strengthening the checks undertaken in the QABME process to address assessment in more detail. A shared question bank was also generally supported, although many lobbied for a voluntary scheme along the lines of those developed by the medical schools associated with the UMAP project and by London medical schools.

f. There was concern that a national assessment might lead to ranking and this was seen as a negative outcome for the examination, although it was acknowledged that it might improve patient confidence.

g. There was concern about the timing, cost and logistics of a national examination. It was suggested that medical students are already struggling
through a heavy exam load and a national exam may be better placed at the end of F1.

h. Some felt that a national examination would be fair and could facilitate more consistent marking against set standards.

Written responses

31. The written responses to the consultation suggest that some perceive a need for reform to the current assessment system in undergraduate medical education. There was a range of responses in the debate on national assessment with many respondents suggesting that there is no evidence supporting a change to the current assessment system in undergraduate medical education while others recommended a standardised assessment in order to demonstrate minimum standards. However, there was strong support for reform to the system in order to develop more consistency between medical schools and students. Most respondents argued that any reform should not undermine the diversity and flexibility in the curriculum enjoyed by medical schools.

32. In order to get a picture of these arguments about national assessment, we asked a series of questions aimed to elicit an overall view on the debate.

33. In response to a specific question posed in the consultation, about two-thirds of respondents considered there were significant risks associated with the current arrangements for assuring consistency in undergraduate medical education assessment. The majority of the groups such as the BMA, CHMS and COPMeD as well as the Royal Colleges did not support this view.

34. The qualitative report indicates that: ‘Many of the risks highlighted, however, were not simply a matter of consistency in assessment procedures but referred to a number of broader issues concerning both the purpose and content of medical education’. Therefore, it is clear that perceived risks in assessment are impacted by the context of medical professionalism and education.

35. About two-thirds of respondents supported reform to the current system to mitigate risk. The majority of the responding doctor representation groups and Royal Colleges suggested that reform was not necessary.

36. Those respondents who supported reform argued that the current system does not provide certainty that standards have been achieved and there is no mechanism to ensure consistency in assessment between medical schools. Most respondents cautioned, however, that there was no evidence that overall competence between graduates from different medical schools was in fact different. Also, there was concern that a move towards more standardised assessments would decrease diversity in the delivery of the undergraduate curricula.

37. The consultation invited respondents to consider six options for reform to the UK assessment system. These options were not ranked in order of preference,
however most respondents indicated in their explanations that they supported one or more options over others. The six options and the results from the consultation are set out below:

a. Increase QABME’s focus on assessment and continue to share best practice. There was strong support for this option amongst respondents. However, individual doctors and medical educationalists disagreed while institutions and organisations, including the Royal Colleges, medical schools and Deaneries supported this option.

b. A more formal and systematic external examiner system. Overall, the majority of respondents supported this option, although the views of respondents within categories were varied.

c. A shared suite of assessment tools. Overall more than three-quarters of respondents agreed or strongly agreed with this option. Many respondents within medical schools, individual doctors and medical educationalists, however, did not support this option.

d. A shared bank of assessment questions that can be used voluntarily. There was less support for this option, although more than half of respondents agreed that it was a potential method for increasing consistency in assessment. Most medical educationalists and patient action groups tended to disagree or strongly disagree with this option.

e. A shared bank of assessment questions that must be used for at least some examination questions. About two-thirds of respondents supported this option. The BMA, individual medical educationalists and students/PRHOs tended to disagree with this option.

f. A national examination prior to provisional registration. More than half of the respondents did not support this option. Medical school respondents, doctor representative group/Royal College respondents and individual student/PRHO respondents particularly rejected it. The strongest support came from patient action groups, Deaneries and GMC Associate/lay respondents.

38. In summary, there was strong support for reform to the current system with a perception that QABME and the external examiner system could play a bigger role in developing consistency in the UK assessment system. The majority of respondents, particularly the medical schools and educationalists, supported some sort of shared database of questions or assessment tools. A considerable number of respondents, however, favoured a national examination. Overall, therefore, the results of the consultation did not indicate a shared consensus of view about the way forward.
Student fitness to practise

Key meetings

39. Participants in the stakeholder meetings considered student fitness to practise to be an area in which the GMC should be leading. There was support for standardisation in decision-making and many supported some sort of system that backs up the medical schools in their fitness to practise decisions. Most participants also supported mechanisms to improve consistency in student fitness to practise arrangements. Most participants indicated that medical schools must retain their responsibility for student fitness to practise and it would be a disservice to patients and students if it were dealt with only by the GMC. Moreover, many participants suggested there needed to be a better mechanism to transfer information on students between undergraduate education and the Foundation Programme. Other themes raised in the meetings indicated that participants believed that students needed to be supported and offered pastoral care in the first instance. Finally, there was a mixed reaction to student registration. Some felt that students would engage with the profession at an earlier stage and it was important to establish boundaries of acceptable behaviour. Others felt that the introduction of a student register would be a disproportionate response to the issues, suggesting that guidance and support for medical schools would be sufficient.

Seminars

40. Similarly, various themes and arguments emerged in the seminars:

   a. There was support for more consistency between universities in establishing good practice and mechanisms for dealing with fitness to practise.

   b. Many felt the GMC should advise on what behaviours and standards are expected of medical students. This was best done through guidance and support for medical schools by the GMC.

   c. Some felt a student register would provide a means of tracking students and develop consistency in outcomes as well as protect the public. It would help formalise the development of professional attitudes and behaviours in students and emphasise the difference between medical students and other students.

   d. Those who supported a student register viewed this as giving added leverage to medical schools by separating local interests and conflicts from the decision making process. However, universities must be allowed to make local decisions with references to the GMC only when necessary.

   e. Many felt there must be different boundaries and thresholds as students move through the medical course and mature, with more tolerance
and support for first/second year students. Medical schools have an educational/developmental role and some behaviour that happens early on in a course should be evaluated in relation to a student’s maturity.

f. Some considered a student register was an extreme solution for a small number of unfit students. Although there was some support for GMC involvement in the final year or related to patient contact.

g. There was concern that if there was a student register, students would be less likely to seek help or inform on a colleague because of the professional consequences.

Written responses

41. Evidence from the written response to the consultation indicated that there is significant dissatisfaction with the current student fitness to practise arrangements. Although there is a broad range of views about the mechanisms that might be used to improve the current arrangements, it is clear that most respondents believe the current arrangements in medical schools may place patients at risk. Concerns were raised about both the content of the curriculum, especially a need to teach and assess professionalism, and the fitness to practise procedures within medical schools. Most respondents felt that the GMC should play a more active role in student fitness to practise and provide leadership in this area.

42. In order to get a picture of these arguments about student fitness to practise, we asked a series of questions aimed to elicit an overall view on the debate.

43. Over 80% of respondents indicated that they considered the current arrangements for student fitness to practise to be linked with significant risks. The majority of responses within all categories acknowledged risk in this area.

44. Respondents raised concerns about both the admission of unfit students into medical schools and medical students who posed a risk to patients during their education but were subsequently allowed to graduate and register with the GMC. The analysis of responses suggests a common perception that a concentration on academic achievement and an apparent disinclination to address behaviour problems earlier allows patterns to become ingrained to the detriment of the aspiring doctor and ultimately their patients.

45. A vast majority of respondents indicated that there was a need for reform to the current system. Respondents suggested a need to develop more consistency between medical schools in the fitness to practise process, including the types of cases pursued and the outcomes of the procedures. The majority of respondents suggested that the GMC should develop guidance to help medical schools put in place more consistent arrangements. There was also fairly strong support for some sort of national register or database for medical students.
46. We asked respondents to consider six options for reform to the UK student fitness to practise arrangements. These options were not ranked in order of preference, however most respondents indicated in their explanations that they supported one or more options over others.

a. Continue with the local arrangements because new statutory provisions will enhance the GMC’s ability to question the fitness to practise of medical graduates and prevent registration where necessary. This was the least popular option with just over half supporting this option. Medical schools and patient action groups particularly disagreed with this option.

b. The GMC develops guidance and protocols on dealing with fitness to practise and medical schools use them in decision-making. This was strongly supported with almost all respondents advocating this option. Only a small number of responses disagreed with this option on the ground that it went beyond the GMC’s powers.

c. A student register could undertake a function similar to the GMC’s Medical Register. About half of the respondents supported this option, especially respondents from medical schools. However, a number of student/PRHO responses and the BMA strongly disagreed with it.

d. Medical schools make all determinations on a student’s fitness to practise and inform the GMC as the holder of the student register of any actions or decisions. Information would be held centrally and could be considered by the GMC when making a decision to register a medical graduate. Less than half of the respondents supported this option.

e. A database could log information about both local and national investigations with the GMC empowered to remove students from the register in the interest of patient safety. There was some support for this option with over half the respondents agreeing with it. Responses from doctor representative groups/Royal Colleges, students/PRHOs and Postgraduate Deaneries were less favourable.

f. Alternatively or in conjunction with the above options, the undergraduate curriculum should include a focus on teaching and assessing professional values such as ethics. A large number of respondents who answered this question agreed or strongly agreed with this statement. Some respondents did not agree with this statement because teaching professional values was already taking place in medical schools and so was not considered an option that would increase consistency in current arrangements.

47. In order to consider fully the question, we asked participants to agree or disagree with a national register for UK students outside the context of alternative options. This question allowed us to check specifically if respondents would consider this a useful mechanism for ensuring patient safety. 60% of the 89 people who answered this question agreed or strongly agreed with this proposition. The majority
of medical educationalists, individual doctors and medical schools supported developing a national register. Responses were skewed across the population of respondents as a whole with the majority of responses from doctor representative groups/Royal Colleges, and students/PRHOs, disagreeing with this option.

48. Most respondents did not see any one option fully addressing the risks in the current system. Rather, there is generally thought to be a need to develop concepts of self-awareness, responsibility and professionalism while setting out behavioural boundaries and sanctions for any transgressions of the appropriate behaviour or action. Respondents felt we needed to recognise the developing nature of undergraduate medical students and take forward procedures that reflect this change in maturity. The qualitative report found that: ‘many respondents argued that a national register would be a constructive step forward but were concerned about its actual implementation.’ In general, there was support for medical schools to continue to make local determinations with the outcomes feeding into a national register.

49. In summary, there is significant support in the written responses for more proactive involvement by the GMC in student fitness to practise. But there was no clear consensus on the precise mechanism, which should be used to achieve that. The majority of participants indicated that guidance on good fitness to practise, as well as recommended indicative sanctions, would be helpful to medical schools. This approach may offer more consistency in the fitness to practise arrangements but it does not ensure that medical students are traceable and accountable for their behaviour throughout their career. Many respondents, especially medical schools and educationalists, argued for a national register of students in order to emphasise the special nature of medicine as a degree, reinforce professional values and track students. There was disagreement, however, on how this register should be implemented.

Admission

50. The consultation sought feedback on the extent to which the GMC should be involved in admissions. Slightly less than half of the respondents indicated that the GMC should develop guidance on admissions. Most medical educationalists, doctor representative groups/Royal Colleges, medical schools and students tended to reject this idea while responses by individual doctors, health service organisations and patient action groups supported the idea. Some respondents suggested that guidance would complicate an already complicated process and could interfere with the medical schools’ responsibilities.

51. Currently, the GMC has no statutory powers to become involved in admissions into medical school. Therefore, we wanted to gauge to what extent we should move into this area. The vast majority did not support a change in our statutory position in relation to admissions.

52. In summary, there is some support for the GMC to develop guidance on admissions but it is not felt necessary to support this development with a change to our statutory powers. However, some respondents indicated that if the GMC were to
become involved in this area, its role should be limited to fitness to practise considerations.

Tomorrow’s Doctors

Key meetings

53. Most participants in the stakeholder meetings indicated that the balance in Tomorrow’s Doctors should be reviewed. There was concern that some areas such as basic science were being under-emphasised in the curriculum, resulting in trainees that are not prepared for the workforce. Some called for a more practical or specific approach to the curriculum, while others supported generic outcomes because they allowed flexibility. In general, most participants advocated embedding some key principles more firmly into the guidance. However, many stressed the importance of the environment in which students learned. Many participants reflected on the impact of role models and the hidden curriculum on how students embrace and develop professional values. There was strong support for communication as a key clinical skill and many said students must be taught to respect and value patients as equal but different participants in medical care.

Seminars

54. At the consultation seminars:

a. There was concern that the balance in the curriculum has moved too far towards the non-technical elements. Students were no longer learning basic knowledge that is necessary for practice.

b. Some felt the five principles raised in the consultation (relating to interprofessional and collaborative learning, patient-centredness, learner-centredness, equality and diversity, and the permanence of change) cannot be integrated simply into the guidance. Most of them hinged on communication skills and respecting other people, whether team members or patients.

c. There was agreement that most of the principles would be best taught through experience and role modelling. Some participants suggested that the principles should be assessed as part of the core curriculum.

Written responses

55. We asked the respondents submitting written replies to the consultation document to comment on the outcomes in Tomorrow’s Doctors and the function of the guidance in medical education.
56. In order to capture what people thought about the guidance in general, we asked participants to consider if *Tomorrow’s Doctors* should be more specific. About three-quarters of respondents indicated that the guidance was about right. However, the majority of patient action groups suggested that the guidance needed to be more specific.

57. In order to tease out what people felt the function should be of the guidance, we asked participants to consider: ‘Should *Tomorrow’s Doctors* be more tied to the requirements of the Health Service?’ Slightly less than half of the respondents supported more connection between the undergraduate guidance and the Health Service. The majority of support for this option came from responses by Health Service organisations, students/PRHOs, doctor representative groups/Royal Colleges and patient action groups.

58. We also asked respondents to consider: ‘Does *Tomorrow’s Doctors* do enough to make medical students and the profession accountable to the public?’ Most respondents indicated that the guidance does increase accountability. However, many participants suggested that it was not the role or purpose of the guidance to do this.

59. The qualitative report found that: ‘many respondents appreciated the on-going development of *Tomorrow’s Doctors* as an important benchmark for medical education.’ The responses raised a variety of questions about the purpose and function of the guidance. Most people agreed that it should set out high-level recommendations and outcomes. Although some respondents felt it should be more directive and specific in particular areas.

**Themes for the undergraduate curriculum**

60. In order to understand how some social or professional themes should be embedded into *Tomorrow’s Doctors*, we asked for feedback on specific areas in the guidance.

**Interprofessional learning**

61. We asked respondents to consider whether *Tomorrow’s Doctors* should place more emphasis on the need for interprofessional learning and practice. About a third of respondents supported this suggestion. All of the responses from the Health Service organisations and a majority of responses by GMC associated/lay members and other healthcare organisations supported greater emphasis on interprofessional learning.

62. Respondents felt interprofessionalism was an important area in medical education, but it was more likely to be embedded into medical practice through experience. There is concern that poorly designed interprofessional learning could harm collaborative interactions and polarise attitudes.
Patient-centredness

63. We asked respondents to consider whether *Tomorrow's Doctors* should place more emphasis on patient-centredness. Slightly less than half of respondents supported this suggestion. Medical educationalists, Health Service organisations, other regulators or health professionals, patient action groups and GMC associates/lay members particularly supported this option. There was much less support from medical schools, students/PRHOs and doctor representative groups/Royal Colleges.

64. There was significant dissent on the importance of patient-centredness in medical education. Some respondents indicated that the term was not well defined and that this theme was pandering to political pressure or fashion. Many felt that it was important to keep this issue at the forefront of medical education partly to take account of broader changes in society’s thinking but equally to enable students to be able to practise with greater efficacy. There was agreement that patients and doctors need to develop a partnership approach to care. Many respondents felt that this was more likely to happen through experience rather than in undergraduate medical education.

Learner-centredness

65. We asked respondents to consider whether *Tomorrow's Doctors* goes far enough to address the needs of students. The majority of respondents were satisfied with the current guidance.

66. We also asked respondents to consider whether we should be continuing to teach a generic curriculum or moving towards more specialised curricula. The vast majority of responses indicated that it was important to continue with a generic curriculum. Only responses by some Postgraduate Deaneries, Royal Colleges and individual medical educationalists indicated a need for more specialised curricula.

67. We asked respondents to consider whether Student Selected Components (SSCs) should become a larger part of undergraduate curricula. Most respondents did not support increasing SSCs in the curricula.

68. Most respondents supported a generic curriculum because it was necessary to ensure students had the basic building blocks in medicine before specialisation. Respondents felt that early specialisation would push out other skills such as communication and management while others felt that it was vital for students to complete a compulsory core curriculum in order to maintain standards.

Equality and diversity

69. We asked whether *Tomorrow's Doctors* reflects adequately the need to promote equality and value diversity. Most respondents were satisfied with the current guidance. Equality and diversity groups that responded to this question, and
the majority of the patient action groups, suggested that the guidance does not go far enough.

70. The majority of respondents felt that the guidance was appropriate but that it was not being implemented effectively in medical schools. Some concern was raised over the admissions process and the need to increase the diversity of medical candidates. Most respondents felt that more specific guidance on embedding equality and diversity into the curriculum was needed perhaps on reflective work or specific scenarios.

Permanence of change

71. We asked respondents to consider whether medical students are properly prepared to work within a constantly changing environment. The majority of respondents that answered this question suggested that medical students are not properly prepared for change. Medical educationalists, individual doctors, Health Service organisations and patient action groups particularly supported this position. The qualitative report suggests that many respondents felt that medical students were not being prepared properly to work in a constantly changing environment. There was still a tendency for students to believe in the certainty of clinical practice both in terms of practice and in terms of their own careers and little in medical education challenges this.

72. We also asked respondents to consider whether the outcomes in Tomorrow’s Doctors prepared students for practice, especially in the first years. About two-thirds of respondents indicated that they were satisfied with the current guidance.

73. In summary, there was general support among the written responses for the breadth and content of Tomorrow’s Doctors in terms of the five themes set out in the consultation. However, most respondents recognised that these areas need to be better embedded into medical education and training through experience and changes in the learning environment.

74. In addition, many respondents mentioned a number of areas that should be considered in our guidance and within the curriculum, including basic medical sciences (especially anatomy and physiology), pharmacology, pathology, microbiology and infection control, and diagnostics. The qualitative report also highlights several skills, areas of knowledge and attitudes that are important for preparing students to work in a changing profession, including critical thinking, problem-solving, flexibility, team work, research skills, political awareness, leadership and management skills, life-long learning, as well as dealing with uncertainty and risk.

Summary of outcomes and next steps

75. It is clear from the three streams of the consultation that there is a great deal of ongoing debate on the strategic direction of undergraduate medical education. There is a wide and diverse range of views, not only on the possible options, but also
on the role of the GMC as a regulator in them. However, there is strong support for some reform to both the current assessment system and student fitness to practise. It is also evident that the majority of participants in the consultation see a leading role by the GMC in these areas.

76. There is no particular consensus emerging for either a national examination or a student register. Several respondents felt these options may raise more questions than they answer. Certainly, many respondents suggested that these top-down, imposed structures would destroy diversity and innovation in medical schools and in students. Increased regulation would only be appropriate if there was strong evidence to indicate their need. Others argued that more formal structures in these areas would lead to better transparency and accountability. It would ensure that medical students were able to demonstrate a minimum professional standard before continuing their career.

77. The consultation results suggest that the review of Tomorrow’s Doctors must consider the balance between clinical knowledge and skill and other professional requirements, as well as the balance between generic outcomes and more specific guidance and direction.

78. The consultation responses indicated widespread support for reform to current arrangements for assessment and for overseeing student fitness to practise, and interest in mechanisms designed to achieve more consistency among the 27 medical schools. However, given the diversity of views expressed on student registration and national assessment, the Education Committee will be considering future policy direction carefully.

79. We anticipate informally consulting on the development of proposals based on the outcomes of the strategic options consultation with a view to launching a formal consultation on a fully worked-up model in Autumn 2006.

80. We will consult on a revised draft of Tomorrow’s Doctors during 2007 with a view to publishing a new edition in 2008. We will then be in a firm position to bring in revised standards and arrangements.