General Medical Council

Regulating doctors
Ensuring good medical practice

Principles of good medical education and training

1 The ultimate aim of all stages of medical education – including basic medical education (for medical students and provisionally registered doctors), postgraduate training and continuing professional development (CPD) - is to improve the health and the health care of the population.

2 This document sets out principles to guide the development and review of programmes of medical education and training. It aims to help medical students, doctors and the providers and regulators of education and training. The providers and regulators can refer to these principles when developing their own guidelines. These principles set out how we (the General Medical Council (GMC) and the Postgraduate Medical Education and Training Board (PMETB)) hope medical education and training will develop.

3 These principles apply to all stages of medical education and all specialties. Checking the quality of individual programmes will continue to use the specific standards that apply, including *Tomorrow's Doctors* for undergraduate training, *The New Doctor* for the PRHO (Pre-Registration House Officer) year and the guidance issued by the Postgraduate Medical Education and Training Board for specialty, including general practice training.

4 This document sets out principles of good medical education. They are deliberately ambitious, but also achievable. All providers should be aiming to follow these principles in full.

Choosing between candidates

5 The organisations responsible for education and training (both undergraduate and postgraduate) should put in place valid, open, objective and fair procedures for choosing between candidates. These should take account of best practice in managing people and equal opportunities.

6 The organisations responsible for education and training should publish information about their procedures, including guidance on how they offer places.

7 The staff responsible for choosing between candidates should have a wide range of knowledge and expertise. All those involved in choosing between candidates should be trained to follow guidelines about entry requirements consistently and fairly.

Curriculums

8 All curriculums should be based on the principles and the standards of competence (skills and knowledge), care and behaviour expected of doctors and set out in *Good Medical Practice* (GMP) under the following seven headings.

a Good clinical care

b Maintaining good medical practice

c Relationships with patients

d Working with colleagues

e Teaching and training

f Probity (see the glossary)

g Health

9 Clear learning outcomes (results) should be set for educational and training programmes so that it is clear what knowledge, skills, attitudes and behaviours students and doctors must have.

10 The outcomes set for assessing the necessary knowledge, skills, attitudes and behaviours should be appropriate for any changes to registration status or professional grade.

11 Curriculums should allow students and trainees to achieve the learning outcomes set. Curriculums should be developed within the framework of the outcomes for that stage of medical education.

12 Each curriculum should include a clear reason for its mix of clinical training, supervised delivery of service and formal educational sessions.

13 Curriculums should allow learning to be developed flexibly, not leaving out students and trainees unfairly. Curriculums should also be assessed for their effects on equal opportunities.

14 Clear documents about the curriculum should be available to everyone, including educators, students, trainees and the public.

15 Learning outcomes should be developed jointly within the specialty or discipline concerned and, wherever possible, with students, trainees, patients, the public and colleagues from other professions. The outcomes should be regularly updated in line with current research and evidence, and as medical practice changes (taking account of patients' expectations). The methods used to set outcomes should be clear, flexible and available to the public.

16 The quality of curriculums should be regularly and thoroughly assessed in line with relevant GMC curriculum guidance available at www.gmc-uk.org, and PMETB's *Standards for Curricula* available at www.pmetb.org.uk.

Assessment

17 This section draws on *Towards Excellence in Assessment in Medicine*, issued by the Chief Medical Officer (England). See also PMETB's *Principles for an Assessment System for Postgraduate Medical Training* at www.pmetb.org.uk.

18 'Assessment' covers a range of testing methods, including examinations. Assessments can be local or national.

19 The purpose of each assessment procedure should be clear, well understood and well communicated.

20 There should be a consistent and effective relationship between the assessment process and the outcomes that need to be achieved.

21 The format and design of the overall assessment system and its methods should be appropriate to what is being tested, such as:

- a clinical skills;
- b knowledge and decision-making;
- c interpersonal (communication) skills; and
- d competence in particular areas.

22 The specific assessment methods should:

- a have appropriate content and methods;
- b be valid;
- c be reliable;
- d be based on evidence; and
- e be assessed against best practice in other settings and other countries.

23 For each specific assessment method there should be procedures written down for:

- a running the assessment and using its results to classify and support students and trainees;
- b setting the standard for grades and pass and fail (where appropriate);

c making observations or marking;

d recording and communicating the results of the assessment; and

e handling the part of the assessment process that relies on the assessor's professional judgement.

24 The process for choosing assessment methods should be fair, clear and available to the public.

25 High-quality documents should support the overall assessment system and the specific assessment methods within it.

26 The assessment should be fair, clear, accurate and well validated (based on evidence about what works).

27 People carrying out assessments should be fully trained and competent, and should receive regular and frequent feedback on their performance.

28 While it is rare for serious mistakes or misjudgements to happen during assessments, the process should allow for students and trainees to give feedback and appeal.

29 The relationship between appraisal and educational assessment should be clear and understood.

30 Assessment should reflect the views of colleagues.

31 Providers of assessments should have a procedure for involving patients and the public in developing assessment tools.

Fitness to practise

32 Organisations responsible for educating and training medical students and doctors should have procedures to:

a identify as early as possible medical students and doctors whose performance, behaviour or health may put patients at risk;

b make sure that students and doctors receive advice, support and more targeted training when appropriate; and

c make sure that students who continue to pose a risk to patients are not allowed to graduate with a medical degree and that the GMC is told about registered doctors when appropriate (see paragraphs 83 to 85 of *Tomorrow's Doctors* and paragraphs 26 to 28 of *Good Medical Practice).*

33 The procedures should be fair.

Teaching, training and support

34 In line with *Good Medical Practice*, doctors should be willing to contribute to training students and colleagues.

35 Doctors with responsibilities for teaching, training and providing CPD should gain and develop appropriate knowledge, skills, attitudes and behaviours. They should be aware of and follow the GMC's guidance on *The Doctor as Teacher*.

36 Students and trainees should be properly supervised. Supervision should be clearly documented.

37 People responsible for educational and CPD programmes should make students and trainees aware of the support, counselling and occupational health services that are available. Support should be available to encourage students and trainees to ask for help.

38 There should be adequate training and support for anyone who provides education, training and CPD.

Resources

39 Programmes of education and training should have adequate resources to deliver their learning outcomes.

40 Students and doctors should have appropriate teaching and learning resources, such as libraries, computing equipment and teaching rooms. These resources should be regularly reviewed and assessed.

41 The professionals providing good medical education, training and CPD need time to do so. Those responsible for programmes should make appropriate arrangements for time to be set aside for the students and trainees. There should be adequate resources, including time where teachers cannot be called away to see patients (bleep-free time), to support assessment and appraisal.

42 All stages of medical education should build on the stage before and contribute to the next. This will help them to be economical, effective and efficient.

Quality assurance

43 The quality of education and training programmes should be thoroughly assessed (quality-assured), internally and externally, to make sure that our standards are being met (or beaten) and that good practice is being shared.

44 All quality-assurance (QA) processes should be as follows.

a Efficient, effective and economical – they should take account of the costs and effectiveness of the training programme as well as the QA process itself.

b Valid - they should measure what they were intended to measure.

c Reliable - they should produce consistent and accurate results.

d Convenient - they should be flexible and practical, and not too much of a burden on institutions.

e Fair - they should not favour any particular person or group, either directly or indirectly.

f In proportion - they should use a standard process but be able to target specific issues. They should use any methods of improving quality in a co-ordinated and appropriate way. Where appropriate, they should be supportive in tackling problems.

g Competent - people responsible for quality assurance should show that they have an appropriate range of expertise and knowledge. Quality-assurers should receive training as and when appropriate.

h Flexible - they should adapt to change in all areas of training programmes. QA should reflect on and develop its own processes in response to improvements elsewhere or constructive criticism.

i Inclusive - they should include the experience and views of students and trainees, educators, service managers, patients, trainees and other users. They may be more open if confidentiality is guaranteed.

j Accountable - they should be open, with procedural documents and reports of findings available to the public (unless there are exceptional circumstances). There should be defined procedures for considering comments and complaints from providers of education and training, and for approving final reports of findings.

k Co-ordinated - they should co-operate with other reviews and quality-assurance processes. They should consider and use available information. They should support sharing information and examples of best practice.

45 There should be a clear statement of QA responsibility for the different parts of each programme. Responsibility should be separated between providers and their external quality-assurers. External quality-assurers should be independent of the funders and providers of education and training.

46 QA systems should make sure that providers have flexibility on how the standards are achieved.

Reflecting current society

47 Medical education and training should reflect current society. This involves reflecting the importance of the following.

a ‘Patient-centred care’ – focusing on patients.

b ‘Learner-centred education’ – focusing on learners.

c ‘Promoting equality and valuing diversity’ – treating everybody fairly and recognising and valuing differences within society.

d ‘Interprofessional learning and practice’ – learning and working with other professions.

e ‘The permanence of change’ – recognising the ongoing developments within technology, medicine and society.

48 All education and training should be based on the need to promote health care that focuses on patients and shared decision-making. Patients’ independence and right to make decisions should be respected, and the health and safety of patients and the public must come first. Good communication skills should be key to all stages of medical education.

49 Programmes and curriculums should try to gain people’s enthusiasm for learning and help people gain skills for self-awareness, self-directed learning and professional development. Learning opportunities should help students and doctors to explore knowledge and analyse evidence critically.

50 Arrangements should encourage and support people from all parts of society to enter and complete medical training. There should be a commitment to monitoring the conditions and the processes for choosing between candidates and for assessment. There should be support for students and doctors who want to learn and work flexibly. Reasonable adjustments should be made for students and doctors who have a disability. Students and doctors with a wide range of disabilities or health conditions will often be able to achieve the standards set for knowledge, skills, attitudes and behaviours. Each case is different and should be treated individually.

51 Medical education and training should include opportunities for learning across and beyond health-care teams, which are available to everyone.

52 Students and doctors should gain and develop the knowledge, skills, attitudes and behaviours necessary to keep up to date. Situations, environments and ambitions change. Doctors need to respond positively to change and to contribute to it. Learning should reflect the changing patterns of health care. As learning extends beyond the formal curriculum, students and trainees should be encouraged to learn from all their experiences at all times, throughout their career.

Glossary of terms and acronyms

Competences	The skills that doctors need.
CPD	Continuing professional development
Curriculum	A statement of the intended aims and objectives, content, experiences, outcomes and processes of a programme, including a description of the structure and expected methods of learning, teaching, feedback and supervision. The curriculum should set out what knowledge, skills, attitudes and behaviours the learner will achieve.
GMC	General Medical Council
GMP	*Good Medical Practice*
Local faculty	Those involved in delivering postgraduate medical education locally, such as clinical tutors, vocational training scheme tutors, GP vocational training scheme tutors, GP trainers, college tutors, directors of medical education and others with specific roles in educational supervision.
Organisations responsible for education or training	Those involved in providing the education and training that students and trainees receive. These include medical schools, postgraduate deans, royal colleges as CPD providers, local faculties and anyone else providing education, training or CPD for doctors.
PMETB	Postgraduate Medical Education and Training Board
PRHO	Pre-registration house officer
Probity	Professionalism, including being honest and sincere, and having strong moral principles.
Programme	A period of managed, supervised training.
Staff responsible for choosing between candidates	Those responsible for admissions to medical school, for entry into the Foundation Programme, and for entry into specialist training programmes.
Student	A person carrying out undergraduate studies.
Supervision	Direct or indirect monitoring which should make sure that patients are safe and cared for, and that students and trainees develop.
Trainee	A registered doctor in training.