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25 March 2009

General Medical Council consultation: draft Tomorrow’s Doctors 2009

1. We welcome the opportunity to respond to the General Medical Council’s consultation on the draft 2009 Tomorrow’s Doctors document.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the ‘voice’ of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 36,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. Tomorrow’s Doctors has the potential to be both an influential and an educational document, and it offers the GMC a significant opportunity to further shape and influence the medical profession. It is for this reason that we are disappointed that the draft 2009 document is technical and bureaucratic in tone. We do not feel that this document, in its current state, will serve to inspire future generations into the medical profession.

4. There are, it should be said, aspects of the document which we consider commendable. We welcome the clear statement of responsibilities of the GMC, medical schools, the NHS, doctors and students (see paragraphs 2 to 6). In particular, we are impressed with the identification of the responsibilities of NHS organisations (see paragraph 4) which will assist medical schools in negotiation with the NHS about the provision of facilities out with hospitals to support medical education in the community.

5. We also commend paragraphs 3 and 19 which state the explicit requirement of medical schools to communicate more clearly with placement providers about what students can be expected to know and do. We also agree that medical schools should be expected to provide placement providers with information about individual students and their performance, where appropriate.

6. We agree with paragraphs 75 and 101 and their emphasis on evidence based learning and assessment. We also support the requirement, as stated in paragraphs 106, 116 and 117, of schools to provide exit qualification and support to students seeking alternative careers. We commend paragraph 114 which outlines whistle blowing protection procedures for students.

7. However, we feel that overall the document fails to capture the essence of being a doctor. This should be stated at the outset as is the case with the GMC’s Good Medical Practice Document¹:

‘Patients need good doctors. Good doctors make the care of their patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity.’

8. A parallel statement is required at the outset in the draft of Tomorrow’s Doctors. We need to know what type of doctor the GMC expects all medical schools to produce. We suggest that, for this reason, the section on ‘outcomes’ should come first and the section on ‘processes’ should follow.

Professionalism

9. We are deeply concerned that ‘professionalism’ has been included as what can only be described as an annex. The importance of professionalism should be made explicit at beginning of the document and it should be a recurrent theme throughout. It must be made clear that doctors must be expected to uphold standards of professionalism at all times.

Patient-centred ethos

10. While we welcome the emphasis throughout on patient safety, which we agree should be a high priority, the language used to describe patients often appears cold, technical and excessively risk averse, and thus fails to articulate adequately the importance of patients in medical education and the need for patient-centred learning. In the College’s response to the previous draft of Tomorrow’s Doctors in 2003, we argued that the undergraduate medical education curriculum should contain elements that would encourage recognition and acceptance of the obligation to practise in the best interests of patients. More emphasis is required throughout on the importance on the patient-centred ethos in all aspects of medical education.

Experiential learning

11. There is a lack of emphasis on the value of experiential learning. Clinical teachers are important role models in two senses. Firstly, they demonstrate to their students the need for patient-centred good medical practice; and secondly, they teach, less overtly, the value of professionalism. It is important that all educators of medical students, from F1 level to professors, understand the principles and techniques of learner-centred teaching. There is extensive evidence that this will ensure that medical schools will produce patient-centred doctors. The document should do more highlight the “primacy of the doctor-patient relationship” and reflect the fact that patients are increasingly better informed and expect to act as equal partners in their healthcare.

Health Inequalities

12. While the new content on health inequalities is encouraging, the need for doctors to appreciate the needs of their patients in the context of the wider health needs of the population is not stressed firmly enough. The document should emphasise the need for

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students to be aware of Dr Julian Tudor Hart’s Inverse Care Law and the contribution that primary care makes to addressing this. Furthermore, to help fully understand diversity and equality, students should learn about international health, including the role of non-governmental organisations (NGOs). We feel that health inequalities would be taught most effectively in a primary care setting and for students to really understand health inequalities issues, experiential learning is essential. Once again, the document would be strengthened by a greater focus on this need.

Equality of opportunity

13. We are encouraged that Domain 3 (equality, diversity and opportunity) is concerned with ensuring that students and applicants to medical schools are treated fairly and impartially, with equality of opportunity. As a College, we are committed to equality of opportunity, and we are currently preparing evidence for the Panel on Fair Access to the Professions led by the Rt. Hon Alan Milburn MP and linked to The New Opportunities White Paper. It is not clear, however, how the treatment of applicants by medical schools is to be achieved or monitored. How is the success of a medical school in ‘encouraging diversity within the student population’ (paragraph 46) to be measured? We are concerned that if the above objective is not monitored, medical schools may not feel that they need to participate in pre-selection procedures to ensure that a wide variety of people from different social backgrounds apply in the first place to medical school. We also feel that students should have clear pathways for discussing or reporting discriminatory practice or attitudes that they encounter within medical schools.

Leadership and Improvement Science

14. The RCGP believes that it is essential for GPs to put forward their own ideas for improving healthcare and act as leaders and advocates for patients. Although leadership is addressed in the document, it should do more to address Sir John Tooke’s view that doctors have a “key role in enhancing clinical services through their positions of responsibility”. Many doctors, as Tooke suggests, move on from clinical leadership and management to leadership roles within organisations on a national and international basis. It could be argued that leadership should be an outcomes category in its own right, though we anticipate that this would cause significant debate.

15. Linked to the above point, we are encouraged by the reference in paragraph 154 to Improvement Science as it is arguable that students must understand this in order to achieve positive system change at a later stage of their careers. We do, however, note that the assessment criteria draw more on the traditional curricula of public health and epidemiology than on more recent thinking about the science of quality improvement which include systems thinking, understanding variation, managing change, models for improvement, influencing people and teams etc. The descriptors in this section are mostly passive ones, such as ‘discuss’, ‘describe’, ‘explain’ – not ‘do’ or ‘practice’. Alongside the practical procedures that need to be taught listed in Box 1, it might be worth considering the benefits of actually doing small scale improvement projects.

Managing uncertainty

16. We are pleased that the document recognises, as an outcome, the need for students to be able to ‘analyse complex and uncertain situations.’ This reflects Tooke’s view that doctors must be capable of “dealing effectively with and managing uncertainty, ambiguity and complexity,” but we believe that the document should develop this further. We anticipate that doctors will increasingly play a role in dealing with the tensions that arise from the many and varied expectations of the public, society, policy makers and
politicians. From a primary care perspective, the ever increasing complexity of the GPs role and the multiple and competing demands which they face give, in our view, a strong argument for increasing GP training from 3 to 5 years.

Basic sciences

17. We would welcome more emphasis in the document on for medical students to graduate with a firm and sufficiently comprehensive understanding of basic sciences including, for example, anatomy. We agree that the knowledge and understanding of science which is required at graduation must be that which is of immediate and direct application. However, the knowledge that undergraduates gain will also provide a foundation for lifetime of learning, which will require an understanding of principles which may not be used in the early years of practice.

Comments relating specifically to sections in the consultation document:

Standards for delivery of teaching, learning and assessment

Domain 1 – Patient Safety

18. We think that ‘Ensure that any planning and judgements involve patient/lay input’ should be added to the criteria.

19. Re para 9: We do not feel that there is a need to specify ‘high quality care’. Patients are paramount and high quality care should follow from that premise.

20. Re paras 13 & 14: It is crucial that there should be a commitment to taking note of issues of concern raised by patients about students and a mechanism by which patients can safely raise these.

21. Re para 15 and the use of the words ‘may have access to patients’: Please see the point we have made in paragraph 10.

22. Re para 16: Students must be absolutely confident in any mechanisms put in place for them to whistle blow on colleagues, particularly if they are in senior positions of power. Students need protection as well as patients.

23. Re para 17: We suggest remove the word ‘qualified’.

24. Re para 19: We agree with the paragraph but there is no mention of keeping the student in question informed that concerns have been raised. There is also an argument for involving patients in fitness to practice procedures, which is still very unusual in universities but should be best practice.

Domain 2 – Quality assurance, review and evaluation

25. Re para 35: Facilities issues will continue to be of increasing importance with increased student numbers. The monitoring of the ‘overcrowding’ of facilities is important. It is unclear whether second sentence means ‘must’ or ‘should’.

Domain 3 – Equality, diversity and opportunity
26. In this section there is no mention of lay involvement in planning, quality assurance or policy decisions.

27. Re para 41: It could be argued that students should also receive training in equality and diversity policies before they start their careers (i.e. at undergraduate stage).

28. Re para 42: We do not think that ‘reasonable’ is the correct word to use here. With tightening legislation this has become almost a statutory requirement. A word is required that encapsulates ‘all possible effort’ rather than ‘reasonable’.

29. Re para 46: We agree with these sentiments but there is little substance on how it is to be achieved and monitored. We are concerned that if the above objective is not monitored, that medical schools may not feel that they need to participate in the pre-selection procedure to ensure that a wide variety of people from different social backgrounds apply in the first place to medical school.

Domain 4 – Student selection

30. Re 57: We would also add the words ‘fair’ and ‘unbiased’.

31. Re 58: There is a need to both ensure equality and diversity and maintain quality.

32. Re 59: This wording sounds judgemental and implies pass/fail. It would be better to say ‘students will meet any requirements’.

33. Re 60: We would add that data should also include the predictive value of selection choices made at interview.

34. Re 61: There is an argument for standardising selection processes across the UK.

35. Re 62: Prejudging students and barriers (final sentence): this should be actively monitored as it is very easy to do this entirely unwittingly.

Domain 5 – Design and delivery of curriculum including assessment

36. Re 70: ‘Students will receive guidance about assessments’…. We wonder if this includes constructive feedback on them.

37. Re 75: There is a case for the introduction of a national core curriculum with flexibility in how it is taught but standardised methods for its assessment. Curriculum design must include dialogue with F1 supervisors/consultants and workforce leads (i.e. the SHA) in determining the needs of today and tomorrow’s workforce.

38. Re 77: This does not specifically mention overseas electives, which are a very valuable way to gain experience and to develop as a person and a doctor as well as to develop new skills.

39. Re 78: Student Select Components (SSCs) may also offer an opportunity to increase breadth and depth of knowledge in clinical areas in addition to research and management areas, depending on the SSC undertaken. Careers guidance should be integral at all stages of the medical school experience and should be tailored around the emerging competencies of the individual students.

40. Re 80: We believe that all SSCs should be justifiably relevant to medicine. These may include non clinical attachments which are nevertheless ‘related’ to the practice of
medicine by virtue of there impact directly or indirectly on clinical care. We would welcome clarification on whether there is any guidance on the breadth of SSC subjects students should undertake.

41. Re 85: This may be problematic in areas which are not ethnically diverse.

42. Re 87: There is nothing here about developing an awareness of health inequalities.

43. Re 90: We agree with the idea of Student Assistantships but we would like to see specific reference to the requirement to ‘train the trainers’. The junior doctors must be fully competent to carry out this role. The GMC’s remit as stated in the intro is, after all, to ‘support and training to those who supervise.’

44. Re 92: Anyone giving feedback must feel it is ‘safe’ to do so and there will be no adverse results if they give negative comments. This is particularly important for patients.

45. Re 94: We would suggest adding ‘and regularly reviewed’ at the end of the last sentence.

46. Re 94 & 101: There is potential for variation between schools based on differing curricula and assessment techniques.

47. Re 101: There should also be consistency of marking across medical schools.

48. Re 102: The transferability of learning portfolio between undergraduate and postgraduate phases is important but it should highlight strengths and weaknesses and be a structured part of the ongoing educational appraisal. We wonder if this would be best kept as a Personal Learning Needs log, which can be discussed with the newly qualified FY1 doctor and their first educational supervisor.

Domain 6 – Support and development of students, teachers and local faculty

49. There is nothing in this section about the support given to and by admin/non-academic staff, which may be substantial. Not infrequently students will turn to admin staff for help or support specifically because they are seen as non-threatening due to the fact that they are not academically concerned with the course.

50. Re 107: Adequate, accessible and confidential services must be provided or commissioned by medical schools to support these students.

51. Re 110: We note that evidence from doctors/teachers and students is not included in this area.

52. Re 112: It is particularly important that students know how to access appropriate support. It is not enough for them to just know that it is available.

53. Re 115: The need for careers guidance strategy is vital and very welcome.

54. Re 117: Students should also be given information on how to pursue these alternative careers, perhaps linking in with other university departments and tutors.

55. Re 118: It should perhaps be compulsory that students are registered with a general practitioner.
56. Re 123: It needs to be clarified as whom might be at risk of ‘death’ or ‘serious harm’. Is this harm to self, to others or both?

57. There could be mention of representation in this section (e.g. by the BMA).

**Domain 7 – Management of teaching, learning and assessment**

58. We have no comments on this domain.

**Domain 8 – Educational resources and capacity**

59. Re 138: Educational facilities and infrastructure are often currently inadequate or under-resourced with many GP surgeries struggle to find adequate space for medical students.

**Domain 9 – Outcomes**

60. Re 149: This should also include student feedback.

**Outcomes for graduates:**

61. Re 150: We think that word ‘safely’ should be mentioned here somewhere.

**Outcomes 1 – The doctor as a scholar and a scientist**

62. Re 153c: The links between work and health could be explored in this section.

63. Re 154b: It is not clear here what is meant to be ‘measured’.

**Outcomes 2 – The doctor as a practitioner**

64. Re 157: This is all very non specific. There is no mention of taking a psychiatric history and it does not specify actions such as examination of the optic fundi or performing rectal or vaginal examination, where appropriate. This is in great contrast to Box 1, a very detailed set of practical procedures which a graduate should be able to carry out.

65. Re 159d: The breaking of bad news should not be equated to discussing alcohol consumption etc. These merit separate items.

66. Re 160: Arguably, the standard that should be able to be delivered is Advanced Life Support, which should be mandatory in medical schools. Immediate Life Support is not sufficient.

**Outcomes 3 – The doctor as a professional**

67. Re 165: There does not seem to be anything here about the student’s awareness and understanding of or the effect his/her own limitations and prejudices may have.

68. Re 166c: Auditing the prescribing of others is used as the most relevant example, but this does not fit with self awareness which appears to be the context of this point.

69. Re 166f: This is fine as long as students have been adequately trained to do so.

Answers to specific consultation questions:
Standards for delivery of teaching, learning and assessment (pages 6-29 of the revised draft of *Tomorrow’s Doctors*)

1(a) Are the draft standards appropriate to ensure that medical education is delivered effectively?

70. Not sure

1(b) Can you explain why?

71. Standards can be interpreted differently in practice and, furthermore, their effective delivery in any educational setting depends not only on the standard aimed for but the expertise, resources and opportunities available. Saying 'must' or 'will' does not guarantee an ability to deliver to that standard.

2(a) Is the structure of the standards helpful?

72. Yes, though we have said previously that the outcomes section should come prior to the standards section.

2(b) Can you explain why?

73. Despite the sometimes legalistic tone of the language, they are reasonably clear and specific.

3. Please state for each Domain whether you believe that it is appropriately prescriptive.

Domain 1 – Patient Safety

74. Yes

Domain 2 – Quality assurance, review and evaluation

75. Yes

Domain 3 – Equality, diversity and opportunity

76. No

Domain 4 – Student selection

77. Not sure

Domain 5 – Design and delivery of curriculum including assessment

78. No

Domain 6 – Support and development of students, teachers and local faculty

79. Yes

Domain 7 – Management of teaching, learning and assessment

80. Yes
Domain 8 – Educational resources and capacity

81. No

Domain 9 – Outcomes

82. Yes

4 (a) Do you think that Domain 2 sets appropriate standards for quality assurance, review and evaluation?

83. Yes

4 (b) Can you explain why?

84. These standards appear to be in keeping with current procedures which are reasonably rigorous.

5 (a) The draft standards drop the requirement in the 2003 edition of Tomorrow’s Doctors that 25-30 per cent of a standard curriculum should normally be available for Student Selected Components. Do you agree that this requirement should be dropped?

85. Yes, but we consider the SSC to be an important area of the doctors training and believe that it should be either appropriately balanced with the core curriculum or incorporated into the core curriculum.

5 (b) Are you content with what the draft standards say about Student Selected Components? (Domain 5, especially paragraphs 65 and 77-80)

86. Not sure

5 (c) Can you explain why?

87. While we believe that there should be options in the curriculum, but we have to ensure that students cover all essential aspects of health. More time is required for core curriculum material, but we should explore the opportunities for students to exercise choice within it. We are concerned that if allowed greater choice students might avoid covering one aspect of health completely.

6 (a) The standards state at paragraph 82: ‘The structure and content of courses and clinical attachments should integrate learning about basic medical sciences and clinical sciences. Students should wherever possible learn in a context relevant to medical practice, and revisit topics at different stages and levels to reinforce understanding and develop skills.’ Do you agree?

88. Yes

6 (b) Can you explain why?

89. This is good sense and based on standards educational theory. The integration of the basic medical sciences and clinical sciences is essential. However, the unnecessary separation of biomedical, psychological and social and population sciences which are all basic medical sciences in paragraph 151 – 153 risks the possibility that some schools will not seek to integrate all of these basic medical sciences.
7 (a) The standards state at paragraph 83: ‘Medical schools should provide opportunities for students to work and learn with other health and social care professionals. This will help students understand the importance of teamwork in providing care.’ Do you agree?

90. Yes

7 (b) Can you explain why?

91. It is essential that medical graduates are fit for practice in the new NHS and therefore they must understand the interface between health and social care as well as the strength and limits of other professions, including those in health care management. This requirement is particularly important with regards to interprofessional communication, managing interpersonal work relationships, care pathways, patient safety and FY1 shadowing. Throughout your career working in different teams and with different health and allied care professionals is integral to your ability to provide high quality medical care. If not learnt and experienced from the start of your career this places you at significant disadvantage later.

8) Do you believe that the standards in Domain 5 would lead to medical students having more direct involvement than currently in delivering patient care?

92. Not sure

9 (a) We believe that students having more direct involvement in patient care would prepare them better for practice after they graduate, without endangering patient safety while they are students. Do you agree? (Domain 5, especially paragraphs 67 and 84-91)

93. Yes

9 (b) Can you explain why?

94. Direct involvement in patient care is the best learning experience and the document should place more emphasis on this. At present some medical schools have little early contact, and others are very constrained in their 'apprenticeship' style learning - this is not helped by historic SIFT imbalances and issues of NHS capacity to manage learners safely. However it is essential that more high quality learning does occur within the patient care setting as this is motivating, and students can make small contributions to care which are valuable in service as well as enhancing professionalism. With the right training and support for supervisors, student assistantships can be a powerful driver for promoting student involvement in patient care and the associated skills.

10 (a) The standards propose Student Assistantships. Do you agree? (Domain 5, paragraphs 67 and 90)

95. Yes

10 (b) Can you explain why?

96. Clinical assistantships allow students protected time to learn the roles and responsibilities of in a protected environment. We would encourage the GMC to point out that these assistantships can be offered and delivered in primary care as well as in secondary care. Our only concern is that adequate training for the supervisors is provided not only in terms of facilitation of learning but in ability to provide appropriate feedback. All potential safety issues must be suitably addressed.
97. It is not necessarily practical, however, to say that students must shadow the post they will do if they are going out of Deanery. They will have domestic commitments, concurrent core teaching, and many other medical schools will not be able to accommodate them. There are other matters relating to insurance and assessment problems.

10 (c) Should the standards be more prescriptive about Student Assistantship?

98. Not sure

10 (d) Can you explain why?

99. We would encourage the GMC to consider a minimum period of student assistantships.

11 (a) Do you agree that: ‘As part of the general induction provided for FY1 doctors, they must work with the FY1 in the post they will take up when they graduate’? (Domain 5, paragraph 91)

100. Not sure

11 (b) Can you explain why?

101. While this makes some sense, there may be considerable practical difficulties. The requirement to shadow their actual FY1 post could decrease geographical mobility of graduates either because of timetable clashes between the home Medical School and the distant Foundation School. Problems are likely to be exacerbated by the need to travel.

11 (c) Should the standards be more prescriptive about responsibility for meeting this requirement?

102. No, while Schools can be held responsible for ensuring that such preparation occurs within its partner Foundation School, it would be impossible for Schools to ensure such exposure with a distant Foundation School.

11 (d) Can you explain why?

103. No comment

12 (a) Do you think that Tomorrow’s Doctors should include requirements relating to ‘electives’?

104. Not sure

12 (b) Can you explain why?

105. It could be argued that “distant” electives fall securely within the SSC and no further specification is required. This should be clarified in the document.

12 (c) If so, what should these requirements be?

106. These requirements should be available to students and must be used to further general medical experience.
13 (a) Do you think that the paragraphs on feedback and assessment are appropriate in content and level of detail? (Domain 5, especially paragraphs 68-73 and 92-101)

107. Yes

13 (b) Can you explain why?

108. The requirements to contribute the role of assessments to staff and students, train examiners, development of explicit standards and compensation are all appropriate.

14 (a) Do you believe the draft guidance is appropriately prescriptive in relation to external examiners? (Domain 5, paragraph 97)

109. No, it is insufficiently prescriptive.

14 (b) Can you explain why?

110. External examiners are an essential part of inter-school quality control in the UK. However, greater consistency is required relating to the standards external examiners apply. Furthermore, clarity is needed about whether external examiners remit is solely to ensure the quality of the school’s assessment processes and their application or whether, and to what degree, they have a voice in individual pass and fail decisions. Such standardisation would be a substantial task and one which would require the GMC’s leadership. A process akin to the fitness to practice workshops could start this process.

15 (a) Do you believe that Tomorrow’s Doctors should encourage the use of pooled question banks for examinations?

111. Not sure

15 (b) Can you explain why?

112. As well as contributing to benchmarking, pooled question banks encourage efficiency, reproducibility and validity. However, the danger is that generic pooled questions or examination stations do not align themselves well with individual curricula, thus having a detrimental effect on assessment.

16 (a) Should it be a requirement that medical students demonstrate every outcome and skill in a summative assessment?

113. No

16 (b) Can you explain why?

114. It is not necessary that every student is tested summatively in every outcome and every skill.

17 (a) Do you think that the draft standards appropriately involve patients and the public in the design and delivery of medical education?

115. No, there is increased room for patients and the public to be involved across the board in medical education from admission, learning outcomes, curriculum, and in setting standards for pass fail decisions at graduation. Medical students must be able to
communicate effectively with patients and inspire confidence and capability as feedback from patients will help to develop essential skills.

17(b) How could that involvement be deepened?

116. The draft should do more to specify the role of patients. We are concerned that the document is not patient-centred enough. For example, the language in of the outcomes in section 9 reads like old fashioned bioscience-dominated curricula. To improve this we suggest that the standards are rewritten with lay input and that patients are involved in planning modules and exams.

18 (a) Do you think that the draft standards appropriately involve employers of doctors and providers of health care in the design and delivery of medical education?

117. No, more clarity is required on employer input and responsibility. To be fit for practise, medical graduates must demonstrate the ability to work within the organisational structures of the NHS. They must also be able to demonstrate corporate responsibility and understanding of basic leadership and organisational skills. Employers, including those in primary care, are well placed to judge those skills. Employers might therefore contribute to learning and assessment strategies.

18 (b) How could that involvement be deepened?

118. Providers are often involved as clinical tutors. However, at present NHS managers / employers need to great greater responsibility for the interface with undergraduates. Medical graduates should be aware of things such as significant event analysis and incident reporting for they start work. Managers could be more involved with senior student curricular planning.

Outcomes at graduation

19 (a) Do the draft outcomes set out the knowledge, skills and behaviour that the public expects of doctors entering the profession?

119. No

19 (b) Can you explain why?

120. We believe that they are too disease orientated and are not adequately patient-centred.

20 (a) Do the draft outcomes set out the knowledge, skills and behaviour that providers and employers need from graduates entering the workplace and the Foundation Programme?

121. Not sure

20 (b) Can you explain why?

122. There is little on potentially abusive situations and how medical graduates should be trained to recognise and deal with these situations. Such situations can be significantly damaging to patients but also to health care professionals if they are not provided with the skills to recognise and deal with them.

21 (a) Do the draft outcomes prepare students for practice in an ageing population where many people have a range of health problems?
123. Not sure

21 (b) Can you explain why?

124. While the curriculum should enable new doctors to cope with any age or set of clinical problems, there should be specific reference to dealing with co-morbidities and inter-actions which are becoming increasingly common as the population ages. Students should also receive teaching on identifying suspected “Elder Abuse” and the appropriate pathway to follow in instances when there is a suspicion.

22 (a) Some disabled students may have difficulties meeting some of the outcomes. Should any of the outcomes therefore be omitted?

125. No

22 (b) Can you explain why?

126. Widening access to the profession for disabled students is desirable and systems should be put in place to enable them to reach the outcomes by a different route, wherever possible. However, for reasons of patient safety, we do not think that any of the outcomes should be omitted.

23 (a) Should the wording for any of the outcomes be rephrased to clarify what could count as a ‘reasonable adjustment’ for disabled students?

127. No comment

23 (b) If so, please give details

128. No comment

Outcomes 1 - The doctor as a scholar and a scientist

24 (a) Do you think the title of this section is appropriate?

129. Yes, but ‘scholar’ is an old fashioned term.

24 (b) Can you explain why?

25 (a) Do you think the draft outcomes are appropriate in relation to applying scientific principles?

130. Yes

25 (b) Can you explain why?

131. No comment

26 (a) Should there be a more explicit expectation that students should acquire knowledge and understanding of science which is not of immediate and direct application to medical practice after graduation?

132. Yes

26 (b) Can you explain why?
133. Not all knowledge will be used straightaway after graduation. It will, however, provide a foundation for a lifetime of learning which will require an understanding of principles which may not be used in the early years of practice

Outcomes 2 - The doctor as a practitioner

27 (a) Do you think the title of this section is appropriate?

134. Yes

27 (b) Can you explain why?

135. No comment

28 (a) Do you agree with the requirements in relation to communication skills (paragraph 159)?

136. Yes

28 (b) If not, what would you change?

29 (a) Do you agree with the requirements in relation to immediate care of medical emergencies (paragraph 160)?

137. Not sure

29 (b) If not, what would you change?

138. It could be argued that an ILS qualification is not sufficient.

30 (a) The 2003 edition of Tomorrow’s Doctors states at paragraph 19m: ‘Demonstrate competence in cardiopulmonary resuscitation and advanced life-support skills.’ Graduates can ‘demonstrate competence in cardiopulmonary resuscitation’ by telling others what to do, rather than doing it themselves. The draft paragraph 160d states instead: ‘Provide Immediate Life Support and cardio-pulmonary resuscitation equivalent to current UK standards’. Do you agree with the proposed 160d?

139. Not sure

30 (b) If not, what would you change?

140. Arguably the standard of ALS should remain.

31 (a) Do you agree with the requirements in relation to prescribing skills (paragraph 161)?

141. Yes

31 (b) If not, what would you change?

142. These are ideal, providing that ST1 doctors are adequately supervised, and have some limitation on their prescribing. Some of these details, such as calculating doses and perhaps, sliding scales, could be learned at this stage, as in the past.
32 (a) Do you agree that competence in all the procedures in Box 1 is necessary at the point of graduation?

143. No, the listed skills must not be so detailed or extensive that it prevents students progressing. It must be continually updated as techniques and equipment rapidly change over time. We are concerned that this list diminishes the fundamental skills of making a diagnosis by thorough history and examination and gives undue weight to technical procedures, which are useful, but should be an adjunct to history and examination.

32 (b) If not, in which procedures in Box 1 do you think competence is not necessary?

144. These include:

- The testing of faeces for faecal occult blood
- Measuring CVP
- Setting up ECG
- Performing a pregnancy test

33 (a) Should the wording or the description for any of the procedures in Box 1 be rephrased to clarify what could count as a ‘reasonable adjustment’ for disabled students?

145. No

33 (b) If so, please give details.

34 Please list any additional practical procedures which you think should be included in Box 1

146. Please see paragraph 149

35 (a) Do you think that we should say that the list of practical procedures at Box 1 is not exhaustive and that medical schools may require students to demonstrate competence in additional procedures?

147. Yes

35 (b) Can you explain why?

148. Each Medical School can and should retain the right to specify what it requires of its students at graduation as long as these exceed the minimum requirements specified in Tomorrow’s Doctors. The list is not exhaustive, and this leaves some room for innovation and advances in practice.

149. Additional comments on Box 1:

- **Measuring blood pressure**: the requirement should be that this should be with manual AND automated devices

- **Oxygen sats**: these are NOT usually taken from the ‘ear lobe’ but using a finger tip device. Ear monitoring is reserved for critically ill and paediatric patients almost exclusively.

- **Glucose monitoring** at bedside: this is probably out of date as machines usually give a specific number.
• **Basic respiratory function tests**: it should state whether this is peak expiratory flow rate or spirometry, or both.

• **Use of Local Anaesthetics**: this is not defined well enough, as it stands the student could be expected to perform all local anaesthetic procedures, many of which would not be appropriate in the undergraduate setting.

• **Measuring body temperature**: Rectal temperature is not mentioned for measuring core temperature. Ear probes might not be as accurate.

• **Administering oxygen**: This does not mention assessment of the concentration of oxygen to be used.

Outcomes 3 - The doctor as a professional

36 (a) Do you think the title of this section is appropriate?

150. Yes

36 (b) Can you explain why?

151. Doctors are professionals and the title reflects their need to manage uncertainties.

37 (a) We have debated whether there should be a separate, additional section on ‘The doctor as a leader’. However, we think it would be unhelpful to separate leadership from other aspects of professionalism. Is it appropriate to include the leadership competencies required of new graduates within this section on ‘The doctor as a professional’?

152. Not sure. Leadership is an important area, perhaps warranting its own section. However, we do nevertheless recognise the close connection between leadership and professionalism. **The critical point is that we do not think that there should be a specific section on ‘the doctor as a professional’ as professionalism should be a common theme throughout the document.**

37 (b) Can you explain why?

153. Please see above.

38 (a) Do you agree with the requirement in relation to knowledge of the NHS (paragraph 168b)?

154. Yes

38 (b) Can you explain why?

155. Medical graduates must understand the environment where they will be working and the standards of the profession they are joining. Failure to understand both could cause risk to patients, risk to other health care professional and waste of resources. This is potentially important for both UK and EU graduates, and non-EU doctors.

Impact and implementation
39 (a) Do you think the impact assessment is an adequate representation of the impact the guidance would have in relation to equality and diversity?

156. No

39 b) What have we missed out?

157. The document notes the disproportionately represented professional and middle class entrants, but does not address how entrants reflect socio-economic demographics, in any way.

40 (a) Do you think the revised Tomorrow’s Doctors would pose any difficulties or barriers for particular communities or groups, such as disabled people or people from ethnic minorities or of particular religions and beliefs?

158. Yes

40 (b) Can you explain why?

159. It does not address how Medical Schools should be assessed on their widening the number of applicants from the working and unemployed socio-economic classes.

40 (c) Should changes be made to address these difficulties or barriers, and if so, what?

160. Yes. Medical Schools should be performance managed on the numbers of applicants they get reflecting the UK’s socio-demographic distribution, so that they have to find innovative ways to get a wide variety of people to apply for a place.

Privacy

41 (a) Do you agree with the proposals in the revised Tomorrow’s Doctors as they relate to collecting and using personal information?

161. Not sure

41 (b) Can you explain why?

162. Re Medical Schools making arrangements so that graduates’ areas of relative weakness are fed into their Portfolio: Perhaps this would be best kept as a Personal Learning needs log, which can be discussed with the newly qualified FY1 doctor and their first educational supervisor.

42 (a) Do you believe that the proposals relating to collecting and using personal information include appropriate detail?

163. Yes

42 (b) Can you explain why?

164. No comment

43 (a) Do you believe medical schools and other education providers have documented governance arrangements to ensure that personal information would be properly collected and used?
165. No

43(b) If not, why not?

166. No comment

**Resource implications**

Comments relating to:

(a) Prescribing and patient exposure

167. The prescribing improvements will require more teaching and assessment. Some of this increase in prescribing teaching could usefully be taught in primary care. The patient exposure will require resourcing, in particular increased GPs, who will need paying to replace their time in surgery, and to allow them to develop appropriate teaching and assessment skills, and that payment as NHS work should be superannuated. The students will need examining rooms in which to examine patients, and this will require capital and revenue funding to expand GP surgeries.

(b) Professionalism and leadership

168. The students should be allowed time off to take part in BMA activities (such as Regional Councils) and view NHS organisation boards. This could be part of a SSC, if considered directly relevant to medicine.

(c) Assessment

169. It could be argued that a single national assessment structure, with some flexibility built in though the use of an assessment menu, would be a worthwhile assessment.

(d) Quality management

170. This is okay.

(e) Student Selected Components

171. Student choice must remain an integral and important element of the medical school experience.

(f) Disability

172. Inclusivity must be supported and human resource and financial costs must be factored in.

45 (a) Do you think that we have correctly identified the six aspects of the revised Tomorrow’s Doctors likely to have the greatest impact on medical schools, the NHS and other bodies?

173. No

45 (b) Can you explain why?

174. A greater emphasis on a doctor workforce that represent our social diversity would potentially mean doctors being more ready to work throughout the country, and hopefully
lead to a virtuous circle, of encouraging more diverse doctors and the wider aim of increasing social mobility.

45 (c) If not, please say what additional aspects you would have covered and what practical steps, evidence or concerns would be involved in their implementation.

175. Medical Schools should be performance managed on the numbers of applicants they get reflecting the UK’s socio-demographic distribution, so that they have to find innovative ways to get a wide variety of people to apply for a place.

176. There are environmental implications caused by extensive travel to placements, which need inclusion and moderation. For example, telling a medical school to increase its student/patient contact by 8 weeks includes greater travel costs. Many schools have small numbers of students on placements who have to travel by car. Placements should, wherever possible, be accessible by public transport and supported group transport.

46 (a) Will medical schools be able to apply the revised Tomorrow’s Doctors from 2010/11?

177. Not sure

46 (b) If not, when should the revised Tomorrow’s Doctors apply to medical schools?

178. No comment

46 (c) Which requirements in the revised Tomorrow’s Doctors will pose the biggest challenge for medical schools?

179. The requirements on assessment and feedback and the training of assessors and teachers to engage with quality assured techniques.

General

47 (a) Is the balance in the draft Tomorrow’s Doctors about right between (a) education in scientific principles, methods and knowledge and (b) training in medical practice?

180. No comment

47 (b) Can you explain why?

48 (a) Do you think that the draft Tomorrow’s Doctors is written at the right level of generality/specificity?

181. No comment

48 (b) Can you explain why?

182. No comment

49 (a) Readers of the draft Tomorrow’s Doctors can look at the list of useful reading at Appendix 1 if they want more specific details about particular aspects of undergraduate education. Is this a good approach?

183. Yes
49 (b) What documents have we omitted that should be included?

184. Arguably a core curriculum should be the next step and should be authored jointly between the medical schools, GMC and clinicians, with patient input.

50 (a) Do you think that the draft Tomorrow’s Doctors would promote high standards in medical education?

185. Not sure

50 (b) Can you explain why?

186. It is rather legalistic in tone. This may lead to 'gaming' to appear as if delivering rather than being able to admit genuine problems.

51 (a) Do you think the draft Tomorrow’s Doctors would allow the General Medical Council to develop and implement an appropriate quality assurance framework for medical schools?

187. No, not necessarily (please see below).

51 (b) Can you explain why?

188. These are examples of additional items to quality assure:

- Culture – Is there a culture of support and challenge and awareness of diversity and respect for others?
- Curriculum – Is there a clear curriculum with all Educators understanding the part they play in delivery?
- Assessment – Are the assessment methods appropriate and implemented fairly and consistently?
- Faculty – Is the faculty appropriately trained, supported with sufficient time in their job plan?
- Careers – Is attention paid to raising awareness of career decisions?
- Balance – Is there sufficient balance between science and humanities?
- Resources – Are resources allocated fairly and transparently?
- Partners – Does the medical school have effective relationships with all its partners?
- Quality Control – Does the medical school have a systematic approach to quality management and quality improvement?

52 (a) Would the draft Tomorrow’s Doctors provide assurance that UK graduates will be robustly assessed against objective and consistent standards?

189. No

52 (b) Can you explain why?

190. Assessment is extraordinarily complex, dependent on time and expertise, and no document or standards can guarantee this. Ultimately, quality of assurance of medical education is dependent on QUABME teams. Each team is required to hold the school it visits to account and there remains a perception that there is variability between teams. The draft Tomorrow’s Doctors alone cannot correct this. Furthermore, it is arguable that the diversity of the curricula, thus the diversity of the assessment processes makes it difficult to quality assure.

53 Do you have any other comments on the draft Tomorrow’s Doctors?
191. Please see opening paragraphs

Dr Maureen Baker
Honorary Secretary of Council