

Response on Behalf of the Higher Education Academy to the General Medical Council Consultation on *Tomorrow's Doctors 2009: A Draft for Consultation* (closing 27 March 2009)

Authored by: Nigel Purcell and Megan Quentin-Baxter, Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine (MEDEV)

Introduction and Perspective

- 1) The Higher Education Academy (Academy) is delighted to respond to the GMC consultation on "Tomorrow's Doctors 2009". This response has been collated by the Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine on behalf of the Higher Education Academy in Learning and Teaching in Health (HEALTH) Network Group, and the Academy as a whole.
- 2) In making this response we have informally consulted a selection of constituency members; invited contributions from our 'nominated primary contacts' (NPCs) in all medical schools; consulted Academy disability groups and advocates; attended the ASME conference (5 February 2009); attended the GMC conference (2 March 2009); hosted an event to support Schools' responses to the call under the *Student Selected Component* theme; and hosted presentations from GMC staff at our relevant workshops falling within the consultation period. We understand that most (if not all) medical schools would wish to respond directly to the consultation.
- 3) Our submission has been circulated to and commented on by the Academy Senior Executive Group; members of our Advisory Board comprised of representatives of the Academy (including the two Subject Centres and the Subject Centre for Social Policy and Social Work (SWAP)); the host institutions for the two centres; British Medical Association (BMA) student representative; Council of Deans of Health (CDH); Dental Schools Council (DSC); General Dental Council (GDC); General Medical Council (GMC); Health Professions Council (HPC); Medical Schools Council (MSC); National Teaching Fellows Association (NTFA); Nursing and Midwifery Council (NMC); Royal College of Nursing (RCN) including a student representative; Skills for Health; Royal College of Veterinary Surgeons/Council of Heads of Veterinary Schools (RCVS/CHVS); and UK Public Health Association (UKPHA). We would like to extend our particular thanks to the GMC/MSD representative, Professor Nigel Bax (University of Sheffield) for his help in preparing this response.
- 4) This response is made from the perspective and priorities of the Higher Education Academy, whose mission is *to support the sector in providing the best possible learning experience for all students*. It aims to:
 - Identify, develop and disseminate evidence-informed approaches
 - Broker and encourage the sharing of effective practice
 - Support universities and colleges in bringing about strategic change
 - Inform, influence and interpret policy
 - Raise the status of teaching

Broad comments

- 5) Thank you for the opportunity to comment on the *Tomorrow's Doctors 2009: A Draft for Consultation*. We extend our congratulations to the Review Group on production of this thoughtful and considered draft. Our comments stem from the perspective and expertise of the Higher Education Academy. It would be inappropriate for us to comment in detail on some (e.g. clinical) aspects.
- 6) We broadly welcome the proposed texts outlined in the *introduction*, nine *domains* and three *outcomes* statements. These useful categories are succinct, generally mutually exclusive while encompassing and reflecting the need for flexibility in allowing schools to offer their own distinctive programmes. We see this flexibility as key to promoting educational innovation in the UK, and the development of excellence in all aspects of curriculum and support for students.
- 7) While the content of Tomorrow's Doctors 2009 remains broad, the context of *this consultation* appears to have been heavily influenced by the specific needs of the Foundation Years 1 & 2¹. While it is essential to recognise the needs of "employers" we would urge the GMC and the Review Group to retain a long-term view of medical education as a preparation for a whole career in medicine (including an understanding of research and research evidence), not just the immediate priorities of the Foundation Years 1 and 2.
- 8) The draft version of Tomorrow's Doctors appropriately references other GMC and PMETB guidance (such as *Good Medical Practice*²; *Duties of a Doctor*³; *Medical Students: Professional Behaviour and Fitness to Practise*⁴; *The New Doctor*⁵; *PMETB Quality Framework for Postgraduate Medical Education and Training in the UK*), and the QAA Code of Practice (such as *Work-based and Placement Learning*), etc.
- 9) However it is generally isolated from, for example, other drivers in Higher Education such as the National Student Survey (NSS), Higher Education Achievement Report (HEAR) and Research Assessment Exercise. There is an overall context of change in health care educational programmes, such as the HPC: "*Consultation on standards of education and training and standards of education and training guidance*" (November 2008); the GDC "*Validation via provisional registration - General consultation*" (March 2008). In 2009-10 the RCN will consult on statutory changes to Nursing and Midwifery Programmes in the UK. We recommend making reference to a wider range of policy drivers, particularly changing expectations of students, the NSS and current HE policy debate such as the DIUS debate on the future of higher education⁶.
- 10) We would like to see a re-ordering of the sections to put '*Outcomes for graduates*' before '*Domains*' as the present order gives undue emphasis to the managerial rather than educational priorities.
- 11) We would like to see a stronger emphasis on educational innovation and enhancement. The Academy is well placed to promote educational innovation and

¹ Illing, J. et al. (2009). How prepared are medical graduates to begin practice? A comparison of three diverse UK medical schools Final summary and conclusions for the GMC Education Committee. General Medical Council, <https://gmc-e-consultation.net/econsult/uploaddocs/Consult56/TD%20Impact%20assessment.pdf> (a. March 2009).

² GMC (2006). Good medical practice, General Medical Council, http://www.gmc-uk.org/guidance/good_medical_practice/ (a. March 2009).

³ GMC(2006). Duties of a doctor, General Medical Council, http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp (a. March 2009).

⁴ GMC (2008). Medical students: Professional behaviour and fitness to practise, General Medical Council, http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/professional_behaviour.asp (a. March 2009).

⁵ GMC (2007). The new doctor, General Medical Council, http://www.gmc-uk.org/education/postgraduate/new_doctor.asp (a. March 2009).

⁶ Denham, J. (2009). Debate on the future of higher education, Department for Innovation and Skills, http://www.dius.gov.uk/higher_education/shape_and_structure/he_debate.aspx (a. March 2009).

sharing good practice leading to the enhancement of the student learning experience in the UK. For example, Para97 (referring only to assessment and feedback) could be split and moved higher in the section, leaving clear the message that “*Medical schools MUST have in place mechanisms, TAKING ADVANTAGE OF SERVICES SUCH AS THOSE OFFERED BY THE HIGHER EDUCATION ACADEMY, to INNOVATE AND ensure comparability of standards with other institutions and to share good practice*” full stop, (deleting “*such as the appointment of external examiners. The duties and powers of external examiners must be explicit.*”). This latter section is discussed in 33) on page 5 below.

- 12) We would like to see a stronger emphasis on the use of new technology to evidence and underpin the delivery and quality management of the curriculum; and stronger context given to the role of simulation, as clearly signposted elsewhere⁷.
- 13) For complete clarity we would like to see a definition of the word ‘standards’, as used here, added to the glossary.

Specific comments

Introduction

- 14) Medical education is a shared educational provision between the Universities and NHS organisations. Universities are responsible for accreditation and assuring ‘fitness to practise’. The statements of responsibility should clearly indicate the clinical teaching provision implicit in “*The four UK Health Departments are responsible for deciding how students may have access to patients on NHS premises.*” (Para15), and “*The four UK Health Departments have the role of ensuring that NHS organisations work with medical schools so that students receive appropriate clinical training.*” (Para137).
- 15) Opportunities for clinical experience are threatened by the needs of other health care programmes and operational changes in some Foundation Trusts. What, if any, are the educational responsibilities of the independent health care sector?
- 16) It should clearly indicate in Para4 that NHS organisations must give medical students access at least equivalent to trainee status (as for trainee nurse and AHPs) in “*Making available the facilities, staff and practical support necessary for delivering the clinical parts of the curriculum, INCLUDING ACCESS TO PATIENTS.*”.
- 17) Responsibility for the ‘Appraisal’ of staff (Para34; Para103; Para109) is not clear. It would seem appropriate to clarify the responsibility for Appraisal (including any aspect of job plans involving undergraduate teaching) in the introduction, particularly Para4 or Para5 (or both).
- 18) We were pleased to see the ‘responsibilities of a doctor’ include Para5 BP2 “*Developing the skills and practices of a competent teacher if they are involved in teaching*” And Para5 PB4 “*Providing objective and honest assessments of student who they are asked to appraise or assess*”. We would recommend referring to the UK Professional Standards Framework⁸ and/or the Academy of Medical Educators⁹.
- 19) Para6 students should also “*RESPOND TO FEEDBACK and provide evaluations of their education for quality management purposes.*”.

⁷ CMO (2009). 150 years of the annual report of the CMO: on the state of public health 2008, DH, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206 (a. March 2009).

⁸ The Higher Education Academy on behalf of Universities UK (UUK), GuildHE and the four UK higher education funding councils (2006). United Kingdom professional standards for teaching and supporting learning in Higher Education (UK SPF), The Higher Education Academy. <http://www.heacademy.ac.uk/ourwork/policy/framework> (a. March 2009).

⁹ Academy of Medical Educators <http://www.medicaleducators.org/> (a. March 2009).

- 20) We would like to see stronger emphasis on learning outcomes for students in the context of 'teacher'.

Domain 1. Patient safety

- 21) We completely concur with the proposed standard and related statements (noting one point in 14) on page 3 above).

Domain 2. Quality Assurance, review and evaluation

- 22) For this vision to succeed it is essential that the GMC sends the strongest possible assurance to schools that the clinical education implicit in paragraph 4 – “*NHS organisations are responsible for*”. Reference to agreements between medical schools and clinical/vocational placement providers (e.g. “*Para24. The medical school will have agreements with providers of each clinical/vocational placement, and will have systems to monitor the quality of teaching and facilities on placements.*”) is made in at least 3 locations (Para24, Para33, (Para87 which refers to Domain 2), (Para133 which is appropriate and refers generally to Para24), and Para136), emphasising its importance, but each is inadequately worded. Much firmer wording should be included in Para24 to reflect the responsibility of the clinical/vocational placement provider. For example paragraph 24 could be amended to read “*The medical school will have agreements with providers of each clinical/vocational placement reflecting their statutory obligations (SUCH AS THOSE SET OUT IN 4 AND 5 ABOVE), and will have systems to monitor the quality of teaching and facilities on placements.*”). Subsequent references to these agreements (Para33, Para87 and Para136) could be reworded to refer to Para24.
- 23) Para29. We recommend changing the wording from “*should inform*” to “*MUST inform*”.

Domain 3. Equality, diversity and opportunity

- 24) We welcome statements of inclusion which we believe are appropriate to Tomorrow's Doctors 2009.
- 25) Para62 sentence: “*This includes the requirement to make reasonable adjustments for students with a disability.*” should be moved to follow Para143 sentence ending “*others with a disability.*” (in Domain 8).
- 26) Para128 could be adapted to “*The medical school must provide appropriate training INCLUDING EQUALITY AND DIVERSITY TRAINING*”.

Domain 4. Student selection

- 27) We concur with the statement, etc., set out in Domain 4. We particularly welcome the need for “*policies and procedures based on research into effective, reliable, and valid selection processes*”. This is an area which is still developing and we see on-going innovation in student selection, which needs to be matched with longitudinal studies of the impact of, for example, widening access programmes in the last eight years, in the next decade.

Domain 5. Design and delivery of curriculum including assessment

- 28) *Student assistantships*: We very cautiously welcome the notion of student assistantships as described in Domain 5. We believe that schools will respond directly on this point.
- 29) *Student Induction*: While we cannot offer a consensus view it seems to us that Student Induction (as described) is fraught with difficulty, in terms of assuring patient safety while achieving outcomes for students. We would recommend changing “*must*” for “*should*” “*work with the FY1 in the post that they will take up when they graduate*” and

adding “*where practicable*” to Para91. What if the FY1 is on leave; the post is vacant; or the post is in another country, etc.

- 30) *Inter-professional*: We would advocate a change to the text in Para83 “*Medical schools should provide opportunities for students to work and learn with AND FROM other health and social care professionals*” reflecting the CAIPE definition¹⁰. We believe that this change is essential to substantiate the claim that “*This will help students understand the importance of teamwork in providing care.*”
- 31) *Feedback*: We would slightly modify Para68 “*Students MUST have APPROPRIATE AND regular feedback on their performance.*”
- 32) *SSCs*: SSCs were viewed as beneficial for staff (to offer subjects in more depth than could be taught to all students) and students (to independently learn, from a broad range of topics), giving them choice during their programme. The workshop held by MEDEV clearly highlighted the on-going need for SSCs (including Electives) to be underpinned by broad principles and learning outcomes in an independent learning context to support “*depth AND BREADTH*”, “*student choice*”, and “*career development*”. It was strongly felt that the guidance should include a % of the programme to be delivered in SSCs, specifically change Para77 from “*must be an integral part of the curriculum*” to “*must be an integral part OF 10%-20% of the curriculum*”. We feel that the language could be agreed to ensure that SSCs were just as important as the ‘core’.
- 33) *External examiners*: Reflecting our recommendation in 10) on page 2 above we suggest that the remaining section of Para97 “*such as the appointment of external examiners. The duties and powers of external examiners must be explicit.*” should read “*MEDICAL SCHOOLS SHOULD APPOINT external examiners, whose duties and powers must be explicit AND CONFORMS TO THE QAA CODE OF PRACTICE.*”.
- 34) Para76 appears to contain a typo; the second line should read “second part” not “first part” (unless the document is reordered, as we recommend above).
- 35) Para85. Delete “*with patients*” to imply a wider range of people including staff, carers, families, etc.
- 36) We strongly endorse Para87 on clinical placements.
- 37) It was felt that Para138 should be amended to make explicit “*The educational facilities and infrastructure must be adequate to deliver the curriculum (INCLUDING SSCs)*”. If it is not appropriate to add it here, reference could be made in Para35 from “*allocation of funding and clear plans...*” to “*allocation of funding (INCLUDING SSCs) and clear plans...*”.

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

- 38) We strongly support the need for support, training and appraisal of those teaching or supporting students.
- 39) The statement “*All those teaching or supporting students must themselves be supported, trained and appraised.*” should be separated out as a distinct standard. Ideally faculty and teacher development would also be a distinct additional domain but we recognise that the domains are based on the PMETB standards, and so may be difficult to change.
- 40) We would recommend adding the words Para104 “*...guidance about the curriculum their placements, PERSONAL DEVELOPMENT PLANNING and how they will be assessed.*”.

¹⁰ CAIPE (2002). The definition of IPE, Centre for the Advancement of Interprofessional Education, <http://www.caipe.org.uk/about-us/defining-ipe/> (a. March 2009).

- 41) A single sentence to describe the faculty and staff development required seems inadequate to give this area the emphasis that it needs. The single quality term 'appropriately' is vague and unhelpful. A substantially increased set of quality criteria are needed here and in particular it would be very desirable to lay down minimum standards for all teachers including those teaching in clinical environments^{8,9}.
- 42) The ideal would be to recommend an appropriate national teacher recognition scheme such as the UK Professional Standards Framework⁸, and/or that of the Academy of Medical Educators⁹. It would be appropriate for those with a substantial involvement with students to achieve Fellowship and for those with a more limited involvement to achieve Associate status.

Domain 7. Management of teaching, learning and assessment

- 43) We believe that this domain is insufficiently distinct from Domains 2 and 5, and should be absorbed into them.

Domain 8. Educational resources and capacity

- 44) Would like to see a greater emphasis on the use of current educational technologies to enhance the students learning experience and counteract some of the limitations imposed on students by health providers. For example limits on access to clinical experience can be partially compensated for by increasingly sophisticated simulators.

Domain 9. Outcomes for graduates

- 45) Overall, the outcomes are well expressed, clear and helpful.
- 46) The 'Overarching outcomes' includes the idea of the graduate showing 'leadership' and being able to 'analyse complex and uncertain situations'. Some further clarification and guidance is needed in relation to the interpretation of both these terms.
- 47) All three broad outcomes are closely interlinked and it would be helpful to present them in a way that makes those links explicit. E.g. perhaps through a diagram showing the connections and relationship.
- 48) We would recommend swapping Outcomes 1 and 2 to put the doctor as a practitioner first.

Outcomes 1. The doctor as a scholar and a scientist

- 49) We strongly endorse the underlying principle that these terms are intended to convey – i.e. that the graduate should have a deep, yet practical understanding of the principles and evidence basis for their practice, however we are uncertain about the terms 'scholar' and 'scientist'.
- 50) We would also wish to see inclusion of the notion of the doctor as a teacher.

Outcomes 2. The doctor as a practitioner

- 51) Perhaps the list of procedures could be placed in an appendix. It is not clear whether all of these procedures listed are mandatory.

Outcomes 3. The doctor as a professional

- 52) We recommend changing "*Demonstrate ability to play various team roles including leadership*" which should read "*Demonstrate TEAM WORKING and ability to play various team roles including and leadership*".