



THE SECRETARY OF EDUCATION
WASHINGTON, D.C. 20202

October 31, 2001

Ms. Helen M. Skardhamar
Education Section
General Medical Council
178 Great Portland Street
London, WIN6JE, England
United Kingdom

Dear Ms. Skardhamar:

At the September 6, 2001 meeting of the National Committee on Foreign Medical Education and Accreditation (NCFMEA), the NCFMEA reviewed the information most recently provided by the General Medical Council (GMC) to reassess the comparability of the United Kingdom's standards to the standards used to evaluate programs leading to the M.D. degree in the United States.

I am pleased to inform you that at the meeting the NCFMEA determined that the current accreditation standards used by the GMC to evaluate medical schools in the United Kingdom are comparable to the standards used to evaluate programs leading to the M.D. degree in the United States (U.S.). This determination of comparability by the NCFMEA has a maximum duration of six years from the date of this letter, unless the Committee withdraws, extends or renews its determination prior to that date. Before expiration of the six-year period, the NCFMEA will seek to confirm that your standards and procedures for accrediting medical schools in the United Kingdom are still comparable to the accreditation standards applied to medical schools in the U.S. If so, its previous determination of comparability will be extended for another period.

The NCFMEA members wish to thank Professor Peter Rubin for attending the meeting to provide additional information regarding the status of medical accreditation activities in the United Kingdom. The members also wish to express their appreciation for the courtesies extended to Dr. Deal and Mr. James during their site visit to the GMC offices in July 2001. The information provided by Professor Catto and you during the July 2001 meeting was extremely helpful to the Committee's understanding of the United Kingdom's accreditation system for medical schools.

In an effort to keep apprised of the accreditation activities of the GMC, the NCFMEA has requested that the GMC submit annual reports to the U.S. Department of Education, with the first report scheduled for review at the September 2002 NCFMEA meeting. The purpose of the annual report is to provide the NCFMEA with a summary of accreditation activities, including the following information:

- **Overview of accreditation activities:** A summary of key activities by the GMC during the period covering August 2001 - June 2002, such as accreditation reviews conducted, accreditation decisions reached, accreditation conferences or training sessions held.
- **Summary of any changes or developments in the following areas:**
 - **Laws and Regulations:** Any changes in your country's laws or regulations affecting the accreditation of your medical schools.
 - **Standards, Processes and Procedures:** Any changes in the accreditation standards, processes or procedures that the GMC uses to evaluate and accredit medical schools.
- **Schedule of upcoming accreditation activities:** A listing of accreditation meetings and listing of on-site visits to medical schools and clinical clerkship sites planned for July 2002 - June 2003.

Please send the annual report by July 1, 2002, to the Executive Director of the NCFMEA at the address below:

Ms. Bonnie L. LeBold
Executive Director, NCFMEA
U.S. Department of Education
1990 K Street, NW - Room 7007
Washington, D.C. 20006-7563
U.S.A.

The Executive Director will contact you in the spring of 2002 to provide information regarding the September 2002 meeting and more details on submission of the annual report. In the interim, if you have any questions, please do not hesitate to contact Ms. LeBold at (202) 219-7009 (telephone), (202) 219-7008 (fax), or Bonnie.LeBold@ed.gov (e-mail).

As a result of the determination of continued comparability by the NCFMEA, any medical school in the United Kingdom that is accredited or approved by the GMC may apply to the U.S. Department of Education to participate in the Federal Family Education Loan (FFEL) program. If a medical school's application is approved, students enrolled in the school who are either U.S. citizens or permanent residents of the U.S. may receive FFEL loans to finance their medical education if they meet all other eligibility requirements. Medical schools that wish to participate in the FFEL program may obtain the proper application forms from the Foreign Schools Team at the following address:

U.S. Department of Education
Foreign Schools Team-Room 73C3
SFA/Schools Channel/CMO
830 First Street, N.E.
Washington, D.C. 20202-5340
U.S.A.

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Please note that it is not necessary for medical schools that are currently participating in the FFEL program to contact the Foreign Schools Team at this time; the status of those schools remains unchanged by the NCFMEA's decision of continued comparability.

Thank you very much for providing information regarding your country's accreditation of its medical schools. The NCFMEA members and the U.S. Department of Education appreciate your ongoing assistance in this matter.

Sincerely,

Rod Paige

cc: Professor Peter C. Rubin
Dean of Medicine
University of Nottingham



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NCFMEA	2001	(S) W

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U.S. Department of Education



**Staff Analysis
of the
Standards Used by
The United Kingdom
for the Evaluation of Medical Schools**

September 6, 2001

U.S. Department of Education

Staff Analysis
of the Standards Used by the
United Kingdom
For the Evaluation of Medical Schools

Prepared February, 2001
Amended August 2001

The *bolded and italicized portions* of this February 2001 analysis *reflect new information* that was presented by the United Kingdom to support its comparability with the system of accreditation used in the United States to evaluate medical education. The balance of the text represents the analysis as presented at the February 2001 meeting of the NCFMEA.

Background

At its February 17, 1995 meeting, the National Committee on Foreign Medical Education Accreditation (NCFMEA) determined that the standards of accreditation used by the United Kingdom to accredit medical schools offering programs leading to the M.D. (or equivalent) degree were comparable to standards of accreditation applied to M.D. programs in the United States. The NCFMEA reviews the comparability of countries' standards on a periodic basis, and in June 2000, the United Kingdom was provided a copy of the NCFMEA's new guidelines and requested to provide information to demonstrate compliance with those guidelines. The information provided by the United Kingdom in response to that request is the subject of this analysis.

At its February 2001 meeting, the NCFMEA deferred a decision on whether the United Kingdom's accreditation process continued to be comparable to that used in the United States until further information could be gathered. On July 24, 2001 a representative from the NCFMEA and a member of Department staff met with representatives of the General Medical Council (GMC) to discuss, more fully, the GMC's role in the evaluation of medical schools in the United Kingdom.

Summary of Findings

In many respects, the system used by the United Kingdom to evaluate medical education in that country may be considered to be generally comparable to the evaluation/accreditation system used in the United States. However, it should be noted that there is, in the United Kingdom, a history of pedagogical autonomy among the

universities. Given this history, the evaluation process used by the United Kingdom to evaluate medical education does not evaluate many of the aspects of medical education deemed important in the United States, such as a specific curriculum model, medical college administration and management, student services, educational resources, faculty qualifications and faculty issues, etc.

GMC representatives noted that their previous response is technically correct in that the law does not specifically give the GMC the authority to dictate to universities many aspects of their process for delivering medical education. However, in practice, the Education Committee always reviews all of the processes related to medical education to ensure that a quality medical education is being provided. The chair of the EC also stated that such a review was within its purview since the EC is responsible for the overall quality of medical education and those processes impact the quality of education offered at the universities.

Based upon the information gathered during the meeting between United Kingdom representatives and the Department's representatives, it does appear that the country has an evaluation system that is comparable to that used to accredit medical schools in the United States.

Staff Analysis

PART I: The Entity Responsible for the Accreditation/Approval of Medical Schools

There should be a clearly designated body responsible for evaluating the quality of medical education in the foreign country, and that body should have clear authority to accredit/approve medical schools in the country that offer educational programs leading to the M.D. (or equivalent) degree.

All of the medical schools in the United Kingdom derive their legal authority to provide medical education from the United Kingdom's Medical Act of 1983. That Act notes that the Education Committee (EC) of the General Medical Council (GMC) is the body that ensures that the medical education provided by the medical colleges is sufficient to prepare students to practice medicine.

The United Kingdom's Medical Act of 1983 consolidated two previous pieces of legislation, the Medical Acts of 1956 and 1978. As part of this process, the 1983 Act continues the existence of "... a body corporate known as the General Medical Council (in this Act referred to as 'the General Council') having the functions assigned to them by this Act."

In pursuance of the implementation of the General Council's powers, there "shall continue to be four committees of the General Council known as the Education Committee, the Preliminary Proceedings Committee, the Professional Conduct

Committee and the Health Committee (in this Act referred to as 'the statutory committees')...."

The statutory charge given to the Education Committee of the General Medical Council is as follows:

"The Education Committee shall have the general function of promoting high standards of medical education and coordinating all stages of medical education."

"For the purpose of discharging that function the Education Committee shall-

- (a) determine the extent of knowledge and skill which is to be required for the granting of primary United Kingdom qualifications and secure that the instruction given in universities in the United Kingdom to persons studying for such qualifications is sufficient to equip them with knowledge and skill of that extent;
- (b) determine the standard of proficiency which is to be required from candidates at qualifying examinations and secure the maintenance of the standard; and
- (c) determine patterns of experience which may be recognized as suitable for giving those engaging in such employment...."

The Education Committee may appoint inspectors to review the medical education offered at universities to determine that the education is sufficient to allow individuals to become proficient medical practitioners. Although the information provided indicated that the United Kingdom does evaluate the effectiveness of the medical programs offered at universities, there was no guidance that indicated that this was done on a regular basis. The Medical Act of 1983 simply states that the Education Committee may appoint individuals to visit medical schools to determine the sufficiency of the medical instruction.

The GMC representatives noted that the Education Committee (EC) is responsible for ensuring the quality of education offered at United Kingdom medical schools. The GMC representatives noted that, historically, the Education Committee has regularly reviewed the quality of education offered in the medical schools and will continue to do so on a regular basis. It was stated that reviews would take place at a minimum of every five years.

PART II: Accreditation/Approval Standards

The entity within the foreign country that is responsible for evaluating the quality of medical education in the country and has authority to accredit/approve medical schools should have standards comparable to the following:

1. Mission and Objectives

- (a) The educational mission of the medical school must serve the general public interest, and its educational objectives must support the mission. The medical School's educational program must be appropriate in light of the mission and objectives of the school.**
- (b) An essential objective of a program of medical education leading to the M.D. (or equivalent) degree must be to prepare graduate to enter and complete graduate medical education, qualify for licensure, provide competent medical care, and have educational background necessary for continued learning.**

The Education Committee of the General Medical Council has produced a publication entitled Tomorrow's Doctors: Recommendations on Undergraduate Medical Education hereafter referred to simply as Recommendations or Tomorrow's Doctors, that provides guidance to medical schools on the medical training that should be provided. The Committee's guidance is referred to in the publication as The Recommendations. The Recommendations include guidance on the goals and objectives for medical education within the United Kingdom. Specifically, they establish that the goals of a medical education program are that -

- a. The student should acquire a knowledge and understanding of health and its promotion, and of disease, its prevention and management, in the context of the whole individual and his or her place in the family and in society;**
- b. The student should acquire and become proficient in basic clinical skills, such as the ability to obtain a patient's history, to undertake a comprehensive physical and mental state examination and interpret the finding, and to demonstrate competency in the performance of a limited number of basic technical procedures;**
- c. The student should acquire and demonstrate attitudes necessary for the achievement of high standards of medical practice, both in relation to the provision of care of individuals and populations, and to his or her own personal development.**

The GMC's publication *Questionnaire for the Education Committee's Monitoring of the Implementation by UK Universities and Their Medical Schools/Faculties of its Recommendations on Basic Medical Education*, a document recently

forwarded to the Department, asks that schools submit evidence that they are implementing the goals and objectives for medical education stated in Tomorrow's Doctors. Further, teams evaluate medical schools to determine if those goals and objectives are being met.

2. Governance

- (a) The medical school must be legally authorized to provide a program of medical education in the country in which it is located.**
- (b) There must be an appropriate accountability of the management of the medical school to an ultimate responsible authority external to and independent of the school's administration. This external authority must have sufficient understanding of the medical program to develop policies in the interest of both the medical school and the public.**

The only medical colleges legally authorized to grant medical degrees are those listed in the Medical Act of 1983. Only graduates with degrees conferred by the colleges listed in the Medical Act may register to practice medicine in the United Kingdom.

Regarding the accountability of the management of a medical school, the GMC reported that medical schools were accountable to their parent universities, and that the universities are accountable to higher education funding councils for public funding that provides funding to the universities. The GMC does not oversee the management of the medical schools; however, the GMC did note that the Higher Education Funding Council for England has contracted with the Quality Assurance Agency to conduct reviews of higher education institutions, including the medical schools, in England and Northern Ireland.

As stated above, the responsibility for the management of a medical school rests with the parent university. The QAA reviews an institution to determine that the institution is functioning according to its self-stated processes and objectives. The Education Committee of the GMC reviews the management of the school to determine that the management of the school is adequate to ensure that a quality medical education is provided. Information is shared between these two groups.

3. Administration

- (a) The administration of the medical school must be effective and appropriate in light of the school's mission and objectives.**
 - (i) There must be sufficient administrative personnel to ensure the effective administration of admissions, student affairs, academic affairs, hospital and other health facility relationships, business**

and planning, and the other administrative functions that the medical school performs.

- (ii) The chief academic officer of the medical school must have sufficient authority provided by the institution to administer the educational program. That individual must also have ready access to the university president or other university official charged with final responsibility for the school, and to other university officials as are necessary to fulfill the responsibilities of the chief academic officer's office.
- (iii) In affiliated institutions, the medical school's department heads and senior clinical faculty members must have authority consistent with their responsibility for the instruction of students

The GMC states that the administrative functions of a medical school are matters for the universities to decide. The GMC does not have any governing authority over how medical schools are administered.

However, the GMC did provide a copy of a report on the Education Committee's informal visits to medical schools from 1995 to 1998. The report notes that the members of the visiting teams had "an appropriate range of medical expertise and knowledge of medical education." And in their response, the GMC noted that an administrator familiar with the Education Committee's policies accompanies the team.

During the meeting with the GMC representatives, it was stated that the teams sent out to review medical schools do ensure that schools have effective administrative practices and are staffed with qualified individuals. The EC also noted that they also keep a close watch on admission criteria for entry to medical schools and how students are progressing through their program. Action would be taken if it was determined that a problem existed in these areas.

- (b) The chief academic official of the medical school must be qualified by education and experience to provide leadership in medical education.

The country notes that this issue is under the purview of the universities and therefore, does not have guidelines covering them.

As noted previously, the law does not specifically give the GMC the authority to dictate the qualifications chief academic officials should have at universities; however, in practice, the Education Committee always reviews the qualifications of the administrative staff to ensure that they are fully qualified. The chair of the EC stated that such a review was within its purview since the EC is responsible for the overall quality of medical education and, as such, sufficiently trained and

experienced administrative officials impact the quality of education offered at the universities.

- (c) The medical school may determine the administrative structure that best suits its mission and objectives, but that structure must ensure that the faculty is appropriately involved in decisions related to--**
 - (i) Admissions;**
 - (ii) Hiring, retention, promotion, and discipline of faculty; and**
 - (iii) All phases of the curriculum, including the clinical education portion;**

The Recommendations state that admissions practices and selection of students rests with the universities. Hiring, retention, promotion, and discipline of the faculty would also be the responsibility of the University. Although the curriculum falls under the responsibility of the medical schools, the GMC makes an effort to determine whether the curriculum issues discussed in The Recommendations are implemented in medical schools within the United Kingdom.

The Chair of the EC clearly stated that they review all of these elements since they are all related to the overall quality of education offered at medical schools. The Chair also noted that it would be expected that faculty are involved in the development of the curriculum. There is a requirement that medical schools review their curriculum on a regular on going basis. In the GMC publication - Questionnaire for the Education Committee's Monitoring of the Implementation by UK Universities and Their Medical Schools/ Faculties of Its Recommendations on Basic Medical Education, medical schools are required to provide information on their admissions practices, all phases of the curriculum, and faculty staff development. Team evaluators are required to review all of these issues during site visits.

- (d) If some components of the educational program are conducted at sites that are geographically separated from the main campus of the medical school, the school must have appropriate mechanisms in place to ensure that--**
 - (i) The educational experiences at all geographically separated sites are comparable in quality to those at the main campus; and**
 - (ii) There is consistency in student evaluations at all sites.**

The GMC reports that the issues in this section of the NCFMEA's guidelines also fall under the purview of the universities and therefore, it does not have any guidelines covering these issues. The GMC did note in its response to the guidelines, however, with regard to consistency in student evaluations, it would expect consistency in medical student assessments and evaluations at sites that are geographically separated from the main university. The GMC also provided a copy of a report of the Education Committee's informal site visits conducted between 1995 and 1998 that showed that student assessment was reviewed by the site visit teams.

The Chair of the EC noted that there are no geographically separated sites in the United Kingdom; however, site teams do visit major clinical sites.

4. Educational Program

- (a) Duration:** The program of education leading to the M.D. (or equivalent) degree must include at least 130 weeks of instruction, scheduled over a minimum of four calendar years.

Section 63 of Tomorrows Doctors states that a program of study leading to a medical degree must follow European Community directives. European Community directives state that basic medical training shall be a six-year course of study or 5,500 hours of theoretical and practical instruction given in a University.

The basic undergraduate medical program is five years in length with the first two and years covering the basic sciences, the next three years covering clinical rotations of varying lengths for all specialties. Following graduation, students undertake additional clinical training, referred to by the UK as the Pre-registration House Officer (PRHO) training, that covers longer term clinical rotations in surgery, general practice, and possibly one other medical specialty.

- (b) Curricular Content:** The medical school's curriculum must provide students with general professional education, i.e. the knowledge and skills necessary to become a qualified physician. At a minimum, the curriculum must provide education in the following:
 - (i) The sciences basic to medicine, including—**
 - (A) The contemporary content of those expanded disciplines that have traditionally been titled anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine; and**

(B) Laboratory or other practical exercises that facilitate the ability to make accurate quantitative observations of biomedical phenomena and critical analyses of data.

The standards used by the GMC are not prescriptive in dictating a specific medical school curriculum. Rather, this is left to the discretion of the individual medical schools. It should also be noted that there is, in the United Kingdom, a history of pedagogical autonomy among the universities.

The GMC refers to "the core curriculum" and "Regulation of the undergraduate course" found in Tomorrow's Doctors as the source for meeting this requirement. However, the discussions within these topics do not dictate specific curriculum course requirements such as courses in the sciences basic to medicine, a variety of clinical subjects, and various ethical, behavioral, and socioeconomic subjects. It seems that the Education Committee provides the framework of what a medical school should cover in its curriculum without dictating what curriculum should be followed. The Committee's report (Tomorrow's Doctors) notes that the core curriculum "requires the joint involvement of both basic scientists and clinicians and mutual agreement on the essential components of the course."

In addition, the Regulation indicates that "reverting to the requirements of the Act, the Education Committee follows the example of its predecessors and sets out its determinations in the form of a series of objectives, which circumscribe a framework on which all medical schools will build their curricula. While it is the acquisition of knowledge and skill that is emphasized in the Act, we would regard the development of appropriate attitudes as of equal importance."

The objectives are classified under three categories with each category identifying the skills and knowledge that medical students must demonstrate at the end of their medical training. They are as follows:

- a. Knowledge objectives – covers the basic sciences, diseases, environmental and social determinates of disease, principles of therapy, reproduction, human relationships, the importance of communication, ethical and legal issues in medicine, and the organization and management of healthcare.
- b. Skills objectives –covers basic clinical methods, basic clinical procedures, and basic computing skills as applied to medicine.
- c. Attitudinal objectives –covers respect for patients and colleagues, patient's rights, the continual pursuit of knowledge, the moral and ethical responsibilities in patient care, the peer-review process, willingness to contribute professionally to the community, the need for continuing professional development, and the need to contribute to the advancement of medical knowledge.

Further, the Tomorrow's Doctors indicates that most medical schools adopt their own curriculum design in accordance with pursuing the objectives. Therefore, it appears that there is no single paradigm for the core curriculum superior to others, but themes common to all, e.g. clinical method, practical skills and patient care, communication skills, human biology, human disease, man in society, public health, handicap, disability and rehabilitation, research and experiment.

The Chair of the EC noted that while there is no specificity in Tomorrow's Doctors regarding the basic sciences, every site team would have a basic science member that ensures that the curriculum covers all the courses outlined in this section. Any deficiencies found in the basic sciences curriculum would be noted in the team report and the university would have to take corrective action.

- (ii) A variety of clinical subjects, including at least the core subjects of internal medicine, obstetrics and gynecology, pediatrics, surgery, and psychiatry and, preferably, family medicine.

Note 1: Medical schools that do not require clinical experience in one or another of the above disciplines must ensure that their students possess the knowledge and clinical abilities to enter any field of graduate medical education.

Note 2: Clinical instruction must cover all organ systems and include aspects of acute, chronic, continuing, preventive, and rehabilitative care.

Note 3: The medical school's program of clinical instruction must be designed to equip students with the knowledge, skills, attitudes, and behaviors necessary for further training in the practice of medicine.

Note 4: Instruction and experience in patient care must be provided in both ambulatory and hospital settings.

Note 5: Each required clinical clerkship (or equivalent) must allow the student to undertake thorough study of a series of selected patients having the major and common types of disease problems represented in the clerkship.

The GMC refers to the issue of clinical experience before graduation in the following sections of Tomorrow's Doctors:

"This theme will clearly have relevance to all the integrated courses comprising the core. It embraces every aspect of clinical study. We have already argued a case against the perpetuation of the traditional pre-clinical/clinical which we believe has militated against a reduction of the content of the course to reasonable proportions. We now see benefit in students being involved with

people from outside their peer group right from the beginning of their course. Some schools have developed very successful programs which bring junior students into contact with families in which a baby is expected or there is an elderly or disabled member. Others have introduced first year students to hospital patients and have encouraged early acquisition of the skills of history taking and examination. One school involves its junior students in community projects which are not necessarily medically oriented." (Section 43)

"While it will be in later years of the course the students acquire most of their clinical experience, the success of experiments of the type illustrated above encourages belief in the advantages of early clinical contact. We recommend this development and at the same time advocate its corollary, the continuation of a substantial basic science component into the later years of the course." (Section 44)

"Clinical teaching must adapt to the changing patterns of patient care in the health service, not simply as an expedient but because medical education should reflect the realities of modern medicine. Students in future will gain more of their clinical experience in out-patient clinics, in general practice and in community health services than they have in the past. The traditional series of attachments of fixed duration to hospital firms may be replaced by a more broadly based supervisory system which ensures that each student obtains the clinical experience laid down in the curriculum and demonstrates proficiency in the requisite clinical skills." (Section 45)

The GMC has developed a booklet on clinical training entitled The New Doctor, Supplement on general clinical training in general practice. This publication provides general information on how clinical training should be conducted, but does not provide any specific guidance on the types or length of clerkships. For example, it notes that clinical training should allow doctors to communicate with patients, understand how to make competent decisions, and understand how preventive medicine is practiced in general practice. The New Doctor also describes what should be covered in learning agreements and the roles and responsibilities of the postgraduate dean, the educational supervisor, and the practice staff.

As noted in the discussion above, Tomorrow's Doctors states that the curriculum requires students to be exposed to "every aspect of clinical study." The Chair of the EC stated that this meant that students were to receive clinical training in all medical specialties. Although at most universities clinical experiences are integrated throughout the entire curriculum, the curriculum allows for a total of three years of clinical training. The first phase of clinical training provides students with clinical rotations of varying lengths that cover all the medical specialties. The second phase of training focuses on five core areas: internal medicine, surgery, obstetrics, gynecology, and psychiatry. The last phase is a year of clinical training referred to as the Pre-Registration House Officer (PRHO)

training. During the PRHO-phase, students may select one of three models to follow:

- **Two six-month clerkships, one in medicine and one in surgery.**
 - **Three four-month clerkships, in medicine, surgery, and a specialty at a university approved post.**
 - **Four three-month clerkships, in medicine, a medical specialty, surgery, and a surgical specialty.**
- (iii) **Disciplines that support the fundamental clinical subjects, such as diagnostic imaging and clinical pathology.**

The GMC did not address this issue.

- (iv) **Ethical, behavioral, and socioeconomic subjects pertinent to medicine.**

Tomorrow's Doctors outlines in section 40.3 several attitudinal objectives that should be the goals of all undergraduate medical education including:

"respect for patients and colleagues that encompasses, without prejudice, diversity of background and opportunity, language, culture and way of life;

"the recognition of patients' rights in all respects, and particularly in regard to confidentiality and informed consent;"

"awareness of the moral and ethical responsibilities involved in individual patient care and in the provision of care to populations of patients; such awareness must be developed early in the course;"

The GMC's publication *Guidance for Education Committee Visitors to Medical Schools in 1998-2001* requires visitors to ensure that a medical school's curriculum includes instruction in legal and ethical issues in medicine. The GMC's publication *Questionnaire for the Education Committee's Monitoring of the Implementation by UK Universities and Their Medical Schools/Faculties of its Recommendations on Basic Medical Education* asks medical schools to ensure that "health promotion, illness prevention, the targeting of populations' needs and awareness of environmental and social factors in health and disease continue to form a key element in student learning during the primarily clinical years."

- (v) **Communications skills integral to the education and effective function of physicians, including communication with patients, families, colleagues, and other health professionals.**

The GMC addresses communications skills under section 46 of Tomorrow's Doctors. Communication skills are to be developed in order to ensure that doctors communicate effectively with medical and nursing colleagues as well as patients. Section 46 states:

"Doctors must be good listeners if they are to understand the problems of their patients and they must be able to provide advice and explanations that are comprehensible to patients and their relatives. Skill in communication is also at the heart of counseling and is an essential ingredient in the establishment of effective teamwork."

The section also points that out communicating through the written word is as important as the ability to communicate orally.

(c) Design, Implementation, and Evaluation:

- (i) **There must be integrated responsibility by faculty within the medical school for the design, implementation, and periodic evaluation of all aspects of the curriculum, including both basic sciences and clinical education.**
- (ii) **The medical school must regularly evaluate the effectiveness of its medical program by documenting the achievement of its students and graduates in verifiable ways that show the extent to which institutional and program purposes are met. The school should use a variety of measures to evaluate program quality, such as data on student performance, academic progress and graduation, acceptance into residency programs, and postgraduate performance; the licensure of graduates, particularly in relation to any national norms; and any other measures that are appropriate and valid in light of the school's mission and objectives.**

Development of the curriculum is left to the universities. The GMC did not provide any information regarding the involvement of faculty in the development and evaluation of the curriculum.

The GMC representatives stated that it would be expected that the faculty must be involved in the development and implementation of the curriculum. The lack of faculty involvement would be a concern to the GMC. Every university must have a curriculum review committee that consists of all communities of interest including faculty, clinicians, administrators, and public members. Evaluation

team members ensure that curriculum review committees are established, functioning, and have proper representation. Further, medical schools must review their curriculum on a regular basis.

All universities must demonstrate that they have effective measures to evaluate the quality of medical education being offered. The EC does not determine what measures are used but does require that schools demonstrate that students have obtained the necessary skills to become effective medical practitioners. The Questionnaire for the Education Committee's Monitoring of the Implementation by UK Universities and Their Medical Schools/Faculties of its Recommendations on Basic Medical Education asks schools to answer the following four questions:

- **"How do you define the product of your medical school, in terms of these goals and objectives [defined in Tomorrow's Doctors], and of our code of professional conduct?"**
- **"How do you seek to guarantee to the GMC, employers and the public that every graduate of your medical school has attained the necessary goals and objectives and is 'fit for purpose' as a registered doctor and pre-registration house officer?"**
- **"What are the threshold standards applied by your university for graduation in medicine?"**
- **"How do you ensure that in addition to the necessary professional skills, your graduates possess the expected range of transferable skills including those in communication, informatics, presentation and teamworking?"**

5. Medical Students

(a) Admissions, Recruiting, and Publications

- (i) The medical school must admit only those new and transfer students who possess the intelligence, integrity, and personal and emotional characteristics that are generally perceived as necessary to become effective physicians.**
- (ii) A medical school's publications, advertising, and student recruitment must present a balanced and accurate representation of the mission and objectives of its educational program. Its catalog (or equivalent document) must provide an accurate description of the school, its educational program, its admissions requirements for students (both new and transfer), the criteria it uses to determine that a student is making**

satisfactory academic progress in the medical program, and its requirements for the award of the M.D. degree (or equivalent).

- (iii) Unless prohibited by law, student records must be available for review by the student and an opportunity provided to challenge their accuracy. Applicable law must govern the confidentiality of student records.**

The GMC reports that it has no responsibility for the admission of medical students and notes that this issue is a matter for the universities. However, it reports that it does address the intelligence, integrity, and characteristics of the students admitted to the United Kingdom's medical schools in various sections of Tomorrow's Doctors. In section 57, the document indicates that "medical schools admit the majority of their students direct from school although many, rightly in our view, encourage deferment for a year. Most provide a limited number of places for mature students. It is right that opportunities should be afforded to those who decide on a career in medicine after gaining experience in other fields and such entrants often prove to be an asset within the student body."

Section 58 further explains that "the definition of criteria for the selection of medical students is a matter for individual universities but the Education Committee would like to encourage the trend towards liberalization of entry requirements so that students may continue to study a broader range of subjects in their later years at school. It is important that school teachers and career advisers should be well informed about and able to rely on the criteria for entry laid down by medical schools so that they may advise their pupils with confidence."

Lastly, section 59 maintains that medical schools recognize that there is considerable variation in the maturity rate in the age range with which they are principally concerned. Moreover, they do not have the resources for sophisticated or extended selection procedures. They are, therefore, obliged to rely more heavily on evidence of academic achievement at school than they might wish, especially at a time when there is increasing emphasis on the non-academic attributes that are expected in members of the medical profession. Looking to the future, the possibility of developing a selection procedure that explores some of these attributes and attitudes and that is administered on a consortium basis should not be excluded."

The GMC did not provide any information pertaining to publications, advertising, and student recruitment. In addition, it reported that student access to their records and confidentiality of student records are issues that are addressed by the universities.

The EC Chair stated that the Committee requires universities to only admit qualified students. The questionnaire sent to all schools prior to a visit asks them to provide information on the selection procedure including what criteria

are used in selecting students, how selection committee members are trained, and how the university makes the public aware of the school's approach to selecting students. Evaluation teams are required to examine a school's selection process.

(b) Evaluation of Student Achievement

- (i) The medical school faculty must establish principles and methods for the evaluation of student achievement, including the criteria for satisfactory academic progress and the requirements for graduation.**
- (ii) The medical school's evaluation of student achievement must employ a variety of measures of student knowledge, competence, and performance, systematically and sequentially applied throughout the medical program, including the clinical clerkships.**
- (iii) The medical school must carefully monitor the progress of students throughout their educational program, including each course and clinical clerkship, must promote only those who make satisfactory academic progress, and must graduate only those students who successfully complete the program.**

The GMC refers to Tomorrow's Doctors under the heading of "Assessment" to address the issues of successful program completion and subsequent awarding of the first professional credential. Section 54 explains that "the assessment procedures of the two parts of the (medical school) course will differ. The core, as it is aimed at equipping the newly qualified doctor to begin the first pre-registration house officer post, must be tested rigorously, in the interests of the public and of the integrity of professional standards. We would recommend the development of a system of progressive assessment that monitors the acquisition and utilization of core knowledge, that explores attitudes and that requires certification of the achievement of competence in the skills demanded by the course. Success in satisfying the assessors of the core component of the course must provide an assurance that the graduate is now fit to take responsibility for the care of patients, albeit under supervision. Such a process of progressive assessment as a major determinant of qualification represents a major departure from the traditional pattern of the final examination. For the purposes of the Medical Act, the assessments will come within the definition of "qualifying examinations." Because of their significance in terms of qualifying, careful monitoring of the achievements of individual students will be necessary. A number of schools have already established effective logbook or computer-based systems for recording student

experience and performance; some have built into their systems the collection of data relating to the fulfillment of teaching contracts and the quality of teaching."

Section 55 maintains "the assessment of the special study module component of the course will require different, but no less important procedures. Demonstration of satisfactory achievement will be as essential to qualification as will be a pass in the core subjects; students should be aware that equal weight will be attached to both. It is likely that assessment of special study modules will provide a means of identifying outstanding achievement and so may assist in the decisions on the award of honors and distinctions. Methods of assessment will vary according to the type of study undertaken but will often take the form of a short dissertation. Again we would acknowledge the amount of work that will fall to supervisors and examiners if fair and consistent standards of assessment are to be maintained."

Further, section 56 indicates "the changes in the assessment system described above will require considerable modification of existing roles and practices of both internal and external examiners. Just as there is increasing emphasis on the need to provide teachers with assistance towards improving their skills, so to guidance, if not training, will be required for those who examine in the new system."

The GMC's questionnaire that medical schools must fill out prior to a visit requires information on how a school assesses student achievement. Schools must describe their philosophy of student assessment, identify the methods used to assess student achievement, and efforts taken to ensure that students and staff are aware of the assessment criteria utilized. Schools must also describe how the assessment tools used actually ensure that the goals and objectives set out in Tomorrow's Doctors are achieved. Schools must also outline how they assess the competence of graduating medical doctors and identify the strengths and weaknesses of their assessment process.

The EC Chair also stated that they require schools to monitor student progress and provide feedback to students on their work. The questionnaire requests schools to describe what actions are taken to assist students who are struggling academically and what assistance is given to students who decide to leave medical school.

(c) Student Services

Students must have access to preventive and therapeutic health services, including confidential mental health counseling. Policies must include education, prevention, and management of exposure to infectious diseases during the course of the educational program.

The GMC reports that the provision of student services is the responsibility of the universities and that it has no authority on this issue.

The GMC reviews the support received by students at the universities. All universities must have an orientation program and provide personal and academic support. They must also have in place programs that assist the student in reducing stress during their medical program.

6. Resources for the Educational Program

(a) Finances: The medical school must have adequate financial resources for the size and scope of its educational program.

(b) Facilities:

(i) The medical school must have, or be assured use of, physical facilities and equipment, including clinical teaching facilities, that are quantitatively and qualitatively adequate for the size and scope of the educational program, as well as the size of the student body.

(ii) The medical school should be encouraged to conduct biomedical research and must provide facilities for the humane care of animals when animals are used in teaching and research.

The GMC reports that the universities are responsible for providing all resources for medical schools and that the GMC has no statutory authority on this matter. However, it does state that it will assist schools in obtaining additional funding if a university is experiencing difficulties in resourcing its medical program. The GMC notes in its response that the Education Committee has, in the past, made presentations on behalf of medical schools to the Secretary of State for Health, who is responsible for providing resources for clinical training within the National Health Service.

The GMC did not address the issue of the conduct of biomedical research or any proviso for facilities ensuring the humane care of animals when animals are used in teaching and research.

The GMC representatives clearly stated that medical schools must be properly resourced. A lack of sufficient resources would be of a concern and would be reported to Privy Council. The Privy Council is a governmental body that the GMC must, by law, report to regarding the quality of medical education being offered in the United Kingdom.

(c) Faculty:

- (i) Members of the medical school's faculty must be appropriately qualified to teach in a medical program leading to the M.D. (or equivalent) degree and effective in their teaching. The faculty must be of sufficient size, breadth, and depth to provide the scope of the educational program offered.**
- (ii) The medical school should have policies that deal with circumstances in which the private interests of its faculty or staff may conflict with their official responsibilities.**

These issues fall under the purview of the universities and are not regulated by the GMC.

The EC Chair noted that its site teams also review the adequacy and qualifications of the faculty at medical schools. Insufficient and/or unqualified faculty would be noted in the site team's report and schools would be asked to take corrective action.

- (d) Library: The medical school must have a library sufficient in size, breadth, and depth to support the educational program and adequately and professionally staffed.**

These issues fall under the purview of the universities and are not regulated by the GMC.

Library resources would also be reviewed by visiting teams and any deficiencies would be noted in the final report. Schools would be required to take action to correct any noted deficiencies.

- (e) Clinical Teaching Facilities The medical school should have affiliation agreements with each teaching hospital or clinical facility it uses that define the responsibilities of each party.**

The GMC reports that the issue of articulation agreements falls under the purview of the universities and are not regulated by the GMC. However, The GMC has developed a booklet on clinical training entitled The New Doctor, Supplement on general clinical training in general practice which provides general information on how clinical training should be conducted. The New Doctor also describes what should be covered in learning agreements and the roles and responsibilities of the postgraduate dean, the educational supervisor, and the practice staff.

The EC Chair noted that site teams are required to review all major clinical sites. Clinical students and staff are interviewed and an assessment is made as to the adequacy of the clinical teaching facilities.

PART III: Accreditation/Approval Processes and Procedures

The entity within the foreign country that is responsible for evaluating the quality of medical education in the country and has authority to accredit/approve medical schools should have processes and procedures for granting accreditation/approval to medical schools that are comparable to the following:

1. Site Visit

The accreditation/approval process must include a thorough on-site review of the school (and all its geographically separated sites, if any) during which sufficient information is collected to determine if the school is in fact operating in compliance with the accreditation/approval standards. This review should include, among other things, an analysis of the admission process, the curriculum, the qualifications of the faculty, the achievement of students and graduates, the facilities available to medical students (including the training facilities), and the academic support resources available to students.

The Medical Act of 1983 authorizes the Education Committee of the General Medical Council to appoint visitors that travel to the universities to evaluate the sufficiency of the instruction offered at medical schools.

The publication entitled Implementing Tomorrow's Doctors provides a discussion of the findings of visit teams that occurred between March 1995 and March 1998. The purpose of the visits were to:

- a. Monitor progress made by medical universities in implementing the principle recommendations outlined in Tomorrows Doctors.
- b. Identify obstacles to change in implementing the recommendations in order to draw them to the attention to key groups that could facilitate the change.
- c. Identify examples of good practice that could be shared with other medical schools.
- d. Request a timetable for implementation of the recommendations from universities where insufficient progress was being made.

All universities were asked to submit a completed questionnaire along with supporting documentation prior to the visit. The questionnaire provided information on the undergraduate medical education and general clinical training provided by the universities. The visits lasted two days with the first day devoted to the undergraduate medical program and the second day devoted to reviewing the clinical training provided to students. Visitors met with key faculty as well as students from each phase of the

medical education program. Following the visit, a report was prepared for the Education Committee that outlined the findings of the team that included items of excellence and identified areas needing change. Once approved by the Education Committee, the reports were forwarded to the medical schools for appropriate action. The country notes that approximately one year after each visit, the schools were asked to provide information on how they addressed the findings outlined in the reports.

Implementing Tomorrow's Doctors also identified a second round of visits that were to occur between 1998 and 2001.

On-site visits have been conducted regularly for several years and the EC Chair noted that they would be continued in the future. The current visits are considered to be "informal" visits designed to promote and gain the cooperation of medical schools in implementing the requirements outlined in Tomorrow's Doctors. The Chair noted, however, that starting in 2003 the visits will no longer be "informal" but would be designed to measure compliance with the recommendations outlined in Tomorrow's Doctors. Compliance issues identified by the team would have to be corrected by the universities. Schools that do not correct the deficiencies could lead the GMC to recommend to the Privy Council that the school lose its registration authority.

2. Qualified On-Site Evaluators, Decision-Makers, and Policy-Makers

The accreditation/approval process must use competent and knowledgeable individuals, qualified by experience and training in the basic or clinical sciences, responsible for the on-site evaluation, policy-making, and decision-making.

Implementing Tomorrow's Doctors notes that teams were comprised of a team leader and two or three visitors who were usually either members of the Education Committee or members of the General Medical Council.

The EC Chair noted that all teams are composed of appropriate academic personnel and medical doctors.

3. Re-evaluation and Monitoring

The accreditation/approval process must provide for the regular reevaluation of accredited/approved medical schools in order to verify that they continue to comply with the approval standards. The entity must also provide for the monitoring of medical schools throughout any period of accreditation/approval granted to verify their continued compliance with the standards.

The Education Committee is responsible for monitoring medical education offered through the universities. Although there appears to be no formal reevaluation/monitoring

program, Tomorrow's Doctors implies that ongoing monitoring exists. The publication notes that annual reports will be submitted for the first five years to demonstrate implementation of the recommendations. Further, Tomorrow's Doctors states that "it has been customary for the [Education] Committee to promulgate its Recommendations about every ten or twelve years, but much can change in the course of a decade. The Committee, therefore, has in mind to update its Recommendations as and when necessary, and may also issue additional guidance notes." The issuance of new recommendations would, if current practice is continued, require additional reports that showed the progress schools were making in implementing them.

The EC Chair stated that schools are required to provide an annual report on efforts to comply with Tomorrow's Doctors. Further, the Chair stated that the reporting requirement would continue in the future. Schools must provide any information regarding curriculum or program changes.

4. Substantive Change

The accreditation/approval process must require medical schools to notify the appropriate authority of any substantive change to their educational program, student body, or resources and must provide for a review of the substantive change by the appropriate authority to determine if the school remains in compliance with the standards.

The GMC reports that medical schools are required to notify the Education Committee of any major changes to their curricula and methods of assessment. Such notifications are first reviewed by the Education Committee's Sub-Committee on Assessment and Monitoring, which might ask schools to provide further clarification from schools, before forwarding them to the full Education Committee.

5. Controls against Conflicts of Interest and Inconsistent Application of Standards

The accreditation/approval process must include effective controls against conflicts of interest and inconsistent application of the accreditation/approval standards.

In response to this section, the GMC states, "members of visiting teams are not appointed by the Education Committee in cases where any link with the school to be visited is known to exist. Members are expected to declare any such interest (such as recent service as an external examiner in the school in question). To ensure consistency of approach, each visiting team is led by the Chairman of the Education Committee or his appointed deputy and is accompanied by an administrator familiar with Committee policy."

6. Accrediting/Approval Decisions

The accreditation/approval process must ensure that all accreditation/approval decisions are based on the accreditation/approval standards. It must also ensure that the decisions are based, in part, on an evaluation of the performance of students after graduation from the medical school.

The Education Committee of the GMC is charged to promote high standards of medical education in the United Kingdom and ensure that the medical education provided by the medical colleges is sufficient to prepare students to practice medicine. It's decisions/recommendations regarding a medical college are based upon the recommendations and guidance outlined in The New Doctor, Supplement on general clinical training in general practice and Tomorrow's Doctors: Recommendations on Undergraduate Medical Education. In fulfilling this charge, it does not seek any information about the performance of recent graduates. However, the GMC notes that it does solicit the opinions of supervisors of placed interns as to the quality of the preparation of interns they supervise.

The EC Chair noted that the GMC does get the results of licensing examinations taken by students at the end of their PRHO and that the Committee does review the results. The Chair also noted that if the Committee noticed that a university had a low pass rate it would take action to determine why and require the university to take appropriate action.

Documentation:

Medical Act 1983: Chapter 54

The New Doctor, Supplement on general clinical training in general practice. General Medical Council. July 1998.

Tomorrow's Doctors: Recommendations on Undergraduate Medical Education.

Education Committee of the General Medical Council. December 1993.

Implementing Tomorrow's Doctors

Draft Guidance for Visitors to New Medical Schools/Inspectors of Qualifying Examinations

Guidance for Education Committee Visitors to Medical Schools in 1998-2001

Questionnaire for The Education Committee's Monitoring of the Implementation

by UK Universities and their Medical Schools/Facilities of its

Recommendations on Basic Medical Education

**FOR
COMPLETION**

GENERAL MEDICAL COUNCIL

QUESTIONNAIRE

FOR

**THE EDUCATION COMMITTEE'S MONITORING OF THE
IMPLEMENTATION BY UK UNIVERSITIES AND
THEIR MEDICAL SCHOOLS/FACULTIES OF ITS
RECOMMENDATIONS ON BASIC MEDICAL EDUCATION
(*Tomorrow's Doctors/The New Doctor*)**

[UNIVERSITY OF]

Round II visits - autumn 1999 - 2001

Notes for compilers

1. The completed questionnaire will represent a major source of information for the visiting team. Team members have only a limited amount of time in which to absorb the key features of learning and assessment at your School/Faculty before making their report to Education Committee. For this reason it is important that the information provided in response to our enquiries is clear and unambiguous.
2. In particular the distinction between current practice and future developments/plans needs to be made explicit.
3. The response of the School/Faculty should include at the relevant points in the questionnaire an up-date for the visitors about developments since we came to you previously, and in particular about the points which in our view needed further consideration. The visitors will have available both the questionnaire you completed for the first round visit and the follow-up report you made to us twelve months later.
4. Ideally supporting documentation should be kept to a minimum. If, however, existing material provides a sufficient response to a particular point, the questionnaire should contain an appropriate cross reference to the section of the document which the team should study.
5. A disk containing the completed questionnaire and any enclosures, in a format that is compatible with Windows 1997, should be sent to the GMC with the other materials for the visit.

MEDICAL SCHOOL DETAILS

<p>Dean:</p> <p>Address:</p> <p>Tel:</p> <p>Email: Fax:</p>
<p>Postgraduate Dean:</p> <p>Address:</p> <p>Tel:</p> <p>Email: Fax:</p>
<p>Administrative Officer (deputed to liaise with GMC visitors):</p> <p>Position within University/Faculty:</p> <p>Address:</p> <p>Tel:</p> <p>Email: Fax:</p>
<p>QAA Institutional facilitator (for 'combined' visits only)</p> <p>Position within University/Faculty</p> <p>Address:</p> <p>Tel:</p> <p>Email: Fax:</p>
<p>Date of Completion of this document:</p>

INTRODUCTION

- Our return visit, like the visit we made between March 1995 and March 1998, will be informal. It has two principal purposes: We will be continuing to review your progress towards implementing the recommendations in *Tomorrow's Doctors*, with a focus on the primarily clinical years of the course, although we will be pursuing other issues, including those deriving from *Duties of a Doctor*. We will also be monitoring your progress towards implementing our guidance about the pre-registration year, as set out in *The New Doctor*.
- The Education Committee's aims for the informal visits programme as a whole are given below:
 - a. To monitor progress towards implementing the 13 principal recommendations in *Tomorrow's Doctors*;
 - b. To identify obstacles to change, so that these may be drawn to the attention of bodies such as the Steering Group on Undergraduate Medical and Dental Education and Research;
 - c. To identify examples of good practice/to note interesting developments so that the Committee may in due course draw them to the attention of other medical schools;
 - d. Where progress towards change is slower than expected, to gain a clear picture of the intended timetable for implementation and to bring forward, as necessary, recommendations for further non-statutory or statutory visits.

General clinical training

- a. To monitor implementation of the key features of *The New Doctor*, bearing in mind the Committee's wish to see the necessary changes introduced by April 2000;
- b. To identify examples of good practice/to note interesting developments so that the Committee may draw these to the attention of other universities with medical schools, the NHS Executive and the GMC/NHSE General Clinical Training Overarching Group;
- c. In the event that the visitors identify deficiencies in the arrangements for general clinical training in a hospital or institution approved by the university, to alert the Committee to these, so that it can:

- **report its concerns to the university**
- **consider whether to carry out a further informal visit**
- **decide whether to institute a formal visit of the kind for which Section 13 of the Medical Act provides**

1. DOCUMENTATION TO BE ATTACHED

Would you please append copies of the following documents:

A. General

- The programme-related self-assessment document prepared for the Quality Assurance Agency's purposes (if applicable)
- A list of those attending each meeting, including names and titles
- A list of venues for meetings
- An index to the documents available in the QAA base room/our base room

B. Undergraduate Curriculum

If not included under A above:

- The current Regulations for your primary medical qualifications
- A separate description of any:
 - franchised programmes or partial components of programmes offered in collaboration with other institutions within or outwith the UK
 - accelerated programmes for graduate entrants
 - programmes with a major research component (e.g. MB/PhD courses)
 - indicating the extent to which these depart from the structure of the basic course and framework of assessment
- A statement of the core content of the curriculum
- A list of special study modules currently available to students
- A list of the competencies/skills in which your students must be competent on graduation
- One study guide or other example of good practice in the preparation of teaching materials for the use of students completing the primarily clinical component of the course
- One example of a staff development programme which demonstrates good practice

- **An updated timetable for implementation of the new curriculum in its entirety**
- **Diagrammatic representations of the curriculum and of the assessment structure**
- **A diagram of the structure for managing teaching and learning in the new curriculum, throughout all phases of the course and on all sites (where you are involved in franchising/collaborative endeavour)**
- **An updated SWOT analysis**

C. *General Clinical Training*

- A list of the competencies/skills to be acquired by the end of the pre-registration year
- Information about the appraisal of PRHOs, and assessment of their suitability for full registration, in your deanery
- An example of the records kept about approved NHS Trusts and recognised posts in your deanery
- Your guidance about general clinical training for NHS Trusts, educational supervisors, PRHOs and others
- The document summarising the outcome of the most recent survey of PRHO opinion in your deanery
- Examples of good practice that have improved the professional life of PRHOs in your deanery
- Any other documentation illustrating quality of training in your deanery that you would like the visitors to see

2. ENQUIRY ABOUT THE UNDERGRADUATE CURRICULUM

Tomorrow's Doctor's addresses thirteen principal recommendations to the medical schools. The questions below are directed towards these, and to the points raised subsequently by the Chairman of our Education Committee in correspondence with all medical schools.¹

(i) The management of change (principal recommendation 3)

a. Supervisory structures

Please describe:

- The roles and responsibilities of the bodies/individuals managing change in the curriculum
- The supervisory structures you have put in place to ensure that the medical school retains proper control of the scope and quality of clinical student learning both within and outwith the teaching hospital
- The ways in which you address any problems that may be identified with regard to management of the curriculum and of the student experience

b. Please tell us about the contribution of students and junior staff to curricular reform.

c. What arrangements are in place or planned for the development of staff in the university or in the NHS?

d. How do you go about promoting teaching as a valuable activity?

e. How does the work of the school/Faculty in this area interface with the university's policies and procedures?

¹ Topics mentioned by the Chairman include ethics, and multicultural health care.

- (ii) *Aspects of the Core Curriculum (Principal Recommendations 1, 2, 5 and 7)*
- a. **Defining the core curriculum**
- Please tell us about the process by which you defined the core curriculum
 - What steps are you taking to refine the core curriculum for the first three years of the course?
 - What are your monitoring mechanisms for this stage of the programme?
 - How do you ensure that the core curriculum is delivered during the clinical years of the course?
- b. **Reducing the burden of factual information**
- What steps have you taken to ensure that the burden of knowledge imposed on students has been substantially reduced both in years 1-3 and in the predominantly clinical years of the course?
 - How do you/will you ensure that the factual burden continues to be contained?
- c. **Learning through curiosity**
- What facilities are available in the university hospital and community to foster students' enthusiasm for and curiosity about medicine, so that they are encouraged to learn more about the problems they encounter during all stages of their education and training?

(iii) *Special Study Modules (Principal Recommendation 6)*

- Please describe your current special study module programme, including its scope and the number and length of modules undertaken by students at each stage of the course
- Please describe the objectives of the programme, and the steps you take to ensure that these have been met by every student
- How are students informed of the availability of special study modules and selected for individual modules?
- What systems do you have in place for ensuring that students have sufficient academic and personal support while undertaking SSMs?
- Please describe your approach to special study modules in the case of the borderline student
- Please state the percentage of student time devoted to special study modules in each year of the course
- What is your assessment policy for SSMs?
- What effect does the policy have on the outcome of the undergraduate course, as far as the individual student is concerned?

(iv) Delivery of the curriculum

a. Teaching methods

- Please tell us about the teaching methods you use to deliver the new curriculum throughout the course, including any innovative methods you deploy
- Please provide a breakdown in percentage terms of the various types of learning opportunities provided for students in each year of the course
- How do you ensure that:
 - there is integration of clinical medicine with the basic sciences in the early part of the course
 - clinical students continue their studies in the sciences basic to medicine

b. Computing and CAL facilities

- What CAL and other computer-based facilities are available to students in the university, the teaching hospital and the community?

c. Other learning resources

- What other learning resources are available to students in the university, the teaching hospital and the community?

d. Keeping up to date with educational theory and practice

- How do you ensure that those responsible for teaching and training medical students keep up to date with educational theory and practice?

(v) *Changing patterns of health care (Principal Recommendation 10)*

- **What opportunities do students have to gain experience of primary care during their last two years?**
- **What opportunities do students have to gain experience of community medical services during the primarily clinical years of the course?**
- **What detrimental effects, if any, have the changing patterns of health care had on student opportunities for learning, for example about aspects of reproduction?**
- **What advantages have the changing patterns of health care afforded in terms of the organisation of clinical training for your students, for example the learning experiences provided by day case procedures?**

(vi) The goals of undergraduate education - attitudes, skills and knowledge

Attitudes (Principal recommendation 3)

- **Please tell us about the teaching and learning opportunities provided for your students covering:**

Good Medical Practice

Attitudes towards patients, colleagues and society

The ethical basis of decision-making

- **When do your students receive the card containing *Duties of a Doctor*, and a copy of *Good Medical Practice*?**
- **What steps do you take to ensure that clinical students are provided with appropriate role models on each attachment?**
- **How do you promote the concepts of *Good Medical Practice* among your clinical teachers?**
- **How do you promote awareness of the importance of the teacher as a role model for the future doctor, among those with responsibility for educating medical students?**

Essential skills (Principal recommendations 4 and 8)

- **Please describe the arrangements you make for ensuring that your students acquire the following:**

Study skills

IT skills

Communication skills

Clinical skills

Teamworking skills

- **How do you ensure that your clinical students maintain and enhance the skills listed above?**

(iv) Aspects of the knowledge base

Public health medicine (Principal recommendation 9)

- **How do you ensure that health promotion, illness prevention, the targeting of population needs and awareness of environmental and social factors in health and disease continue to form a key element in student learning during the primarily clinical years?**
- **In particular, how has your school responded to recent government publications which address aspects of the population's health, in terms of the undergraduate curriculum?**

Legal and ethical issues

- **What opportunities do you provide for clinical students to consider legal and ethical issues arising in the course of their training for patient care?**

Medicine in a multicultural society

- **How do you ensure that your students are properly prepared for the practice of medicine in a multi-cultural society?**

Complementary medicine

- What opportunities do your students have to learn about 'treatments that do not conform to the conventional orthodoxies'²

² *Tomorrow's Doctors*, paragraph 6.

(viii) Assessment of the process and the product (Principal recommendation 12)

The outcome of the course

The goals and objectives of the core programme of undergraduate medical education are set out at paragraphs 39 and 40 of Tomorrow's Doctors. The GMC's expectations of every registered doctor are set out in Good Medical Practice.

- How do you define the product of your medical school, in terms of these goals and objectives, and of our code of professional conduct?
- How do you seek to guarantee to the GMC, employers and the public that every graduate of your medical school has attained the necessary goals and objectives and is 'fit for purpose' as a registered doctor and pre-registration house officer?
- What are the threshold standards applied by your university for graduation in medicine?
- How do you ensure that in addition to the necessary professional skills, your graduates possess the expected range of transferable skills including those in communication, informatics, presentation and teamworking?

Assessment methodology

- What is your overall philosophy of student assessment?
- What systems of assessment are used throughout the course?
- Are your assessment criteria known to students and staff?
- How have you ensured that your system of assessment of practical competence, knowledge and professional values:
 - a. reflects the nature of the core curriculum
 - b. properly tests attainment of the goals and objectives set out in *Tomorrow's Doctors*
 - c. is mapped onto *Good Medical Practice*?
 - d. is of increasing complexity, to match the developmental stages of the students concerned
- In particular, how do you assess the competence of the graduating student in terms of your own statement of threshold standards?
- What do you perceive as your strengths and weaknesses in relation to assessment?

(ix) Other issues

Student support

- Please describe your induction programme for new students
- Do you have a system whereby senior students act as mentors to new students, or to new clinical students, or both? If so, how is this organised?
- What systems do you have in place to ensure students have sufficient academic support during the core component of the course?
- What systems do you have in place to ensure students have sufficient personal support
 - in the early years of the course?
 - in the predominantly clinical phase?
- How do you identify students in difficulty, whether academically or personally, and how do you tackle the problem?
- What mechanisms do you have in place for assisting the student who, for whatever reason, is leaving medicine?
- What steps have you taken to minimise any stress students may experience when transferring to primarily clinical work?
- How do you ensure that students in district general hospitals or out in the community have the support they need?
- What help is given to students in terms of travel to and from distant centres?

Feedback to students

- Please describe your system for giving formal and informal feedback to students.
- Can students request extra informal feedback on their work and if so are they aware of this?

Quality control

We have assumed that in the case of schools which have been or are in the process of being reviewed by the QAA, the self-assessment document will cover the points in which we are interested. We have however listed them below both for reference purposes, and for the benefit of schools not involved with this exercise.

- What mechanisms are in place for assessing the quality of:
 - the learning provision at the School
 - learning and educational supervision in the clinical setting
 - learning materials
 - student support, whether academic or personal
 - assessment procedures
 - feedback to students (including its immediacy and its relevance)

- What mechanisms does the school have for ensuring student concerns about the quality of their training are addressed?
- What part do external examiners play in the quality control mechanisms?
- What use is made of external advisers in assisting with the achievement of quality control?

(x) Other

Please use this space to tell us of anything special about the training provided at your school which you have not been able to include in your responses to our specific questions.

3. ENQUIRY ABOUT GENERAL CLINICAL TRAINING DURING THE PRE-REGISTRATION YEAR

A. *Updating the visitors*

In July 1998 we asked you to provide information to help us establish a baseline position in relation to the recommendations in *The New Doctor*, one year after its publication.

We will have available your response to these enquiries³. We would therefore like you to bring us up to date as regards the changes, if any, which have taken place since then in the distribution of NHS Trusts in your deanery and of PRHOs among them.

If there have been no changes please state this.

Background information

1. The number of NHS Trusts presently providing medical care in your deanery
2. The number of these Trusts employing:
 - a. house physicians only
 - b. house surgeons only
 - c. house physicians and house surgeons
 - d. house officers in posts in other specialties
3. If you are a net exporter of PRHOs, whether you have formal links⁴ with NHS Trusts providing medical care in other parts of the UK, and the number of Trusts involved.
4. If you have such links, the number of such Trusts employing:
 - a. house physicians only
 - b. house surgeons only
 - c. house physicians and house surgeons
 - d. house officers in posts in other specialties

³ For schools visited in 1995 and 1996, we will also have available your responses to our first round enquiries about general clinical training.

⁴ By this we mean that the Trust has PRHO posts subject to systematic approval by your university.

5. The number of recognised:

- house physician posts
- house surgeon posts
- house officer posts in general practice
- house officer posts in hospital specialties other than medicine and surgery and their sub-specialties (please list the specialties involved and the number of posts in each

in your deanery at the present time.

6. Any changes in the house officer complement in your deanery already planned.

7. By completing the table below, would you please show the extent to which the following key facilities are now provided for house physicians, house surgeons and other house officers in your deanery. Please code your responses using the scale:

1 = none; 2 = some; 3 = half; 4 = most; 5 = all (where 1 = 0-9%; 2 = 10-39%; 3 = 40-59%; 4 = 60-89%; 5 = 90-100%)

Facility	house physician posts	house surgeon posts	other posts (by specialty) ⁵
Induction training			
House officer's handbooks			
Learning agreement			
Job description/contract of employment			
Educational programme			
Proper clinical supervision at all times ⁶			
Systematic clinical training			
Proper educational supervision, including regular feedback and appraisal			
Final assessment on completion of post			
Access to career advice			
Access to counselling/occupational health services			
Satisfactory accommodation			
Proper catering when on duty			
Arrangements to secure personal safety			

⁵ See question 5 above.

⁶ Paragraph 33b of *The New Doctor* requires PRHOs to have available to them in the hospital, at all times of the day or night, a more senior member of staff in an appropriate specialty who can provide cover and help.

B. IMPLEMENTATION OF THE NEW DOCTOR

B1 Responsibility/Accountability

The GMC expects clear lines of responsibility and accountability to be established in each deanery and to be known and understood by all concerned with the pre-registration year.

a. Organisational Structure

- Which body is responsible for the overall management of the pre-registration year?
- What are the main functions of this group?
- What are the functions of each group that reports to it?
- How is the membership of the various groups made up?
- How often does the membership change?
- How often do the Groups meet?
- How is the work of the different groups co-ordinated?
- What arrangements do you make for co-ordinating general clinical training with other medical schools?
- How does the deanery relate to the health departments and other organisations with an interest in the pre-registration year?

b. Approval of posts

- **Who is responsible for approving posts?**
- **What are your criteria for approving individual posts?**
- **How do you obtain the opinions of PRHOs about their house officer posts?**
- **How do you use the information provided?**

c. Communication

- **How do you ensure the aims and objectives of general clinical training are known and understood by PRHOs, educational supervisors, clinical tutors and NHS Trusts in your deanery?**

- d. **Monitoring of the overall quality of PRHO education and training**
- **What monitoring systems have been put in place in your deanery to guarantee the elements of a high quality PRHO post, as set out in *The New Doctor*, by testing the compliance of NHS Trusts and others with the GMC's guidance and your own more detailed requirements for PRHO training?**
 - **What is involved in the monitoring process?**
 - **How often do you monitor posts?**
 - **What combinations of posts would you prohibit?**
 - **Where shortcomings have been identified, what steps are taken to bring all posts in your deanery up to the level of the best posts?**
 - **Have you ever removed a post from your list of approved posts and if so why?**
 - **What procedures did you adopt for removing the post?**
 - **Do you have any general reservations about your current PRHO posts and if so what are they?**

e. Selection of PRHOs

- **What system is in place in your deanery to facilitate appointments to PRHO posts?**
- **What steps do you take to ensure that the appointment of PRHOs is fair, open, and conforms with equal opportunities legislation and best practice?**
- **If your deanery is a net exporter of PRHOs, what steps do you take to help final year students without a local post to obtain an appointment in another deanery?**

B2 The components of a high quality PRHO post

The GMC believes that new graduates entering medical practice deserve the best possible start to their careers

a. Induction training

- Do you provide a shadowing scheme and if so what form does this take?
- How long do final year medical students spend shadowing a PRHO?
- What form do Initial and extended Induction training take in your deanery?
- What advice do you provide for staff preparing induction programmes and written materials for PRHOs?

b. Educational opportunities

- **What formal educational opportunities are available to PRHOs?**
- **Who arranges the formal educational sessions for PRHOs?**
- **Are PRHOs involved in choosing the topics for formal educational sessions?**
- **What is the format of the formal educational sessions?**
- **What steps are taken to ensure that all PRHOs are able to attend formal educational sessions on a bleep-free basis?**
- **What procedures are in place to monitor attendance by PRHOs?**
- **What are the consequences of poor attendance?**

c. Educational supervision

- **What is the contractual status of the educational supervisors in relation to postgraduate deans and Trusts?**
- **Please describe the mechanism for appointing educational supervisors.**
- **How do you ensure that the educational supervisor and the PRHO meet on a regular basis to discuss the PRHO's work?**
- **Do PRHOs and their educational supervisors have a list of aims and objectives for each post?**
- **What steps do you take to ensure that PRHOs do not regularly undertake tasks of little or no educational value?**
- **What training and support do educational supervisors receive in teaching methods, assessment, counselling and support and other issues, and how often?**
- **What training and support do clinical tutors receive in teaching methods, assessment, counselling and support and other issues, and how often?**
- **What mechanisms do you have in place to deal with unsatisfactory performance by educational supervisors and/or clinical tutors?**
- **Apart from the educational supervisor, how do you involve medical staff on the firm or in the practice, and non-medical staff, in the appraisal of PRHO performance?**

d. Clinical training and supervision

- **Is there a core of generic clinical training for all medical, surgical and other PRHOs in your deanery?**
- **If so, what does this comprise?**
- **How do you ensure that the core component is delivered?**
- **What mechanisms do you have in place for dealing with unsatisfactory performance among clinical supervisors?**
- **How do you go about ensuring that other medical staff, and non-medical staff, are involved in the training and supervision of PRHOs?**

e. Monitoring the progress of PRHOs

- **How is the progress of PRHOs monitored?**
- **What mechanisms do you have for dealing with a PRHO whose performance is unsatisfactory?**
- **How is the postgraduate dean informed of unsatisfactory performance in a particular post and at what stage?**
- **How do you deal with a PRHO who has missed a substantial amount of the post through ill health?**
- **How do you monitor the progress of your graduates in posts outside your deanery?**
- **Who is responsible for signing Certificates of Experience and how are decisions to sign these taken?**

B3 Professional development and personal well-being

Appropriate provision should be made for the professional and personal welfare of PRHOs

a. Careers advice

- Please provide information about the resources available in your deanery to PRHOs seeking advice on their future careers.
- How do you promote uptake of these facilities?

b. Support for PRHOs

- **What facilities are available to PRHOs needing advice about the practical and educational aspects of the PRHO year?**
- **What other support services are available for PRHOs (e.g. counselling, occupational health)?**

c. Accommodation, catering and personal safety

- **How do you monitor the standard of accommodation and catering for PRHOs?**
- **What steps do you take if either the accommodation or catering facilities are unsatisfactory?**
- **What steps do you take to ensure the security of PRHOs?**
- **What steps do you take if the security arrangements are unsatisfactory?**

d. Contractual matters

- **How do you monitor the hours PRHOs work, to ensure they are in conformity with the 'New Deal'?**

B4 Other

a. General Clinical Training In general practice

- **Please describe the arrangements that have been put in place in your deanery for PRHOs spending part of the pre-registration year in general practice**

b. General

- **Are there any points about general clinical training in your deanery, or in other deaneries but under the supervision of your university, that have not otherwise been covered in our questionnaire and that you would like to draw to our attention at this time?**

GUIDANCE FOR EDUCATION COMMITTEE VISITORS TO MEDICAL SCHOOLS IN 1998-2001 - VISIT TO THE UNIVERSITY OF

Background

1. The Education Committee has embarked on a programme of informal visits to all medical schools to monitor the implementation of *Tomorrow's Doctors*, the Recommendations on Undergraduate Medical Education (1993). From autumn 1998 onwards, monitoring will be extended to cover implementation of *The New Doctor*, the Recommendations on General Clinical Training.
2. Every school had been visited once by the spring of 1998. A second round of visits began in October 1998. These visits are designed to assess the further progress made towards introducing new-style curricula, particularly during the primarily clinical years. The visitors will also be considering the arrangements made to assess medical students.
3. Some of the visits to be undertaken in 1998-2000 will involve collaborative work with teams appointed by the Quality Assurance Agency (QAA) to carry out a review of medicine in universities in England and Northern Ireland. In such cases further information about the practical arrangements which flow from this will be provided for team members prior to the visit.

Practical Arrangements for the visit

The visiting team

4. Your team will be led by .

The remaining members of the team are:

The team will be accompanied by from the Education Section who will be responsible for making the practical arrangements, with the exception of the travel arrangements, for members of the team.

Dates of the visit

5. The visit will take place between . Some members of the team also intend to observe meetings held by the Quality Assurance Authority on .

Accommodation

6. During our stay we will be staying at: .
Confirmation of your reservation is enclosed.

Useful telephone and fax numbers

7.

Programme for the visit

8. The visit will commence with an informal discussion meeting over dinner on . Please meet in the hotel's reception area. The first full day of the visit will be devoted to the undergraduate curriculum, and the second to general clinical training.

9. Formal briefing meetings will be held for visitors, as specified on the timetable enclosed with your information pack.

Documentation provided

10. The following documents are enclosed:

- Questionnaire completed by the medical school.
- Supporting material provided by the medical school.
- *Duties of a Doctor* and the associated student card
- *Tomorrow's Doctors*
- *The New Doctor/Supplementary Guidance on General Clinical Training in General Practice*
- Areas of good practice and for further consideration from the visit report
- Letter from the QAA of June 1998 about the observation of clinical teaching and other matters

Other materials in this pack

- Expenses claim form
- Notebook
- Name tag
- Envelope for the return of the 'blue bag'

Aims of visit

Undergraduate medical education

11. a. To monitor progress towards implementing the 13 principal recommendations in *Tomorrow's Doctors* (see Appendix A);
- b. To identify obstacles to change, so that these may be drawn to the attention of bodies such as the Steering Group on Undergraduate Medical and Dental Education and Research;
- c. To identify examples of good practice/to note interesting developments so that the Education Committee may in due course draw them to the attention of other medical schools;
- d. Where progress towards change is slower than expected, to gain a clear picture of the intended timetable for implementation and to bring forward, as necessary, recommendations for further non-statutory or statutory visits.

General clinical training

12. a. To monitor implementation of the key features of *The New Doctor*, bearing in mind the Education Committee's wish to see the necessary changes introduced by April 2000;
- b. To identify examples of good practice/to note interesting developments so that the Education Committee may draw these to the attention of other universities with medical schools, the NHS Executive and the GMC/NHSE General Clinical Training Overarching Group;
- c. In the event that the visitors identify deficiencies in the arrangements for general clinical training in a hospital or institution approved by the university, to alert the Committee to these, so that it can:
 - report its concerns to the university
 - consider whether to carry out a further informal visit

- decide whether to institute a formal visit of the kind for which Section 13 of the Medical Act provides

Role of the visitors

13. The team leader will manage the visit.
14. The general approach to be taken during the visit will depend on the information in the questionnaire completed by the medical school prior to the visit and the documents attached to it.
15. Visitors should read the completed questionnaire and make a note of any points they wish to explore further, either because more work needs to be done in a particular area or because the practice of the medical school seems noteworthy. In addition to this overview, each visitor will be asked to study sections of the questionnaire in more detail, in preparation for the team briefing meetings.
16. Under the guidance of the team leader, the team must decide:
 - a. which issues need to be raised during the visit
 - b. with which groups these issues should be raised
 - c. which member of the team will introduce each issue

Appendices A (undergraduate curriculum) and B (general clinical training) will be a point of reference for the briefing meetings.

17. The team leader must ensure that all matters of concern have been covered adequately during the visit.
18. The questions of selection and student progress do not feature in our questionnaire as the Education Committee does not have any jurisdiction over them. However, it is useful to know about the medical school's selection policy and the number of students completing the course in order to obtain an overall picture of the quality of the course. It is expected that these issues will have been adequately covered in the QAA self-assessment document. If not, the team leader will make enquiries during the visit (see Appendix A).

The preparation of a report for the Education Committee

19. The visitors will be expected to present a report of their findings, normally within three months of completing the visit. The administrator accompanying the team will prepare a draft report.
20. Any visitor who is not a member of the Education Committee will be invited to attend the meeting of the Committee at which the report is to be discussed.

The duties and responsibilities of the Education Committee with regard to informal visits

21. These are outlined in the document at Appendix C.

Financial arrangements for the visit

22. The following will be paid:

travel expenses
accommodation and meals
locum expenses (a receipt will be required).

23. You will be paid £25 per half day for the visit.

ISSUES TO BE RAISED ABOUT THE UNDERGRADUATE CURRICULUM

(To be completed during briefing meeting)

THE BURDEN OF FACTUAL INFORMATION

(See sections A4, B2 of the completed questionnaire)

To be raised by:

LEARNING THROUGH CURIOSITY

(See section B2 of the completed questionnaire)

To be raised by:

ATTITUDES/GOOD MEDICAL PRACTICE

(See sections A2, B2 of the completed questionnaire)

To be raised by:

ESSENTIAL SKILLS

(See sections A3, B1, B2 of the completed questionnaire)

To be raised by:

CORE CURRICULUM

(See section B2 of the completed questionnaire)

To be raised by:

SPECIAL STUDY MODULES

(See section C1 of the completed questionnaire)

To be raised by:

SYSTEMS-BASED, INTEGRATED CURRICULUM

(See section B2 of the completed questionnaire)

To be raised by:

COMMUNICATION SKILLS

(See sections A3, B2 of the completed questionnaire)

To be raised by:

PUBLIC HEALTH MEDICINE

(See section B2 of the completed questionnaire)

To be raised by:

CHANGING PATTERNS OF HEALTH CARE

(See section B2 of the completed questionnaire)

To be raised by:

LEARNING SYSTEMS

(See sections A5, B2 of the completed questionnaire)

To be raised by:

ASSESSMENT

(See section C2 of the completed questionnaire)

To be raised by:

SUPERVISORY STRUCTURES

(See sections A1, B2 of the completed questionnaire)

To be raised by:

LEGAL/ETHICAL ISSUES

(See section B2 of the completed questionnaire)

To be raised by:

TRANSCULTURAL MEDICINE

(See section B2 of the completed questionnaire)

To be raised by:

ALTERNATIVE MEDICINE

(See section B2 of the completed questionnaire)

To be raised by:

STUDENT SUPPORT

(See section C3 of the completed questionnaire)

To be raised by:

FEEDBACK TO STUDENTS

(See section C4 of the completed questionnaire)

To be raised by:

STAFF DEVELOPMENT

(See section A1 of the completed questionnaire)

To be raised by:

QUALITY CONTROL¹

(See section C5 of the completed questionnaire)

To be raised by:

¹ Note: Unless there are pressing reasons to proceed otherwise, quality control issues will be left to the QAA teams to pursue, when collaborative visits are taking place.

OTHER ISSUES (if any)

(See section C6 of the completed questionnaire)

To be raised by:

STUDENT SELECTION²

What is the selection procedure?

What selection criteria are used?

How are the selectors trained?

Are selectors given equal opportunities training?

Are the selection criteria and procedures in the public domain, so that prospective students are aware of the school's approach?

If necessary, to be raised by: Team Leader

² Note: Unless there are pressing reasons to proceed otherwise, student selection issues will be left to the QAA teams to pursue, when collaborative visits are taking place.

STUDENT PROGRESS³

What percentage of students complete the course successfully?

What are the main reasons for not completing the course successfully?

Do you permit students to be admitted to the second or subsequent year of the course? If so, on what grounds?

If necessary, to be raised by: Team Leader

³ See note on page 27.

Appendix B

ISSUES TO BE RAISED ABOUT GENERAL CLINICAL TRAINING

(To be completed during briefing meeting)

ORGANISATIONAL STRUCTURE

(See section B.1a of the completed questionnaire)

To be raised by:

APPROVAL OF POSTS

(See section B.1b of the completed questionnaire)

To be raised by:

COMMUNICATION

(See section B.1c of the completed questionnaire)

To be raised by:

MONITORING OF OVERALL QUALITY OF EDUCATION AND TRAINING

(See section B.1d of the completed questionnaire)

To be raised by:

SELECTION OF PRHOs

(See section B.1e of the completed questionnaire)

To be raised by:

INDUCTION TRAINING

(See section B.2a of the completed questionnaire)

To be raised by:

EDUCATIONAL OPPORTUNITIES

(See section B.2b of the completed questionnaire)

To be raised by:

EDUCATIONAL SUPERVISION

(See section B.2c of the completed questionnaire)

To be raised by:

CLINICAL TRAINING AND SUPERVISION

(See section B.2d of the completed questionnaire)

To be raised by:

MONITORING PROGRESS OF PRHOs

(See section B.2e of the completed questionnaire)

To be raised by:

CAREERS ADVICE

(See section B.3a of the completed questionnaire)

To be raised by:

SUPPORT FOR PRHOs

(See section B.3b of the completed questionnaire)

To be raised by:

ACCOMMODATION, CATERING AND PERSONAL SAFETY

(See section B.3c of the completed questionnaire)

To be raised by:

CONTRACTUAL MATTERS

(See section B.3d of the completed questionnaire)

To be raised by:

GENERAL PRACTICE

(See sections B.4a of the completed questionnaire)

To be raised by:

OTHER ISSUES (if any)

(See sections B4.b of the completed questionnaire)

To be raised by:

Appendix C

INFORMAL VISITS TO THE UNIVERSITIES WITH MEDICAL SCHOOLS - 1998/2001

The duties and responsibilities of the Education Committee

Agree the overall programme for the second cycle of visits, for a period ending in December 2001, having regard to the wishes of some medical schools for collaborative working between the GMC and the Quality Assurance Agency.

Agree the arrangements for further informal visits (if any) in and after 1999.

Within each visiting year, agree the annual programme, including the dates by which the visitors' reports must be submitted for consideration.

Agree such general guidelines for the universities with medical schools and for the visitors as may be required.

In relation to each visiting cycle, agree the general purpose of the visits, and the particular points to be explored with the medical schools to be visited, taking account of the written enquiries being made at that time, as well as the outcome of previous enquiries.

Select, or authorise the Chairman to select, appropriately qualified and experienced persons to visit the medical schools, on the basis of criteria to be agreed in advance by the Committee.

Provide, through the person of its Chairman, appropriate briefing for visitors to medical schools.

Review the reports received from its visitors at the conclusion of each visiting year, and agree on the action to be taken, which might include:-

A decision to institute one or more formal visits in terms of Section 7 of the Medical Act 1983.

A decision to make further informal visits as planned within the forward programme.

A decision to make further, extraordinary, informal visits to pursue matters of concern but not of sufficient gravity to merit a formal visitation

A decision to propose remedial mechanisms

and communicate accordingly with the medical schools visited.

Agree the terms of the reports summarising the Committee's interim and definitive conclusions on the outcome of the visits programme.

Take whatever steps may be necessary to amend the guidance in *Tomorrow's Doctors* and *The New Doctor*, or issue notes of guidance pursuant to these, in the light of information received from the visitors, and by other means.

Maintain a dialogue with the Privy Council about the Committee's plans for monitoring, and the results of its enquiries.

Keep Council informed of work in progress.

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Draft guidance for visitors to new medical schools/inspectors of qualifying examinations

Objective of the exercise

1. To produce the written evidence needed to assure the Education Committee of the GMC that:
 - graduates of the new course are fit for purpose in terms of the recommendations in *Tomorrow's Doctors*¹
 - the names of the universities with responsibility for the course should be added by the Privy Council to the list of bodies entitled to hold qualifying examinations².

Duration of the exercise

2. The exercise will extend, as far as team members are concerned, from the date of their appointment until the Education Committee has considered and signed off their final report. This is expected to take place shortly after the first cohort of students to be admitted to the new school has completed the final qualifying examination or assessment. There will be some further work for the Committee to do, but that will not involve the team (see paragraph 4).

The statutory background

Mechanism for ensuring that graduates of new medical schools can register with the GMC

3. The creation of new medical schools is a matter for the government. However, a positive recommendation by the Education Committee is required if graduates of these schools are to be able to register with the GMC and work as doctors.
4. The Committee must indicate to the Privy Council that in its view, the names of the parent universities should be included in the list [in the Medical Act 1983] of bodies entitled to hold qualifying examinations and award primary degrees in medicine or surgery. This normally happens towards the end of the final year, for the first intake, provided that the Committee is satisfied about the quality of the educational processes through which graduates have gone, and their fitness for purpose.
5. The Committee's rôle in accrediting new medical schools is described at Section 8 of the Medical Act 1983:

'If it appears to the Education Committee [of the GMC] that the standard of proficiency required from candidates at examinations held or to be

¹ A new version is expected towards the end of 2001

² Medical Act 1983, Section 4

held by any university or combination of universities in the UK for the purpose of granting one or more primary UK qualifications does or will conform to the prescribed standard of proficiency, the Committee may represent to the Privy Council that it is expedient that those examinations should become qualifying examinations for the purposes of this Part of the Act.

Her Majesty may by Order in Council give effect to any [such] representations made to the Privy Council...'

6. The Act is not specific about the evidence the Education Committee will need in order to reach this conclusion. The Committee therefore models the procedure for dealing with new medical schools on that which it uses when visiting the teaching and/or inspecting the examinations of the universities whose primary medical degrees are already registrable.

Inspection of qualifying examinations

7. Section 6 of the Act stipulates that:

'For the purpose of securing the prescribed standard of proficiency the Education Committee may appoint such number of inspectors as they may determine, and the inspectors shall attend, as the Committee may direct, all or any of the qualifying examinations held by any university or other body specified in Section 4 (3) [of the Act].

Any person deputed for the purpose by the Education Committee may attend and be present at any examination held in the UK which has to be gone through in order to obtain a primary UK qualification...

Inspectors ... shall not interfere with the conduct of any examination but it shall be their duty to report to the Education Committee their opinion as to the sufficiency of every examination which they attend, and any other matters relating to such examinations which the Committee may require them to report.'

8. For the purpose of this work, the attainment of 'sufficiency' in relation to a qualifying examination or assessment is taken to mean that the standard of proficiency specified by the Education Committee in its guidance about undergraduate medical education, *Tomorrow's Doctors*, has been maintained by the examining body.

9. The GMC is presently (June 2001) revising the guidance in *Tomorrow's Doctors*, and a new edition is expected by early 2002.

10. The most significant change has been the recasting of *Tomorrow's Doctors*, so as to describe how the professional standards and behaviour set by *Good Medical Practice*³ can be delivered through undergraduate medical education.

³ Not published when *Tomorrow's Doctors* was drawn up.

11. The 13 principal recommendations which encapsulated our 1993 guidance no longer feature in the draft text as most medical schools have already responded to them. Much has, however, been retained, including the commitment to a rigorously defined core course, supplemented by significant opportunities for student choice in their non-core studies. The revised text continues to avoid all reference to traditional subjects and disciplines.

12. We have included a new section which outlines the procedures that should be put in place by medical schools and awarding bodies to ensure that appropriate standards are maintained. We have also augmented the guidance we offer on student appraisal and assessment.

Visitation of teaching

13. Section 7 of the Act states that:

'The Education Committee may appoint persons to visit... places where instruction is given to medical students under the direction of any university or other body [entitled to hold qualifying examinations].

It shall be the duty of the visitors... to report to the Education Committee as to the sufficiency of the instruction given in places which they visit and as to any other matters relating to the instruction which may be specified by the Committee either generally or in any particular case; but no visitor shall interfere with the giving of any instruction.'

14. The attainment of 'sufficiency' in relation to the opportunities for teaching/learning is interpreted as meaning that the university concerned is providing its students with the instruction that will equip them with the knowledge and understanding, practical skills and professional attributes laid down in *Tomorrow's Doctors* (see also paragraphs 9-12 of this note).

Appointment of visitors/inspectors

15. Under Sections 6 and 7 of the Medical Act 1983, the Committee has appointed a number of medically qualified and non-medical individuals to act both as visitors and inspectors, as far as the new medical schools established in 2000 and 2001 are concerned.

16. As the extracts from the Act show, it is the duty of these persons to report to the Committee on the sufficiency of the teaching and the assessments/qualifying examinations of the new medical school.

The principal focus of the exercise

17. Inspection of the qualifying examinations and the summative assessments will be the principal focus of the team's work. These must provide a sufficient guarantee that the graduating medical student has attained the standard necessary for provisional registration with the GMC, and is fit to engage for the first time in professional practice as a doctor. However, judgements about the sufficiency of the assessments cannot be formed

without considering in similar depth the curriculum and the arrangements for teaching and learning.

18. In their capacity as visitors, team members will therefore be asked to consider and report on a range of issues relating to the curriculum, and the learning environment within which it is delivered. The team may find it helpful to consider its dual task in terms of the six headings used by the Quality Assurance Agency in its review of medicine 1998-2000:

- curriculum design, content and organisation
- teaching, learning and assessment
- student progression and achievement
- student support and guidance
- learning resources
- quality management and enhancement.

19. The EEA Medical Directive (to which the UK is signed up) is concerned with the total period of basic medical education leading to full registration, and the final aspect of the team's report will therefore be concerned with preparation for and the transition to general clinical training during the pre-registration year. The GMC's guidance, *The New Doctor*, will be relevant to this part of the team's work.

Composition and role of the team and its leader

20. Each team includes a pre-clinician, a physician, a surgeon, a general practitioner, an obstetrician and gynaecologist, a public health specialist, a member with special expertise in medical education and a lay member. Some members will have a dual role.

21. Each team has an appointed leader, who will be responsible within the context of *Tomorrow's Doctors* and this note of guidance for the overall management of the visits/inspections, including the team's relationship with the host university, and the preparation of the team's reports to the Education Committee. The team leader will be supported by a member of staff from the GMC's Education Section (see below).

22. The team leader will assign responsibility for considering and reporting on particular aspects of the teaching, examinations and the learning environment to individual members of the team, according to their expertise.

22. Historically, the GMC has relied on the professional wisdom of its visitors and inspectors to interpret its educational guidance, when considering whether appropriate standards are being applied by each examining body. Team members will be offered the opportunity to participate in the programme of training the GMC plans to put in place for those who will visit and inspect the existing medical schools in 2003-2006. However the initial stages of the exercise will have to be put in hand in advance of this.

23. Professional and other pre-existing commitments may sometimes prevent members from attending events planned at the medical school. However it is expected that all members of the team will play a full part in its work both on and off site, including reviewing and commenting on written material provided by the school, participating in any briefing/debriefing meetings arranged by the team leader, and making detailed contributions to the team's reports.
24. The quorum for attendance at key activities at the medical school, such as qualifying examinations or assessments, will normally be three members of the team. Other arrangements may apply for attendance at end of attachment summative assessments.
25. It is inevitable that team members will become involved with developmental issues as the new curriculum, and the arrangements for student assessment, are rolled out. However, members need to remember that their principal role is judgmental, and their line of accountability to the Education Committee. This must not be compromised. Through its reports for the Committee, the team will be playing its part in assuring the public about the quality of our future doctors.
26. Visitors must discuss with the medical school any concerns they have about the way in which the curriculum is developing or being implemented. Although some issues will prove to be a matter of opinion or emphasis, significant problems cannot be left unresolved - there must be opportunities for the medical school to address the visitors' anxieties.
27. If an accommodation cannot be reached between the team and the medical school, outstanding issues should be mentioned in the team's reports, so that they can be considered by the Education Committee.
28. While on site the team is likely to be working throughout the day and into the evening. For this reason, spouses, children or other non-members of the team cannot be accommodated on the visits.

The role of the team administrator

29. The team administrator will work closely with the team leader and members of the team at all times. In particular the team administrator will help the team leader prepare the formal reports needed by the Education Committee.
30. The team administrator will act as the point of contact between the team and the host medical school when the team is not on site, and this will be made clear to the school. The team administrator will also liaise as necessary with medical school staff, for example to secure a room for the team's use while on site, and any written material that the team may require both on site and subsequently.

31. The team administrator will also be responsible for intra-team communication between site visits, and will set up an electronic network to facilitate communication among team members.

32. Members will be responsible for making their own arrangements for travel to and from the medical school or other location where a site visit is to be made. The cost of travel and incidental expenses will be reimbursed by the GMC on presentation of a completed claim form, supported by receipts. [Explain the prevailing levels of payment at this point.]

33. The team administrator will, however, organise any transport needed between sites, once team members have assembled for a visit. The team administrator will also arrange hotel accommodation for the duration of each visit. The bills for accommodation and meals taken in the hotel will be sent direct to the GMC. [Explain here about signing the bills, and any unacceptable expenditure]

Our expectations of the medical school

34. To assist us in our work we will ask the school to nominate a member of staff to act as a facilitator and first point of contact for our team administrator.

35. We will expect the medical school to make available to us all written material relating to:

- the development and implementation of the curriculum, including a curriculum map showing amongst other things the division of time, year on year, between core studies and student-selected elements, and the proportion of time allocated to different types of learning (e.g. lectures, small group learning and SDL/DSL)
- the arrangements for student assessment
- the physical, electronic and human resources available within the learning environment, including the arrangements for student support and guidance
- its plans for developing the expertise of those who will teach the students
- preparation for the pre-registration year

We may wish to receive this material electronically when off site.

36. The team will also need opportunities to sample individual and group student work, in addition to that submitted for formal assessments.

37. We will need from the medical school, at the earliest opportunity, timetables showing the dates when key meetings or other events such as summative assessments or qualifying examinations are to be held, so that

members of the team can plan for these. We will also need timetables showing the teaching and learning opportunities available during each year of the course so that members can arrange to sample the teaching.

38. From time to time we will ask the school to arrange meetings between the team and students or staff of the school.

How the team will discharge its responsibilities

39. The visit will begin with the initial meeting between the team and representatives of the medical school. Amongst other things this will cover:

- The team's terms of reference
- How the process of accreditation works in terms of current legislation
- The procedures we envisage for managing the exercise
- How the school plans to respond to the needs identified at paragraphs 36-39
- Any issues the school wishes to raise

40. Site visits thereafter will normally be limited to attendance at key events such as major meetings and qualifying examinations or summative assessments, sampling the teaching provided for students and discussions with students and staff. Wherever possible the team will use electronic methods of communication to deal with documentation relating to the development and implementation of the curriculum. The team also hopes to be able to observe student teaching in the periphery from one of the principal sites, where electronic means of doing so are available.

41. There are several reasons for limiting the scope of our on-site interaction with the medical school. First, the Education Committee is required only to be satisfied about the 'sufficiency' of the qualifying examinations in order to support a recommendation to the Privy Council that the name of the university concerned be added to the list of bodies entitled to hold qualifying examinations. The team must of course have regard for the totality of the learning experience that leads up to the qualifying examination and prepares the new graduate for initial practice as a doctor, as discussed at paragraphs 17 and 18.

42. Second, the Committee is conscious of the many demands made on the time of those who have agreed to be appointed as visitors and inspectors and wishes to protect them from an entirely open-ended commitment. The Committee also has to operate within an annual budget set for the GMC.

43. Finally, given the increasing proliferation of graduate and other variant courses the Committee has already agreed that there is a need to focus more on the overall fitness for purpose of graduating medical students, and their

attainment of the goals and objectives set out in our educational guidance, than on the fine detail of the educational processes deployed by each medical school. Nevertheless, the Committee must continue to assure itself that medical school curricula are broadly consonant with its recommendations.

Reporting to the Education Committee

44. The Education Committee's Sub-Committee on Assessment and Monitoring (SCAM) meets quarterly. SCAM will consider informal reports of the team's progress, provided by the team administrator on behalf of the team leader, on a quarterly or other regular basis. These reports will take the form of position statements created for the team's benefit and will not involve members in any additional work.

45. Formal reports from the team will be needed after every major encounter, such as the summative assessments conducted at the end of a stage or phase of the curriculum. Formal reports must be sent by the Committee to the School for its comments.⁴

46. The final report will normally be submitted towards the end of the last year of the course, as taken by the first intake. Provided that the position is regarded as satisfactory, the objective is to ensure that graduates of the new school will be able to register with the GMC and start their pre-registration year in the August after qualification.

47. Depending on the timing of the final examinations or assessments, and the cycle of meetings of the Privy Council, the team may need to submit a short supplementary report on these after the Education Committee has reached an overall view about the sufficiency of the qualifying examinations and informed the Privy Council of its conclusions.

Reporting to the Privy Council

48. The Education Committee is required by the Medical Act 1983 to forward to the Privy Council a copy of every formal report submitted by its visitors or inspectors, together with the observations on the report from the university or universities concerned. The Committee's own comments on the report and observations are normally forwarded to the Privy Council at the same time.

49. Subject to the views of the Privy Council we plan to publish the team's formal reports, once the new medical school has been 'accredited' and its graduates have become entitled to GMC registration.

The scope of a visit/inspection report

50. The team will in due course be provided with a separate check list of issues to consider in relation to compliance of the new school's arrangements with the Committee's revised guidance on undergraduate medical education.

⁴ There is nothing to prevent the team from checking with the school the factual accuracy of parts of their report, before presenting it to the Committee.

Other points, particularly relating to the delivery of teaching and the Health Service context, may however occur to the team in the course of its work.

51. The team's reports will cover the following broad areas:

Terms of reference

General conclusions

Procedure of the team

Facilities for student learning

Human, physical, electronic

Supervisory structures

Students

Intake, progress, support/guidance, feedback, fitness for purpose as PRHOs

Curriculum

Overview of core and student selected opportunities; provision of teaching; any unresolved problem areas

Appraisal and assessment

Academic and fitness for practice

Preparation for practice

Setting and maintaining standards, including quality control

Provision made for general clinical training of the School's graduates