



Good Doctors, Safer Patients

A joint response from The Council of Heads of Medical Schools (CHMS) the Academy of Medical Sciences (AMS), and the Medical Research Council (MRC)

CHMS, AMS and the MRC welcome the opportunity to respond to the CMO report. We acknowledge the degree of public concern regarding the quality of healthcare, and support the endeavour to ensure patient safety and excellent clinical care. The report covers a broad range of issues relating to regulation of doctors, the MRC has only commented on those aspects relevant to clinical academics and research implementation (summarised in the first and third sections below).

In identifying the causes of substandard medical practice, the report acknowledges that system failure and human error are the commonest factors, rather than the professional failures of individual doctors. The emphasis of the report on increasing regulation and assessment of doctors in order to identify a small number of 'bad apples' may deliver limited benefits. The associated work and opportunity costs will be very substantial, and need to be balanced against the likelihood of achieving a material decrease in risk to patients and increase in public confidence.

The comments below are restricted to those aspects of the report which affect the education of doctors and academic medicine. More general points are dealt with first, followed by specific responses to the recommendations.

Consideration of Clinical Academics and Educators

The report does not consider clinicians who have substantial commitments as researchers or educators. The dual role of clinical academics necessitates special consideration. Any restructuring of medical regulation should ensure that appraisal and validation processes for this group are appropriate and fit for purpose. For example:

- Appraisal and validation processes must recognise the fact that a significant proportion of a clinical academic's time will not be spent on direct clinical activity.
- Revalidation processes should accommodate the need for clinical academics to take periods of time out from UK clinical practice, e.g. to pursue research full-time or to work overseas.

Medical Education

Provision and oversight of medical undergraduate education should be considered in light of recognised UK strengths. Care should be taken to ensure that any new proposals do not damage a highly regarded learning experience.

- British medical undergraduate education is internationally recognised as cutting edge. Its guiding principles, *Tomorrow's Doctors*, published by the GMC have been emulated worldwide.
- Medical education in the UK is firmly placed in universities where students are exposed to scholarship and critical thinking in a multiplicity of disciplines. The current system of independent regulation has permitted considerable diversity in medical education, and produces broadly educated doctors with the flexibility to respond to changing environments during their medical career.
- The GMC Quality Assurance of Basic Medical Education (QABME) process provides a robust and continuing cycle of quality improvement.

Clinical Appraisal and Revalidation

- It is essential that doctors continue to learn throughout their career. An appraisal and revalidation system which assists this would be highly desirable.
- In setting standards for appraisal and revalidation there should be explicit recognition of the need for doctors to be aware of research findings that are relevant to their field, in particular those that directly relate to clinical standards and practice.

Recommendation 16: *The creation of clear universal standards for generic and specialist medical practice so that everyone understands what a good doctor should be. A universal, operational definition of a 'good doctor' needs to be devised.*

The GMC's documents *Good Medical Practice* and *Duties of a Doctor* go a considerable way towards addressing this. A good doctor should be technically competent, capable of initiating an appropriate and effective treatment regime based on a sound diagnosis, honest, professional, respectful and helpful with good communication skills.

Devising a better operational definition will be challenging, and the result may be too generic to be useful operationally.

Recommendation 17: *Clear and unambiguous standards to be set for each area of specialist medical practice.*

Patients can and should expect that treatment will always be of high quality. Formulation of explicit standards will help to achieve this.

Recommendation 19: *The role of the GMC to set the content of the medical undergraduate curriculum and to inspect and approve medical schools should be transferred to PMETB.*

We regret the lack of evidence to support this recommendation. After consideration of the proposals, and in view of the success of the current arrangements, we strongly favour the GMC retaining responsibility.

- The GMC, through its Education Committee, has made good progress in promoting appropriate changes in the medical undergraduate curriculum

and quality assurance. Indeed, the QABME process is rigorous and respected by Medical Schools. Altering this system would be a high-risk approach.

- Doctors contribute to the generation of national health and wealth and Medical Schools provide the foundations for the new graduate to deliver this agenda in diverse ways. The reputation of UK Medicine and our ability to develop and lead new healthcare solutions relies on a rich, educational undergraduate experience. The UK approach has fostered broad education rather than a narrow training. Regulation by a body that is independent and committed to high professional standards across the entire breadth of medical activity has contributed to this.
- Seamless education, from student registration through to retirement, is desirable. It might be argued that transferring responsibilities for undergraduate education to PMETB would assist this. However, consistent progress has been made over the last 15 years towards bringing undergraduate curricula and professional standards progressively closer. CHMS, COPMeD and the GMC have worked very effectively towards improving the transition from Medical School into the workplace, for example through: the introduction of PRHO shadowing; the new Foundation Programme Quality Assurance process; the wider involvement of NHS staff and the public in the curricular changes at undergraduate level; and developmental work on student Fitness to Practise. Our view is that progress in this direction is being sustained under the current arrangements, and would not be improved by transferring supervision to PMETB.

Recommendation 20: Pre-employment assessment of clinical communication to be introduced.

- Novel methods to sample genuine clinical communication and rectify problems have potential as a strategy to improve patient safety. This is likely to apply not only at the point a doctor seeks a job, but to the earliest stages of medical education and throughout a doctors' career.
- UK medical schools already assess clinical communication. If a new pre-employment test is introduced, consideration should be given as to whether this is required for students whose mother tongue is English and who have graduated from a Medical School at which English is the language of instruction. This may avoid unnecessary duplication of formal evaluation.

Recommendation 21: The possibility of a national examination for all EU graduates prior to registration with the GMC in addition to university Finals.

- There are concerns that a national examination would stifle innovation and encourage rote learning rather than detailed enquiry of benefit to patients. The logistics and cost of implementing such an exam are daunting and should not be underestimated.
- An alternative approach would be to encourage medical schools to continue to work together to ensure that exams are of a comparable standard.

Recommendation 22: PLAB to move to PMETB with the clinical components commissioned from and delivered by UK Medical Schools.

- UK medical schools already contribute to PLAB and it is not clear that a reorganisation would improve the examination.

Recommendation 23: *Student registration with GMC. GMC affiliates on Medical School staff to operate fitness to practise systems in parallel with the new system for registered doctors.*

- The potential benefits of student registration with the GMC are recognised. This would help achieve a coherent approach in difficult areas such as fitness to practise and professional conduct.
 - For student investigations, a national or regional team of affiliates with real experience of issues which arise in Medical Schools is likely to be preferable to multiple local affiliates.
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Council of Heads of Medical Schools

The Council of Heads of Medical Schools (CHMS) is a partnership of all UK Medical Schools working together to promote national health, wealth and knowledge generation. CHMS facilitates the sharing of experience in medical education and research and works to develop and promote health and education policies of benefit to society.

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