Just how prepared can we expect new medical graduates to be?

Emma Salisbury, Andrew Frankel

THE PROBLEM

In December 2010, The Lancet published the findings of a global independent commission of 20 professional and academic leaders who came together to develop a shared vision and a common strategy for education in medicine. Their problem statement was damning, “...fresh health challenges loom... Professional education has not kept pace with these challenges, largely because of fragmented, outdated and static curricula that produce ill-equipped graduates.” They urged ‘concerned stakeholders’ to join them in ‘rethinking for reforms of professional education’ and in response, in 2011 the General Medical Council (GMC) published the first edition of a report entitled ‘The state of medical education and practice in the UK’. The GMC is ultimately responsible for determining and assuring quality of the outcomes of medical education and training in the UK, and sets out the standards for undergraduate education in the document ‘Tomorrow’s Doctors 2009’. The ‘fresh health challenges’ referred to by The Lancet report describe the advance of modern medicine seen by industrialised nations such as the UK, combined with better hygiene, vaccination programmes and greater relative affluence. People are living longer, but with a growing burden of chronic disease. The public has also become better educated and more informed, assisted by the information technology revolution. These factors have placed increasing demands on the healthcare service, as well as contributing to an altered doctor–patient relationship with a new emphasis on partnership and negotiated care. As pressure on the healthcare service has mounted, tensions have grown between service delivery and protected time for medical education and training.

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Doctors 2009' in relation to clinical placements, at a time when their relationship with local NHS services may be challenged by the pressure on budgets for all services. After a recent study of 300 000 hospital admissions found a small but significant increase in mortality in August, attributed to the influx of newly qualified doctors, ‘Tomorrow’s Doctors 2009’ recommended that all final-year undergraduates undertake a structured shadowing period within the foundation posts that they would be commencing work in. Shadowing offers an ideal opportunity for appointees to familiarise themselves with the work environment and to be introduced to the clinical team they will be joining. They can question the outgoing foundation year 1 (F1) doctor about the nuances of the role and get a clinical handover about the patients for whom they will be responsible. Furthermore, the appointee gains a real-life appreciation of the ‘first day competences’ required to work as an F1 doctor. At the time of writing this Editorial, the Medical Education England Shadowing Steering Group has made the recommendation that by July 2012 all F1 appointees should spend at least four remunerated days shadowing the F1 job that they will be taking up.

In addition to these changes being made at a national level, new teaching methods are also being promoted and curricula altered at local levels. In response to concerns voiced by one of its NHS trusts, the East Anglian Foundation School moved Advanced Life Support training from foundation year 2 to F1, resulting in improved confidence among its F1 doctors and a reduction in critical incidents involving F1 doctors and the deteriorating patient. Inspired by East Anglia’s success, this curriculum change is due to be rolled out in other deaneries later this year.

The development of increasingly sophisticated simulation training is, meanwhile, offering opportunities to expose trainees of all levels to challenging clinical scenarios and a multi-sensory environment, useful in the assessment of knowledge, clinical reasoning and teamwork, while protecting patient safety. The London Deanery’s and NHS London’s Simulation and Technology-enhanced Learning Initiative is an award-winning flagship project which contributed to the Chief Medical Officer’s report ‘Safer Medical Practice: Machines, Manikins and Polo Mints’. It promotes the use of simulation and e-learning to enrich the delivery of healthcare professional workforce training and ‘Hospital at Night Simulated Enhanced Learning’, ‘Emergency Medicine patient safety course’, ‘Patient Centric Healthcare’ and ‘Safety Skills in Surgery’ are just some of the resources available.

In conclusion, preparedness for practice is a critical success factor in the transition from undergraduate to new doctor. Much has been done to address the issues surrounding this preparation in the very recent past and so, it is reassuring to see the first evidence of improvement emerging. The ‘Foundation Programme Annual Report 2011’ has just reported a year-on-year decline in the number of foundation doctors reported as in ‘difficulty’ since 2009. Ultimately, as Professor Sir Peter Rubin said in his November 2011 letter to all GMC-registered doctors, ‘...It is one thing to learn how to do a procedure; it’s quite another to have the judgement to know whether to do it in the first place....’ Competency is central to the practice of high-quality medicine and it requires specific knowledge, practiced skill and appropriate attitude. Graduates cannot be expected to be proficient in every area of their work when newly qualified, but they can be expected to contemplate their competences on a daily basis.

They will often be the first doctor to be called to assess a patient. Being able to recognise when they have reached the boundaries of their competence, and need to give away ownership of the care of the patient to the team leader, is an essential skill to learn. For, the same duties apply to every doctor, trainee or expert, registered with the GMC:

- Provide a good standard of practice and care
- Keep your professional knowledge and skills up to date
- Recognise and work within the limits of your competence
- Work with colleagues in the ways that best serve patients’ interests.

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REFERENCES


