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A core medical curriculum

Two recent reports presage changes in medical education

The education committee of the General Medical Council (GMC) has recently quietly reviewed the teaching of the clinical and diagnostic disciplines in British medical schools.¹ Some of the details of the council's report are curiously consonant with the "Edinburgh declaration" from the world conference on medical education despite the Edinburgh report reading somewhat like an educational revelation from St John the Divine (Report of the world conference on medical education, Edinburgh, 1988). Yet the Edinburgh conference was in little doubt that medical education is up a gum tree whereas the GMC report concludes that "there is a vigour in the pursuit of the delivery of medical education, and a diversity of opportunity that is impressive" and that "the council's recommendations on basic medical education are everywhere being followed." Reading between the lines we detect concerns at the GMC about the state of British medical education.

Surprisingly, the council's report shows considerable differences among schools in the form of their clinical courses. The length of surgical clerkships (and its specialties) ranges from 13 to 36 weeks; the size of teaching groups in psychiatry ward rounds varies from one to 14 students; students may spend from six to 50 weeks doing clinical work away from the main teaching centres; and in two schools about 90 necropsies are seen by students whereas in another they are "probably" not attended at all by many students. Eight schools provide no patient contact in the preclinical period, and three schools have no curriculum committee. Student research is little encouraged; the taking of intercalated degrees is often dependent on personal finance, and the degrees are rarely taken in clinical departments. The separation of pathology from clinical teaching is seen as possibly impairing an understanding of their interrelations. The "second MB barrier" still exists in most schools, and with the exception of those from departments of psychology and sociology few preclinical teachers contribute to the clinical teaching. Finally, although schools accept the importance of teaching communication skills, many provide no formal teaching and have not identified ways of doing so or assessing communication skills. Overall the curriculum is seen as "already overcrowded," with exposure to some subjects being so brief as perhaps to be without benefit. The possibility thus arises of the education committee stipulating a "core course with options."

The Edinburgh declaration specifies 24 steps for an "international collaborative programme for re-orientation of medical education." Despite—or perhaps because of—the revolutionary and idealistic sentiments of the Edinburgh

report the likelihood of a radical change in undergraduate medical education in Britain seems remote in the short term. Resources are too restricted, and the apparatus of medical education contains too much friction and inertia. But if such a revolution is to occur then it may well come from the GMC's own education committee, which has for many years succoured and supported the institutionally unfashionable and underresourced subjects of behavioural sciences, community medicine, and general practice.² The education committee may well find many of its sentiments set out within the Edinburgh declaration. Thus under "competence in individual diagnosis and management" the report states:

"Students have to learn to listen to patients attentively, to look at them with the intensity of the trained observer, and to communicate well with patients, relatives, and other health professionals. They must also learn to prevent and treat common disorders, to keep clear the accurate records, to handle common emergencies and also about rehabilitation. They must learn to recognise when they must seek help from others."

The action needed to achieve such a goal is to "define the essential *core of knowledge* and professional competence which is required . . ." (our emphasis). The definition of a core curriculum, previously advocated by students themselves,³ is now technically feasible with methods such as the critical incident technique in which thousands of real medical events are analysed to determine the skills needed to do the job.⁴ Core syllabuses in each subject—perhaps determined by consensus conferences organised by the GMC—would not only reduce curriculum overloading but also might help to shift the educational emphasis away from being taught towards actively learning.

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