Q1a. Do you think there is anything missing from the draft outcomes?

Yes

Including:

- Details of ability to recognise uncertainty in clinical practice
- Evidence based practice and the increasing use of guidelines/protocols
- Critically appraise the literature.
- Position of the information from NICE and SIGN
- Understanding fluids and their constituents and administration

Compassion: There is no mention of the need for new medical graduates to behave compassionately with patients, in teams with colleagues and indeed to exercise self-compassion. Compassion can be defined as: '.. more than an emotion; it is a felt **and enacted** desire to alleviate suffering.' Worline, M, Dutton, J. *Awakening compassion in the workplace.* p5. Berrett-Koehler Publishers, Oakland California. 2017.

In more detail, compassion is: 'A **sensitivity** to suffering in self and others with a commitment to try to alleviate it'.

This includes the **courage** to turn towards, engage and be in touch with pain and distress, rather than opting to avoid or ignore it. The preparedness to acquire the **wisdom** we need to behave appropriately in the face of suffering.

Gilbert P: *Compassion, Research and Applications*. Routledge, London 2017.

There is growing evidence of the evolutionary importance of compassion and the centrality and need for compassion in personal and professional interactions. For an up to date multidisciplinary perspective, including from medicine, see:

Seppala E, Simon-Thomas E,Brown T, Cameron C, Morline M, Doty J *The Oxford Book of Compassion Science.* Oxford, 2017

There are now instruments to measure compassion and empathy which are reliable and valid:

Gilbert et al: *The development of compassionate engagement and action scales for self and others*. J Compassionate HealthCare. 2017;4:4 DOI 10.1186/s40639-017-0033-3

Relational empathy is closely related to compassion. The CARE measure has been used for postgraduates for appraisal for over 10 years.

Mercer S, Maxwell M, Heaney D, Watt G. *The consultation and relational empathy (CARE) measure: development of an empathy-based consultation process measure. Fam Pract* 2004; **21**: 699-705.

It is important intrinsically as a central professional value. There is now ample evidence – see above—that it is also instrumentally important in achieving good outcomes for both doctors themselves and for patients, and that tools exist to measure it, if that were thought necessary.

Q1b. Do you think there is anything in the draft outcomes that shouldn't be there?

No

Q2a. Do you think there is anything missing from the draft procedures?

Yes

- 11c) to include - 'where the patient lacks capacity to reach and communicate a decision on their care needs'. This aligns to skill defined in 12h)
- Taking blood gases
- 17- administering fluids
- 18 - making up drugs
- 20 – giving IV and IM injections

Q2b. Do you think there is anything in the draft procedures that shouldn't be there?

Yes

Procedure 15 - It is reasonable to expect newly qualified doctor to undertake an assessment of mobility and to expect them to have the skills to obtain an ADL history from a patient. However there was concern that it was not reasonable to expect them to undertake an **assessment** of ADLs.

Q3. Do you think there should be a list of procedures included in the outcomes

Yes

It is important for assessing competency and maintaining patient safety that these have been signed of appropriately.

Q4. If you answered 'yes' to question three, do you think newly qualified doctors should have experience of performing the procedures on real patients, or in simulation?

Real patients

Newly qualified doctors should initially gain experience using simulation. However, there are real differences in being able to communicate and perform procedures on real patients, which an employer would wish to have assurances have been achieved.

Q5. Do you think the draft outcomes set out the knowledge, skills, values and behaviour that patients and the public expect of newly qualified doctors entering the profession?

Not sure

The College believes that patients and the public expect doctors to behave in a way that is patient centred, encourages shared decision making and supports self-management where appropriate. This cannot be achieved without compassionate behaviour, as defined in Q1a. It would be helpful to be explicit about this. If the changes suggested to 1a are made then the College would agree.

Q6. Do you think the draft outcomes set out the knowledge, skills, values and behaviour that employers need from newly qualified doctors entering the workplace and the Foundation Programme?

Yes

Q7. Do you think the outcomes set out, at the right level and in the right detail, what newly qualified doctors must know and be able to do in relation to their responsibility for patient safety?

Not sure

It is important to stress the need for junior doctors to know their limitations and where and when to seek assistance and from whom. It is unlikely that newly qualified doctors will have had experience in this full range of settings. This can be addressed as doctors choose specialty to pursue after graduation. Dealing with multiple morbidity and complexity requires significant experience with patients with these conditions. College Fellows have suggested this as being a partially completed expectation at the transition from undergraduate to postgraduate trainee.

Q8. Do you think the outcomes set out, at the right level and in the right detail, what newly qualified doctors must know and be able to do in relation to their responsibilities for equality and diversity?

Yes

The outcomes cover the basic skills, communication, consultation, professionalism, reasoning, time, team work etc

Q9. Do you think we have sufficiently addressed the need for newly qualified doctors to be able to provide care in a variety of settings?

Not sure

College Fellows would not expect all newly qualified doctors to have had experience in this full range of settings. This can be addressed as doctors choose specialty to pursue after graduation. Dealing with multiple morbidity and complexity requires significant experience with patients with these conditions.

Q10. Do you think we have sufficiently addressed the need for newly qualified doctors to be able to care for patients with multiple morbidities and long term physical and mental conditions?

Not sure

This is likely at a basic level, but there is much complexity with some patients with long term conditions such as diabetes and renal disease where many specialities are involved. This is likely to be more advanced for their abilities but requires an understanding of the team such as specialist nurses.

Q11. Do you think outcome 25 should include the list of disciplines?

No

With the expansion of medicine this would need updating anyway with items such as impact of genomics, proteomics and precision medicine.

Q12. If you answered 'no' to question 11, do you think the list of disciplines should be included in a separate guidance document or online resource?

No

Fellows have suggested a list is not required, as it is mandatory in a curriculum of biomedical scientific practice. However evidence-based practice is important to include.

Q13. Do you think we should structure the outcomes to match the nine domains of the Generic professional capabilities framework ?

Yes

It may make it easier to evaluate the medical school curriculum and assess those junior doctors who have challenges early in their career.

Q14. Do you think we should update the outcomes approximately every two years, to reflect changes in medical education and medical care and practice?

No

Two years seems rather short even with medical advances and would require much change in medical schools.

Q15. Please give any suggestions on how, and how often, we should update the outcomes.

The College would suggest 5-6 years as this reflects a cycle of medical school graduation.

Q16. Do you have any suggestions on drafting of specific outcomes?

Outcome 2 - Professional skills. Recommend addition in 11c) to include - 'where the patient lacks capacity to reach and communicate a decision on their care needs'. This aligns to skill defined in 12h)

In 14f in the draft, it would be sensible to include ' and situational awareness' after evidence, as evidence is often limited and inadequate for the complexity of clinical decision making in the real world of the FY doctor. As well as mentioning uncertainty, it might be good to mention 'and dealing with risk appropriately'.

In 23c, the wording should be 'frameworks (plural) across the UK' as there is no single UK framework.

In 23g, Fellows have suggested that the statement should say that 'doctors as managers have to strive to balance best use and prioritisation of resources with the needs of the individual patient.' That would include the human resource of the doctor in a system which is at times, under extreme pressure.

In 23i, perhaps it should be considered adding after 'risk posed by own health' 'including that of work related fatigue affecting clinical judgement.'

Q17. Is there anything you'd like to add?

- Fellows commented that this document should broadly be welcomed; however some problems that are evident are not addressed. As examples, retention in medicine is poor. By the end of medical school 10% in Scotland fail to take on pre-registration posts. This continues through junior doctor jobs.
- Fellows have commented that some FY1s are better prepared for their posts than others. Knowledge is important but does not train an FY1 to "run" a ward (even with senior support) and prioritise to the patients' advantage. A lot of FY1s find their job extremely stressful – which is not fair to them- and are not prepared.
- Having a list of procedures can be useful but can be used as a tick box exercise. Juniors should be encouraged to undertake procedures, to feel confident and go on to teach them.
- The College would welcome more focus on clinical examination skills and on doctors insight into decision making bias and process, and also on resilience training.
- There is reference to the NHS and the social context within which healthcare is practised in the UK in section 23 of the Outcomes. The College suggests that this needs to be brought into the overarching statement. It is crucial that all doctors understand the context within which they will be working and the boundaries between primary and secondary care and other areas of the public and private sectors – social care etc. Ideally the overarching statement should say something about ensuring an understanding of the patient journey through various health and social care settings in the UK.
- There is no clear reference to the need to manage co-morbidity in the UK's ageing population.

- There is reference to *Good Medical Practice* in the Outcomes but the College's Lay Advisors have suggested that these concepts be brought out and included explicitly in the Outcomes. They are difficult to test but key to being registered and staying registered.