Medical Schools Council

Medical Schools Council Student Conference 2016

Wednesday 22 June

Chaired by Professor Iain Cameron and Professor Jenny Higham

Summary Report

Medical students across the UK were invited to attend the first Medical Schools Council Student Conference on Wednesday 22 June 2016. 72 medical students took part in the conference representing 30 medical schools. The conference was co-chaired by Professor Iain Cameron and Professor Jenny Higham.

Professor Iain Cameron welcomed attendees to the meeting and outlined the themes of the day.

An Introduction to the Medical Schools Council
Professor Iain Cameron – Medical Schools Council

Professor Iain Cameron, Chair of the MSC, introduced the role and structure of the Medical Schools Council and outlined key areas of work:

- The Council is involved in supporting medical schools in their aim to select applicants who demonstrate the potential to become good doctors. To assist this process, the Medical Schools Council has developed guidance and publications relating to medical school admissions.
- The Council works to widen participation in medicine and improve access for applicants from a broader range of backgrounds. The recent 'Who's in Health?' campaign was discussed which aimed to promote health careers and science to primary aged children. The campaign saw medical students run teaching sessions in primary schools about health and working as a doctor.
- The Medical Schools Council helps to develop and administer assessments which include the Situational Judgement Test (SJT) and the Prescribing Safety Assessment (PSA). The Council is also involved in developing an online bank of assessment questions through the MSC Assessment Alliance.
- The Council works to promote clinical academic careers and produces an annual survey, jointly with the Dental Schools Council, of clinical academic staffing levels in UK medical and dental schools.
- Working jointly with the General Medical Council, the Medical Schools Council has helped develop advice on student fitness to practice and professionalism.
- The Medical Schools Council also works closely with other organisations in the health, education and research sector. Examples include: Health Education England and its counterparts in the devolved administrations, the National Institute of Health Research, the Wellcome Trust and the Academy of Medical Royal Colleges.

In subsequent discussions it was emphasised that the Medical Schools Council does not regulate medical schools. It represents the interests of medical schools while working closely with the regulator, and is independent in its decision-making.

What do today's medical students want from their future careers?
Professor Iain Cameron – Medical Schools Council

It was mentioned that a key aim of the conference was to provide an opportunity to hear the views and concerns of medical students. The changes occurring within the NHS were discussed, with emphasis on the Shape of Training Review, the Five Year Forward Review and the debate around the new contract for trainee doctors. In

light of these changes, delegates were asked to discuss questions about their career, the medical workforce and the perception of doctors. The following points were made:

When you decided to become a doctor, what factors motivated your choice?

- There is a difference in motivations for school leavers and graduates – graduates are likely to have completed more in-depth research into medicine as a job than a school leaver. For school leavers, work experience and role models (particularly influential teachers) were big factors.
- Realising personal achievement goals – this is particularly important for students coming from backgrounds where studying medicine was not encouraged as it was assumed they would be unsuccessful. Medicine provides the chance to prove naysayers wrong.
- Other personal factors included having a strong interest in people, a love of science and learning, and the rewarding nature of a career in medicine, particularly the difference doctors can make in patients' lives.
- The perception of doctors by the public was a motivating factor. Medicine is considered a highly recognisable and respected career.
- Medicine is attractive because it leads to a structured career with good job security. Skills are transferable; there are a variety of career options within the profession and opportunities to work abroad.

Do you think your time at medical school and the two years of the Foundation Programme will give you enough time and experience to decide what you might like to do as a future career?

- Opportunities at medical school exist but students need to be 'proactive' and seek out guidance, use mentors and utilise placements. Students may have rough ideas about their future but time needs to be invested in those who are less pro-active and need support. Those who know what they want to do beforehand usually benefit more.
- It was mentioned that the amount of time and experience available heavily depended on the individual medical school.
- The majority answered no but agreed that clinical rotations and placements helped in decision-making. However, learning-focused placements sometimes lacked realistic views of specialities. It was agreed that there should be more careers discussion in logbooks and less focus on ruling out specialties.
- Student-selected components in the curriculum, 'snapshot' placements and regular careers sessions are opportunities that provide guidance, yet they are not offered by medical schools equally.
- There is little time to make future career decisions; students are expected to apply early, placements can be too short and there is too much of a rush to specialise. Delegates mentioned that big career decisions should not be expected after only two years of being a doctor.
- There should be more emphasis on clinical teaching (but basic science as a foundation) including in years one and two. Students should also be given the chance to experience medicine away from the pressures of exams to allow better focus and appreciation.

What draws you to some specialty areas and puts you off others? Where were your opinions formed on this – at medical school, before, or elsewhere?

- Opinions on specialties constantly change – students may have a small idea pre medical school from what they have seen/read in the media but at medical school it is during rotations where long term opinions are formed.
- Positive exposure during placements was a common theme. This includes the quality of placements, the funding and facilities available, the morale of staff working in the specialty and the enjoyment of the module.
- The structure of the specialty is important: the amount of patient contact, whether it involves being on-call, whether it involves working in a team or mostly alone, the working hours and pay.
- Discussions with professionals are incredibly influential, particularly those whose opinion students value such as role models and teaching staff. Positive representation of a specialty is important – dismissing or even making jokes about certain specialties, such as general practice, can be off-putting. Doctors who work with medical students should be trained on how to encourage students' interest in their specialty – mentor training.
- Personal interest plays a large role when deciding specialties. This includes the chances for progression, variety, academic potential, whether it has immediate results (eg surgery), the types of procedures and the ability to affect change at vulnerable moments.
- Previous exposure to a speciality before any actual engagement can influence students' beliefs, eg from media – GPs are often portrayed as stressed and overworked.

The government has suggested that 50% of current medical graduates will be required to work in general practice. What are your views of general practice? What has been most influential in shaping them?

- There are significant differences between medical schools and the amount of general practice exposure they offer. It was noted that some offer very few GP placements with no placements until Year 4, whereas others were very good at exposing their students to General Practice throughout their medical school career. Early exposure helps make the speciality more attractive by challenging misconceptions and stereotypes.
- Lots of frustration is often taken out on GPs as they are front line. The profession is perceived negatively in the media, it is 'doom and gloom' with lack of staff, overworked doctors, lonely, lots of bureaucracy and paper work and high levels of scrutiny when mistakes are made. There is not enough positivity surrounding general practice.
- There is a stigma around becoming a GP with a common negative view that it is the 'easy' way out. Students may sometimes feel uncomfortable disclosing their desire to become a GP in fear of being judged. Some delegates believed that GPs are not respected by hospital staff which helps to reinforce the negative stereotypes.
- There is a perception that general practice relies too much on protocol and 'ticking boxes'. The current structure is seen as very target-orientated with large amounts of gatekeeping.
- To help recruitment, strong GP societies, positive and passionate GP tutors, strong patient relationships and attractive work-life balance should all be promoted. Training could also be improved by including the option to study special interest areas alongside general practice. This could improve communication between GP practices and hospitals.

The NHS Five Year Forward View states that, in the future, more care will be delivered in a community setting rather than in hospitals. How is this likely to influence the type of job you might wish to do in the future?

- The majority of delegates did not feel this would affect their decision or it would have minimal impact, though it may affect the location of their job. It was mentioned that knowledge of the changes to the way care is delivered is not particularly strong.
- The benefits of moving to a community setting were discussed, particularly the potential to reduce pressure in hospitals and increase access to care. Delegates were encouraged by the prospect of building stronger relationships with patients.
- There were concerns about the cost of delivering good quality care in every community, the lack of infrastructure in place to move to a community setting, the already difficult task of finding consultants for rural areas and the affect this would have on training.

The Shape of Training Review identified the need for medical graduates to deliver more generalist care across a variety of settings, in hospitals and in the community. What is your view of this idea?

- It was felt that that there is very little understanding of the Shape of Training Review amongst medical students. Changes and the structure of the NHS should be discussed more at medical school.
- The definition of 'generalist care' and its progression opportunities are not always clear.
- The overall idea was well received, particularly retaining generalist knowledge and skills. It was mentioned that paediatrics is often seen as an attractive speciality because it is quite generalised. It was agreed that specialities should work harder to retain their generalist knowledge.
- There were fears about how this would influence speciality programmes and was perceived as being targeted to those who were unclear about which specialty they wanted to train in.
- Questions were raised as to whether this would affect GP recruitment.

Have your views of the medical profession changed since you started medical school? If they have, what changed your view?

- Doctors are not like what is portrayed on TV; medicine is just as much about prolonging life as it is about saving it. Doctors are not superhuman and are affected by their emotions.
- A greater respect for the profession. Doctors are not just clinicians; they are mentors, managers, researchers and have more responsibilities than the public are aware.
- The stress and workload is greater than expected. Many were unaware of the struggles doctors face with lack of resources, little time off to maintain work-life balance, having to move location for training and the little time allowed to explore specialties.
- There are lots of extra costs in medicine, such as GMC registration and Royal College exam fees.
- There was little knowledge on the external factors that affect a doctor's ability to care for patients such as paper work, time, money and inefficiency and bureaucracy of the NHS.
- The fear of getting in trouble was never discussed prior to starting medical school. Students were unaware of medical negligence, fitness to practice and accountability issues.
- It was mentioned that career choices are influenced by which medical school a student attended – some

schools focus heavily on academia and others begin clinical routes early.

- The extent of the role politics played in medicine and healthcare was seen as a shock. This became particularly noticeable after the recent contract disputes.

How do you feel doctors are treated?

- It was believed that, although doctors are less respected than they previously may have been, respect remains strong and is particularly evident from the public reaction to the contract disputes.
- Expectations of doctors from management and patients are very high in a time and resource-sparse health service. These high expectations can lead to feeling undervalued.
- While support from the public is very positive, the media portrays doctors unfairly – as privileged 'Moet doctors'. The government sees doctors as political leverage to sway public opinion.
- It was mentioned that treatment from NHS management was often poor and unhelpful, particularly around admin and rota issues.
- Treatment of doctors depends on varying factors – the size of the hospital, how busy the trust is and whether senior staff are willing to guide and mentor junior colleagues.

What do you think could be done to improve morale in the NHS?

- Improved teamwork building with other professions is vital. It was mentioned that doctors are sometimes perceived as separate from the rest of the team.
- There should be more doctors with clinical experience in NHS management who can empathise with heathcare staff. Managerial staff are seen to lack empathy and compassion and are too focused on what is seen as arbitrary targets by healthcare staff which impede on the quality of treatment.
- Better staff rewards and benefits other than monetary funds are needed. It was felt that the majority of staff in the NHS are undervalued by both patients and managers. The NHS needs to do more to recognise the effort and work of health care staff and make them feel valued.
- The number of doctors and healthcare staff should be increased to relieve the pressure in hospitals and better the distribution of workload. This is dependent on the government and funding available but is essential to improve morale.
- Managers should understand the importance of small things, such as having more say in rotas and being able to book holidays.

An introduction to the General Medical Council

Martin Hart – General Medical Council

Martin Hart, Assistant Director, Education and Standards at the GMC, summarised the functions and responsibilities of the General Medical Council. The General Medical Council is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

Key responsibilities of the GMC include:

- Standards and Ethics – the GMC provides guidance to doctors on standards of professional conduct, professional performance and medical ethics. The GMC has published a core piece of guidance, 'Good medical practice' relating to this.
- Registration – the GMC maintains three registers for doctors in the UK: the register of medical practitioners, the specialist register and the general practitioner register.
- Fitness to practice – when a serious concern is raised about a doctor's behaviour, health or performance, the GMC investigates to see if the doctor is putting the safety of patients, or the public's confidence in doctors, at risk.
- Revalidation – the GMC ensures that licensed doctors are regularly checked for their fitness to practice medicine.
- Education – the GMC is responsible for regulating and quality assuring medical education and training. New standards were published in January 2016, called 'Promoting Excellence'.

Delegates were asked to discuss how the GMC can improve medical education. The following points were made during discussion:

How can the GMC learn from medical students about issues at medical schools?

- There should be more frequent visits from regional liaison officers.
- Greater communication is needed between the GMC and BMA representatives.
- The GMC should build awareness in medical school early, beginning with first year students.
- There should be an annual evaluation form (most suggested they would accept a ten-minute survey; this should have concise language and leave room for students to expand with their own thoughts).
- GMC should be present at freshers' fairs.
- GMC student representatives should be established.
- There should be a means of passing anonymous feedback to GMC.
- Placements at the GMC have been received well and should be expanded so that more can benefit.

What should the GMC do to improve medical education?

- The GMC should encourage teaching on the subject of the NHS as a structure and how it is managed.
- It was suggested that the number of weeks on placement could be standardised. There was mixed sentiment on this.
- There were many broader remarks on standardisation versus autonomy, with most leaning towards preserving autonomy.

The proposed medical licensing assessment

Martin Hart – General Medical Council

The conference was informed of current work being undertaken to develop a UK medical licensing assessment (MLA). The aim of the project is to create a single, objective demonstration that those applying for a licence to

practise medicine in the UK can meet a common standard for safe practice.

The reasons that led to decision to introduce an assessment were discussed, including increasing evidence that medical schools cannot demonstrate a common minimum standard and that there exists variation between schools in graduates' preparedness. Other factors included the emergence of new schools and overseas programmes, the risks from any abolition of Provisional Registration, the need to demonstrate fairness between UK and international medical graduates and the early assurance on safety and performance of all doctors new to UK practice.

It was emphasised that the GMC will work closely with medical schools and experts when developing the MLA with the aim of creating an internationally recognised medical assessment. The benefits of the assessment were highlighted, in particular that it will provide assurance to patients, regardless of where doctors are trained. It was explained that the assessment would consist of three parts: a test of applied knowledge; a test of clinical skills which would both be taken by UK and international medical graduates to achieve registration; and a third part for revalidating doctors which would confirm their fitness to practice.

It was mentioned that extensive pilots of the proposed medical licensing assessment would be completed during 2018–2021 with full implementation from 2022.

The following points were made by medical students:

- It was suggested that any mandatory exam will encourage learning to pass, rather than learning to expand knowledge.
- The introduction of the MLA seemed like a vote of no confidence in the medical schools.
- The rationale of the assessment is still not clear.
- The assessment does not predict performance as meaningfully as continuous assessment.
- Delegates felt that their opinions were irrelevant as it is assumed the MLA will happen either way. It was therefore queried why they were being asked these questions.
- It is unclear what an additional assessment will specifically measure in regards to a medical student's potential to be a doctor which is not already being measured.
- It is essential that it is possible to take the assessment across the UK without requiring significant travel.

It was asked whether the MLA should only be a pass/fail licensing exam, or also rank candidates for the Foundation Programme. The response was overwhelmingly in favour of pass/fail.

2016 Doctors in Training Proposal

Danny Mortimer – NHS Employers

Danny Mortimer, Chief Executive of NHS Employers, presented the proposed 2016 junior doctors contract. Delegates were informed of the background that led to the proposed contract. Negotiations with the British Medical Association surrounding a new contract had begun from 2013 but broke down in 2014. In May 2016, the government and the BMA agreed on details of a new contract which will be voted on by the BMA membership. The contract negotiations focused on three key areas: safe working, pay and training and deployment.

Safe working

New limits will be placed on working hours to protect safe working of doctors; this will be overseen by a 'guardian of safe working' in every trust with new financial penalties in place to ensure these are not breached. The new contract includes added measures to allow NHS staff to raise concerns without fear of repercussions from employers (whistleblowing) including bodies responsible for overseeing their training.

Pay

The current incremental pay system will be replaced with a series of nodal pay points based on attainment and responsibility rather than time served. This will lead to an average basic pay increase of between 10 and 11%. Weekend work will not be divided up between normal and social hours; instead supplements will be paid depending on how many weekends are worked over the course of a year. Hours worked between 21.00 and 07.00 will receive a premium of 37%, Flexible Pay Premia will be increased and doctors on-call will receive an 'on-call availability allowance'.

Basic pay and allowances

NHS Employers

Stage of training			Nodal point	Value
Foundation	Core specialty training	Run-through/Higher specialty training		
FY1			1	£26,350
FY2			2	£30,500
	CT1 CT2	ST1 ST2	3	£36,100
	CT3	ST3 ST4 ST5 ST6 ST7 ST8	4	£45,750

Night hours = 37% premium

On call availability allowance = 8%

(Actual work done when on call is separately paid)

Weekend Frequency	Allowance
1 in 2	10%
<1 in 2 – 1 in 4	7.5%
<1 in 4 – 1 in 5	6%
<1 in 5 – 1 in 7	4%
<1 in 7 – 1 in 8	3%
<1 in 8	N/A

Training and Deployment

Additional support will be made available for doctors who have taken time out, such as women who go on maternity leave, to allow catch up on training. This will include funding and access to mentorship. Deployment processes will be reviewed with HEE. NHS employers will work alongside the BMA to improve rostering and ensure best practice. All parties will work to improve and nurture good relationships between doctors and employers and improve morale in the NHS.

The BMA will have an ongoing role in the implementation, and the review (planned for two years' after implementation). It was noted that to ensure a smooth implementation, transitional pay protection would be extended for one year.

A referendum will be held on 6 July 2016 for the BMA membership to decide whether the new contract should be accepted.

In subsequent discussions, the following points were made:

- Scotland, Wales and Northern Ireland will continue to use the old contract. The devolved administrations had chosen not to pursue a new contract during early discussions.
- It was queried that the new contract will lead to staff shortages. The response noted that the levels of recruitment on training programmes would be reviewed and emphasised that there is more work to do to repair the damaged relationship.
- The impact of locum doctors on hospitals was discussed. It was agreed that there is a dependency on locum doctors. The new contract includes initiatives to address some of these issues however it is a conversation that the NHS will have to return to.
- It was mentioned that the overall cost to employers would actually increase with the new contract as pensionable pay will rise.
- The speaker agreed that lessons have been learned during the negotiations and there remains more for employers to do to improve their relationship with junior doctors.
- The positive aspects of the new contract were highlighted, including the increase in basic pay, the protections for 'whistle-blowers' and the protections for women who choose to take time out – pay is paid on progress rather than time served and the new contract will provide investment in training to allow catch up.

Anti-Bash Campaign

Maddie Daley, Alice Neale, Rosie Abi Aoun, Abina Dharmaratnam - RCPsych Students

Medical students from the University of Leicester discussed the 'Anti-Bash' campaign, supported by the Royal College of Psychiatrists, which is working to address the stigmatisation of certain medical specialties.

Bad mouthing, Attitudes and Stigmatisation in Healthcare, or BASH, is having a detrimental effect on specialties such as general practice and psychiatry. The bashing is usually considered as 'banter' but it leads to medical students being put off working in these specialties, resulting in under-subscribed training programmes. Students who show interest in specialties like psychiatry are seen as 'half a doctor' leading to misconceptions and stereotypes. This undervalues the work of psychiatrists and does little to reduce the stigmatisation that already exists around mental health. Bad mouthing specialties are not only common place amongst students, but are also reinforced by some teaching and senior medical staff who openly 'bash' in front of students and colleagues.

The #BanTheBash campaign has been working to challenge these misconceptions. Medical students across the UK have been involved in highlighting these issues to their peers both on their own campuses and through social media. Early exposure, more dedicated teaching and engagement with sixth-formers, medical students and doctors is needed to combat this issue.

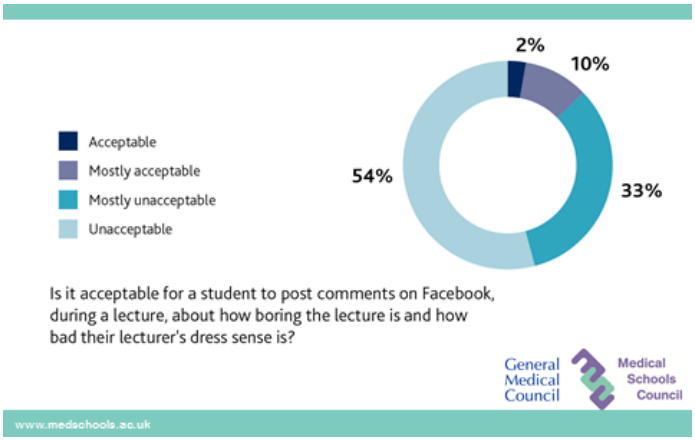
Delegates were provided with information on how they can support and get involved in the 'Anti-Bash' campaign.

Achieving good medical practice – new guidance on professional values for medical students

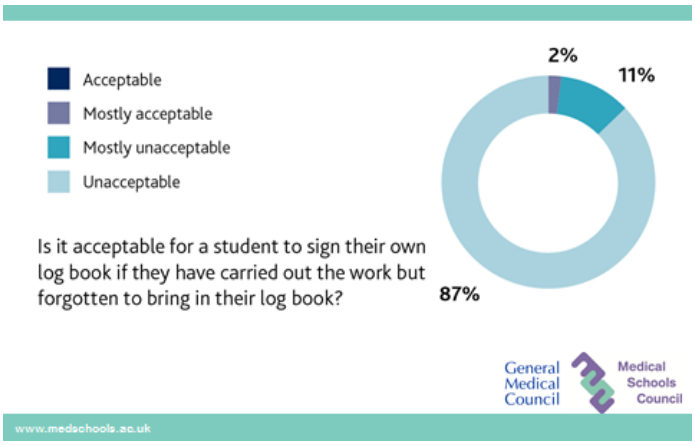
Clare Owen – Medical Schools Council

Clare Owen, Policy Adviser at the Medical Schools Council, introduced the new guidance for students on professional values, called 'Achieving good medical practice'. The Medical Schools Council and General Medical Council worked jointly to produce the new guidance.

It was mentioned that the original guidance, 'Medical students: professional values and fitness to practise', was very generic and needed updating. This led to a full review that found that medical students were unaware of the resource. Following this, a high level survey was completed to find out what student's thought about different areas of professionalism.

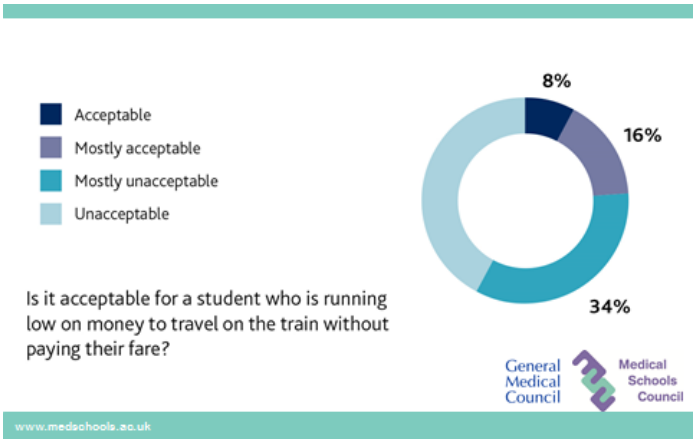


The results of the survey and other engagement work including discussions with FTP leads in medical schools, led to the splitting of the old guidance: 'Achieving good medical practice' for medical students and 'Professional behaviour and fitness to practice' for medical schools and their students. The importance of professionalism at medical school was outlined and delegates were made aware of areas that may cause concern. It was stressed that one of the main reasons that medical schools look into these types of issues is that they can indicate an underlying issue for the student such as a health condition or that they require extra study support.



'Achieving good medical practice' is divided into sections which each focus on an aspect of good medical practice and how it relates to medical students:

- Domain one: knowledge, skills and performance.
- Domain two: safety and quality.
- Domain three: communication, partnership and teamwork
- Domain four: maintaining trust.
- Annex: brief overview of fitness to practice processes in medical schools.



It was noted that copies of the new guidance will be sent out to all medical students later in the year. Further resources will be produced to support students and medical schools in their understanding of the guidance.

Q&A

Professor Iain Cameron, Professor Jenny Higham, Dr Katie Petty-Saphon, Martin Hart

Delegates were invited to ask speakers questions about the Medical Schools Council and the future of medical education and training. The following points were made:

- Questions were raised about the proposed UKMLA. Delegates agreed that the GMC should ensure communication with students is maintained throughout the development.
- The involvement of students in developing the new GMC and MSC guidance documents on SFTP was discussed. It was reported that students responded to the consultation as individuals and the BMA Medical Student Committee also put in a response. Changes were made to the guidance as a result of this feedback. Specific examples included the addition of a text box giving more details on the use of social media and whether students have a legal responsibility to raise concerns about patient safety.
- Equality for women in medicine is improving. It was mentioned that the proposed junior doctor contract will allow doctors who take time out, such as maternity leave, the opportunity to catch up through accelerated training initiatives. Additional resources will be available to support these doctors including investment in their training. This is an important step forward for equality as it will mean women who take time out to start a family will still be able to progress in their career and be eligible for promotions.
- The diversity of the Medical Schools Council was discussed. It was agreed that this was an issue, particularly BAME diversity, but noted that the female membership had increased greatly over the last few years. The members of the Medical Schools Council are the deans or faculty heads of medical schools who are appointed by their university. While improvements are being made in the area of diversity and equality, it was agreed that more work needs to be done.
- It was noted that widening participation in medicine was an important area of work for the Council. The MSC has been committed to improving access to medicine through working with schools on improving selection methods, running outreach projects and creating resources to help students with their applications. The MSC welcomes any student suggestions on how they feel WP can be further improved.
- It was queried whether the referendum outcome will have an effect on medical schools. The response noted that if the UK voted to leave the EU it would create a high level of uncertainty for universities; therefore it was difficult to give a definitive answer.

Summary and final thoughts

Delegates were thanked for attending the meeting and agreed that it would be helpful to hold another student conference next year.

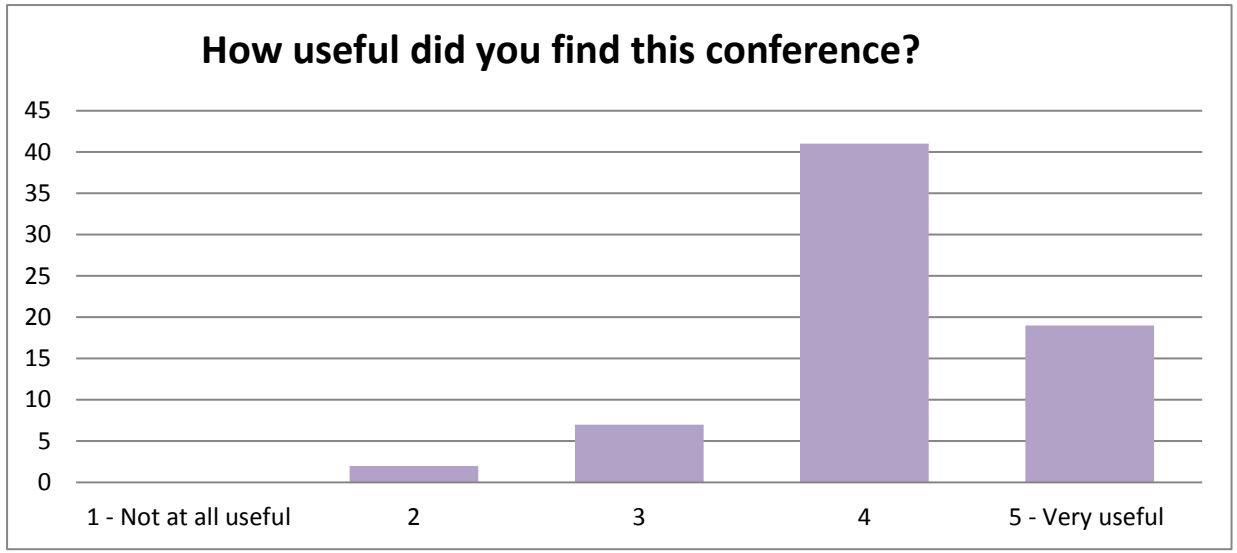
Feedback was gathered from delegates which has been summarised on the next page.

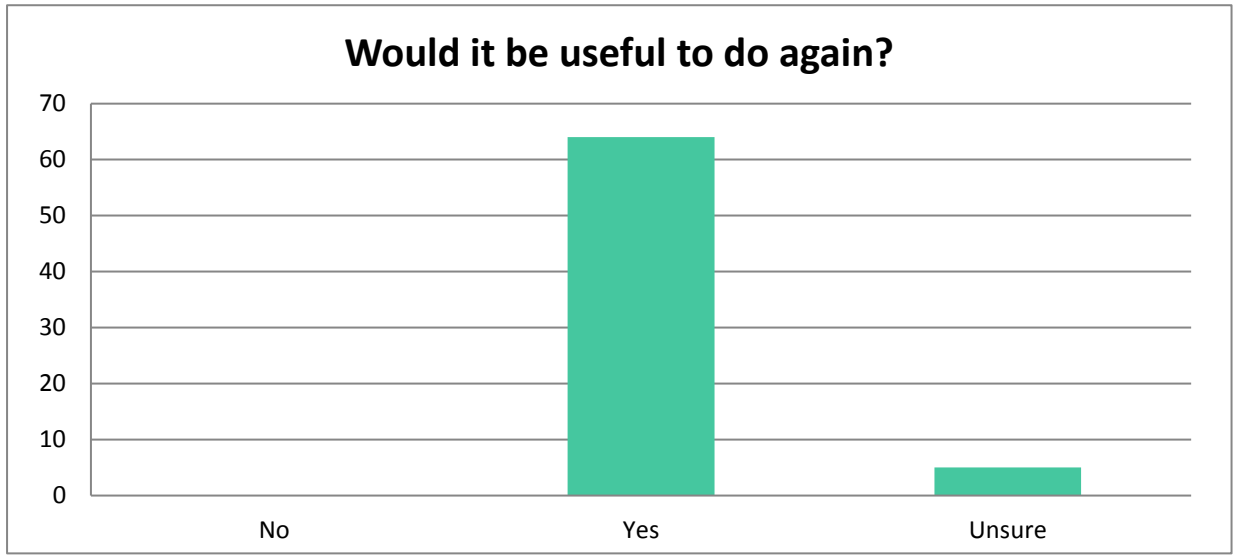
What worked well?	• Lots of time for question and group activities • Opportunities for discussion and to relay opinions • Well organised and slick handling of cheques • Engaging talks and tasks • Broad range of speakers • Interactive sessions • Being able to hear opinions of different medical schools • Timing and friendly format of day • Refreshments and lunch • Q&A session • Opportunity to talk to NHS Employers and GMC • Good to give students a platform to discuss their future • Anti-Bash session
What didn't work so well?	• No seating plan – would prefer to be mixed up with different medical schools as many schools just sat together. Students should move tables for each new feedback session • Not enough experience for first and second year students to answer questions in some areas – aim for fourth and final years (possibly 3rd year) • Date of conference too close to exams • Agenda sent quite late • No clear theme of conference • Afternoon was quite talk-heavy and worked less well – perhaps one less speaker with more time for discussions/debate • Sometimes not enough questions after talks e.g. GMC MLA talk • Not enough questions taken from back of room

	• NHS Employers did not clearly answer questions • Some feedback sessions were lengthy and led to repetitive answers – vary questions or don't ask all tables (as answers had been written down) • No NHS reps throughout the day • Strong focus on English schools despite being UK wide • Slightly long day • Some talks felt biased and gave the impression that students' opinions did not matter – MLA. Maybe only discuss topics where students can influence or at least have a say in the decision. • Not enough knowledge to answer all feedback questions – e.g. Shape of Training and Five Year Forward View – perhaps provide background beforehand or have tutor going round ensuring all students understand questions. • Did not feel qualified to answer all questions – e.g. improving morale of NHS would be better asked of foundation doctors • Not sure how useful event was for students – felt more useful to speakers
What issues relating to medical education would it be helpful to consider at a future conference?	• Academic training • Geographical locations • More emphasis on specialty selection and student understanding of current affairs • The medical curriculum and current/ potential changes • Exam structure and assessment – SJT, EPM, PSA, OSCE's • Balance between standardisation and individuality of medical schools • Any relevant hot topics/ current issues at the time e.g. currently contract changes • Delivery of skills based learning • Foundation doctor speakers or someone from UKFPO • What to expect as you progress through your career • Clinical academic opportunities/ introduction

	• Details about Item bank procedure and evidence • Useful to discuss the wide variation in how different schools operate and what can be implemented elsewhere • Course design and similarities/ differences • More on professionalism in medicine – perhaps handouts provided • Private medical schools – how they are regulated and how they will affect publicly funded schools, Foundation Programme places, funding etc. • The role of technology in medical education and health care in general • Student welfare • Perhaps get in touch with students in advance of the conference to ask for suggestions they would like to hear about • More representation from bodies who can relate issues affecting the devolved nations • Only discuss issues where our opinions could make a difference e.g. weight of SJT, GP, psychiatry and A&E recruitment, access to medicine, welfare etc. • Widening participation - lack of socioeconomic and ethnic diversity in medical schools and academia • Placements • Life as a junior doctor • Business/ cost side of NHS – perhaps have speaker discussing hospital structure • Improving student experience • Maintaining health (including mental health) as a doctor, handling stress, difficult situations, mentors for medical students etc. • The cost of a medical education/ students being treated as consumers • More student led sessions – many MedSocs have sessions on good practice and it is always nice to hear from peers

	• Teaching values, morals and ethics • What is being done to boost morale in NHS • Showcase more student input in MSC to avoid looking like a "top down" organisation – is there student representation in MSC sub-committee meetings?
Do you have any additional comments?	• Quite GMC heavy for an MSC conference – would like to have discussed WP, admissions procedures and balance between pure clinicians, educator clinicians and clinician scientists. • More talk about MSC and current work e.g. clinical academia • Thank you for organising and reimbursing travel • Useful if more info about the conference was given before hand • A similar conference by the GMC would be useful • Council paper and feedback from meeting should be sent to students (before university emails expire for final years). Regular email contact confirming what is being done with information gathered. • Maintaining communication during initial steps of MLA so students are aware rather than feel like another assessment has been imposed without say • More time should be offered for discussion on the big issues affecting medical education rather than lectures. • More representation from MedSoc • Name badges should mention medical schools • Make the day more interactive rather than listening to lectures then answering questions with a microphone • MSC should provide access to PowerPoints after the event • Materials (such as GMC resources) should be provided or told where we can access them





Number of attendees: 72

Feedback forms returned: 69

Average feedback score: 4.3