Undergraduate preparation for prescribing: the views of 2413 UK medical students and recent graduates

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WHAT IS ALREADY KNOWN ON THIS SUBJECT

- Adverse drug events are common in National Health Service (NHS) hospitals where junior doctors take responsibility for most of the prescribing.
- Safe and effective prescribing of drugs is a core competency expected of all medical graduates.
- There is a perception from some of those who supervise the prescribing of drugs in the NHS that undergraduate teaching in this area may be deficient, although this view is contested.

WHAT THIS STUDY ADDS

- Our study suggests that a large proportion of medical students and recent graduates from UK medical schools who responded also believe that their teaching and assessment in this area was inadequate.
- This result implies that those responsible for overseeing undergraduate education should urgently review teaching and assessment of competency in relation to prescribing in all UK medical schools.

AIMS

To gather opinions from UK medical students and recent graduates about their undergraduate training to prescribe and their confidence about meeting the relevant competencies identified by the General Medical Council (GMC).

METHODS

We designed a web-based survey that was distributed to UK medical students and first year Foundation doctors (graduation years 2006–2008) via medical schools and postgraduate networks.

RESULTS

Analysis was restricted to 2413 responses from students graduating in 2006–2008 from the 25 UK medical schools (mean 96.5 per school) with a complete undergraduate curriculum. Distinct courses and assessments in ‘clinical pharmacology & therapeutics (or equivalent)’ were identified by 17% and 13%, respectively, with mode of learning described most commonly as ‘opportunistic learning during clinical attachments’ (41%). Only 38% felt ‘confident’ about prescription writing and only a minority (35%) had filled in a hospital prescription chart more than three times during training. The majority (74%) felt that the amount of teaching in this area was ‘too little’ or ‘far too little’ and most tended to disagree or disagreed that their assessment ‘thoroughly tested knowledge and skills’ (56%). When asked if they were confident that they would be able to achieve the prescribing competencies set out by the GMC, 42% disagreed or tended to disagree, whereas only 29% agreed or tended to agree.

CONCLUSIONS

Many respondents clearly perceived a lack of learning opportunities and assessment related to the safe and effective use of drugs and had little confidence that they would meet the competencies identified by the GMC. There is an urgent need to review undergraduate training in this area.
Introduction

The ability to prescribe commonly used drugs safely and effectively is a core competency of the newly qualified doctor. New graduates are typically required to prescribe many times each day in the hospital drug chart and write the majority of hospital prescriptions. The demands of this task have increased in recent years because of several trends that include an expanding national formulary, increased number of drugs per patient (polypharmacy), higher patient throughput, older, more vulnerable patients, more complicated therapeutic regimens, greater demand from patients for information and the increased threat of litigation.

Prescribing errors are common in UK hospitals. One study from a London teaching hospital detected 135 errors each week, one-quarter of which were potentially serious, with most made by junior or senior house officers [1]. The National Patient Safety Agency database receives >50,000 reports annually of medication incidents from acute and general hospitals [2]. An Audit Commission report has suggested that adverse medication events were responsible for the death of 1100 hospital patients in 2001 in the UK, a fivefold increase over the previous 10 years [3]. There is evidence that inadequate training is often a contributory factor in such events [4, 5]. An analysis of 88 serious medication errors in a UK hospital has suggested that deficits in 'skills and knowledge' were a factor in 60% of cases [4]. Several studies have suggested that the delivery of targeted education can improve prescribing performance and reduce prescription errors [6–9].

Not surprisingly, the General Medical Council (GMC), which regulates undergraduate medical education, has identified knowledge and skills competencies in relation to the use of drugs that are required of all UK medical students at the point of graduation (Table 1) [10]. However, there have been widespread concerns that these objectives are not being met, partly because of recent changes in the medical curriculum that reduce the emphasis on traditional scientific disciplines such as pharmacology and clinical pharmacology and therapeutics (CPT) [11–13].

Medical students have a particular interest in this debate, although their views have rarely been heard, except for anecdotal comment by individuals [16] or small studies relating to individual medical schools [17, 18]. The purpose of this study was to survey the opinions of a large cohort of medical students and recent graduates from around the UK about their undergraduate training and assessment in pharmacology and therapeutics, their acquisition of skills relevant to prescribing and their confidence about meeting the outcomes identified by the GMC.

Methods

The study was conducted across all UK Medical Schools and National Health Service trusts. An online questionnaire was designed to ask specific questions regarding undergraduate experience with respect to 'basic pharmacology' (defined as 'what drugs are and how drugs work') and 'clinical pharmacology & therapeutics' (defined as 'using drugs in the clinical setting including prescribing') (Table 2). In addition, the survey asked questions concerning: the style of medical course; whether there were identifiable teachers who coordinated learning; confidence in relevant drug-related skills; experience in writing prescriptions; availability of e-learning resources; evaluation of teaching and assessment in this area; and opinions as to whether this had allowed or was likely to allow them to meet the competencies outlined by the GMC (Table 1). Explanations to questions were provided where appropriate, with opportunity for free text comments. All questions required a response for a successful form submission. Form results were stored within the online website (http://fs12.formsite.com) and downloaded in Excel format.

The questionnaire website was highlighted initially within articles in the BMA News [19], the Student BMJ and the BMJ [13]. The survey URL was brought to the attention of students due to graduate in 2007 and 2008 at all medical schools in the UK by e-mails forwarded through student organizations or by highlighting on electronic notice boards. Deaneries and Postgraduate Medical Education Managers enabled the distribution of the survey (through either e-mail, newsletter or notice board posting) to recent medical students.

Table 1

Learning outcomes of undergraduate medical education identified by the General Medical Council in Tomorrow’s Doctors (2003)

<table>
<thead>
<tr>
<th>Graduates must know and understand the principles of treatment including:</th>
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<td>• ‘know . . . how errors can happen . . . and principles of managing risks’ (item 4)</td>
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<tr>
<td>• ‘know and understand principles of treatment . . . and . . . evaluate effectiveness against evidence . . . the effective and safe use of medicines as a basis for prescribing, including side effects, harmful interactions’ (item 16)</td>
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<td>• ‘work out drug dosage . . . write safe prescriptions . . . give IV, IM and SC injections . . . administer oxygen therapy and use a nebuliser correctly’ (item 19)</td>
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<td>• ‘provide enough information . . . to allow patients to make informed decisions’ (item 30)</td>
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graduates from 2006 (current Foundation year 1). Responses were submitted anonymously. From a total of 32 medical schools in the UK, two did not yet have final year clinical students, three managed purely preclinical aspects of the course, and two were partnered with other institutions. The final analysis was restricted to 25 institutions, each randomly allocated a number 1 to 25. The chi-squared test for independence was used to detect statistically significant relations between two categorical variables. All statistical analysis was performed at the 95% significant level. Microsoft Excel Analyse-It package was used to complete all statistical analysis.

### Results

A total of 2783 responses were received between 3 August 2006 and 20 February 2007, of which 2413 met the eligibility criteria (the 25 medical schools above, graduation years 2006–2008). The mean number of responses per medical school was 96.5 (range 5–170), and all but two schools provided at least 50 responses. The number of responses (%) from each graduation year from 2006 to 2008 was 453 (18.8), 991 (41.1) and 969 (40.1), respectively. Respondents identified the style of their course as 'integrated'(39%), 'traditional'(19%), 'problem-based'(19%) and...
‘graduate-entry’ (5%), with 17% using a combination of descriptors.

**Learning and Assessment in ‘Basic Pharmacology’ and ‘Clinical Pharmacology & Therapeutics’**

Respondents identified a variety of styles of learning (Figure 1). Although 25% had a distinct course, the majority (51.2%) learnt ‘basic pharmacology’ as part of a course in basic sciences or by integrated system-based learning. The majority of respondents reported that ‘basic pharmacology’ was assessed as part of a broader course assessment, with 19% describing ‘a specific assessment’ and 11% ‘no identifiable assessment’. The learning pattern in CPT was described most commonly as ‘opportunistic learning during clinical attachments’ (41%), as well as being ‘integrated within systems-based modules’ (30%), as a ‘distinct course’ (16.8%), and as ‘self-directed learning through problem-based learning (PBL) casework/discussions’ (12%). Only 13% of respondents identified a specific assessment in ‘CPT (or equivalent)’, with the majority stating that this area was included within a ‘broader integrated assessment’.

![Figure 1](image.png)

**Figure 1**

Learning style for ‘basic pharmacology’ (a) and ‘clinical pharmacology & therapeutics’ (b)

**‘I feel confident in the following skills’**

When asked to identify which drug-related skills the respondents could approach with confidence, 94% identified drug history taking. Rather smaller proportions felt confident about accessing high-quality information about medicines (55%), prescription writing (38%), drug dosage calculation (24%), and preparing and administering drugs (15%). When asked how many times they had ‘filled in a hospital prescription kardex during training’, 90% and 60% of 2008 and 2007 graduates, respectively, reported having undertaken this task three or fewer times. The proportion for those who had already graduated was 23%, with 7% of this group reporting never having done so prior to qualifying.

**Learning resources**

Overall 56% respondents were able to identify an individual teacher who coordinates this area of the course, although the proportion varied greatly between medical schools. When asked to identify professional group(s) that played a major role in teaching about drugs and medicines, the following groups were identified: clinicians (89%), general practitioners (43%), nurses (10%), basic pharmacologists (21%), clinical pharmacologists (37%) and pharmacists (27%). A number of schools have introduced a limited list of drugs or a ‘student formulary’ to help to prioritize learning and avoid factual burden [20], but this was identified by only 29% of respondents. Significant e-learning resources to reinforce learning were available to 35% of respondents.

**Overall views about training**

When asked about the amount of teaching in pharmacology, therapeutics and prescribing during their course, the majority of respondents from all graduation years felt it was ‘too little’ or ‘far too little’ (Figure 2). When asked whether the assessments in this area ‘thoroughly tested knowledge and skills’, 56% responded ‘disagree’ or ‘tend to
disagree', with a further 25% neutral (Figure 3). In response to the final statement ‘I feel confident that my training will enable me to achieve the prescribing competencies set out by the GMC’, 42% of students who responded to the survey disagreed or tended to disagree, whereas only 29% tended to agree or agreed (Figure 4a). The likelihood of agreeing or tending to agree rather than any other view was associated with having already graduated (36% vs. 27%, \(P < 0.001\)), the presence rather than absence of an identifiable course coordinator (37% vs. 17%, \(P < 0.001\)), learning in CPT based on a distinct course rather than opportunistic learning (47% vs. 17%, \(P < 0.001\)), the presence rather than absence of a distinct assessment in CPT (46% vs. 26%, \(P < 0.001\)), agreement rather than disagreement that CPT had been assessed thoroughly (66% vs. 14%, \(P < 0.001\)), and sole identification of the style of course as ‘traditional’ rather than ‘PBL’ (34% vs. 19%, \(P < 0.001\)). There was also marked variation between medical schools (Figure 4b).

**Discussion**

The main findings of this study are that (i) a minority of respondents receive distinct courses and assessments in either basic pharmacology or clinical pharmacology, (ii)
few felt confident about key skills such as prescribing and calculating drug doses, (iii) prescribing was very rarely practised prior to graduation, (iv) less than one-third of respondents felt that they had met or were likely to meet the standard expected of them in relation to the use of medicines at the point of graduation, and (v) there were marked variations in the responses of students from different medical schools.

There has been a widespread perception that doctors are not as well prepared for prescribing at the outset of their careers as they should be and that this may contribute to prescribing errors and compromise patient safety [4, 21, 22]. Others have countered that there is no firm evidence of underpreparation for prescribing [15] and, indeed, the GMC regularly inspects the quality of education in all UK medical schools. There are two major problems in providing clarity on this issue. First, since few schools now have a distinct assessment in this area of competence, it is difficult to assert with confidence what level of competence is being achieved. Indeed, the majority of respondents in this study felt they had not been thoroughly assessed in this area of study. Second, the required competencies are stated only in very general terms (Table 1), making it difficult to design exit assessments that unequivocally demonstrate the required outcomes. For these reasons, indisputable evidence to resolve this issue is unlikely to emerge in the near future, even though signals of a significant problem persist [23].

Although the importance of official inspections of curricula and associated assessments cannot be diminished, the views of medical students about their training are also relevant. Our study is by far the largest to explore a specific aspect of the curriculum in detail, and the results are consistent with those of smaller local surveys of opinion [17, 18]. The results describe the prevalence of an integrated style of learning and assessment in an area that was traditionally delivered as a specific discipline within the curriculum. Whatever the pattern of learning, Figure 2 shows that a large majority believes that the overall amount is insufficient. Respondents showed a general lack of confidence about prescribing, a skill that they would be expected to undertake regularly from day one of their career. Although a degree of caution on this point is understandable, this feeling is perhaps not surprising given that many respondents reported having little practice. Figure 4 shows that overall self-rated attainment of competency varied between students of different schools, as previously noted in relation to other core skills [24].

It is clear that learning about drugs poses considerable challenges for students and teachers, but it has previously been suggested that, in any curriculum style, this might happen more effectively with clear leadership, focusing learning around a limited list of commonly used drugs, and with the support of e-learning resources [20, 25]. Only a minority of respondents reported that they had these facilities available.

Our study has a number of methodological limitations, so the results have to be interpreted with some caution. First, it was publicised at a time when there had been adverse comments made about prescribing education in the medical and lay media. Second, the respondents represent only a small proportion of graduates for the years 2006–2008 and cannot necessarily be extrapolated to represent the views of the whole cohort. It is possible that our respondents may have been biased towards those who are generally malcontent or concerned about their educational needs. This might have been clarified by seeking opinions on a ‘control’ area of undergraduate education. Nevertheless, the findings in relation to prescribing are similar to those of smaller studies [17, 18]. Third, those graduating in 2007 and 2008 had not completed their course and had to base their responses to some of the questions on 70–90% of their complete undergraduate experience. However, most students would be aware of the total content of their studies by this stage. Although there was greater confidence about having met the GMC criteria amongst those who had graduated, this belief was expressed by only one-third of that group. Fourth, it relies entirely on self-rated confidence rather than objective demonstration of knowledge and skills. Finally, since this was an uncontrolled web-based survey, we cannot rule out the fact that some respondents may have been motivated to enter multiple responses.

In conclusion, this is the largest survey so far undertaken of UK medical student opinion concerning preparation for prescribing drugs. In spite of its obvious limitations, our study has shown that, at the very least, a substantial minority of students believe that they are not being adequately prepared for prescribing when they begin their medical careers. We think that the following actions are now required: (i) the requirements in terms of knowledge, attitudes and skills with respect to drugs should be clarified in detail by the GMC as a matter of urgency; (ii) once this task is completed, all medical schools should be required to have robust assessment structures to ensure these outcomes have been met; and (iii) there should be a coordinated effort undertaken by UK medical schools to share best practice and learning materials in this area.

Competing interests

S.R.J.M. and D.J.W. are clinical pharmacologists and members of the British Pharmacological Society.

Postscript

In response to concerns that had been expressed about education for safe prescribing the GMC convened a meeting in January 2007 at which preliminary data from this study, as well as data and opinions from other relevant stakeholders, were presented.
This meeting concluded by setting up a Safe Prescribing Working Group under the auspices of the Medical Schools Council and GMC, which also included representation from the National Health Service, Postgraduate Deans, National Patient Safety Agency, National Prescribing Centre and British Pharmacological Society. A major outcome was an agreed statement of the knowledge and competencies in relation to prescribing that might be expected of a newly qualified doctor in the UK. This statement, as well as a report of the other activities of the Safe Prescribing Working Group can be accessed at http://www.chms.ac.uk/documents/finalreport.doc.

REFERENCES


