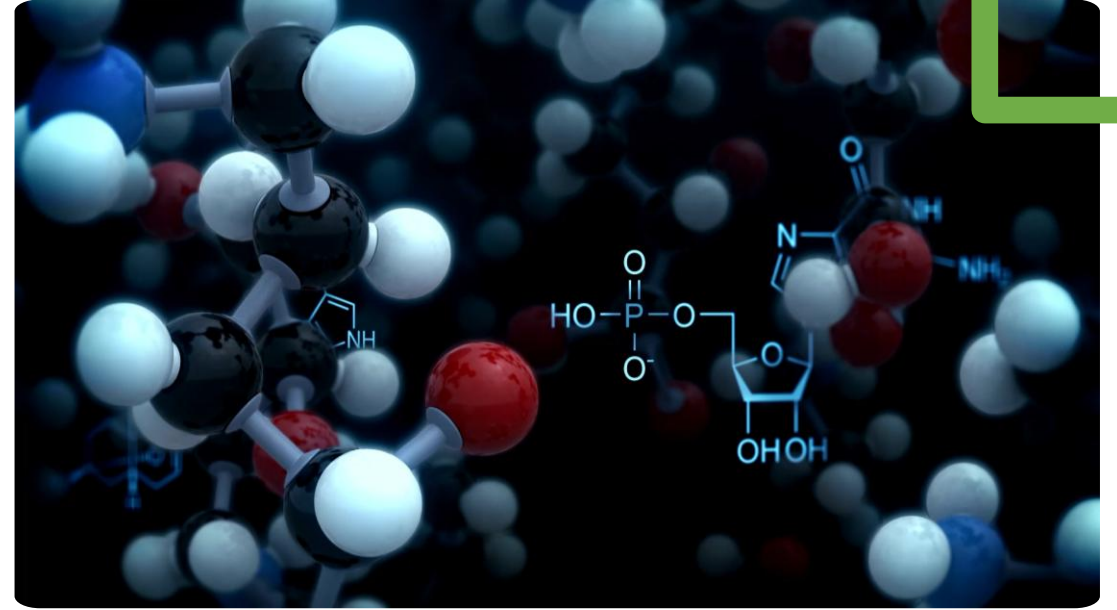


The Future of Undergraduate Medicine

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The Future of Undergraduate Medicine: Preparing Tomorrow's Doctors for Today's Challenges

- **Provocation for Change:** Are we still training yesterday's workforce for tomorrow's NHS? The evolving landscape of medicine demands a transformative approach.
- **Why This Matters Now:** Today's students will face a radically different healthcare environment — community-based, digital-first, and demographically complex.
- **Session Goals:** 1) Understand key health economy challenges, 2) Explore the ARU School of Medicine's innovations, 3) Invite dialogue and critique.



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Demographic and Disease Trends

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Ageing Population

The UK population is ageing rapidly, increasing demand for healthcare services. Life expectancy gains are coupled with more years lived with illness.



Multimorbidity Complexity

Patients increasingly present with multiple chronic conditions. The average GP consultation now involves managing at least three concurrent problems.



Deprivation and Disease Burden

Multimorbidity is more prevalent and occurs earlier in deprived communities, exacerbating health inequalities and straining primary care.

Workforce Pressures

- **Consultant and GP Shortages:** High vacancy rates across specialties and declining GP-per-capita ratios are undermining service delivery and education quality.
- **Burnout and Early Retirement:** Healthcare professionals are retiring earlier, citing workload stress, moral injury, and lack of support — shrinking the mentor pool for trainees.
- **Educational Impact:** Clinical education is being squeezed by service pressures. Fewer staff are available or have time to teach, risking a dilution of training quality.



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Traditional Model of Medical Education

- **Hospital-Centric Structure:** Medical education has historically been dominated by inpatient, hospital-based learning, marginalising community-based experience.
- **Content Overload:** Curricula are dense with biomedical content, often at the expense of applied, real-world complexity such as population health and digital care.
- **Graduates Lacking Contextual Skills:** Many students graduate highly competent in foundational science but underprepared for health inequalities, interdisciplinary care, or complexity.



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The ARU Approach

- **Community-Embedded Training:** ARU's medical programme is rooted in Eastern England, with strong placements in primary care and community health settings.
- **Widening Participation:** The programme proactively recruits students from underrepresented backgrounds, aligning with local workforce needs and reducing inequality.
- **Partnerships for Place-Based Learning:** Collaborations with NHS trusts and community providers ensure students learn within — and about — the populations they will serve.



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Community-First Training

- **Care Outside Hospitals:** The majority of patient care occurs in homes and communities, yet undergraduate training remains largely hospital-based.
- **Expanding Community Placements:** ARU is scaling up primary care placements and apprenticeships, fostering early, consistent community exposure for students.
- **Grow-Your-Own Models:** Local recruitment and training models aim to produce doctors who stay and serve in the regions they know — addressing retention and access.



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Capabilities Over Content

- **Information Saturation:** Students face a tidal wave of medical content — impossible to master and often divorced from real-world complexity.
- **Critical Capabilities:** Core capabilities like adaptability, digital literacy, teamwork, and navigating uncertainty are essential to modern practice.
- **Curriculum Reform at ARU:** ARU embeds capability development through early exposure to population health, complexity thinking, and team-based learning.



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Belonging

- **Beyond Professionalism:** Technical competence is vital, but it's the sense of belonging that sustains students through challenge and adversity.
- **Inclusion as Strategy:** ARU fosters inclusive environments where diversity is seen as an asset and students feel medicine is a place for them.
- **Anchored in Region:** Students are supported to see themselves as part of the healthcare fabric of the Eastern region — building identity and commitment.



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Attendance vs Engagement

- **Shift in Philosophy:** ARU's policy moves beyond punitive attendance models to a focus on engagement — valuing interaction, immersion, and student voice.
- **Insights, Not Enforcement:** Attendance is now tracked to identify struggling students and inform session quality, not as a disciplinary tool.
- **Flexible and Responsive Learning:** Students want autonomy, interactive learning, and scheduling that reflects their diverse responsibilities and learning styles.
- **Staff and Cultural Challenges:** Embedding this mindset requires sustained work with educators — shifting culture from surveillance to support.



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What If We...

- **Cut to Four Years?:** Would a shorter, more focused programme better match the real demands of modern practice – or compromise depth?
- **Mandate Community Service?:** Could a required year in primary care or underserved areas strengthen place-based retention and broaden perspectives?
- **Over-Produce Doctors?:** Would deliberately training more doctors reduce workforce pressure, or risk devaluing the profession and training quality?



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ARU as Testbed

- **Scaling Innovation:** ARU is expanding medical school intake and piloting apprenticeship routes — redefining access and pathways into medicine.
- **Community-Based Education:** The curriculum embeds community learning as central — not peripheral — shaping identity and practice from early years.
- **Eastern Region as Microcosm:** From rural deprivation to urban diversity, the region reflects NHS-wide challenges — making it a live lab for new models.



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Rethinking Postgraduate Training



Outdated Structures, Modern Demands

Postgraduate training remains specialty-dominated, rigid, and slow to adapt to evolving NHS needs like multimorbidity, community care, and digital systems.



Shape of Training Imperatives

Calls for broader generalist skills, flexible entry points, and less fragmentation across primary, secondary, and community placements remain largely unmet.



Mismatch and Bottlenecks

Undergraduate expansion outpaces postgraduate capacity. Trainees face geographical constraints, rotational instability, and service pressure-driven burnout.

A Place-Based Training Future

- **Training Anchored in Place:** Allocating students and trainees to a defined geography — and aligning training with that region's population and workforce needs — fosters retention and relevance.
- **Employers as Co-Educators:** Local NHS providers are not just placement sites but partners. They help shape the curriculum, employ graduates, and support long-term professional growth.
- **Reducing Geographic Inequities:** Prior allocation models can reduce training deserts and improve workforce equity in underserved areas by embedding education in community contexts.



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Implications for Medical Schools

- **Curriculum Must Reflect Place:** Medical education should be tailored to local population health needs, not generic national standards alone.
- **Partnerships Over Placements:** Community and employer relationships must be longitudinal, collaborative, and focused on shared workforce outcomes.
- **Identity Rooted in Context:** Training in one place — with continuity of mentors, patients, and purpose — fosters belonging, resilience, and relevance.



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Call to Action



Tomorrow's Leaders, Today

Today's students will soon lead the NHS. Their preparation must align with the complexity, diversity, and community-focus of future care.



Teachers as Architects

You are more than educators — you are shaping systems, norms, and mindsets that will define the next era of healthcare.



Time for Transformation

This moment demands more than incrementalism. It calls for bold shifts — in curriculum, culture, and collective vision.