What is already known on this topic

Traditionally, the foundation years of medical education have grounded students in biomedical sciences but offered little, if any, clinical exposure

Worldwide, curriculums are moving towards becoming more "vertically integrated"

This move is parallel to and loosely tied with an increasing emphasis on personal and professional development in medical curriculums

There is, however, a paucity of empirical evidence or even arguments that are soundly grounded in theory to support early experience

What this study adds

"Experience" can be defined as authentic human contact in a social or clinical context that enhances learning of health, illness or disease, and the role of the health professional

A lack of early experience can demotivate students and leave them vulnerable to negative emotions when they finally enter the clinical environment

An inventory of likely benefits of early experience includes greater motivation and confidence, greater social and self awareness, and more rounded and practically relevant theoretical understanding

Viewing medical education as a process of socialisation—into the population that the future doctors will serve, and the profession they will join—helps redefine the task of medical education in the 21st century

shows much early experience research to be poorly grounded in theory, methodologically weak, and at the level of opinion rather than learning outcomes.[9] However, it supports our respondents' view that awareness of professional roles, preparedness for clerkships, and early detection of students with difficulties are probable benefits of early experience. Two recent qualitative studies have, like ours, characterised medical education as developing a professional identity.[10 11]

The blend of cognitive, social, and affective learning fits well with social cognitive theory.[12] Our results also fit well with new conceptualisations of apprenticeship, according to which an important part of professional learning is developing a sense of identity within a community of practice.[7]

The challenge for future research is for educators to base their interventions on theory and evaluate them rigorously enough to advance knowledge through implementation.[13]

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Corrections and clarifications

Taking account of future technology in cost effectiveness analysis

An oversight during our editorial process resulted in a line drawing being omitted from this education and debate article by Joshua A Salomon and colleagues (25 September, pp 733-6). The picture printed was a computer generated image of hepatitis C virus, whereas the line drawing, which can now be seen on bmj.com, shows the natural course of hepatitis C infection.

Effect of a flow chart on use of blood transfusions in primary total hip and knee replacement: prospective before and after study

In this quality improvement report by Muller and colleagues (*BMJ* 2004;328:934-8) a misunderstanding during editing led to an error in reporting the authors' methods. In the third paragraph of the section "Strategy for change," the correct text should read, "We provided [not obtained] feedback twice during routine staff meetings" and "We presented [not determined] the proportion of patients who had received allogenic or autologous blood transfusion after total joint replacement." Technology led to a further slip, this time at proof stage. At the end of the fourth paragraph of the section "Effects of change," a confusion caused by "track changes" resulted in the misrepresentation of an increase in units of transfused blood. The correct increase in units of transfused blood in Zurich should be from 52 700 to 60 600 (+15%) [not plus/minus 15%].