24 October 2012

Expert Advisory Group

SHAPE OF TRAINING

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To consider

What trainees want from postgraduate medical education and training

Issue

1. Reform to postgraduate medical education and training will have a great impact on junior doctors and the way they develop their careers. This paper explores the issues and possible options for changing postgraduate training to meet the trainees' needs and how we will gather evidence from this stakeholder group.

Recommendations

2.

a. To discuss implications of a more general training programme on junior doctors (paragraphs 7 to 19).

b. To seek feedback on these issues and possible options with trainees as part of the evidence informing the review (paragraph 20).

Further information

3.

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Background

4. On 17 July 2012, the Expert Advisory Group considered how doctors may work and train in the future and how this may impact on the current medical career path.

5. In item 3, we discussed some of the tensions faced by organisations employing junior doctors. For example, employers will be able to plan their workforce better if they have more control over the kinds of doctors that emerge from training. We also discussed the benefits for employers if training is shortened and linked more explicitly to local needs. As Annex A shows, the current training pathway is a long one, and certainly longer than in many other countries.

6. In this paper we look at training from the perspective of trainees, some of the challenges driving change in the medical career pathways and how those challenges might be met for different groups of trainees. At this stage, the ideas discussed are tentative and provisional. They will need to be tested, modified, refined or discarded in the light of the research and other evidence we aim to gather in the coming months.

Discussion

7. The way medicine is practiced is being transformed by scientific and societal drivers such as patient needs and expectations. Doctors' expectations and goals will also need to change to meet these demands. Trainees will not train and work in the same way as their predecessors.

8. We will need in the future more doctors such as general practitioners and specialists who able to provide care in the community and in acute admission settings. In Item 3, we discussed the implications of this trend on training, with a possible move towards a more general approach that would focus on preparing doctors to provide general, front line care. Further specialisation would then be completed through subsequent credentialing of specialist knowledge and skills, once the broad based training has been completed.[1] This could be delivered in a modularised format in the workplace.

9. The way junior doctors train is changing:

[1] Credentialing is defined as a process which provides formal accreditation of attainment of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice. (PMETB Report of the Credentialing Steering Group to the Department of Health (England) 2010).

a. The Working Time Regulations (WTR) has limited the number of hours doctors can work and this has impacted on the way trainees access a range of learning opportunities.

b. Many trainees are seeking more flexible work arrangements and part time work to accommodate other aspects of their careers or personal lives.

c. A number of trainees want to develop a career in academic training. The current training arrangements often bring their clinical and academic opportunities into conflict.

10. Many trainees, at some time, struggle to get meaningful learning experiences because of the pressures of service delivery in combination with complex rotas. This often leads to problems with handing over their patients to other doctors, having time to learn new skills and to reflect on that learning.[2] This could potentially affect the abilities of doctors coming out of training to work effectively without some supervision and support at the GP and consultant level. This possible shortcoming is being address to some extent by the Royal Colleges by introducing specific, post-CCT learning packages aimed at new GPs or consultants. For example, the Royal College of General Practitioners has structured a support programme for GPs during their first five years. And for similar reasons, many surgical trainees are undertaking fellowships.

What makes people want to become doctors

11. Becoming a doctor is still highly regarded in the UK with only the best and brightest students being selected into medical schools. But it is also recognised as a difficult and long journey to reach what for most is the desired end point – becoming a consultant or GP.

12. Other high status professions such as banking and law tend to attract people who are motivated by financial rewards.[3] But the reasons people pursue a career in medicine are more complex with an emphasis on the intellectual challenges offered by medicine and social factors such as providing support and caring to patients.[4] Medical students seem to be motivated by a desire to help people, the importance of decision making and leadership, a desire to be respected for their knowledge and skills, and an interest in science, learning and new experiences.

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[2] GMC National Training Survey 2012 http://www.gmc-uk.org/education/surveys.asp

[3] Charles Daniel and Michael O'Brien. Why Study Medicine? Pre-meds not in it for the money, survey says, April 2008 http://studentdoctor.net/2008/04/why-study-medicine-pre-meds-not-in-it-for-the-money-survey-says/

[4] Mcmanus I et al. The attractions of medicine: the generic motivations of medical school applicants in relation to demography, personality and achievement. *BMJ Medical Education* 2006, 6:11.

13. Junior doctors, like medical students, tend to select their careers based on their clinical interests, perception that the specialty is highly regarded and the work intensity. For example, a study looking at career preferences for medical students in Scotland found Surgery (22.5%),medicine (19.0%), general practice (17.6%) and paediatrics (16.1%) were the top career choices. Specialties were selected based on a number of factors: work–life balance, perceived aptitude and skills, intellectual satisfaction, and amount of patient contact. Students are more likely to go into general practice if they view work–life balance and continuity of care as extremely important.[5] Similarly many doctors, particularly women, decide against a career in some specialties such as surgery and emergency medicine because they do not provide a good work-life balance.[6]

14. Any changes to postgraduate medical education and training have to take note of the factors that attract people into medicine and into specific specialties. Trainees want to see what happens to their patients. Employers, as discussed in Item 3, want doctors who can provide care in communities and in acute admissions settings. Both these needs could be addressed (at least in part) with a more general approach to training that emphasises generic knowledge and skills. Doctors would then provide both front line care and support patients and manage their case from start to finish.

15. But there is still a need to manage junior doctors' career expectations. Based on competition rates for specialty training in 2012, core surgical training posts with a ratio of 3.8 applications per post is one of the most popular career choices for trainees. Neurosurgery had a ratio of 15.9:1, in part because there were only 16 available posts in this specialty. In contrast, specialties like psychiatry (1.4:1) and paediatrics (1.9:1) continue to attract less trainees, although these ratios have improved over previous years. These trends suggest trainees still see their careers developing in a way that might not align with the kinds of doctors that will be needed by patients and the service in the future. By shifting the purpose of postgraduate training from developing specialists towards developing generalists, it may help raise the status and acceptance of general practice and general specialty roles – areas where more doctors will be needed as the health of the UK population changes.

What junior doctors think about training

16. The GMC National Training survey 2012 shows a generally positive picture of trainee doctors' perceptions of the quality of training in the UK.[7] But significant concerns were raised in some key areas, including the quality of induction, handover, feedback, assessment and the quality of the experience some trainees are

[5] Jennifer Cleland et al. Associations between medical school and career preferences in Year 1 medical students in Scotland. *Medical Education* 2012: 46: 473–484

[6] Goldacre, MJ et al. Doctors who consider but did not pursue specific clinical specialties as careers: questionnaire surveys. *J R Soc Med* 2012: 105: 166-176.

[7] GMC National Training Survey 2012 http://www.gmc-uk.org/education/surveys.asp

receiving in their posts. Similarly about a quarter of trainees said their practical experience was only fair or even poor. About 19 % of trainees said they would rate the quality of clinical supervision in their current post as fair or poor.

17. This feedback suggests trainees would welcome changes to training where they have more learning opportunities in supervised and supported environments. They want a more effective assessment system that meaningfully measures their competencies and skills. A training structure that reinforces time to learn and reflect on that learning. This means junior doctors may no longer deliver large parts of the service and fill in rota gaps. Changes to the training structure would emphasise that the teams in which trainees work should be staffed always by consultants and trained doctors. This mirrors the options discussed in Item 3 for a more consultant-present workforce.

Options to better meet trainees needs

18. More general training programmes could perhaps give trainees more chance to experience different medical situations and disciplines. They would also need less time to meet a set of broad competencies, resulting in a shorter length of training. This approach could provide the service with doctors trained to a level at which they can deliver a generalist service in a number of general areas and provide front line care, without the need for close supervision. They could also be developing more specialist skills over time. It could also mean consultants would not be locked into one particular area of practice for the rest of their career. They would have opportunities through credentialing to change their sub-specialty and scope of practice. It would mean that doctors could plan their career to take on some work in intense areas such as emergency medicine while knowing they can retrain in different areas as their career goals change. This level of flexibility could also support doctors who want to pursue an academic career.

19. This approach would also better support junior doctors who want to develop a career focused both on clinical work and academic research, leadership, medical education and management. Many trainees postpone or pause their training in order to pursue their academic interests while others find it difficult to link together their clinical training with the structure of an academic career. Academic trainees need a training structure flexible enough to allow them to move in and out of clinical training while meeting the competencies and standards of that training. They must develop general knowledge and skills to allow them to undertake clinical work safely and competently but they then need opportunities to specialise within their academic area. One way of approaching this would be a postgraduate training structure based on three to five years of general specialty training followed by more specific specialty training (through credentialing). This could give academic trainees more flexibility to develop their research and academic careers.

> **Recommendation:** To discuss implications of a more general training programme on junior doctors.

20. To test and develop these ideas further, we will give trainees the opportunity to feedback to the review through seminars, the written call for evidence and oral evidence sessions. We are also discussing these issues with trainees at various hospital and primary care sites throughout the UK. We have developed an extensive stakeholder list that includes both national bodies such as the British Medical Association's Junior Doctor Committee and local groups of junior doctors through the postgraduate deaneries and royal college.

> **Recommendation:** To seek feedback on these issues and possible options with trainees as part of the evidence informing the review.

Resource implications

21. As we begin to explore and develop potential reforms for the future shape of postgraduate training we will identify the resource implications of the different options.

Equality

22. The review will consider the impact of its recommendations on patients, doctors, trainees and medical students. We will include specific questions and opportunities to feedback about equality issues through our formal evidence gathering activities.

Communications

23. Information about the review will be available on the Shape of training website.