DILEMMAS AROUND THE JUNIOR MEDICAL WORKFORCE – UNITED KINGDOM

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"When you win, nothing hurts":
(Joe Namath, former athlete)

> "The essence of the daily running of a complex social system is certainty; the essence of steering it towards the future is uncertainty."
>
> David Casey (1993) Managing learning in organisations, OUP

INTRODUCTION

1. People expect their doctors to be knowledgeable and skilled, and trust them to provide the highest standards of care. Those of us entrusted with providing the highest standards of education and training for junior doctors must lay the foundation for a lifetime of professional practice that meets this expectation. We must also prepare these colleagues for lifelong learning, equipping them to maintain their competencies and continue their professional growth and development.

2. This paper briefly reviews the past and present contexts of health service delivery in relation to the training of doctors, and identifies some important issues and dilemmas.

MEDICAL MANPOWER AND MEDICAL MANPOWER PLANNING: THE HISTORICAL CONTEXT

3. It has been said that it was not until 1912 that "the random patient, with a random disease, consulting a random physician, had a better than fifty-fifty chance of benefiting from the encounter"[1]. During the eighteenth century and the early part of the nineteenth century, medical care was provided by barber surgeons, physicians, apothecaries and not a few quacks. Even though the medical professions were consolidated and controlled by the formation of the General Medical Council in 1858, doctors in the mid-nineteenth century had a heterogenous background.

4. The earliest census figures, derived from the Census of England and Wales[2], showed that in 1851 there were approximately 14,000 doctors or surgeons in England and Wales. For the next three decades the number of doctors recorded in the medical register remained constant, even though the population steadily increased. From 1881 onwards the number of doctors in England and Wales rose faster than the population as a whole[2]. The temporary interruption of medical training, because of the First World

War, slowed down the increase in the number of doctors. After 1921, the ratio of doctors to the population rose steadily.

5. When the National Health Service (NHS) was set up, two out of every three doctors in it were engaged in general practice[3]. For this reason, the problem of distribution of general practitioners was seen as sufficiently important to merit a special statutory committee, the Medical Practices Committee. Before 1948 there were few junior hospital posts available, and young doctors rarely continued working full time in hospitals after they qualified.

6. The history of medical manpower forecasting and planning begins essentially after the Second World War. Manpower forecasting refers to the attempts to predict the future stock of doctors, or the future demand for doctors. Manpower planning, on the other hand, is concerned with the implementation of policies.

7. The first attempt to tackle the problem of medical manpower in the post-war period was made by the Inter-Departmental Committee on Medical Schools under the chairmanship of Sir William Goodenough[4]. The terms of reference of this Committee were to examine the organisation of medical schools in the light of the Government's post-war hospital policy. The Committee believed that the Government plans for improvement in the health services meant that more specialists would be needed. The inadequacies of the available data were recognised.

8. The Government accepted the main recommendations of the Committee's Report, acknowledged that greater financial support for medical education was required, but left individual medical schools to determine independently their levels of intake of medical students.

9. The broad principles of the career structure for doctors in the NHS as we understand them still today, were established in the Report of the Inter-Departmental Committee on the Remuneration of Consultants and Specialists (the Spens Report)[5], whose recommendations were accepted. This Report recommended that after completion of the pre-registration period, there should be three grades of training doctors in the hospital based specialties. These grades were to be of limited tenure, and passage through them would lead to a permanent post in the consultant grade, although it was accepted that not everyone would achieve promotion. These posts were originally designated junior registrar, middle registrar, and senior registrar. This structure also established the hierarchical form of the consultant-led firm, which persists today.

10. However, during the late 1940s and early 1950s the flow of new doctors emerging from medical schools increased. The fears of competition for jobs were expressed in the Cohen Report in 1955 [6]. These fears led to the appointment of another Committee to examine the problem of medical manpower. This Committee was set up, under the chairmanship of Sir Henry Willink, to consider the future numbers of medical practitioners and the appropriate intake of medical students[7].

11. Analysis in retrospect showed the Willink proposals to be seriously flawed. Abel-Smith and Gales demonstrated, in 1962, that in the preceding ten years almost one quarter of the output of British-born graduates of British medical schools had emigrated from Britain and not returned[8], far more than the estimate made by Willink. Moreover, Lafitte and Squire drew attention to the fact that the population projections used by Willink were unsafe by about 44% [9].

12. By 1958, it was estimated that up to 2,500 overseas doctors were working in hospitals in England and Wales[10]. The number of such doctors grew rapidly in the 1960s and 1970s. By 1976 overseas-born doctors in the hospital service numbered some 12,000[11], amounting to more than half the total number of junior hospital doctors and up to 80% in some specialties. Merrison reached the "inescapable conclusion …. that there (were) substantial numbers of overseas doctors whose skill, and the care they offer to patients fall below that generally acceptable in this country"[12]. Even in 1976 Doran was concerned that, despite medical school expansion and the introduction of vocational registration, there was no hope of reducing the heavy dependence of the hospital service at that time on foreign graduates[13].

13. Successful medical manpower planning is said to have been handicapped by the many years it takes to train doctors for career posts[14]. However, Paton considers that the career problems of junior medical staff were apparent within a few years of the founding of the NHS[15].

14. Problems prompted the establishment of a Royal Commission to review medical education, both under-graduate and postgraduate, in Great Britain[16]. Developments that were presaged, but still resonate today, included fully trained specialists (consultants and general practitioners) delivering medical services; the undergraduate course producing "not a finished doctor but a broadly educated man (sic) who can become a doctor by further training"; linking national (service) need with manpower requirements; merging London medical schools; and maintaining overseas doctors "as a facet of technical assistance to developing countries"[16].

15. In October 1987, arguably one of the several most important policy documents in the lifetime of the NHS was published. 'Hospital Medical Staffing – Achieving a Balance' represented the outcome of negotiations between teams from the Joint Consultants Committee and the (then) Department of Health and Social Security, with representatives from the regional health authority chairmen and academic medicine, and after consultation with the profession[11]. This detailed and comprehensive national medical manpower policy document saw the underlying problem of hospital medical staffing as due to the basic conflict between two principles: that all junior doctors seeking a hospital career are in training for consultant posts; and that all consultants should have adequate support.

16. The first principle seemed to be based on a questionable assumption. Parkhouse sharpened the debate when he asked how the NHS could reconcile a good service for

patients with effective postgraduate training for doctors and a healthy research programme[17]. His perception was that the system had survived because overseas doctors had provided a cushion and this reflected badly both on the past performance of the health service in medical manpower planning, and its commitment to this group of doctors.

17. The 'Achieving a Balance' document proposed a range of measures which, it was hoped, would bring the hospital staffing structure into balance in relation to consultant expansion, the number of registrars, and the need for support for consultants without training doctors for non-existent posts.

18. The proposals included mechanisms to enhance the rate of consultant expansion; senior registrar numbers to continue to be reviewed by the Joint Planning Advisory Committee (JPAC); arrangements to relate the numbers of registrar posts available for UK graduates to the number of consultant opportunities in each specialty, whilst ultimately reducing the overall number of registrar posts; arrangements to maintain good quality training for overseas graduates; the introduction of a new non-training grade; and the introduction of career counselling for junior doctors[18].

19. The 'Achieving a Balance' document placed special emphasis on the concept of doctors unlikely to make further career progress. These so-called 'stuck doctors', a widely used though somewhat stigmatising and unfortunate term, were not precisely defined. However, it was envisaged that the concept would embrace most of those who had spent five years in the same specialty at Senior House Officer (SHO) grade, or alternatively five years as a registrar, or a total of 10 years since registration without reaching the then senior registrar grade[11].

20. The new staff grade post was intended to be a major way of resolving the problem of 'stuck' doctors. This new non-training career grade was seen as a secure career for what was thought to be the small minority of doctors who did not wish or were unable to progress to the consultant grade. 'Achieving a Balance' recognised that its proposal night lead to an increase in the average time spent in the SHO grade, rather than the bottleneck occurring at registrar grade. A modest increase in SHO numbers was proposed to accommodate this.

21. In 1991, the New Deal on junior doctors' hours introduced a plan to reduce them through the use of new working arrangements and explicit limits on contracted hours of duty[19]. At the time of writing the New Deal is to be relaunched having been overtaken by the requirements of the European Working Time Directive[20].

22. The Report of the Working Group on Specialist Medical Training, 'Hospital Doctors: training for the future' was published in April 1993[21]. The measures, for what has come to be known as the Calman reforms to specialist training, were intended to ensure compliance with European Community legislation, and included shorter, better structured and more intensive programmes of training; the introduction of the

Certificate of Completion of Specialist Training (CCST); and the introduction of a unified higher training grade to replace registrar and senior registrar posts. It was expected that patients would benefit as more care would be provided by doctors who had completed their specialist training. Transition to the new arrangements was completed on 31 March 1997.

23. The Calman reforms prompted a dilemma in that the JPAC was issuing quotas based on the old senior registrar and career registrar structures when the departmental policy was moving in a different direction. A single body was needed to oversee all workforce issues, supported by a streamlined advisory structure. During 1994 Ministers approved the establishment of this new Advisory Group on Medical and Dental Education, Training and Staffing (AGMETS). One of AGMETS' major tasks is to provide advice to the NHS Executive, through a sub-group, the Specialist Workforce Advisory Group (SWAG), on the number of doctors in higher specialist training.

24. The need for planning arises out of the possibility that future demand will not be met by future supply[22]. Policy decisions by manpower planners are therefore dependent on forecasts of the supply and demand for future manpower. The Medical Workforce Standing Advisory Committee (MWSAC; formerly the Medical Manpower Standing Advisory Committee) was set up to take a long term view of planning of the medical workforce, and published its first report in 1992 [23]. This and subsequent reports recommended that more doctors needed to be trained in the UK. Recommendations have taken account of cost implications and the capacity of medical schools, as well as other issues that affect medical workforce planning, including advances in technology and changes to the skill mix among health professionals required for service delivery.

> ***Dilemma 1.***
> History tends to repeat itself: "If you always do what you always did, you always get what you always got." (Granny Donaldson; grandmother of Professor Liam Donaldson, the Chief Medical Officer). How can we do things differently and get a different better result?

THE PRESENT CONTEXT – THE CHANGING ENVIRONMENT

25. Whilst the previous section highlights some of the evolutionary steps in medical workforce planning, there have been revolutions in the NHS environment in which all this takes place.

26. The Conservative government reforms of the early 1990s attempted to devolve responsibility for health services to localities and dispersed it within them. Regional health authorities were abolished [24]. District health authorities and family health services authorities were merged into local health authorities (some of these have subsequently merged), planning and purchasing services from semi-autonomous provider trusts [25]. The internal market was born.

27. With the election of a Labour government after eighteen years in May 1997, it is natural for there to be a change of pace and style. In December 1997 the new vision was defined, in which the third way (building on what has worked; discarding what has failed) was applied to the NHS[26]. This White Paper defined a national service, with delivery a matter of local responsibility, with the NHS working in partnership. Greater efficiency was envisaged through a more rigorous approach to performance and by cutting bureaucracy, but maintaining a focus on quality and excellence, and so rebuild public confidence in the NHS as a public service. The internal market was dead.

28. In March 1999 the House of Commons Health Select Committee recommended that there should be a major review of workforce planning in the NHS. The results of this review were published in April 2000 [27]. In a perceptive analysis, this important document looked at what we are trying to achieve, defined what is meant by workforce planning, looked at present arrangements and where there are problems, and made suggestions for what is to be done. An emphasis was placed on: team working; flexible working; streamlining workforce planning and development (stemming from the needs of patients rather than professionals): maximising the contribution of all staff to patient care; modernising education and training; developing new, more flexible careers; and expanding the workforce to meet future demands. Many of the dilemmas highlighted in this paper were identified and a number of important recommendations were made.

29. These various proposals have been developed further in the just published NHS Plan[28]. The Plan followed the announcement in March 2000 of significant extra funding with the proviso that the NHS "modernised". The Prime Minister has laid down five challenges to the NHS: there must be improved partnership; improved performance (clinical and health service productivity); within the professions and the wider workforce there must be increased flexibility in training and working practices with removal of demarcations (in the context of major expansion in the workforce); improved patient care; and improved prevention, tackling inequalities. There are to be 7500 more consultants, 2000 more general practitioners, 1000 more specialist registrars and 1000 more medical school places.

30. The additional funding promised to support these developments is dependent on changes in the ways in which health care is provided. It is intended that the greater flexibility among professional groups will also lead to a change in skill mix and break down demarcations.

31. Whilst the introduction of the New Deal for junior doctors in 1991 [19] has, somewhat slowly, delivered better hours and changes for the better in work patterns for many of this group of doctors, a review of this approach is overdue, particularly in the light of the European Working Time Directive (see below). Attempts to reduce so-called inappropriate duties has had at least two unforeseen side effects.

32. The term itself is increasingly seen as pejorative, with nurses and others resentful of what is seen as the passing over of mundane or tedious tasks. In the context of moves towards greater integration this is unhelpful.

33. The removal of time consuming repetitive venepuncture rounds from the junior doctor routine, by the employment of phlebotomists, has, in the view of some, led to doctors being less skilled in such procedures and less able then to take on this work in more challenging patients or situations.

34. As another important externally imposed factor, the European Working Time Directive[20] has the potential to profoundly affect the working practices of doctors and hence impact on education and training. Junior doctors were originally excluded from this agreement, together with transport workers and deep sea fishermen, but will now have to meet the 48 hour working week target in nine years' time. However, a further requirement that doctors in training must have a minimum of 11 hours rest in every 24 hour period of duty is due to be implemented in 2004. This will have far reaching consequences as it will effectively bring about the demise of on-call rotas and mean that these doctors will all work shifts.

35. One other important cultural change is set to permeate professional medical practice for some time. A number of high profile cases, including probably the biggest serial killer in the world (the general practitioner, Harold Shipman) and a number of surgeons whose technical failures were arguably only matched by the perceptions of their arrogance, have seriously undermined public trust in doctors. Whilst seldom manifest in an individual doctor-patient relationship, the fundamental challenge to the fiduciary nature of the consultation makes it all the more difficult now to be effective as a doctor.

STANDARD SETTING

36. The General Medical Council (GMC) defines the principles of good medical practice and the standards of competence, care and conduct expected of doctors in all aspects of their professional work[29]. The GMC have also set out the generic clinical, educational and personal needs of SHOs, the second largest group of doctors in the NHS after consultants[30]. There is little in this admirable document that does not apply equally to all other training grades and the principles form a sound blueprint for high quality training.

37. The Royal Colleges are responsible for specifying the standards of specialist care, and defining the curriculum for training. In handling elements of specialist training at a national level they act on behalf of the Specialist Training Authority or the Joint Committee for Training in General Practice (the competent authorities under European legislation regarding entry to the Specialist Register – the ticket of eligibility for a consultant appointment, or practice as a principal independent general practitioner). They maintain standards principally through visiting processes and the educational approval of posts at a local level. However, recent examples of the precipitate removal

of accreditation without regard to any impact on service provision have fuelled perceptions about excessive influence.

Dilemma 2.

How can the multiplicity of visiting mechanisms, which are costly to administer and expensive particularly in terms of the time required, be rationalised without sacrificing quality control?

PRESENT STRUCTURES FOR WORKFORCE PLANNING

38. Once qualified and awarded their degree, doctors must satisfactorily complete a year in a programme of training before full registration by the GMC can be granted. These programmes are normally managed by Postgraduate Medical Deans on behalf of the universities, with accountability for their quality to the GMC. The number of posts available nationally is sufficient to meet this requirement for what is now widely regarded as the sixth year of undergraduate training where knowledge and skills acquired at university can be put in to practice in a closely supervised and suitable environment.

Dilemma 3.

The notion of an additional undergraduate year sits uncomfortably with the employment legislation, including equal opportunities, that governs the employment of doctors in these posts. How can this be reconciled?

39. After full registration, doctors apply for SHO posts. Career paths begin to diverge at this point. For general practice, doctors may 'sandwich' two (usually 6 months each) periods of general practice training around a range of SHO posts from a prescribed list consisting of posts deemed relevant eg obstetrics and gynaecology; paediatrics. For medical and surgical specialties, and to gain entry to higher specialist training, doctors aim to get on rotations that help them meet the minimum entry criteria for specialist training specified by the relevant higher training committees of the Royal Colleges.

40. The number of SHO posts has a centrally determined ceiling but with some flexibility in relation to a small number of shortage specialties (eg. radiology; histopathology, and some psychiatry specialties) where a limited increase may be allowed in order to encourage recruitment to higher training. These doctors are normally employed by hospital trusts. These doctors have been referred to as the 'lost tribes'[31 32] because of the lack of attention to their training and career needs.

Dilemma 4.

How can we ensure that the best practice, as defined by the GMC, is turned into reality particularly for this group of doctors and also more widely, but without compromising the needs of the service?

41. To become a specialist, doctors in training must gain entry competitively to a programme of specialist training, becoming Specialist Registrars (SpRs). Numbers of

SpRs are determined nationally by SWAG (see above) using a formula designed to reflect the needs of the NHS, the length of training required, losses due to deaths and retirements etc, and a number of other factors. National patterns may not be reflected by the local distribution of specialists, with some areas, notably in the South of England, having more doctors per head of population than other, often more deprived, areas.

Dilemma 5.
Workforce planning is an inexact science, but getting it wrong can have serious consequences (cf obstetrics in England). How can competing requirements be better matched?

42. To be eligible to be a principal in general practice a minimum of two years of training at SHO level and one year training in general practice is required for certification. There has been for some time a view that the length of time spent training in general practice is inadequate, and there are plans in progress to extend this.

43. Higher specialist training, of usually between four and six years, is punctuated by annual assessments which must be collated (Records of In-service Training Assessments – RITAs) in order to obtain a CCST. RITAs are intended to be a summation of evidence from appraisals, relevant examinations, log books of procedures or cases, and other material usually specified by Royal Colleges and local Specialty Training Committees (who act on behalf of and provide advice to Postgraduate Medical Deans).

44. Doctors in training may train flexibly, for a minimum of half time. Although still predominantly female more doctors are choosing to train and work flexibly. This can be enormously helpful for doctors with health and other problems, allowing them to be supported and the service to benefit without wasting their expertise and the investment in the training so far. With the increasing proportion of women in the junior and senior medical workforce (for example, the current intake of Newcastle University medical school is about 70% female) the gender shift is set to have a significant impact.

Dilemma 6.
How can the gender shift best be accommodated and managed in training?

45. The funding of postgraduate medical education and training in England is complex. The principal source of funding is via the Medical and Dental Education levy (MADEL). This is managed locally by Postgraduate Medical Deans with a line of accountability for what are significant sums of money. Much of this money is used to meet the salary costs of doctors in training. Normally the Postgraduate Medical Dean meets 100% of the salaries of pre-registration house officers (PRHOs), and 50% of the salary for other training grades; the other 50% is met by the hospital trust in recognition of a partnership arrangement and the service contribution made by these doctors. The Deans' funding is supplied to trusts on the basis of an Education Contract which

includes specifications as to what is required. Although a relatively unsophisticated tool at present it is one of the few but powerful levers available to Postgraduate Medical Deans to achieve change.

46. Some Deans have a lead employer trust arrangement (whereby a single hospital trust employs all the doctors in training in that area or specialty irrespective of where they may work and train), but this is not universal. This is believed to offer significant advantages, including simplicity of the technicalities of employment such as tax etc, easy movement among hospitals especially in programmes of training with frequent short attachments, and overall consistency of policies.

47. As well as funding the Postgraduate Medical Deans and their infrastructure, MADEL also supports Clinical Tutors and postgraduate education centres in hospitals to some extent, as well as meeting the costs of study leave for doctors in training. Study leave is a contractual right with regard to time and funding but there are a number of caveats. Funding for training in general practice has also recently been brought into this levy.

48. Two other related levies are important. The Service Increment For Teaching (SIFT) is designed to compensate hospitals particularly involved with teaching and training undergraduates for the additional infrastructure and staff required. The Non-Medical Education and Training levy (NMET) funds the training of nurses, professions allied to medicine, radiographers, clinical psychologists etc. Funding from both levies may contribute to the infrastructure of education, such as to support libraries and information services and postgraduate centres.

49. One of the recommendations of the review of workforce planning [27] is for these levies to be merged. The principle underlying this is to promote integrated workforce development given that we need a service delivered by an integrated workforce.

A MODEL PROCESS

50. Ideally, all doctors in training at every stage should have a good range of clinical and educational opportunities, with appropriate clinical and educational supervision. They should have been appointed through high quality appointments processes that conform to the best equal opportunities practice. They should be working in training locations that meet or exceed minimum standards. An induction course in each new training location should be available, including general and departmental or specialist components.

51. All experienced doctors have a responsibility for the personal and professional development of the junior doctors with whom they work, as role models, teachers and supervisors[30]. Given the crucial role of modelling, educational supervisors (as well as those in other professional leadership roles in education and training) should be both credible doctors as well as in possession of appropriate educational knowledge and skills.

52. There should be an early opportunity to identify their learning needs and formulate learning plans (as part of a wider or longer term Personal Development Plan) to meet them. There should be opportunities for multi-disciplinary multi-professional learning and working. Every trainee should receive regular informal and formal feedback on performance and progress, including through appraisal. There should be formative and summative assessment, including of generic and specialty skills. Trainees, as adult learners, should also have been made aware of their responsibilities.

SOME ISSUES

53. Doctors have a responsibility to keep up to date and maintain their skills. From this fundamental precept has emerged the concept of lifelong learning with the idea that learning continues through undergraduate training, into basic and higher specialist training, and throughout one's professional lifetime.

> ***Dilemma 7.***
> How are the attitudes and skills to sustain lifelong learning to be instilled in our doctors?

54. The considerable number (although involving only a very small proportion of doctors overall) of the high profile cases alluded to above, where performance fell well below acceptable professional standards, has sharpened the focus on competency-based approaches to training and assessment. Although considerable progress has been made, this remains a difficult area of work with a dearth of national standards. Whilst specialist areas of practice are relatively well defined in some specialties, few Royal Colleges have yet placed sufficient emphasis on the more generic aspects of professional practice, including communication skills, personal effectiveness, working in teams, knowledge management, self and adult learning.

> ***Dilemma 8.***
> How can doctors and their organisations be best helped to draw on the available evidence, within and without medicine, to develop robust approaches to defining standards and competency assessment?

55. The loss of trust referred to has brought public and governmental pressure for better regulation of the medical profession. It seems incomprehensible to much of the general public that a doctor may practise largely unchecked throughout a career after initial registration. Professional self-regulation, through the GMC, has been the corner stone of the approach so far but present arrangements are no longer considered adequate. To bolster the arrangements and restore public and payer (the government) confidence, the GMC has embarked on an ambitious plan for revalidation of a doctor's practice[33]. Postgraduate Medical Deans have agreed with the GMC to meet the revalidation requirements of doctors in training through training mechanisms.

Dilemma 9.

How can training structures and processes be enhanced to meet the requirements of revalidation or otherwise reassure government and public about the competency of doctors who complete training?

56. There is always likely to be a tension between service provision and meeting educational and training needs. Competing policy imperatives (eg. the pre-occupation with waiting lists; performance management, and the quality agenda) are often seen as creating excessive dissonance. This is likely to be compounded by the European Working Time Directive, squeezing even further the time doctors in training spend on care or meeting their own educational needs. With the increasing demands placed on health professionals (including rising public expectations; technological and demographic changes; waiting list and other initiatives; the requirements of clinical governance; clinical audit; and research), it is increasingly difficult for consultants or general practitioners to meet these demands individually. The trend is towards a multidisciplinary clinical team that has to take corporate responsibility for meeting a range of responsibilities including the delivery of a service to a specified standard, as well as meeting education and training responsibilities. This means that increasingly the question to be posed by Postgraduate Medical Deans, for example when carrying out their Education Contract monitoring visits, is to the whole team and must be to ask them how, given the competing pressures outlined above, they are meeting these responsibilities.

Dilemma 10.

How can the levers available, including Education Contracts and funding, as well as educational approval, best be managed and used so as to monitor organisational performance in delivering high quality education and training (such as to the model set out above), as well as motivating and stimulating further development?

57. Another consequence of this greater corporacy will be its necessary recognition by senior managers in hospitals and the NHS Executive. In part the proposals for appraisal for all senior doctors, heralded in “Supporting doctors, protecting patients”[34], will also make teaching and training roles and responsibilities more explicit. One hope is that this recognition and increased weighting may lead to greater resource availability, especially of time. For doctors in training, the proposals in the NHS Plan[28] for joint training across professions in communication skills and in NHS principles and organisation, together with a new common foundation programme, to enable switches in career and training paths to be made more easily, are also likely to be helpful.

Dilemma 11.

If doctors in training in future have to work in multi-disciplinary multi-professional teams, and work across primary and secondary care as well as health and social care interfaces, how can they be helped to acquire the skills to do this effectively?

58. One of the consequences of the reforms to specialist training is the shorter time spent by doctors in higher specialist training before reaching eligibility to apply for consultant posts. There is concern in a number of quarters that, compounded by the reduction in working hours, many doctors coming out of training may not be sufficiently experienced, for example in certain procedures or operations, or particular aspects of specialist practice. There is also a view, particularly evident in general practice, that trainees who emerge from higher training are inadequately equipped to cope well with fully independent practice as a consultant or principal in general practice. To some extent this could be seen to merely reflect an appropriate stage of professional development whereby there remain a number of skills and experiences to be acquired as part of lifelong learning. Indeed, this lies behind the recent proposal for a new post-CCST specialist grade of doctor[27].

Dilemma 12.

How can we ensure, without unduly lengthening the total training period, that doctors emerge from training with appropriate general and specialist clinical and educational experience?

59. A key issue to emerge recently has been the extent to which consultants, most of whom are involved in education and training often of undergraduates as well as postgraduates, are equipped with the attitudes, knowledge and skills of good educators. Whilst the Calman reforms to specialist training have by and large put the structures in place, it is not at all clear that the lofty ideals and expectations created by these changes are being met.

Dilemma 13.

How can we ensure that all consultants are suitably equipped to meet their education and training responsibilities, and that these skills are appropriately deployed in practice?

60. Study leave by doctors in training consumes considerable resources, directly in terms of funding both for courses and the associated travel and subsistence, as well as the time involved. No-one would doubt the need. The Conference of Postgraduate Medical Deans recently published helpful guidelines[35]. However, there is little evidence that study leave reflects learning needs or that it conforms to sound educational principles (Are objectives specified? Are the methods to be used specified and appropriate? Is there follow up to ascertain the extent to which objectives have been met? etc). There also seems to be a prevailing culture that required professional examinations cannot be passed without resorting to a course, with large funding implications and profits accruing to many organisations which run and promote them.

Dilemma 14.

How can study leave be organised and managed to conform to sound educational principles within reasonable resource constraints of time and money?

SUMMARY OF THE DILEMMAS IDENTIFIED

Dilemma 1

61. History tends to repeat itself: "If you always do what you always did, you always get what you always got." (Granny Donaldson; grandmother of Professor Liam Donaldson, the Chief Medical Officer). How can we do things differently and get a different better result?

Dilemma 2

62. How can the multiplicity of visiting mechanisms, which are costly to administer and expensive particularly in terms of the time required, be rationalised without sacrificing quality control?

Dilemma 3

63. The notion of an additional undergraduate year sits uncomfortably with the employment legislation, including equal opportunities, that governs the employment of doctors in these posts. How can this be reconciled?

Dilemma 4

64. How can we ensure that the best practice, as defined by the GMC, is turned into reality particularly for this group of doctors and also more widely, but without compromising the needs of the service?

Dilemma 5

65. Workforce planning is an inexact science, but getting it wrong can have serious consequences (cf obstetrics in England). How can the competing requirements be better matched?

Dilemma 6

66. How can the gender shift best be accommodated and managed in training?

Dilemma 7

67. How are the attitudes and skills to sustain lifelong learning to be instilled in our doctors?

Dilemma 8

68. How can doctors and their organisations be best helped to draw on the available evidence, within and without medicine, to develop robust approaches to defining standards and competency assessment?

Dilemma 9

69. How can training structures and processes be enhanced to meet the requirements of revalidation or otherwise reassure government and public about the competency of doctors who complete training?

Dilemma 10

70. How can the levers available, including Education Contracts and funding, as well as educational approval, best be managed and used so as to monitor organisational performance in delivering high quality education and training (such as to the model set out above), as well as motivating and stimulating further development?

Dilemma 11

71. If doctors in training in future have to work in multi-disciplinary multi-professional teams, and work across primary and secondary care as well as health and social care interfaces, how can they be helped to acquire the skills to do this effectively?

Dilemma 12

72. How can we ensure, without unduly lengthening the total training period, that doctors emerge from training with appropriate general and specialist clinical and educational experience?

Dilemma 13

73. How can we ensure that all consultants are suitably equipped to meet their education and training responsibilities, and that these skills are appropriately deployed in practice?

Dilemma 14

74. How can study leave be organised and managed to conform to sound educational principles within reasonable resource constraints of time and money?

CONCLUSION

75. This paper looks at a number of aspects relating to the junior medical workforce now and in the past. A number of dilemmas are highlighted. Many of the early issues and problems persist. However, in a climate of considerable change, there are pressures and opportunities to address these problems.

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