

UK postgraduate education: all change

Junior doctors' training in the United Kingdom is changing. New arrangements will affect current medical students, but will it make them better doctors? **Adam Poole** explains

Modernising Medical Careers, the British government's statement on reforming postgraduate medical training, was published in February 2003 (www.doh.gov.uk/shoconsult/shoconsultresponse.pdf). It sets out permanent changes to the grades of preregistration and senior house officer (PRHO and SHO), which will affect every doctor in the United Kingdom when the changes are fully implemented in 2004.

An intercollegiate working party has almost finished devising a new curriculum, and the first pilot scheme is due to begin this August. But outside the corridors of power and postgraduate deaneries, not much is known about new look postgraduate training. A recent survey of over 300 medical students showed that 86% didn't know about the substance of the changes.

The title for the consultation preceding *Modernising Medical Careers* was "Unfinished Business," which set out by its very name the background to the problem. No one really doubted the need for reforms, especially as changes to the specialist registrar grade in the late 1990s were largely popular. SHO posts are universally criticised for being enormously variable. Some entail lots of protected teaching time, others none at all. Some allow study leave for preparing for college exams, and others don't. The quality of the "product" is therefore extremely unpredictable.

What's changing?

Plans have not yet been finalised, but three major changes are already in evidence, outlined in the box.

Changes to postgraduate medical education in the United Kingdom

A new two year foundation programme

- Replaces current preregistration and first year senior house officer (SHO) positions
- Allows SHOs in their first year to sample more specialties by working in three or four over the year, with a "release," typically once a week, into other specialties
- Introduces personal development plans and more structured career advice

Redefining "core" skills

- Builds on changes in medical school curricula recognising the vital role of training in non-clinical skills
- Includes communication, team working, time management, etc

Limited time in the SHO grade

- Prevents SHOs from continually adding on more six month jobs at the end of their rotation
- Identifies doctors who haven't yet decided which specialty to enter and helps with this choice
- Provides for additional support—including retraining if necessary—if an individual is unable to proceed in the chosen specialty

So what isn't changing?

The content of PRHO year will remain largely unchanged, although the General Medical Council is currently reviewing the standards required of doctors before they are granted full registration at the end of the first foundation year. College examinations, already in a state of flux—with the introduction of objective structured formats, for example—aren't altered by *Modernising Medical Careers*. The "exit route" from the SHO grade, usually by obtaining a specialist registrar number, is also unchanged, although this could possibly happen sooner in a doctor's career.

Pay will remain unaffected (although in the long run doctors could earn more, by reaching consultant level sooner). Finally, responsibilities will remain unchanged; although it's argued that identifying a year one SHO as a Foundation Programmer will help distinguish them, so seniors' expectations can be better managed.

What do people think of the changes?

For the government, the changes could not happen soon enough, given its commitment to providing extra consultants. The reaction from others involved in designing or implementing the new training scheme is also encouraging.

The changes were made after consultation with several stakeholder groups, although interestingly not medical students—who are to be affected by them imminently. Students unsurprisingly have more mixed, although on the whole supportive, reactions to the key changes.

Consultancy by the age of 30

A media spotlight recently fell on the fact that the amount of training time before reaching consultant posts will be reduced. "Consultants by the age of 30" was the headline of an article in the *Times*. This has been made possible as both a new "general consultant" role is proposed and the SHO grade will be shorter than at present. There will be a point at which all SHOs will have to move upwards out of the grade, or else be moved into another specialty. This is predictably controversial as clearly not all doctors decide on their specialty at the same speed. Just because they don't decide to do orthopaedics in the first month as an SHO doesn't make them any worse an orthopaedic surgeon 10 years later.

Medical students have picked up on the controversy. Forty four per cent of students think that being a consultant by the age of 30 is a bad idea, with the main concern being an anticipated lack of experience. Liam Donaldson, chief medical officer for England, speaking at the "Modernising Medical Careers" conference in February, disagrees: "We can produce the same level of expertise we have now by structuring training much better."

The debate has intensified because many believe that current training has already "dumbed down" preparation for the consultant post. Andrew Foster, director of human resources at the Department of Health, admitted in January: "People coming into consultant posts are not as fully practiced. I am not just talking about clinical expertise, I am talking about confidence, communication skills." Shortening the SHO grade could make this worse.

The counterargument is that there is an artificial feeling that once made a consultant, or a general practitioner (GP), the need for training stops. Somehow consultants are supposed to know all the answers all the time. This view could be corrected by altering the way in which teams work in hospitals, improving mentoring of new consultants, and developing senior doctors' management and leadership skills to make them more effective.

What about hours?

Leaving aside the issue of fewer years in training, many hospital trusts may struggle to make doctors' shifts fit in with the requirements of the European working

time directive: 48 hours per week by 2012, down from 58 hours in August 2004. New SHO posts are supposed to be compliant with the directive, but local trusts have to implement the regulations and their track record under the New Deal hasn't been satisfactory. And if more time during the week has to be spent on non-clinical training how is this to be factored in to calculations on hours and shift patterns?

Ed Neville, who heads the intercollegiate working party designing the curriculum, admits that one of the biggest concerns is that the cumulative effect of these changes could ultimately affect service delivery.

Are hospitals any good at helping SHOs make career decisions?

Another area of controversy has been the notion of career support. Currently this is haphazard or non-existent for most SHOs. Unless fundamental changes are made to the way career decisions are supported and encouraged there simply isn't the manpower to help SHOs make vital choices so quickly. No one has yet come up with a practical answer, but *Modernising Medical Careers* calls for the introduction of "rigorous counselling and career advice."

What's the BMA doing about it?

The Medical Students Committee (MSC) of the British Medical Association is aware that students may feel anxious about the lack of detail on the proposed changes to PRHO and SHO training. We are doing our very best to obtain the information and guarantees necessary from the government to provide you with the information and advice you require and allay these fears.

The MSC welcomes the chance to address some of the existing inadequacies in the early postgraduate training years. We believe the proposed foundation programme offers the potential to radically improve the educational experience of the PRHO and first SHO years. It could potentially ensure greater supervision and support for young doctors, expand the breadth of clinical and research experience available and enable greater flexibility in training and working for a rapidly diversifying medical graduate population.

Currently the proposals are very much in their infancy and not much information has been determined even at the highest levels of the civil service. Despite our grave concerns regarding the speed at which the government is planning to establish and implement these radical changes, the current lack of detail provides us with an excellent opportunity to influence the curricula being developed and help bring about a training scheme we can both enjoy and be proud of.

We have written to Aidan Halligan, deputy chief medical officer for England and the official responsible for leading the reforms, outlining our views and seeking a meeting at the earliest opportunity. In particular we have requested reassurance that:

- The second year of the two-year foundation programme will not become a second PRHO

Sarah Thomas, the postgraduate dean for South Yorkshire and South Humber Deanery, based in Sheffield—the first deanery to pilot year two of the Foundation Programme from August 2003—says: "Trainees often don't know what they want to do. They will be better able to identify what they are good at with objective assessments of their competencies and will also be encouraged to become more self aware, by taking advantage of the career advice on offer."

Individual "personal development plans," which set expectations for training, are a step in the right direction and are one of the innovations being pioneered at the Northern General Hospital in Sheffield.

Jack of all trades, master of none?

All second year foundation programmes will feature acute care and emergency medicine, general practice, psychiatry, and surgery. Rotations will be four programmes of three months or three of four months. Trainees will also have day release into other disciplines such as radiology or pathology for one day every week or two.

The fact that foundation year two exposes SHOs to a range of specialties was very well

year. Full registration will continue to be granted after one year after graduation and the existing pay scales for SHOs will be honoured for the second year of the foundation programme.

- Doctors on the foundation years will not be exploited as service providers at the cost of their continuing professional training and current recommendations for SHO education.
 - Students who have accepted PRHO jobs on the understanding that they were entering the existing training scheme will not find themselves entering foundation year programmes.
 - Students accepting jobs on pilot programmes will be guaranteed that the posts meet the standards required for training approval.
- We are also seeking clarification as to:
- Where and when the foundation programmes will be piloted and how the pilots will be evaluated to assure that any widespread changes are evidence based.
 - The structure, content of modules, learning objectives and assessment methods for the programme.

As soon as we have received this information the MSC will write to all penultimate and final year medical students. In the meantime, we have established a Foundation Years web forum with information, links and a chat forum and are keen to hear what you think should be in the foundation programme.

Please post your comments through www.bma.org.uk/students or talk to your medical school BMA representative. If you're not sure who your MSC rep is, find out by going to the "meet us" section of the BMA website www.bma.org.uk/students

Advanced Medical Courses surveyed 319 medical students attending its revision courses for final exams in April 2003

- 44% of students knew about the changes in principle
- 14% knew about the details of the changes
- 77% of students felt foundation year two is a good idea
- 44% felt a greater emphasis on training in non-clinical skills such as communication and team work is a good idea
- 76% felt integrated e-learning is a good idea
- 66% of students thought being a consultant by the age of 30 is a good idea

received by medical students: 77% agreed that this was a good idea. The remainder mostly asked the legitimate question of "what if I know which specialty I want to enter in advance?"

But Sarah Thomas believes that every deanery has underperforming trainees, and one reason may be that they don't end up in the right job. She also sees this as an important counterargument to the reduction in working hours, which in effect means that junior doctors now have less experience on which to base their career choices relative to doctors of 10 years ago: "Even if you have decided on your career path early, surgery for example is about pre- and post-care, so acute medicine and intensive care are incredibly relevant as generic modules additional to surgery itself."

Will these changes make you a better doctor?

Without question the most important issue for the health service, doctors, and patients alike. When you first entered medical school you probably had a stock answer to the question "What makes a good doctor?" Now your answer would probably be rather different, and during training it will change further. The concept of a "good doctor" is deeply personal and reflects your own values, emotions, and background

The challenge that faces the medical profession in the United Kingdom is not technical—we have a highly trained group of doctors. The challenge reflects the need to provide a service to patients and to positively influence the continuing debate around provision of health care. *Modernising Medical Careers* may result in thoughtful, questioning, motivated doctors with aspirations to developing themselves. This can only be positive.

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The author is keen to hear your comments. Also, see career focus 7 June, 2003 (at bmj.com/content/vol326/issue7401#career).