Dear Sir/Madam,

Expansion of Undergraduate Medical Education

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The Association welcomes the opportunity to respond to the Department of Health. Please find enclosed the BMA’s submission.

We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely,

Raj Jethwa
Director of policy

Enclosure: BMA full submission
Question 1: How would you advise we approach the introduction of additional places in order to deliver this expansion in the best way?

− The BMA has long argued that the NHS needs to recruit and retain more doctors in order to meet rising demand for health services. The NHS currently faces an unprecedented workforce crisis that threatens the quality of patient care and the quality of medical education and training. We therefore broadly welcome an increase in the number of student places at UK medical schools. Any increase, however, must be matched with sufficient funding and resources to ensure universities are able to maintain educational standards and provide a high quality educational experience for students. This requires front-loading investment in both university training infrastructure (lecture theatres, access to teaching labs and equipment, tutors, assessment, etc.) as well as both trust-based and primary care clinical teaching placements.

− The new places must also be matched with additional foundation and subsequent specialty training posts to mitigate the risk of unemployment within the medical profession. With student debt exceeding £80,000 for many medical graduates,\(^1\) in addition to the investment in medical education made by the NHS, medical academic staff, universities and tax payers, the Government has both a moral and fiscal responsibility to ensure that medical graduates are able to secure a high quality training post upon qualification.

− It is worth noting that we recognise this expansion as part of a longer term strategy for addressing the undersupply of doctors in the NHS. However, it can take more than 10 years to train a doctor to senior level and therefore the additional places will have only a limited effect on the medical workforce in the near future. There must be equal focus on retaining doctors in high quality jobs which will provide more immediate relief to an overstretched medical workforce, as well as plugging current gaps through highly skilled migration to ensure patients continue to receive high quality care.

− Looking ahead, the consultation proposes a number of changes with regards to international students. Some of these endanger the important contribution international students make to the NHS and domestic medical students, others may well lead to an imbalance in medical student numbers. It is important, therefore, that the impact of the proposed changes is closely monitored. In particular:

  − We disagree with the assumption that international students do not represent an investment in the NHS, and that they therefore need to pay even higher fees. In most cases, these students will stay in the UK and contribute to the NHS for years. They are no more or less likely to move abroad or enter private practice than a UK national who has graduated from a UK medical school.

  − We disagree that paying for the clinical placements of international students takes away funds from training the domestic medical workforce. The high fees paid by international students subsidise places for UK/EU students. We are also concerned about the impact of Brexit on the supply of students from EU countries if it means they will be charged higher fees. Besides exacerbating the shortage of doctors in the NHS, a decrease in the number of EU students could have broader implications for the diversity they bring to the workforce.

\(^1\) The lifetime cost to English students of borrowing to invest in a medical degree: a gender comparison using data from the Office for National Statistics.
Removing the cap on international students could create a perverse incentive for universities to attract more international medical students as this will increase their income. This could result in an imbalance in the makeup of medical student bodies and the consultation recognises this risk. We believe that the medical profession needs to be representative of the people that it serves and would therefore agree that safeguards should be put in place to protect against such an imbalance.

**Question 2: What factors should be considered in the distribution of additional places across medical schools in England?**

- Answer options: (please choose as many as appropriate)
  - University staffing capacity
  - University estates/infrastructure capacity
  - University capital funding capacity
  - NHS/GP clinical placement capacity
  - Mobilisation / timing capability
  - New medical schools
  - Others: (please specify)

All of the above factors should be considered. It is also critical that the expansion does not adversely affect or compromise the quality of medical education provided to those in any new places and on existing courses. Universities, therefore, should be required to demonstrate their ability to meet educational standards.

**Question 3: Do you agree that widening access and increasing social mobility should be included in the criteria used to determine which universities can recruit additional medical students?**

We agree that the medical profession needs to be representative of the people that it serves and that more needs to be done to ensure that it does so. We would welcome specific efforts to encourage applications from under-represented groups. This might require especially close working between medical schools and secondary schools in their area and a commitment to enabling these students to work where they have grown up and have been educated.

**Question 4: Do you think that increased opportunities for part-time training would help widen participation?**

Enabling more men and women students and trainees to take up part time studying, training and working would be a very progressive step in encouraging a more diverse range of students to apply for medical degrees. However the provision of a part time undergraduate course, training placement or job is only one issue amongst a whole range of practical constraints to part time working that need to be addressed.

Facilitating part time training/working also requires:
- better long-term workforce planning that takes account of the fact that more doctors are likely to want to work part-time at some point in their careers and creating capacity for this to happen;
- the provision of affordable and more flexible childcare;
- shift patterns, including how job sharing is arranged – for example, in the context of junior doctors training, often for a LTFT (less than full time) trainee who works 70% of an FTE role, it is impossible to find someone to fill the rest of the role, and so a locum is brought in to make up the hours;
- ensuring part time trainees don’t miss out on training opportunities – eg ad hoc courses, learning and seminars which take place on days which they are not working;
− part time working throughout the medical career, not just at student / post-graduate trainee level;
− the status of part time working – for example, in the context of junior doctor training, LTFT trainees are frequently viewed as ‘second rate’ and feel undermined in the workplace by colleagues and management.

See our response to Question 24 for more detail.

**Question 5: If you have any additional information/experiences around widening access and increasing social mobility that would be helpful in developing the allocation criteria, please provide it here.**

− The BMA's Right Mix report\(^2\) highlights the potential of outreach activities by medical schools to reshape the demographic of medical students. We know, anecdotally, that some doctors are already visiting schools and talking to pupils about medical careers. There is little focus in the consultation/proposals regarding outreach activities and we encourage more to be done in this area.

− The BMA regularly hears from students who struggle to get through the assessment process for medical school and/or speciality training because of learning difficulties. Better awareness amongst assessors of the need for dyslexia and dyspraxia testing, wider advertising of reasonable adjustments which can be made and reasonable adjustment policies on assessments would ensure that students are better informed of the process for requesting reasonable adjustments.

− Close working with secondary schools to enable students to gain access to as wide a range of opportunities as possible at this level, and also to ensure sixth form provision is actually available for the very groups who currently may be denied it.

**Question 6: Do you agree that where the NHS needs its workforce to be located should be included in the criteria used to determine which universities can recruit additional medical students?**

*Answer options:*

**Yes / No**

− Yes, provided that the NHS locally has the capacity to absorb extra medical students and provided steps are taken to improve training attractiveness, so that doctors choose to continue post graduate training. We would not support medical students being required to continue to live and work in the areas in which they were educated following graduation, as this undermines the need and development of efforts to make training good enough for doctors to choose it. However, we recognise that there may be specifically targeted access programmes that may make such a provision. In such cases, there must be suitable jobs for the students to go to on graduation.

− Equality-related factors must also be considered, including the particular needs of some students/trainees to train/work in particular locations.

− Encouraging more students from disadvantaged backgrounds to apply to medical degrees may require facilitating placements close to their home so that they can remain at home to reduce living/associated course costs.

− Some students/trainees who have children in school/nursery may find it difficult to move location. In many families where both parents work, their location near to extended family who help out with childcare is extremely important. A student/trainee who is the sole carer for children will be even more reliant on a placement near to home.

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\(^2\) [https://www.bma.org.uk/features/therightmix/](https://www.bma.org.uk/features/therightmix/)
− Other students are restricted over the medical school and workplace they can attend because they have a disability/ or care for a dependent relative who is older, frail or disabled. Specific protection has recently been introduced\(^3\) to enable specialty trainees with a disability/caring for someone with a disability to be pre-allocated to their required region. This should not be limited by the current proposals.

**Question 7:** If you have any additional information/experiences about attracting doctors to areas facing recruitment challenges that would be helpful in developing the allocation criteria, please provide it here.

We acknowledge the lack of data around how doctors choose their career paths, both in terms of specialty and location. We are aware that many medical graduates tend to continue to train and work in the region of their medical school, particularly during their foundation years. However, the NHS must provide high quality training placements consistently across geographical areas to support recruitment efforts. Consideration needs to be given to incentivise graduates to train in high-need geographical areas, including, but not limited to financial incentives, subsidised accommodation, assistance meeting debt, research opportunities, research support and experience.

**Question 8:** Do you agree that supporting general practice and shortage specialties to attract new graduates should be included in the criteria used to determine which universities can recruit additional medical students?

We agree that exposing students to general practice and shortage specialties via high quality clinical placements could help with recruitment and all medical schools should offer such placements.

With regard to general practice in particular, currently 34.5% of English practices take medical students\(^4\) and so, there is spare capacity (one school has succeeded in engaging 45% of practices in its health economy\(^5\)). However, the cost to universities to support GP placement programmes is not insignificant. It has been estimated at an average of £5,000 per student placement year\(^6\) in England and is currently unfunded. With the median distance between a practice and the medical school from which it takes students being 27Km,\(^7\) further expansion will inevitably entail greater travel and/or accommodation and subsistence costs. These are also currently unfunded.

**Question 9:** If you have any additional information/experiences about attracting doctors to general practice and shortage specialties that would be helpful in developing the allocation criteria, please provide it here.

− Robust recruitment initiatives and clear plans to recruit to general practice and other shortage specialties are essential. Each specialty has its own unique issues and challenges, but it is clear that stress and burnout due to an increasingly unsustainable workload are discouraging doctors from taking up training posts in certain specialties.

− A lack of capacity leading to increased workload creates a vicious cycle impacting morale, recruitment and retention. A 2015 BMA survey\(^8\) found that across the UK:

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\(^{7}\) Derbyshire H, Rees E, Gay SP, Mckinley RK. Undergraduate teaching in UK general practice: BrJ GenPract 2014; : 336–45.

− 93% of GPs feel that their workload has negatively impacted on the quality of care they are able to give to patients;
− 68% of GPs experience a significant but manageable amount of work-related stress, but a further 16% report experiencing a significant and unmanageable amount of work-related stress; and
− less than half of GPs would now recommend general practice as a career path.

− Expanding research opportunities could also attract graduates into primary care and shortage specialties. However, this would require the necessary infrastructure being in place in these specialties and a means of meeting the financial implications this would bring.

Question 10: Do you agree that the quality of training and placements should be included in the criteria used to determine which universities can recruit additional medical students?

Yes. Universities need to evidence their ability to meet standards. Regulatory bodies under their Quality Assurance and Academic Review processes must all work to review and assure the quality of the course before it is approved. In addition, the invitation to bid for the new places must emphasise the quality of the places being offered over the speed at which they could be implemented. We do not believe that priority in the bidding process should be given to institutions who claim to be able to increase numbers very quickly over and above institutions who are more realistic in their proposals.

Question 11: If you have any additional information/experiences about how to improve the quality of training and placements that would be helpful in developing the allocation criteria, please provide it here.

A key responsibility lies with the NHS partner provider in ensuring that adequate time is allowed for staff to engage with students and not be wholly focussed on immediate service delivery. Supporting professional activities (SPA) allocation for consultants and SAS (staff and associate specialist) doctors is key to this, and is very often inadequate for the current numbers of medical students. Those organisations quality assuring medical education in the NHS must have the tools necessary to ensure that provider organisations deliver the best possible educational experience. There needs to be a demonstration of the support and engagement of the local NHS, including GP practices in delivering excellent training for this new student cohort.

Question 12: Do you agree that all providers should be offered the opportunity to bid for the additional medical school places?

Yes, as long as bidders are expected to meet minimum education and training quality thresholds and provide realistic timescales for the implementation of the new places. Caution should be exercised as there is a need to ensure an evidenced ability to meet standards.

Question 13: Do you agree that innovation and sustainability should be included in the criteria used to determine which universities can recruit additional medical students?

Institutions should be encouraged to innovate in the provision of medical education, but the overall quality of the programme offered and the long-term sustainability of the medical school needs to take precedence. Educational principles must be followed at all times and any innovation robustly tested and researched before full implementation.

Question 14: If you have any additional information/experiences about how to encourage innovation and sustainability that would be helpful in developing the allocation criteria, please provide it here.
Innovation in medical education must be subject to careful peer review and requires support for academic staff that allows them to develop concepts and ideas, and such efforts will require time and funding.

**Question 15:** We would be interested in hearing views on how meeting the needs of the NHS aligns with the role universities wish to have in the future distribution of places in an expanded market - please provide your views here.

We note that local service needs can fluctuate at a different pace compared to the time it takes medical schools to adapt to changes. Medical education must be responsive to changes in demand and in the way services are provided. All skills and knowledge doctors attain in the course of their undergraduate education must be directly or indirectly (as in the case of research skills, for example) beneficial to patient care.

**Question 16:** Do you agree with the principle that the tax payer should expect to see a return on the investment it has made?

Tax payers get a significant return on their investment from the dedicated service provided by all doctors over the course of their career.

**Question 17:** Do you agree in principle, that a minimum number of years of service is a fair mechanism for the tax payer to get a return on the investment it has made?

- It is our view that such a policy is unnecessary as only a small minority of doctors do not complete their training in the NHS. Requiring a minimum number of years of service will only serve to exacerbate poor morale within the workforce and discourage medical students.

- Patients deserve a health service in which doctors want to work, not one in which they are forced to work. Applications to medical courses have been steadily decreasing\(^9\), showing that medicine is becoming less desirable career choice. It is vital that the Government addresses the underlying issues that are affecting the NHS’ ability to recruit and retain staff, and provide them with attractive and flexible careers, in order to provide the best possible care for patients.

- There are a range of sectors in which doctors can work that are in the long-term interests of the tax payer which are not acknowledged in the proposal, including the Defence Medical Services, academia and public health. In addition, some doctors may choose to work flexibly, take leave to pursue research, or to undertake clinical training outside of the NHS for a period of time\(^{10}\). This risks being restricted by the Government’s proposals, and detrimental in the long-term to patient care, innovation and research in the NHS.

- We are very concerned about the potentially discriminatory effects the proposal would have on women who tend to take more career breaks than their male colleagues. See our response to Question 22 for more detail.

**Question 18:** Do you have any views on how many years of service would be a fair return for the tax payer investment?

None. We do not agree with the proposal to introduce a return of service agreement.

**Question 19:** Do you agree with the principle that graduates should be required to repay some of the funding invested in their education if they do not work for the NHS for a minimum number of years?

\(^9\) UCAS figures, October 2016.

No. This proposal would only serve to exacerbate the recruitment crisis by making medicine a less attractive career choice. A recent study found that for many, student debt can exceed £80,000 (including maintenance) and that medical graduates on an average salary are unlikely to repay their SLC debt in full. Such a policy would potentially increase an already unsustainable amount of debt and would particularly discourage potential students from lower socio-economic backgrounds that the Department has indicated earlier in its consultation document that it wishes to encourage into the profession.

**Question 20: Can you think of any potential impacts of requiring graduates to repay some of the funding if they do not work in the NHS for a minimum number of years?**

− This proposal is inconsistent with the consultation’s objective to widen participation in medicine. It may prove to be a deterrent to students contemplating a career in medicine, particularly those from poorer backgrounds. Research shows that levels of debt incurred by medical students from tuition fees alone are worth almost £40,000, with women hit the hardest. Also, fear of debt (or increased debt) rather than debt itself is known to be a key barrier for poorer individuals.

− As stated in our response to Question 17, some doctors may choose to work flexibly, take leave to pursue research, or undertake clinical training outside of the NHS for a period of time and this risks being restricted by these proposals, and detrimental in the long-term to patient care, innovation and research in the NHS.

**Question 21: Is this a policy you wish to see explored and developed in further detail?**

No. However, if the policy is to be developed further, then careful consideration must be given to the impact it would have on recruitment to medical school, retention of medical students, widening participation in medicine and the morale of medical graduates.

**Question 22: Do you have any comments about the impact any of the proposals may have on people sharing relevant protected characteristics as listed in the Equality Act 2010?**

− The proposal to require graduates to repay some of the funding if they do not work in the NHS for a minimum number of years would impact more severely on women medical graduates due to the pay gap that exists for these groups of doctors. There is evidence that women are already adversely affected by debt incurred from tuition fees, given their lower career earnings (in, and outside medicine) compared to men, due to factors including discrimination, career breaks, career choices, part-time work and motherhood. We know that:

− There is considerable evidence that a gender pay gap exists in medicine, particularly impacting women who work part time and/or who take time off to have children. Looking at the whole of the medical profession, women earn an average of 30% less than men. Indirect discrimination has also been cited as one of the reasons behind this gap. Other factors are thought to be: choice of speciality and career progression/lack of women in senior posts. The proposal would only compound the impact on women financially.

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11 The lifetime cost to English students of borrowing to invest in a medical degree: a gender comparison using data from the Office for National Statistics.
12 The lifetime cost to English students of borrowing to invest in a medical degree: a gender comparison using data from the Office for National Statistics
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The Government has committed to an independent review of this gender pay gap – identifying the reasons behind this and implementing measures to tackle the barriers women face will be critical in attracting more women into medicine, especially those from a low-income background who have, or are planning to have, children. The proposal would, therefore, run counter to these efforts.

An ‘ethnicity pay gap’ has also been identified in medicine— BME (black and minority ethnic) doctors earn less than their white counterparts. This is reflected in lower numbers of BME consultants and medical directors, lower levels of BME applicants and winners of CEAs (clinical excellence awards). The proposal would therefore impact BME doctors more severely than their non-BME colleagues.

Finally, there is a real risk that the proposals will increase discrimination against international medical students. There is a risk that the language of the consultation, the objective of which is to “increase our supply of home grown doctors” will lead to xenophobia/racism against international students and medical graduates studying and working in the NHS. These are groups who have made significant contributions to the NHS and who already report growing levels of prejudice and discrimination.

Question 23: Is there anything more we can do to advance equality of opportunity and to foster good relations between such people and others or to eliminate discrimination, harassment or victimisation?

The ‘differential attainment’ of some groups of doctors in some specialty exams has been recognised by the major medical stakeholders. Reports emphasise the individual learning and support that should be put in place for students and trainees who may require additional help.

Recruiting medical students from a wider range of backgrounds is only the first step in creating a more diverse medical profession. The BMA’s report, the Right Mix, identifies how students from non-medical families are at a disadvantage throughout medical training. Continued attention and resources therefore need to be made available to support students and trainees throughout their early career.

A new Health Education England pilot will shortly get underway to widen access to LTFT training in emergency medicine. All existing higher Emergency Medicine (EM) trainees and current ST3 run-through EM trainees who are expected to progress to ST4 in August 2017 may submit an application to train LTFT under the category of personal choice. Successful applicants will be offered more flexibility about the percentage of a full time post that they work. This pilot may well produce some useful lessons with wider application for flexible working amongst medical students, trainees and doctors.

All training bodies and employers have a duty to proactively act on and eliminate incidences of bullying and harassment in their organisations. For example, the NHS England staff survey shows that over a fifth of doctors and dentists have experienced workplace bullying and harassment in the past 12 months. It also shows that BME and disabled staff are more likely to experience bullying and harassment. Other research shows that women are more likely to experience sexual harassment and the BMA regularly hears from LTFT trainees who believe that they experience prejudice or undermining at work due to their part-time status. Younger doctors may be more likely to experience bullying because of their more junior status and because they may be under pressure not to exception report. The current climate may also risk increasing bullying and harassment of IMG doctors.

Part of the duty to foster good relations involves tackling prejudice and promoting understanding between different groups. Training bodies, employers and the government could do more to ensure

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16 Understanding differential attainment across medical training pathways: A rapid review of the literature. GMC, November 2015.
that there is understanding of the value of doctors from a diverse range of backgrounds, including doctors who have qualified overseas and the contribution that they make to the NHS. More could be done to address bullying and harassment through policies, procedures and by addressing organisational factors that influence workplace culture.

**Question 24:** We are interested to hear views about the impact the proposals may have on families and relationships. For example, do you consider training more doctors will have a positive impact on flexible working because of additional system capacity?

- Increasing numbers of women are becoming doctors. For over 20 years, there have been more women medical students than men – the current ratio is 55 per cent to 45 per cent - this is almost identical amongst trainees (54%/ 46% women to men). The recent DDRB (Review Body on Doctors’ and Dentists’ Remuneration) report\(^\text{17}\) emphasises the need for employers to take greater account of changing demographics and the entry of the ‘Generation Y’ cohort into the labour market, with both men and women having different expectations about work and family life.

- While there are increased opportunities theoretically to train and work more flexibly the reality of work patterns indicates that we are still far from the work-life balance many families need. LTFT trainees for example incurred a financial loss, with the move away from automatic pay progression in the new contract. Whilst this will be temporarily alleviated by transitional pay protection arrangements, the reality is that opting to train part time will require proper planning and financial saving, and may influence the choice of speciality trainees opt for.

- It can take more than 10 years to train a doctor to senior level, therefore the additional places promised by the consultation will have only a limited effect on the medical workforce in the near future. It is thus unlikely we will see a significant change in the situation described above.

- If the Government wants to make a real impact on recruitment and retention issues in medicine, it needs to look at flexible careers in a more holistic way. We discussed this earlier in our response to Question 4. Flexible working includes not just part time working, but parental leave, more flexibility around shift patterns, out of hours working and locum working. Addressing these issues would make a practical difference to work life balance:
  
  - **More flexibility in part time medical roles** – Currently the proportion of part time working permitted depends on the LETB (local education and training board), trust, speciality and grade, as well as restrictions set by the General Medical Council. LTFTs are often also restricted on the amount of out-of-hours work they can do. The choice facing many is working 100 per cent with 100 per cent of the on call rota, or working 50 per cent with no on-call work. Many doctors would like wider range of opportunities for part time working and if there were more flexibility some would be able to work more hours than they are currently contracted to. The BMA, HEE, and the Royal College of Emergency Medicine has recently agreed a pilot to open up opportunities for LTFT training, including options to work at 50 per cent, 60 per cent or 80 per cent of full-time hours.

  - **Part time work should be a reality throughout medical careers.** Yet the evidence shows that despite many wanting to work part time, the vast majority\(^\text{18}\) of consultant posts are only advertised as full time roles. Similarly adopting a more flexible approach may well encourage many doctors to delay retirement. Encouraging part time working throughout medical careers will reduce the stigma of and discrimination against this working pattern.

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\(^{17}\) Review Body on Doctors’ and Dentists’ Remuneration 45th Report: 2017

- **More affordable childcare that is flexible and available to cover out of hours work** The Academy of Medical Royal Colleges\(^{19}\) has found that almost 70% of doctors surveyed reported no family support, indicating most are paying expensive private providers. This cost increases for out-of-hours childcare.

- **Shared parental and carers leave** – whilst shared parental leave right exists in theory, in practice it still has very low take up. If the government wants to change the culture to encourage more fathers to take it, it must ensure the same occupational pay that is available for maternity leave is made available for shared parental leave. Carers’ leave would be an important recognition of people’s caring responsibilities for older, frail and disabled relatives and allow many people to work longer.

- **E-rostering** – current arrangements for rostering shifts mean that LTFT trainees do not get advance notice of shifts and are not guaranteed the same shift patterns from week to week. They may therefore struggle to arrange shifts around fixed childcare and caring responsibilities.

- **Shift patterns** – although many trainees work beyond the end of their shift the implications of finishing late for LTFT trainees with caring responsibilities who need to collect children from nursery and school can be extremely serious.

\(^{19}\) “Maternity/Paternity Survey Results.” Academy of Medical Royal Colleges, 2016.