Pre and post qualification training and development of doctors: A British Medical Association vision
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UK medical education and training over the last two decades has been characterised by a continuous cycle of review and renew. As different pressures have come and gone, providing a rationale for various reports and accompanying recommendations, all too often structural or process-related, change has followed with little attention to fundamental details such as resource, requirement or impact.

Some drivers for change are so important that the need to reform is clear and cannot be ignored because they are organisationally or professionally inconvenient. Other drivers may have roots that lie more in political expediency or inadequate analysis.

In recent times, commonly perceived pressures are converging and growing stronger and more urgent. Examples include:

- The UK’s population is ageing with an increasing prevalence of multiple co-morbidities; the service, as configured, struggles to cope.
- Expectations of patients and governments have changed; informed patients seek more personalised and joined-up healthcare; governments in all four countries of the UK strive to define more precisely the concept of quality of care.
- The composition of the medical workforce is changing and there is a growing demand for more flexible training and working arrangements.
- Medical science and technology are advancing rapidly.
- The economics of the health service have changed, putting pressure on all resources.

Medicine needs to remain a challenging, rewarding and worthwhile career if it is to continue to attract and retain bright, creative and motivated doctors.

Crucially, change in medical training should be evolutionary and evidence based. It should learn from and build upon current and past experience. Training and development must again become integral to services and service planning, specifically and explicitly resourced and based on quality and need rather than convenience.

The UK medical profession is open to effective change, but rightly expects that any change must be purposeful and beneficial to patients, as well as supportive of the essential professionalism of medicine, to ensure a healthy future for the profession and our patients.

This paper has been informed by existing BMA work, policy decisions, consultation with members through deliberative events and written submissions.
Core principles for medical education and training

The purpose and goals of medical education, training and development must be universally understood, clear and agreed with the profession. This document does not aim to define the content and outputs of this process — i.e. describe the role of the doctor — but seeks to establish some broad principles which must underpin the structure and process of training, and any training reforms, so that it can both evolve with patient need and continue to produce motivated, compassionate and effective doctors.

The needs of patients and rewarding medical careers should drive each other and form a virtuous circle that maintains professionalism and continuously improves care.

This underlying purpose and dynamic of medical training, and what it should be achieving, is underpinned by the following principles.

Medical education, training and development must be:
- Responsive to the population’s health requirements
- Rooted in an ethos of professional excellence
- An inspiring process of continuous lifelong learning
- Fair and inclusive
- A supportive, flexible process for learners and trainees
- Valued and supported, by employers and infrastructure

‘Training should be fun. It spurs you to learn, and makes you think ‘That’s what I want to be like’ or ‘That’s the specialty I want to be in.’

Doctor, London
**Principle 1:** Responsive to the population’s health requirements

The training and education of doctors must ultimately be guided by the best possible care of their patients.

All skills and knowledge doctors attain in the course of their undergraduate education, post-graduate training and thereafter, through their continuing professional development (CPD), must be directly or indirectly (as in the case of research skills, for example) beneficial to patient care.

There is a perception amongst policy-makers that post-graduate medical training is not keeping up with a changing world and so not delivering on this goal as well as it could.

The reasons for this perception are twofold;

- The changing characteristics of the population — with a far greater proportion of older patients with multiple conditions — and
- changing public expectations of healthcare.

**1. Changing population characteristics: getting the training balance right**

The fundamental premise of the UK wide *Shape of Training* review and the resulting Greenaway Report is that changing population characteristics are creating demand for a larger supply of generalist medical skill; doctors need to be better equipped to cope with a growing and ageing population with a higher level of comorbidities, the review concludes.

The traditional medical paradigm (in western culture at least) was based on certain notions;

- a single agent will produce a single disease which can be treated with a single treatment;
- prevention consists of identifying and eliminating causal agents;
- treatment consists of identifying the disease, administering the treatment and restoring normality.

This was a highly effective model in the past but it does not reflect the complex medically, socially and psychologically determined needs of the most numerous categories of patients presenting at GP surgeries and hospitals now, nor the rising prevalence of chronic disease. It does not in itself encourage whole-person care.

The National Health Service needs doctors who are technically specialised but also those who have the broader skills to be able to treat complex patients in a holistic way. ‘Generalist’ is often used to denote that second category of skills; however, there is no commonly-accepted understanding of what a ‘generalist’ doctor is.

*’We don’t actually know what patients want. The public probably wants generalists but an individual patient will probably say they want the best specialist’*

Doctor, London
2. The role of general practitioners and hospital generalists

A good part of the solution to this challenge could lie in UK general practice. The UK’s general practitioners are expert generalists in the community but improving responsiveness to changing health needs is not just a question of redirecting patients or redeploying our GPs; general practice is currently stretched to the limit and has little if any remaining capacity to offer patients more time and holistic management.

General practice needs significant expansion and investment to better manage vulnerable patients through the system in the more holistic way that is required.

There is a strong case for what could be termed ‘specialised generalists’. These already exist in a number of specialties, such as care of the elderly and community paediatrics. Another piece in the jigsaw lies in investment in these specialties and spreading existing good examples of these specialties, working around the patient, rather than around an institution.

There are already training programmes for specialist-generalist care in these and other areas, and a large proportion of physicians with general internal medicine training combine this with a specialist interest, as do doctors in other specialty areas.

We have categories of generalist doctor already and the means to train more of them, particularly if a focus for change is on access to and best use of existing training opportunities. If patients with complex needs are given access to the right generalist teams, they will get better, more holistic care.

Recommendation 1: All doctors should be able to provide a level of generalist care. Any need for more generalist care should first be met by existing groups of doctors – GPs and hospital generalist specialties – with investment in and by sensible deployment of those doctors – rather than remodelling the entire training system.

A third solution lies in the way that doctors work with nurses and allied health professionals. Many multi-disciplinary teams work very well, but this is by no means universal in NHS workplaces. The earlier different health professions work together – during their early training ideally – the stronger will be the mutual understanding of roles later in their careers. This is surely the best way to ensure the collaboration that will ultimately be to the benefit of patients and their experience of better, joined-up care.

Recommendation 2: In the general context of the growing need for generalist care, detailed consideration should be given to the respective roles of doctors and other health professionals and how the training of each can be used to cement collaborative working.

‘The movement in medicine is towards increasing specialisation and that’s because there’s more and more knowledge. To be a good generalist who provides the same standard of care you get now would require an immense if not impossible level of knowledge’

‘What really worries me about Shape of Training is that there’s been an evolution of MMC and now they are changing things again. It’s ridiculous to propose changes without first looking at the effects of the current model’

Doctor, Edinburgh
3. Changing expectations – quality of care

Any health service should strive for the highest possible quality of patient care, and in recent years, all four countries of the UK have sought to define more precisely what quality in healthcare means. The NHS constitution for England, for example, defines its three elements as:

- care that is **clinically effective** – not just in the eyes of clinicians but in the eyes of patients themselves;
- care that is **safe**; and,
- care that provides as positive an **experience** for patients as possible.

The NHS in Scotland, Wales and Northern Ireland have similar quality strategies in the form of the Healthcare Quality Strategy for NHS Scotland, the 2012-16 Quality Delivery Plan and Quality 2020 respectively.

NHS England’s definition of quality is further developed by sub-domains underpinning a strategy for continuous improvement in the quality of NHS care. It presents a significant challenge to the service, as it places an equal emphasis on the whole patient experience as on clinical safety and effectiveness.

However, medicine has always been guided towards the need to continuously improve care quality, by its underlying professional ethos and through its professional and specialist bodies and regulator. The profession is already well regulated for quality and the new revalidation system run by the General Medical Council (GMC) has so far demonstrated that the overwhelming majority of doctors are meeting the high standards set for them.

**Recommendation 3:** The professional standards set for doctors by the GMC and Royal Colleges guide doctors, and the system that trains them, well in matters of quality and should continue to do so. These standards should be sufficient to guarantee the medical input to high quality patient care.

**Recommendation 4:** Doctors should be held to different or additional criteria for quality, which may be organisational or political, only in so far as these standards are aligned with properly and professionally considered professional standards and guidance.

**Recommendation 5:** The renewed emphasis on and clarity about quality of NHS care need not lead to revisions in the way doctors are currently educated, trained and developed, as their existing professional standards and guidelines already put the patient and the quality of their care at the centre of everything they do.

4. Changing expectations – location of care

For many years, there have been calls for greater integration of care in the NHS – for more care to be provided outside hospitals and closer to the patients’ homes and for different structures that will allow NHS staff to deliver care in a more coherent and efficient way. Policy-makers believe that, as the proportion of ‘frail elderly’ increases and the NHS faces mounting financial pressures across the UK, the future sustainability of the NHS relies heavily on new models of care.

In Scotland, the Public Bodies (Joint Working) (Scotland) Act provided a framework to drive forward integrated working in healthcare. NHS England’s *Five Year Forward View* for the English NHS suggests new models of care to transcend the rigid organisational boundaries that still exist in many parts of the English NHS.

It is questionable whether the current system of training encourages cross-sector working and it clearly needs to adapt to a healthcare landscape that may rapidly and fundamentally change in the years ahead.

For example, community placements during the foundation programme could expose junior doctors to cross-sector roles early on in their careers. GP trainees already have the option to include secondary care in ‘GP plus’ rotations.
However, the creation of community rotations for multiple hospital specialties would take these trainees away from acute front-line service provision and without adequate planning, rotas would lose service provision and trainees could lose acute experience, including out of hours work.

**Recommendation 6:** There needs to be a thorough assessment of how the current systems of education, training and development of doctors could be improved to encourage and facilitate cross-sector collaboration and integrated care, but this must take into account the implications for service provision and acute experience.
Principle 2: Rooted in an ethos of professional excellence

Most UK medical graduates go on to work in the NHS, and the NHS funds their postgraduate training, yet doctors are still trained as professionals, not just highly skilled, employed technicians. All stages of medical training, education and development need to be rooted in an ethos of professional excellence that underpins medicine as a vocational profession, not just a job, and is independent of the NHS as the main employer of doctors.

Three examples of what form this may take are: research, leadership and standards.

1. Research

Undergraduate and postgraduate education should equip the doctor not only with clinical skills but also with the scientific skills to enable lifelong learning and enquiry.

Delivery of medical care is based on decisions informed by the best available research evidence to determine the best treatment. A doctor’s practice is, therefore, intimately linked to the scientific evidence base. Where that evidence is not to hand, doctors should ideally search it out, evaluate it for scientific validity and assess its practical application. Clearly, in reality, there are time and resource constraints to doing that as fully as most doctors would like to.

Every practising doctor should maintain up-to-date knowledge relevant to delivering care in their specialty, and achieve an understanding of how to evaluate and apply evidence. This is a key principle of the General Medical Council’s (GMC) Good Medical Practice; doctors should ‘provide effective treatments based on the best available evidence’.

While not all doctors may be suited to conducting research, they should all subscribe to evidence-based practice and understand the concepts and value of research. How this can be better instilled in education, training and development is a complex question that we will not answer in detail here but is discussed in the BMA paper Every Doctor a Scientist and a Scholar.

2. Leadership training and development

The profession and the NHS often cite more and better clinical leadership of NHS institutions as desirable goals, and some elements of these are considered core responsibilities of a doctor. What exactly this means and how can it be instilled in training and reinforced throughout doctors’ careers is less often considered in specific detail.

A major impediment to doctors taking on more management of the NHS is an unhelpful cultural divide between clinicians and managers that, in some places of work, is exacerbated by mutual mistrust, often based on mutual misunderstanding of and prejudice about the role of the other.

Some doctors feel that taking on leadership positions in the NHS poses a risk of becoming an instrument of non-clinical priorities, such as financial control, which they may feel could conflict with their values as medical professionals.

Many of those who do take on roles like medical director struggle because of insufficient induction and mentoring and the step change in responsibility that comes with the job. This applies equally to those taking on principal posts in general practices.

1  http://bma.org.uk/developing-your-career/career-progression/every-doctor-a-scientist-and-a-scholar
2  Leadership and Management for All Doctors (2012). General Medical Council
Recommendation 7: Doctors should be informed about different opportunities for how to engage in leadership from the very beginning, starting at medical school, then continuing throughout the foundation years.

Recommendation 8: Trainee doctors — particularly those interested in being future leaders — and NHS management graduate trainees should share experiences in the early stages of their training, fostering better relationships further down the line.

Recommendation 9: Once they have taken on management or leadership roles, doctors must be provided with mentors to guide them in the role, and must be given sufficient time in their job plans to undertake their leadership responsibilities to the best of their abilities.

Recommendation 10: Doctors in management positions should not routinely be allocated as supervisors to higher trainees. The reduced clinical exposure imposed by the supervisor’s time constraints, and reduced training opportunities, can be detrimental to the trainee.

3. Standards of practice – the certificate of completion of training (CCT)

The CCT and certificate of equivalence to specialist registration (CESR) represent the accepted standard for entry to independent consultant and GP practice. CCT curricula are constantly evolving and subject to review by the relevant Colleges. As such, they are currently professionally determined. This is a standard that the BMA strongly supports.

Access to training opportunities has already been significantly reduced by working time regulations as well as a number of system pressures. Curtailing this further by setting lower limits to formal qualification would produce less well-rounded doctors. It may produce doctors technically equipped to deal with some immediate service pressures but it would compromise the quality of care in other ways by undermining the professional aspect of medicine which develops and adapts, researches and drives forward innovation and new treatments.

Recommendation 11: The certificate of completion of training should remain as the standard for doctors aspiring to independent GP or consultant practice.

Standards – training for general practice

GP training systems have long been held to be an example of best practice in training and development, with regular accreditation and assessment of both trainers and practices, development and networking workshops, and training-focussed clinical sessions. However the pressures being faced in general practice have put this model under considerable strain.

Whilst the current general practice training programme is clinically comprehensive it is not well future-proofed in terms of how models of care might develop. This, coupled with the challenges in general practice, inevitably mean that the GPs of the future will need to be trained differently.

The case for enhanced GP training and increasing the number of training placements has been widely accepted by the profession. This is seen as one of the key solutions to increasing workload pressures for doctors in both primary and secondary care.

The BMA has long supported enhanced GP training as a response to changing demands of the role of the GP and we have been calling for its implementation. However, to date, implementation has stalled due to insufficient funding.

The BMA has supported plans to extend the GP training period from three to four years, with at least 24 months spent in GP settings. Ideally, there would be an increase to five years in the future, so that GP trainees could spend the extra year developing skills in innovation and leadership.

3 The role of the GP in other EU countries is different to that of the NHS GP, notably in dealing with mental health problems, which are almost exclusively treated by psychiatrists in most other EU countries).
Principle 3: An inspiring process of continuous lifelong learning

Medical education and training and subsequent continuing professional development must facilitate doctors’ personal and professional growth throughout their careers for two very important reasons; first, to ensure their skills, knowledge and behaviours remain up to date and continuously improve, but also to keep them inspired and motivated throughout their careers.

We know from surveys that doctors’ morale is low⁴ and that this is in part connected with declining career satisfaction. This is a great waste of the innate enthusiasm and talent that most doctors bring to the profession after graduating.

We believe that doctors in training can offer the health service a great deal of insight. Because they rotate so frequently, they can compare different workplaces, observe different practices, learn new skills and spread good practice. Trainees, therefore, can have valuable insight into how care can be improved.

Doctors in the mid to later stage of their careers have the confidence that comes with years of experiential learning. They will have reached the high level of knowledge, skills and confidence in their chosen field and grade, which carries huge benefits for both patients and the younger doctors they train.

Doctors do not always feel adequately encouraged and supported by the education, training and career development systems to reach and make use of their potential throughout their careers. We know for example that there are many SAS doctors who do not feel supported or encouraged to develop their skills and careers and to train further. The recently published SAS Charters have gone some way to trying to address these issues.⁵

The expected outputs of medical education and training are comprehensively regulated in detailed guidelines, such as the GMC’s Tomorrow’s Doctors and Good Medical Practice, describing the skills, knowledge and behaviours doctors need to have accumulated, and be exhibiting, by certain stages of their careers. However, there has been less stringent regulation of the inputs — such as careers support, training resources and learning opportunities. This is covered in the final section of this paper. In publishing Promoting excellence: Standards for medical education and training⁶, the GMC emphasises support for medical students and junior doctors—an encouraging move toward achieving some of the objectives set out in the following sections of this paper.

Recommendation 12: Royal Colleges and providers should put in place a function that supports the educational welfare of all career-grade doctor (including SAS doctors). A more structured programme for training, support and appraisal akin to those available for trainee doctors should be available for those who need or want it.

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⁴ The results of the seventh (April 2013) annual cohort report found that cohort doctors with lower levels of morale also reported lower levels of dedication to their specialty. Cohort doctors with low morale were also less likely to be willing to work above their contracted hours. Conversely, cohort doctors with high levels of morale showed greater dedication to their careers and were more determined to reach their career goals.

⁵ http://bma.org.uk/developing-your-career/sas-grade-doctor/sas-charters

⁶ http://www.gmc-uk.org/education/standards.asp
Principle 4: Fair and inclusive

Training and assessments must be fair and equitable. Doctors must be treated objectively by colleagues, managers, trainers and examiners. They must have fair opportunity throughout their careers, from selection through to training and assessment; and feel confident that they are being so treated.

Furthermore, patients and the public must be confident that the system is fair and recognising the most able.

The shape and size of the medical workforce in the UK has changed and continues to change. As the size of the workforce increases, the proportion of female doctors continues to grow with 44 per cent of doctors on the register, and 54 per cent of medical students in 2013, being female.

The proportion of BME (black and minority ethnic) doctors increased by 13 per cent between 2010 and 2013. 34 per cent of medical students were BME in 2013 — the largest growth since 2010.

Additionally, the number of doctors coming from abroad to work in the UK is also increasing with over 30 per cent of doctors having gained their primary medical qualification outside of the UK, and a greater number of graduates arriving from within the European economic area.

No medical student or doctor should face unfair discrimination on any grounds.

Though reliability, validity and fairness (as in freedom from any bias that is not based on ability and merit) are all crucial in the development of training and assessment systems, fairness can often be overlooked. There must be a balanced focus on all three of these factors through the entire journey of the trainee to reduce bias.

A number of actions have been identified to help realise this vision. These fall into three broad categories; training, assessment and monitoring. See box for some examples.

Training
- Individual learning plans and career advice for all trainees.
- Personalised support plans for all trainees/doctors to support individual learning needs (including a fit for purpose induction system for international medical graduates).
- Early warning systems for identification of trainees/doctors who are struggling and tailored interventions.
- Consistency in deanery recruitment standards and processes.

Assessment
- Standardisation of assessment methodology across medical schools and royal colleges to ensure consistency, fairness, reliability and validity.
- Detailed and constructive feedback given to every unsuccessful candidate from both examiner and the patient (if applicable), with feedback to medical schools/Academy of Medical Royal Colleges/General Medical Council.
- Diversity amongst examiners — characteristics should reflect the pool of candidates.

Monitoring
- Standardised and systematic annual monitoring of equality and diversity data for trainees, candidates (information on pass rates, drop-out rates and complaints), examiners, trainers, committees etc.
- Collection of data on exam pass rates by medical schools to track medical students/trainees earlier in their careers.
- Equality and diversity training for examiners, trainers, colleges, local education and training boards, and hospital staff.

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— Adherence to the PSED (public sector Equality Duty)\(^8\) by all organisations and acceptance as best practice. The EDS 2 (Equality Delivery System for the NHS)\(^9\) toolkit may be a useful starting point in ensuring this.

**Recommendation 13:** All medical trainees and doctors should receive learning plans tailored to their individual educational needs to support their lifelong development.

**Recommendation 14:** All organisations must develop and implement equality and inclusion policies, and provide context-specific equality and inclusion training for all those involved in medical education, training and examination.

**Recommendation 15:** Equality and inclusion data on candidates in pre and post-qualification examinations and on training programmes must be monitored and analysed, with annual reports to the GMC.

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**Principle 5: A supportive process for learners and trainees**

The system must actively support training and development not simply by setting standards and educational governance but by helping all doctors to achieve educational and professional goals in all stages of their careers.

1. **Support through career transition points**

There are certain points in a doctor’s career where they experience a step change in responsibility. Even though they may have good technical competence and/or knowledge when they enter these transitions, many feel under-confident in coping with them.

*Medical school to foundation year*

One of the most challenging stages of a doctor’s career is taking up their first clinical post. Foundation year doctors generally feel ‘thrown in at the deep end’ and regardless of talent, most find their first few clinical jobs very stressful. They may feel unprepared for direct clinical responsibility or it may be their first taste of working in, or even leading, a multi-disciplinary team.

During the foundation year medical graduates participate in and provide diagnoses and treatment with close supervision which cannot be matched by current clinical experience placements during medical school. We feel this year allows trainees to learn by experience and improve confidence in their abilities. This also offers trainers significant opportunity to identify, supervise and support struggling trainees.

The current proposal to scrap provisional registration and move the point of full GMC registration to graduation is likely to make the transition from medical school to medical practice even harder.

The second 2006 BMA cohort study report revealed that around one-third of cohort doctors felt their undergraduate course was poor in helping them to deal with working conditions and clinical governance issues. In addition, 35% were of the view that they had been asked to undertake tasks which were beyond their capabilities as a FY1 doctor.

There are many steps that could be taken, and attitudes that could be changed, that would transform this experience. For example:

- A longer period of paid shadowing of the role each F1 will take up. The final medical school term could finish earlier to allow students to take a break and move to their new F1 job several weeks in advance of their official start date.
- More time should be built into rotas so that new doctors can have the space to think about their decisions and consult colleagues if necessary.
- Buddying or mentoring systems should be put in place for each new F1 in each rotation, overseen by the Foundation School, where the mentor had dedicated time to devote to supporting the new F1 through regular meetings during which they can give advice on cases.
- There should be a greater emphasis of aspects of professionalism and coping mechanisms during medical school training, including time, management, multi-tasking and relationship management. Clearly, this should not squeeze out clinical education, and there is a question mark over how much more can feasibly be added to undergraduate curricula without compromising clinical knowledge.

*For me as an FY1, the structure of the programme which gives you training in service provision is really fantastic. Getting the training and the supervision really helps make that transition from medical school*. Doctor, Edinburgh.

[10](https://hee.nhs.uk/2015/01/29/stakeholder-engagement-exercise-announced/)
The proposal to move the point of full GMC registration to graduation has not been properly thought through and no convincing rationale for it has yet been advanced. The provisional year is an essential part of new doctors’ continuing education, and has the added benefit of close supervision, regular support from multiple actors (medical school, foundation programme, ward staff, senior medical staff) and the opportunity to support struggling trainees.

In the foundation year, new doctors undergo some of their most intensive and useful learning. Without the pressure of responsibility, those final skills of real decision-making, working under pressure and leading a clinical team cannot be learned. We are highly sceptical that any changes to the undergraduate curriculum could offer a safe substitute for this vital experience.

Recommendation 16: The point of registration with the GMC should remain where it is at the end of FY1.

Foundation Programme to Specialty Training

The transition between the foundation programme and specialty training is another difficult step for many trainees. Where specialty programmes are uncoupled there is a further, perhaps more pronounced change in responsibility and expectations between the last year of core training and the first of specialty training. In some cases, trainees choose not to make the transition immediately and instead take a career break or gain wider experience outside the NHS to support them later in their training.

During the last year of their core or foundation training, all trainees should be offered a meeting with their educational supervisor to discuss their career plans and any concerns they have about moving into the next stage of training. This should take place several months in advance of the application window.

Discussion should include a full appraisal of their interest in and suitability for their selected specialty and could include feedback collected from key staff involved in their training. It should also cover the likely competition for training posts and discussion about the type of career and working life the specialty will offer.

More time should be provided for educational supervisors to help advise trainees at key points in the career planning decision-making process.

Each deanery/LETB should offer a mentoring scheme, with mentors having dedicated time in their job plans for this responsibility.

A much more flexible approach should be taken when trainees apply to take time out of training. Likewise, there should be flexibility and common competencies amongst specialty training programmes that would allow trainees who wish to change specialty to switch training pathways without having to start back at the beginning.

Trainees returning to work after a career break

Trainees returning to work after a break should be allocated a contact within the deanery/LETB that they can go to for specific advice and support. The exit/re-entry process should be clear and well documented so that there are no administrative barriers to trainees wishing to return.

Headroom should be built into each local training programme system to allow those returning from a break to re-enter without having to wait for a vacancy to arise. Trainees should be offered an orientation training package to allow them to catch up on developments in their specialty and in the wider NHS before returning to work.
Recommendation 17: Support for returning trainees needs to begin before they leave. Information should be available in a coherent, organised form, on such matters as
- Maintenance of foundation competencies
- Phased return
- Pensions
- GMC registration and revalidation
- Indemnity
- Pay progression/protection and the contractual implications of taking time out for continuity of service

From training grade to career-grade practice
The transition to working as a consultant, a GP, or as a specialty doctor has always been challenging, and remains so.

Most doctors relish a challenge and this step will for many be one of the most fulfilling of their careers. There are, however, a few actions that could ease the transition and allow doctors to reach their full potential more quickly.

- New consultants/GPs should feel able to continue their training dialogue with their former educational supervisor (if the latter is willing and able to do so), or another supervisor with the right experience (if the new consultant/GP prefers), for as long as they feel necessary.
- Appointing bodies should allocate a local member of medical staff to act as an adviser to the new consultants/GP as part of the appointment process and help them develop in all aspects of their new role: clinical, professional, managerial etc. They should be a source of support to draw on in difficult situations and should be able to advise on important contacts to make, networks to join, adjusting to their new role, how the management structure works, how to develop the service, local procedures to be aware of, and generally provide advice and support on day-to-day activities.
- Royal colleges and professional organisations including the BMA should review the advice and guidance they offer to newly appointed GPs and consultants and develop it as necessary.
- The appraisal process should be a focus of support for new consultants/GPs and employers should ensure more time is invested in the process, especially within the first 2 years of unsupervised practice.

2. Work-life balance
Changing societal norms about achieving a good work-life balance are being reflected in the medical profession. An increasing proportion of doctors – especially those who are parents – wish to train and work flexibly to strike a better balance between their personal and professional lives, or to develop a portfolio career. The implications of these changes for the structure and size of the workforce are significant, and failure to take account of them risks the loss of talented doctors.

Six years after graduation, 98 percent of doctors in the BMA cohort study strongly agreed or agreed that work-life balance is important to them and 90 percent believed that dissatisfaction with work-life balance is the primary reason why doctors leave medicine to work overseas.

‘Doctors don’t mind working hard, but there are only so many hours in the day’
GP, London

11 (BMA 2006 Cohort Study; Eight Report; 2014)
3. Self-assurance: building doctors’ confidence and resilience
Doctors need to project confidence in their diagnoses and in deciding treatment recommendations. While medicine is often shrouded in uncertainty, there is a difficult balance between explaining this uncertainty to the patient, and providing advice and direction about the best course of treatment.

Society has rightly moved beyond a ‘doctor knows best’ model of medical intervention, but to pretend that the relationship between the patient and doctor is one of equality of knowledge and clinical judgement is misplaced and ultimately unhelpful.

Projecting confidence is necessary to reassure patients that they are in competent hands but may often mask uncertainty about whether or not the right clinical judgements are being made. Doctors need to feel supported throughout their training and beyond, particularly by the assessment and regulatory systems.

That support should be three-fold:

- it should offer them reassurance that they are safe and competent (or, where necessary, assist them in supportive improvement);
- it should equip them with the skills to reassure patients in the face of uncertainty, particularly in such complex processes as devising drug plans and obtaining consent to treatment;
- it should equip them with the resilience to deal with the stress and anxiety that may come with uncertainty and having to make complex clinical judgements under time pressure. However, the concept of resilience should not be used as ‘sticking plaster’ training to disguise unsafe and unsustainable working practices or workload.

4. International medical graduates (IMGs)
International medical graduates working in the UK come from all over the world and make a huge contribution to the NHS. However, many report that they find it difficult to adjust to working in the NHS. The reasons for this are varied but consistently include communication problems, variations with informed consent and other culturally specific patient based concepts. These issues can act as barriers to successful integration and career progression.

Familiarisation with ethical, legal and cultural contexts tends only to begin when IMGs have entered employment, and so they are left to find their own way through issues that will impact heavily both on their colleagues and patients’ perceptions of and interactions with them, and vice versa. This can reinforce the sense of subtle (and not so subtle) discrimination that many IMGs feel in the workplace and compound feelings of cultural and professional isolation.

**Recommendation 18:** The GMC reports that two thirds of doctors who are not on the GP or specialist register did not graduate in the UK. More needs to be done to address the barriers faced by IMGs to career progression within the NHS. Those who did not graduate in the UK should have equal opportunity to progress in their careers as they choose.

**Recommendation 19:** Organisations need to make a full assessment of the support and resources currently available to international medical graduates, evaluate whether the needs of those newly arrived to work in the UK are being met, and implement induction packages that support integration in the UK and the health system.
Principle 6: Valued by employers and supported by infrastructure

The NHS remains the main provider of medical training in the UK. All health services need to treat training and development as core to their activities and integral to quality of care, both in the short and long term. Therefore, the NHS should factor in the cost of high-quality education, training and development as part of the cost of high-quality care.

Commissioners and providers of training, as well as doctors themselves, should understand that the content and emphasis of training must be rooted in what patients need, and that the structures, processes and resources that support training must be linked to the best possible patient outcomes.

Patients understand that the care they are receiving will often be providing training opportunities for inexperienced doctors, suitably supervised by more senior doctors.

Respondents to our consultation overwhelmingly believed that training opportunities were inadequate and restricted by:

- Changes in the design and expectations of training before the infrastructure and support have been put in place — indeed changes in service working against changes in training;
- pressures on service delivery — this has been an increasing problem due to workforce shortages, particularly in the acute medical specialties but service/training tension affects all trainees much of the time;
- productivity drivers — severe financial pressures mean providers having to prioritise efficiencies and productivity over training;
- downward pressure on training opportunities — time pressures and targets have created an imperative to maximise the throughput and speed of clinics, lists and rounds, which is not a conducive environment for training;
- pressure on supporting professional activities (SPAs) for trainers;
- diversion of routine elective work to other sectors or other professions.

These pressures are growing, so everyone in the workplace needs to be focused on the core requirement to train and on finding creative, effective approaches to maximising opportunities for high quality training.

These principles were the subject of a detailed report "Maintaining Quality of Training"\(^\text{12}\), whose recommendations remain relevant albeit within a changed infrastructure.

The Quality of Training report proposed three key elements of training:
- Education: usually set away from the workplace e.g. courses, lectures, clinical skills, labs, seminars etc.
- Training: learning through working with supervision, observing more senior staff, being observed and receiving feedback.
- Experience: providing appropriate service and supervising/teaching more junior staff consolidates learning and increases confidence. Typically through less proximally / indirectly supervised practice.

‘There is huge variability between quality of trainers and trainees. A system is good when it supports the weaker ones without causing a rush to the bottom. I don’t think that’s what we’ve got at the moment’.

Doctor, Edinburgh.

\(^\text{12}\) Maintaining Quality of Training in a Reduced Training Opportunity Environment; recommendation to the MMC Programme Board, January 2009.
Whilst the balance of these will vary, each element makes an important contribution to the attainment of skills and competences. In a changed political and organisational landscape, there needs to be a flexible and imaginative approach to optimising the use of time, people and skills to ensure that training continues to use all three elements.

**Time and support for trainers**

Almost all doctors including SAS (staff grade, associate specialist and specialty doctors) and those in the training grades, have some form of training role.

They need dedicated time in their job plans or schedules to fulfil their training activities and the amount of time should be regularly reviewed in both timetables and objectives. However, surveys of hospital doctors and GPs show that they are not getting this time, due to pressures on time generally and on other essential supporting resources. This lack of time for trainers impacts heavily on the quality of training they are able to deliver as well as the enthusiasm with which they can do it. If this trend continues, no training reform will be successful by any measure.

The sorts of training which need organisational resource include:

- **Active**: Specific training activities with time additional to scheduled clinical activities required to allow formal training to take place alongside provision of care
- **Intrinsic**: Use of clinical activity to provide observational training opportunity within provision of care
- **Trainee Support/Administrative support**: Supervision, planning, appraisal, pastoral support
- **Programme Organisation**: quality control, supporting trainers including multiprofessional team, co-ordination at provider and/or other levels.

Training, development and support must also be provided for trainers in senior roles. Maintaining and assuring their skills and standards is essential for both motivation and training quality assurance.13

Time is crucial in motivating trainers. Recognition in other ways such as innovation or financial awards, networking opportunities and other initiatives are important factors and must form part of any strategy. However adequate time and support to do the job well are the primary drivers.

**Recommendation 20**: Providers must acknowledge and emphasise the need for their medical staff to teach and train, ensuring that trainers and trainees have sufficient, accessible time for training and educational leadership roles.

**Recommendation 21**: The importance of high quality in training should be recognised with support and development, and should be rewarded through local and national mechanisms including consultant award schemes.

**People and Skills**

Contributing towards the education of the next generation of doctors is a fundamental role of doctors14. Nonetheless, not all doctors will make excellent teachers or trainers, nor will every department or every provider have the resources and/or skills to be a training department.

In recent years the General Medical Council, the Academy of Medical Royal Colleges and the Faculty of Medical Leadership and Management have put a considerable amount of work into developing standards for trainers. Appropriate and, crucially, useful standards are needed and these must be transferable across sectors and providers, enabling quality improvement systems without excess bureaucracy.

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13 'Leadership and Management for All Doctors’ 2012 (principles 64 & 65). General Medical Council
14 Good Medical Practice 2013. General Medical Council www.gmc-uk.org/
Many SAS doctors have skills and experience that would be invaluable to training and education and could be used to much better effect. Where the right knowledge, skills and training exist, this group of doctors should be supported and developed alongside their peers and colleagues. The loss of SAS doctor career development funding (in England) suggests a worrying lack of understanding of their training potential.

Further work on methodology to both recognise the best education and training opportunities and ensure flexibility to make best of them is long overdue. Recognising also that much service is provided as part of training (whilst taking account of the valid criticism that under-resourced service infrastructure means considerable amounts of service that have minimal training value or support and oversight continue to be provided by those in training) the impact on services and consequent need for investment should be part of any such review.

Trainees are not and must not be seen as passive recipients of training, but should feel empowered as active partners in seeking out and improving training opportunities. Systems, curricula and employment infrastructure should allow learning agreements to be a two-way process of mutual responsibility.

Recommendation 22: Further work is needed to develop standards that are consistent and useful in ensuring and developing high quality training and development.

Recommendation 23: All doctors with the knowledge skills and training to contribute to the training and development of others should be developed and used.

Recommendation 24: The impact of any education and development changes upon service organisation, and vice versa, should be assessed and provided for as part of such change.

Environment
Since April 2014, control over education and training resources, including study leave budgets, has shifted to employers from LETBs/deaneries in England, with the introduction of a new tariff system for funding education and training.

Whilst the concept of funding following the trainee has some logic, there is widespread concern that this method of implementation leads to resources for education and training being pooled with other provider funding, risking diversion for other purposes or failure to sufficiently prioritise education and development. It makes sense that departments and providers are able to clearly identify the funding streams for educational provision and thus prioritise time and other resource accordingly in job or service planning.

As training and development are core to the very essence of healthcare delivery it follows that service commissioning and monitoring should acknowledge and support the needs and impact of training. With funding now increasingly localised, such commissioning standards are feasible without compromising core educational standards.

Recommendation 25: Funding mechanisms should ensure that the intended purpose can be clearly matched to delivery of educational activity, in particular to reverse downward pressure on time provided for such activities or productivity pressures.

Recommendation 26: The need to train should be incorporated into service design and planning and accounted for in commissioning and development/continuity plans by both commissioners and providers.

Assessment
Assessments of trainee progress should be made in an entirely supportive environment that is focused around the quality of training. Where this does not happen, problems with the quality of trainer, trainee or the infrastructure supporting training may not be identified, usually to the detriment of the trainee and the efficacy of the training programme.

The output of training should not be merely the acquisition of particular knowledge or practical skills; just as essential is the framework within which those are used, and the confidence to use such clinical and other skills appropriately. Assessing those attributes is complex with qualitative judgement required. Developing such assessment tools must give proper regard to diversity issues and take account of different skillsets and inclusivity.

Recommendation 27: Where, despite best efforts, access to training opportunities has been insufficient to reasonably allow attainment of competencies, consideration must be given to the contributing factors and to appropriate remedy as part of a supportive and non-judgemental approach. Where necessary lengthening the duration of training for individuals might be appropriate without detriment to the trainee concerned.
Training and development in medicine requires a whole-system approach which recognises the unique role of the doctor as part of the healthcare team. Change is complex, often slow, and almost always inter-dependent between multiple factors. The dangers of adopting an approach of expediency or short-termism must be resisted for the benefit of our patients and populations.

A recurring theme throughout this document relates to resource — and in particular time. Sequential visions of change in medical education have faltered because they have been seen as a short-term shopping-list from which the cheaper elements can be extracted and implemented, without addressing the more complex underlying and confounding factors. Without the right resource and the right infrastructure, all change is flawed.

We urge all concerned with training to support the principles contained in this document as essential to all future reform. With these principles universally acknowledged and accepted, we can future proof the medical profession as a rewarding, inspiring career that will care for patients to the best of its ability through the challenging times ahead.

Conclusion

High quality education, training and development should be treated by the NHS as being part of the cost of care – essential to organisations, individuals, the medical profession and the population.
Pre and post qualification training and development of doctors

Appendices
Appendix 1

Recommendations

Recommendation 1: All doctors should be able to provide a level of generalist care. Any need for more generalist care should first be met by existing groups of doctors – GPs and hospital generalist specialties – with investment in and by sensible deployment of those doctors – rather than remodelling the entire training system.

Recommendation 2: In the general context of the growing need for generalist care, detailed consideration should be given to the respective roles of doctors and other health professionals and how the training of each can be used to cement collaborative working.

Recommendation 3: The professional standards set for doctors by the GMC and Royal Colleges guide doctors, and the system that trains them, well in matters of quality and should continue to do so. These standards should be sufficient to guarantee the medical input to high quality patient care.

Recommendation 4: Doctors should be held to different or additional criteria for quality, which may be organisational or political, only in so far as these standards are aligned with properly and professionally considered professional standards and guidance.

Recommendation 5: The renewed emphasis on and clarity about quality of NHS care need not lead to revisions in the way doctors are currently educated, trained and developed, as their existing professional standards and guidelines already put the patient and the quality of their care at the centre of everything they do.

Recommendation 6: There needs to be a thorough assessment of how the current systems of education, training and development of doctors could be improved to encourage and facilitate cross-sector collaboration and integrated care, but this must take into account the implications for service provision and acute experience.

Recommendation 7: Doctors should be informed about different opportunities for how to engage in leadership from the very beginning, starting at medical school, then continuing throughout the foundation years.

Recommendation 8: Trainee doctors – particularly those interested in being future leaders – and NHS management graduate trainees should share experiences in the early stages of their training, fostering better relationships further down the line.

Recommendation 9: Once they have taken on management or leadership roles, doctors must be provided with mentors to guide them in the role, and must be given sufficient time in their job plans to undertake their leadership responsibilities to the best of their abilities.

Recommendation 10: Doctors in management positions should not routinely be allocated as supervisors to higher trainees. The reduced clinical exposure imposed by the supervisor’s time constraints, and reduced training opportunities, can be detrimental to the trainee.
Recommendation 11: The certificate of completion of training should remain as the standard for doctors aspiring to independent GP or consultant practice.

Recommendation 12: Royal Colleges and providers should put in place a function that supports the educational welfare of all career-grade doctor (including SAS doctors). A more structured programme for training, support and appraisal akin to those available for trainee doctors should be available for those who need or want it.

Recommendation 13: All medical trainees and doctors should receive learning plans tailored to their individual educational needs to support their lifelong development.

Recommendation 14: All organisations must develop and implement equality and inclusion policies, and provide context-specific equality and inclusion training for all those involved in medical education, training and examination.

Recommendation 15: Equality and inclusion data on candidates in pre and post-qualification examinations and on training programmes must be monitored and analysed, with annual reports to the GMC.

Recommendation 16: The point of registration with the GMC should remain where it is at the end of FY1.

Recommendation 17: Support for returning trainees needs to begin before they leave. Information should be available in a coherent, organised form, on such matters as
- Maintenance of foundation competencies
- Phased return
- Pensions
- GMC registration and revalidation
- Indemnity
- Pay progression/protection and the contractual implications of taking time out for continuity of service

Recommendation 18: The GMC reports that two thirds of doctors who are not on the GP or specialist register did not graduate in the UK. More needs to be done to address the barriers faced by IMGs to career progression within the NHS. Those who did not graduate in the UK should have equal opportunity to progress in their careers as they choose.

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Appendix 2

A brief history of recent medical training reforms

During the 1990s, the Calman reforms delivered significant change. They established for the first time a clear end point of training and standardised the content and length of speciality training programmes.

Regular assessment of progression through training was now required, and standard-setting organisations were obliged to work more closely across specialties.

In 1999, summative assessment on completion of GP training was introduced for the first time, with provision for supplementary training for those who did not meet the standards.

Then in 2003, as a result of long-standing concerns about the earlier stages of training and a renewed government focus on the structure of the medical workforce, the Modernising Medical Careers (MMC) initiative was launched.

In 2005, the Foundation Programme was established to provide a more structured and time-limited experience for new doctors. Around this time access to training and CPD for staff and associate specialist grades were also clarified.

MMC’s focus on further reform of specialist training eventually delivered significant improvements, but the introduction of the Medical Training Application System (MTAS) was beset with problems that left trainees desperately confused and anxious about their futures.

The MMC reforms included clarification and streamlining of training pathways and timescales, more stable and fair recruitment processes, the creation of a transferable competencies framework and new assessment tools. What’s more, the combination of MMC principles and EWTD pressures led to more focused and structured training compressed into a shorter time frame. With the exception of MTAS, the BMA generally has supported MMC training reforms and been a constructive partner in bringing them to fruition following the initial disastrous implementation of MTAS, which the BMA strongly opposed.

Since MMC, work to improve the quality of specialist training has been progressing. Recent examples of this are the renewed emphasis on values based recruitment and the focus on improving the quality and regulation of training environments.

In 2008, the GMC assumed responsibility for the entire continuum of medical education and training – undergraduate, postgraduate and continuing medical education.

The Shape of Training Review was announced in 2012 and the report published in May 2013. Its main recommendations included the introduction of more broad-based training programmes to allow for the training of doctors with better generalist skills, the replacement of the CCT with a Certificate of Specialist Training and a return to a more apprenticeship-based models of training.

The BMA’s main concerns about Shape of Training are that specialist training should not be shortened across the board, that moving the point of registration to graduation would need a much more coherent rationale and set of protections before it could be supported, and that credentialing must not be allowed to supplant or harm the current processes of specialist and GP registration.
### Appendix 3

**Membership of the BMA council task and finish (training and development)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Ian Wilson</td>
<td>Chair of Working Group</td>
</tr>
<tr>
<td>John Maingay</td>
<td>Working Group Secretariat</td>
</tr>
<tr>
<td>Anthea Mowat</td>
<td>Deputy Chair of Representative Body</td>
</tr>
<tr>
<td>Andrew Collier</td>
<td>Junior Doctor</td>
</tr>
<tr>
<td>Brian Keighley</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>Catherine Macadam</td>
<td>Patient Liaison Group</td>
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<tr>
<td>Charles Bell</td>
<td>Medical Student</td>
</tr>
<tr>
<td>Elizabeth Lee</td>
<td>Junior Doctor</td>
</tr>
<tr>
<td>Harrison Carter</td>
<td>Medical Student</td>
</tr>
<tr>
<td>Krishna Kasaraneni</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>Peter Bennie</td>
<td>Consultant</td>
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<tr>
<td>Peter Dangerfield</td>
<td>Medical Academic</td>
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<tr>
<td>Trevor Pickersgill</td>
<td>Consultant</td>
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