Has Modernising Medical Careers lost its way?

Originally intended to address problems with the senior house officer grade, Modernising Medical Careers has since expanded in scope and radically altered its plans for specialist training. **George Madden** and **Anthony Madden** question whether it is still fit for purpose

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The Medical Training Applications Service (MTAS) has caused huge upset within the UK medical profession. Not only has it failed to allocate trainees in a fair and transparent way, but it failed to ensure that all allocations were completed in time for the 1 August 2007 changeover of staff.

In recent months, the distinction between MTAS, the selection process, and Modernising Medical Careers (MMC), the actual reforms, has often been overlooked. This year MMC will implement the specialist training programme, the most ambitious and radical overhaul of medical training in living memory. If it fails, there will be no easy way to repair the damage. In light of the failure of MTAS, one must ask if MMC can succeed.

What is Modernising Medical Careers?

MMC is a system designed to produce consultants in seven to nine years after graduation, and general practitioners in five. It begins with the foundation programme, a two year introduction to the core skills of medicine. It then goes on to the new specialist training programme, which trains doctors in their chosen specialties. Each stage is time capped.

Application to the specialist training programme begins mid-way through the second foundation year, when a trainee has had only 18 months' experience and little opportunity to show an aptitude for any particular specialty. This approach seems to work in North America and Australasia[1] and some European countries, but new medical graduates in the United Kingdom do not currently have the support structures needed to make an informed choice about their definitive career path so early.

Candidates who fail to gain a specialist training position can take a fixed term specialist training appointment or move to a career post, which means not progressing to consultant grade. In theory they can move back into a training post or seek a certificate of completion of training by an alternative route, but returning to training would generally have to be at specialist training year 2 or above, and vacancies will depend on others dropping out.

The original idea

So how does this situation compare with the original plans? The origins of MMC lie in a consultation document, *Unfinished Business—Proposals for Reform of the Senior House Officer Grade*, written by England's chief medical officer, Liam Donaldson.[2] It proposed a scheme with the aim of improving training for doctors while also meeting the needs of the health service. The original proposal was for a two year foundation programme, followed by basic specialist training in a broad specialty grouping (general medicine, general surgery, child health, etc), and then higher specialist training in a specific specialty. The split between basic and higher specialist training meant that trainees would gain a wide breadth of training and would not have to commit to a specialty until they were more senior. Overall, however, training would be shorter by virtue of a more structured programme.

The greater structure also meant that administration would be easier. Places on foundation programmes and in basic specialist training would be determined by the number of applicants. Availability of higher specialist training posts would depend on the needs of the service. If a shortage in a specialty arose, it could take as little as two years to produce new consultants to make up the shortfall.

The need for modernisation

Unfinished Business argued that senior house officers "have been left behind" in previous reforms, and that the grade lacked structure.[2] Reform of the senior house officer grade was to be underpinned by "key principles" to address the failings (box 1). In addition, Donaldson recognised that there needed to be "sufficient opportunities for flexible (part-time) training" and that "there should be access to early and regular career advice."

Donaldson also cited the lack of any central planning of senior house officer numbers as a reason for reform, and stated his intention for training numbers to be determined by "workforce requirements." He argued that shortening the training time would allow service requirements to be met more swiftly, and that time-capping training would ensure a more reliable flow of trained specialists. More radically, he presented the idea of creating "generalist" consultants with shorter training but greater flexibility: "So they would become a consultant in, for example, general internal medicine or general paediatrics. This would make a distinction between two categories of specialist: the 'generalist' consultant and what some have dubbed the 'ologists'."

All these proposals indicate an attempt to balance the needs of trainee doctors with the needs of workforce planners and employers. The plans also met the government objective to create a consultant delivered NHS.[3]

Responses to the consultation

Responses to the plans included some reservations (box 2) One response went so far as to suspect "secret agendas and underhand attempts to introduce important change without proper consultation."[4]

The defence for the increased scope of the reforms was: "These ideas were not part of the original objectives of this Report, but inevitably arose as the 'knock-on' effects of a modernised SHO grade were thought through."[2] Yet the other training grades had only recently undergone reform.[6] *Unfinished Business* was meant to complete the reforms, not to revise them.

Despite these reservations, the general tone of the responses was approving. They accepted the need for reform, and that the plans met that need. In essence, Donaldson was forgiven for going beyond his brief because the ideas produced were good ones.

However, one proposal in *Unfinished Business* raised particular concerns. It was presented only as a future direction for reforms, yet its resemblance to the current system is striking: "It is proposed that urgent work is undertaken to explore, specialty by specialty, the appropriateness of creating a 'run-through' training grade in which doctors would move seamlessly through training with satisfactory progress checks. This could not be implemented immediately. Given the needs of the service and the availability of training places, the need for application and competition prior to progression should be explored."

Evolution of MMC

After consultation, the proposals were reviewed by the health ministers.[7] At this point, the emphasis began to shift towards the run-through training proposals. One particular paragraph hinted at this, though it did not explicitly state a change of direction: "We will support and encourage the Postgraduate Medical Education and Training Board working with the Royal Colleges to develop competency-based training and assessment and to review the length of training programmes. This will be done on a specialty by specialty basis and include training for general practice. It will aim to provide seamless specialist training programmes leading to a CCT [certificate of completion of training]. The time in these specialist programmes should count towards the acquisition of a CCT."

Box 1 | Five key principles for reform of the senior house officer grade[2]

- Training should be programme based
- Training should begin with broadly based programmes pursued by all trainees
- Programmes should be time limited
- Training should allow for individually tailored or personal programmes
- Arrangements should facilitate movement into and out of training and between training programmes

Box 2 | The British Medical Association's response to *Unfinished Business*[5]

"We are surprised . . . at the inclusion of discussion and recommendations on a number of important issues not directly associated with SHO grade . . . These issues were not originally included in the remit of the Chief Medical Officer's working party, they were not discussed in full by members of that group, and have been incorporated over the course of the year since meetings ceased, thereby subjecting the publication of the report to long delay."

The idea of individually tailored programmes seems to have been forgotten, career advice is lacking, and the provision for flexible training is uncertain

Interestingly, this statement was referred to in a subsequent document[8] and used to justify the move from a basic and higher specialist training structure to seamless, run-through training: "This signalled that thinking had moved beyond the Basic Specialist Programmes foreseen in *Unfinished Business* and reflected the growing view that a single, run-through approach was not only desirable but also achievable."

This statement is peculiar; it is not clear in what quarters the "growing view" had developed. Was it the Department of Health, the medical royal colleges and specialties, the BMA or some combination of these? Only 20 months previously, *Unfinished Business* had said, "The proposal is not that the NHS generally moves immediately to a 'run-through' training grade . . . This could not be implemented immediately."[2]

The president of the Royal College of Physicians is reported to have said, "Although the medical royal colleges were involved in early training reform talks . . . the final product is a far cry from what they originally signed up to."[9] This implies that the royal colleges have had little input since the emphasis moved to run-through training.

Has MMC lost its way?

MMC has changed radically since its first proposal. Its aim was to solve a specific set of problems. The question now is whether it still does so. Central to the plan was the need to satisfy five groups—trainee doctors, workforce planners, NHS employers, the government, and patients.

The doctors need a robust, modern training system that satisfies the "five principles" for reform (box 1). The current plans are disappointing. Although specialist training will be programme based and time limited, it will not be as broadly based as originally envisaged, nor will it be easy to move between programmes. The idea of individually tailored programmes seems to have been forgotten, career advice is lacking, and the provision for flexible training is uncertain. It certainly will not "ensure breadth at [the training] stage of a doctor's career, reducing the possibility of a hasty career decision."[10] In fact, the opposite will happen. MMC therefore fails to meet most of the principles on which it was supposed to be based.

The turnaround time from recruiting trainees to producing consultants is also important. The original plans would have reduced this to three or four years, but with MMC this will be between five and seven years. This is not good news for workforce planning.

SUMMARY POINTS

Modernising Medical Careers began as an attempt to address longstanding problems with the senior house officer grade

It has since expanded in scope to reform all levels of postgraduate medical training and bears little resemblance to the proposals that were approved during consultations

There is now a real danger that it will deliver a generation of highly specialised doctors who lack the breadth of experience and flexibility that will enable them to manage unusual clinical problems or change as medicine advances

This cannot be good for patients, NHS employers, or the government, indicating that MMC may not be fit for purpose

Employers cannot be pleased with a situation that reduces the number of senior house officers, the most flexible medical staff, and reduces their time spent providing a service in favour of training. A workforce made up of doctors forced into specialties they do not really want is not a happy prospect either.

The government at least has better news. Its "increasing need for hospital services to be delivered by fully trained doctors"[10] will be met by the shorter training, and thus longer time spent as a consultant.

The consequences for patients are not good. Consultants produced by MMC will have less experience than those trained in the past. They will have a more limited range of expertise and be less able to meet the increasingly complex needs of patients. There is a real danger that these highly specialised doctors will be unable to manage unusual clinical problems, especially in an emergency, or have the flexibility to change as medicine advances.

It is difficult not to conclude that MMC has lost its way and will not fulfil its original aims.

We thank Neville Goodman, Chris Johnson, and Nick Timmins for their comments during preparation of this article.

Contributors and sources: This article was developed from a briefing paper prepared by GBPM during his elective in 2006 working as an intern for New Health Network. GBPM wrote the first draft. APM contributed substantially to the development of the final text and is the guarantor.

Competing interests: GBPM graduated in July 2007 and began the foundation year 1 training programme in August. APM is an interested parent and trainer of junior doctors.

Provenance and peer review: Not commissioned, externally peer reviewed.

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Me and my friends

It was my guitar teacher who introduced me to the concept of peri-performance β blockade as a way of controlling the befuddling anxieties that could imperil my infrequent recitals.

Sitting in his front room one Saturday morning, I heard the rustle of pills in a bottle as he lifted his guitar from its velvet lined case. Keen to show off my own medical knowledge, I inquired gently as to the nature of his ailment, and he replied that the propranolol was used prophylactically for stage fright. At first I was disappointed to learn that my guitar hero was just as susceptible as his student, but later I realised the propranolol was not a treatment for genuine stage fright but rather another tool for squeezing the best out of every dying note.

In the following weeks I persuaded my general practitioner to prescribe me some propranolol, and I began to test its physiological effects. As a medical student, I was faced with endless interviews and vivas, all of them marred by pounding in my temples, sweaty palms, and shakiness. Propranolol was very effective in dealing with these symptoms.

But one question remained; would propranolol impair my cognitive performance? I searched the literature and discovered that several rather circumspect trials had shown that propranolol improved cognitive performance during stressful events. However, taking it in the long term could cause memory impairment, albeit in rats.

Propranolol was one of my most treasured discoveries at medical school, and I shared my knowledge with only a few of my closest friends. Over the years, I have used it sparingly but to great effect, having fulfilled all of my ambitions thus far (except with MTAS, the medical training and application service). Nevertheless I cannot help but contemplate whether using propranolol constitutes an artificial advantage, or whether any benefit is simply imagined anyway. Still, there must be a reason why it is banned from professional snooker games.

Fortunately my love affair with propranolol ended abruptly when I nearly collapsed during an interview. These days my mouse pointer often hovers precariously close to the "Add to basket" button on websites proffering modafanil as the latest in cognitive enhancers.

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