MEDICAL TRAINING **Niall Dickson**

Moving the point of doctors' registration

Any such shift would take time and would require a major rethink of the undergraduate curriculum

The point at which the UK General Medical Council grants registration to newly qualified doctors has for some time been the subject of debate.[1] In the past few years concerns have risen over the prospect of oversubscription to the foundation programme (the first part of medical training in the United Kingdom) and the possibility of newly qualified graduates finding themselves not only unemployed but unemployable.[2]

In its first report on the state of medical education and practice, the GMC pointed out that although "doctors do not have a right to a job for life any more than any other profession . . . students who enter medical school have a legitimate expectation that if they pass their examinations and graduate they should have the opportunity to qualify as a doctor."[3] The moral obligation here is therefore not to give every medical graduate a job but to make it possible for those who passed the requisite examinations and assessments to become a doctor.

The debate was given added impetus last year when the independent *Shape of Training* review led by David Greenaway recommended moving the point of full registration from the end of foundation year 1 back to the point of graduation, providing that certain conditions were met.[4]

The two year foundation programme was introduced in 2005 (as part of the Modernising Medical Careers programme) and has had broad support, reflected in *Aspiring to Excellence* (the report of John Tooke's independent inquiry into Modernising Medical Careers[5]) in 2008 and in Naren Patel's review of 2010.[6] The programme continues to produce doctors able to enter postgraduate training and, as a result, attracts eligible graduates from other European countries and across the world.

Nevertheless, the current arrangements have unsatisfactory aspects. Perhaps the strongest of these is that a medical graduate who failed to gain a place on the foundation programme would be left with what many would regard as a useless degree. Moving registration would overcome this and also clear up the question of who—in practice rather than in theory—has oversight of doctors in the first year of the foundation programme. Medical schools could argue that they have fulfilled their obligation by producing registered doctors, while the UK health services could set and enforce a cap on the number they wish to fund and train.

However, it is worth noting that the solution is unlikely to deal with medical unemployment among those who have just qualified; indeed, competition for foundation year 1 places would increase significantly, as many more recently qualified doctors in Europe would become eligible for the new foundation course.

The GMC has indicated that it has no objection in principle to moving the point of registration,[7] but the starting point must be the safety of patients and the quality of medical education—not balancing supply and demand of the medical workforce.

The GMC uses the assessed standard expected of a doctor at the end of foundation year 1 as the standard in its "PLAB" (Professional and Linguistic Assessments Board) process for assessing international medical graduates seeking to practise in the UK.[8] Unless it could be shown that the UK graduates emerging on to the register without the benefit of the foundation programme were of the same (or better) standard than those completing the programme's first year, the GMC would be obliged to lower the standards in its PLAB assessment. It is inconceivable that the GMC's governing council could sanction such a move and hard to imagine any politician supporting such a diminution of medical standards. Realistically, then, any move of the point of registration would take time and require a fundamental rethink of the undergraduate curriculum.

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- Feature: Minority report: how the UK's treatment of foreign and ethnic minority doctors needs to change (*BMJ* 2014;348:g2838)
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- Research: Annual Review of Competence Progression (ARCP) performance of doctors who passed Professional and Linguistic Assessments Board (PLAB) tests compared with UK medical graduates (*BMJ* 2014;348:g2622)

Two further practical obstacles exist. Firstly, moving the point of registration would put in jeopardy the UK's 15 graduate entry medical programmes, which produce just under 1000 future doctors every year.[9] The legal advice that the GMC has obtained from senior counsel on this is unequivocal: excluding foundation year 1 from the minimum time requirement for full registration would mean these four-year courses not complying with European law.

The second difficulty is the absence of a legislative vehicle to deliver a move any time soon. Until recently it had looked as if the UK government would introduce a bill this year based on the Law Commission's work,[10] which would reform the legal basis of all the UK health professional regulators. This would have enabled parliament to give powers to the GMC to move the point of registration; however, it now seems unlikely that the bill will be become law before the next election. In short, even after a change were agreed and had passed through the legislative process, it would take at least five years for a new cohort of students to go through the system. Whatever else it may achieve, such a change could not deal with the immediate challenge of oversubscription to the foundation year.

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MEDICAL TRAINING **Geraint Fuller, Iain A Simpson**

MMC to Shape of Training: how soon we forget

The greatest cost in the latest proposal for the training of doctors may be the effect on patient care

Modernising Medical Careers (MMC) changed all aspects of medical training from its introduction in 2005. It shortened the duration of training, introduced "run-through training," and reduced flexibility.[1-3] MMC got doctors protesting on the streets and led to questions being asked in parliament and to John Tooke's report into its failings.[4] The longest run-through programmes are just completing their first cycle.

It would be useful to analyse the current state of training and thus identify the sources of several problems. These include the shortfall in core medical trainees needed to fill specialist training in acute medicine and geriatrics; difficulties in appointing locums, with consequent disruption of training and service delivery; and falling numbers of specialist trainees dually accredited in general medicine, because limited training time is only just enough to train adequately as a specialist.[5]

Instead we have the Shape of Training review of all medical and surgical specialties.[6] Despite explicitly excluding workforce or economic analysis, Shape of Training gives very specific recommendations on the duration and content of specialist training that will have far reaching consequences for the training of specialists—and thus the practice of these specialties in the future.

The review's core thesis is that we need more doctors capable of providing general care in broad specialties, a need driven by the ageing population and the growing number of people with comorbidities.[6] Shape of Training's proposal is to increase the amount of generalism and reduce the amount of specialism in an overall shorter training period, with the specialist deficit made up for with "credentialing" (certification or a "credential" for particular skills) after training is completed.

This thesis and approach are worth questioning. Patients undoubtedly need access to competent generalists (such as when presenting in an emergency to hospital), but they also need access to specialists with expertise in their problems—in the acute setting and in the long term. Not only do patients have more comorbidities, but treatments for each disease have become more complex. Patients expect to see specialists with expertise in their particular problem, something enshrined in guidelines issued by the National Institute for Health and Care Excellence. This guidance reflects the evidence: specialist care has better outcomes, such as better survival in stroke units[7] and reduced mortality among patients with heart failure who are treated by cardiologists.[8] The increasing complexity of treatment might argue for longer rather than shorter specialist training. The presumption in the proposed model is that a wholly new concept, credentialing, could fill this gap. It would pose a significant risk for patients if it did not—and if, as we suspect, specialty training is in fact more than just a series of modules bolted together. Older doctors may find the proposed system familiar: it describes the training they had as senior house officers and registrars, but without the subsequent training as senior registrars.

The review of evidence for Shape of Training recognises that a range of interpretations of "generalism" exist and that evidence comparing generalist and specialist approaches is lacking.[9] Shape of Training recommends that "any changes . . . that promote an increasingly generalist slant to the profession should be accompanied by primary research and evaluation."[9] In other words, there is not enough evidence for the wholesale introduction of generalism proposed by Shape of Training. More generalism will mean less specialism. Surely the balance between the number of competent generalists and specialists depends on careful analysis of the numbers of each needed by our patients, but the review's brief specifically excludes such an analysis of workforce planning and services. Shape of Training proposes greater flexibility between programmes (which we welcome) to rectify the balance if it goes wrong, but a swing to generalism across the board, with dilution of all specialist training, seems likely to deprive many patients of access to the specialists they need.

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- Letter: Serious implications for prospective medical students of the Shape of Training report (*BMJ* 014;348:g1288)
- Editorial: Medical education's authenticity problem (*BMJ* 014;348:g2651)
- Editorial: Modernising Medical Careers: final report (*BMJ* 2008;336:54)
- Editorial: Modernising Medical Careers laid bare (*BMJ* 2007;335:733)

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In addition, the process is flawed. MMC was introduced with a fairly inflexible framework and little debate. Many of MMC's unintended consequences were predicted and hence avoidable. It seems extraordinary that a forward looking report on training is being adopted without subjecting its interesting and innovative proposals to scrutiny, discussion, and debate.

Change comes at a cost, but Shape of Training has no costings, whether of financial costs, opportunity costs, or costs to the service and to trainees—or to medical education in general from another wholesale reorganisation. If the ideas, such as credentialing, are sound, they should be costed and piloted rather than implemented untested and at unknown cost. It seems unlikely that one model will fit all specialties. The greatest cost of all may be the effect on patient care.

Shape of Training should be a "green paper" for discussion and debate, not a "bill" for implementation. This would allow the effective involvement of the medical profession in policy making on training, something that was identified as being weak in MMC.[4] As Tooke wrote recently, we need "care in transition."[10] Good ideas could then be developed and unintended consequences avoided, with minimum disruption and cost. And no protests on the streets.

Have we forgotten the lessons of MMC?

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