The BMJ Interview: Sir John Tooke
Tony Delamothe interviews Sir John Tooke about his report concerning junior doctors' training

Professor Sir John Tooke is dean of the Peninsula Medical School. He led the successful bid for the creation of the Peninsula Dental School, awarded in 2006 and is the inaugural executive dean of the new, integrated Peninsula College of Medicine and Dentistry. He graduated from Oxford in 1974, and his clinical and research interests in diabetes and vascular medicine continue.

In April 2007, **Professor Tooke** was asked by the government to investigate the failed implementation of the government's Modernising Medical Careers programme.

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Announcer: The BMJ: Helping doctors make better decisions. This is the BMJ Interview. This week, Tony Delamothe, deputy editor of the BMJ, interviews Sir John Tooke about his report concerning junior doctors' training.

Tony Delamothe: Your interim report was published less than three months ago to great acclaim – nearly 200 pages long, 11 appendices, 45 recommendations. So what's happened in the interim and how does this new version differ?

Sir John Tooke: Well, as you know, the report has been out for consultation since publication in October and I'm pleased to say that there has been tremendous support for the recommendations that were in that interim report. 87% of those that responded agreed or strongly agreed with the recommendations, and only 4% disagreed. So, a remarkable degree of consensus behind the recommendations that we made.

TD: There was something reassuringly medical about the interim report. Self-consciously you used medical terms like "etiological factors," and I like to think your report read very much as diagnosis followed by treatment. You listed eight etiological factors but identify no single main cause. You were quite clear that all parties shared some of the blame. Each constituency has been found wanting thus far, you said. And yet it's hard, I found, when you trace the lines of accountability, although some of them are extremely convoluted indeed, not to see the main failure as residing with the Department of Health. Is that an unfair reading of the report?

JT: I think you've covered the complexity of the situation very well, and the fact that the governance mechanisms and accountability structures are so ambiguous makes it very difficult to point a finger of blame at any one individual, or indeed at any one individual constituency. Clearly the Department of Health had a guiding role, however, in creating the governance structures, and therefore a lot of responsibility must lie in that particular direction. But I would not wish it to be perceived that the medical profession was without blame. As we pointed out in the interim report, I think there was a dearth of medical leadership and influence over the development period of MMC, and that's something we need to address as a profession as we move forward.

TD: And that was really the source of some of your recommendations. Can you say more about what you think doctors need to do to achieve a single voice?

JT: Well, I think it would be somewhat naive to assume there can be a single voice. We are a diverse community. We have multiple subspecialties with various requirements. I think the best that we can hope for is a coherent voice around matters that are of major importance to the profession and the health of the nation as a whole. And we need to create structures which enable us to reach that coherent viewpoint. Now one of the important messages that comes through from the final report is the creation of a new body – NHS Medical Education England – and one of the many functions that

that body would provide is the ability to create that coherence of professional opinion that could then feed in to policy makers.

TD: Your brief was to look at all of Modernising Medical Careers, of which MTAS was merely a part, although it was MTAS's failures which were the major cause of the pain experienced by mainly doctors in training last year. Yet even if the Medical Training Application System performed magnificently, there is still the issue of numbers. In 2007 there were 32,000 applicants for 23,000 Specialist Training jobs in the UK – 9,400 unsuccessful candidates therefore. Why was there such a mismatch?

JT: I think it was principally due to lack of foresight and the fact that there were conflicting policies: an open doors policy as well as a self-sufficiency policy in terms of medical trainees in this country. And until those policy differences are reconciled, we are going to be left with a continuing problem.

TD: Presumably you think that we should be striving for that as a country, that all countries should be striving for self-sufficiency of doctor training.

JT: If you don't have self-sufficiency then you immediately raise the question about what countries you rely on to provide you with your medical workforce. Those are the countries that have trained their own workforce to graduate level, and at one level you could be seen as exploiting them by taking their graduates away from the country from whence they came. So I think self-sufficiency is a sensible goal for something as important as a medical workforce.

TD: As I said previously, there were about 9,400 unsuccessful candidates and if you look at your report I think you number around about 10,000 highly schooled migrant programme doctors. It seems that you could almost explain the oversupply by highly skilled migrant doctors. What do you think needs to be done about this group? I mean, clearly there are doctors working in the UK now, and everybody is arguing that nothing should change in their terms of engagement with the UK. But do you think that the programme should be turned off for doctors going forward?

JT: I think what needs to happen is the policies that are currently in play need to be reconciled, the self-sufficiency policy versus the open doors policy. I do think we need to respect the contribution that international medical graduates have made to the NHS in this country. I do think that those who are in educationally approved posts need to have equal access to training positions as those graduates from UK medical schools. There clearly has to be a further reconciliation given the judicial review recently announced on the position of international medical graduates in this country. And we urge that that is reconciled urgently.

TD: I now want to move on to what most affects doctors in training on the wards and in the GP clinics: that's basically the structure of postgraduate training. You want a structure that provides broad-based beginning and flexibility, and the value of experience, and the promotion of excellence, and that's exactly what the straightjacket of run-through training didn't provide in your opinion. Could we go through now the structure of the training as it exists and then your recommended changes to that?

JT: Indeed we can.

TD: So if we think of the medical student qualifying in their final medical degree, they would now enter Foundation Years 1 and 2 and the first of your proposals is to split Foundation Years 1 and Foundation Years 2, to uncouple them, unbundle them. Can you say more about your rationale for that?

JT: The fundamental rationale for uncoupling the two Foundation years is an employment issue. And as things currently exist, it is impossible to guarantee the new graduate from the UK Foundation Year 1, the pre-registration year without which they cannot go on to become a registered medical practitioner with the General Medical Council, and therefore be guaranteed future employment as a doctor. And it is a simple fact that whilst Foundation Year 1 and Foundation Year 2 remain coupled, then entry into that Foundation programme has to be open to European competition and therefore we cannot guarantee a place for our UK medical graduates. Now in the panel's view it is completely unacceptable to put people through medical school in this country at public expense, for those new graduates to have incurred a considerable amount of debt in the process, and for them not to be

guaranteed a pre-registration position which guarantees them employment beyond that phase. And strive as we may, we've been unable to find any other way of guaranteeing that initial engagement in a pre-registration position unless we uncouple Foundation Year 1 from Foundation Year 2. But what I would like to emphasise is that we do recognise the hard work that's gone into the creation of the two-year Foundation programme, and we do recognise some of the strengths within that current provision, although it is indeed very early on in the process. But that good work does not need to be abandoned as we move forward with our new proposals. We believe that Foundation Year 2 can gradually move into a themed year of Core medical training, themed according to maybe four major Core areas. And the experience and the curriculum that's been developed that embraces the entirety of the two-year Foundation programme can be merged into that Core programme over time. So I think we can retain what's good about Foundation but deal with this real threat that our UK medical graduates will be denied pre-registration posts unless this situation is resolved.

TD: In your interim report you talked about an examination between Foundation Year 1 and Foundation Year 2. Is that still the case in the final report?

JT: No, it's not. We've been persuaded by cogent arguments put forward that it would be wrong to complicate the life of the trainee in Foundation Year 1 further by introducing yet another exam at that stage. Nonetheless we do need processes to select into Core. What we are proposing is that work is begun on a common element of the final exams for medical students, which could be used to inform that later transition. But we expect that the majority of that transitional arrangement, that transitional selection from Foundation Year 1 into Core would be through a local interview process.

TD: Now under the current system, the Foundation Year 2 person would then apply for a run-through training post: ST1.

JT: Indeed.

TD: But in your new model you are proposing that Foundation Year 2 gets coupled with ST1 and ST2 to become Core Specialty Training 1 to 3, I think.

JT: Indeed. That's precisely right. And it is that that provides us with this fantastic opportunity for broad-based beginnings to training which we think are so important. So important because it is well recognised that increasingly doctors are going to have to deal with considerable amounts of comorbidity in an ageing population, to understand the different specialties and branches of medicine better than they would be able to do had they embarked early on a run-through career into one of 57 essentially subspecialties. So broad-based beginnings are critically important, and we would hope to see the crafting of very well developed Core programmes, as is mentioned, in perhaps four or five key areas: medical specialties, surgical specialties, community specialties, acute common stem, for example. The detail of that needs to be worked up in conjunction with the profession, but we feel that would provide a very profound foundation onto which to build your specialty expertise at ST3 level and beyond.

TD: So what we saw with the competition for the ST1 post, that would now be sort of a rerun of ST3 level?

JT: Indeed, but by that time, of course, the trainee would have a clearer view of where their career aspirations lay, they would have a broader foundation, they would have completed four years of postgraduate training, and they would be more broadly employable, whatever else happened. So we believe they would be in a stronger position at that point to make the right decisions for their own careers. Now clearly, intrinsic to the reforms we're recommending is a revision of the selection process into Higher Specialty Training to negate many of the problems that were apparent with MTAS. And it is critically important in our view that the selection processes are professionally informed and have real face validity as a candidate taking the assessment. They need to be able to believe in the outcome, and that clearly wasn't the case with MTAS, and therefore the selection process needs to embrace aptitude for the specialty, relevant academic achievement and experience, and whether they can exhibit the skills relevant for the specialty they're moving into. And so we're suggesting a process whereby the trainee would take a selection centre type assessment which would judge those various things, rank that student, that trainee, against a national standard, and then enable the trainee to elect to apply for a position at a deanery or graduate school level, at a local level

rather than the very big areas that they previously had to apply to. And they could apply to those localities knowing the competition ratios that were operative in those localities. So they would be better informed about where they stacked up in terms of the competition and they would understand the competitiveness of the environment in which they were entering. When we talked to trainees around the country as part of the roadshows that we did in advance of the interim report, it was quite clear to us that trainees recognised that entry into Higher Specialist Training was going to be a competitive process. Trainees acknowledged that. They too aspire to excellence, and they welcome that level of competition as long as it is fair and they are equipped with the relevant data to make informed choices about whether they are going to succeed with their aspirations.

TD: Can you say what happens when doctors emerge from Higher Specialist Training? I mean, presumably they'll be granted a certificate of completion of training.

JT: Indeed, that's very much the intention, and we understand that that means they are capable of independent practice at the level of consultant.

TD: Is that a specialist level or a consultant level or a sub-consultant level as is being bandied around at present?

JT: I think in this regard we need to be careful to separate out issues and nomenclature, terms and conditions from roles. I was very careful with the words I chose in that I think that a CCT holder should be capable of independent practice at the level of a consultant. The consultant can assume a number of roles. They may be a specialist in their particular area; indeed, they inevitably will be a specialist in their particular area. They may have subspecialty expertise. They may pursue one or more enhanced roles as part of their consultant status. For example, they may be involved in service management; they may be involved in research, in higher education... What is important I think, in looking forward, is that we prepare the consultant of the future for some of the enhanced roles they may wish to assume, and that's why we make particular reference in the training programme to the opportunity to acquire some of the skills in relationship, for example, to education and research or global health issues, early on in the programme, so they get to the point of completion of training with a spectrum of enhanced skills which reflect their aspirations. I don't think the sub-consultant grade is necessary. We think that the series of enhanced roles that I've suggested can be played out within the existing consultant contract, if that consultant contract is used more flexibly to reflect contribution as opposed to seniority.

TD: I was at the stakeholders meeting when your interim report was released and I sort of perceived an audible sigh of relief amongst the assembled company. It was as if here's a doctor/researcher/dean – he's obviously one of us. He talks of etiological factors, he's recommending the structure that we remember when we were qualified. Because really what your model of the future is is just a repackaging of the past it seems. You've got a Pre-Registration Doctor now, you've got three years of Core Training which is like the SHO grade, you've got Higher Specialist Training – the Registrar grade – and after the certificate of completion of training you've got the Senior Registrar grade then onto Consultant. Do you think that's why doctors have found your report so reassuring? You say that 87% of respondents signalled agreement to your proposals. Is it because it is exactly what was around for years?

JT: Well, I would argue it is not exactly what was around and I do accept that SHO training, for those for whom it was a well structured programme and from which they advanced, was highly successful. Unfinished business occurred because many people in the SHO grade were not in that fortunate position, and therefore revision was necessary. But what I think perhaps should have happened at that time was a proper option appraisal about what was good about that programme, rather than just a focus on what needed to be reformed. I don't think it's simply the familiarity with something that resonates with the past that is the appeal. I think we resonate with the profession in the sense that we are proposing an aspiration to excellence. One of the striking things again when we met with trainees around the UK was how many of them stated that they didn't qualify in medicine to be "good enough". They qualified in medicine because they wanted to make the best possible contribution that they could to the wellbeing of patients. And it was they that aspired to excellence, and I think what we're doing is simply echoing that vocation, which is alive and well and trying to create a structure which enables them to realise their ambition in that regard.

TD: Your executive summary quotes your 87% agreement rate amongst respondents and to quote your report: "thus fulfilling the term of reference to make recommendations to ensure that it has the support of the profession in future. There is thus the compelling mandate for the implementation of the proposals." And I detected a sort of sense of anxiety here. It's almost as if you are saying, well, the government has to accept my recommendations. And do you think they will accept them in toto?

JT: I don't know. I very much hope so because I think they are right and there is such a professional mandate as you stated. There are a number of workstreams being implemented to look at some of the ramifications of the report, but what has become clear to us since the interim report is that there has to be the creation of this new body – NHS Medical Education England – which will fulfil a number of functions and will ensure implementation and cohesion and concerted action moving forward. Those functions include creating the interface between policy development, which must also involve the profession, and implementation. There are real concerns that the implementation of postgraduate training programmes should not be left to a department of state but needs to be conducted by professionals skilled in the processes of implementation and educational processes. That it's important that this body relates to a revised medical workforce advisory machinery. That it's important that this body assures commissioning of postgraduate medical education and training in England at an SHA level and ensures that value for money is being achieved by the initiatives being taken there.

TD: Do you think it will succeed in all the ways the Department of Health failed? I mean is this body going to be meant to be doing the sorts of things that the Department of Health messed up?

JT: Well, as the final report makes clear, this body ticks many of the boxes in terms of implementing the recommendations. It will subserve many of the functions and overcome many of the deficiencies that we identified in the interim report. Importantly, it will act as this interface with the Department. It will enable creation of cohesive curricula, which take into account certain service requirements as well as the needs of the Royal Colleges and provide a mechanism to present unified curricula to the regulator who will oversee the introduction of those curricula.

TD: Sir John, this new body you are recommending is called NHS Medical Education England, but the UK has got four nations. How do you see these principles working across the kingdom as a whole?

JT: Indeed it is very important to recognise that the NHS has devolved to four nations. We're clear from our enquiry that things have gone better to a certain extent in the devolved administrations, reflecting the smaller scale and tighter loops between the various bodies involved. And we are trying to create that same sense of cohesion within England. I would anticipate that the head of NHS Medical Education England would relate to their opposite numbers in the devolved administrations, for example, NHS Medical Education Scotland, and enable the right level of coordination at an operational level, which has been lacking to date. You are absolutely right – it's important that we do have a UK-wide perspective because the medical workforce is mobile across the four nations. And this is one way of assuring the necessary collaboration to achieve that.

TD: Your interim report had 45 recommendations. The recommendation about this new educational body is one new recommendation, and the only other new recommendation you've made was trying to lessen the impact of the European Working Time Directive. Can you say more about what you're recommending for this?

JT: It's clear that synchronous with MMC has been the adoption of the European Working Time Directive, which inevitably limits the experience that trainees can gain during their postgraduate years. And we are arguing that we need to explore whether there are legally defensible ways of interpreting the directive which enable us to maximise the education and training experience that the new trainee acquires and if we can't offset it in any way, how do we compensate for it by, for example, enhancing further the professionalisation of training or perhaps even advancing some of the clinical training more into the undergraduate years.

TD: Thank you, Sir John.

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