



Response from the Medical Schools Council (MSC) to the MMC Inquiry

Introduction

It is clear from the problems outlined in *Unfinished Business* and discussion throughout the last decade that SHOs have constituted a 'lost tribe' in terms of training (although less has been made of the positive aspects of SHO training, including the in depth clinical experience that this grade has been exposed to, along with career choice flexibility). Therefore the overall aims of MMC, to reform this phase of postgraduate training in particular and to streamline postgraduate medical training in general, have been a welcome and positive development. The years that some individuals spent in SHO posts with heavy service commitments and little training were unacceptable and the greater security created by entering a formal specialist training programme has been another positive step. It is also clear that a competency-based, rather than time-based, assessment process is desirable for trainees.

On the other hand, some of the apparent drivers behind the proposals, such as a benefit from doctors having a reduced length of training in order to develop a consultant led service, may have created short term solutions which in the long term may prove as undesirable as the problems MMC set out to address. Trainers and trainees themselves have expressed concern that the proposed training programmes may not provide sufficient time for optimal clinical experience, and further urgent attention will need to be paid to the implications of the European Working Time Directive in relation to this matter.

It is imperative that any new system recognises the changing demography and requirements of the medical workforce. More women than ever before are now graduating from Medical School in the UK. The system must be adaptable enough to allow trainees to balance their medical careers with the demands of family life and other commitments, with flexible training and working arrangements both widely available and clearly visible.

Key issues that a new system must address include concerns that: current arrangements force trainees to make premature career choices; the present system is inflexible and inhibits the acquisition of a range of experience; the inflexibility jeopardises academic medicine in particular; the current selection process acts to disguise academic ability.

Developments within Medical Schools

The introduction of *Tomorrow's Doctors* marked a watershed in UK medical education and training. All Medical Schools have developed innovative curricula and assessment methods and produce graduates who have the essential core skills to equip them for practice over several decades of intense change in patient diagnosis and management. Medical Schools also have responsibility for the F1 year, with full GMC registration only being possible after the university has confirmed that the F1 year has been completed successfully, a task usually now delegated to the Postgraduate Dean.

The plan by MMC to contrive a two year Foundation Programme was grafted on to the pre-MMC PRHO year, with the undesirable result that the responsibility for determining standards in the Foundation years now lies between two bodies, the GMC and PMETB. Moreover, Medical Schools have not had a major role in the development of the Foundation curriculum and assessment processes. The Medical Schools Council has drawn attention in consultations to the over-emphasis within the Foundation curriculum on acute conditions at the expense of chronic diseases which are likely to occupy most practitioners through their careers, and to the possible duplication of curricular material already well covered during undergraduate education. **It would be better to have a more co-ordinated linkage between undergraduate and postgraduate curricula and to insist that responsibility for determining standards lies with a single body, the GMC.**

Another problem which has compounded the sense of dislocation between Medical Schools and the Foundation Programmes has been the diverse and changing relationships that Schools have had with Postgraduate Deaneries. The creation of WDCs in the penultimate reorganisation of Health Authorities led to a weakening of links between Postgraduate Deans and Medical Schools. The idea of bridging this gap through Foundation Schools has not yet reached consistent maturity across the UK.

The division of responsibilities between Postgraduate Deaneries and Medical Schools could be improved, for example through better coordination of the educational levies and creation of a seamless educational programme. Following the creation of new Strategic Health Authorities in 2006, further reorganisation within Postgraduate Deaneries is now occurring, with models of a single regional Postgraduate Deanery, widening into the whole of multi-professional education, emerging. Although there are potential benefits to the NHS from such developments, they are unlikely to address the separate need for a close relationship between individual Medical Schools and their Deaneries to ensure a better transition from undergraduate to postgraduate medical education.

A consistent national model for Postgraduate Deanery operation, with clear and detailed arrangements in respect of partner Medical Schools and more formal integration of functions, will be essential to ensure that all staff and students understand whatever reforms emanate from this Inquiry and to assure delivery of a co-ordinated programme of education.

Registration and UK graduates

One of the most important concerns for Medical Schools, amongst the many raised by this Inquiry, is the need to guarantee that all graduates have the ability to obtain full registration with the GMC. This is not a plea for job protection. The Medical Schools Council recognises that doctors, like other professionals, must compete for the best jobs, although it also is highly desirable that medical undergraduate numbers match as closely as possible national requirements, given the expense to the taxpayer of undergraduate training. Guaranteeing opportunities for full registration is the only way to enable graduates to practise in the range of possible careers within and outside the NHS.

This Inquiry provides an opportunity to review the best time for full registration. Options are: that full registration is granted at the end of the undergraduate year, at the end of F1 or at the end of F2. The goals set out in the *'The New Doctor'*, published by the GMC, demonstrate the desirability of a defined period of time when a recently qualified doctor may practise and gain experience whilst under supervision. These principles, underlying the PRHO year, have stood the test of time and continue to work well. Therefore the majority of members of the Medical Schools Council do not recommend full registration at the end of undergraduate study. The remaining options are to retain the present arrangements or to extend full registration to the end of F2. The award of full GMC registration at the end of the second Foundation year has a number of potential benefits, considered further below, but will require extra resource for Schools. If this option is not pursued, the role of Medical Schools in the F1 year requires strengthening and formalising nationally.

Unless full registration is granted immediately after qualification, sufficient training places must be available to accommodate graduates in posts that will allow completion of this phase of their education. In addition, some solution must be found to the problem of allowing appropriate access to EU applicants. Differing legal opinions have been obtained on this matter, and the Inquiry should recommend that a definitive opinion is obtained to clarify the position, and then that appropriate measures are put in place. Enhancing the responsibility of Medical Schools for F1, or extending this into F2, thus creating a '7 year' MB programme, would be other possible solutions. **Whatever the outcome of the Inquiry, the Medical Schools Council would insist that a**

mechanism is devised to ensure there are sufficient placements for all eligible UK graduates to achieve full GMC registration.

There is also a wider issue in relation to overseas applicants to specialist training. Australia, for example, allocates training positions to foreign applicants after the needs of local trainees have been considered. We need to ensure that UK graduates can complete their training for full GMC registration, but at the same time we must comply with EU legislation and also permit high quality overseas graduates to undertake clinical and academic training in Britain. Again, a definitive legal opinion should be obtained in relation to this matter.

Foundation Programmes

The Inquiry into MMC offers the opportunity to look again at the overall structure of the Foundation Programmes and the timing of full registration with the GMC. The majority of members of the Medical Schools Council believe that Medical Schools should have a greater role in developing Foundation curricula and assessments as the best means of ensuring continuity between undergraduate and postgraduate education.

This issue also needs to be linked to the recent consultations undertaken by the GMC over the need for a national qualifying exam for undergraduates. Although not subject to a formal discussion, in the context of this response to the MMC Inquiry, many members of the Medical Schools Council are concerned that such an exam at the end of undergraduate training could prejudice much of the improvement Schools have made to curricula recently and threaten the diversity of educational provision. However, some form of competitive assessment in the Foundation programme could provide a transparent means of selection into specialist training, provided this is used along with other selection methods.

One way forward would be an assessment towards the end of F2; this could lead to full registration as well as being a determinant of competitive entry into specialist training later. There has not been unanimity over this proposal and the Medical Schools Council has not had sufficient time to debate it fully prior to responding to this Inquiry. **It would be very useful if the views of the GMC on national assessment are made clear and discussed with all parties as soon as possible, so that any developments can be integrated into the outcome of this Inquiry, rather than imposed subsequently.**

An additional proposal, favoured by some but not all members of the Medical Schools Council, is the creation of an optional F3 year, which could consolidate basic training in the graduate's intended career and improve overall clinical experience, allow for any deficiencies to be addressed (so that re-application can be made by undertaking reassessment halfway through F3) and permit exploration of detailed career options within a broad chosen specialty such as Medicine or Surgery. Those wishing to pursue an academic career could use F3 as a means of developing their research plans, in an enhanced version of current academic Foundation programmes.

Greater flexibility is one of the key concerns of trainees and allowing extension of the Foundation Programme to three years in this way would allow increased flexibility for trainees at a critical point in their training.

Specialty training could then be 4 years, plus F3, in certain specialties, whilst 5 years, plus F3, in others. This proposal would also address the question of a national qualifying exam by permitting an assessment at a much more appropriate stage in the educational pathway, when graduates will have had two years of experience after Medical School qualification, although not all members of the Medical Schools Council agree with a competitive assessment-based entry at this point. As discussed below, the end of ST2 is an alternative (or additional) point for selection, and for the creation of a flexible year around this transition.

Any assessment at the end of F2 (July), whether along current lines or incorporating a national examination, would be too late to be used in an application process for specialist training that would commence in the summer after completion of F2. Possible options therefore would be to extend the proposed F3 year to all trainees rather than make this optional, or to hold the assessment at an earlier stage (for example, 18 months after qualification). A national assessment towards the end of F2 could be either generic or broadly subject-specific (e.g. Medicine, Surgery, Pathological Sciences etc.). In either case these assessments could be a substitute for Part 1 College examinations. In this way the overall burden of post-qualification examinations would not increase.

Responsibility for establishing appropriate outcomes and assessments would lie between the Medical Schools and the Colleges, and in this way truly seamless education would be guaranteed, as inevitably outcomes and assessments drive education and learning. Another consequence would be that Medical Schools would have to have a stronger role in creating suitable curricula which do not duplicate undergraduate programmes and however achieved, this avoidance of duplication must be a priority for future reforms.

In summary, we suggest that the timing of full GMC registration should be reviewed, that the implications of a national qualifying exam are explored in relation to the timing of registration and entry into further training and that Foundation Programmes could include an F3 year to add flexibility and extend the range of training opportunities. Whether or not the idea of a F3 year is adopted, Medical Schools should be more involved in the development and delivery of education and training in the Foundation years, not least to prevent duplication between undergraduate and postgraduate programmes. This last proposal will also require adequate funding for Schools from within the existing MPET budget and creation of new management structures; there will be benefits to the NHS from the educational experience developed within Medical Schools. A seamless transition from undergraduate to postgraduate development will only be achieved by increasing the role of Medical Schools in wider postgraduate medical training.

Selection for Foundation Programmes

Another key concern for Medical Schools has been the development of the MTAS scheme for entry into Foundation Programmes. The scheme as initially launched has created consternation in both Foundation Schools and the undergraduate body. Much of the drive in assessment over the last decade has been to develop exams which test competence and encourage learning. The process as now established has used examinations to create rankings in a post hoc fashion, albeit only in quartiles, and will encourage strategic rather than deep learning. In addition, there have been concerns over the veracity of statements made by applicants and inconsistencies in assessing the completed forms. Although undergraduates have now become used to the current process, and to some extent tolerance has developed, nonetheless **we advocate a complete overhaul of the MTAS application system for Foundation entry in the medium term, although work will need to start immediately on this.**

Already changes are proposed which will help to check on rankings and detect plagiarism and these must be pursued. In addition, more thought needs to be given to assessing academic qualities and establishing methods by which these can be properly assessed in a prospective fashion, taking into account the views of the student body and Medical School Education Units. Whilst a national qualifying examination might offer a method to differentiate candidates, this would not take into account the full range of skills taught within Medical Schools. This could easily lead to over-emphasis on satisfying the criteria for the national examination at the expense of developing self directed learning, clinical skills and other professional attributes, thus losing all the gains of the last 15 years in undergraduate education. Further use of structured interviews at a local level may offer a better way forward.

Whatever the solution, the Medical Schools Council believe that current selection procedures for Foundation programmes should be improved. We need to be clear with students, well in advance of any changes, how their selection will be conducted. If there are fundamental changes to the present scheme, as we anticipate, it may be preferable to run with the existing selection scheme for current undergraduates and to inform all new graduates of any revised arrangements from 2008 or 2009, depending on the pace of change, so that they can know exactly how to approach their undergraduate education in anticipation of the new scheme. **It will also be extremely important to ensure adequate piloting of any changes to prevent a repeat of recent high-profile problems.**

Career Choice and Assessment

A further implication of the current Foundation Programme is the accelerated need for students to select career choices. Much greater emphasis will be needed on careers advice and whilst many Medical Schools have already begun to provide this, it is an area in which Postgraduate Deaneries could do more with their partner Medical Schools, reaching back into the undergraduate curriculum to ensure that students are properly appraised of career choices. The use of special study modules is one way that students can experience a range of career options, and further developments will be required in the upcoming version of *Tomorrow's Doctors* to ensure that these aspects are given full attention by Medical Schools.

The final aspect of the Foundation Programmes that the Medical Schools Council would comment on concerns delivery of assessments. As already stated, members agree that competency-based training is preferable to a time-based system but have concerns about the training of assessors and their ability to undertake assessment at multiple points throughout the Foundation Programme. The amount of time available in new consultant job plans in many cases does not allow sufficient scope for educational support, especially taking into account the different levels of trainee. **There is considerable potential for the extended role of trainers in the new postgraduate training programmes to erode their contribution to undergraduate education. Adequate resources and careful monitoring will be essential to ensure that there are no adverse effects from the recommendations of the Inquiry on undergraduate medical education.**

Specialist Training

Medical Schools are particularly concerned with the implications of MMC for academic careers and this issue is as important to the Medical Schools Council as the need for guaranteed full registration. The

MTAS scheme so far has not operated to allow the best applicants to obtain the best academic posts, not least because those responsible for selection were not allowed access to the applicants' CVs.

It is essential that applications for Academic Specialist Training Posts are dealt with before non-academic Specialist Training Posts. This will allow those who are unsuccessful in their academic applications to compete for alternative training posts. It is equally essential that different selection criteria to those in the standard application form are used to emphasise the academic attributes of the applicant and that, providing an acceptable clinical competence level has been demonstrated, selection is thereafter based on academic potential alone. Selection should be by means of an interview conducted by those with the essential academic and clinical skills and based on the availability of a full CV. More local devolution of selection to a tripartite group comprising Medical School, Postgraduate Deanery and employing Trust is highly desirable. Thought should be given to developing a national conference so that local selectors for academic programmes can share experiences and develop best practice, thus improving the quality of clinical academics throughout the UK. There should also be multiple entry points through the year and greater freedom for academic trainees to change their final specialty.

More generally, it is clear that the MTAS scheme itself needs a thorough overhaul and no doubt other bodies will comment in greater detail on this. Within the training grade, we have already indicated that it is vitally important that there is sufficient flexibility to accommodate trainees who, under present arrangements, will experience severe problems in switching specialty after successful application and entry into the programme. We must also not lose sight of the current generation of trainees whose careers have been affected in the last year by the shortcomings in the selection process through MTAS; short term solutions to accommodate them in flexible programmes should be found as soon as possible.

A new national selection process for specialty training, provided it is properly developed and thoroughly tested, would offer a fair and transparent system. However, the units of application will need to be much smaller to accommodate those seeking training posts in less common specialties. We are aware of proposals from other bodies to create an extra year during the Specialty Training grade period and to have an assessment-based competitive entry point around ST2. Although these proposals run the risk of increasing examination burden and creating a new 'lost tribe' unless carefully managed, they would also be an alternative to the suggestion of a flexible F3 year and would achieve the overall flexibility which has disappeared from the current system.

An additional concern is the need to ensure that undue rigidity in the training pathways does not undermine innovation and evolution of specialist training pathways, or indeed set back developments

that have only recently borne fruit. The regulatory body (be it PMETB or the GMC) needs to be responsive to the specialist bodies and societies and needs to have sufficient flexibility to deal, for example, with so-called dual certificate specialisation.

We also recommend a greater emphasis on academic competence for those entering non-academic specialty training programmes, so that the ability to select those individuals who will make invaluable contributions to research and teaching within the NHS is maintained. Without this emphasis there will inevitably be a “dumbing down” of the consultant body, with considerable implications for future clinical research and education in the UK. This recommendation is particularly timely in light of heightened awareness of the importance of clinical and translational research, as outlined in the Cooksey Report and Best Research for Best Health.

The Medical Schools Council has two final and more general recommendations. **First, a considerable public and professional relations exercise needs to be mounted to ensure that all undergraduates and graduates understand any new processes introduced in the wake of the Inquiry.** Considerable harm has been done within the medical profession by the unswerving insistence by MMC on introducing its proposals too rapidly and without thorough testing of each aspect. **Second, further clarification of the role of PMETB is equally essential, as there is considerable uncertainty nationally over the role that this body has in standard setting. A strong argument can be made to replace PMETB with an enhanced role for the GMC, via its Education Committee, in standard setting for the entire postgraduate medical training programme in the UK.** This would strengthen the concept of a continuum of medical education with a co-ordinated transition from undergraduate to postgraduate training.

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