Round pegs in square holes: getting career choices right

Anne Dornhorst and Helen Goodyear

Introduction

The conference title highlights the potential conflict between the workforce and workplace. Dr Helen Goodyear, Chair of the Intercollegiate Improving Working Lives (IWL) Committee, explained that the Committee chose this theme to match the aspirations and expectations of doctors and dentists with NHS service demands, which is key to achieving a good work–life balance. The speakers and invited audience included several presidents of royal colleges and medical schools and postgraduate deans with experience in workforce planning, medical education, professional development and planning of NHS services. The conference examined the influences behind career choices made by undergraduates and junior doctors and how changes in career development and support throughout doctors' and dentists' careers will need to be managed in order to meet future NHS service needs. Dr Goodyear stressed that professional attitudes towards the way we work will also need to change.

Selecting students

Dr Judy Curson, Chair of the Workforce Review Team, spoke about the challenge of selecting students to deliver healthcare over the next four decades. Attrition rates of 1% per year among specialist registrars (SpRs) and less than 10% among medical undergraduates emphasise the need to get the initial selection right, as doctors are not 'quitters'. Career choices and changes are being made in order to achieve a work–life balance, and this is set to continue. The 'pegs' for tomorrow's consultant 'holes' will work fewer than 48 hours a week while training, and continuity of care will be undertaken by teams. If an individual medical career can be considered as a 'hole', then Dr Curson likened the totality of medical careers as a honeycomb with various sized hole. Pegs and holes will need to adapt together according to medical advances, financial pressures and professional bodies.

Trust in doctors

Professor Angela Coulter, Chief Executive of the Picker Institute Europe, spoke about how patients sought implicit trust in their doctors and self-involvement in care. Trust, she said, must be earned. Over the past 10 years, doctors have consistently scored above judges, priests and police officers in MORI polls in response to the question 'Who do you trust to tell the truth?' Medical selection should identify individuals who are best suited to earn patients' trust and respect. Training needs to include handling uncertainty, communicating risk, promoting shared decision-making, and promoting self-management based on best evidence and appropriate cost-effectiveness.

Changes in the NHS

Lord Norman Warner, Minister of State for NHS Delivery, Department of Health (DH), gave a keynote speech on changes within the NHS. As society does not stand still, change within the NHS is non-negotiable and the medical profession needs to adopt new working practices. The implementation of the European Working Times Directive would require doctors to work in competency-based teams, as outlined in the Hospital at Night model. Junior doctors released from previous roles by increased numbers of non-medical personnel will have time for skill- and competency-based training. Lord Warner was optimistic that Modernising Medical Careers (MMC) would provide greater career advice and enable doctors to change career direction in order to ensure that NHS service provisions were met. He stated the government's commitment to IWL policies and said that tangible benefits included more opportunities to work flexible hours and improved childcare provision. He also emphasised DH commitment to improving the occupational health service within the NHS to combat work-related stress and other illness.

Motivation for doctors

Professor Chris McManus, Department of Psychology, University College London, spoke about the social and psychological motivators behind people becoming doctors and the personality traits that determine junior doctor career choices. Potentially, dissatisfaction could result if personality and motive are not congruent with actual career and/or specialty. Professor McManus showed that

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career choices within the general population are linked with six basic personality traits: investigative, artistic, social, realistic, conventional and enterprising. These six traits influence career choices among doctors, are present on entering medical school and change little during training. Surgery and anaesthetics attract personalities with a mixture of realistic and investigate traits and a tendency to prefer things and ideas rather than people and data. Psychiatry attracts individuals with artistic and social personalities and who favour ideas and people.

In order to examine motives for applying to medical school, a questionnaire was given to secondary-school pupils attending a medical career fair. The desire to help people was evident among most applicants. Other motives such as to be indispensable, to obtain respect and to have an interest in science were normally distributed. Professor McManus is convinced that personality traits could be assessed objectively and that these influence future career choices, motivation and individual learning styles. He is, however, not an advocate for personality testing as a means of student selection.

Conference programme

- **Introduction and welcome**
  Dr Helen Goodyear, Chair of IWL Intercollegiate Committee
- **Trends in recruitment–what is causing round pegs in square holes?**
  Dr Judy Curson, Director, Workforce Review Team
- **What patients want**
  Professor Angela Coulter, Chief Executive Pickers Institute Europe
- **Keynote speech**
  Lord Warner, Minister of State for NHS Delivery, Department of Health
- **Factors affecting doctor's career choices**
  Professor Chris McManus, Department of Psychology, University College London
- **Junior doctors views about their current job and future work intentions**
  Professor Michael Goldacre, Unit of Health Care Epidemiology, University of Oxford
- **Career support for newly qualified and junior doctors**
  Professor Shelley Heard, Deputy Dean Director, London Deanery
- **Morning synopsis**
  Dr Clair du Boulay, Royal College of Pathologists; IWL Representative; Dean of Wessex Institute of Postgraduate Education
- **Career choices – the junior doctor perspective**
  Dr Simon Eccles, Former Chair BMA Junior Doctors Committee
- **Achieving the transition from junior doctor to consultant**
  Dr Andrew Mooney, Former Chair of Royal College of Physicians New Consultants Committee
- **Senior doctors in management – the final goals**
  Dr Sheila Peskett, Centre for Health Planning and Management
- **Final synopsis**
  Professor Sir Alan Craft, Chair of the Academy of Royal Colleges and RCPCH President
- **Closing comments**
  Dr Anne Dornhorst, IWL Officer, Royal College of Physicians and Dr George Cowan

Career intentions

Professor Michael Goldacre, UK Medical Careers Research Group, spoke on career intentions and views of pre-registration house officers (PRHOs) from cohort studies. Data were collected from postal questionnaires sent to all UK medical qualifiers from certain years and at regular intervals thereafter, with response rates above 70%. Overall in 2003, more than 75% of doctors enjoyed their PRHO year, higher than in 2000 and 2001, with more satisfaction with time spent outside work. However, half of all 2003 PRHOs felt that their medical school training had ill-prepared them for their PRHO year. Less than 50% agreed with the statement 'My training as a PRHO was of a high standard'.

Male and female PRHOs in 2003 gave more favourable responses than those in previous years to a range of questions relating to general training and conditions of pay and work. Questions showing significant male/female difference ($p<0.001$) were 'I was sometimes unable to obtain a senior doctor's help when needed' (31% *v* 37%), 'The NHS remunerated me fairly for my basic hours' (60% *v* 67%) and 'Working conditions, eg food and accommodation, were good' (49% *v* 56%). These findings suggest that female PRHOs feel the need for greater senior support but are less critical regarding basic pay and work conditions.

Data from the past 30 years show a decline in popularity of general practice among men and a recent dramatic fall of male trainees in obstetrics and gynaecology. The percentages of men and women choosing a hospital-based medical specialty are now similar, although women remain a minority in surgical specialties. Factors influencing specialty choice are broadly similar at the end of the PRHO year among men and women but diverge later in training. Hours and working conditions were a major determinant at three years after qualifying on career choices, ranked by 84% of women and 78% of men seeking work as GPs as the major influence. UK-trained doctors from ethnic minority groups and graduate entrants had similar career choices to those of the main cohorts, although general practice and psychiatry were slightly less represented among non-white graduates and graduate entrants were more likely to seek a career in general practice.

Professor Goldacre confirmed the low attrition rate among doctors, dismissing the popular perception that a greater proportion of women than men leave the profession early. Among the 2002 cohort, 2.5% of men and 1.5% of women indicated they may leave medicine, and 18.2% of men and 18% of women said they may work overseas in medicine or take short breaks for domestic reasons.

Modernising medical careers

Professor Shelly Heard, Deputy London Dean and a member of the MCC team working on the operational framework for foundation programmes, outlined the career support that MCC would give junior doctors. The old system relied too much on serendipitous experiences and chance encounters. The Workforce Planning Review of 2000, Unfinished Business of 2002 and MMC of 2003 highlighted the need for improved career counselling and support early on and throughout medical training.

MMC would bring exposure to six different clinical specialties, including general practice, within the first two clinical years. By introducing individuals to shortage specialties, eg the pathologies, recruitment would, potentially, improve. Taster weeks for specialties not experienced previously would be introduced. Greater specialty exposure would help juniors to identify their clinical strengths. As part of MMC, foundation career directors would be appointed to coordinate career management delivery extending from school-leavers interested in a medical career through to doctors approaching retirement. This would help to align aspirations and aptitudes with future NHS medical workforce needs.

Career choice

Dr Simon Eccles spoke about career choices from a junior doctor's perspective. His career has included chairing the BMA Junior Doctors' Committee, working as a medical advisor to Hospital at Night, working with the DH on its information technology (IT) programme and acting as medical advisor to the Health Insight Unit. Dr Eccles felt that his career path to becoming a consultant in accident and emergency medicine was a result of chance rather than any specific career advice. In the past, limited exposure and access to skilled mentors during training in certain specialties has bred uncertainty. Postgraduate examinations such as MRCP, due to timing and being a pre-requisite for entry into a training programme, can deter and delay career options. Dr Eccles welcomed the MMC changes outlined by Professor Heard, particularly the shortened and focused training and provision of a greater breadth of specialty exposure in the early years. Trainees would be able to make choices based on what they enjoyed and were good at, thereby minimising wasted years and dissatisfaction and promoting shortage specialties.

Challenges for the newly appointed consultant

Dr Andrew Mooney, former Chair of the Royal College of Physicians (RCP) New Consultants Committee, spoke of the need for support for newly appointed consultants. The transition period from junior doctor to consultant was a 'quantum step' and, although there is an 87-page guide to foundation training, there is no guide to becoming a consultant. Dr Mooney asked whether new consultants/Certificate of Completion of Specialist Training holders were in danger of becoming the new 'lost tribes'. New consultants have new responsibilities and find themselves for the first time in charge of their own timetables. They need to appreciate the proportion of working hours required for non-clinical professional activities. A 2003 survey by the RCP New Consultants Committee showed this to be an average of 18.25 hours per week, spilt equally into management and education/research. Despite this, the new consultant contract is based on a ratio of 75% direct clinical care and 25% supporting professional activities. New consultants were, Dr Mooney said, ill prepared for their new management roles. Only 5% of junior training is devoted to what would become 20–25% of their final job. New consultants need guidance on subjects not covered in training, eg business- and job-planning, avoiding litigation, managing change, people, stress and time, and advising on support networks and communication. New consultants need to be taught how to access resources, resolve conflict and handle procedures relating to employment, selection and discipline. It is hoped that a new consultants' development programme and mentoring scheme will soon be available for all. The first intercollegiate conference of the New Consultant Committee will be held in 2006.

Medical management

Dr Sheila Peskett brought her own experience as a medical manager and professional mentor to give the last talk of the day by discussing how doctors should plan for their retirement. She stressed the importance of time for personal reflection and planning, whilst acknowledging that the pressured environment of clinical medicine does not encourage these activities. Individual careers follow a stepwise progression from initial education and training, through entry into the workplace and career progression, to final retirement. Often, however, there is a phase of disengagement before final retirement and knowing when to quit before this phase requires the individual to be proactive. Critical self-appraisal and stock-taking are essential. Regardless of the individual's present career, future decisions are made easier by critical analysis of personal motives, values and talents. Retirement should be a time to take opportunities both in and outside the workplace. Finally, when planning for retirement, it is helpful to involve the employing organisation so that it can plan for the employee's departure.

Discussion

The general discussions around the topics covered were remarkably consensual. Among the many eminent thinkers and shakers from the different parties represented in the audience, there was an acceptance that royal colleges, medical schools, postgraduate deaneries and the DH all have a role to play in ensuring that career development and support are provided throughout a professional clinical lifetime. Neither the NHS nor individual careers stand still; each needs to be managed in order to complement the other.