How do doctors choose their specialty: first love, arranged marriage or second time around? And how may an affair with MMC change this?

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ABSTRACT – Modernising Medical Careers (MMC) asks trainees to commit to their specialty sooner than ever before. There has been a great deal of good-quality research on the career intentions of doctors in training. It is time to review this data with MMC's changes in mind and reflect on how earlier enforced choice may affect trainees. There are distinct patterns to career choice: those who commit strongly and early; those who wait and commit later; and those who move on from previous career choices. The specialty is imperative for some that commit early. Those in this group who fail to be selected will need focused career support. Doctors who commit late are more likely to be affected by quality of life and flexibility. The present 'one size fits all' system does not reflect the natural history of present career selection and commitment to specialty.

KEY WORDS: careers, commit, Modernising Medical Careers

Introduction

The proposed changes to medical training have been designed to create specialists earlier. Non-training years have been removed and out-of-programme experience has not been emphasised. The net result of Modernising Medical Careers (MMC) will be to provide the UK with consultant-ready trainees at a younger age. This much is known and the controversies are well documented. An overlooked feature is that career choices will be made much earlier than ever before. This will occur halfway through the foundation year 2 (18 months into training). This paper aims to focus on published evidence to predict how this (and run-through training) may affect career choices and career progression.

Sir Liam Donaldson's report entitled *Unfinished business* provided the recommendations that founded MMC.[1] The document recognised the need for flexibility in that 'not everybody can or indeed wishes to make definitive career decisions early in their postgraduate training'. Nor should they be pressed into making premature decisions. Not only has this not been formally addressed, but ironically the swift and often changing implementation has meant that meaningful advice has been harder than ever to give.

When do doctors commit to their specialty?

The 1977 cohort of medical graduates were followed for 18 years and their career intentions and commitment separates them into three groups.[2]

Commit early

The first group contains mostly surgeons. Surgeons are born, not made. These individuals decided early: 84% of eventual surgeons knew their career path by the end of house jobs and a staggering 94% two years after that. This suggests quick, confident and decisive decision making; very much like the surgical stereotype. This is a group where those who succeeded to consultant posts did not need much careers advice but those who failed certainly did.

Commit over time

The second group consists of the other 10 specialties in the study. This group committed to their specialty mostly between years one and three, but a significant proportion (medicine 18%, oncology 17% and pathology 13%) decided later than year five after graduation. Interestingly, intention at the end of house jobs made a very poor prognostic indicator of future direction – a profound thought for any trainee. In surveys of why people leave certain specialties, their self-perceived aptitude is always ranked highly. A greater (and earlier) knowledge of self seems fundamental but presently unobtainable for young trainees. Foundation year assessments presently focus on becoming competent rather than identifying personal strengths.

Commit late

The third group includes radiology and accident and emergency (A&E). Not one eventual A&E practitioner considered this career at the end of house jobs and only 50% considered it after five years of

training. In radiology only 18% of consultant radiologists had this career aspiration during their house jobs. The future plans for these and many specialties will be competitive selection after a minimum of 18 months of training. Although A&E is a popular choice (2.6% of senior house officers (SHOs) presently plan a career there),[3] there is obviously a tradition of late bloomers arriving and staying in both specialties.

How would MMC change commitment levels?

Since the 1977 cohort there have been the changes of the specialist registrar (SpR) grade in the Calman reforms, in working hours, and in the greater proportion of female graduates. Presently, twice as many first year doctors wish to have a career in surgery and paediatrics than the proportion that presently practices there. More than any other specialty, previous experience of paediatrics was a feature that drove their ambition although there is a dropout rate of 56% between years one and 10.[4] The new generation of paediatricians may be aided by foundation training, which frequently includes paediatrics before career choice needs to be taken.

Commit early

Surgeons, once selected, would be unchanged by run-through training. The debate about reduction in training hours will not be entered into here. However the present data cannot predict what might happen if trainees were dissatisfied, and not able to leave any training system so readily.[2]

Surgeons who fail to be selected via this new recruitment process face significant disappointment. Those who chose surgery were more certain of their future intentions than any other group.[5] It is unclear whether today's trainees will be encouraged into non-consultant posts (fixed-term specialty training appointment and the 'yellow box' appointments).[6] There has been much concern that for some there will only be one opportunity to obtain a training post, compounded by the fear that this forced change of direction may lock them out of the system permanently. In 1975, 15% of graduates had surgery as their first choice,[7] this has now risen to 20% at the same stage,[5] and 16% in SHOs presently working.[3] In contrast, only 9.6% of all senior doctors are surgeons. Junior numbers are surprisingly difficult to estimate. However over 30,000 people applied via the Medical Training Application Service, 5,225 of them for specialty training (ST)1 (entry level SHO grade) in surgical specialties. There were over six applicants per post, resulting in a surplus of 4,000 applications and disappointing a minimum of 584 potential surgeons.[8]

Commit over time

Would this group benefit from better focused careers advice? Do they know what they want to become but commit later? Quality of life, flexibility and location are important here.[2,9] Of present trainees, 21% intend to train flexibly if possible.[10] The MMC training programme has stripped away a lot of this flexibility in terms of specific location. Now doctors apply to deaneries or coalesced deaneries known as Units of Application (UoA), rather than specific hospitals. So for example, if you had a child at a special needs nursery in Aberdeen, instead of applying directly to the local hospital, you would apply to the UoA (all of Scotland), which could place you in Aberdeen, but equally could place you in Glasgow, Wick or Dumfries.

Posts in MMC are a minimum of a year long, while previously there was more of a range. It was also possible to mix training and non-training opportunities to include overseas voluntary work, placements at centres of excellence outside the deaneries or even the experience of working in a complimentary specialty.

This group may get disillusioned. The inflexibility and forced early career choice will also mean that some will start to train in what will eventually be the incorrect specialty. The opportunity to compete again at entry level will have to be open, but this may lengthen training rather than shorten it (the original premise).

Commit late

The third group are in difficulty. Career direction for some may have been problematic in the late 1970s, as many specialties lacked a clear route for trainees. This has been remedied by MMC. Consultants here, however, all had experiences elsewhere prior to specialisation. This trend can become self-perpetuating as the new generation's role models may offer advice to choose late. Of the present group of radiologists, over 80% would have made eventually incorrect career choices if forced to commit earlier in their careers.

General practice

Modern graduates have less insight into the fact that 51% of senior (consultant grade) doctors are general practitioners (GPs). In 1977 61% of people who became a GP chose to do so in their first year.[2] In 2002 only 23% of people at the same stage had ambitions to be a GP, while in 2006 only 23% of all SHOs had similar plans.[3] Was there a shortfall in filling GP places when junior doctors were asked to decide earlier in 2007? Not at all, training in general practice remains highly prized and competitive.

Some trainees who foresaw the disruption of MMC decided that general practice was a better organised and more favourable route. In addition the new GP job plan, compared with increasing demands of the acute hospital take may have made GP training look increasingly attractive. Perhaps therefore GP training could inherit a group of doctors who do not feel ready to make a specialty choice and would prefer general training, or those who intend to move on and chose another training path later. It is interesting to note that general practice is the specialty least likely to be rejected by juniors after they have given it consideration.[9]

Summary

Mick Jagger said (and it has always been) 'you can't always get what you want': a desire to specialise in a field has never been a

guarantee of a career. Career advice should therefore be focused at those who fail to make the cut at ST1 and particularly ST3 levels. Greater flexibility, however, is needed for those who choose to change direction. Although it may be easier to plan and subsequently explain to graduates, the 'one size fits all' system of MMC cannot be recommended from the evidence concerning career choice and direction. Indeed why would we expect psychiatric and surgical trainees to need equal time to train at equivalent grades? The dichotomy of 'competency-based training' against a rigid MMC framework with a person specification seeking 'time spent in post' is yet to be resolved.

A metaphor

Surgeons fall in love with their childhood sweethearts. Many remain married for life. Anyone denied this union will run the risk of being under fulfilled. Unrequited surgeons need better advice and, if possible, need to be identified prior to commitment, which occurs as an undergraduate.

The second group have 'played the field' prior to commitment. Traditionally some have fallen into the right relationship early; others needed time to do so, with the occasional false start. This cohort will be coerced to do the decent thing and may start a lifelong relationship with their specialty after 18 months of work. Their choice of partner can be greatly affected by their current and future prospects. An arranged marriage here would suit some, but not all.

The third group have tried something different first; they would be people who find love in their second marriage. Forced or early union here would not benefit the trainee or speciality.

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