

Going to the dark side: clinicians, leadership and the Department of Health

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Background

In early 2007, I was nearing the end of three years as Clinical Vice President (CVP) at the Royal College of Physicians (RCP). Throughout my time at the RCP I had maintained specialist clinical work, and was looking forward to returning to an increased clinical commitment, as well as more time at home. I had previously served for seven years as Clinical Director of Medicine, and I had been asked to take on a second term. As a previous RCP Regional Advisor, I had a continuing interest in education and training in Wessex and had been appointed as Head of the School of Postgraduate Medicine to the Wessex Deanery. The future seemed clear.

Then, over one weekend in March 2007, as the interviews for Round 1 came out, confidence in the application system fell and then plummeted as the Medical Training Application Service (MTAS) crisis unfolded. The clinical advisors to Modernising Medical Careers (MMC) resigned, senior members of the profession engaged in damage limitation and the Douglas Review Group was set up to salvage recruitment and selection for specialty training posts for August 2007.¹ I received a request to talk to Martin Marshall, the Deputy Chief Medical Officer (DCMO), about the possibility of joining the MMC team as clinical advisor (Box 1). At that time, relationships between the profession and the Department of Health (DH) had become severely strained over the training reforms and the potentially catastrophic impact on the service and the careers of many junior doctors. The post of clinical advisor appeared to be a poisoned chalice, and many of the colleagues with whom I discussed this expressed significant reservations about the wisdom of such a move.

The Department of Health was seeking a clinician who could act as the interface between the department and the profession, providing advice and helping to restore confidence and rebuild relationships with clinical leaders and the wider medical profession. As one of the senior officers in the RCP, I had worked closely with many other medical royal colleges and faculties. The RCP holds joint council meetings with the Royal College of Surgeons and the Royal College of General Practitioners, and meets regularly with senior officers from other colleges.

Through the Medical Specialties Board and RCP Council, as well as my work in developing specialist recertification, I knew many of the Specialty Association Presidents and the Chairs of the Joint Specialist Committees. As CVP, I attended most regional updates, when, at the open forum, we would listen and respond to the concerns and questions from Fellows and Members. Through membership of the College Trainees' Committee and the New Consultants' Committee, I had heard many of the difficulties in service and training. After reflection, I believed that the role of CVP had given me an excellent preparation to try to undertake the role offered by the DH. I saw the post as a challenge and an opportunity to influence future policy and improve medical training. I was encouraged by support from within the RCP, although the parting words of the President, following my appointment, were 'Don't go native!'

Working in the Department of Health

I have now been on secondment to the DH for just over a year. Despite the dark warnings I received, I have seen no evidence of conspiracies against clinicians or Machiavellian plots to dumb down medicine or medical training. I am working with hardworking, intelligent teams, just as I do in my clinical practice, and the goal of civil servants is no different to that of clinicians; we are united in wanting confidence that we can select and train future generations of doctors to deliver the best possible care to patients.

The problems that led to the MTAS crisis have been subjected to rigorous reviews and in-depth inquiries.^{1,2,3} Despite some continuing expressions of 'it wasn't broken, so why try to fix it?' it is important to

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Clin Med
2008;8:589-91

Box 1. Job description for Clinical Advisor to Modernising Medical Careers (MMC).

- 1 The provision of advice from the clinician's perspective on the reforms that the MMC programme proposes to introduce from time to time.
- 2 Engage effectively with programme stakeholders and team members.
- 3 Provide written submissions to the MMC Programme Board and senior management team on issues related to MMC reforms.

remember that there were significant problems in the training and the career pathways for doctors before the reforms. In the 'good old days' doctors worked long hours, making multiple applications for posts and moving frequently with career uncertainty over many years. Trusts might receive hundreds of applications for a six-month post and selection processes were not perceived as transparent. There were no formal specialty curricula or formal assessments of increasing clinical proficiency.

These difficulties led to progressive reforms to improve and modernise training for doctors, starting with the Calman unification of the registrar and senior registrar grade, and the establishment of curricula and formal structured educational requirements. In 2002, the Chief Medical Officer (CMO) Sir Liam Donaldson highlighted the continuing problems for those in senior house officer (SHO) grades in his report *Unfinished business*.⁴ The principles behind developing new policies to improve training for 'the lost tribe' of SHOs (consistent national standards for training and assessments, structured curricula and a transparent selection process) received widespread support from the profession. However, two of the fundamental principles in the CMO's first report, those of broad-based initial training and flexibility, were lost in translation in the second report *The next steps*,⁵ with the concept of run-through training (RTT) which combines basic and higher specialist training into a single specialty training grade. Although many now argue (including myself) that RTT is not appropriate for all specialties, it did receive strong support from some stakeholders, including the British Medical Association's (BMA) Junior Doctors' Committee and a significant number of royal colleges.

The inflexibility and unsuitability of the RTT structure for some specialties was only one problem. Although 2,000 additional training places were made available in 2007 compared with 2006, the very attractive offer of a training post guaranteed to run through to a Certificate of Completion of Training (CCT) (subject to satisfactory progression) triggered over 30,000 applications for around 15,000 training posts. The conflict between two opposing policies, that of self-sufficiency (increase in UK medical student numbers with four new medical schools and substantial expansion and investment in existing medical schools) against the policy of open borders (encouraging able applicants from all round the world) was made explicit. Indeed the UK has relied on and valued the contribution of international medical graduates (IMGs) over decades and the realisation of direct competition for a limited number of training posts was uncomfortable for many clinicians.

The security breaches and the slow running of the MTAS system under the burden of the very high number of applications contributed to increasing anxiety from consultants and junior doctors alike. Furthermore, although the application form proved highly reproducible (with 6% of the applicants receiving four invitations to interview), it was clearly not appropriate for the different levels of training posts or different specialties. There was an excess of non-discriminatory 'white space' and too little emphasis and credit for academic achievements and experience. In retrospect there were too many changes too quickly including:

- changes to the selection process
- lack of piloting of the computerised application system
- changes to the structure of postgraduate medical education and training
- insufficient planning for the transition.

How have we got back on track?

Martin Marshall proved an inspirational, if transient, leader setting up the MMC England Programme Board in July 2007. The board reviewed the principles underpinning the reforms, and reaffirmed and strengthened them, reiterating the commitment to flexibility in training and to broad-based programmes where appropriate. The purpose of the board, however, is not in agreeing principles, but in strengthening the governance and in bringing together the key stakeholders to find solutions. The board is co-chaired by a representative from the Academy of Medical Royal Colleges (AoMRC) and by the Senior Responsible Owner for MMC. There are five college presidents on the board, plus representatives from NHS Employers, Postgraduate Deans, the BMA, academic medicine, hospital trusts and strategic health authorities. Trainees are well represented, clinicians are in the majority, and DH representatives, of which I am one, are in a minority.

The board has worked at a detailed operational level over the first year, as well as at a strategic level, and its strength has been the collaborative working between DH and all the other stakeholders. Consultations have been as wide as possible before recommendations have been made to ministers, and to date all recommendations have been accepted. The board had particular concerns regarding opportunities to enter specialty training at higher levels (ST3 and ST4) and funding was secured for 215 additional ST3 training posts in 2007 and 165 additional ST3 posts in 2008 to support those experienced trainees caught in transition. We have worked with postgraduate deans to maximise the training opportunities at every level, and the Home Office has introduced changes to the immigration rules which will give preference to UK and European Economic Area graduates in the future. Foundation programme and general practitioner recruitment had worked well, and a national system with a single application supported by information technology (IT) has continued. Most specialties recruited at deanery level occurred with no national IT, but there was some centralised recruitment led by deaneries or by royal colleges. Following the success of the Royal College of Obstetricians and Gynaecologists and Royal College of Paediatrics and Child Health in leading centralised recruitment other colleges, including the RCP, have expressed an interest in developing a national system, in partnership with deaneries.

Recruitment and selection have dominated the agenda, but MMC addresses many other important aspects of training. The final structure of postgraduate medical education has yet to be decided but, following extensive consultation, the 'mixed economy' of training offers to applicants was agreed for 2008, and will continue until NHS Medical Education England (NHS MEE) agrees the final model. It was clear that some specialties and colleges had benefited from RTT and wished to continue with these

offers (eg obstetrics and gynaecology, paediatrics and child health and some surgical specialties such as neurosurgery). Others, like the RCP, believe that recruitment into core medical training followed by a further competitive selection into higher specialty training, suits their specialty better. This has been termed 'uncoupling' of core from higher training posts. One size does not fit all, and it is important that specialties have the flexibility to decide which model best suits their training.

The future

There remain many decisions for the future. Both the Tooke Inquiry and the Health Committee report emphasised the need for consensus and for the profession to find a way of speaking with one voice.^{2,3} Yet there remain disagreements in some key areas. The Tooke Inquiry recommended uncoupling for all specialties, with the abolition of RTT and the second year of foundation programme training, but some colleges wish to retain RTT and significant numbers of stakeholders value the two-year foundation programme. The Health Committee report recommended retaining the mixed economy of offers and the two-year foundation programme, and advised that the programme board should be further strengthened, rather than establishing NHS MEE, as recommended by Tooke.

Lord Darzi addressed these dilemmas in his *Next stage review* final reports.^{6,7} He recommended the establishment of NHS MEE by the end of 2008. This new independent body will commission a formal evaluation of the foundation programme and will develop and agree the final structure of postgraduate medical education and training over the next three years. In the interim, the mixed economy of offers will continue. He notes that the clarity required by Sir John Tooke on the role of the doctor is being addressed by joint work between the Medical Schools Council, the AoMRC, NHS Employers and the BMA. He also charges NHS MEE with developing modular credentialing, with formal accreditation of competence at defined points in a career pathway. This will improve flexibility for clinicians and employers, as well as providing patients with the reassurance they need that their doctors are certified as competent for the level of service that they deliver. This work will be a significant challenge for the colleges and one which we must take forward. He also charges NHS MEE with the responsibility of developing better and more robust methodologies for selection and again colleges will have a big role to play here.

The challenge for the profession

We do not escape criticism in the formal investigations into the problems of 2007. In particular, it is clear that the profession's

engagement was patchy and insufficiently robust. Furthermore, both the Tooke Inquiry and the Health Select Committee note that the profession is frequently not united thus weakening our ability to advise effectively and to influence policy.^{2,3} When there are difficulties, we tend to retreat to our own constituencies. The Health Select Committee Report recommends that the AoMRC must find a way of making decisions on behalf of all royal colleges, and Tooke recommends that the profession must develop a mechanism for providing coherent advice on matters that affect the entire profession. We have failed in the past to provide career advice to our trainees, allowing some to spend many years trying to gain access into highly competitive specialties with little chance of career progression. The problems of 2007 represent an opportunity for the profession to work more effectively in the future, with each other and with the DH, in order to contribute to the development of future reforms and new policies. Those of us who bridge the gap between the two play a part in facilitating this.

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