

# MODERNISING MEDICAL CAREERS

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## What is Modernising Medical Careers?

Modernising Medical Careers (MMC) is the name for a couple of major changes in the way doctors are trained. These are, the introduction of the Foundation Programme and the merger of senior house officers (SHOs) into specialist registrars (SpRs) to form run-through training. The Foundation Programme is a replacement for the old pre-registration house officer posts and is made up of six four-month blocks. The first year has to include medicine, surgery and another hospital specialty. The second year will always include general practitioner (GP), with the other two posts being mainly conventional hospital SHO posts but including some innovative posts in pathology or research.

Run-through training involves linking SHO posts to the existing SpR posts. For example, if at the moment training was normally two years as an SHO followed by five years as an SpR, people will enter a seven-year programme as a specialty trainee.

## So people within two years of qualification will be committed to a specialty for the rest of their life?

That is pretty much what is going to happen. It is very different from the days when people could spend as long as they wanted trying different SHO jobs until they hit on a specialty they liked. Many people have said that it is too early for people to make such an important choice. There are a number of contrary arguments to this, one is that in the United States there is no Foundation or Pre-Registration Programme and people apply from medical school straight into specialty training. The other point is that there is now a lot of careers support for foundation doctors.

The Deanery has invested in 'Windmills' skills cards, a career workbook package from Medical Forum, and SCI 45, which is a computer programme that suggests specialty choices based on your preferences. The foundation doctors will have had experience in four or five different specialties by the time they get to the point of application. They also have taster weeks using some of their study leave to get experience in some of the specialties which have not been provided on their Foundation Programme. This is a massive increase in the amount of career guidance and support over the negligible quantity that was provided in the old days and it is hoped that this will compensate for the need to make a decision earlier.

## Why are so many junior doctors up in arms about the change?

One way of looking at it is to say that the ten years of career uncertainty faced by trainees of my generation have now been condensed into about ten months. The specialty application process is going to feel as though they are playing for very high stakes compared with the multiple opportunities to get into training that were present in the previous system.

The other issue is that the number of SHOs at present relate mostly to service needs and the political power of the various specialties and does not relate at all closely to likely training opportunities. For example, in surgery in the North West, 40 people are currently given entry to specialist training as SpRs. On the basis of spending two years as an SHO, it would need 80 surgical SHOs to feed into that – the North West possesses 380. The only way of resolving this situation is that some people spend a very long time as an SHO before getting into specialist training and some will never make it!

Under the new system people will discover during their second foundation year whether they have the realistic prospect of becoming a consultant or not. It is worth remembering that the bottleneck to the consultant grade has always been SpR appointment, while that to GP has always been GP registrar posts. There is no reduction in these posts and so this year's cohort have as good a chance of getting into their favoured career as any other cohort. The difference is they will no longer be able to delude themselves for a period of years that they will get where they want to go.

## How will the application process be managed?

The entire application process is electronic. At the time of writing we are half way through the fortnight in which the web site will be open for applications. Trainees can apply for four posts; this can be one specialty in four deaneries, two specialties in two, or four specialties in one deanery. GP is managed slightly differently in that they already have a national application system. So if you want to apply for GP, it only counts as one choice but there will be a clearing system that could lead you to ending up somewhere else.

The application includes some general material and some which is specialty specific. If you apply for several specialties, those short listing will not know what else you have applied for, so you can tweak your application to demonstrate your total commitment to both community paediatrics and cardiothoracic surgery.

References will also be electronic – if you don't have an email address you can't be a referee.

## What will happen to the people who don't get into their first choice specialty and what will happen to the SHO posts that are in excess of those needed for run-through training?

The SHO posts could go into one of five things. They can go into run-through training, fixed term specialty training (FTST) posts, foundation posts, GP schemes or they can disappear. The reason some will go into GP schemes is that there will be no more self-construct GP schemes anymore. Quite a lot of people entering GP were never on a formal VTS but did their own thing. This will no longer be possible and so the number of GP VTSSs has to be increased to accommodate them. Clearly, some SHO jobs lend themselves

more readily to GP training than others. SHO posts left after dividing up between specialty training, GP and foundation will be called FTST posts. They will last a year and may have

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the potential to be renewed for a second year but for no longer. Someone very committed to training in a specialty that was unable to get into a specialty training programme, would occupy an FTST

post where they would be a reserve and plug any gaps that open up in specialist training – if any one changes their mind or emigrates. Apart from plugging these gaps there is no career path and the intention would be that if at the end of the first year as an FTST no vacancies in your first choice specialty had appeared, you would then apply for run through training in a second choice specialty.

**How many doctors will get their chosen specialty? Are there going to be lots of round pegs in square holes?**

There isn't much information to guide us here. Most people have a rough idea which specialties are attractive to our local graduates and which are not but nobody really knows why. For example, virtually no United Kingdom graduates enter training in obstetrics and gynaecology and there is a big short fall in psychiatry and pathology too. Doctors will be making a decision on whether to apply for their first choice specialty in four deaneries or whether to put a safety net in of their second choice specialty somewhere. They will also have to decide whether or not to be considered for an FTST (there is a box to tick to say whether or not they would wish to be considered for this). If they are told at the end of the first round that they have not been successful in getting into run-through training, then they will be asked if they want to do an FTST post. At that time they will also be given information about what unfilled speciality training posts there are around the country. That means that if they applied for a competitive specialty in four popular deaneries, they will be able to choose between doing an FTST in their first choice region and applying for run through training in the second round in other deaneries that haven't filled up with applicants. If they

don't fancy an FTST and there are very few places left nationally they can apply for different specialties in the second round.

At the moment we simply have no idea what kind of 'tactical voting' junior doctors will make. It has been compared to a casino but I think a better analogy is the stock market, in which thousands of highly intelligent and strongly motivated individuals are trying to guess about what thousands of other similar people will be deciding to do.

**What does it mean for those of us that aren't applying for this programme?**

The major impact on most of us is going to be the enormous potential for chaos on the 1st August 2007. I think this has far more potential to destabilise the NHS than the dreaded millennium bug, which turned out to be such a damp squib. Lancaster will have approximately 120 new doctors starting on site that day as every SHO and registrar in the country rotates simultaneously. The only doctors remaining within a given hospital will be those moving on from F1 to F2 and those entering the second year of a GP training scheme. In my view urgent action is now necessary. At the time of going to press, annual leave will already have been booked by a substantial number of senior and permanent staff. A moratorium on further staff absence is now appropriate. Those that are left will need to keep the clinical service going and run induction days for all the various grades that are starting in their departments. There will be a major strain on the Human Resources and Occupational Health departments that day. The Trust is putting a fair bit of planning into this but there is still plenty more to be done.

**Editorial Comment**

*Harold Wilson's famous statement 'A week is a long time in politics' applies to the business of 'modernising' medical careers also. The editor is pleased to see the Clinical Tutor defending the new system with considerable eloquence and tenacity. We will have more news on MMC in the next issue.*

*See letter on page 127.*