MMC AND MTAS

What's going on?

David Burch, Clinical Tutor

The room signed 'Dining Room C' in the restaurant of the Royal Lancaster Infirmary is a quiet place to go for lunch. If David Burch is there, lunch is also the opportunity to hear his views on the controversial medical training application service (MTAS) for selecting postgraduate medical trainees for hospital careers. So much adverse publicity has been highlighted in the national press and media that one can be forgiven for thinking that the system is in total chaos, that all the predictors of doom are justified in their anxieties. David does not share these views, although he is diplomatic enough to recognise that the system has needed and will continue to need help with its evolution. The *Journal* compiled its list of 'FAQ' from conversations that various people have had with David over the year: the publication of this edition coincides with the deadline of August 1st, which he had previously suspected would be a date for chaos and confusion. If your planned annual leave or lunch has been cancelled, it is worth reading a characteristically robust defence. An optimist might consider that University Hospitals of Morecambe Bay have got away lightly in modernising medical careers (MMC).

At the time of writing, round one of specialty and GP recruitment is coming to an end and offers are being given out. By the time you read this, round one will be completed. The prediction is that about 80% of jobs will be filled on round one, probably all the run-through training posts in popular specialties will be gone and only fixed term specialty training (FTST) will be left. However, there will probably be some run-through training posts in the less popular specialties, such as obstetrics and gynaecology, or psychiatry.

Round two will be managed at the level of the deanery rather than nationally. However, the jobs will be advertised through the NHS jobs website. It is thought that the closing dates for applications for a lot of these jobs will be very short with some jobs only being available for 72 hours. This is because without a national system there is the potential for every doctor to apply for every job. Some people may have accepted an FTST in round one; they will be able to apply for run-through training in a different specialty in round two. It is quite likely that people will not be appointed to jobs in round two in time to start work on the 1st of August. This means that there will be unfilled jobs as well as unemployed doctors in August. The original prediction was that virtually every doctor in the country would be rotating on the 1st of August; it is now clear that a proportion will not. Unfortunately, it is by no means clear that for any individual trust the unemployed doctors will be in the same specialty as the unfilled posts. Where possible, of course, people will be kept on until the end of round two.

How many unemployed doctors will there be?

The Department of Health believes that there are currently 6,000 unemployed doctors, either those who have come to the United Kingdom with the Professional and Linguistic Assessment Board (PLAB) qualification and are currently doing clinical attachments, or those looking for work. If that figure is correct then there will necessarily be at least 6,000 unemployed doctors in August 2007. Furthermore, some trusts have a number of non-standard trust grade posts at SHO level. There are very few in Morecambe Bay, but some hospitals have a lot. All the doctors in these posts will be applying into specialty training and some will be successful; this means that they will resign the trust doctor posts and these will then come onto the market to be opportunities for the doctors who would otherwise be unemployed.

Another factor that has come up at the specialty training interviews is that some of the candidates did extremely poorly and were marked as unappointable by the assessors. Most of these will be doctors who have come from overseas and never been successful in finding work in the NHS. This means that they both lack familiarity with the NHS and have lost clinical skills through a period of being away from work.

Why did things go so badly wrong?

The short answer is that the government tried to introduce too many changes too quickly. It is not entirely fair to say that the profession was not consulted at all. There were, after all, plenty of Deans and other professional medical educators on the various MMC bodies, but the rate at which the changes were introduced was so fast that before doctors had a chance to comment on one plan it was superseded by another.

To get to the detail, the problems relate to selection for hospital specialty training. The situation for general practice seems to have run much more smoothly. There are several reasons for this:

- they have had a centralised system much longer
- their short listing was carried out in exam conditions using a machine-markable test – more of these later
- the actual structure of general practitioner training is not contentious

None of these applied to the hospital specialties. This is because there is still disagreement about whether it is appropriate to have a seven-year run-through training programme for hospital specialties. The main problems are that it is impossible to guess manpower needs seven years ahead and that it may be very difficult for trainees to choose a specialty after only eighteen months of foundation training, but particularly that it is extremely difficult to think of any sensible way of selecting people for the various specialties. Earlier in the evolution of MMC it was suggested that there might be a year or two of core training for each of, say, eight major specialties, ie medicine, surgery, anaesthesia, paediatrics, obstetrics and gynaecology, etc, followed by a further competitive interview for the next five years or so. This second selection process would be informed by the doctor's performance as a basic specialty trainee. This model offered the further advantage that it could adapt to doctors who progressed at a different speed of gaining practical

skills. It could be possible for somebody who has acquired the skills necessary to function as a registrar on call to progress at that point, whether that be after one, two or three years. Anyhow, this model was rejected in favour of a seven-year run through. It is for this reason that the Royal College of Surgeons has walked away from the review into the MMC process.

What about the dreaded 'white space' application forms?
I think it's fair to say that this method of short listing is now totally discredited. I think they were introduced with the best of motives, in so far as they are just formalising the sorts of questions that tend to be asked at interview. However, asking the questions at interview means we get the candidate's response, not one they have paid an agency for. The MMC team ran anti-plagiarism software over these applications; they detected virtually no cases of plagiarism, but did find the same stories coming up time and again. I don't think they had realised that doctors are clever enough to throw in a few changes of detail when they pinch other people's ideas.

What's wrong with CVs for short listing?
The value of CV as a short listing tool is directly proportional to the seniority of the post. No-one in their senses would contemplate short listing for a consultant job by any means other than CV. However, the CV has already been removed from application for foundation posts because it offers no way of discriminating between those outside the top 5 or 10% academically at medical school. The same problem would apply for using CVs for short listing into run-through training straight from foundation. Using CVs for short listing would mean you would get an interview if you had done three audits but not if you'd done two. I don't know anyone who thinks this would be any use as a method. Clearly the MMC team would have managed the transition a lot better by piloting a new method of short listing for the foundation doctors applying into ST1 while allowing the deaneries to use CVs to short list for ST2 and 3. The often-heard criticism that doctors' experience and qualifications were ignored in the appointments system is, of course, invalid since the entry criteria for each level of specialty training did relate to years of experience and exam passes. Clearly, it would not have been sensible to allow a very experienced SHO to compete at ST1 level simply so they would gain more points on their application from their years of experience.

So, shouldn't we go back to the old way of doing things?
We need to remember that the big problem in selection to specialty training isn't the interview stage, it's the short listing. The interviews have been run as several stations, each testing a different aspect of a doctor's ability; for example, in obstetrics and gynaecology there was a station using a handover list of problem patients to check the doctor's vigilance and ability to prioritise and delegate, there was a communications skills station where they had to break bad news, and there was a portfolio review and discussion section. Most of those who took part regarded this as a perfectly valid way of selecting people. Other specialties did very similar things.

So, if we know how to interview but don't know how to short list why not interview everybody?
This is the main argument for some degree of centralisation. Imagine the country possesses 100 ST1 posts in a given specialty, and 150 foundation doctors would like to apply. If each trust advertised separately the first wave would each receive 150 applications. You could not interview 150 people for one job, so you would be compelled to short list. Neither CV nor 'white space' forms would be of any use for this, and you might as well just take the first five to come. However, if the trusts pooled their resources and advertised in blocks the excess of applicants over posts would not be so great and it would be possible to do far more rigorous assessment on everybody, which would be a much more certain method of getting the best candidate into that specialty. It is ironic that the MTAS system has been called a lottery. The old system was a lottery; for example, I got my registrar job at Addenbrooke's in competition with an extremely weak field of doctors far less able than myself, not due to any brilliance on my part but because every London teaching hospital had interviewed the preceding week, thus the very strong competitors who might otherwise have gone to Cambridge had all been removed from the pool with which I was competing.

How will we be selecting into specialty training for 2008?
This is a huge problem. By the time round two is over, the dust has settled and the review of MMC has reported we will need to recruit. My guess is that since the only bit of this year's recruitment that worked was general practice the hospital specialists will follow suit. If this prediction is correct, we will see hordes of junior doctors trooping off on various Saturdays early in the New Year to sit tests for the specialties they wish to enter.

What will these tests look like?
I predict these test will all be machine markable. They won't be straightforward multiple choice question (MCQ) tests, which are really only any use as a test of factual knowledge. They're more likely to be extended matching questions (EMQs). You will get an idea of the sort of thing on offer if you type 'situational judgement tests' into Google®. Most of the top hits on this don't relate to medicine. They could also be machine-markable clinical problem solving tests. This is likely to be the short listing tool for the future. Interviews probably don't need to change much, although various refinements may be introduced over time. Apparently, an exercise where the applicant has to telephone a consultant requesting advice with a difficult case is a good method.

Will there be tests for dexterity for those entering procedure-type specialties?
The literature suggests that it is possible to select out the bottom 10% of doctors as lacking the dexterity to enable them to enter a procedure-based specialty. There isn't any evidence that the tests are any more discriminatory than that, ie they don't allow us to rank candidates so we can confidently appoint, for example, the top 20 or 30%.

Aren't we just reinventing the postgraduate examinations that junior doctors already take?
No. Firstly, selection is about predicting potential rather than measuring achievement. Secondly, a conventional exam is about ensuring somebody has reached a minimum standard to enable them to do something, ie to qualify as a doctor, to become a member of a Royal College or to pass their driving test. These sorts of things do not set out to rank people, which is the whole point of selection; after all, in a competitive specialty many highly competent doctors would be turned away.

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Entry Criteria

Career Progression*Will you have completed less than 12 months' experience (at SHO level) in this specialty by August 2007 (not including Foundation modules)? Yes No

If necessary, please explain how you meet the above criterion/criteria for application at this level of entry. (Only complete this box if the information is not clear from your employment history.)

75 remaining words

Selection Criteria

Commitment to the Specialty*A1 Why are you motivated to pursue a career in this specialty? In what way are you able to demonstrate that your own skills and attributes are suitable for a career in this specialty?

150 remaining words

*A2 What plan have you followed to develop your understanding of this specialty? How have your actions developed your insight into this specialty? 150 remaining words

*A3 Provide evidence of activities/achievements over and above your regular scheduled daily activities that demonstrate your personal commitment to the specialty (or development of relevant skills). Indicate date and place relating to the evidence. 150 remaining words

Clinical or Technical, Academic & Research Skills*B1 Describe a situation when applying your clinical judgement had a significant impact on patient health. What did you do and how did your judgement contribute to patient health? 150 remaining words

*B2 Describe your understanding of the importance of medical research to a trainee doctor. You may use examples to illustrate your answer, either from your own experience or from publications if you have not had the opportunity to be involved in research. 150 remaining words

Please provide evidence of your undergraduate and/or postgraduate academic and research achievements under the following headings (where appropriate).

B3 Additional Qualifications

You may include details of up to 5 additional qualifications in this section, e.g. PhD, research degree (state class of degree awarded). Please include here any relevant qualifications listed as desirable on the person specification.

Qualification/Examination	Awarding Body	Date passed (mm/yyyy)

B4 Prizes, awards and other distinctions

Prize	Awarding Body	Date awarded (mm/yyyy)

B5 Publications, presentations/posters at conferences (shortlisted candidates will be asked to bring copies of all abstracts and publications to the interview) 150 remaining words

*B6 What experience of delivering teaching do you have? 150 remaining words

*B7 What experience of clinical audit have you had? Please state when and where and clearly indicate your level of involvement. 150 remaining words

Personal Skills

A range of personal skills have been identified as important for this specialty. For each of the questions below, please give an example (preferably recent) from your own experience to illustrate how you dealt with particular situations. You may draw your experiences from work or other activities (unless otherwise specified).

*C1 Describe a time when you have had to explain a complex term or procedure to someone. What were the main challenges and the strategies you used? 150 remaining words

*C2 Give an example of a time when management of a patient was complex. What strategies did you use to identify an appropriate solution? How effective were these strategies? 150 remaining words

*C3 Describe a recent example of when you have worked as part of a team with other professionals to achieve a specific objective. What approach did you take and how did your actions influence the outcome? 150 remaining words

Probity*D1 Provide a specific example of a work situation where professional integrity was required on your part. What approach did you take and how did your actions demonstrate integrity? 150 remaining words

Next Steps

You now need to move onto the next stage of the application form.

To leave this page without saving any changes click "Cancel". your details will not be saved.

cancel

To save any changes you have made to this section of the application form click the "Save" button. You are then free to continue with the other sections of this form, or to return to it at a later date.

save

To submit your application you need to move to the submit page. Please note that before submission you must ensure that all areas of the application form have been completed.

An example of the discredited 'dreaded white space' application form

What about all the assessments the foundation doctors do? Why can't they be used for selection into specialty training?
When the foundation assessments were brought in they were primarily intended to develop doctors. The observed clinical encounters can be regarded as a master class in medicine in which a senior person offers hints and tips for improvement. This is totally different from assessment, on which a person's future career progress may depend. Industry has studied tying pay and promotion to appraisal and has found it alters the whole validity of it. I think we can discount using the foundation assessments for selection to specialty training.

What other changes ought to be made for 2008?
The 'white space' questionnaires used were poor at discriminating between better and worse candidates. However, they were pretty reproducible. The problem with this is that it meant that lots of people had four interviews and lots had none. Since on average there were two interviews for every post the effect tended to be that the top scoring 50% each had four interviews and the bottom scoring 50% had none. It meant that three quarters of the interviews were a waste of time since the candidate would be appointed elsewhere and that the system would be incapable of filling more than half of the posts. The MMC team has never stated whether this was their intention or whether it was wholly unexpected. They may have felt happy to only fill half the posts in the first round and felt that this would provide information about competition ratios to the unsuccessful candidates and allow them to choose different careers. However, the volume of protest was such that the review group allowed everyone an interview in their first choice specialty and deanery. This, of course, took a great deal more deanery and consultant time into the second wave of interviews. I don't think consultants would be prepared to work like this again and the only way out of it is to limit the number of interviews that are necessary. This could be done by limiting the choice available to junior doctors, but they would probably find that unacceptable. However, general practice only allowed applicants to apply to a single unit of application, but said that if they were unsuccessful by a narrow margin their application would be considered elsewhere in a kind of internal clearing system. I suspect other specialties will do this too. The other great advantage of the machine-markable specialty-specific tests is that since they aren't labour intensive of consultant time to mark the foundation doctors could sit as many of the tests as they liked. These scores would then inform selection into the much more labour intensive interview process.

Apart from fire fighting the problems caused by specialty selection what else is happening?
The other changes we will need to make as MMC comes in relate to departmental teaching programmes. I'd like to start a debate on these programmes now. They serve a number of purposes:

- junior doctors new to a specialty need training in the clinical and other skills that they will need to exercise in their work and to this extent the departmental meetings can be seen as a continuation of the induction programme
- departmental meetings are valued by the junior doctors as preparation for postgraduate examinations
- they are an opportunity to practice presentation skills
- they are a forum in which a department can meet and sort out any problems that are going on

There may be other reasons for having these meetings as well, not least that deans, colleges, etc expect us to have them.

We do need to put some thought into how we run the departmental meetings though, as the composition of our junior medical staff evolves. For example, in the Lancaster department of obstetrics and gynaecology of our seven SHOs, four are on the general practice scheme, two are in the second year of foundation and one will be a specialty trainee (I hope one will emerge from the appointments system). We already have a very well-thought-of educational programme for the general practice trainees and for the foundation doctors. The assumption is that the specialty trainees will also have some sort of regional or sub-regional teaching programme. If we are releasing trainees for these various programmes, how often do we need to run one in our department? If we do run a cycle of educational meetings, what do we do about the fact that the general practice trainees will rotate every six months and the foundation doctors every four months? If one of our objectives is to prepare our general practice trainees for the DRCOG examination, is a weekly or fortnightly session interrupted by annual leave and night shifts the right way to do it? Perhaps, online or distance learning is the way to prepare for an exam. If our objective is to teach our trainees the skills that they need to function as an SHO in obstetrics and gynaecology from a clinical governance point of view maybe what they need is weekly teaching obstetrics and gynaecology for the first two months of the post without attending general practice training, then once they are up to speed as a clinician in the department they could go to the general practice teaching every week and we could stop running a departmental meeting.

These are the issues in the Tutor's own specialty, Obstetrics and Gynaecology. The Journal *is pleased to contribute to the debate on any matters to do with MMC or MTAS. Please send your contributions to the editor.*