ROYAL COLLEGE of PHYSICIANS of EDINBURGH

Is Generation Z another generation lost?

Defining RCPE priorities for improving the experience and quality of PGME

Executive Summary

As we enter a new training year, and in the context of the recent GMC National Training Survey reports, the Leng report, recruitment crises and industrial action, there is an urgent need for a genuine and meaningful focus on medical training to avoid creating the next Lost Generation of medical doctors and to assure high standards of patient care. The College has defined its training priorities for the coming year and lays out the following key areas for attention:

- Recruitment, ensuring equitable opportunities for progression through training and beyond and at every stage, improved service and workforce planning in conjunction with all key partners, addressing of rota gaps and consideration of the impact on international medical graduate colleagues to support fair access and transparent processes

- Prioritisation of time for training for trainers as well as residents, including robust job planning, recognition of the value of trainers, and implications of the development of MAP scope and standards

- Costs of training, including study leave budgets and employer support, backlogs in Portfolio Pathway (previously CESR) reviews, and Widening Access in Medicine

- Rotational training, recognising the need for better balance and flexibility and for collaboration with stakeholders to support the workforce and thus delivery of patient care across varied geographies

Introduction

Since the "lost tribe" of Senior House Officers was first defined in1993[1] there have been multiple attempts to reform medical education, from the introduction of competency-based training with MMC (Modernising Medical Careers) and the challenges of MTAS (Medical Training Application Service) to the more recent Shape of Training developments resulting in the introduction of Internal Medicine Training.

However, the recent experience of resident doctors, described in the GMC National Training Survey (NTS)[2] results, further industrial action and feedback in social media and beyond, reflects growing dissatisfaction, disillusionment and at times despair that suggest the unintentional but critically important development of a similar new "lost tribe", this time of Generation Z doctors - a potential new Lost Generation. Bottlenecks in career progression, pay erosion, rota gaps, the development of roles undertaken by other healthcare professionals, loss of confidence in examination results and other factors are contributing to poor morale. None of us wishes this for our colleagues and future healthcare leaders.

These challenges come at a time when training is more competitive and demanding than ever. From entrance to university through to higher qualification, the journey carries significant costs, both financial and personal. Throughout their years of training, resident doctors deliver critically important care in an NHS that is more demanding and complex than previously seen. There are more patients, and these patients are older, sicker, more comorbid, more complex, and have different expectations of the care they wish to receive. The intensity of delivering medicine has steadily increased as a result. In parallel, residents must progress through postgraduate curricula, meet training requirements, participate in regular reviews of competence, and complete challenging and high stakes gold-standard postgraduate examinations, to assure that the highest standards of training and patient care are upheld. It should therefore be no surprise that the GMC NTS describes high rates of burnout risk amongst residents and trainers.

The NHS is respected throughout the world for the standard of care it provides, defined and delivered by its multidisciplinary workforce, and resident doctors are a critical part of that workforce. For the NHS to survive and to address the concerns of our resident doctor colleagues and future consultant workforce, we describe the need for urgent attention to medical training, with key areas of focus as follows.

Recruitment and rota gaps: a double-edged sword

Over a quarter of resident doctors in the 2025 GMC NTS report that their training is affected by rota gaps, data closely corroborated by trainer feedback. 26% of resident doctors and 29% of trainers said that training was adversely affected because rota gaps were not appropriately managed (28% and 35% respectively in Scotland).

As well as eroding opportunities for training, rota gaps carry direct risks for patient safety in healthcare systems that are generally resourced to meet minimum requirements rather than to operate with the necessary additional capacity (and hence redundancy) to safely accommodate daily fluctuations in patient numbers, emergencies and sickness absence.

Rota gaps and the perception of increasing staffing challenges are difficult to defend both in terms of patient safety and quality of training, although reflect public sector financial constraints. These are increasingly seen at all levels of the medical (and indeed wider healthcare) profession across the UK including recruitment freezes for consultant vacancies driven by local Trust/Board budgetary pressures or national directives. However, it is our view that such short-term savings are offset by the far greater costs associated with delays in care, error or other harm.

These rota gaps also reflect an unacceptable mismatch at a time when the UK has increasingly challenging competition ratios and bottlenecks to enter training. Current competition ratios[3] of 5.2:1 for Internal Medicine Training (previously Core Medical Training) are at an all-time high - over triple that of ten years ago[3] - and the majority of physicianly higher specialties have seen increases in competition ratios with applications significantly outpacing the number of available posts.

It is unclear why Medicine has remained on the UK shortage occupation list for so long when there is evidence of oversubscription to training programmes, and implications of the change to the Immigration Salary list in 2024 are similarly uncertain. Whilst the Secretary of State in England has indicated that the forthcoming 10 Year Health Plan will prioritise UK medical graduates over doctors who have studied overseas, he offers little granularity or assurance as to how this will occur and how we can ensure that International Medical Graduate colleagues (IMGs) already working in the UK will not be disadvantaged or discriminated against. In 2022, more than half of doctors who joined the UK medical workforce had a Primary Medical Qualification (PMQ) from outside the UK[4]. The NHS has historically relied on these valued colleagues to fill workforce gaps, particularly in hard to recruit to areas, and the diligent contribution of these doctors must not be overlooked. Where IMG colleagues are recruited, they must be integrated and included in a supportive and resourced way. Those supporting their integration and practice must also receive adequate training and resources.

The decision to continue to expand UK medical school student numbers and to allow unrestricted numbers of doctors to sit the Professional and Linguistics Assessments Board test (PLAB) without urgently addressing the issue of competition ratios further, needs to be scrutinised. It does not make financial or moral sense for the UK to train too many resident doctors without ensuring options for progression through postgraduate training and assurance of patient care.

Better workforce planning, and government commitment to urgently review training numbers (including a move to Whole Time Equivalent recruitment and expansion where appropriate, and better alignment of posts to specialties where there are future consultant opportunities/patient care need), are essential to address this gap to ensure that the future medical workforce can meet the needs of the population, and to avoid losses of trained doctors to other healthcare systems. This must include considered approaches for each specialty informed by data and advances in care, decided with all key stakeholders. There is no one size fits all option.

Time to train

The 2025 GMC NTS revealed that, whilst 90% of trainers reported enjoying their role, only half could always use their allocated time for training specifically for that purpose (48% in Scotland, 52% overall). Senior doctors require adequate protected time, embedded in job plans, to support the education and training of the next generation. Job plans that bear little semblance to the actual demands upon clinicians must no longer be supported. The value of training current and future cohorts of clinicians must be valued as highly as other aspects of service delivery. Without this training, future generations of senior clinicians, our future patients and the NHS will flounder.

Adequate protected training time will improve the experience of trainers as well as residents, and in turn improve patient care with better supervision and assurance of high standards. The training and supervision of existing resident doctors and medical students must be prioritised in consultant job plans. Consideration needs to be given to the multiple roles held by senior clinicians working in smaller healthcare facilities, with proportionately fewer experienced doctors, to ensure these colleagues have sufficient remunerated time as well as resource for essential non-clinical activity including training. Such facilities are often in the UK's remote, rural and island locations, compounding the existing challenges already seen in these settings.

Consultant-led patient care improves patient outcomes, ensures efficient use of resources, and optimises training opportunities for resident doctors and other healthcare professionals. The benefits of reduced variation in care, fewer unnecessary investigations and interventions, shorter in-hospital stays and optimisation of evidence-based system improvement must not be underestimated and cannot be eroded by avoidable rota gaps and the recruitment challenges described. The healthcare workforce is of course a multidisciplinary one, and doctors cannot work in professional isolation. The contributions and expertise of colleagues from a range of backgrounds are integral to excellent care. However, careful consideration of roles is critical, and the permanent replacement of doctors by other healthcare professionals in areas where doctors should be delivering the safest and highest quality patient care cannot be supported. An integrated plan for services to deliver patient care is required across all four UK nations, underpinned by a robust workforce plan

and appropriate training and development frameworks, seeking opportunities for multidisciplinary co-design and delivery whilst recognising the important distinctions in roles and responsibilities. Safe and excellent patient care must remain central.

We support the use of consultant time to teach, train and support others in the multidisciplinary team – but this should never be at the expense of resident doctors. We note the divisive nature of the recent debate around Medical Associate Professionals and the strength of feeling from our resident colleagues. We welcome many recommendations in the Leng report[5] and will discuss them further in our Council and with other stakeholders. We agree that a vision is essential to demonstrate how the role of MAP sits as a distinct, valued and respected function in the wider medical team.

However, we are cognisant of the fact that our College is primarily funded by the subscription, examination and delegate fees of doctors. The College develops and reviews all physicianly speciality postgraduate training curricula, develops, delivers and assures exams and provides important externality to recruitment, assessment panels and interview processes across the UK in an unfunded model. The costs and time investment around development of MAP scope and standards therefore needs further explored by Council and we will engage in important discussions with the government and other stakeholders regarding how this area can be progressed in a four-nation approach. This should extend to wider discussion about frameworks to underpin the UK's high standards of care being reliant on doctors giving of their own time to advance education and training.

Cost of training

Data released in 2023 from the Student Loans Company suggests that UK medical graduates leave university with an average of £32,435 of debt.

Thereafter, resident doctors are required to register with professional bodies, attend courses and sit high-stakes postgraduate exams to meet their training requirements. A recent publication estimated the hidden financial cost of postgraduate medical training in the UK to vary from £17000 to over £71000 (specialty-dependent)[6]. Compared to other professions including law, accountancy, banking, teaching and social work, where UK graduates may receive employer funding or bursaries for postgraduate examinations and training, these essential components of training are almost entirely self-funded, with the exception of study leave budgets which are often limited and which have not increased in line with inflation or covered the costs involved.

RCPE intentionally subsidises the cost of educational events for resident doctors and students wherever possible. We have worked with NHS Education for Scotland to provide the popular block grant scheme in addition to this. However, we believe there is work yet to be done to better support study leave budgets through collaboration with our key partners. For example, where employers require specific training to lead the hospital cardiac arrest/medical emergency team, necessitating certification and regular renewal, consideration should be given to employer funding to enable resident doctors to utilise study leave to meet the requirements of their training curriculum.

Funding for training in terms of recognised and protected time for trainers is explored earlier. However, we must also consider time to support the training of doctors undertaking the Portfolio Pathway (previously Certificate of Eligibility for Specialist Registration (CESR) pathway). The growing backlog of Portfolio Pathway reviews experienced in many specialties reflects that this is yet another professional task that is undertaken free from renumeration and often not reflected in job planning or other recognised time. The complexity and volume of information in each application, and significant level of responsibility of decision-making involved, may be additionally off-putting for consultants to offer on a charitable basis. If we are to support our Specialty and Associate Specialist (SAS) and Locally Employed Doctor (LED) colleagues to seek entry on to the Specialist Register in a timely manner, then it is essential that time for Portfolio Pathway assessments is appropriately resourced by factoring these into job plans or via direct financial renumeration.

The above financial and time considerations are particularly important if we are to genuinely commit to widening access in medicine. We are in no doubt about the value of supporting individuals from underrepresented and disadvantaged backgrounds to pursue medical careers, thus not only improving equity of opportunity but also ensuring that the medical workforce better reflects and represents the communities it serves, and in order to address systemic barriers that may limit access to medicine as a profession for all it is critically important that meaningful and proportionate financial support is available.

Rotational training

Rotational training has for some time been considered a gold-standard in ensuring exposure to a breadth of opportunities and practices, completeness of curriculum coverage, enhanced learning from extended teams about different ways of working, and to support the workforce across our varied geographies.

However, it is increasingly recognised that loss of the "firm" structure provided by longer placements, and frequent changes in unit, hospital and at times regions, can be disruptive and significantly impact wellbeing. It is unlikely that a one-size-fits-all solution can be achieved, and consideration must be given to offering varied programme rotations which support a variety of options. Collaboration between the NHS Statutory Education Bodies, Royal Colleges and Faculties, politicians, governments and, crucially, doctors in postgraduate training posts, is essential in designing rotations that meet the needs of both resident doctors and the public we serve.

Summary

Here we have set out RCPE's immediate priorities for training in the changing landscape of postgraduate medical education. As a College we are committed to boldly and articulately reflecting the voice of our profession and to working with other professional bodies to ensure we are front and centre of such leadership. Our central aim must be the equitable provision of the right staff with the right skills to meet our population needs whilst maintaining the highest standards of care for which the NHS is upheld, and valuing and supporting our medical workforce is central to this.

References

1. Dillner, L. (1993) 'Senior house officers: The lost tribes.', *BMJ*, 307(6918), pp. 1549–1551. doi:10.1136/bmj.307.6918.1549.
2. General Medical Council (2025) *National training survey 2025 results*. Available at: https://www.gmc-uk.org/-/media/documents/national-training-survey-2025-results-report-111657596.pdf (Accessed: 19 July 2025).
3. *IMT recruitment - full, comprehensive guidance on applying to IMT posts in UK ACCS-AM and CMT Training Programmes*. Available at: https://www.imtrecruitment.org.uk/recruitment-process/planning-your-application/previous-years-data (Accessed: 19 July 2025).
4. General Medical Council (2023) *Workforce report 2023*. Available at: https://www.gmc-uk.org/-/media/documents/workforce-report-2023-full-report_pdf-103569478.pdf (Accessed: 19 July 2025).
5. Department of Health and Social Care (2025) *Independent Review of the physician associate and anaesthesia associate roles: Final report*, *GOV.UK*. Available at: https://www.gov.uk/government/publications/independent-review-of-the-physician-associate-and-anaesthesia-associate-roles-final-report (Accessed: 19 July 2025).
6. Jerjes, W. and Majeed, A. (2025) *The unseen costs of medical training in the UK: A growing crisis*, *Frontiers in medicine*. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12116428/ (Accessed: 19 July 2025).