The state of medical training: refocusing our narrative

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Introduction

Medicine has long been seen as a vocation rather than a job and, while this is debated, it is clearly still a profession that comes with a lot of additional roles outside of the 'normal' day-to-day job. It is varied, interesting, challenging, reactive *and* proactive. It also gives a sense of 'helping others'; the British Medical Association (BMA) cohort survey found that 88% of medical staff reported that interactions with patients boosts morale.[1] At present, however, we are in a recruitment crisis with applications to medical schools falling and many specialities facing significant gaps.[2]

A Challenging Time headlines the General Medical Council's (GMC) most recent report on the state of medicine in the UK, encapsulating the rising tension between what is expected from the medical profession and what can realistically be provided.[3,4] It recognises that 'doctors highly value engaging with patients'. But it also highlights that 83% of junior doctors 'do not feel valued by managers', and, perhaps more concerning, 60% 'do not feel valued by their consultants'.[3] This has a detrimental effect on patient care as there is a recognised link between low morale and lower standards of care for patients.[3]

These findings are unsurprising given the report was produced in the year that saw the first ever 'all-out' strike of NHS junior doctors in England. A round table discussion regarding the industrial action quickly concluded that 'dissatisfaction runs deep', stating 'juniors feel undervalued and not listened to', commenting that there are significant concerns about difficulties with 'life outside work as they rotate through different shifts and hospitals'.[5] It is not enough to merely state we need more doctors, we need to look at the issues faced by our current doctors and the solutions available to ensure medicine remains an appealing choice of career.

Recognising the problem

Good patient care is at the heart of all doctors' practice; however, funding constraints, increasing service demands and an ageing population have all put increased strain on staff and services.[3,6] NHS finances are becoming increasingly stretched in order to balance quality care with a huge surge in demand. In England, between 1998 and 2013, there was a 124% increase in short stay admissions (under two days) and, in addition, patients' needs are becoming more complex.[7] As the frontline 'gatekeepers' to health services, doctors can feel like they are failing when they cannot meet their patients' needs or expectations.[8]

The current role of the doctor in the NHS also has a greater emphasis on non clinical work, including more involvement in management; however, provision of adequate training for physicians in this has been lacking. As noted in the *Learning from Serious Failings in Care* report this has led to physicians feeling unable to undertake management roles, further reducing the engagement between physicians and non-clinical management.[9] A poor working relationship between physicians and management deters physicians from participating in activities such as quality improvement.[10,11] This is not unique to the UK or to the current generation of trainees. Studies worldwide looking at engagement and commitment to quality improvement found older clinicians stating they were less engaged than they had been.[12]

In a review by the Royal College of Physicians of London, physicians explained they feel their 'vision for medicine… is drowned out by critics who have little direct experience of delivering care to patients'.[13] Top-down policies with continual structural changes to the NHS regularly affect doctors with 'politics' deemed unnecessary leading to public distrust and physician disillusionment.[14,15] This is exaggerated by the availability of 24/7 news and regular reporting of the current crisis.

Recruitment of doctors

As noted in a recent paper in this journal on valuing trainees in the UK, 'training and service provision are inextricably linked…training tomorrow's doctors while meeting the needs of today's NHS, undoubtedly adds additional pressures for trainees'.[16] Given the difficulties faced by doctors in the workforce it is not surprising that surveys show that that the percentage of physicians recommending a career in medicine to their children has dropped significantly.[17]

We are currently seeing more doctors leaving medical training following completion of their foundation years (the first two years after graduation).[18] This trend continues into core medical training (the next few years of postgraduate training) with only 44% planning to enter directly into higher specialty training in 2016.[19] These trainees are dedicated to good patient care and will often work over their allocated hours

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to ensure this is delivered, but it may be at the expense of a better work/life balance.[6] A survey of medical trainees revealed that medical registrars often cite work/life balance as their main stressor.[20] Unfilled training posts also create rota gaps, often in what are seen as less desirable geographic locations, putting more pressure on the trainees who remain and stretching NHS finances with wages for locums (which are typically higher than those for doctors in established posts).

Changing the narrative

What can we do to change this pattern of poor recruitment and retention? We know that many trainees highly value the location of their training with areas such as London and Thames Valley being significantly more competitive for jobs than, for example, in Wales.[21,22] It is for this reason that there are often 'golden' handshakes for 'hard-to-fill areas'.[23] While video consultations and modern communications allow us to provide more services from a central location, ultimately medicine is about the doctor/patient interface and we must recruit to all areas. A study about factors affecting career choices of 1,323 trainees in 2013 found that trainees' valued good working conditions most (needing the greatest monetary compensation to work in an area with poor working conditions compared to any other factor including location).[24] This may reflect the increasing importance doctors are placing on work/life balance and the ability to adapt working patterns to busy lives.[20]

Changes to the way doctors' train and practise are already underway in all four countries of the UK. For medical trainees, it is likely that the curriculum will change significantly with a 3-year core training programme allowing more exposure to specialities in high public demand such as acute medicine, geriatrics, and ambulatory care.[25] There is also a call for safer and more constructive learning environments, such as mandatory simulation training. This will be combined with longer rotations allowing doctors to foster better relationships with senior colleagues, ward staff and, most importantly, patients. We hope that this, in turn, will help trainees to feel more connected with their department, give them a feeling of closer 'mentorship' from more senior clinicians, and provide a better quality of care to patients. Mentoring can improve retention and help doctors in their careers, as outlined in a 2004 Department of Health paper, and is encouraged by the GMC and BMA because of its benefits for all doctors.[26–28] Mentoring was discussed in this journal in 2015.[29,30]

There is significant ongoing work around the assessment of doctors in training. The Joint Royal College of Physicians Training Board is aiming to move towards a global assessment of competencies rather than a 'tick-box' approach. It is hoped this will reduce the administration time associated with assessments and provide a more accurate evaluation of trainees' abilities while maintaining appraisal quality.[31] Medical educators will also be supported more through recent initiatives such as the implementation of 'Recognition of Trainers' and the GMC trainers' survey.[32,33]

There has been a societal change as medicine moves towards more patient-centred care with goals that truly matter to patients. In 2016, Catherine Calderwood, Chief Medical Officer for Scotland, published *Realistic Medicine* with the aim of promoting a more personalised approach to care.[34] In 2015, the Academy of Royal Colleges launched *Choosing Wisely* with the aim of reducing over-investigation and treatment.[35] Both these reports encourage an open dialogue and partnership between patient and doctor, rekindling a more balanced relationship that hopefully will provide more satisfaction for patients, and doctors.

Refocusing our communication with staff

Train people well enough so they can leave, treat them well enough so they don't want to.[36]

Nationally there has been increasing significance given to staff engagement between local NHS organisations and employees with the potential to improve standards of care and support employees to feel empowered. This is in part due to the awareness raised by reports such as *Francis* and *Learning from Serious Failings in Care*, noting that staff often did not feel able to speak up.[9,37] NHS England regularly measures this through staff surveys and hospitals can also participate in formal reviews of staff engagement via the Medical Engagement Scale.[38] NHS Scotland has started a new process to measure staff engagement called iMatter.[39] Both are used to measure, but, more critically, also to improve local staff engagement with their organisations. It is vital that organisations show all trainees that they are valued and listened to by their employers.

The Royal College of Physicians of Edinburgh is currently looking at the issues associated with recruitment and retention via trainee surveys and interviews. It also encourages collaboration and networking via a wide range of educational events, such as the Evening Medical Updates, aimed at trainees, which are webstreamed to thousands of participants worldwide. These Evening Medical Updates are arranged by the Trainees and Members' Committee which represent trainees in areas such as curriculum changes, and support a range of events to assist trainees in their career progression. The Recently Appointed Consultants Committee helps to support those transitioning into new posts or those navigating the demands of their post. Importantly the College has a national voice with which to influence medical practice and training. Through education, committees and mentoring, the College will help to challenge preconceived ideas about medical practice and shape medical culture.

Conclusion

Blaming junior doctors in relation to seven day working or General Practice for the pressure on patients attending A&E fails to recognise the complexity of healthcare and merely adds pressure to the system.[40]

The medical workforce is currently in crisis, facing widespread vacancies and low morale. The wellbeing and morale of doctors is important, not just at an individual level but as a reflection of a functioning, sustainable and valued workforce. By taking care of our staff we will enable them to care for our patients more effectively and efficiently, now and in the future. The problem is now being recognised on a public scale and initial changes are being made towards generating solutions that will improve working lives, increase engagement and, ultimately, improve patient care. In the meantime, we need to continue to refocus the conversation with our doctors and patients in order to help them provide high quality and realistic medicine.

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