**Department of Health: Expansion of Undergraduate Medical Education**

**A consultation on how to maximise the benefits from the increases in medical student numbers**

**Question 1**

**How would you advise we approach the introduction of additional places in order to deliver this expansion in the best way?**

The College suggests that the demands on medical schools to deliver a complex curriculum would favour those schools that already have GMC approval for issuing a primary medical qualification. The idea that students could start at a school that does not have this ability risks the unacceptable possibility that students would graduate unable to apply for provisional registration.

Additionally, our Fellows have challenged the assumption that increasing undergraduate places alone will actually address the underlying problem, which is that significant numbers of graduates leave the NHS within a few years of qualifying. Workforce planning needs a clear strategic direction to address recruitment and retention issues, including investment in our current and future workforce to create a culture where colleagues have the time to care, time to train, and time to research. We must retain high quality training programmes and value our junior doctors to ensure the UK remains an attractive place to train and work.

**Question 2**
**What factors should be considered in the distribution of additional places across medical schools in England?**
*Answer options: (please choose as many as appropriate)*
*University staffing capacity*
*University estates/infrastructure capacity*
*University capital funding capacity*
*NHS/GP clinical placement capacity*
*Mobilisation / timing capability*
*New medical schools*
*Others: (please specify)*

*NHS/GP clinical placement capacity*
The College's Trainees and Members' Committee have first-hand experience of the difficulties in provision of clinical placements. Medical students must have clinical placements that are capable of providing high quality training. 40% of respondents to a recent survey from the Joint Royal Colleges of Physicians reported formal and informal teaching was stopped due to consultant rota gaps[1]. The introduction of additional students where there is no capacity will risk not only failure to educate students, but also damaging students' experiences in specialties which may affect their further career choices. Any proposal to shift placements to specialties that are in recruitment difficulty must be supported by additional resources (not necessarily financial) to that speciality.

[1] https://www.rcpworkforce.com/analyze/ReportPreview.aspx?rid=kzpz9pO9DO

**Question 3**

**Do you agree that widening access and increasing social mobility should be included in the criteria used to determine which universities can recruit additional medical students?**

*Answer options: Yes / No*

**Question 4**

**Do you think that increased opportunities for part-time training would help widen participation?**

*Answer options: Yes / No*

**Question 5**

**If you have any additional information/experiences around widening access and increasing social mobility that would be helpful in developing the allocation criteria, please provide it here.**

There is a disparity between recruiting more graduates from all backgrounds, and allowing students to self-fund their entire medical degree (whether international/EU or UK students). This is likely to worsen inequality in access to medicine as a career.

If there is to be no limit on international student numbers and these students will be fully self-funding, then acceptance to medical school has the potential to create an inequality that would shift the balance in favour of those with access to funding rather than those with the best academic and interpersonal standards. This risks a fall in standards. It is essential that quantity should not replace quality. Merit should be recognised and grants, awards and scholarships targeted to ensure diversity and equality.

Processes which monitor equality, such as Athena SWAN awards, must be given appropriate prioritisation in the allocation of students. The College also highlights that areas of medical need (including primary care; mental health/psychiatry; dementia; and other community services as a particular priority) and quality of student experience should be important factors in the allocation criteria.

**Question 6**

**Do you agree that where the NHS needs its workforce to be located should be included in the criteria used to determine which universities can recruit additional medical students?**

*Answer options: Yes / No*

**Question 7**

**If you have any additional information/experiences about attracting doctors to areas facing recruitment challenges that would be helpful in developing the allocation criteria, please provide it here.**

The College acknowledges the evidence that doctors are more likely to continue to work in areas that they are either from, study at or train in. There is, of course, the requirement for students to be exposed to all areas. However, medical schools have a duty to provide first class education, this is their primary role in the provision of the medical workforce. Additional places should be granted to

schools that have the capacity to provide the education. This should not be unfairly distorted.

Fellows of the College have suggested incentives could be considered – not necessarily directly financial - by organisations in less popular areas that need to differentiate themselves from other more popular sites. This could include proposals such as shorter post graduate training periods.

**Question 8**
**Do you agree that supporting general practice and shortage specialties to attract new graduates should be included in the criteria used to determine which universities can recruit additional medical students?**
*Answer options: Yes / No*

**Question 9**
**If you have any additional information/experiences about attracting doctors to general practice and shortage specialties that would be helpful in developing the allocation criteria, please provide it here.**

Trainees consistently advise the College that they are drawn towards OR away from specialties due to experiences that they have in training. They also look up to those they work with in the different specialties as role models. If medical students are placed in areas that are struggling then, without additional support, they will be further discouraged from these specialties in later years. Trainees are routinely stating that the reason they are leaving the UK is to look for experience elsewhere as they do not feel the training provided is equipping them for the job that is expected of them. A loss of control or? lack of clear expectation links to burnout in later stages of careers, something that directly affects patient safety, workforce supply and directly affects the doctor involved.

A significant point of note is that the majority of trainees return to work in the UK in the NHS having gained experience elsewhere that then benefits patients in the UK. In light of the GMC guidance on flexibility in training and the upcoming recognition of generic training, any perceived detriment to doctors gaining experience elsewhere and not being accounted for in UK training should be addressed.

**Question 10**
**Do you agree that the quality of training and placements should be included in the criteria used to determine which universities can recruit additional medical students?**
*Answer options: Yes / No*

**Question 11**
**If you have any additional information/experiences about how to improve the quality of training and placements that would be helpful in developing the allocation criteria, please provide it here.**

Placements in District General Hospitals often allow for a far better ratio of student to trainer teaching. However more rural district hospitals can have lower volumes of patients. This is usually compensated by good quality teaching (from properly trained and enthusiastic clinicians). Further to

this, placements should be allocated with ratio of staff and patients to student numbers taken into account. Placements for medical students are good when the doctors have time and enthusiasm to teach.

Logistically it should also be appreciated that these places are difficult to travel to and they should be supported by accommodation and high quality internet access for education.

**Question 12**
**Do you agree that all providers should be offered the opportunity to bid for the additional medical school places?**

This question is unclear. Whilst the College feels it should be equitable and not restricted to certain universities to be able to bid, the question does, by its wording, also include private medical schools and those which are not currently established. The College is apprehensive about allowing private medical schools to bid for the additional medical school places, due to the potential for a two-tier system which is not necessarily favourable to the highest quality candidates.

**Question 13**
**Do you agree that innovation and sustainability should be included in the criteria used to determine which universities can recruit additional medical students?**

This statement is currently vague and needs more clarity before the College can form a definite opinion. We welcome innovation and sustainability but the implications of this from the question above are not clear.

**Question 14**
**If you have any additional information/experiences about how to encourage innovation and sustainability that would be helpful in developing the allocation criteria, please provide it here.**

Innovation from the medical workforce requires encouragement, resource and reward. We would encourage medical schools to highlight the value of programmes such as intercalated degrees, academic and medical educational training programmes for students and medical trainees. We welcome the additional emphasis on teaching more about the medical working environment through leadership and management *whilst ensuring that all the basic medical knowledge is provided* - this is already a significant challenge and critical areas such as anatomy are not covered in such detail as they were historically, primarily due to the multiple other advances in medical innovation and demands on the curriculum.

**Question 15**

**We would be interested in hearing views on how meeting the needs of the NHS aligns with the role universities wish to have in the future distribution of places in an expanded market - please provide your views here.**

Universities should be a place to inspire students to achieve their goals whilst giving them realistic and practical careers advice for how they can best do this. Universities aim to understand the needs of the population that the NHS serves and they must follow the current stringent guidance from the GMC regarding variety and duration of placements. However, they also must be able to give students flexible placements that students can independently choose in order to gain greater experience in areas of interest which we know affects their career choices at a later stage. The College therefore strongly supports a system where both clinical and academic excellence are enabled to flourish.

**Question 16**

**Do you agree with the principle that the tax payer should expect to see a return on the investment it has made?**

*Answer options: Yes / No*

**Question 17**

**Do you agree in principle, that a minimum number of years of service is a fair mechanism for the tax payer to get a return on the investment it has made?**

*Answer options: Yes / No*

This does not apply to other non-health professional groups and ignores global health challenges so the College feels this question is subjective. It also does not recognise the individual who may begin working as a doctor but for their own personal health/well-being find they are not suited to the job and do not wish to continue.

**Question 18**

**Do you have any views on how many years of service would be a fair return for the tax payer investment?**

*Answer options: 2 / 3 / 4 / 5 / more than 5*

N/A

**Question 19**

**Do you agree with the principle that graduates should be required to repay some of the funding invested in their education if they do not work for the NHS for a minimum number of years?**

*Answer options: Yes / No*

**Question 20**

**Can you think of any potential impacts of requiring graduates to repay some of the funding if they do not work in the NHS for a minimum number of years?**

Medical school is not the equivalent of working in the NHS, regardless of how well advanced the apprentice-ship style blocks are at the end of medical school. Some doctors do not cope with work psychologically and this may not be apparent until they are working. Financially forcing doctors to work in the NHS will ensure that they are less likely to seek help if they are struggling with the pressures of work– this not only becomes a problem for the doctor but a patient safety issue.

As with everyone trainees can also face significant caring responsibilities (often for a short period of their working career) that mean that they cannot commit to full time - or indeed any - work. The majority of these trainees will go back into work and then work for a significant period of time in the NHS: penalising these people at this stage will not encourage them to return.

Trainee doctors also take time to undertake commitments such as a PhD; working in management; education; or in health policy, which are significant health service contributions even if not front line service - how would these be explored in the context of repayments? The College would also request clarity on the decision to select medical education for a minimum service requirement compared to other public service training.

A significant number of medical students graduate from university significantly in debt – due to the length of their degree, the number of expensive books/equipment they must buy, and their rotations which often mean they must travel significantly for placements (which is not fully reimbursed). There are huge implications if they are expected to repay financially. There is a risk of creating an elitist system with only certain people able to consider applying for medicine with the financial implications.

It is also important to note that unlike other university students who may be able to secure temporary jobs during their university years to sustain themselves, this is realistically impossible for medical students who are expected to have a full 9-5pm working week, shorter holidays when they enter clinical attachments, and are increasingly expected to learn by doing shift work (nights/evenings). That combined with the length of their degree mean they come out of university in debt and repay their student loans over many years – this is before being asked to further to repay funding if they do not continue in the NHS.

When a person decides at 16/17 years old to enter medicine they may then later realise they do not have the ability (including psychologically to cope with the extreme emotional impact of life as a doctor). Penalising someone by forcing them to repay for their training is a very blunt instrument. Some doctors will go to work in universities or in teaching roles outside of the NHS. These are still invaluable contributions to society and they should not be made to financially re-pay for their medical training. We would be in danger of having the wrong people stay as doctors simply because they could not afford to leave and re-pay their medical degree. This would be detrimental for patient care also. It is important to note that most doctors already spend at least 4 years after graduation in the NHS[i].

Furthermore the College feels that the comparison to the armed services is not valid. Those who join the services are paid a significant amount of money through their university education, given extra training during this time, given guaranteed jobs with additional accommodation arrangements made and given appropriate expectations for their training options. Those who undertake military medical bursaries are paid a significant amount more than the standard military bursary at university. They are then given a significantly larger salary in their foundation years, given extra training through-out this time and have consistent careers advice and experience alongside. This is not replicable to all medical students, nor should it be.

**Question 21**
**Is this a policy you wish to see explored and developed in further detail?**

The College received mixed views on this subject.

**Question 22**
**Do you have any comments about the impact any of the proposals may have on people sharing relevant protected characteristics as listed in the Equality Act 2010?**

Yes. Without provision of fair work place environments and access to childcare there is the potential to discriminate against both males and females who wish to have families or support their existing families.

Further to the question regarding a set duration of work or reimbursement this will disproportionately affect those in lower income brackets. It could possibly put off those in lower socioeconomic classes from applying for medicine. We also seek clarity on allowing 'unlimited' international students to pay fully for their education which has the potential to discriminate against UK students.

**Question 23**

**Is there anything more we can do to advance equality of opportunity and to foster good relations between such people and others or to eliminate discrimination, harassment or victimisation?**

The College has no specific comments on this question.

**Question 24**
**We are interested to hear views about the impact the proposals may have on families and relationships. For example, do you consider training more doctors will have a positive impact on flexible working because of additional system capacity?**

At present the medical training and service contribution are inherently linked: the College welcomes this as trainees have stated that they value learning from every one of their patients and patient contact is a large contributor to trainees' morale. However, this often means that service provision

determines where trainee placements will be. This is a significant strain on families as often this is communicated back to trainees at a late stage: the organisation of placements and communication (especially timing) needs to improve and this will have a more positive impact than simply increasing numbers.

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[i] Prof Ian Cumming, chief executive of Health Education England
http://www.telegraph.co.uk/news/2017/03/14/doctors-could-forced-work-nhs-least-five-years-plans-home-grown/