



Response to the Review of Modernising Medical Careers

July 2007

The Academy of Medical Sciences

The Academy of Medical Sciences promotes advances in medical science and campaigns to ensure these are converted into healthcare benefits for society. Our Fellows are the UK's leading medical scientists from hospitals and general practice, academia, industry and the public service.

The Academy seeks to play a pivotal role in determining the future of medical science in the UK, and the benefits that society will enjoy in years to come. We champion the UK's strengths in medical science, promote careers and capacity building, encourage the implementation of new ideas and solutions – often through novel partnerships – and help to remove barriers to progress.

This response is published by the Academy of Medical Sciences and has been endorsed by its Officers. Contributions by the working group are made purely in an advisory capacity.

The members of the working group participated in an individual capacity and not as representatives of, or on behalf of, their affiliated hospitals, universities, organisations or associations. Their participation should not be taken as endorsement by these bodies.

Contents

Introduction and Broad concerns over MMC and MTAS	4
General Principles concerning academic training in postgraduate medicine	6
Recommendations	8
Appendix I MMC working group membership	10

Introduction

The Academy was invited by Professor Sir John Tooke FMedSci, Chair of the Modernising Medical Careers (MMC) Inquiry, to advise on the changes it would like to see in the Clinical Academic Career pathway throughout the training grades, giving particular attention to the issues of choice, flexibility and the assessment process used to select for academic national training numbers (NTN(A)s).

This paper sets out the Academy's position, in particular with respect to academic medicine. The Academy supports the development and promotion of careers for biomedical scientists and encourages good practice in training and development across all sectors. The Academy's ultimate goal is to foster the best biomedical research in the UK, and to translate this into improved outcomes for patients. The UK's world-class position in medical science is underpinned by a first class workforce. It is vital that the UK's medical training and career structures are attractive to the next generation of young researchers.

Broad concerns over MMC and MTAS

The implementation of Modernising Medical Careers (MMC), via the Medical Training Application Service (MTAS), has resulted in an unmitigated disaster. A top-down, prescriptive approach has been taken and there has been a failure to engage effectively with the medical profession. We are concerned that the country's future ability to deliver quality biomedical research and excellent patient care will be compromised.

In finding robust solutions for the future, frank acknowledgement that medical training was not perfect beforehand is important. A particular concern has been the decline in the number of clinical academics over recent years and significant loss of research capacity in some specialties. The National Coordinating Centre for Research Capacity Development (NCCRCD)'s 'Walport' initiative is an important measure to address this. We strongly support this scheme which aims to provide a career pathway for clinical academics and particularly regret that evaluation of its progress is compromised by MTAS. But in considering the potential impact of MMC and MTAS on academic medicine it is important to recognise that the NCCRCD integrated academic training (IAT) scheme applies only to a small proportion of academic trainees.

The majority view from the Academy is that MMC in its current form will limit diversity, flexibility and excellence in medical training. The consequences of limiting flexibility and failing to value excellence would be particularly serious for academic training and hence for the future contribution of UK biomedicine to the health and wealth of the nation.

The following are the Academy's general recommendations:

Carefully designed pilot schemes must be used in the future.

The NHS is an large and complex organisation. Major changes in direction have often led to unintended consequences. Pilot schemes should be used to test and refine ideas before

full implementation. Extensive testing and validation of any changes to training should be carried out in those grades and specialties which have most to gain from a change.

Developing solutions will require a constructive dialogue.

Relations between doctors, their professional bodies, and government are at a low ebb. Many doctors are suspicious of the government's motives concerning postgraduate medical training. There is also widespread criticism by doctors of their professional bodies on the grounds that they should have prevented or refined these changes. To develop solutions professional leadership needs to be re-established and government and the profession will need to work together. Both must be guided, and be seen to be guided, by the desire to deliver the best care and the best research for patients.

Low morale amongst trainees must be considered and addressed.

Many are distressed by the prospect of not having a job, and by uncertainty about where they will be working or what will happen to their career. There is an immediate need to deliver practical solutions and a longer-term requirement to rebuild morale.

Automatic progression via a run-through system must be reconsidered.

Under MMC, entry into ST1 is pivotal. Subject to adequate performance in competency-based assessments individuals will *automatically* emerge with a CCT. We are gravely concerned that this is inherently inflexible and that competency-based assessment will be insufficiently robust to ensure high standards or to identify problems reliably. Run-through creates the need for irrevocable career decisions at a stage when insufficient assessable evidence is available to either the applicants or their scorers. To this extent the problems of MTAS are entwined with an inherent aspect of MMC. Introducing a competitive progression point (probably at the end of ST2) would provide a robust external assessment of the knowledge and skills acquired to date. This would assist identification of those at both ends of the ability spectrum. It would create a natural point at which individuals could adjust their choice of specialty and/or training program. It would thus objectively benefit both the individual trainees and the quality of those entering the senior grades in all segments of the profession. However, careful planning will be essential to avoid creating another 'lost tribe' at the end of ST2.

General Principles concerning academic training in postgraduate medicine

Academic medicine and medicine in general are symbiotic

In order to thrive, academic medicine requires a well-organised clinical environment and well-trained clinicians. Mainstream clinical medicine draws on discoveries, innovations and developments pioneered and implemented by clinical scientists in academic medicine. There are great benefits from exposure of all trainees to academia and a key objective should be to increase this exposure. There is an inherent artificiality in regarding academic medicine as a separate discipline - even more at a time when the importance of research to the NHS as a whole is recognised. There is a risk that identification of individual trainees as 'academic' implicitly regards the rest as 'non-academic'. Academic values and the spirit of enquiry should be pervasive throughout the NHS.

Access to research training and appropriate credit

Time spent undertaking research does not automatically provide clinical skills training. But medical science is evolving rapidly and all doctors need to be able to evaluate advances and decide how to apply them. Out-of-programme experience for research is an excellent way of fostering this and there should be a constructive approach to recognising this as professional training. MMC should consider how it could facilitate academic exposure in mainstream training. We recommend that research for a higher degree should be considered as credit for one year of clinical training (subject to demonstrating the required clinical competencies). This approach should be adopted across all specialties, although it is recognised that a minimum duration of clinical training is required, which will vary across specialties.

Flexibility

Academic training requires flexibility with the possibility of entry (and exit) at different stages, as emphasised in the MMC/UKCRC report on academic training. The NCCRC IAT programmes provide a useful framework for this. However, they apply to a restricted number of trainees. We are concerned that for others there will be much less flexibility. Transferring from standard training posts to academic programmes or fellowships must be straightforward for all trainees. Operational simplicity is also essential for the local training programme. To achieve this we recommend that approved out of programme experience (OOPE) for research would generally be covered by additional NTN's. Training programmes which have a track record of trainees undertaking 3 year OOPEs should be provided with additional NTN's for this purpose. Control over numbers of NTN's in this way will have benefits for workforce planning at the local and national level.

NTN(A)s

We are concerned that differentiating between clinical and academic trainees at an early stage by badging the latter NTN(A) will be inconsistent and may in some circumstances be unhelpful. Illustrating this, in the Gold Guide, NCCRC IAT trainees would have

NTN(A)s, which they would retain during OOPE, while other trainees awarded MRC or Wellcome Training Fellowships would not have NTN(A)s. We are also concerned that having two classes of NTN will make transitions between academic and standard training paths less flexible. A further issue is that NTN(A) could be regarded as providing less effective clinical training – making IAT posts less attractive, and possibly rendering individuals less competitive for subsequent clinical appointments. There is utility in NTN(A) for Clinical Lecturers, and Intermediate Fellows / Clinician Scientists where they are valuable in identifying a specific cohort who are most probably committed to an academic career.

Entry to Consultant Grade

Training for clinical academics takes longer than standard clinical training. It is important that seniority at appointment to Consultant grade, and eligibility for Clinical Excellence Awards, take this into account. We consider that this is essential if academic medicine is to be protected from serious attrition in future as reward differentials accumulate.

Alternative route to consultant grade

We support Article 14 which allows individuals to apply for a Certificate of Eligibility for Specialist Registration. Although we envisage that most academic trainees will obtain a CCT, the Article 14 route provides an important route to eligibility for a sub-specialty post at Consultant level. This flexibility should be communicated more widely to the profession, providing reassurance to trainees who are considering or pursuing an academic pathway.

Recommendations

Taking the general principles set out above, the Academy recommends:

1. Competitive progression points

Automatic progression of trainees in a run-through system should be replaced with a mechanism for at least one robust assessment. We support an assessment point at the end of ST2, requisite for competitive entry to ST3.

2. Accreditation for academic work

Research for a higher degree should be considered as credit for one year of clinical training (subject to clinical competency).

3. Flexibility

Trainees would have a standard NTN irrespective of their chosen career path which will be retained during OOPE for research training fellowships. An initial allocation of additional NTN's to local training programmes could be based on the average number undertaking approved OOPE for research over the past 3-5 years, coupled with allocations to develop new, high quality schemes. NTN(A) would be restricted to Clinical Lecturers and Intermediate Fellows. ACFs who have already been allocated NTN(A)s would have these changed to NTNs.

4. Opportunities

MMC should consider how it could facilitate academic exposure in mainstream training. Allowing innovative Deanery/University/Trust partnerships which would provide research exposure during clinical training – based on the Walport ACF model – would be one route. Biomedical Research Centres, and Research Council Institutes, would provide fertile environments for trainees to gain insight into biomedical research. Masters level courses designed for medical graduates can be very valuable, and should be recognised by consideration of reduction of the direct clinical training time required to attain CCT (subject to clinical competencies being attained).

We recognise that workforce planning is important and that allowing additional NTNs to facilitate OOPE will make training pathways less predictable. However, the overall numbers will be relatively small (compared to those requiring flexibility to bring up a family) so this should be a relatively minor issue.

5. Specific recommendations concerning entry into NCCRCD (Walport) programmes

We recommend the following with respect to appointments to academic training posts:

- Academic training posts should be appointed in a separate recruitment round.
- A single, joint academic and clinical interview should be held.
- Academic training posts should be advertised nationally, but controlled at the regional/local level, to allow flexibility and ease of operation. Specialty Programme Directors must be closely involved in the recruitment process.
- Deanery/University/Trust partnerships should be afforded some flexibility to transfer Walport scheme posts across specialties.
- Deanery/University/Trust partnerships should have the freedom to advertise throughout the year.
- Short-listing and interview should take place at the local level.
- A complete CV should be required for the short-listing process.
- The interview panel needs to be composed of individuals who will have the authority and competence to assess both academic and clinical ability/competence.
- Trainees should be allowed some flexibility to change their clinical discipline during the academic training programme.

Rationale:

- Separate recruitment will increase visibility of the academic training programmes.
- Handling appointments to Walport posts locally will allow programmes the opportunity to readvertise if suitable calibre individuals are not identified.
- The appointment process must allow individuals to return to full-time clinical training legitimately, without the need for an additional assessment step.

6. Recommendation to expand academic training based on the NCCRCD (Walport) model

Expansion of the number of academic fellowship programmes should be considered. We would like to see University / Trust / Deanery partnerships being given the freedom to propose new programmes of similar design to the NCCRCD schemes. Sustained strong support of these by the Funders such as the Medical Research Council would add further strength. These initiatives would probably need a central approval and monitoring system.

Appendix I MMC working group membership

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