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Academy of Medical Royal Colleges

Recruitment and recognised achievements in medicine

Academy Resident Doctors' Committee

The Academy Resident Doctors' Committee [ARDC] [formerly the Academy Trainee Doctors' Committee - ATDC] represents resident doctors in postgraduate training. It has over 60 representatives drawn from the 23 medical royal colleges and faculties in the UK and Ireland. The members are all at different stages of their postgraduate training pathways. By working together to identify issues and challenges that affect resident doctors and suggesting solutions, we strive to implement changes across the whole health service. In particular, we look at ways to improve the support given to resident doctors throughout their postgraduate years to enhance training, recruitment and retention of this crucial component of the workforce.

This paper

There is currently considerable interest in all aspects of recruitment, retention and well-being of NHS staff. The ARDC has published a library of papers which address key dimensions that relate to training, including retention, self-development time, the cost of training, and recruitment and selection. This paper drills down into medical workforce recruitment and specifically the role of recognised achievements in the selection processes. It is a companion piece of the then ATDC's REFORM principles. The audience for this paper is key decision-makers within government, national educational bodies, medical schools and royal colleges and faculties. As the voice of resident doctors from across all specialties in the UK, the ARDC is well placed to provide a short, sharp, comprehensive assessment of this key issue.[1-5] This paper reflects the thinking of the ARDC on this important issue.

This is important because, improving the experiences and well-being of doctors will improve patient care, experiences and outcomes.

Background

Medical training represents a substantial investment of both time and individual and public resources, often spanning over 14 years from the onset of medical school.[6] The journey towards specialisation is arduous, characterised by an intense commitment to learning and clinical practice. Many doctors in training face a considerable burden of 'out-of-hours' responsibilities, which exact a toll on their time, physical well-being, and mental health. Amidst this demanding schedule, individuals are challenged to strike a balance between professional aspirations and personal fulfilment.

It is important that we look at this now because as the latest NHS England data illustrates there has been a dramatic increase in the number of applications for training places over the last year.[7] Beyond this, we know that competition ratios in key specialties have doubled and even trebled in the period between 2019 and 2023[8] and that there is a 'bulge' coming through which will further increase competition as a result of the welcome 1,500 additional medical places which were added in September 2018.[9] Taken together, with concerns about the absence of specialty numbers in the NHS long-term workforce plan, these all have implications for resident doctors, the implementation of the plan, and wider government policies, including immigration.

This paper explores the issues which play a part in shaping training experiences, and specifically factors which impact recruitment at different stages of training. We hope it will inform thinking at a national level about recruitment and training more widely.

What affects access to training posts and experiences?

There are 8 factors including those relating to system bottlenecks, allocations, value and financial considerations which impact recruitment and resulting experiences:

1. The increasing number of resident doctors. Training more doctors is a positive thing, but the mismatch in postgraduate numbers means that competition intensifies as the increased number of UK doctors completing their foundation year 2 (F2) join an ever-larger pool of resident doctors.[9]
2. Difficulty securing specialty training places. According to published NHSE data, competition for virtually every training programme has increased markedly over recent years.[10] At the higher specialty level, particularly in non-run-through training programs, significant bottlenecks have emerged. Many doctors risk being left in a state of limbo, partially trained in their specialties but unable to progress further.
3. The apparent disconnect between approaches to training and immigration policy. Immigration and the contribution of International Medical Graduate [IMG] doctors and other overseas healthcare staff are crucial to the effective delivery of patient care and the sustainability of the NHS. The inclusion of medicine on the Shortage

Occupation List, and the introduction of the Health and Care Worker Visa, which have ensured effective parity between UK and international medical graduates has also led to even greater competition for training places and opportunities.[3] In turn issues remain with respect to the rights of IMG doctors to remain in the UK post training.[11]

4. System strain. Increased applications place pressure on an already understaffed and underfunded recruitment system. Consequently, the emphasis has shifted to producing a manageable shortlist rather than allowing equity of access to interviews for all potentially appointable candidates.

5. Preference Informed Allocation. To alleviate some of the historic challenges around allocation, particularly around inequalities, the United Kingdom Foundation Programme Office [UKFPO] has transitioned to a preference based system. While this adjustment has eliminated the need for medical students to undergo the situational judgement test, there are a number of colleagues who feel that they have been disadvantaged by the process.

6. Valuing excellence. There are also concerns that the shift to preference-informed allocation has resulted in a reduction in the emphasis on acknowledging and driving excellence among our medical students and risks undermining the primary incentives for foundation programs to produce doctors who understand how to practice in the UK system and are fit to move onto specialty training, and to drive improvements.

7. Valuing different achievements. Increased applications mean a greater need to rank candidates, and there is concern that greater weight may be attached to certain achievements by national scoring matrices during the shortlisting process. Moreover, there should be acknowledgement that access to such opportunities can be influenced by factors like one's socioeconomic circumstances, personal networks, and regional disparities. It's imperative that we avoid inadvertently perpetuating disparities in attainment by disproportionately valuing certain accomplishments over others.

8. Finances. Resident doctors incur a range of costs associated with their training, and this can vary between specialties and employers. They may may be charged for conferences, even if they are presenting abstracts. They may also be expected to pay upfront for expenses and then claim these back retrospectively, which can be a complex, slow and difficult process. This specifically disadvantages people from particular socio-economic backgrounds. Efforts to standardise these practices are necessary to ensure equitable access and uphold the integrity of academic pursuits amidst the evolving landscape of medical research and professional development.

It is imperative to recognise that resolving core training challenges is intricately linked to addressing higher specialty training issues. We need to achieve a position in which foundation posts match core posts which match higher specialty posts which in turn

match the number of consultant posts. There are clearly a number of challenges at various stages as more resident doctors move into Locally Employed Doctor [LED] and Specialty and Specialist [SAS] doctor roles, leave medicine, emigrate or wish to work less than full-time.

What might improve recruitment and selection?

Having identified the barriers, we now identify 16 actions that could improve experiences.

Strengthening workforce planning by:

1. Setting out training numbers for individual specialties.
2. Flexing available national training numbers (whole time equivalents) to overcome the multiple bottlenecks in both core and higher speciality training.
3. Ensuring long term workforce planning matches increased medical school expansion to postgraduate training numbers and specialty training places. In addition, the appropriate number of consultant level posts required should be identified.
4. Ensuring that resident doctors can access high quality experiences in the full range of settings in secondary care, primary care, public health [locally, nationally and internationally], pharmaceutical medicine and other specialties.
5. Exploring how workforce planning aligns with immigration policy to ensure that we have the right numbers in training.
6. Refreshing current processes to reflect the reality that increased competition means that individual resident doctors now apply for multiple positions.
7. Ensuring the national recruitment service has the capacity to deliver a high quality service that is free of multiple delays and errors and adapts to the changing landscape of medicine.

Revisiting the application and interview scoring systems by:

8. Equally valuing excellence in clinical care and academic achievements and reflecting the full range of behaviours outlined in the GMC's good medical practice, including those around patient-centred practice, and ensuring parity of esteem for all experiences, including for those working in primary care, public and others working in community settings.[12] For example, positive multisource and patient feedback could be given appropriate weighting in scoring matrices.
9. Excluding courses, by name or number, that directly or indirectly influence scoring matrices unless they are reimbursed through the national study budget allocation system.

10. Evaluating academic activity holistically, moving beyond a focus on publications. Scoring matrices should reflect experience in this area such as, but not limited to, study consent and data collection, participating in carrying out studies, intercalated BAs, and positive as well as negative results which are adversely reflected in publication rates.

11. Ensuring that high-quality regular commitments at a local level should be equally valued in scoring matrices as regional and national projects in the assessment of teaching and quality improvement.

12. Ensuring that scoring matrices do not indirectly indiscriminate against people from particular socio-economic backgrounds or protected characteristics by placing undue emphasis on national rather than local initiatives, which may be less accessible.

13. Avoiding the use of additional recruitment exams for shortlisting purposes and where necessary, utilising existing mandatory exam scores such as the Medical Licensing Assessment. If utilised, these should only form a proportion of the overall score in a more holistic assessment of the candidate.

Embedding self-development time by

14. Incorporating dedicated educational and self-development time for individual specialties within all training programs and across all regions, allowing doctors to pursue additional achievements in academia, education, and quality improvement. This should reflect resident doctors' and colleges' training priorities within their individual specialties.

Establishing a conference register by

15. Listing conferences held by professional organisations, royal colleges, or faculties, which are eligible for study budget funding. And revisit attendance fees for resident doctors whose abstracts are accepted for presentation.

Notifying candidates about of changes to recruitment processes by

16. Ensuring adequate notice is provided to prospective candidates before implementing any changes to the recruitment process. As a minimum there should be a 2-year notice period from the start of the recruitment. The longer the notice the easier it is for resident doctors to plan and adjust.

Conclusion

Our shared challenge is to ensure that we have an equitable and merit-based system which recognises, and rewards excellence required of resident doctors.

As well as identifying a number of known barriers, this paper identifies a series of simple steps the Government, NHS England, medical schools, royal Colleges, faculties and other national and regional bodies, can take to improve training experiences. The ARDC and the wider Academy of Medical Royal Colleges are ready to work with partners to make progress on this important issue.

Notes

1. ATDC [2024] *Six simple ways to retain doctors in training in the health service: ATDC reform principles*.
2. ATDC [2023] ATDC statement: *Physician and anaesthesia associatesin healthcare: the perspective of postgraduate doctors in training*.
3. ATDC [2023] *Self-Development Time – exploring the benefits and logistics of implementation*.
4. ATDC [2023] *The cost of medical postgraduate training examinations: The pressures, challenges and possible remedies*.
5. ATDC [2023] *Implementation of changes to specialty recruitment and selection processes*.
6. Dr Ollie [2023] *How Long Does It Take To Become A Doctor?[Ages & Full Timeline]* Medical School Expert.
7. In 2023 42,794 applications were made for the 12,680 specialty training posts available at CT1, ST1, ST3 and ST4 training level. An overall competition ratio of 3.37:1. This marks an increase of 6,231 in the number of applications from the 36,563 made in 2022 (an increase of 17%). It also represents a 4.8% increase in the number of posts, with 12,105 posts available in 2022.
8. Between 2019 and 2023 competition ratios doubled for training in general practice, anaesthetics, paediatrics and obstetrics and gynaecology and tripled for training in core psychiatry, ophthalmology and cardiothoracic surgery. Competition ratios. Medical Hub, Health Education England.
9. House of Commons Library [2024] *The NHS workforce in England*.
10. HEE [2024] *2023 Competition ratios*. Medical Hub, Health Education England.
11. Price, K [2022] RCGP letter signed by 4,000 GPs demands solution to 'nonsensical' IMG visa rules. *Pulse Today*.
12. General Medical Council [2024] *Good Medical Practice*.

Dr Waqas Akhtar
Chair of the Academy Resident Doctors' Committee

On behalf of the following members:

Association of Surgeons in Training
British Orthopaedic Trainees Association
Faculty of Dental Surgery
Faculty of Intensive Care Medicine
Faculty of Medical Leadership and Management
Faculty of Occupational Medicine
Faculty of Pharmaceutical Medicine
Faculty of Public Health
Faculty of Sexual and Reproductive Healthcare
Faculty of Sports and Exercise Medicine
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Obstetricians & Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics & Child Health
Royal College of Pathologists
Royal College of Physicians & Surgeons in Glasgow
Royal College of Physicians of Edinburgh
Royal College of Physicians of London
Royal College of Psychiatrists
Royal College of Radiology (Clinical Oncology)
Royal College of Radiology (Clinical Radiology)
Royal College of Surgeons of Edinburgh