THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

Department of Health Consultation on Expansion of Undergraduate Medical Education

1. Our plan is to introduce all remaining additional places as soon as possible via a competitive bidding process. The expectation is that these places will be available by 2019/20 or earlier, depending on institutional capability. How would you advise we approach the introduction of additional places in order to deliver this expansion in the best way?

Comments:
A staged expansion over 2 or 3 years seems sensible, with on-going evaluation of the quality of education. There needs to be a balance between institutions that have the capacity to expand rapidly and institutions that produce excellent young doctors. By expanding rapidly, certain institutions may be overwhelmed and unable to continue providing an adequate level of education and clinical experience. Medical schools must demonstrate that they have the capacity to deliver both classroom based teaching and the clinical aspects of the course.

Some UK areas find it much more difficult to recruit doctors than do others. For instance London and the South East are much more popular than are Yorkshire and the Humber, the North East of England, and the Highland region of Scotland. It is important that this is taken into account in selection of placements.

2. **What factors should be considered in the distribution of additional places across medical schools in England?**

- [x] **University staffing capacity**
- [x] **University estates/infrastructure capacity**
- [x] **University capital funding capacity**
- [x] **NHS/GP clinical placement capacity**
- [ ] **Mobilisation / timing capability**
- [x] **New medical schools**
- [x] **Others: (please specify)**

Comments (if other): All of the above are likely to be important.

Should the availability of undergraduate clinical tutors and other clinical placements also be considered?

Studies from the early 2000s about career choice demonstrated that being near family and friends was of the same or greater importance to junior doctors than was choice of specialty. Many doctors stay in the areas in which they went to medical school and completed foundation jobs. Many others return to near where their family live. It would be worth considering ways in which recruitment can be enhanced in those geographical areas that currently struggle to recruit. For instance, it may be that

wider access schemes for mature students who are tied to these under-doctored areas would be of value.

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?**
Yes

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

Yes. This may be particularly beneficial for a graduate entry programme. Although the length of the course might put many applicants off undertaking it part time, others might appreciate the opportunity to earn part-time, and incur less debt during their undergraduate years. Generation X and Generation Y have a more robust attitude to achieving a sensible work-life balance.

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.

Comments:
Currently there are a number of people who don't get into UK medical schools, but who go abroad to do English-based medical qualifications in Europe (e.g. Holland, Croatia, Czechoslovakia), and return to the UK. These people make good doctors. Costs of training are variable, but currently some European qualifications cost less than UK programmes. This would suggest that the current requirements for performance at A-level, UK CAT and GAMSAT are too stringent, and that academic qualifications are given greater weight than tenacity and determination.

It would be useful to review the experience and career progression of the group of doctors who have permanent UK addresses, completed their undergraduate degrees abroad, and returned to the UK as foundation or core trainees. This might identify other criteria that can be used in selection.

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?
Yes (please see our comments in Q1)

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.
Comments:
There are several studies (e.g. BMA cohort study) about how doctors make career choices, that show doctors place as much weight on being close to family and friends as they do on choice of specialty. In some disciplines (e.g. surgery) people will move location to obtain the right job. But in many other specialties young doctors consider it more important to stay close to their family and friends and those areas facing recruitment challenges are much more likely to attract people to work there if they have a social network in that area.

It is common for young doctors to move away from the area in which they trained early on in their career. There is no guarantee that if they complete medical school in an area facing recruitment challenges, that they will then stay, especially not to consultant level. This migration throughout

medicine can provide useful learning opportunities and changes in practice as doctors pass on their knowledge in different areas of the country. But it also means that there need to be mechanisms to ensure that those areas in which recruitment is more challenging have sufficient local people going to medical school. As an example, the North East of England has had recruitment difficulties for many years, yet the local university requires UKCAT scores in the top quartile and pays no attention to where students come from.

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?
No

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.
Comments:
Studies on career choice suggest that early exposure to inspiring role models and the nature of the clinical work have important influences on career choice. That said, being near family and friends can be more important – people will change specialties to achieve a better personal life. Generations X & Y consider that being respected and valued at work are key; without this they will leave jobs.
We note that General Practice is afforded a special mention, and think there would be value in identifying other disciplines. Medical schools could ensure that students have sufficient exposure to specialties such as anaesthesia and psychiatry that face more difficulties in recruitment. For instance, there is much useful learning about physiology in anaesthesia, yet it features very little in many medical school curricula.

The majority of medical students do not have clear career intentions, the exception being surgery, where a larger percentage of people come to medical school with this career in mind. Furthermore, positive choice of career changes as we progress through our careers and it would be difficult to base medical school expansion on the ability to recruit to shortage specialties. Trying to pigeon-hole young medical students too early may well cause further issues in the future. Doctors are an intelligent mobile group who will go where their ambitions take them. If we try to force them in to specialities that fall short of their intentions they will vote with their feet as they have very good transferrable skills.

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?
Yes

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.
Comments:
A medical student cannot complete satisfactory training without excellent clinical placements and not every university/medical school will have the ability to expand these placements immediately, depending on how much clinical training is available. Hence, it will be useful to review how much underused clinical educational opportunity exists. Business cases will need to be reviewed from each university in question and the likelihood of their ability to provide for new students assessed.

12. Do you agree that all providers should be offered the opportunity to bid for the additional medical school places?
No

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

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.
In an evolving, and ever environmentally conscious world, providers should be able to show actual or proposed methods for improving sustainability in their delivery of education. Innovation by the provider may also act as a catalyst for students to think more about their own practices.

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.
Comments:
Universities see medicine as a lucrative source of income from students. They do not seem to place much importance on their role as the major providers of the next generation of doctors. Currently they place far more emphasis on the intellectual ability of their students, than on their ability to survive and thrive in the current very pressurised NHS environment. It would be useful to use this opportunity for medical school expansion to reward universities that provide the NHS with doctors who are motivated to work in under-recruited areas and in shortage specialties.

One way to achieve this would be to ensure that a proportion of places were offered to mature students who are already geographically tied to areas that struggle to recruit. Another would be to offer the programme on a part-time basis; people who are already employed in a geographical area might be more likely to stay.

It may be possible in the future to 'reward success' by having a small extra fund that allocated to universities only if the local foundation core or specialty posts are filled. This would only be made available to those universities geographically situated in under-recruited areas.

For students, it is vital that expectations are made clear from the start. If the local health economy expects a contribution from those who qualify in an area, people must be made aware of this when they apply to medical school.

16. Do you agree with the principle that the taxpayer should expect to see a return on the investment it has made?
Where the taxpayer has made an investment, this would seem appropriate. What seems more important is that those working in a health economy who support the development of the next generation of doctors, should see an investment in the efforts they make in practical clinical teaching.

17. Do you agree in principle, that a minimum number of years of service is a fair mechanism for the taxpayer to get a return on the investment it has made?
This mechanism is used by the armed forces. We wonder if there are data to suggest this will be effective in medicine? We consider it better to maintain our medical workforce by appreciating and valuing them.

18. Do you have any views on how many years of service would be a fair return for the taxpayer investment?
If so, please choose from the following options: 2 Years
This is equivalent to foundation year jobs, which is the system we have now. This seems to be the fairest. However, we would much rather this was achieved through rewarding universities that

demonstrate an effective recruitment strategy to support the local healthcare economy than by mandating.

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?
No

Medical students already graduate with significant debt due to the cost of the course, the length of their training and its full time nature, which limits opportunities for part-time work. We think adding to that may be a step too far and will prevent people applying, particularly those who choose medicine as a second career.

It is well known that motivated and enthusiastic workers deliver better quality care; if we have people who are forced to work because they are unable to pay off debts, this will be unhelpful.

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?
Comments:
Currently with tuition fees at £9,000/yr the minimum level of debt for medical students leaving university is £45-54,000 and this may rise in the future. It is unreasonable to expect a young person to commit to this level of debt in addition to being locked in to service for the NHS for a certain number of years. There is the potential for this to be of sufficient concern that fewer people will apply to medical school, negating the benefit of the proposed changes. There are several reasons for this:

a. *People from disadvantaged backgrounds are much less likely to be able to afford to repay funding reducing the choices they will have over their careers. Indeed, it may put many such people off applying; this will be counterproductive when we know that in industry a more diverse workforce is more innovative and achieves better results.*
b. *There are generational differences in peoples' approach to debt. Generation Y and the Millennials may not want to take on large debts and the prospect of having to pay money back if, in the end, a medical career is not for them, might decide against applying. Generation Y want a good relationship with employers; they expect to be trained, have positive bosses and encouragement and want a good working atmosphere & family friendly approach. They are known not to stay long in bad jobs and the current stressful working environment, with a contract imposed on them, may go against their core values.*

Where similar 'minimum service' terms are used (e.g. the military), there is often a large funding grant to reduce or eliminate the debt accrued at university. This has not been suggested here.

Another side effect of this proposal would be the reduction in shared experiences of doctors who travel to work in Australia/New Zealand/Canada/Europe during the early years of their career. This provides valuable experience to the doctor and the NHS when they return to work in the UK and it is much easier for them to logistically manage earlier in their career when family and finances are more flexible.

Finally, we wonder how career breaks and maternity leave will be managed?

21. Is this a policy you wish to see explored and developed in further detail?
No

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?**
Comments:
No

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?
Medicine is already seen as elitist, with a higher percentage of entrants who have had a private education. Such people often do better at school and achieve higher grades, in part because of the more individual attention they receive. Motivated people from less well off backgrounds can get into medical school, but they have to have the confidence to apply and the intellectual capacity to achieve high academic qualifications. Some of those with protected characteristics have to be exceptional to overcome other societal barriers and have the resilience to apply for medicine. An application system that places higher value on resilience, tenacity, and excellence in teamwork and communication might lead to more applicants with protected characteristics. The UKCAT and GAMSAT do not test this.

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?
Comments:
There is the potential for this increase in the numbers of doctors to have a positive impact on flexible working. But this will take several years to achieve. Some areas of the UK and some specialties are so under-doctored that it will take several years to fill current vacancies and return to a full complement of staff. At the same time the demands on the NHS are increasing, with a higher birth rate and a larger population of elderly patients with complex health needs. It is uncertain whether an extra 1,500 medical students per year will be sufficient to keep up with future demands.

More doctors will only be of value if there is more money to pay them. It may reduce the need for locums but you cannot force doctors into jobs they find unattractive or to places where they do not wish to work. This results in career breaks or doctors simply entering the locum market or leaving the profession.

It must be recognised that the combined effects of work intensity, a feeling of lack of respect from the imposition of the junior doctors contract, and the chronic fatigue from filling rota gaps in under-recruited specialties has disillusioned many junior doctors and medical students and caused many more to consider working abroad.

Doctors themselves recognise that current levels of stress and overwork are not compatible with working into their late 60s. Working flexibly and working for fewer hours are likely to help to sustain doctors' enthusiasm to remain in the workplace and have longer careers. Thus, if training more doctors equates to more people working in the NHS, this will be a positive step.
A career in medicine comes with the expectation that certain personal sacrifices will be required. At present the NHS already has shortages in many areas, which severely affects morale among the workforce.

We do not envisage a significant impact on personal circumstances in the near future even with 1,500 medical students per year, who will not become doctors until approximately 2025.

There are some specific issues. The mechanism for placement at FY1 and thereafter is family unfriendly and makes no allowance after FY1 for relationships or families. The national selection

process is a major factor here. It is well known from research that doctors will place greater emphasis on where they work (being close to family and friends) than on choice of specialty.

It is important to consider whether the current medical school selection process is fit for purpose when there is such a proportion of young doctors choosing not to progress through training. The core values and principles of those who are likely to apply to medical school should form a stronger element in medical school recruitment, with a move away from the requirement for A and A grades.*

Introducing a conscription-like process in which people are required to work for the NHS even if they have personal circumstances that make this difficult, may jeopardise family relationships and reduce applicants.

The proposal for repayment is impractical.