

Medical recruitment and manpower in 2013

Few can forget the chaos that took place in 2007 with the introduction of Modernising Medical Careers (MMC) and the Medical Training Application Service (MTAS) recruitment process for doctors. Bayne et al (2007) described the waves of anger that ran throughout the medical profession, partly as a result of the selection techniques, but also because of the rigidity of the training model that was being implemented. Six years later the processes for selection and recruitment are vastly improved, while the manpower problems in medicine are still partly unsolved.

Selection and recruitment

Many specialties have chosen to use a range of selection processes, rather than a single interview. Work by Gale and colleagues (2010) in anaesthesia established the benefits of using multiple 'stations' rather than a single interview. Applicants for training posts were selected based on four separate scores, looking at their past behaviour and achievements, and at simulated work tasks (presentation and simulation). This scheme has been adopted by the specialty throughout the UK, and has been reviewed annually.

Selection processes are designed to pick the best applicants, but many studies have found it difficult to get reliable outcome data. The career paths of successful candidates are easy to track, while those that are rejected are lost to follow up. However, this may soon change – there are proposals to develop a centralized process across all specialties. The Medical and Dental Recruitment and Selection is driven by financial and logistic objectives, but it should be able to provide extremely useful long-term outcome data on the fate of applicants who were initially unsuccessful.

Offers and points of entry

Another major benefit to junior doctors applying for specialty training is the development of a centralized offers process. Many applicants apply to multiple special-

ties, and are anxious to view the progress of each of these applications before making a considered decision on a post that is offered to them. The UK Offers System was piloted successfully with three specialties as part of 2012 specialty recruitment with over 3500 applicants using the system, and has been used in Scotland for the past 5 years.

This year the Department of Health has restricted the number of entry points into training. Entry at CT2 is to be discontinued in all specialties with the exception of emergency medicine and core psychiatry. In many ways this restriction will be of benefit to junior doctors. CT2 has always been a difficult area for recruitment and has often attracted a weak cohort of applicants, but trainees who have come to the end of their training programmes, without the necessary competencies or examination passes, have been displaced by new entrants to training. The ending of CT2-level entry might now permit training programme directors to use their discretion in managing those trainees that require additional time in training.

Numbers of doctors and the shape of training

The 'Shape of Training' review is currently hearing evidence in order to determine the best structure for the future. It is looking at the duration of training overall, and the balance between 'generalist' and specialist training. It is also looking at balancing the number of doctors at different stages of their careers with the needs for patient care.

Current Department of Health plans are for the number of specialty or core training recruits (across all specialties) to not exceed 6500 nationally. This is a slight reduction from the 2012 figure of 6700 posts. However, this seemingly modest reduction in numbers is to be spread unevenly across the country, based on weighted capitation figures.

General practice is regarded as a priority area. It is therefore proposed that half of all doctors should go into this field, in order

to provide sufficient trained GPs for anticipated needs. In order to facilitate this, the General Practice Recruitment Office aims to increase the number of entrants from 3000 entrants per year to 3250. In fact there is already a slight shortage – the actual number of vacancies advertised in 2012 was only 2687.

Conversely, the number of entrants into core surgery is to be reduced. The total number is to be dropped from 600 down to 550, with London bearing the brunt of this reduction.

Doctors who change career

Will the perceived competition influence career choices of junior doctors? It is already well established (Thomas, 2008) that there are some doctors who commit strongly and early in their careers, often motivated by the choice of specialty. Others wait, and commit later or move about, driven by the quality of life and flexibility. In surgery, as well as other specialties, lifestyle is viewed as an important factor for choosing a career (Corrigan et al, 2007).

General practice was placed as first choice by just over 20% of doctors in their first year after qualification (Lambert and Goldacre, 2011). This proportion increased by year 3 after qualification, but was still short of the required 50%. There were significant differences between medical schools, and doctors from newly established English medical schools showed the highest preference for a career as a GP. Those applicants who decided early in their careers to enter general practice cited the variety of the work, continuity of patient care and work-life balance as their main drivers, and were statistically more likely to have undertaken a foundation placement in general practice than their peers (Irish and Lake, 2011).

I would welcome moves that would make it easier for doctors to switch careers, and support any changes that could facilitate this. In particular, I would like to see training curricula simplified, in order that trans-

ferable skills can be more easily recognized and recorded, but this might take some time to come to fruition. In the meantime, doctors who wish to change career often need to start afresh at CT1. However, they often bring useful skills with them, albeit not always explicitly recordable.

The impact of Generation Y

Finally we need to remember that the current cohort of trainees comes from a different generation to their trainers. Mitchell (2008) has pointed out that the baby boomers, who now hold senior posts, were brought up within a culture that saw medicine as a tireless vocation. This made them the workhorses of the profession. Younger generations, who are making up an increasing proportion of the workforce, were brought up with an ideology that favours more mobility, and that seeks a different balance between work and life outside. How this generation will respond to the changes in competition in medicine remains to be seen. **BJHM**

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KEY POINTS

- The processes for selection into core training and for issuing offers to successful applicants have improved considerably over the past 6 years.
- There are moves to encourage doctors to follow a career in general practice, coupled with a reduction in the number of trainees in core surgery.
- The current generation of junior doctors has been brought up with a different view of work–life balance than their parents.

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