Academy response to the NHS Consultation Document: Unfinished Business – Proposals for reform of the Senior House Officer grade

Executive Summary

The Academy agrees that the SHO grade is in need of reform and development. It notes that the consideration of trainees who plan a career in academic medicine has been omitted from this report. Whilst this is an important omission, it creates for the first time an opportunity for the NHS, in partnership with the academic community, to develop integrated career pathways for those who intend an academic career. The hall-mark of such pathways must be flexibility, and an essential requirement to achieve this must be competence rather than time-based assessments of progress through training, a feature of the report that the Academy welcomes.

The Academy has identified several key areas where action can help remedy the current situation. The Academy proposes that: -

1. The Postgraduate Medical Education and Standards Board should develop a subgroup with specific expertise and sympathy for the supervisory oversight of the training of academics.

2. The period of training for SHOs with academic career intentions should normally be contained within three years rather than four.

3. A small number of SHO training programmes should be designated for trainees with academic backgrounds and intentions. These would be an addition to the eight programmes, set out in paragraph 3.17 of the proposals, and would provide an explicit academic training route for SHOs.

4. The appointment to such rotations should remain the responsibility of the Postgraduate Deans but the composition of the appointment panels should be fit for the purpose of selecting those with academic as well as clinical flair.

5. Specific academic SpR training programmes should be developed. Clinical training requirements for this group should be determined on an individual basis, run by a national training committee for academic clinicians.

6. Shorter clinical programmes for academic trainees should lead to the award of a CCST for those satisfactorily completing training programmes in training in either the "generalist" elements of a specialty or within a narrower subspecialist area.

The Academy believes that further discussion around these proposals could lead to the implementation of imaginative new schemes for the training of clinical academic staff that will complement the new training programmes proposed in this consultation paper. It would be pleased to enter into further discussions with the Department of Health aimed at implementing a scheme for the training of the academic leaders that are essential for the future vitality of the NHS.

---

1 Background

1.1 The Academy of Medical Sciences agrees that the SHO grade is in need of reform and development. It notes the omission of any consideration of trainees who plan a career in academic medicine. This omission is disappointing but does provide an opportunity for the extension of the successful partnership between the NHS and the Academy of Medical Sciences in developing joint clinical and academic training schemes for academic clinicians. This started with the creation by the Department of Health of posts for Clinician Scientists in response to the Academy report 'The tenure-track clinician scientist: a new career pathway to promote recruitment into clinical academic medicine'[1].

1.2 In this response we propose a training programme that caters for the specific needs of medical academic trainees. This builds on many of the proposals in the consultation document. We start from the premise that academic medical staff are essential to the NHS in their roles as leaders and providers of medical education and research. We summarized the importance of the medical academic to the NHS in our recent report 'Clinical academic medicine in jeopardy: recommendations for change'[2]. Just as in any other branch of medicine, academic medical staff require specific training programmes that integrate clinical, teaching and research training.

1.3 The four following sections of our response deal in turn with the mechanisms for supervisory oversight of training programmes, the options for entry to research training, proposals for the clinical training of academic clinicians, and finally some comments on specific aspects of the proposals in the consultation paper.

2 Training Programmes for Academic Staff

2.1 We propose here a training programme for those who are committed to a career in academic medicine. The essence of such training is the requirement for flexibility and for progress to be measured by attainment of skills and expertise, rather than

---

[1] '*The tenure-track clinician scientist: a new career pathway to promote recruitment into clinical academic medicine'* was produced by an Academy working group chaired by Professor John Savill, FMedSci. The report was published in March 2000.

[2] '*Clinical academic medicine in jeopardy: recommendations for change*' was produced by an Academy working group chaired by Professor Sir Peter Morris. The report was published in June 2002.

by the time-served mechanism that currently dominates medical training. This approach places new demands on both trainees and trainers to demonstrate that specific skills and competencies have been acquired. The Academy of Medical Sciences proposes that the Postgraduate Medical Education and Standards Board develops a subgroup with specific expertise and sympathy for the supervisory oversight of the training of academics.

3 Entry to Research Training:

3.1 There is no single right time for a medical academic to undertake a formal period of research training. At present a small number of individuals enter medical school to undertake an MB PhD programme. This group needs special attention if their early research training is to be of value to the health service. The present danger to these is trainees that, on completion of their MB PhD, they enter clinical training as PRHO followed by SHO. Because of the lack of opportunities for continuing academic work during this period of early clinical training, their research experience may become 'stale' and this reduces the likelihood of such individuals re-entering and developing their research career.

3.2 A second group undertakes training during or at the end of their SHO training. Because there may be a bottleneck for entry to the SpR grade in some specialties an increasing number of trainees are applying for research training at this point in their careers. This may be the correct time for some academic trainees to start there research training. However, others may be choosing to enter research at this bottleneck in their clinical training for reasons of career expediency rather than because of a primary desire to undertake research. This is undesirable for both the NHS, which loses trainees from clinical practice, and for the research community and funders, who acquire an unmotivated and expensive research trainee.

3.3 The third group enters training for research from SpR training rotations having already gained an NTN. This group is presently the best catered for in terms of continuity of research and clinical training. The Academy's report 'The tenure-track clinician scientist: a new career pathway to promote recruitment into clinical academic medicine'[3] led, in partnership with the NHS, to the creation of additional NTN(A) training numbers, accompanied by a series of tenure-track clinician scientist fellowships. However, unless special arrangements are introduced for the clinical training of such individuals, doctors pursuing this route may be penalized by the requirement to complete 4 years of SHO training, coupled with generalist followed by specialist training at SpR level. The Academy of Medical Sciences believes that this would provide a severe disincentive to entry to academic medicine.

[3] *'The tenure-track clinician scientist: a new career pathway to promote recruitment into clinical academic medicine'* was produced by an Academy working group chaired by Professor John Savill, FMedSci. The report was published in March 2000.

3.4 The Academy believes that the possibilities must be maintained to enter training for research during the MB programme or at SHO or SpR grade. This must be achieved in conjunction with clinical training of the highest standards that will enable the academic trainee to develop the clinical skills of a consultant as well as making major contributions in teaching and research.

4 Clinical Training for Medical Academic Staff

4.1 The following proposals for a career structure for medical academic staff follow three principles. The first of these is that the large majority of academics will opt for training in a specialized field of clinical practice rather than as generalists, though for a minority the corollary may apply. The second is that many will make earlier choices of career pathway rather than sampling varied specialties before opting for a particular route. The third is that progress through training will be based on an assessment of competence rather than time-served.

4.2 The Academy proposes that the period of training for SHOs with academic career intentions is normally contained within three years rather than four. This could be achieved by reducing the necessity of SHOs for broad sampling of career options and by close monitoring of the content of the posts within a rotation to ensure that they provide training in core general skills. Time in research could be recognized as counting towards up to one year of SHO training, in the context of approved shorter clinical rotations. What would be the criteria for allowing SHOs to undergo this abbreviated clinical training option? One entry criterion would be the possession of both MB and PhD qualifications. The second would be strong evidence of career intent that was academic. This would need to be judged by interview but supporting evidence would be a good class in an intercalated degree, coupled with general strength in the academic record during training and a clear vision of career intent. By their strong undergraduate education records such individuals would have already satisfied tests of high competence, which should act as a surrogate for more rapid subsequent training progress.

4.3 We welcome the call for consistently high standards of appointment to the SHO grade and management of SHO training programmes by means of the involvement of regional postgraduate deans. However, there is a problem with ‘one size fits all’ rotations and appointment mechanisms that means that bright young trainees with an overt commitment to training in research and education might be assessed by appointment panels that are biased towards service requirements and away from the inconveniences associated with the flexible training requirements of academics. We would propose that a small number of SHO training programmes are designated for trainees with academic backgrounds and intentions. This would be in addition to the eight programmes, set out in paragraph 3.17 of the proposals, and would provide an academic training route for SHOs. The Academy proposes that appointment to such rotations would remain the responsibility of the Postgraduate Deans but that the composition of the

appointment panels would be fit for the purpose of selecting those with academic as well as clinical flair.

4.4 After SHO training, there would be several options for career progression for academic trainees. The first would be entry to a Clinical Training Fellowship for those lacking a PhD. This would be achieved by competition for a Training Fellowship Scheme run by a funding body such as the MRC, Wellcome Trust or other AMRC charity. For those trainees who had completed a PhD as part of an MB PhD programme, they would be able to compete for a Clinician Scientist Fellowship at this point in their career. A third option would be competition for an NTN and entry to an SpR training programme, with a view to entering a research training programme after one to two years of SpR training.

4.5 Some academic trainees might choose to exit academic training programmes at this point and indeed at any other point during their training. For these individuals as for others seeking a change in the direction of their careers, the Academy welcomes the approaches set out in paragraphs 3.20 – 3.22 of the report for a number of placements on individual programmes for those doctors requiring support in changing career direction. The consultation paper suggests that the numbers of such individual programmes will be limited and the Academy agrees that it is unlikely that individual programmes will be needed by large numbers of trainees. However, the Academy urges that such programmes should be made available to all those who have genuine needs for individual programmes.

4.6 The Academy proposes that specific academic SpR training programmes are developed. For trainees who will also be in receipt of Research Fellowships during their SpR training we suggest that liaison is developed with research funders and universities to ensure matching between the expectations of research and clinical training. This liaison could be achieved by appropriate membership of an academic training subgroup of the Postgraduate Medical Education and Standards Board.

4.7 There would need to be joint clinical and research eligibility requirements for entry to academic SpR training programmes. One requirement would be satisfactory progress through clinical training and eligibility for entry to the clinical career pathway. A second requirement would be successful award of a Training Fellowship or Clinician Scientist Fellowship (for candidates holding a PhD) by a funding body. It is estimated that less than 200 junior doctors each year nationally will enter higher training by this route and this number should not perturb significantly manpower numbers for any individual specialty. It is proposed that clinical training requirements for this group are determined on an individual basis, run by a national training committee for academic clinicians, constituted and led by Medical Postgraduate Deans in consultation with research funders and appropriate specialist training committees. This committee could be identical to or separate from an academic subgroup of the Postgraduate Medical

Education and Standards Board. Supervision of the content of Clinical Lectureships could fall also within the remit of this subgroup.

4.8 As a parallel to the proposal in the report that "new and shorter programmes should lead to an award of an earlier CCST for those satisfactorily completing training in the "generalist" elements of a specialty" the Academy of Medical Sciences proposes that shorter clinical programmes for academic trainees should lead to the award of a CCST for those satisfactorily completing training in either the "generalist" elements of a specialty or, much more likely in a subspecialist area – for example 'diabetic medicine' or 'renal transplantation surgery'. The Academy notes that the report distinguishes between two categories of specialist: "the 'generalist' consultant and what some have dubbed the 'ologists'". The report proposes a career pathway that means that all 'ologists' proceed to that training after completing a 'generalist' training. The Academy proposes that some academic consultants may train as 'ologists' without the necessity for a complete 'generalist' training.

4.9 The report places particular emphasis on "opening up new opportunities for doctors in non-consultant career grades to re-enter training and become a consultant". The Academy supports this aim. Furthermore, there must be pathways that enable a doctor with a CCST as a generalist to proceed to further specialist training and *vice versa*. It is essential that this is achieved by training accompanied by competence-based assessment – doctors may broaden or narrow their expertise after a number of years as consultants. There is no point in subjecting the former category of consultant to prolonged periods of formal retraining and equally a danger of under-retraining of the latter category. Systems for the re-training or broadening the scope of the training of consultants are currently lacking – their formal implementation is essential; the needs of the academic community are only one of many drivers for this development.

4.10 The Academy believes that further discussion around these proposals could lead to the implementation of imaginative new schemes for the training of clinical academic staff that will complement the new training programmes proposed in this consultation paper. It would be pleased to enter into further discussions with the Department of Health aimed at implementing a scheme for the training of the academic leaders that are essential for the future vitality of the NHS.

5 Academy comments on specific sections of the consultation paper.

5.1 Two of the most significant changes proposed in the consultation document are not part of SHO training and without the relevant supporting arguments and evidence it is difficult to judge whether the changes will improve the training of junior doctors. The first of these is **the development of the two-year Foundation Programme**. The content of this is not defined in any detail in the consultation document, nor its relationship to the current PRHO year. The Consultation is not explicit about whether the Foundation Programme replaces training that is thought

to be deficient in the current PRHO year or provides a different type of content to the first SHO year. Paragraph 3.13 of the consultation gives some insight into the thinking in that it will provide "broader experience of medicine and of career options available….". Again it is not clear what is intended. A number of PRHO training schemes already provide a period in general practice as well as in hospital specialties. What is the broader experience that will be provided? In any cohort of young doctors there are a significant number who will have made informed choices during their training or at the very start of their careers. In the case of academic medicine, a small number have made the onerous commitment of undertaking an "MB PhD" Programme. There seems to be little merit in forcing such individuals to undertake a two year programme when one year can provide the relevant training. Similarly, if a young doctor is committed from an early stage to a career in a specific branch of clinical practice, then offering an excessively broad menu during the foundation training may not be appropriate.

5.2 The second important change proposed outwith the SHO grade in this consultation is to change **the nature and timing of the award of the certificate of the CCST**. The proposal developed in section 3.5 is that for those trained in the generalist elements of a specialty, a CCST should be awarded following satisfactory completion of training after 3 to 4 years (presumably as compared with the 4 to 5 years required in most specialties at present). This proposal begs some very fundamental questions about the boundaries of practice of consultants. What would be the restrictions on practice of a consultant who had a CCST in the "generalist" elements of a specialty? How would clinical governance operate to handle a generalist who was dabbling in specialist areas for which a longer period of training had been defined? How would this system operate in the craft specialties? Is it argued that the practical skills that would allow high quality general surgery can be acquired more rapidly than the skills to undertake a specialized branch of surgery? If a little knowledge about a great deal can be acquired in a short time then the corollary is that a great deal of knowledge about a limited area of specialization can be similarly acquired quickly.

5.3 Comments on proposed flexibility of training

5.3.1 The Academy applauds the emphasis on flexibility of training that is proposed throughout the report. However we are concerned that some of the proposals in the Consultation paper will act as a severe barrier to the flexibility of training. Firstly there is the proposed time-capping of the period of SHO training. Time capping imposes a high degree of inflexibility – what will a trainee do if a training vacancy in his or her specialty of choice is not available? Human resources planning in the NHS has always been stymied by exit blocks to training grades and these proposals may introduce a further block. The default option for trainees at career hiatuses in medicine has always been to undertake a period of research. As emphasized above this may be a waste of time for those with no academic intent or alternatively force trainees to undertake research training at the wrong time for both their clinical and academic training.

5.3.2 Secondly, the move towards a 'run-through' training grade (Proposal 17), will reduce flexibility. It is already difficult for trainees to move from one training rotation to another. Similarly within training rotations, competing demands between trainees and variation of entry and exit times, mean that there is less flexibility for trainees within rotations. The consequence is that trainee choice of posts within rotations can often not be achieved.

Further information: Executive Director, Academy of Medical Sciences, 10 Carlton House Terrace, London SW1Y 5AH. Telephone: 020 7969 5288. Email: apollo@acmedsci.ac.uk