

Junior Doctors in the NHS: Preparing medical students for employment and post-graduate training

Skills for
Health



A study of NHS organisations' views of the outcomes of current undergraduate medical training and whether the proposals in the draft 'Tomorrow's Doctors 2009' will meet the future needs of the NHS

Study undertaken by Skills for Health, on behalf of the General Medical Council, as part of consultation on the draft 'Tomorrow's Doctors 2009'

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The GMC thanks Skills for Health and employers across the UK health sector for their contribution to this survey for the Tomorrow's Doctors consultation. Employers are a key interest group for the GMC. The GMC looks forward to further collaboration to ensure effective implementation of the standards in the 2009 edition of Tomorrow's Doctors.

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Foreword

The Tomorrow's Doctors 2009 initiative is an important step towards securing a better prepared medical workforce, and we would like to thank the General Medical Council for inviting Skills for Health, the Sector Skills Council for the UK health sector, to take part. Together, we have a shared interest in seeing the best possible education and training for doctors that is aligned with the needs of employers and equips medical staff for their critical role in improving health and healthcare across the UK.

Thank you to all those who took part in the Tomorrow's Doctors consultation through our wide ranging discussions across the health sector. These discussions have provided a unique and valuable insight into employers' experience of medical education and training and its outcome. Feedback from over 200 chief executives, medical directors, workforce directors, clinical directors, clinical tutors, consultants and other staff has been instructive.

We were told that standards have been improving with some excellent junior doctors coming through, but there is still much to be done to meet current and future needs. This report shows that there are challenges for all of us in helping to develop our future doctors. There is a need for all employers to take a direct and proactive interest in the practical arrangements for training medical students and junior doctors. There are issues to be faced and dealt with if we are to secure the best possible training for the sector and ensure safe, world class, quality healthcare for patients.

Feedback also shows a willingness among employers to encourage new models for supervision, support and guidance for junior doctors, and medical students on clinical placements. We welcome this shift towards employers playing a greater part in shaping the medical workforce, and feel there is scope for further work around issues raised, to ensure good practice is extended across the health sector. Greater partnership working across medical schools and NHS organisations will be needed if we are to ensure future doctors have the right opportunities to gain vital clinical skills and expertise, and to develop much needed clinical leadership for the sector.

Working together we can build on the momentum of the Tomorrow's Doctors 2009 consultation, and find ways to help under-graduate and post-graduate medical education become even more attuned to the current and future needs of the NHS.



Chris Hannah
Chair, Skills for Health

Executive summary

1. This study was undertaken by Skills for Health in support of the General Medical Council's consultation on the draft Tomorrow's Doctors 2009. The study set out to seek views from employers in the NHS about the outcomes of current medical undergraduate training and whether the proposals in the draft Tomorrow's Doctors 2009 will meet the future needs of the NHS. In particular, the study aimed to assess:
 - The extent to which existing junior doctors are appropriately trained for the roles expected of them by the NHS now and in the future
 - The extent to which the GMC proposals in Tomorrow's Doctors 2009 will result in junior doctors who are appropriately trained for the roles expected of them by the NHS now and in the future
 - The feasibility and impact of the GMC's proposals to deepen students' hands-on experience of patient care and to secure educational benefit from undergraduate placements.
2. A total of 230 semi-structured interviews were conducted with a range of NHS staff from across the UK, in two phases. The content of these interviews was then analysed and the findings are summarised in this report.
3. Interviewees were keen to say that some junior doctors are excellent and some respondents thought that standards were generally improving. The message from many respondents was, however, that junior doctors are generally not meeting the needs and expectations of the current NHS. The main areas which cause difficulties are lack of confidence and competence in clinical-decision making, clinical procedures and prescribing in practical situations, lack of understanding of the NHS and how it works, and standards of professionalism which are below those generally expected of NHS employees.
4. These difficulties stem from some aspects of under-graduate training, especially the way in which clinical placements are organised and are exacerbated by the organisation of post-graduate training. The European Working Time Directive and Modernising Medical Careers, in particular, four month rotations, have resulted in larger medical teams who do not know each other well. Junior doctors therefore have less of a sense of belonging to a 'team' of people whose members know each other and are supporting their learning and development.
5. The changing nature of the NHS and changing clinical practice add to some of the difficulties for junior doctors. Patients stay in hospital for shorter periods of time and services are under pressure to treat them more quickly. More care is now delivered outside hospital and patient and relatives are now better informed about their care.
6. Some of the behaviour of the NHS contributes to the plight of junior doctors. Some people interviewed said it was no longer worth 'bothering' with training junior doctors or trying to change their behaviour because they are within the service for such a short time. Others commented on junior doctors not having a place to work while on duty or access to an appropriate rest area. The attitude of some NHS staff to junior doctors is dismissive rather than encouraging.
7. In general, respondents were positive about the proposals in the draft Tomorrow's Doctors 2009 and felt that these should produce doctors that meet the needs of the NHS – if implemented across the UK. Strong doubts were, however, expressed about the extent to which it will be implemented in practice. Particular difficulties in implementing the proposals on clinical placements were envisaged. Many respondents foresaw difficulty in obtaining the necessary educational benefit within the current structure

of post-graduate medical education and with the service pressures on clinical teams – unless the service concerned is very committed to under-graduate education. New models of supporting and guiding medical students on clinical placements are needed. Medical schools and NHS organisations must work much more closely together. Senior NHS staff who were interviewed were keen to do this but did not feel they have the forum to do so or the influence they needed.

8. This report concludes that the four month rotation of junior medical staff should be reviewed and that Workforce Deaneries and NHS organisations should be working together to develop new models for supervision, support and guidance for junior doctors.
9. NHS organisations need to look very seriously at how they help junior doctors to ‘belong’ to the organisation and the service within which they are working. They need to engage with junior doctors in tackling practical, behavioural and cultural factors.
10. These issues need to be addressed with some urgency. The implications of failing to act are serious. Firstly, patients will continue to be at risk because of the inexperience of some junior doctors. Secondly, the role of junior doctors may need to be redefined – with significant cost to the NHS if extra staff are put in to compensate for junior doctors’ lack of experience. Thirdly, the NHS faces loss of morale, motivation and commitment of a whole generation of doctors in whose training we have invested heavily. The NHS needs doctors at all levels who are committed to their work in the NHS, who feel they belong to the service and who are able actively to improve the services which are offered to patients. We cannot afford to ignore the messages contained in this report and must start to ‘be bothered’ about our junior doctors.

Introduction

BACKGROUND AND AIMS

11. The General Medical Council (GMC) regulates undergraduate medical education. The GMC does not set a national curriculum, but determines the knowledge, skills and behaviour ('outcomes') that students must be able to demonstrate in order to graduate, acquire provisional registration and start to practise and train in the Foundation Programme and the NHS. The GMC also lays down standards for the delivery of teaching, learning and assessment that must be met by the medical schools. These outcomes for graduates and standards for delivery are set out by the GMC in Tomorrow's Doctors, which was most recently published in 2003. The GMC is in the process of revising Tomorrow's Doctors and issued a draft Tomorrow's Doctors 2009 for consultation in December 2008.
12. Skills for Health is the Sector Skills Council (SSC) for the UK health sector. Skills for Health helps the whole sector develop solutions that deliver a skilled and flexible UK workforce in order to improve health and healthcare. In particular, Skills for Health works with partners to develop and manage national workforce competences, profile the UK workforce, improve workforce skills and influence education and training supply. Skills for Health's key goals are to address skills gaps and shortages, improve productivity and performance, increase opportunities to boost skills and improve learning supply.
13. Both the GMC and Skills for Health recognised that, in the past, NHS organisations which employ doctors have had relatively little influence on their training. As part of the consultation on Tomorrow's Doctors 2009, Skills for Health therefore agreed to work with the GMC to seek views from employers¹ in the NHS about the outcomes of current medical undergraduate training and whether the proposals in the draft Tomorrow's Doctors 2009 will meet the future needs of the NHS. Junior doctors are the immediate outcome of undergraduate medical education and so this study focuses on junior doctors and the extent to which they are meeting the NHS's needs.
14. The study specifically set out to assess:
 - The extent to which existing junior doctors are appropriately trained for the roles expected of them by the NHS now and in the future
 - The extent to which the GMC proposals in Tomorrow's Doctors 2009 will result in junior doctors who are appropriately trained for the roles expected of them by the NHS now and in the future
 - The feasibility and impact of the GMC's proposals to deepen students' hands-on experience of patient care and to secure educational benefit from undergraduate placements.

APPROACH

15. This study was undertaken in two stages. Firstly, Skills for Health conducted semi-structured interviews with a range of staff in seven NHS organisations:

Belfast Health and Social Care Trust	Powys Local Health Board
Borders General Hospital NHS Trust	Somerset Partnership NHS Foundation Trust
Camden Primary Care Trust	Worcestershire Acute Hospitals NHS Trust
Nottingham University Hospitals NHS Trust	

¹ NHS employers and NHS organisations includes NHS Trusts, PCTs, Local Health Boards, Health Boards, Health and Social Services Boards, Health and Social Care Trusts, Strategic Health Authorities and other special Health Authorities / Boards.

16. These interviews were used to refine the questions and formulate initial findings. In the second phase of the study, Skills for Health UK Networks Directors interviewed staff from a variety of backgrounds within their region / country. Appendix 1 shows the semi-structured questions used for these interviews.
17. A total of 230 interviews were carried out in January to early March 2009 covering all regions and countries of the UK. Table 1 shows the distribution of respondents by role. The themes described in this report came from all parts of the UK with no significant differences between regions and countries.

Table 1 – Respondents by Role

Role	No.
Chief Executive / Deputy	15
Medical Director / Deputy	32
Workforce Director / Deputy	16
Other Executive Director	7
Clinical Director	17
Clinical Tutor / Medical Educator	42
Other Consultant / GP	12
Pharmacist	21
Business / Service Manager	28
Modern Matron / Ward Manager	17
Foundation / Community / Specialist Trainee	22
Total	230

18. Content analysis of the points made during the interviews was then carried out, the results of which are summarised in this report. The number of respondents expressing a particular view is indicated in the text by the use of the words ‘some’, ‘several’, ‘most’ and ‘nearly all’. The strength with which views were expressed is also reflected in the report. Several of the issues identified are, however, inter-related and these issues may have been expressed in different ways by different respondents. The percentage of respondents is included in some places to emphasise the strength of particular views.
19. The findings of this study are presented as context and general messages followed by responses summarised using the structure of the draft Tomorrow’s Doctors 2009. The needs of the NHS of the future and implications for the GMC and for NHS organisations are then identified. The themes described in this report are, of necessity, generalisations. Respondents were keen to point out that some junior doctors are excellent. Some of the specific examples in this report may apply to a relatively small number of junior doctors. The general themes came out strongly in our interviews, however, and clearly apply to a significant proportion of the junior doctors currently working in the NHS.

ACKNOWLEDGEMENTS

20. Skills for Health would like to acknowledge the support and help from the organisations which participated in phase 1 of the study (listed in section 15), all those who agreed to be interviewed and gave their time and insights to this process, Jane Eminson who steered the project and wrote up the report and David Frith for analysis of the responses.

Findings: Are junior doctors trained appropriately for the roles expected of them now?

CONTEXT

21. It is important to recognise the context within which this study was carried out and interpret the findings accordingly. Four points are particularly relevant. Firstly, some of the people interviewed saw the past as a glorious place where all was well. Others showed more awareness of potential influencing factors, for example, saying “We are now much more aware of and open about errors” or “Problems with junior medical staff used to be dealt with by having a ‘quiet word’ – that doesn’t happen any longer”.
22. Secondly, the NHS itself is changing rapidly. In particular, patients and their families are expecting, and are being offered, more information, involvement and choice in decisions about their care; patient pathways are being speeded up; the drive to improve efficiency continues to reduce length of stay and increase day case rates; roles are changing and becoming more flexible; more care is being delivered outside hospital; new techniques are being developed and implemented; governance systems are being strengthened; the European Working Time Directive and Modernising Medical Careers have been introduced; a range of service improvement initiatives are showing real impact, including LEAN and ‘productive’ hospitals, general practice and community services.
23. Thirdly, the role of medical students and junior doctors within this system is less clear and less consistent than in the past. The role on completion of post-graduate training is clearer but roles between graduation and completion of post-graduate training are less clear. The responsibilities of doctors in training overlap, sometimes significantly, with other healthcare professionals. Doctors in training are expected, especially in the initial stages, to be ‘followers’ rather than leaders. Several respondents commented that the role that junior doctors are expected to perform may need to change, that is, that some of the difficulties described in this report may be due to the role expected rather than problems with the skills and competences of the junior medical staff.
24. Finally, all employee / employer relationships are two-way. In some cases, the actions of NHS organisations appeared to be contributing to the difficulties experienced by junior doctors. This report is therefore not intended to be critical of medical students or junior doctors. They are part of a system and, in part, are responding in ways that the system causes them to respond. Section 89 discusses the way in which NHS organisations could help under-graduate and post-graduate medical education become better able to meet the current and future needs of the NHS.

GENERAL MESSAGES

25. There were a variety of views over whether, in general, junior doctors are appropriately trained for the current needs of the NHS. Some respondents considered that they are generally appropriately trained, with comments such as “They are generally better trained and more fit for purpose” (Medical Director) and “Some are ready for the job from day 1, others grow into it, none of them are not going to cope” (pharmacist).
26. A much more common and more strongly expressed view coming from all parts of the UK was that, although some aspects of their training have improved considerably, recent medical graduates are generally not meeting the needs of the current NHS. This is partly because of issues relating to their undergraduate training. Difficulties are exacerbated by the way in which post-graduate training is

organised – which then impact onto under-graduate medical students. The changing nature of the NHS itself is another contributory factor.

27. The main areas which cause difficulties are:

- lack of confidence and competence in clinical-decision making and prescribing in practical situations,
- lack of understanding of the NHS and how it works, and
- standards of professionalism which are below those generally expected of NHS employees.

28. Many respondents linked these difficulties with changes in the organisation of medical ‘teams’ and a consequent system-wide reduction in junior doctors’ sense of ‘belonging to a team’. EWTD limitations on numbers of hours worked were seen as good, because doctors were not working excessively long hours, but mean that junior doctors’ exposure to patients, learning opportunities and colleagues is reduced. The number of staff working within a service is greater and colleagues may not see each other for long periods because of the way shifts are organised. The four month rotation of junior medical staff means that junior doctors do not have long to get to know their medical ‘team’, nursing staff on the ward or other staff within the hospital – or to build up confidence and competence in clinical practice.

29. Many respondents said that the consequence of EWTD, four month rotations and reduction in ‘belonging to a team’ is that junior doctors are, in general, not sufficiently clinically confident and competent for the roles expected of them.

30. These problems impact on medical students and the learning experience during clinical placements. There is less sense of a team to which they can belong. There are more medical staff to whom they have to relate and the junior doctors who teach and guide them are less confident and competent.

OUTCOMES

OUTCOME 1: THE DOCTOR AS A SCHOLAR AND SCIENTIST

Apply biomedical scientific principles, method and knowledge to medical practice

31. Some respondents (8%) said that junior doctors have a lack of basic scientific knowledge. More of those interviewed (27%) mentioned that junior doctors have difficulty applying biomedical scientific principles, method and knowledge to medical practice in the practical situations in which they find themselves as Foundation Programme doctors. These difficulties included assessing common disease presentations, selecting appropriate investigations, interpreting the results of investigations and selecting appropriate management. Nearly all respondents talked about junior doctors not having had enough experience in clinical situations and so not having the confidence and competence needed to make decisions about the clinical management of patients. As one respondent said “The NHS is having to take responsibility for finishing their basic training.”

32. Several respondents mentioned that junior doctors need to have greater awareness of local and national guidelines and protocols that they should be following and greater understanding of the need to follow protocols rather than (as suggested in the draft Tomorrow’s Doctors 2009) ‘select appropriate forms of management... from first principles’.

33. Comments from some respondents were about the need for greater awareness among junior doctors that guidelines / protocols may differ between specialties and, in particular, may not always be the same as in adult general medicine or surgery. Respondents from mental health, paediatrics and GU medicine gave specific examples of junior doctors failing to appreciate that guidelines / protocols are different.

These respondents did not expect junior doctors starting work in their specialty to know the detail of these protocols; they did expect junior doctors to appreciate that they may be different. Examples included inappropriate prescribing, failure to refer to a specialist centre and failure to arrange investigations. Several staff working in mental health services said that junior doctors do not generally have sufficient understanding of mental health-related issues.

34. Respondents' strong views on drug actions and pharmacokinetics are covered in sections 46 to 48. Some respondents saw junior doctors' difficulties in this area as a lack of basic knowledge of pharmacology but many more considered them to have difficulty applying this knowledge in clinical practice.

Apply population and improvement science principles, method and knowledge to medical practice

35. As with biomedical knowledge, the difficulties raised related mainly to 'apply... to medical practice' rather than concerns about the junior doctors having the relevant knowledge base. The two areas where significant concerns were raised were 'health and health service policy including issues relating to health economics and equity, and clinical guidelines' and 'apply the basic principles of communicable disease control'.
36. Nineteen per cent of respondents commented on junior doctors' lack of understanding of the NHS as an organisation and as a business – even though this area was not specifically probed in the interviews. This was seen as hindering their ability to do a good job and limiting the benefit which the NHS could gain from their presence. In practice, junior doctors have the potential to make a huge difference to improving the efficiency, quality and responsiveness of NHS services. One Surgical Directorate Manager commented "They do not understand the business of the NHS as well as they might – especially management, governance, finance, service development and EWTD. They need to understand the language and drivers of management – this would improve performance and reduce conflict with managers. To help this they need to be exposed to the patient-focused rationale for processes."
37. This concern was linked with some comments about the lack of understanding of NHS policies changes at more senior levels and, for some junior doctors, the lack of good clinical role models showing active involvement in implementing NHS policy. There were also comments, including from junior doctors themselves, that NHS policy and targets are seen by junior doctors as irrelevant and unhelpful "The only time I see a manager is when they are worried about ridiculous targets."
38. Infection control was raised by 14% respondents as a specific example of failure to follow local protocols. For example, one Clinical Lead commented "We consistently struggle with junior doctors not adhering to infection control and other safety guidelines." A ward manager said "Junior doctors are very poor at wearing gloves for examinations and washing hands between patients – but the consultants are not always good role models." One junior doctor's comment was "There is no evidence base for the 'short sleeves and no ties policy' and so I don't see why I should do it." Another interviewee said that when challenged about not following infection control procedures a junior doctor had said "You are not going to sack us – you have invested too much money".

Outcomes 1: Other areas

39. Fewer concerns were raised about the outcomes 'apply psychological and social principles, methods and knowledge to medical practice' and 'apply scientific method and approaches to medical research', possibly because the interview schedule did not specifically ask about these areas.

OUTCOME 2: THE DOCTOR AS A PRACTITIONER

Diagnose and manage clinical presentations

40. The findings covered above (sections 31 to 34) about the difficulty in applying biomedical knowledge to medical practice are also relevant here, especially in relation to the outcome 'diagnose and manage clinical presentation'. Twenty seven per cent of respondents commented on some aspect of this area and many felt strongly that junior doctors had not had sufficient exposure to patients to develop their confidence and competence in this area to an appropriate level. There was also seen to be a compounding effect during post-graduate training – the combination of less time worked, larger teams and four month rotations means that learning is not embedded. Junior doctors therefore start each subsequent rotation at a lower level of confidence and competence than would have happened previously and learn less during each rotation than they would have done previously. This also impacts on their confidence in teaching and supervising under-graduate medical students (see sections 83 to 86). One respondent also commented that it is taking longer for doctors in difficulty to be identified.
41. Specific points were made by some respondents about junior doctors' approach to investigations. These are linked with the issue of clinical confidence. One respondent's comment illustrates the general view expressed: "Their attitude is – do all the tests you can think of, ignore the normals and ring the consultant about anything abnormal." One laboratory manager commented on junior doctors expecting laboratory staff to advise on how patients should be treated; others mentioned junior doctors not completing request forms correctly.

Communicate effectively with patients and colleagues in a medical context

42. Communication was specifically asked about during the interviews and responses about communication with patient can be summarised as "Students are better trained in communication and empathy but they are going to need even more." Seventeen per cent of respondents recognised improvements that have resulted from developments in medical education, including techniques such as videoed consultations. Several interviewees commented that "everyone needs more training in this area" and some observed that "students are often assessed in situations which don't relate to their clinical practice". One respondent commented that junior doctors are now better trained in communication than other health professionals on graduation.
43. Underlying the generally positive comments on communication with patients were several (13% respondents) about the need for junior doctors (as other staff) to be more responsive to the needs and wishes of patients. Comments included: "They [junior doctors] need to go the extra mile and think of the patient's perspective." "Patients are now much more knowledgeable about their conditions and expect to be treated as equal partners." "Junior doctors lack confidence in finding out what the patient really wants to know." Respondents also mentioned that junior doctors, in general, need to treat the patient as if they are right (not wrong), have more humility and be prepared to say that they are sorry; summarised by one respondent as "treating patients as they would expect to be treated". The link with complaints was sometimes mentioned, for example "If they had just thought from the patient's perspective it would have been nipped in the bud." (This finding could also be described as a lack of awareness of NHS policy of increasing responsiveness.)
44. Respondents' views on communication with colleagues were less positive. Several interviewees (11%) commented on some aspect of difficulty of communication ranging from junior doctors being rude through to them having difficulty filling in the appropriate clinical information on requests for investigations. Junior doctors themselves mentioned that they received little training on communication

with other departments. These difficulties were sometimes explicitly linked with the issue of junior doctors spending less time on each placement and feeling less part of a team: “We just don’t know them well enough to have the chance to modify their behaviour” and “They are only here for four months and so it’s really not worth bothering with them.” The implications of poor communication were also recognised, for example “Most complaints in teams relate to communication”. One junior doctor commented “I get stroppy because everyone rings up wanting me to do something at the same time – the nurses want me to see a sick patient, radiology want more information on a form and then the education centre bleep me to say I should be at a teaching session – and I don’t know any of the people I am talking to.” Further findings on communication in relation to asking advice are given in section 65.

45. Communication on discharge was mentioned by some respondents with comments made about delays or poor communication, for example “They must give the GP enough information to safely continue care, including about medication to be prescribed, and sometimes that just doesn’t happen.”

Prescribe drugs safely, effectively and economically

46. Difficulties with prescribing were the most commonly mentioned way in which junior doctors are not meeting the needs of the current NHS. Some aspect of prescribing was mentioned by 65% respondents. Some respondents recorded very real concern at the current standard of prescribing by junior doctors and the consequent level of risk to patients. They described a worsening situation and spoke of prescribing as “needing very urgent attention” and being “very poor”, “a big issue”, “dreadful” and “appalling”. One ward manager mentioned having to deal with 15 drug errors in one day. The difficulties mentioned included:

- Insufficient knowledge of pharmacology
- Incorrect dosages, contra-indications and potential interactions
- Failure to follow local and national protocols
- Transcribing errors and poor handwriting
- Failure to stop and review prescriptions
- Insufficient awareness of the mechanics of completing drug charts, especially in the early days as an FY1
- Insufficient awareness of fluid prescribing
- Slowness in preparing ‘TTOs’ and facilitating discharge.

47. Some respondents said that Trusts had introduced their own prescribing training and assessment programmes in response to these difficulties. One (whose training programme included a workshop, workbook and assessment) reported that “Junior doctors all say it’s great but they should have had it much sooner in their training”. Another commented “FY1s get a baseline test and if they fail more than three times they have their prescribing rights withdrawn until they pass. This is working very well and seems to concentrate minds!”

48. Other respondents commented on the systems which were compensating for the difficulties experienced, in particular, ward-based pharmacists and electronic prescribing. One respondent suggested that this could cause junior doctors to be less careful and had observed a change in behaviour from FY1 to FY2, with an initial carefulness being replaced by a rather slap-dash approach “Just leave it like that because the pharmacist will sort it out”.

Use information effectively in a medical context

49. Some respondents commented that junior doctors are not keeping accurate, legible and complete clinical records with a variety of specific examples, including death certification. Specific comments were made about junior doctors apparently not understanding the importance of a complete record of events, including the action taken, a signature and date. One respondent commented “Attention to detail is just not drilled in – they must do things properly or patients will die.” Other comments were about the response of junior doctors when mistakes were pointed out, for example, one respondent said “I can’t get over to them that ‘I was too busy’ won’t stand up in court”.

Outcome 2: Other areas

50. There were fewer comments on performance against the outcome ‘provide immediate care of medical emergencies, including First Aid and resuscitation’, possibly because no specific questions were asked about this. One junior doctor herself commented that she felt insufficiently trained for the more assertive communication style needed during resuscitations. Comments were made on ‘carry out practical procedures safely and effectively’ as part of the very strongly held views on ‘diagnose and manage clinical presentations’ and have therefore been covered above (sections 40 and 41).

OUTCOME 3: THE DOCTOR AS A PROFESSIONAL

51. Many respondents (31%) made general points about the professionalism of junior doctors and real shortcomings compared to what is expected of an NHS professional today. These have been grouped into three themes: appearance, behaviour and attitude, and the doctor as an employee. One Director of Operations summarised his concerns with the comment “I sometimes cringe when I go onto the wards and see the junior doctors at work.” Several other respondents commented on specific aspects of ‘the doctor as a professional (see sections 59 to 71). The combination of these issues suggests a greater emphasis needs to be given to a holistic model for the modern professional.
52. Comments on appearance were made by 11% respondents, including inappropriate dress (for example, jeans, trainers, revealing necklines, midriffs showing and very high heels).
53. Behaviour and attitude were also mentioned by some of those interviewed. Comments included concern about junior doctors texting while on duty, turning up late for work, and rudeness to each other and other staff. One HR manager gave the example of inappropriate and unpleasant responses from junior doctors to HR staff chasing work diaries: “I’m a busy doctor – it’s not on my agenda to do this.”
54. The theme underlying comments on behaviour and attitude was of a group of junior doctors who are less ‘bothered’ than in the past. Examples given were of junior doctors not chasing up results and not preparing for ward rounds. Insufficient handover was mentioned by some respondents, for example, one Medical Director noted that “‘Handover’ relates to the mechanisms but also the onus and the responsibility, including the professional responsibility to promote continuity of care. Importantly, there are issues also about the learning that comes from that exchange of information. There is a tendency to have a brief interest in a case, but then to abandon any attempt to learn from it because the case is no longer theirs.” One Clinical Tutor thought that ‘not bothering’ arose partly because junior doctors don’t see the results of their work: “The buzz of being a doctor comes from seeing a patient come in very ill, sorting them out and seeing them go home much better. Junior doctors these days don’t see what happens to their patients and so don’t get the buzz nearly as often.” Other respondents gave examples of opportunities being made available to junior doctors (audit prizes, F2 mock interviews) but with a very low take-up.

55. 'Clock watching' was mentioned specifically by some respondents – with some recognition that this partly resulted from the emphasis placed on not working over contracted hours.
56. Some interviewees talked about junior doctors not behaving appropriately as employees. One example was of junior doctors being required to undertake training on blood gas machines but using other people's numbers in order to avoid doing the training. Other comments related to forms "They are not exempt from filling in the form just because they are a doctor." A number of people commented that junior doctors would not 'get away with' the current standards of attitude and behaviour if they were working in another profession.
57. These general comments on professionalism were summarised by one respondent "The current cohort are not really sure what being a professional really means". Some of those interviewed recognised that driving forces may be two-way "They don't behave like professionals and so they don't get treated like professionals." Some people suggested that senior staff may not always provide good role models. The theme that came through very strongly was of disappointment in the professionalism of a significant number of junior doctors.
58. Some Trusts said that they are now including sessions on professionalism as part of junior doctors' induction. Like additional prescribing courses, this represents organisations trying to mitigate the effects of doctors not meeting the current needs of the NHS.

Behave according to ethical and legal principles

59. There were a few comments relating to this outcome. Some respondents specifically mentioned privacy and dignity of patients with comments such as "They need to be more careful in introducing themselves to patients and explaining who they are" and interviewees stressing the need to close curtains to make sure patients are appropriately covered.
60. Respondents were generally positive about junior doctors' understanding of equality and diversity issues and said that junior doctors have covered this area well in their training, although the context within which medical students and junior doctors are responding to these issues varies across the UK. A few respondents stressed the need for patients to be treated with respect regardless of the illness from which they are suffering, including mental illness and other stigmatising illnesses, and said that this did not always happen.
61. One respondent, responsible for managing the hospital's mortuary, mentioned sometimes serious difficulties with death certification, including junior doctors not understanding the implications for the family or when to involve the coroner / procurator fiscal.

Reflect, learn and teach others

62. Several respondents commented that junior doctors are generally not meeting the needs of the NHS in relation to some aspect of this outcome. These comments fall into four themes:
 - thirst for knowledge,
 - management of time,
 - asking for advice and
 - responsibility for teaching others.

63. Some interviewees reflected that, in general, junior doctors do not have the ‘thirst for knowledge’ that they expected, including a determination to reflect on and improve their own practice.
64. The ability to manage time and prioritise tasks was identified as a significant problem for the transition from undergraduate training to working life as an FY1 doctor. Several people, including junior doctors themselves, said that they had received insufficient training in how to organise a ward and how to manage and prioritise the range of tasks, with comments such as “They are very protected as medical students and are not prepared for workload pressures.” Ward managers commented on the difference which having a good junior doctor made to efficiency of the ward. One junior doctor said she had been helped by being given a ‘bay’ of patients to manage (under supervision) while a medical student but this practice did not appear to be widespread. The ability to manage a ward is usually learnt fairly quickly but respondents said that some junior doctors persist with unhelpful approaches and others just “could do it much better”.
65. Some respondents commented, sometimes with considerable frustration, on ‘asking advice’ – although views were divided on whether junior doctors ask for advice too often or not often enough. A common theme was “They used to be able to make decisions for themselves more quickly.” The importance of this was sometimes stressed: “Incidents are usually about who ought to have asked and at what point”.
66. Several of the junior doctors interviewed said that they had not been taught how to teach. Some respondents took teaching very seriously and understood that this was part of their responsibilities. Others did not see teaching as part of their core job and made comments about teams not being reimbursed for the time involved in teaching at both undergraduate and post-graduate levels. This may reflect the shift of the NHS to a more business-like approach, the introduction of service line management and the lack of transparency in the allocation of SIFT funding within Trusts.

Learn and work effectively within a multi-disciplinary team

67. Responses to questions about multi-disciplinary working were divided between those people who felt that junior doctors are now better trained to work in a multi-disciplinary setting and those who thought there were still problems. Some respondents mentioned that multi-disciplinary working had improved, partly because of improvements in theoretical teaching and partly because of students and junior doctors being more exposed to multi-disciplinary clinical practice.
68. Thirty six per cent of respondents felt, however, that there was still a problem, with comments falling into three groups: being arrogant, being ‘a breed apart’ and failure to relate to other professionals. Arrogance was mentioned by a small group of respondents with comments such as “Hasn’t anyone told the medical schools that this kind of hierarchical environment where Doctors know best doesn’t apply in the real world?” (HR Director). Comments about junior doctors being ‘a breed apart’ were more common as illustrated by one HR manager’s comment “The Trust has experienced significant difficulty breaking down an ‘us and them’ mentality. The Doctors are not engaged in the wider Trust community, and are not aware of organisational priorities. There is a communication route for medical staff and one for everyone else” and by a Director of Nursing “They appear to be disconnected with the team and the Trust as a whole. Sometimes it feels as if we are providing a service to them and not the other way around”. A small number of respondents mentioned that some junior doctors tend to ask only other doctors for advice rather than involving other healthcare professionals, especially allied healthcare professionals. This was sometimes explicitly linked with junior doctors’ lack of confidence in the clinical setting – and not wanting to expose this uncertainty to others.

69. There was widespread evidence of expectations that junior doctors will not work collaboratively and that the NHS may not be enabling collaborative working. This may be causing the behaviour about which respondents were concerned. Some of the junior doctors who were interviewed said “people assume all doctors are arrogant and don’t want to change”. Other respondents commented on the way that the NHS does not help junior doctors to ‘belong’. In addition to short rotations, respondents mentioned lack of appropriate rest facilities, including junior doctors not being allowed into the ‘nurses’ room’; lack of space for junior doctors to work with Foundation Programme doctors having to perch on the end of the ‘nurses’ station’; specialist trainees having nowhere to dictate letters or do other work; and having nowhere on the ward to leave handbags. Although junior doctors have a Trust email address, many do not use this, especially at junior grades, and so do not receive ‘all staff’ communications.
70. In relation to leadership, some respondents commented on the mixed messages which junior doctors may receive. There is relatively little leadership within their jobs as junior doctors but their roles when fully trained will involve significant leadership. One Postgraduate Dean commented “We must begin building the foundations for leadership at medical school. Leadership is also about being a good follower. There is now a distributed leadership. In certain areas others lead, and junior doctors must know and understand their roles when not leading. It is important to identify early future leaders for health services.” The last part of this comment was echoed by other respondents who said that future clinical leaders need to be identified and developed early in specialist / community training.

Protect patients and improve care

71. Respondents’ comments on how well junior doctors are achieving this outcome have already been covered under ‘understanding the NHS’ (section 36), reflecting on their own practice (section 63), and adherence to control of infection policies (section 38). Some respondents did mention that junior doctors, in general, appear to have little commitment to improving the use of resources – over which they could have considerable impact. Junior doctors themselves felt they had less power and some commented on areas where they knew use of resources could be improved but where they did not expect anything to change.

STANDARDS FOR DELIVERY OF TEACHING, LEARNING AND ASSESSMENT

Student selection

72. Some respondents (9%) questioned the rigour and relevance of the initial medical student selection procedures, feeling that not enough attention is given to how candidates will function in the clinical environment. One Medical Director said “leadership skills, people skills and organisation skills are crucial, and it is important to ensure these inform decisions on selection. While we do need academics to develop medical science, for the majority of safe patient care it is better to have an organised and conscientious member of the team than someone who knows all the latest microbiology.” A Director of Medical Education also felt that “there should be more emphasis on personal qualities, including self-awareness”.

Student selected components

73. Several respondents (17%) commented that student selected components are not currently being managed appropriately and that the time spent on these elements of training is not sufficiently valuable. Specific points mentioned were a shortage of appropriate options and a lack of supervision and rigorous assessment. Several people had suggestions for improving this aspect of the curriculum. These are described in section 82.

Clinical placements and experience

74. Many interviewees (27%) had concerns about this area with the general view that sufficient benefit is not being gained from the current clinical placements. Respondents were clear that there are lots of opportunities for medical students to gain clinical experience but these are often not taken: “So long as they had signed in – that was all that was needed” and “They have the attitude that it is more important to learn from the books”. Some people said that medical students are often not really supervised and therefore ‘do the minimum’: “You often see them hanging around waiting to have a job allocated”. The experience is also variable: “Some consultants don’t want medical students”; “I felt I was getting in the way all the time”; “I sat in the corner, I couldn’t see anything and I was ignored”; “Sometimes it’s really good”. The size of the group clearly makes a difference with many respondents more positive about the learning when medical students are in smaller groups. Continuity was also emphasised with respondents preferring longer placements – so long as they are with a good team. Some respondents commented that medical students are not being taught about time management and organising the ward – or about their responsibilities to the organisation. One example given was of a medical student saying “I don’t want to clerk Mrs X – I’ve already seen one of those [condition]” rather than understanding that Mrs X needed to be clerked.
75. The current shadowing of the FY1 whose post they will take up when they graduate was also described as a variable experience depending largely on the interest of the incumbent FY1. Several examples were given of unclear expectations, not feeling welcome, medical students not staying for the whole shift – and so missing out on interesting events – and feeling that the experience was a waste of time.

Findings: Are junior doctors appropriately trained for the roles expected of them in the future?

76. Respondents' comments about the needs of the future NHS were an extension of their comments on whether junior doctors are, in general, meeting the needs of the current NHS. Specific areas of future need were:

- More responsive to the needs and wishes of patients, including more informed patients
- More multi-disciplinary working and greater flexibility of roles within a team, including the role of the doctor
- Different and more variable patient pathways with a greater proportion of care being in non acute settings
- More patients in all settings having dementia
- Impact of a greater plurality of providers.

Findings: Will Tomorrow's Doctors 2009 produce doctors which meet the needs of the NHS?

77. In general, interviewees were happy with the content and, in particular, with the increased emphasis on gaining clinical experience. There were, however, significant concerns about whether Tomorrow's Doctors 2009 would, and could, be implemented. Comments on clinical placements are covered in sections 83 to 86.
78. Respondents considered that the Outcomes sections of Tomorrow's Doctors 2009 should come before the standards for delivery of teaching, learning and assessment in order to emphasise that this is what medical schools should be working towards. The list of clinical procedures was generally welcomed. Some respondents considered that there should be a similar list of common disease presentations and common clinical cases. Having the detail of procedures without the detail of disease presentations / clinical cases was thought to be unbalanced.
79. Nearly all respondents wanted the draft Tomorrow's Doctors 2009 to place more emphasis on the areas in which junior doctors are seen to be experiencing difficulties, in particular, clinical experience, pharmacology and prescribing, understanding the NHS, communication and multi-disciplinary working.
80. Some interviewees mentioned the need for the professionalism agenda to be more strongly embedded within the medical school culture. One Chief Executive commented that "the medical school should be fore-shadowing the environment within which the students will work" and cited an example of visiting medical school toilets that were dirty with nowhere to dry hands and no reminders of the importance of hand-washing.
81. In terms of assessments, respondents made strong pleas for more consistent assessments that are more closely linked with the competences expected. Some respondents suggested that undergraduate medical students should be building up a portfolio of competences that they would then take into the Foundation Programme². One interviewee said "This would get them into the way of taking responsibility for their own learning and introduce them early to the systems they will experience after graduation". Some commented that this would allow areas where students may need additional experience or support to be identified and 'handed over' to the Foundation Year employer.
82. In addition to the general comments that Student Selected Components should have more rigorous management, including clear outcomes, supervision and assessment, there were some specific comments. Some respondents thought that those who had undertaken Student Selected Components (or post-graduate training) in other countries tended to perform better at consultant interviews because of having a broader experience on which to draw. Others thought that, because doctors are now having to choose career options earlier in their post-graduate training, it is really important that under-graduates are given opportunities to sample careers in which they may in future be interested. One respondent suggested that this should be formally supported by an analysis of the students' personality and aptitude for different medical careers. Another interviewee said that, because of the emphasis on publications in

² Respondents were generally positive about the portfolio approach within Foundation Year and Specialist / Community Training although there were some specific comments about inconsistent assessment and no one taking an overview of an individual's development. Some junior doctors commented that those people who 'did best' on getting their portfolios completed were not doing such a good job at providing a service to patients on the ward.

post-graduate training, students should be encouraged and supported to publish work undertaken during Student Selected Components.

83. Some respondents suggested that all medical students should be subject to an assessment of fitness to practise before graduation and not only those about whom there are concerns. It was suggested that this assessment should include health related behaviour (obesity, smoking, drug and alcohol consumption) as well as clinical conditions and that any concerns should be formally handed over to their Foundation Year employer. Junior doctors should understand their responsibility as a healthcare professional to demonstrate good health-related behaviour.

Findings: Proposals to deepen students' hands-on experience of patient care

84. The study specifically set out to look at the feasibility and impact of the GMC's proposals to deepen students' hands-on experience of patient care and secure educational benefit from placements. It was generally felt that better use needs to be made of the time medical students currently spend on clinical placements – otherwise there is a danger that they will just 'waste' more time and the outcomes could be even worse. The suggestions for improvement included:
- More guidance on the learning options available in each placement (e.g. clinics, theatres, time on the ward, time with other healthcare professionals – especially a pharmacist, time with specialist teams)
 - If possible, smaller groups of students
 - Clear learning outcomes expected from each placement (which could link with the portfolios mentioned in section 81). These learning outcomes should include management of time and priorities, tasks expected of junior doctors, knowledge of the NHS and how the hospital works as well as clinical management of patients
 - Consistent supervision during each placement
 - Robust, consistent assessment of learning outcomes by someone who knows the student.
85. Several respondents welcomed the proposals in the section 'Clinical placements and experience', including the proposals for Student Assistantships although respondents considered that the proposals were not sufficiently specific about the amount of time medical students should spend on clinical placements, including as Student Assistants. There was a more general concern (33% respondents) that the proposals would, or could, not be implemented in practice.
86. Many respondents (33%) could not see how the necessary educational benefit could be achieved within the current structure of post-graduate medical education and with the service pressures on clinical teams – unless the service concerned was very highly committed to undergraduate teaching. Several people suggested that new models of supporting and guiding medical students on clinical placements are needed, for example, mentoring or professional development nurse models.
87. Another issue raised by some respondents, which also impacts on post-graduate medical training, is the growth of specialisation. Some people consider that general medical and general surgical wards will soon cease to exist in the NHS and that medical and surgical assessment units will diagnose, initiate treatment / prepare the patient for treatment and then transfer them to an appropriate specialist ward. The organisation of undergraduate clinical placements will need to respond to this change and medical schools and the NHS should be thinking now about the implications.

Wider implications

88. As well as the implications for undergraduate medical education, the findings of this study have implications for post-graduate training, for the NHS and for the way in which these organisations work together.
89. Firstly, this study suggests that the organisation of post-graduate medical training in four month rotations should be reviewed. Whether or not this is changed, the GMC, Royal Colleges, Workforce Deaneries, Post-graduate Medical Education Training Board and NHS organisations should be working together to improve the supervision, guidance and assessment of post-graduate medical trainees. In particular, assessment of the individual doctor's overall development needs to be strengthened. New models of supervision, guidance and assessment need to be developed with more emphasis on continuity across rotations and on being assessed by someone who knows the doctor concerned.
90. Secondly, NHS organisations need to look very seriously at how they help junior doctors to 'belong' to the organisation and the service within which they are working. There must be ways of mitigating the effect of having larger, more disparate medical teams and shorter rotations. NHS organisations need actively to engage with their junior doctors to develop and design new approaches. There is the opportunity for these approaches to be more multi-disciplinary, more collaborative and more reflective of a 'modern' NHS. They will need to address practical issues of 'having somewhere to work and rest' as well as cultural and behavioural issues. Alongside more active engagement with junior doctors, NHS organisations should be actively managing behaviour and attitude to ensure junior doctors achieve appropriate professional standards.
91. Finally, medical schools, workforce Deaneries and NHS organisations should be working much more closely together. Several senior NHS staff expressed frustration at their lack of influence on the training of doctors and were keen to be more involved. Three quotes illustrate this point:
- “How do I as a Chief Executive know that the person who is being employed in my organisation is competent? Where do I get involved? At what point can I influence the curricula of medical schools?” (Chief Executive)
- “This document pays lip service to the importance of the NHS institutions. We are not just vehicles for on the job training. We have vicarious liability for our employees yet we have no involvement nor do we seem to have any influence on the finished product. Too much is left to the medical schools. Employers are fundamental stakeholders in this process.” (Director of Nursing)
- “Much more partnership working is required between the sector, medical schools and Post-graduate Deaneries. At what point does health policy become incorporated into the curricula? Where can employers directly influence the end product of medical schools? They don't at present. That is a huge gap, and the general public would be alarmed at the thought of a junior doctor being given a job without an interview. It's this kind of medical elitism that has to come to an end. There is nothing in the document that repairs the disjointedness between medical schools, educators and employers.” (Postgraduate Dean)
92. The consequences for the NHS if the issues described in this report are not addressed could be serious. Firstly, patients may be at risk because some junior doctors do not have the necessary confidence and competence in the practical application of their skills. Secondly, some of the organisations interviewed were already introducing compensatory mechanisms, including additional training. Others were

suggesting that the role and expectations of junior doctors may need to be redefined in response to their lack of experience. Such changes could be extremely costly, especially if they involve employing additional staff. Finally, we face a loss of morale, motivation and commitment of a whole generation of doctors in whose training we have invested heavily. Some of those interviewed talked about sickness levels and junior doctors choosing to leave the profession. The NHS needs doctors who are committed to their work in the NHS, who feel they belong to the service and who are able actively to improve the services which are offered to patients. We cannot afford to ignore the messages contained in this report and must start to 'be bothered' about our junior doctors.

Appendix 1: Semi-structured interview question framework

1. To what extent are the doctors currently completing undergraduate medical education appropriately trained for their work in the current NHS?
2. Are there any specific issues around:
 - i. Communication
 - ii. Patient experience
 - iii. Professionalism
 - iv. Multi-disciplinary team working
 - v. Prescribing
 - vi. Leadership
 - vii. Equality and diversity
3. Do you have any comments on:
 - i. The way they have been assessed during their training
 - ii. The Student Selected Components of their training
 - iii. The transition from being an undergraduate to a Foundation Year 1 Doctor
4. Thinking of how the NHS is changing, are there ways in which undergraduate medical education needs to change to ensure that doctors will be appropriately trained to work in the NHS of the future?
5. Will implementation of the draft Tomorrow's Doctors 2009 result in doctors who are appropriately trained for their work in the NHS now and in the future?
6. The draft Tomorrow's Doctors 2009 includes proposals to deepen students' hands-on experience of patient care and to secure greater educational benefit from undergraduate placements. Are these proposals feasible? Can you foresee any difficulties with their implementation?
7. Are there any areas that you think are missing from the draft Tomorrow's Doctors 2009?

Skills for Health would like to thank all those who have helped in contributing to this report. In particular those who set time aside to arrange and / or participate in interviews from the following organisations.

5 Boroughs Partnership – Mental Health Trust	NHS East Midlands
Ashton Leigh & Wigan PCT	NHS Lanarkshire
Basingstoke Hospital Foundation Trust	Norfolk & Norwich University Hospital Trust
Belfast Health and Social Care Trust	Norfolk & Waveney Mental Health Partnership NHS Trust
Blackpool Fylde & Wyre Foundation Trust	North Bristol NHS Trust
Borders General Hospital NHS Trust	North Tees and Hartlepool Foundation Trust
Bradford District Care Trust	Northern Health & Social Care Trust
Cambridge University Hospitals NHS Foundation Trust	Northumbria Healthcare Trust
Camden Primary Care Trust	Nottingham City PCT
Cardiff and Vale NHS Trust	Nottingham University Hospitals
Central Manchester University Hospitals NHS Foundation Trust	Nottingham University Hospitals NHS Trust
Chesterfield Royal FD	Nottinghamshire County PCT
Cornwall Partnership NHS Trust	Nottinghamshire Healthcare Trust
Countess of Chester NHS Foundation Trust	Oxfordshire & Buckinghamshire Mental Health Foundation Trust
County Durham and Darlington Foundation Trust	Pennine Acute Trust
County Durham and Darlington PCT	Plymouth Hospitals NHS Trust
Cwm Taff NHS Trust	Post Graduate Deanery Yorkshire and Humberside
Derby Hospitals FD	Powys Local Health Board
Derbyshire County PCT (Community Hospital)	Royal Devon and Exeter Hospitals NHS Trust
Derbyshire Mental Health Services	Salford Royal NHS Foundation Trust
Devon Healthcare NHS Trust	Sheffield Health and Social Care Trust
Devon Primary Care Trust	Sheffield NHS Foundation Trust
East of England Deanery	Sheffield PCT
EM Healthcare Workforce Deanery	Somerset Partnership NHS Foundation Trust
Essex Rivers Healthcare NHS Trust	South Central SHA
Guys and St Thomas's Foundation Trust	South Devon Healthcare NHS Trust Torbay
Harrogate District Foundation Trust	South Essex Partnership NHS Trust
Hartlepool PCT	South Tees Hospitals Foundation Trust
Heart of Birmingham PCT	South West London and St George's Mental Health NHS Trust
Hull and East Yorkshire Medical School	Southampton City PCT
Hull and East Yorkshire Trust	Southampton University Hospital
Kettering General Hospital FD	Southend University Hospital NHS Foundation Trust
Kings College Hospital Foundation Trust	Tameside Hospital NHS Foundation Trust
Lancashire Care Mental Health Foundation Trust	Tees, Wear Valley and Eskdale Trust
Lancashire Teaching Hospitals Trust	The East of England Regional Pharmacists Group
Leeds Partnership Foundation Trust	The Princess Alexandra Hospital NHS Trust
Leeds Teaching Hospital	University Hospital Coventry and Warwickshire NHS Trust
Leicester City PCT	University Hospital North Staffordshire NHS Trust
Leicestershire County & Rutland Community Health Services	Walsall Hospitals NHS Trust
Lincolnshire Partnership FD	West Essex Primary Care Trust
London Deanery	West Suffolk Hospital NHS Trust
Manchester Mental Health and Social Care Trust	Worcestershire Acute Hospitals NHS Trust
Mid Yorkshire NHS Trust	York NHS Trust
Newham PCT	



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