Naomi Pritchard describes the challenges facing today's junior doctors

JUNIOR DOCTORS IN A NEW ERA

glossary of terms

- **MTAS**: Medical Training Application Service - a national online scheme for job allocation launched in 2007 but now obsolete
- **MMC**: Modernising Medical Careers - the new system of specialty training
- **FY1 / FY2**: Foundation Year posts - replaces PRHO and 1st year SHO
- **CT**: Core Trainee - first years of specialty training, replacing SHOs
- **ST**: Specialty Trainee - senior years of training, replacing SpRs /registrars
- **EWTD**: European Working Time Directive - legislation limiting the number of hours worked per week to 48, averaged over a six month period.
- **Hospital at night**: a new staffing structure introduced to cover the hospital overnight, involving reduced numbers of doctors on site, with some junior doctor roles delegated to nurse practitioners
- **ARCP**: Annual Review of Competence Progression - yearly appraisal replacing the RITA (Record of In-training Assessment)
- **Work place based assessments**: system of forms to be completed by senior colleagues (either on paper or on-line) to provide evidence of clinical competencies. These include:
  - **DOPS** - Directly Observed Procedural Skills
  - **Mini-CEX** - Mini Clinical Evaluation Exercise
  - **CBD** - Case Based Discussion
- **Stand-alone posts**, not part of a rotation:
  - **FTSTA**: Fixed Term Specialty Training Appointments
  - **LAT**: Locum Appointment for Training
  - **LAS**: Locum Appointment for Service (non-training post)
- **GPVTS**: General Practitioner Vocational Training Scheme
- **CCT**: Certificate of Completion of Training

How can CMF support trainee doctors in the UK? That was the question behind a seminar entitled 'Bringing juniors and seniors together' which I co-hosted at the Graduates conference in April with Dr Richard Vincent, Emeritus Professor of Cardiology and Executive Chair of PRIME, and Dr Gemma Sheridan, ST3 Obstetrics and Gynaecology from Mersey, and CMF junior doctors' committee member.

After the introduction of the Foundation programme for newly graduated doctors in 2005, 2007 saw sweeping changes to junior doctor training, job applications and career progression. Doctors may well remember the angst amongst trainees navigating the new 'Modernising Medical Careers' application process and struggling to make any sense of the soon-abandoned MTAS website.

Consultants and GPs echoed Richard's experience of the training system. They recalled 72 hour on-calls for their wards of patients, feeling like they lived at the hospital, falling asleep at the desk or whilst taking someone's blood! The long hours could make relationships and family or social lives near impossible, but yielded invaluable opportunities to see and experience a wealth of presentations and have hands on, practical, procedural training. There was an overwhelming sense that, although they never wanted to repeat those years, there was good camaraderie and a sense of family in the firm when training.

There were stories of life in the Mess, supporting fellow team members though their house-jobs, and being entertained in the homes of consultants who took a keen interest in the progression and career aspirations of the teams who remained under their care for six months to a year. Job applications were often in-house events, or applications to individual hospitals, enabling more choice as to where you worked.

There are several key differences in the experience of today's MMC trainees.

The pressure to choose

During your F2 year (18 months after graduating) you must choose which specialty you would like to pursue. This choice is often made with no hands on experience in that field, although 'taster days' in different specialties may be available. A more recent development is that many doctors feel they must have part 1 of their speciality exams to be competitive at interview.

Relocation, relocation

FY1 and FY2 posts are usually rotations in different specialties, three to four months each, often rotating between different hospitals, often in different towns. Training has always entailed travel, commuting and relocating to take-up posts. Currently, anonymous applications are made at a national or deanery level so there are very few opportunities to select the region you work in, let alone the hospital.

Trainees often have to relocate great distances for each stage of training. Each new address means finding a new church and social support network. For many married juniors, or those with children, these relocations can be especially complex and stressful, particularly if both partners are going through the same application process. Is it any wonder CMF has difficulty keeping up with the location of junior members?

Team players

Due to financial constraints, modern hospitals often have staff shortages. With modern rotas and the European Working Time Directive (EWTD), the team structure and 'firms' within the hospital have been widely disrupted. Juniors often now find themselves in 'super-firms', working for a group of consultants spread out to cover the rota. Depending on who is on nights, on-call and on leave, you might find yourself working in a different team from week to week. This degradation in team structure naturally lends itself to a reduction in accountability, support and seniors taking a personal interest in your development and wellbeing. The more sinister side of this arrangement is, if you are not seen as someone's team mate, you also do not work under their protection or loyalty; you are simply 'another junior doctor' rotating through, and can be subject to neglect or bullying from seniors who feel no responsibility for you.

Lacking in experience

In our seminar, the prevailing initial opinion of modern training was that due to the EWTD, it was easier and less strenuous. Junior doctors no longer carry a bleep for 72 hours straight, however, the responsibilities and

roles of juniors during their on-calls have changed. Rather than being called to your own ward to see patients you are familiar with, now the small team, on-call out-of-hours, cover their specialty for the entire site and do whatever crops up, wherever it happens in the hospital. It is also common to do on-call for a specialty in which you have no experience due to cross-covering arrangements.

When we started, we all worked at night and remember learning to deal with 'proper sickies' for the first time at 4 o'clock in the morning. Due to the new 'Hospital at night' policy of staffing, many do not experience full night shifts until they are FY2s, whose specialist senior support may not be on-site.

Despite this, we are expected to take senior responsibility earlier. Gemma started as a registrar in ST3 with only two years obs and gynae experience; routine now, but at least a year earlier than under the old system.

When you take out weekends, nights and evening on-call shifts from the new hours-limited working week, the consultant contact training time has been vastly reduced. As an anaesthetist I have to show I have completed a certain number of sessions in different types of theatres, but have regularly found myself not taking allowed annual or study leave in order to rack up the required training time. It is a scary thought that you are going to be a consultant sooner than ever before, with less experience along the way.

A form-filling exercise

With the introduction of new training pathways come new ways of measuring competency. Many doctors are familiar with 'workplace based assessments': forms and websites that need filling in to sign off that you are capable of performing practical procedures and certain patient interactions. Ever adapting, many of the curriculums have been developed as trainees navigate through the process, with different colleges moving the goal posts as to what is required to pass Annual Reviews of Competence Progression (ARCP) and move to the next year of the training. These yearly meetings with the training programme directors in the deanery are also progressing from an exercise in form filling, to online e-portfolios; a new tool seemingly designed to baffle educational supervisors.

It must be so frustrating to be keen to teach a trainee a new skill or technique, or spend your time discussing a topic, only to have them ask you to fill in a DOPS for the chest drain they've just inserted, or a CBD on that conversation you had about the COPD patient yesterday. It seems to degrade what used to be a meeting of minds and a passing on of knowledge and skills, to a mercenary act of opportunism on the part of the trainee. Trainees dislike this routine just as much as the consultant rolling their eyes, but the Post-graduate Medical Education and Training Board (PMETB) have the last say.

With reduced training hours and staffing levels, the opportunities to see, and be taught to do certain procedures, or supervised once deemed competent, are also reduced.

I spend much of my time stalking dark corridors at night, intubating people in cardiac arrest, or inserting epidurals for labour analgesia. A novel 'catch 22' situation often rises when a consultant refuses to sign me off as competent for a procedure as he or she is not there to observe my practice, then requests that I carry it out unsupervised, often in the middle of the night.

Dead ends

Although most juniors access training posts, some will find themselves on LAS posts, or struggle with exams and have to take time out of their programmes. Once out, it can be difficult to get back in, and it must be so frustrating doing the same job as your peers, but not gaining the same recognition.

CMF's role

CMF's junior doctors' committee have made great efforts to remain connected to and support doctors in training throughout the UK. We attend the national student conference every year and obtain permanent contact details for all final year medical students. We have set up social media networks to help link people, and host the yearly junior doctors' conference with relevant, topical seminars.

The annual MMC Career Day Conference provides juniors with careers advice from consultants in a wide range of specialties. The Values Added programme, a partnership with PRIME, offers local ongoing support and training to help juniors to infuse their daily practice with a Christian worldview (*www.values-added.org*). We are passionate about providing chances for contact and local support for junior doctors, and are excited about the plans for developing links with every hospital and foundation school. We have just published *Foundations* which is reviewed overleaf. Contact CMF for your copy.

There are many ways CMF members can support junior doctors. The juniors' page on the CMF website (*www.cmf.org.uk*) lists all our events - please pray for us. You can volunteer to share your experiences at the future MMC Career Day Conferences; join or host an Open House or Values Added programme for juniors in your area; become a mentor, a link person or follow us on Facebook. Sarah Maidment, another JDC member has written a superb article giving an excellent account of life and experiences of a junior doctor, and how seniors can support junior colleagues. It's available on our webpage *cmf.li/MVBcoG*

The new training structure may seem like a Goliath that needs to be faced. It takes precious time to get to grips with the new assessment process and job titles for junior colleagues, but junior CMF members need the spiritual support, fellowship, and educational encouragement of senior members. In turn, we trust that CMF will benefit as junior doctors thrive and mature as part of a united and flourishing fellowship. It will be difficult for senior graduate members to swim against the tide of the training culture, but junior doctors will appreciate the help and support as we all seek to be salt and light in the NHS.

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career paths

- The modern-day training pathway: after graduating from medical school, all newly qualified doctors enter the Foundation Programme, organised in Foundation Schools, to complete Foundation years 1 and 2 which have replaced the previous pre-registration house officer and first year SHO posts respectively.
- Terms such as Senior House Officer and Registrar have been replaced with 'Core Trainees' (CTs) usually referring to the first two years/ pre-membership exam period, and 'Specialist Trainees' (STs) the new SpRs in hospital specialties.
- The number on a doctor's badge, (eg CT2 / ST4) denotes the year.
- Depending on the specialty, after completion of ST years you can gain your Certificate of Completion of Training (CCT) and apply for consultant posts.
- GP training schemes: after foundation, you can enter GPVTS training, (two years' hospital based training as CT1/2 GPVTS) then do the final year as a GP registrar in a practice.
- Also new: some roles are either Stand-Alone, such as LATs (locum appointment for training) and Fixed Term Specialty Training Appointments (FTSTAs). Trainees completing the required workplace based assessments can have that period of time counted towards their CCT, however there is no guaranteed post to progress into. They must reapply for the next stage or a series of FTSTAs.
- There are also non-training posts, LAS (locum appointment for service) which carry no training recognition at all, although the day-to-day job very closely resembles those done by any other practitioner. This band of jobs tends to be grouped with the trust doctor grades and lead into Staff grade and associated specialty posts, without potential for progression to consultancy.
- Visit the Welsh Deanery site *careers.walesdeanery.org/map* for an overview of all of these career paths, including those taking the 'academic route' or going into research.