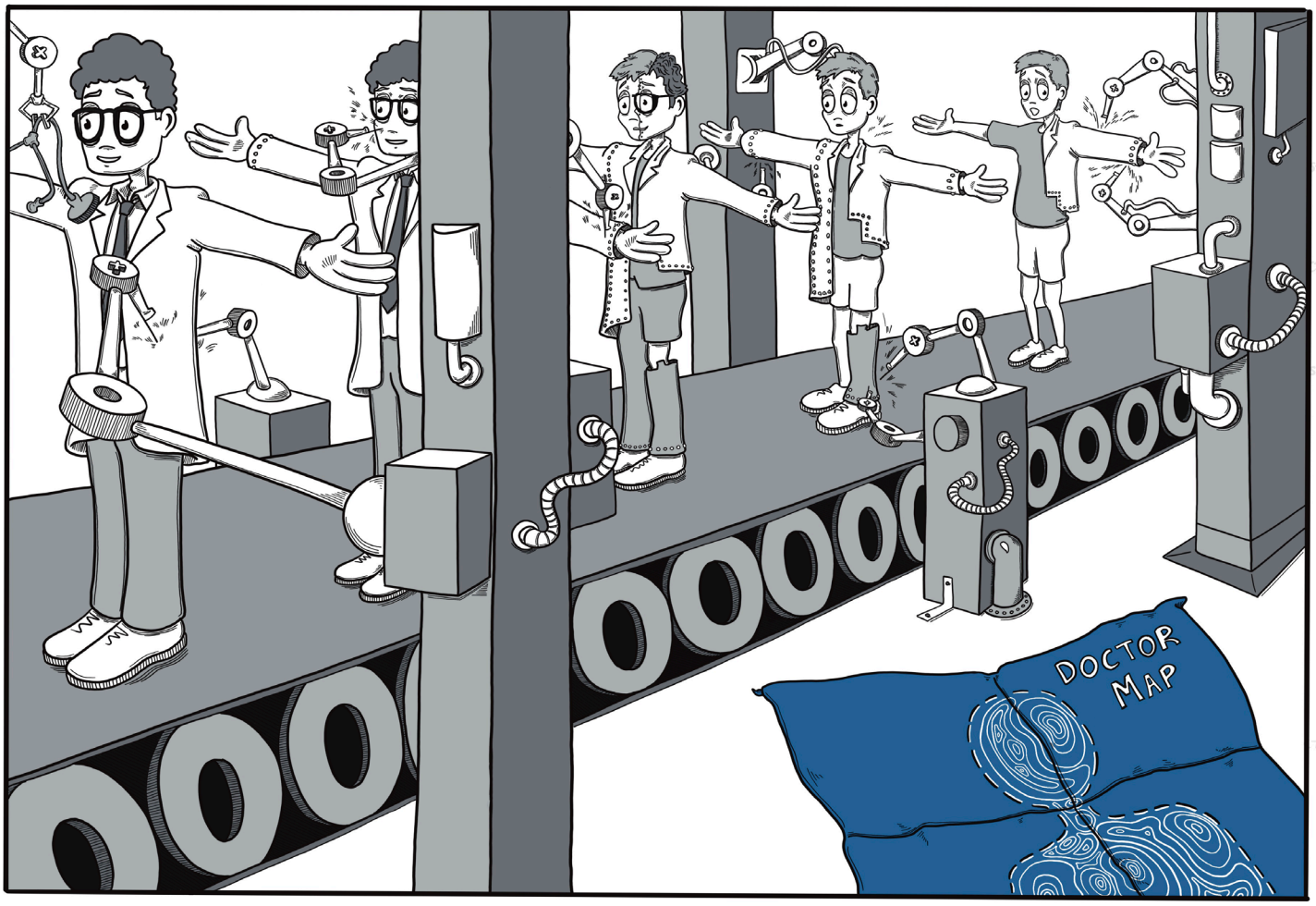
MEDICAL TRAINING PATHWAYS:

UNDERSTANDING WHY SOME PEOPLE STRUGGLE TO SEE A DOCTOR



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Introduction - Why is it so difficult to see a doctor?

Access to healthcare relies on there being enough doctors in an area to treat patients. There are fewer doctors in some areas, despite the greater healthcare needs of the population, and it affects people's health because they cannot see a doctor when they need to. The problem of not having enough doctors is known as 'underdoctoring.'

Some areas struggle to recruit doctors to serve the local population, especially in areas where there are other inequalities, and this is an issue because people struggle to get appointments with doctors, experience long waiting times, and travel long distances for healthcare.

How medical training programmes are organised is important, because we know that where doctors train is a big influence on where they end up working. Our study "Mapping underdoctored areas: the impact of medical training pathways on NHS workforce distribution and health inequalities" has investigated why doctors work where they work, thinking about how the healthcare system as a whole is organised as well as individual choices that doctors make.

Here, we share some of the findings from our interviews with 100 doctors, showing how medical training has changed over time, and how it has been experienced by doctors and impacted on their choices.


"Medical
Education
&
Training
has
an
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"TRIAL BY SHERRY"

Trial by sherry

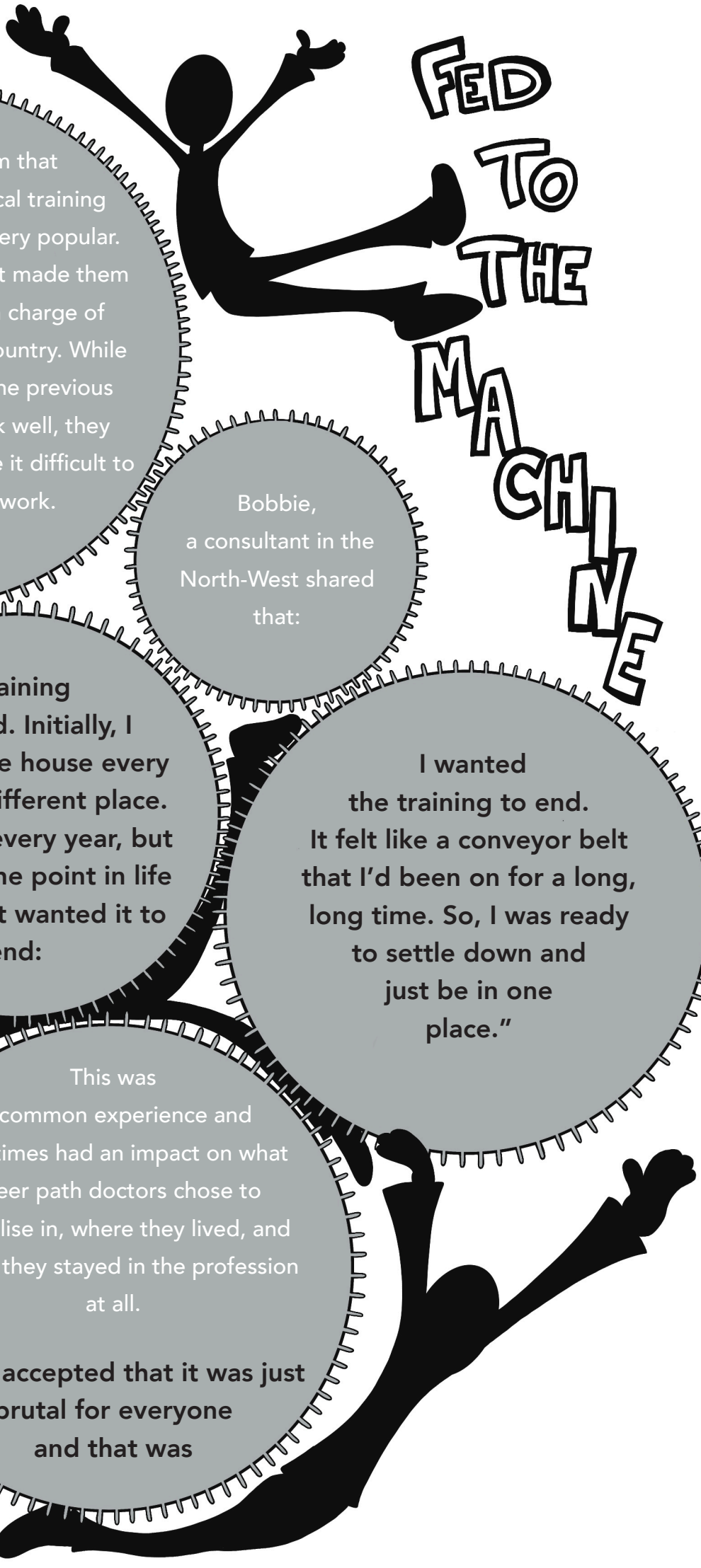
In 2005, a new allocation system was introduced to organise medical training at a national level. The previous 'firm' system was seen as very unfair, as trainees would apply directly to join the team of a particular consultant in a hospital, who had the power to control new appointments to the team. There was a lot of potential for discrimination, as Yosef, who works as a consultant in the North West explained:

"In those days… you looked around for a consultant job and then you went and had your trial by sherry. You'd get six or seven applicants per job, most prospective departments would have a party, and it's called a sherry party: they used to say, 'Come around for a sherry'. And you had to go and bring a significant other to see if your face fits." (Yosef, consultant, North-West England)

Faith, a doctor from Lincolnshire who had started her medical training in London in the 1990s confirmed that "it wasn't very objective, the way it was organized" and "it felt very much that it was kind of who you were connected with and sort of fitting in" (Faith, doctor in training, Lincolnshire).

However, the new allocation system, which we still use, also has its issues. Doctors told us that it has become a very impersonal process, with this national allocation of training places meaning that have to move around to new hospitals to get different training experiences, sometimes over a wide geographic area. It is more meritocratic and has overcome the unfairness of 'trial by sherry' but makes it difficult for doctors to settle in one place in early training. Around 40% of doctors who still work in the NHS trained under the old 'firm' system, and so it is important to understand what has stayed the same and what has changed.

FED TO THE MACHINE



The allocation system that currently organises medical training placements is not always very popular. Doctors talked about how it made them feel like a machine was in charge of moving them around the country. While doctors recognised that the previous 'firm' system did not work well, they found the new system made it difficult to manage life outside work.

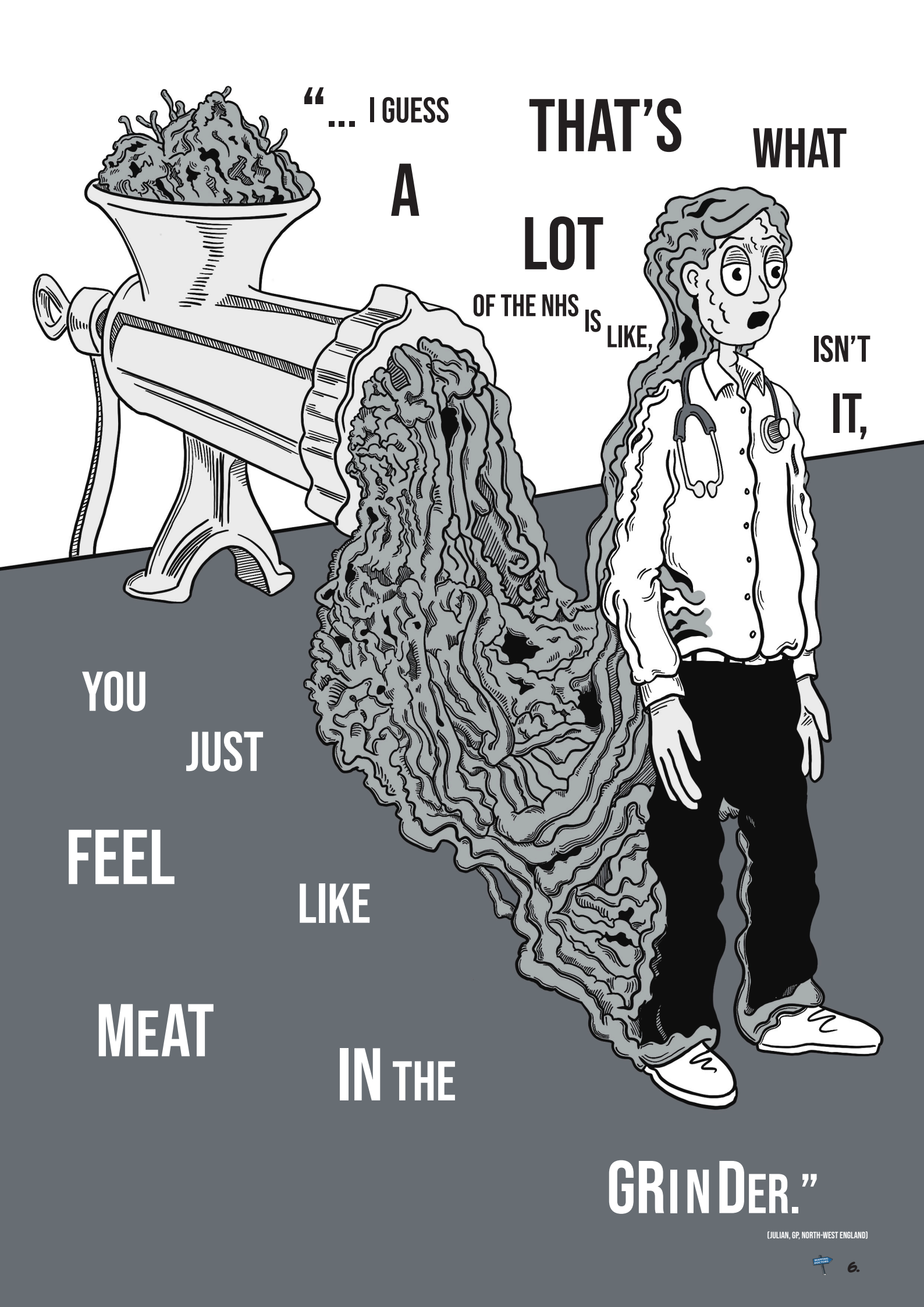
Bobbie, a consultant in the North-West shared that:

"Training was hard. Initially, I would move house every year to a different place. So moved every year, but I'd got to the point in life where I just wanted it to end:

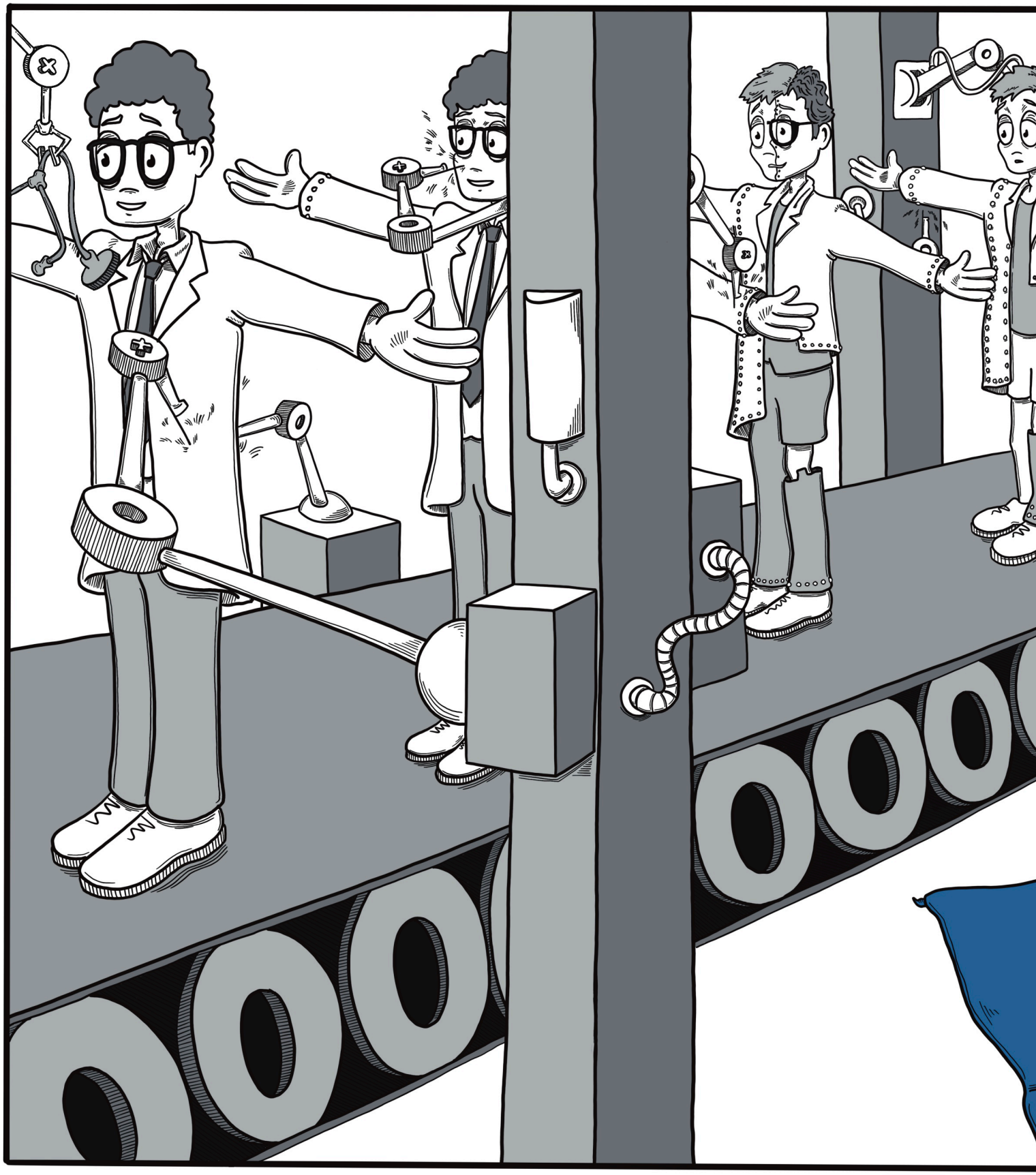
I wanted the training to end. It felt like a conveyor belt that I'd been on for a long, long time. So, I was ready to settle down and just be in one place."

This was a common experience and sometimes had an impact on what career path doctors chose to specialise in, where they lived, and even if they stayed in the profession at all.

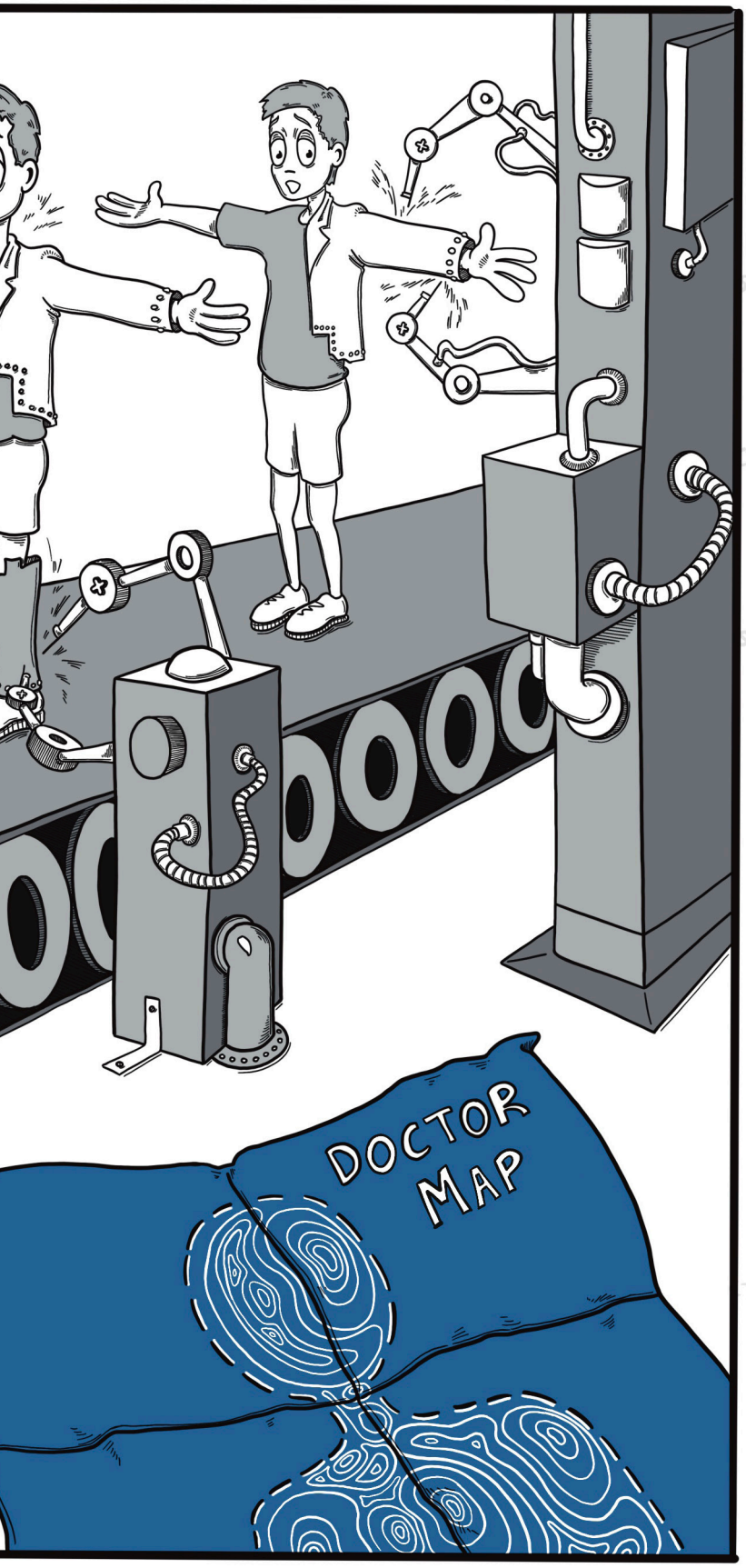
"I just accepted that it was just brutal for everyone and that was just the way it was. It's hard to push back against that..."



(JULIAN, GP, NORTH-WEST ENGLAND)



"JUST A



NUMBER"

Just a number

Moving around for training was hard – some places were more popular than others for training.

Being made to feel valued and cared for at work was considered to be important.

"It just felt like [one organisation] were making an effort, whereas in these other places, you think you're just one of the numbers, really."

(Noah, doctor in training, North-East England)

Doctors also had to plan their lives around their training placements, which came at a cost to family life.

"There seems to be more appealing offers in [region], so if I compare this job to the other job I was offered, the salary was better in [region], and also the amount of CPD time you get and study leave. Just more of an appealing package, and there seemed to be more flexibility, because they obviously wanted to take people on."

(Evelyn, consultant, Lincolnshire)

"If I'm forced to move, it depends on what is happening with my family at that time.

If there's still a need to settle family, I'd rather stay with maybe [a lower grade] post and ensure my family is well settled before I move."

(Hector, locally-employed doctor, Lincolnshire)

“ADDITIONAL

HIDDEN

WORKLOAD”

Bread and butter work

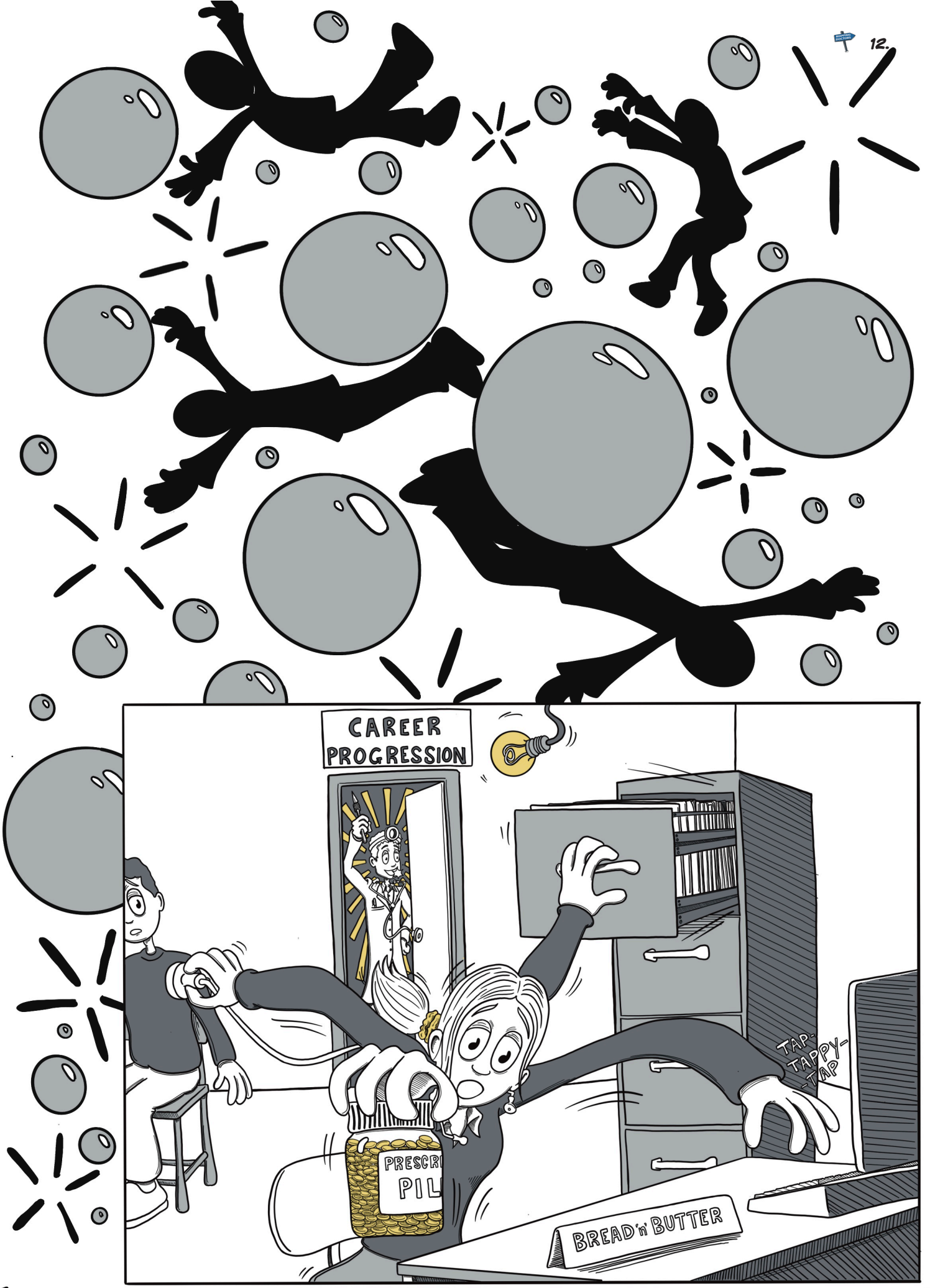
Because some places struggle to recruit and retain doctors more than others, this means that the workload for doctors working in those areas is higher. In some areas, patient characteristics mean that there is greater need for services, which also has an impact on workload.

A lot of the day-to-day work that doctors do involves taking care of basic and ordinary patient care. This is true for GPs, and for hospital doctors. It is routine work, and often not what people, trainees and patients think of when they think about doctors' work, or watch TV programmes like the BBC's Casualty or the American series Grey's Anatomy.

Many of the doctors we interviewed talked about the hidden 'bread-and-butter' work they did, which was not as visible, but very important.

"I suppose for the general public, the only part of my job that they see is the patient-facing part of it, so the clinics that I do, the people that I go and visit, that is essentially what most people think a GP does. But there is all that sort of additional hidden workload. The clinical load attached to reviewing bloods, reviewing discharge letters, going to Multi-Disciplinary Teams, catching up with all my community partners to make sure all my vulnerable patients are being looked after, all of that, it's an additional cognitive stress, isn't it?"
(Hassan, GP, Lincolnshire)

Trying to juggle all of these tasks meant that they did not have time for other aspects of medical work, like doing research or teaching, which could be a barrier to career progression and continued professional development.



"BREAD & BUTTER WORK"


"Initially, I would move house every year to a different place."
Cardiff
Windermere
Carlisle
Edinburgh
YORK
Blackpool
Lincoln
Plymouth

Our research has worked with doctors to understand more about the decisions they make in their careers, and to think about how the structures of medical training have an impact on these choices. We want to work with NHS organisations at a local, regional and national level to think differently about how we make sure that the healthcare needs of the population are met, but also that doctors want to work in the NHS and see the training process as supportive and fair.

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THE FUTURE AWAITS...

Lancaster University Medical School

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