Does it matter that medical graduates don't get jobs as doctors?

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YES Before last year, this question would have been seen as academic and irrelevant, more colloquially a complete “no brainer.” As a nation we invest in medical training because we want the services of doctors, not to produce management consultants or playwrights. The thousands of young people who compete fiercely for medical school places each year do so because they want to work as doctors, not gain an expensive general education. Of course not all medical graduates pursue lifelong careers in medicine. Doctors have always made high profile contributions in other fields—Jonathan Miller and David Owen are good contemporary examples in the United Kingdom. But the cohort studies of the UK Medical Careers Research Group clearly show that more than 95% work in medicine in the long term, though not necessarily in the UK or the NHS (M Goldacre, personal communication).

Historically, the UK never trained sufficient doctors to meet the needs of the NHS. One practical consequence of this has been that UK graduates, provided they were willing to be flexible about their career choices, could be reasonably assured of being able to pursue a full medical career as a consultant or general practitioner in the UK. That this is no longer the case is the direct result of a catastrophic failure in government policy on medical immigration.¹ This has created a huge surplus of eligible applicants for specialist training. The Department of Health estimates that in 2007, 1300 UK graduates were unable to secure training places. A similar picture is expected this year and potentially for some years to come.² This is certainly now a subject for serious debate.

Staffing needs

In the late 90s it was decided to reduce the dependency of the NHS on large scale recruitment of doctors from overseas by

expanding medical school places by 40%.^{3,4} There is clearly little point in investing in more doctors if they cannot train to the level necessary to make useful long term contributions to the NHS. However, attempts by the Department of Health to give priority to local graduates were confounded by the Home Office's highly skilled immigrants programme, which gave skilled people the right to enter the UK job market.⁵

The rules of the highly skilled migrants programme have now been amended to exclude new entrants from competing for medical training posts from next year. However, this still leaves an estimated 10000-12000 overseas graduates who have already been accepted on to the programme in competition with local graduates. Without further remedial action, which itself is currently being vigorously contested in the House of Lords, it is projected that 700-1000 UK graduates will be displaced each year from 2009 until balance is restored.²

Senseless waste

This situation is impossible to defend on any front. It is completely incoherent in policy terms; we carefully planned and invested to achieve greater medical self reliance and thereby protect other countries, only to throw our doors open to all comers. We set out to train 2000 more young doctors each year but lost more than half of that increase last year and look set to repeat this for several years to come. Even if it could be argued that there are labour market advantages in having a glut of doctors, these would operate meaningfully only if those doctors were sufficiently senior to deliver NHS targets.

The scale and importance of this problem has attracted remarkably little comment or protest, even from medical organisations. As well as the disaster for the people concerned and the waste of both talent and public money, there are also important long term implications of breaking the link between medical training and a career in medicine. Medical students already graduate with average debts of £21 000.⁶ A 15-20% risk of

having to choose between emigration and a change of career at the end of basic medical training would be a strong recruitment disincentive, particularly to graduate applicants and those with a strong caring vocation. Increased vocational emphasis risks being undermined if medical school becomes, for a substantial proportion of each intake, simply a route to a range of future employment. And it will be correspondingly difficult to secure permission for student involvement in patient care if this cannot be honestly portrayed as necessarily contributing to the training of the doctors of the future.

Most immediately and importantly, however, the present situation represents a betrayal of the legitimate expectations of those who entered UK medical training in recent years: expectations not of guaranteed jobs but of being able to pursue a career that reflected the needs of patients and the NHS. Much has been made by the BMA and others of the importance of abiding by the undertakings made to overseas doctors. It is surely just as important that we keep faith with our own medical students and graduates, whose recruitment and training has been on the explicit understanding that they are needed to work as doctors. The present situation does not just matter; it is a scandal.

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Last year's shortfall in training places looks set to be repeated. **Graham Winyard** believes this is a betrayal of students' expectations, but **Alan Maynard** thinks it is inevitable if patients are to get the best care

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NO The government, as the main employer of doctors in the UK, is responsible for planning the medical workforce proficiently so as to deliver patient care. This requires it to model demographic trends, specialty needs, skill mix, technological change, and resource consequences. But its failure to plan efficiently does not create the responsibility or need to guarantee medical graduates employment.

Doctors cost hundreds of thousands of pounds to train. This training gives them specific skills as well as transferable skills. The training expenditure is a sunk cost—that is, once spent it cannot be retrieved. If medical graduates are unemployed this loss can be mitigated by their finding employment in other sectors of the economy, just as graduate lawyers do if they are unable to find jobs after academic and practical training.

Medical graduates, like all other graduates, gamble when they invest in their training. Their success brings riches, but if they fail due to lack of skills in making career choices and because of their inadequacy as doctors, they are no more eligible than other graduates for

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compensation in terms of job guarantees.

Practitioners in any field should be given jobs only if they have appropriate knowledge, skills, and personal behaviours consistent with meeting their employers' and customers' needs. Medical school training can be likened to studying 50 GCSEs, requiring a breadth of knowledge but needing little application of the great intellectual proficiency of the academic elite that is recruited to medicine. The nice challenge for students is the application of these skills in a caring, humane, and efficient manner.

Guarantees are incompatible with efficiency

Delivery of health care is highly inefficient. Much of medical practice lacks an evidence base of clinical let alone cost effectiveness.¹

Variations in medical practice are ubiquitous and have been researched for decades and ignored.² "Practice style" learnt in medical schools from peers and drug marketers, leads to patients with similar needs and characteristics getting very different packages of treatment, while at the same time proved therapies are not delivered to patients.

Thus in the US Medicare system potential savings of 30% of the budget have been identified² and it is estimated that Americans get only 55% of the health care they need.³ Similar findings were publicised by the then Secretary of State for Health, Barbara Castle, in 1976,⁴ and are now "core business" for the NHS Institute for Innovation and Improvement.⁵ Improving this may mean a complete rethink of the way we deliver health care.

The tardy recognition of the inefficiency of health care delivery worldwide means that the market for medical graduates in the future is uncertain. This uncertainty is reinforced by changes in skill mix. For instance, the Blair government in a direct challenge to the monopoly power of medicine began the licensing of nurses and pharmacists as prescribers. The emergence of nurse endoscopists, nurse anaesthetists, and the training of nurses to carry out minor surgery have the potential to reduce the demand for medical graduates.

Primary care has also seen an increase in the employment of nurse practitioners and nurse prescribers. It is unclear if these

are substitutes or complements to GPs, but tighter NHS resource constraints may lead to nurse led primary care and reduced employment opportunities for medical graduates.

Survival of the fittest

As hospital managers move from their current emphasis on tactics to hit government targets to the recognition that their survival depends on strategic quantitative management of the medical workforce, their scrutiny of the variation in activity and outcomes among practitioners will intensify. The government now publishes comparative data on the work levels of all consultants.⁶ Hospital tariffs (payment by results) make accurate collection of data on activity a priority to ensure funding. This together with investments in cost and outcome data at the level of the practitioner will make clinical performance in hospitals more transparent. Employers will seek to identify outliers and be more rigorous in recruitment and retention practices.

The thrust of Labour and Conservative NHS policy is local flexibility and the decentralisation of job markets. The success of the recent contractual negotiations in increasing payment and making medical graduates expensive to employ means that employers will increasingly look for economy and changed skill mix. The European Union working time directive together with the feminisation of the workforce with medical graduates whose activity rates may be lower than those of their male peers,⁷ may palliate the threat of unemployment.

The over ambitious expansion of medical workforce numbers by the Blair government will lead to some unemployment, raising a middle class furore which has to be resisted. The purpose of the NHS is to deliver patient care that is compassionate and efficient. It should not guarantee the employment of medical graduates or any other group regardless of patient need, personal skills, and the finite resource constraints of the NHS.

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All references are in the version on bmj.com

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