



Supplying the Demand for Doctors

The need to end the rationing of medical training places

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Summary

The NHS has a clear shortage of doctors. Across the organisation, vacancy levels for permanent positions are high, especially in unfavourable specialities such as A&E and in remote parts of the country. Each year the NHS must recruit from abroad (often depriving other countries of their much needed clinicians) and source its medics from staffing agencies to fill vacant shifts. Despite this severe shortage of doctors, the government restricts medical school places to just over 6000 per year and, to exacerbate the problem, a proportion of newly trained doctors leave the NHS upon graduation to work for staffing agencies, private providers or to work abroad. There is a particular shortage in the next generation of recruits going into GP practice, a worrying development for the future of primary care. So what can be done to ensure a sufficient number of doctors for the future?

This report proposes that instead of Health Education England (HEE) making upfront payments for the training of its medics (via bursaries, fifth year tuition fees and clinical placement fees), medical students should be required to take out a loan from the Student Loans Company to cover the total cost of their training; thus transferring the NHS's immediate training costs to an asset on the Department for Business, Innovation and Skills' balance sheet. The eradication of upfront payments by the NHS would mean the current cap on the number of doctors training each year could be lifted and the UK could finally train the number of doctors it needs. Importantly, such a training loan would be repaid on behalf of each medic by the NHS through HEE on condition that doctors work for the NHS after graduating. If graduates leave the country to work abroad or transfer from the NHS into the private sector they would become liable for the repayment of these loans. Currently, either of these career moves by a newly trained doctor leaves the taxpayers' huge investment in such medics' training wasted. This proposal would finally safeguard such an investment.

Additionally it addresses another problem. Currently the system does not always efficiently use the funds it is given for training. There are low levels of accountability in teaching hospitals for this extra funding they receive. The mismanagement in the training system is illustrated by the case of international students who come to the UK to study undergraduate medicine. They are given their placement fees (at £34,000 per placement year); the same as any UK national student. These fees come out of the NHS's training budget, meaning the NHS is paying up to £12 million per year for overseas students to study here, using NHS training facilities, with no requirement to stay and work in the UK at the end of their course. The proposed placement fee loan would ensure that such students

either remain and work for the NHS after graduation or fully pay back their placement fees if they wish to return home.

The case for training more medics

'There are serious flaws in the Government's approach to staffing the NHS and without urgent action the public will pay for it on multiple fronts. Frontline staff such as doctors and nurses are the lifeblood of the service, yet the supply of these staff in England is not keeping pace with demand.'

- Meg Hillier, Chair of the Public Accounts Committee¹

In 2014, 84,850 applications were made for pre-clinical medicine courses via the University and Colleges Admission Service (UCAS)² but in its 2014/15 commissions, HEE allocated only 6,071 undergraduate medical training places, this figure has been kept the same for 2015/16 (a ratio of over 12 applicants for each place).³ (For information on the process of training doctors see the Appendix).

HEE claims that this number will achieve a steady year-on-year growth in qualified doctors without risking an over-supply of professionals who would, in effect, become 'highly skilled unemployed people'.⁴ However, the NHS's workforce requirements are rapidly increasing. Between 2000 and 2009 the average annual medical workforce growth rate was 3.4 per cent, and numbers of hospital doctors alone have increased by 30 per cent in the decade up to 2012;⁵ 150,273 doctors were employed inside the NHS in 2014, 32,476 more than in 2004.⁶ The NHS now has 43.7 per cent more full-time equivalent consultants than in 2004, representing an annual increase of 3.7 per cent. Junior doctor numbers are similarly increasing by 2.8 per cent annually. Outside hospitals, GP numbers are also increasing due to rising demand for their services, despite reduced numbers of students training to be future GPs.⁷

The Department of Health gives similar reasons for limiting medical school places, ie. to avoid a potential future 'glut' of medics in the system.⁸ A 'glut' which would result in too many consultants for available posts in the future. However, with some hospital trusts having as many as 83 doctor vacancies (Northern Lincolnshire and Goole Hospital),⁹ and with unpopular specialities such as Emergency Medicine having around one in five consultant places unfilled,¹⁰ there seems little evidence for such a 'glut' occurring in the foreseeable future. The Royal College of Physicians found in its February census that 40 per cent of advertised consultant

physician vacancies could not be filled 'due to a lack of trained applicants'. The recruitment situation is even worse when looked at regionally. In the North West and West Midlands only 55 per cent and 60 per cent of appointments were filled. A fifth of consultants also stated that rota gaps were 'frequent, such that they cause significant problems for patient safety'.¹¹ The staggering complexity of human physiology and the personal nature of the patient-clinician interaction also make large-scale computerised diagnoses or robotic surgery unlikely in the foreseeable future. There seems little political or public appetite for such changes,¹² meaning the medics we train now will be in demand throughout their careers.

To meet staff shortages, an increasing proportion of doctors are employed by the NHS from overseas or through staffing agencies. Of the 23,544 doctors who applied to the GMC in 2014 to be registered as 'fit to practice', 15,201 were from the UK, 4,621 from the EEU and 3,722 from non-EU countries.¹³ The number of overseas doctors applying for GMC approval in 2014 (8,343) is higher than the total number of commissioned UK medical school places in the same year (6,071). These figures strongly suggest we are training too few doctors in this country. To make the situation worse, many UK trained doctors leave the UK to work abroad. A freedom of information request made by The Observer newspaper revealed that on average, 2,852 certificates permitting UK doctors to work abroad were issued each year between 2008 and 2014.¹⁴

Imminent retirement rates amongst doctors are also high, with around 13,500 consultants and general practitioners set to retire in England over the next five years. Worryingly, while many are retiring, the consultant and GP workforce must grow by around 9,400 posts (2.2 per cent, per annum) between 2015 and 2019 to meet projected demand.¹⁵ The medical director of the University Trusts of Birmingham, Dr David Rosser believes that the NHS simply 'doesn't have the number of doctors it needs, making us dependent on foreign trained doctors'. This, he states, is because 'we aren't training enough doctors in this country'.¹⁶ Of the total of 267,150 doctors currently registered to practice in the UK (in both the NHS and private sectors) 97,915 of these have been trained overseas.¹⁷ Rosser claims that centralised NHS workforce planning is the main cause of this shortage and recruitment problem. Two years ago, the chairman of the Patients Association, Vanessa Bourne also colourfully described the present NHS staffing situation as 'bonkers' and in need of a 'complete overhaul'.

The recent government cap on staffing agency charges will limit the amount the NHS can pay for staffing each shift for any staff group.¹⁸ From April, trusts are not able to pay more than 55 per cent more per shift than if those shifts were staffed by permanent employees.¹⁹ Nevertheless, it will be interesting to see how often Trusts

use the 'exceptional circumstances' clause to override this limitation, and, if this is done regularly, whether the practice will be adequately investigated.²⁰ Presently, the principle reason for employing agency locums is to cover permanent vacancies that cannot be filled.²¹ Covering doctors' shifts, mainly in the acute sector, represents the biggest expenditure on agency fees for the NHS, larger even than that spent on temporary nursing staff.²²

Problems with the current training system

Medical students usually require student loans for their tuition fees and living costs. They only have their £9,000 tuition fees paid by the NHS in their fifth year of study, when they additionally receive a £1,000 non-means-tested NHS bursary. Some students from families with lower incomes also receive bursaries.²³ Those students who are taking postgraduate degrees in medicine (applying after graduating in other disciplines) are, in their first year, eligible for a student loan of £5,535 towards tuition fees, having to pay the remaining £3,465 themselves. In their second, third and fourth years, postgraduate students receive a tuition fee bursary of £3,465 in addition to the same tuition fee loan as in their first year. Tuition fees typically leave a medical graduate with a student loan debt of approximately £40,000. After living costs are added to this, a medical student can expect to leave university with a debt of around £70,000 (£82,000 if they have studied in London).²⁴ Tuition fee contributions for medical courses (£52.6 million) do not presently represent a large proportion of HEE's total training expenditure, and bursaries for medical undergraduates only cost the body £17.5 million per year. By far the largest proportion of the HEE's medical undergraduate training expenditure is consumed by funding each student's clinical training placements, currently £798 million,²⁵ which is over 15 times more than is allocated for tuition fee payments.²⁶

Until 2013, clinical placements were funded by Service Increment for Teaching (SIFT) payments which covered the costs incurred by the NHS in providing such placements for undergraduates, normally to the value of around £34,000 per student.²⁷ However, there were no effective controls on how this money was spent. Even the Department of Health acknowledged that it did not know how most SIFT payments were actually allocated in recipient teaching institutions.²⁸ In fact, SIFT payments were commonly added to central contingency funds and used to prop up clinical services. Only a few University Hospital Trusts around the country specifically earmarked SIFT payments for teaching purposes.²⁹ Furthermore SIFT payments often varied widely with some London hospitals receiving an average

income per student of around £70,000 as compared with only £36,000 in Hull York medical school.³⁰ This lack of monitoring and consistency helped SIFT funding to be diverted for other uses around teaching providers.³¹

By their nature, payments for training placements are more open to variable interpretation in their allocation than are many other educational payments. For example, it is hard to accurately compensate financially the effect that teaching duties might have on a clinical unit's productivity, such as slower ward rounds occurring when students are present. Certain costs may however be more predictable, such as the provision of student libraries, practice dummies or student occupational health services.³²

Medics generally undertake clinical training placements in the latter years of their courses. However, based on HEE's £798 million yearly placement budget and the 6,071 annually commissioned medical school places, each undergraduate is receiving an average of £26,288 per year in placement fees during the 5 year course (a total of £131,444). The amount of time they spend on placement varies with each year of their course which is why this figure is not £34,000 per year. This yearly amount is more than half the total cost of training a nurse, including their three years of tuition fees, placement costs, and maintenance bursaries.³³

The former SIFT payments are now administered through HEE's Future Workforce Undergraduate Medical and Dental budgets,³⁴ and are paid via the undergraduate placement tariff which links a set amount of funding to each student per placement year.³⁵ This means that if medical schools now remove students from a placement offering unsatisfactory teaching and move them to another institution, the poor-performing teaching provider suffers financially. This finally introduces an incentive (although still fairly modest) for teaching providers to invest more of the placement fees they receive into enhancing teaching quality. Tariffs for placement providers are set at £33,965 multiplied by a market forces factor (for that geographical location) for a year's worth of full-time-equivalent placement, per medic.³⁶ A 1.9% reduction in this tariff for the year 2015/16 is intended to encourage training providers to operate more efficiently.³⁷ This move is to be welcomed, but, in the light of the pressing shortage of doctors in the NHS, it is imperative to know if the present funding of training placements is offering good value for money. The maintenance of historic agreements still causes some hospitals to be paid more than others for providing the same teaching activities.³⁸ If such inconsistencies are resolved, more funded training placements might be made available. This will ultimately mean that more doctors can be trained.

When junior doctors (ie. post qualification) occupy a training placement they bring sizeable HEE tariffs (£12,400 + market forces factor) to the institution offering it. In addition, a large proportion (around 50 per cent) of their salaries are also paid to their employing NHS body.³⁹ This report contends that this standard placement fee for all junior doctors from foundation to specialist makes little sense. Junior doctors steadily gain experience while working and are rapidly able to do more, with far less supervision than recently graduated foundation year one doctors.⁴⁰ Post-qualification doctors, in the same way as undergraduates, receive both timetabled, formal, teaching through tutorials but also informal education in daily practice by working alongside more senior clinicians.⁴¹ That this experience warrants a £12,400 a year payment to the providing institution is far from certain. Junior doctors are already essentially working full-time for these providers, being granted only short study-leave periods of around 10 days a year from their duties.⁴² With HEE already spending a total of £1.19 billion per year on salary support for its junior doctors, it seems excessive to also be paying £522 million for placement fees to the hospitals which employ them.⁴³

Medical schools are free to take a small number of international, non-EU, students up to a limit of 7.5 per cent of total entrants. The tuition fees charged to these students vary between institutions. Sheffield University, for example, charges £19,500 for pre-clinical years and £34,750 for clinical (placement) years,⁴⁴ while the University of Nottingham charges as little as £10,500 for pre-clinical and £19,000 for clinical years.⁴⁵ Imperial College London charges a standard £36,400 for both clinical and non-clinical years.⁴⁶ Such variation in how much universities charge non-EU students suggests an inconsistency in the cost of training across the country. This is illustrated by the fees charged by the University of Buckingham which has become the trailblazer for a rising number of private UK Universities who offer, or plan to offer, medical courses. Fees for Buckingham medical students are set at £35,525 per year.⁴⁷ It is surprising that Buckingham University can expect to cover all costs of educating medics for such a comparatively low figure (which includes both tuition fees and placement costs) while the NHS's undergraduate placement tariff alone is set at £33,965.⁴⁸ Buckingham University has forged an agreement with the Milton Keynes NHS Foundation Trust, to enable their medical students to take training placements at the hospital.⁴⁹ The fees for these placements were negotiated at a far cheaper rate than those paid by state universities thus enabling the total cost of the Buckingham course to be so much lower, relatively.

Concern has been raised at the possible adverse consequences of sending students on placement to what is currently not an officially recognised teaching

hospital. However, despite such misgivings, it should be acknowledged that Buckingham University has succeeded in establishing a medical course that meets the General Medical Council's exacting standards. Buckingham's undergraduates have to take the same examinations as all other medical students. If they pass these exams, it can reasonably be asked how Buckingham has managed to educate doctors of equal calibre to state trained ones at such a reduced cost. Similar private medical courses are becoming established at the University of Central Lancashire and elsewhere; charging similar fees. For example, the University of Central Lancashire charges £36,500 per year⁵². However, at present, no private universities are allowed to accept home students due to the aforementioned government restrictions on numbers of UK citizens studying medicine.⁵⁰

Another reason for the variability in the fees that overseas students are charged could be due to HEE's current practice of paying the placement fees for international medical undergraduates.⁵¹ Each year medical schools inform HEE as to how many full-time equivalent medics will attend each placement provider that year. HEE then pays each provider the agreed tariff regardless of whether the students concerned are from the UK or international.⁵² Presently there is no requirement for international students to remain in the UK after graduation and to work within the NHS. They are permitted to leave the UK after completing their undergraduate medical course without working a single day inside the NHS despite receiving tens of thousands of pounds in placement fees. As stated earlier, medical schools are permitted to recruit up to 7.5 per cent of their medical undergraduates from abroad, with each student set to receive up to £34,000 per placement year from HEE with no conditions attached. Although medical schools are not obligated to fill the 7.5 per cent limit of international students each year, due to the greater income to be made from the higher tuition fees charged, many do. This means that the NHS spends up to £11.97 million per year on international student placement fees.

Making such students personally responsible for the cost of their clinical training placements if they choose to return to their home countries after graduation seems only just. For those international students not willing to commit themselves to such an agreement, the private medical training offered by some independent universities in partnership with the NHS remains an option. We cannot be financing the training of international students with NHS money while its services have insufficient doctors and while UK applicants, likely to work for the NHS after graduation, are denied the opportunity to embark on their intended career. The funding system for medical training is in disarray. The NHS must become more accountable in the way it funds medical training, especially placements in hospitals

if it is to get value for money and if we are to increase the numbers of medics training each year. This section suggests there is still a substantial potential to save further money in placement tariffs; money that could be diverted to train much needed extra doctors.

The proposal

- Medical students would take out a loan to cover the cost of their tuition and placement training fees: with all bursaries and tuition fees contributions abolished. This loan would be steadily paid back on their behalf by the NHS, if medics work for the organisation after graduation.
- If medics leave the organisation to work in the private sector or abroad they then become liable for repaying the loan themselves.
- As the NHS would no longer be paying upfront for each medic it trains, the current centralised cap on the number of medical students would no longer be required. This country could finally train the number of medics it needs, giving far more of our nation's bright applicants the opportunity to become a doctor.
- Such a proposal disincentivises leaving the NHS upon graduation and protects the taxpayers' sizeable investment in each doctor's training. It also means less medics would want to work privately for agencies as they would then be required to make the loan repayments themselves.
- Doctors who do leave the NHS will be paying back money formerly spent by the NHS, creating a new income stream which could help finance the loan repayments of the increased numbers of doctors being trained.
- Increasing the number of medics in the system will create competition for jobs, helping to fill vacancies, including those in less popular specialities or remote areas of the country, and thus reducing the bargaining power of agencies as there would be fewer vacant shifts for them to fill.

The only way to solve the current medical staffing crisis is to find a way to train more medics in this country. It is clear, from the high doctor vacancy rates around the service, that we are not successfully making up for this shortfall by our intensive recruitment of medics from other parts of the world. As competition to recruit international medics rises globally the problem can only get worse. It can also be argued that such a tactic is irresponsible as it often entails depriving lower-income countries of their much needed medics. The UK, as a high income nation, should not be draining the limited work forces of lower-income countries.⁵³ It is also

an unsustainable practice to rely on expensive agency medics to temporarily fill shift gaps in rotas. What we need is a far larger pool of medics from which we can produce a stable, permanent workforce. It is also imperative we ensure that doctors continue to work for the NHS after the UK taxpayer has made such a major investment in their training.

In 2015, HEE's total budget for undergraduate training placements was £798 million. Over five years of study, assuming that numbers beginning training will remain at the same level as in 2015 (6,071), an average of £26,289, per year is currently spent on each medic's training placements. Based on these figures, medics training under the suggested scheme would take out an additional loan of around £131,500 to cover these placement fees over their course. These new medical student loans would not operate like standard student loans. The NHS would commit to paying back the entire amount on behalf of all successfully graduating students, provided they continued to work within the organisation once qualified. If the loan repayment period was set at 30 years (this time scale has been picked as a reasonable example), the NHS would repay around £4,381 per year to the Student Loans Company on behalf of each medic for their placement loan repayments. Added to this would be repayment for a new loan replacing the NHS's previous contribution towards tuition fees in the 5th year of study, lower income bursaries and the £1,000 NHS maintenance grant bursary, meaning the total repayments made each month by the NHS on behalf of a typical doctor would amount to around £4,715 per year, or £393 per month (equivalent to the total amount that the NHS would have paid up-front to students and their placement providers). In parallel to the proposed new loans, medics would still pay back their standard student loans (for their tuition fees for years 1-4 and living costs) as they did before.

Medics trained under this new system would only become personally responsible for repaying their training costs if, after graduating, they chose to work in the private sector, abroad or for agencies. Hence, it is hoped that the annual repayment on a doctor's behalf of £4,700 per annum might act as an incentive for doctors to remain working within the NHS, at least at the lower paid junior doctor level. Nevertheless, if qualified doctors chose to work for often higher salaries in the private sector, thereby becoming responsible for their loan repayment, they would, in effect, be repaying the cost of their medical education to the state. Those medics who wished to leave the public sector would be free to do so, but on this understanding.

Qualified doctors who chose to specialise in research after training would, under the proposed scheme, continue to have loan repayments made on their behalf by

the NHS; their work being recognised as beneficial to healthcare generally. Medics would also not be required to personally repay loans if they are unemployed, for example when taking a career break to raise a family or if unable to work due to long-term illness or disability.

The new loans would appear as an asset on the Department for Business Innovation and Skills's (BIS) balance sheet. This government department is already administering student loans awarded through the Student Loans Company,⁵⁴ a company it owns 85 per cent of.⁵⁵ Qualified doctors' loans would be steadily paid off by HEE on behalf of the Department of Health both via set standard contributions (which, due to the size of the loan would be substantially higher than for normal student loans) and through Resource Accounting and Budgeting (RAB) contributions which are intended to cover that proportion of the loan (as is the case with other student loans) predicted never to be paid off over the course of an average career.⁵⁶ Due to the NHS's commitment to pay back the new extra loans and to the high salaries of medics, meaning they are likely to pay off their normal student loans, the BIS can expect a much higher proportion of medics to pay back all their fees compared to the average graduate of other university courses.

Replacing the present upfront payments from HEE to prospective doctors and providers with a retrospectively repaid loan will eradicate the need for centralised yearly limits on numbers training. Stiffer competition for job vacancies, a result of training more doctors for the system, would make such positions easier to fill and so reduce Trusts' reliance upon expensive staffing agencies, and thereby prove cost-effective, enabling the development of a stable, permanent, workforce. Training more doctors in the UK would also reduce the need to recruit doctors from abroad, currently a major expense to the NHS. Many of those recruited return to their home countries fairly rapidly. The higher education of citizens is also held to benefit the economy as a whole by eventually yielding a higher tax revenue from a more productive and a healthier workforce,⁵⁷ in this case making increased doctor numbers an even more cost effective move, especially as their line of work enhances the rest of society's health.

As the NHS becomes properly staffed, with vacancies finally permanently filled, doctors will be able to work safely and effectively, making fewer mistakes and having more time to spend with each patient, recognising and addressing their needs more effectively. Even modest subsequent improvements in such patients' outcomes would reduce the chance of complications and the likelihood that further treatment is needed, thus saving the NHS money. A new income stream would also be created from doctors working outside the NHS. With this proposal, such

doctors would not be eligible for having their loans re-paid by the NHS and thus either they, or their new employers (if offered as a recruitment incentive) would be paying this money back into the system. These funds could be reinvested to increase the capacity of the medical training system such as increasing the number of available places on foundation courses for new medical graduates. Last year, nationally, 235 graduates had to be placed on a reserve list for foundation places; 202 of whom were UK nationals. They had to wait for foundation vacancies to occur from the withdrawal or failure of exams by other students in order to obtain a place.⁵⁸ This seems to be the only area in the entire system where there are more medics than vacancies. As foundation training is provided by a loose collective of medical schools, local deaneries (now Local Education and Training Boards), hospital trusts and other providers,⁵⁹ it would seem that the system might have flexibility to expand. However at present, there seems no apparent will to do so.

The NHS, faced with a staffing crisis and serious underfunding cannot reasonably be expected to fund the training of medics who have no desire to work for the organisation. Those medics who want to work in the private sector or abroad after qualifying might, in the light of the proposed scheme, be encouraged to consider undertaking their medical education overseas or even in the rapidly expanding private medical university sector (providing that these become open to UK nationals). It is possible that some private or overseas healthcare employers might be prepared to repay student loans on behalf of their employees as an incentive to work for their enterprises. As mentioned previously, such independent providers would be repaying the NHS for educating the staff they need. If doctors were more personally accountable for the costs incurred in their state-funded undergraduate training, they would be more likely to work within the NHS after graduating. In effect, their loyalty to the organisation would be recognised financially. Medics, feeling more responsible and more aware of the cost of their training through obtaining loans might also, as a consequence, demand more from training providers in terms of quality. This could improve placements generally, perhaps reducing costs, helping the NHS to train more medics within the same budget.

Conclusion

This proposal offers a means of training far more of our NHS doctors here in the UK, and thus ending a long-standing reliance on both overseas medics and agency staff to fill vacancies. Increasing overall numbers of UK trained medics puts the NHS in a far stronger position; able to choose who it hires and enabling vacancies to be filled in every part of the country with permanent employees. Furthermore

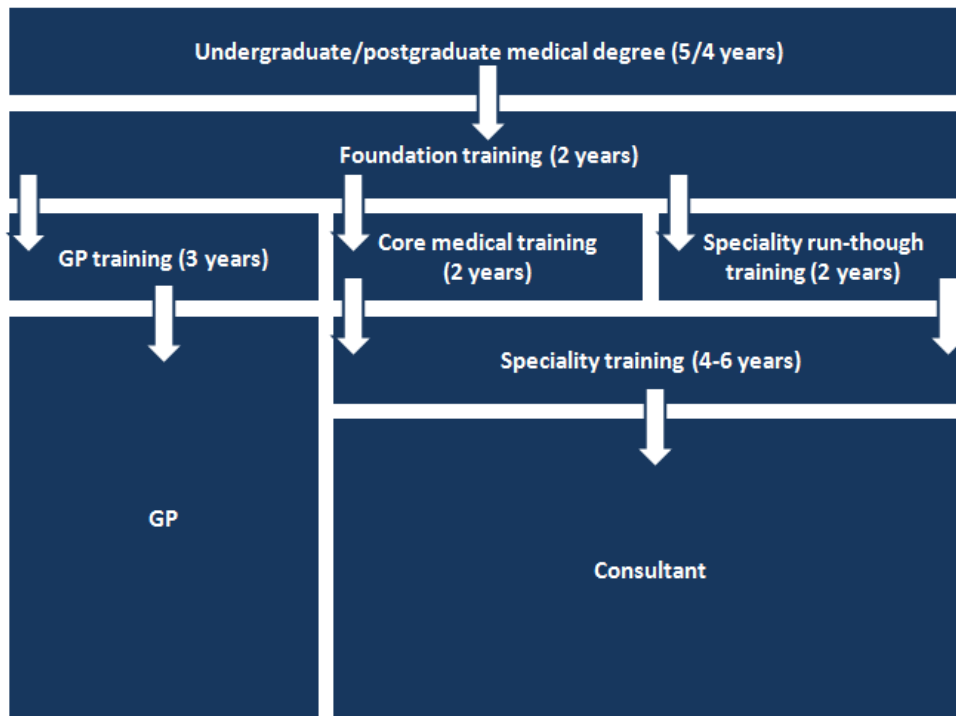
such home-trained graduates will have an excellent understanding of the health system that they have spent so many years training inside. In a time of unprecedented financial pressure on the NHS, the organisation cannot afford to lose the medics it trains (funded by the British taxpayer) to the private sector or abroad. The proposed loan scheme would also ensure that the NHS's investment in training its staff is protected whilst never penalising those doctors who choose to work within it. It is likely to ensure that more of those it trains are retained in the NHS.

This report further suggests that the present system of payment of clinical training placement fees by the NHS should be reviewed, especially its policy of financing international students. An independent review commissioned by the government would be welcome, with no involvement for medical schools, the Department of Health or teaching hospitals. The fact that we fully fund the placements of international students is alarming. The money saved from the NHS no longer paying clinical training placement fees on behalf of such students could fund the training of many more UK medics, although perhaps some of this money could be set aside to provide bursaries to help needy overseas students from countries with underdeveloped medical institutions, on a case by case basis, particularly for those from former Commonwealth countries; nations, it could be argued, that have played a part in Britain's development as a high-income nation. However, almost all money saved from reformed placement funding urgently needs to be re-invested in the national training infrastructure, particularly with regard to current priorities; perhaps in the creation of more foundation training places. We should also evaluate whether £12,400 per junior doctor for placement fees is always needed, especially as these doctors work long hours at far cheaper rates than consultants. There is potential to save a sizeable chunk of the £500 million HEE allocates for this group's placement fees. After all, even in foundation year one these medics are working flat out with 5 weeks of holiday per year.⁶⁰ A lack of funds is usually cited as being the principle justification for limiting doctors' training numbers, yet at the same time parts of the available training budget can still diverted by trusts to support general clinical services. If trusts need more money it should be provided through more appropriate channels. Inefficiency in the allocation and utilisation of training finance is depriving the NHS of the doctors it needs.

Appendix

A standard undergraduate course lasts for 5 years (4 for postgraduate entry). Successful students are awarded a Bachelor of Medicine, Bachelor of Surgery (MBBS) upon graduation. Training follows the stages in Figure 1.

Figure 1: Stages of medical training: undergraduate to consultant



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