Junior doctor titles following implementation of Modernising Medical Careers in the UK

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Summary

Objective Recent changes in postgraduate medical training in the UK collectively organized under the auspices of Modernising Medical Careers (MMC) have created new labels for junior doctors in training. It would appear that many nurses and other health workers do not understand the new terminology. We aimed to investigate the knowledge of nursing staff about new junior doctor titles in a district general hospital. As far as we are aware, this is the first survey to determine the views and knowledge of the new terms among staff working in the NHS.

Design Questionnaire study.

Setting District general hospital, West Midlands, UK.

Participants Fifty-five randomly selected staff nurses working in the surgical directorate.

Main outcome measure Questions were asked about their views and knowledge of the current nomenclature. To objectively assess knowledge of the new titles respondents were asked to match equivalent positions with those based on the old system.

Results Only 22% (n = 12) of respondents felt that they fully understand current terms in usage. Seventy-six percent (n = 42) felt that it was ‘very important’ that titles accurately convey role and seniority of the doctor. The most common titles correctly matched were FY1 and House Officer (n = 45, 81%) and FY2 and First Year Senior House Officer (n = 35, 64%). Only 9% (n = 5) of staff nurses correctly matched ST3 to Junior Registrar and 13% (n = 7) correctly matched ST7 to Senior Registrar. Ward-based staff nurses demonstrated greater familiarity with titles when compared to nurses who work mainly in the outpatient clinic and theatre setting (p = 0.017). We did not identify a statistically significant association with demographic characteristics (age, gender, experience) and knowledge of the new terms (p > 0.05). Approximately 98% (n = 54) of the staff surveyed felt that terms are confusing to nurses and need to be simplified.
**Conclusions**  Our survey revealed that nursing staff lacked knowledge of the current terminology to describe doctors in training. This may have implications for staff expectations regarding specific role of junior doctor in terms of clinical decision-making, working relationships and communication between team members, and ultimately patient care.

**Introduction**

Recent changes in postgraduate medical training collectively organized under the auspices of Modernising Medical Careers (MMC) have transformed training structure for junior doctors in the UK. This programme was an attempt to improve medical education and training, and also modify the recruitment process, so as to create a ‘transparent and efficient career path’ for junior doctors working in the NHS.

These reforms were implemented in August 2005; as well as changing the model of training these revamping procedures have also created new labels to replace the traditional grades for junior doctors in training.

A few of the terms in current usage include FY1, FY2, ST1, CT2, ST3, ST7, FTSTA. Foundation Year 1 (FY1) and Foundation Year 2 (FY2) are equivalent to House Officer (HO) and first year as Senior House Officer (SHO). Specialty and Core Trainee year 1 and year 2 (ST1/CT1) are equivalent to the prior second and third year of SHO grades, respectively. Specialty Trainee 3 (ST3) is a point at which subspecialty training is commenced and usually attracts a national training number and is equivalent to the previous junior registrar (SpR) (Table 1).

The changes brought about by the implementation of MMC have become extremely unpopular among many medical professionals in the UK, and a recent independent review of the reforms criticized many aspects of it. It has been suggested that the current nomenclature in usage to describe doctors in training in the UK is an undesirable legacy of the Medical Training Application Service (MTAS), and as such, many of the terms lack familiarity and intuitive meaning especially for those individuals who do not have detailed knowledge of the medical training system. Anecdotally, many junior doctors working in UK hospitals have noticed that there is particular confusion among nurses and other allied health professionals in regards to their knowledge and interpretation of the new terms to describe junior doctors.

These issues have even more relevance in the current era where hospitalized patients are being increasingly cared for by multidisciplinary teams, including the extended roles of nurses, physiotherapists and non-medically trained professionals. It appears paramount that titles need to be explicit and clear so that patients, carers, nurses and other health workers are aware of the specific role of the individuals in the medical team, their level of competence, and the qualifications that they possess. Such knowledge is important for a harmonious working relationship and the delivery of optimal patient care.

The aims of this study were to survey surgical nursing staff in a district general hospital (DGH) and to elicit their perception and knowledge (subjective and objective) of titles in current use to

| Table 1 UK Junior Doctor Training Grades |
|-----------------------------------------|
| **Old training system** | **New MMC system** |
| House Officer (PRHO) | Foundation Year 1(FY1) |
| Senior House Officer (SHO) year 1 | Foundation Year 2(FY2) |
| Senior House Officer (SHO) year 2 | Specialty Trainee (ST1) |
| Senior House Officer (SHO) year 3 | Core Trainee (CT1) |
| Junior Registrar | Specialty Trainee (ST2) |
| Senior Registrar | Core Trainee (CT2) |
| Trust Registrar/Staff Grade | GP-VTS |
| Staff Grade/Associate | Specialty Trainee (ST3) |
| Specialist | Clinical Fellow |
| Specialty Doctor | |
describe junior doctors in training. Our survey was also designed to elicit objective data on nursing staff ability to match the level of training and competence of a clinician against the doctor’s current title. As far as we are aware this is the first survey to assess views and knowledge of new junior doctor titles among health professionals working in the NHS since the implementation of MMC in 2005.

**Methods**

This study was a survey of general surgical nursing staff working in a DGH in the West Midlands, UK. Fifty-five randomly selected staff nurses working in the surgical directorate answered a simple, anonymous, structured questionnaire. The questionnaire included questions to obtain demographic information, including age, gender, level of experience (years qualified) and also details about the clinical area that they carried out the majority of their work (inpatient, outpatient, theatres). We elicited information on their views and subjective understanding of the new terminology to describe junior doctors, and also asked how important they felt it was that doctors’ titles accurately convey the clinician’s role and seniority. In order to accurately assess knowledge of the new terms and elicit objective data, recipients were asked to match the equivalent position for some of the new titles with those based on the traditional (old) system (Table 1). Responses were collected over a two-week period in September 2010. Results were analysed using SPSS for windows version 15. (Chicago, IL, USA). Data were expressed as mean (± standard deviation). Statistical comparison was performed using Mann Whitney U test with the significance level at \( p < 0.05 \).

**Results**

Fifty-five completed questionnaires were available for analysis. The demographic data of the nursing staff surveyed are summarized in Figures 1 and 2. Of the 55 participants in the survey, 85.5\% (\( n = 47 \)) were women and 14.5\% (\( n = 8 \)) were men. Fifty-eight percent (\( n = 32 \)) of the nursing staff surveyed worked on the wards predominantly caring for inpatients, the remainder worked in theatre and outpatient clinic settings (Figure 2). Fifty-three percent (\( n = 29 \)) of the respondents had been qualified for more than 10 years, 23\% (\( n = 13 \)) had qualified between 5–10 years, and 21\% (\( n = 12 \)) had qualified less than 5 years.

The results show that 76.4\% (\( n = 42 \)) of the surgical nursing staff surveyed felt that it was ‘very important’ that the junior doctor title should convey the clinical role and seniority of the clinician, 16.4\% (\( n = 9 \)) felt that it was ‘quite important’ and 7.3\% (\( n = 4 \)) felt that it was ‘not very important’.

Only 21.8\% (\( n = 12 \)) felt that they fully understood the new titles in current usage to describe junior doctors. All nurses in our survey were familiar with the traditional grades of junior doctors. Of the 55 nurses surveyed, none were able to correctly identify and match equivalent position of all 11 new terms with old traditional titles (Figure 3). The most common title correctly

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**Figure 1**

Age distribution of respondents

**Figure 2**

Respondents’ area of work

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**Figure 3**

Table 1: Equivalents of junior doctor titles in current usage to describe junior doctors
identified was FY1 with over 81% \((n = 45)\) of nursing staff correctly matching this term to the equivalent House Officer position. Similarly, 63.6% \((n = 35)\) correctly matched FY2 to the correct old title. Nine percent \((n = 5)\) correctly identified ST3 as equivalent to a Junior Registrar and only 12.7% \((n = 7)\) correctly matched ST7 to senior registrar. Most confusion would appear to be centred on the CT1/ST1 position with more than 96% \((n = 52)\) of nurses incorrectly matching this title to the equivalent old title.

We did not find a statistically significant difference in the number of correctly matched responses with respondents’ age or gender. We defined ‘experience’ as the number of years a staff member had been qualified. The mean score for correctly matched titles was not significantly different for the group of nurses who had been qualified for less than 5 years, compared to those who had been qualified between 5–10 years and for more than 10 years, respectively. Although none of the respondents correctly matched all titles, those nursing staff who claimed that they understood the new nomenclature scored significantly higher than those who felt they did not understand the new terms \((4.0 \pm 1.95\) versus \(2.35 \pm 1.23\) \([p = 0.003]\)). Respondents who felt that it was ‘very important’ that a doctor’s title should accurately convey seniority demonstrated significantly increased familiarity with the new terms, compared to nurses who felt that such information was either ‘quite important’ or ‘not very important’ and/or ‘not at all important’ \((3.6 \pm 1.81\) versus \(2.4 \pm 1.43\) \([p = 0.026]\)). Nursing staff who worked predominantly in a surgical ward setting looking after inpatients demonstrated greater familiarity with the new doctor titles compared to those who worked mainly in theatres and outpatient clinics \((3.55 \pm 1.57\) versus \(2.34 \pm 1.31\) \([p = 0.017]\)).

Of the 55 respondents 98.2% \((n = 54)\) indicated that the current system of describing junior doctors’ positions was confusing to nurses and the same percentage felt that the current terms should be simplified.

**Discussion**

The titles used to describe junior doctors should be easily distinguishable and convey to staff and patients the individual’s role in the team and level of seniority.\(^3\) Our results demonstrate considerable confusion among surgical nursing staff regarding the new titles for doctors in training.

Twenty-one percent of nurses surveyed \((n = 12)\) were confident that they understood the new terms, their confidence was correlated to higher
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scores in the matching test (Spearman’s rho = 0.42, p = 0.002). We did not identify a statistically significant association with demographic characteristics (age, gender and experience) and knowledge of the new terms.

Despite the majority of nursing staff demonstrating good knowledge with regards to the role of the foundation doctors (80% staff correctly matched FY1 and 60% correct matching FY2, respectively), our study demonstrated very poor knowledge of the remaining junior doctor titles. Approximately 90% of respondents incorrectly matched equivalent roles for CT/ST and ST3–ST7 positions. Only 9% of nursing staff surveyed correctly identified ST3 as a ‘registrar’ equivalent, with the majority participants incorrectly matching ST3 to the old SHO position. This finding is somewhat concerning given the fact that the majority of patient care in NHS hospitals is Registrar (ST3–ST7) and/or SHO (FY2/CT/ST) led, particularly during the out-of-hours period.

Our study suggests that knowledge of newer titles within the group of nursing staff surveyed was affected by personal factors (views on its importance) and also influenced by their specific working environment. Despite the fact that we did not find statistically significant differences with regard to the subjective knowledge of terms, between the different groups of nurses, based on area of work. Ward-based nursing staff demonstrated significantly more familiarity, with more correct matching of the new terms, than did nursing staff who worked in a non-inpatient setting (p = 0.01). This observation is perhaps not surprising given that ward-based staff work more closely with junior medical staff compared to those nurses working within the outpatient departments and theatres. An interesting finding in our study was that nursing staff who felt that it was ‘very important’ that junior doctor titles convey position/seniority demonstrated greater knowledge of the current terminology compared to staff who felt it was ‘quite important’ and/or ‘not very important’ (p = 0.02). It could be hypothesized that the perception of the importance of doctors’ roles and place within the medical hierarchy may have positively influenced nursing staff motivation to both learn about the titles and one’s receptivity to the new terminology.

There are several possible explanations for high levels of confusion with regard to the terminology highlighted in our survey. One of the key factors contributing to confusion is the current ‘mixed economy’ of training structures to meet the needs of individual specialties. Such a system allows for some specialties to continue ‘run through training’ and also affords other specialties the option to de-couple from the run-through training structure and recruit trainees in a more flexible manner. Currently, the presence of different cohorts undertaking training within different structures, within the same institution, and labelled to match the specific model of training the junior doctor is pursuing, e.g. Core Surgical Trainee (CST), Core Medical Trainee (CMT), Specialty Trainee (ST), Primary Care Vocational Training Scheme (GPVTS), Acute Care Common Stem Trainee (ACCS), is undoubtedly contributing to the confusion about terminology and lack of appreciation of the specific role that these doctors play in the team, as highlighted in the present study.

As mentioned earlier, MMC has become extremely unpopular among many medical professionals in the UK. The presidents of the Royal Colleges of Physicians and Surgeons issued a joint statement emphasizing that the medical profession ‘could not underestimate the immense damage inflicted on British medicine by implementation of MMC’ and welcomed the independent review of training.1

Sir John Tooke was commissioned by the Department of Health to carry out an independent review of MMC, and this report was published in 2008.2 Several recommendations were proposed following this Inquiry. In the context of postgraduate training and nomenclature, Tooke recommended specific changes such as breaking the link between the two foundation years and revision of titles. Tooke proposed that FY1s in the future should be called ‘provisionally registered doctors’, and that the current FY2 position should be ‘uncoupled’ and incorporated as the first year of ‘core specialty training’ and that these trainees should be titled ‘registered doctors’. Furthermore, the Tooke inquiry recommended that doctors in higher specialty training, in all specialties, including general practice, should be referred to as ‘specialist registrar’. The aforementioned titles ‘provisionally registered doctors’, ‘registered doctors’ and ‘specialist registrar’ are unambiguous and clearly define the role
of the junior doctor, and should be relatively easy to implement since the role of ‘registrar’ is already well-known by patients and nursing staff and other healthcare workers in the NHS organization. The authors would also support the use of the titles ‘intern’ and ‘resident doctor’ similar to that used in the American system which is appropriate and accurately conveys seniority and unlikely to be misconstrued by patients and other healthcare professionals. Such terms are currently in use within some of the member states of the European Union.

Since 1 April 2010 the General Medical Council (GMC) has merged with the Postgraduate Medical Education and Training Board (PMETB), thereby creating a single regulator for medical education. This merger may represent an opportune time to re-visit and re-appraise issues related to professional role and the current terminology.

There are several important discussion issues arising from this survey and may be interesting questions for further research. First, there is a question about transparency. For example, if hospital-based healthcare professionals who work most closely with junior doctors in the peri-operative management of surgical patients lack knowledge and familiarity with current terms, is it realistic to expect members of the public to appreciate the subtle differences in nomenclature to describe roles of junior doctor? Do members of the public need to know this information? Another important issue revolves around the different roles of junior and senior doctors and nursing staff expectations with regards to key patient management decisions. The logical question is: could lack of awareness of new grades of doctors and knowledge of the level of responsibility potentially hinder effective communication between doctors and nursing staff and could this have an adverse impact on patient care?

The authors believe that in the modern healthcare environment with increasing focus of interprofessional care and blurring of professional boundaries, members of the public have a right to clear information. It would appear that the current nomenclature with a letter and number is impersonal and lacking in familiarity with staff who work most closely with junior doctors.

There are several limitations to this study worthy of mention, such as the relatively small sample size, survey restricted to surgical nursing staff, and there also issues related to the validity and reliability of the responses obtained from self-reported/questionnaire-based research.

Despite the above limitations our study highlights that further discussion on junior doctor titles are necessary. At the time of writing the Royal College of Psychiatrists is canvassing the views of its members on new titles to inform the debate. As we go through this transition period with the new coalition government, it seems highly likely that the current model of training will be subject to further revision in the near future, with possible introduction of new nomenclature to describe junior doctors. Craddock and van Niekerk 3 state that ‘whatever terminology is used, it should be simple, help to indicate with clarity the level of qualification of the practitioner, minimise confusion and have a lifespan that can outlive the inevitable technical changes to training pathways’.

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