Research training and Calman reforms: a role for the MSc?

Implementation of the Calman report,1 and the consequent creation of a unified training grade, will reduce the number of junior doctors exposed to research (box 1). Clinicians in structured specialist training programmes will not need to spend two to three years doing a research degree in order to obtain certification of eligibility for a consultant appointment, indeed it will slow their progress if they do. As a MD or MS will no longer be a semi-obligatory requirement for a consultant appointment, the motivation to work for a research degree will be considerably reduced. It is likely that only those people who want a career in academic medicine, or are driven by their own interests, will do research leading to a doctorate, and in most cases they will probably opt for a PhD.

One consequence of these changes will be a cadre of consultants who have never been exposed to research. As a result they will be less able to evaluate and adapt to new advances in their field, both because they will not have spent time studying the scientific aspects of their subject in depth, and because they will not have been exposed to research techniques and methodology. A second consequence will be that junior doctors will not have a period to consolidate and explore the scientific background of the specialty in which they are going to spend the rest of their working life. Such knowledge is not only of intellectual interest, but can also sharpen clinical skills by providing an academic framework for their subject.

There is considerable support for a continuing role for science and research training in postgraduate medical education. Indeed, many training programmes identify the value of spending a year in this way. However, it is not possible to do a full doctorate in one year. One solution would be to increase the use of MSc courses. These degrees (when taken full time) typically last one year and so are in line with the Calman reforms. The majority of MSc courses have two components, a taught module that explores the subject in depth, and a closely supervised research project (typically 6 months) (figure). The roles of the MSc, which include education in a scientific discipline as well as exposure to research, would fulfil many of the criteria needed to form part of the postgraduate training of doctors.

The opportunity to immerse themselves in an academic subject for a year would be of invaluable benefit to clinicians, both to update themselves on advances made since they were at medical school, and to ground themselves in the scientific principles of their chosen subject.

There is increasing pressure on universities to increase the research training component of MSc courses (leading ultimately to the development of the MRes or Master of Research),2 and for these to become an integral first step in a PhD programme. Such courses will include teaching of broader skills than current MSc courses (management skills, commercial understanding, etc). It would be possible to modify such degrees to introduce elements of specific interest to clinically qualified students (organising and running clinical trials, evidence-based medicine, etc). The courses would also give clinicians wanting to go on to a PhD an initial academic training, and would allow them (and their potential supervisors) to gauge their aptitude or interest for research.

There are several questions that need to be addressed before the MSc can become widely acceptable as a postgraduate qualification for clinicians. The first is the nature of the courses. There is a large variety of MSc programmes available. For example, at the Royal Postgraduate Medical School we offer 10 courses, ranging from the most scientifically oriented (eg, immunology, molecular medicine) to those with a strong clinical component (eg, nuclear medicine, histopathology, surgical science, etc) (box 2). Each of these would have some role in the training of clinicians, but there will also be a need for new and more applied MSc courses.

Calman report

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<th>The Calman report recommended a number of changes with the aim of improving the specialist medical training in the UK. The major points of these are:</th>
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<td>• the specialist registrar grade (unified training grade) will replace existing career registrar and senior registrar grades (aim to be launched 1 April 1996)</td>
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<td>• a structured training programme will include</td>
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<td>- specified length of training</td>
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<td>- appraisal and counselling during training</td>
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<td>- acquisition of skills, competence and experience</td>
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<td>- entry requirements to begin specialist training</td>
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<td>- assessment prior to completion to obtain a Certificate of Completion of Specialist Training (CCST)</td>
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<td>• award of CCST linked to the specialist register to guarantee the future quality of candidates for consultant posts</td>
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Box 1

Figure Composition of typical MSc course. As an example we have chosen the MSc in Immunology. This consists of a five-month taught component, made up of a mixture of lectures, practicals, research seminars, tutorials, journal clubs, and videos. This module is examined by essay-based and practical examinations. The seven-month research module consists of a placement in a research laboratory, where the students participate in the ongoing research work of the group and write up a mini-thesis that is examined by viva voce. Currently this MSc is full time, however, it would be readily adaptable to a part-time course by taking the taught module over a longer period of time. It would be desirable for at least a proportion of the research project to be full time, though this would depend on adequate funding being identified.
MSc courses available at Royal Postgraduate Medical School

- immunology
- infectious diseases
- surgical science
- human reproductive biology
- toxicology
- neuroendocrinology
- haematology
- histopathology
- nuclear medicine
- molecular medicine

*These MSc courses are run in conjunction with other Institutes of the University of London

Box 2

The second question to address is the funding of the courses. Currently most clinicians on MSc courses (at least in our institution) fund themselves by taking locum appointments. This clearly is not satisfactory. One solution would be for MSc courses to be recognised as part of clinical postgraduate training, and central funding be provided, for example, through Postgraduate Deans. Moreover, this type of training programme might be more attractive to both clinicians and National Health Service Trusts if MSc courses were developed that could be taken on a part-time basis by doctors in the unified training grade, with suitable study leave provision made both for attendance at lectures and for an extended period of research. This may eventually lead to the development of rotations that incorporate an MSc course as an integral part of the whole training programme.

There is a clear need for a scientific component to the postgraduate training of hospital doctors. The current use of the MD and MS, which has sprung up in an ad hoc manner, is unsatisfactory and unlikely to survive the changes instituted by the Calman report. Masters courses, which are being seen as having an increasing role to play in the training of scientists, have the potential to provide clinicians with an efficient but highly comprehensive training in both scientific theory and research.

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