Medical Training Review
JRCPTB response

Theme 1: Is postgraduate medical training meeting the needs and expectations of patients, healthcare services and doctors?

Subtheme 1.1 - Workforce Distribution

Q4. 'The current system of recruitment to and distribution of training posts meets the health needs of patients and the population.'

1. Expansion
IMT. There is an urgent need to expand training numbers in early medical training. Internal Medicine Training Stage One (IMT) has seen an almost exponential rise in application numbers with almost 10000 applications for approximately 1700 posts by 2025. There is growing concern that applicants from Foundation training are unlikely to secure an IMT post and the overseas application numbers are rising year on year. There is now considerable tension between UK employed doctors and International Medical Graduates regarding appointment to IMT rotations. Many Foundation doctors are then taking up locally employed non-training posts or leaving UK to gain experience abroad.

HMT. We are now seeing 100% fill rates across most of both Group One and Group Two higher medical specialties. Nevertheless, some important specialties for our increasingly aging and co-morbid population e.g. geriatric medicine and acute internal medicine, still struggle. Analysis of applications do reveal that we are still dependent on IMGs to fill the specialties. Recent surveys reveal that at least 60% of HMTs have a desire to work LTFT, both in training and upon subsequent Consultant appointment. Workforce planning has not addressed the implications of this, and we remain at serious risk of being unable to fill Consultant vacancies now and in the future. Indeed, we have large numbers of vacancies across all physician specialties in UK at present. We require an expansion of training numbers to address this shortfall.

Expansion of training must have the educational infrastructure required to deliver quality education and training, including TPDs, administrative staff etc.

2. Redistribution
The planned review of current training posts in England was suspended in 2024 following extensive work looking at redistribution of training posts from areas with apparent overprovision to areas with significant deficiencies. This suspension is regrettable if we are truly to provide an equitable service across the UK.

Modelling of regional healthcare provision including review of healthcare inequalities pertaining to aging populations, social deprivation etc should be performed and influence training needs on a more granular basis.

The maldistribution of training posts means there is a risk of polarising the medical workforce: The less popular the location and the fewer training positions in these locations, means the greater the potential for a clustering of IMGs and doctors unsuccessful in securing posts in more popular locations. The result of this is a potential cycle of lower service quality and increased risk to patients and may perpetuate health inequalities

3. Conversion
There is a strong case to be made to convert Locally Employed Doctor posts into formal training posts. The money for these posts come from the public purse, but are streamed through Trust funds rather than SEBs.

If such an approach was to be considered, as with 1.1.3 above, it would be essential to support the increased training numbers with the educational infrastructure required to deliver quality education and training, including TPDs, administrative staff etc. It is well recognised that the present organisation of training support is inadequate, and strides must be taken to improve the infrastructure and encourage clinicians to take on training roles.

4. Involvement in the process by those providing training
Involvement of those providing training in any future planning is essential. It would not be appropriate to make changes to any programme without the input of the Training bodies, including JRCPTB, Federation, Deaneries etc

5. Competitive advantage for popular location
It has long been recognised that certain geographic areas are more popular than others (London, Oxford, Cambridge) and attract large numbers of applicants.

Less popular regions should be given options to attract more applicants including enhanced financial backing, incentives etc. This approach must be encouraged to promote formal training pathways. We believe that formal pathways are more supportive for trainees where their capability acquisition and maturation can be monitored. With innovation to address trainees concerns these pathways could be made more attractive.

Training can transform hospitals - Increasing the number of training posts in less popular places may be the catalyst needed to help create the clinical infrastructure to drive training and an improved quality of service for patients. The prospect of becoming a training hub should assist with consultant recruitment and service development to help embed a permanent improvement. We could potentially look at greater utilisation of remote learning in order to enhance training opportunities in more rural areas. Possibly encourage rotations in more rural areas as opportunities for research, audit and exam preparation?

6. National recruitment preferred to local recruitment
We are of the opinion that national recruitment should remain the standard. We are concerned that moving to local recruitment would be inefficient and expensive have detrimental effects and lose any cohesion and monitoring of training

7. Primary / Secondary Care interface
Within our increasingly elderly, and co-morbid population and especially post-Covid, we are seeing increasing pressures in the secondary care setting with rising admission numbers, corridor-treatment, backlogs in Emergency Departments and Acute Medical Units and delayed discharges. Patients are increasingly using secondary care as their access point to diagnosis and treatment because of variable access to primary care. Increasing waiting lists are putting further pressure on primary care to refer patients into hospitals.
Unless there is expansion in secondary care capacity to cope with the above, we predict major problems in flow into and out of hospitals throughout the year.

Q5. 'The current distribution of training posts meets the needs of healthcare service providers in delivering healthcare and developing their future medical workforce.'

1. WTE equivalent vs NTN
As stated in 1.1.2 above, the move to greater numbers of LTFT resident doctors is placing service provision in great difficulty. However, the reason for the desire for LTFT training has not been adequately determined and it is felt that this should be investigated further. Given that the trend for LTFT training may well continue we should also allow training appointments on a whole-time-equivalent basis rather than using NTN numbers as this would allow local training programmes more flexibility and the possibility of maintaining the service requirements needed.

LTFT challenges. A much greater percentage of resident doctors, and consultants, will work flexibly and this requires the service to develop workforce plans that account for this move to LTFT working. More research needs to be done into the drivers for LTFT training and work. It may be much cheaper to provide better support to staff (such as free childcare support for NHS staff) than expanding the number of LTFT doctors.

As stated above, there are many regional variations that need greater local control in skill mix, training programme numbers and use of epidemiological data to determine the optimal training needed to support healthcare provision on a region-by-region basis and provide more equitable distribution of physicians.

2. IDT
Inter-Deanery transfers are difficult to manage and currently are very difficult to obtain. Resident doctors should have more flexibility and choice when it comes to where they train but this must be balanced by service needs and ensuring equity of access to high quality care across the country. As noted above this means that there must be encouragement and incentivisation for training to be undertaken in those areas that are less popular now.

3. Reconsider Training vs LED balance
A move towards training posts as opposed to LEDs would be desirable and deliverable (given our application numbers for IMT and HMT) and would provide greater structure and ability to plan service needs in future.

4. Resident doctors should not be expected to rotate through too many units as all survey data suggests that stability, working in a team structure and locale are all very important for

work-life balance and job satisfaction. Training programmes should be constructed to allow resident doctors more choice in where they train, balanced by the need to experience different working environments and systems.

Subtheme 1.2 Experience of being a Resident Doctor

Q6. 'The current model of postgraduate medical training meets the personal and professional needs of most doctors.'

1. Accept that there are problems
Survey data reveals considerable unhappiness regarding training. There are many factors that affect job satisfaction and some of these are listed below. One overriding consideration however is the availability of trainers who are on the specialist register. Many hospitals have employed consultant staff on locum contracts which can continue for many years. The lack of standardisation in the quality of these doctors can affect training considerably and a focus should be on providing enough consultants who are on the specialist register to cover the necessary NHS services including training.

The balance of Generalist vs Specialist training (in Group One Higher Medical Specialties) is of concern and there is unwarranted variation in the delivery of generalist training. The desire for a significant proportion of the medical specialties not to take part in generalist training must continue to be opposed if we are to create a medical workforce that can manage the population needs that are anticipated.

Burn-out. Many resident doctors express concerns about “burn-out” due to the increasing pressures on them. post-Covid Satisfaction levels have continued to be low since the pandemic, largely due to the huge workload in secondary care and are exacerbated by the increasing demand in LTFT training. Emphasis must be placed in ensuring that there is increased support for doctors in rotating posts which are minimised in geographical distribution. Furthermore, there needs to be recognition of the need for more family friendly facilities that support resident doctors to stay in training. As noted, this could include better availabilities of childcare facilities with associated financial support.
LTFT without increasing the availability of job sharing or similar mechanisms to maintain the workforce can result in significant rota gaps and puts further stress on an already stressed system. The sickness rates in the hospital sector continue to rise and this may well reflect this stress.

Should we explore a strategy of deliberately creating more LTFT NTN posts in order to increase capacity for the number of trainees within the formal training system? This may also support recruitment to rotations out to rural/less popular locations if they are not full-time roles, especially for those tied to certain areas with family/dependents who may only need to spend a portion of the working week away.

Academic Training. Surveys have revealed major concerns on how Academic Training is very difficult. There are fewer academic options available and delivering General and Specialty training in addition to academic research is problematic. Recent surveys suggest that the availability of adequate academic support for many who believe themselves to be in an

academic is inadequate, and the definition of academic training undoubtedly needs to be more robust. If this does not occur there are worries that the nation will see a drop off in academic output as doctors opt for non-academic careers.

Service vs Training needs. The balance here can be precarious. As secondary care becomes ever busier, we need to balance the pressures in running hospitals with the need to provide high quality training environments. We do not see the Physician Associate model as a credible solution without those roles being far better defined. As noted above we are of the opinion that training expansion is the only realistic option to cover the needs in both primary and secondary care.

Bottlenecks in training
IMT requires mandatory training in Geriatric Medicine (4 months) and Critical Care (minimum 12 weeks). Whilst arranging Geriatric training blocks is not difficult, there are capacity issues with Critical Care and expanding IMT would require an increase in Critical Care opportunities.

There are major bottlenecks in obtaining an IMT post due to the very high competition ratios that now exist. This is influenced by the numbers of applicants who do not have their primary medical qualification from the UK and, as noted above this leads to dissatisfaction for those who have been through the training structure in the UK. We can ill afford to lose medical graduates from this country.

Recruitment into IMT is a major concern to us, with applicant numbers expected to be over 10,000 in 2026 for only 1,650 posts. We urgently require addressing the increasing number of IMG applications and protect the ability of UK graduates in obtaining an IMT rotation.

2. What we can do vs what we cannot
As a training body, we have limited powers to influence governmental decisions on the future model of healthcare. The current move to bolster primary care must not be done by simply diverting resources from secondary care. There are real concerns that if this was to be attempted the augmentation of primary care would not decrease the pressures on secondary care significantly and thus the problems in that section of care would be exacerbated. A joined-up approach with Social Care is essential and could partially address the increasing hospital admissions of multi-morbidity elderly patients who could be managed in community rather than secondary care settings.

3. Specialism vs Generalism tensions
The new Medical Curricula, implemented since 2019 following the Greenaway Shape of Training review, have attempted to address the need for more generalists however there is growing tension from medical specialties that wish to see a move back to highly-specialised clinicians working within their specialty and with little interaction with the acute care of medical patients. We are determined to continue with generalist training in Group One specialties and would be open to expanding the group to include other specialties currently within Group Two.

Subtheme 1.3 Flexibility in training

Q7. 'Current training processes are flexible enough to meet the needs of most doctors.'

1. Balance between Training and Portfolio pathways
We believe that formal training programmes offer a structure, curriculum and provision of educational support that is preferable to an unstructured, portfolio approach.
We are cognisant that resident doctors are looking for greater flexibility in training and, as a result, may opt for a portfolio route. We would support greater flexibility in formal training programmes including OOP options including research, education, training and pauses.
2. Professional support
Resident doctors pursuing a portfolio approach do not have the same formalised educational support or ARCP structure available to those in formal training programmes. We feel that these doctors need that support as we firmly believe that those approaching the specialist register via the portfolio pathway have to meet the same standards as those going through formal training. Investment in educators is essential to maintain training standards both in formal training and for those working as locally employed doctors. Improve IDT options. Inter-Deanery transfers are difficult to manage and currently are very difficult to obtain. Resident doctors should have more flexibility and choice when it comes to where they train concomitant with the needs of the service in any area of the country.

Theme 2: Training capacity, delivery and quality

Subtheme 2.1 – Preparation for future practice

Q8. 'The current postgraduate medical training adequately prepares doctors for the professional and clinical demands of their future roles.'

1. Realistic Medicine
We believe that embracing the concepts of realistic medicine, whereby people using healthcare services and their families feel empowered to discuss their treatment fully with healthcare professionals, including the possibility that a suggested treatment might come with side effects – or even negative outcomes, are necessary to protect service and use resources to the best value. This means that the doctors of the future must embrace the principle that patients will feel able to ask why a test, treatment or procedure has been suggested, and that all decisions about a person's care should be made jointly between the individual and their healthcare team.

There is a need to balance training doctors in clinical/'technical' skills and the other skills that contribute to patient experience, welfare, safety and outcomes. The majority of complaints at a hospital level do not relate to clinical skills but rather communication, attitude and system issues. We need to ensure we do not see skills such as personal leadership, leading and working across systems and professional boundaries, empathy, active listening as competing [in terms of inputs, time spent etc] with training in clinical skills. They are less easily measured, but they are powerful and have a profound impact on the patient experience and outcomes.

2. Sustainability
All training programmes need to embrace sustainability. We are aware that the current curricula have not made enough progress towards this and thus need revision.

3. Mentorship schemes
Whilst we firmly believe that resident doctors need good quality educational supervision, the current one-to-one model is proving difficult to maintain as the job plans of consultants are moved more towards service provision and direct clinical care (DCC). The service must recognise the value of training and the provision of adequate support for this. This may mean that as a result, we should examine alternative models of educational supervision and look at mentorship of more junior resident doctors by those more senior in their training
4. Better training to be a Consultant in NHS

Upon Specialist Registration at the end of formal training, there is a lack of support for newly qualified consultants, and we need to develop greater mentorship and support structures for this group.

Those consultants coming towards the end of their careers have a great deal to offer and should be given opportunities to provide expert mentorship and training for those in training and newly appointed to consultant posts

Subtheme 2.2 – Quality of the learning environment

Q9. 'The current system of postgraduate medical education provides doctors with a high-quality learning environment.'

1. Balance of training vs service
Although the principle of supporting both service and training is probably correct the imbalance continues to be a major concern. We must protect training and prevent erosion of quality training by service commitments. At the same time, resident doctors must understand that educational opportunities always exist within the workplace and that training does not equate to formalised educational events.

2. Rotations vs stability
Whilst it is important to experience a wide range of clinical training, there are benefits to be gained from stability in a training environment. Striking the correct balance is critical for both TPDs and Deaneries to recognise.

The “apprenticeship” model of training has many advantages, both for the local unit and for the individual resident doctor. We would propose that local education teams, via Deaneries and Trusts, should look at developing quality educational rotations that give greater time in single units and prevent unnecessary rotations to geographically distant sites.

3. Problems of ES time
High quality learning environment is entirely dependent upon having the appropriate educational supervisor, TPD and administrative support structures. We are concerned that NHS England WTE are limiting appointment of TPDs and recently stopped a freeze on administration recruitment.

4. Support for LEDs
The College Tutor system in England is of great value in supporting the TPD / Deanery structures, and this system needs to be bolstered. We are aware that the College Tutor system in not UK-wide and this should be addressed.

Subtheme 2.3 – Educator capacity

Q10. 'Trainers in postgraduate medical education have sufficient time, support and resources to deliver quality supervision and training.'

1. Job planning
There are major worries that recruiting ES / TPDs / PG Deanery team is becoming increasingly difficult due to the service pressures upon consultant staff and the need to dedicate time to DCC.

It is imperative to protect training time and adherence to the suggested 0.25wte per resident doctor is not occurring across the country. We are aware of some NHSE regions who do not provide any job plan sessions for educational supervision – this inevitably will result in sub-standard supervision.

2. Alternative models of Educational Supervision
The current one-to-one model of educational supervision is proving difficult to maintain and we may need to look at alternatives such as individual consultants with interest in education having greater protected time (perhaps 4 sessions or more) to look after a large cohort of resident doctors.

3. Formalised pathways into consultant activities (Management / Education / Research)
Currently there is little formalised structure to allow consultants to develop the important roles needed to support the NHS including management, education and research. We would propose developing clear pathways to provide training and support for consultants wishing to develop their skills in this way

Subtheme 2.4 – Equality, diversity and inclusion

Q11. 'Postgraduate medical training creates an equitable and inclusive environment for doctors from diverse backgrounds, including those from minority ethnic groups and those with disabilities.'

1. EDI scope within Federation
We have a robust dataset supporting our strong stance on EDI issues. We completely support the need for equitable and inclusive training environments
2. Reasonable Adjustments within curricula
We are fully supportive of making reasonable adjustments, where possible, for resident doctors both in the examination system and in the training environment
3. Differential Attainment
1.1. There is increasing evidence that variations in attainment result from complex cultural and environmental factors starting well before medical training commences but it is incumbent upon the Federation in both training and assessment to ensure that the pre-existing variations are not exacerbated during the resident doctors progression. To that end there is a active research programme in the Federation investigating differentials related to protected characteristics in recruitment, training and assessment. Analysis of ARCP outcomes indicates differential attainment between UK and International Medical graduates
4. Sexual Harassment policies
We have recently published guidance on Sexual Harassment in the workplace

Theme 3: Enabling and reforming postgraduate medical education to achieve the 3 NHS mission shifts

Subtheme 3.1 – Hospital to community

Q12. 'Postgraduate medical training should include more opportunities in community-based settings to better align with patient and community needs.'
We believe that this question is phrased in such a way as to answer the question rather than look for constructive commentary. It assumes that there is a greater need for community-based schemes. Given the UK government push in this direction, we understand the sentiment but have major concerns if this would be achieved at the expense of secondary care funding

1. ICBs
There is a need for greater communication between community and secondary care providers. This is frequently seen to be of benefit in integrated Trusts but this not an exclusive phenomenon.

We need to think of secondary sector as a service, not a place. The way we train our doctors is fundamental to achieving this mission. Such a shift will require different skills (and indeed mindsets). Doctors will need to work differently with and within the primary and community setting. They will need to understand this terrain and how to lead and work effectively and efficiently within it. Health complexities and co-morbidity presents challenges for patients and doctors alike. Patients are too often shunted around various specialties, specialists and services; poor communication and co-ordination besets their care, experience and outcomes. Multi-disciplinary working too often starts and stops with multi-disciplinary meetings with little changing in terms of mind sets, systems and processes that need to change to enable a holistic approach to the health and care of patients. We need to look at how we train and prepare trainees to manage in this context.

2. Virtual Wards
We agree that these can be of value but must be structured and staffed appropriately. In this situation the GIRFT work on virtual wards have shown utility including some reduction on the pressure in secondary care but this is not universally the case.

3. Community liaison
We need better training for Resident Doctors on understanding the needs of the community. Perhaps this should be early in training and the potential for all Foundation doctors to have a defined time (e.g.4/12) providing care in the community.
Certain specialties lend themselves to closer community links (e.g. Diabetes and Endocrinology) whereby specific training in the community may be useful. Other specialties are predominately secondary / tertiary care based (e.g. Cardiology) and for these it may focus on those aspects of care that are mainly managed in the community e.g. cardiac failure.

4. Outpatient clinic changes
Learning about the provision of outpatient care in both the hospital and community settings has been undervalued and should be actively facilitated but the mechanism by which this is achieved has to be carefully considered. Taking secondary care providers into community clinics has the dangers of increasing the pressures on the already stretched hospital teams. Therefore, the definition of the community role of secondary care doctors has to be carefully considered. For some specialties it is already occurring but not for all and therefore a one size fits all approach would not be appropriate.

Alternatively, revisiting the GPwSI model with formalised medical specialty training for GPs could be of great value. This would need more formalised training structure than have occurred previously as experience of GPwSI in the early 2000s was very variable and the effect for patients was similarly showed variation.

5. SDECs
These are highly effective in facilitating early discharge from hospital however there is a danger that they are being used as quick-access point to hospital team to circumvent waiting lists at clinics. The necessity for all SDECs to adhere to the national definition of managing a patient within a day where they would otherwise have required admission will avoid these valuable resources being swamped and their effectiveness lost.

There is increasing evidence of inappropriate referral to SDECs by community-based teams as not all patients are seen by individuals who have the necessary capabilities to ensure that the patient is being sent to the most appropriate place for their needs. This is again resulting in too many patients being seen in secondary care than is necessary.

There is a growing but erroneous belief from patients that attending hospital is likely to be more beneficial than seeing a GP. This should be the subject of an education pathway for the public.

Subtheme 3.2 – Treatment to prevention

Q13. 'Postgraduate medical training curricula should include a stronger focus on addressing health inequalities, social determinants of health and population health.'

1. Dual accreditation expansion
Group One medical specialties are likely to remain as they are though some are expressing a wish to disaggregate from GIM (eg Cardiology).

Some Group Two specialties could potentially move into Group One (Medical Oncology, Haematology, Dermatology) as they often deal with acutely unwell patients who require their consultants to be well trained in GIM. It is likely that such a move would be opposed by the relevant specialties and it has the potential to increase training time by at least 12 months.

No likelihood that future consultants in those specialties would be involved in the Acute Unselected Take however they could have greater input to front door care as has occurred with the new Group One specialties (Neurology, Palliative Medicine and GU Medicine)

2. Possible alterations to training across specialties (eg GIM / Paediatrics / Psychiatry / General Practice)
A much more radical approach to training that may have benefits in Remote and Rural medical practice

Subtheme 3.3 – Analogue to digital

Q14. 'Postgraduate medical training should incorporate more content on digital health, AI and remote care, including the use of technologies such as extended reality, AI and machine learning, to enhance learning experiences and improve training cap

1. Remote/Digital clinics
Already happening, stimulated by the pandemic, but likely to expand further. We need to develop more structured training in Remote / Virtual clinic for resident doctors

2. AI education possibilities
This area is expanding rapidly, and we need to develop plans on how this will impact training.

It can only be advantageous for trainees to embrace what is coming and understand the risks and benefits digital developments may bring. Post-covid, remote care is now embedded and helps improve patient access, AI has increased efficiency.

We do need to ensure that the soft, interpersonal and communication skills are not eroded as the use of technology increases, and where possible ensure that the efficiencies gained allow a reinvestment in better quality interactions with patients and supported training.

3. Review specialties where potentially AI changes career (eg Radiology / Surgery)
Workforce planning needs to take into consideration the impact that new technologies are having in some specialties (e.g. do we need Radiologists in future when AI is already accurately reporting XR and CT/MR scans)

At present, medical specialties are not majorly affected by such advances however this may change in future and we need to be aware of the threats (and opportunities) that they may bring. Due consideration does need to be given to career changes and certain training programs may need to adjust focus to ensure that the scope of skills attained will meet future demand. There needs to be horizon scanning work for all specialties to ensure adjustments are made to accommodate this.

Career expectations and system gaps/issues impacting on satisfaction

Q15. What factors are the most and least important for a rewarding and satisfying postgraduate medical training pathway?
Rank 1/2/3 MOST important

1. Ability to develop and / or deliver effective patient care pathways
2. Ability to train and work in one's desired location
3. Ability to train and work in one's desired specialty
4. Access to high quality mentorship and supervision
5. Being a member of an effective multidisciplinary team
6. Confidence in career progression
7. Contributing to an effective healthcare service
8. Flexible training options
9. Leadership, research, quality improvement or teaching opportunities
10. Making a difference to the wellbeing of individual patients
11. Professional identify and status
12. Professional/technical 'mastery' of one's craft
13. Support for personal and professional development
14. The opportunity to improve health of a local community at a population level
15. Work-life balance and workload
16. Working conditions
17. Other(s) (please specify below)

Q 16. What are the most and least significant barriers to a rewarding and satisfying postgraduate medical training pathway?
Rank 1/2/3 MOST and LEAST important

1. Cost of training (for example, examinations and college membership fees)
2. Current rotational training structure
3. Inadequate physical and IT infrastructure to support training
4. Lack of access to high quality supervision
5. Lack of access to high quality training opportunities
6. Lack of access to simulation, virtual, digital and AI-based education
7. Lack of flexibility to gain experience across multiple setting
8. Length of training

9. Limited protected time for portfolio development (research, quality improvement, teaching, leadership)
10. Burden of portfolio requirements
11. Relevance of curricula
12. Rigidity of training structures / career progression routes
13. Service pressures/time to train
14. Training bottlenecks at key progression points
15. Other(s)

Q 17. Please select the 3 most important options for reforming postgraduate medical education:

1. Addressing bottlenecks in training progression at key transition points
2. Addressing burnout and improving resident doctor wellbeing
3. Balancing general and specialist training opportunities
4. Creating formal pathways for doctors to pursue extracurricular interests (for example, informatics, medical entrepreneurship, academic medicine)
5. Creating longer-term trainer/resident mentorship structure
6. Embedding training to tackle health inequalities and social determinants of health into curricula
7. Ensuring access to physical and IT infrastructure required to facilitate training (for example, shared desk space, reliable digital systems)
8. Establishing clearer pathways into medical education, with appropriate incentives
9. Expanding training in community settings
10. Geographically smaller training programmes
11. Giving local health systems greater input into shaping postgraduate medical training placements and specialty numbers
12. Greater ability to have capabilities gained in any post counted towards training progression
13. Greater access to flexible working patterns
14. Making greater use of extended reality, AI and machine learning in the delivery of postgraduate medical education
15. More curriculum focus on doctors' competencies in digital health, AI and remote care
16. Offering better support for doctors pursing clinical academic careers
17. Offering targeted incentives to work in underserved areas
18. Protecting time for educators
19. Providing better career coaching/mentorship/personalised career planning support
20. Reducing the frequency of rotations within a program
21. Reform of the specialty training recruitment processes to support the specialty preferences of candidates
22. Reform of the specialty training recruitment processes to support geographical preferences of candidates