Medical Degree Apprenticeships

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There has been much in the news about the possibility of an alternative route into medicine using medical apprenticeships. According to the *NHS Long Term Workforce Plan 2023*[1]:

> *NHS England is piloting a medical degree apprenticeship from 2024. This will enable the NHS to attract and recruit from a wider pool of people in local communities and enable individuals from under-represented backgrounds to start medical training who otherwise would not have done so through full-time higher education and training routes.*

Pilots of 200 places start in 2024/25, up to 400 places by 2026/27 and perhaps 850 by 2028/9.

Apprentices are employer-led , employees of an NHS body. The proposals have been greeted by a wide range of responses[2,3]. Although only limited information is in the public domain and final judgement must await the pilots, it is worth identifying some of the issues that may arise.

The concept of apprenticeships in medicine is not new. The GMC's 2015 paper ***Tomorrow's*** *Doctors* highlighted a perception that something had been lost in recent reforms to training, and this was followed by a move back to a more experiential educational framework. Many undergraduate courses now have sections labelled apprenticeships .

It's worth spending a moment considering the definition of an apprentice, and the distinction between education and training, two concepts that are actually quite different. To adapt a famous quote by Eric Hoffer:

> "*in times of change learners inherit the earth; while the trained find themselves beautifully equipped to deal with a world that no longer exists.*" [4]

In practice, education aspires to be a learning process that prepares future professionals to engage in critical thinking and creativity when they meet situations or diagnoses they have not come across before. Training is still important in up-skilling people to practice safely, and both processes can happen in parallel, but care will is needed to educate for the future, rather than just train for today.

With that caution, the idea is attractive. Workplace-based learning is congruent with many components of adult learning theory, as is the implication of a progressive increase in responsibility and practical care for patients. Medical student debt is considerable and must both discourage new applicants with even moderate means and contribute to the current unhappiness of junior doctors. Although precise figures are lacking, it is probable that a majority of medical students already have jobs while studying. Given this likelihood, would it not be better to be working in a health environment than in a supermarket?

Educational and management issues

The suggested plans require apprentices to achieve a medical degree from a medical school recognised by the GMC and pass the Medical Licensing Assessment. By inference therefore, the learning outcomes for apprentices are the same as for all other medical students as laid out in *Outcomes for Graduates*. The immediate question is how the work component can be fitted into the normal undergraduate programme, remembering that medical students do not, conventionally, have time on their hands.

The answer must depend to a large extent on the type of work. The essence of an apprenticeship is that students perform the task, under supervision, that they would do once qualified; the learning is situated in the task. Curricular change in the past 20 years has increased early student exposure to patients, so there would be few timetabling problems. This offers an opportunity to reverse the trends of the last half century, where students seem to have been doing less and less; the problem is to define those tasks which are both educationally useful to the apprentice and of value to the employer. That could be difficult; as an example student clerkings are currently of no standing in a court of law; would that be different if they were apprentices and therefore employees? Would employers take the risks of reliance on an apprentice-derived clerking? Any value to the employer is not likely to accrue unless there is some role substitution by the apprentice for another person.

Little account so far seems to have been taken of the multidisciplinary approach to service delivery and the upskilling of other health professionals to undertake greater responsibility in patient care following the COVID pandemic. Indeed, further work is needed to identify what roles newly qualified doctors would be expected to undertake whatever the form their education and training took – and how that would play out over their career.

To break away a little from the apprenticeship model, could medical apprentices perform some other task of value to the employer, notwithstanding that the medical educational value was slight? This would apply if the apprentices were already, for example, nurses or physiotherapists or if they became healthcare assistants. However, once the learning and the work are separated, the learning time is reduced unless some further action is taken.

Three possibilities for such action suggest themselves. The curriculum could be shortened. This has been much touted, but appears difficult if apprentices need to pass the same assessments as other students. Further, no one comes to designers of medical courses with ideas of material to take out – quite the contrary. Secondly, can it be assumed that there is spare time in the curriculum, as evidenced by students already taking up employment? This may be a large assumption; just because some students take some time out to earn, can that be applied to the whole cohort? Thirdly, can the course be lengthened? This seems largely absent from the discussion, but a part-time, proportionately longer course, would answer most of the anxieties about recruiting part-time students from a wider pool.

If the educational issues can be resolved, then the management issues may be soluble. Current uncertainty seems to derive from whether the apprenticeship levy, paid by all employers and returned when they take an apprentice, is sufficient in these circumstances to pay a wage as well as the training costs. Any calculation needs to factor in the financial return to the employer of the work performed by the apprentice.

There are two income streams into medical undergraduate education: to medical schools and to placement providers. Universities and their medical schools will continue to need both the normal student fee and the supplement from the Office for Students for an expensive course for any apprentices they teach. Placements are funded through the Tariff ; the current rate is £31,937 per student per year. A significant charge on this Tariff is the provision of protected time for student teaching; which is, nevertheless, difficult to achieve routinely. Implicit in the apprenticeship model is that the employer (an NHS body) provides training from within their own resources, as above. With two different models for funding protected instruction, it will be important to dovetail the experience so that both groups can achieve the learning outcomes.

Careful thinking will be needed about several other issues. Apprentices are both employees and students registered for a degree; the contracts are quite different. In addition, paid apprentices would work alongside students, who are accumulating large amounts of debt, a potentially frustrating working arrangement for the latter cohort. Finally, thought needs to be given to the importance of

professional role modelling and identity formation for this new group of learners as they transition to doctors. Educational supervisors may need to adjust so that these learners, moving from legitimate peripheral participation in a community of practice, are supported by those who recognise the hazards, can manage the uncertainty they feel and can safely facilitate the change required.

1. NHS England » NHS Long Term Workforce Plan

2. Morgan MD, Alom J, DE-Alker E, Curtis S. (2023) Medical doctor apprenticeships are coming to the UK. BMJ 2023; 382 p1826 doi: https://doi.org/10.1136/bmj.p1826

3. nhs-long-term-workforce-plan-for-england.pdf (bma.org.uk)

4. Hoffer E. (1982) Between the Devil and the Dragon: The Best Essays and Aphorisms of Eric Hoffer, Glasgow, HarperCollins.