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Should we end rotational training for physicians?

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Rotational training, which is the periodic movement of resident doctors between specialties, hospitals and even regions, has defined UK postgraduate medical education since Modernising Medical Careers embedded the 2-year foundation programme in 2005 and formalised subsequent core and higher specialty pathways.[1] Every August and February more than 50,000 resident doctors uproot and re-induct in new trusts.[2] While this mobility undeniably broadens early clinical experience, it is increasingly criticised for fragmenting care, fuelling burnout and discouraging doctors from remaining in the NHS.[3,4] This paper argues for a staged approach: frequent rotation should be retained during the foundation and internal medicine training (IMT) years to maximise breadth and informed career choice. After specialty entry the priority should shift decisively toward geographic and organisational stability, allowing doctors to consolidate advanced skills, build enduring professional networks and establish a settled home life.

Historical intent and structure of rotation

The rotational model originated to deliver two linked goals. Firstly, it guaranteed resident doctors a wide case mix: emergency medicine, surgery, psychiatry, community health – thought essential for modern 'generalist-first' practice.[5] Secondly, it allowed postgraduate deaneries to distribute labour to peripheral hospitals that struggle to recruit permanent staff.[6] The Shape of Training review reaffirmed these principles, emphasising versatility in responding to the increasing prevalence of multiple health conditions.[5] Consequently, placements of 4–6 months became the norm in foundation and early core years and, by default, persisted into higher specialty training, sometimes for a decade-long programme. What began as a pedagogic strategy thus developed into administrative routine; a routine now contested by resident doctors and professional bodies alike.[7]

Educational strengths in foundation and IMT

During the first 3–4 postgraduate years the benefits of rotation are compelling. Exposure to multiple specialties helps novices construct robust diagnostic 'illness scripts', accelerating the safe recognition and management of undifferentiated presentations.[8] Experiential learning theory holds that competence emerges from repeated cycles of concrete experience and reflection across varied contexts; rotation operationalises that cycle.[9]

Breadth of exposure clearly shapes career thinking: ~40% of F2 doctors reported revising their preferred specialty at some point during foundation training,[10] potentially averting later attrition. Professional socialisation is likewise enhanced; juniors must adapt to new IT systems, multidisciplinary teams and leadership styles, cultivating agility that is desirable in modern healthcare.[11] Early moves, furthermore, seed expansive professional networks that facilitate collaboration throughout a consultant career.

Finally, rotation supports service equity: deaneries can mandate placements in rural or underserved trusts, guaranteeing patients in remote areas access to doctors with up-to-date skills.[6] Taken together, these advantages justify maintaining regular 4–6 month rotations through the 2-year foundation programme and the 3-year IMT or equivalent core pathways.

Mounting costs beyond core training

Once resident doctors commit to a higher specialty, typically from specialty training year 3/4 (ST3/4) onwards, the marginal educational return from further geographic moves diminishes, while the personal, clinical and organisational costs escalate. Patient care continuity suffers when registrars leave before follow-up milestones; a systematic review showed lower all-cause mortality when patients saw the same doctor over time.[12] Ongoing quality improvement projects, research studies and service development initiatives stall every time the project lead rotates out.[13]

Rotational instability is also a recognised driver of burnout among resident doctors.[14] In the 2024 General Medical Council National Training Survey, 63% of resident doctors screened positive for moderate or high risk of burnout.[4] Qualitative accounts confirm the burden: resident doctors describe themselves as ‘permanent visitors’ reluctant to challenge unsafe practice because ‘we'll be gone in 4 months’. Financial and domestic strain compounds the problem; relocation allowances rarely cover tenancy exit fees,[15] partner job disruption or childcare upheaval and the relocation allowance has not increased since 2010 to be in line with inflation.[16] Kent, Surrey and Sussex resident doctors reported that 69% believed their commute harmed physical health and 68% their mental health, while modelling showed that assigning doctors to their nearest hospital would markedly reduce travel-associated carbon emissions.[17]

Operational inefficiency accompanies every move. Trust-specific inductions, login credentials and duplicated mandatory training modules consume teaching time and erode morale.[18] Environmental costs accrue as long car commutes inflate the NHS carbon footprint, undermining its net zero commitments.[17] These cumulative disadvantages turn rotation from an educational asset into a liability precisely when resident doctors should be deepening specialist competence.

Why stability matters in higher specialty training

Advanced procedural or cognitive skills such as interventional cardiology, complex oncology and neonatal intensive care demand immersive, longitudinal exposure to a single high-volume service. Six-month blocks scattered over disparate sites squander adaptation time and fragment operative logs.[19] Continuity allows registrars to steer patients through entire treatment arcs, such as a chemotherapy course, enhancing outcomes and satisfaction.[12] Stable placements foster close trainer-resident doctor relationships that yield granular feedback and academic mentorship, leading to higher assessment scores and publication output.[19]

Personal wellbeing follows suit. Stable postings enable partners to pursue careers, mortgages to be secured and children to remain in one school, factors linked to lower burnout and higher retention.[20] Locally embedded registrars understand idiosyncratic pathways, chair multidisciplinary team meetings and drive sustained quality-improvement projects.[13] They also become future consultants already familiar with local culture and colleagues, easing the perennial consultant vacancy crisis.

Addressing counter-arguments

Two objections surface repeatedly. Firstly, some argue that frequent rotation is essential to distribute labour to understaffed hospitals. Yet Robinson's study of core surgical training showed that hospital type (teaching vs district general) and rurality had no significant effect on assessment or operative outcomes,

indicating that desired competencies can be achieved without continual relocation.[19] Expanding local training numbers or employing physician associates to fill rota gaps could relieve staffing pressures without uprooting resident doctors.[7]

Secondly, curricula sometimes list exposure to specific subspecialties across multiple centres. But targeted out-of-programme (OOPT) blocks can deliver niche experiences without significant moves.[21] North American programmes demonstrate feasibility: residents remain in a home institution and rotate out only briefly for skills unavailable locally.[7]

A phased, hybrid model

Evidence therefore favours a hybrid structure – **breadth first, depth later** – that balances educational breadth with the need for stability.[3] A pragmatic model would comprise:

Foundation (F1–F2): 3–4 month rotations across core specialties within one deanery, preserving diversity and career exploration.

IMT or core surgical/ACCS (years 1–3): Longer, 6-month blocks limited to hospitals within a 45-minute travel hub, consolidating acute generalist skills while reducing relocation frequency.

Higher specialty training (ST3/4+): A designated base hospital (or tightly linked network) for at least 70% of time, with short elective secondments for mandated niche skills.

Policy levers already exist. Lead employer contracts keep resident doctors on one payroll despite local rotations, smoothing HR and pension continuity.[6] Regional hub-and-spoke schemes restrict moves to trusts along a single transport corridor, reducing commuting burden.[17] Competency-triggered 'settling' would allow resident doctors who achieve entrustable professional activities early to remain in one post for research or leadership development.[3] Digital induction passports could eliminate repetitive e-learning modules across trusts.[4]

Implications for resident doctors, patients and the NHS

Adopting phased stability promises multiple dividends. Resident doctors gain predictable schedules, facilitating childcare and partner employment.[22] Wellbeing improves as long commutes and relocation anxiety decline.[17] Patients benefit from longitudinal relationships that demonstrably reduce mortality.[12] Hospitals retain experienced middle-grade doctors who understand local systems, enhancing service efficiency and consultant recruitment. Environmentally, reduced travel cuts carbon emissions, aligning postgraduate education with NHS sustainability pledges.[17]

Conclusion

Rotational training remains educationally indispensable during the formative foundation and IMT years, where breadth catalyses competence, adaptability and informed career decisions. Beyond that point, however, perpetual mobility imposes clinical, personal and environmental penalties that increasingly outweigh marginal gains. A phased approach – breadth first, depth later – offers the best combination of patient safety, resident doctor wellbeing and workforce sustainability. By embedding higher-level resident doctors within a consistent clinical community and restricting further moves to targeted, time-limited secondments, the NHS can preserve the virtues of breadth while restoring the stability physicians need to flourish both professionally and personally.

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