Recruitment and retention in obstetrics and gynaecology in the UK

The problem of recruitment and retention into obstetrics and gynaecology could translate into serious manpower problems if not addressed now by making the experience of trainees and medical students rotating through the speciality memorable and improving trainees' work–life balance.

Obstetrics and gynaecology allows doctors to maintain interests in medicine, neonatology, physiology and surgery, and it follows life from cradle to the grave. In addition, it includes research, teaching, administration and clinical work. One can develop expertise in the most sophisticated and most demanding procedures in gynaecology and can look after well women passing through a normal life event in obstetrics. Sometimes this may develop into an emergency situation needing major surgery, with complex fetal or maternal problems and clinical dilemmas.

Major advances and breakthroughs in medicine like ultrasound scanning, laparoscopy and in-vitro fertilization took place in obstetrics and gynaecology through dedicated academic research in a clinical practice setting. Future developments in areas such as embryonic stem cell research will be exciting. The chance of being a pioneer in this developing field at the cutting edge of medicine may lure trainees into obstetrics and gynaecology.

Current problems

Having said that there are obstacles to the bright future in the speciality. The current problem of recruitment and retention into obstetrics and gynaecology could translate into a serious manpower problem in the future if it is not addressed now (Royal College of Obstetricians and Gynaecologists, 2006).

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In a survey carried out at the North Staffordshire University Teaching Hospital Department of Obstetrics and Gynaecology, 86% of trainees were looking forward to their future in the speciality although they felt that there is a high level of perceived work–life imbalance and stress at work. Being on call for obstetrics and gynaecology involves long hours of mental and physical work on the labour ward compared to other specialities where doctors on call are rarely called out. The survey showed that improvements in the working lives of obstetrics and gynaecology trainees are still needed, especially given the current difficulty with recruitment and retention of trainees (Thangaratinam et al, 2006).

The decreasing numbers of male medical graduates showing an interest in a career in obstetrics and gynaecology is marked, especially in the London area where hands-on experience is not always possible because of gender.

The effect of major restriction of numbers of specialist registrar training posts since the early 1990s has acted as a severe disincentive for recruitment into the speciality. This is reflected in the number of UK-trained doctors taking the MRCOG part 2 examinations which has fallen to 5.5% of those doctors taking the MRCOG in 2004 compared to 16.3% in 1995 (Higham, 2006). The unwillingness of young doctors to enter obstetrics and gynaecology may relate to concerns about workforce planning and career progression problems, rather than any lack of enthusiasm for the speciality itself (Turner et al, 2006). Although the restriction in specialist registrar numbers was necessary in the 1990s to prevent consultant expansion and reduce cost, with the European Working Time Directive and the need for consultant cover on the labour ward as part of risk management, there is now a need for expansion of the trainee grade which will in due course manifest as expansion in the consultant grade.

There is an increased likelihood of patients declining medical students' involvement in their treatment by withdrawing consent (Rizk et al, 2002). The ready availability of real patients and their acceptance of students' participation is crucial for successful practice and acquisition of clinical obstetrics and gynaecological skills, particularly those skills that involve the discussion of private and personal problems or an intimate physical examination (Rizk et al, 2002).

There has been a reduction in patient-based experiential learning with increased use of mannequins and gynaecological associates. Poor undergraduate experience of the speciality has a negative influence on recruiting and retaining trainees especially now that the time allocated to gaining experience in obstetrics and gynaecology in most UK medical schools has been reduced to between 5 and 11 weeks, with a mean of 7.8 weeks duration, compared with an average of 11 weeks 'pure' obstetrics and gynaecology in 1989 (Higham, 2006).

Another factor deterring trainees is litigation: obstetrics and gynaecology has the highest pay out in litigation cases in the NHS and the second highest number of cases after orthopaedic surgery. The most common cause of obstetric dispute is 'cerebral palsy' (22%), while the commonest cause of gynaecological dispute is failed sterilization (19%). In all cases of litigation in NHS hospitals, 19% were the result of incompetent care, 12% the result of an error of judgment, 9% lack of expertise, 7% failure of communication, 6% poor supervision and 1% inadequate staffing (B-Lynch et al, 1996). Adequate staffing levels with well-supported, motivated and dedicated staff can help to reverse this trend of serious litigation in the specialty.

Another disincentive to recruitment and retention is the need for consultants to be resident on call 24 hours a day. Such out-of-hours work must be adequately reimbursed both financially and in time off work as compensation so as to make the specialty more attractive to trainees. Presently there is no clear policy on this important issue.

Recommendations

The problem of recruitment and retention in obstetrics and gynaecology will be determined by addressing trainees' work–life balance, remuneration of consultants' resident on call and improving medical students teaching and experience during obstetrics and gynaecology rotation.

Interesting learning methodologies like problem-based and computer-assisted learning, bedside patient-focused small group teaching, use of vertical and horizontal integration techniques which are popular in the USA and focused evidence-based learning should become the norm for the medical students of the future.

Considerations for students and training

Increased use of mannequins and simulated patients (gynaecological teaching associates) and use of special skills laboratory for teaching and assessment, although mannequins should augment clinical experience rather than replace it completely.

Special effort should be made to make undergraduate experience in obstetrics and gynaecology very welcoming, especially male students as they fare worse in acquiring hands-on experience. The Royal College of Obstetricians and Gynaecologists trainees' web address (www.rcog.org.uk/education-and-exams) should be included in all medical students' induction packs to enable them to access it early in their medical career.

A fairer method of assessment such as objective structured clinical examination, rather than multiple choice questions, should be used in all medical schools in the UK.

Every unit should identify mentors who like working with students to give feedback, encouragement and information, and to talk about electives, jobs and other opportunities in the speciality. Other consultants should teach and treat students well, making them welcome in the department during their postings and help to act as role models for medical students. There is a need for more opportunities to expose doctors in the foundation years to obstetrics and gynaecology so that they can experience it first hand again after medical school and consider it as a career choice.

Medical students should be exposed to audit and clinical research methodology and given opportunities for hands-on experience.

In addition to the usual clinical research, feedback questionnaires on how to improve the clinical experience of medical students passing through the department should be organized for all groups passing through the unit so that continuous improvement is ensured. Other foundation doctors may be invited to the department to allow them to ask relevant questions.

Each year, obstetrics and gynaecology departments should organize a 'careers fair' for years 3–5 medical students and foundation year doctors rotating through other specialities where obstetricians and gynaecologists can discuss the benefits of a career in obstetrics and gynaecology and ask them to consider a career in the speciality.

Considerations for consultants

Time spent being resident on call should be adequately reimbursed financially and with time off work to act as an incentive. A copy of the report from the Royal College of Obstetricians and Gynaecologists (2005), *The Future Role of the Consultant*, should be made available to trainees in their final year so that they can know exactly what to expect from their contracts.

The contribution of consultants to recruitment and retention into obstetrics and gynaecology in the future will include making themselves accessible friends and mentors to the students passing through their departments. They will not only teach and assess the understanding of trainees but will also exchange information in the friendliest and easiest possible way to facilitate assimilation of the information provided. They should also provide pastoral care when necessary, allow adequate time for giving feedback and answer any question to the best of their ability.

Consultants should also champion the development of vertical and lateral integration for medical students into the speciality; and the development of an assessment centre in the unit for prospective postgraduate trainees – this is better than an interview for assessing candidates (Mitchison, 2009).

Considerations for the specialty

There may be a need to divide obstetrics and gynaecology into two separate specialties to facilitate recruitment and retention in the future. In a survey of Yorkshire trainees 42% preferred gynaecology only, 28% of participants preferred obstetrics only and only 23% wanted combined practice (Pandey and Lindow, 2006). The problem of separate specialties for obstetrics and gynaecology is that obstetrics will suffer staff shortages as most consultants presently prefer only gynaecology contracts because of obstetrics night on-call commitments.

Every unit should establish a journal club. As well as the traditional function of critiquing published articles, this provides a good setting for review of prospective papers before submission to peer-reviewed journals, for brainstorming new ideas for research proposals and for encouraging departmental staff and other trainees to write papers for publications and facilitate their progress and hopefully therefore retention in the speciality.

In addition to having a consultant mentor for medical students, there should also be a 'midwife mentor' to facilitate the inte-

KEY POINTS

- There is a problem of recruitment and retention in the speciality of obstetrics and gynaecology, which could become a manpower problem in the future if it is not tackled now.
- The problem is soluble if we improve medical students' experience during their rotation through the speciality, improve trainees' work–life balance and improve resident consultants' remuneration.
- The speciality of obstetrics and gynaecology may have to be statutorily split into two although obstetrics staffing will suffer in the long run.

gration of the medical students onto the labour ward which can be an intimidating environment for students (Royal College of Obstetricians and Gynaecologists and Association of Academic Obstetrics and Gynaecology, 2006).

Consultant staff should take part in activities to help ring fence education and training budget for the trainees so that they can have adequate funds for courses, study leave pay and mandatory training, thereby making the speciality more attractive.

Conclusions

The problem of recruitment and retention in obstetrics and gynaecology is soluble if we can make the experience of trainees and medical students rotating through the speciality memorable, improve the trainees' work–life balance and reimburse resident consultants with time off work. **BJHM**

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