

Postgraduate education and training: challenges for the future

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In spite of much attention to the needs of doctors in the training grades over the last decade, the current agenda for change in the NHS is very large and much needs to be done to fit these trainees for the career grade doctors of the future. This article looks briefly at some of the issues facing training grade doctors as they train for a career in the NHS in the first part of the twenty-first century.

INTRODUCTION

Postgraduate medical education has been under the spotlight for some years. The recent history of this attention probably dates from the so-called Calman report (Department of Health, 1993) which directed attention on the group of doctors in training now known as specialist registrars (SpRs). More recently there has been attention on preregistration house officers (PRHOs). For the purposes of this review I will consider this group as the start of postgraduate education, although this period also qualifies under European law as the final year of basic medical education.

The publication *The New Doctor* from the General Medical Council (GMC, 1997) set the scene for improvements to the PRHO year in educational terms and there have been systematic although imperfect changes to workload through the regional task forces.

The one type of training post that has not received much attention is the senior house officer (SHO) and even in 1993 Bulstrode et al described this group as 'The Lost Tribes' of medicine. The need to improve SHO training has been widely recognized recently (Cooke and Hurlock, 1999; Hayden, 1999) and there are rumours in the weekly medical press that wholesale changes are in the offing (Smith, 1999).

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At the same time the NHS has undergone many changes in the last year or so to try to improve quality (e.g. through the concept of clinical governance), to enhance the preventative aspects of work in the NHS (Department of Health, 1999a) and to try to confront various issues affecting health care (Hine, 1999).

The reader might surmise from this brief introduction that all is well with the world in terms of educating and training our career grade doctors of the future but it would most foolish to come to this conclusion. I hope to highlight in the rest of this article some of the many areas where problems are present. Regrettably it will not be possible to go into great detail in any of them.

WORKFORCE PLANNING

It might be thought that workforce planning is of little concern to the average junior doctor, and the advent of the SpR was expected to solve issues after accession to this grade. This has certainly not happened and the debacle now confronting us in obstetrics and gynaecology (O&G) is testament to this.

For a variety of reasons there is an excess of some 112 SpRs in this discipline who have obtained their certificate of competence in specialist training (CCST) and for whom there is no consultant vacancy at present. This number is expected to rise to nearly 200 next year. This is an abject failure of workforce planning and there are concerns that a similar problem could occur in other disciplines.

A partial solution is in sight with a number of regions creating additional consultants in O&G. However, there is no central funding for the posts, so the resource for the consultant salaries has had to be found by reducing the high number of SHO posts in the discipline and recycling the resource liberated.

It is clear that workforce planning must be improved by, among other things, coordinating the usual top-down process provided by such bodies as the Specialty Workforce Advisory Group (SWAG) with bottom-up knowledge provided by organizations such as the Local Medical Workforce Advisory Groups (LMWAGs). We must also look at all aspects of workforce planning so that it addresses the needs of the community in an integrated way. There is much to do in this area and with the large increase in medical student numbers announced recently, additional numbers of all grades of junior doctor will need to be created over the next decade or so.

WORKLOAD CONCERNS

There is no doubt that the hours of work of junior doctors in general have decreased considerably over the last few years, but this has often been accompanied by an increase in the intensity of working. This has been demonstrated by a reduction in the hours of work as judged by the regular task force returns.

The intensity of work has been slower to change, but over the last few years it has fallen, largely thanks to

support given to junior doctors by skilled 'nurse practitioners' who have taken over many of the routine tasks of junior doctors, especially during the night. In spite of this the returns from regions at the end of March showed that over 20% of junior doctors are still not meeting the New Deal targets that have now been agreed nationally (Department of Health, 1998a).

Worse is to come, for the latest European Directive on this issue has decreed that no junior doctor should be working more than 48 hours per week by 2012. This may seem a long time and the European Union has produced a staged process to achieve this target. Nevertheless it will require a major effort to achieve this target and most of the recent large increase in medical students will be swallowed up in the medium term in achieving this goal.

EDUCATION AND TRAINING

In addition to the reduction of work intensity, junior doctors are receiving better education than in the past. Most, but not all, junior doctors get some protected time for education and there has been a general improvement in the way in which juniors are educated, but there is much still to be done, particularly in the SHO grade (Cooke and Hurlock, 1999).

A considerable number of consultants are skilled in educational techniques, but many have still had no training on how to teach (or encourage learning) which is readily on offer from the postgraduate medical deans. Some consultants still feel that what they have been doing in this regard for many years is perfectly alright, but increasingly consultants are recognizing that this is not the case any more.

The new generation of medical graduates are coming from undergraduate medical courses that are quite different from the didactic courses of the past. The problem-based learning, or problem-orientated learning approach to undergraduate training produces a doctor whose communication and practical skills are likely to be excellent and who is likely to be very questioning of the way of the world. They

are also likely to be selectively weak in factual knowledge (which can actually be looked up in the literature) and thus a new approach to teaching is needed by consultants and principals in general practice.

In many ways our general practice colleagues have had a far more adventurous approach to skilling up teachers than has been seen in the hospital service. Not only will consultants need to change but so will Royal Colleges. At present Royal Colleges are seen as having an important role in specialist training and in the setting of standards, but too often this has caused problems in service delivery for some NHS trusts. In addition the specialist examinations will need to be changed to accommodate the educational backgrounds of the new graduates since many such examinations are based on recall of factual knowledge.

SERVICE AND TRAINING

The educational requirements mentioned in the previous paragraph have had a major impact on the grade of staff that has been called on, in the main, to deliver the system. Consultants have found their workload increased not just by an increased demand, but also by a need to pick up the decreased workload of junior doctors and by having to find time to provide the educational input. The lack of the expected increase in consultant numbers in most disciplines has had a further major impact here. Consultants are correct to complain that enough is enough and yet we still need to improve the education of junior doctors.

In addition we have somehow lost the old ethos that medical training is an apprenticeship and the training that many of us received in the past was not wholly bad. Many junior doctors feel that they are not experienced enough, particularly in the later SpR years, to pick up the mantle of a consultant post. This is particularly seen in the surgical specialties where consultants have often commented that SpRs do not always have the technical skills possessed by their old senior registrar colleagues.

There must be a way of blending service with training and the Government have recognized this by releasing money to each deanery from the Modernisation Fund in order to address this. All postgraduate deans are now looking for innovative ways to spend this money in a way that will improve the training of junior doctors and also improve patient care.

THE GENERALIST VS SPECIALIST DEBATE

There has been a gradual trend over the years towards more and more specialization in medicine with consequent emphasis on the specialization aspects to the detriment of areas such as general medicine and general surgery. This is a difficult area since modern technology demands more and more specialization and yet there is a view, often expressed by those who run NHS trusts, that we need more generalists to deliver health care (Heard et al, 1998).

We need to create a cohort of doctors who are well able to take a holistic view of the patient, their illness and their family, and yet have the ability to work in-depth in specialized areas of health care. We need to be aware of this debate and encourage the generalist approach while recognizing the need for specialist training.

MULTIPROFESSIONAL EDUCATION AND TRAINING

Nowadays health care is very much a team approach and it follows that much education and training will also be delivered in a multiprofessional forum. This concept is very much in its infancy at present but many groups are starting to look at how this might be delivered. This does not mean producing a 'generic worker' and there will always be particular educational needs in medicine. However, there are many health-care topics that can be taught on a multiprofessional basis (e.g. ethical issues) and an important part of this educational innovation will be the assessment process that will hopefully show the benefits of this kind of education.

CLINICAL GOVERNANCE AND LIFELONG LEARNING

The concept of clinical governance is relatively new and in some ways is an unfortunate term since it implies governance of clinicians which is not the prime aim. The term was first mooted for the NHS in the white paper *A New NHS* and this was consolidated in the document *A First Class Service* (Department of Health, 1998b). It is primarily concerned with improving the quality of care that patients receive and will only be successful if there is ownership of this concept by everyone working in the NHS. The definitive guidance was issued by the Department of Health earlier this year (1999b). Thus junior doctors and their supervisors are or should be very much involved with the system.

In addition, clinical governance is very much about improvement of education and training for all staff in the NHS. The new undergraduate medical courses are aiming to instil in students a desire for and an ability to undertake lifelong learning. The recent publication *Continuing Professional Development: Quality in the New NHS* (Department of Health, 1999c) shows the importance of continuous professional development for all health-care workers and this has been obvious in the medical scene for some time. However, much needs to be done to make this a reality and, for example, our library services and our information technology services are very poorly developed.

We also need to pay more attention to how education and training can be provided flexibly for those junior doctors who have other responsibilities. Often it has been stated that flexible training is available, but this concept is rarely put into practice (Goldberg, 1997).

ASSESSMENT AND APPRAISAL

Regular appraisal with an identified educational supervisor is one of the key elements of an effective training programme, but is still not uniformly delivered (Cooke and Hurlock, 1999). This requires that the supervisor has received training themselves in

appraisal techniques and every post-graduate dean has a programme to meet this end.

Each junior doctor in training should have a personal development plan (PDP) which includes opportunities in work-based learning, formal training and study leave. The PDP should cover clinical areas (both generic and specialist) and non-clinical concerns such as management skills and self-development. There is a tendency to think that all educational needs can be met by attending courses but effective workplace learning is probably more important. There is also a need for more formal assessment to ensure that educational objectives have been met and this will become an increasing part of the training of junior doctors.

The whole area of assessment and appraisal is coming under the microscope, particularly following recent decisions by the GMC in some high profile cases. Doctors are coming to accept that regular appraisal is part and parcel of everyday life and this will include appraisal of clinical decision making. While the very large majority of doctors are good clinicians it is becoming increasingly important to try to identify poorly performing doctors as early as possible so that remedial steps can be taken. This applies just as much to doctors in training as to career grade staff.

CONCLUSIONS

While in many ways the training of junior doctors has improved very much over the last decade, it is clear that there are many problems still to be solved in the next decade. In many ways the pace of change is increasing

in the NHS, and the current government has stated that it expects further changes in health and health-care delivery over the next decade. Postgraduate medical education is in good hands but deans will need help from a variety of staff to make the most of the opportunities ahead. **HM**

While the views expressed in this article are my own I wish to acknowledge the help I have had from many people in discussing these matters over many years, in particular Dr Trevor Bayley, Professor Jacky Hayden, Dr David Graham, and Dr Ed Neville.

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KEY POINTS

- Multiprofessional education and training will be important but limited to general areas and accompanied by proper evaluation.
- Clinical governance will be important for all doctors to improve quality of care and should be linked to lifelong learning.
- Problem-based learning in undergraduate medical schools will affect postgraduate training and College examinations.
- General professional training (senior house officer years) now need more attention from educators.
- Appraisal and assessment will become part and parcel of clinical life for doctors.
- We need to plan workforce development on an integrated (i.e. cross profession) basis.