Specialist registrar training in obstetrics and gynaecology: have we got it wrong?

Charles SW Wright

The introduction of the Calman proposals for radical reform of the training of young doctors is now nearly 3 years past. Obstetrics and gynaecology was one of the first major specialties to go through the convulsions of transition and it has emerged on the other side well organized and in tune with the requirements of the reforms, but just how are they perceived by the trainees and trainers?

THE HISTORY

Before 1996, training for a consultant career in obstetrics and gynaecology was an unstructured process. After a few years in the senior house officer (SHO) grade, usually based around teaching hospitals, trainees would seek a registrar post in, or linked by rotation with, a teaching hospital. Two or three years would be spent in that grade while the doctor gained necessary experience and the acquisition of skills, mainly by virtue of the large service commitment that the long hours of work provided in those days.

At the same time the doctor would obtain the Part II Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) and attempt to persuade his/her academic colleagues that he/she was worthy of the responsibility of a research post leading to a higher degree. This was deemed a necessary qualification even to be short-listed for attempts to squeeze through the tight bottleneck that existed at the registrar/senior registrar (SR) level.

These junior registrars also knew that the best volume of surgical experience was most often obtained while working in busy district general hospitals (DGHs) or abroad, but they were reluctant to work in these hospitals unless the contract brought with it a designated link back to a teaching hospital post. The 'power' of the teaching hospitals to make or break a doctor's progress in the profession was unwritten but recognized by all.

This position of 'patronage' had its good and bad sides. A trainee, if hard working, competent and loyal, could expect (and did receive) one-to-one training in an apprenticeship manner sometimes lasting for many years. Based on this 'ownership' of the trainee, the trainer would expect (and did receive) loyalty and in many cases, much after-hours assistance, in return for support to get successfully through the SR bottleneck. The few that did were virtually guaranteed a consultant post in an NHS hospital suited to their training, expertise and geographical wishes. The trainee's career was thus pyramidal, hierarchical and based strongly on patronage.

It might have been 'unstructured' but the 'rules' were clear and well understood. The few that succeeded entered the consultant grade well trained (in the style of their trainers) and usually with nearly 10 years of practical experience in their chosen branch of the profession.

They also usually emerged with strong ties of loyalty to their training alma mater. This would remain with them throughout their consultant career, these links of friendship often leading to training rotations being set up between their new hospital and their teaching hospital. These rotations were often established without necessarily being geographically and socially suitable for the trainee themselves.

Under this system the DGH without such 'links' could rarely hope to have UK trainees in the registrar grade, relying heavily on graduates from developing countries who came and provided a vast pool of service commitment in return for hopefully gaining the MRCOG during their stay. These doctors had little or no structure to their training and received poor reward and little recognition for forming the basis of the service commitment for obstetrics and gynaecology throughout the UK.

THE ARRIVAL OF STRUCTURED TRAINING

With the introduction of specialist registrar (SpR) training in 1996, all UK/EEC doctors who happened to be in a registrar post (or who were in a research post but had already held a registrar post) in obstetrics and gynaecology were automatically provided with a national training number (NTN). Thus many doctors who would have never, under the old system survived the bottleneck at the SR hurdle, avoided it altogether by virtue of simply being in the right place at the right time.

Before April 1996 the appointment of a registrar was not based on the decision 'Will this doctor make a good consultant?' but on the assumption that he/she would need to show over the next few years whether they had the required and necessary support to face that question at the SR interview. It therefore seemed abundantly clear to most of us in the profession that the number of NTNs awarded were far in excess of those that would be needed to provide

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the consultant numbers that the previous system required. Manpower planners, however, appeared to take a different view.

Based on the assumption of a 7% expansion in the consultant grade year on year, combined with the previous 40% drop-out of trainees post-MRCOG — the numbers were deemed to be in balance. Whatever the Government's estimate of the projected consultant expansion (based apparently on the number of doctors applying for merit awards!) the truth is closer to 2%. There is also a drive in many areas of the country for units to merge and this will inevitably lead to a further reduction, not expansion, of the consultant numbers.

The previously noted high drop-out rate post-MRCOG was predominantly (but not wholly) the result of female doctors bailing out of a system which they saw as increasingly difficult to combine with family commitments. Female doctors in training now with a NTN have protected rights of continuing employment either side of maternity leave. They also have an easier route into part-time training that does not lead down a professional blind alley, but ultimately to the same certificate of completion of specialist training (CCST) and place on the specialist register as they had previously targeted.

In 3 years of stewardship of the North Thames West region training programme, I have only had one doctor voluntarily given up their (her) number. Furthermore, no-one awarded a NTN in open competition since the beginning of recruitment to SpR training, has given up their number voluntarily, nor looks likely to in the near future.

THE NEW DEAL

At the same time as we began the Calman revolution towards a 5-year training programme (just 1 year longer than many trainees had previously spent simply in the SR grade), we were also hit by the requirements for shorter working hours as stipulated in the 'New Deal'. These reductions have dramatically shortened the amount of time spent on the labour ward and with a synchronous fall in many obstetric manoeuvres (i.e. vaginal breech delivery), trainees are not getting the same exposure to abnormal or complicated obstetrics as their predecessors did.

Put alongside a significant cut-back in most hospitals of theatre time for gynaecological surgery and we have the double problem of trying to train and give experience to our young doctors with less material in a shorter time. Although we can, and have, improved the use of their limited time by structuring their training and providing centralized teaching, there is no short cut to 'hands on' surgical and obstetric experience.

The loss of 'ownership' of the trainees by their trainers has also radically changed the relationship between them. In most programmes trainees now rotate annually between different hospitals, the consultant of which probably had little or no input into their appointment in the first place. The trainees appear to develop a strong loyalty to the region that is training them rather than a particular hospital or trainer, and this has definitely weakened the loyalty apparent in the opposite direction.

THE OVERSEAS TRAINEES

How does the overseas trainee fit into the new system? At present there is no structure at all for the vast majority of the overseas doctors who have come to this country to train. Previously most would have come with the expectation of obtaining experience and training in registrar posts and would hope to obtain MRCOG during their stay. If their immigration status changed while here, they had little chance of breaking into the SR grade and thus rarely became consultants — usually settling for service posts in DGHs.

Many now perceive the CCST as their goal, together with a place on the specialist register, so when they do return home they will do so as a recognized 'specialist'. In reality only a very few will achieve this as they have to apply for a type I training post (the only route to a CCST) in open competition with UK/EEC graduates. In the North Thames West region only one overseas doctor has been successful in obtaining a place on a type 1 training programme in the last 3 years. During this time thirty UK/EEC trainees have been appointed. Unless the goalposts are moved I see little chance of the numbers of overseas doctors achieving type 1 training increasing.

CRISIS APPROACHES?

We are now rapidly approaching a numerical brick wall. Approximately 150 trained doctors are beginning to roll off the end of the training programmes in the UK each year, having obtained a CCST and a place on the specialist register. This is now a requirement for application to a consultant post and was thought by most trainees to virtually promise one.

At present there are probably only 50–60 posts becoming available annually and the spectre of increasingly large numbers of unemployed specialists looms ever closer. A recent decision to extend the period of grace within the training programme after the award of a CCST from 6 to 18 months has delayed the crisis for a year but not attended to the solution.

THE FUTURE: A PERSONAL VIEW

The overseas trainee

I would like to see a separate training programme set up for overseas doctors — running parallel with present SpR training — with rotations of equivalent quality. In fact the rotations should be identical, with holders sometimes being UK/EEC graduates and sometimes coming from overseas.

The overseas doctors' programme would last for 4 years and the holder would be expected to obtain his/her MRCOG during that time. The RCOG could 'sponsor' these doctors and could arrange for senior fellows of the College to vet them in their home country before their arrival here. The College should then arrange a full induction programme

for all the doctors together, introducing them to the demands and expectations they will face in a UK hospital post.

The doctors would then be placed by the regional higher training committee in a SHO post in the region in which they are to be trained and if, after 1 year, they are settled and assessments are satisfactory they would then enter a 3-year registrar structured training programme in that region.

UK/EEC trainees

For the SpRs there appears to me to be only two solutions to the impending crisis. The first uses the 'market place' to resolve the problem. The best doctors will get the few available posts and the remainder will have to seek other career opportunities or settle for sub-consultant staff or trust grade posts.

The supporters of this solution use the argument that this simply replicates the original drop out that used to occur at the registrar/SR level and will be inevitable anyway, as many obtaining their CCST had been 'handed' a NTN at the beginning of the changes and would never have 'made it' under the previous system. This nihilistic approach ignores the fact that since the introduction of SpR training, a large number of superbly trained and motivated young doctors have entered the training programme and the majority of them would be expected to become excellent future consultants.

The second solution calls for a sudden dramatic funded expansion of the consultant grade — aiming to virtually double the consultant numbers within 3–5 years. This would be in parallel with a drastic reduction in the number of trainees to be appointed, probably by the order of 50%. The loss of the training posts would partially pay for the consultant expansion but the need for considerable new money is inevitable. It seems impossible to imagine that this could be achieved without a dramatic change in the work pattern of the 'new' consultant.

The reduction in the number of trainees who at present provide the service element would require this work shortfall to be undertaken by a combination of staff/trust grade doctors and the new consultants, all presumably resident on call. It seems likely that for the first few years of the new consultant's career, he/she would have professional cover by a 'senior' consultant and thus a two-tiered consultant grade, although unpopular within the profession both among senior and junior colleagues, does seem inevitable.

Is it all gloom and despair? Certainly there are some very worried CCST holders wondering where and when their next job is coming. SpRs in training look ahead and wonder what the consultant job they will be applying for in the next few years will look like, and frustrated SHOs debate how long they can afford to continue to circle in the SHO grade waiting for an opportunity to open up for them in the specialty of their choice.

This last group can and is being proactive. Many now realize that they must seek a research post and get a higher degree (and/or obtain the MRCOG) before entering SpR training. For this, a link with a teaching hospital becomes increasingly important and so the power-base of training goes full circle and returns to the same base.

The requirements for entry into SpR training begins to look more and more like the requirements for a SR post under the previous system! However, under that system it was still possible for the skilled and dedicated clinician and surgeon to break through without a research pedigree, but under most of the unsatisfactory point-scoring systems used for shortlisting for SpR training programmes today this is very difficult if not impossible.

My feeling is that we will muddle our way out of the present dilemma. A few CCST holders will not obtain a consultant post and a moderate Government-funded consultant expansion will take place, paid for by enforced and unpopular changes in working practices. NTNs will be reduced and entry will remain very competitive. MRCOG Part II will probably become an entry requirement for SpR training and the FRCOG could be awarded alongside the CCST.

The RCOG and the Deaneries will have to work ever closer together and the teaching hospitals will once again reign supreme in the nurturing of the obstetricians and gynaecologists of the next century. HM

KEY POINTS

- 'Calmanization' of the training for the registrar/senior registrar grade in obstetrics and gynaecology began in 1996.
- The previous training had been pyramidal, hierarchical and based strongly on patronage.
- Expected expansion of the consultant grade has not occured.
- The problem of an imminent over-production of training with their certificate of completion of specialist training needs an urgent solution.
- The working pattern of future consultants in obstetrics and gynaecology seems likely to change.