Both service and training demand attention in obstetrics and gynaecology

John Biggs

New proposals for workforce planning, training and ways of working in the NHS are under consideration. Aspects of service, training and workforce in obstetrics and gynaecology that call out for change include training in the senior house officer grade, especially for GPs and non-EC doctors, and the work of consultants. Proposals for change present a golden opportunity for the specialty to lead in new systems of both service and training, which are closely linked.

INTRODUCTION

The review of workforce planning in the NHS entitled *A Health Service for All the Talents: Developing the NHS Workforce* looks at the service demands upon medical staff and the possibilities for restructuring the workforce (Department of Health, 2000). It also calls for a major revision of medical training, especially in the senior house officer (SHO) grade. Discussion of the seeming conflict of service and training has been prompted by the Royal College of Obstetricians and Gynaecologists (RCOG) in a wide-ranging debate entitled *Service or Training* (RCOG, 2000).

This paper puts forward the maxim service and training, for the connection of the two is clear. The task is to strengthen both through better service planning, better use of multiprofessional teams and better training, and this is a challenge for the NHS and the RCOG.

This paper deals with the subject under three headings: an historical review of service and training in a medical context, noting the uneasy relationship of the two throughout the 52 years of the NHS; how service to patients is likely to be delivered in the future NHS, and how this will affect training; and finally, how training in obstetrics and gynaecology is to be provided and how this will affect service delivery.

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A HISTORY OF SERVICE AND TRAINING IN THE NHS

Henry Ford said that history is bunk. Hegel said that people and governments never have learned anything from history. Bishop Stubbs, bishop of Chester in 1884 and later of Oxford, wrote that history is a pack of lies. Accepting these perfunctory dismissals as stimulants for further enquiry it is instructive to look to the origins of NHS medical training.

Much of this can be found in a report of the committee chaired by William Goodenough in 1942–4 to examine the organization of medical schools and clinical teaching, and arrangements for postgraduate teaching and research (Biggs, 1998). Goodenough set the scene for medical education in the NHS when he wrote 'the spirit of education must permeate the whole of the health service…'. He was emphatic about the demands of the training role and believed 'that the trainee should not be overburdened with routine work'.

The Lancet (Anonymous, 1944) responded to the Goodenough report:

'Our present system (of training) has developed in a haphazard way. Medical education can no longer be regarded as incidental to the hospital service.'

By 1950, according to Platt, the SHO and registrar grades had been declared 'non-training', becoming by inference for service only. On the subject of medical staffing in hospitals Platt asked 'whether a structure designed for training in a specialty can effectively fulfil service needs?' (Ministry of Health and Department of Health for Scotland, 1961).

Todd reported on medical education in 1968, making a number of comments and recommendations that still have relevance (Department of Health and Social Security, 1968). He was critical of the registrar grade which:

'offers no certainty — or even a reasonable assurance — of suitable training facilities and experience'.

He was also critical of the years after the PRHO year which presented:

'the most urgent problems, because of the number of trainees involved and the present disorganised state of training during those years'.

He saw a need for more staff because the proposals of his committee would:

'make heavy demands on the time of senior staff, particularly in hospitals, …more appointments will be necessary if both teaching and service responsibilities are to be met'.

He saw Royal College exams as an unsatisfactory assessment of general professional training, being especially critical of high failure rates. He thought assessment should be on a progressive basis throughout general professional training with a general check at the end of each year based, in part, on reports of supervisors. He specifically recommended introduction of rotational training schemes in all regions, involving both university teaching hospitals and district general hospitals.

The Calman report of 1993 recommended that:

'any change in postgraduate education proposed must ensure

standards of both medical education and clinical service to patients are maintained or improved' (Department of Health, 1993).

One senses an awareness of the conflict expressed in the phrase 'service or training' throughout the history of the NHS. This paper suggests that current policy development in the NHS gives the RCOG a unique opportunity to be part of changes that will raise standards of both service and training.

HOW SERVICE IS LIKELY TO BE DELIVERED AND HOW THIS WILL AFFECT TRAINING

The workforce review calls for a new approach to team working (Department of Health, 2000). This paper examines the workforce's components, specifically in obstetrics, and begins with midwives, who provide a non-medical workforce that makes obstetrics almost unique as a discipline. No other specialty has such a well-defined and trained paramedical staff, which gives the specialty the golden opportunity of moving to teamwork in the new order of things.

Next, the SHOs in obstetrics are a large group, working in antenatal wards and clinics, delivery units and operating theatres. Their input must be important, for consultants in several hospitals with about 2000 deliveries a year tell me it isn't possible to run the unit without five or six SHOs. A senior midwife at a recent regional conference on changes in service delivery in obstetrics said that SHOs were not needed in the delivery unit. SHOs tell me their obstetric duties are demeaning; they are what Professor John Anderson used to call clerk phlebotomists (Anderson, 1986). A clerk phlebotomist could do nearly all the SHO jobs in obstetrics.

Further up the service scale are specialist registrars (SpRs). They are learning their craft and becoming progressively more capable, taking up specialist skills, caring for the disorders and trauma of pregnancy and learning the operative procedures in which they will lead on becoming specialists. As SpRs progress, their skill level and service contributions merge with those of the consultants.

The NHS workforce review speaks forcefully of services being delivered by fully-trained doctors and puts forward plans for a specialist grade working alongside consultants but possibly taking more of the clinical load both day and night (Department of Health, 2000). The review calls for a rethinking of job plans and responsibilities, and team working that breaks down conventional barriers. The opportunity for obstetrics to lead the NHS in this process is thus presented. SHOs would be few, replaced by clerk phlebotomists, and midwives would be more in number, working much more closely with specialists/consultants and the SpRs. The SHOs that remain would be almost supernumerary, present mostly in the daytime to learn and at other times as shadowers or followers of SpRs. There would be a big impact on SHO training in the specialty, but SpR training would continue to evolve as it has done since the Calman reforms were introduced in late 1995.

HOW TRAINING IS LIKELY TO BE DELIVERED AND THE IMPACT ON THE SERVICE

The 11th annual report of the RCOG on medical workforce in the specialty gives important data on the numbers of trainees and their career aims and opportunities (RCOG, 2000). It shows that in May 1999 there were 1652 SHOs in the specialty in England and Wales. Of these, 1018 were aiming for a career in the specialty. In the NHS year from April 1999 there were only 65 places in England and Wales for promotion of SHOs to career programmes in the SpR grade; in the year commencing April 2000, there will only be 26 such places. There is thus a great disparity between career aims and opportunities.

Career SHOs are in two groups: those wishing a career in the NHS, mostly UK graduates, but also some from other European community countries; and those from abroad wishing to augment their training by experience in the UK. Those in the first group should be working in busy obstetric units of excellence, in closely supervised and planned programmes. Smaller hospitals, perhaps those delivering fewer than 4000 mothers a year, may see none of them, and this will change the service arrangements significantly.

The non-EC doctors have often had extensive although different experience and may already have a wide range of skills when they arrive in the UK. Their training should be planned according to need and may often be akin to that of junior SpRs. These doctors should be assessed abroad and come to the UK for planned programmes of defined duration. Many will be preparing for College exams and should be fitted in with junior SpRs as fixed-term training appointees. If properly assessed, chosen and placed, they will provide valuable service while gaining the planned experience they desire at a higher level than other SHOs. Having a 33-year-old doctor from abroad with 6 years' experience in the specialty compete for SHO posts with UK and other European doctors who have just finished house jobs is ludicrous. The RCOG wishes to change this situation and deserves the support of its fellows and members, and that of the government in making fit-for-purpose training available.

There are also large numbers of SHOs preparing for a general practice career (634 in May 1999) who take 6-month posts in obstetrics and gynaecology. These are aimed at giving them better knowledge and clinical skills in the care of pregnancy and disorders of the female genital tract. The 6-month posts were contrived in another age and often bear little relation to the work of GPs; they need urgent reconstruction. These SHOs tell me they are passed by in labour ward, attend few clinics, hold retractors in operating theatres for hours, see no community midwifery, and don't become confident in the management of menstrual disorders or family planning.

This is an extraordinary and highly unsatisfactory situation and re-working of the training for future GPs is an urgent need. The time in the specialty might be shorter. The obstetric list arrangements must be re-written so that 6 months of training is no longer needed; perhaps the obstetric list is an anachronism. Training in obstetrics

and gynaecology might be better provided by secondment from an extended time as a general practice registrar, the trainee following the pregnant and gynaecological patients of the practice into hospital and clinic, learning with the community midwife, and learning with the gynaecologist who sees the patients referred from, or in future in, the primary care trust. By whatever approach, training needs to be planned to meet the needs for general practice. There will be an inevitable reduction in the service provided in acute trusts by SHOs aiming for general practice.

The NHS workforce review calls for drastic rethinking of the SHO grade (Department of Health, 2000). It says:

'The SHO grade is…a problem area with trainees providing an undue service commitment…staff in a training grade who are not in reality in training at all'.

It adds

'Steps need to be taken urgently to sort out the SHO grade…'.

The SpR grade, established with the Calman reforms of 1995/6, has changed for the better quite dramatically and is still in evolution. In obstetrics and gynaecology there has been overproduction of doctors who have completed specialist training and many of them have not found consultant places. On 1 April 2000, there were 127 people in this situation, a number that has been almost constant for the last year and a half. Steps to overcome this situation are continuing and the initiative begun by Professor John Temple in the West Midlands region is bringing a reduction in numbers of SHOs and an increase in the number of consultants giving immediate supervision of delivery units.

The workforce review has proposed a new specialist grade which would also help the process of assimilation of these trainees. The grade could almost be said to be made for obstetrics and gynaecology. The advantages proposed for the grade are that it gives an appointee time to concentrate on gaining experience and skills, without all of the responsibilities of a consultant. There has been heated debate about the proposal, much of this suggesting that a change in the nature of a consultant's work may well be achievable, if we can avoid being caught on the barbs of a new title.

KEY POINTS

- Service and training requirements have been in conflict from the start of the NHS.
- Delivery of patient care by fully trained doctors will demand a rethinking of trainees' service contributions.
- Trainees from non-EC countries need better-planned programmes.
- General practice training in obstetrics and gynaecology urgently needs revision.
- The senior house officer grade needs sorting out.
- The proposal for a specialist grade has attraction: perhaps another name would help.

CONCLUSION

The opportunity for the NHS and the RCOG to grasp new approaches to restructuring the working of the NHS through new service planning, interprofessional working and new systems of training comes back to the thesis of this paper — that we are involved in a serious review of both service and training. HM

Conflict of interest: none.

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Anderson J (1986) The purpose of the pre-registration year. *Br J Hosp Med* **36:** 161–3

Anonymous (1944) Future of medical education. *Lancet* **ii**: 113–4

Biggs J (1998) The Goodenough Report and medical education in 50 years of the National Health Service. *Health Trends* **30**: 16–19

Department of Health (1993) *Hospital doctors: training for the future: the report of the Working Group on Specialist Medical Training.* Chair: Dr Kenneth Calman. Department of Health, London

Department of Health (2000) *A Health Service of all the talents: Developing the NHS workforce.* Department of Health, London

Department of Health and Social Security (1968) *Royal Commission on Medical Education 1965-68 Report.* HMSO, London

Ministry of Health and Department of Health for Scotland (1961) *Report of the Joint Working Party on the Medical Staffing Structure in the Hospital Service.* Chair: Sir Robert Platt. HMSO, London

Royal College of Obstetricians and Gynaecologists (2000) *Medical Workforce in Obstetrics and Gynaecology.* Eleventh annual report. Royal College of Obstetrics and Gynaecology, London