

Specialist registrar training: what still needs to be improved?

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It is 6 years since specialist training in the UK was radically reformed. Is educational quality still improving or have early improvements slipped as the novelty has worn off? What further improvements are needed to ensure the production of specialists who are properly prepared to be the consultants of the future? The authors address these questions from the perspective of one postgraduate deanery.

INTRODUCTION

Specialist registrar training in the UK has been subjected to widespread reform (Working Group on Specialist Medical Training, 1993). The new arrangements placed more emphasis on structured teaching and supervised learning and less on experiential apprenticeship. Posts were linked into rotations that delivered a defined curriculum for each specialty. At the beginning of each post, trainees and their supervising consultants were to discuss the educational objectives to be achieved and sign a training agreement. Regular appraisal was to take place, offering trainees feedback on their progress from the supervising consultant.

Transition to the new system was completed in 1997. Two years after transition to the new system was complete, there was evidence of positive change (Paice et al, 2000). Another 4 years on, have the educational quality improvements been maintained? Is the new system fair for all? Does it prepare those emerging from training with their certificates of completion of specialist training to be consultants in a modern health service? Are further improvements required?

This article uses information gained from trainees within one postgraduate deanery to address these questions and consider what steps postgraduate deans

should take to improve the quality of specialist registrar training.

TRAINEE SURVEYS

Questionnaire surveys of trainees have been carried out every 2 years since 1996, using the same methodology (Paice et al, 2000). Trainees working in NHS trusts in west, north and north-east London were invited to take part. The questionnaire was loaded onto portable electronic survey units which were taken to participating NHS trusts. Each question was displayed on a screen and the respondent keyed in the number of the response chosen. Confidentiality was assured. Non-responders were chased up with postal questionnaires. Doctors not in training grades and short-term locums were excluded. SPSS 8.0 was used for statistical analysis, and significance calculated using Chi squared.

RESULTS

Over a thousand specialist registrars responded to each of the surveys, with response rates of over 70% (Table 1). Their responses to questions about the educational quality of their posts are summarized in Figure 1. There was no evidence of slippage against any of the quality standards, and significant, if modest, improvement in most of them.

DISCUSSION

Educational objective setting and training agreements

Written educational objectives make it clear what the trainee is expected to achieve in each post. Without such clarity misunderstandings can arise which are not conducive to good training. Equally, the trainee is entitled to know what learning opportunities will be made available. Educational objective setting, recorded in a training agreement, is becoming more common (Figures 1a and b) but should be a feature at the start of every post.

Appraisal

In the latest survey just over 80% of specialist registrars had sat down with their consultant to discuss their progress in the current post, or knew that such a meeting was planned (Figure 1c). Appraisal should be carried out by a consultant who is well informed about the trainee's performance, and the discussion should be as constructive as possible.

While a proportion of trainees and trainers are still uncomfortable with a formal session, and prefer informal feedback on a daily basis, the postgraduate deans do not believe this is a substitute for a more formal reflection on performance over a period.

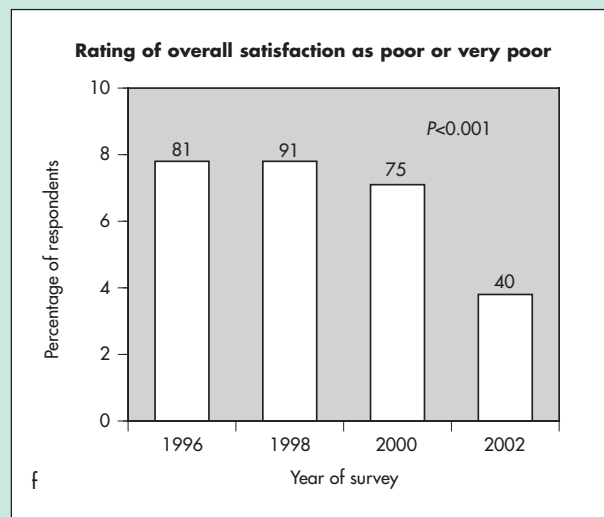
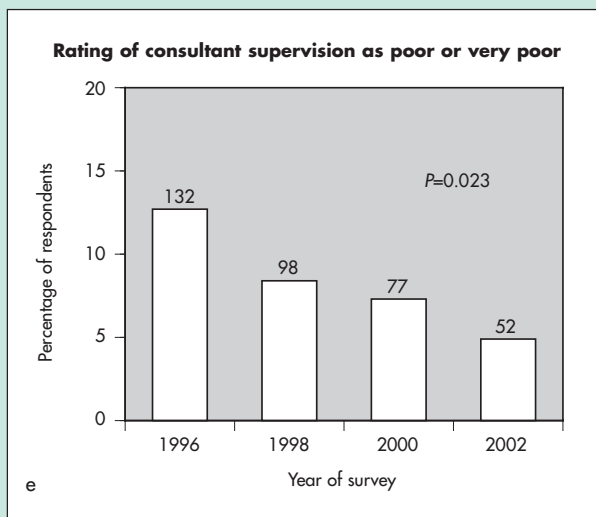
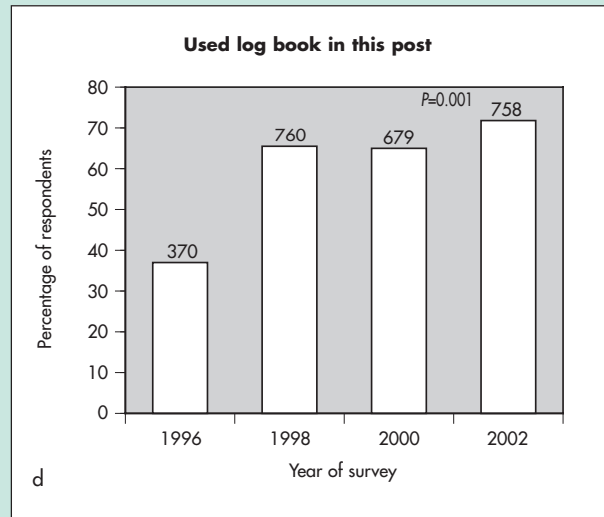
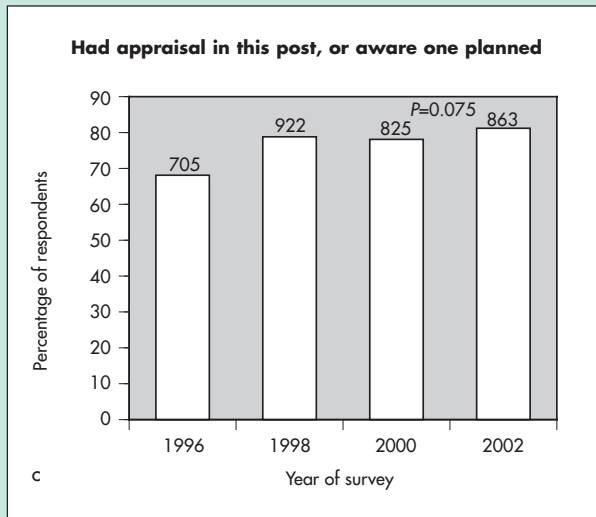
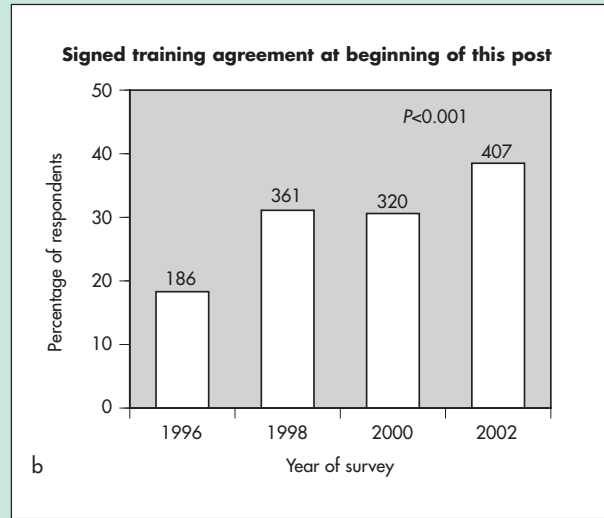
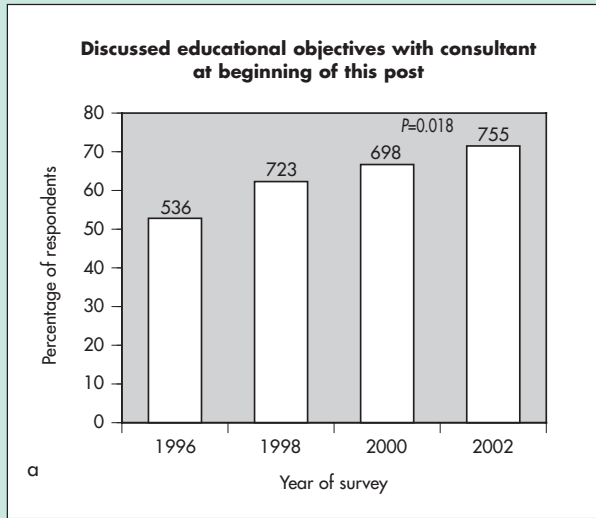
TABLE 1.
Number of respondents to survey

	Year			
	1996	1998	2000	2002
Number of respondents (response rate)	1036 (71%)	1170 (74%)	1057 (72%)	1063 (72%)

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Figure 1. Responses to survey questions. P values give the significance of the difference between responses in 2000 and 2002.



Appraisal should take place for every trainee at least once a year.

Use of log books

A powerful means of ensuring that skills and experience are recorded is the use of a log book. Many royal colleges introduced log books as part of the reforms, and made their usage compulsory. Uptake continues to rise (*Figure 1d*). Log books are an excellent means of recording experience and competencies gained, and should probably be a feature of all specialist registrar training.

Consultant supervision

The single most important factor in determining whether a trainee is satisfied with a training post is the quality of supervision provided by the consultant trainer. The proportion of trainees rating the supervision provided by their consultant as poor or very poor has declined (*Figure 1e*), but ideally should be none.

Consultants are appointed primarily to provide a service for patients and their role as teachers and trainers of other doctors is a secondary one. Not all consultants are interested in being or talented as trainers. In the past, when junior staff outnumbered consultants, it was difficult for consultants to avoid the role of trainer. Now the ratio is changing and the intention is for consultants to outnumber their juniors. This will make it much more realistic to say that not all consultants need to train and the job can be delegated to those who have an appetite and talent for it.

In the future it may be more appropriate to have approved trainers working within approved departments. But even excellent and committed consultants cannot train if they are under pressure to reduce waiting lists or meet other throughput targets. It is always quickest if the most experienced member of a team does the work without supervising a junior learning to do the task. In training departments, time must be set aside for teaching, training, appraisal and assessment, and trainers' needs for development should be met.

Overall satisfaction

Although the proportion of trainees rating their posts as poor or very poor has fallen (*Figure 1f*), it is disappointing that the training experience for some trainees remains unsatisfactory. An analysis of the characteristics of trainees registering dissatisfaction with their posts showed no association with gender or age. Trainees working part-time were more satisfied than those working full-time, as has been previously noted (Goldberg and Paice, 1999). Overseas qualified doctors were less satisfied than UK graduates, especially if they were in long-term locum posts. The quality of training should be consistent, regardless of the trainee's country of qualification or type of appointment.

WHAT ELSE NEEDS IMPROVING?

Structured training

One of the planks of the Calman reforms was the concept of structured training. Rather than let trainees opportunistically gain whatever experience came their way, rotational programmes were designed to ensure that each trainee had the opportunity to learn the full range of competences expected from a new consultant in the specialty. When a trainee had learned a procedure, they were supposed to move on to the next challenge, rather than being used as pairs of hands to carry out the procedure learned.

In specialties that are heavily procedure-based, such as surgery, there has been much argument about how to know when competence has been achieved. Time served in a unit where the procedure is carried out is on its own a poor indicator. The number of procedures observed, assisted at or carried out as first operator is more widely accepted.

If the procedure is one that trainees need to master, then it must be the responsibility of the training committee to ensure that sufficient opportunities exist for the trainee to do so. The Royal College of Surgeons, in inspecting training posts, has rightly insisted on a maximum number of trainees and other middle grade staff

that a unit can accommodate. Circumstances change, and a waiting list initiative, a consultant retirement or the closure of a theatre can impact on the experience available in a hitherto excellent training unit. In these cases the trainee may need to be moved to another unit in order to get the experience needed, rather than simply continuing the rotational programme originally devised. Training should then be targeted to ensure that the deficient experience is made up, with no blame being attributed to the trainee.

Competency-based assessment

There is rarely an agreed number of procedures carried out that would be accepted as proof of competence in that procedure – there are reasons for this. Competence implies more than time served or numbers collected. It implies more than technical skill.

Competence in a procedure includes an understanding of its indications, contraindications and risks; an ability to communicate these to the patient in gaining informed consent; an appreciation of the role of other team members in carrying it out; an ability to recognize when things are not going according to plan and when to call for help; an understanding of the postoperative needs of the patient; and an understanding of clinical audit and continuous quality control in respect of the procedure. Most importantly, it implies competent performance of the procedure in the workplace. Simply counting procedures carried out is no way to assess competence.

From trainee to consultant

The transition from trainee to consultant is a tough one, comparable to that from student to preregistration house officer, but less well-managed. There is much more to the role than competently carrying out procedures on patients. For the first time, the new consultant will be in a managerial relationship with other staff. No supervision will be available unless specifically asked for, and asking for help is not part of the current consultant ethos.

There will almost certainly be inadequacies in staffing, equipment or other resources and the new consultant may have to enter into difficult negotiations for the first time. It is all too easy to alienate colleagues and managers by an inappropriate negotiating style, and the damage to relationships from an aggressive start may prove irreparable. Trainees need to be prepared for this transition, and not just by means of the traditional 1-week management course. The specialist registrar training programme should contain training in communication, negotiation, conflict management, teamwork, managing meetings, time and resource management and similar generic topics (Heard et al, 2001).

Even with such training, the transition to the consultant role will be tough. For the past 2 years, the London Deanery has been running a series of training days for new consultants, and hearing about their experiences (Houghton et al, 2002). One of the themes that has come out has been the need for a system of mentoring. Some new consultants organize this for themselves, but many do not feel able to ask for such help. The authors believe a system should be in place to offer new consultants a named mentor, selected with their assistance (Paice et al, 2002). The mentors in turn need to be trained and supported in this role.

THE WAY FORWARD

Continued efforts to address the concerns of those who are dissatisfied with their training remains a priority for the deanery. Any allegations of unfair discrimination, bullying or harassment will continue to be treated seriously. A good induction and an early discussion of educational objectives with the supervising consultant are quality standards that should be met in every training post. Deaneries and royal colleges should ensure that both take place reliably and consistently for every trainee.

In London, the specialty training committees will be asked to ensure that written objectives have been agreed at the start of each post, and this will be checked at the annual review of in-training assessment (RITA). Informed and constructive appraisal should be carried out at least once in each post or once in 6 months, whichever is the more frequent. Appraisal is most useful if both parties have prepared for it. An online interactive training package is available (<http://www.appraisal-skills.com/>).

The RITA process must be strengthened to ensure that all domains of performance are assessed. Objective means of assessing skills (using simulations wherever possible) are being developed within many royal colleges and deaneries. The development of a

competency-based system of assessment of trainee performance is a priority for London Deanery.

The development of interpersonal skills, teamwork, leadership and negotiation are highly important, and must be both taught and assessed. Training in these should be mandatory for all trainees, and should be delivered in an interprofessional context. Mentoring should be available for all those making the transition from trainee to consultant. London Deanery is committed to providing training for consultants who would like to become mentors.

CONCLUSION

From the evidence provided by specialist registrars responding to regular confidential surveys, it appears that most of the improvements to training brought about by the Calman reforms of specialist training have been sustained. Nonetheless, some trainees remain dissatisfied with their training, and it is important to ensure that quality standards are consistently met, individual concerns are addressed and the experience is improved for all.

The purpose of the specialty training programme is not the award of certificates of completion of specialist training, but the production of consultants who are fit to lead the development of a modern NHS and motivated to give of their best in improving patient care. **HM**

KEY POINTS

- Improvement immediately following the specialist registrar reforms has been sustained, but further improvement since then has been modest.
- The London Deanery is committed to achieving the following:
 - Induction processes to include discussion of educational objectives and written training agreements.
 - Appraisal for all trainees carried out at least once a year.
 - Competency-based assessments developed in conjunction with royal colleges.
 - Targeted training provided where programmes have failed to deliver sufficient procedural experience.
 - Interprofessional generic training programmes available to all specialist registrars.
 - Online interactive training resources made available to trainers and trainees.
 - Training in mentoring provided for consultants.

Conflict of interest: Professor Paice is responsible for maintaining the quality of postgraduate medical education in London.

Goldberg I, Paice E (1999) Flexible specialist training compared with full-time training. *Hosp Med* **60**: 285-90

Heard SR, Schiller G, Aitken M, Fergie C, Hall L (2001) Continuous quality improvement: educating towards a culture of clinical governance. *Quality in Health Care* **10** (Suppl II): ii70-ii78

Houghton A, Peters T, Bolton J (2002) What do new consultants have to say? *Career Focus. BMJ* **325**: 145

Paice E, Aitken M, Cowan G, Heard S (2000) Trainee satisfaction before and after the Calman reforms of specialist training: questionnaire survey. *BMJ* **320**: 832-6

Paice E, Heard S, Moss F (2002) How important are role models in making good doctors?. *BMJ* **325**: 707-10

Working Group on Specialist Medical Training (1993) *Hospital Doctors: Training for the Future*. Department of Health, London