Training in obstetrics and gynaecology in the UK: present and future

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Postgraduate medical training in obstetrics and gynaecology has changed radically over the last 10 years in the UK. It is likely that future developments will see training evolve further still.

Training in obstetrics and gynaecology offers a fascinating mix of medical knowledge and surgical experience. From caesarean section to colposuspension, by way of hormone replacement therapy and genetic counselling, it is a specialty where there are seemingly limitless avenues of expertise. Trainees in the past traditionally gained experience in all of these areas and hoped to come out at the end of their training as a general obstetrician and gynaecologist able to deal with anything.

For today's trainees, the concept of being a 'generalist' is fading fast. Increasingly medical management of conditions such as menorrhagia means that the frequency and type of surgery undertaken during training has changed dramatically. Advances in molecular biology have opened up new approaches to the prevention and treatment of disease and disorders. Training now has to encompass as much as possible but in the knowledge that the job to be done may be very different from that of 10, or even 5 years ago.

ENTRY TO OBSTETRICS AND GYNAECOLOGY

Trainees entering the specialty usually complete 2 years at the senior house officer (SHO) level before applying for a national training number (NTN), and part one of the membership examination (MRCOG) must be attained during this time. During years 1–3 of the specialist registrar (SpR) grade, a core logbook of competencies must be completed, and part two of the MRCOG is usually taken at the end of year 2 or during year 3 of SpR training. A typical day might involve an antenatal or gynaecology outpatient clinic, an elective caesarean section list, a major gynaecological surgery theatre list with cases such as hysterectomy, vaginal repair or endometrial ablation, or a minor surgery list with diagnostic laparoscopies and hysteroscopies. Much of the day and night on-call work revolves around the labour ward, seeing emergency admissions with complications of pregnancy and, of course, delivering babies. Gynaecology on call can be just as busy if there is a ruptured ectopic pregnancy to deal with.

Years 4 and 5 are designed to expand upon the core knowledge and skills already gained with the additional opportunity to develop areas of specialist knowledge. There are a limited number of places for entry into 2-year subspecialty training programmes in maternal and fetal medicine, urogynaecology, reproductive medicine, gynaecological oncology, or sexual and reproductive health. More recently, the Royal College of Obstetricians and Gynaecologists (RCOG) has developed a wider programme of special skills modules (SSM) (RCOG, 1999) in areas such as gynaecological ultrasound, menopause and labour ward management. Trainees have one or two sessions a week dedicated towards the special interest area and it is hoped that in the future, most year 4–5 trainees would be able to take part in, and complete, at least one module.

TRAINEES' ATTITUDES

The changing nature of medical knowledge and practice is not the only thing that has altered for today's trainees in obstetrics and gynaecology. Since 1997 a number of significant factors have impacted on training: the implementation of a structured training programme, European legislation on hours of work and national restrictions on recruitment. The RCOG Trainees Committee has organized three national training surveys, in 1995, 1997 and, most recently, 2002, to examine trainees' experience of and attitudes towards their training and future jobs (RCOG, 2003).

Nearly 1000 trainees took part in the most recent survey. Demographically, there has been a

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shift towards a female-dominated workforce (61% of respondents), compared to 44% in 1995. Despite the perception that the length of training is shortening, the average age of trainees is older in the most recent survey. The average age of consultant appointment is 39 years, which is certainly no younger than in previous years (Warren, 2002). The gender issue is especially relevant when one considers the split for future career intentions, with only 35% of trainees expecting to work full time for the NHS (11 sessions) and the majority hoping to work part time. With time taken off for raising children, the current complement of doctors in training is likely to fall well short of the desired workforce of a consultant-provided service.

Currently more trainees aspire to subspecialty training than is likely to be required (47% of junior SpRs), but there is no rationing or control over the intake (unlike other countries such as Australia). SSMs are proving to be popular with senior SpRs with nearly 60% of trainees preferring obstetric-related topics. It is felt that future service needs should be the driving force behind the distribution rather than trainee demands, however, again, there is no workforce planning to their allocation.

Over the three surveys, experience gained in clinics and labour ward seems to remain of a good standard, and satisfaction with audit and research projects has improved. Ward round supervision remains consistently poor. However, the most striking observation is that, although supervision in theatre remains of a good standard, trainees' satisfaction with operative teaching and the number of theatre procedures has declined consistently over the last three surveys. This is likely to be the result of a decline in operating volume and parallel lists, so that most operations are now performed with a consultant present.

Research training

Attitudes towards research training have changed little and remain positive. In the most recent study 81% of respondents stated that they either 'agreed' or 'strongly agreed' that research training is essential to obstetrics and gynaecology training, 3% more than in 1997. In addition 73% of trainees wished to maintain a research focus as a consultant. However, only 45% of senior SpRs had done full-time research so far in their career. Trainees understand the importance of research not just as part of the training programme but also as an integral part of their future careers. It is probably not feasible for all trainees to do full-time research, therefore it is disappointing that in the survey 55% of trainees felt that there were no opportunities for doing research projects alongside their clinical jobs and 28% of trainees described training in audit and research as poor or very poor. Precious few NHS consultant job plans allow for research time and academic clinical medicine appears to be under threat from a variety of directions. With the introduction of the new academic NTNs (NTN(A)s) it is hoped that those with a real interest in an academic career will have the opportunity for a structured academic training and career plan.

Working systems

In the 2002 survey, 21% of trainees were working a full shift, as opposed to approximately 10% in 1997. At the time of the survey, 47% of trainees were still on band 3 pay supplements, and with the further implementation of the European Working Time Directive, the number of trainees on full shifts is likely to have risen significantly since then. However, trainees perceive that shifts are worse or much worse for training, quality of life and continuity of care without any significant improvements for safety for the patient. Many trainees are concerned that shift working affects the working relationships between consultants and junior grades, as the loss of a team structure isolates those in junior positions, leaving them uncertain of their roles and responsibilities.

The most popular form of working system for the same number of hours per week was a rota with a protected day off after 24 hours on call, with 71% of trainees stating that they preferred this. In addition, this system was felt by 83% of responders to be beneficial to patients, in comparison to 42% for shift systems and 47% for a conventional 1 in 5 rota (a trainee could believe more than one system was beneficial). Although the shift system was the least preferred among all respondents, the 2002 survey has shown an increase in those who did prefer this system, from 7% in 1997 to 14% in 2002. Increasingly, full shift working patterns are being forced upon doctors in training with very little consultation by trusts, and careful consideration by both juniors and consultants is required to enable trainees to achieve their training targets within the time limitations.

Length of training

The implementation of the run-through grade and *Modernising Medical Careers* (Department of Health, 2003) has still to take place, but the prospect of changes in the length of training have been broached in several quarters in recent

years. In the most recent survey, trainees were asked their opinion of the minimum number of years that an obstetrician and gynaecologist should train in the SpR grade, and 83% of trainees thought that SpRs should be trained for 5 years or longer. At the time of designing the questionnaire not one of the 20 trainees on the RCOG Trainees Committee thought that 3 years would be an option in the future and therefore this option was not given in the survey. However, trainees had the opportunity to suggest an alternative to the specified options in free hand. Only one trainee out of the 930 who responded indicated that SpRs should be trained for 3 years only.

Future perceptions

Regarding future perceptions of the specialty, the overall percentage of trainees who stated that they would never be resident on call when a consultant, 17% in 2002, had fallen from 30% in 1997 and 24% in 1995. However, there was a split in opinion, with 15% of junior (year 1–3) SpRs saying never and 28% of senior (year 4–5) SpRs saying never. Of those who were prepared to be resident on call, a large proportion suggested that they would not expect any commitments the following day (70%) and just under half (47%) felt that they should receive time off in lieu. Of those who would be prepared to be on call 64% would expect to be financially compensated. A total of 58% of trainees felt that obstetrics and gynaecology will become two separate specialties in the future but only 34% thought they should.

Clearly, issues surrounding shift patterns, length of training and eventual consultant role are of concern to trainees in all specialties (British Medical Association (BMA), 2004). However, when students and newly qualified doctors have been surveyed regarding their career intentions, obstetrics and gynaecology seems to have suffered more than some. The eighth report of a longitudinal BMA cohort study following 545 doctors qualifying in 1995 was published in May 2003 (BMA, 2003). In 1995, 5% of the cohort had stated an intention to pursue a career in obstetrics and gynaecology. By 2002, this figure had dropped to 1%, with only 0.8% of males and 1.6% of females intending to train in the specialty compared to 3% and 7% respectively in 1995. A further published study of career intentions of doctors who graduated in 1999 and 2000 during their preregistration year found that the numbers planning to train in obstetrics and gynaecology had fallen to the lowest recorded levels in any previous similar survey by the same authors (Lambert et al, 2003a). A number of factors were cited in both surveys, including:

- Career paths and promotion prospects
- Competition for SpR posts
- Hours of work
- Working relationships
- Concerns regarding work–life balance

Although these issues were, and are, of concern to trainees in other specialties than obstetrics and gynaecology, another more specific factor may have played its part in obstetrics and gynaecology. The impact of the severe restrictions on recruitment at SpR level which occurred as a result of workforce predictions from 1997 onwards have had a lasting effect on recruitment. During the following 3 or 4 years, many career trainees were not able to obtain an NTN and while some entered research or obtained additional experience in senior SHO or locum appointed for training (LAT) positions, a significant number eventually left the specialty to enter other fields of medicine.

Medical graduates who reject obstetric and gynaecology as a career seem most likely to do so because of concern about career paths (Lambert et al, 2003b). Of a 1996 cohort 15% gave this as their main reason but, by 1999, this figure had risen to 77%. Uncertainties with respect to the new consultant contract, job plans, and resident on-call requirements has left current trainees with uncertainties regarding their eventual consultant role. Students and junior doctors thinking about entering obstetrics and gynaecology look to both their consultants and the junior team to gain an insight into the specialty. It is therefore not unreasonable to assume that uncertainties felt by those

KEY POINTS

- Core training occurs between specialist registrar years 1 to 3.
- Special skill modules and subspecialty training can be taken in years 4 and 5.
- There is a shift towards a female workforce.
- There is a decline in the number of operative procedures trainees now perform.
- Training is moving towards competency-based assessment rather than numbers.
- Many trainees are still working outside the European Working Time Directive.
- Trainees are committed to a 5-year specialist registrar training programme.
- Not all trainees are prepared to work resident on call when a consultant.
- Uncertainty over career paths has affected recruitment to the specialty.
- Recently, there has been an increase in registrar posts nationally.

already in training will impact on those who have not yet made a decision on whether to pursue a career in this specialty.

CONCLUSIONS

There are currently three RCOG working parties in operation, looking at the roles of both the consultant and the SHO, and at recruitment into the specialty. Even though increased numbers of NTNs have become available through various means since 2002, medical students and junior house officers may continue to perceive the specialty to be one with very few numbered posts and therefore may not consider entering for this reason. This raises the worrying prospect that within a very short space of time, there will be a major deficit in the numbers of trainees emerging from Calman training with a consequent deficit in the numbers of consultants (Warren, 2002). Paradoxically it is an ideal time to commence a career in the specialty.

Obstetrics and gynaecology remains an exciting and stimulating specialty and it will be imperative that those charged with the responsibility of advising and monitoring training ensure that trainees get every opportunity to experience the best that the specialty has to offer. In the meantime, those who are interested in forging a career in obstetrics and gynaecology should be aware that training opportunities have increased and will hopefully continue to do so over the near future. HM

Conflict of interest: none.

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