

Training the future consultant in obstetrics and gynaecology

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The training period for specialist registrars is now shorter and the demography of both gynaecology and obstetrics is changing rapidly. The specialist training in obstetrics and gynaecology must ensure that the future consultant is appropriately and adequately trained.

The provision of a safe and effective service to ensure that women and their babies receive the best possible care is central to the working life of the consultant obstetrician and gynaecologist. Changes to the role of the consultant have come about as a result of advances in the treatment of many common gynaecological conditions. There is now less major operating and more emphasis on medical therapies. In addition, on the grounds of safety and training, the presence of the consultant is now required much more frequently on the delivery suite (Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, 2000).

In addition to providing more hands-on direct patient care the consultant has had to absorb the need to provide formal educational supervision. Dealing with complaints and litigation has also become a significant part of the consultant's workload. Providing timely responses and navigating cases through the complaints procedure leaves many consultants overwhelmed, isolated and vulnerable.

The provision of training for the future consultant must recognize the changes that have occurred to the consultant role. Consultants must be trained for the job they are going to do rather than for the job that used to exist. In addition future training must address the perception, real or otherwise, that training currently produces consultants insufficiently trained for the job. This perception may also be shared by trainees who are almost universally extending their training well beyond the current 5-year specialist registrar (SpR) training programme (Royal College of Obstetricians and Gynaecologists, 2003a).

Traditionally the consultant has worked in isolation but there is now a recognition that there needs to be a move towards team working, with

the consultant leading a multidisciplinary team to ensure that health provision is woman centred and appropriate.

TRAINING IN OBSTETRICS AND GYNAECOLOGY

There remains a consensus that the consultant in obstetrics and gynaecology will have trained and been deemed competent at performing a range of medical and surgical interventions even if, as their careers develop, they no longer use some of these skills. Limiting training too early will produce a specialist with a narrow range of skills and without the foundation that will facilitate movement into other areas as careers develop. Therefore, the majority of trainees will train in both obstetrics and gynaecology and complete core training in both areas. This will produce a cohort of doctors with a sound foundation who, after further training, will be capable of providing a consultant service.

As the majority of new consultant posts now require a special interest this requirement must be recognized and provided for during advanced training. The majority of trainees will undertake one or possibly two special skills modules while continuing advanced training in emergency gynaecology and obstetrics. The special skill modules currently available include training in the menopause, maternal medicine and labour ward management (Royal College of Obstetricians and Gynaecologists, 2002). A few trainees will opt to undertake subspecialty training in specialist areas and the majority that do so will drop either obstetrics or gynaecology as appropriate.

TRAINING FOR OBSTETRIC PRACTICE

In the last few years there have been significant changes in the demography of obstetric practice. More than a third of women giving birth now

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experience some form of operative delivery. The caesarean section rate in 1994 was 15%, by 2002 this had risen to 22% and seems set to rise further (Information and Statistics Division, 2002). In addition a substantial proportion of the money paid out in clinical litigation settlements by the NHS each year arises from obstetric problems, which result in the birth of babies with significant brain damage. These claims account for 50% of the NHS litigation bill (Department of Health, 2000). In a number of serious critical incidents reported to the National Patient Safety Agency lack of senior staff presence, lack of supervision and delay in seeking or getting help were important factors in the poor outcome. This sits against a background of repeated Confidential Enquiry reports citing substandard care as a major factor in the reported poor outcomes (The Stationery Office, 1998; Confidential Enquiry into Stillbirths and Deaths in Infancy, 2001).

The current number of obstetric interventions seems set to rise and there are still babies born with brain damage as a consequence of problems in labour that were avoidable. Consultants have to take a more active role on the delivery suite to provide more direct care and reduce unnecessary interventions while improving safety for the mother and her baby. A large part of this role will include teaching trainees about the labour process and good intrapartum care so that the next generation of consultant obstetricians are appropriately trained to provide a similar service.

Increasingly there is a need for a prepregnancy counselling role for the obstetrician, and evidence (Murphy et al, 2003) that some women experience extreme psychological stress during childbirth suggests an increasing role for the obstetrician in the postnatal period.

Consultants will continue to work closely with midwives within the context of a multidisciplinary team. The role of the midwife is to provide care to the low-risk mother while the obstetrician will focus on the high-risk pregnancy, but there needs to be an interface as the roles will necessarily overlap in order to ensure safe and effective care for the mother and her baby. While the care of the low-risk mother will increasingly take place within midwifery-led units, lines of communication must be developed to ensure that midwives are supported in their role and have assistance when difficulties ensue.

Training in obstetrics must address all of these issues. In order to ensure that trainees have sufficient skills in both vaginal operative delivery as

well as caesarean section there must be a consistent consultant presence on the delivery suite to support and train them. Trainees, even those with proven competencies in many areas, may not have the breadth of experience to allow them to cope with the rare but life-threatening emergencies. Left to cope alone many young doctors experience extreme stress, the end result of which is to choose not to continue in obstetrics. Consultants, especially those working in large units, must be immediately available to train the junior doctor to anticipate complications and to provide a safe and effective response to intrapartum emergencies.

The training must also include guidance on the risk management process, how to deal with complaints and management of the delivery suite. In addition trainers must ensure that trainees have the opportunity to contribute to the workings of the multidisciplinary team.

TRAINING FOR GYNAECOLOGY PRACTICE

The UK Department of Health hospital episode statistics (Department of Health, 2004) show a 20% reduction in hysterectomy rates from 1996–2002. In addition the changing gynaecological demography suggests that there will need to be an increased emphasis on areas of gynaecological practice away from the operating theatre. The adolescent population has an increasing need for gynaecological advice and treatment, and the current training programme does not yet adequately reflect this. The decreasing age of first sexual intercourse and the rising incidence of sexually acquired infections, along with an increase in the number of teenage pregnancies, will demand an increase in the number of gynaecologists working in this area and the training programme must provide sufficient experience for them.

As advances in medical treatments develop many conditions will be managed in ways other than with major surgery. The current training programme demands quite advanced surgical skills for all trainees and yet as the number of major surgical procedures declines the trainee is struggling to obtain sufficient experience to attain and maintain competencies. The reduction in the number of cases available may eventually result in advanced pelvic surgery training being part of a special skills module, with trainees concentrating on attaining competencies in the medical management of many gynaecological conditions, while developing skills in day surgery and minimally invasive techniques.

Many gynaecologists will work with a special interest and the training programme must recognize this requirement. Currently 50% of consultants either have subspecialty training or spend more than 50% of their time working within a special interest area.

Currently more trainees aspire to undertake subspecialty training than there are places available. The sole determinants for numbers undertaking training in any particular area are the wishes of the trainee and the availability of places. This situation is unsustainable. Efforts must be made to estimate how many subspecialists are needed and train accordingly. While this may lead to training places being under-filled it does allow for overseas doctors who require the acquisition of advanced skills to be trained and to return home to develop services locally.

LENGTH OF TRAINING

There has been a considerable amount of debate recently about the length of training required to produce a consultant. In the latest trainees survey (Royal College of Obstetricians and Gynaecologists, 2003b) 83% of trainees felt that SpRs should be trained for longer than 5 years. This is certainly reflected in the current average length of training.

However, the emphasis is increasingly on competency-based training, the length of training being determined by the time taken to acquire the required competencies. There must, however, be a minimum length of training and possibly also a maximum length of training beyond which a trainee cannot be allowed to continue if he/she has failed to acquire basic competencies.

CONCLUSIONS

Previously training was unstructured and over long, with trainees providing much of the service during the working day and the majority of the

out of hours service. The system relied heavily on the very experienced senior registrar to train and support the more junior doctor. The hours were excessive and the formal education poor. There was no formal assessment process and competencies were not defined.

Since then many factors have impacted on how junior doctors are trained. The introduction of structured training in 1996 led to an improvement in the training, with the balance between service and training being addressed for the first time. The formal assessment process was developed alongside structured training to allow trainees to move 'seamlessly' to the next phase of training. With the introduction of competency-based training there was a way of ensuring that trainees had the skills they needed for the job, assuming of course that the assessment process was adequate.

The 'New Deal' reduced the number of hours worked, at the expense, in many cases, of the 'firm' system and the experience gained, but did lead to an improvement in the work-life balance. However, the European Working Time Directive will further reduce the time the trainees are available to be trained and the training system must rise to the challenge to ensure that the consultants of the future continue to be trained for the job. **HM**

Conflict of interest: Dr Blott is the Royal College of Obstetricians and Gynaecologists Workforce Advisor.

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KEY POINTS

- The trainee must be trained for the job he or she is going to be doing, reflecting changes in the management of many common gynaecological conditions.
- Many more women now experience obstetric interventions and the number of consultants must increase to absorb this increasing workload.
- The consultant of the future will provide more direct patient care, particularly in the emergency situation.