

## PERSONAL VIEW

## The effect of Calman reforms on recruitment training and service provision

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The 1948 Spens report on the remuneration of consultants and specialists anticipated that a medical graduate 23-24 years old would achieve specialist status by the age of 32.<sup>1</sup> In practice, most doctors are appointed to their first consultant post between the ages of 35 and 40. Sir George Pickering commented in his 1962 review of postgraduate medical education, "I cannot believe that any responsible body would have so long a period of training (10-15 years) . . . the situation has got out of hand."<sup>2</sup>

The introduction of the specialist registrar grade in December 1995<sup>3</sup> was the first major change in speciality training since the inception of the UK National Health Service (NHS). This change was prompted by the need to meet European models and to provide a means to a certificate of completion of specialist training (CCST); to provide a shorter, more structured training programme; and to control the numbers of people entering this grade relative to expected consultant vacancies. These changes have been met with scepticism and in some cases antagonism. They have caused greater focus on what is required and desired in the making of a competent specialist. There is, however, continuing concern that the training period is too rigid and too short for many.

The implementation of this change has come on top of the "New deal" in 1990, which had already significantly increased the number of junior doctors required to provide for service. New rotas have led to the loss of the "firm" structure, and responsibility for continuity of patient care has meant longer working hours for consultant staff. At the same time the demands of formal provision of postgraduate education and the organised supervision and appraisal of junior doctors has eroded consultant time, which previously was spent on service, personal professional development, and leisure. The promised expansion in consultant numbers has been limited by inadequate funding.

In spite of this, most paediatricians have responded positively to the requirements of meeting parents' and children's expectations for better health care, while taking very seriously their increased responsibilities for trainees.

### Recruitment

Early concern about recruitment into paediatrics led to a widely held view that success in MRCP (Paed) part II almost guaranteed an appointment into higher specialist training. However, the number of doctors passing this examination has more than doubled since 1990 to in excess of 500/year.<sup>4</sup> There are currently 1200 National Training Numbers (NTNs) for paediatrics. Thus, there is competitive entry to the grade, which has resulted in the need for assessment of breadth of senior house officer (SHO) experience, maturity, initiative, and ability to relate to all types of families and children as well as passing the examination. This has led for many to a longer than expected time spent as an SHO. Selection to the specialist registrar grade is very carefully considered, as the main criteria for completing higher specialist training is still time spent (five years).

A further factor that compounds the problem of recruitment is the increasing number of women entering the speciality, many of whom will require flexible training at some time and hence longer training time. This will distort long term manpower assessments and must be taken into account before any of the planned reduction in training numbers occurs.

There is a need to recruit into the speciality doctors who practise to the highest standards laid down by the General Medical Council. While there is a move towards protocol driven medicine, the art of practice depends on making a diagnosis, the ability to communicate, think laterally, and explore all concerns clinically. Children should not undergo unnecessary and, to them, punitive investigations. As severe illness becomes less frequent, doctors are needed who can explore children's and family concerns where there is no serious diagnosis without being dismissive. By showing concern and explaining sympathetically and satisfactorily, childhood morbidity is reduced. Professionalism that emanates confidence but not arrogance is paramount. Choosing paediatricians for the future is a heavy responsibility.

### Training

Without doubt the greatest benefits of the specialist registrar grade has been the formalisation of training programmes, improved skills acquisition, and information sharing. On entry,

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trainees are appointed to a programme of education and training within a deanery and not necessarily to a specific department. This has led to a more equitable distribution of trainees within a deanery. For the best advantage to be made of this I believe that, as in academic training, there needs to be more than one trainee in a training department to provide a critical mass for the “ethos of training, camaraderie, and healthy rivalry”.<sup>5</sup> In this situation consultants are more likely to take on the responsibility of learning to train and appraise appropriately. However, too many trainees dilute training opportunities and care must be taken to ensure that there is sufficient experience for all. The development of portfolios, the new guidance on the use of study leave and follow up reporting,<sup>6</sup> the development of regional core training programmes, the protected study time for MSc, research, and audit are all helping to formalise the education process. Supervised service and apprenticeship learning must not be underestimated. It is, however, true that continuity of care and the ability to follow through a treatment plan has been seriously affected by the shorter working week.

Two years after the implementation of specialist registrar training in paediatrics it has become apparent that it is difficult to satisfy all trainees. Their destiny once in the programme is dependent on their career aim and those of others within their deanery. As was at senior registrar level, competition may be necessary for speciality training, taking account of previous performance and competencies. To find the best trainees for the “national treasure” posts in speciality training, cross deanery competition should be the norm.

Speciality training within paediatrics now has clearer curricula. These posts need to tie in tightly with projected numbers of consultant vacancies. Shorter periods of speciality training remain valuable for the general paediatrician, including time spent in community training, particularly focusing on the new morbidities and behavioural paediatrics. For trainees wishing to be a general paediatrician with an interest, consultant appointments should plan links with tertiary centres for continued professional development and network-alliance working.

Medical education is a popular new speciality acquisition for trainees. This allows an improved understanding of the process of best learning and the transfer of knowledge and skills using methodology tested by other professions. The need for competent consultant trainers with sessional commitments freed to deliver education programmes and appraisal-assessment will ensure that future generations of doctors make the best use of the reduced training time.

Standardisation of the appraisal process will be helped by guidelines produced by the Royal College of Paediatrics and Child Health (RCPCH). Record of in training assessments (RITA) are becoming more rigorous, and while the failing trainee needs to be supported by targeted or intensified training, continuous failure to progress must result in being asked to leave the grade. This process is cumbersome

and reluctantly implemented as a result. Conversely excellence needs to be rewarded.

### Service

A real concern about providing service needs exists. The high demand for flexible training, for time out overseas, research, or for travel and family reasons, present an increasingly difficult task for programme organisers. Fixed term training appointments to fill the gaps are often in community and district hospital training placements and are not always what applicants wish, especially as most of these are from overseas. Interdeanery transfers are not easy or available at the times desired. As seems likely, when the total number of NTN falls I believe these difficulties will be exacerbated and increasingly service will need to be provided by consultant and non-consultant career grades.

During the past 10 years, with the reduction of junior doctors' hours and the introduction of the Calman training grade, there have been significant changes in the working life of consultants. The promised increase in consultants has not materialised and has moved downwards from a steady 8–9% increase in the early 1990s to a projected 3–4% increase for the millennium. We need to urge the government to expand the consultant grade urgently.

Changes in medical staffing arrangement, team working, and the nature and need for some, but not all, departments to train will alter the way the service is shaped. Nurses and other non-medical staff are taking on roles that used to be the preserve of junior doctors, and they are becoming very competent.

The increase in non-consultant career grade doctors needed to support the service in all departments is recognised. Many of these doctors will have their membership of the RCPCH by examination and need to be valued and supported in their professional development. Departments will need to develop competencies to form alliances and networks with other hospitals. Not every paediatric department will need to be, or can afford to be, open 24 hours, or be fully staffed by training grades and consultants.

As the development of the Calman-Hine organisation and delivery for cancer services<sup>7</sup> has been successful, so might the same system be used to create integrated care pathways in paediatrics. This is not only a real possibility for neonatal medicine, but also for children's services. As the more severe forms of childhood illness are less frequent, the need for assessment, though not necessarily admission, of the less severely ill, has increased. The need to provide local assessment and treatment services linked to fully staffed inpatient units may need to be considered more rigorously than before. All this may well be driven by the development of the primary care led NHS.

This decade is seeing major changes in policy and practice. Paediatricians of the future need to be appropriately trained and competent to deal with the children of the 21st century. Collaboration and rationalisation in many areas is needed to provide the

best local care that can be afforded, while the more sick children may need to make a longer journey.

Calman training has been implemented. It may have its problems and may need modifications, but if the service to the children will improve as a result, then we should support it.

1 Ministry of Health and Department of Health for Scotland. *Report of the inter-departmental committee on the remuneration of consultants and specialists* [Chair Sir W Spens]. London: HMSO, 1948.

- 2 Pickering G. Postgraduate medical education: the present opportunity and the immediate need. *BMJ* 1962;i:421-5.
- 3 Working group on Specialist Medical Training. *Hospital doctors: training for the future*. London: Department of Health, 1993.
- 4 *The Medical Workforce in Paediatrics and Child Health 1995-1997*. London: Royal College of Paediatrics and Child Health, 1998.
- 5 Aynesley-Green A. What's to be done about the malaise in science training in paediatrics and child health? *Arch Dis Child* 1998;78:101-4.
- 6 *Guidelines for study leave*. The conference of Postgraduate Medical Deans of the United Kingdom, 1998.
- 7 Department of Health. *A policy framework for commissioning cancer services*. A report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales. London: HMSO, 1995.