CURRENT TOPIC

Effects of the Calman reforms: a two year review

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The recommendations of a working party set up to ensure that the procedure for UK specialist certification complied with European law (the Calman report)¹ have had implications that extend beyond the immediate concerns over abbreviated training into every area of paediatric practice—hospital and community, district general hospital, and tertiary centre. Proponents of the reforms promised that more structured training would offset the inevitable reduction in clinical experience, and that careful assessment and targeted retraining would allow only competent paediatricians loose on the public. Sceptics warned that future generations of consultants would have neither the knowledge to deliver training nor the experience to treat children safely. Trainees in paediatrics and child health entered the transition phase of “Calman” in 1996.² At the time the British Paediatric Association (BPA) was an appendage of the Royal College of Physicians without direct responsibility for training or examinations, or even the right to a voice on the new decision making bodies; working hours were becoming progressively shorter for junior doctors (but not for consultants); and the specialty was unattractive to potential recruits.³

In the two years since then much has changed: the BPA has become a Royal College and acquired statutory responsibilities for training and examinations; the recruitment crisis has shifted to primary care; and there has been a change of Government, which has been accompanied by an explicit demand for more public accountability.

Postgraduate medical training in Britain has undergone a sea change, but how many of us would recognise the brave new world of living networks, effective educational structure, and measurable standards portrayed in a recent review?⁴

Training**SELECTION**

There is now a clear definition of programmes (type 1) that will lead to a CCST and those that will not (type 2). The criteria for acceptance on a type 1 programme have clarified the position for applicants and have enabled the training focus to be shifted away from the examination. The selection process itself has become more structured and less open to bias, but it places

Glossary

Birmingham declaration—A statement from COPMED in May 1997 setting out the conditions by which overseas doctors could enter a type 1 training programme
Calman—Chief Medical Officer and chairman of the working group in reference 1

CCST—Certificate of completion of specialist training

CSAC—College (of Paediatrics and Child Health) specialty advisory committee

COPMED—Committee of postgraduate medical deans

MRCP (examination for)—Membership of the Royal College of Physicians

NTN—National training number

RITA—Record of in training assessment

Specialist registrar—The unified training grade leading to a CCST

heavy demands on selection committee members who may be tempted to short circuit some of the safety mechanisms. In addition there is a necessary limitation on the number of trainers who can participate in the appointments process, and both trainees and trainers have voiced concern about the lack of choice they have over who fills which post. Although this has probably resulted in a more equitable distribution of trainees there is a danger that the sense of loss of control might result in a lack of commitment from either party.

CORE TRAINING

The concept of a core period has the general support of both trainers and trainees, and should ensure that all consultants of the future have a grounding in the broad discipline of child health. The content (general, neonatal, and community) has been based on the most common pattern of consultant practice and will need modification to reflect changing patterns of childhood morbidity and consultant work as behavioural and social disorders assume more importance, and the distinction between general and community paediatrics becomes more blurred.

POSTCORE TRAINING

Specialty training programmes are still at an early stage of development. Many CSACs have yet to produce written guidance on training

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content, and the requirements of those who intend to have "an interest" have yet to be delineated from those training to be tertiary specialists. It is still only possible to acquire a generic CCST in paediatrics although the specialist register allows for an accredited specialty to be recorded. Paediatric neurology has already applied for approval as a separate specialty; others will follow once they have had time to demonstrate that they can deliver an effective curriculum.

RESEARCH AND ACADEMIC TRAINING

The compressed training period and the lack of an educational structure in some research posts threaten the future of academic paediatrics.⁵ Academic high fliers can follow a fast track through clinical training but the number of university posts available have diminished. Formal research experience leading to a higher degree is still strongly advised for tertiary specialists and academics. A mandatory module of methodology, statistics, and critical analysis would be an effective method for all trainees to sample research and to prepare the ground for anyone who developed a serious interest. Trainees will want the standard of training and supervision in research to match that expected in clinical medicine, and research supervisors will need to adjust their sights accordingly.

LENGTH OF TRAINING

The minimum length of the training period for most aspiring paediatricians has already grown from four to five years. The inclusion of a research programme for tertiary specialists and academics will lengthen this by a further one to two years (one year may be counted towards training). Additional modules or any reduction in the length of the current working week (such as is implied by the European Working Hours Directive) will extend it further. The average training time is currently nearer six years and training for tertiary specialists is longer.

FLEXIBLE TRAINEES

Flexible trainees have retained the advantage of a top sliced budget held solely by deans. In many departments they are welcomed as a free pair of hands, but the supernumerary nature and inflexibility of their timetables can work against them. Job sharing allows ownership of a substantive post and will become an increasingly important method of working as the number of flexible trainees grows. Funding constraints dictate that trainees still need to give "well founded" (usually family or health) individual reasons why they cannot work full time.

OVERSEAS TRAINEES

Overseas trainees have seen the goalposts move several times. Posts were lost during transition, then the Birmingham declaration removed at a stroke the advantages conferred by changes to immigration law. Many have now opted to apply for type 1 programmes so that they have stability for five years and the flexibility at the

end of the programme to return home or to apply for posts in the UK.

CONSULTANT TRAINERS

The training role of consultants has been augmented overnight with, for most, no preparation or training and no extra time to deliver the enhanced responsibilities. It was recognised early that not all consultants make effective trainers, but the concept of a limited number of nominated trainers with protected time has fallen victim to the pressures of time and funding. A few trainers have taken advantage of university based teaching programmes and their number will hopefully grow. A module of medical education incorporated as an option into the programme of today's trainees would provide one possible solution.

ANNUAL REVIEW AND ASSESSMENTS

All trainees with contracts for more than one year must attend an annual review. The RITA procedure provides a framework for this, but the information that feeds into it is often haphazard. Consultants on specialty training committees may not themselves have been trained in the skills that they need, and the roles of appraisal, assessment, and mentoring are neither clearly understood nor consistently applied. Trainees have criticised the review procedure both for being too rigid and for not being rigorous enough. Trainers have voiced concerns that, in the absence of the need for regular competitive interviews, trainees are becoming complacent. Many trainees are beginning to realise that the onus is now on them to produce evidence that they are learning, and supervisors are recognising that they must address poor performers by helping them and working with them rather than ignoring them.

Service

There is raised awareness that trainees are there to learn as well as provide a service, but the educational potential of service experience has yet to be fully exploited. The increased number of specialist registrars has enabled targets for reduced hours to be met, and extended the coverage of the safety net in many hospital units, but these advantages have been offset by a reduction in exposure to clinical material. Consultants have had to ensure that trainees are not undertaking unnecessary unsupervised service work and have frequently had to absorb this work themselves in addition to trying to fulfil their obligations as trainers. In community settings much of the existing service load has been transferred to non-consultant career grade doctors.

Supply and demand

Consultant numbers had to rise if the twin aims of enhanced training and more consultant delivered care were to be realised. The increase was to be achieved by a short term expansion of trainee numbers. Initial concern about recruitment faded when the number of aspiring UK paediatricians passing the MRCP increased with the advent of the first fully paediatric

examination. The pump priming phase is now over and the College has successfully pressed for a period of stability with no further increases or decreases in specialist registrar numbers for the next three years. At the end of this time the pool of type 1 trainees will need to shrink to about half its current size if a steady state in consultant numbers is to be achieved.⁶ Service gaps will need to be filled by consultants, type 2 trainees, or non-consultant career grade doctors, and the changes may force a reconfiguration of paediatric services. The tagging of trainees with a unique number that remains with them throughout their stay in the training programme has made workforce planning easier. Data quality has steadily improved, but its implications as a modelling and marketing tool have yet to be fully realised. Plans for the introduction of an additional unique numbering system and competitive interviews for tertiary specialty trainees should help to redress the current imbalance between training slots and consultant opportunities.

Winners and losers

In spite of the many shortcomings, much has been gained. The imposition of a structure has forced clear thinking on how training can be delivered. The emphasis on objective assessment is in the interests of children and is the profession's best protection against public dissatisfaction. The increased transparency means that both trainers and trainees know what to expect both from the programme and from each other. Better identification of trainee numbers and the probable date of their certification has brought much needed clarity if not yet stability to workforce planning. Some of the more unworkable rigidities have been relaxed—trainees can now retain a number and remain on the programme if they have genuine difficulty finding a consultant post, and there is provision for additional training after the statutory period is complete even for those who have been issued with a CCST.⁷ The procedure for review and appeal is clearly laid out and seems to be just. There is now more equity for doctors from overseas, and integrated programmes have resulted in a more stable family life. The imposition of the time limit as the first step rather than the last has been responsible for many of the teething problems but has been an effective catalyst for change.

Against this must be set some serious flaws both in the basic philosophy and in the implementation process. Consultant paediatric practice in the UK is never likely to resemble the predominantly office based model of Europe and if shortening the training period had been the only result of a need to conform with Brussels we would have committed a serious folly. The anxiety experienced by trainees that they are being forced into consultant practice before they feel they are ready was summed up by a comment at a recent review meeting: "I want to have enough training to know what I'm doing." A substantial service commitment is seen as an essential part of the learning process but is still not effectively used as an educational resource. There was no new funding for consultant

expansion and the deans' portion of funding for specialist registrar posts has been rationed to about a third of the approved new NTN's, partly by the Treasury but also in a conscious attempt to divert trainees from hospital practice to primary care.

Much power is vested in the dean. Practicalities dictate that many of these powers are delegated, often to administrative staff. The real responsibilities lie with regional advisers who have taken on a hugely increased workload with no compensation in clinical time. The load is shared with programme directors in many deaneries but there are large discrepancies in constituency size. The lack of uniformity between deaneries is a source of frustration for trainees who are confused by contradictory criteria for appointments, the wide variation in the availability of training numbers, and the differing interpretations of community based training. Movement between deaneries occurs but is rare. The main grounds are personal (family) and educational, but the latter is only valid if the new deanery is able to provide an opportunity that is unavailable in the host one; this is explicitly expected to be a rare occurrence. Gone are the days of the six monthly move but breadth of experience has been sacrificed in the process.

Where now?

The introduction to the first edition of the "Orange Book"⁸ tells of the changes producing "a shorter, more structured and organised training pathway". So far the pathway is definitely shorter, more structured in the sense of less flexible, and more organised in that the numbers, names of, and posts held by trainees are known. But the actual educational experiences of trainees are little changed. We must ensure that supervision, appraisal, and assessment continue to drive improvements through their implications of specialty syllabuses, curricula, and standards. The improvements in service based training, through proper supervision by those trained and rewarded for the task and through a purposeful appraisal structure, will come. A national framework of common, clearly defined, and agreed objectives to turn the syllabus into educational action will come. Valid, reliable, and relevant assessments that will stand up to public—and possibly legal—scrutiny will come. But they will come too late for today's trainees whose only experiences of the "improved quality of training" will be of being told where they must work, and of unfocused assessments? A postgraduate dean said recently: "Two years is a short time in a process of change"—little comfort for trainees who will soon be receiving their letters asking for evidence that they have applied for consultant posts.

Tomorrow's paediatricians must justify the confidence of the children in their care. They will not be able to do so if the trainers of today are expected to work on goodwill alone. The organisation, delivery, and development of training must be on a professional footing. This means recognising the skills that are needed, ensuring that trainers are equipped with them,

and giving them the time to deploy them. Concern about the adequacy of training will continue unless real improvements are made and can be shown to be effective in preparing trainees for the challenging and changing world of senior medical practice.

The 1998 edition of *A guide to specialist registrar training* is available free from the Department of Health, PO Box 410, Wetherby, West Yorkshire LS23 7LN.

- 1 *Hospital doctors: training for the future*. Report on the working group on specialist medical training. London: Department of Health, 1993.

- 2 Milligan DWA, Hall DMB. The implications of the implementation of the Calman report on child health and paediatrics. *Arch Dis Child* 1996;**74**:260–3.
- 3 *Recruitment into paediatrics*. London: British Paediatric Association, 1996.
- 4 Biggs JS. A good guide for postgraduate educators: lessons learned in Britain. *Medical Teacher* 1998;**20**:200–2.
- 5 Aynsley Green A. What is to be done about the malaise in science training in paediatrics and child health? *Arch Dis Child* 1998;**78**:101–4.
- 6 The medical workforce in paediatrics and child health 1995–1997. London: Royal College of Paediatrics and Child Health, 1998.
- 7 *A guide to specialist registrar training*. London. Department of Health, 1998.
- 8 *A guide to specialist registrar training*. London. Department of Health, 1996.