

The effects of the Calman reforms on training, service provision, and recruitment

A Specialist Registrar

The proposals by Kenneth Calman¹ to restructure the training of middle grade staff were introduced to “produce a shorter, more structured and organised training pathway so that independent clinical competence as a consultant can be achieved much earlier than in the past in many disciplines”.² By the allocation of a National Training Number (NTN) and a more formalised training programme, the goal was to provide the health service with doctors of a consistently high quality in appropriate numbers for the forecast consultant vacancies. From the registrars’ point of view they would receive their NTN, which guaranteed, subject to satisfactory progress, training in their chosen discipline, and a training post within a specific region.

Unfortunately the realisation has differed somewhat from these ideals. The key weaknesses in the current implementation are:

- A wide heterogeneity of assessment and appraisal—the benchmarks for monitoring trainees’ progress
- A lack of flexibility in the system to encompass the training requirements of either paediatric subspecialists or academic paediatricians
- The regional allocation of trainees can cause clashes between regional manpower requirements and an individual’s training needs
- A fixed length of training applied at the same time as the “new deal” on hours is severely limiting experience before consultancy.³

These points are discussed in more detail and I propose amendments to the current system to address these shortcomings.

I speak from the position of a paediatric specialist registrar, just starting my third year of higher specialist training. Much of my time has been spent trying to understand the Calman training programme and to make the best use of the bureaucracy that has evolved to support it. Unfortunately, the rapid introduction of this system has led to many omissions. Notably, it does not cater for the diverse needs of trainee generalists, academics, and subspecialists.^{2,3} It has led to confusion over training issues both at registrar and consultant level, and a lack of uniformity of implementation throughout the country. Furthermore, the selection procedure is such that specialist registrars may find themselves working in hospitals that they had not included on their preinterview shortlists, in positions not ideal for their chosen career path.

In some regions, like North Thames, it is not possible to plan your career beyond the next set of interviews, while elsewhere the full five year programme may be allocated at the outset.

It cannot be denied that there is now some degree of uniformity of training. However, I share the view of others³ that this exists at the lowest common denominator—that is, adequacy rather than excellence. The danger is that the system nudges along the less motivated trainees while generating cumbersome bureaucracy that stifles the enthusiasm and aspirations of those who are prepared to make major changes to their own and their family’s lives to achieve their career goals. Overall, is this not a recipe for demotivation and mediocrity?

By now all paediatricians are beginning to become familiar with the regular patterns of appraisals and once yearly assessments. But does everyone understand their roles? I have eluded to the diversity of implementation of this task. In North Thames region every appraisal is extremely comprehensive and generates eight or more pages of A4 paperwork. Reports on the trainee are written by one or two consultants and a senior nurse. While the appointment of these assessors is by agreement with both the registrar and local consultant responsible for training, it is not always possible to select appropriate people who are familiar with the trainee and conversant with the use of the paperwork. (In my experience, inappropriate entries have been made.) The Wessex scheme has tried to address this issue by designing much shorter pro forma paperwork, which is more directly focused on the specific training goals of the individual registrar (with their intended career in mind). Both of these methods may have their merits—but what of uniformity of standards of training?

The diversity has arisen because of an absence of central guidance. Clearly this is the role of the Royal College of Paediatrics and Child Health (RCPCH). Our college has a difficult task in fulfilling this role, not least because it was formed almost simultaneously with the implementation of the Calman reforms and has many priorities. However, I understand from regional trainees’ meetings that registrar training has been given a high priority and that plans to address this need are significantly advanced. I am sure we all look

forward to the formal recommendations. From discussions with colleagues training in other disciplines we are not lagging behind any of the other Royal Colleges in this task.

In addition to regulating assessment and appraisal there must be regulation regarding standards of skills and knowledge. This is a complex process, difficult to do well, and the College provides an ideal forum to involve educationalists to guide us through this process. The RCPCH log book¹ attempts to address this issue with a structured check list of the knowledge and skills each trainee should expect to acquire. Does anyone fill it in? Does anyone ever look at it? More importantly, how many trainers and trainees know how to use it? I believe the answer to these questions is “some”, “no”, and “very few”. In all my appraisals, assessments, and within programme interviews I have not once been asked to produce this document. I am sure that those who designed this book had clear ideas of how it should be used but these have not been passed on and I fear that those who make any attempt to complete it treat it as no more than a checklist. Also, does anyone know exactly what a Calman portfolio should contain?

What of the trainee subspecialist? There is no doubt among my colleagues that the basic training in acute paediatrics, neonatology, and community child health is a sound basis on which to build. But surely this should, within reason, be tailored to the career plans of the individual. For example, a future community trainee should not be expected to take a position on a level 3 neonatal unit as part of their training. Similarly, it is inappropriate for a paediatric intensive care unit trainee to spend 90% of their community training doing school clinics when they should be concentrating on neurodisability. In addition, having secured one year posting in a subspecialty one might expect some provision for those specialists declaring their interests to continue to a second or even third year, subject to satisfactory progress. Surely this is not only appropriate but also a good use of resources. Is it only me who feels that the person who interviews well and comes out candidate number 1 is not necessarily the best candidate for their first choice job? Only recently I had contact with a trainee from one of the northern deaneries with two years' specialist training and with a job offer in London who was having to reapply for a new NTN because their region wanted them to return and take up a non-specialist job. Is this a logical way of exploiting this individual's expertise and the investment in their training?

I believe that the NTN should be exactly that—**national**. To regulate the training of paediatric subspecialists these disciplines must be formally recognised and appropriate NTNs issued. The numbers of these should be modulated by the forecast demands for consultants. It will be desirable to maintain some fluidity, but those who have focused career goals at the beginning of their higher specialist training should be able to compete for these numbers—with any registrars who wish to transfer into that programme from general numbers.

The other group not considered by the Calman system are the academic trainees. We are desperately short of people to take up senior academic posts in paediatrics. Professor Ainsley-Green has recently proposed a structure of training for those wishing to pursue this avenue.⁵ Should this not have been done much earlier? I hope his proposals can be quickly considered and incorporated in the specialist registrar training structure before another group of paediatric trainees are sidelined.

At several regional college trainees' meetings it has been suggested that trainees will be able to apply for positions in any branch of paediatrics after gaining their certificate of completion of specialist training (CCST) and that this is a great advantage of the current set-up that does not recognise the paediatric subspecialties. For those with general training this is surely true, but for those who wish to subspecialise not only would they not wish to take up a general post but they would also be unsuitable. Personally, I would consider leaving paediatrics or clinical medicine rather than practise in an area that I do not enjoy. Consequently, each individual who chooses to subspecialise must take responsibility for the fact that they may not find their ideal consultancy.

Finally, the problem of Calman and “the new deal”. For better or for worse junior doctors are now working much shorter hours than they used to. There are clear benefits in terms of patient safety and the personal life of doctors. But continuity of care has suffered and continuity of training—for example, a trainee does not always see the consequences of the treatment they instigate. Logically the way to counter this is to allow a longer period to be spent training—but as we know the Calman deal actually limits higher paediatric training to five years.

My recommendations

Having highlighted some of the shortfalls of current specialist training I would like to make some proposals that may enhance the structures already in place:

- A unified approach to assessment and appraisal driven by the RCPCH to be in place as soon as possible
- All consultants involved in assessment and appraisal must receive training in these processes or forfeit the privilege of supervising trainees
- New and existing registrars should be given a clear explanation of the role of assessment, appraisal, log books, and portfolios
- Paediatric subspecialties must be recognised by the Calman system and appropriate **national** NTNs issued
- *Fixed* length higher specialised training should be replaced with *minimum* length training.

In conclusion we must not forget that “the Calman revolution” has forced our whole profession to focus on and formalise training structures, which, in the long term will benefit both us and our patients.

- 1 *Hospital doctors: training for the future*. Working Group on Specialist Medical Training. London: Department of Health, 1993.
- 2 *A guide to specialist registrar training*. London: Department of Health, 1995.
- 3 Barber P. The Colleges, Calman, and the new deal. *Lancet* 1998;**350**:974.
- 4 *A syllabus and training record for general professional and higher specialist training in paediatrics and child health*. London: Royal College of Paediatrics and Child Health, 1996.
- 5 Aynsley-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.

Conjugate pneumococcal vaccine

Children are able to respond to protein antigens before they can respond to polysaccharide antigens. The response to pneumococcal polysaccharide vaccine is poor before the age of 2 years and some older children with recurrent respiratory infection also respond poorly to the 23-valent pneumococcal polysaccharide vaccine. Protein conjugate vaccines have been shown to induce significant antibody responses in young infants and now researchers in New Orleans, USA (Ricardo U Sorensen and colleagues, *Pediatric Infectious Disease Journal* 1998;**17**:685-91) have shown response to a heptavalent conjugate vaccine in children who did not respond to the polysaccharide vaccine.

They studied 95 children aged 2-13 years who had been referred because of recurrent respiratory infections and who did not have immunoglobulin or IgG subclass deficiencies. After a single dose of 23-valent pneumococcal polysaccharide vaccine the subjects were divided into three groups on the basis of IgG antibody response to nine pneumococcal serotypes: 67 children had an adequate response to five or more of the nine serotypes and they were not offered further immunisation; 111 responded to fewer than five serotypes but did respond to four or more of the serotypes also present in the protein conjugate vaccine and they were given a second dose of polysaccharide vaccine; 17 children responded to fewer than five serotypes and were unresponsive to four or more of the conjugate vaccine serotypes and they were given the experimental heptavalent conjugate vaccine that had as the carrier protein CRM197, a non-toxic variant of diphtheria toxin. In the group given a second dose of polysaccharide vaccine there was no significant increase in antibody concentration to any of the nine serotypes tested. In the group given the conjugate vaccine mean antibody concentration increased for all seven vaccine serotypes although for each serotype there were some patients who failed to respond.

Failure to respond to the 23-valent polysaccharide vaccine is fairly common in children with recurrent respiratory infections (5-10% of such patients in the New Orleans paediatric allergy/immunology clinic). Conjugate vaccines offer hope of treatment but they are not yet available for clinical use.

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