Specialist training

EDITOR,—The Junior Doctors Committee is currently submitting evidence to the chief medical officer's working group on specialist training. It calls for a structured training within each specialty with regular appraisal of practical skills, continuing education, reciprocated assessment of trainer and trainee, and a fixed period of training within each specialty.¹ I recognise the benefits of these aspects of training. The committee's preferred outcome (option 4) makes further proposals for more radical changes in postgraduate medical education, including some that may lead to a large number of junior specialists who have completed a limited training within their specialty and then remain at this "health service consultant" grade for an unlimited time. They also support the idea of a single training grade.

The collegiate trainees committee of the Royal College of Psychiatrists, which consists of elected representatives from all regions in the United Kingdom and Ireland, has represented the views of trainees in this specialty since 1979. Perhaps the college's willingness to have trainee representation on its committees may have contributed to the development of psychiatric training schemes that already have weekly continuing education, approval teams of which a trainee is a part, and reciprocal assessment of trainer and trainee, as well as firm recommendations for the duration and structure of each phase of training. Through such mechanisms individual posts and individual trainers can be "disapproved." The collegiate trainees committee recognises the need for continual efforts to improve training, particularly in matters such as career guidance.

The collegiate trainees committee recently discussed both option 4 and its own submission to the chief medical officer's working group. The collegiate committee, which represents 8-10% of hospital junior doctors, in no way supports the Junior Doctors Committee's proposals. Their implementation would lead not only to no improvement in psychiatric training but also to a possible decline in standards and potentially to more "stuck" doctors who would not have the benefits of being "trainees." The collegiate trainees committee believes that the current duration of training in the specialty to become a consultant (six and a half to eight years) is about right and that the different grades of trainee are essential to enable subspecialty training. There are clear differences in the structure and goals of general psychiatry training and higher training at the senior registrar grade. In its submission to the chief medical officer's working party the collegiate trainees committee supports many of the proposals outlined in "option 1" detailed by the working party.

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1 Beecham L. Junior doctors and specialist medicine. *BMJ* 1992;305:836. (3 October.)

EDITOR,—As the debate on specialist training progresses, misunderstandings have grown up that the Junior Doctors Committee might jettison "the long term quality of [doctors'] careers for short term advantages in becoming specialists more quickly."¹ The mandate of the committee for developing policies on this issue has been questioned.²

Junior doctors have been foremost among the crafts of the BMA in applying the democratic process to this debate. The quality and duration of training have been adopted as leading issues for the 1990s, and thus the committee was well placed when the European Commission's infraction proceedings prompted the formation of the chief medical officer's working group.

All junior doctors in Britain, whether members of the BMA or not, are represented through the Junior Doctors Committee, which consists of elected representatives from the regions and nations of the United Kingdom. The committee debated specialist training in June this year, as did the annual conference of junior doctors the next day. While these resolutions determined the course of events through the summer, a special conference devoted entirely to specialist training was held in September.³ All junior doctors had the opportunity through their regional or national Junior Doctors Committee to send motions to that special conference or to be elected as a representative. Dr Edwin Borman, who has been associated prominently with the committee's policies on specialist training, was re-elected chairman of the committee the next day.

The reforms that the Junior Doctors Committee is proposing are those that will be best for junior doctors. Existing agreements between training and specialist grades, such as *Achieving a Balance*, retain their fundamental importance, and the profession will not accept a solution that does not reduce the current time between registration with the General Medical Council and specialist recognition. Reform at any price is not being pursued.

But what of the newly recognised specialist? Perhaps inevitably, many juniors on the brink of appointment as a consultant, after far too long slogging through the training grades, feel that there is more to lose than to gain from reform of the system. These concerns are shared by the Junior Doctors Committee, which is committed to maintaining the status of consultants while recognising, as do the Department of Health and most other parties, that the present process of recognising those suitable for appointment as a consultant contravenes certain laws.

R R Turnock proposes a referendum.² The Junior Doctors Committee's policy has been formulated with scrupulous attention to the diversity of views among the nearly 30 000 junior doctors. It is not usually appropriate to hold a referendum during an evolving process; the time and question must be chosen carefully. The Junior Doctors Committee's submission to the chief medical officer's working group is but a step on the path, and when the secretary of state for health releases her views in the new year I will be among those arguing that every junior doctor in the country should be asked whether the proposed course of action is acceptable.

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- 1 Kisely S, Morriss R. Specialist training. *BMJ* 1992;305:1021. (24 October.)
- 2 Turnock RR. Specialist training. *BMJ* 1992;305:1021. (24 October.)
- 3 Beecham L. Junior doctors and specialist medicine. *BMJ* 1992;305:836 (3 October.)

EDITOR,—I have followed with interest Stephen Brearley's editorial,¹ subsequent correspondence in the *BMJ*,² and Calman's letter.³ I graduated in France, wrote an MD thesis on the free circulation of doctors within the European Community,⁴ and successfully pursued postgraduate training in England.

On the continent most specialists practice from their own premises, performing mainly outpatient procedures. A minority are hospital based, achieving promotion to the equivalent of an NHS consultant after several years' experience. Most specialists on the continent have not faced the competition for the senior registrar grade or required research publications, a second qualification, etc. Many patients are treated in the private sector and not exposed to specialist trainees in public hospitals.

Nowhere else than in Britain do trainees face such a wide clinical exposure and so many weekly working hours,⁵ and the European Commission is aware of this.^{6,7}

The directives define only the minimal criteria for the purposes of free circulation; member states are free to impose higher training standards.⁷ The United Kingdom is not out of line by using a consultant led system. However, the new GMC register denoting accredited specialists might discriminate against "consultant grade" specialists wishing to migrate to the United Kingdom.

The purpose of the EC directives was to facilitate the free circulation of doctors within member states by defining certificates and minimum periods of specialist training (three, four, or five years). European specialists can apply for senior registrar and consultant posts in Britain. The directives do not oblige the United Kingdom to convert from a consultant led to a specialist system. In question is the access to private practice, only accessible to the consultant grade in the United Kingdom.

Specialist manpower and quality of training was not covered by these directives. Unemployment of doctors on the continent is alarming (France 6%, Germany 8%, Italy 17.3%) but rare in the United Kingdom (0.3%).⁵ In Germany, the Netherlands, and Spain the numbers of medical students are related to the capacities of medical schools rather than to manpower needs.³ Royal colleges responsible for standards and structure of training do not exist. Therefore a wide variation exists in the quality of specialists, although the European Commission has stated that it was not aware of any complaints.¹⁰

I do not believe that the majority of specialist trainees in the United Kingdom wish to change the consultant led system. The solution lies with the expansion of the consultant grade, proposed by *Achieving a Balance* and by Baigrie and Reed in their letter.² A properly organised, continually assessed and audited specialist training programme could be considerably shorter, resulting in better trained specialists in the United Kingdom. However, neither the directives nor the treaties of Rome or Maastricht oblige the other member states to follow—as has been recently shown by our dealings with the exchange rate mechanism.

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- 1 Brearley S. Specialist medical training and the European Community. *BMJ* 1992;305:661-2. (19 September.)
- 2 Correspondence. Specialist training and the EC. *BMJ* 1992;305:887, 1021-2. (10, 24 October.)
- 3 Calman KC. Specialist medical training in the UK. London: Department of Health, 1992. (PL/CMO(92)13.)
- 4 Mascarenhas LJ. Consequences de la libre circulation des médecins dans la CEE [dissection]. Tours: Medical Faculty, 1986.
- 5 Brearley S. Medical manpower. *BMJ* 1991;303:1534-6.
- 6 Comité Consultatif Pour La Formation Des Médecins. *Rapports, avis et recommandations adoptés par le comité du 6 Avril 1979 au 31 Décembre 1984*. Commission des Communautés Européennes 1985. (III/D/1003/85-FR.)
- 7 Cresson E. Question écrite No 816/79 à la Commission des Communautés Européennes. *Journal Officiel des Communautés Européennes* 1978; No C 107/9. (8th May.)

EDITOR,—A J K Frew is mistaken in asserting that senior registrars appointed as consultants are automatically accredited on the basis that they satisfied an appointment committee.¹ Frew may be confused by two factors: firstly, the relevant college may accept up to three months of a consultant appointment as creditable; and, secondly, it is usual to give three months' notice after accepting an appointment. Thus an unaccredited person might legitimately be appointed up to six months short of his or her accreditation date and, in due course, receive a certificate of accreditation without any "foul play."

Frew also alludes to the difficulties of obtaining accreditation for those in academic posts. In