Training

Career intentions and prospects of basic surgical trainees in the Northern Region of England

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Objective: To determine the seniority and career intentions of doctors in posts recognised for basic surgical training in the Northern Region of England and to relate it to the number of specialist registrar posts available.

Methods: Postal questionnaire to and telephone interviews with 270 doctors. The main outcome measures were: demographic details, career stage, and intentions regarding subspecialties of choice.

Results: Of the post-holders, 171 (63%) intended to pursue a surgical career and, of these, 69% (118/171) were graduates of British universities. Of these 171, 28% (48) were uncertain of their subspecialty of choice and 10% (17) intended to work abroad. The overall ratio for SHO:SpR posts was 1.6:1 for this region and 40% of all basic surgical trainees were in favour of a specialist training programme after PRHO.

Conclusions: Planning for surgical training and workforce needs to be supported by information about trainees' career plans and prospects.

Key words: Basic surgical trainees – Career intentions – Prospects

Calman reforms aimed for a seamless transition from basic surgical training to higher surgical training and were envisaged to offer a shorter, more organised and certain career path.¹ However, the training of basic surgical trainees (BSTs) is less well structured than that of specialist registrars (SpRs).^{1,2} There is no mechanism to identify surgical trainees, to perform a co-ordinated appraisal or to match their training with SpR posts in their chosen specialties. This survey aimed to determine the career intentions and seniority of BSTs in the Northern Region and evaluate the discrepancies existing between their numbers and those of SpR posts.

Methods

All posts approved for basic surgical training by The Royal College of Surgeons of England in October 2001

were identified. Each trainee occupying a post was sent a questionnaire and non-responders were followed up by telephone interviews. The questionnaire requested demographic details, year and place of graduation, intended subspecialty, final intended country of work, progress in the MRCS examination and their views or suggestions on training.

Results

Response rate and post details

There were 270 college-approved posts in the Northern Region in November 2001. The response rate was 88% (239/270). Of the 31 non-respondents, 10 were doctors in accident and emergency posts, 6 posts were vacant and

Figure 1 Career choice of trainees in the Northern Region of England.

Figure 2 Number of qualified BST to SpR posts.

the other 10 trainees were not contactable. Four posts were staffed by locums and one trainee was on sick leave.

Overall, 171 (63%) intended to pursue a surgical career. BSTs comprised 86% of SHOs in non-accident and emergency posts and 31% of accident and emergency post-holders. Out of all 171 respondents, 19 (13%), 84 (56%), and 47 (31%) of trainees decided to do surgery while still in school, medical school and as a PRHO, respectively, with no data recorded from 21 (15%) of the trainees.

Career progress

In assessing career progress and plans, trainees were asked whether they had passed their MRCS examination, had chosen their specialty and the intended final country of work. Graduates from British universities made up 64% of the trainees. Only 49 respondents (28%) had obtained their MRCS examination and were thus eligible to apply for SpR posts.

Figure 3 Job ratio (number of qualified BSTs to 1 available SpR post). The overall job ratio for the Northern Region of England was 1.6:1.

Ratios for the number of BSTs eligible for SpR posts in the Northern Region to available posts were calculated as shown in Figure 3, assuming there are equal numbers of posts each year for a 6-year higher surgical training programme. The overall ratio for the region is 1.6:1. Five out of the 49 post-MRCS BSTs were still uncertain of their career intention.

All BSTs were also asked if a specialist's training programme after PRHO would help in career progression. In all, 129 BSTs provided feedback on this with 40% supporting a specialty-training programme immediately after house jobs. The main reason cited against such a programme was uncertainty of career choice.

Discussion

Surgical training involves a year of PRHO followed by 3 or 4 years as SHO in basic surgical training. After completion of the MRCS, trainees may spend 1–2 years in research before their 6 years of SpR training. When the Calman system was introduced, surgical training in the UK underwent significant changes. Its implementation moved the hurdle in career progression to BST/SpR level and the ensuing discrepancy created the 'SHO bulge'. SpR training is now well structured but, in comparison, basic surgical training remains less well structured and there has been no attempt to match BST numbers to the SpR posts likely to be available. It has become increasingly apparent that there is a significant discrepancy between the number of basic surgical trainees seeking type 1 higher surgical training programmes and the number of those programmes available for appointment.² The extent of this discrepancy within the Northern Region was assessed in this survey. Data from The Royal College of Surgeons of England² showed that, for the year 2000/2001, the national

overall ratio of SHO:SpR posts was 4:1, while from this survey it showed that for the Northern Region it is 1.6:1 with 49 SHOs eligible to apply for SpR posts. It should be noted that differences exist within different specialties and the imbalance seem to be increasing each year.²

The regional and national figures quoted only include basic surgical trainees in recognised SHO posts. They do not include trainees seeking type 1 programmes who are currently in career grades, locum, or other non-training posts, engaged in research or have gone abroad to obtain further training.² This survey found that many surgical training posts were filled either by non-surgical trainees (e.g. ENT posts occupied by GP trainees) or BSTs who had rejected a surgical career. Clinical fellow posts are also an increasing potential problem as creation of such posts increase the number of trainees needing SpR posts. This survey showed a pattern which was also found in other regions, with better SHO:SpR ratios in a few different specialties in this region compared to others.

Female trainees made up 31% of the respondents. An earlier survey carried out on medical students in this region recorded up to 40% of them rejecting a career in surgery³ with perception of male bias and negative attitude cited as reasons. There was still a major imbalance between sexes and this may be set to continue with increasing numbers of female graduates.

Foreign graduates occupied a significant proportion of posts (53 [31%]) in the region and this was consistent with the 1995 NHS figures quoting that nearly 30% of its workforce⁴ were from overseas. Although there was an overseas doctors' training scheme available, places were limited. Calman reforms with its accompanying resorption of higher surgical training posts reduced these further.⁵ With a more stringent entry requirement, it became more difficult for foreign doctors to obtain type 1 higher surgical training posts.⁴ In this survey, the majority (29, or 52%) of them intended to remain in the UK and this would continue to increase the SHO bulge, further contributing to increase or continue the existing SHO:SpR posts' discrepancy.

This survey recorded many different opinions on BST training. Of all trainees, 40% were in favour of a long specialty programme immediately after PRHO. Some well-structured programmes commencing immediately after PRHO have been started in some subspecialties in other

regions, e.g. the Basic Orthopaedic Specialty Training Programme in Bristol.⁶ We should also consider adopting a fairer selection process in appointing new SpRs, such as introducing a graded MRCS examination where the top-rated candidates are allocated available SpR posts.

Recommendations

An in-depth assessment of the whole structure of surgical training and workforce should be conducted to help match the number of BST and SpR posts. BSTs must be aware of the discrepancy in SpR numbers and would greatly benefit from career guidance. We should consider introducing, at a national level, an integrated or a more structured basic surgical training programme based on subspecialties for senior BSTs. A fairer method to appoint SpRs (e.g. a graded MRCS examination) should be adopted.

Conclusions

Many posts recognised for surgical training do not contain trainee surgeons. There are too many BSTs for all of them to gain SpR posts. Surgical training resources could be focused on a smaller number of posts that contain BSTs and the imbalance in job numbers needs to be addressed.

References

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