CHANGES IN UK ORL-HNS TRAINING SCHEME: DOES THE INDIAN TRAINEE HAVE A PLACE ANYMORE ?

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Abstract: The determination of the UK Government to modernise medical careers, the shortage of training jobs for local medical graduates, the establishment of the Postgraduate Medical Training and Education Board (PMETB) and European Union rules have combined to change the scheme of surgical training in the United Kingdom. In the opinion of the author, the Indian Otorhinolaryngological (ORL) trainee can no longer aspire to reasonable higher training in the UK.

Keywords: Training, Otorhinolaryngology, Head & Neck Surgery

INTRODUCTION:

A large number of Indian medical graduates go to the UK for higher training; traditionally the Fellowship of the Royal College of Surgeons has been perceived to be an indicator of having received good surgical training. In the past year, however, significant changes have occurred in both the UK surgical training scheme and immigration law. This article looks at these changes, and the impact they may have on the Indian ORL trainee aspiring to higher training in the UK.

CALMAN:

The scheme of surgical higher training in the UK underwent significant change following the publication of the Calman Report in 1993^{1,2}. From October 1999, no UK medical graduate could appear for the old FRCS examinations (General Surgery, Otolaryngology, Ophthalmology). The training scheme was reorganised into Basic Surgical Training (BST) and Higher Surgical Training (HST). The old system of Registrars and Senior Registrars was abolished, replaced by a structured 6 year Specialist Registrar (SpR) post³, with an Intercollegiate FRCS exit examination in the 5th year⁴, followed by the award of a Certificate of Completion of Specialist Training (CCST) by the Specialist Training Authority (STA). Training was deemed complete, and the certified specialist could then apply for a Consultant post.

It was recognised, however, that, with the limited number of SpR jobs available each year, a growing number of junior doctors were spending several years at the SHO level – the so-called ‘Lost Tribe’.

PMETB:

In 1997 the Labour Party came to power in the UK, and the new Prime Minister Tony Blair made reform of the National Health Service (NHS) a central goal of the new administration. With the growing cost of healthcare it was felt that, compared to other European nations (with arguably better healthcare systems), the UK was overtraining its new Consultants. In the ORL-HNS context, was it really necessary for each and every SpR to be trained in complex micro-ear surgery, paediatric airway reconstruction or head and neck surgery? The argument was advanced that the District General Hospital Consultant needed

only to be trained in ‘general’ ORL, with complicated cases to be referred to a small number of tertiary centres.

In 2003⁵ the Department of Health came out with a proposal, ‘Modernising Medical Careers’ (MMC), ostensibly to reform basic medical and surgical training, but in actual fact completely reorganising basic and higher training.

With public confidence in the medical profession shaken by the Bristol and Alder Hey scandals, and the ability of the GMC to safeguard patients called into question by the Shipman affair, the Government set up a new body – the Postgraduate Medical Education and Training Board (PMETB) – by an Act of Parliament in 2003, ‘to set standards for postgraduate medical education and training and to ensure that the standards are met’. On 30th September 2005 PMETB took over the role of the STA, and the CCST was replaced by the Certificate of Completion of Training (CCT).

MODERNISING MEDICAL CAREERS:

MMC has been in effect since 2005, and will completely replace the previous surgical training scheme in August 2007. Under the new system, the newly-qualified medical graduate will enter a two year Foundation training rotation. This will comprise six four-month rotations, which may also include para-clinical specialties. In the course of the FY1 (Foundation Year 1) and FY2 rotations, the trainees will learn generic clinical skills transferable across all specialties. Although several Foundation schemes have been piloted since 2005, the plans remain uncertain and controversial, with many clinicians unhappy that the selection process is neither evidence-based nor robust. The trainee who wishes to become a surgeon will then do an Intermediate year of surgical rotations, although for the aspiring ORL trainee this may not be necessary. The trainees will then be allotted to specialist training by some form of competency assessment – the MRCS examination, though desirable, will not be a necessity.

There will then be several years as a Specialist Trainee; originally it was to be 4 years (ST1 to ST4), but the Surgical Royal Colleges have all protested that this is too short a period, so it may well remain 6 years⁶. The intercollegiate FRCS will remain as an exit

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examination; the trainee will receive a CCT, and will be judged competent to become a general ORL Consultant. If the trainee wishes to become, for example, a Skull Base Surgeon, he/she will have to do one or two years of post-CCT Fellowship training, the details of which are still unknown.

UK TRAINING AND THE INDIAN OTOLARYNGOLOGIST:

Most Indian newspapers have carried articles referring to the sudden change in UK immigration law which could potentially result in several thousand junior doctors from the Indian sub-continent having to leave the UK. Until 2006 foreign medical graduates did not require a work permit to work in the NHS at the SHO and registrar level, as this was held to be training. This was suddenly changed because of the growing number of UK medical graduates who are finding it difficult to obtain jobs. The Department of Health has informed all Hospitals that any doctor they employ who is not a UK or European Union (EU) graduate will now require a work permit. Moreover all NHS Trusts were told that they could only employ foreign medical graduates if they could not find a suitably qualified UK or EU candidate, and this would have to be confirmed in writing. Not surprisingly it has become extremely difficult for the Indian medical graduate to secure a training post in the NHS. The British Medical Association has voiced fears that, under MMC, thousands of UK medical graduates may fail to obtain training posts too. Faced with increasing criticism, the GMC has suspended the PLAB test until 2007.

It is apparent that the traditional route followed by the Indian Otolaryngologist to obtain higher training in the UK no longer exists. At present there is no direct entry into the ST years for them. Under the MMC scheme, the Specialist Trainee will receive between four and six years of training in 'general' ORL. With the European Working Time Directive (EWTD) limiting trainees to working 40 hours a week, there are real concerns as to the actual quality and quantity of surgical training that will be possible⁶. A small number of British ORL Departments have an Overseas Fellow post, usually offered to trainees from Australia, which provides a year of focussed specialist training. The Indian candidate will still require a work permit, and, if the PLAB remains suspended, the only way of obtaining GMC registration will be to sit either the MRCS or DOHNS (the successor to the old DLORCS) examinations.

Indian ORL trainees have a reputation for high standards in the UK⁷. The AOI is in a unique position to catalyse changes in Indian ORL training (e.g. exchange programmes for MS students, post-MS Fellowships); in the so-called 'Asian' century, Indian ORL trainees should take advantage of the excellent training available in centres across the country rather than embark on an increasingly uncertain and expensive attempt to obtain higher training in the UK⁸.

DISCLAIMER:

Although reasonable care has been taken to provide accurate information, readers are referred to the list of links below for the latest rules and regulations.

USEFUL WEB LINKS:

Postgraduate Medical Education and Training Board
<http://www.pmetb.org.uk>

General Medical Council
<http://www.gmc-uk.org>

Royal College of Surgeons of Edinburgh
<http://www.rcsed.ac.uk>

Royal College of Surgeons of England
<http://www.rcseng.ac.uk>

Royal College of Physicians and Surgeons of Glasgow
<http://www.gla.ac.uk>

British Association of Otorhinolaryngologists, Head & Neck Surgeons
<http://www.ent-uk.org>

British Medical Association
<http://www.bma.org.uk>

REFERENCES:

1. Department of Health (1993) *Hospital Doctors: training for the future, in Report of the Working Group on Specialist Medical Training*. DOH, London
2. President of the Royal College of Surgeons of Edinburgh (1995) *Surgical Training after Calman*. Newsletter of the Royal College of Surgeons of Edinburgh, 42, 1 – 4
3. Department of Health (1996) *A Guide to Specialist Registrar Training*. DOH, London
4. Maran A.G.D. (1992) *The intercollegiate assessment – 'the third part'*. *Clinical Otolaryngology* 18, 97.
5. Department of Health (2003) *Modernising Medical Careers: The response of the four UK Health Ministers to the consultation on unfinished business*. DOH, London
6. Chikwe J, deSouza AC, Pepper JR (2004) *No time to train surgeons*. *BMJ* 328: 418-19
7. Personal communication
8. Khan S A (2006) *The Way I See It*. *BMJ Careers* 333:66

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