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College Tutors' Seminar

The College Tutors' Seminar was held at the Royal College of Physicians on 3 March 1994

Current affairs

Professor Sir Leslie Turnberg (President, RCP) reminded College Tutors that the far reaching changes imposed on the Health Service will have an impact not only on medical education but also on the workload and necessary commitment of the tutors at grassroots level.

Although the Calman report *Hospital doctors: training for the future* has been accepted by government, no new resources will be allocated to implement its proposed changes. It is envisaged that these changes will take place slowly enough to allow them to be funded by a shift of resources from within the Health Service itself; yet the timetable set out in the report is relatively short.

The planned demise of the regional health authorities and the relocation of postgraduate deans also creates as yet unresolved problems. It is unclear whether the deans will become responsible to the regional offices of the Medical Executive (ROME), to the head office of the Medical Executive (HOME), or to the universities. The College itself sees a need to strengthen its own involvement at regional level and a proposal has been made to the NHSME at regional level that there should be 'regional chapters' comprising several Colleges.

The President also touched on the plight of SHOs, their need for a core curriculum and the benefits of protected formal education time. This last issue stimulated a lively discussion during question time.

Implications of the Calman report

Professor Brian Pentecost (Linacre Fellow of the RCP) described the effects of the Calman report on shortening the period of higher specialist training and reducing the number of doctors in training. To achieve these aims, the new combined registrar/senior registrar grade trainees would require more structured training programmes supported by specific curricula

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devised, monitored and assessed by the 26 specialist advisory committees (SACs) of the JCHMT. No new exit examination is envisaged. On starting higher training, each trainee would be given a unique national training number; once the trainee has been awarded the certificate of completion of specialist training (CCST), this number would be handed on to the next trainee after a *reasonable* time. The fate of the accredited trainee who has not obtained a consultant post within this time remains unclear, as does the place of research within the new scheme.

SHO education and training

John Temple (postgraduate dean for the West Midlands region) saw his role as a purchaser of education and organiser of local programmes; he regarded the Colleges as standard setters and inspectors. By giving him one half of the SHOs' training budget, the Department of Health (EL92(63)) had enabled him to prescribe changes in the structure of training and its assessment through education contracts with individual units and Trusts. He emphasised the role of educational supervisors and anticipated that not all consultants would be trainers. The service implications for consultants without trainees and the possibility that some service departments currently employing SHOs might lose training status, were highlighted.

Study leave arrangements may also see changes. If all SHOs within the region were to take the full 30 days study leave entitlement its funding would have to be increased sixfold. Savings could be made by developing more locally based programmes, thereby reducing the costs of travel, subsistence and locums.

Associate College Tutors

Dr James Ahlquist (Chairman, Standing Committee of Members of the RCP) pointed out that, following discussions at last year's College Tutors' meeting, there are now between one and two hundred Associate College Tutors. Their role is to represent trainees at the College, to help the College Tutor relate to trainees in the district, to assist the College Tutor in his/her work for the College and themselves to gain some experience in training, education and manpower issues.

Associate Tutors should intend to pursue a career as a physician and should be a registrar or perhaps, where appropriate, an SHO. Their appointment, which should be for a minimum of a year, should reflect both the wishes of the trainees in the hospital and those of the College Tutor.

The College intends to convene a meeting of Associate College Tutors to discuss concerns pertinent to those in the training grades, such as the Calman report.

Training in internal medicine in the army

Professor Lt Col M J World (Royal Army Medical Corps, London) remarked that, in contrast to civilian medicine, attendance at educational and training activities in the army is almost always 100%. In principle, no matter in which specialty a military physician may ultimately be trained, he will primarily be a proficient intensivist. In addition to basic military training, all medical officers receive training in military, tropical, nuclear, biological, chemical and war medicine and surgery. After registration and the first two years as a regimental medical officer (RMO), the medical officer (MO) is expected to pass the first part of the MRCP(UK) examination before proceeding to general professional training (GPT). This begins with 12 months of acute medicine with duties in accident and emergency, intensive therapy and coronary care units in the Cambridge Military Hospital, Aldershot. It is followed by rotations every four months through gastroenterology, respiratory and renal medicine. All MOs spend four months in the intensive therapy unit of the Brompton Hospital, London, before moving to the Queen Elizabeth Military Hospital, Woolwich, where they gain experience in management of complicated 'cold' cases during rotations, every four months, in cardiology, hepatology and neurology/endocrinology. Higher professional training (HPT) lasts four years and is in general internal medicine with another specialty. Training is decided by the relevant SAC in conjunction with the department of army medicine and the Linacre Fellow (RCP, London). Training in gastroenterology, cardiology and respiratory medicine is shared between military and civilian hospitals, while training in other specialties is accomplished in civilian units only. Research for MD is encouraged. Consultant appointments are made by the Armed Services Consultant Approval Board (ASCAB) which is chaired by the President of the Royal College of Physicians.

Overseas training schemes

Sir Eric Stroud (Director, Overseas Office, RCP) explained that the Overseas Doctors Training Scheme allows individual consultants to sponsor an overseas doctor to work in this country without sitting the Professional Language Assessment Board (PLAB) examination. As PLAB has a high failure rate, the GMC has expressed its concern to the College as to whether the standards of overseas doctors coming to the UK on individual sponsorship are as good as those of doctors who enter the UK directly and have passed PLAB. To meet the GMC's concerns, the Overseas Department at the College will coordinate all overseas doctors' training. It would greatly help the Overseas Department if it could receive short biographies of overseas doctors notified to it by individual consultants or of those who had achieved a higher medical qualifi-

cation abroad, particularly in the presence of a British external examiner.

Consultants with good training programmes seeking an overseas doctor, or those with knowledge of an overseas doctor who wants to work in this country, should contact the Overseas Department at the College.

Continuing medical education

Dr Peter Toghill (Director, Continuing Medical Education, RCP) said that medical disasters, widely reported in the media, act as reminders of the importance of continuing medical education (CME) for consultants, staff grades and others. Some Royal Colleges have already initiated programmes of CME while others are setting up pilot studies.

The Royal College of Obstetricians and Gynaecologists launched its scheme in January 1994: consultants are expected to acquire 200 credits over five years; the credits can be accumulated at a rate of one per hour for participating in various activities. After five years the College will publish the names of those with 200 credits on a roll of trained specialists. The Royal College of Radiologists has had a voluntary scheme since January 1994: consultants accumulate points for attending meetings. The Royal College of Physicians also recognises the importance of CME and published its scheme in April 1994. In a recent survey 96% of consultants gave lack of time and heavy clinical load as reasons for not attending educational activities. The UK has fewer doctors per 1,000 population (1.4) than Canada (2.2), Switzerland (2.9), Norway (3.1), Spain (3.8) and other Western countries. Allocation of two hours per week for CME, though a modest target, should be comfortably achieved. The bulk of CME will take place in clinical units or wherever physicians practise medicine and will be known as internal CME. Meetings, symposia and conferences organised by the RCP, Royal Society of Medicine and other specialist societies and associations will be known as external CME and will be eligible for study leave. Physicians may choose elements of the CME programme that are relevant to their needs.

Some specialist societies are already taking the lead by setting up programmes of CME which will extend over a three to five year period and comprehensively cover their specialty. The RCP does not want CME to be made mandatory but it should be encouraged. Finding the time and making funds available are predictable obstacles posed by NHS Hospital Trusts. They need to be reminded that a good hospital can only function with good, up to date and efficient doctors. The RCP will fight for more money to be made available.

College census submission to JPAC

Professor Stephen Semple (Director, Manpower, RCP) said that it is essential for the College to have accurate records of the numbers of consultants, senior registrars and registrars from each medical specialty for its discussions with JPAC on the implications of reducing higher specialist training to four years on registrar and consultant numbers. Comparisons of figures from JPAC, the Department of Health and previous College censuses have revealed gross discrepancies, particularly in registrar numbers. It is hoped to improve the accuracy of the College numbers by asking consultants in individual medical specialties to let him know how many registrars they have in training, including those in research and academic posts. It is therefore essential for consultants to reply to the 1993 census and to subsequent requests for accurate numbers of registrars.

How many medical beds should there be in a district general hospital?

Dr G V Williams (Northern Region) investigated the acute medical bed situation in the Northern Region overall and looked in detail at the Gateshead medical services. The number of beds relative to the hospitals' catchment areas varies widely between the district general hospitals (DGHs). In Carlisle and Sunderland there are over 2,000 residents for each bed compared with around 1,200 in North West Durham. Junior staffing levels (SHOs) in different DGHs also vary greatly. The number of beds per junior doctor varied from around 30 in Northumberland to 10 in South Tees. A DGH seems to be able to manage with fewer beds if it has relatively more doctors in training; otherwise it is risky and difficult to maintain emergency medical admissions without reducing standards of care. The standards need to be set with regard to the number of acute medical beds, junior doctors and catchment population. Dr Williams concludes that a DGH should have slightly more than one acute bed for about 700 of the resident population and 16 beds per junior doctor.