Higher specialist training in accident and emergency medicine—past, present and future

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Abstract
Objective—To assess the quality of accident and emergency (A&E) medicine higher specialist training as perceived by current trainees and those who have recently completed training.
Methods—Postal questionnaires to three groups of A&E specialists either currently in training or having recently completed training.
Results—Levels of satisfaction were generally high. Previously identified deficiencies in management training remained and the implementation of guidelines regarding formative assessment and time for study and research was inconsistent. Conclusions—While clinical training is largely satisfactory, areas where higher specialist training could be improved have been identified. Continued development is necessary to meet the challenges of the new specialist registrar grade and opportunities and threats to training in the future are proposed and discussed.

Keywords: accident and emergency training; education.

After many years in which the postgraduate training of doctors to consultant level received little attention, the recent years have seen proposals for radical change to specialist medical training. Restrictions have been placed on the hours worked by junior doctors and the threat of infraction proceedings under European Community law led to government ministers establishing a working group on specialist medical training which produced its report, Hospital doctors: training for the future, in 1993.

The history of higher specialist training (HST) in accident and emergency (A&E) medicine is relatively short. The first A&E consultant posts were established in 1972 and senior registrar training schemes were inaugurated in 1977. Since that time training has evolved rapidly. There is currently an attempt to produce rapid consultant expansion that has been limited by a failure to first expand training posts. There is a temptation for trainees to take up consultant posts before the end of their training.

In many ways the proposals in Training for the future mirrored the course of action already taken by A&E for a shortened period of HST following general professional training. It is recognised that in order to maintain educational standards a more structured and intensive programme of HST is necessary. Against this background it seems appropriate to review the current state of HST in A&E.

In this paper we assess the quality of training in A&E as perceived by recent and current trainees and discuss potential improvements to the current schemes.

Methods
Three groups of trainees and former trainees were asked to complete questionnaires regarding aspects of their training.

(1) Adequacy of recently completed training
Postal questionnaires were sent to 42 consultants in A&E medicine who had been appointed to senior registrar posts within two years of the study. This study examined satisfaction with training in specific clinical, teaching and managerial skills at the end of training. Attitudes towards research as a component of HST was also assessed.

(2) Current registrars—quality training?
To assess the views of new entrants into HST, a list of registrars in A&E was compiled with the help of the Joint Committee on Higher Medical Training and the British Accident and Emergency Medicine Trainees Association (BAETA). A total of 110 questionnaires were sent out in early 1995. Respondents were asked to express their views on the quality of their training, including clinical skills and management. The allocation of protected study time and availability of study leave was also examined.

(3) Training—supervision, assessment, and appraisal
In order to assess the overall level of supervision to all trainees a questionnaire was circulated to registrars and senior registrars in A&E by regional representatives of BAETA. The relationships of the trainee with their trainer and educational supervisor and the occurrence of annual reviews of the trainee and appraisal of the training post were assessed.
Higher training in A&E

Figure 1 Quality of clinical training overall (All), in A&E and secondment specialties general medicine (Med), anaesthetics (Ana), ophthalmology (Eye), gynaecology (Gyn), and psychiatry (Psy); 38 replies from newly appointed consultants.

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Results

Adequacy of recently completed training

Of the newly appointed consultants, 38 out of 42 returned questionnaires from a single mailing. Most (68.4%) had accredited or expected to be awarded accreditation in A&E. Most respondents were satisfied with their clinical training in general and secondments to major specialties. Training in the non-essential secondment specialties was, however, thought to be less satisfactory (fig 1).

Most of the newly appointed consultants (85.7%) had participated in formal management training courses. Most of these courses were regionally organised for trainees from a broad spectrum of specialties. A minority had attended a management course specifically for A&E trainees (36.8%). Despite this, many felt unprepared to deal with management problems when they took up post (fig 2). Suggestions from respondents for improvements had a common theme of increased day to day involvement in management by trainees shadowing their consultants.

Teaching is recognised contractually as an important part of an A&E consultants’ role; however, only just over half the consultants had received some formal training in teaching methods (56%). This had occurred, with only one exception, as instructor training for life support courses.

Most respondents (70.1%) thought that the production, publication, and presentation of research was an important component of training in A&E. The major factors restricting research activity were thought to be lack of practical help (secretarial and statistical) and lack of leadership in research locally. Less than a third had received any formal instruction in study design and data evaluation.

Current registrars—Quality training?

In the study of registrars, 68 completed questionnaires were received out of a total of 110 (61.8%) distributed. Two replies were excluded as the respondents were already senior registrars. Information was therefore available on 66 out of the 102 filled registrar posts (64.7%).

Most registrars expressed satisfaction with their training in general (80.3%), three being dissatisfied and the remainder undecided. However, 20 (30.3%) were unhappy with the amount of training offered in management and administrative matters.

Forty nine respondents (74.2%) stated that they typically had a full or half day of protected study and research time per week. Most had been able to obtain paid study leave with expenses particularly to attend life support courses.

Training—Supervision, Assessment, and Appraisal

Fifty six replies were received from registrars and senior registrars. Most trainees knew who their trainer was (89.1%) but few knew the identity of their educational supervisor (21.4%). A formal interview or discussion of the trainee’s progress had taken place for 83.8% of the trainees within the past year; however, in two cases the trainee concerned was not present at the time. Less than half of the trainees (44.6%) had seen their trainer’s written report on their progress, and only nine (16.1%) had been asked to provide a written appraisal of the training programme.
Discussion
As with a previous study of A&E senior registrars in 1988, this study shows that most A&E trainees are satisfied with the training they receive. We have, however, found that current training schemes do not consistently comply with Specialist Advisory Council (SAC) recommendations on protected time for study and research. Training for the future calls for rigorous formative assessment of trainees; however, this practice has not at present been uniformly applied in A&E. Training and preparation for management is also identified as inadequate, showing no improvement over the situation in 1988 when “the positive views of clinical training contrast sharply with the administrative and managerial components”.

This deficiency is not unique to A&E.

The objectives of HST in A&E have recently been formally defined in the curriculum produced by the SAC in Accident and Emergency Medicine and the Faculty of Accident and Emergency Medicine. This document highlights specific areas of clinical practice but also recognises that skills in management, teaching, and research are required by the trained A&E consultant. This has been reinforced by the requirement for trainees to complete a log book that monitors progress towards the goals set in the curriculum.

Research as a component of HST is valued by trainees. However, lack of practical support and local expertise is thought to limit activity. Our results show that nearly 30% of recently appointed consultants did not consider that research was an important component of HST and would therefore have difficulty supervising their own trainees’ research. In this respect the recent initiative by the Faculty Research Committee to visit regions and advise on research projects is to be commended.

Many current problems facing A&E medicine are threats to the provision of high quality training. The consistent year on year increase in workload and shortage of senior house officer places pressure on trainers and trainees to accept more service commitment. Similarly the requirement for departments to provide more on site, out of hours middle grade or senior cover reduces opportunities for training. With the advent of trusts holding contracts for registrars, nationally implemented safeguards are needed to protect training time from pressure from trusts to provide service commitment to meet government targets.

While in the long term consultant expansion can only help the specialty, the recent rapid increase in consultant numbers in A&E has led to a decline in competition for posts and the ability to achieve consultant status before completion of training. This is viewed by many within the specialty as a threat to the quality of training. With the introduction of the requirement to possess a certificate of completion of specialist training before consultant appointment, this problem will disappear. In general, satisfaction with training in these surveys appears related to the content rather than to its duration. In improving the quality of training in A&E medicine, potential exists for the current training period to be better used.

There are, however, opportunities presented by the recent changes to improve the quality of A&E training further. The inauguration of the Faculty of A&E Medicine offers greater regulation of the quality of training. A curriculum has been set and, as of this year, success in achieving its goals will be tested by examination for fellowship of the Faculty.

The role of the trainer should be recognised and the skills required to perform this task developed in schemes similar to the “Training the trainers” courses now run by the Royal College of Surgeons of England.

The specialty of accident and emergency medicine has the opportunity to develop its higher specialist training further and to set an example of good practice to other specialties. Effective control of training standards by the Faculty and SAC is required to achieve uniformity of high standards nationally and the specialty should give these bodies its support.

A reputation for excellent higher specialist training will attract quality candidates for training and produce the consultants needed to advance the reputation and status of A&E in the next decade.

We are grateful to all our colleagues who participated in this work by completing and returning the questionnaires.

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