ORIGINAL ARTICLE

ASME proposals for reform of SHO training: threat or opportunity for the specialty of accident and emergency?

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A report is made on proposals for change in postgraduate medical training that may have profound implications for the specialty of accident and emergency (A&E). The proposals are detailed with their background and rationale, together with some of their possible effects on A&E.

The Association for the Study of Medical Education (ASME) is an organisation whose membership is comprised of educationalists and clinicians with a commitment to medical education and is an influential body in developing medical educational structures. Members include deans, (postgraduate, undergraduate, and general practice) and hospital clinical tutors, together with trainee and student members. In October 2000 a meeting of the Association was held entitled: *SHO training—time for reform*.

The delegates included representatives from the NHS executive, SCOPMED (Standing Committee on Postgraduate Medical and Dental Education) Colleges of Surgeons and Physicians, the GMC, the BMA, the UK medical careers research group and many deaneries, universities, hospitals and general practitioner tutors. Speakers included Professor Temple, chairman of SCOPMED and adviser on postgraduate medical education to the department of health.

Subsequent to this meeting a working party has been set up with the department of health to refine and develop reforms to SHO training.

It can be seen that this is an influential body and many of their proposals are likely to be implemented. The core of the proposal will profoundly involve A&E and affect our working practice.

PROPOSALS

A radical shake up of postgraduate medical structure is suggested by Calman, Temple, *et al* (1999), to produce a streamlined, planned career pathway from the end of the compulsory preregistration and "foundation" years. Further details of the proposals will be published by ASME and placed on their web site (www.asme.org.uk). They include the provision of a post-registration year, the Foundation year, comprising three 4 month periods in selected specialties designed to provide basic experience of a "core of acute care". Specialties suggested for this include general practice, A&E, and obstetrics and gynaecology.

This "Foundation" would lead to entry to competitively appointed, numbered SHO posts in specialty programmes, leading into the specialist

registrar (SpR) programme and together lasting a total of approximately six years and leading to Certificate of Specialist Training (CST), or to General Practice training. Movement in and out of such programmed training would be facilitated by acceptance of the concept of trainees spending time in non-career grade work, such as research, staff grade (or equivalent) positions, locum posts or work abroad (see figure 1)

A&E medicine has been proposed to form a part of the foundation year because of the need to have a grounding in acute care and decision making, in recognition of the specialty's role in teaching and its pivotal role at the interface of primary and secondary care. The proposals' proponents suggest that no extra posts would be necessary as the foundation SHOs would take the place of existing SHOs. Implementation of the proposals is intended to be "cost neutral".

THE RATIONALE FOR THE ASME PROPOSALS

Calman implementation has given greater structure to specialty training. However, entry into SpR training remains haphazard and variable. For both manpower factors and satisfactory career planning a structure is thought to be necessary. The concept of an intercalated SHO/SpR programme provides that structure. However, if this tramlined training is to be adopted then a broad background is essential, particularly in the assessment and management of the acutely ill patient. Medical students have less and less opportunity to take decision making roles and to manage sick patients. House officers are rarely involved in acute care and when they are the decision making is supervised or taken out of their hands. Hence this proposed "foundation" year.

BACKGROUND

(1) The Calman proposals for higher specialist training were implemented over the last years of the 20th century. These introduced a formal structure for SpRs, culminating with a CST recognised throughout the European Community. The former grades of registrar and senior registrar were eliminated. Practice of hospital medicine has changed after "Calmanisation". One feature that has been widely discussed has been the level of experience of trainees at both the SHO and the SpR grade.¹⁻¹⁰ Additionally consultant workload in terms of formal education, supervision, appraisal and assessment has increased while the service workload that can be expected from SpRs has diminished. This has put a huge burden on

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Figure 1 Flow chart for proposed SHO training.

consultants and has not been accompanied by Calman's anticipated increase in consultant numbers.¹⁻³

One consequence of implementing the New Deal for junior doctors has been a decrease in the level of experience gained by junior doctors becoming A&E SHOs over the past two to three years.^{1 6 7 9 10} In my experience and that of many colleagues this has led to the need for increased supervision and education. (Indeed we at the Lister Hospital have had correspondence with our deanery highlighting this problem and received the advice that we must ensure adequate support, supervision, and education).

Attitudes in hospital medicine are changing. The adage of "see one do one" is no longer tenable. In the post "Bristol" climate it is recognised that skills must be learned thoroughly and competencies assessed before undertaking clinical activities. "As regards patient care there can be no learning curve." (Barry Jackson, President Royal College of Surgeons). Expectation of education by junior medical staff has increased and they demand "on the job" teaching, formal protected teaching, and study leave.^{2 5-7 10-12} They are supported in this by the deaneries, by risk management policies and by the Academy of Royal Colleges and Faculties. For example, ATLS courses are considered almost mandatory for surgeons and anaesthetists in training. Patient expectations have also increased and this combines with the negative media representation that medicine has suffered to nurture a questioning and demanding attitude. Increased tendency to litigation goes hand in hand with this.

Changes in working hours and pay structures have been one factor in reducing experience. The new banding arrangements will no doubt lead to further amendments to SHOs' conditions of employment.

These factors make adequate education and supervision mandatory.

Additionally it has been recognised that consultant workload has increased and that its intensity varies.^{1 3 6 10} The new intensity payment may improve morale in this disillusioned body. However, with trainees now in a position to earn substantially more than their mentors the climate is not conducive to introduce more consultant based working to take on the necessary service commitment.

COMMENT

The inclusion of accident and emergency medicine in the proposed foundation year acknowledges the respect in which the specialty is held and we should be proud of this. However, I believe the proposals may pose a severe threat to A&E. Few specialties have such a high proportion of junior doctors who, in addition to experiencing service based learning and structured formal education, make a substantial proportion of the service contribution. In recent years consultant and middle grade numbers have expanded but SHOs remain the backbone of A&E. We find that junior doctors taking up A&E medicine

SHO appointments have over recent years become less experienced, less ready to take on responsibility and make decisions, require more supervision, and take longer to learn to usefully fulfil their service commitment.^{6 7 9 10}

Any senior and middle grade expansion has been absorbed to fill the gap created by such less experienced SHOs, who work fewer hours, and in increasing the provision of formal education with protected teaching, induction, appraisal, review, and final assessment of both SHOs and SpRs. The expansion has therefore failed to create anticipated improvement in A&E services, waiting times, and standards of care. We have turned to protocol driven care to attempt to provide a safe service, but this does not provide a substitute for experience.

Employing the same number of SHOs for four months would further erode experience and diminish service provision. If this were introduced it would not be possible to achieve the present standard of service with the same number of medical staff and without cost implications. If the year were to be compulsory we would also be faced with some juniors who were in post against their will, giving rise to attitude and cooperation difficulties in addition to the problems outlined above.

Perhaps now is the time to question whether it is right for juniors to carry out the majority of the care of A&E patients. The Royal College of Paediatrics and Child Health recommend that SpRs seeing patients in clinics discuss each case with the consultant. This is partly for educational benefit, but compare this situation, carrying out a planned assessment of a non-acute patient with consultant supervision at a relatively senior grade, with that of the more junior A&E SHO, seeing acute patients, with considerably less opportunity for supervision or discussion, with inherent pressures to manage the case him/herself, combined with time, space, and equipment limitations. Clearly the A&E situation is less than ideal or safe.

Calman training for SpRs was envisaged against a background of consultant expansion but was implemented before this expansion occurred.^{1 3 6 8 11} This has caused significant difficulty and much increased consultant workload. We should not accept this SHO reform as a cost-neutral plan. The four months attachment is unfeasible. The idea of running three induction courses a year and attempting to teach essential knowledge and skills, together with the obligatory appraisal and assessment, within four months, is daunting. The service element would diminish and such an arrangement would require the SHOs to be largely supernumerary. This can only be achieved after significant middle grade and consultant expansion. Indeed the numbers of SHOs may need to be reduced to ensure the quality of their learning and supervision during this foundation year. In addition we must continue developing the skills of other professionals such as emergency nurse practitioners. Should the posts be for six months the need for increased education and senior support will still demand increasing middle grade and senior input.

CONCLUSION

The proposed foundation year is not a practicable proposition unless it is preceded by senior and middle grade expansion and changes in the way service is delivered in A&E departments. We should not adopt what could be thought of as an expansion of Calman training without learning from our experience with implementation of the SpR grade and ensuring that the new framework permits us to provide quality care for patients. The specialty of A&E medicine should take this opportunity, while SHO training reforms are being discussed, of considering their workforce requirements. We should explore programmes that would be suitable for prospective A&E medicine SpRs and develop SHO rotations appropriate to the needs of the specialty. Service needs demand senior input to provide safe high quality patient care and we must ensure adequate middle grade and consultant numbers to provide this. To be satisfactory for trainees, training appointments must be balanced against service requirements.

Finally, I think it essential that we participate in the development of any proposed reforms in order to ensure that we are in a position to provide a safe effective service after their implementation.

Contributor

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