Training programmes for medical registrars: How we did it in the West Midlands

In the early part of 1990, the Regional Manpower Committee for the West Midlands invited the postgraduate deans’ office to advise them on the creation of training programmes in all specialties within the region along the lines indicated by Achieving a balance [1]. For medicine, a working party was set up which included the chairman of the Senior Registrar Training Committee in Medicine (now to assume a similar role for registrars), representatives from major centres out of Birmingham (Stoke and Coventry), a geriatrician, and the regional advisers of the Royal College of Physicians.

It was judged likely that, in future, all career registrars would require the MRCP, the acknowledged entrance to higher medical training (HMT). It was recognised that all training programmes would be rotational and that career and visiting registrars would be totally integrated. In addition, all programmes would provide HMT, usually based on a specialty, while continuing to offer experience and training in general (internal) medicine. In planning rotations between teaching and district general hospitals, we were in some difficulty, given that there is only one faculty of medicine in the West Midlands. We decided that other major centres with substantial specialist services within the region should on occasion fulfil the role of a teaching hospital.

All physicians were informed of the plans, and information was collected from all districts concerning the number of registrar posts and the potential for providing HMT in medical specialties within the district. All posts, whether on the academic or NHS establishment, were reviewed. No existing rotational training programme was regarded as immutable; all were considered for integration into the regional system.

In constructing the programmes we were sensitive to the large size of our region and, in an effort to reduce travelling for trainees, produced three groups of programmes based on the north, centre and south of the region. With regard to specialty, we tried to keep the proportion of specialties roughly in balance with the number of senior registrars in that specialty within the region. It would be considered inappropriate to have, for example, 15% of our posts based in one particular specialty when the proportion of senior registrars in the specialty was only 5%. We realised that there would be considerable movement of trainees between regions when seeking senior registrar appointments, but it seemed sensible to maintain specialties roughly in balance with the proportions in the more senior training grade. Most of the training programmes lasted for three years, though some were two years in length.

All existing registrar posts were evaluated in terms of their training potential. Some specialties were relatively strong in training terms, while others were weaker, and this was reflected in the number of possible training programmes in each individual specialty. We found it possible to devise relatively fewer programmes in geriatric medicine than in the specialties of general medicine. As good training posts are developed this imbalance will be redressed. In those specialties where there appeared to be too many training posts, or where the HMT potential appeared better with a consultant other than the one with whom a registrar currently worked, some degree of internal rearrangement of registrar deployment within the district was explored.

The provisional programmes were then discussed with all physicians in the region, and in the light of debate some were substantially amended.

Geographical isolation of relatively small district general hospitals was a problem. Many such hospitals have in the past employed pre-MRCP registrars. They have been extremely effective in training junior doctors for the MRCP, those who are successful moving on to a major centre. Some district general hospitals found it difficult to offer HMT in a subspecialty, but were well equipped to provide it in general internal medicine, particularly in a programme directed towards geriatric medicine. In others, a case could have been made for regrading the registrar to SHO. We believe it likely that many smaller district general hospitals will in time wish to do that, continuing to train high-quality graduates for the MRCP. At present there is a Department of Health ceiling on the number of SHOs, and it is not possible to make such a redesignation. It is, however, possible to exchange a registrar in one district for an SHO in another, provided that the employing authorities agree to the financial implications. This was done on several occasions to the mutual benefit of both districts. Geographical isolation will continue to present a problem for both district and trainees; the latter will inevitably have to do...

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more travelling than before, and the employing authority will have to provide additional residential accommodation when the registrar is on-call.

It was always our intention that the creation of good training programmes would attract high-quality visiting registrars, so that the impact of the required reduction of career registrars from 94 to 54 over five years would be mitigated. The standard of visiting registrars may vary and not all will have the MRCP, but the advantage and attraction for visiting registrars is that they are totally integrated into the training programme along with the career registrar, thereby avoiding professional isolation. Although Achieving a balance [1] states that every district should have a career registrar in a major specialty, our programme will result in districts having a combination of career and visiting registrars. One or two districts, without registrars for historical reasons, will remain deprived, and it remains to be resolved whether they continue with their SHO training programmes or eventually become integrated into the registrar system.

The present arrangement allows fine tuning in terms of the visiting/career registrar numbers. As a principle, every rotational training programme should have at least one career registrar. The remaining ratio of career to visiting members will depend upon future allocations. Adjustments can be made by advertising for visiting registrars only when the allocation of career registrars is full.

Registrars have progressively been appointed to the new training programmes over the course of the past year. Success, in terms of meeting clinical need, will depend upon our ability to continue attracting high-quality visitors. Manpower calculations implicit in the schemes will be severely damaged if a significant number of visiting registrars change status. Should that happen, the principle of inviting visitors into these programmes which provide equal opportunities for visiting and career registrars would be severely undermined.

The creation of rotational training programmes at registrar level represents only a beginning. Those responsible for training must review programmes regularly and, when necessary, rearrange them. Those responsible for manpower considerations must ensure that the total number of career registrars within the region remains within the JPAC target and that their distribution is equitable.

Reference

1. UK Health Departments, the Joint Consultants Committee, and the Chairmen of the Regional Health Authorities. Hospital medical staffing: achieving a balance—Plan for action. London: Department of Health and Social Security, 1987.

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