THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

Report of the

Working Party to Audit Structured Training

December 2000

Setting Standards to Improve Women's Health

© Royal College of Obstetricians and Gynaecologists 2001

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of the publisher (Royal College of Obstetricians and Gynaecologists).

Further copies of this report can be obtained from:

RCOG Bookshop
Royal College of Obstetricians and Gynaecologists
27 Sussex Place
Regent's Park
London
NW1 4RG

Tel: (0) 20 7772 6275
Fax: (0) 20 7724 5991
Email: bookshop@rcog.org.uk
Website: www.rcog.org.uk

Contents

The Working Party 2

Recommendations 3

1 Introduction 5

2 Appraisal and assessment 7

3 Educational supervisors and College Tutors 10

4 Education 12

5 Logbooks 13

6 Personal development files 14

7 Examinations 15

8 Revalidation 16

9 Senior house officer training 17

10 Academic trainees and structured training 18

References 18

Appendix A Questionnaire for Regional College Advisers 19

Appendix B Questionnaire for Chairs of Regional Specialist Training Committees 20

Appendix C Survey of SpRs (end of general training) and CCST holders 23

Appendix D Trainee evaluation form 32

Appendix E North Western Deanery Annual Assessment Interview 33

Appendix F Survey of Specialist Registrars who have completed year 3 34

1 The Working Party

Members of the Working Party

Mr P A R Niven FRCS FRCOG (Chairman)
Consultant Obstetrician and Gynaecologist, St. Michael's Hospital, Bristol

Dr J S G Biggs FRCOG

Postgraduate Dean, East Anglian Deanery

Mr I E Boyd FRCS FRCOG
Consultant Gynaecologist, The Princess Anne Hospital, Southampton

Miss J E Bridges MRCOG
Consultant Obstetrician and Gynaecologist, Chelsea and Westminster Hospital

Mr S Butler-Manuel FRCS MRCOG
Specialist Registrar, The East Surrey Hospital

Mr J P Calvert FRCOG
Consultant Obstetrician and Gynaecologist, Singleton Hospital, Swansea

Dr M J Carty FRCS FRCP FRCOG
Consultant Obstetrician and Gynaecologist, Southern General Hospital, Glasgow

Mr A A Hollingworth FRCS MRCOG
Consultant Obstetrician and Gynaecologist, Whipps Cross Hospital

Mr M P Milligan MD FRCOG
Consultant Obstetrician and Gynaecologist, Kent and Canterbury Hospital

Acknowledgements

The Working Party acknowledges with thanks contributions received from:

Mr K Allenby MRCOG
Consultant Obstetrician and Gynaecologist, William Harvey Hospital

Dr G Cooper FRCA
on behalf of the Royal College of Anaesthetists

Professor W Dunlop FRCOG
Chairman, Specialist Training Committee

Professor C Galasko FRCS
on behalf of the Royal College of Surgeons

Professor J Grant FBPsS FRCGP
Director of the Joint Centre for Education in Medicine

Miss B Grantham-Hill
Head of Postgraduate Training Department, RCOG

Mr M James MRCOG
Chairman, Trainees Committee, RCOG

Dr H Mather FRCP
on behalf of the Royal College of Physicians

Dr S J Mountfield MRCOG
Specialist Registrar, Royal Hampshire County Hospital

Mr N A Myerson MRCOG
Specialist Registrar, East Glamorgan General Hospital

Professor C H Rodeck FRCOG
Chairman, Academic Committee, RCOG

Mr L E P Wood FRCS MRCOG
Consultant Obstetrician and Gynaecologist, Walsgrave Hospital

Recommendations

Appraisal and assessment

1. The terms appraisal and assessment should replace formative and summative assessment.

2. There should be a rigorous assessment of Specialist Registrars (SpRs) in year 3 in order to plan training in years 4 and 5, which, while consolidating clinical experience, should include modules of special skills training. A module on educational supervision, management and administration should be mandatory prior to recommendation of the award of a Certificate of Completion of Specialist Training (CCST).

3. The Record of In Training Assessment (RITA) process at the end of year 3 of SpR training should be an in-depth assessment involving external assessors drawn from a central College panel.

4. External assessors drawn from a central College panel should be involved also in the RITA process at the end of year 5 prior to the recommendation of a CCST.

5. Trainees should not progress to year 4 of SpR training without having passed the MRCOG examination.

6. Clinical assessment of trainees in the workplace should be undertaken, initially as a pilot study.

Educational Supervisors and College Tutors

7. The term District Tutor should be replaced by College Tutor.

8. The Educational Supervisor should be the main appraiser of the trainee throughout the year of each rotation and should act as advocate for the trainee at the time of assessments carried out by the College Tutor and RITA panel.

9. The Educational Supervisor should be allocated one flexible session per week.

10. College Tutors should have had at least two years of previous experience as Educational Supervisors, have a special interest in training and act as lead trainer for obstetrics and gynaecology in an individual trust.

11. College Tutors should be allocated fixed sessional time.

12. Educational Supervisors and College Tutors should have attended training courses in educational supervision, appraisal and assessment and should regularly update themselves in these areas.

Education

13. There should be regular local education sessions in individual hospitals or groups of hospitals, organised on a modular two- or three-year rolling programme, acknowledging the different educational requirements of year 1–3 SpRs from those in years 4–5.

14. There should be strong consultant involvement in educational sessions integrated with continuing professional development (CPD). Educational sessions should be chaired by a consultant.

15. Consideration should be given to organising a national forum to synchronise and develop educational ideas with a view to establishing a national curriculum.

16. A register of attendance should be kept at all educational sessions and trainees should attend 75% of eligible sessions.

Logbook

17. Separate logbooks should be developed for SpRs in years 1–3 and for SpRs in years 4–5.

18. There should be a progressive move towards electronic logbooks as standard.

Personal Development File

19. The Personal Development File (PDF) should be replaced by a slimmed-down Training Portfolio concentrating on trainees' progressive achievements and assessments, with other administrative details of structured training being provided in a separate booklet.

Senior House Officer training

20. Career SHOs should have regular three-monthly appraisals and six-monthly assessments.

21. To qualify for an SpR post, SHOs should:
    - have undertaken at least 12 months of obstetrics and gynaecology train ing in a career SHO post
    - hold the Part I MRCOG
    - be certified as having satisfactorily completed basic surgical skills, resuscitation and obstetric emergency courses
    - have documented evidence of satisfactory attendance at available educational sessions.

1 Introduction

The Working Party to Audit Structured Training was asked to agree measures of success of structured training and to audit these measures. In addition, during the lifespan of the Working Party it was asked to comment on the interaction between SHO and SpR training and also to consider the relationship between SpR training and revalidation.

There are a number of positive aspects of structured training. Firstly, the length of time to achieve consultant status has been shortened to a basic minimum of seven years of training in obstetrics and gynaecology. Secondly, there is potential job security for the trainee from the time of entry to the SpR grade until achievement of a CCST five years later, given satisfactory annual assessments, without the need to move outside a particular Region. Thirdly, for the first time there is an ordered structure to training in the Registrar grade.

In contrast, both trainers and trainees have expressed a number of concerns.

1.1 Length of training

Some have stated that five years is too short a time to train a consultant.

1.2 Diminished experience, particularly surgical experience

Diminished operative experience and length of training have been highlighted by the reduction in junior doctors' hours and the need for trainees to have a day off after a night on call. Some hospitals have been hard hit by curtailment and cancellation of operating lists. Although the caesarean section rate is rising, it is salutary to reflect that, if one divides the number of hysterectomies undertaken nationally per annum by the number of career trainees, a figure of 27 is produced and, of course, not all those hysterectomies are available for training.[1]

1.3 Lack of competition

In the past, Registrars had to surmount a hurdle between the Registrar and Senior Registrar grade. Many believe that, without the abolition of that obstacle, several year 4/5 Calman trainees would not have achieved Senior Registrar status under the old system.

1.4 CCST

Several feel that the award of a CCST has been a 'rubber-stamping' exercise in the main and that there has been less involvement by the College in the award of a CCST than there was under the old accreditation system.

1.5 Record of In Training Assessment

Again, there has been a strong belief that this has been a 'rubber stamping' exercise in many cases, and there is certainly a lack of both documentation and uniformity across the Regions in the RITA process.

1.6 Logbook and Personal Development File

The present logbooks and PDFs lack details of clinical experience.

1.7 Education

There is considerable variation in the way education is delivered and supervised across the Regions.

1.8 MRCOG

Hitherto, a number of trainees had taken and passed the MRCOG prior to entry into the SpR grade. There is a strong feeling that this is contrary to the place of this examination in overall training in obstetrics and gynaecology.

It should be pointed out that the Calman system of structured training started in April 1996, so that, although many trainees have experience of the new system of structured training, none has completed the full menu of structured training from year 1 to year 5. Undoubtedly, there has been a 'learning process' for both the trainees and those responsible for delivering education, training and assessment under the new system.

The Working Party undertook the following surveys:

- Regional College Advisers, regarding educational programmes available in their Region (Appendix A)
- Chairmen of Regional Specialist Training Committees regarding RITAs (Appendix B)
- post year-3 SpRs and CCST holders regarding their views of structured training (Appendix C)
- a group of SpRs who had completed a RITA form at the end of year 3 (Appendix F).

2 Appraisal and assessment

It is recommended that the old terms of formative and summative assessment be discarded in preference to Appraisal and Assessment as used in other medical disciplines. Appraisal is defined as the regular discussion and feedback that occurs between the SpR and their senior about the SpR's progress and training needs. Assessment is defined as the conscious and systematic gathering of valid and reliable information about the SpR's performance to enable judgements to be made about satisfactory progress (Southgate L, Grant J, Mulholland H. *Evaluation of the Reforms to Higher Specialist Training Guidelines on Assessment and Appraisal.* Unpublished consultation document commissioned by the Department of Health, September 1999).

There should be careful documentation of all appraisals and assessments and the contents of all such records should be available to the trainee. The view has been expressed repeatedly that there should be no confidential information withheld from the trainee by appraisers or assessment panels.

The Working Party recommends changes to the current documentation used in appraisals and assessments. The AP1 and AP2 forms would be replaced by a standard 'Appraisal Record Form'. The TO1 and TO2 forms would be retained but perhaps better named 'Teamwork Assessment Forms'. These forms should be distributed by the College Tutor to relevant parties (for example, labour-ward supervisors, senior SpRs, ward sisters, anaesthetists) with the full agreement and knowledge of the trainee. The SA1 and SA2 forms should be called 'Progress Assessment Forms' hereafter. The EV1 form has not been a success and many Regions have used their own adaptations of this form. It is suggested it be replaced by a 'Trainee Evaluation Form' and a suggested format for that is shown in Appendix D.

In most Regions SpRs rotate annually but tend to work for two different consultants or consultant teams each for six months in any given year in a particular hospital. Based on this format, it is recommended that an SpR has an induction appraisal by his or her Educational Supervisor at the start of each SpR year, followed by an appraisal three months later by the Educational Supervisor. These appraisals will be documented on the Appraisal Record Forms. At six months, there will be an assessment by the College Tutor, attended by the Educational Supervisor as the trainee's advocate, with information from the Teamwork Assessment Forms and documentation of this assessment being recorded on the Progress Assessment Forms. At nine months, there will be a further appraisal by the Educational Supervisor and, at the end of the year, a RITA.

At the RITA, the Appraisal Record Form, Teamwork Assessment Forms and Progress Assessment Forms would be available to the panel, together with the Trainee Evaluation Form. In addition, it is recommended that a checklist of topics to be covered during the assessment is available. Appendix E gives an example of the checklist used by the North Western Deanery and, in the interests of uniformity across the Regions, it is recommended that all Regions use this list or a similar one. The RITA panel would be expected to consist of the postgraduate dean or his representative, the chairman of the Regional specialist training committee and the Regional College adviser together with representative College Tutors.

Information about a trainee's previous appraisals and assessments should be passed on to their next Educational Supervisor with each successive rotation.

On the basis of the new design of the MRCOG being a summative assessment of knowledge, clinical experience and judgement, it is recommended that trainees should not progress to year 4 of SpR training without having passed that examination.

In year 3, SpRs should have a rigorous assessment with their Educational Supervisor and College Tutor, with a view to planning their training in years 4 and 5. It is envisaged that it is in these years that trainees will consolidate clinical skills and strengthen any weaknesses. Further, it is anticipated that they will undertake one or more modules of special skills training,[2] including a mandatory module on educational supervision, management skills etc. required in a new consultant post. In placing trainees in special-skills modules in year 4 and 5 there may have to be a degree of selection and priority should be given to those trainees who are considered by their trainers to be most meritorious.

Many Regions use external assessors in the RITA process. To maintain College involvement in the assessment of trainees towards the award of a CCST, it is recommended that there should always be an external assessor drawn from a central College panel at the RITA at the end of year 3 of SpR training, which should be a particularly rigorous assessment. A similar external assessor should always be involved where a trainee is being reassessed after previously receiving a RITA D or E. Finally, it is recommended that College external assessors should be involved in the RITA process at the end of year 5, prior to the recommendation for a CCST. It is envisaged that the RITA at the end of year 5 would be a stringent assessment highlighting the trainee's acquisition of not only clinical skills but also requisite communication, administrative, leadership and interpersonal attributes necessary to practise independently as a consultant, in conjunction with consultant colleagues. It is recommended that with experience, discussion and training, the external assessors will be able to oversee the development of a uniform structured RITA, with an objective scoring system.

It is recommended that a standard objective RITA be developed in conjunction with COPMeD.

2.1 Clinical assessment

At the time of the setting up of this Working Party there were a number of high-profile media events involving apparent surgical negligence. With these in mind, the Working Party was keen to evaluate ways in which not only surgical skills could be assessed but also the wider area of communication and technical skills, record keeping, decision making and judgement. There is concern that trainees who lack these skills should be identified comparatively early in their training and not allowed to progress to SpR years 4 and 5 without recognition of such deficiencies.

A Royal College of Surgeons Working Party on Structured Training is currently considering clinical assessment in the workplace, where an outside assessor sits in with the trainee in outpatient clinics, accompanies them on ward rounds and observes the trainee operating. This sort of assessment is undertaken by the Royal Australian College of Obstetricians and Gynaecologists, although they are dealing with a much smaller number of trainees.

The Royal College of Surgeons has estimated that it would require 30–40 extra consultants to undertake such external assessment of trainees in the workplace and recognises that there are considerable cost implications. The RCOG Working Party considered that such clinical assessment in the workplace should be undertaken initially as a pilot study, either on a Regional or local basis, in order to minimise disruption and expense. It is recommended that this be done in year 3.

Where assessment of surgical competence is concerned, it is expected that SpRs in the future will have completed a basic surgical-skills course and that other methods of assessing surgical competence should be considered, e.g. the use of simulators, videos or objective structured assessment of technical skills (OSATS).

Where surgical ability is concerned, it is recognised that, in clinical governance terms, trainees require supervision but that when they obtain a CCST they are free to practise independently. There should be an evolution of supervision throughout training as outlined in the logbook. Up to the end of year 3, it is felt that, ideally, trainees should be supervised by an appropriate senior colleague at all times. However, it is recognised that, while this may be feasible in gynaecological practice, until there is a more comprehensive consultant-based service, it may not be practicable at all times in obstetric care. In years 4 and 5, a degree of supervision must be maintained but the trainee should be allowed to develop competence and confidence to operate independently by the time the CCST is obtained.

Continuing with clinical assessment and appraisal, there should be sufficient opportunity on ward rounds for patients to be presented by trainees and management options discussed with trainers. Perhaps more importantly, in the outpatient situation the workload should be designed such that there is ample time during the session for the management of the patients to be discussed formally by the trainer and trainees.

3 Educational Supervisors and College Tutors

The term District Tutor is now obsolete as Districts no longer exist and, in line with other medical disciplines, it is recommended that this title be replaced by 'College Tutor'.

The role of the Educational Supervisor was a deanery-generated post, introduced at the time of Calman in 1996 without clear definition of its role. The roles and responsibilities of Educational Supervisors have been defined in *A Guide to the Management and Quality Assurance of Postgraduate and Dental Education*.[3]

The day-to-day clinical supervision of trainees remains the responsibility of the consultant with whom they are working. Assuming that a trainee undertakes two six-month rotations in one hospital, it is logical to expect that one of the consultants with whom they work would be designated the Educational Supervisor. It is expected that, when the trainee moves on to the next arm of the rotation, a new Educational Supervisor in that new hospital would take over but that there would be liaison between Educational Supervisors to provide seamless training for trainees from one rotation to another.

Based on criticisms of the system of educational supervision thus far, both from trainees and trainers, the Educational Supervisor should be a consultant in the NHS with a commitment to training and an active participant in CPD.

The Educational Supervisor would have one or more allocated trainees throughout the year of each rotation and would oversee the training needs of the trainee. They would have received a report of the trainee's previous appraisals and assessments.

The Educational Supervisor would be the main appraiser of the trainee and would act as an advocate for the trainee at the time of assessments carried out by the College Tutor and the RITA panel.

The Educational Supervisor should have attended a basic course in 'Training the trainers' and an assessment and appraisal course, as well as having experience of shortlisting and interviews. The Educational Supervisor should be prepared to be assessed on a three-yearly basis.

The Educational Supervisor would be expected to actively participate in educational programmes for trainees and be prepared to chair such sessions.

In order to be able to carry out these duties the Educational Supervisor should be allocated one flexible session per week.

It is anticipated that an Educational Supervisor would have three trainees as a maximum but, with the anticipated reduction in trainees, the trainer-to-trainee role is likely to move to less than one. This means that that some consultants will have no trainees and would therefore lose their role as Educational Supervisors.

Consultants should be encouraged to regard clinical and educational supervision as complementary and integral components to their overall job commitment. Those who decide to opt out of educational supervision may not have trainees allocated to them.

3.1 Criteria for the College Tutor

In addition to the RCOG job description, the College Tutor (formerly District Tutor) should have had at least two years of experience as an Educational Supervisor and should have a special interest in training and act as the lead or core trainer for obstetrics and gynaecology in the trust.

The College Tutor leads the appraisal and assessment process of trainees and is involved in the RITA process.

The College Tutor would also lead the induction and training of Educational Supervisors and support the Regional College Adviser.

The College Tutor should be actively involved in auditing training and, most importantly, should be allocated fixed sessional time according to the number of assigned trainees, typically one session a week.

Typically, the College Tutor would hold the post for three years, renewable for a further three, and there should be a system of rotation of sessions of the College Tutor to avoid deskilling of clinical activities.

In some trusts, the number of trainees may require more than one College Tutor.

It is apparent that only a minority of Educational Supervisors and College Tutors has attended training courses in educational supervision, appraisal and assessment. It is important that all trainers should attend such 'Training the trainer' courses. It is hoped that there are opportunities to partake in such courses at a local deanery level, where generic issues concerning supervision of trainees are discussed. However, there are specific issues related to obstetric and gynaecological training. The Working Party therefore recommends that the College runs a 'Training the trainer' course on an annual basis.

Educational Supervisors and College Tutors should update themselves on a three-yearly basis.

4 Education

It is evident that, while there are some similarities, there is considerable variation in the way in which formal education is delivered to trainees around the Regions.

The educational requirements of year 1–3 trainees are broadly based on the MRCOG curriculum but vary from the requirements of year 4–5 trainees, which are much more geared to special interest subjects.

Most Regions run a two- or three-year rolling, and often modular, programme at a fixed time free from other clinical commitments.

These meetings vary from weekly local meetings to less frequent deanery 'away-days' held in a particular centre in the Region.

Trainee attendance at such meetings is variable and consultant input disappointing.

In most Regions, trainees receive a budget for study leave of around £750 per annum but, in several areas, funds are deducted from these budgets in order to organise local education programmes.

Some Regions have education sub-committees including College Tutors and trainees dedicated to educational input.

Distance learning via the internet has yet to be developed in most Regions.

It is recommended that, in addition to day-to-day education in the clinical setting, regular education sessions should be held in protected time in individual hospitals or groups of hospitals. These are best organised for year 1–3 SpRs and career SHOs on a modular two- or three-year rolling programme.

Similar regular educational programmes should be available for those in years 4 and 5 but, in these years, the educational session should be used as part of a portfolio to develop knowledge and skills.

SpRs in years 4 and 5 can be used as facilitators and supervisors of the modular programme for SpRs in years 1–3.

In addition, less frequent but regular deanery meetings organised on a regional or sub-regional basis and occurring monthly or two monthly, are recommended. The latter type of meeting might include invited outside speakers, symposia, debates etc.

There should be much greater consultant involvement in educational sessions. The Working Party recommends that each educational session be chaired by a consultant and that consultants should make every effort to be present when an area of their particular interest is involved. Trainees have frequently mentioned that they find educational sessions more fruitful where consultants are present. Many of these educational sessions could be integrated with CPD attendance for CCST holders.

A detailed register of attendance should be kept of all educational sessions and trainees

should attend 75% of eligible sessions. Failure to maintain 75% attendance may count against a trainee in appraisal and assessment and detract from their priority in seeking a special skills module in years 4 and 5.

Trainees should actively participate in the organisation of educational sessions and an educational sub-committee including College Tutors, Educational Supervisors and trainees should be established on a Regional or sub-Regional basis, meeting every two to three months to organise, review and audit educational sessions and attendance.

Every encouragement should be given to develop individual and distance learning via computer assisted learning, video conferencing and the internet. College Tutors should be alert to electronic developments that may enhance the delivery of education.

The Working Party endorses the view expressed by the National Trainees Committee that there should be a national forum to develop and bring together educational ideas in order to develop a national curriculum.

5 Logbooks

Current logbooks have come in for criticism from both trainees and trainers.

Again, there is thought to be too much 'rubber stamping' and, in their present form, logbooks lack any detail of clinical experience. The Working Party is of the opinion that separate logbooks should be developed for SpRs in years 1–3 and years 4–5. In years 1–3, without specifying criteria of appropriate clinical experience, it is suggested that assessors should view a snapshot of the trainee's clinical experience in a four-week period prior to any assessment. For years 4–5, when trainees are increasingly developing their ability to practise independently, it is felt that all clinical experience should be logged in detail, following on as a continuum into Revalidation after acquisition of a CCST. Details of clinical experience should also record details of supervision.

At present, the logbooks are cumbersome and it is recommended that the aim should be for trainees to have electronic logbooks, and a suitable information technology system should be developed by the College.

6 Personal Development File

The present PDF is bulky and contains much information that is concerned with the structure of training and the deanery system, in addition to sections dealing with the trainee's progress and achievements.

It is suggested that the following sections become part of a separate booklet:

- Section 1 – Objectives of training in obstetrics and gynaecology
- Section 2 – Training in obstetrics and gynaecology: an outline plan
- Section 3 – Structure of the Region/deanery
- Section 4 – Training programme in the Region/deanery SpR rotations
- Section 5 – List of terms used in structured training.

It is recommended that the remaining sections be renamed the 'Training Portfolio'.
Those sections would be:
1 – Appraisal and assessment
2 – Logbooks
3 – Award of the CCST
4 – Curriculum vitae
5 – Trainees' log of academic work completed.

In summary, the Working Party advocates a slimmer Training Portfolio concentrating on the trainee's progressive achievements and assessments to replace the PDF, with other administrative details of structured training to be provided in a separate booklet.

7 Examinations

7.1 MRCOG

As stated previously, there had been concern about some trainees obtaining the MRCOG before acquiring an SpR post. The Orange Book states that 'the outcome of an examination should not by itself determine progress' and the new-style MRCOG assesses clinical experience and acumen as well as knowledge. The new design of MRCOG then is part of the overall assessment of the trainee and, to reiterate, the Working Party is of the opinion that this qualification should be obtained before progressing to SpR years 4–5. In the life of the Working Party, the number of years in training before a trainee can sit the MRCOG has been increased to four.

A survey of SpRs whose most recent RITA was at the end of year 3 demonstrated that 89% had passed the MRCOG. Of those who had not yet obtained the MRCOG, some had not yet attempted the examination and some and taken it three or more times (Appendix F). It would seem then that the imposition of the regulation that SpRs should obtain the MRCOG before progressing to year 4 would not produce an impracticable hold-up of large numbers of SpRs at this stage. Provision will be required for a system of career advice and counselling for those SpRs who have not obtained the MRCOG by the completion of year 3.

7.2 Exit examination

The Working Party discussed whether there should be an additional exit examination in year 4–5, such as in the Australian College, where the exit examination leads to the award of a Fellowship of that College. The Royal College of Surgeons also has an exit examination involving objective structured clinical examinations (OSCEs), clinical critiques and review of academic work. Many consultant appointments now involve formal presentations by candidates and the Working Party considered whether they should recommend a formal exit examination involving some of these devices. On balance, it was felt that, with the new design and regulations for the MRCOG and with a strictly applied system of monitoring training, appraisal and assessment should be robust enough to obviate the need for an exit examination at the present time.

8 Revalidation

The College Working Party on Revalidation in Obstetrics and Gynaecology recommends mechanisms to ensure that a doctor maintains 'good medical practice'.[4] These mechanisms include audit appraisal and assessment linked with CPD.

For CCST holders, in the future these mechanisms will have existed already as part of structured training. It is hoped that, by keeping a detailed log of clinical activity in the latter part of training, there can be a seamless progression from structured training into revalidation.

It is acknowledged that doctors may be considerably less experienced clinically when they obtain the CCST in the future than were their forebears at the equivalent stage. During structured training, a trainee has an Educational Supervisor who acts as advocate and friend. No such individual exists for the trained doctor and the Working Party considered whether the CCST holder should have a designated mentor or 'buddy' but no firm conclusions were reached.

9 Senior House Officer training

Non-career SHOs normally undertake a six- or twelve-months' post and their clinical exposure is geared towards general practice. They should have an induction interview and mid-term appraisal with their Educational Supervisor and a final assessment with their College Tutor and Educational Supervisor prior to the end of the appointment. They work towards the completion of the basic logbook and are encouraged to take the DRCOG examination after the conclusion of their post.

Similarly, career SHOs have an induction appraisal and three-monthly appraisals with their Educational Supervisor, together with an assessment of progress with their Educational Supervisor and College Tutor at six-monthly intervals.

Again, they complete targets in the basic logbook to be achieved after 12 months of training in obstetrics and gynaecology and thereafter move on to targets in the main logbook to level two or three (varying with module) appropriate for training towards the MRCOG.

Currently, to qualify for an SpR post, SHOs are required to have passed Part I MRCOG and to have undertaken one year of post-registration training in obstetrics and gynaecology.

At the time of writing (October 2000), most SHOs will have completed two years of training in obstetrics and gynaecology before being appointed to an SpR post.

It is proposed that, in the future, to qualify for an SpR post SHOs should have:

- Part I MRCOG
- twelve months of training in obstetrics and gynaecology in a career SHO post
- basic surgical skills course certification
- resuscitation course certification (e.g. Advance Training in Life Support)
- obstetric emergency course certification (e.g. Advanced Life Support in Obstetrics scheme)
- documented evidence of at least 75% attendance at available education sessions.

It is recommended that proper rotations be organised for SHO training.

10 Academic trainees and structured training

Concern has been expressed about recruitment in training of doctors wishing to pursue a clinical academic career in obstetrics and gynaecology. Many trainees are reluctant to take time out of the training programme to allow them to undertake research posts, having the perception that it would be difficult for them to return. In addition to this perceived inflexibility, it has become increasingly difficult to obtain funding for clinical research, as this is now frequently directed towards laboratory-based research.

A Working Party of the Academy of Medical Sciences[5] has recommended a two-phase programme for academic training, the first phase involving five years of flexible SpR training combined with a research fellowship, followed by a second phase in a clinical-scientist post where there would be a 'flexible mingling with SpR training to gain a CCST and two- to three-years' post-doctoral training' leading to a Senior Lecturer post. Including research time, this would involve some twelve years of training, which was felt by the Working Party to be too long. Nevertheless, the principle of a two-phase programme for academic training was supported and, further, it is suggested that there should be a register of academic trainees within the College and designated posts for academic training under the aegis of the Academic Committee of the College.

The Working Party considered that research in general and those wishing to pursue an academic career in obstetrics and gynaecology should be encouraged, by making structured training as flexible as possible. There should be no artificial barriers or constraints for those who wish to move in and out of the Calman system in order to undertake research projects.

References

1 Royal College of Obstetricians and Gynaecologists. *Medical Workforce in Obstetrics and Gynaecology Eleventh Annual Report, April 2000.* London; 2000

2 Royal College of Obstetricians and Gynaecologists. *Special Skills Training in Obstetrics and Gynaecology.* London; October 1999.

3 Working Group of the Academy of Royal Colleges and COPMeD. *A Guide to the Management and Quality Assurance of Postgraduate and Dental Education.* London; January 2000.

4 Royal College of Obstetricians and Gynaecologists. *Discussion Document on Revalidation in Obstetrics and Gynaecology: Report of a Working Party*. London; January 2000

5 Savill J. More in expectation than in hope: a new attitude to training in clinical academic medicine. *BMJ* 2000;**320**:630–3

Appendix A

QUESTIONNAIRE FOR REGIONAL COLLEGE ADVISERS

1. Is there a designated education programme (e.g. Friday afternoon educational sessions) in every hospital in your Region?

2. Is there collaboration between two or more hospitals in your Region to provide a rolling programme?

3. Do educational sessions take place every week of the year or only for a limited length of time, e.g. academic term?

4. Do trainees have any difficulty attending such educational sessions or are they restricted by service commitments? This may be a particular problem if they have to travel to other hospitals for an educational sessions.

5. Are records kept of attendance at such sessions?
   If so, the Working Party would be grateful for copies of the attendance records.

6. How are any educational sessions arranged? For example, do year 4 and 5 SpRs teach trainees in Years 1–3?

7. How much consultant participation is there in such educational commitment? The Working Party would be interested to hear of the consultant attendance at such sessions.

8. Have any consultants in your Region attended 'Training the trainers' courses?
   Have you held such courses for trainers in your Region?

Signed: Region:

Commentary

1. There was a designated education programme in all Regions and the majority provided a rolling programme with collaboration between local hospitals.

2. There was variation as to whether educational programmes took place weekly throughout the year or only during academic terms.

3. Trainees frequently reported difficulty in attending educational sessions because of clinical commitments or geographical separation.

4. Records of attendance of trainees were kept in most Regions but audit and action in connection with such registration was variable.

5. Year 4 and 5 SpRs were involved in teaching year 1–3 trainees and, in general, year 1–3 trainees found the educational sessions much more valuable than did those in years 4 and 5. The organisation of the educational sessions was extremely variable.

6. Consultant participation was generally poor and only a minority of consultants had attended 'Training the trainers' courses.

Appendix B

QUESTIONNAIRE FOR CHAIRS OF REGIONAL SPECIALIST TRAINING COMMITTEES

1. How many trainees for whom you are responsible possess:

   a) NTNs
   b) VTNs
   c) LATs
   d) FTTAs?

2. What is the manpower constitution of your annual assessment panel and, in particular, do you have an external assessor from outside your own Region, deanery etc. (there does seem to be a variation among Regional Training Committees)?

3. How many trainees have you assessed since the introduction of Calman training?

   How many trainees have been issued with RITA D forms?

   How many trainees have been issued with RITA E forms?

4. How many trainees have withdrawn from Calman training?

   Of those how many have withdrawn:

   - voluntarily
   - after advice from the RSTC?

   Have any trainees been dismissed and have there been any appeals? If so what has been the outcome of the appeal?

5. Do you use any confidential information in the assessment of trainees or is all information about any given trainee openly available to him or her?

6. As well as the EV1 form, do you use any other form of assessment to assess training?

7. Is there any assessment of trainers?

   How many trainers in your Region have been on training courses e.g. ' Teaching the Trainers?

8. Are there any other particular points you would like to make or any particular issues you feel should be audited by the Working Party?

Signed: RSTC Region:

SUMMARY OF QUESTIONNAIRE SENT TO REGIONAL SPECIALIST TRAINING COMMITTEE CHAIRS

Questionnaires were sent to 22 RSTC Chairman. 21 were completed and returned (as at 14 September 1999) and these are summarised below.

Region	No. of trainees (question 1)				Assessment details (question 3)			Withdrawal from Calman dismissals and appeals (question 4)						
	NTNs	VTNs	LATs	FTTAs	No. of trainees assessed	RITA Ds	RITA Es	V[a]	R[b]	No. of dismissals	No. of appeals	Appeal successful	Appeal dismissed	Appeal in process
NE Thames	72	2	7	24	13	3	5	2	–	1	1	0	1	0
NW Thames	77	1	10	6	–	3	3	1	–	0	0	0	0	0
SE Thames	55	10	18	5	–	1	3	2		0	0	0	0	0
SW Thames	48	0	3	5	200	2	0	0	0	0	0	0	0	0
Northern	51	2	11	31	130	3	1	1	–	0	0	0	0	0
Yorkshire	40	1	2	6	50	0	0	2	0	0	0	0	0	0
Mersey	32	2	6	10	–	2	0	2	0	0	0	0	0	0
North Western	63	10	4	15	107	0	1	0	0	0	0	0	0	0
Mid Trent	21	–	2	–	42	0	0	1		0	0	0	0	0
Trent	24	9	6	0	46	1	0	6	5	1	1	0	0	1
South Trent	23	2	3	6	24	13	9	1	2	1	0	0	0	0
East Anglia	23	4	0	18	–	2	0	1	0	0	0	0	0	0
South Western	45	1	6	4	–	–	–	1	0	1	0	0	0	0
West Midlands														
Oxford	33	4	18	5	75	2	3	–	1		3	1	0	0
Wessex	39	0	6	17	–	0	4	–	1	0	0	0	0	0
Wales	38	7	1	14	110	6	1	1	–	0	0	0	0	0
SE Scotland	18	0	2	8	50	0	0	0	0	0	0	0	0	0
West Scotland	31	0	0	5	102	1	0	0	0	2 × FTTAs	0	0	0	0
East Scotland	10	0	0	2	–	0	0	0	0	0	0	0	0	0
N/NE Scotland	11	3	0	1	12	1	0	0	0	0	0	0	0	0
Northern Ireland	21	–	2	20	40	0	0	0	0	0	0	0	0	0

[a]withdrawn voluntarily; [b] withdrawn after RSTC advice

Commentary

1. Most annual assessment panels included the Chairman of the Regional Specialist Training Committee or Training Programme Director, Regional College Adviser, Deanery representative and representatives among the District Tutors. External asses sor involvement was variable.

2. The number of trainees assessed and the numbers issued RITA Ds and Es are tabulat ed (see table).Variable results are accounted for by the fact that some respondents included the number of trainees assessed while others included theoverall number of assessments. It is seen that, apart from South Trent, the number of RITA Ds and Es issued is comparatively small.

3. Comparatively few trainees have dropped out during structured training and only one or two appeals against dismissal are known to have occurred.

4. There was a general feeling that all information relating to assessments should be available to trainees and confidential information avoided.

5. The EV1 form was generally unpopular and many Regions used their own form.

6. There is virtually no formal assessment of trainers and a minority of trainers had been on 'Teaching the trainers' courses.

7. Finally, a number of general points were raised including:

   - the need for greater supervision of Educational Supervisors and trainers
   - the need for a more rigorous and standardised system of assessment
   - the need for Educational Supervisors and TPDs to be given sessional time to organise such education and training
   - diminishing surgical experience for trainees.

Appendix C

Survey of SpRs (end of general training) and CCST holders

Acknowledgements

Special thanks go to Mrs S Isard, Mrs M Green and Ms N Rice for help in the preparation of this document.

Introduction

Considerable concern has been expressed to members of the Working Group by both trainees and trainers in certain very specific areas:

- quality, content and supervision of training
- appraisal and assessment process
- (most importantly) the length of training.

Taking into account the 'new deal' for the reduction in junior doctors hours to no more than 72 hours a week, with subsequent pressure from the European Commission to bring this down to a maximum of 48 hours, a situation has been created where trainees might not be achieving the appropriate number of training opportunities in the time allowed. Reports on the introduction of shift patterns to reduce hours, which only compound the problem of trainees missing highly relevant training opportunities, have already been published.[1-12]

A recent report in the *Scottish Medical Journal*, entitled *Calman and the new Deal: Compromising Doctor Training and Patient Care*, specifically looked at the problems concerning length of training.

The study identified major concerns, particularly in surgery, where 60% of the trainees felt that they could not be adequately trained within Calman's desired seven-year period. Even if the quality of training was improved during this period, they felt that they would be unable to make up the deficit. Interestingly, only 10% of the trainees felt that a 48-hour week would be adequate for training and 83% wished to work 72 hours or more.[13]

In order to address these concerns, the Working Group decided to survey and obtain the views of SpRs who had completed their general training (end of year 3) and were therefore passing into higher training and also all those trainees who had completed the CCST prior to August 1999. It was recognised that, in the group containing SpRs who had completed general training, some would have been appointed by open competition while others were appointed during the transition process. As to the CCST holders, it was appreciated that none of them would have been completely through the new Calman system but all of them would have had at least two to three years of the new process. It was felt that these two groups would produce an interesting insight as to the present state of training in obstetrics and gynaecology at SpR level.

Methods

A confidential questionnaire was therefore prepared and distributed by the Royal College of Obstetricians and Gynaecologists; 287 were sent out to SpRs who had been identified from the postgraduate training database as having completed their general training and obtained third year RITA. Of these, two were returned undelivered and seven returned

incomplete, as the respondents did not consider the questionnaire relevant to their situation. There remained, therefore, the potential for 278 to be returned. Currently, 185 (66.5%) have been returned and analysed.

In the CCST-holders group, 310 were identified as having obtained their CCST in January 1997 and August 1999 (CCST holders); 296 were sent out (the remaining 14 doctors either had overseas addresses or no address on the database). At present, 161 (54%) have been returned and 152 have been fully completed. The remaining 9 were not completed as the respondents did not feel they were applicable as they had undertaken all their training prior to Calman. As this was a confidential survey and the rotational demands of their posts required continuous change of address, it was concluded that the overall response rate of 60% was reasonably representative.

The questionnaire devised covered the two groups described and looked at three main areas related to training.

Section 1: Specialist trainees' preparation for the next stage in their development

- those passing on to higher training
- those having completed their training in preparation to become a consultant.

Section 2: The appraisal and assessment process

- looking at the tools of the process; e.g.,SA2, TO2, PDF and logbook.
- the role of the trainer in assessing trainees' needs.

Section 3: The role of formal education and its quality and content as part of protected time training.

Section 4: The views of CCST holders as to the assessment of the Calman process and its effectiveness compared with previous non-structured training.

Results

Section 1: Specialist trainees' preparation for the next stage of their professional development

The most important outcome for any training programme is the ability of the trainee to move on to the next stage of their professional development; 67.5% of the SpRs at the end of their general training agreed that they were adequately prepared for higher training in years 4 and 5. However, it must be noted that 6.4% strongly disagreed and a worrying 8.1% decided that they could not offer a response to this. In the CCST-holders group, far fewer (53%) agreed that they were adequately prepared at the end of structured training to become a consultant. However, of those trainees in the survey who had actually achieved a consultant post, only 47% agreed.

In order to seek more details, both groups were asked questions about the details of their preparation. In the SpR group, the questions were related more to clinical aspects while in the CCST-holders group they were more related to the many other skills required of a consultant.

SpRs

Over 75% in this group agreed that they received adequate supervised training in both practical obstetrics and antenatal care. In gynaecology, 72% agreed that they received adequate supervised training in basic surgical skills and 69% in gynaecological surgery.

An even greater number approved of their training in perioperative care and outpatient gynaecology. In contrast, only 41% felt they had received adequate training in communication skills.

CCST holders

In this group, only 53% felt that, overall, they had been adequately prepared for a consultant post, although, more encouragingly, 60% agreed that they had received adequate structured training in their special interest. This result was improved when looking at the CCST holders who had already achieved a consultant post. However, when looking at the skills required for trainers, less than 50% had received adequate training in presentation skills and only 41% in research and audit. More encouragingly, 53% felt they had received adequate preparation for teaching and training.

In contrast, the percentages for the other skills required for a consultant post in the National Health Service were greatly reduced. Only 41% considered that they had received sufficient training in administration, a similar number in risk management and, more worryingly, only 33% of respondents felt that they had received adequate training in NHS management. Again, it was noticed that, with already-appointed consultants, the response was more likely to be that they were not prepared for a consultant post.

Section 2: The appraisal and assessment process

The audit asked questions concerning the assessment process in two different areas. Firstly, as to the methods or 'tools' of the process; e.g., SA2, TO2, RITA process, PDF and logbook. The second aspect of the questionnaire related to the role of the Educational Supervisors in correctly identifying the needs of the trainees at assessments and, once identified, addressing them. Both groups of trainees were asked similar questions and the results will be presented in comparison.

Methods or 'tools' of the assessment process

Overall, 50% of respondents felt that the assessment process correctly identified their training needs and, interestingly, this percentage was equal in both groups. When looking at the summative assessment process (SA2, TO2) as an appropriate representation of training progress, in the SpR group only 38% agreed and in the CCST-holders group 48% agreed. When questioned about the RITA process as an appropriate method of monitoring individual training progress, both groups of trainees were in similar agreement of just over 50%. Only 39% of the SpR group felt that the PDF served its designed purpose of aiding progress in training and even fewer (31%) agreed with this statement in the CCST-holders group. Again, when asked whether the logbook had been successful in measuring their progress, only 37% agreed in the SpR group and even fewer (29%) in the CCST-holders group.

The role of the trainer in assessing trainees' needs

The next section of the questionnaire asked both groups of trainees whether they felt that the Educational Supervisor had correctly identified their training needs and, when identified, whether they had been suitably addressed. In the SpR group, 54% felt that their Educational Supervisors had correctly identified their training needs but, sadly, only 41% felt they were appropriately addressed. In the CCST-holders group a greater percentage (60%) felt that their training needs had been correctly identified but this again sadly fell to only 40% who felt that the Educational Supervisor had addressed them.

Section 3: The role of formal education, its quality and content as part of protected time training

Again, both groups of trainees were asked similar questions; 83% of the SpR group and 89% of the CCST holders agreed that formal education was an essential part of structured training. When asked about the content of formal education, however, the results were not so good, with only 56% of the SpRs and 61% of CCST holders happy with the content of formal education. When asked about the quality of their formal education, in both groups the percentage of trainee agreement was reduced to less than 50% in the SpR group and 58% in the CCST-holders group.

Section 4: The views of CCST-holders as to the assessment of the Calman process and its effectiveness compared with previous non-structured training

An alarming 61% disagreed that the Calman process was a better way of training than its predecessor and nearly one-third of the respondents strongly disagreed on this particular point. However, this response may simply represent dissatisfaction with the current training system rather than the concept of 'Calman'.

Discussion

The purpose of the audit was to measure the degrees of success in structured training. Success has always been a difficult word to quantify. In any large group survey such as this, there will always be a small core of disaffected people who, due to reasons other than the training programmes, are unhappy with their professional development. It is therefore reasonable to assume that, if more than 70% of respondents agree with a statement, it indicates that, in that particular area, there are no problems, apart from individual trainee problems. At the other end of the scale, if less than 40% of those surveyed do not agree with the statement, there must be an underlining major problem and it would seem to indicate that the subject on which the question is based has serious problems that need to be totally rethought. Between these two extremes, it is more difficult to consider a differential scale. One way of analysing the data from this survey would be as follows:

Respondents (%)	Response
≥70	No problems
60–69	Few problems – needs fine tuning.
50–59	Problems – needs some serious adjustment
40–49	Significant problems – needs rethinking
<40	Big problems – needs major rethinking

For the following discussion, please see Table 1 (page 30).

≥70% – no problems

SpRs

The SpRs appear to be happy with the teaching supervision of practical obstetrics, antenatal care, basic surgical skills, perioperative care and teaching in gynaecological outpatient clinics. This would appear to indicate that there is good supervision in these groups and is contrary to some of the comments being made about consultant supervision of training.

CCST

It would appear significant that only one of the subjects questioned throughout the survey fell into this group with CCST holders agreement that formal education is an essential part of structured training. This by itself would appear to be a significant finding.

60–69% – Few problems

SpRs

It was rewarding to find that, overall, the SpRs moving into higher training felt there were only few problems in their preparation. This would seem to reflect the general improvement in the process of structured training and it will be interesting to see if they hold these views at the end of their training and when they achieve their CCST.

CCST

Those who had completed their training felt that there were few problems in their special interest training. Those who had actually achieved a consultant job were even more positive. They were reasonably happy that the Educational Supervisor had assessed their needs successfully and interestingly, were happier with the content of education than their junior colleagues.

50–59% problems – needs some serious adjustment

SpRs

This group of trainees appears to have significant reservations about the RITA system and the way that the Educational Supervisors assess their needs and, as will be seen later, they were even more critical as to the way the Educational Supervisor addressed them. They also felt that there were problems in the content and quality of formal education. Interestingly, they seem to be more critical of the latter than their CCST counterparts and this appears to be contrary to the individual comments suggested that the most formal education was pre-MRCOG based.

CCST

It is of great concern that this group felt that there were problems in the preparation of trainees for consultant posts, with only just over 50% agreeing that it was satisfactory. This group of trainees also had reservations about the RITA system and, as already stated, they had concerns about the quality of formal education. Presentation skills also fall into this group and, considering the role of the modern consultant, this is of some concern.

40–49% – significant problems (needs rethinking)

SpRs

This group of trainees expressed significant doubt as to the ability of Educational Supervisors to address their needs once identified. This is supported in the free comments section of the questionnaire and it would appear that serious thought needs to be put to the training and skills of trainers. In spite of the introduction of formal education, communication skills still seem to be a concern within this area and training programmes need to be changed to reflect this need.

CCST

It is a great concern to see exactly how many serious problems appear in this category for CCST holders. They consider that there were serious problems in their training in research and audit, teaching and training, administration and risk management. They also concurred with the other trainees in the ability of Educational Supervisors to address their needs once identified and they had serious misgivings concerning the assessment process in the form of TO2 and SA2. It would appear to be a serious deficiency of our training programmes that those people achieving CCST should feel that they have had such deficient training in areas of such importance for NHS consultants.

<40% – big problems (needs major rethinking)

SpRs

SpRs were even more critical of the assessment system in particular, TO2 and SA2, the PDF process and the role of the logbook. This is a significant finding and changes must be made in this area for the future good of the training programmes. However, it does not distinguish between the actual process of assessment or whether or not the process is being applied in the most appropriate way. From the free comments, it does seem to be that there is a great need for further training of the trainers in this area, in order to get a more consistent approach across all areas. The free comments also highlighted the particular dislike of the TO2 form and its implications. It would also suggest that serious reconsiderations of the form and role of the personal development file and logbook needs to be addressed.

CCST

Again, this group of trainees agreed with their junior colleagues in considering that the PDF and logbook have major problems. Another major finding in this group was the lack of appropriate training in NHS management. It would appear that a fairly major rethink on the curriculum needs to incorporate a mandatory module in this area, together with administration and risk management, already discussed. Finally, and most importantly, the CCST holders gave a strong message that they felt that the Calman process is not a better way of training than its predecessor. Again, it is impossible to tell whether this relates to the process being applied or the fundamental thinking behind the process. It would appear that further work should be carried out in this area to establish which of these two are most relevant.

Looking at further breakdowns within the groups, there seems to be little difference in the views of SpRs appointed during transition and those by appointment. There appears to be a strong feeling in the CCST-holders group that the assessments are too subjective, training is too short and, rather sadly, they seem to prefer the old system of training. Those who have already been appointed consultants with CCST were more likely to say that they were not prepared for a consultant job and they were not sufficiently trained in NHS management. At the same time, they were more likely to say they had better training in special interests and also had better training in presentation skills and, presumably, this might be the reason why they have been successful in obtaining an appointment.

As to formal education, there appears to be a need to rethink the curriculum and methods of education. There would appear to be a need to divide pre- and post-MRCOG education and that there should be a more up-to-date method of education, led by Educational Supervisors.

There is a strong feeling running throughout the audit, both in the results and free comments, concerning the Educational Supervisors commitment and ability to train within a five-year structured training programme. There would appear to be a serious need for a

development of criteria for Educational Supervisors. They would have to demonstrate commitment to training, have adequate time allocated in their job plan and take on active participation in their own CPD. They would need the basic skills of trainers, especially in the areas of assessment and appraisal, shortlisting and mentoring. They would need expertise in the methods of education and be able to arrange and lead effective educational sessions.

Finally, there seem to be serious concerns about the length of training. The Calman report states 'There should be a reduction in the duration of training without compromising standards'.

There can be little doubt that implementation of this report has produced a significant step towards improving the structure.[13] If standards are not to be compromised, a considerable amount of rethinking needs to be carried out to make sure that the trainee passing through structured training is not going to be disadvantaged in their eventual preparation for a consultant job in the NHS.

Summary (see Table 1)

SpRs

It is clearly shown in Table 1 that this group of trainees are satisfied with supervision of their clinic skills. This includes practical obstetrics and rather goes against current thinking concerning the possible lack of trainee supervision in labour ward. They generally felt that they were well prepared for higher training, although there were some problems concerning access to gynaecological surgery. However, they were considerably less happy with the quality and content of education and the recognition of their training needs by their Educational Supervisors. There was a clear dislike of the PDF, the logbook and the appraisal assessment system and this needs to undergo a major rethink.

CCST holders

These trainees were far less happy with their development of skills required for preparation for a consultant post and there was particular dissatisfaction with the training of non-clinical skills, such as administration, NHS management and risk management. Although a high number agreed the need for formal education, the quality and content was less satisfactory. There appears to be criticism of the training skills of Education Supervisors and indeed their own preparation for being 'trainers' themselves. Like their colleagues, they expressed serious problems concerning the appraisal and assessment process and a dislike of the PDF and logbook. Both groups felt that the RITA needed some serious adjustment.

Table 1 Summary

			SpRs (*n* =185;66.5%)		CCST-holders (n = 161; 54%)	
			Question	Agreed (%)	Question	Agreed (%)
1	≥70%	No problems	Need for formal education	83	Need for formal education	89
			Gynaecological outpatient clinic	81		
			Antenatal clinic	75		
			Practical obstetrics	75		
			Basic surgical skills	72		
2	60–69%	Few problems – needs fine tuning	Gynaecological surgery	69	Content of education	61
			Preparation for higher training	67	Special interest	60
					Training needs by Educational Supervisor	60
3	50–59%	Problems – needs some serious adjustment	Training needs by Educational Supervisor	54	Quality of education	58
			Content of education	54	Teaching and training skills	54
			RITA	52	Preparation for consultant	53
			Quality of education	50	RITA	52
4	40–49%	Significant problems – needs rethinking	Communication skills	41	Presentation skills	49
			Training needs addressed by Educational Supervisor	41	TO2, SA2	41
					Research audit	41
					Administration	41
					Risk management	40
					Training needs addressed by Educational Supervisor	40
5	<40%	Big problems – needs major rethinking	Personal development file	39	NHS management	33
			TO2, SA2	38	Personal Development File	31
			Logbook	37	Calman process better than predecessor	31
					Logbook	29

The Working Group should therefore consider making the following recommendations:

1. The present formative/summative assessment process (SA2, TO2) needs major review with particular reference to the personal development file and logbook.
2. A standardised objective RITA should be developed in conjunction with COPMED. There should be greater College involvement, with particular emphasis on the assessment prior to higher training.
3. Formal education should remain an integral part of protected time training, although the content and quality should be reviewed, particularly in the areas of non-clinical skills required by a consultant in the NHS. A national forum of those responsible for education should be convened in order to develop new methods of modular training.
4. Criteria for the skills required to be an Educational Supervisor need to be clearly defined and a national training programme should be developed to support this role.

It is hoped that these recommendations, coupled with a more structured preparation of SHOs for the SpR grade, will remove the need to lengthen the time of training. Whether or not this is successful can only be assessed by a future working party.

References

1. Calman K. *Hospital Doctors: Training for the Future. The Report of the Working Group on Specialist Medical Training.* London: Health Publications Unit; 1993.
2. Collins REC. Surgeons and the New Deal: good deal or raw deal. *Ann R Coll Surg Eng* Suppl 1995;77:297–8.
3. Royal College of Physicians of Edinburgh. *Review of the Working Patterns Training and Experience of Medical SHOs in Scotland.* Edinburgh; 1997
4. Potter RW. Surgical training and education. *J R Coll Surg Edinburgh* 1996;41:204–6.
5. MacIntyre IM. UK Surgical training: current problems and possible solutions. *J R Coll Surg Edinburgh* 1996;41:209–12.
6. Hunter S, McLaren P. Specialist medical training and the Calman Report. *BMJ* 1993;306:1281–2.
7. Dumskyj M. Experience is paramount for successful management of disease. *BMJ* 1998;316:1828.
8. Hollingworth T. Reservations about the implementation of the New Deal. *Br J Hosp Med* 1993;150:621.
9. Carter D. New CMO criticises training reforms. *BMJ* 1996;313:947.
10. Collier SO, Calne R. Surgical training: experience sacrificed to change in practice. BMJ 1993;307:1210.
11. Crofts TL. Surgical training: an objective assessment of the recent changes for a single health board. *BMJ* 1997;307:871–2.
12. Campbell W, Moorehead RJ. Junior surgeons lack practical experience. *BMJ* 1993:871–2.
13. Bourne MC, Paterson-Brown S. Calman and the new deal: compromising doctor training and patient care. *Scot Med J* 1999;44:147–8.

Appendix D

TRAINEE EVALUATION FORM

(For completion by Specialist Registrars)

Please complete this document and take it with you to your Deanery Assessment Panel interview, where it will be used to focus discussion. The form is also used to audit the quality of training in the Deanery so you should leave it with your interview panel who will pass it to the Specialist Training Committee Chairman.

Do not write your name on the form so that if any criticisms are fed back to the hospital at a later date they cannot be attributed to you.

SpR Year or
FTTA Year 1–3, 4/5 _______ Months in this post __________Special interest ___________

Consultant _____________ Hospital _____________________

CLINICAL TRAINING	**Deficient**	**Satisfactory**	**Good**	**Comments**
Gynaecological outpatient clinics				
Antenatal clinics				
Ward rounds				
Specialist clinics (specify)				
Clinical review sessions				
Audit sessions				
Journal review sessions				
PRACTICAL TEACHING				
Adequate opportunity to operate				
Adequate opportunity in labour ward				
Adequate demonstration of gynaecological techniques				
Adequate demonstration of obstetric techniques				
Adequate supervision in theatre				
Adequate supervision in labour ward				
Communication/rapport with consultant				
RESEARCH Opportunity				
(Specify sessions) …………………				
Encouragement				
CAREER ADVICE				
CLINICAL MANAGEMENT				
Did the consultants allow adequate responsibility for patient management?				
Did you have adequate support with advice for emergency cases?				
Did you have adequate support in theatre for emergency cases				
Did you have adequate support in the labour ward for emergency cases				
FEEDBACK				
Did the consultants give you appropriate feedback about your performance				
OTHER AREAS (Specify)				

Appendix E

North Western Deanery Annual Assessment Interview

Suggested topics to be covered during assessment

Review of updated CV

Confirm Calman year and estimated CCST date

Discuss trainer's assessment of trainee

- assessment form in respect of current post
- previous assessment documentation

Discuss trainee's assessment of post

- post assessment form (if available)
- appraisal system

Review logbook

- number of patients
- appropriateness of cases
- level of supervision

Review timetable

- able to take research session
- supervision session (if appropriate)
- able to attend teaching sessions/take study leave
- number of theatre sessions (if appropriate)
- satisfactory on-call commitment

Progress with MSc/other research

Plan for Research year / Fellowship year (if appropriate)

Course meetings

- attended during 12 months
- planned for next 12 months

Management experience

Teaching experience

Audit experience

Achievements over previous 12 months

Aims for next 12 months

Review / Summing up

- Satisfactory/unsatisfactory assessment – *i.e. able to progress to next year of training or requires targeted training/repeat year*
- General overview from trainee's perspective – strengths, areas needing continued atten tion
- Whether obtained the training as specified in the Training Programme
- Any follow-up actions to be taken by the Chairman
- Review of sickness record over previous 12 months
- Applying for full time consultant posts.

Appendix F

Survey of Specialist Registrars who have completed year 3

Number in survey	88			
Passed MRCOG	78			
Not passed MRCOG	10 →	Times attempted:	0 =	3
			2 =	3
			3 =	2
			4 =	2
			TOTAL	10

	In obstetrics		In gynaecology	
MRCOG logbook – targets completed				
	0–25%	2	0–25%	1
	26–50%	3	26–50%	3
	51–75%	10	51–75%	17
	0ver 75%	68	0ver 75%	61
	No reply	3	No reply	4
	N/A	2	N/A	2
CCST logbook – targets completed	In obstetrics		In gynaecology	
	0–25%	2	0–25%	2
	26–50%	5	26–50%	13
	51–75%	23	51–75%	28
	0ver 75%	54	0ver 75%	41
	No reply	4	No reply	4

Commentary

1. The SpRs in this survey had undertaken all their training within the Calman system.

2. 88 responses represents approximately 65% of SpRs in year 3.

3. 78 (89%) of SpRs had obtained the MRCOG by the completion of year 3. Of the rest, a small number had not yet taken the examination and a few had attempted it three times or more.

4. Thus, the proposed regulation to restrict progression to year 4 to SpRs who have passed the MRCOG should not lead to a significant hold-up at the year 3–4 stage.

Questionnaire for Specialist Registrars

Name ____________________________________

Deanery

Please circle your answer

1 Which SpR year did your last RITA review?	1	2	3	4	5
2 Have you passed the MRCOG?	Yes	No			
3 In which grade did you pass the MRCOG?	SHO	SpR 1	SpR 2	SpR 3	SpR 4
4 How many times have you attempted the MRCOG?	0	1	2	3	> 3
5 What proportion of your MRCOG logbook targets have you achieved in obstetrics?	0–25%	26–50%	51–75%	Over 75%	
6 What proportion of your MRCOG logbook targets have you achieved in gynaecology?	0–25%	26–50%	51–75%	Over 75%	
7 What proportion of your CCST logbook targets have you achieved in obstetrics?	0–25%	26–50%	51–75%	Over 75%	
8 What proportion of your CCST logbook targets have you achieved in gynaecology?	0–25%	26–50%	51–75%	Over 75%	