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Review Article

Single grade specialist training in otolaryngology – a survey of attitudes among present and recent trainees

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Abstract
The authors present the results of a postal questionnaire about possible advantages, disadvantages, and logistics of a single grade training scheme. Replies were received from 13 recently appointed consultants and 42 otolaryngologists in training. The majority (43) were in favour of a single grade training scheme, although it was felt that certain potential problems would need to be carefully addressed, particularly the potential for narrow clinical exposure and the difficulties inherent in early selection for higher surgical training. It was also felt that for such schemes to work, considerable extra consultant time would need to be set aside purely for teaching. The respondents' ideal training scheme is outlined.

Key words: Otolaryngology; Education, graduate

Introduction

The recently published report of The Working Group on Specialist Medical Training (Department of Health, 1993) proposes, *inter alia*, that specialist training should comprise a single run-through training grade, in contrast to the current periods as Registrar and Senior Registrar. It has long been held that the barrier between the two levels is artificial and stands in the way of a planned, progressive, comprehensive, higher surgical training scheme (Lettin, 1992). Although higher surgical training at Senior Registrar level is controlled by the Specialist Advisory Committee, a recent survey showed that most Senior Registrars were satisfied with their posts (Watson, 1991). Specialist training at Registrar level has been less strictly controlled and far more variable in length and content. Members of the Association of Surgeons in Training, when recently polled on the issue of a single grade specialist training programme, were divided roughly equally between 'in favour' and 'against' (Hill, 1992; personal communication). In Spring 1992, the authors conducted a postal survey of attitudes among current and recent otolaryngological trainees on the question of single grade training and issues surrounding the restructuring of ENT training in the UK.

Method

One hundred and forty questionnaires were sent to members of the British Association of Otolaryngology whose entries in the Medical Register showed them to be currently in training or recently appointed to consultant grade. Questions concerned potential advantages and disadvantages of a single grade training scheme, the appropriate length, structure, and content of such a scheme, the ideal role and frequency of assessment during training (of the trainee and of the training scheme!) and the extra facilities which might need to be provided to implement the suggestions made. Many of the questions were of the 'open response' type to encourage free comment.

Results

Fifty-five questionnaires were returned completed, 13 from consultants and 42 from trainees of varying grades (see Table I). Of the 55 respondents, 43 (78 per cent) felt that a single grade specialist training scheme was desirable. Six felt it was undesirable and six did not state a clear preference.

Advantages and disadvantages

The perceived advantages and disadvantages of a single grade training scheme are listed in Table II.

Ideal single grade training scheme

Length

Most respondents felt that the training scheme should be of five years duration, following an introductory period of ENT and basic surgical training (see below), though the range was from four to seven years (see Table III).

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TABLE I
RESPONDENTS' SENIORITY (n = 55)

Consultant	13
Associate Specialist	1
Senior Lecturer	1
Senior Registrar	19
Registrar	16
Senior House Officer	3

Entry requirements

Most respondents felt that a basic surgical training including 12 to 18 months of ENT should be completed before entering higher surgical training. Half of the respondents felt that the Clinical-Surgery-in-General Examination with an Otolaryngological component should be required before appointment to a career training post, as recommended by Ludman (1990). Forty-three out of 55 respondents felt that research publications at the stage of entry to higher surgical training were unnecessary or of value only to show interest and enthusiasm.

Structure

The majority of respondents felt that a traditional style 'rotation' would be preferable to a 'fixed length/fixed plan' scheme (where a trainee would always start with Firm A, progress to Firm B etc., and would cease training after Firm X). Thirty respondents preferred a 'rotation' while 13 stated a preference for a 'fixed length/fixed plan' scheme. Where a reason was stated for the preference for a 'rotation', this was usually because of worry about what would happen at the end of a 'fixed length/fixed plan' scheme (despite the fact that such a scheme might offer better tailoring of training modules to a trainee's level of experience, and better opportunities for assessment). A second perceived advantage of a 'rotation' was that it would offer more flexibility to allow for the unexpected, such as a trainee leaving the scheme, or to facilitate elective periods or subspecialization.

Composition

Most respondents felt that time in training should be divided on about a 50 : 50 basis between District General Hospital training and Teaching Hospital training with the number of house moves required limited, ideally to one and maximally to two. It was felt that modules of training should be six or 12 months in duration, and should include basic training in otology, rhinology and general head and neck surgery. The relative importance of various non-mainstream subspecialties to canvassed trainees is listed in Table IV. Forty-eight respondents felt that an elective period should be available at least as an option, to be used for research, travel, subspecialization, or possibly management training.

TABLE II
PERCEIVED ADVANTAGES AND DISADVANTAGES OF SINGLE GRADE SPECIALIST TRAINING

Advantages
Security of training advancement once selected for training
Shorter, less repetitive, better restructured training schemes
Standardized progression of responsibility and experience
Continuity and improved quality of research
Less domestic disruption
Balance of training considerations *versus* service commitment
Disadvantages
Possibility of limited experience if exposure to different centres/teachers restricted
Need for greater input/supervision/organization
Potential problems if trainee found to be unsuitable
Less scope for individuality
Lack of stimulus to work if no reselection to Senior Registrar level

Assessment of trainee

Virtually all respondents felt that regular discussions between trainers and trainees were important, at six-monthly or at most 12-monthly intervals. It was felt that these could be formal or informal, and should cover not only clinical, surgical, and research development but also administrative and interpersonal skills and career advice. There were many comments that trainees, unsuitable for advancement to consultant level, would benefit from **early** counselling and guidance into another career.

Assessment of training scheme

Almost all (49) respondents felt that it was important to have a regular opportunity to discuss the training scheme, looking at supervision, clinical experience and possible deficits in training.

Extra facilities needed

To implement the suggestions outlined above, 18 respondents stated that considerable extra organization and coordination would be needed and 16 felt that consultants would need to have more time set aside purely for teaching.

Discussion

The large majority of respondents were in favour of a single grade training scheme in principle, though possible disadvantages were pointed out which would need to be addressed in setting up such a scheme. It was felt that considerable extra consultant time would need to be set aside purely for teaching, if the potential advantages of a single grade training scheme, i.e., brevity and efficiency, were to be realized. This need for extra consultant work is only one of two reasons why proposals for a shortened single grade training period may fail without expansion of the consultant grade. Hunter and McLaren (1993) make the point forcibly that unless expansion of the consultant grade occurs, a gap is likely between completion of the new shorter training scheme and appointment to consultant grade, during which comprehensive continuing train-

TABLE III
DESIRABLE LENGTH OF SINGLE GRADE TRAINING

Years	No. in favour
4	4
5	35
6	12
7	2

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TABLE IV
RELATIVE IMPORTANCE OF SUBSPECIALTIES

Subspeciality	Desirable for all	Special interest only
Rhinoplasty/Soft tissue	37	3
Endoscopic sinus surgery	35	3
Paediatric laryngology	33	1
Reconstructive surgery/flaps	31	4
Thyroid/parotid surgery	31	1
Neuro-otology	27	2
Voice clinic	23	3
Audiological rehabilitation	22	2
Base of skull surgery	13	10
Cochlear implants	10	10

ing would be hard to find (and to fund). The extent of our respondents' worry about this problem is reflected in the fact that so many stated a preference for a rotational training scheme because of worry about what would happen at the end of the fixed length scheme if no consultant job were available.

Our respondents favoured a longer training period than that recommended by the report of the Secretary of State for Health (seven years from qualification). Most of our respondents felt that trainees should complete at least a year of general surgery and at least an introductory year of otolaryngology before entering a five-year specialist training programme: these seven years would at present have to be preceded by a pre-registration year after qualification, and until now by a year preparing for the primary fellowship. This minimum total of nine years from qualification to completion of specialist training would assume success at the first attempt for the primary fellowship and acceptance at the first application into an ENT training programme. It remains to be seen precisely which of the above modules would be cut out or abbreviated in order to condense training to the period recommended by the Calman Report.

The main perceived potential disadvantage of a single grade training scheme, which would need to be addressed when setting up such a scheme, was that a very narrow range of trainers and opinions might be provided: most respondents commented that the present system, though long and unwieldy, eventually provided a broad range of clinical and operative experience. High priority should therefore be given, in designing a new system, to maintaining this breadth and scope of experience and although respondents generally felt that a single grade training scheme would be less socially disruptive than the present system, very few felt that a good broad training scheme could be completed without any house moves.

Critics of single grade higher surgical training query whether one's stimulus to work would be removed by the abolition of competition for Senior Registrar jobs. It has however been pointed out by Lettin (1992) that the Intercollegiate Examination should compensate more than adequately for this. It is anticipated that the Intercollegiate Examination in conjunction with successful completion of a recognised training scheme will take over previous accreditation.

A potential problem with a single grade training scheme is that 'consultants-in-waiting' would be selected at a very early stage. A mechanism for weeding out unsuitable trainees would need to be carefully devised, and one suggestion was a probationary period, while others suggested that the 'in house' assessment should provide the opportunity for a regular review of the trainees' suitability for the training scheme. Certainly the early selection of likely consultants at the time of appointment to recognized training schemes would throw into strong focus the need for thorough career advice at senior house officer level: the shorter the exposure to a specialty before choosing a specialist training scheme, the more difficult the choice would be.

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