Scenes from Postgraduate Life

Career chaos

*The Times*¹ published an obituary to Professor Robert Milnes Walker in a week when I sat on two separate committees to appoint senior registrars in surgery. Milnes Walker had been professor of surgery at Bristol and a pioneer in the surgical management of portal hypertension; he had performed a porta-caval shunt on one of the longest surviving of my patients with cirrhosis. But this is not a personal reminiscence; my purpose is to emphasize two features of his career which, depending on individual prejudice, might be considered either hopelessly archaic or relevant to present times. He was appointed a consultant surgeon at the Royal Hospital, Wolverhampton, then considered one of the provincial centres of excellence (J.H. Sheldon of haemochromatosis fame was one of the physicians) at the age of 28, and he subsequently transferred to the chair at Bristol.

There were between 20 and 30 applicants for each of the two senior registrar posts in which I was involved. It was extremely difficult to select half a dozen for shortlisting, so comparable were they all in experience and excellence. Their ages ranged from 31 ('too young') to 41, and in the event those we appointed were over 35. All of them had either written or obtained a mastership in surgery; the amount of research (frequently a year or two as a research fellow or lecturer), and the number of presentations and publications would have gladdened the heart of an academic; their experience of surgery seemed quite sufficient for me to put myself in their hands with complete confidence. One candidate remarked wryly that this was his 55th application and his 15th interview. When asked if he appreciated what the competition was like, he said that he had heard there were 800 registrars in the country, most of whom had the Fellowship (*Health Trends*² gives the total number in general surgery as 668 at September 1984).

I kept having to remind myself that this was an appointment for a senior registrar; that with the present block in surgical appointments – surgery and thoracic medicine are the two specialties at present showing 'negative growth' – none of the successful candidates was likely to obtain a consultant appointment till his early forties. Nor was this an exceptional experience. At a similar interview for a senior registrar in cardiology at St Elsewhere, the short-listed can-

didates had done cardiac catheterizations, insertions of pacemakers, and echocardiograms in the hundreds. When I remarked to my neighbour that I would be happy to have any one as a consultant colleague, a voice across the table remarked 'not at this institution'. The average age on appointment as a consultant was 37 when last recorded², with a relatively narrow range among the specialties of 34.7–41.1. As far as I am aware no one has questioned 32 as the optimum age for consultant appointments recommended in early reports on the hospital career structure.

Whenever I sit on appointment committees for senior registrars I hear despairing comments from my colleagues that any one of the applicants could do the job; that juniors seem to be increasingly cloned into recognizable stereotypes by the system; and that our specialty training schemes are becoming a laughing stock in other parts of the world. Certainly the days when a specialist diploma conferred consultant status in some developing countries are gone, but it is equally ridiculous to expect someone to do ten years' training *after* obtaining a higher qualification. As a colleague remarked at one of the interviews, 'What do you do with such a highly qualified registrar? He's done all the things we normally expect of a senior registrar, and now he will have to mark time'. Indeed it has been known for a long time that many senior registrars undertake consultant work; in some cases they may resist becoming consultants because of the large number of UMTs they can obtain, especially if, as some do, they continue on a 1 in 2 emergency rota. The problem may be eased by creating more consultant posts, but there must surely be a limit to the number that a health district can accommodate. Understandably, members of medical specialties feel that their own interest should be represented and there have been calls for physicians with an interest in, for example, diabetes, rheumatology and cardiovascular medicine, to be appointed in every district. While increasing the trend towards specialization such a move would undoubtedly dilute an individual physician's experience of general and emergency medicine, and hence the general professional training of juniors.

While physicians have for some time had to offer a special interest, surgeons are now beginning to follow suit, with urology, gastrointestinal surgery, vascular surgery and oncology the most common options. The first of these has now been recognized by the Royal College of Surgeons as a specialty in its own right, so that it is possible to obtain dual accreditation. This

¹*The Times*, 28 August 1985; ²DHSS Medical and dental staffing prospects in the NHS in England and Wales, 1984. *Health Trends* 1985, 17, 45–52.

provides both a means of prolonging training (the introduction of a third part into some of the diploma examinations is another sinister omen), and a way of excluding individuals because they are not accredited. For, while the Colleges insist that accreditation is not essential for consultant appointments, everyone knows who will get the job when two candidates are equal apart from accreditation. Increasingly too, the Colleges are losing their flexibility as regards requirements for accreditation: training takes precedence over experience to the extent, for example, that when someone has been doing a locum consultant appointment for some time, he or she may not be able to apply for jobs because training has not been completed.

Time-expired senior registrars say that it is now virtually impossible to obtain consultant appointments outside the region in which they have trained. While this may be an excuse for their difficulties, there

are certainly demands for teaching hospitals to take more responsibility for their own trainees. Indeed I know of one provincial medical school where a rotation is arranged from senior house officer to senior registrar, with virtually assured appointment to a consultant post in the region. While this may be admirable as far as the security of the individual is concerned, I cannot help wondering whether it is good for a specialty to be so parochial; it is perhaps heartening to hear that a similar scheme elsewhere failed because of complacency and lack of enterprise on the part of those involved.

The problems of the hospital career structure have been with us almost since the beginning of the NHS, and their complexity should not be underestimated. Postgraduate deans spend a great deal of time agonizing over them, but I sometimes wonder whether the profession shares their view that a solution is becoming daily more urgent.

Alex Paton
Postgraduate Dean
North East Thames Region
British Postgraduate Medical Federation
33 Millman Street
London WC1N 3EJ