

## Commentary (Series editor: David Taylor)

### Are ophthalmologists overtrained?

To the observer from Mars, the length of ophthalmology specialist training in the UK may appear to be rather long in proportion to the content or to the job to be done as a consultant. Are ophthalmologists overtrained?

Evidence the Martian might cite could include a comparison with training elsewhere in the world. A steady stream of Australian and New Zealand trainees nearing the end of their own postgraduate training programmes spend a year or so in the UK doing official and unofficial fellowships or registrar locums, thereby fulfilling their accreditation requirements and then return home (“practise makes practice”, as one wit put it). How come, the question goes, these individuals reach accreditation standards at least as high as those in the UK in about 4 years when it takes at least 8 years here? This calculation is made simply by adding the minimum 2 years currently required in basic surgical training at senior house officer (SHO) grade together with 4.5 years as a specialist registrar (SpR), which works out at a minimum of 6.5 years. As many SHOs wait for 3 years before becoming SpRs and most SpRs spend the full 5 years allowed, the modern UK average time is at least 8 years. A similar discrepancy is found between North American practice and here. Elsewhere in Europe the surgical content in training programmes is variable and generalisations are impossible.

Well, of course, there are several reasons why the UK training remains so long. For one thing, higher specialist training places in ophthalmology in the UK tend to be oversubscribed, so extra time in basic surgical training or in research waiting for a place is not unusual. The number of training places nationally is highly regulated in an effort to make a good match between the number of consultants required and the number of fully trained specialists eligible to apply. Inevitably, this creates a competitive bottleneck earlier on in the system. This is just one of many differences between the UK and those countries where the numbers of consultants at any one time is not so carefully controlled.

A further reason is the need for wide clinical and surgical experience before starting out as a consultant. This explains the 6.5 year time currently laid down by the Royal College of Ophthalmologists and the Royal College of Surgeons of Edinburgh. In the UK, a new consultant starting out with a full time or maximum part-time NHS contract takes on at least two operating lists a week and a patient population of between 70 000 and 100 000, requiring a secondary level ophthalmic service which is likely to include the common cataract co-morbidities of glaucoma and macular degeneration, not to mention diabetics and children. This cannot reasonably be compared with primarily private sector based appointments that can be built up quickly or slowly depending on local circumstances. In fact, there are those who believe that in order to be qualified for such a job *and* offer a subspecialty interest, the training should actually be longer than it currently is to include the appropriate subspecialty training. Debates as to whether such extra training should be provided before accreditation as advanced subspecialty training opportunities (ASTOs) or after accreditation as fellowships continue. The rub here, of course, is that while the profession, and probably also the public, would like to have suitable

numbers of subspecialists, current regulations only recognise a generic qualification. Newly appointed consultants are frequently encouraged to offer a subspecialist interest, and this extra expertise is acquired in a variety of ways both at home and abroad. The end point of training therefore remains somewhat imprecise.

A related comment, frequently heard, is that since the abolition of senior registrars, the introduction of the uniform “Calman” training grade for specialist registrars, and the stipulation of maximum hours of on-call, the level of expertise among senior trainees may have gone down. This is debatable—more probably it reflects the fact that the best training which used to be exclusively available only to the best trainees has now been opened up to much larger numbers spending proportionally less time in the best centres. For some, trainers led to the impression of lowering standards rather than any improvement.

At the other end of the training ladder, there are interesting questions about the utility of the SHO grade except as a way of sorting out a highly heterogeneous workforce before entry into higher specialist training. There does seem to be a certain amount of duplication of effort in the latest Royal College of Ophthalmologists curriculum for basic surgical training and that for higher specialist training itself. As for SHO posts which are not currently recognised for basic surgical training, it is hard to predict their survival.

Of course, it is not simply the length of training and which technical competencies need to be acquired that are currently being debated. There are also debates about the human side of specialist training. In the “Consultant 2000” process introduced by the postgraduate dean in our region to help with highly competitive selection procedures, much thought has gone into creating fair and equitable ways of choosing specialist registrars, and thereby prospective consultants. Much of this is derived from the GMC’s publication *Good Medical Practice*. As part of the process, a structured application form is reviewed by a panel and scored using agreed criteria. Following short listing and interview, appointments are made, in theory selecting those who not only have a wide knowledge base, a proved aptitude for microsurgery, and an ability to initiate and undertake meaningful research, but also to demonstrate a range of personal skills.

These include:

- Communication and language skills
- Decisiveness/accountability
- Use of a non-judgmental approach to patients and colleagues
- Flexibility
- Resilience
- Thoroughness
- Showing initiative/drive/enthusiasm
- Probity.

Having recently been part of the recruitment process in the North Thames Region I found the exact way in which these sterling qualities are really assessed remains somewhat vague. At least it is a start to write them out clearly, and obviously the candidate who fabricated some of his citations hadn’t read the bit about probity or didn’t understand the meaning of the word! All applicants had to fill in

the section of the application form entitled: “Communication and Interpersonal Skills (*You need to be sensitive to the likely reactions of others to your actions. You must have the ability to work effectively with others and be aware of your own impact. You will need to be able to communicate clearly and present an argument persuasively*). In the space below, give a recent example that demonstrates that you possess these skills.”

Clearly there were some applicants who might struggle with contemporary UK culture: one wrote “assertive behaviour is necessary to maintain self respect in response to negative criticism . . . effective planning is impossible without a dairy (sic) system”.

Others were more constructive and fell into the categories of:

- “*Caring and compassionate*”—“I stayed late after the end of the clinic to talk to the family of a child with a suspected malignant brain tumour”.
- “*Coping and stressed out*”—“none of my seniors were in the clinic and I had to talk to the angry abusive patient and her husband about her pseudophakic cystoid macular oedema myself”.
- Some were “*future leaders*”—“I successfully argued the case for an extra laser list”.
- Others were “*clinical scientists in action*”—“I was able to audit the use of frozen section lid biopsies in our unit and show that current practice needed to be revised”.
- “*Supportive*”—describing her role in supporting an accident and emergency nurse in the aftermath of an incident with a violent patient.

Comparing one account with another is not easy, but they do all in their own way show how doctors see themselves acting in the public arena that must be valuable. Surely the point of these highly intensive processes is educational and not just a way of eliminating the odd rotten apple—our masters who are trying to reshape the medical profession into something more in their own image have devised a system which I would imagine does impart some its values to the applicants—and possibly to the panel as well. The humane aspects of doctors’ work should not be overlooked as they become specialists, and stressing these aspects need not lengthen training, but certainly will influence the content.

Another Martian who was probably not an ophthalmologist or even medically qualified might go on to ask why ophthalmologists even needed to be doctors in the first place—surely such a “straightforward” procedure as cataract surgery could be carried out just as well by paramedics or nurses, in the same way that resuscitation, routine intensive care procedures, and some accident and

emergency care have been successfully taken over by well trained non-medics? After all, with ageing populations and reducing surgical thresholds, how else can the inevitable rise in demand for cataract surgery over the next 10 years be met?

Simply handing cataract surgery over to paramedics and nurse practitioners so as to tackle underprovision of care and long waiting lists begs many questions (diagnostic accuracy, case selection, training, risk management, skills ownership, medicolegal responsibility to name but a few) which the long distance observer might fail to perceive. There are also powerful emotions surrounding this debate, which of course a Martian would never notice. The results of pilot studies are awaited with interest.

And behind these detailed debates about the duration and content of specialist training, the bigger picture of ongoing professional education is changing markedly in the 21st century. Undergraduates and postgraduate/specialist trainees may always have been told what to learn, but the nature of what has, up until now, been called voluntary continuous medical education during a consultant career is currently under intense public scrutiny. Time limited certification, revalidation, and other compulsory forms of keeping specialists up to date are being widely canvassed internationally. This is very likely to impact on the way in which we have tended to see a trainee as a complete and perfectly formed specialist from the day they first become accredited to the day they retire. Why go to such lengths before accreditation if ophthalmologists have to prove they are doing more training afterwards, possibly at their own expense?

Inevitably, one answer to the question “Are ophthalmologists overtrained?” is “It all depends on what you mean by training . . .” UK training remains highly regarded and there is much to be proud of in the present arrangements, judging by the numbers of overseas doctors who seek to come here to augment their own programmes. However, sticking my neck out to express a personal view, I would have thought that if shorter training really is required to bring the UK into line with the best internationally and not the worst, then it is the SHO grade and the concept of mandatory basic surgical training that may come under the most pressure.

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