Alternative training pathways

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The Problem

There is a workforce shortage. The evidence is overwhelming, so why is nothing being done? Whether we are 100 or 200 posts short out of 1000 or 800, nearly every department is aware of the problem. Burnham Market, Blakeney, Walberswick, Southwold are delightful small Norfolk towns with artistic heritages, reasonable house prices and glorious beach walks. But many of the DGHs in Norfolk and Suffolk have long-standing consultant vacancies.

Why is there a problem? Politics

Five years ago, the BAD had meetings with the Department of Health workforce planners. They accepted our calculations and recommended more training numbers. These recommendations were reversed by politicians. The same happened this year; we met with Health Education England: they accepted our calculations, agreed the problem, recommended more posts, then senior people intervened. In earlier years the resistance was driven by a belief by politicians that teledermatology and GPwSIs would reduce demand for dermatology. The greater political priorities of emergency medicine and general practice led this year to the U turn.

Can we not change politicians' minds?

Politicians change their minds if people complain. The politicians say to us that the hospital chief executives are not complaining about problems with recruiting dermatologists. Why is this? I suspect two reasons: the chief executives are more bothered about crises in A&E than about breaching dermatology patients and dermatologists are working long hours of overtime to prevent hospitals failing. By going the extra mile for the sake of our patients (or in some instances for other reasons) we are preventing the system failing: so politicians think there is no problem.

Some mathematics

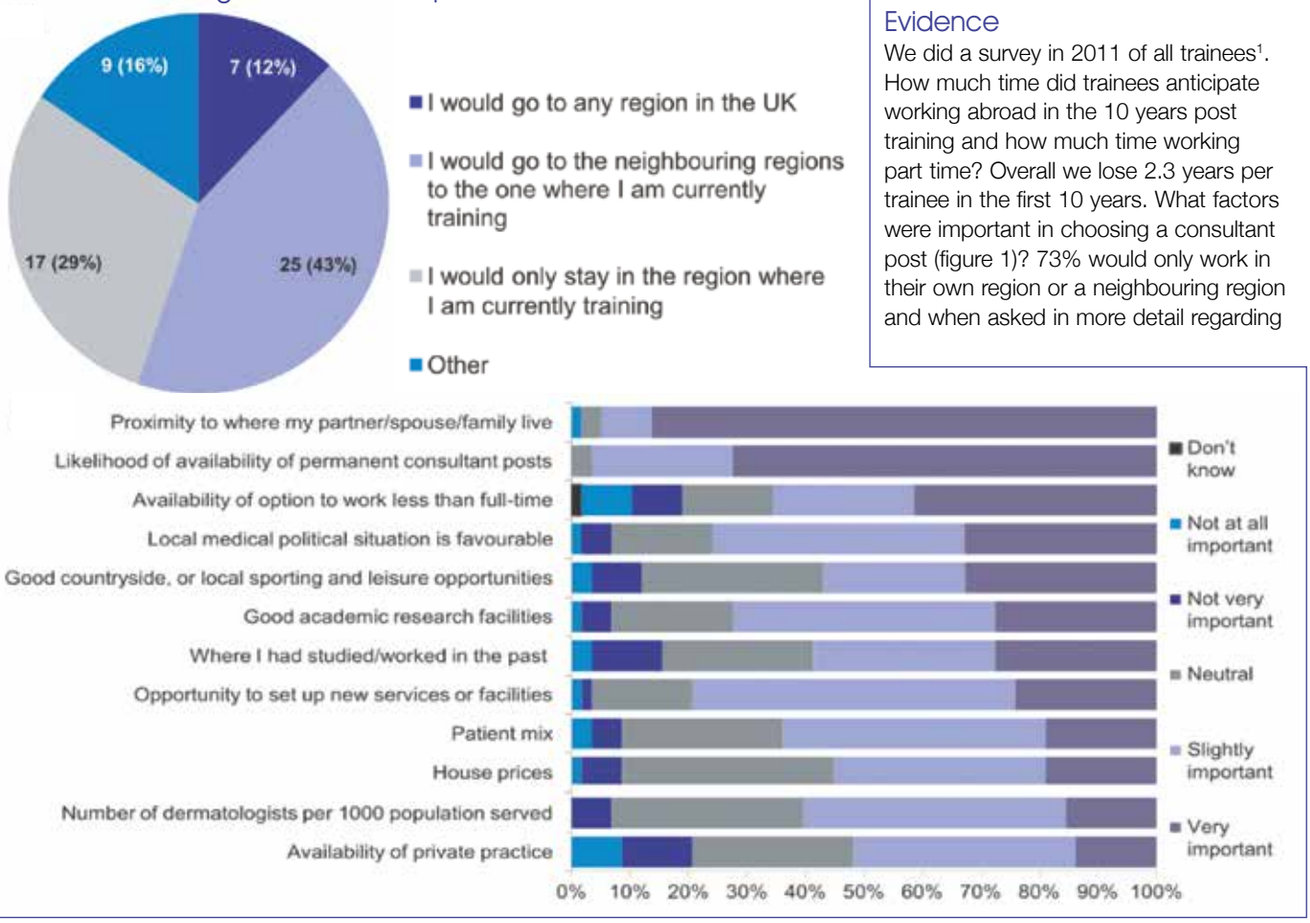
We have about 800 consultants who retire on average at the age of 60 after a career of 25 years. We know some people go earlier, frazzled by the system, but we all know amazing and robust colleagues in their 70s still wielding scalpels and liquid nitrogen, fortified by irrepressible enthusiasm, a need to provide succour for offspring who never seem to leave home and a selection of magnifiers worthy of the national observatory. 800 consultants/25years = 32 consultants retiring per year.

We have around 200 trainees who spend 6.5 years on average in the system allowing for research and children producing 200/6.5 = 31 new consultants per year. So we are not producing sufficient to hold a steady state, to fill the empty posts and to deal with the year on year rise in skin cancer.

Evidence

We did a survey in 2011 of all trainees[1]. How much time did trainees anticipate working abroad in the 10 years post training and how much time working part time? Overall we lose 2.3 years per trainee in the first 10 years. What factors were important in choosing a consultant post (figure 1)? 73% would only work in their own region or a neighbouring region and when asked in more detail regarding

Figure 1:
Factors influencing where trainees planned to work as consultants

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priorities, proximity to partner and family was the most important factor.

Are we picking people for DGH consultant posts?

Dermatology is the best job in the world and the figures prove it. The recent training round had 168 applicants; over 100 were shortlisted; 90 were appointable for only 30 posts. In the setting of a workforce drought, we are awash with fine applicants most of whom we are turning away. We are picking the academic elite of the medical profession with PhDs, intercalated degree 1sts and national prizes. I hope that these superb new colleagues perceive themselves as being the future generations of professors, academics and leaders to make the star of UK dermatology shine ever brighter. However are we also picking some people who will be content working as DGH consultants, who will lead fulfilled and valued lives as members of their local, rural, small town community? Where is the future generation of DGH consultants to come from?

Can the RCP help?

No. The college wishes to train more doctors in acute medicine. This is the priority. The RCP would make our 200 trainees train also in acute medicine, making training longer, reducing the number completing training each year, worsening our shortage. The RCP would like consultants to do acute medicine to reduce pressure off the hospital front door. This would reduce time in outpatients. If they can't get this, then the RCP will lengthen training to include more acute medicine; this will make consultants older on appointment, shorten the time spent as consultants and reduce the dermatology consultant workforce. The RCP policies worsen our workforce problem. As past President of the British Society for Medical Dermatology, I think this approach of the RCP leadership is regrettable. I have spoken to senior members of the RCP to express these concerns. They see our problem, but the acute medicine problem is to them a greater priority, and they think we should agree. They fear letting dermatology "off the hook" with regard to acute medicine as other specialisms will then wish not to participate. They don't recognise that some dermatologists, by contrast with other physicians, may work two years in internal medicine only as a means to getting into dermatology. Acute medicine is increasingly unattractive; but rather than making it more attractive the RCP are trying to force people into it.

The Alternative training pathway

Why not take control of our own destiny? After the discussion on local training at the BAD AGM last year, I came back to Norwich, where I am clinical director, and looked at what we are doing to solve the problem. Julia Schofield and I had already been in discussion about other training models and I decided that in Norwich we should try to formalise this. Our idea is to train people locally as registrars (clinical fellows) then senior registrars (specialty doctors) to pass the CESR route to become a consultant. How can this work?

Clinical Fellows (registrars)

We appoint aspiring dermatologists with MRCP and NHS dermatology experience into a clinical fellow post on a 6 or 12 month contract which is renewable. The clinical fellows are encouraged to get an eportfolio for approx £150/year and to do the same workplace based assessments (WBA) as trainees. They work in medical and surgical dermatology, teach students, do some on call and ward referral work, participate in audits, NIHR research and get 10 days study leave for meetings. They attend departmental and trust CPD activities. If they generate income through research they can use this to fund study leave. They have an annual appraisal and educational supervisors.

Specialty Doctors (Senior Registrars)

When we are happy that these doctors are competent to work without a supervising consultant in the department, they are promoted to specialty doctors. They get more specialised areas of training as they wish, continue to do WBAs if they wish and are allowed to progress at their own pace. This varies. We expect that our alternative trainees can eventually submit an eportfolio that will contain the same material as a classical trainee when they wish to apply for the CESR certificate route to being on the GMC specialist register.

Who pays?

The clinical fellows do 6 clinics/surgical lists per week with a cost to the trust that is a fraction of the cost of locums or of waiting list clinics. They have dermatology experience so hit the ground running. Any clinical director should be able to sell this to the Trust chief executive. The clinical fellows are on short contracts so do not provide a risk to the trust. When they are promoted to specialty doctors they still provide excellent value for money.

Risks

There is no significant risk to the trust or to the department. The trainees run the risk that the trust may go broke and fail to renew their contract. However the dermatology skills acquired will make them employable in the wider NHS and more eligible for specialist training. Some trainees have moved to be specialty doctors or StRs. The scheme requires buy-in from local consultants who do the WBAs. Running the scheme in a DGH would require links with local teaching hospitals to acquire certain specialist skills.

The time has come to help ourselves

This is an evolving strategy that we are improving every year. We have been encouraging eportfolios for the last year or so and have asked for MRCP (or equivalent) for the last 2-3 years. The new BAD education board (and possibly the new college if this works out) should be able to guide and support development of the scheme, to facilitate DGH links to teaching centres for specialised training. Julia Schofield and colleagues have a similar programme in Lincoln and others have been in contact to develop local training.

My colleagues in Norwich have worked on developing and supporting the programme. Ruth Murphy, SAC lead, other SAC members and Irene Leigh BAD Academic VP have been supportive. Senior members of Health Education England acknowledged to me at a meeting last year that as they can't help with our workforce crisis it is reasonable for dermatology to look at innovative solutions to solve the problem within our profession.

Reference

1. Galinskaya E, Levell NJ Too far, too long, too few: workforce planning in dermatology **Clinical and Experimental Dermatology** 2012; 37: 913–914,