Although a letter from Scotland might at first seem rather less exciting than from the previous more exotic locations, the subject is one that I believe troubles neurologists worldwide – how should we best train doctors to become good, even excellent, neurologists? Most (although not all) of my own training took place in the UK, and I shall focus on the changes occurring here, along with a commentary on the advantages and disadvantages of the new system.

For many years in the UK, junior doctors in all specialities were ‘trained’ in an apprenticeship system. This meant long hours with often vicious on call rotas, and little organized teaching. Junior doctors, mostly working in service orientated posts, became good (or bad) senior doctors. Once they had completed their general medical training (three years minimum after their first year residency in medicine and surgery), and obtained the relevant qualification (Membership of the Royal College of Physicians – MRCP or the ‘membership’ – for neurologists and other physicians), they passed on to the registrar grade for 2 or 3 years (perhaps stopping off for a few years to obtain a higher research degree). As registrars they started their specialist training in neurology. They then moved on to senior registrar status and there they might stay for years on end, awaiting a consultant post, perhaps achieving this in their late thirties or early forties. Some never got that far, and tumbled down the steep slope, opting to move into ‘softer’ career options such as radiology, clinical neurophysiology or general practice (in fact, none of these are softer options, there were just more positions available, hence less competition).
In the mid 1990s, it was recognized that this was a wasteful, inefficient and frankly inhumane system, and the specialist training programme was completely overhauled, with registrar and senior registrar grades being replaced by the specialist registrar (SpR) grade. Within this grade, trainees now participate in a time-capped training programme, usually lasting 4 or 5 years, with the ultimate goal of achieving listing on the Specialist Register via the Certificate of Completion of Specialist Training (CCST) (Calman et al. 1999; DOH 1993). Very recently, the Department of Health has published a consultative document on proposed changes at the general medical training level (house officer and senior house officer grades), before the SpR stage (DOH 2002). Add to all this the effects of the New Deal for Junior Doctors (DOH 1997) and the European Working Time Directive (both dramatically reducing the hours that junior doctors are allowed to work), and it is clear that major changes in the way in which junior doctor training has evolved and are being implemented in the UK.

Consider what is required to become a competent neurologist. I believe there are two essential ingredients - knowledge and experience (of course communication skills, empathy and all that sort of thing are important too, but I include those under experience, and no, I do not think they can be taught in the classroom or video lab, but one polemic at a time). How well do the proposed changes at the pre-SpR level, and the already implemented changes at the SpR level, provide for these? Unquestionably, providing high quality, regular, organized teaching is a major improvement for today's junior doctor, and theoretically the programme-based school of training can deliver this. There are a few uncertainties, such as who should provide all this high quality teaching, how do we monitor the quality and so forth, but the theory is sound. But things are less satisfactory when we turn to the aspect of experience.

The amount of clinical exposure for junior doctors has been dramatically reduced - the contact time with patients is much less. There is considerable regional variation, but the total number of hours that juniors may work is now strictly limited, and hospitals have become increasingly aggressive at enforcing these hours. As a result, many units have been forced to drop the previous on call rota (1987–91), and a one in two (1997, whilst in exile in Australia), and it is clear that major changes in the way in which junior doctor training has evolved and are being implemented in the UK. A further knock on effect of shift systems is that it has become unusual to have a full complement of junior staff during the day, when much of the work and training (particularly in neurology) takes place. Finally, such systems make it very difficult for junior doctors to attend the teaching sessions I referred to above - either because they are off duty, or they are too busy trying to cover two or more colleagues who are off duty. This is already a serious problem at the pre-SpR level in my own unit, and may well become similarly problematic at SpR level as the European Working Time Directive starts to bite over the next 2 years. Ultimately, we will end up with relatively inexperienced young consultants, who may have become conditioned to working in rather short bursts.

So what is the answer? Simple - a return to common sense, and the original rota system, so that junior doctors work a normal week, plus on call. No one wishes to return to the one in three rota of yesteryear, but surely a one in six and above is acceptable? Of course it’s not that simple, as the working time directive is European Union and UK law, but I believe we need to realize that we have travelled too quickly from one extreme to the other, and as ever, the middle ground is probably where we need to be.

DECLARATION OF INSIGHT
I acknowledge that this article sounds alarmingly similar to the sort of rants I had to listen to from my father (a surgeon) when I was training. And I know the pain of a prospective one in three rota (1987–91), and a one in two (1997, whilst in exile in Australia but where ‘men are men!’).

REFERENCES

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