Trainees in Endocrinology and Diabetes - are we getting what we need?

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A question. Is any of us happy with the training that he is getting? Not the actual day-to-day run of the mill clinical experience, but the overall set up? Knowing and speaking with quite a few trainees in my region I would suggest the answer from most is a resounding NO!!

Firstly, I am aware from personal experience that this CME Bulletin has not been getting either the exposure or the circulation amongst the juniors - or seniors - that it deserves and I hope that by the time you read this that these problems will have been ironed out and that you will begin to receive a regular copy of this journal.

I start as I mean to go on. I wish to start some sort of constructive dialogue amongst the trainees in endocrinolooy and diabetes in all regions. The idea of this page is to get some sort of idea as to the variety and quality of training that is being offered across the country in both DGH's and in a teaching hospital environment. My own personal experience ranged from the senior trying to rearrange his clinic timetable to fit in with mine - his first specialist registrar - to ensure that I got the maximum possible benefit from the variety of appropriate clinics that were available, to another of my previous bosses trying to discourage me from attending a postgraduate degree course as it interfered with his diabetic clinic. What I would like to know - not necessarily in too much detail (or lots of detail if you want to remain anonymous) is what your experiences as Calman registrars (or old style SR's) has been to date - be they good or bad. It may be that minimum standards for the curriculum have been set, but what training is being offered, and is it what you think you need, or what your bosses think you need. It is only by comparison that standards between hospitals may be assessed and so, if necessary, be held up as paragons of good practice or made aware of the need for change. In short are you getting what you need?

One of my predecessors on this page wrote an article on the 'widespread confusion and ... disaffection' caused by the implementation of the Calman reforms. An example of the disillusionment felt amongst juniors is the annual wait for the next year's placement. This anxiety provoking time came earlier this year than last, when in the South Thames region we were only told some three weeks before where we would be going to. Now for those people with no commitments, this is no big deal (except that it may mean a delay in organising the social life); however, for those where the move involves long distances or for those with families, this is obviously not good enough.

Another anecdotal example was of a trainee 3 years and when the time came to come 'back into the fold' for their final year, hopefully to a central post, they found themselves being posted to another provincial town, this time further away in the other direction! This trainee is clearly unhappy and has rightly kicked up a stink to try to get what he sees as justice. The original idea of 'the first 2 years in a DGH, then the next 2 centrally with the final year either central or DGH depending on whether you are an academic or not' whilst meaning well, seems a little whimsical.

What do the panels deciding on placement around the country base their decisions on? I would welcome their replies. Of course, they have a large number of people to accommodate at various stages in their training and most are placed in the appropriate hospitals, for but what of those who feel aggrieved? Have those trainees who have felt hard done by had some way of voicing their dissatisfaction, and if so, what action - if any has been taken? One of the ways put forward to overcome this is by allowing the trainees themselves to chose where they would most like to go - or have a 'matching scheme' between applicants and seniors. It has been said that when people are placed, if the senior says 'I don't want that person here', then trouble arises.

Moving on - what room is there for flexibility? Have trainees been allowed to pursue higher degrees (e.g. an MSc) without hindrance, and what of the opportunities for taking an Out of Program Experience (OOPE) e.g. an MD or even a period of training in an unrelated speciality that has 'taken your fancy'? For those of you who know me, this is a subject close to my heart, as I have been trying for some time to get training in an unrelated speciality prior to finishing my training in diabetes and endocrinology. I am being encouraged to do so and take time out of the program, but does this enthusiasm come from the tutor taking an interest in me and my personal professional development or from the fact that someone in the periphery needs to come back into the teaching environment and is kicking up a fuss? Maybe I'm just a cynic at heart.

RITA's. Now there's an interesting topic. Mine was all fairly innocuous, as I just mentioned, keen to encourage me to do an OOPE; however, there has been one person who told me that at his annual assessment he was told - to his face - 'you are not consultant material'. A matter of months from their CCST date. Harsh, demoralising and nasty even. On assessment courses, people are taught how to give feedback. It should be constructive. If the feedback is either good or bad, it should not just be 'you're doing alright', or if it is bad it shouldn't be 'that was crap' - it

improved. To be told a devastating statement like the one above and no constructive feedback afterwards is medicine from the 1950's. Trainer's please take note.

. . Having read through my ranting I may have come across as a mad anarchist; however, I and many others, are grateful to have been accepted onto the training program and for the training that we have received. I'm sure that we are all aware of other colleagues who have come to the end of their training and are left looking for non existent consultant posts (what happens to those poor folks once their contract finishes is a different story, and thankfully not too many in this field have had to face it), or at the other end of the spectrum, the shortage of SpR numbers leading to a bottleneck causing a rise in the number of people staying as SHO's. Many have such difficulty that they consider doing research prior to getting the SpR post of their choice. This may be good for getting the post, but when the time comes for the all important consultant interview, there is the potential for that oft heard lament "they said my research was too old".

I will finish by restating what I said at the start; that I want to get a discussion going and that only with the help of you, dear reader, can that happen. I would welcome any view from any grade. It is only through dialogue that change can be initiated.