formance and should have the power to intervene. We would like to suggest that people who undertake school health work should consider deeply and sincerely their motivations to do so.

"... It is our belief that children have special needs which they cannot articulate for themselves and society therefore has a duty to ensure that these are identified and cogently represented."⁹

Postscript

This report was completed in 1978 and discussed with several members of the school health service and of teaching staff. We were pleased to know that during the following year some positive steps were taken in respect of auditory screening procedures which we all hoped would improve its performance. We have briefly reassessed the situation a year later. It seemed that the sincere effort was defeated and that the risk of a child's having an undiagnosed hearing loss that might adversely affect the quality of his future life was still in evidence. We considered that the whole system of auditory screening needs rethinking and have therefore decided to let our findings be known. We would welcome our colleagues' comments.

Nick Harding is employed by the Inner London Education Authority and states that the views expressed in this paper are not necessarily those of the authority.

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References

- Ingram TT. Intermittent hearing loss in young children. *Dev Med Child Neurol* 1976;**18**:239-41.
- Martin JAM. Hearing loss and hearing behaviour. In: *The child with delayed speech*. London: Heineman, 1978:87-93.
- Department of Health and Social Security. *Hospital ENT service, a design book*. London: HMSO, 1974.
- Hamilton P, Ovrid HO. Comparison of hearing and socio-cultural disadvantage in relation to verbal retardation. *Br J Audiol* 1974;**8**: 27-30.
- Sheriden MD. Reported incidence of hearing loss in children aged 7 years. *Dev Med Child Neurol* 1972;**14**:296-303.
- Renfrew CA. Speech therapy. *Dev Med Child Neurol* 1972;**14**:244-9.
- Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976:150. Cmnd 6684. (Court Report P10.18.)
- Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976:161. Cmnd 6684. (Court Report P10.58.)
- Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976:279. Cmnd 6684. (Court Report P16.19.)

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Flexibility in general professional training

J G ROBSON

The royal colleges and their faculties have been anxious for some time to ensure maximum flexibility in the general professional training period, roughly the first four years after graduation. It is most desirable that young doctors should have adequate time to gain varied experience so that their career may be chosen on an informed basis and that as much as possible of that experience should be acceptable across the specialties. The Conference of Medical Royal Colleges and their Faculties in the United Kingdom requested that I report on areas of common training between the specialties so that ways and means of ensuring flexibility could be examined.

Present requirements

The colleges and their associated joint higher professional training committees have opted for formal training to (NHS) consultant standard, unlike the practice in many other countries where formal training stops some two to four years short of this point. International comparisons are not valid unless they take into account the time of achievement of the standards which we require of consultants. When such times are examined there appears to be little difference between any of the developed countries so that attempts to reduce the training period have to take our accepted system into full account. For practically all

the specialties the colleges and joint committees have a target duration of training of eight years from qualification to consultant eligibility. The question really is whether or not the training regulations of individual colleges and faculties introduce such rigidity that they add significantly to this time.

With two exceptions, the Royal College of Radiologists and the Royal College of Pathologists, the colleges and faculties base their specialty qualifying examinations on the assumption that they will be attainable at about the fourth year after graduation. It is therefore important to know what time has been "lost" at this point if a late realisation of mistaken choice forces a change of career. A brief description of the recommended flexibility in the main specialties is revealing and I will attempt to summarise them, although reading the full regulations and consulting with the relevant college adviser is recommended to individual doctors.

The training requirements of the three colleges in medicine that award the MRCP (UK) and those for the MRCP (Ireland) are adequately non-rigid. The membership is required for all the medical specialties for which training is individually determined by the Joint Committee for Higher Training in Medicine. The examination is expected to be taken about three years after qualification, the only firm requirement being that the part II examination may be taken only after a year in an approved post practising acute medicine. Graduates who set their sights on a medical specialty can, in their first four years, have the option of at least two full years to explore other specialties in hospital or elsewhere, and it is not the wish of the colleges that they should specialise in a medical specialty at an early stage. The requirements for the Faculties of Community Medicine and Occupational Medicine make no impositions in the first

Conference of Medical Royal Colleges and their Faculties in the United Kingdom, London W12 0HS

J G ROBSON, FRCS, FFARCS, honorary secretary

three or four years but regard their specialties appropriately as higher training when special subjects such as epidemiology are studied.

In surgery general professional training leads to a fellowship in surgery from the Royal College of Surgeons (England and in Ireland) the Royal College of Surgeons (Edinburgh) or the Royal College of Physicians and Surgeons (Glasgow). The regulations for these fellowships require that they cannot be taken in under four years after qualification, but all these colleges expect their candidates for examination to be broadly trained in approved posts, specialisation coming in the higher professional training period. While their regulations differ one from another in detail, there is adequate flexibility. For example, the Royal College of Surgeons of England requires six months in a major surgical specialty—for instance, orthopaedics—six months in an accident and emergency post, and one year in general surgery, so that if a preregistration post was held in general surgery then 18 months out of the first four years are wholly uncommitted. The surgical colleges approve strongly of trainees spending time in general medicine, pathology, etc, but the time is one of free choice of approved posts in any discipline.

There has been some unnecessary concern about the implementation in August 1982 of the Vocational Training Act which puts general practice on to a statutory training basis. This will, to a minor extent only, limit the ability of young doctors to move into this specialty. The Joint Committee for Higher Training in General Practice will examine past training in a flexible way to determine its equivalence, so that it will be unlikely to be more difficult to enter general practice than any other specialty after three or four years of postgraduate experience. A wide range of experience is acceptable to the JCPTGP, but if there has been extended specialty training in hospital only part of this could be accepted. Any trainee, however, who has maintained the flexible options of any specialty in the first four years would have little difficulty in entering general practice with the minimum time penalty. In this sense general practice comes into the realm of higher professional training, and it will require a year of general-practice traineeship. It might help to give an example of a hypothetical surgical trainee who wishes to move into general practice. He could have his preregistration year, one year of general surgery, and six months of accident and emergency accepted, and he would be required to do perhaps six months of paediatrics and one year as a trainee in general practice, so that he could be qualified as a general practitioner rather sooner than he would be in a surgical specialty from the same starting point.

In obstetrics and gynaecology trainees have to hold approved posts for two years in these subjects, but they also have an elective year that they are expected to spend in one or more posts of a wide range of disciplines, which includes surgery, medicine, pathology, research, etc. It would therefore not be difficult for a trainee to select options that would leave him in the least committed state in case he wished to change with a minimal time penalty.

The standards of the specialty of anaesthetics are controlled by the Faculty of Anaesthetists of the Royal College of Surgeons of England in concert with the Faculty in the Royal College of Surgeons, Ireland. The fellowship, FFARCS, is expected to be taken not less than four years after graduation, and apart from preregistration house posts the faculty requires two years of work in approved posts, at least one of which has to be in the United Kingdom or Ireland. This leaves one year of complete flexibility after registration. With some forethought and advice, trainee anaesthetists could arrange backstops for careers in almost any other specialty in the general professional training period and "waste" a minimum of time.

The regulations for the MRCPPath are very flexible. In the first four years the college accepts a wide range of experience. For part I of the MRCPPath 18 months in approved laboratories is required and higher qualifications such as FRCS, MRCP, etc exempt from the examination. Part II requires three years of approved posts and is a higher professional training option. A decision to follow a career in pathology therefore places little

restriction on choice in the first four years and allows, with little time penalty, a change to other specialties.

The Royal College of Psychiatrists requires that trainees spend three years in recognised hospital posts and up to two years should be in approved psychiatric training. Very flexible options are available, and two years out of the first four may be spent in posts of individual choice.

The breadth of experience required to make a good radiologist or radiotherapist puts the requirements for the FRCR (D or T) into the higher professional training stage. The college welcomes those with other qualifications but requires one year of approved radiological experience for part I of the examination and three years for part II. The specialty subdivisions naturally require further training, but trainees at this stage would have made a firm career decision. In radiology and radiotherapy therefore there is great flexibility in college requirements, and only one year in the first four need be wasted if a change of speciality is desired.

I have sketched out only the general part of postgraduate medical training that is under college supervision, but clearly with some forethought and with guidance from those such as postgraduate deans who are in a position to see the overall specialty picture, trainees may explore their own inclinations and test their abilities for about two years in the first four after qualification without wasting time. Time spent in good posts that are not on a direct specialty career path is not regarded as being inappropriate or a waste of time by the colleges and faculties.

Why is the system so inflexible?

In the light of the foregoing one must ask why the system appears to be so inflexible. This is a complicated question that can be answered only partly and on a speculative basis. The trainees themselves seem to introduce rigidity. Many think that if they stray even in a specialty approved manner from the direct NHS career path then they will be diminishing their competitive position on the NHS career ladder. This combines with the appointing side of the NHS in that it is also fairly certain that within limits many appointing committees select from candidates with the greatest practical experience, presumably on the grounds that these candidates have decided on their careers and that they are most worth training. Certainly it appears to be difficult for surgeons and anaesthetists, for example, to compete successfully for good general medical training posts in the interests of broadening their education once it appears that they have made a career choice, yet it would be most helpful to general medicine in partly redressing the great disparity between the numbers in its training posts and the available career posts. The colleges and faculties, with the two noted exceptions of radiology and pathology, regard the attainment of fellowship or membership only as an indication that the trainee has serious career intentions in the specialty and will seek a higher professional training post. Unfortunately, it is at this point that college training requirements and NHS staffing structures may become incompatible. Many young doctors wishing to practise in the more popular and overcrowded specialties find that at the end of three or four years and with a higher qualification they must spend even more time as a registrar to improve their competitive chances for senior registrar posts. This is not a college or a higher professional training committee requirement. It is therefore likely that the NHS staffing structure with its imbalance between trainee posts and permanent posts is the main cause of the observed lack of a true general professional training period for young graduates. This will not be amenable to change in college and faculty examination and training regulations, although it has been agreed that the colleges will take what educational steps they can towards better career advice to achieve their own highly recommended flexibility.

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