Career focus

Neurology

Trevor Pickersgill and Martin Sadler discuss a specialty that combines clinical acumen and high tech investigation in equal measure

It used to be said of neurologists that they saw their patients twice: once to make a diagnosis, and a second time to tell them what they had and that there was no treatment. Happily, this is now not the case. Neurology is to do with diseases of the nervous system and of muscle. As these systems influence the rest of the body's physiology, the range of illnesses that may be caused by neurological disturbance are legion.

At present, neurologists' diagnostic capabilities outstrip their treatment armamentarium, and this gap looks set to widen as specialties such as neurogenetics expand. On the other hand, exciting and controversial developments have recently occurred in the pharmacological treatment of previously untreatable disorders such as motor neurone disease (riluzole), multiple sclerosis (interferon beta), and dementia (donepezil). In the future neurologists will probably have a pivotal role in the coordination and, unfortunately, rationing of such treatments.

Patient management is not restricted to specific treatments, and there are many ways in which neurologists help to ease the burden of chronic disease in their patients. This is usually as part of multidisciplinary care, and team management, coordination, and good communication skills are essential.

The illnesses encountered must be among some of the most fascinating in medicine. This interest is increased by the fact that neurologists use some of the best toys in the hospital, the scanners, to investigate their patients. Imaging has not de-skilled neurology, however, and diagnosis and management of most conditions rely on clinical skills. As it is generally considered a complex and difficult postgraduate specialty, many medical students (and doctors) have been discouraged from fully getting to grips with the neurological examination. This lack of familiarity with neurological disease ensures that a neurologist can often pull a diagnosis out

Pros and cons of neurology

Plus points

- Still very clinically orientated
- Variety of clinical disorders ranging from acute emergencies to lifelong chronic illness and disability
- New treatments arriving constantly
- Multidisciplinary teamwork
- Retention of links with academic centres
- Many district general hospitals want more neurology input—job prospects are good
- No exams after MRCP (UK)—yet
- Well structured training programmes
- Low intensity of on call work

Minus points

- Long (and sometimes very long) waiting lists
- Large number of untreatable disorders
- Research now almost a prerequisite for entry into training
- Often underresourced
- Rationing of new, expensive treatments

of the hat with a baffling case just by being able to take a careful history (most neurologists have obsessive personality traits) and perform an adequate neurological examination. It also means that neurology trainees are especially popular in the run-up to MRCP examinations.

Organisation of services

Neurology remains principally an outpatient specialty, although the number of inpatients is likely to increase as the number of neurologists increases and patients presenting to hospital with acute neurological problems (such as stroke) are seen and cared for by a consultant neurologist from the outset. Currently, there are too few junior and senior staff in neurology to provide this level of service except at large centres. Accordingly, most neurology services in Britain are organised on a hub and spoke model. The hubs are the centres for neurology (and usually neurosurgery), and the spokes are the surrounding district general hospitals that have a neurologist for a few sessions a week. Inpatient beds are usually in the neurology centre. Most consultant neurologists either have their main job at a neurology centre or are affiliated to a local centre that they attend for neuro-

science postgraduate meetings and possibly to provide subspecialty expertise.

General training

In common with the other medical specialties, applicants for specialist registrar posts in neurology should have completed a minimum of two years of general professional training, which should include 24 months of direct patient care and at least 12 months of exposure to unselected acute medical intakes. The MRCP (UK) is required, and a senior house officer post in neurology is desirable but not essential: a far cry from the pre-Calman days, when experience of general medicine at registrar level was considered essential.

Higher specialist training

The duration of training in neurology is five years. There are currently just under 180 UK trainees, 50 or so of whom are in research. There are also 80-90 research fellows not holding national training numbers. Training in a region is supervised and organised by a specialty training committee, which acts under the delegated authority of the neurology specialty advisory committee of the Joint Committee of Higher Medical Training of the three Royal

Colleges of Physicians. Training may be at a single centre if it is large enough to provide experience in all areas of neurology.

In London trainees are likely to rotate between large centres that are geographically close to each other, each with several consultant neurologists. Away from London, things are more variable. Commonly, training may rotate through a large centre and one or more district general hospitals or, occasionally, between two or more regional centres. In the latter case, trainees may have to relocate for each job as the distances between centres may make daily commuting impractical. These factors should be borne in mind when comparing job descriptions as they have a great bearing on the quality of life. There should be a clear schedule for the training programme from the outset so that you should know when and where you will be for each part of your training.

As well as the management of the full range of adult neurological disorders, there are a number of other subjects in which trainees will be expected to have gained experience,¹ including paediatric neurology, neuroradiology, clinical neurophysiology, rehabilitation, neurogenetics, neurosurgery, intensive care, neuro-ophthalmology, uroneurology, neuropsychiatry, and neuropathology.

Entry into the specialist registrar grade is currently very competitive. Many more trainees in research posts were allocated national training numbers during transition to Calman programmes than there were clinical positions available to accommodate them. The absorption of these trainees into clinical posts blocked entry into training programmes for those not having a national training number for a period. This situation has now largely passed and open recruitment is again possible. Nevertheless, many applicants for specialist registrar posts will have postgraduate qualifications and publications, and there are a large number of research fellows apply-

ing for clinical training schemes. As many recent trainees entered Calman schemes beyond year 1 because of their previous experience, there is a bulge in the numbers of trainees due to gain their certificate of completion of specialist training in 2001-2. Consultant posts for these trainees may be hard to come by unless the rate of expansion of new consultant posts is maintained or accelerated from the current 6.8%. After this, there is a dip in numbers qualifying, and so prospects may be more rosy for those who are about to start a full programme of training.

The on call commitment should be for neurology alone and should range between 1 in 4 and 1 in 8. This will usually be non-resident.

Dual certification in neurology and clinical neurophysiology can be achieved if a trainee completes four years of neurology, two years of neurophysiology, and an additional year in either discipline or in research. Thus, a total of seven years' training is required. A similar scheme exists for dual certification in neurology and rehabilitation medicine. There are shortages of specialists in both of these disciplines, and applicants with dual certification may be particularly attractive to district general hospitals.

Research and academe

Most neurologists spend a period in research culminating in a PhD or MD. Research can contribute up to one year of training. However, this is the maximum period of accreditation regardless of the total duration of research, which if directed toward a MD or PhD is likely to be two or three years. Research is encouraged in neurology, and up to 30% of trainees may be in research at any one time. If you are not keen on taking time out for research then

neurology may not be for you. At present, there are a large number of neurology research fellows, many having entered research after senior house officer posts. In future there is likely to be a more rigid correlation between research posts and clinical posts, more closely tied to the possession of a national training number. Neurology lends itself to academic and research endeavour, and career academic posts exist in most if not all medical schools and university hospitals.

As there are few neurology trainees, it is relatively easy to get to know many of them, either at the biannual Association of British Neurologists (ABN) conferences, or locally at the regional SpR training days. As today's specialist registrar with a research interest becomes tomorrow's best opinion, friendships forged at these events may become invaluable when, in later life, you are confronted by a patient with a mysterious illness (and in neurology you will be). Specialist registrars, research registrars, and senior house officers wanting to pursue a career in neurology are all eligible to join the association, and there is a trainees' section (ABNT) with regional representatives. The ABNT holds regular meetings and keeps members informed of issues likely to affect them through a newsletter and email.

Job prospects

There are too few consultant neurologists in Britain. The target ratio suggested by the Association of British Neurologists is 1 per 100 000 of the population.² Currently, the figure is nearer 1 per 200 000, and in some regions such as Wales the ratio is nearer 1 per 300 000. To meet this target there is an expansion of consultant posts (although the real expansion is less than that

planned), which should augur well for a career in neurology. At present, only 25% of neurologists are based in district general hospitals, with the rest being in the larger centres. The Joint Consultants' Committee recently recommended that there should be at least three neurologists in every district general hospital to meet service needs.³ Because of the need for the support and interaction of a larger centre containing several other neurologists, it is unlikely that single handed posts will be created. The specialised nature of the investigations (such as electrophysiology and magnetic resonance imaging) and their accompanying neuroradiologists and the need for grouping of neurologists to enable adequate continuous professional development will dictate that most expansion will be in further spokes from a larger centre or with the establishment of new centres.

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1 Association of British Neurologists Training and Education Subcommittee. *Memorandum: neurological SpR experience in the neurological subspecialties*. London: Association of British Neurologists, 1998.

2 Stevens DL. *Neurology in the United Kingdom: numbers of clinical neurologists and trainees*. London: Association of British Neurologists, 1996.

3 Joint Consultants' Committee. *Organisation of acute general hospital services*. London: JCC, 1999.

Useful contact addresses

● Association of British Neurologists, Ormond House, 27 Boswell Street, London WC1N 3JZ (ABN@abnoffice.demon.co.uk)

● Joint Committee of Higher Medical Training, Royal College of Physicians of London, 11 St Andrew's Place, Regent's Park, London NW1 4LE

Briefing

● Changes in the recruitment of GP registrars will be mean that training practices can no longer independently advertise for a registrar. The change comes as a result of the decision to include the funding for registrars in the Medical and Dental Education Levy (MADEL) administered by the postgraduate deans, rather than the General Medical Services budget as at present. The directors of postgraduate general practice education will be involved in the decision appoint every GP registrar, though it is intended that "both GP trainers and registrars have maximum choice." The changes will allow new flexibilities including "training on the basis of educational need," presumably a new euphemism for additional training required of a registrar after failure of any part of the summative assessment procedures.

● The sixth edition of the BMA's *Guide to House Jobs in Yorkshire* appeared recently, surveying hours of work and standards of accommodation and catering across the region. Although some improvements have taken place, its authors say that "catering remains shamefully poor in most hospitals" and that "there are still too many posts where the intensity of work has not been properly addressed." Eight years after the signing of the New [sic] Deal, not a single acute hospital in Yorkshire can claim accreditation. It's not all bad news, but the glacial rate of change is somewhat depressing.

● A culture of openness is one of the key tools in managing organisational stress levels, according to a recent review (*Health Service Manager Briefing* 1999;48:3-5). Managers have a responsibility to assess the risk, take complaints of stress seriously, and ensure that staff have the skills needed to competently and confidently fulfil their role.

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