Three generations of paediatric training

Lionel P Balfour-Lynn,[1] Rosie E Balfour-Lynn,[2] Ian M Balfour-Lynn [3]

In the UK, the life of a paediatric trainee has undoubtedly changed over three generations, spanning the last 70 years. LPB-L, who is retired, started training in the mid-1950s; his nephew IMB-L, a consultant, started in the mid-1980s; and his daughter REB-L, is a first-year trainee in the 2020s. It has certainly changed, but is it always for the better?

MEDICAL SCHOOL

Paediatric education starts at medical school and has not changed appreciably in the UK. It still plays second fiddle to adult medicine and surgery, placements generally being for 2 months only out of 3 clinical years, sometimes with optional extra time available in electives. In the 1950s, the huge majority of students were male, in 1980 60% were male, but currently 43% of the intake are male.[1 2]

TRAINING STRUCTURE

1950s

Paediatric training was not formalised, one applied for jobs at a junior level, and then after a few years applied for a more senior post, until eventually becoming a consultant. One could apply for a post as soon as the next one came up if unsuccessful at a previous interview. Patronage from the consultant was most important, and references were critical, especially the phone call from your boss. The 'old boy network' was definitely in play. Training was essentially an apprenticeship learning on the job, formal teaching did not exist aside from the hospital grand rounds. Experience gained was huge due to the extremely long hours spent at work, although often unsupervised by a senior paediatrician; consequently, trainees were more confident and experienced sooner in their careers for decision-making. There was no concept of appraisals or assessments. Learning was done from books or journals in the hospital library. Subspecialism within paediatrics was far less common.

1980s

Training was more formalised in that there were standard times spent at senior house officer (2–3 years), registrar (2 years) and senior registrar (4 years) levels. One still applied for jobs as they came up, with posts increasing in length with increased seniority. Patronage was waning although consultant references were still important. Formal training was still minimal, and it was largely an apprenticeship, learning from consultants and senior colleagues. Mandatory training did not exist. Hours were better than in the 1950s, but still long enough to provide plenty of clinical experience, and consultant help was always available (usually over the phone). There was still no concept of appraisals and assessments. Books and paper journals were still in use.

2020s

Training is now rigidly controlled and far less flexible, with tight General Medical Council regulation. Interviews are held annually making it harder for people who miss out entry to the ST1 training grades or ST6 subspecialty training. People can subspecialise via 2–3 years of national grid training, and there is also an option to become a general paediatrician with a special interest. Once in the run through scheme, progress is almost inevitable, with hold up only if there has been a serious problem. Patronage has gone, references are bland standardised forms. Appointments are fairer now although paediatric consultants no longer have any say over who is joining their department. Training is curriculum and competency based, and in theory can be shortened from the 8 years, although usually is not. Appraisal and assessments with an educational supervisor are regular, with logs and portfolios. There is a lot of formal teaching with 'protected' time. Centrally funded study leave is available to go on courses. Mandatory training is overwhelming now, some of which is barely relevant. Everything is online, ready access to all information including drug formularies is available on a smartphone in the doctor's pocket.

LIFE OF A TRAINEE

1950s

Life was quite tough for trainees, mostly due to the exceptionally long hours worked. Standard rotas were one in two, making it about 110 hours per week averaged over the 2 weeks; weekends on call started Friday morning and ended Monday evening. Juniors certainly felt part of a team, the clinical firm. Part-time working was most unusual.

1980s

On call was more often one in three, averaging 72 hours per week, and long weekends on call were arduous. Clinics the day after being up most of the night were quite challenging. One still felt part of a clinical team although the concept of cross-covering other paediatric teams at night came in.

2020s

Hours are strictly controlled following the European Working Time Directive but personal lives of trainees are still severely disrupted. Working less than full time is not at all unusual now, often with formal job sharing. Hours must average 48 hours per week with complex rules. Breaches are recorded by exception reporting with hospitals having guardians of safe working hours to protect the trainees. It is likely these are under-reported due to concerns how it will be perceived by the seniors and management. Less hours means less clinical experience and not always knowing the outcome of a patient admitted during a night shift, although this is balanced by far more formal teaching. Fewer hours also means less practical experience but simulation training and use of models may compensate to an extent. Handover rounds are extensive but shifts impact continuity of care. Errors can follow multiple handovers, however this is balanced by trainees not making mistakes due to lack of sleep.[3] Emails are relentless.

ATTITUDES AND SHARED DECISION-MAKING

1950s

Doctors were highly respected by the public and hospital staff, and were looked after well, for example, cups of tea on ward rounds and decent food when on call. What the doctor said was almost always agreed with, and most parents had a 'doctor knows best' attitude. They were less susceptible to criticism by patients/relatives due to their status, and to an extent, expectations of the public were lower.

1980s

Respect for doctors had waned following the 1975 consultant and junior doctor

[1]Retired, London, UK
[2]Department of Paediatrics, Whipps Cross University Hospital NHS Trust, London, UK
[3]Department of Paediatric Respiratory Medicine, Royal Brompton Hospital, London, UK

Correspondence to Dr Ian M Balfour-Lynn, Royal Brompton Hospital, Sydney Street, London SW3 6NP, UK; i.balfourlynn@ic.ac.uk

strikes, although in the 1980s a morning cup of tea was still brought to doctors in the on-call rooms at Great Ormond Street Hospital. Parents were increasingly questioning doctors' decisions.

2020s

Respect for doctors probably decreased further after the 24-hour strikes of non-emergency work in 2012 and 2016, but has had a recent boost alongside all National Health Service workers in the COVID-19 pandemic. Parents are constantly questioning doctors' decisions and are better informed; this is positive as they are a major part of decision-making now. However, outside influences such as social media and the internet are responsible for a lot of false information leading to misguided decision-making at times.

THE WARDS

In the 1950s, parents were allowed to visit their sick children, on open wards, during brief visiting hours each day. This had relaxed by the 1980s. There is now unrestricted access, and indeed, they are expected to stay and help look after them.[4] Where possible children are in cubicles to reduce cross-infection.

Electronic notes have mostly replaced paper and a fountain pen. Aside from the often illegible writing and notes missing in clinic, it is not necessarily a step forward, as it can be difficult to get the feel of a complex patient from multiple electronic entries, risking missing important information. It is certainly easier to find test results, and digital radiology is a huge step forward, with X-rays never lost assuming the system is not down.

Many diseases have disappeared from the wards (eg, in the 1950s LPB-L saw a number of children with polio inside 'iron lungs'), however safeguarding concerns, mental health issues and childhood obesity seem so common now.

CONCLUSIONS

Paediatric training remains hard going. Many aspects (eg, hours and formal training) have improved, but not everything is better (eg, loss of firms, less continuity of care). However, it is still a wonderful specialty to work in.

Contributors All three authors contributed equally to the content of the paper. IMB-L wrote it with the other two authors editing.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Author note Dedicated to the first Dr Balfour-Lynn – Stanley. Brother, father and grandfather. An inspiration to us all.

To cite Balfour-Lynn LP, Balfour-Lynn RE, Balfour-Lynn IM. *Arch Dis Child* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/archdischild-2021-322160

Received 29 March 2021
Revised 3 May 2021
Accepted 6 May 2021

Arch Dis Child 2021;**0**:1–2. doi:10.1136/archdischild-2021-322160

ORCID iD

Ian M Balfour-Lynn http://orcid.org/0000-0002-0754-3863

REFERENCES

1 McManus IC, Sproston KA. Women in hospital medicine in the United Kingdom: glass ceiling, preference, prejudice or cohort effect? *J Epidemiol Community Health* 2000;54:10–16.
2 GMC. The state of medical education and practice in the UK. Available: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk [Accessed 29 Apr 2021].
3 Rahman SA, Sullivan JP, Barger LK, *et al*. Extended work shifts and neurobehavioral performance in Resident-Physicians. *Pediatrics* 2021;147:e2020009936.
4 Sainsbury CP, Gray OP, Cleary J, *et al*. Care by parents of their children in hospital. *Arch Dis Child* 1986;61:612–5.