

**JOINT ROYAL COLLEGES OF PHYSICIANS TRAINING BOARD  
(JRCPTB)**

**Annual Specialty Report for Audiological Medicine to  
The Postgraduate Medical Training Board (PMETB)  
for August 2007 to July 2008**

**1. Establishing Schools**

This very small specialty forms part of the School of Medicine in London. There are good relationships within the Deanery between the Specialist Training Committee and the head of the school, Jeremy Levy. One of the members of the STC was appointed, at a small specialties meeting last July, as representative of the small specialties on the board of the School of Medicine. Unfortunately there has not as yet been a board meeting of the School of Medicine. There are obviously teething problems within the School of Medicine particularly with regard to communication, but we are hopeful of a supportive relationship.

**2. Triggered Visits**

The specialty has not been involved with any PMETB 'Triggered Visits'

**3. Effect of changes to the specialty**

As a specialty we welcome and embrace all therapeutic advances but there are no such specific advances that are likely to have a significant impact on the specialty or on the delivery of service. Impact is more likely to come from reorganisation of services rather than advances.

**4. Key concerns for the future of the specialty**

1. The specialty has several concerns for the immediate and longer term future of both the specialty and the service we offer.
  - a. **Consultant Numbers.** There will shortly be a crisis in manpower within our field, due to the imminent retirement of a significant proportion of our consultant body. Approximately 50% of the consultant Audiovestibular Physicians are expected to retire within the next 7 years<sup>1</sup>, and in addition, we will be losing many Community Paediatricians with an interest in Audiology, many of whom have joined our specialist association. The Royal College of Paediatrics and Child Health has not recognised Audiovestibular Medicine as a subspecialty and has failed to support training in the field. Many of these posts are highly specialised and replacement consultants are being taken from our trainees who are too few in number to continue to fill these posts. There will shortly be a large gap in service provision for children.

The retirement of consultant Audiovestibular Physicians will have an impact on both adult and paediatric services. It has been estimated that 5 new centrally funded training numbers need to be appointed every year for the next five years in order to provide adequate medical cover in our field<sup>1</sup>.

b. **Recruitment.** Currently we are not training sufficient specialty/specialist registrars to fill consultant posts that will become vacant within the next few years<sup>1</sup>. Audiovestibular medicine is a recognised shortage specialty and it is known that we need to increase training posts but we have been unable to do this. There are several reasons for this:

i. **Difficulty recruiting.** In common with other small specialities recent recruitment policies have had a devastating effect on our ability to recruit into the specialty. The turmoil of MMC recruitment in 2007 served to direct juniors towards the large specialities and away from the smaller ones. In addition we were severely limited in the number of rounds of recruitment we were able to perform and, being a specialty where we need several rounds of recruitment during the year, as we only ever recruit one or two candidates per round, we were prevented from recruiting as we needed to. This has led to about one third of posts being unfilled for prolonged periods over the last two years.

We have had agreement this year to recruit nationally and this we welcome as it will ensure equality of recruitment across the UK.

ii. **Loss of trainees.** The stress of recruitment in 2007 and the feeling that trainees had to make their final move at that time coincided with a temporary paucity of consultant posts. This served to undermine the confidence of several trainees and we lost three to general practice.

iii. **Inadequate number of posts.** We are dependent on central funding for post expansion and there have been no new posts. We also have few consultants and they are generally spread around the UK making rotations (except in the London area) difficult to organise conveniently. We acknowledge that while we are unable to recruit we cannot expect an increase in funding for new posts.

- iv. **MMC.** There is a complete change in the career structure of juniors with implementation of MMC and the new curricula. Recruits into Audiovestibular Medicine have traditionally come from Paediatrics, ENT surgery and General Medicine (Neurology or Rehabilitation Medicine). Our recruits have tended to be more mature trainees who have decided on a career change. MMC favours a quicker route into specialty training with trainees making career choices earlier; change is no longer as easy as it used to be and this reduces our recruitment pool. Paediatrics is currently a shortage specialty reducing the potential movement into Audiovestibular Medicine.
- v. **Curriculum** The changes to the curriculum, with the entry requirements specifying the need for CMT and MRCP, have effectively reduced our intake from ENT surgery – the hurdle to join us is much bigger than previously. Once recruited we ‘lose’ trainees to Core Medical Training for one to two years.

While we have always required our recruits to have had 2 years of general medical training, the change in training has meant that this is now being delivered at a different point in career progression.

- c. **Confusion of terms.** There is continuing confusion of terms within our field. The Department of Health continues to fail to differentiate adequately between Audiological Physicians (doctors who specialise in the medicine of hearing and balance disorders) and Audiologists (scientists concerned in the physiological measurement of hearing and balance) leading to confusion. This is then reflected in documents and in service development often leaving a significant gap in provision as the medical aspects of hearing and balance disorders are poorly catered for. In order to minimise the possibility of confusion, several years ago the specialty elected a change of name, from ‘Audiological’ to ‘Audiovestibular’, the better to reflect the full range of our expertise. Unfortunately the name change has not as yet been effected.
- d. **Payment by results.** This is a potential threat to our specialty. The tariff for ‘Audiology’ has been set at a very low rate to cover the cost of a simple hearing test by a technician or scientist. The complexity of the service we offer as physicians within a specialist multi-disciplinary team has not yet been considered. The actual cost of the service is three to six times the current Audiology tariff but in view of the confusion of terminology in the Department of Health we have significant concerns that the eventual tariff will not enable us to provide the services

needed.

- e. **Increasing demand for our services.** The development of services, such as the Newborn Hearing Screening Programme and the increase in recognition of balance disorders have led to an increase in demand for the services we offer. We work as part of team to provide services but increasing knowledge of the importance of the medical aspects of hearing and balance disorders has had an impact on the way we work particularly in view of our small, and shrinking, workforce.

The document produced by the College in February 2008 following a working party review 'Hearing and Balance Disorders; Achieving excellence in diagnosis and management' <sup>1</sup> highlights the need for the specialty and the lack of manpower and resources. A more recent Department of Health document 'Transforming services for children with hearing difficulty and their families: a good practice guide' September 2008<sup>2</sup> provides further evidence of the need for doctors specialising in disorders of hearing and balance in children.

- f. **Small specialty issues.** There is an ever increasing demand for documentation, protocols, curricula etc and we have very few consultants, all of whom are hugely over-stretched. Whereas a large specialty may have a pool of several hundred consultants to, for example, rewrite the curriculum or produce an immediate response to the Department of Health, we have a total pool of about 44, many of whom will not be in a position to help. The demands made upon us mean that very little of the extra work can be done within contracted hours.

The pressures of complying with 18 weeks have been considerable. Waiting times within Audiology have been some of the longest in the UK and while much of the thrust for improvement has been with the physiological measurement and provision of hearing aids, nevertheless that has had a knock-one effect on the medical clinics that complement this work. Trust approval of professional leave to attend national meetings has been one of the casualties of 18 weeks.

- g. **Training for trainers.** Again, we have few consultants and proportionately a lot of trainees, so the need to ensure most of our consultants are up to date with training for trainers imposes a burden. The nature of our work, purely out-patient based and with a high proportion of rehabilitative work, is different from many other medical

specialties and so certain aspects of the training have to be specific to our needs making delivery of training a difficulty.

- h. **Equality of training.** A recent issue that we have been grappling with is ensuring equality of training between the Northern rotation (North West Deanery and Cardiff) and the Pan-Thames rotation. A PYA in March 2007 highlighted the discrepancy between the training in the North and in Pan-Thames. This was based on a lack of equipment in the North-West and the existence of specialised clinics using the equipment in London. While we have arranged for trainees to be seconded to London for this part of their training it has nevertheless highlighted the question of equality of training.

Another such issue for our trainees is the fact that the MSc in Audiovestibular Medicine forms the knowledge based assessment of our specialty, in the absence of a similar course in the North-West. Trainees from Cardiff and the North-West have to travel to London for the course.

An additional problem which still exists, is the fact that trainees from overseas have to pay significantly more for the MSc in Audiovestibular Medicine than home students. The difference is of the order of £14,000. We still have overseas students in training and the MSc is mandatory.

- i. **PMETB Trainee survey.** The recent trainee survey reported in May 2008 indicated generally acceptable performance although we were concerned about a relatively high report of bullying. This was addressed within a combined STC meeting (North-West and Pan-Thames) in June 2008 and it was considered that the questions asked in the trainee survey would attract positive answers of bullying both from trainees who were being bullied but also from those who were failing and needed to have extra input which they may have found difficult to accept. As we have few trainees even one disgruntled trainee would make a difference to the percentage score. Another possible reason was highlighted by trainees who were unhappy with some aspects of clinical supervision and this has resulted in the preparation of a document outlining a 'contract' between the trainees and trainers for clinical supervision. This was drawn up by members of the Pan-Thames STC and a trainee. It will be taken to the SAC at the next meeting for national approval.

The SAC has also considered that the PMETB survey did not address issues which were peculiar to our specialty and an additional survey was drafted by consultants and the trainee representative on the SAC. This will be circulated in May and, we hope, will complement the

PMETB survey, allowing us to consider training needs more specifically.

**j. Academic posts.** We currently have 2 Academic Clinical Fellowships which we have had difficulty filling. One has now been filled and the other is currently advertised. In addition we have a lecturer's post to which we will be recruiting in May. There is a need for increased academic output in the field which we hope will result from these appointments.

1. Hearing and Balance Disorders; Achieving excellence in diagnosis and management. Report of a Working Party Published February 2008 RCP
2. Transforming services for children with hearing difficulty and their families: a good practice guide' September 2008 Department of Health.

**5. RITAs/ARCPs.** The following includes the responses we have received from the Heads of Specialist Training for this specialty

All trainees for this specialty have had successful RITAs/ARCPs. It has been reported that of the 19 trainees enrolled in Audiological Medicine, one trainee received a RITA E. This was subsequent to a previous failure when the trainee was kept down in year 1 and received targeted training for a year. The second failure resulted in a RITA C and an OOPE while he considered his future. The trainee is fully expected to leave the specialty.

**6. European Working Time Directive (EWTD):** The following includes the responses we have received from the Heads of Specialist Training for this specialty

There have been no concerns reported for this specialty.

**7. Training Programme Director Report information**

We have not received these reports for every Deanery for this reporting period but intend to include the themes in subsequent reports.

**8. Examinations**

We do not have examination data available for this reporting period.

**9. Assessments**

Workplace based assessments for the medical specialties including Direct Observation of Procedural Skills (DOPs), mini CEX, and Multisource Feedback (MSF) have been in place since 2005. Although there have been concern within each specialty with regard to the time involved to complete these, their use has been widely encouraged so that PMETB standards are met. We continue to pilot further workplace

based assessments.

### **10. e-portfolio**

Pilots for the specialty e-portfolios have been completed and hope to go live by April 2009 for enrolled Audiological Medicine StRs. In the meantime, trainees had been advised to complete paper records or to continue to use their CMT e-portfolio.