transitional arrangements of the regulations. However, the main route to become a consultant is now via obstetrics and gynaecology. Trainees compete for a NTN to enter the first 3 years of general obstetrics and gynaecology training. If they successfully complete core training (the first 3 years), they can then apply for subspecialty training in sexual and reproductive health (previously community gynaecology) to obtain a Certificate of Completion of Specialist Training (CSST) in sexual and reproductive health. This requires a further 3 years of training in an approved centre with time for research and acquisition of Membership of the Faculty of Family Planning and Reproductive Health Care (MFFP). There are 15 approved centres with 22 approved places. However, there are a number of vacant training places due to a lack of funding and NTNs rather than a lack of interest in the subspecialty. In 2003, the FFPRHC and RCOG bid for additional NTNs in England. Four ring-fenced and fully funded NTNs for sexual and reproductive health, and 63 unfunded NTNs for general obstetrics and gynaecology, were granted.

In 2001, the RCOG allowed eight post-CCST trainees in obstetrics and gynaecology to complete a 'top-up' year in sexual and reproductive health. Of these, five are now consultants in the specialty and one an AS. Five doctors who have trained with the Faculty of Public Health Medicine have taken another route: by obtaining a CCST in public health medicine and choosing to specialise in sexual health during the last years of their training. They may choose either a career in public health with special skills in sexual health, or to apply for a consultant post leading a sexual health service.

Career grade trainees

Another training route is via the Faculty's 3-year career grade training programme including acquisition of MFFP. At present this training does not lead to entry to the Specialist Register and consultant status, and is better suited to those who wish to be a senior doctor in the field. It leads to a Faculty Certificate confirming Completion of Training (FCCT). The programme started in 1999, and initially there was a transition period when experienced doctors could complete their training in less than 3 years. This is now closed to new entrants and all must undertake the 3 years, with an allowance of 6 months for previous experience. Currently there are 40 training sites and 31 registered trainees. To date, 41 doctors have completed training and have been awarded the FCCT; some have become non-consultant Lead Clinicians, others are senior doctors in their service.

Other grades

There are plans in the UK to develop a single-spine, non-consultant career grade structure, with several tiers decided by competency. At present, doctors can only become staff grades after 3 years of experience in the field, which encourages employment of sessional doctors. This is undesirable because of the variable employment conditions. There is need for an opportunity for development of Senior House Officer posts. Services are already restructuring, with more nurse-led sessions, as nurses become capable of prescribing and taking on skills that have previously been medical.

Conclusions

The UK has the highest rate of teenage pregnancy in Europe and there are increasing rates of STI with subsequent morbidity. The family planning or sexual and reproductive health services have reacted, and expanded services as required. There is still, however, an urgent need to find funding and NTNs so that the number of subspecialty trainees can be increased to match the expansion in consultant posts. Other staff also require appropriate career structures so that they can support the service and train colleagues in primary care and related specialties.

Statements on funding and competing interests
Funding. None identified.
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Book Review

Polycystic Ovary Syndrome: A Guide to Clinical Management. AH Balen, GS Conway, R Homburg, RS Legro. London, UK: Taylor & Francis, 2005. ISBN: 1 84214 211 9. Price: £80.00. Pages: 210 (hardback)

Adam Balen and his colleagues have provided up-to-date, evidence-based information about this important and increasingly prevalent syndrome with its numerous consequences on reproductive and general health. With people in many parts of the Western world currently experiencing a relatively sedentary lifestyle coupled with an abundance of food, there appears to be an epidemic of obesity and consequent hyperinsulinaemia resulting in the precipitation of the clinically apparent syndrome in an increasing number of symptomless women with polycystic ovaries. This book has been published at a most appropriate time.

The authors have discussed the diagnosis of the syndrome with reference to ultrasonography and serum endocrinology, and have dealt with the epidemiology, pathophysiology and genetics of polycystic ovary syndrome to provide an insight in the current understanding of the disorder.

There are significant contributions to our understanding of hyperinsulinaemia and its short-term and long-term health consequences. The treatment options for distressing symptoms like hirsutism and acne and also for menstrual disturbance are considered. There is an excellent chapter on the management of infertility associated with the syndrome, providing a thorough, evidence-based review of the available therapeutic options.

The format of the book is superb. Many illustrations are excellent. Each chapter is concluded with carefully worded key points, providing a concise source of revision to postgraduate students. Each chapter has a valuable list of references.

I strongly recommend this marvellous comprehensive text not only to gynaecologists and specialists in infertility but also to general practitioners who need to deal with this important endocrine disorder with its widespread manifestations. For clinicians with a special interest in reproductive endocrinology, this book is indeed invaluable.

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