

New developments in medical specialty training

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ABSTRACT – Medical specialty training is changing which will result in shorter, more focused training programmes. Senior house officer posts will disappear from August 2007, and be replaced by training posts and trust grade doctors. Eventually specialist registrars in higher specialty training will join with these new training posts to create run-through training. Curricula development and delivery with quality assurance is now the responsibility of a new training board – the Postgraduate Medical Education and Training Board (PMETB). There is an opportunity to create a new specialty of acute medicine to help meet the crisis of care for acutely ill patients in our hospitals.

KEY WORDS: acute medicine, foundation programmes, Joint Committee on Higher Medical Training (JCHMT), Modernising Medical Careers (MMC), Postgraduate Medical Education and Training Board (PMETB), Specialist Advisory Committees (SACs), specialist training, visiting

The advent of Modernising Medical Careers (MMC) and the Postgraduate Medical Education and Training Board (PMETB) is leading to a fundamental review of the nature of all postgraduate medical training. Not surprisingly, this has resulted in a great deal of uncertainty and worry for medical students, doctors in training and trained doctors. The NHS too is awaiting the deliberations of these two organisations and is concerned that significant changes in doctors' training could have an adverse impact on the service. MMC and PMETB are separate but linked initiatives working to different agendas and timescales. They have taken on a sizeable task, so it is no surprise that delivering effective solutions to the problem of postgraduate training is taking more time than initially envisaged. Many doctors feel totally uninformed as to what is going on, and query whether the new arrangements for training will emerge in time for the doctor about to go into foundation training, and will be appropriately quality assured. Setting aside the worries about implementation, the Colleges of Physicians have taken the view that here is an opportunity to build on the quality of present medical training to provide better trained specialists for the future NHS. The Joint Committee on Higher Medical Training (JCHMT) and the Joint

Committee on Basic Medical Training (JCBMT), both training bodies of the Federation of the Royal Colleges of Physicians, are working with MMC and PMETB along with other colleges and the deaneries, to help develop new training pathways, specialist curricula, quality assurance of programmes and criteria for entry to the specialist register. This article discusses the aims and objectives of MMC and PMETB, the progress achieved thus far, and attempts to look into the future for medical specialty training.

The Postgraduate Medical Education and Training Board

PMETB was created by an Act of Parliament in April 2003 specifically to take over the role of the Specialty Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP). For the first time, this brought together the training regulatory bodies for all hospital-based and other specialists with those of GPs. Their first act was to insist on a common certificate for training for all doctors (specialists and GPs) – the Certificate of Completion of Training (CCT). This replaces the Certificate of Completion of Specialist Training (CCST) for specialists, which has no equivalent for GPs, and comes into effect on 30 September 2005. PMETB aims to be an independent body reporting to Parliament. Thus it is separate from the Department of Health and crosses all four UK nations.

PMETB's first duty is to be a regulatory body approving medical training, but it has aspirations to be a developmental body promoting higher standards of education and training for the profession. Its structures (see Fig 1) reflect its chief function of assessment and training. Practically, the main tasks it must complete in the coming months are to implement the criteria, systems and paperwork for doctors applying for direct entry to the Specialist Register under Article 14, and to develop systems for quality assurance of training ('visiting'). In addition, all Colleges have been asked to review their specialty curricula, and ensure that they meet PMETB criteria.

Visiting

Colleges are conducting visiting programmes to ensure the quality and provision of appropriate training of senior house officers (SHOs) and

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specialists within hospital trusts until 30 September, when PMETB goes live. Previously, general professional training (GPT) and specialist training have been inspected separately (although joint visits have occasionally occurred). Visitors would inspect premises, facilities for trainees, speak to programme directors, educational supervisors (consultants) and the deanery; an important component was speaking to trainees either separately or together to hear whether there were any concerns about training. Reports were agreed by the GPT Committee and the Specialist Advisory Committees (SACs) before being sent to the deanery and programme directors. Three decisions were possible:

- (1) to approve training for a further five years
- (2) to approve training for specified time (usually one year) with the proviso that recommendations be implemented, or
- (3) to recommend to the STA that training approval be removed.

PMETB were concerned at the perceived high level of previous visiting schedules; the potential for training approval to be withdrawn precipitately (a rare but possible occurrence); and the lack of lay involvement. Though yet to be finalised, it is expected that the foundation of quality assessment (QA) in future will be annual programme-specific questionnaires completed by the trusts and a five-year rolling programme of generic visits (ie not specialty based) to trusts and deaneries with prominent lay involvement. Interviews with trainees will be limited. In the interim period (from October 2005 to April 2006) Colleges will only conduct visits where concerns about the training are explicitly expressed by trainees, deaneries or previous visitors. From then onwards, new systems will be in place, though they may take longer to bed in, particularly as at present individual GPT trainees are visited rather than training programmes (which are awaiting confirmation by MMC).

Modernising Medical Careers

MMC was created to respond to the consultation paper, *Unfinished business*,¹ published by the Chief Medical Officer, Sir Liam Donaldson, in August 2002. Its aim was to address the continuing training problems of senior house officers ('the lost tribe') and the career aspirations of non-career grade doctors (NCCGs). MMC recognised two separate but related problems:

- (1) the need for additional training following the pre-registration year – Foundation Programmes
- (2) the need for shortened run-through specialist training, merging where possible SHO training and higher training.

Foundation training

From August 2005 all medical graduates will enter Foundation Schools, which will deliver two years of foundation training (F1 and F2). Although the first year replaces the pre-registration year, registration will continue to take place following F1 but eventually F1 and F2 will merge together to provide a coordinated two-year programme of four-monthly clinical attach-

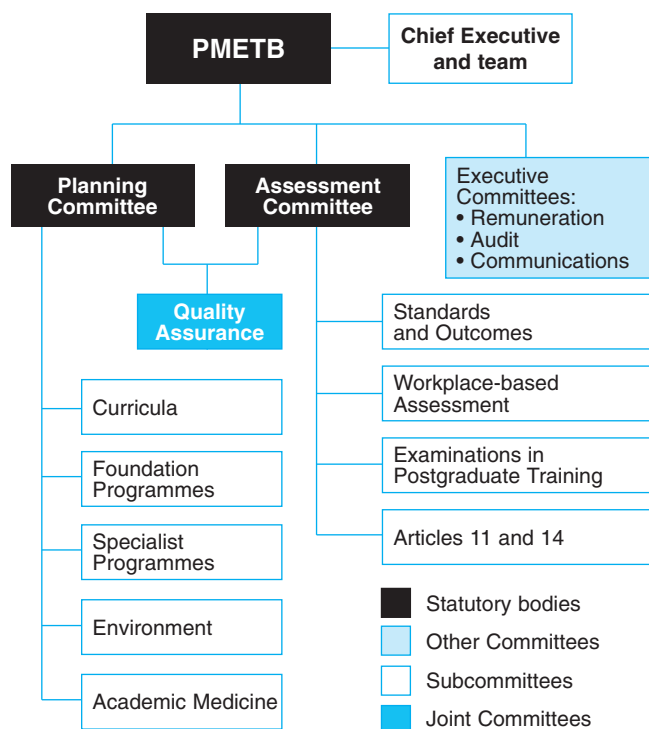


Fig 1. PMETB structure.

ments. The aim of foundation training is to produce doctors able to diagnose and initially manage the acutely ill patient of whatever cause. The curriculum has been published (see mmc.nhs.uk) and the assessments are in place (Table 1). With the availability of additional funding, most foundation trainees will have exposure to general practice within the next three years, and some to small specialties and specialties that have difficulty recruiting trainees (Table 2). Tasters of other specialties

Table 1. Assessment of Foundation Programmes.

Name	Description	Frequency
Minicex	6-point scale assessment of clinical encounter	4 per year
Multi-source feedback	360° assessment	1 per year
Case discussion	Structured discussion of clinical cases	4 per year

Table 2. Foundation training: small specialties and specialties that have problems recruiting.

Allergy	Intensive care medicine
Audiological medicine	Medical microbiology
Chemical pathology	Nuclear medicine
Clinical genetics	Psychiatry
Genito-urinary medicine	Public health medicine
Histopathology	Radiology
Immunology	Virology

Fig 2. Suggested training route – medicine. AIM = acute internal medicine; CCT = Certificate of Completion of Training; F1, F2 = foundation training; ST = specialist training (all); HST = higher specialist training; MST = medical specialist training.



will be included, usually on a day-release basis, and with additional training with the multidisciplinary team. This extra exposure and training will be taken from existing SHO study leave (15 of the 30 days available). New financial resources will support the administrative structure required. The main cost, though, will be the time consultants will provide as educational supervisors, assessors etc. Trusts will need to recognise this as explicit time within consultants’ programmed activities.²

The two-year programme will hopefully deliver doctors fit for practice within the NHS and ready for specialist training post foundation; all doctors will be competent to be part of planned hospital-at-night teams.

Specialist training

Following completion of foundation competencies, trainees will compete for entry to specialty programmes (with other doctors, both home-grown and overseas, who will need to demonstrate foundation competencies). As yet MMC has not agreed the final structure of specialty programmes or how selection may operate. It is likely that a number of specialties will opt for run-through training (eg radiology, histopathology, neurosciences, general practice), selecting from foundation. However, many specialties are not presently ready to move to that option, reflecting the fact that a significant proportion of trainees are not ready to select their final specialty at that stage. The Federation of the Royal Colleges of Physicians has submitted a proposal in line with the BMA Junior Doctors’ favoured option which has garnered much support (Fig 2).³ Trainees opting for a medical specialty and others who consider basic medical training a good foundation for other specialties would apply for medical specialty training (MST1 and 2). During the second year (MST2), if assessments are satisfactory, they will be in a position to apply for more defined specialty training (now MST3 to 6 or 7, previously higher specialty training). MST1 and 2 would consist of broad-based medical training; for instance four-month blocks of elderly medicine, A&E medicine, intensive care and other specialties (neurology, cardiology, nephrology etc).

Selection

The methods of selection into both MST1 and MST3 have yet to be decided; there are many problems, not least the huge demand that presently exists for training in certain specialties (eg cardiology). Among the suggestions is a national scheme which would match trainee choices for a preferred specialty and geo-

graphical area with an available scheme. Deaneries will be responsible for selection but need guidance as to the potential of candidates to train in physicianly and other specialties. Trainees will need to be confident that previous evidence of excellence (eg intercollegiate degrees, publications) are taken into account. Some form of ranking will need to be considered, either through new and novel means at assessment centres or utilising known externally referenced exams such as Membership of the Royal Colleges of Physicians (MRCP(UK)). MRCP(UK) is a high quality exam which has few international rivals and could be changed to rank or band trainees. Ranking could be one point of selection. Interviews, if conducted, need to become more objective and valid; several models have been developed where candidates are observed in clinical situations, eg breaking bad news, and are scored objectively by observers.

Throughout both basic and higher medical training there will be regular assessments which will inform the RITA (record of in-training assessment) process (Table 3). These are presently being piloted in higher training and will become standard practice in the next year.

Role of exams

Membership (MRCP(UK)) will remain as an externally validated test of knowledge, clinical skills and attitudes, although it will need PMETB approval. MRCP(UK) Part 1 provides an MCQ (multiple choice questionnaire) assessment of general medical knowledge and ‘PACES’ – an objective evaluation of clinical and communication skills. It is clear that many specialties would like to develop additional knowledge-based assessments (KBAs) specific to their specialties. These could ensure a satisfactory level of knowledge prior to penultimate year assessment (PYA). It is likely that passing the specialty KBA will become mandatory prior to PYA. Presently five specialties (gastroenterology, elderly medicine, cardiology, neurology, dermatology) have been selected to take part in pilots due for completion by summer

Table 3. Assessments during medical training (MST1 onwards).

Minicex	– 9-point clinical rating scale
DOPS	– Direct Observation of Procedures
Multi-source feedback	– 360° appraisal
Knowledge-based assessment	– MCQ examination of best-of-5 questions

MCQ = multiple choice questionnaire.

2006. If successful, all trainees entering training in 2007 will be expected to have taken the KBA by year 2 or 3 of higher specialist training (HST). Most specialties have opted for 100 MCQs written in best-of-five style. Two diets per year are expected of an invigilated paper-based exam. The Medical Colleges are strongly committed to specialty exams and, as for Membership, these will be expected to be of high quality, validated and externally referenced. They will be developed in liaison with their professional bodies and may well form one part of future revalidation for consultants. The public expect their medical specialists to be safe, competent and up to date. This form of testing would be one visible way of demonstrating that.

Acute medicine

One of the most important and difficult tasks an acute hospital faces is management of the acutely ill medical patient. The Colleges of Physicians have strongly supported the development of a new specialty – the acute physician. MMC has offered the opportunity of developing a specific run-through training for acute physicians (probably two years basic plus three years higher medical training, ie MST1–5). Acute physicians could lead the management of the acute take and would have their own specific entry on the Specialist Register. At present, the acute take is supervised by physicians, many of whom are specialists and the majority have dual accreditation with general internal medicine (GIM). This situation will continue for the foreseeable future. Most trainees training in the major medical specialties will continue to train in internal medicine, eg supervising the acute take as a specialist registrar, but will gradually become more specialist as training continues. That acute or internal medicine training should be recognised, perhaps through a continued specialist registration, so that trusts can be sure that all specialists will still make a major contribution to the acute ‘take’ and are competent to do so.

Direction of healthcare and training

Repeated initiatives and White Papers have made it clear that the Government sees the priority for development of the health service as being within the community and led by primary care.⁴ This is particularly so for chronic disease management, where the vision is for patients to be followed and proactively managed in the community by appropriate clinicians such as community matrons, thereby relieving hospitals of their large follow-up out-patient population. Additionally, large secondary care providers, eg acute general hospitals, will be challenged by private providers and others (eg treatment centres) who may strip away ‘contestable’ services (eg cold elective surgery). Thus, despite the evidence that hospitals are getting busier (mainly through increasing A&E work), specialists of the future will need to consider several different work locations. They will need to work across primary and secondary care boundaries, providing their expertise where it is most useful to the patient pathway. Hence, some specialties that have traditionally been developed within a hospital setting may reasonably also be provided within the community setting,

Key Points

The Postgraduate Medical Education and Training Board (PMETB) takes over from the Specialty Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) from 30 September 2005

Trainees will undertake a Certificate of Completion of Training (CCT) from 1 October 2005, not a Certificate of Completion of Specialist Training (CCST)

Modernising Medical Careers (MMC) is presently reviewing medical specialist training which will start from August 2007

Acute medicine will become a specialty in its own right

eg neurology, cardiology and elderly medicine. This means that the Colleges, when designing training curricula, will need to be more flexible. Breaking down the components of training into discrete competencies will enable modular training and nationally agreed specialty competencies that can be shared amongst different specialties (eg neurology, elderly medicine and general practice) and between different professional groups (eg diabetes, endoscopy). One suggestion is that all higher specialty trainees in higher medical training should undertake a period of general practice training (in addition to that undertaken in foundation programmes). A more radical proposal is that specialty training should take trainees both from hospital-based basic specialty programmes (eg MST1, 2) and from those who have completed GP specialty training. The result may meet patients’ needs more effectively, with some specialists based in hospital backing up the acute medical team, and others (which may eventually form the larger group) employed by primary care trusts (PCTs) to deliver specialty care in the community, working alongside GPs and other healthcare professionals. Having trained together, both groups are more likely to work together, providing the seamless care between community and hospitals that patients require.

Conclusions

Change is always challenging. Although some doctors may feel disenfranchised by the current negotiations and think there is an ulterior political motive to undermine the authority of the medical establishment, there are opportunities from MMC and PMETB to make a real difference to how we train UK doctors. Training must be relevant to patient needs and be delivered in the shortest time possible. It must be properly quality assured, assessed and be open to public scrutiny. Patients and the public need the evidence that doctors are being properly trained to do the job and that this process continues throughout their professional lives. The UK has delivered world-class medical training for many years and will continue to do so. The new world demands that its specialists not only be competent and safe, but are able to change to meet different demands and have the generic skills which not only ensure that they care for the patient but are also able to lead the development of healthcare delivery.

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