

What's happening in postgraduate medical education?

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“It is a secret, both in nature and state, that it is safer to change many things at once.” (Francis Bacon, “Of Regiment of Health”, *Essays*, 1625)

- To provide a more broad experience of medicine in a variety of clinical settings and specialties
- To allow for experience in primary care.

It is no exaggeration to claim that postgraduate medical education in the UK is currently undergoing the most significant change in living memory. Most aspects of training will soon be transformed; furthermore, everything seems to be changing simultaneously and at a rapid pace. In order to appreciate the implications of all this for paediatrics and child health, it would be useful to consider what is actually happening, why it is happening, and what effects it will have on both training and trainees. Table 1 summarises the most significant drivers for change and their perceived impact.

MODERNISING MEDICAL CAREERS

Of all the initiatives currently relevant to postgraduate medical education, Modernising Medical Careers (MMC) has received the most attention. But what exactly is MMC? A reappraisal of the Senior House Officer (SHO) grade? An effort to produce trained clinicians in a shorter period of time? A strategy to improve the quality of postgraduate medical training? MMC embraces all of these challenges and much more. In 2002, the Chief Medical Officer's consultation document *Unfinished Business*¹ recommended seven principles for future SHO training in that it should be trainee centred, competency assessed, service based, quality assured, flexible, coached, and structured. The response of the four UK Departments of Health, *Modernising Medical Careers*² endorsed the consultation document and made further recommendations for the future direction of postgraduate medical training. A key principle of MMC is that of the two year Foundation Programme which represents a bridge between undergraduate training and entry to general practice or specialty training. Foundation Year 1 (FY1) from August 2005 equates to the Pre-Registration House Officer year which enables newly qualified doctors to become fully registered with the General Medical Council (GMC). It should be noted that the GMC has undertaken a review of this year of training, the conclusions of which are reflected within a transitional version of the New Doctor³ which will be effective until 2007. Foundation Year 2 (FY2) has several objectives:

- To ensure delivery of an agreed curriculum⁴ in both acute clinical and generic skills

Following successful completion of the Foundation Programme, doctors will then enter shorter, more focused and streamlined training programmes (previously known as the “run-through grade”) in one of the specialties or in general practice (fig 1). Much must be achieved by then in terms of selection criteria, appointments procedures, and curriculum development. Completion of training will result in the award of a CCT (Certificate of Completion of Training) for both specialists and general practitioners. There will be limited opportunities for CCT holders to undertake subspecialist training (for example, paediatric endocrinology), but details of how this will be achieved have yet to be decided. While future training will be more streamlined, there will be opportunities for doctors to change their career direction without the need to repeat competencies previously gained.

The guiding principles for Foundation Programmes are defined in the Operational Guide.⁵ Each stage of training (including FY1) has clear outcomes with explicit and incremental standards along with defined competencies that must be assessed. The assessment framework has now been agreed with a suite of tools including multi-sourced feedback.⁶

It should also be noted that MMC represents an opportunity whereby academic careers should be both enhanced and protected. A discrete career pathway for a limited number of academically gifted trainees has been suggested.⁷ In response to this, some Deaneries have set up special academic foundation programmes to commence in August 2006. These posts will have a separate process for recruitment (especially with respect to person specification which should reflect on undergraduate academic achievements and ability) from that of foundation programmes in general.

WHAT IS PMETB?

The Postgraduate Medical Education and Training Board (PMEBTB) was established as a result of the General and Specialist Medical Practice Order (GSMPO) 2003.⁸ It will develop and maintain standards for postgraduate

Abbreviations: CCT, Certificate of Completion of Training; FY1, Foundation Year 1; FY2, Foundation Year 2; GMC, General Medical Council; GSMPO, General and Specialist Medical Practice Order; MMC, Modernising Medical Careers; PMETB, Postgraduate Medical Education and Training Board; SHO, Senior House Officer; WTD, Working Time Directive

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Table 1 Main drivers for change

Initiative	Key features	Impact
Modernising Medical Careers	Foundation programmes Streamlined programmes Assessment of competencies	Shorter and more focused training More protected time needed for consultants and other supervisors for supervision and assessment
Postgraduate Medical Education and Training Board	Single competent authority for maintaining standards in postgraduate specialty and general practice training from September 2005 Definition of standards for entry and recruitment Responsible for quality assurance of postgraduate medical training Article 14 applications to specialist register on the basis of training, qualifications and experience	Changing roles for Royal Colleges with possibility reduced power and influence More lay and public input to postgraduate medical training More doctors will be admitted to the specialist register
Working Time Directive	August 2004: maximum 58 hour week August 2007: maximum 56 hour week August 2009: maximum 48 hour week Innovative approaches to learning and training needed Hospital at Night projects	Radical change to the way in which training is delivered Perhaps longer training needed for the surgical specialties Reconfiguration of services

medical education and training from September 2005 onwards when it replaces the Specialist Training Authority and the equivalent body for training in general practice (Joint Committee for Professional Training in General Practice). It is a UK wide body, independent of government but accountable to Parliament. While it will soon be the single competent authority for the approval of specialist and general practice training, its remit does not include undergraduate medical education or dental training.

The PMETB committee structure is well defined and includes both training and assessment. The continuing evolution of PMETB policy is available from its website (<http://www.pmetb.org.uk/pmetb/about/>). Attention is drawn to the PMETB Rules that cover such issues as CCT standards, certification, fees, and the appeals process. The remit of PMETB is wide and complex. However, the following issues are of immediate relevance to everyone who is involved with postgraduate medical training:

- PMETB is in consultation with Royal Colleges/Faculties, Postgraduate Deans, and others with respect to agreement of eligibility and selection criteria for entry to training programmes.
- There will be a standard system for the quality assurance of postgraduate medical education. The current system represents a highly variable combination of visits and surveys with poor coordination between Colleges and Postgraduate Deaneries. A standardised approach to quality assurance will be undertaken by PMETB in the near future. This is likely to consist of a data collection exercise comprising surveys, reports, and other sources of information that will help to provide an overview regarding standards of training as well as likely problem areas within Trusts. Visits to Trusts would be less frequent and would look at more than one specialty. Exceptional visiting would be triggered by concern from trainees, Colleges, or Deans. There will be lay representation on visiting teams.
- PMETB will consider applications for entry on to the specialist register under Article 14 of GSMPO. In order to inform this process, a doctor's qualifications, training, and experience will be taken into consideration. The application process began in July 2005. Once an application is accepted, it will be reviewed by the relevant College or Faculty. PMETB will then decide the outcome as follows: agree to entry onto the specialist register, refuse entry,

recommend a work based assessment or top-up training. For doctors whose experience and training has been mainly based in the UK, the standard would be that of a CCT; for those doctors applying from outside the UK the standard will be that required of a UK consultant. It should be noted that while successful application under Article 14 results in entry to the specialist register, it does not grant a CCT.

WORKING TIME DIRECTIVE

Circular 93/104/EC from the European Union Council laid down the requirements of the Working Time Directive (WTD) and was instigated on the basis of health and safety concerns.⁹ Since August 2004, doctors in training should work no more than 58 hours per week averaged over a period of 26 weeks and should have 11 hours rest every 24 hours. However, further efforts are needed by 2009 when the working week will be further reduced to 48 hours. While compliance with the Directive has been largely achieved and sustained by Trusts, anxiety has been expressed by trainees and Royal Colleges about the perceived negative impact of both a shorter working week and shift working on training.^{10 11} It will be some years before the true relation between WTD and training will be fully appreciated. However, there is anecdotal evidence that access to structured training events (departmental teaching, grand rounds) by trainees has reduced to about 50% since last August. WTD represents a considerable challenge for both trainers and trainees. The Directive is here to stay and cannot be ignored.

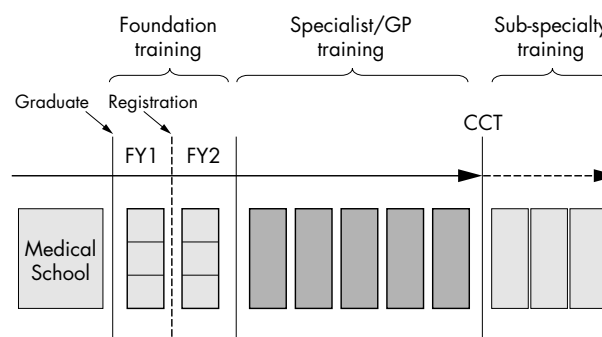


Figure 1 The future of postgraduate medical training.

Rather it must be accepted that the delivery of training must acknowledge the implications of the Directive and adapt appropriately. So can quality training be delivered in a shorter working week? Sinha and Kumar have made simple but achievable suggestions that require imaginative approaches from trainers and commitment from trainees.¹² Every moment of time that is spent in a clinical situation (outpatients, ward rounds, handovers) should be exploited in terms of learning opportunity. A useful reference in this respect is the excellent but overlooked *Liberating Learning* document which was written some years ago in anticipation of the implementation of WTD.¹³

The challenge does not end with WTD however; a recent development known as the Hospital at Night Project will result in new training needs for doctors in terms of team working, decision making, and role flexibility.¹⁴ The project, conceived before WTD became an issue, represents a radical review of how cover is provided for hospitals out of hours. It consists of a combination of initiatives that include:

- Moving non-urgent work from the night to the evening or daytime
- Effective multi-specialty handover in the evenings
- Other staff taking on some of the work traditionally done by junior doctors
- Reducing the unnecessary duplication of work by better coordination.

In effect, care at night time is provided by a small, multidisciplinary team that has the skills necessary for a wide range of clinical scenarios with the option for calling in specialist support when necessary. Hospital at Night pilot projects have shown benefits in terms of achieving WTD compliance and also more effective delivery of certain aspects of patient care.¹⁵ However, specific challenges are apparent for certain specialties, including paediatrics and obstetrics, where cross cover from other disciplines is either undesirable or not feasible. Furthermore, impact of the Hospital at Night project on medical training is as yet unknown.

WHY IS ALL THIS CHANGE HAPPENING NOW?

Medicine exists in a complex and changing environment. Rapid advances in medical knowledge and technology have developed in parallel to changes in the way we teach and learn. The demography of our populations is changing with resulting variation in disease patterns. One emerging theme is that of increasing public awareness and interest in health care issues. It follows that medical training must be in tune with these external challenges and that doctors of the future are fit for purpose. We will need clinicians who are patient centred, good team players, evidenced based practitioners, and above all are accountable for their actions. Acquisition of excellent clinical skills alone will not be sufficient in achieving these objectives. Medical training must adhere to the principles of medical professionalism which consists of a combination of reflective practice, ethics, a demonstrable ability to work with others, taking responsibility for one's own actions, and respect for patients.¹⁶

WHAT WILL ALL THIS MEAN?

All of the above will have profound implications for everyone involved in training in paediatrics and child health. Trainees will need to:

- Make early and firm decisions regarding their future career pathways; at the latest by the end of their foundation programmes
- Balance their ambitions against service requirements; the new system will produce generalists with more limited opportunities for subspecialisation dependent on local population health need
- Take responsibility for their own training by making the most of all available experiences and learning opportunities and by being proactive
- Develop a flexible approach to their training and service commitments
- Be adaptable as even more change is likely in the future.

Trainers will be required to:

- Try to keep abreast of what is happening in postgraduate medical education
- Continue to provide high standards of teaching, supervision, and support
- Embrace inevitable change rather than ignore it (or even challenge it!)
- Maintain a positive attitude with both trainees and students.

All of the preceding issues will result in new responsibilities and challenges for the College. High standards for training must continue and in collaboration with PMETB, new curricula need to be defined and implemented. Paediatrics has an enviable track record with respect to postgraduate training. It was one of the first specialties to offer placements within the previous PRHO year and in addition, most deaneries will include child health placements within FY2 posts. Training the paediatricians of the future is a significant responsibility and we need to ensure that we continue to rise to the challenge.

Competing interests: none declared

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