

JRCPTB

Joint Royal Colleges of Physicians Training Board

Clinical academic training within the new physician curricula

Introduction and background

The Shape of Medical Training Review (SoT – Greenaway report) was delivered to Ministers in November 2013. The report was commissioned because of the recognition that the needs of patients and service providers is subject to continual change. The report stressed the importance of generalism and the need to make physicians appreciate that training should focus, first and foremost, on producing physicians with broad generalist skills who could then specialise. The Joint Royal College of Physicians Training Board (JRCPTB) as part of the Federation of Royal Colleges of Physicians responded to SoT and the proposed developments were largely accepted by the UK SoT Steering Group in 2015. One of the major aims of SoT was to recognise that **“most trained doctors will require to contribute to the acute unselected take within their broad clinical discipline”**.

JRCPTB developed new curricula for all 30 physician specialties based on the model that had been accepted by the SoT Steering Group. Prior to SoT, the majority of physician trainees had trained and received a Certificate of Completion of Training (CCT) in both their own specialty and in General Internal Medicine (GIM) – so called ‘dual’ training’. A smaller number of trainees ‘single trained’ in their specialty alone. It was not unusual in some specialties (notably, but not restricted to, cardiology) for trainees to enrol in dual training (GIM plus specialty) but at later stages of their training they would seek to ‘drop’ GIM training and gain a CCT in specialty alone. This always required the permission of the local Postgraduate Dean but in practice such permission was rarely withheld. (For clarification, General Internal Medicine is now referred to as Internal Medicine throughout all training documents but the final CCT remains one in GIM as the necessary legislation to facilitate the name change from GIM to IM has not yet occurred).

One of the main tenets of the JRCPTB response to SoT was to ensure that more doctors would complete training in both GIM and specialty. It was appreciated that a small number of specialties had never trained in GIM and, as their specialty was mainly out-patient based with less requirement to interact with the acutely unwell patient, they would not be required to dual train. These specialties are referred to as Group 2 specialties (and they can recruit to their specialty at ST3 following successful completion of 2 years of Internal Medicine Training (IMT), together with successful completion of MRCP(UK)

The majority of physician trainees practise within the Group 1 specialties. They are recruited at ST4 level following completion of the 3 year IMT programme. Three specialties that had traditionally not dual trained in GIM (neurology, genitourinary medicine and palliative care medicine) became Group 1 specialties and from August 2022 all trainees in these specialties will be dual trained.

In order to meet the professional need for significant generalist expertise trainees in any Group 1 specialty can no longer 'drop' their internal medicine training, and to promote the ideals of SoT, the curricula have been written so that the capabilities of Internal Medicine are inextricably bound within the specialty curriculum. Thus, it is not possible to complete training in a Group 1 specialty without completing training simultaneously in Internal Medicine. In other words, whilst there is a 'stand-alone' curriculum for IM, there is no stand-alone curriculum for cardiology, renal medicine or any other Group 1 specialty. This has been overtly and expressly stated in all the JRCPTB documents on changes to curricula.

Impact on clinical academic training

Trainees who follow an 'academic pathway' face different and additional challenges in training progression compared to their non-academic colleagues. In addition to gaining all their clinical training and experience, achieving all their requisite exams (MRCP and SCEs) and Capabilities in Practice (CiPs), they also must develop their academic skills in research and teaching. Notably, almost all of them will need to develop a project worthy of funding from research councils or other funders. Most will spend 3 years out of programme for research (OOPR) to gain a higher degree (usually a PhD but sometimes a MD). Some trainees may follow an academic pathway throughout their training. Although the precise terminology of the posts undertaken may differ in each of the home nations, the trainee may begin as an academic foundation doctor, continuing into the relevant core specialty academic training and subsequently move into a clinical lecturer post. Others may flex between academic and non-academic appointments. Most importantly, on completion of training, a substantial proportion of academic trainees (at the moment over half) will take up substantive, non-academic NHS posts following completion of their doctorates. It is therefore essential that their clinical training is every bit as comprehensive and robust as that of their non-academic colleagues.

The concept of some form of 'academic CCT' that would require less training/clinical experience has been discussed at various meetings between JRCPTB and the academic community but has always been rejected by all on a matter of patient safety alone; nobody could support the appointment of a physician who is less clinically capable than their non-academic colleagues.

This means that there is no alternative to academic trainees in Group 1 specialties having to complete training in their higher specialty, in internal medicine and in their academic pathway. It may mean that some trainees may require additional time within their training environment to achieve and demonstrate all necessary capabilities. This additional training time can be achieved by granting an ARCP outcome 3 at any stage of training and once again, it should be stressed that any 'non-standard' ARCP outcome should not be regarded as in any way pejorative but merely a recognition of reality that the individual trainee needs more time to develop all relevant capabilities. One way to offset this would be to develop guidance indicating that it may be anticipated that in one or more years of the academic training pathway an 'academic ARCP outcome 3' could be selected in recognition of the additional capabilities such trainees must achieve and the additional time required for this.

Flexibility within the training pathway

While the present curricula are capability, and not time based, in practice, it is helpful to suggest approximate times needed to achieve sets of capabilities, whilst acknowledging that the interaction of opportunities provided by the training environment and the aptitude of the trainee, will mean that some trainees will need less time and some will need more. The 'indicative' duration of training for the majority of Group 1 specialties is 4 years from entry at ST3 to CCT (5 years for cardiology and neurology). Of this 4 years, an indicative 12 months should be spent in Internal Medicine and 3 years in specialty training. JRCPTB has encouraged that, in most programmes, training in IM will be integrated within higher specialty training (HST) and guidance documents have been published on how this integration can be best achieved.

Flexibility with numbers

As noted above, all curricula are 'capability based' rather than time based. Therefore, training should be considered complete when a trainee has achieved level 4 capability (capable of independent practice) in all the clinical Capabilities in Practice (CiPs). Some trainees may progress more rapidly and achieve all their CiPs faster and JRCPTB has produced a policy to facilitate acceleration towards CCT. Other trainees may require additional training time and that can be achieved by granting an ARCP outcome 3 (see above). Although achievement of CCT is based on higher learning outcomes (the CiPs), it is recognised that to achieve and demonstrate appropriate levels of capability in each CiP, a certain amount of experiential learning is required. However, it is also appreciated that from a single clinical encounter or training experience, an individual may be acquiring capability in their specialty CiP, their IM clinical CiP and in their generic capability. Thus, the indicative numbers of clinics, patients seen etc should be seen as a guide as to what most trainees will need to see/do in order to achieve that appropriate level of capability.

Flexibility with OOPR

Traditionally, a trainee going OOPR could ask the GMC if they could have a year of their time out of programme to 'count' towards their time spent in clinical training. These requests would be reviewed by JRCPTB and the appropriate Specialty Advisory Committee (SAC) and a recommendation made to the GMC about how much research time OOP would 'count'. Little note was taken of whether the period OOPR included ANY clinical contact whatsoever or whether it was purely laboratory based. Clearly, a trainee may be gaining generic capabilities within a laboratory-based research environment, but they will be gaining little (if any) clinical capability. Other trainees may be undertaking research activity that is very clinically based (e.g., doing a regular research clinic), others may elect (sometimes for financial reasons) to undertake regular clinical sessions during their OOPR. Clearly such trainees will be acquiring clinical in addition to generic capabilities. JRCPTB have now developed a policy that suggests trainees should maintain contact with their clinical educational supervisor during their OOPR and that on return to clinical training an assessment should be made as to what capabilities have been gained and as to whether the CCT date can be brought forward by the appropriate period (in certain circumstances, this may be in excess of 12 months).

Potential to train in Internal Medicine alone

As stated above, there is no standalone curriculum for any Group 1 specialty but there is a standalone for Internal Medicine so academic trainees who feel that the demands of clinical training are excessive could opt to withdraw from specialty training and achieve a CCT in (G)IM alone. This would allow them to enter the specialist register and they could, of course, then be appointed to a consultant post within the specialty in which they had previously been training provided it is clinically appropriate (being on the GMC specialist register in any specialty means that you can be appointed to any specialist post). It is appreciated that this may not be suitable or attractive for many trainees as they would probably wish to be on the specialist register in their own particular specialty. However, it might be an option in some cases and one could imagine that they might achieve much of their (G)IM capability whilst pursuing specialist clinical activity.

Summary and conclusions

JRCPTB recognises the challenges that curricula changes have brought to academic clinical training. It especially appreciates that the requirement for all trainees in Group 1 specialties to complete training in internal medicine may be unpopular with some trainees and trainers. However, such a requirement is consistent with the spirit of the Shape of Training Review, the career pathways of most academic trainees and the needs of the patients that the NHS serves. Nobody wants a differential CCT for academics that suggests that they are in some way clinically less able. This means that those in group 1 specialties will have to achieve the capabilities in specialty and (G)IM to reach CCT. JRCPTB has tried to provide guidance that maximises the flexibility of approach within training to mitigate the issues that curricula changes have imposed. JRCPTB would wish to work closely with the academic community to promote academic training and academic careers but would also want to help to address the issues in academic career pathways which affect longer term career progression.

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