Hospital doctors : training for the future : the report of the Working Group on Specialist Medical Training, and, Training for specialist practice : a report to the Chief Medical Officerś Working Group to advise on specialist training in the United Kingdom.

HOSPITAL DOCTORS: TRAINING FOR THE FUTURE

The Report of the Working Group on Specialist Medical Training

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REPORT OF WORKING GROUP ON SPECIALIST MEDICAL TRAINING

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WORKING GROUP ON SPECIALIST MEDICAL TRAINING
EXECUTIVE SUMMARY

This report reviews the current arrangements for specialist training and calls for changes consistent with EC law. It also identifies areas for further review and development.

The report reviews progress with the development of structured and planned training programmes, and notes the potential for the duration of specialist training to be reduced. Based on the evidence provided by the Medical Royal Colleges and other educational bodies, it set out the principles to be taken into account in the planning of training programmes. As a result the report recommends:

- the introduction of improved training programmes by the end of 1995
- the establishment of a single training grade by mid-1995 to replace the career registrar and senior registrar grades
- the establishment of regular discussions between the educational bodies and the Postgraduate Deans as soon as possible
- the introduction of a new Certificate of Completion of Specialist Training (CCST). This is to be awarded by the GMC on the advice from the appropriate College that a doctor has completed a training programme which meets the requirements of the EC directives to a standard compatible with independent practice and eligibility for consideration for appointment to a consultant post.

The report goes on to identify the need for the award of a CCST, or the equivalent qualification from another EC member state, to be shown on the medical register by the introduction of "CT" as a specialist indicator, together with the relevant specialty, the year of award and the member state in which the qualification was awarded.

The implications of these recommendations for the consultant appointment system are noted, and it is recommended that guidance for Advisory Appointment Committee members should be reconsidered. A number of issues are referred for further consideration to the forum which is to review the operation of the consultant appointments procedure.

The report then considers wider issues arising from the Group's work; first how the UK input into EC medical legislation, and liaison with European colleagues, might be organised better. In particular it calls for the establishment of improved communication and liaison arrangements, including changes in the membership of the UK delegation to the Advisory Committee on Medical Training. Implications for career structure, manpower planning, and service provision are also discussed; in particular the need for increases in the number of consultants.

Finally, the report notes the need for transitional arrangements during the period of change from one system to another and sets out the main strands of action required. It recommends that:

- its recommendations should be implemented within 2 years of being accepted by Ministers
- the Chief Medical Officer should monitor the action being taken forward.

1. BACKGROUND

Introduction

1.1 In July last year the Secretary of State for Health announced the establishment of a Working Group under the Chairmanship of the Chief Medical Officer at the Department of Health. She asked the Group to advise her on any action needed to bring the UK into line with the EC directives on medical training.

1.2 The European Commission had expressed concern that the system in place in the UK for the mutual recognition of specialist medical qualifications between ourselves and our European partners might not fully comply with the 1975 Directives. The Commission's view was firstly that there would be an infringement if the UK were not to recognise other member states' certificates as being evidence of completion of specialist training. Secondly they considered that if the UK certificate, issued for the purposes of the 1975 Medical Directive, was awarded at an intermediate point during postgraduate training rather than at its completion this would be contrary to the Directive. On the basis that the UK position was considered to be unsatisfactory, the Commission decided to initiate the first stages of infraction proceedings against the UK. The Chief Medical Officer held a number of preliminary meetings with representatives of the Medical Royal Colleges, the General Medical Council (GMC), the Central Consultants and Specialists Committee and the Junior Doctors' Committee following which the Secretary of State established the Working Group. A full membership list is provided at Annex A1.

Terms of reference

1.3. The Group's terms of reference were:

- to consider the present UK arrangements for postgraduate medical education and career progression in the NHS, taking into account European Community law

- to consider scope for further harmonisation of specialist qualifications in Europe

- to advise UK Health Ministers within six months on any action which needs to be taken.

1.4 The Working Group notes that its terms of reference are primarily concerned with hospital specialists. The Group recognises that general practice is also a medical specialty, and does not recommend any major changes to the structure of training for general practice at the present time. Any manpower or training implications for general practice arising from

the Group's recommendations will be considered by the UK Health Departments in consultation with the appropriate NHS professional and educational representatives.

Working methods

1.5 Three subgroups to the main Group were established, each focusing on a major area for consideration. The remaining issues were considered by the full Group in plenary session. Some subgroup members were co-opted from outside the main Group to broaden the debate and enable input from those with particular expertise in the individual subjects to be discussed. Details of the terms of reference and membership of the subgroups are provided at Annex A2.

2. CONSULTATION

Consultation exercise

2.1 In October a range of organisations was invited to put evidence to the Group. Nearly 60 responses were received from a number of interests, enabling the Group to take account of a wide range of views. The analysis of the responses indicated widespread interest in the potential for improving training programmes. Many respondents commented that training is at present too long. However opinion was more variable on other key subjects, particularly career structure and consultant appointment procedures; responses were generally evenly divided between those who favoured minor changes to align the UK more closely with the EC and those who called for more substantial reform. A more detailed analysis of the comments received, which was considered by the Working Group, is attached at Annex B.

Consultation with the independent sector

2.2 The Chief Medical Officer met representatives of independent health sector organisations on two occasions to discuss their systems for recognition of specialists in the light of the Group's proposals (see paragraph 9.2). A list of those attending the meeting is provided at Annex A3.

Meeting with representatives of patients

2.3 The Chief Medical Officer also met representatives of patients' organisations to hear their general views and their reactions to the Working Group's proposals (see paragraph 9.3). A list of those attending the meeting is provided at Annex A3.

3. SUMMARY OF RECOMMENDATIONS

Recommendation: a . The Working Group *notes* the progress already made by the Medical Royal Colleges and their Faculties in developing more organised training programmes. In particular, it *welcomes* the opportunities created for a significant reduction in the duration of training, without compromising standards. It strongly *supports* the continuation of such work which it considers will ultimately enable most doctors to obtain their certificate of completion of specialist training generally within a period of seven years. The Working Group therefore:

i) recommends that the Medical Royal Colleges and their Faculties specify the curricular requirements for planned specialist training programmes *no later than July 1994.* In doing this it recognises that different colleges have reached different stages in this process. It is expected that this work will take account of the specific recommendations made in the report of subgroup A

ii. while acknowledging the complexity and extent of these changes, the Working Group recommends that Postgraduate Deans, Medical Royal Colleges and other relevant educational bodies together with NHS management implement these programmes *by the end of 1995.* The Group accepts that this timescale may need to be reviewed in the light of changing circumstances

iii. recognises that the Medical Royal Colleges and their Faculties must monitor the impact of these changes carefully to ensure that standards are being maintained.

b. The Working Group recommends that further consideration be given to the period of general professional/basic specialist training and suggests that this be examined by a working party convened by the GMC, with appropriate representation of other interests, which would submit positive proposals *by the end of 1993* for the GMC to consider and consult on *by mid-1994.*

c. The Working Group recommends that the UK Certificate of Completion of Specialist Training (CCST), be awarded by the GMC on advice from the relevant Medical Royal College that the doctor has satisfactorily completed specialist training, based on assessment of competence, to a standard compatible with independent practice and eligibility for consideration for appointment to a consultant post. In making this recommendation the Working Group acknowledges the need to distinguish between the *completion of specialist training* as indicated by the award of the CCST and *continuing medical education,* which should extend throughout a doctor's career.

d. The Working Group recommends that the Medical Royal Colleges should take into account in their development of specialist training programmes the specific recommendations made in paragraph 22 of subgroup A's report about the nature of the training programmes to be developed. In particular

i) the term "specialist training", for the purposes of the EC Medical Directives, applies to the whole of the period of training following full registration and lasts until the award of a UK CCST (Certificate of Completion of Specialist Training) (see paragraphs 40-43 of Annex C);

ii) the structure of training programmes needs to be sufficiently flexible to enable there to be choice of career pathway within the period of specialist training as well as at entry to and exit from it;

iii) the arrangements for the first phase of specialist training must provide sufficient flexibility to enable a trainee doctor to make an initial commitment to a broad range of specialties and, where he or she so chooses, to delay a final commitment to pursue a particular specialty training programme; and that

iv) throughout the period of specialist training only that experience and training which fulfils the requirements and meets the standards of the accrediting authority would be recognised for the award of a UK CCST (see paragraphs 40-43 of Annex C).

The Medical Royal Colleges must also take into account the need for a clear specification of criteria for satisfactory completion of training in respect of each specialty, and should consider the implications for academic and research medicine.

e. The Working Group recommends that the Health Departments, following appropriate consultation, reconsider the training grade structure in the light of subgroup A's recommendations with the aim of introducing a combined higher training grade to replace the registrar and senior registrar grades as soon as is practicable and in any case *no later than the end of 1995*; and consider whether integration should proceed further once the GMC has determined the future place of general professional/basic specialist training within the overall specialist training framework.

f. The Working Group recommends that:

i) the CMO (England) on behalf of the UK Health Departments convene a series of meetings between representatives of the Medical Royal Colleges and Postgraduate Deans. These meetings would provide a forum for continuing dialogue on matters of mutual concern, beginning with a discussion of their respective roles in relation to specialist training within the NHS. Such a

dialogue should take account of the views of other interested parties, such as the Junior Doctors' Committee, the Central Consultants and Specialists Committee and representatives of general practice training interests

ii) The NHS Management Executive, on behalf of the UK Health Departments, convene regular meetings at national level involving NHS management, Postgraduate Deans, the Medical Royal Colleges and other appropriate educational bodies, such as the Committee of Vice-Chancellors and Principals. Such meetings would provide a means by which NHS management could advise the Medical Royal Colleges about the needs of the NHS and for the Colleges to satisfy themselves that training in the NHS continued to be delivered to the required standard. The initial task would be to develop a set of principles to govern the relationship between service and training. This would be expected to take account of the views of other interested parties such as the Junior Doctors' Committee and the Central Consultants and Specialists Committee

iii) the Postgraduate Deans should build on existing local co-ordinating mechanisms, such as regional specialty committees, to ensure that professional and educational interests are properly taken into account in the delivery of postgraduate training.

g. The Working Group recommends that the GMC should award the CCST to trained specialists on the advice of the Medical Royal Colleges. Individuals in possession of a UK CCST or the appropriate EC certificate specified in the Medical Directives will be indicated at their request by the addition of "CT" to the Medical Register, together with details of the appropriate specialty/ies, date of the award and the member state which issued the certificate. The necessary legislation to implement these changes should be enacted *without delay*. Consideration should be given to the establishment of a statutory appeal mechanism.

h. The Working Group recommends that the current discussions on the consultant appointment system include consideration of the guidance for AAC members by those responsible for its promulgation, with particular regard to the requirements of EC legislation, and should make recommendations for any necessary changes *no later than September 1993*.

i. The Working Group recommends that the operation of the consultant appointment process be reviewed. This review would involve the profession, the Health Departments and NHS management and would take into account the papers produced for the Working Group. The Group supports the reconvening of the Working Party on the Appointment to Consultant Regulations, chaired by the Chief Medical Officer for Wales, to carry out such a review, and recommends that it be completed *by March 1994*.

j. The Working Group recommends that:

i) the Health Departments establish a forum to facilitate the work of members of the Advisory Committee on Medical Training (ACMT)

ii) the Health Departments give further consideration to the membership of the UK delegation to the ACMT. This should be carried forward by the Chief Medical Officer for Northern Ireland in consultation with the above forum. Recommendations should be made *before* the next nominations for ACMT membership are due in *early 1996*.

k. The Working Group recommends that:

i) the workforce and career structure issues arising from the implementation of their recommendations be taken forward within the context of the current review of the implementation of Achieving a Balance. The Chief Medical Officer (England) should take this forward in consultation with the other Health Departments and appropriate professional, educational and NHS management interests. This review should be completed *by July 1994*

ii) the Chief Medical Officers consider reconvening the Tripartite Group (with representation of the profession, the NHS, the Health Departments and academic and research medicine) should they consider it necessary to review the fundamental agreements about medical manpower control in the UK

iii) the UK Health Departments consider the implications for the control of higher specialist training posts in the UK, and should seek advice about the longer term implications for the supply of medical manpower from the Medical Manpower Standing Advisory Committee.

l. The Working Group recommends that a group should be convened whenever necessary by the Chief Medical Officer (England), on behalf of the Health Departments, to confirm that appropriate action is being taken forward.

4. TRAINING: STRUCTURE, LENGTH AND CONTENT

4.1 At the outset the Working Group determined that their consideration of changes needed in the structure and organisation of specialist medical training should be founded on three central principles:

- that specialist training is an integral part of the wider continuum of medical education and training which begins on entry to medical school and is only completed on retirement from active practice

- that any changes proposed must ensure that standards of both medical training and clinical service to patients are maintained or improved

- that the assessment of doctors in training would be based on competence.

4.2 In January the Working Group received the report of subgroup A, which had looked at criteria for specialist training programmes under the chairmanship of Mr Stanley Simmons. The report provides a detailed consideration of the issues surrounding the structure, length and content of training programmes. In particular it reports on the significant amount of work already undertaken by the Medical Royal Colleges to improve the quality of specialist training in the UK. The report is based on evidence provided to the subgroup by the Medical Royal Colleges, their Faculties and the UK Conference of Postgraduate Medical Deans. The report (Annex C) has been accepted by the Working Group.

4.3 The subgroup report demonstrates that the Medical Royal Colleges and Faculties have already carried forward work on actively reviewing training programmes. Potential for further reorganisation and improvement of specialist training was identified. The implementation of these improvements will make it possible to reduce the minimum duration of training programmes to 7 years or less in most specialties. A reduction in the length of time spent in training was widely supported by those responding to the Working Group's consultation exercise (see para 2.1). However subgroup A additionally found that lack of career opportunities was an important factor in prolonging time in training posts.

4.4 The Working Group confirmed the key responsibility of the Medical Royal Colleges and their Faculties for determining content of training and the standard to be achieved. The evidence provided to subgroup A showed that Medical Royal Colleges are already taking forward the improvement and restructuring of training programmes. Significant changes are also occurring in relation to the management and funding of postgraduate training by the Postgraduate Deans. The Working Group considers that these changes will enable doctors to complete specialist training at an earlier age without compromising standards. They also believe that these improvements now enable the completion of training to be marked by the

award of a specific Certificate of Completion of Specialist Training (CCST), in line with the EC Directives.

Recommendation: a . The Working Group *notes* the progress already made by the Medical Royal Colleges and their Faculties in developing more organised training programmes. In particular, it *welcomes* the opportunities created for a significant reduction in the duration of training, without compromising standards. It strongly *supports* the continuation of such work which it considers will ultimately enable most doctors to obtain their certificate of completion of specialist training generally within a period of seven years. The Working Group therefore:

i) recommends that the Medical Royal Colleges and their Faculties specify the curricular requirements for planned specialist training programmes *no later than July 1994*. In doing this it recognises that different colleges have reached different stages in this process. It is expected that this work will take account of the specific recommendations made in the report of subgroup A

ii) while acknowledging the complexity and extent of these changes, the Working Group *recommends* that Postgraduate Deans, Medical Royal Colleges and other relevant educational bodies together with NHS management implement these programmes *by the end of 1995*. The Group accepts that this timescale may need to be reviewed in the light of changing circumstances

iii) recognises that the Medical Royal Colleges and their Faculties must monitor the impact of these changes carefully to ensure that standards are being maintained.

4.5 Subgroup A identified a need to examine further the arrangements for training during the phase of general professional training/basic specialist training. During this period a doctor develops the wide range of general and basic specialist skills needed for more specialised practice. The report recommends that consideration be given to including a phase of general training in all structured training programmes. The emphasis placed on this component at present varies between specialties. The Working Group notes that general professional/basic specialist training is an important component of the overall continuum of undergraduate and postgraduate medical education and needs to be considered in the light of the content of the undergraduate curriculum.

b. The Working Group recommends that further consideration be given to the period of general professional/basic specialist training and suggests that this be examined by a working party convened by the GMC, with appropriate representation of other interests, which would submit positive proposals *by the end of 1993* for the GMC to consider and consult on *by mid-1994*.

4.6 The Working Group has considered the means by which the point of completion of specialist training can be formally established in line with the requirements of the EC Medical Directives. Subgroup A recommends that the UK Certificate of Completion of Specialist Training (CCST) should be awarded when the relevant Medical Royal College considers that training has been satisfactorily completed. On this basis the subgroup is satisfied that for all specialties a CCST would be awarded at a standard compatible with independent practice and would demonstrate eligibility for consideration for appointment as a consultant within the NHS. The Working Group notes that the process of assessment leading to the award of a CCST must be competency based, structured and interactive, with opportunities for discussion between the assessors and the individual being assessed. In particular regular assessment will be vital in ensuring that the appropriate standard for the award of a CCST can be reached, within a training period significantly shorter than that provided for at present.

c. The Working Group recommends that the UK Certificate of Completion of Specialist Training (CCST), be awarded by the GMC on advice from the relevant Medical Royal College that the doctor has satisfactorily completed specialist training, based on assessment of competence, to a standard compatible with independent practice and eligibility for consideration for appointment to a consultant post. In making this recommendation the Working Group acknowledges the need to distinguish between the *completion of specialist training* as indicated by the award of the CCST and *continuing medical education,* which should extend throughout a doctor's career.

4.7 The subgroup determined that the term "specialist training" should apply to the whole of the period of training starting with full registration and extending until the award of a UK CCST. The subgroup identified several fundamental principles for the development of specialist training:

- the term "specialist training" applies to the period between full registration and the award of the CCST
- specialist training is part of an overall continuum of medical education which extends from entry to medical school until retirement from medical practice
- arrangements will need to be sufficiently flexible to meet differing requirements of different specialties
- equally there needs to be sufficient flexibility to enable doctors in training to exercise choice between specialties and career options
- entry to training programmes must be competitive
- the needs of overseas qualified doctors will need to be accommodated
- only that experience and training which fulfils the requirements and meets the standards of the relevant Medical Royal College will be recognised for the award of a UK CCST
- arrangements must comply with the EC Medical Directives

Whilst endorsing these fundamental principles the main Group also considers that the educational bodies will need to set out clearly in respect of each specialty the criteria to be fulfilled in order for each specialist training programme to be completed satisfactorily. The Group notes that proper account must be taken of the special needs of trainees aiming at careers in academic medicine, together with a need for flexibility to ensure that the interests of academic and research bodies in medicine are properly protected. The Group emphasises that new arrangements must not impede efforts to improve opportunities and arrangements for flexible training including part-time and job-shared training.

d. The Working Group recommends that the Medical Royal Colleges should take into account in their development of specialist training programmes the specific recommendations made in paragraph 22 of subgroup A's report about the nature of the training programmes to be developed. In particular:

i) the term "specialist training", for the purposes of the EC Medical Directives, applies to the whole of the period of training following full registration and lasts until the award of a UK CCST (Certificate of Completion of Specialist Training) (see paragraphs 40-43 of Annex C)

ii) the structure of training programmes needs to be sufficiently flexible to enable there to be choice of career pathway within the period of specialist training as well as at entry to and exit from it

iii) the arrangements for the first phase of specialist training must provide sufficient flexibility to enable a trainee doctor to make an initial commitment to a broad range of specialties and, where he or she so chooses, to delay a final commitment to pursue a particular specialty training programme; and that

iv) throughout the period of specialist training only that experience and training which fulfils the requirements and meets the standards of the accrediting authority would be recognised for the award of a UK CCST (see paragraphs 40-43 of Annex C).

The Medical Royal Colleges must also take into account the need for a clear specification of criteria for satisfactory completion of training in respect of each specialty, and should consider the implications for academic and research medicine.

4.8 Difficulties in progressing from one phase of training to another have undoubtedly extended the duration of training. The Group has therefore considered the need to continue to maintain three discrete training grades - the senior house officer, registrar and senior registrar grades. Subgroup A recommends the introduction of a combined career registrar and senior registrar grade as soon as is practicable. A further option to replace the present three training grades with a single specialist training grade was considered as a possible future option; further consideration cannot be given to this until there is greater clarity about

the place of general professional/basic specialist training within the overall continuum of specialist training.

e. The Working Group recommends that the Health Departments, following appropriate consultation, reconsider the training grade structure in the light of subgroup A's recommendations with the aim of introducing a combined higher training grade to replace the registrar and senior registrar grades as soon as is practicable and in any case *no later than the end of 1995*; and consider whether integration should proceed further once the GMC has determined the future place of general professional/basic specialist training within the overall specialist training framework.

4.9 Subgroup A calls for improved liaison between Medical Royal Colleges, Faculties and Postgraduate Deans to help deliver structured or organised postgraduate training programmes to meet the standards set by Colleges and Faculties. It was recognised that an important item of further work was the need for a review of methods of assessment leading to the award of a CCST. The Working Group has also identified a need for a mechanism for communication between those responsible for training standards (the relevant Medical Royal Colleges), those involved in the management of postgraduate education (the Postgraduate Deans) and the employing authorities. The Group emphasises that the overall responsibility for maintaining standards and determining the content of training continues to rest with the Medical Royal Colleges. It recognises that this responsibility is not limited to the NHS and is part of the Medical Royal Colleges' broader national and international role in setting standards in medical education. At the same time the Working Group also notes that the bulk of training takes place within the NHS and that the primary responsibility for organising the delivery of such training in the regions rests with Postgraduate Deans. The Group therefore considers that both NHS management and Postgraduate Deans have a legitimate interest in the development of structured training. An initial step might be the identification of a clear set of principles governing the relationship between service and training in the post-reform NHS.

f. The Working Group recommends that:

> **i) the CMO (England) on behalf of the UK Health Departments convene a series of meetings between representatives of the Medical Royal Colleges and Postgraduate Deans. These meetings would provide a forum for continuing dialogue on matters of mutual concern, beginning with a discussion of their respective roles in relation to specialist training within the NHS. Such a dialogue should take account of the views of other interested parties, such as the Junior Doctors' Committee, the Central Consultants and Specialists Committee and representatives of general practice training interests**

ii) the NHS Management Executive, on behalf of the UK Health Departments, convene regular meetings at national level involving NHS management, Postgraduate Deans, the Medical Royal Colleges and other appropriate educational bodies, such as the Committee of Vice-Chancellors and Principals. Such meetings would provide a means by which NHS management could advise the Medical Royal Colleges about the needs of the NHS and for the Colleges to satisfy themselves that training in the NHS continued to be delivered to the required standard. The initial task would be to develop a set of principles to govern the relationship between service and training. This would be expected to take account of the views of other interested parties such as the Junior Doctors' Committee and the Central Consultants and Specialists Committee

iii) the Postgraduate Deans build on existing local co-ordinating mechanisms, such as regional specialty committees, to ensure that professional and educational interests are properly taken into account in the delivery of postgraduate training.

5. REGISTRATION OF COMPLETION OF SPECIALIST TRAINING

5.1 The Working Group has considered the concerns of the European Commission about the present UK system of specialist accreditation and registration. At present, the award of the "T" indicator by the GMC denotes completion of UK specialist training and is awarded on the advice of the Medical Royal Colleges to those who have been accredited or have equivalent status. The present system makes no reference to holders of specialist qualifications from other Member States or to the CCST. This creates a level of specialist recognition which may appear not to be equivalent to the CCST and to which individuals with corresponding qualifications from other European countries may not have equal access.

5.2 The Working Group recognises that on satisfactory completion of specialist training a doctor will have reached a standard compatible with independent specialist practice and should be eligible for consideration for appointment to a consultant post, (or as a principal in general practice in the case of individuals in GP training). The GMC is ultimately responsible for standards of medical practice and general oversight of all medical education. It recognises that the Medical Royal Colleges now envisage that both the certificate and the "T" indicator could properly be awarded at the conclusion of more structured training programmes. The GMC has therefore agreed to issue a CCST on confirmation by the relevant training body that a doctor has satisfactorily completed a planned and organised programme of specialist training which equips him/her for independent practice in the relevant specialty in the United Kingdom, and which complies with the requirements of the EC Medical Directives.

5.3 On award of the CCST, the GMC will indicate that the certificate holder has the status of a trained specialist by marking their entry on the Medical Register with a specific letter followed by the name of their specialty/ies. The Working Group has considered whether the present "T" indicator should be changed, for example to "CT" to indicate "certificate of training". The change of the indicator would make it clear that a change has been introduced and would avoid confusion with the old system; on balance the Working Group favours this. Any doctor from another EC country who had obtained one of the certificates specified in the EC directive in a specialty recognised in the UK would be eligible, on application to the GMC, to be entered in the Medical Register with the appropriate specialist indicators. The specialty in which the certificate was awarded, the year of award, and the member state in which the certificate had been issued, would also be shown (for UK doctors as well as those trained in other European countries). The information would be available to the general public through inspection of the Register. The Group believes that this will meet the requirements of the European Commission and will establish a means of equivalent recognition for all European trained specialists whose specialties are recognised in the UK.

5.4 The Working Group recognises that in some cases the length of specialist training in the UK will exceed that which is required by the Directives. It is also important to emphasise that the latter is a *minimum* specification: the Directives allow for training programmes which

are longer than the minimum periods specified in the Directives. This means that some UK doctors may for the time being have to spend longer in training in order to satisfy the requirements for the CCST than colleagues from other member states. The Group also notes that the European Commission's intention to consider modifying existing community legislation will provide a welcome opportunity for member states to provide updated information to the Commission about developments in medical education since 1975.

5.5 The Group recognises that legislative changes will be necessary to implement the change to the award of a CCST and the introduction of the new indicator: this will be for the Health Departments to pursue in consultation with the GMC, the educational authorities and the profession. It will also be necessary to consider the establishment of a formal appeal mechanism to provide for the resolution of disputes over decisions about the award of the CCST.

5.6 The Group has considered the option of creating a "restrictive" specialist register, which would prevent those not entered on it from undertaking independent specialist practice and from applying for consultant posts. Concerns have been expressed by patients' organisations that some patients - particularly those who use the independent sector but do not have private insurance - may be vulnerable to practitioners who describe themselves in misleading terms. The majority of the Group has agreed that a restrictive register would be an unnecessary step at this time in view of the wide range of safeguards already in place. While recognising the importance of protecting the public from improperly trained practitioners, the Group believes that this is adequately achieved by GP referral to consultants, by the NHS consultant selection procedures, and by the private sector's use of criteria for specialist recognition. The Group therefore proposes that the registration of specialists be on a voluntary basis and should be indicative rather than restrictive.

g. The Working Group recommends that the GMC should award the CCST to trained specialists on the advice of the Medical Royal Colleges. Individuals in possession of a UK CCST or the appropriate EC certificate specified in the Medical Directives will be indicated at their request by the addition of "CT" to the Medical Register, together with details of the appropriate specialty/ies, the date of the award and the member state which issued the certificate. The necessary legislation to implement these changes should be enacted *without delay*. Consideration should be given to the establishment of a statutory appeal mechanism.

6. APPOINTMENT TO CONSULTANT

6.1 The Working Group recognises that the consultant appointment arrangements are a key link between the medical training and career structures. Subgroup B was established under the chairmanship of Mr Ross to review the current arrangements for consultant appointments (the subgroup's terms of reference and membership are set out in Annex A2).

6.2 Subgroup B's remit was to ensure that the arrangements for consultant appointments were compatible with both EC legislation and UK employment law. The subgroup noted that the current legislation on Advisory Appointment Committees (AACs) does not demand any qualifications other than primary medical registration. It thus does not discriminate against doctors with qualifications obtained in other member states and therefore does not conflict with EC law. At the same time the subgroup noted that some of the information provided for members of AACs contained references to the status of certificates of completion of training and other qualifications. Changes to the way in which the CCST is awarded will therefore need to be reflected in guidance provided for AAC members, whether issued by the Health Departments, Medical Royal Colleges or other agencies. The subgroup is also aware that aspects of the appointment system are under consideration by representatives of the profession, the Health Departments and NHS Management.

6.3 The Working Group recognises that while the current regulations for appointment of consultants are not in breach of EC or domestic law, the guidance which is provided to members of AACs should be reviewed by those responsible for its promulgation to ensure that it is fully compatible with EC legal requirements.

h. The Working Group recommends that the current discussions on the consultant appointment system include consideration of the guidance for AAC members by those responsible for its promulgation, with particular regard to the requirements of EC legislation, and should make recommendations for any necessary changes *no later than September 1993*.

6.4 The Working Group also identified a number of areas for further consideration. These partly reflect the changes to the intensity and duration of training noted elsewhere in this report. They also arise because of the changes which have taken place in the management and organisation of the NHS. The new status of the CCST and the implications for the treatment of qualifications from other EC member states will also have an impact upon the appointment system. Subgroup B gave some consideration to these and related issues. Two analytic papers were produced - on the role of the Medical Royal Colleges and the impact of the NHS changes - which the main Group was unable to consider in depth. However the Working Group welcomes subgroup B's identification of key factors, which are outside the scope of this report but which should now be developed further within the forum established

to review the Appointment to Consultant regulations. The issues which need to be addressed include:

- whether any modification needs to be made to the content of statutory instruments which regulate the system of appointments
- the role of the Colleges on the AAC
- the means of resolving any differences of view between members of the AAC
- the implications of the changes to postgraduate training for the criteria for eligibility for consultant appointment
- the need to ensure that fair and non-discriminatory practices are followed at all times and that appropriate guidance is produced for AAC members

i. The Working Group recommends that the operation of the consultant appointment process be reviewed. This review would involve the profession, the Health Departments and NHS management and would take into account the papers produced for the Working Group. The Group supports the reconvening of the Working Party on the Appointment to Consultant Regulations, chaired by the Chief Medical Officer for Wales, to carry out such a review, and recommends that it be completed *by March 1994*.

7. SPECIALIST TRAINING IN EUROPE

7.1 The difficulties experienced over the implementation of the Directives have emphasised the need to examine the way in which the UK communicates with the European Commission in relation to medical education and training. Subgroup C was established under the chairmanship of Dr McKenna to consider the means by which the UK makes input into European legislation and how the UK liaises with European colleagues on medical training and workforce issues (the terms of reference and membership of the subgroup are set out in Annex A2). The subgroup identified several areas for action to enhance the UK's role in Europe in relation to legislation on medical training, and recognised that this action is of increased importance in the light of the European Commission's readiness to reconsider the requirements of the EC Medical Directives. The subgroup met on 2 occasions and has submitted its draft report to the main Group (Annex D).

7.2 The subgroup has considered carefully the various options for improving co-ordination of the UK input to EC affairs. It has recommended that the Health Departments should establish a forum for the UK Delegates to the Advisory Committee on Medical Training (ACMT). This forum would provide an opportunity to brief the UK delegates about the broader UK context of issues being considered by the ACMT and also to enable wider consideration of the outcome of ACMT discussions. The Working Group supports that proposal; it notes in particular the subgroup's concern that the outcome of ACMT discussions should be communicated to UK organisations.

7.3 The Group welcomes the proposed establishment of a co-ordinating body to improve communication between UK professional organisations on European matters and to help provide a structure for the professional organisations to put forward their views to the statutory bodies.

7.4 The Group also notes the subgroup's concerns about the membership of the ACMT and their recommendation that membership should be reconsidered in order to achieve representation of the Medical Royal Colleges, Faculties and specialist associations.

j. The Working Group recommends that:

i) the Health Departments should establish a forum to facilitate the work of members of the Advisory Committee on Medical Training (ACMT)

ii) the Health Departments should give further consideration to the membership of the UK delegation to the ACMT. This should be carried forward by the Chief Medical Officer for Northern Ireland in consultation with the above forum. Recommendations should be made *before* the next nominations for ACMT membership are due in *early 1996*.

8. CAREER STRUCTURE

8.1 The Working Group recognises that implementation of its recommendations for the development of specialist training programmes will have implications for the medical career structure and for NHS workforce arrangements. In particular the likelihood that doctors will complete specialist training, and hence will be eligible for consideration for appointment to consultant posts, earlier than at present, may have a significant impact. Training programmes will also become more structured and better organised leading to adjustments in the level of service provision that can be expected from doctors in training. These factors will have major implications for the way in which medical care in hospitals is organised in future. The implications will be intensified by a number of other recent and current changes; changes to contracts and other employment arrangements as an increasing proportion of consultants are employed by Trusts; pressures on junior doctors' time from the implementation of the New Deal; and impending changes in the way that postgraduate training is managed and funded. The combined effect of these factors is likely to be that there will be an increase in the proportion of care provided by the consultant grade and greater demand for consultant posts within the NHS.

8.2 The Working Group has not considered the implications for "Achieving a Balance" in any detail but recognises that a faster rate of expansion in the consultant grade will be needed, at least for an interim period, as the duration of specialist training reduces. Clearly this expansion can only be justified if it is also needed to meet patient care requirements. It should also involve the development of a choice of different career pathways and greater mobility within the consultant grade.

8.3 The identification of a clear end-point to specialist training (the award of the CCST) will also highlight the existence of any "gap" in between the award of the CCST and appointment to a consultant post. The Group has discussed a range of options for dealing with the "gap". They recognise that indefinite continuation in the existing training post until appointment to a consultant post may call into question the appropriateness of the work and the funding of the post. It could also lead to the blocking of a training opportunity. On the other hand, expecting the doctor to vacate the training post immediately would result in insecurity for the individual concerned and would be wasteful in terms of the resources already invested in training. The Group is opposed to the creation of an alternative specialist career grade junior to consultant, as it might become a permanent grade for some, leading to a "two-tier" structure for the profession and a two-tier service for patients. The option of proleptic appointment has also been discussed; the Group sees it as a viable option for appointments to be made contingent on the award of the CCST or the obtaining of further experience, but believes that this is unlikely to have much impact on the "gap" problem.

8.4 The Working Group notes that the problem of the "gap" will be eased by the expansion in consultant numbers referred to above, particularly if this is to be combined with an increased range of career choices and greater mobility within the consultant grade. The

Group also recognises that further attention must be given to the question of the "gap" and has identified several principles to be maintained:

i) contracts of employment for trainees should specify that on obtaining the CCST, the individual should be able to remain within a training programme for a period of time while seeking appointment to a consultant post. This should be subject to further discussion with the Health Departments about how such an extension might be accommodated within the existing system of employment contracts. The duration of time spent in the post should be limited and subject to regular review by Postgraduate Deans. The Working Group recognises that similar arrangements are not available for GPs on completion of vocational training; however the Group notes that the total number of consultant posts available within many hospital-based specialties is very much smaller than the number of general practice principal opportunities and so requires different arrangements

ii) numbers in training should continue to be regulated

iii) when an individual finally relinquishes a place in a training programme, having been unable to obtain a consultant post, he/she will have the option of re-entering training in another specialty, working outside the NHS until he or she obtains a consultant post or obtaining a non-consultant career post

iv) effective manpower planning will be required to help to keep the number of trained specialists who are in the "gap" at any time to a minimum. This will primarily be achieved by the measures needed to maintain service provision as the duration of training reduces: a short-term increase in the number of consultant posts, and more rapid growth of the consultant grade subsequently

8.5 The Working Group is aware of a range of reviews by various bodies currently examining issues relating to medical manpower planning; these will provide adequate opportunities to take forward consideration of the manpower implications of this report.

k. The Working Group recommends that:

i) the workforce and career structure issues arising from the implementation of their recommendations be taken forward within the context of the current review of the implementation of Achieving a Balance. The Chief Medical Officer (England) should take this forward in consultation with the other Health Departments and appropriate professional, educational and NHS management interests. This review should be completed *by July 1994*

ii) the Chief Medical Officers consider reconvening the Tripartite Group (with representation of the profession, the NHS, the Health Departments and academic and research medicine) should they consider it necessary to review the fundamental agreements about medical manpower control in the UK

iii) the UK Health Departments should consider the implications for the control of higher specialist training posts in the UK, and should seek advice about the longer term implications for the supply of medical manpower from the Medical Manpower Standing Advisory Committee.

9. IMPLEMENTATION AND MONITORING

9.1. Bearing in mind the need to ensure that the standards of training and of patient care are not jeopardised, the Working Group believes that the changes recommended in this report should be implemented as quickly as possible. In particular the Group considers that the current arrangements for the implementation of the Directives should be replaced by the new arrangements for the award of the CCST by the GMC with associated changes in the Medical Register as soon as the necessary changes can be made to UK legislation.

9.2. The Working Group recognises that the positive support of the other major interests involved will be helpful in the smooth implementation of its proposals and for this reason discussions have already taken place with particular groups. Once the Working Group had identified its options, the Chief Medical Officer met representatives of independent health sector organisations to seek their agreement to reconsider their systems for recognition of specialists in the light of the Group's proposals. The independent sector organisations welcomed the proposed system for registration of specialists and indicated that this would be a useful basis for identifying those doctors potentially eligible to undertake private practice both from the UK and other EC member states. They recognised that there was an intention in the EC Medical Directives that equal consideration should be given in the UK to doctors trained in other EC member states, if those doctors held certificates in specialties recognised in the UK (as listed in Directive 75/362). They reserved the right to use any further criteria that they deemed appropriate for granting admitting rights to private hospitals or for determining eligibility for payment, provided these criteria were consistent with EC and domestic law. The independent sector organisations also drew attention to their ability to provide clinical experience for recognised specialist training. The Chief Medical Officer agreed that this would be explored further after the Working Group had reported.

9.3. The Chief Medical Officer has also met representatives of patients' organisations to seek their reactions to the Group's proposals. The representatives welcomed the progress that the Group had made, and agreed that the proposed changes were broadly in the interests of patients and the general public. They were also interested in the potential for further development of the Group's proposals, and placed particular emphasis on public access to registration information and on the "gatekeeper" role of GPs.

9.4. The Working Group notes that transitional arrangements will be needed during the period of change from one set of arrangements to those now proposed; all transitional arrangements will need further consideration by the Health Departments in the light of legal advice. The new legislation required to implement the Working Group's recommendations will clarify the implications for various groups. The following groups will need to be considered:

- those who have been awarded a certificate in the UK under the existing system but who would not necessarily be eligible for the CCST

- those UK doctors who have applications pending for certificates under the existing arrangements, for the purpose of working abroad

- those with specific accreditation applications pending. The Medical Royal Colleges will need to bear in mind that the new arrangements for award of the CCST should overtake the need for them to issue accreditation certificates

- all accredited specialist doctors and/or holders of NHS Consultant posts. The GMC will need to consider with the Medical Royal Colleges and the Health Departments whether they should be eligible to be awarded a CCST and indicated as such in the Register.

The Working Group also recognises that the Health Departments will need to consider with the profession and Postgraduate Deans what arrangements are needed in respect of doctors who have completed training but who are still in specialist training posts.

9.5 Given the need for rapid expansion of the consultant grade, the Working Group recognises that in some cases the employing authority may wish to consider converting an existing senior registrar or registrar post to a consultant post - at minimal additional cost - to meet service pressures. Such action will need to involve the active participation of the postgraduate dean and local College representatives to ensure that the needs for training continue to be met. Candidates for converted posts will still need to be individually assessed and considered by Advisory Appointment Committees in open competition. The Working Group also notes that any significant expansion in the consultant grade may require central resources. The Health Departments should consider whether such additional costs should be met from a central fund, bearing in mind the possible restrictions on resource growth in the NHS and the influence this may have on the timescale for the expansion.

9.6. In addition to the transitional measures and immediate action indicated above, the Working Group has identified at least five distinct strands of further work:

- the specification and implementation of curricular requirements for planned specialist training programmes as described in recommendation a. This would also require the establishment of closer links between the Medical Royal Colleges and the Postgraduate Deans at both national and local level. The Working Group considers that this can best be taken forward through the meetings proposed in recommendation (f).

- the review of the operation of the consultant appointment system and guidance for AACs proposed in recommendations (h) and (i)

- further consideration of ways of improving the presentation and co-ordination of the UK input to the development of European

Community policy and legislation on medical staffing and training issues. The Group considers that this can best be pursued by the group which they have recommended should be established by the Health Departments to provide improved support for ACMT members (recommendation j(i))

- the identification and implementation of changes to the medical career structure and medical manpower planning system to accommodate the changes taking place within specialist training, which the Group considers can best be pursued as described in recommendation k

- consideration of the statutory framework needed to implement the new arrangements for certification, in particular the means by which the GMC, as the competent authority, would be advised by the Medical Royal Colleges and relevant educational bodies about the award of the CCST. The GMC will need to specify the educational bodies from which it expects to receive advice on the award of CCSTs. There will also be a need to consider the establishment of a formal appeal mechanism to provide for resolution of disputes over decisions about the award of the CCST (recommendation g).

9.7. The Group considered that the action identified in paragraph 9.6 - together with the more specific action points and recommendations listed in the summary of recommendations in section 3 - should be completed within a period of two years from the date its recommendations are accepted by Ministers. Their effective implementation will need to be monitored carefully.

l. The Working Group recommends that a group should be convened whenever necessary by the Chief Medical Officer (England), on behalf of the Health Departments, to confirm that appropriate action is being taken forward.

ANNEX A1

MEMBERSHIP

Working Group on Specialist Medical Training

The Secretary of State invited the following individuals to join the Working Group:

Dr Kenneth Calman (Chairman) - Chief Medical Officer
Dr Trevor Bayley - Dean of Postgraduate Medical Education, University of Liverpool
Dr Edwin Borman - Chairperson, Junior Doctors Committee, British Medical Association
Prof Norman Browse - President, Royal College of Surgeons of England
Mr John Chawner - Chairman, Central Consultants and Specialists Committee
Sir Colin Dollery - Dean, Royal Postgraduate Medical School
Dr Jacky Hayden - Regional Adviser in General Practice, North Western Region
Mr James Johnson - Deputy Chairman, Central Consultants and Specialists Committee
Sir Robert Kilpatrick - President, General Medical Council
Dr Martin McNicol - Chair, Central Middlesex Hospital NHS Trust
Mr Robert Nicholls - Chief Executive, Oxford RHA
Mr Paddy Ross - Chairman, Joint Consultants Committee
Dr Alastair Scotland - Regional Medical Officer, NE Thames RHA
Prof David Shaw - Chairman, General Medical Council Education Committee
Mr Stanley Simmons - Chairman, Conference of Medical Royal Colleges and President, Royal College of Obstetricians and Gynaecologists
Mr David Wrede - Deputy Chairperson, Junior Doctors' Committee, BMA; Chairman, Hospital Doctors' Association

Observers attended from:

Scottish Office Home and Health Department
Scottish Royal Colleges (Dr Anthony Toft)
Welsh Office
DHSS, Northern Ireland
General Medical Council (Mr Peter Towers, Registrar)

The Secretariat was provided by the NHS Management Executive as follows:

Dr Peter Bourdillon
Mr Stephen Catling
Dr Robin Cairncross
Dr Howard Bloom
Ms Louise Gitter
Ms Lesley Hawksworth

SUBGROUPS

The terms of reference and membership of the subgroups were as follows:

Subgroup A Criteria for specialist training programmes:

- **Terms of reference:**

to review the criteria, both current and proposed, of postgraduate training programmes with particular regard to structure, duration, standards and quality of training to be achieved, methods of assessment and how recognition in more than one speciality may be accommodated.

- **Membership:**

Mr Stanley Simmons (Chairman)*

Dr Trevor Bayley*

Dr Edwin Borman*

Dr Alastair Scotland*

Professor David Shaw*

Professor Alastair Spence - President, Royal College of Anaesthetists

Dr Anthony Toft - President, Royal College of Physicians of Edinburgh

Professor Leslie Turnberg - President, Royal College of Physicians of London

(* Member of Main Group as listed in Annex A1)

Subgroup B Criteria for consultant appointment:

- **Terms of reference:**

to review the arrangements for appointing consultants, to ensure they are compatible with Community and UK legislation.

- **Membership:**

Mr Paddy Ross*

Mr Andrew Black - Chief Executive, Central Middlesex Trust

Professor Norman Browse*

Mr Stephen Catling*

Mr James Johnson*

Mr Robert Nicholls*

Mr Malcolm Reed - Association of Surgeons In Training

Mr Martin Staniforth - NHS Management Executive

(* Member of Main Group as listed in Annex A1)

Subgroup C Liaison with the European Community:

- **Terms of reference:**

to consider the arrangements by which the UK contributes to the development of EC legislation on medical training, and liaises with European colleagues on medical training and workforce issues; to consider how these arrangements might be improved; and to report findings back to the Working Group.

- **Membership:**

Dr James McKenna - CMO Northern Ireland (Chairman)
Dr Trevor Bayley*
Dr Philip Evans - Royal College of General Practitioners
Mr Leonard Harvey - British Medical Association
Dr Jacqueline Hayden*
Mr Thomas Hide - British Medical Association
Mr Joe Kearns - British Medical Association
Professor Peter Lachmann - President, Royal College of Pathologists
Professor Alan McGregor - former Chairman, European Society of Clinical Investigation
Mr Adrian Marston - Conference of Colleges
Sir David Mason - President, General Dental Council
Dr Dewi Owen - Welsh Office
Mr Paddy Ross*
Dr Alan Rowe - British Medical Association
Professor Wendy Savage - President, Medical Women's Federation
Professor David Shaw*
Professor Andrew Sims - President, Royal College of Psychiatrists
Mr David Wrede*

(* Member of Main Group as listed in Annex A1)

ANNEX A3

ORGANISATIONS REPRESENTED AT MEETINGS WITH THE CHIEF MEDICAL OFFICER ON SPECIALIST MEDICAL TRAINING

Representatives of patients and the general public

Mr T Harris	Director, Association of Community Health Councils for England and Wales
Ms M Rigge	Director, College of Health
Mrs L Lamont	Director, The Patients Association
Lady Lovell-Davis	Caring for Children in the Health Services
Ms Y Helsby	Office of Fair Trading

Representatives of the independent health sector

Dr I S Bailey	Medical Advisor, WPA Health Insurance
Mr J Copleston	Health Insurance Centre Manager, Sun Alliance
Mr B Hassell	Chief Executive, Independent Healthcare Association
Mr E Hemming	Independent Healthcare Association
Mr J Randle	Chairman, Independent Healthcare Association
Mr A Dexter	Independent Healthcare Association
Dr R H McNeilly	Director of Health Services, PPP
Dr H Thelwall-Jones	Group Medical Director, BUPA
Mr A Walford	Company Secretary, BUPA
Mr D Cavers	Managing Director, Norwich Union Healthcare
Mr T Baker	Norwich Union Healthcare

WORKING GROUP ON SPECIALIST MEDICAL TRAINING IN THE UK

RESULTS OF CONSULTATION EXERCISE

Introduction

1. The following analysis of the results of the consultation exercise was initially extracted from the 50 responses received by the deadline, which was extended to 6 November. Eight late responses have now been incorporated and a complete list is attached (Annex B2). A number of further comments were received, some in response to specific invitations from the Chief Medical Officer and some in the course of other correspondence. These have been incorporated into this analysis where appropriate and a list is attached at Annex B3.

2. The consultees listed at Annex B4 were sent a discussion paper which provided a consideration of the main issues concerning specialist medical training and set out various options for change. Five main options were described as follows:

Option 1 *essentially retained the existing process of primary and higher specialist training. It was recognised that this would involve:*

> *i. full eligibility for EC trained doctors, who could have obtained certification after a much shorter period, for accreditation and the award of the "T" indicator*
>
> *ii. significant disadvantage for UK trained doctors wishing to practice in other EC countries.*

Consultant appointment procedures would be as before.

Option 2 *essentially suggested a shortened period of specialist training leading to accreditation and/or the award of the EC certificate and appointment to an NHS specialist post, a new career grade during which additional experience (and relevant further qualifications - eg MD, PhD) might be obtained leading to consultant appointment - a* ***higher*** *career grade. The "T" indicator might be awarded at the lower level or replaced by a factual indicator of consultant appointment. This was recognised to be a radical departure from existing training and career structure systems.*

Option 3 *essentially suggested similar arrangements as Option 2 but with appointment as a consultant via open competition for posts without the requirement for an AAC.*

Options 4 and 5 *essentially involved a single career grade, achieved after a shortened specialist training period, with appointment to the career grade co-incident with EC certification and accreditation. Various changes to the overall training process were also recommended - including a more open assessment process, reliance on duration of training rather than end-point assessment, a more clearly structured training pattern - which while not strictly germaine to the objective of meeting EC requirements, may be changes whose introduction as part of the overall process might be worth considering. The essential difference between options 4 and 5 is that the latter would involve systematic variation between various 'types' of consultant post - with varying emphasis on clinical work, teaching, management, research etc specified within each contract (and presumably with the possibility of widespread variation in pay levels).*

This paper takes each of the major topics identified in the replies in turn and sets out the overall reaction from those who responded.

Option preferred (from paper ECWG1)

3. Less than half the respondents expressed a preference for one of the given options; of those that did, the most popular options were 2, 4 and 5, suggesting a preference for change in the career grade structure. Those who preferred option 1 (four in total) pointed out that this would be least disruptive to implement. Several suggested combining elements of the various options, or modifying them. However some appeared to misinterpret the options as described in the paper, so it may be advisable to treat the comments on these with some caution.

Training: length, structure and content

4. The larger proportion of responses focused particularly on changes to the content and nature of training. The vast majority favoured shortening the current training period; different specific suggestions were made for various specialties. Only three responses expressed concern that shorter training might lead to inadequate standards. Many expressed the view that improved quality of training could enable standards to be maintained or even raised while shortening its overall duration. One respondent (South West Thames Regional Health Authority) suggested that standards were being kept high at present by the length of time taken to reach the consultant grade, not by the quality of the training received within that time. The Department of Social Policy at the University of Bristol questioned whether the taxpayer receives value for money from the present system. The importance of "training the trainers" and increasing the level of supervision was frequently emphasised.

5. There was also concern that the service contribution expected from trainees was too great and was a barrier to the improvement of training programmes (8 direct comments). The manpower and resource implications of reducing the service commitment were mentioned and were a cause for concern for some; however this was seen as consistent with the need to reduce junior doctors' hours. It was also suggested that changes in the career structure would help to alleviate the problem of meeting service needs, by providing a staff grade or

alternative specialist grade.

6. The need for general professional training was emphasised in a number of comments (8 respondents). It was seen as particularly important for those specialties whose clinical experience may later be limited (Faculty of Public Health Medicine), and also provided an opportunity for flexibility in making career choices and providing experience based on the needs of the individual. The majority commented on the need for training to be structured, though few expressed support for introducing a syllabus for each specialty; most envisaged a more flexible system, with some specifying that learning objectives should be set for the individual. There was some emphasis on the need for training to cover non-clinical skills such as management, audit, and communication. Concern was expressed that a more intensive training period might lessen the opportunity for research; seven respondents specified the need for research to be retained as an option for trainees.

Setting of standards

7. Most of those commenting on setting of standards considered that the responsibility for maintaining standards of training should lie with the Royal Colleges and their Faculties; some also commented that local co-ordination should continue to fall to Postgraduate Deans. East Anglian RHA suggested that a new body should be set up with representation of the Medical Royal Colleges, the BMA, the GMC, Postgraduate Deans and the Department to oversee the standards of training programmes. The British Postgraduate Medical Federation suggested that a joint body with representation of postgraduate medical deans and the Medical Royal Colleges could be established. Some suggested that all training posts should be approved (by Medical Royal Colleges?) to ensure that they provided appropriate learning and experience.

Assessment

8. Some were concerned about the possibility that "time-serving" might replace assessment of the trainee's progress, though there were different views as to the nature of the assessment process required. A substantial number (12) favoured some form of continuous assessment, as well as, or instead of, formal examinations. However several also mentioned the need for exit exams or some type of summative assessment on completion of training. There was also emphasis on the need for counselling and career guidance for trainees as part of the assessment process.

9. There were also a few comments about the need for training and assessment of the trainers themselves, in relation to the general concern about improving the quality of the training received.

Single training grade

10. Of the 14 who commented on this, only the Collegiate Trainees Committee of the Royal

College of Psychiatrists were opposed to combining the current registrar and senior registrar grades. The College of Ophthalmologists commented that this would end the difficulty in progressing from registrar to senior registrar and would help shorten total training. The Scottish Council for Postgraduate Dental and Medical Education also suggested the creation of a single grade amalgamating HO and SHO to combine general clinical training with basic specialist training.

Certification and accreditation/GMC register and "T" indicator

11. All those commenting agreed that some alteration to the present system of system of accreditation and the "T" indicator was needed. Some respondents were not entirely clear about the interpretation of terms "certification" and "accreditation", however it appears that 12 favoured a system where on satisfactory completion of training or passing the necessary exams the trainee would gain a certificate which was both valid for EC purposes and indicated that he/she was eligible for consideration for a consultant post. Some who recommended this option also suggested that it should still be possible to require additional experience beyond receiving the certificate in order to compete successfully for some or all consultant posts. There were a few suggestions for an "S" to replace the "T" on the GMC register.

12. Others, while wishing to separate appointment to consultant and accreditation from the completion of training, considered it necessary to introduce some alternative form of certification to mark the end of formal training and to keep in line with practice in the EC. The Faculty of Public Health Medicine suggested that the introduction of a specialist qualification which would be a requirement for appointment to consultant would be welcome as it might help avoid premature appointment to the consultant grade in shortage specialities. The need for private insurance companies to have some means of recognition of specialists for reimbursement purposes was recognised, though opinions were divided as to whether they should simply reimburse all specialist certificate holders or whether it would be possible to limit reimbursements to consultants only. BUPA suggested that they might be obliged to introduce their own criteria for recognising specialists if a "two-tier" career system were to be introduced, though it was also suggested by other insurers that an alternative career grade to consultant might help reduce private care costs for routine procedures.

Appointment to consultant and role of AACS

13. Views on appointment to consultant were largely dependant on whether the respondent envisaged all trained individuals as being eligible for consultant posts, or whether they favoured the creation of an alternative career grade. Some wanted all higher trainee posts to be numbered and only released for new trainees on appointment of the existing postholder to consultant. Some specified that possession of a specialist certificate should not guarantee a consultant post, and that further experience before consultant appointment should be valuable in career terms; in particular, a period of research between finishing training and consultant appointment was considered to be valuable both to the individual and to help maintain interest in research which might otherwise have to be left out of a shortened training

programme.

14. There were differing views on the effects of introducing new requirements for appointment to consultant. Some felt that the present system, where the only formal requirement is a basic medical qualification, should be maintained as it enabled EC doctors to compete for posts on an equal footing. However there was also a view that the loose formal requirements led to allegations of a system of patronage and possible discrimination (JDC), and it would therefore be preferable for certification to determine eligibility.

15. 9 respondents specifically supported the retention of AACs for selecting consultants. Some believed that AACs in their present form were effective at maintaining standards, particularly because of the input of the Colleges. Others thought that AACs required additional guidance or changes in procedure; the Association of Community Health Councils for England and Wales thought that equal opportunities should be promoted, and the BMA suggested that AACs should be reminded that there is no requirement for appointment other than a basic medical qualification and candidates are judged on merit alone. The Medical Women's Federation proposed that AACs should be more representative of the local population, and suggested that they should include representatives of patients, nursing staff and general practitioners. The Overseas Doctor's Association thought that medical audit performance review would ensure the fairness of an open system for progression to consultant based on expertise and seniority, with no need for AACs.

Preferred structure for career grade

16. Ten respondents were strongly opposed to the creation of a career grade alternative or supplementary to consultant. Nine envisaged a new grade of specialist either as an alternative grade for those not willing or able to progress to consultant, or in some cases as an intermediate grade for accumulating further experience in preparation for appointment to consultant. Others suggested a single grade with two or more possible levels of responsibility, to be recognised in job description, contract and salary differences; there were suggestions that a "chef de service" level was required for those with most responsibility; and that an expansion in the consultant grade would be needed. Other suggestions included that specialists not able to reach consultant level should re-enter training at an appropriate stage and that the need for continuing education should be written into contracts.

Other manpower issues

17. There was a range of comments on the link between the number of trainee posts and the number of consultant posts. Some felt the proportion of consultants should be increased, to achieve consultant posts for a larger number of trainees on completion of training and to provide a better service. A few supported the use of trainee numbers to provide a close correlation in numbers of posts. However the British Postgraduate Medical Federation said that this matching of numbers would no longer be valid when Trusts were free to appoint to career posts without central control, and if mobility between EC countries increased. The

Scottish JCC emphasised the need to bear in mind changes in the distribution of staff, particularly as Scotland is an "exporter" of trained doctors. The South West Thames RHA said that poor manpower controls made entry into training frequently competitive.

18. Some commented on the manpower implications of their own proposed changes to training and consultant appointments; in particular that the introduction of a career specialist grade would help end the reliance on trainees to provide out of hours and emergency cover. It was also recognised that improving the quality of training would involve increased use of consultants' and trainers' time for supervision, teaching and assessment (Lothian Health Board).

Transition to new structure

19. Only a few respondents made substantial comments on transitional arrangements. Their views varied, partly according to the degree of change that they recommended. Estimates of the time required for change ranged from 4 to 15 years. Several commented on the need for additional resources to carry through the introduction of a new structure, though others believed savings would help to offset costs. Some emphasised that careful management and assessment of the changes would be necessary.

Overseas doctors

20. The three respondents commenting on overseas doctors all supported moves to recognise the qualifications of doctors with EC certificates whether or not they were EC nationals and without disadvantage for those with non-EC primary qualifications.

Comments on legal interpretation and directives

21. Some stated that the requirements of the directives could only be met by the introduction of a specialist indicator, or by the removal of the need for further experience after completing training before being eligible for consultant posts. Grampian Health Board thought that the requirements could be met without dismantling the accreditation system, while Trent RHA considered that the directives did not allow the present system of accreditation to which those trained in other member states do not have access. The Chairman of the European Committee of the BMA pointed out that there was disagreement on the meaning of EC certification and on whether it was simply a statement of entitlement to payment from social security/insurance systems.

22. The Faculty of Public Health Medicine was concerned that the requirement for doctors from other EC member states was simply to be in possession of an appropriate certificate and did not specify that the certificate was to be awarded on completion of training. Overall responses were fairly evenly divided on whether the requirements of the directives could be met by making minimal changes or whether they required a more extensive overhaul of the current system.

European aspects

23. Some respondents thought standards in the UK were higher than in other European countries, and were concerned that these standards should not be reduced in the interests of harmonisation. A few also pointed out that other countries have training periods in excess of the EC minimums, and expect further experience or training before appointment to hospital posts. There were seven comments that some form of harmonisation of training, certification and standards would be helpful; the Department of Social Policy at the University of Bristol said that simply co-ordinating the award of specialist status would not meet the problems of disparity in length of training or discrimination against UK nationals. The Forth Valley Health Board said that it would be simpler to harmonise training and certification throughout the EC than to try to bring together the award of specialist certification at the end of different systems. Some identified a need for negotiation between EC countries, and for the UK to consider how it liaised with other member states.

Miscellaneous comments

24. The responses contained a range of comments on issues related to specialist medical training. Some focused on the high standards produced by the current system, while others emphasised the need for change. Four commented that the GP's role as "gatekeeper" to specialist services is valuable and should be maintained. Some also commented on the need to involve specific interests in continued consultation, eg patient representatives, overseas doctors, and there were comments about the need for an appropriate timescale for discussion.

25. The Department has also received a number of other comments on specialist medical training not directly related to the consultation exercise. Many of these were offered in response to the Chief Medical Officer's letter to all doctors. Some of these are concerned with doctors' individual experiences of standards in Europe and the difficulties encountered by UK doctors wishing to practise abroad. Representatives of specialties also made points relating to their own training programmes and the recognition of their certificates.

Conclusion

26. Despite the short timescale most of those responding appeared to have considered the issues in depth. There was a wide range of views in relation to career structure and registration of specialists, with broadly an even split between those who favoured change and those who preferred to preserve the status quo as far as possible. There was an overall consensus in favour of moving towards a reduction in the period of time currently spent in training.

ANNEX B2

INDEX TO RESPONDENTS TO CONSULTATION

ROYAL COLLEGES

A1 - Royal College of Anaesthetists
Professor A Spence

A2 - Royal College of Physicians - Faculty of Occupational Medicine
Dr D S Wright

A3 - Royal College of Physicians - Faculty of Public Health Medicine
Professor D L Miller

A4 - Royal College of Physicians (Edinburgh)
Dr A Toft

A5 - Royal College of Psychiatrists
Dr F Caldicott

A6 - Royal College of Psychiatrists (Collegiate Trainees Committee)
Dr R F Kehoe

A7 - Royal College of Radiologists
Dr C D R Flower and Dr R G B Evans

A8 - College of Ophthalmologists
Mr B Martin

OTHER BODIES

B1 - Association of Community Health Councils for England and Wales
Mr T Harris

B2 - Association of Medical Research Charities
Ms J Lloyd

B3 - Association of Surgeons in Training / British Orthopaedic Trainees' Association
Mr M Reed and Mr P Kay

B4 - Association of Surgeons in Training
Mr M Reed

B5 - Committee of Regional Advisers in General Practice in England
Mr J Egan

B6 - Hospital Consultants and Specialists Association
Mr S J Charkham

B7 - Medical Research Council
Dr D C Evered

B8 - Medical Women's Federation
Professor W Savage

B9 - Overseas Doctor's Association
Dr S Venugopal

B10 - Scottish Joint Consultants Committee
Dr V H Nathanson

B11 - Patients Association
Mrs L Lamont

B12 - College of Health
Mrs M Rigge

B13 - University of Bristol (Social Policy and Planning Department)
Dr D E Gladstone

B14 - Hospital Doctors' Association
Mr D Wrede

BMA GROUPS

C1 - The British Medical Association
Mr M J Lowe

C2 - The Committee for Public Health Medicine and Community Health
Mr C V Hartley

C3 - The European Committee
Mr J L Kearns

C4 - The General Medical Service Committee
Mr I G Bogle

C5 - The Junior Doctor's Committee
Dr E Borman

C6 - Scottish Council
Dr V H Nathanson

C7 - Welsh Office
Miss R Roberts

EDUCATION

D1 - Royal Postgraduate Medical School
Sir Colin Dollery

D2 - Scottish Council for Postgraduate Medical and Dental Education
Mr K M Parry

D3 - Standing Committee on Postgraduate Medical Education
Dame Barbara Clayton

D4 - University of Liverpool
Dr T J Bayley

D5 - University of Wales College of Medicine
Professor Sir Herbert Duthie

D6 - National Association of Clinical Tutors
Dr P Wilkinson

D7 - British Postgraduate Medical Federation
Dr M Green

D8 - Eastern Regional Postgraduate Medical Education Committee
Mr R Blair

HEALTH AUTHORITIES

E1 - Argyll and Clyde Health Board
Dr A A Reid

E2 - East Anglian Regional Health Authority
Mr M O'Brien

E3 - Forth Valley Health Board
Dr D C Moir

E4 - Grampian Health Board
Dr M Murchison

E5 - Highland Health Board
Mr G V Stone

E6 - Lothian Health Board
Dr H Zealley

E7 - Northern Regional Health Authority
Professor L Donaldson

E8 - South West Thames Regional Health Authority
Dr S Griffiths

E9 - Trent Regional Health Authority
Professor R Alderslade

E10 - Lanarkshire Health Board
Mr F Clark

E11 - South East Thames Regional Health Authority
Mr P Rankin

E12 - South Ayrshire Hospitals NHS Trust
Dr J Campbell Ferguson

E13 - Greater Glasgow Health Board
Mr S C Hinshelwood

E14 - RHA Chairmen and Regional General Managers Inter-Regional Secretariat
Sir William Doughty

E15 - Wessex Regional Health Authority
Dr G Winyard

PRIVATE COMPANIES

Insurers

Fi1 - BUPA
Dr H Thelwall-Jones

Fi2 - Norwich Union
Mr D Cavers

Fi3 - Private Patients Plan
Dr R H McNeilly

Fi4 - Sun Alliance Insurance
Mr J Copleston

Fi5 - WPA Health Insurance
Dr I S Bailey

Fi6 - Exeter Hospital Aid Society
Mr R B Cawse

Providers

Fp1 - Independent Healthcare Association
Mr B Hassell

ANNEX B3

Other comments incorporated in consultation exercise

Medical Practitioners' Union
Dr S J Watkins

Regional Postgraduate Dean, Addenbrooke's Hospital
Dr J S G Biggs

British Nuclear Medicine Society
Dr S E M Clarke

Junior Advisory Committee, RCPS Glasgow
William Reid, Chairman

British Cardiac Society
Dr Chamberlain

Regional Medical Officer, Mersey RHA - for RDsPH
J E P Simpson

Exeter Community Health Service
Sylvia Russell, Chairperson

ANNEX B4

BODIES CONSULTED ON SPECIALIST MEDICAL TRAINING

All Presidents of Medical Royal Colleges

Faculty of Public Health
Dr J M O'Brien

Faculty of Occupational Medicine
Dr D S Wright

College of Ophthalmologists
Mr P Wright

Conference of Medical Royal Colleges
Mr S Simmons PRCOG

Conference of Royal Colleges and Faculties in Scotland

Royal College of Physicians of Edinburgh

Royal College of Physicians and Surgeons of Glasgow
Dr R Hume

Royal College of Surgeons of Edinburgh
Professor P S Boulter

Standing Committee on Postgraduate Medical Education
Dame Barbara Clayton

Scottish Council for Postgraduate Medical and Dental Education

Committee of Postgraduate Medical Education
Dr T Bayley

Committee of Regional Advisors in General Practice
Dr H Patterson

Council of Deans of UK Medical Schools and Faculties
Professor Sir Colin Dollery

Committee of Vice Chancellors and Principals
Dr D Harrison

British Postgraduate Medical Federation
Ms P Smith-Piggot

University Hospitals Association
Professor D R Wood

Association of Surgeons in Training
Mr M Reed

British Orthopaedic Trainees Association
Mr P Kay

Medical Research Council
Dr D C Evered

Association of Medical Research Charities
Mr D Shaw

All Regional General Managers

All Directors of Public Health

All Chief Administrative Medical Officers in Scotland

All Health Board General Managers in Scotland

National Association of Health Authorities and Trusts
Chairman

NHS Trust Federation
Dr M McNicol

RHA Chairmen, Inter Regional Secretariat
D Blyth

Institute of Health Services Management
Mr S Fletcher

British Medical Association
Dr I Field

British Medical Association in Scotland

British Medical Association, Junior Doctors' Committee
Dr E Borman

British Medical Association, Public Health Medicine Consultative Committee
Dr M O'Brien and Mr C Hartley

British Medical Association, European Committee
Dr J Kearns

Hospital Consultants and Specialists Association
Mr S Charkham

Joint Consultants Committee
Mr A P J Ross and Mr M Lowe

Scottish Joint Consultants Committee
Dr Ford

General Medical Services Committee
Mr I Bogle and Mr L Harvey

Hospital Doctors' Association
Mr D Wrede

Joint Medical Advisory Committee
Professor M R Bond

GMSC Trainee Sub Committee
Dr I Banks

Medical Women's Federation
Professor W Savage

Overseas Doctors' Association
Dr R K Prasad

The Patients Association
Mrs L Lamont

The Consumers Association
Mr P Whitehead

Monopolies and Mergers Commission
The Secretary

College of Health
Mrs M Rigge

Association of Community Health Councils (England & Wales)
Mr T Harris

Allied Medical Assurance Services Ltd.

Avon Insurance Company Ltd

Bristol Contributory Welfare Association

Britannia Life Assurance Ltd

British United Provident Association

Civil Service Medical Aid Association

Eagle Star Life Assurance Company

Exeter Hospital Aid Society
Mr R B Cawse

Iron Traders Insurance Group

London & Edinburgh Insurance Company Ltd.

National Farmers' Union Mutual Insurance Society Ltd.

BUPA
Dr H Thelwall-Jones FRCOG

BUPA
Mr P A Jacobs

Norwich Union Healthcare
Mr D Cavers

The Orion Insurance Company Plc

Post Office and Civil Service Sanatorium Society

MGI Prime Health Limited

Private Patients (Anglia) Ltd.

Private Patients' Plan
Dr McNeilly

Provincial Insurance Plc

Provincial Hospital Services Association

Sun Alliance Health Insurance Centre
Mr J Copleston

Western Provident Association

Association of British Insurers

Independent Healthcare Association
Mr B Hassell

ANNEX D

WORKING GROUP ON SPECIALIST MEDICAL TRAINING

SUBGROUP ON LIAISON WITH THE EC

Introduction

1. The subgroup was established to consider the arrangements by which the UK contributes to the development of EC legislation on medical training, and liaises with European colleagues on medical training and workforce issues. The subgroup has considered the current process for UK input into European legislation and the mechanisms for negotiation with European colleagues and has identified concerns about the functioning of the present systems and the effectiveness of the UK's role in Europe in relation to medical training. Several areas for potential change and improvement have been identified, particularly in relation to ensuring proper representation of UK interests in Europe and improving co-ordination of the various UK bodies.

I. REPRESENTATION OF THE UK IN EUROPE

Advisory Committee on Medical Training (ACMT)

2. The ACMT is the statutory body with responsibility for the exchange of information between member states, development of common standards and the ongoing review of medical training. The European Commission is obliged to take the opinion of the ACMT into account, so the Committee has a key role to play in providing input to legislation. The subgroup has identified concerns about the UK representation on the Committee and has discussed possible means of co-ordinating the input of the UK representatives.

ACMT membership

3. Member states are represented by one delegate and one alternate from the practising profession, the medical faculties of universities and the "competent authorities". At present in the UK nominations for the practising profession are sought from the BMA who provide one candidate from general practice and one from specialised practice; nominations from the universities provide one undergraduate and one postgraduate dean; and the competent authority seats are filled by the Health Departments and the GMC. The subgroup has considered whether changes in these arrangements might be of benefit to the UK delegation.

4. The subgroup accepted that all of the present interests must remain involved and also strongly supported the concept that a representative of the Medical Royal Colleges - probably

from the Conference of Colleges - should be included in the UK delegation. However the balance of representation and the number of delegates to the ACMT is determined by the European Commission with the agreement of all member states; since the Colleges' responsibility in relation to postgraduate education is unique to the United Kingdom, it is unlikely that a change in the composition of the delegations could be agreed.

5. The subgroup therefore sought to identify a means of including the Colleges by adjustments within the existing framework. Several possibilities were considered:

- that the Colleges rather than the Postgraduate Deans should represent postgraduate education. This would be undesirable because Postgraduate Deans are assuming even greater executive responsibility for the delivery of postgraduate education;

- that the practising profession should be represented by one nominee from the Conference of Colleges and one from the BMA. This would have the disadvantage of dividing the professional representation;

- that the GMC and the universities reduce their representation to allow the Colleges to nominate to one of the "education" places

- that one or more of the representatives should be mandated by more than one interest; for example, the General Medical Council in its role as competent authority has a major responsibility in undergraduate education.

It was recognised that the two latter suggestions would require discussion with the GMC and the Committee of Vice Chancellors and Principals, neither of which was represented at the meeting.

The subgroup recommends that the Health Departments should give further consideration to the membership of the UK delegation to the ACMT with the aim of providing a place for a College representative.

ACMT organisation

6. At present the UK representatives on the ACMT have no formal co-ordinating forum. The subgroup recognises that the establishment of a structure for the co-ordination of the UK representatives would enable them to meet prior to Committee meetings to exchange information and agree their priorities, and would permit wider consideration of the outcome of ACMT discussions. The subgroup is also concerned that a means should be established to ensure that the outcome of ACMT discussions is communicated to UK organisations. The co-ordinating forum would also provide the opportunity for discussion and exchange of information with representatives of the Committee of Senior Officials in Public Health

(CSOPH) and thus help both bodies to give consistent advice to the Commission. It might also help to identify potential allies in relation to individual issues in other European countries, so concerted action could be planned where interests were shared by member states. The subgroup recognises that it is of particular importance that the means to achieve this is carried forward now that the Commission has expressed its willingness to reconsider the medical directives.

The subgroup recommends that the Health Departments give consideration to the establishment of a UK based co-ordinating group to organise meetings of ACMT representatives prior to each ACMT meeting, to brief representatives ahead of meetings and to help disseminate information about the outcome of ACMT discussions.

UK input to EC legislation

7. The subgroup believes that the implementation of the above recommendations will help to achieve greater UK influence on EC legislation on medical training. The differing systems of medical education between member states can make it difficult to agree on joint objectives; at the same time the EC's willingness to reconsider the directives provides an opportunity for the UK and other member states to:

- identify what our legislative needs are to ensure confidence in the standards of training between member states
- identify current barriers to implementation of the existing directives
- press for change through both statutory and non-statutory medical bodies (with agreed priorities) and where possible with support of other member states

8. This is an ongoing role and underlines the need for co-ordination of the UK's input into EC discussions on medical training.

II CO-ORDINATION OF EUROPEAN ORGANISATIONS

9. The subgroup recognises that there is a substantial number of professional organisations which represent UK interests in Europe. There is concern that these organisations may each be replicating effort in their individual approaches to European affairs, and lack co-ordination. They also lack a structure for putting forward their views to the statutory bodies.

10. The subgroup recognises that:

- there is a need for information about proposed policy and priorities to be channelled down to the professional organisations

- that a co-ordinating body could greatly improve the quality of submissions by those bodies, individually or in concert, to the Health Departments/European statutory bodies

The subgroup recommends that a group should be identified to take on the role of co-ordinating the professional organisations.

III. LIAISON WITH THE PROFESSION IN OTHER MEMBER STATES

12. The subgroup have emphasised the need for co-operation and exchange of information with the profession in other member states.

13. The European Union of Medical Specialists (UEMS) has [30] monospecialist sections which report to its Management Council. Within these sections European boards have been established to provide a means of communication between the profession and the Commission, and the ACMT. The UEMS also has a Harmonisation Committee which is furthering the establishment of harmonised standards of specialist training between member states. The subgroup recognises the importance of the role of the monospecialist sections which can help identify shared objectives between countries and establish the means for co-operation between them. It is vital for the UK to make full use of its representation on these sections and to form links with other European countries through them. The subgroup recognises the role of the Medical Royal Colleges, the faculties and the specialist organisations in communicating with the profession in other member states, and acknowledges the need to carry forward work on particular areas including:

- specialities where the duration/content of training varies widely between member states

- specialities which are recognised in some member states but not in others

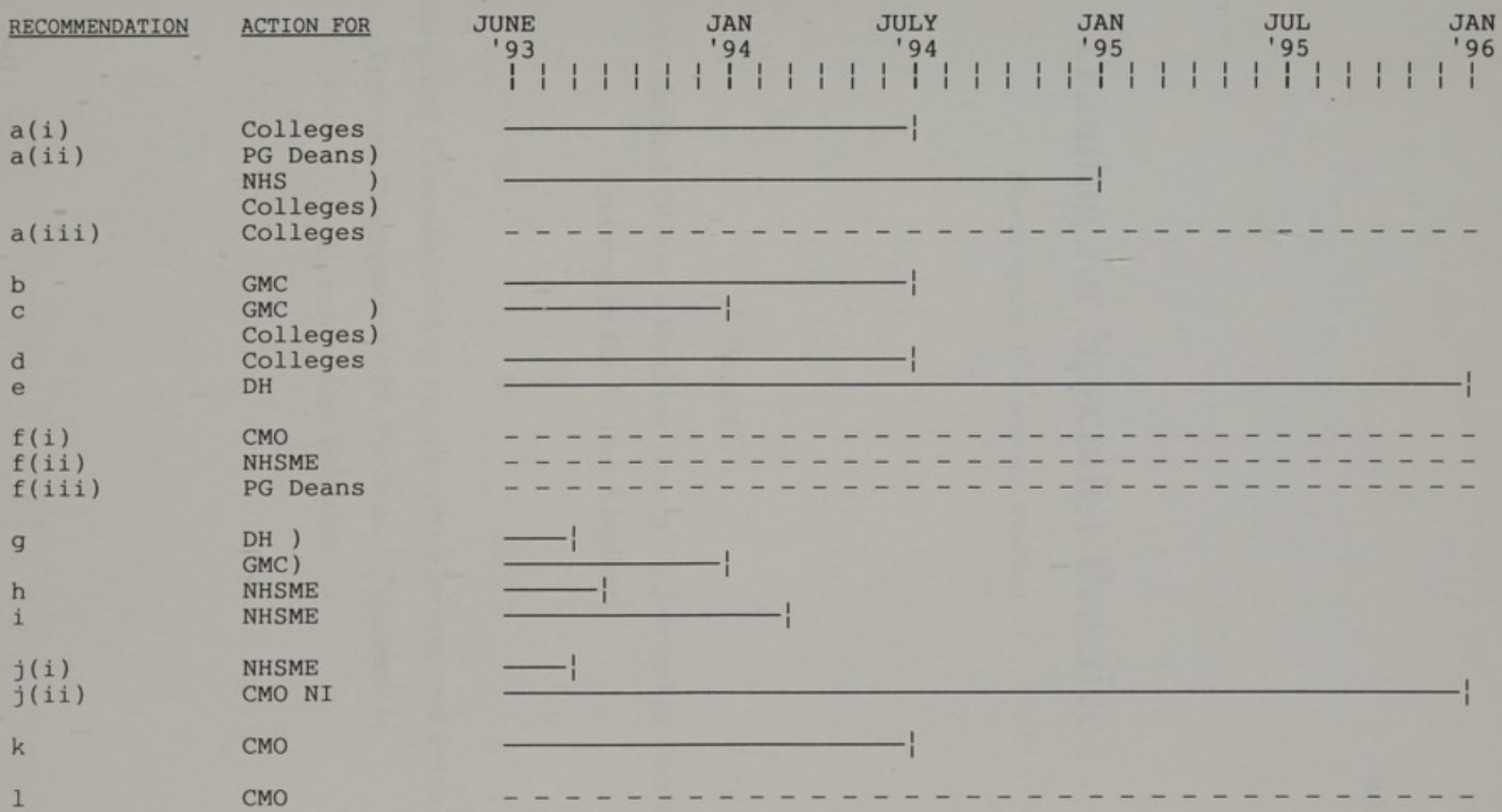
- willingness of health services to recognise qualifications and experience gained in other member states

- fluency in language as a prerequisite to employment in member states

- need for more information on movement of doctors between member states and the potential manpower implications

The subgroup recommends that the profession in the UK be encouraged to maintain and develop their formal and informal links with the profession throughout the EC.

TIMESCALE FOR IMPLEMENTATION OF RECOMMENDATIONS



Annex C

Training for Specialist Practice

(Bound separately in previous print run)

A Report To

The Chief Medical Officer's Working Group To Advise On Specialist Training in the United Kingdom

by

The Sub-group Commissioned to Enquire into Current and Proposed Training Programmes with Particular Reference to Structure and Duration

February 1993

CONTENTS

Acknowledgements

Members of the Sub-group and the Department of Health wish to thank Royal Colleges, their Faculties and representatives, and postgraduate deans who prepared detailed submissions for the Sub-group to consider, and who gave freely of their time to meet with them. Members are particularly conscious that, owing to restrictions on time for preparing submissions, opportunities for representatives to consult with colleagues or to have their views endorsed by respective college councils, were frequently not possible. Consultation took place in a spirit of constructive cooperation which, for the members of the Sub-group, provided a unique learning experience.

Preface

The Sub-group on Specialist Training is pleased to present its report.

Bearing in mind our brief, we have taken both written and oral evidence from those with primary responsibility for specialist training - Colleges, Faculties and Postgraduate Deans - and have been impressed by their cooperation and goodwill. In general Colleges and Faculties regarded the invitation to submit evidence as an opportunity to review specialist training and to contribute constructively by advising on current and proposed programmes of education. There was a remarkable consistency in the views expressed although, bearing in mind the independence of the various Colleges, these were not unanimous. Within the Sub-group itself the atmosphere of co-operation has been a particular feature of this exercise.

There is unanimous agreement on the need to **shorten** the time from the initiation of specialist training to career appointment and general agreement to "organise" training, so called "structured" training, such that unnecessary delays are avoided and the overall duration of training shortened. There is a spectrum of collegiate activity aimed at achieving this goal, eg: from Colleges operating structured programmes, *anaesthesia*, to those examining pilot studies, *pathology, urology*; from those preparing such programmes, *obstetrics and gynaecology*, to others currently examining the advantages, disadvantages and the need for change.

While acknowledging the need to shorten the length of training, there is absolute consistency of view that this must not be done at the expense of quality or of standards. Moreover, it is generally believed that the long time taken until career appointment is as much due to lack of opportunity as length of training.

Inevitably, a number of questions arise from the introduction of structured programmes and those identified have been addressed by the Sub-group. Where it is clear that there may be a number of solutions to these problems or where there is a clear consensus view within the Sub-group, these views have been identified.

There remains, however, a minority but strongly held view that, should any significant change in training, career structure and appointment procedures be considered or recommended, a much more broadly based group should be established to study the various issues in depth.

In particular, questions that arose included:-

i. the point of entry to specialist training, and how it is determined;

ii. the means of preparing and delivering programmes of training, including the roles of both formative and summative assessment;

iii. the point of exit from specialist training and how it is identified;

iv. the procedures for certification and registration;

v. the need for balance between earlier completion of training and career opportunity; and

vi. the problems that may arise from a "gap" occurring between these two points in a professional career.

We found no enthusiasm from any source for the career posts at the completion of structured training to be other than "consultant". Nor was there any support for the philosophy of a new career "specialist grade".

Inevitably more organised training resulting in reduction in its length would result in younger appointments as consultants. We believe that this would lead to a more dynamic and flexible attitude of newly appointed consultants requiring, not least, an acceptance of further career goals, opportunities, and **"mobility"**. This new culture could only be of benefit and could remove the otherwise stagnating effect of the present system. The Sub-group believes that such reforms as are already taking place will, of necessity, take time and have major implications for manpower and resources. There will clearly be a need to increase the number of consultants, and this is entirely consistent with the evidence given by the Royal Colleges to the Medical Manpower Standing Advisory Committee (*MMSAC or Campbell Committee*).

However, shortening the length of training by implementing the programmes suggested to us would release funds currently absorbed by unnecessary time spent in and allocated to training and training posts - we refer particularly to senior registrar posts. Funds would also be released if the recommendation to reduce the length of time in the senior house officer grade, *basic specialist or general professional training,* is implemented. In short, better organisation brings considerable financial benefit.

Finally, if the emphasis in "residency" programmes is more on training than service, the possibility of an increased service need will also have to be addressed.

The Sub-group believes that all the questions raised, while presenting logistical difficulties, are achievable and we look forward to further discussion within the CMO's Working Party.

Stanley C Simmons
Chairman

Remit of the Sub-group

In view of the remit of the Chief Medical Officers's Working Group to advise on any action that may be required to be taken to bring the UK into line with EC law on specialist training, the Sub-group has been asked to review the criteria, both current and proposed, of postgraduate training programmes with particular regard to structure, duration, standards and quality of training to be achieved, methods of assessment and how recognition in more than one specialty may be accommodated.

Membership of the Sub-group

Mr S C Simmons, PRCOG and Chairman of the Conference of Medical Royal Colleges and their Faculties in the United Kingdom *(Chairman of the Sub-group)**

Dr T J Bayley, Dean for Postgraduate Medical Education, The University of Liverpool*

Dr E M Borman, Junior Doctors Committee*

Dr A D Scotland, RMO, NE Thames RHA*

Professor D A Shaw, Education Committee, The General Medical Council*

Professor A A Spence, PRCA

Dr A D Toft, PRCP Edin.*

Professor L A Turnberg, PRCP Lond.

Dr R G Cairncross, Department of Health

Mr S D Catling, Department of Health

Ms L A Gitter, Department of Health

* *Serve as members or observers on the Chief Medical Officer's Working Group to which the Sub-group reports.*

Royal Colleges, Faculties and Others with Whom the Sub-group Met
(Listed in the order in which the Sub-group met with their representatives)

The Royal College of Anaesthetists	Professor A A Spence
The Royal College of General Practitioners	Dr S E Josse
The Royal College of Pathologists	Professor P J Lachman, Dr M G Rinsler and Dr N J Ketley
The Royal College of Radiologists	Dr C D R Flower & Dr R G B Evans
The Royal College of Obstetricians and Gynaecologists	Professor W Dunlop & Dr N Patel
The Royal College of Psychiatrists	Dr F Caldicott
The Royal College of Surgeons of England	Professor N L Browse & Professor G D Chisholm
The Royal College of Surgeons of Edinburgh	Mr A C B Dean & Professor G D Chisholm
The College of Ophthalmologists	Mr P Wright & Mr B M Martin
The Committee of Postgraduate Medical Deans & The UK Conference of Postgraduate Deans	Professor T M Hayes
The Royal College of Physicians of Edinburgh	Dr A D Toft
The Royal College of Physicians of London	Professor L A Turnberg & Dr B L Pentecost
The Royal College of Physicians and Surgeons of Glasgow	Dr R Hume & Professor D Campbell
The Faculty of Public Health Medicine of the Royal Colleges of Physicians of the UK	Professor D L Miller & Miss L Frankland
The British Paediatric Association	Professor S R Meadow
The Faculty of Occupational Medicine, Royal College of Physicians of London	Dr T C Au
The Faculty of Dental Surgery, Royal College of Surgeons of England	Mr K R Ray & Mr P Banks

Some Definitions

The United Kingdom "Certificate of Completion of Specialist Training"

1 EC Directives 75/362 and 75/363 concern the mutual recognition of diplomas, certificates and other evidence of formal qualifications of medicine, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services, and the coordination of provisions laid down by law, regulation or administrative action in respect of activities of doctors.

2 Article 4 of EEC 75/362 requires that "each Member State recognise the diplomas, certificates and other evidence of formal qualifications in specialised medicine awarded to nationals of Member States by other Member States.....by giving such qualifications the same effect in its territory as those which the Member State itself awards."

3 Article 5 of EEC 75/362 requires that "the diplomas, certificates and other evidence of formal qualification awarded by the competent authorities or bodies referred to" is in the United Kingdom the "*certificate of completion of specialist training* issued by the competent authority recognised for this purpose."

Minimum period of specialist training

4 The Directives define a minimum period of specialist training commencing once a doctor has completed the periods of basic medical education and general clinical training and, in the United Kingdom, obtained full registration or its equivalent *(see para 7)*.

Other Directives

5 There are separate EC Directives referring to Dentistry and to General Medical Practice and other professions. **This Report is confined to those Directives relating to specialist medical practice.**

Phases of medical education

6 The Education Committee of the General Medical Council has recognised that there is no generally accepted terminology for the periods of training following full registration. In 1987 it defined the phases of postgraduate education in its publication "Recommendations on the Training of Specialists". These definitions are, with certain exceptions, used within this Report;

7 ***Basic medical education*** comprises the period of undergraduate medical education, culminating in the final professional or qualifying examination (such as MB BS), and the period of ***general clinical training***. This is the statutory term for the pattern of experience acquired during what is generally known as the pre-registration year.

Completion of this stage of medical education leads to full registration.

8 ***Basic specialist training*** occupies two or three years following full registration, during which a doctor acquires increased but supervised responsibility for patient care, and develops the wide range of general and basic specialist skills needed for practice in the specialty concerned. The term ***general professional training*** was used in the Report of the Royal Commission on Medical Education 1965-68 (the Todd report) to identify this period. It has since acquired several different meanings. Nevertheless, it is accepted that some bodies concerned with postgraduate education wish to retain it even though for many, if not most, trainees "basic specialist training" more clearly describes the specific experience gained. More recently ***common trunk or core training*** are further terms which have been applied to part or all of this period of postgraduate education.

9 ***Higher specialist training*** follows basic specialist training, normally intended to last 3 to 5 years, at the end of which a doctor is regarded as having completed specialist training and as being ready to accept consultant (or equivalent) responsibilities. Completion is usually attested by accreditation as a specialist or by an "exit" qualification.

10 ***Vocational training for general practice*** is the three year period of experience prescribed by the National Health Service (Vocational Training) Regulations 1979, or the period of experience accepted by the Joint Committee on Postgraduate Training for General Practice as equivalent to the prescribed experience.

11 ***Independent practice*** is practice carrying unsupervised responsibility for patients, for example as a consultant in a hospital, as a principal in general practice, or in independent private practice. (Note this definition is in contrast to the more restrictive interpretation where independent practice equates to private practice.)

12 ***Continuing medical education*** is the term for the continuing process by which a doctor seeks to maintain and enhance his or her competence as an independent practitioner.

What is structured training?

13 Deficiencies in the present arrangements for postgraduate and continuing education are well known. But postgraduate education with its emphasis on training and learning through experience requires arrangements distinct from those of continuing education. The more structured learning environment of postgraduate education, often influenced by diploma examinations, is in contrast to more liberal strategies essential for effective continuing education. In both, learning needs have to be met and personal responsibility for professional development accepted.

14 A singular feature of postgraduate education is that all doctors in training will participate or will have participated in recognised training programme(s). The term "structured" is taken to mean training organised or planned in a "seamless" fashion

so that unnecessary delay or obstruction is avoided. This does not mean, however, inflexible programmes of training - indeed modular training specifically allows for exit and re-entry and for added elements of experience, research etc. to meet individual requirements. It is also understood that structured or "residency" programmes are delivered to standards determined by competent standard setting authorities, are subject to regular evaluation and may include many of the following features: a statement of aims and, where relevant, objectives; entry criteria; provisions for assessing or monitoring progress; supervised practical experience; access to theoretical courses and learning resources to support private study; and means for indicating satisfactory conclusion of training.

The EC Directives: defining the duration of training

15 The EC Directives 75/362 and 363, 82/76 and 89/594 stipulate for certain specialties the minimum length of relevant training courses. These are listed in *Table 1* along with the minimum requirements for training within the UK which the Sub-group understands would be required before the award of a UK "Certificate of Completion of Specialist Training" *("UKCCST")* is recommended. Further information regarding particular specialties may be found in the Annex attached to this Report.

16 For the purpose of defining the **minimum duration of training** in the United Kingdom the Sub-group has accepted that it should commence from the acquisition of full or equivalent registration and terminate when the doctor is eligible for the award of the *"UKCCST"*. It has also accepted that, at present and for a number of reasons, the actual duration of training is commonly likely to be longer - particularly when, in certain specialties, it reflects time taken until consultant appointment. Factors conspiring to prolong training inappropriately will be considered later *see paras 46 - 49.*

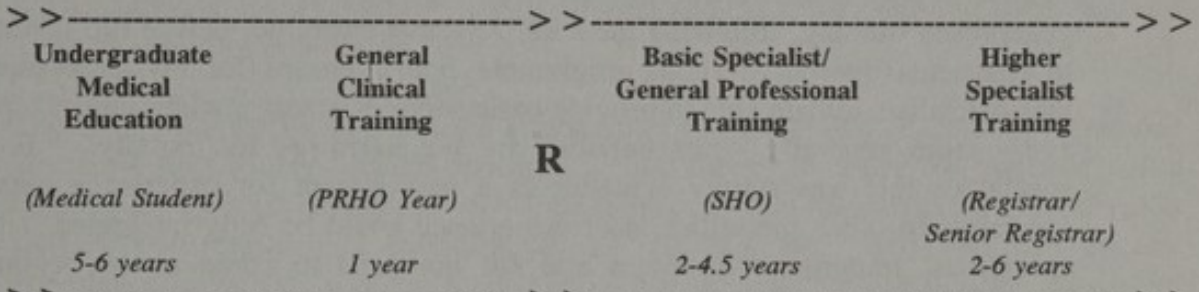
17 Thirty nine specialties are identified in the EC Directives, *Table 1*, for which the average minimum period required for training is **4.0 years** *(range 3-5 years)*. It is, however, understood that training programmes in other Member States commonly exceed the EC minimum requirements.

18 The present duration of training in the United Kingdom in general significantly exceeds the EC Directives. However, the comparable average minimum period for training recommended or proposed by various specialties, starting from full registration and ending with the award of the *"UKCCST"*, is **6.2 years** *(range 5-9 years), Table 1*. One reason for the continuing disparity is that, in most specialties as a pre-requisite to specific training within a specialty, a period of general professional or basic specialist training is required.

Specialist Training Programmes

A framework for specialist training

19 The general pattern of medical training, from entry to university to appointment as an NHS consultant, currently consists of 4 phases:



Notes i) "R" = full registration.

ii) The first two phases - undergraduate medical education and general clinical training - are known as "Basic Medical Education".

iii) The time scales shown reflect the minimum duration of training for the two phases of post registration or specialist training. This varies between specialties (see Table 1).

iv) Training in several of the medical specialties at registrar level, post MRCP(UK), can be approved for Higher Specialist Training by the JCHMT.

v) Basic Specialist/General Professional Training (BST/GPT) in training programmes required by the Royal College of Psychiatrists currently includes experience or training gained in SHO and registrar posts while Higher Specialist Training (HST) is confined to the senior registrar grade.

20 The Sub-group identified certain fundamental principles which apply to specialist training:

i) it should be part of the continuum of medical education;

ii) arrangements for training must be flexible to take account of the differing requirements of specialties;

iii) flexibility should be sufficient to enable doctors in training to exercise a reasonable degree of choice between specialties and career options allowing trainees to change direction and to obtain some credit for previous experience - this is the particular value of an initial phase of specialist training;

iv) there should be a reasonable level of competition on entry to specialist training programmes *(see paras 33 - 35)*;

v) only that experience and training which fulfils the requirements and meets the standards of the accrediting authority should be recognised for the award of a UK CCST or its equivalent;

vi) the particular training needs of overseas qualified doctors should be accommodated *(see para 54)*; and

vii) the arrangements must comply with the EC Medical Directives.

21 The Sub-group acknowledged the need to define specialist training in relation to the EC Medical Directives. Although there was general agreement in respect of *higher specialist training*, the Sub-group was aware of differing interpretations of the phase of *general professional/basic specialist training*. Some consider that a period of more generalised training, following the PRHO year is desirable, before full commitment to a particular specialty training programme, both to ensure (for physicians especially) that specialists remain able to provide basic services across a wider clinical spectrum and - more generally - that horizons are not narrowed too rapidly. For some specialties this was simply a matter of a requirement for experience outside the specialty. In other specialties, such experience could be fully integrated within the specialties' training programmes and did not need to come at the beginning of training. (A more detailed account of the Sub-group's deliberations on *basic specialist/general professional training* is provided in the following section *(paras 23 - 29)*.) The Sub-group was also aware of the view that post registration experience or training which was a requirement for entry to higher specialist training programmes was, *de facto*, a part of specialist training.

22 **Based on evidence received from College representatives and careful consideration of the range of options for structured training within the overall framework of specialist training the Sub Group recommends that:**

i the term *"specialist training"*, for the purposes of the EC Medical Directives, should apply to the whole of the period of training following full registration and last until the award of a UK "Certificate of Completion of Specialist Training" (CCST) or its equivalent *(see paras 40 - 43)*;

ii the structure of training programmes is sufficiently *flexible* to enable there to be *choice* of career pathway within the period of *"specialist training"* as well as at entry to and exit from it;

iii the arrangements for the first phase of *"specialist training"* should provide sufficient flexibility to enable a trainee doctor to make an initial commitment to a broad range of specialties and, where he or she so chooses, to delay a final commitment to pursue a particular specialty training programme; and that

iv throughout the period of *"specialist training"* only that experience and training which fulfils the requirements and meets the standards of the accrediting authority should be recognised for the award of a UK "Certificate of Completion of Specialist Training" (CCST) or its equivalent *(see paras 40 - 43)*.

Basic specialist or general professional training

23 A feature of British postgraduate education is that, with few exceptions the requirements for training in any specialty include a period of general professional or basic specialist training. The General Medical Council[1] has identified the aims of this phase of training - to address: content common to training for all specialties; communication skills; certain practical skills; the application of strategies for the prevention of illness and the promotion of health; teamwork skills; knowledge and skills relating to management; problem solving; and the knowledge and skills required to cross specialty boundaries.

24 The Sub-group established that the arrangements to effect this phase of postgraduate education vary widely between specialties. In some, eg *anaesthetics, psychiatry and ophthalmology* such training normally takes place within the particular specialty. In *surgery* core training is proposed which will last two years and will require experience in various surgical specialties, while in *medicine* and in other specialties experience outside the specialty is either required or encouraged. In *obstetrics and gynaecology* an elective period of one year outside the specialty is both valued and required. There was a consensus view that, in terms of career development, the doctor should remain at this stage pluri-potential. Further the Sub-group understood the optimum duration of this phase of training to approximate to two years *(range 2 - 4.5 years, see Table 1)*. However, in some specialties this was regarded as inadequate, eg *public health medicine, paediatrics and occupational medicine*, since either exposure to the specialty in question during basic medical education or general clinical training was perceived inadequate *(paediatrics)* or significant clinical experience was sought before entry to a "non-clinical" specialty *(public health medicine)*.

25 The Sub-group did not specifically examine the provisions for organised or structured training recognising that arrangements varied between specialties - some being more structured than others. Further it was unable to determine how far the aims of basic specialist or general professional training as expressed in *para 23* were being met.

26 The Sub-group noted that recommendations by the General Medical Council proposed for basic medical education and general clinical training could, if implemented, have significant implications for basic specialist and general professional training - direct progression from general clinical training without a period of basic or general professional training was not likely to be desirable.

27 The present difficulties associated with the pre-registration year were acknowledged and required to be addressed. There was no support for a formal extension of this period to two years but the possibility of a prescribed period of more general experience before proceeding to specialist training (a required period of training in an undifferentiated SHO post) was noted. These strategies would prolong specialist training and would delay the point at which career change could be implemented since, for some specialties, direct experience of the work involved was essential before such a decision could be addressed. Progress through this phase should

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[1] Recommendations on the Training of Specialists, General Medical Council Education Committee, 1987.

accommodate the interests and requirements of individual doctors and "fast track" candidates should not be unduly delayed.

28 The Sub-group identified that arrangements for basic specialist/general professional training must also:

i) accommodate the requirements of general practice and in particular those of vocational training; and

ii) take account of any changes in the other phases of medical education: undergraduate, general clinical training, higher specialist training and continuing medical education.

29 **The Sub-group:**

i recognises the value of this phase of postgraduate education, its important contribution to specialist training and the opportunities it provides for doctors, while at an early stage of training, to change career pathways or to prepare for a career in general practice;

ii acknowledges that the arrangements for and the duration of this phase of training vary significantly but that such flexibility is believed both desirable and appropriate; and

iii recommends that, since a number of factors and interests require to be accommodated to enable this phase of medical education to provide a sound foundation for more advanced specialist training, further examination of the arrangements for training during basic specialist and general professional training (to include consideration of a required period of non-specialty-specific training) is now merited.

Higher specialist training

30 The Sub-group noted the variation in minimum recommended periods for higher specialist training *(range 2 - 6 years, see Table 1)*. In part the disparity was influenced by the definition of the phase of higher specialist training: in some specialties this was applied only to doctors holding senior registrar appointments; in others it included those who also held career registrar appointments; in some specialties the view prevailed that general professional or basic specialist training fell outside the period of specialist training while for others it was included. The Sub-group also noted that most, but not all, specialties are moving to include career registrar appointments within the phase of higher specialist training. For this reason and because successful completion of a minimum recommended period of basic specialist or general professional training is almost universally required to fulfil the requirements for entry to higher specialist training, the sum of both phases is shown for each specialty in *Table 1*. The minimum recommended periods from full registration to the point where the doctor would be eligible for the award of a *certificate of completion of specialist training* is shown *(average 6.2 years; range 5 - 9 years)*.

31 The Sub-group noted that most colleges and faculties had either implemented or were intending to implement structured training programmes in one form or another. Inevitably arrangements varied between specialties. A particular view presented to the Sub-group was that the division between basic/general and higher specialist training was unhelpful: accommodating this experience *within* specialist training and a single specialist training grade could provide a more flexible and effective model.

32 **The Sub-group welcomes the move to include the career registrar grade within the period of higher specialist training and is encouraged by the progress made by many colleges and faculties in introducing structured training programmes.**

Entry requirements for training programmes

33 Where there is a clear bar between basic and higher specialist training then most specialties require competitive entry to higher training programmes. Increasingly initial appointment as a career registrar coincides with entry into higher training. However, for some specialties higher specialist training is still identified with appointment as a senior registrar. Candidates for higher specialist training will have undertaken the general professional/basic specialist training required and often, in addition, will have passed a relevant diploma examination, eg MRCP(UK). In some specialties, eg *anaesthetics*, which may recruit from the pre-registration year, progress is determined by success within the specialty's training programmes and by passing the relevant diploma examinations. In other specialties, eg *radiology* all training takes place within registrar and senior registrar grades and entry to programmes is often very competitive. As a result market forces dictate that candidates will improve their chances of appointment if they first complete general professional training in medicine, surgery or a similar discipline and acquire an appropriate diploma. This experience is not specifically required by the specialty and in acquiring it training is inevitably prolonged.

34 Educational entry requirements for general professional/basic specialist training are not often specified but, *ophthalmology*, for instance, expects its entrants to the two years of basic specialist training to have first acquired Part I of the FCOphth.

35 **During the period of specialist training, the Sub-group encourages competitive entry to specialist training programmes.**

Assessment

36 Assessment is an essential element of all structured training programmes. It may be summative (usually at the completion of training or at certain points during the training period) or formative (of a more general educational nature, helping the career development of the doctor). Both forms of assessment are needed in specialist training.

37 Assessment informing progress within structured training programmes, whether formative or summative, is often distinct and independent from the summative assessment (eg diploma examinations) required by standard setting bodies. Both

forms of assessment are relevant, valued and can therefore be regarded as complementary. Colleges, Faculties and postgraduate deans all participate in the assessment process.

38 Summative assessment by diploma examination may not uncommonly mark the end of basic specialist/general professional training and is often a requirement for entry to higher specialist training. The arrangements to assess progress during higher specialist training vary and in some specialties, eg *pathology and occupational medicine*, an "exit assessment" is an indicator of the conclusion of training. More commonly reports attesting to the satisfactory conclusion of an agreed training programme will lead to "accreditation". However, evidence required for and the procedures applied to accrediting doctors at the conclusion of higher specialist training are not uniform across specialties - some are more rigorous than others. Further, in certain shortage specialties appointment to a consultant post can precede accreditation and conclusion of formal training: conversely for other doctors appointment to a career grade may follow sometime after accreditation and the conclusion of training.

39 **The Sub-group recognises that the methods of assessment which lead to the award of a *"certificate of completion of specialist training"* or its equivalent may merit review. It notes that some colleges, faculties and specialty advisory committees have already begun to address the matter.**

The UK "Certificate of Completion of Specialist Training" ("UKCCST")

40 The Sub-group notes the recommended or proposed minimum duration of specialty training in the United Kingdom *see Table 1* and the specific requirements for specialist training summarised in the *Annex*. It considers that, provided certain specific problems relating to particular specialties can be accommodated (see paras 62 - 66), then doctors who satisfactorily complete specialist training will be eligible for the award of a United Kingdom "Certificate of Completion of Specialist Training" *"UKCCST"* or its equivalent. It is also satisfied that, for all specialties, a doctor to whom the Certificate is awarded would be capable of independent practice and eligible for consideration for appointment as a consultant.

41 If the *"UKCCST"* or its equivalent is to be awarded, then the arrangements to record this by the competent authority in the United Kingdom - the General Medical Council - must be clarified.

42 The way in which completion of specialist training, for those UK specialties not listed in the EC Directives, is identified must also be clarified.

43 **The Sub-group:**

i **recommends that the UK *"Certificate of Completion of Specialist Training"* or its equivalent be awarded on satisfactory completion of training;**

ii **is satisfied that, for all specialties, a doctor to whom such a certificate is awarded would be capable of independent practice and eligible for consideration for appointment as a "consultant" within the National**

Health Service;

iii **recommends that the arrangements to record the award of a UK *"Certificate of Completion of Specialist Training"* or its equivalent by the General Medical Council be clarified; and**

iv **recommends that the arrangements to record completion of training from those specialties not listed in the EC Directives must also be clarified.**

Special arrangements for training involving more than one specialty

44 During basic specialist/general professional training many doctors will acquire experience of more than one specialty and, as described in *paras 23 - 29* credit for this experience may be given when the doctor seeks a position in a higher specialist training programme.

45 **The Sub-group recommends that the arrangements for acquiring dual certification or accreditation or for completing a shortened training programme within a second specialty be clarified.**

Impediments to effective training

46 The Sub-group confirmed that the present arrangements for training are often inefficient and that as a result training in the United Kingdom takes too long. Perhaps the most important factor contributing to and exacerbating this problem is lack of opportunities to advance both within the training grades and on completion of training. Structured training programmes can shorten training but their potential for doing so is limited by the present structure of the training grades - difficulties in obtaining promotion or transfer to a suitable post can delay and inappropriately and significantly extend training. Several colleges have proposed that, within higher specialist training, a single grade (combining career and senior registrar grades) be introduced as soon as is practicable. This would enable the development of "run through" programmes - perhaps four or five years long - with progress dependent on the educational attainment of the trainee. The Sub-group noted a further option to replace the present three training grades with a single specialist training grade.

47 Within the period of structured training there should be no "bottlenecks". However, such "bottlenecks" may well occur at the point of competitive entry to programmes and at their conclusion if doctors, who have completed training, are unable to progress immediately to definitive career appointments. This latter scenario has been referred to as *"the gap"*. The Sub-group recognises that, with respect to individual specialties, manpower requirements may well dictate the number of doctors in *"the gap"* at any one time and that with effective manpower management this number can be controlled. Nonetheless it recommends that, if such doctors are not to block training opportunities, the following strategies could be considered:

i) proleptic consultant appointments;

ii) interim or short term appointments of defined duration - perhaps to undertake

research or gain further experience; and

iii) remaining in the training grade post although undertaking a substantially increased service load. (Such doctors could, for manpower reasons, retain a "training number" so denying access to new trainees and may continue to be remunerated as a trainee. The Sub-group rejected "decanting" doctors on completion of training but accepted that the period of time granted to find an appropriate position would be finite).

48 The Sub-group acknowledged that the titles "junior" or "trainee" were perhaps as inappropriate as referring to the doctor by his or her training grade. The present exercise provides an opportunity to examine alternative names, eg "assistant physician, assistant pathologist, assistant surgeon etc" to cover the training period. Once the doctor had attained his *"UKCCST"* or its equivalent, the title might change to "physician, pathologist, surgeon etc". The term "consultant" would not be applied until the doctor had been so appointed.

49 **The Sub-group:**

i recommends the introduction of a combined career and senior registrar grade as soon as is practicable;

ii recommends that strategies aimed at resolving the position of doctors who have completed training but who have not secured a career appointment be considered; and

iii suggests that an alternative title or titles for doctors in training be explored.

Delivering postgraduate medical education

50 The application of the 1991 unnumbered working paper "Postgraduate Medical and Dental Education" introduced throughout the health service a means for managing and delivering postgraduate and continuing education though an infrastructure of which the regional postgraduate dean is the chief executive. Over the past eighteen months the regional postgraduate organisation has been progressively revised and effective management practices introduced. In April 1993 postgraduate deans will assume responsibility for funding approximately one half of the salaries of all training grade posts. A mechanism is therefore being developed in concert with parallel reforms within the NHS to ensure the effective delivery of postgraduate medical education. Colleges, faculties and higher training committees, with their own network of advisers and tutors, have identified the importance of working closely with postgraduate deans to ensure the provision of optimum training.

51 **The Sub-group recommends increasing opportunities for liaison between colleges, faculties and postgraduate deans and recognises that, in the first instance, assessment is an important topic of mutual interest. (It has been suggested that a working party be established to enable the medical royal colleges and postgraduate medical deans to examine this interface).**

Research

52 The sub-group is aware that colleges, faculties and joint higher training committees encourage with varying emphasis participation in research. It is also aware that in seeking to identify minimum periods for training, opportunities for research were ordinarily not included. Likewise the requirements of academic trainees have not been specifically addressed.

53 **The sub-group recommends that further consideration be given to the role of and opportunities for research during specialist training and to the particular requirements of doctors pursuing a career in academic medicine.**

Overseas qualified doctors

54 Two areas of concern follow from the Sub-group's recommendations on structured training programmes which impinge on the provisions for training overseas qualified doctors within the United Kingdom. The first is the more general question of relevance of shorter structured specialist training programmes to the needs of doctors who intend to return to their native country. The second relates to the points of entry to training programmes - basic or higher specialist - and the time available within the constraints of the Immigration Rules for the doctor to complete training.

55 The Sub-group recommends that, in the light of a wider application of structured training programmes, consideration be given to reviewing the arrangements for training of overseas qualified doctors.

Further experience

56 Most colleges and faculties with whom the Sub-group discussed structured training leading to the award of a *"UKCCST"* indicated that for certain consultant appointments, eg in sub-specialties of *surgery, paediatrics, and obstetrics and gynaecology,* **further** experience would be required. It was also noted that during the period of specialist training many trainees may wish to obtain **other** relevant experience not directly, or necessarily, included in specified specialist training programmes. It would also be important to ensure flexibility in training arrangements to cater for those who pursue an unorthodox career or who may wish to enter an academic career.

57 **The Sub-group recognises that, while further experience could not be part of formal specialist training, opportunities for advancing personal careers will be required.**

The consultant grade

58 The Sub-group detected no support for the introduction of a new NHS specialist grade, capable of independent practice, which would supplement the present consultant grade. On appointment to a single consultant grade there should be

opportunities to progress and inducements for doing so, eg to directorships of clinical services or to advanced clinical practice *(eg vascular surgery or gynae-oncology)*, or to undertake significant responsibilities for teaching, training or management. Within the grade consultants should enjoy greater mobility.

59 With respect to manpower the Sub-group reiterates the advice already provided by colleges and faculties to other fora for the need for a substantial increase in the number of consultants.

60 **The Sub-group recommends that, within a single consultant grade, there should be opportunities to progress and develop interests, and inducements for doing so. It reaffirms advice already given that a substantial expansion of the consultant grade is required.**

Resources

61 The Sub-group recognises that resource implications arising from its recommendations fall outside its remit. Nonetheless it has identified that shortening the length of training would release funds currently absorbed by unnecessary time spent in and allocated to training and training posts. In short, organisation through the introduction of more structured training programmes has considerable financial benefit. However, it is also apparent that with the introduction of a shorter training period, coupled with a decrease in the number of hours worked in training grades, there could be significant implications for the maintenance of appropriate and safe levels of services to patients. This should be carefully monitored.

Specialties encountering specific problems in accommodating the EC Directives

62 The Sub-group recognises that, in accommodating the requirements of the EC Directives in relation to specialist training, there may be particular difficulties for certain specialties: ophthalmology, pathology, paediatrics and medicine.

63 **The Sub-group identifies particular difficulties for ophthalmology, paediatrics patholgy and medicine in accommodating the EC Directives and suggests that these merit further examination.**

Conclusions

The Sub-group:

1 recommends that the term *"specialist training"*, for the purposes of the EC Medical Directives, should apply to the whole of the period of training following full registration and last until the award of a UK "Certificate of Completion of Specialist Training" (CCST) or its equivalent *(paras 19 - 22 & 40 - 43)*.

2 recommends that the structure of training programmes is sufficiently *flexible* to enable there to be *choice* of career pathway within the period of *"specialist training"* as well as at entry to and exit from it *(paras 19 - 22)*.

3 recommends that the arrangements for the first phase of *"specialist training"* should provide sufficient flexibility to enable a trainee doctor to make an initial commitment to a broad range of specialties and, where he or she so chooses, to delay a final commitment to pursue a particular specialty training programme *(paras 19 - 22)*.

4 recommends that throughout the period of *"specialist training"* only that experience and training which fulfils the requirements and meets the standards of the accrediting authority should be recognised for the award of a UK "Certificate of Completion of Specialist Training" (CCST) or its equivalent *(paras 19 - 22 & 40 - 43)*.

5 recognises the value of general professional/basic specialist training *(GPT/BST)*, its important contribution to specialist training and the opportunities it provides for doctors, while at an early stage of training, to change career pathways or to prepare for a career in general practice *(paras 23 - 29)*;

6 acknowledges that the arrangements for and the duration of *GPT/BST* vary significantly and that such flexibility is believed both desirable and appropriate *(paras 23 - 29)*;

7 recommends that, since a number of factors and interests require to be accommodated to enable the phase *GPT/BST* to provide a sound foundation for more advanced specialist training, further examination of the arrangements for training during this phase (to include consideration of a required period of non-specialty-specific training) is now merited *(paras 23 - 29)*;

8 welcomes the move to include the career registrar grade within the period of higher specialist training and is encouraged by the progress made by many colleges and faculties in introducing structured training programmes *(paras 30 - 32)*;

9 during the period of specialist training, encourages competitive entry to specialist training programmes *(paras 33 - 35)*.

10 recognises that the methods of assessment which lead to the award of a *"Certificate of Completion of Specialist Training"* or its equivalent may merit review. It notes that some colleges, faculties and specialty advisory committees have already begun to address the matter *(paras 36 - 39)*;

11 recommends that the UK *"Certificate of Completion of Specialist Training"* or its equivalent be awarded on satisfactory completion of training *(paras 40 - 43)*;

12 is satisfied that, for all specialties, a doctor to whom such a certificate is awarded would be capable of independent practice and eligible for consideration for appointment as a "consultant" within the National Health Service *(paras 40 - 43)*;

13 recommends that the arrangements to record the award of a UK *"Certificate of Completion of Specialist Training"* or its equivalent by the General Medical Council be clarified *(paras 40 - 43)*;

14 recommends that the arrangements to record completion of training from those specialties not listed in the EC Directives be clarified *(paras 40 - 43)*;

15 recommends that the arrangements for acquiring dual certification or accreditation or for completing a shortened training programme within a second specialty be clarified *(see paras 44 - 45)*.

16 recommends the introduction of a combined career and senior registrar grade as soon as is practicable *(paras 46 - 49)*;

17 recommends that strategies aimed at resolving the position of doctors who have completed training but who have not secured a career appointment be considered *(paras 46 - 49)*;

18 suggests that an alternative title or titles for doctors in training be explored *(paras 46 - 49)*;

19 recommends increasing opportunities for liaison between colleges, faculties and postgraduate deans and recognises that, in the first instance, assessment is an important topic of mutual interest. (It has been suggested that a working party be established to enable the medical royal colleges and postgraduate medical deans to examine this interface.) *(paras 50 - 51)*;

20 recommends that further consideration be given to the role of and opportunities for research during specialist training and to the particular requirements of doctors pursuing a career in academic medicine *(paras 52 - 53);*

21 recommends that, in the light of a wider application of structured training programmes, consideration be given to reviewing the arrangements for training of overseas qualified doctors *(paras 54 - 55)*;

22 recognises that, while "further experience" could not be part of formal specialist training, opportunities to advance personal careers will be required *(paras 56 - 57)*;

23 recommends that, within a single consultant grade, there should be opportunities to progress and develop interests, and inducements for doing so. It reaffirms advice already given that a substantial expansion of the consultant grade is required *(paras 58 - 60)*.

24 identifies particular difficulties for ophthalmology, pathology, paediatrics and medicine in accommodating the EC Directives and suggests that these merit further examination *(para 63)*.

Table 1: Minimum Duration of Full Time Training

(Based on information derived from the EC Directives and from information supplied to the Sub-group by Colleges and Faculties)

Specialty[1] *Terminology as applied to the United Kingdom in EC Directives 75/362, 75/363, 82/76 & 89/594*	**EC: Minimum Length Required of Specialist Training Courses** *(years)*	***UK: Minimum Period Recmded***[6]***.*** *Basic Specialist or Genrl. Prof. Train. BST/GPT (yrs)*	***UK: Minimum Period Recmded***[6]***.*** *Higher Specialist Training "HST" (years)*	**UK: Minimum Period from Full Registration to the award of the** *UKCCST*[2] *(years)*	**Comments**
Anaesthetics	3	*4*	*2*	6	One year of BST is ordinarily spent outside the specialty & may precede entry to training.
Cardio-vascular disease	4	*2	*6*	8	
Chemical Pathology	4	*3*	*2*	5	See Morbid Anatomy & Histopathology
Child & Adolescent Psychiatry	4	*3-4*	*4*	7-8	1 year of GPT **may** be taken outside the specialty or in research
Clinical Pharm. & Therapeutics	4	*2	*4*	6	
Communicable Diseases	4	*2	*4*	6	
Community Medicine	4	*4*	*3*	7	2 years GPT + 2 years BST as registrar + 3 years HST as SR
Dental, Oral & Maxillo-fac Surgery	4	*2*	*5*	7	Requires **both** Basic Medical & Dental Education
Dermatology	4	*2	*4*	6	
Diagnostic Radiology	4	*4*	*2*	6	1 year GPT outside specialty + 3 years BST + 2 years HST
Endocrinology & Diabetes Mellitus	3	*2	*4*	6	
Gastroenterology	4	*2	*4*	6	
General Surgery	5	*2*	*5*	7	"Sub-specialty training" will follow as suitable experience after the UKCCST.
General Medicine	5	*2	*4*	6	
Geriatrics	4	*2	*4*	6	HST Approval of training arrangements by JCHMT & RCPath.
Haematology	3	*2	*4*	6	JCHMT requirements shown see also Morbid Anatomy & Histopathology

Specialty[1] *Terminology as applied to the United Kingdom in EC Directives 75/362, 75/363, 82/76 & 89/594*	**EC: Minimum Length Required of Specialist Training Courses** *(years)*	*UK: Minimum Period Recmded*[6]*. Basic Specialist or Genrl. Prof. Train. BST/GPT (yrs)*	*UK: Minimum Period Recmded*[6]*. Higher Specialist Training "HST" (years)*	**UK: Minimum Period from Full Registration to the award of the** *UKCCST*[2] *(years)*	**Comments**
Immunology	4	*2	4	6	JCHMT requirements shown see also Morbid Anatomy and Histopathology
Medical Microbiology	3	2	3	5	See Morbid Anatomy & Histopathology
Morbid Anatomy & Histopathology	3	3	2	5	The RCPath recommends that UKCCST is awarded after 4 years training in pathology and on passing **Part I** of the new **MRCPath**. Such doctors can certainly be regarded as "specialists". a) Requirements for Part I: 2.5 years spent in the subject examined and 3 years in the discipline. Experience in other training programmes may be accepted. One years clinical experience is required and the PRHO year is acceptable. b) Requirements for **Part II**: 5 years full time approved training, 2 years of which are in posts recognised for HST and 4 years in the branch of pathology chosen.
Neurology	4	*2	4	6	
Neurological Surgery	5	2	5	7	"Sub-specialty training" will follow as suitable experience after UKCCST.
Nuclear Medicine	4	*2	4	6	
Obstetrics & Gynaecology	4	4.5	2	6.5	Includes an elective year during BST taken outside the specialty. The RCOG is actively reviewing training.
Occupational Medicine	4	3	4	7	
Ophthalmology	3	2	4	6	College of Ophthal. propose 6 yrs full time training **wholly within** the specialty. Pt I FCOpth is recommended *before* entry to BST.
Orthopaedic Surgery	5	2	5	7	"Sub-specialty training" will follow as suitable experience after the UKCCST.
Otolaryngology	3	2	5	7	"Sub-specialty training" will follow as suitable experience after the UKCCST: 5 years HST is now proposed.

Specialty[1] *Terminology as applied to the United Kingdom in EC Directives 75/362, 75/363, 82/76 & 89/594*	**EC: Minimum Length Required of Specialist Training Courses** *(years)*	***UK: Minimum Period Recmded***[4]***.*** *Basic Specialist or Genrl. Prof. Train. BST/GPT (yrs)*	***UK: Minimum Period Recmded***[4]***.*** *Higher Specialist Training "HST" (years)*	**UK: Minimum Period from Full Registration to the award of the** *UKCCST*[2] *(years)*	**Comments**
Paediatrics	**4**	*3*	*5-6*	**8-9**	Faculty's proposals: GPT will ordinarily occur wholly within the specialty and might be reduced to 2 years; HST provides limited possibilities for research & will be extended for some trainees. Further "experience" will be required for appointments post UKCCST
Paediatric Surgery	**5**	*2*	*5*	**7**	"Sub-specialty training" will follow as suitable experience after the UKCCST.
Plastic Surgery	**5**	*2*	*5*	**7**	"Sub-specialty training" will follow as suitable experience after the UKCCST.
Psychiatry	**4**	*3-4*	*4*	**7-8**	1 year of GPT **may** be taken outside the specialty or in research
Radiotherapy	**4**	*4*	*2*	**6**	1 year GPT outside "clinical oncology" + 3 yrs BST + 2 yrs HST
Renal Diseases	**4**	*2	*4*	**6**	
Respiratory Medicine	**4**	*2	*?*	**?**	Separation in HST of training for those pursuing an interest and those specialising is not "useful"
Rheumatology	**4**	*2	*4*	**6**	
Thoracic Surgery	**5**	*2*	*5*	**7**	"Sub-specialty training" will follow as suitable experience after the UKCCST.
Tropical Medicine	**4**	*2	*4*	**6**	
Venereology	**4**	*2	*4*	**6**	
Urology	**5**	*2*	*5*	**7**	"Sub-specialty training" will follow suitable experience after the UKCCST.

Department of Health, HCD-MME: November 1992 - Refer to Report of Sub-Group to CMO Working Party on Specialist Training

Notes Referring to Table 1

* Currently 3 years. The minimum period required for General Professional/Basic Specialist Training in specialties related to "Medicine" will soon be shortened from 3 to 2 years. However, possession of the MRCP(UK) will be included in the criteria required for admission to Higher Specialist Training and before appointment as a career registrar. Arrangements are in hand to incorporate all registrar posts within HST programmes supervised by the JCHMT .

1 The designations currently used in the UK which correspond to the specialist training courses as identified in the relevant EC Directives.

2 "UKCCST": **United Kingdom Certificate of Completion of Specialist Training** as issued by the competent authority recognised for this purpose - refer to *Article 5(2) EEC75/362.*

3 Unless otherwise stated these minimum training times exclude any provision for research.

4 The minimum times presented are for certification for a single specialty - different arrangements would pertain for dual certification.

5 A number of specialties are not mentioned in the Directives in respect of the UK; eg Accident and Emergency, Clinical Genetics, Medical Oncology, Palliative Medicine, Rehabilitation Medicine, Spinal Paralysis, Transfusion Medicine, Vascular Surgery, Forensic Psychiatry, Psychotherapy, etc. - arrangements relating to the conditions for training for such specialties are addressed in *Article 8 EEC75/362.*

6 Recommended or proposed by royal colleges or their faculties.

Annex

Summary of the Information

Provided by

Royal Colleges, their Faculties and by Postgraduate Deans

(Presented in the order that the Sub-group met with representatives)

THE ROYAL COLLEGE OF ANAESTHETISTS

Duration of training (see Table 1)

- 4 years basic specialist training
- 2 years higher specialist training
- 6 years minimum

European requirement (see Table 1)

- Minimum 3 years

General professional/basic specialist training

- 1 of the 4 years may be spent other than in anaesthetics, might include research or experience in other specialties and may be taken at any time.
- entry possible after full registration or equivalent.
- initial emphasis on acquiring a thorough grounding in basic medical sciences.
- the three parts of the Fellowship Examination are taken during this phase.

Higher professional training

- arrangements are under review.
- entry on completion of BST and by acquiring the Fellowship.
- second of the two years permits either in depth experience of general anaesthetic practice or opportunity to develop an interest in specialist practice.

Exit assessment

- after six year course would be eligible for *"UKCCST"* or its equivalent
- supervision and regular assessment by college tutors and advisers is a feature of the programme.

Career alternatives

Other comments

- concern that training has been unnecessarily prolonged
- supervised training in each hospital and local training committee normally established.

THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

The following points regarding training for general practice were raised in discussion:

- separate EC Directives apply to general practice;
- training for general practice is a planned experience;
- initial moves to introduce training started in the mid sixties and training was originally conceived as a five year programme - 2 years in hospital and three in practice. In the event, primarily because of resource constraints, training was confined to a minimum of three years - ordinarily two in approved hospital posts and one as a trainee in practice;
- in 1973 responsibility for advancing voluntary programmes in general practice passed to regional postgraduate committees and this structure enabled GP trainer, adviser and course organiser appointments;
- the 1977 NHS Act led to the introduction of Statutory Instruments regulating the provision for mandatory vocational training as a pre-requisite for appointment as a principal in general practice. A statutory body was established The Joint Committee on Postgraduate Training for General Practice (JCPTGP);
- assessment is currently under review since completion by "attending" the required training programme is not deemed adequate. Both formative and summative assessment are being considered;
- programme organisers are encountering difficulties in ensuring that the period of hospital experience meets their requirements;
- vocational training (VT) programmes are flexible - there are various approaches that doctors may take in planing their career to meet the requirements of the JCPTGP - both "equivalent" and "prescribed" experience is accepted;
- agreement that the SHO should remain pluri-potential;
- investment in training trainers is given a high priority; and
- agreement that doctors wishing to pursue a career in hospital medicine would benefit from a period in general practice but principal block is securing an administrative arrangement to fund such experience.

THE ROYAL COLLEGE OF PATHOLOGISTS

Duration of training (see Table 1)

- 5 years minimum

European requirement (see Table 1)

- Minimum 3 years

General professional/basic specialist training

- there is no common trunk in pathology training and an early commitment to the branch of pathology is made.
- distinction between basic and higher specialist training is not so relevant.
- one year's clinical experience is required before entry to training and the pre-registration year is acceptable.
- a flexible and challenging educational programme is offered which can accommodate individual needs, eg research.
- requirements for Part I of new MRCPath are a minimum of 2.5 years spent in the subject examined and three years in the discipline. Experience in other training programmes may be accepted.

Higher professional training

- Requirements for Part II MRCPath are five years full time approved training, two years of which are in posts recognised for higher specialist training and four years in the branch of pathology chosen.

Exit assessment

- College recommends the *"UKCCST"* may be awarded after 4 years training in pathology and on passing Part I of the new MRCPath.

Career alternatives

Other comments

- concern re accommodating EC Directives *(see para 62)*.
- importance of providing an academic pathway.

THE ROYAL COLLEGE OF RADIOLOGISTS
Faculties of Clinical Radiology and Clinical Oncology

Duration of training (see Table 1)

- 1 year clinical practice outside of specialty
- 3 years basic specialist training as registrar
- 3 years higher specialist training as Senior registrar
- 6 years total - minimum

European requirement (see Table 1)

- Minimum 4 years

General professional/basic specialist training

- competitive entry to both disciplines.
- many doctors have either MRCP(UK) and some have FRCS or MRCOG.
- different curriculum for both faculties but structured programmes are in place.
- fellowship taken before entry to higher training.

Higher professional training

- where relevant enables subspecialty experience.
- regular college programme of visits to training programmes and teaching departments.

Exit assessment

- Fellowship plus regular appraisal of progress.

Career alternatives

Other comments

- all training is within the registrar grades in radiology
- concern that harmonising with EC may be difficult since training here is ordinarily longer.
- clinical oncology is a small specialty and size does not make it easy to plan programmes to accommodate manpower requirements.

THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

The College is actively reviewing it arrangements for training with a view to introducing more structured training programmes. This process has not yet been concluded.

Duration of training (see Table 1)

- 4.5 years basic specialist training
- 2 years higher specialist raining
- 6.5 years - minimum

European requirement (see Table 1)

- Minimum 4 years

General professional/basic specialist training

- one year of elective experience outside the specialty is included as a requirement within this period
- MRCOG examination can be concluded about 3.5 years (minimum) from registration

Higher professional training

- entry requires MRCOG

Exit assessment

- "UKCCST" would be equivalent to accreditation.
- role of MRCOG is under review.

Career alternatives

Other comments

- further experience in O&G subspecialties would be required post conclusion of formal training.
- interest in developing various strategies for formative assessment.

THE ROYAL COLLEGE OF PSYCHIATRISTS

Duration of training (see Table 1)

- 3-4 years basic specialist/general professional training
- 4 years higher specialist training
- 7-8 years total - minimum

European requirement (see Table 1)

- Minimum 4 years

General professional/basic specialist training

- possibility of having one year outside the specialty is recognised
- development of structured planned training schemes.
- supervised progress of trainees
- require to pass part I of MRCPsych before appointment to registrar grade.

Higher professional training

- 4 year programme as SR although many consultant appointments are made after three years.

Exit assessment

- no accreditation: either complete 4 year programme or gain consultant appointment.

Career alternatives

Other comments

- accreditation procedures will require to be examined in light of EC Directives.
- system of well developed structured training programmes, supervisors and regular college visits to evaluate standards.
- training prolonged because of manpower difficulties in getting SR appointments.
- EC comparisons for shorter training periods are misleading.
- target duration for training is 5 - 6 years.

THE ROYAL COLLEGES OF SURGEONS
(proposed arrangements)

Duration of training (see Table 1)

- 2 years of core (common trunk) in surgical posts followed by 5 years of specific specialist training (4 years for Ophthalmology and ENT).
- total 7 years (6 for Eyes and ENT) starting after full registration.
- structured programmes in place or are being introduced.

European requirement (see Table 1)

- Minimum 5 years (3 for Eyes and ENT)

General professional/basic specialist training

- no specific entry requirement - influenced by performance during pre-registration year.
- four six month intensive training posts at SHO level

Higher professional training

- entry requirement . in-course (log book) assessments (possible)
  . college examination (under revision)
- competitive entry.
- annual assessment through course reports, interviews, log books, etc.
- opportunity for a period in research.
- limited amount of non-surgical experience encouraged.
- proposed five years in approved posts or programmes.
- preference for a single "run through" grade with progress identified by year in training.

Exit assessment

- fifth year Intercollegiate Assessment in trainee's specialty
- this Assessment + 5 years' higher training necessary for Colleges to recommend award of *"UKCCST"*.

Career alternatives

- would require another year's sub-specialty experience to work at sub-specialty level.

Other comments

- clinical competence is an imperative and would not be compromised by delivering training programmes of "minimum duration".
- monospecialty training - concern re adequacy of general experience
- programmes need to provide for those wishing to undertake research.

THE COLLEGE OF OPHTHALMOLOGISTS

Duration of training (see Table 1)

- 2 years at SHO grade.
- 4 years as higher surgical trainee.
- total 6 years - minimum

European requirement (see Table 1)

- Minimum 3 years experience

General professional/basic specialist training

- 2 years as SHO within the specialty

Higher professional training

- at present registrars hold FCOphth or FRCS (ophthalmology)
- would prefer entry examination for higher training to be a modified ie Fellowship examination leading to an MCOphth
- would prefer to introduce a single training grade with structured training and continuous assessment.
- a research year is optional.

Exit assessment

- higher training continuously assessed resulting in the award of FCOphth
- alternatively award of *"UKCCST"* might be: MCOphth and six years' training of which four years would be as a higher trainee.

Career alternatives

Other comments

- practice of continental specialists does not equate to British consultant (see main text *(see para 62)*.
- requirement to train a significant cohort of staff grade or equivalent to undertake out-patient work.
- desperate need for more trainers before specialty could be expanded.
- different structure for diploma examinations in other surgical colleges compared to that proposed by College of Ophthalmologists.
- for doctors not progressing to consultant - 2 years as SHO, 2 years in higher specialist training plus 2 years in a non-consultant career grade could lead to the award of *"UKCCST"*.

THE COMMITTEE OF POSTGRADUATE MEDICAL DEANS AND THE UK CONFERENCE OF POSTGRADUATE DEANS

Points raised in discussion by postgraduate deans who:

- share disquiet at the pace of change but welcome the opportunity to improve the provisions for postgraduate education. Deans are united in their commitment to meet this challenge.
- are aware of the need to balance training and service and of the importance of reducing the length of training while at the same time not compromising standards.
- see postgraduate education as part of a continuum - it should not be considered in isolation.
- are aware that at the beginning of postgraduate training a significant minority of trainees have not determined what their chosen specialty will be. Training programmes must reflect this. Therefore the initial phase of training must provide flexibility, be broad based and enable opportunity for change in career.
- feel that appointments should be made to programmes - not posts (assures better standards for training)
- see merit in having a common model for training across specialties although this should not be prescriptive.
- see danger if shorter programmes mean more rigid programmes.
- recognise the colleges' primary role in approving programmes but identify local mechanisms to complement this, working to college guidelines.
- see the importance of providing structured training programmes which include provision for assessment, monitoring and feedback.
- emphasise that formative assessment is vital and that PG deans have a significant role in ensuring that it is appropriately applied to all doctors in training
- recognise the importance of counselling those who are failing to make adequate progress.
- recognise the importance of investing in training trainers and question whether every consultant should be a trainer or only those so recognised.
- suggest that post award of *"UKCCST"*, doctors will not be formally in training and will have to develop their career through some form of continuing education
- recognise that they (deans) will be able, though their responsibility for part of training grade salaries, to influence the opportunities for training.
- see value in colleges and deans developing an effective local *modus operandi* to ensure that standards of training are met and welcome opportunities to discuss the matter further with colleges and faculties.
- agree that the number of "approved posts" in programmes is likely to exceed the training establishment if a range of training opportunities is to be available.
- agree that there needs to be procedures for "auditing" postgraduate education.

THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

Duration of training (see Table 1)

- two years minimum general professional training
- four to six years specialist training
- total six to eight years.

European requirement (see Table 1)

- Minimum 3 - 5 years

General professional/basic specialist training

- would prefer opportunities to encompass a range of specialties although emphasis is on gaining general medical experience

Higher professional training

- would prefer a better success rate in the membership examination which governs entry to higher specialty training

- aim is to produce a generalist with a "specific interest" and there may be less need for further sub specialty training/experience.

Exit assessment

- *"UKCCST"* should indicate specialist training but doctors should be able to pursue further experience.

- some form of assessment is required - merely completing the minimum period required to satisfy the award of the Certificate is not sufficient.

Career alternatives

-

Other comments

- see *(see paras 44, 45 and 62)* and problem re dual accreditation.

THE ROYAL COLLEGE OF PHYSICIANS OF LONDON

Duration of training (see Table 1)

- 2 years general professional training (minimum from 1.1.93)
- 4 years higher specialist training
- total 6 - 8 years.

European requirement (see Table 1)

- Minimum 3 - 5 years

General professional/basic specialist training

- Education committee recommends formal structured programmes administered by College Tutors at district level.
- SHO posts assessed by the College
- point of entry is from pre-registration year
- training reflects essential "generalist" foundation not only for medicine and it many specialties but also for other disciplines
- unrealistic to make specialty choice early in doctors career hence is regarded as pluri-potential

Higher professional training

- entry criteria include MRCP(UK) or in some circumstances MRCOG or FRCS
- training has been recently reorganised
- all registrar posts will offer training in a specialty with experience received both at DGHs and major centres.
- there should be opportunity to train in more than one discipline.
- assessment will take place at least at the end of the first and fourth years of training.
- welcomes idea of trainees holding a "number" - immediate introduction of unified grade may not be practicable as grades not yet "in balance".

Exit assessment

- preference for local assessment and interview (involving PG deans) rather than an examination
- award of UKCCST and/or accreditation at the end of appropriate period of training with a satisfactory assessment.
- arrangements should accommodate individuals who are capable of appointment as consultant but whose career pathway does not accord with that required for accreditation.

Career alternatives

Other comments

- number of trainees not in balance with number of consultant posts.

THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
(Medicine)

***Duration of training** (see Table 1)*

- 3 years core/GP training (being reduced to 2 years minimum)
- 3 years internal medicine) 2 years reg
- 3 years in a specialty) 4 years SR
- total 8-9 years plus.
- physician with a specialty interest could be shorter.
- training for dual accreditation could appreciably lengthen training

***European requirement** (see Table 1)*

- Minimum 3 - 5 years

General professional/basic specialist training

Higher professional training

- support for single higher training grade
- assessment based on annual assessment - reports from supervisors coupled with career advice.
- flexibility in training arrangements important to retain

Exit assessment

- Satisfactory reports lead to certification/accreditation. There may be a need to develop an examination?

Career alternatives

Other comments

- EC should not move to lengthen the minimum period of training already stipulated
- need to clarify how far training in one specialty can count towards certification in another - dual certification. *(see paras 44,45 and 62)*
- Will posts requiring "physician with a special interest" require dual certification and will EC doctors without this experience be prevented from applying?

- (Surgery) The College is in accord with the other surgical colleges.
  Note move to develop surgical examinations (intercollegiate and reflecting specialty interests)

THE FACULTY OF PUBLIC HEALTH MEDICINE

Duration of training (see Table 1)

- 2-3 years of general professional training, 1-2 years academic course/research, 3-4 years higher professional training.
  Total 7-9 years.
- Education Committee is SAC of JCHMT. Training is planned

European requirement (see Table 1)

- Minimum 4 years experience
- Public Health as a specialty exists only in the UK, Ireland and France.

General professional/basic specialist training

- two years in hospital or general practice posts, 1 year in public health medicine posts or in academic course leading to MSc or PtI MFPHM.

- since UG and PRHO year do not provide adequate base PG clinical experience is valued.
- advantageous to have more than minimum general medical experience.

Higher professional training

- require part 1 of Membership of Faculty of Public Health Medicine exam for senior registrar posts (however, there is no automatic promotion fro Reg to SR) Note also some entrants may have MRCP/FRCS etc.
- training in approved posts as senior registrar, lecturer or research fellow
- variety of routes through training are available. Part-time posts acceptable for accreditation. Research is encouraged
- prefer to keep distinction between registrar/senior registrar posts

Exit assessment

- Part 2 of MFPHM exam, and completion of 4 years' higher specialist training before accredited. Examination is not perceived as an exit examination

Career alternatives

Other comments

- importance of acquiring appropriate level of clinical experience before entry to the specialty.

- Premature appointment of candidates to consultant posts before completion of specialist training ("shortage specialty")

THE BRITISH PAEDIATRIC ASSOCIATION

Duration of training (see Table 1)

- 2 - 3 years rotational training as an SHO mainly in paediatrics
- 7 years higher professional training
- 9 - 10 years total.

European requirement (see table 1)

- Minimum 4 years.

General professional/basic specialist training

- experience of range of paediatric practice including community and general practice. Rotational programmes are popular
- structured programmes provide study time and opportunities for appropriate training.
- Part I MRCP(UK) by end of year 2 and would prefer the examination to be complete by the end of year 3. (Difficult to get PtI within 2 years)
- move to develop a paediatric version of the "Membership" examination
- paediatric experience is essential since UG & PRHO provide insufficient experience on which to base a training programme.

Higher professional training

- MRCP(UK) required for entry
- first part: rotational programme between DGHs and teaching hospitals or other specialist units ending in a formal review of trainee.
- second part: competitive entry to approved posts
- research is important and may in part be accommodated within training period
- need for "further experience" to become "sub-specialist"

Exit assessment

- should enrol for accreditation at first or second part of HPT
- accreditation gained by completion of appropriate experience - some form of assessment a possibility

Career alternatives

- possible moves to enable a career mostly in the community paediatrics

Other comments

- need for more consultant posts (specialty is growing and is currently a "shortage" specialty - there are recruitment problems) and for more trainees to reduce pressure on posts and make them more attractive to candidates.
- need for a higher proportion of time for teaching
- concern re EC paediatric practice not being equivalent to UK (*see para 62*).

THE FACULTY OF OCCUPATIONAL MEDICINE

Duration of training (see Table 1)

- 3 years general professional training after pre-registration year
- 4 years higher professional training in the specialty
- 7 years total

European requirement (see Table 1)

- Minimum 4 years

General professional/basic specialist training

- 3 - 4 years - candidates often have MRCP or MRCGP - various backgrounds
- 3 years clinical experience valued but may in part be in general practice

Higher professional training

- training mostly outside NHS in an approved post - hands on and supervised
- the Associate is awarded by examination after 2 years
- Membership on submission of a dissertation after a further 2 years
- annual reports are required from trainers.
- propose that UK cert. of completion of specialist training would equate to award of MFOM.

Exit assessment

- requires Membership or submission of dissertation to get accreditation.

Career alternatives

Other comments

- clinical experience before entry to the specialty is valued.
- concern that UK is more stringent in training requirements (training is also longer) than rest of EC.

THE FACULTY OF DENTAL SURGERY
(Maxillofacial Surgery)

Duration of training (see Table 1)

- Undergraduate: Registration in both medicine and dentistry is required. 4-5 years basic dental education plus 4-5 years basic medical education (some allowance may be made but depends on the particular university). Majority enter by taking a dental degree first.
- Postgraduate:
  2 years core training (1 year surgical, 1 year dentistry) but most fulfil more than the minimum
  5 years specialty training including 4 years higher specialty training
  7 years minimum

European requirement (see Table 1)

- Minimum 4 years for accreditation

General professional/basic specialist training

- most undertake more than the minimum time required for core training

Higher professional training

- 5 years specialty training with 4 years in higher training programme
- supervision by an intercollegiate assessment board

Exit assessment

- accreditation after completion of training
- possibility of making passing intercollegiate part III FRCS necessary before appointment as a consultant.

Career alternatives

Other comments

- concern over duration of training.
- note different Dental Directives also apply.

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