

A curriculum for SHO training – what is it and why has it changed?

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Abstract: The Royal Colleges of Physicians have revised the core curriculum for SHOs in medicine and the medical specialties to make it objective based. The objectives, knowledge, skills and attitudes for ‘core skills’ use ward based and outpatient clinical scenarios in specialty areas. There are also important sections on ‘generic skills’ including communication skills, team-working skills etc., cross-specialty areas, training in practical procedures and selection of investigations.

Only in up to 41% of posts do SHOs in medicine get regular appraisal. A new appraisal replacing the personal training record has been designed to help SHOs reflect on their experience and identify gaps in their training using the revised curriculum.

The new edition of the core curriculum should also allow the RCPs to set standards on the assessment of competence of SHOs to inform the postgraduate deans’ SHO RITA process.

Introduction

The Bristol cardiac surgery affair, poorly performing gynaecologists and the dreadful case of Harold Shipman have generated calls from politicians, the public and indeed the medical profession for greater accountability^{1,2}. At the same time, the shift in emphasis of the chief executives’ role away from predominantly financial responsibility towards responsibility for clinical effectiveness, ‘clinical governance’, has led to a review of training, appraisal and assessment of competence at all grades.

The universities supervise preregistration house officer training and the Joint Committee on Higher Medical Training of the Royal Colleges of Physicians (JCHMT) supervises specialist registrar training on behalf of the Specialist Training Authority (STA). The STA views medical senior house officers’ (SHO) training as part of GIM specialty training and has nominal responsibility for it, but despite this, SHOs remain a ‘lost tribe’^{3,4}. Standards for SHO training are set by the Royal Colleges of Physicians (RCP) and the postgraduate deans are responsible for the delivery of this training. The SHO training programmes are accredited by the RCPs on behalf of the STA.

Changes are afoot in SHO training in medicine. Welcome reductions in hours of work, and the less welcome introduction of shift systems coupled with relentless increases in service demands, have made SHO training in medicine increasingly difficult to deliver⁵. There are problems with both the quantity of training, including access to enough experiential learning, and the quality of SHO training. A study of a London district general hospital in 1999 demonstrated that despite lighter rotas, SHOs continued to get exposure to common medical conditions⁶. However, for many years medical education for SHOs has suffered from ‘post code’ variation similar to that for prescribing for patients with cancer⁷.

The MRCP examination has served as a method of summative assessment of SHOs since 1859⁸. In 2001 the introduction of ‘PACES’ will change the clinical exam to a more objective and modern method of assessment⁹. The MRCP examination will remain a yardstick in the process of assessing knowledge and clinical examination skills for SHOs. An innovative distance learning package, the ‘Medical Masterclass’, which has CD-ROM and web-based elements is being developed by the RCP London to help SHOs study for the MRCP.

However, attaining the MRCP is not a guarantee of achievement of all the skills required for higher specialist training, general practice training, consultant 2000 or even perhaps of being a good doctor. In 1996 Professor John Wass, the previous Linacre Fellow of the Royal College of Physicians, introduced a core curriculum for SHOs in general (internal) medicine which underwent minor revisions in 1997¹⁰. A personal training record (‘Blue Book’) for SHOs was produced in 1998 to record appraisal¹¹. This book gave guidance on the role of appraisal as well as forms to complete which included agreed learning objectives.

These documents were revolutionary, as it was the first time that the College had produced any detailed information about its expectations for SHO trainees and trainers. The College was making explicit the standards for SHO training that had previously been implicit. However, it is difficult to draw up criteria for assessment from the 1997 curriculum. Moreover, critics of the document say that the breadth of subjects listed is daunting and unrealistic^{12,13}.

In 1999 a re-drafting of the curriculum was necessary and in another revolutionary step the Royal College of Physicians in conjunction with its two sister Colleges in Scotland appointed a specialist registrar for a six month secondment to assist the re-write.

What is a curriculum?

In educational terms a curriculum is a system of planned activities intended to bring about specific learning outcomes¹⁴. It is broader than a syllabus, which is simply a list of learning topics, and includes aims, objectives, teaching and learning methods as well as guidance for assessment and evaluation.

In practical terms it outlines the training that SHOs should receive in knowledge, skills and attitudes. A curriculum is not meant to restrict learning, and indeed the curriculum experienced by SHOs may differ from the planned curriculum because of differences in case-mix or specialty.

A curriculum based educational programme for SHOs has been used successfully across five specialties in a district general hospital in the North West¹⁵, and the British Geriatrics Society has developed training objectives for SHOs in geriatric medicine¹⁶.

Process for rewriting

When the process of rewriting the SHO curriculum began, the Specialist Advisory Committees of the JCHMT were already reviewing the SpR curricula to make them more objective based. A similar structure was used for the SHO curriculum. A committee was set up with representatives from the three Colleges of Physicians and the postgraduate deans. Educational advice was given by the Head of Education at the RCP in London. Relevant sections of the draft curriculum were circulated to their respective specialty advisory committees for comment. Occasional conflicting advice was received, particularly in the grey area describing what is appropriate core training for an SHO as distinct from a specialist registrar. The steering committee ensured cross-specialty consistency in this area.

Structure of the third edition

Throughout the new curriculum the knowledge, skills and attitudes are defined for each learning objective.

The largest part of the curriculum covers the 'core skills'. To simplify the document and prevent it from being too weighty and, importantly, to allow the curriculum to be a basis for more rigorous assessment of competence, objectives have been carefully defined for these 'core skills'. The curriculum is divided into specialty areas such as cardiology, gastroenterology etc, and within each section there are objectives for common problems which might be encountered by SHOs 'on take', on the wards or in the outpatient department. These should apply to all SHOs and be achieved by the end of their general professional training.

Also listed for each specialty are additional topics that SHOs might encounter whilst in the specialty. These constitute extra

Key Points

SHO training needs review.

A revised core curriculum for SHOs in medicine and the medical specialties which is objective based, and outlines the knowledge, skills and attitudes that SHOs should acquire, has been developed.

Only 40% of SHO posts include regular appraisal. A new appraisal portfolio based on the revised curriculum has been produced.

The revised curriculum gives an opportunity to develop assessment of competence for SHOs.

learning opportunities which are useful but not part of the essential core learning package, and may be revisited by SHOs when receiving higher training as a specialist registrar.

There is also a very important section on 'generic skills' including communication skills and team-working skills. It has been suggested that these skills are innate and cannot be learnt. However, there is increasing evidence that this is not the case, at least for communication skills¹⁷. Poor communication affects patient outcomes¹⁸, the well-being of health care professionals¹⁹ and forms the basis of many of the complaints within the NHS²⁰ and makes litigation more likely²¹. It is therefore imperative that SHO training in this area improves.

The new curriculum also gives guidance on training in practical procedures selection and interpretation of investigations.

To give guidance on how training and assessment should be delivered, learning opportunities and methods of assessment have been suggested.

SHO appraisal folder

Appraisal is defined by the chief medical officer as 'a positive process to give someone feedback on their performance, to chart their continuing progress and to identify development needs'. It is a forward-looking process essential for the developmental and educational planning needs of an individual²². Appraisal at work can benefit both the employer and the employee²⁰.

Despite the introduction of the personal training record ('Blue Book')¹¹, SHO appraisal is patchy throughout the UK. An analysis of reports from RCP London External Assessor visits in 1999 showed that although 88% of SHOs are receiving the 'blue book', its use is variable and in only 41% of posts do SHOs get regular appraisal. These data are likely to overestimate the actual figures (unpublished data).

With the development of a new curriculum it was important also to strengthen the appraisal process. Individual SHOs need to produce personal learning plans for each post to aid the delivery of appropriate training. The personal training record has therefore been rewritten to become an SHO appraisal folder containing templates for personal learning plans.

In the appraisal folder there is a confidence rating scale based on the topics listed in the curriculum and space to reflect on critical incidents, difficult or interesting cases, audit experience and study leave. This document has been designed to help SHOs reflect on their experience and identify gaps in their training.

Formal 'log books' can improve appraisal. They have been used by doctors in training, including SHOs, with variable success^{23,24} and sometimes form part of the assessment process²⁵. The limitations of logbooks include poor compliance by SHOs (40% in one study), coupled with ambivalence on the part of educational supervisors²⁴. For physicians in training, a record of experience is not an ideal tool for assessment. Without tedious form filling and signing by both the SHO and the doctors supervising there are considerable difficulties in confirming the validity of the recorded data. Moreover, exposure does not equate to competence.

In view of these problems it was decided that a confidence rating scale should be used by the SHO to inform the appraisal process, by identifying training needs, and not as an assessment tool. Low scores on the confidence scales will demonstrate perceived areas of weakness. The new appraisal folder, containing the confidence rating scale and documentation for personal learning plans, will replace the personal training record.

Assessment of competence

The curriculum defines the minimum standard of knowledge, skills and attitudes that all SHOs should have achieved by the time they complete general professional training. The varied nature of SHO rotations and experiential learning does not allow definition of what should be achieved for all SHOs at a particular time-point. The Royal Colleges of Physicians will depend therefore on the experience of educational supervisors to know what is appropriate at each stage of SHO training. However, since these skills are fundamental to every day work the Royal Colleges of Physicians will expect all SHOs to achieve competency in them after 12 months of SHO training.

The postgraduate deans are introducing a RITA process for SHOs. To gain information on an individual SHO's progress, assessment of competence of each SHO will be required to feed into this process. It is envisaged that assessment of all SHOs in medicine and medical specialties will be done in the workplace by continuous assessment of clinical skills, attitudes and behaviour together with a confirmation that the SHO has a practical understanding of the knowledge base. Whilst assessment of an SHO should co-ordinate throughout a post, more formal assessments on specific areas at relevant time-points may be appropriate. A document setting standards and giving detailed guidance for this process is currently being developed by the RCPs.

Summary

The third edition of the core curriculum for SHOs in medicine and the medical specialties identifies the detailed knowledge, skills and attitudes that need to be assessed to determine whether an SHO is competent. Using a self-assessment confi-

dence rating scale based on the new curriculum to develop personal learning plans in appraisal, SHOs will be able to identify, with their educational supervisor, their training requirements. By identifying and helping the minority of SHOs who are not progressing satisfactorily early in their career there will be greater job satisfaction for those SHOs, a safer environment for patients and clear demonstration to the public that the profession takes these issues of competence seriously.

We hope that the revised core curriculum will improve SHO training in medicine and medical specialties and consequently improve the care of patients.

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