The Shape of Training – a flexible friend?

The independent review *Shape of Training* has recently reported.[1] Prof David Greenaway's report was commissioned by a consortium comprising Medical (now Health) Education England, corresponding bodies from Scotland, Wales and Northern Ireland, the General Medical Council, the Medical Schools Council, postgraduate deans and the Academy of Royal Colleges. Its subtitle, *Securing the future of excellent patient care,* may be regarded as either ambitious or anodyne.

The immediate message of the report – certainly the one that will be most carefully scrutinised by trainees and those that are at early stages in their careers – is that continuing generalist service in broad areas of medical practice (the report offers patient care themes such as women's health, child health and general surgery as exemplars) must be provided by virtually every trained doctor. The required expertise, attesting to the ability to perform without clinical supervision but in multi-professional teams, will be documented by achievement of a 'Certificate of Specialist Training' (CST), reached after 2 years of foundation training and 4 years of broad-based specialty training. The report thus chimes with the Royal College of Physicians' direction of travel outlined in the Future Hospital Commission report.[2] There are other, more subtle, recommendations, including a shift in the timing of full registration from halfway through the foundation years to the time of graduation. And trainees should be able to shift from one career aim to another during the period of basic specialty training, carrying recognition of relevant skills with them rather than going back to the starting post (the flexibility referred to above).

Working through the implementation of this approach opens up a myriad of implications. Those doctors planning their careers will be particularly sensitive that 'way-marking' generalists capable of working without clinical supervision raises (though the report does not advocate) the possibility of a 'sub-consultant grade'. Others will certainly debate that at length. However, the implications of deferring acquisition of and credentialing in subspecialty skills until a CST has been acquired are wide-ranging. The ability to acquire such skills will depend on an acquiescent employer – who may or may not see the benefits of this, depending on local and regional considerations. The time to perfect subspecialty skills and acquire competence will be affected by the continuing commitments to generalism; this anxiety has been notably strongly expressed by communities such as the neurologists and dermatologists. In view of the evidence – acknowledged by the report – that specialist care may provide better outcomes than generalists, is there a likelihood that quality care 'at the top end' will be damaged?

One hopes not. Other recommendations of the report should mitigate this. Some, such as that training should be concentrated in locations with the commitment and the skills to carry it out properly, are welcome and overdue. Academic medicine comes out of the report well. It is recognised as vital, with flexible pathways of exit and entry from standard training. Perhaps most importantly for the 'top end' of specialisation is the acknowledgement that this group may well practice only in their specialist areas, without continuing generalist commitment. No wonder the report was appropriately welcomed by the Academy of Medical Sciences.[3]

Previous editorials have commented on the numbers of recommendations that recent reports on provision of medical care have produced. This report is to be commended on its continence in this regard, with fewer than 20 formal recommendations, covering not only the issues alluded to above but, for example, the necessity for careers advice in medical schools, patient involvement in training and education, revision of curricula and appropriate structuring of continuing professional development. It is a huge agenda, to be delivered over a decade or more. It is depressing to observe that the timeline for implementation foresees the period in which there is a systematic way of managing medical workforce numbers as being in '5–10 years and beyond'. It is salutary to note that an early starting point in the report is the listing of the six major inquiries into the structure of medical education that have been produced in the last 10 years.

How will this report's recommendations be translated into action? Perhaps understandably (for an independent report commissioned by a number of sponsors) this remains ambiguous. Twelve of the 19 recommendations commence 'Appropriate organisation must, or should. . . .' So the nineteenth recommendation becomes the most important – setting up a UK-wide delivery group. If that becomes an effective instrument perhaps the report will indeed have made a major contribution to securing the future of excellent patient care.

References

1 Shape of Training. *Securing the future of excellent patient care.* London: Shape of Training, 2013. www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf [Accessed 3 December 2013].

2 Future Hospital Commission. Future hospital: Caring for medical patient. London: FHC, 2013. www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf [Accessed 3 December 2013].

3 Academy of Medical Sciences. *Response to the 'Shape of Training review' report published by Professor David Greenaway.* London: Academy of Medical Sciences, 2013. www.acmedsci.ac.uk/download.php?file=/images/pressRelease/Academyr.pdf [Accessed 3 December 2013].

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