sequence is unique for each individual. This image reflects the modern image of the College and its Journal.

ROBERT ALLAN

Reference

1 Goldie M, Wokler R (eds). *The Cambridge history of eighteenth-century political thought*. Cambridge: Cambridge University Press, 2006.

Professor W Ian McDonald

Professor W Ian McDonald, an ambassador for British neurology, a world authority on multiple sclerosis and a musician, died suddenly on 13 December 2006. He was a friend to many in all walks of life and was a valued member of the Editorial Board. We had made plans together for a series of articles in the Journal on music, medicine and the mind. His co-editor, Dr Jason Warren, has kindly agreed to develop the series which will be dedicated to Ian McDonald's memory.

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Modernising Medical Careers and the birth of postgraduate specialty schools of medicine

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Introduction

Across the UK new bodies, to be called the postgraduate specialty schools, are being established to manage postgraduate specialty education. These structures, which reflect the development of mature postgraduate programmes, fuse the functions of the Royal Colleges and the postgraduate deaneries to the potential huge benefit of specialist education. All physicians, at training and career level, will be affected by the new structure which could realise the brightest hopes for Modernising Medical Careers (MMC).

Modernising Medical Careers

Unfinished business,[1] the Chief Medical Officer's report on proposals for the reform of the senior house officer (SHO) grade, recommended that all postgraduate medical education should take place within programmes designed primarily for education. This proposal received general support from the medical profession through feedback from Royal Colleges, deaneries, service delivery bodies, specialist societies and university medical schools. The subsequent white paper entitled *Modernising Medical Careers* crystallised this idea with a two phase introduction of these programmes.[2] Phase one was the introduction of a two-year foundation programme, which added a second generic year to the pre-registration house officer (PRHO) year. Phase two merged the SHO grade with the specialist registrar (SpR) grade, to create new run-through grade (RTG) specialty training programmes. These reforms were a logical evolution of the 1996 Calman reforms to specialty training, which, following comprehensive evaluation, were deemed a success.[3] In 2005, foundation programmes were established in all deaneries across the UK. Reformed specialty programmes have now been established, and are currently recruiting, for foundation graduates to enter in August 2007.

Why was change needed?

Some commentators have complained that all this reform is quite unnecessary. Why 'fix' an essentially well functioning system? UK postgraduate medical education is, after all, the envy of the world and has produced many of the best specialists. It would be true to say that, for forty or more years, the apprenticeship model of postgraduate education did seem generally effective, but the working and training environment has changed. In the past, the exposure of trainees over 100-hour weeks to many clinical cases, more or less well supervised (depending on the firm) did seem to allow the gradual accumulation of confidence and, in the main, competence. Today, however, the NHS is different. Patients demand to be

cared for by someone of proven ability. The European Working Time Directive limits working hours, and the current intensity of clinical activity certainly would render a 100-hour week unsafe. The demands of clinical governance require that chief executives be satisfied that those who work in their trusts are competent to the level at which they practise. Cost pressures have led to consideration of workforce re-profiling, which clarifies thinking around the role of the doctor. Furthermore we now understand much better how learning takes place, and how clinical teachers can best support trainees in achieving the knowledge, skills and qualities of an independent practitioner. There is a general consensus that an *ad hoc*, opportunistic approach to the postgraduate training of doctors is no longer reliable. In my first SHO job I turned up at the weekly diabetic clinic, did not meet my consultant, received no guidance as to how one managed outpatients, was given thirty sets of notes and got on with it. It was four weeks before I realised that the consultant was in another room down the corridor doing exactly the same thing. Was this apprenticeship? This was a common experience in those days, and of course there have been vast improvements to postgraduate education in recent years. MMC seeks to embed these improvements in a coherent and properly managed education programme structure for all doctors in training grades.

What is an education programme?

An education programme is more than a rotation. A programme is structured and managed, has a programme director, and is based on a clear curriculum which specifies the assessments necessary to confirm achievement. It incorporates a structured series of service and learning experiences, is responsive to individual trainee needs, is delivered by competent trainers and is time limited. An educational programme will include specific educational components, notably meaningful and regular appraisal to support trainee progress and quickly to identify and remedy weaknesses. Programmes fairly and transparently recruit trainees and are expected to monitor the quality of their education against clear standards. It is apparent from this list of functions that programmes need sound management and administration. This management, in the world of MMC, is delivered through schools of education, first the foundation schools and now the specialty schools.

Foundation schools

There are 26 foundation schools in the UK to manage the foundation programmes. Each has a programme director and a structure based on a number of hospital trusts and primary care trusts (PCTs). Each school is accountable to the local postgraduate dean. The programmes deliver the national foundation programme curriculum, which specifies the competencies expected of a foundation graduate and the assessments required to inform judgements of competence. Foundation schools deliver the functions of medical education programmes listed above, and are subject to inspections, currently carried out jointly by the Postgraduate Medical Education and Training Board (PMETB) and the General Medical Council (GMC).

The development of run-through grade specialty training

Since the Calman reforms, SpRs have been recruited by deaneries and trained in programmes based in hospitals and PCTs. Consultant supervisors provided evidence to the record of in-training assessment (RITA) panels supporting or obstructing trainee graduation as certificate of completion of specialist training (CCST) holders, and the specialist training authority (STA) issued certificates upon recommendation from deanery and Royal College. Quality assurance of training was provided by infrequent Royal College visits and parallel, and usually more frequent, monitoring within postgraduate deaneries. The routine collection of quality assurance data within deaneries has, however, been patchy. Within deaneries, specialty training committees (STCs) have been led by committed senior consultants, usually without a clear job description, but the above listed functions of programmes could not always be met.[3]

SHOs were usually appointed by trusts, who were often seeking experienced doctors to support services. Those appointed were often doctors who had not progressed to higher specialty training but who did not need further SHO level training. Sometimes poor recruitment practice was used. In most cases, SHO education lacked a coherent programme structure although in trust-based rotations SHO education has often been of very fine quality, as judged by five yearly Royal College visits.

Now, as RTG programmes merging SpR and SHO education are established we have the opportunity to learn from our experience of the SpR and foundation programmes, incorporating the best of educational practice into new programmes which will place education at the forefront of every trainee doctor's working day.

After foundation training, doctors will compete for places in specialty training programmes. In medicine the first two years will deliver core medical training (CMT) to level one of the new general internal medicine (GIM) (acute) curriculum.[4] Those in RTG programmes will, if they pass annual progress reviews, move seamlessly through to receipt of a certificate of completion of training (CCT) and eligibility for appointment as a consultant. Others will train in fixed-term specialty training appointments (FTSTAs), also under the wing of the specialty school, but without the automatic right to move on to run-through training. Some will prefer this route, to prepare them for working in another specialty, and others will be able to apply to CMT year 2 placements which are being set up to exceed the previous year's CMT 1 numbers during the transition. It will have been a relief to many physicians to realise that there will essentially be no loss of medical SHO level posts in this reorganisation. SHO posts have generally been replaced by RTG, FTSTA or general practitioner training posts, and we are optimistic that there will be an overall growth in medical training posts in the next few years, as funding moves from less favoured,

especially surgical, specialties. After CMT the trainees in run-through programmes will move to train in one of the 30 or so specialties in medicine which can be fed from CMT, through an allocation process which will need to be centrally managed.

In 2005, the PMETB took over from the STA as the central body in the UK accountable for the quality of postgraduate education and the case for colleges and deaneries to join forces to deliver postgraduate education has never been clearer.

Postgraduate specialty schools

In November 2005, the Academy of Medical Colleges and the Conference of Postgraduate Medical Deans jointly produced a consultation document, *Developing local postgraduate schools*, proposing the establishment of deanery-based postgraduate specialty schools responsible for managing RTG training. These would fuse deanery responsibility with the education responsibilities of the relevant Royal College. The postgraduate schools, of for example medicine, surgery, general practice, and radiology, would be headed by directors appointed jointly by college and deanery and who would be dually accountable. School boards would include programme directors and Royal College advisers, NHS Employer representatives, lay representatives, and representatives of university medical schools. The specialty schools would ensure the delivery of all components of the specialty education programmes. The Royal Colleges would independently be responsible for producing curricula (to be signed off by the PMETB), for producing training portfolios, identifying programme entry criteria, for training the trainers, and for examinations and other assessments.

Postgraduate deaneries and Royal Colleges have adopted the new model with enthusiasm. In this deanery twelve postgraduate specialty schools have been established, heads have been appointed, and many initial board meetings have been held.

The West Midlands Postgraduate School of Medicine is headed by a director appointed jointly by the President of the Royal College of Physicians (RCP) and the regional postgraduate dean. The board includes all the deanery medical STC chairs, the Royal College regional adviser and deputy adviser, College tutor representatives, academic representatives, trust and trainee representatives and the newly appointed CMT director. Day-to-day school business is conducted by a management committee on which College and deanery representation is broadly equal. An early goal for the school is to engage the RCP tutors in the new RTG programmes in a more structured way than in the past, and CMT programmes are being established in geographical zones to allow local collaboration and governance. The board has established a CMT subcommittee, chaired by the RCP regional adviser and managed by the new CMT director, a physician with experience as a clinical tutor and a foundation school director, who will lead this early phase of run-through training and the implementation of the new curriculum for GIM (acute) at level 1. Lead College tutors will be identified within CMT zones to support him in this project. The board has also identified a need for a subcommittee for quality control (evaluation of programmes) and another for selection, recruitment and allocation from CMT year 2 into the specialties which are fed from CMT level. Faculty development and training for trainers in delivering the new curriculum, especially the workplace-based assessments, is also expected to be an early need.

In the past, UK postgraduate education has sometimes suffered from a fragmentation of responsibilities between deaneries, trusts and Royal Colleges.[3] The new postgraduate school structure offers a fusion which should remove such fragmentation and should be used to empower education in an NHS environment in which, many fear, education is under threat.

References

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