Clinical Medicine 2009, Vol 9, No 5: 441–3

Post-Certificate of Completion of Training fellowships

Andrew RL Medford

ABSTRACT – Postgraduate medical training has changed. There is a significant reduction in hours of experience and training time due to the European Working Time Directive, a relative lag in substantive consultant post expansion and a resulting 'bulge' of trainees joining the specialist register having attained a Certificate of Completion of Training (CCT). Until the necessary expansion takes place, it is therefore less likely that all post-CCT trainees will immediately acquire substantive positions. Traditional historical alternatives for career progression at this point have been a locum consultancy, a period of research or an overseas fellowship. This article discusses the pros and cons of another more controversial alternative: a post-CCT fellowship.

KEY WORDS: post-CCT fellowships, postgraduate medical training, workforce

Postgraduate medical training continues to evolve. Substantive consultant post numbers are lacking in a variety of specialties, including respiratory medicine, to accommodate the ever increasing number of trainees who achieved their Certificate of Completion of Training (CCT). Training time and hours accrued are also being shortened as a result of the European Working Time Directive (EWTD) and a 48-hour working week from August 2009. Although training is becoming competency based, there is a finite amount of time needed to acquire that competency, ie there will never be any substitute for experience based in time.

The Modernising Medical Careers Programme Board in 2007 allocated over 100 12-month post-CCT fellowships to provide extra training not covered in the curriculum but also to help reduce the specialty training (ST) trainee 'bulge' assisting in National Training Number (NTN) recycling. It was envisaged that these posts would provide an additional year of supervised specialised experience post-CCT in specialties where there was a strong need clinically and in terms of workforce. Mostly posts in surgical specialties have been awarded so far (about 80) but a few have been created in anaesthetics, obstetrics and gynaecology, psychiatry, radiology, paediatrics and more recently adult medical specialties including stroke medicine, gastroenterology and respiratory medicine. Other specialties have developed variations on this; for example, in neurology, the Association of British Neurologists Training and Education Committee is considering proposing six-month subspecialty fellowships with the possible help of some of the major neurological charities.[1]

Opinion about these posts among existing trainees is mixed. Many in current peri-EWTD programmes (ie around the time of EWTD changes) advocate an extension in standard higher specialist training to reflect the reduction in working hours and maintain the standard of CCT. However, most trainees also agree that a limited introduction of post-CCT fellowships might be of great individual benefit on a select basis but also feel strongly that such posts should not become a standard intermediate grade between specialty registrar (StR) and consultant.

So who might such posts appeal to? Trainees who have not yet done a period of research, or who have trained in the peri-EWTD era of shortened hours (where training has to be inevitably focused on all core areas of the curriculum at the expense of optional extras) and/or who are in a specialty where there is a relative shortfall of consultant posts and slow consultant expansion (for example, respiratory medicine, among many others) might potentially want to consider such a post, while waiting for the required consultant expansion and a suitable substantive consultant post. The potential benefits to that trainee might be extra subspecialist skills that are not part of the mandatory specialty core curriculum (practical or clinical) or research experience, service development experience in that post and curriculum vitae enhancement to make that individual more attractive as a future consultant post applicant. It should also be noted that overseas fellowships in centres of excellence in North America or Australasia, for example, have been undertaken by select individuals in the past and perceived as worthwhile in posts not dissimilar to post-CCT fellowships.

Post-CCT fellowships have the support of some professional bodies. The Royal College of Surgeons (RCS) has stated it is the intention of such post-CCT fellows to be able to deliver their subspecialist services within a larger group of specialists within a regional centre and possibly to aid larger research networks to improve the evidence base in their field.[2] However, they are also clear that completion of such a period of time denotes simply completion of a period of study which should only rank alongside other experience and training to be judged on its merits. Importantly, the RCS also does not see these posts as a passport to the sub-consultant grade (a commonly cited potential longer-term criticism of such posts, discussed later).

What are the potential drawbacks? Possible pitfalls highlighted by other professional bodies, might include:

- timing in the job market, ie the post-CCT fellowship postholder completing that post only to compete with yet

Andrew RL Medford, Post-CCT Interventional Pulmonology Fellow, Glenfield Hospital, Leicester

more post-CCT trainees in the 'bulge' (although proponents of such posts would argue that if the fellowship post has been carefully selected and a success then the applicant should be better placed to compete in this situation)
- loss of national terms and conditions on a junior doctor pay scale and contract (absence of the quality assurance safeguards of postgraduate medical education or an educational contract, ie not overseen by the Postgraduate Medical Education and Training Board (PMETB) or the deanery) in a non-standard job subject to local implementation with no formal recognition of the service provision demands that are received via the consultant contract
- the lack of a clearly defined training outcome or learning objectives and the potential just to be treated as another trainee rather than an accredited (post-CCT) specialist
- potential adverse effects on existing pre-CCT trainees' training
- the lack of an obvious workforce need for such posts
- the fear of shifting closer towards the development of a subconsultant grade.[3]

Finally, it has been suggested that a locum consultant post could deliver the extra subspecialist training with appropriate remuneration for experience and maintain service delivery in one negating the need for such posts.

Releasing further NTNs in specialties which are oversubscribed may compound the problem. A more important caveat is that post-CCT fellowships should not put into question the standard or validity of a CCT in that given specialty, ie they are an optional extra but the training curricula vetted by PMETB are of the required standard. In some specialties, there has been a requirement for an English NTN (as opposed to other parts of the UK) to apply for such posts leading to inequality in access. Rumours of a diploma on completion of these posts have yet to be realised so worries of creating a two-tier system at the point of consultant entry can be put on hold.

Personal experience and conclusion

With this background of contentious issues in mind before contemplating doing such a post, my own experience has been unequivocally positive doing a post-CCT interventional pulmonology fellowship in a UK tertiary thoracic centre (Glenfield Hospital, Leicester), the first in this particular subspecialty area at post-CCT level in the UK at the current time. I have been able to acquire a variety of new practical techniques including transbronchial needle aspiration via endobronchial ultrasound (EBUS-TBNA), local anaesthetic 'medical' thoracoscopy, and chest/neck ultrasound (USS)-guided thoracocentesis/fine needle aspiration (FNA) as well as selective application of endoscopic ultrasound – guided fine needle aspiration (EUS-FNA) of targeted lymph nodes, which are not routinely done in every local respiratory department, and are not mandatory parts of the core curriculum. ('Blind' TBNA without EBUS has been standard practice for years although it is not mentioned in the most recent curriculum and thoracic ultrasound is currently optional but level 1 competency is likely to become core curriculum in the near future.[4,5])

Part of my post has allowed me to further my own experience in service development and management; for example, development of a portable USS pleural/neck FNA service, and conducting cost analyses of existing interventional services. Finally, the post gives me the opportunity (once technically proficient myself) to teach other higher specialty trainees some of these techniques as well as maintaining other generic skills such as contributing to departmental audit and research.

Many of these subspecialist and generic management skills are invaluable when becoming a new consultant. Although generic management skills can be developed on the job, it is not straightforward developing subspecialist skills especially if they relate to a practical procedure that is not already in house which requires service development, due to limits in study leave and heavy service commitments. For the reasons mentioned earlier (EWTD and shortened training time), it is also unlikely that the higher specialist training programme will enable time to learn all these subspecialist techniques either, as training will inevitably (and quite correctly) focus on the core curriculum.

In conclusion, it is an important time for post-CCT trainees in the 'bulge' who are unable to find immediate or appropriate substantive consultant posts to develop other contingency plans. A carefully selected and designed post-CCT fellowship in a relevant subspecialty may offer another possible alternative to locum consultancy, a period of research or an overseas fellowship. Importantly, the post-CCT holder must go into such a post fully aware of all the potential pitfalls as well as the local contractual, organisational and governance factors. Potentially, with careful planning and mentorship, such posts can be exciting, rewarding and offer further practical subspecialist skills and service development experience which can only improve the chances of a subsequent substantive consultant post. These posts should be few in number in recognised UK centres of excellence (akin to the North American/Australasian/overseas model) and not set a precedent prior to attaining a consultant post in the future; attainment of CCT alone must continue to enable trainees to do this. However, they may offer another option at a time when employment prospects in many medical specialties are challenging while awaiting the further necessary consultant post expansion.

References

1 Kelso A. Association of British Neurologist Trainees – message from the chair. *ACNR* 2008;8:24.
2 Ribeiro B. Post-CCT fellowships. *Ann R Coll Surg Engl (Suppl)* 2008;90:150–1.
3 British Medical Association: post-CCT fellowships, www.bma.org.uk/ap.nsf/Content/postcctfellowships
4 Joint Royal Colleges of Physicians Training Board. *Respiratory medicine specialty training curriculum 2007, ST3+*. London: JRCPTB,

2007. www.jrcptb.org.uk/Specialty/Documents/Respiratory%20Medicine%20Specialty%20Training%20Curriculum%202007.pdf

5 Royal College of Radiologists. *Ultrasound training recommendations for medical and surgical specialties*. London: RCR, 2004. www.rcr.ac.uk/docs/radiology/pdf/ultrasound.pdf

Address for correspondence: Dr ARL Medford, Department of Respiratory Medicine, Institute for Lung Health, Glenfield Hospital, University Hospitals of Leicester NHS Trust, Leicester LE3 9QP.
Email: andrewmedford@hotmail.com