The Shape of Training: what is it and how does it affect Neurology?

Introduction
‘Shape of Training: Securing the future of excellent patient care’ is the report of an independent review, led by economist Professor David Greenaway, into medical training in the UK and was published in October 2013. The stated aims of the Shape of Training (SoT) Review were to “make sure we continue to train effective doctors who are fit to practise in the UK, provide high quality care and meet the needs of the patients and the public”. It also aimed to ensure that UK trained doctors are competent to deal with changes in the demographics of society; managing patients with chronic illness and multiple co-morbidities. The Shape of Training Report recommends a change to postgraduate medical education and training to create a better balance between doctors able to provide general care in a specialty area as well as those providing a more specialised service. The review was co-sponsored by Health Education England, the Academy of Medical Royal Colleges, the General Medical Council, the Medical Schools Committee, Conference of Postgraduate Medical Deans of the UK, NHS Education Scotland and representatives from Northern Ireland and Wales.

Background
In recent years, significant changes have been made to UK medical training, based on recommendations from a number of seminal reports. In 2007, the Tooke inquiry reported on the controversial Modernising Medical Careers (MMC) programme and called for an overhaul of medical training with an emphasis on a more flexible and broad-based approach. Several other reports have been published describing deficits in standards of UK healthcare that have highlighted the need to re-examine training in addition to service organisation and workforce planning.14 The central theme that has emerged from these reports is that healthcare is becoming increasingly disjointed; expert specialist services exist but a lack of collaboration means that patients with complex medical needs are often being failed. Furthermore, acute and internal medicine is increasingly perceived as an unrewarding career choice: departments are often understaffed and medical registrars feel overworked and undervalued.15

In 2013, The Future Hospital Commission (FHC) reported to the Royal College of Physicians (RCP) and proposed a new model of inpatient medical care. The proposal included a better balance between generalists and specialists in the workforce and a more collaborative approach to healthcare by ensuring that specialists retain good general medical knowledge and provide a seven-day service for patients across varied care settings.10 Shape of training, therefore, marks the most recent attempt to reconcile UK medical training with workforce planning for an ageing population with increasingly complex needs. The report has been met with a mixed response from doctors. The BMA and RCP have released responses to the report both of which broadly support the underlying concept of improving training proposed by SoT but raise serious concerns about shortening the length and reducing the depth of specialist training.11,12 There is also concern that plans to rapidly implement another overhaul of training, with little trainee consultation or piloting are all too reminiscent of the MMC debacle.11

The Shape of Training Proposals
Here we discuss some of the proposals of SoT and how they may impact on neurology training.

1. Postgraduate training should be structured within broad specialty areas based on patient care themes
The SoT report proposes that the generalist nature of the early years of medical training should continue into the higher training. This move would address concerns that some trainees complete their training in specialties allied to medicine with suboptimal general medical knowledge or experience. However, a crucial drawback of the SoT document is vagueness. The concept of training being centred on “patient care themes” is ill-defined. The examples of patient care themes used throughout the report are women’s health, child health and mental health. It is hard to appreciate how these re-branded “themes” are any broader than their existing counterparts: obstetrics and gynaecology, paediatrics and psychiatry. By their own admission, the panel have not attempted to define how each specialty would fit into a broad-based, patient-centred training model, how patient care themes would be organised and how specialties would be grouped together.

Similarly no attempt has been made to address specialty curricula to determine how they would be adapted to a broad-based training model, how sufficient skills and experiences would be obtained during the time available and how the curricula would be regulated. Within their training programme, it is proposed that a trainee would have the opportunity to spend up to one year working within a particular specialty. It is not clear whether this means a neurology trainee would be able to spend a year in, for example, movement disorders; or whether it means that trainees with aspirations to become neurologists would train in General Internal Medicine but get to spend one year dedicated to neurology. Any response to the
report hinges entirely on how it is interpreted and yet there is no transparent pathway laid out for consultation or implementation.

A central principle of SoT is that doctors should be trained to provide general care in broad specialties across a range of different settings. The implication of this is that SoT aims not only to alter the method of training but also to significantly alter the emerging workforce. Of the 61 medical specialties recognised by the GMC, only a handful are regarded as being true "generalists." It seems that the SoT model promotes broadening training in order to create an army of generalists who can overcome current emergency department strain and understand medical rotas but at the expense of specialty skills. With respect to neurology, there are several reasons why this sentiment is misguided.

Firstly, the number of patients with chronic neurological conditions requiring long-term outpatient care will remain unchanged. Many of these patients will prefer to see a specialist rather than a generalist and there is considerable evidence that specialist care results in better patient outcomes. Secondly, trainees who are either coerced into becoming generalists or given no certainty about whether they will be able to specialise (opportunities to specialise are proposed to be determined by local need) are likely to feel undervalued and may opt for an alternative career with more certain prospects.

Finally, significantly altering the balance between numbers of generalists and specialists should be accompanied by a careful consideration of the emerging service model – the detail of which is lacking in the SoT Report.

2. Shortening of training
Both the BMA and RCP have raised concerns that the Shape of Training proposals would shorten the length of training in a way that would redefine the meaning of certification. Current postgraduate training in neurology takes six to eight years (not including academic research and fellowships) to achieve certification of completion of training (CCT). The model that emerges from SoT is a reduced six to eight years of "broad-based specialty training" to achieve a certificate of specialty training (CST). CST would equip doctors to "practise with no clinical supervision within multiprofessional teams and networks [and] to make safe and competent judgements in broad specialty areas".

If neurology trainees were required to follow a general medicine training scheme with only limited opportunities to gain dedicated neurology experience, it is clear that despite supposed "certificates of specialty training", the emerging "specialist" would be very different from existing consultants. Existing trainees who dual-accredit in general internal medicine feel under-equipped to provide general medical care on reaching consultancy and only 72% of neurology trainees feel that the existing training prepares them adequately to practise as neurology consultants. These figures tell us that shortening training while broadening the curriculum is not a viable option.

3. Academic pathway
A positive feature of the SoT proposals is that they recognise the importance of training doctors who "straddle both clinical and academic areas" to encourage innovation and advances in medical treatments. The proposals allow for doctors moving into and out of academic training at any point during their broad-based specialty training thus encouraging a more flexible approach. They suggest that academic endeavour will no longer need to be undertaken outside of training although the detail is once again lacking.

Neurology trainees are currently facing limitations on moving out of programme to academic posts because of the perceived need to protect the clinical rotas (and therefore clinical trainees). The SoT report does not outline how these rotas gaps would be filled if trainees had enhanced flexibility to move into research. Nor does the report guarantee an extension to training duration in order to allow trainees to achieve adequate clinical competence, stating only that "time spent in academic experiences will still be counted within training. It will have to be recognised that some of these doctors may occasionally take longer to reach the exit point of postgraduate training, in particular those training in craft specialties such as surgery.

4. Credentialing
Once in a consultant post, doctors would be able to gain further specialist experience via a process called "credentialing". Some existing neurology trainees already choose to undertake post-CCT fellowships to gain further subspecialty experience. Some may feel that certain subspecialty components of the existing neurology curriculum could be omitted without compromising the report's recommendation that "flexibility into the workforce. Trainees would be empowered to switch specialties more readily with transferable competencies. Naturally, flexibility is well-received by the workforce and yet there is the subtle inference that this flexibility will favour the service providers rather than the trainees with statements such as "local workforce and patient needs should drive opportunities to train in new specialties or to credential in specific areas". Workforce planning is crucial and yet surely it cannot be imposed locally at a trainee level; should a trainee be compelled to change from neurology to respiratory medicine due to local workforce issues? The individual may well have ambitions to work elsewhere in the future. This adds to concern that the report places too much emphasis on service provision, at the cost of a considerable reduction in training duration and depth.

Shape of Training: what is the alternative?
The Shape of Training model is one proposed solution to the crisis that is facing emergency medical care in the UK. However, other proposals have been made to address the crisis that focus far more on service issues such as broadening access to high-quality specialist care, improving the attractiveness of general medicine as a career option and promoting better liaison between services and specialties.

The Association of British Neurologists (ABN) collaborated with the RCP in 2011 to establish guidance on the shape of neurology services for the next decade. One of the three core recommendations of the ABN/RCP report was for a shift in emphasis from scheduled to emergency neurological care with consultant neurologists engaging in acute services. Neurological conditions account for more than 10% of acute medical admissions. By engaging more in acute care, neurologists could considerably reduce the burden on general physicians while maintaining a specialist approach.

One of the factors contributing to under-staffing of emergency care is poor recruitment into careers involving general internal medicine. Negative perceptions of the medical registrar role are thought to play a major part in this shortfall. However, the idea of forcing doctors to unwillingly look after patients with general medical complaints seems fundamentally flawed. A recent report produced by the RCP has set out a strategy to improve the medical registrar role by enhancing their support system, redistributing some of their workload, improving their training conditions and raising the profile of their career. To recruit trainees by offering greater incentive to those who have an interest in generalist careers rather than filling posts under duress seems a more rational and sustainable approach.

Summary
Many specialty doctors are likely to share an aspiration to improve patient services by equipping trainees with good general medical knowledge and experience and by bridging the gap between healthcare sectors whilst
incorporating a holistic approach to care. However, concerns voiced by the BMA and RCP will be upheld by many; that broadening knowledge in this way and shortening the duration of training are incompatible goals. Careful interpretation of the Shape of Training document will be crucial to avoid the covert creation of a sub-consultant grade or even the abolition of specialties as we know them. The report appears more focused around changing the shape of service than the shape of training and its “one-size fits all” approach may not be compatible with all specialties.

In responding to the Shape of Training Report, it is crucial that we separate the question of “should neurologists play a greater role in acute medicine?” from the question of whether current training is really broken. The ABNT feel that current training is fit for purpose and that skills within emergency medical units to better meet the evolving needs of patients without being re-branded as generalists. ◆