THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Ophthalmic Trainees' Group

Response to the Shape of Training Report

Securing the future of excellent patient care

April 2014

SUMMARY

The members of Ophthalmic Trainees' Group (OTG) comprise an elected and representative committee of ophthalmic trainees from fourteen regions of the four countries of the United Kingdom.

The Shape of Training review was launched in early 2013 by organizations responsible for medical education and training in the UK. It set out to gain evidence and review how post-graduate (PG) medical doctors were trained, and reshape PG clinical training pathways. The OTG recognize the incredible amount of input and work that went into the production of the final Shape of Training Report[1].

The Shape of Training report lacks some detail (especially, and by default, in the implementation of the recommendations), and it is unclear how the recommendations would apply to ophthalmology, much like radiology and other 'ologies'. However, it provides a great opportunity to review PG training of doctors wishing to become consultants. It is difficult for ophthalmology training, in light of the recommendations, to embrace a "one size fits all" philosophy of postgraduate medical education.

Of the nineteen final recommendations made in the Shape report, a number have been specifically highlighted during numerous discussions within the OTG, together with input from ophthalmic trainees across the United Kingdom. The OTG recognizes that there are compelling economic and social realities that are driving the review of the current PG training system, and that the report highlights and tries to address these.

Despite the necessary patient-focused, fiscal, demographic, and workforce-flexibility impetus behind the report, the OTG will frame this response only and wholly on the premise of **improving** already excellent post-graduate training. Regardless of any recommendations of the report, there is absolutely no vision of reducing the quality or scope of current training. Furthermore, there is absolutely no appetite for, or tolerance of even the notion, of the outcome of PG training being a sub-consultant, or lesser-qualified consultant grade ophthalmologist. The UK public and patients would, and the OTG do, completely reject the idea of reforming PG training to produce a less-qualified consultant doctor. In fact the production of Comprehensive (or Generalist) Consultant Ophthalmologists as per the Shape recommendations would, in our view, necessitate more intensive training (although perhaps not more time).

The current Ophthalmology Specialty Training (OST) program and curriculum provides high quality training, and produces consultant doctors capable of meeting the healthcare needs of patients. OST training already produces consultant ophthalmologists with the broad skills to be 'generalist', or perhaps better phrased 'comprehensive' Consultant Ophthalmologists. We are concerned that the Shape of Training recommendations would not *per se* improve ophthalmology training or patient care. The Shape report has been produced at a time when the first cohort of doctors trained entirely in the post modernizing medical careers (MMC) era are about to become consultants. This is a natural time when we should take stock and look at how training could be improved.

We will structure this response in four sections. Firstly, recommendations with which the OTG, representing UK ophthalmology trainees, support and agree; then ones that create a slight divergence of views and for which more evidence is sought; thirdly aspects that the OTG reject; and finally ideas of a way forward.

SUPPORT & AGREEMENT

Flexibility

- *Recommendation 14: Appropriate organisations, including postgraduate research and funding bodies, must support a flexible approach to clinical academic training.*
- *Recommendation 6: Appropriate organizations must introduce a generic capabilities framework for curricula for postgraduate training based on Good medical practice that covers, for example, communication, leadership, quality improvement and safety.*

The OTG fully support the opportunity to explore other academic areas, less than full time training, management and leadership training, and out-of-programme experience; and allow trainees to fully explore these areas with the full support of their training Deaneries[2 3]. There is ambiguity regarding academic training in the Shape report. Clarification would be needed regarding the number of academic posts, the stage at which they could be undertaken, and who would fund them.

Apprenticeship-model Training

- *Recommendation 8: Appropriate organisations, including employers, must introduce longer placements for doctors in training to work in teams and with supervisors, including putting in place apprenticeship based arrangements.*

The OTG would fully support the re-introduction of apprenticeship-based training; at the heart of this is the valuable trainer-trainee relationship.

Dedicated Training Units and Training Consultants

- *Recommendation 9: Training should be limited to places that provide high quality training and supervision, and that are approved and quality assured by the GMC.*

We are in agreement with the Shape of Training report that activities undertaken in training should be focused towards training rather than service provision. We also agree that training should only occur in departments with a track record of delivering high quality training.
The idea of specifically appointed consultants for trainees sounds very appealing, but will need to be properly funded and accredited. We envisage that trainees will have to be involved with much less service provision and more training opportunities. This may make having trainees unattractive for many busy NHS trusts and an unintended consequence of the Shape report may be the loss of trainees from established training hospitals. Structured surgical training is proven to improve outcomes[4].

DIVERGENCE OF VIEWS, AND FURTHER EVIDENCE SOUGHT

Length of Training

- *Recommendation 7: Appropriate organisations must introduce processes, including assessments that allow doctors to progress at an appropriate pace through training within the overall timeframe of the training programme.*

Comprehensive ophthalmic specialty training in 5-6 years is achievable but the risk would be trying to do too many things at once. Shortening training cannot be achieved without taking away from

the curriculum unless training is more intense, more focused, and provided by recognized training institutions with dedicated consultant trainers *(Recommendation 9: Training should be limited to places that provide high quality training and supervision, and that are approved and quality assured by the GMC.)*

Intensive training would need greater resources – less service provision, and more funds for consultant trainers and units providing the training[5]. Simulated surgical training could have an important educational role[6-9].

The current reality is that very often, and even after 7 years of OST training, additional fellowships lasting up to 2 years are still deemed necessary in order to get the chance to achieve the clinical and surgical experience and expertise to be offered a consultant post in the current workforce climate.

If we reduce the time in training without significantly intensifying the training, it will not be possible to deliver the full curriculum. The OTG believe that whatever the eventual qualification of the new breed of consultant doctors created by Shape, the current OST curriculum is appropriate, and nothing in the current curriculum is excessive or too specialist. Therefore in order to shorten training, a huge change in the methods and mode of curriculum delivery would be needed. This could be an opportunity to improve training but will undoubtedly come at a cost.

It is important to recognise that the development of expertise (as a consultant doctor) includes knowledge, skills, **and professionalism** (or ontology: attitudes and the process of 'becoming'). Learning, fostering, and developing professionalism to be a consultant takes time. Shortening training with a focus purely on skills and knowledge would be counter-productive.

The OTG welcomes the focus on ensuring that postgraduate medical education and training is responsive to the changing demographic and patient needs. However, like any craft based specialty, ophthalmological surgical skills take time to master. It is unclear how, without significantly lengthening or intensifying of their training, surgeons in highly specialist areas such as cataract surgery would acquire the necessary skills, experience and expertise, in the proposed broad-based training programmes.

Generalists / Comprehensive Consultants

- *Recommendation 11: Appropriate organisations, working with employers, must review the content of postgraduate curricula, how doctors are assessed and how they progress through training to make sure the postgraduate training structure is fit to deliver broader specialty training that includes generic capabilities, transferable competencies and more patient and employer involvement.*

Current service provision framework does not allow patients to be treated holistically. Trainees now working towards becoming wide-ranging consultant Ophthalmologists would require more training to include non-clinical skills in management and public health[10].

The report does not adequately define what they consider a generalist CST consultant doctor. It is unclear if the report's definition of a generalist would meet what is considered to be the minimal competency level of consultant ophthalmologist.

In recent years, the driver for sub-specialist ophthalmology services has been improved clinical and surgical outcomes[11 12]. As further advances in technology occur and treatments become more complex, there may be a need for further expansion of consultants with a sub-specialty interest.

It is very risky to play with ambiguous training plans, which have huge implications on public health. We do need sub-specialists input in many areas of health care.

Credentialing

- *Recommendation 16: Appropriate organisations, including employers, should develop credentialed programmes for some specialty and all subspecialty training, which will be approved, regulated and quality assured by the GMC.*
- *Recommendation 1: Appropriate organisations* must make sure postgraduate medical education and training enhances its response to changing demographic and patient needs.*

The OTG have reservations against a 'credentialing' model. Nothing should or could be removed from the current OST curriculum. It could, however, be an opportunity to validate fellowships and create a competitive entry system, matching the best people to fellowships of real value.

The Shape of Training report does not adequately describe how credentialing would be funded. Doctors undertaking 'credentialing' would not be subject to the protection of either the junior doctors or consultant contract. We are concerned that the financial burden for obtaining these necessary skills would fall upon the doctor rather than the training organization or future employer.

Certainly credentialing could provide more flexibility in responding to changing demographics and patient needs.

The OTG does not believe that the current training programme has driven sub-specialization or that changing the structure of training can reverse this trend. Over the past 5 years 90% of advertisements for consultant ophthalmologist appointments have specified a requirement for a sub specialist interest/skills (source- BMJ careers 2008 -2013). So long as sub-specialty skills are required by the employing hospitals, trainees will endeavor to obtain these skills both within training or afterwards. It is unclear from the Shape report, what the definition of a 'Generalist' or 'Comprehensive' Consultant Ophthalmologist would be.

The report recommends that some general competencies and all sub-specialist competencies be removed from training programmes and these should be obtained by post CCT/CST 'credentialing'. We are concerned that removal of any competency from the current OST programme curriculum represents a decline in the standards of training. In addition, we fear that 'credentialing' would become a de-facto requirement for most consultant posts.

There is concern that post-CST credentialing could potentially create a sub-consultant grade, which is not in patients' best interest. Currently patients expect that when seen by a consultant, the consultant will be fully knowledgeable in that particular field. It would be beneficial to involve patients, taking expectations and needs into account when defining a generalist/comprehensive consultant ophthalmologist, and a credentialed sub-specialist. *(Recommendation 2: Appropriate organisations should identify more ways of involving patients in educating and training doctors.)*

Community-based training

Allocated consultants are ultimately responsible for patients, while trainees have the opportunity to complete their training under supervision. Who would be responsible for patients out in the community? The risk is that minimally supervised training in the community would become one prolonged period of service provision.

REJECT & DISAGREE

Broad-based training

- *Recommendation 10: Postgraduate training must be structured within broad specialty areas based on patient care themes and defined by common clinical objectives.*
- *Recommendation 18: Appropriate organizations should put in place broad based specialty training (described in the model).*

Regarding flexibility meant in the general sense of transferability, the OTG consensus is that such notion should be rejected. The OTG consider that anyone transferring into OST training would need to start at ST1. Ophthalmology would be badly served by the proposed broad-based approach because there are not sufficient transferrable skills to other specialties, with the exception of Medical Ophthalmology.

The report also looks at flexible working, and states that medicine has to be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers. This in principle is very admirable; however it is difficult to see how this could be possible. The College has taken big steps in creating a curriculum for medical ophthalmology, which can be further aligned to current OST curriculum. However, the introduction of broad-based core training will be very difficult, and if the first one to two years are spent doing core training (in other speciality areas) this will leave insufficient time, the OTG believe, to undertake the training required to become a competent consultant ophthalmologist.

There are many specialty specific skills that are required for competence and excellence in ophthalmology that cannot be obtained from time spent in other specialties. It would be inappropriate for trainees from other backgrounds to transfer into anything but ST1 level ophthalmology. Likewise, it would be inappropriate for senior ophthalmologists to transfer to anything other than ST1/CT1 level in other specialties.

Medical Ophthalmology (currently in the remit of the Royal College of Physicians) and Surgical Ophthalmology could be more formally combined as valued partners in a 'broad-based' specialty. But it should remain clear that the training and competencies of these doctors are different. This should perhaps be reflected in an award of a different CST.

Knowledge of some other specialties would be advantageous to ophthalmologists but we feel that this knowledge should be obtained at F1/2 level and not at the expense of time spent obtaining ophthalmology skills and experience.

The Shape of Training report does not adequately recognize the time required within a single specialty area to obtain specialty specific knowledge, expertise and skill. We do not feel that a "broader base" or sharing a training "theme" with other specialties would benefit training and this would be detrimental to the attainment of skills and experience in ophthalmology.

The OTG recognises that there are many generic competencies shared by all medical and surgical specialities. Professionalism (including attitudes, ethics and responsibilities; and decision-making, reasoning and judgement), communications skills, health promotion and disease prevention, are crucial skills shared by all trainees and consultant doctors.

Doctors providing acute and emergency care

- *Recommendation 12: All doctors must be able to manage acutely ill patients with multiple co-morbidities within their broad specialty area and, continue to maintain their skills in the future.*

While the OTG fully support ophthalmology trainees and consultants providing acute and emergency care within the ophthalmology specialty area, it does not support ophthalmology trainees or consultants providing acute medical care in broader areas. Ophthalmologists should be trained to manage patients with optic nerve threatening thyroid orbitopathy, but not manage a patient with thyroid storm. Similarly, ophthalmology consultants at the end of CST training should manage proliferative diabetic retinopathy, but not acute diabetic ketoacidosis.

Implementation

- Outline of Delivery plan (p.56)

The OTG have grave concerns regarding any hurried or premature implementation of any recommendations or reforms. Modernising Medical Careers (2005-7) was implemented within a relatively short time-frame, and it failed to allocate trainees in a fair and transparent way, and also failed to ensure all allocations were completed in time[13].

Specifically, we are concerned with the 'Shifting of all curricula towards broad based training within patient care themes and putting in place necessary requirements for the new training structure based on broad based training within 2–5 years'. A staged, well thought through approach with all stakeholders involved, on an evidence-base could be possible in a slightly shorter time-frame. The OTG are also finally concerned with the lack of the term 'consultant' doctor in the report. We would strive to see the 13th 'change needed', termed: 'Legally award Certificate of Specialist Training which recognises that **Consultant** doctors are able to make safe judgements and to practice safely **and independently**'.

A POTENTIAL WAY FORWARD

We agree with the Shape of Training report that training should be competency-based rather than time-based, however we do have concerns about shortening training to 4-6 years as suggested by the report. We note that many trainees who currently complete a 7-year training program do not feel adequately trained to undertake consultant posts and often undertake 1 or 2 years further training in post CCT fellowships to obtain the required skills.

However, if training were more intense, focused, and led by dedicated and appropriately remunerated consultants and units it could be possible to shorten training to perhaps 6 years. A clear definition of the outcome of CST being a comprehensively trained and expert Consultant Ophthalmic Physician / Surgeon, who would be on exactly the same contract and pay scale as any Consultant subsequently choosing to credential in a sub-speciality, is needed.

Surgery, Proficiency, and Expertise

Despite the idea that 10,000 hours are needed to gain expertise, formed by Ericsson[14], it is recognized that any craft and surgical training to consultancy expertise needs time, sustained deliberate practice, and appropriate feedback, in order to succeed. Simply saying that it is possible to shorten training, in any speciality or broad-based theme, without embracing an underpinning educational theory and validity, and an evidence-base for its reform, is disingenuous.

SUMMARY

The OTG recognise the patient, demographic, and financial need to look at improving PG medical education in the UK for trainee doctors on their way to becoming consultants. The OTG do have concerns:

- That there is any hurried implementation of recommendations of the Shape report;
- About the lack of an evidence base for any reform to already excellent PG medical education;
- That the 'ologies' (including ophthalmology) would not fit into a 'broad-based' patient theme;
- The danger of a sub-consultant grade resulting from the Shape recommendations.

If the four UK Ministries of Health do indeed adopt the Shape of Training report and recommendations, the OTG would certainly be keen to play a role in the implementation of improvements to already excellent PG medical education, and in securing the future of excellent patient care.

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