JRCPTB

Joint Royal Colleges of Physicians Training Board

Training Recovery after COVID-19

Although the effects of the COVID-19 pandemic are still apparent and are likely to be around for some time, the need to ensure that trainees in the medical specialties are being given adequate opportunities to re-engage with training is of critical importance. The Statutory Education Bodies have given impetus to the fact that training relies on adequacy of learning opportunities and development of capability. For the physician specialties this means that there must be reality in assessment of capability in trainees, and by the trainees themselves, so that we are not simply working to time-based parameters but truly reflecting on the progress that each individual is making and assessing when their capabilities will be commensurate with acquisition of the certificate of completion of training.

The situation is complicated by the forthcoming transition of trainees to the newly approved curricula for their specialties and, for some, the need to expand their learning experiences. This applies especially to the new group 1 specialties: neurology, genitourinary medicine and palliative medicine, the group 1 specialties that frequently did not dual train in specialty and internal medicine e.g. cardiology and the group 2 specialties that are increasing scope e.g. the combination of allergy and clinical immunology.

We have produced several documents that reflect how dual training should be achieved including the decision aid for Internal Medicine Stage 2 (available via this link), how transition should progress and for whom this applies and the need for all to review their training to date and provide a gap analysis to demonstrate what capabilities have been achieved, what are still to be achieved and how appropriate learning opportunities can be exploited to facilitate that achievement (see JRCPTB website transition guidance).

The return to training requires co-operation from all parties that have previously been engaged. This includes the patients, without whom clinical teaching would not be possible. All cases should be viewed as potential training or learning opportunities and every patient (with appropriate consent) should have a trainee involved in their care.

Trainees

Trainees in all the physician specialties should be aware of the curricula requirements for each year of training and if these have not been achieved because of the pandemic it is likely that the last ARCP would have determined an outcome 10.1 or potentially an outcome 10.2 if there was a critical decision point in training (including the CCT date). Trainees should be aware from their own knowledge of the curriculum which capabilities are still to be achieved and the timescale that this will require. If difficulties are perceived these should be actively addressed and escalated. This may require amendments to normal training pathways/experience to ensure delivery.

There should be a full discussion with their educational supervisor, the results of which should be communicated to the relevant training programme director and the personal development plan for the trainee should reflect the results of these discussions. The forward-looking training plan based on the gap analysis and created to fill gaps in learning opportunities should be explicit in its intent to provide the necessary learning and the timescale by which this should be achieved.

Trainees in the same specialties should help each other by identifying in advance where training opportunities are likely to be available and ensure that all in the specialty and in that placement are aware and can sign up appropriately.

Consultants/SAS doctors/senior trainees

Each member of these groups should take opportunities to train trainees of all grades who may be engaged in ward work, outpatient clinics, acute take, multi-professional meetings, and practical procedures where they are working. The opportunities should be related to their present level of attainment and their need to progress within each training environment. For instance, the opportunity to lead post-acute take ward round is likely to be later in training but leading on a downstream ward round may well be an experience that could be encouraged earlier. While the focus from JRCPTB may be on physician trainees there are also more junior trainees who would benefit from this focus because such a training emphasis may encourage the more junior trainees to think seriously about applying for physician specialty training posts. Such an outcome is far less likely if the more junior trainees do not perceive that the training needs of all trainee physicians are taken seriously.

Opportunities to discuss cases and their own performance should be given to each trainee including the opportunity to undertake structured learning experiences. These require high quality feedback with the abilities of the trainer to provide this and the trainee to actively receive. This is especially true in the outpatient environment where the introduction of virtual clinics has emphasised changing work practices but also the reduction in number of clinics that might be experienced. The introduction of the OPCAT assessment tool will help to determine learning progression and development of capability in that setting.

Clinical and Educational Supervisors

All supervised trainees should have recognition of their progress in training and where there needs to be specific focus to give necessary learning opportunities from across the curricula requirements. To do this adequately all supervisors must be aware of the changes to the curricula and the associated changes in the training role. Information is available on the JRCPTB physician trainer resources webpage. Clinical supervisors and educational supervisor must work in a co-ordinated fashion so that there is adequacy of feedback from the CS to the ES on how the trainee is performing. Clarity should be obtained from the Training Programme Director about the training requirements that should be achieved in each placement. This means that the training plan for each trainee will have to be tailored and documented, considering how well the trainee has been progressing and their own personal needs. The educational supervisor should have regular meetings with their trainee to ensure that anticipated progress is being made and determine if any of the specific aspects of the curriculum that must be achieved are proving problematic. Specific consideration should be given from trainees in group 1 specialties of the balance of training between specialty and internal medicine. The guidance that has been provided should be referred to if a trainee feels that their training programme is unbalanced, and they are being asked to train in one part of their CCT programme to the detriment of another part. In that situation it is critical that there is communication between the supervisor responsible for training in IM and the specialty supervisor. The trainee should be made aware of the results of such communication.

Training Programme Directors

The key position of the training programme director means that they are ideally placed to understand the effect that the pandemic has had within their locality, the individual variations within the geography and the individual redeployment of trainees that occurred. The documentation of the training that each trainee has had within their specialty Is crucial. The TPD should review and respond to the discussions that the ES and trainee have had and ensure that all parts of the training programme have been considered in the forward-looking training plan including for group 1 specialties the balance of IM training and that of specialty. The TPD should approve the forward look plan so that there is consistency in approach and opportunities offered for all trainees. Trainees may wish to take time out of programme including for research. Trainees must be made aware of the opportunities that still do exist and encouraged to pursue these if they fit with their perceived career progression.

Service delivery

The role of service delivery from trainees is understood but there should also be recognition that if training is not delivered in each placement then the development of the future consultant workforce will be delayed. Trainees who do not feel supported are far less likely to return as consultant to that organisation. Significant amounts of funding in providers are associated with the training role – this must be recognised, and adequate provision made for training.

In-programme teaching

The teaching programmes that accompany all physician training programmes have been recommenced. In many situations this will include the ability to access virtual teaching sessions. Trainees should be encouraged to attend 100% of these sessions using bleep free sessions and taking opportunities to ask questions. If it is not possible to attend in real time all attempts and opportunities should be made to review the recorded sessions.

Consideration should be given to developing additional new modes of in-programme teaching that optimizes the incorporation of technological advances in training while not being overwhelmed by the technology.

Portfolio review

Training programme directors should review the engagement of trainees in their programmes by reviewing the portfolio use by trainees and their trainers. This should include review of the induction meeting, the number of educational meetings that have occurred and an overview of the SLEs that have been attempted by trainees. Feedback should be given to the trainee and supervisor to provide support and direction over the progress that is being made.

A member of the STC should meet individually with each trainee to discuss their progress and plans at least once each academic year.