Response from Genitourinary Medicine Specialist Advisory Committee (SAC) to the JRCPTB proposal for a flexible curriculum for internal medicine

Prepared by Dr Rak Nandwani
GUM SAC Chair

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Summary

- Genitourinary Medicine (GUM) views itself as a physicianly specialty and there is general support for the proposal for a flexible curriculum in internal medicine.

- The GUM SAC feels that an additional third year of CMT is essential and would provide a better grounding for all specialty training.

- There is clear consensus from the GUM SAC, supported by trainees and colleagues outside the SAC, that dual accreditation with a joint CST in GUM and internal medicine would be desirable.

- Given the ageing HIV cohort and the multi-system impact of many sexually transmitted infections, the SAC recommends an increase in GUM trainee participation in relevant allied specialties throughout the 4 year programme.

- Medical specialties with particular relevance to GUM clinical practice include: dermatology, hepatology, gastroenterology, cardiology, oncology, ID, clinical pharmacology, geriatric medicine, rheumatology, endocrinology and metabolic medicine.

- The SAC is supportive of GUM trainees spending 3 months of the first year of specialty training participating in acute unselected take as part of the “fourth year” in internal medicine.

- The SAC recognises the value of further 3 month blocks of acute unselected take in years 2-4, combined with ward and out-patient attachments in allied relevant specialties, however there are outstanding issues relating to the impact on gaining GUM specialist competencies, diverse SAC views on post-CST training and variation in existing GUM service models, that need to be addressed first.

- Pending wider discussion and consultation, a pragmatic interim option might be 3 months of acute selected take each year (‘specialty’ on call for HIV/infection unit plus ward and out-patient attachments to designated allied specialties).

- The SAC and trainees are concerned about how the proposal might impact on existing GUM trainees and future employment prospects, particularly if competing against newly dually accredited colleagues.
Introduction
This response has been prepared on behalf of the Genitourinary Medicine (GUM) SAC and incorporates comments from SAC members, including discussion at SAC meetings. The SAC trainee representatives also compiled feedback from existing GUM trainees across the UK which has been fed in. In addition, there has been wider debate with specialty colleagues and trainees using social media and other means, which has informed this response.

The two key specialty associations (the British Association for Sexual Health & HIV – BASHH and the British HIV Association – BHIVA) as well as the GUM Joint Specialty Committee (JSC) will also be submitting direct responses to JRCPTB. To aid these, the SAC Chair provided further information including a set of specific questions (see appendix).

General comments on the proposal
The GUM SAC warmly welcomes the proposed 7 year model for physician training with its renewed focus on patient needs, generalism and a more flexible career structure. There is considerable support for the proposal both within the SAC and from the specialty who have described it as well thought out and pragmatic. This positive view extends to delivery of the spiral curriculum across all physician specialties with GUM making its contribution as part of a wider redesign. Several mentioned that they felt the model was in keeping with other countries.

The third year of core medical training with increasing responsibility for acute medical take is felt to be essential to support the development of subsequent specialty competencies and enhanced patient care. The SAC feel it would improve the grounding for specialty training in GUM.

The SAC agrees that the assessment of competencies in practice leading to a trusted decision in the model are a major step forward from the current “tick box” system. The existing GUM curriculum already contains graded descriptors at levels 1-4 for each competency. However, it is felt that a pilot is required to evaluate how this potentially simplified strategy works in practice.

The 14 competencies in practice listed in the example framework for the assessment of a competent physician were all felt to be relevant to GUM with no suggestions for any additional ones to be added. Indeed, the SAC felt that the majority are already being delivered and can be demonstrated within the existing GUM curriculum. It was highlighted that the specialty may wish to offer examples of good GUM/HIV practice in competencies such as the management of long-term conditions and medical problems in patients in other specialties.

The proposal recognises that implementation requires flexibility across physician specialties and the demographics of the trainee workforce (which is particularly relevant to GUM given the high proportion of female doctors). The remainder of this response aims to describe possible ways that GUM might consider implementing the
model. In doing so, specific issues are raised which may be applicable to other JRCPTB managed specialties.

Current GUM relationship to other specialties
GUM views itself as a mainstream physicianly specialty with internal medicine at its core. Given the multi-system nature of HIV infection, syphilis and other presentations, the GUM curriculum already links with many major specialties. The existing curriculum includes attachments to other specialties including ID, rheumatology, dermatology, public health, laboratory-based specialties and medical gynaecology as well as obstetrics and community sexual & reproductive health (CSRH). In turn, these specialties often have trainees undertaking attachments in GUM. Given the large number of patients who present themselves to acute GUM clinics without referral, GUM already bridges primary, secondary and tertiary care in a way that other hospital-based services aspire to in relation to “moving into the community”.

Current GUM contribution to acute take during training
There is usually no current involvement in first on acute unselected medical take. Despite GUM’s grounding in internal medicine as described, relatively little of its workload enters the system via acute receiving. With the exception of late presentation of previously undiagnosed HIV, it is unusual for GUM patients to present to the acute take. In part, this is because of rapid patient access to GUM clinics and direct referral pathways from primary and secondary care. In 2014, excluding HIV, there were 439,243 new STI diagnoses made in England alone.

The majority of GUM patients are aged under 30, transitioning to adulthood and for many this is their only contact with any NHS service. Inequalities and vulnerable populations are frequently seen, with patients who rarely present elsewhere (eg men who have sex with men, asylum seekers). Association with complex psycho-social issues (eg child safeguarding, gender-based violence and use of new psychoactive substances) is common. Wider protection of public health is a core pillar of GUM practice that is not usually a consideration in medical take. Therefore, compared with other medical specialties such as respiratory, renal or endocrinology, there is relatively little overlap in caseload between acute take and core medical specialty caseload.

Enhanced internal medicine “generalist” competencies for GUM training
Given the positive impact of effective HIV therapy, there is an ageing cohort of people in HIV care with over a quarter now aged over 50 owing to improved survival. Antiretroviral treatments may also affect cardiovascular risk, renal function and bone health as well as issues with drug interactions with increasing polypharmacy.

Combined with the multi-system impact of many STIs and improved hepatitis drugs, the SAC recommends implementation of the spiral curriculum by increasing GUM trainee participation in relevant allied specialties during the programme. Medical specialties with particular relevance to GUM practice include: **dermatology,**
hepatology, gastroenterology, cardiology, oncology, ID, clinical pharmacology, geriatric medicine, rheumatology, endocrinology and metabolic medicine.

There will need to be co-operation, negotiation and local flexibility about the best way to implement wider “generalist” competencies across all specialties to maximise educational value. GUM is willing to support relevant competencies for other specialties as it already does at present.

**Future GUM contribution to acute take during training**
The GUM SAC greatly valued Prof Black’s video explaining that the proposed flexible curriculum training model is not all about the acute unselected take and that different specialties may contribute in different ways. The SAC is keen to maintain values consistent with other physicians and to make a contribution by sharing acute workload across as many specialties as possible.

Therefore, the SAC is supportive of GUM trainees spending 3 months of the first year of specialty training participating in acute unselected take as part of the “fourth year” in internal medicine and following on from the proposed extra third year in CMT. This would require educational supervision outwith GUM and deliver educational value towards competencies in practice such as managing the acute unselected take over a standard shift and procedural skills.

What is unclear at present is how to best integrate enhanced internal medicine “generalism” during years 2,3 and 4 of the GUM training programme without losing or diluting essential existing specialist competencies in STIs, HIV and contraception.

The GUM SAC view, supported by trainees and colleagues outside the SAC, is that dual accreditation with a joint CST in GUM and internal medicine would be highly desirable. There would need to be sufficient acute take experience during the 4 years to maintain and develop procedural competencies in practice and to be perceived by peers as credible physicians capable of delivering the acute take at the same level as trainees gaining internal medicine accreditation with other specialties.

Thus, the logical consequence would be for GUM trainees to repeat 3 month blocks in years 2-4 participating in acute unselected take, combined with out-patient clinics and ward work in the allied relevant specialties listed above. The expectation is that trainees would be based out of GUM services, and would also be able to bring relevant specialist knowledge to any HIV/GUM patients that presented to the acute take or to acute based specialties, including those in O&G and surgical practice.

However there are three issues that need to be addressed by the wider specialty of GUM beyond the SAC, to be able to progress this aspiration of 12 months acute unselected take in the 48 month specialty programme:

1. **Impact on gaining GUM specialist competencies**
2. **Diverse views on post-CST training**
3. **Existing GUM service models**
1. Impact on gaining GUM specialist competencies

GUM competencies are not currently well covered in undergraduate or CMT training. The extra 3rd year CMT provides an opportunity to address this, especially in relation to increased recognition of undiagnosed HIV by primary care and other specialties. HIV competencies are almost absent from the existing curriculum for General Internal Medicine 2009 (2012 amendments), but this could be addressed as part of the current proposal.

Current GUM trainees are required to pass three external SCEs to progress; the DipGUM by the end of year 2, the DFSRH in year 3 and DipHIV before the end of year 4. SAC members are concerned that trainees will have difficulty achieving these if the proposal is implemented, especially if further SCEs are added in relation to generic professional capabilities and/or internal medicine competencies. One of the stated aims of the proposal is to reduce the “burden of assessment” rather than increase it. To progress the internal medicine proposed model, a review of all SCEs and their timing in the updated curriculum will be required.

The current GUM curriculum includes a range of specialist competencies over and above the 14 proposed competencies in practice which cover the “bread and butter” of GUM clinical practice with flexibility to incorporate emerging challenges. There is also opportunity to develop a broad range of interests within the curriculum. Examples include enhanced complex reproductive health and adolescent care. Increased internal medicine content may squeeze out topics such as sexual dysfunction and sexual assault to mere recognition rather than advanced practice. It will also be challenging to fit in the current two weeks full-time laboratory based attachments. Patients with genital dermatoses commonly self-present to GUM services. Implementation of the proposed model may limit patient care to limited recognition and diagnosis (with fewer procedures other than punch biopsy).

2. Diverse views on post-CST training

Following on from the previous point, there are a range of opinions (both within the GUM SAC and in the wider specialty), on what competencies a trainee should have attained at the time of CST. Some take a view that post-CST training can be used to deliver specialist competencies that only a minority (say less than 10%) of consultants will do as part of their job plans, whilst others believe that post-CST fellowships should not be the norm. They argue that a dual CST in GUM plus internal medicine, and the training underpinning it, should be appropriate to produce a consultant able to do 99% of current jobs.

There is however consensus that there may be a role for credentialing for a small number of trainees, and possibly once appointed to a consultant post, to take on a more specialist role not covered by the curriculum to provide tertiary services such as complex HIV in-patient care or sexual assault with forensic competencies. The GUM SAC also support joint development of defined post-CST training across different specialties such as complex reproductive health with CSRH or complex HIV in-patient care with colleagues in Infectious Diseases, in order to provide consistent standards for patient care.
3. Existing GUM service models
Local flexibility will be required as current GUM service models are variable throughout the UK. The majority of GUM services are no longer located on acute hospital sites. Many clinics are integrated with contraception delivery in areas accessible to the local community. This is now the standard care model in all NHS Scotland services. Therefore GUM trainees on internal medicine attachments in A&E, wards and medical out-patients may be physically absent from the remainder of the multidisciplinary GUM team. Trainees provide significant service provision, especially in smaller units and this will have an impact.

In England, sexual health services were moved out of the NHS to the control of Local Authorities in 2012. Many services were put out to tender by commissioners and postgraduate specialty training was not always included in service specifications. Some sexual health tenders were won by non-NHS providers such as Virgin Care and Spire. Therefore there may be local issues arising in relation to trainee banding and on-call payment if the proposal is implemented. A further re-organisation which returns responsibility for sexual health services back to the NHS from Local Authorities in England would greatly aid implementation of the proposed model, but politically the likelihood of this happening appears low at present.

Proposal for a way forward
As already described, little GUM core caseload presents to the acute unselected take and there has been a clear statement that different specialties could contribute in ways most relevant to their specialist practice. Therefore, pending wider consultation and discussion, a pragmatic interim solution could be 3 months of acute selected take each year (‘specialty’ on call in the local HIV/infection unit) combined with ward and out-patient attachment to designated allied specialties.

There will need to be clarity about which on-call rota the GUM trainee is working on with appropriate supervision and documented educational outcomes. The key issue across all the medical specialties is whether participation in acute selected take is perceived to be inferior to acute unselected take in delivering competencies for dual accreditation.

Additional trainee perspectives
Finally, there are additional important issues raised by many of the 122 current GUM trainees, which may also apply to other specialties. GUM trainees recognise the importance of improving patient care and safety as well as career flexibility. It was felt that the proposal would enhance trainee employability. However the most frequent issue raised was how might the proposal impact on existing GUM trainees at all stages of the programme.

Some trainees described how they purposely chose to enter a specialty that did not require unselected acute take after becoming disillusioned with the pressure of medical receiving. Others had caring or other responsibilities that made it difficult to work out-of-hours or full-time; GUM has one of the highest proportion of female
trainees who make up over 80% of the workforce. Some trainees are a considerable period since MRCP(UK) and last participation in acute take.

It is difficult to predict the impact of implementing the proposed model on future attractiveness on GUM as a medical specialty and hence recruitment. Those who chose GUM because on less intense on-call may be discouraged from applying to medical specialties entirely and choose career options such as general practice instead. Conversely, GUM becoming more engaged with acute medicine may attract other trainees (particularly in areas where HIV cohorts are smaller) with perhaps a shift to more male applicants. However recruitment to GUM will continue to be challenging given uncertainty about Local Authority priorities and the reducing pool of doctors entering acute medicine because of negative perceptions of being a medical registrar. It is hoped the proposed model will address the latter.

There are additional specific issues for the 10 or so GUM Academic Clinical Fellows who feel it would be impossible to complete all the required academic training plus the GUM plus the internal medicine competencies without lengthening the programme duration. Trainees nearer the start of the programme (including existing ACFs) feel they would be at disadvantage if they end up competing against new dually accredited CST holders for consultant posts in 5-6 years. This may be an issue for ACFs in other specialties too. There is already a relative deficiency of ACFs in GUM and the new model may inhibit further application for such posts, particularly given the lack of co-ordination with recruitment rounds for non-academic posts.

A point made by several trainees is that, in future all GUM consultant job descriptions may demand dual accreditation as standard and they will be unable to apply. This is also a wider concern for some current GUM consultants as relocation following first appointment becomes increasingly commoner in light of the variety of GUM service providers and movement of individuals.

In summary, some existing GUM trainees feel that the Shape of Training reforms are generating uncertainty about what they should be doing in the current programme to maintain their competitiveness; should they be asking to take time out of programme to gain more acute take experience? Trainees have welcomed active engagement in discussions and have expressed carefully considered views but for others this has created uncertainty and anxiety and they are keen for greater clarity to emerge in coming months.
Appendix
Specific questions put to SAC members, trainees and specialty association colleagues

The JRCPTB consultation refers to all medical specialties who support patient care and not just GUM. What is your view on them both in general and specifically in relation to GUM and HIV? Do you support an extra year of core medical training for all?

What is your view on the shift away from the current way of assessing large numbers of individual competencies towards competencies in practice leading to a “trusted decision”?

What are your thoughts on the 14 sets of competencies listed in the example framework? Are they all relevant? Are there any that you feel GUM can share learning to support others?

Do you support GUM joining this model with dually accredited training in both GUM and internal medicine (i.e. with a joint CCT at the end)?

Do you think it is deliverable in your own work settings (including community-based and outside Thames areas)?

Given that the duration of specialty training will remain 4 years, how do you feel the further year of internal medicine should be incorporated? Three month blocks each year over the 4 years or in another way?

What might this internal medicine experience consist of? Acute unselected medical take? Selected take (eg HIV, infection, another specialty)? Out-patient clinics following up acutely unwell patients (but relevant to HIV/GUM such as hepatitis C, renal, cardiovascular, bone)? Or some combination of this?

Given the potential incorporation of internal medicine, what topics in the existing GUM curriculum should be covered in less depth?

Should all trainees be expected to be manage less common AIDS conditions by the time they get their CCT?

What would be suitable topics for post-CCT fellowships? Suggestions have included complex reproductive health, sexual problems, sexual assault as well as more general topics such as medical leadership, management and commissioning.

Would you support credentialing of HIV in-patient care after the dual CCT had been attained? Do you have a view about of doing this jointly with colleagues in Infectious Diseases?

More widely, what GUM and HIV competencies should be included in the internal medicine curriculum and delivered by physicians in all dually accredited specialties?