The growing role of the JRCPTB and Federation in international postgraduate physician education and training

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Background

The three UK Colleges of Physicians, individually and together through their Federation, have a long and distinguished history of supporting development in an international context.[1,2,3] This has traditionally revolved around supporting overseas doctors' training in the UK, or provision of MRCP(UK) examinations and CPD opportunities, usually delivered overseas. All these activities played a significant role in developing medicine, especially in developing countries, and parts of the 'old Commonwealth'. Indeed many doctors who have had experience of training in the UK have risen to very senior political or managerial positions within their own country's healthcare system. Despite the well-recognised challenges of the NHS, UK postgraduate medical education is still very highly regarded in many countries.

However, there has been significant change in the political and educational landscape in the last 10 years. First, immigration policy in the UK has made it very much harder for doctors from overseas to come to the UK either for a complete postgraduate period of training, as many did in the past, or even for shorter periods of time. The Medical Training Initiative (MTI) scheme, well supported by both the London and Edinburgh Colleges,[4,5] has proved complex to organise at times and unfortunately now seems to be bumping up against government quotas. There is considerable frustration since there are currently many empty, fully funded training posts in virtually every specialty in hospitals across the UK.

The second change is the use of examinations. MRCP(UK) has been very successful in providing all parts of its examinations overseas with nearly constant growth, year on year. A particularly important change has been the growth in delivery of PACES overseas. But as educational theory increasingly points out, exams only ever test part of the curriculum, usually around knowledge and some skills, though they are also critically important in driving learning. In the UK, the Joint Royal Colleges of Physicians Training Board (JRCPTB) has had competency-based curricula since 2007, yet while examinations such as MRCP(UK) and the specialty specific exams (SCEs) are mandatory to progress within training, they are no longer in themselves sufficient to demonstrate all the competencies that must be acquired before someone can be signed off as completing training, in particular achieving a Certificate of Completion of Training (CCT).

This change in focus and understanding of the role of examinations is gradually being understood in many more countries. Increasingly, many national regulators understand that simply holding a diploma or examination does not mean you are trained, and that an examination needs to be part of a training programme that assesses the whole of a doctor and their performance. A growing importance for international doctors who often travel widely between countries is to have evidence of both completing a recognised training programme as well as passing appropriate examinations. Some countries have recognised this for a long time, such as Hong Kong, where the MRCP(UK) diploma is fully embedded in the Hong Kong MD training programme and where doctors in Hong Kong must pass and complete the whole training programme, not just the MRCP(UK) examinations.[6]

In a number of developing countries there has also been a large expansion of undergraduate but not postgraduate education. Postgraduate education is often university based

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and those organisations have found it very difficult to expand capacity. In the UK, postgraduate training is service based through the deaneries and local education training boards (LETBs). Some developing countries are beginning to look for help to understand how they can significantly increase postgraduate training, probably by using other models, rather than just expanding the current university base.

A third, smaller change has been the apparent 'exporting' of a US model of postgraduate physician education. This has been promoted to a number of countries based on the American model of highly specialised, investigation-intensive medicine, while downplaying, and certainly not testing, clinical skills. There is some anecdotal evidence that this is not necessarily the best model to be followed by middle income countries, as it is technologically not clinical based, and so may be more expensive and not necessarily meeting local patient needs.

The role of JRCPTB

The JRCPTB, like MRCP(UK), is part of the Federation and has three main roles:

1. Setting and reviewing curriculum and assessment standards for physicians as required by the General Medical Council (GMC). This includes the curriculum for 29 specialties and three sub-specialties, the development of relevant workplace-based assessments and close links to MRCP(UK), while supporting the role of the 33 Specialty Advisory Committees.
2. Supporting trainee progress through training. This includes coordinated recruitment (Core Medical Training (CMT) and 21 other specialties), monitoring progression, approving Out of Programme Experience, ensuring PYAs (Penultimate Year Assessments) have been undertaken and all requirements obtained before making a final recommendation of CCT to the GMC. It also oversees the process of CESR (Certificate of Eligibility for Specialist Registration) and develops the ePortfolio for all specialties.
3. Working with deaneries, LETBs and the GMC on quality management of training. This includes producing the Annual Specialty Reports for the GMC, developing quality materials such as CMT Quality Criteria and promoting the use of other quality metrics.

Until 2014, the JRCPTB had no international role at all. Curricula are freely available on the GMC website and there is little doubt that people overseas would often borrow parts, usually around the knowledge based syllabus, rather than the wider curriculum developments on overall assessment. However, the changes previously mentioned began to raise the question whether a wider international remit was both sensible and appropriate. The arguments for change included:

- MRCP(UK) and the SCEs are all blueprinted to the UK curricula. It would therefore be logical to be able to offer the full curriculum to interested partners. MRCP(UK) would become fully embedded as part of training and not just a standalone examination
- The JRCPTB now has very considerable expertise in competency-based education, both its successes and its challenges, and has developed an ePortfolio to support that education. There can be no doubt that developing an ePortfolio is complex and fraught with operational challenges
- There were already examples of export of UK training. For example, the GMC approved Foundation training is delivered in Malta.[7] There is also wide undergraduate experience in a number of medical schools that are providing undergraduate training internationally. which is considered equivalent to UK training by the regulator
- There was a concern that if we were not able to support training in countries with considerable use of MRCP(UK), other curricula might be developed that would no longer require MRCP(UK) examinations

However the catalyst for change came from an unexpected source. A simple email from Iceland to the JRCPTB asking if Iceland could use our ePortfolio.

The Icelandic pilot and programme

The Icelandic experience has been written up in more detail elsewhere,[8] however the original email asking for use of our ePortfolio was the start of an important and eventually very successful project for Iceland as a country and JRCPTB and the Federation as organisations. The Icelandic project developed in a number of steps that now form the basis for the development of other international programmes.

The email led to a video conference and quickly the involvement of key medical policymakers in Iceland. It was crucial to determine what Iceland needed because at that stage they had no structured postgraduate education. Very early on, the decision was made that the most straightforward thing to do would be to implement UK Core Medical Training in its entirety in an Icelandic context.

Involvement of key stakeholders from the beginning

Change cannot be driven by a Department of Medicine alone but requires the highest level of support within the hospital(s) where training occurs and all the current players in local postgraduate education. In the Icelandic context this also required governmental support and indeed a change in the law to ensure adequate governance of the processes.

To ensure a thorough understanding of what was being expected and the change in culture needed in Iceland, we provided an intensive development day in the UK on all aspects of CMT. The outline of the programme is set out in Box 1. We now see this as a key part of starting a relationship with any new partner as they need to understand CMT is not 'a course to pass MRCP(UK)' but a comprehensive, modern, competency-based curriculum. This will involve very considerable culture change, understanding, and

Box 1 Understanding UK Core Medical Training Programme

Introduction to the programme
What is the CMT curriculum?
Why a 'gold guide'?

Assessment
Assessment of curriculum content:
- Workplace based assessment (WPBA)
- MRCP(UK)

Annual review of competence progression (ARCP)

Using the ePortfolio
Various roles of TPD, Educational and Clinical Supervisor, College Tutor
Training the trainers
Trainees in difficulty

Other learning: Simulation, Procedures, Audit, Quality Improvement and reflective practice
Standards and programme accreditation
Discussion on specific country issues
Final questions and wrap up

training of both the trainers and the trainees who will start the programme. It is vital that all new partners have an in-depth understanding that this will not be an easy or possibly straightforward process.

Following the development day, a formal agreement was developed and agreed with a Memorandum of Understanding between the Federation and Iceland.

- The implementation in Iceland required setting up new local committees and a new governance structure. There were monthly video conferences between JRCPTB and the lead Icelandic doctors to go through all the challenges of recruitment, programme planning, designing taught programmes and planning for support for trainees to undertake MRCP(UK).
- Icelandic doctors attended recruitment and Annual Review of Competency Progression (ARCP) sessions in the UK to gain experience.
- A detailed 'training the trainers' package was put in place to ensure all educational and clinical supervisors, many of whom had no experience of postgraduate supervision and training, were brought fully up to the expected UK standard. This involved providing two 3-day sessions in Iceland. In the second session trainees who were about to start were also trained, including hands-on experience with the ePortfolio. Iceland was set up on the ePortfolio exactly the same way as any UK deanery.
- Video conferences continued after the start of the programme to deal with any issues and UK expert externality was provided to the first set of ARCPs undertaken in 2016 after the programme had been running for a year. It is a requirement of Federation that UK externality at ARCP is mandatory if the programme is to be formally accredited by JRCPTB
- Despite all the training, it took time for clinical supervisors, in particular, to fully engage with workplace-based assessment. However we found a high degree of trainee engagement and support.
- MRCP(UK) needed to develop local delivery of written exams and make arrangements for ring-fenced PACES examination spots for those going through this Federation programme.
- From the start we planned a formal accreditation process based on usual UK GMC quality standards for training as well as the JRCPTB CMT curriculum and using well-rehearsed deanery visiting methodology. This would involve two senior medical educators and an administrator from the UK.
- The original plan was for an accreditation visit after two years of the programme but the speed of development suggested we could do this after one year. This was undertaken and two years accreditation has subsequently been agreed by the three Presidents at Federation Board. JRCPTB require that all such accreditation visits are publically available on the websites.[9]

Outcomes

As well as a successful accreditation process, Icelandic trainees are doing at least as well as UK trainees in MRCP(UK) and it is hoped that many of these doctors will wish to apply for higher specialty training in the UK, rather than going to Scandinavia or North America as was the case in the past. Within Iceland a number of other specialties have been impressed with the programme and are working now with other Colleges in the UK. This includes emergency medicine, obstetrics and gynaecology, and anaesthetics.

Further expansion

Based on the learning from Iceland, the JRCPTB started to look for new partners in 2016. The second major partner has been Aster DM Healthcare. They are a large private organisation with hospital sites across the Middle East, six sites in India and also in the Philippines. They were already in discussion with MRCP(UK) on possibly delivering PACES and this led to a discussion around training and an introduction to the JRCPTB. Using the same change model as Iceland, development days were held in the UK for Aster clinicians from Kochi in Kerala and subsequently for Aster clinicians from Dubai. Based on this experience, both requested that we introduce full CMT to their sites.

There was a similar process of regular video conferences, arranging for visits to the UK to experience recruitment and ARCPs, intense faculty development and support for the use of the ePortfolio.

It has been our policy to say that it is entirely up to local partners to decide how to recruit doctors into the programme. However both Dubai and Kerala, having experienced current CMT recruitment in the UK, decided to use exactly the same methodology locally to select from those that had passed their required national standards or eligibility exams.

The programme in Kerala started in July 2017 and in Dubai in September 2017. Both will have UK externality at their ARCPs in 2018 and subsequently go through the standard accreditation process.

From the point of the JRCPTB, once programmes have been accredited, have continued UK externality at ARCP and maintained their accreditation, we will treat doctors who successfully completed their programme and pass MRCP(UK) in the same way as we would treat any UK trained doctor for application to Higher Specialty Training.

So far the learning and experience we have gained from Iceland has been repeated in both Kerala and Dubai. In particular:

- Very enthusiastic trainers and trainees.
- The need for very significant faculty development. It is a major conceptual and cultural change in these counties although in all three sites there were a number of doctors who had recently been in UK training which helped the process.
- Supporting them in all aspects of new programme development. Wide deanery experience is very helpful to this process.
- Ensuring full local support from the beginning at the very highest level; be that political or local service. There is a cost of both time and money but the partners we have dealt with so far have clearly seen the advantages of trade off in terms of quality of training and competition to enter the programmes, therefore attracting doctors to provide excellent patient care.

During the summer of 2017 a number of other potential partners are in discussion with the JRCPTB. These include another Aster site (DMWIMS Wayanad), KIMS Trivandrum where there is already an accredited MRCP(UK) course, the Aga Khan University in Nairobi, the University of West Indies, and the Department of Health, Myanmar. Most of these are either small countries or big organisations in countries that struggle to provide enough capacity in postgraduate medical education. The model of developing UK CMT appears to work in those environments as it is 'off the shelf'. This would not be the solution to support a large country that needs to develop postgraduate physician education. In this circumstance they need more bespoke help and possibly the introduction of a 'demonstrator site' where aspects of competency-based medical education linked to our curriculum and MRCP(UK), can be introduced from which local educators and medical regulators can gain a greater understanding of what would really work locally in their country. We believe medium and large size countries will always need their own developed and supported model long term. The JRCPTB, on behalf of the Federation, are starting to talk to countries about such support but this is at a very early stage.

Box 2 Accreditation levels

UK CMT International Accreditation: Level 3
This approves training equivalent to full UK CMT. Trainees successfully completing this training programme and passing all parts of MRCP(UK) will fulfil the 'experience' criteria required to apply directly for higher specialty training in the UK, i.e. that their clinical experience and competences would be considered the exact equivalence to someone completing CMT in the UK.

JRCPTB International Accreditation: Level 2
This reflects the provision of the detailed local curriculum for the early years of physicianly training with a modern competency based curriculum. All parts of the MRCP(UK) form part of the programme of assessment of this locally determined curriculum. The accreditation process will be undertaken using local curricula as well as relevant generic standards of postgraduate education derived in part from the UK GMC standards.

JRCPTB Preparatory International Accreditation: Level 1
The provision of an organised local training programme that allows candidates to prepare for all parts of the MRCP(UK) examination as part of that training programme. The programme will be assessed against relevant generic standards based on GMC UK standards and will have evidence of an active process of developing and implementing a modern competency based curriculum.

Accreditation

As described with the Icelandic experience, the JRCPTB has now introduced a process of international accreditation.[10] We believe this is the recognition granted to an institution, an organisation, or even a country, where their postgraduate medical education meets the standards set by the Federation of the Royal Colleges of Physicians of the UK.

Federation has approved three types of accreditation (Box 2). The first of these, the highest level, is UK CMT international accreditation level 3. This has been achieved by Iceland where we are accrediting full training equivalent to full UK CMT. It is hoped that the Aster sites in Dubai and Kerala can be accredited to this level in due course. However, Federation believes that we should be doing more to promote and ensure a high quality of physician education beyond these sites and accreditation can be done at both levels 1 and 2 to support local development of competency-based education, particularly where it is linked to use of the MRCP(UK) examinations. Importantly accreditation is always seen by the Federation as being both part of a partnership and an ongoing developmental process.

The standards that we use are based on the GMC standards which we adapt as seem appropriate to the country. The accreditation process uses two experienced consultants and an educational administrator and, when approved by Federation Board, can be awarded for up to 3 years.

Ethical aspects

In all international activity undertaken by the Colleges there are ethical issues. The experience we have had so far has been extremely positive and very welcome but it has been in very small countries and very small partners. There is the challenge of whether competency-based medical education is really appropriate for middle income countries. Medical politicians and leaders we meet think it is because of the type of professional it is designed to produce. Even within the UK context it is complex, time consuming, not always welcome, and there have been considerable concerns about 'a tick box culture'. In the UK we are reforming our curricula to try and make them simpler and more authentic and hope that by working closely with partners abroad they will be fully part of those changes and not part of a static one-off model.[11]

We have made it clear that this training needs to be accredited to a UK standard. We would be concerned for trainees of organisations that did not meet accreditation standards, or chose not to be accredited in the future. We believe this emphasises the importance of choosing partners with great care who really understand the change and work involved to making the long term commitment to high quality physician education.

Conclusions

A number of drivers encourages Federation through the JRCPTB to increasingly engage in supporting a postgraduate physician education abroad in close collaboration with MRCP(UK).

We have gained considerable experience around the change management process required to develop a new programme abroad and while so far we have developed relatively small programmes based on CMT, these have been well received by both trainees and trainers.

There is a bigger challenge in supporting larger countries in developing their own solutions to training doctors, but we believe we can support those in partnerships through both an accreditation process based on well understood standards of postgraduate medical education and the possibility of developing local 'demonstrator sites'. Importantly, we have found a continued appetite for UK medicine and in particular UK physician education and training.

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