PAEDIATRIC TRAINING IN EUROPE – THE COMMON TRUNK

As outgoing chairman of the European Board, I was asked to prepare a paper on the Common Trunk (CT) for the Rhodes meeting. This must inevitably be a personal view and is biased toward the UK perspective. It is intended to stimulate discussion, not to provide answers.

There are several issues:

1. Since we first debated this and wrote a syllabus for the CT and for primary, secondary, and tertiary care, many countries have made changes in their training programmes, but not necessarily in the direction of adopting the CT.

2. Some countries have however used the CESP template to argue for a longer training programme.

3. There has been debate about the extent to which the trainees should do both secondary and tertiary care training, and how much they can "double-count" time spent in this training. (For instance, can 1 or 2 years of training count both towards secondary and tertiary care recognition?).

4. The UK have run a pilot of the MCQ part of their exam, the MRCPCH in several member states (Membership of the Royal College of Paediatrics and Child Health) and it was found that trainees performed very creditably even though they were not taking the exam in their own language and had done little or no preparation – this suggested that the standard might be about right for creating minimum common standards. (The UK exam is taken at the end of the UK equivalent of the CT).

5. An exam of this type could be taken at any point in the training as a way of demonstrating that either a trainee or an institution (if the exam is taken anonymously) is reaching that minimum standard.

6. In the UK, there is growing interest in the fact that primary and secondary care seem to be coming closer together and there is much discussion about combining elements of training in primary and secondary care.

I suggest that the CESP approach might be as follows:

- The CT (which is equivalent to the UK two-year requirement for senior house officer training) should where possible be the prelude to the more advanced training in primary, secondary or tertiary care.

- However, for those countries with a different structure the main consideration is to ensure that all trainees cover the CT syllabus – although the CT is a logical concept and one that the UK supports, it may not matter greatly if countries follow other routes – what matters is the end product.

- One message that has become very clear in the UK is that to be a good paediatrician means being a good all-rounder, at least in the early years. On the other hand, we have also realised that the training to be a specialist in a large university hospital might actually be shorter than that needed to be a good generalist in a district hospital.

- Being an all-rounder reminds us that paediatrics is the care of children – it is not just the internal medicine of children but also recognition of surgical conditions (though not operative technique etc) , children's mental health, children's dermatology, allergy, ENT, orthopaedics and public health. It also includes adolescent health care. It emphasises the care of long term and chronic disorders as well as acute and straightforward disorders. This means that in the early years we need to ensure a broad exposure to more than just hospital medical paediatric illnesses.

- Skills must include excellent communication and consultation skills, talking to children of various ages, including teenagers, working with and eventually managing teams, and understanding local networks and services.

- All trainees need to understand the issue of probabilities and uncertainties – the GP in primary care knows that most illnesses and complaints are self-limiting and much of general practice is about cautious observation and waiting, whereas the hospital doctor starts from a presumption that the child is more likely to have a real problem. Doctors who work in primary care and those in secondary care need to understand each others' perspectives on this issue.

- The essential ingredients of CT are therefore a broad base of knowledge and sound basic clinical skills.

The UK exam is evolving to make sure that these basic skills are acquired and tested as well as the more sophisticated knowledge tested by our MRCPCH exam. In the past there has been a tendency to concentrate on high powered knowledge and ignore these basics – thus we have seen candidates who know all about glutaric aciduria but not breast feeding or measuring height accurately.

We do not think that any trainee, whether a primary care paediatrician, a district hospital generalist or a high powered academic research neonatologist, should be allowed to exit training without showing basic competence in dealing with, for example, a child with disability, or a parent with severe depression or drug abuse problems, or a suspected case of child neglect or abuse. There is no specialty of paediatrics where these skills are irrelevant.

The challenge to CESP is to ensure that trainees get this broad base and are assessed on their broad knowledge and skills, no matter what the stricture of training and assessment in each country.

The UK is investing in better training in these difficult areas, especially in mental health and in managing child abuse. This is time consuming and expensive but progress is being made.

This is the crux of the matter – it is easy to write a syllabus but difficult to turn it into a plan of action, especially as we are calling for a marked change of the culture in which trainees are educated in paediatrics.

David Hall, 16th April 2003.