

## **Modular Credentialing: The views of the Academy Trainee Doctors Group August 2009**

### **Background**

In his July 2008 report *A High Quality Workforce*, Lord Darzi states “*we will develop plans to introduce modular credentialing for the medical workforce over the coming decade. This means the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience.*”

Some preliminary work has considered how this might be taken forward. In May 2009 PMETB and GMC organised a Modular Credentialing Event and the Modular Credentialing Steering Group was formed. At this time the potential benefits and risks of credentialing were discussed. Distinction was drawn between “Pre-CCT credentialing” and “Post-CCT credentialing”. There appeared to be significant support for credentialing post-CCT but uncertainty about whether credentialing pre-CCT during training was beneficial.

### **ATDG views**

- We have significant concerns about credentialing pre-CCT during training for the following reasons:
  - Postgraduate Medical Education has recently undergone a significant reform via MMC and we believe that a period of stability is required to ensure that the changes are fully evaluated.
  - There is mounting evidence that care delivered by Consultants results in both improved patient outcomes and efficiency of care (AoMRC 2008). The British public have the right to receive healthcare that is always supervised, and usually delivered, by fully trained doctors who are on the specialist or GP registers. The end-point of training should therefore be the CCT. The introduction of modules and/or credentials would risk an increase in medical service roles below the CCT level (ie a sub-consultant grade), resulting in a subsequent reduction in the quality of care provided within the NHS.

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- The CCT is a well-established level of achievement with recognised routes of determining its standard. The concept of credentialing prior to CCT implies there would be an alternative method within structured training of reaching various standards. This would undermine the principle of the CCT, a process which is highly valued and desired by trainees.
- Existing PMETB approved College curricula are designed to be completed in their entirety. The value of curricula is greater than the sum of their parts and dismantling them into credentials is likely to result in disjointed, uncoordinated training.
- The vast majority of trainees do not wish to take breaks in training for reasons other than research, out-of programme experience, or to have a family. There are currently sufficient existing mechanisms for the above and therefore no trainee-perceived benefit for the introduction of a fragmented training pathway. Concerns that newly appointed consultants do not have sufficient experience should be addressed within existing training programmes.
- We think that the current new curricula, WPBA, and ARCP processes already allow for the clear demonstration of competencies throughout training. Work may be required to simplify the communication of an individual trainee's current competences and experience to patients, but this does not require the fragmentation of training into modules or credentials.

Reference:

Academy of Medical Royal Colleges (2008). *Medical Workforce Project to identify the added value Doctors bring to the Healthcare team.*

[www.aomrc.org.uk/aomrc/admin/reports/docs/Medical%20Workforce%20Project.pdf](http://www.aomrc.org.uk/aomrc/admin/reports/docs/Medical%20Workforce%20Project.pdf)

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