



FACULTY OF PHARMACEUTICAL MEDICINE

OF THE ROYAL COLLEGES OF PHYSICIANS OF THE UNITED KINGDOM

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A response from the Pharmaceutical Medicine Virtual Deanery to the GMC's final report on its review of training in pharmaceutical medicine

We welcome the GMC's final report on its review of the PMST programme and its visit during Spring 2018 to meet with doctors in training, Educational Supervisors (ESs), Specialty Advisers (SAs) and representatives from the Faculty of Pharmaceutical Medicine (FPM) and the Pharmaceutical Medicine Virtual Deanery (PMVD). The FPM/PMVD's response to the report are detailed below.

Summary of findings

We welcome the GMC's findings.

Areas working well

We welcome the GMC's observations of the areas that work well at the PMVD.

Requirements

We accept the GMC's requirements, and will consider how the PMVD will implement these requirements. Regarding requirement 1, we agreed with the GMC visit team that achieving equity in the training experience means ensuring that a common standard of access to training opportunities is demonstrated for all LEPs. Where LEPs wish to exceed this standard, that should be encouraged.

Recommendations

We accept the GMC's recommendations, and will consider how the PMVD will implement them.

Patient safety and raising concerns

Doctors who work in pharmaceutical medicine are highly regulated and they take patient safety seriously. We note the GMC's observation that "doctors in training, ESs and SAs we spoke to were unsure whether such incidents [e.g. breach of ABPI Code of Practice] should formally be brought to the attention of the PMVD." We will consider what guidance the PMVD can provide doctors in training, ESs and SAs about reporting concerns.

Bullying and undermining

We are pleased that during the GMC's visit that no bullying and undermining concerns were raised.

Recruitment and selection

We note the GMC's comment no. 13. The FPM has a LinkedIn group that all members can join, and a trainees sub-group open to pharmaceutical physicians enrolled on the PMST programme. These groups can be used by doctors in training and ESs who work in small organisations to contact peers to form informal support networks. However, we will consider what more the PMVD can do to assist these groups of doctors.

Out of programme

We note the GMC's comment no. 15 and would welcome a discussion with the GMC's approval team. Our OOPT process is based on a protocol that the PMVD agreed with the Postgraduate

Medical Education and Training Board (PMETB). We will send a copy of the protocol to the GMC to review.

Educational supervision

We note the GMC's comment no. 19. This refers to a single case that was managed in this exceptional way whilst the requirements for an ES were clarified and an ES was appointed. Use of this exceptional practice is not recommended nor supported by the PMVD.

We note the GMC's comment no. 23 concerning ESs from outside the employing organisations. It is not the PMVD's experience that ESs from outside employing organisations are disadvantaged by not fully appreciating the training opportunities available within the LEPs, but we will consider how the PMVD can check whether that is the case or not.

We will consider how the PMVD can help ESs in small organisations form informal support networks, and provide further training for ESs.

Support for trainers

We note the GMC's comment no. 25 that "some agenda items, whilst still of interest, may not always be directly applicable to the PMST programme." We will seek ways (or similar strategies to those of an annual meeting) to address the collective needs of doctors in training, ESs and SAs.

Annual Review of Competence Progression (ARCP)

We note the feedback from the doctors in training and ESs about their perception of the PMVD's ARCP process. We are satisfied that the PMVD follows the requirements of the Gold Guide; we are aware that doctors in training are not required to attend their review in person, but we consider it an important part of the review process that we have face-to-face ARCPs because it provides an ARCP panel the opportunity to give constructive feedback to a doctor in training, and to discuss other training-related issues. This is particularly relevant to pharmaceutical medicine, whose LEPs are a disparate group of competitive companies or organisations; there is not the cohesive harmony of a single employer, such as the NHS. The face-to-face ARCP allows all disparities and individualities of *ad personam* programmes to be addressed head-on and differences to be reconciled as best as possible and on a continuous basis.

Specialty Advisers (SA)

We are proud and appreciative of the work that our SAs do on behalf of the PMVD. We will work to ensure that SAs receive the necessary training, support and clear guidance they need to perform their role effectively. The GMC recorded in comment no. 39 that the PMVD "are aware of SAs continuing in the role despite no longer having a licence to practise and have discussed possible transitional solutions, but that no succession planning has been finalised." There were two SAs who were without a licence to practise; the first SA stepped down and their LEPs transferred to a SA with a licence to practise, and in the second case, the PMVD is working closely with the MHRA to find a suitable replacement for its SA as it has special requirements because it is a regulatory authority.

Quality management

We will clarify the role of the SA and provide training where required so that SAs can perform their role effectively. We will also consider refining the PMVD's QM procedures so that there is consistency of approach and clearly documented outcomes.

Programme management

We think that the PMVD's focus should be on ensuring that LEPs are meeting the required standards rather than trying to achieve parity/equity regarding training experience because the business of

each LEP, whether it is a large pharmaceutical company, a CRO or a regulatory authority will be different, and it will not always be possible for a doctor in training to gain the same training experience as a peer in another company or organisation. We would like to reiterate that the PMVD does not work with a single employer, such as the NHS, but manages LEPs in a disparate group of competitive companies and organisations. We will never achieve 'parity' of training experience across the pharmaceutical industry and landscape. PMST is a collection of *ad personam* programmes.

Data collection

We will consider what data the PMVD collects, how it is analysed and how that analysis is recorded.

Supporting doctors in difficulty

We acknowledge that we need to develop a clearer policy on supporting and managing doctors in difficulty. In developing our policy, we must consider carefully regulations on the processing and sharing of personal data (i.e. General Data Protection Regulation) for example. In addition, it needs to be recognised that the PMVD is neither the employer of its doctors in training nor representing the employers. In dealing with trainees in difficulty, following diagnosis, it needs to be decided first whether this is a difficulty of training (fitness to train), or of employment (fitness to practise). Routeing the next steps involves a complex interplay between the PMVD, possibly the FPM, the employer, possible health/occupational health bodies, the relevant designated body (up to GMC level). The rules of case law and precedence come into play here, and in pharmaceutical medicine to date there have been few cases/examples of trainees in difficulty from which to derive policy and best practice.

Time for learning

We will analyse the results of the programme specific questions from the 2018 national training survey alongside previous results and consider how the PMVD can work with LEPs to allow doctors in training the time off needed to attend meetings and courses relevant to their programme of training.

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