Common trunk medicine in the EC

In the UK and Ireland, would-be specialists have to undertake a two to three year period of general professional training (GPT) before embarking in more specialised training programmes. It covers several specialties within medicine, with a major emphasis on acute general medicine. In the other EC countries training programmes in specialties affiliated to internal medicine also incorporate a period of non-specialist training, the ‘common trunk’. However, this common trunk is not strictly analogous to GPT. Within the EC, by ‘common trunk’ is understood a period of time, usually two years, when an intern may rotate through branches of medicine not related to the final choice of speciality. If this common trunk training period is deducted from the duration of the specialist training programme, it may make ‘specialist’ component as short as two years. On the other hand, by any criterion, the UK has the longest training programme of all in virtually all specialties and this is a continuing irritant to our fellow Europeans.

The widely disparate duration of training programmes in postgraduate medicine can be gleaned from a recent UEMS document (Table 1). Fundamental to these disparities are the differences in the definition and function of specialists within the EC. Their salary is based on their specialist credentials. In several European countries the number of ‘externally based’ specialists far exceeds that of the hospital based specialists.

### The common trunk

The duration of training in EC countries is subject to the statutes implicit in the 1975 directives. Apart from explicitly stating that all undergraduate degrees and the status of specialists are equivalent among individual member states, they also make direct recommendations on the minimum—but not optimum—duration of training for all medical specialties in the EC. These directives do not mention quality and content of training and so cannot be expected to overcome the barriers and suspicions that exist between member states concerning the real quality of training and the equivalence of such training. In 1982 the Advisory Committee on Medical Training (ACMT), an offshoot of the EC Commission, revised the minimum training requirements in its recommendations (Table 2). However, a recent document from the UEMS shows that so far there has been scant adherence to many of these recommendations.

The continuing discrepancies in training schedules between EC states represent a possible barrier to the free movement of doctors within the EC as envisaged by the Single European Act.

Until recently, the necessity for a ‘common trunk’ component akin to GPT prior to starting specialist training had not met with universal uptake in the EC. There is a consensus that such ‘common trunk training’ is desirable, but its insertion as a prerequisite to

### Table 1. Number of years spent training in medical specialties in the EC.

| Specialty   | B | D | DK | E | F | GR | I | IRL | L | NE | P | UK |
|-------------|---|---|----|---|---|----|---|-----|---|-----|---|----|
| Allergy     | – | 3 | 6  | 4 | 2 | 5  | – | –   | – | 6   | 7 | 7  |
| Cardio      | 8 | 8 | 7  | – | 4 | 7  | 4 | 7   | – | 6   | 7 | 6  |
| Derm        | 4 | 4 | 5  | 4 | 4 | 6  | 4 | 7   | – | 4   | 5 | 7  |
| Endo        | 6 | 7 | 6  | 4 | 4 | 6  | 4 | 7   | – | 6   | 5 | 7  |
| Gastr       | – | 7 | 6  | – | 4 | 6  | 6 | 7   | – | 6   | 7 | 7  |
| Int Med     | 5 | 6 | 5  | 5 | 5 | 5  | 5 | 7   | 5 | 6   | – | 7  |
| Neuro       | 3 | 4 | 5  | 4 | 4 | 4  | 4 | 7   | 4 | 6   | 5 | 7  |
| Paeds       | 5 | 5 | 5  | 4 | 7 | 7  | 4 | 7   | 4 | 5   | 5 | 7  |
| Thorac      | 5 | 9 | 6  | – | – | 4  | – | 7   | 10| 6   | 5 | 7  |
| Rheum       | 5 | 2 | 6  | – | 5 | 6  | 4 | 6   | – | 6   | 4 | 8  |

B, Belgium; D, Germany; DK, Denmark; E, Spain; F, France; Gr, Greece; I, Italy; Irl, Ireland; L, Luxembourg; NE, Netherlands; P, Portugal; UK, UK.

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158 Journal of the Royal College of Physicians of London Vol. 27 No. 2 April 1993
common trunk. For example, in the case of endocrinology, a further four years' experience will be necessary to obtain full accreditation, (ie a total of at least six years). These recommendations will be forwarded to the executive bureau of the UEMS. It remains to be seen whether they will be fully implemented. Some interest was also expressed during this meeting in the MRCP part II examination as a model for examining competence in general internal medicine at the end of the common trunk.

It is important to realise that such training will be legally recognised and enable the practitioner to set up as an external specialist in those EC countries in which the title 'specialist' is legally protected. This is not the case in the UK and Ireland. Hospital based (internal) specialists will in most instances have to continue amassing more experience for these more competitive posts.

The Boards of the UEMS

The creation of European Boards, as working groups of the monospecialty sections to oversee specialist training within the EC, represents a challenging initiative which has the full backing of ACMT, and the UK and Irish Royal Colleges (Table 3). The Board structure of the UEMS represents the best opportunity yet to obtain a wide consensus from the profession itself as to how to organise training and instal the necessary audit measures to ensure its quality in every member state—in contrast to the *dictates* implicit in previous directives from the Commission. There is a need actively to encourage the full participation of appropriate representatives from each member state for each specialty, and with reasoned argument persuade

specialist training has met with resistance.

This position may change in the wake of a meeting in Rotterdam on 31 October 1992 between the internal medicine section of the UEMS and the presidents and secretaries of the cardiology, rheumatology, endocrinology, chest medicine and gastroenterology sections. They agreed that 'higher training' should start with a period of practical experience in acute general internal medicine and the major medical disciplines, akin to GPT. At least two years of such full time practical experience in approved training centres is desirable. Since this trunk will be common to all the medical specialties, high priority should be given to defining the requirements and duration of this com-

Table 2. Summary of ACMT reports.

1. Need for a competent authority in each state to assess quality of training.
2. Specific training should begin after basic training.
3. Specific training should start with common trunk in the relevant specialties—but duration and content adjusted in relation to final objective.
4. Training should be full-time and remunerated, with trainee assuming progressively greater responsibilities.
5. Need for selection/inducement to guarantee quality and use of non-university hospitals.
6. Establish channels of communication between member states to encourage exchange of authorised training posts.
7. Escrow unnecessary prolongation of training period—rather encourage continuous medical training.
8. Caution in the establishment of new specialties—integrated rather than separate training favoured.

Table 3. European Boards of UEMS.

*Table 3. European Boards of UEMS.*

Aims: the main objective is to guarantee the highest health care standards in the specialty

**Purpose of Boards**

1. Boards to recommend training standards and their maintenance.
2. Make proposals for quality of training and syllabus.
3. Recommend procedures to achieve free movement of specialists in Europe.
4. Recommend criteria to which training centres should conform.
5. Assess real content and quality of training in different EC countries.
6. Facilitate exchange of specialist trainees, ensuring 'better harmonisation and quality of training'.
7. Set up a system for 'recognition of qualification'.

**Composition of Boards**

1. Boards to comprise two representatives for specialty from each country.
2. Representatives must be members:
   - of national professional associations
   - representing universities
   - of practising profession.
3. One representative shall be a member of the national delegation to the monospecialty section.
4. Boards to establish contact with a European scientific society of their specialty. Delegates from latter to have consultative status.
those EC members who still perceive the Boards as a threat to their own autonomy of training programmes to accept them.

Looking ahead

What sorts of specialists do we need? Social, cultural, political and financial imperatives demand a very broad approach in order to reflect the diversity of health care systems that exists in Europe (Table 6). It will then be necessary to define the optimal mix and synthesis of vocational, educational and research components to produce the high quality specialists that will be needed in the next millennium.

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