

Rough Guide to Rehabilitation Medicine **Guidance for training programme directors,** **supervisors and trainees**

May 2021

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Introduction

This is a guide to becoming a doctor specialised in rehabilitation. It is based on and complements the curriculum for doctors training to become a consultant in the General Medical Council approved speciality of Rehabilitation Medicine. It expands upon some areas of the curriculum, explains others, and gives advice upon the process of training, helping trainees and trainers to achieve the best training possible.

The goals of the Rough Guide are to:

- explain what rehabilitation is, and the role of a doctor specialised in rehabilitation
- give any doctor interested in the speciality an overview of the speciality with more detail than the formal curriculum
- help both trainees and their trainers understand the curriculum and how its goals can be achieved
- act as an up-to-date resource for training, listing sources of help and information
- respond to or clarify any issues that may arise in training that are not covered directly or explained clearly in the formal curriculum

The Rough Guide is reviewed regularly by the Specialist Advisory Committee, which welcomes comments, questions and suggestions from anyone at any time [via curriculum@jrcptb.org.uk]. For example, it can give advice on how to adapt training in the light of changes such as those arising from Covid-19. It does not and cannot change the curriculum itself, but it can suggest ways of delivering the curriculum.

This version of the Rough Guide is dated November 2020. To check if there is a more up-to-date version, and to contact someone for more information, please email: curriculum@jrcptb.org.uk. The 2021 curriculum and ARCP decision aid can be found on the JRCPTB [webpage](#) for Rehabilitation Medicine.

Rehabilitation Medicine is the name given to the medical speciality of doctors who work in rehabilitation. All medical training is overseen by the General Medical Council (GMC) who ensure that curricula lead to a level of knowledge and skills that will ensure safe independent medical practice at a consultant level. The GMC standards for curricula and assessment require curricula to be based on high level learning outcomes. Each speciality has identified a limited number of capabilities that define the specific characteristics of the speciality. Rehabilitation medicine is defined by eight specific Capabilities in Practice, which differentiate this speciality from all other medical specialities.

The 2021 curriculum sets out the training needed to acquire the six generic Capabilities in Practice that every doctor needs to achieve, and the eight specific Rehabilitation Medicine capabilities. The curriculum is, necessarily, written and set out in a style and with a layout that is formal and is also similar across all curricula. The curriculum can be altered, but only after going through a lengthy process, which means that it is written at a high-level so that detail does not become dated and need changing, and also so that it remains appropriate when expected or unexpected changes occur in the healthcare environment.

The curriculum's focus on capabilities rather than specific knowledge, or skills, or named competencies leaves much that a trainer or trainee may need help with, within the training programme. The Rough Guide is, as its name implies, guidance intended to flesh out details where necessary. The Rough Guide is concerned with **how** the curriculum is delivered, not **what** the curriculum is. It does not and cannot add to the curriculum, nor can it set new or different standards.

The layout of the Rough Guide is based on that of the curriculum itself, and it should be used and read with the curriculum. Towards the end, it also gives guidance on changing or emerging areas of clinical practice and how they fit into the curriculum. It gives some references to allow anyone interested to read around some topics. References are numbered in the text and are found at the end of the document together with a list of other resources and links that might be of interest.

Purpose – training in a process

The curriculum's purpose statement sets out what rehabilitation is, justifies the need to train doctors in Rehabilitation Medicine, explains what the curriculum aims to achieve, and outlines the scope of the role that a consultant in Rehabilitation Medicine will be trained in.

Many doctors and other healthcare professionals have no clear understanding of what rehabilitation actually is. The nature of rehabilitation is outlined in many articles [1][2][3][4][5] which cover its goals, the processes used to achieve those goals, and the nature of rehabilitation 'treatments', a word covering interventions leading to benefit for the patient. Most effective interventions are not drugs, surgical interventions, or other direct actions on the patient.

The curriculum's purpose statement emphasises that training focuses on the knowledge and skills required to undertake **rehabilitation as a process**, and that the expectation is that, after training, the doctor will be able to work within any rehabilitation team working with any disabled patients of any age, at any stage in their illness, and in any setting.

The three previous curricula specifically included training in specific areas, such as spinal cord rehabilitation or musculo-skeletal rehabilitation, and they were centred on the secondary care, hospital setting. They focused on acquiring experience and on a large set of specific, limited competencies. In contrast, this curriculum mirrors the scope and the practice seen in most other countries. It covers a broad range of conditions, and covers rehabilitation in the community and nursing homes, as well as in all hospital settings, including intensive care.

Doctors within rehabilitation

Many doctors are uncertain and unclear about the role of a doctor in rehabilitation. This lack of understanding extends to other healthcare professions, patients, commissioners, and

the public. The curriculum itself does not specify or discuss how and why doctors are integral to rehabilitation. A brief explanation of the roles a doctor fulfils in rehabilitation is given here.

The starting point is that rehabilitation requires a multidisciplinary team [6] that can cover, from within its own resources, the majority of the problems a patient may have. The patient's disease diagnosis does not dictate or closely determine the patient's rehabilitation, but knowledge about disease is nonetheless a central and important factor in most rehabilitation decisions. This follows from the defining characteristic of rehabilitation, its holistic approach to a patient using the biopsychosocial model of illness. [7] The model includes disease, but additionally includes patient experience (symptoms), a person's ability to undertake a wide range of activities (termed disabilities when limited), social interaction and social roles, and all aspects of the patient's environment (context).

Disease can have an important influence on all aspects of rehabilitation. The doctor involved must not only have a good understanding of all aspects of disease, as acquired from pre-graduate training and core post-graduate training, but they also need to be able to use their professional knowledge and skills within the context of the rehabilitation process and team. The training programme enables the doctor to make a much broader use of their professional knowledge and skills than in many other specialities. At present other non-medical professions do not have specific training in rehabilitation leading to formal recognition of their rehabilitation expertise to complement their professional expertise. [8] This means that the trained doctor will often have a much fuller understanding of rehabilitation than most other team members.

Within the rehabilitation team, the doctor has some roles reliant specifically on their medical knowledge and skills;

- confirming given diagnoses and diagnosing the cause of any new symptoms or problems;
- managing disease-specific treatments, in liaison with other specialists if needed;
- prescribing, reviewing, stopping or starting drugs relating to any aspect of a person's illness;
- setting medical information in a rehabilitation context, guiding team activity through
 - identifying what problems are likely or unlikely to be present given the disease(s), and
 - estimating the person's likely prognosis.

There are other roles that the trained doctor will have, some uniquely, some that may be shared with other professionals, and some that arise from accumulated experience ("seen it before"):

- being the named person within the healthcare system responsible for the patient's well-being;
- taking the lead when the team is faced with complex or challenging cases or situations;
- ensuring that all problems are identified and considered, and that priorities are set;
- leading on ethical issues and awareness of legal and other broader considerations such as protecting vulnerable patients;

- often being the first person to see a patient, and being able to consider all aspects of a person’s situation and be aware of the potential contributions of all professions;
- representing the service in higher-level meetings with commissioners, Trust management etc;
- initiating and/or taking the lead in service development, and in investigations into any serious incidents.

The training programme gives the doctor the skills to fulfil all these roles, and others, but the doctor needs to earn or warrant the roles through their performance. The doctor is also trained to support others taking the lead when that occurs.

The outcomes of training

This curriculum differs from earlier curricula by focusing on achieving a relatively small number of high-level capabilities – 14 in total. This contrasts with the previous approach to training which focused on the accumulation of experience measured in time and/or in number of episodes, and in acquiring a mass of competencies in specific techniques.

The capabilities fall into two categories: six **generic** categories common to all medical specialities, and eight **speciality-specific** capabilities. The latter are specific to Rehabilitation Medicine and differentiate this speciality from other specialities. They define rehabilitation, although some specialities may have some similar capabilities.

The capabilities in practice are shown in the table below, taken from the curriculum.

Learning outcomes – capabilities in practice (CiPs)
Generic Capabilities in Practice
<ol style="list-style-type: none"> 1. Able to successfully function within NHS organisational and management systems 2. Able to deal with ethical and legal issues related to clinical practice 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement 4. Is focussed on patient safety and delivers effective quality improvement in patient care 5. Carrying out research and managing data appropriately 6. Acting as a clinical teacher and clinical supervisor
Specialty Capabilities in Practice
<ol style="list-style-type: none"> 1. Able to formulate a full rehabilitation analysis of any clinical problem presented, to include both disease-related and disability-related factors 2. Able to set out a rehabilitation plan for any new patient seen with any disability, this plan extending beyond the consultant’s own specific service 3. Able to work as a full and equal member of any multi-disciplinary rehabilitation team

4. Able to identify and set priorities within a rehabilitation plan
5. Able to diagnose and manage existing and new medical problems in a rehabilitation context
6. Able to recognise need for and to deliver successfully specific medical rehabilitation treatments
7. Able to work in any setting, across organisational boundaries and in close collaboration with other specialist teams
8. Able to make and justify decisions in the face of the many clinical, socio-cultural, prognostic, ethical, and legal uncertainties and influences that arise in complex cases

For each capability some indicative behaviours are given in the curriculum, showing the behaviours that will help demonstrate (or otherwise) that a trainee has the capability. The list of behavioural descriptors given is not exhaustive, and it is not intended to be. They are illustrative. They do not form a list of mandatory behaviours needed to demonstrate capability. Conversely, simply demonstrating these behaviours alone does not necessarily show capability.

For each capability, the types of evidence likely to provide support for the capability is given. This, also, is only a guide. Moreover, one piece of clinical evidence might relate closely to two or more capabilities. Both the descriptors and the likely types of supporting evidence are shown in detail in the curriculum. (pp 13-24)

Thus, to assist both trainee and educational supervisors, each trainee should link each piece of evidence added to their portfolio to one or more capabilities. At the end of training, the trainee should then have a substantial body of evidence linked to each capability.

The evidence from the training programme, usually equivalent to four years full-time, is used to confirm that, at the end of training, the trainee is 'entrustable' in all 14 capabilities.

All capabilities are mapped to the GMC's [Generic Professional Capabilities framework](#) which sets out the essential generic capabilities needed for safe, effective and high quality medical care in the UK.

Entrustability is a relatively new method for determining professional performance, and the separation between entrustment, competence and experience is not always clear[9][10][11][12][13]. In practice, it means that the educational supervisor uses their expert judgement to determine that the trainee has reached a level of performance such that he or she can be trusted to undertake the capability safely and effectively without requiring any supervision and support.

Once a trainee is entrustable in all 14 capabilities, she or he will then be able to be an independent consultant in rehabilitation medicine, able to take on any consultant post in Rehabilitation Medicine offered, safely and effectively. This is not to say that the doctor will know or be expert in everything. All consultants continue to learn and acquire expertise after training, so that over time the appointed consultant will become more expert in some

areas of practice according to service need and/or personal interest and/or opportunities. Equally, there will still be difficult situations where the newly appointed consultant will need to discuss matters with a colleague, and not necessarily a medical colleague. Seeking and taking advice is, or should be, part of normal practice at all levels.

It must be stressed that entrustment is a judgement. It is obviously based upon evidence and the evidence is that present in the portfolio. But the judgement is not dictated simply by the quantity of evidence or by specific pieces of evidence. The judgement depends upon considering all the evidence 'in the round', and the weight given to different pieces of evidence is part of the judgement.

The judgement is, ultimately made or confirmed by the Annual Review of Competency Progression (ARCP) panel.

Training Programme: entry criteria, duration, transferable capabilities etc

Doctors may enter the training programme from a wide variety of early training programmes (see below). This reflects the broad range of skills needed within the speciality. Every trainee accepted will have particular strengths that are relevant within the practice of rehabilitation. By the same token, each new trainee will have areas of relative weakness.

Entry criteria:

1. Internal Medicine Training stage one (2 years)
2. ACCS-Acute/Internal Medicine (3 years)
3. Level 1 Paediatrics training (3 years)
4. Core Surgical Training (2 years)
5. Core Level Training in Anaesthetics (2 years)
6. Core Psychiatry Training (3 years)
7. Basic (ST1 and ST2) Obstetrics and Gynaecology training (2 years)
8. ST1 and ST2 of Ophthalmic Specialist Training (2 years)
9. General Practice specialty training programme (3 years)

Consequently, every new trainee should have a discussion with his or her Educational Supervisor shortly after joining the programme, to identify areas that may need more attention and areas that may need less attention during the programme. Most people from any background will succeed in learning all the knowledge and skills needed within the four-year programme, but out-of-programme experience can be arranged to cover weaker areas if necessary.

The training programme, full-time, is an indicative four years in duration. This is extended pro rata for people participating in less than full-time training. There is no exit examination. Each calendar year there is an (ARCP) undertaken by a panel, and the curriculum sets out the expected rate of progression in terms of Level of Entrustability.

There is, additionally, a formal review of progress by an external assessor (from a separate Deanery) at one year before the anticipated date of awarding the Certificate of Completion of Training (CCT). This is the Penultimate Year Assessment (PYA). At the penultimate year assessment, specific mandatory and recommended targets are usually set, to ensure that the trainee has all necessary capabilities and all necessary evidence by the final ARCP.

If a trainee is considered to be entrustable before the given date for completion of training, and this is confirmed by an ARCP panel, then the trainee may apply for their Certificate of Completion of Training (CCT) and the training programme will end.

Poor performance will be managed in line with the Gold Guide.

Trainees from other specialities may wish to transfer into Rehabilitation Medicine training. Often these trainees will have acquired relevant knowledge, skills, and capabilities directly transferable and relevant to rehabilitation. Trainees who transfer may well not need four years to complete training. There is, currently, no list of equivalences, and each person transferring will have their situation considered by the Speciality Advisory Committee. Specialities that will certainly have acquired some relevant experience include:

- Neurology (and other neuroscience specialities)
- Rheumatology
- Orthopaedic Surgery
- Trauma surgery, and accident and emergency medicine
- Sports and Exercise Medicine
- Psychiatry, including both liaison psychiatry and learning disability
- General medicine
- Geriatric medicine.
- Paediatrics
- Palliative Medicine

Generic Capabilities in Practice

There are six generic Capabilities in Practice, common across all medical specialities, and the descriptors for these are common across all specialities (see pp 13-16 of the curriculum).

Nonetheless, there are a few aspects of generic capabilities that need rather more emphasis within training in Rehabilitation Medicine. Both trainees and trainers should consider paying particular attention to the aspects shown here. For each capability there is a brief description of why and how the generic capability has a different focus, followed by a behavioural descriptor which the Educational Supervisor and trainee could use to ensure full capability appropriate for this speciality.

CiP 1 Able to function successfully within NHS organisational and management systems

This capability depends upon the doctor having a good understanding of how the NHS works, and the descriptor assume that the majority of the doctor's interactions will be with

other NHS health services. In rehabilitation, doctors not only interact widely within NHS healthcare, but will interact much more widely, with non-NHS healthcare services, Social Services, non-statutory organisations and others. Familiarity with these is essential.

It is suggested that a trainee in Rehabilitation Medicine should also demonstrate:

- working collaboratively with other services within NHS, and partner organisations outside the NHS and outside Healthcare

This requires a reasonable understanding of what different organisations do and are responsible for (e.g. Social Services, patient support groups, Department of Work and Pensions) and how to access them.

CiP 2 Able to deal with ethical and legal issues related to clinical practice

The standard descriptors do not specify expertise in the application of the Mental Capacity Act 2005. [14] There is much evidence that the Act is poorly understood and is infrequently acknowledged and acted on within healthcare. [15] Many patients with rehabilitation will have reduced capacity. A good if not excellent understanding of the Act is essential and, more importantly, excellent implementation of the Act is a vital capability for a consultant in Rehabilitation Medicine.

It is suggested that a trainee in Rehabilitation Medicine should also demonstrate:

- full awareness and good knowledge of the Mental Capacity Act 2005 and good skills in applying it to daily practice, both in judging a patient's capacity and in determining their best interests.

Good ethical decision making requires an understanding of how the situation is impacting on those involved as people. Rehabilitation Medicine is an intensely human speciality requiring integrity, compassion and other personal qualities. The seeking out of patient accounts of disability and experience is encouraged. The trainee should also try read books covering matters well outside medicine, such as ethics, law and sociology.

CiP 3 Communicates effectively and is able to share decision making, while making appropriate situational awareness, professional behaviour and professional judgement

The third generic capability concerns communication, and trainees in Rehabilitation Medicine need excellent communication skills including active listening. [16][17]

One particular aspect of communication is not covered in the standard descriptors. Many patients in rehabilitation (and in other specialities such as geriatrics) will have impairments directly affecting communication, such as aphasia, slurring of speech, and marked cognitive impairment. Moreover, some patients (and some families) present with challenging behaviours related to the disabling illness. Trainees need to become skilled in analysing and understanding the wide range of difficulties in communication that may arise in rehabilitation. They also need to develop excellent skills in establishing and maintaining communication in the many different situations they may encounter.

It is suggested that a trainee in Rehabilitation Medicine should also demonstrate that they:

- Identify the nature of a patient's communication difficulties (e.g. due to cognitive impairment, motor impairment, visual or hearing losses, language impairment, emotional factors etc);
- Establish and maintain good communication with patients whose communication and social interaction are affected as part of their illness;
- Maintain good communication with families who are challenging and/or distressed and/or have strong opinions contrary to the patient's best interests or wishes.

CiP 4 Is focused on patient safety and delivers effective quality improvement in patient care

Almost all patients with significant disability will be engaged with other services, including many outside the NHS. The rehabilitation service may or may not be working with these other services, but their performance will affect the quality and safety of patient care. The trainee needs to consider not simply how his or her service might improve, but also how the whole system involved with people who have a disability might improve. Rehabilitation Medicine cares for people who are vulnerable and at risk. Trainees should be encouraged to think widely about risks and preventable disability, and to be assiduous in minimising these external risks.

It is suggested that a trainee in Rehabilitation Medicine should also demonstrate:

- Recognition of the importance of system-wide factors in maintain the patient's safety and access to treatment, and communication and collaboration with all services involved with a patient, both within and outside the NHS

CiP 5 Carries out research and manages data appropriately

Rehabilitation research differs from traditional medical (biomedical) research in several ways, all arising from the biopsychosocial model. Its central goal is always patient-centred, usually focussed on (functional) activities. The interventions are usually very complex and delivered by a multi-disciplinary team, and they are not focused on curing or managing disease. Instead they involve acting on almost all other domains. Moreover, patients are not necessarily best categorised by disease diagnosis.

It is suggested that a trainee in Rehabilitation Medicine should also demonstrate:

- Use of the biopsychosocial model when selecting appropriate data or measures for audit or research, and when interpreting findings
- recognition of the important of patient-reported disability-level outcome measures

CiP 6 Acts as a clinical teacher and clinical supervisor

Teaching is integral to all healthcare jobs. Rehabilitation professional need to participate routinely in teaching other team members as part of daily clinical interactions and, equally important, participating in the formal teaching of a wide range of healthcare and other professions (e.g. social workers) who are involved directly or indirectly with rehabilitation.

The educational content of any teaching has two parts: teaching about the biopsychosocial model of illness; and explaining and teaching about the process and content of rehabilitation. Trainees should be encouraged to use their supervisory role with junior colleagues, presentations at medical meetings and liaison work with other specialties to promote a positive attitude to disability and to the inclusion of a rehabilitation component in all medical treatments.

It is suggested that a trainee in Rehabilitation Medicine should specifically demonstrate:

- teaching about and explanation of the biopsychosocial model of illness, and its use;
- teaching about and explanation of the process of rehabilitation (within the model).

Specialty Capabilities in Practice

The descriptors for the eight capabilities are shown in the table in section 3.3 (pp16-25) of the curriculum. It is worth re-emphasising that the descriptors are not a complete and comprehensive list, nor are they a checklist of what it is sufficient to demonstrate, nor are they a checklist on what must be demonstrated. Rather they show examples. The important question is whether the trainee is entrustable on the capability; these descriptors guide both trainee and educational supervisor but do not dictate. In other words, the descriptors are an expansion and explanation of the capability, helping to explain what each capability is covering.

The details are set out in the curriculum, but a few points about each capability will be emphasised here. The overall theme is that the trainee should at all times focus on being holistic, considering everything from a patient's perspective, and not from a medical or healthcare perspective.

CiP 1 Able to formulate a full rehabilitation analysis of any clinical problem presented, to include both disease-related and disability-related factors

This requires the trainee to consider all aspects of a patient's situation using the biopsychosocial model of illness. The trainee needs to acquire the ability to analyse a problem and to formulate (explain) it fully. It depends upon an ability to identify which particular domains are of most importance, from the eight domains in the model. It means, for many trainees early in training, a marked reduction in the traditional focus on symptoms, signs and disease and a concomitant marked increase in attention to context (social and physical), patient beliefs and expectations, social roles and functional abilities.

CiP 2 Able to set out a rehabilitation plan for any new patient seen with any disability, this plan extending beyond the consultant's own specific service

The emphasis in this capability is on considering long-term and social goals even at the outset, so that there is always a consistent and persisting sense of direction to the plan, and an early identification of key actions needed to achieve a satisfactory outcome. It specifically requires the trainee to recognise the importance of involving other services and agencies.

CiP 3 Able to work as a full and equal member of any multi-disciplinary rehabilitation team

The emphasis in this capability is on the trainee's ability to be led by another team member in some circumstances, as well as being able to act as a leader in other circumstances. This applies not simply to rehabilitation planning meetings but everything from discussions about groups of patients to initiating and carrying through service projects. A doctor's role is often to support and coach someone from another profession (or another doctor) in the skills required to be a good leader.

CiP 4 Able to identify and set priorities within a rehabilitation plan

Many team meetings discuss relatively easy and immediate plans and overlook longer term goals. One consequence, often, is a failure to identify and give priority to important goals. The doctor is often well placed to identify and set priorities, because the doctor's direct medical actions are often limited. The doctor will usually have less emotional or professional investment in any actions and can take a more dispassionate overview. The capability also requires skill, to persuade others of the need to prioritise particular actions outside their professional realm.

CiP 5 Able to diagnose and manage existing and new medical problems in a rehabilitation context

This is the first of two specific medical capabilities. Most patients are referred with an existing diagnosis. It is imperative that the doctor always considers the accuracy of the given diagnosis critically, however expert the referring person or team may be. Not infrequently there are inaccuracies, and occasionally the given diagnosis is simply incorrect. Moreover, patients involved in rehabilitation present with new problems needing a medical (disease-focused) diagnosis.

The increasing complexity of the patients being seen within rehabilitation coupled with a trend towards earlier, hyper-acute rehabilitation of medically unstable patients (often jointly with other specialities) also requires a high level of medical expertise, if only to recognise quickly when help is required from another specialist.

CiP 6 Able to recognise need for and to deliver successfully specific medical rehabilitation treatments

The main skill required is in using drugs correctly, a skill that is unique to doctors. Many patients are referred taking a large number of drugs, and the practical skill needed is to review and reduce the number and amount to drugs being taken. An important related skill is being able to select drugs rationally to cover two or more problems, such as using amitriptyline for bladder urgency, sleep, and depression/anxiety.

In some rehabilitation services, specific procedures are undertaken by Rehabilitation Medicine consultants with the necessary expertise. This includes procedures and treatments such as joint injections, refilling baclofen pumps, and using botulinum toxin injections.

CiP 7 Able to work in any setting, across organisational boundaries and in close collaboration with other specialist teams

This capability is associated with capabilities one and two, and it is another sequel of taking a holistic approach. Many patients will be in active contact with another specialty, and almost all will be in contact with primary care and community services - and those who are not will become so before leaving the rehabilitation service. Continuity of care and consistency of approach are both vital for anyone with a long-term condition. Rehabilitation services, including the doctors within them, must work pro-actively and collaboratively across all organisational and service boundaries. This especially requires excellent, clear and consistent communication in meetings, in letters, in hand-over documents and in all conversations.

CiP 8 Able to make and justify decisions in the face of the many clinical, socio-cultural, prognostic, ethical, and legal uncertainties and influences that arise in complex cases

This is the most challenging capability. Patients who do not obviously fit any other service and who are disabled and who are not well managed are often referred to rehabilitation services. In a small proportion of these, the presenting difficulty cannot be solved, and the patient continues to have complex and resource-intensive long-term care needs such that few if any existing services can manage them. There is usually also disagreement about financial and clinical responsibility.

It is often appropriate for rehabilitation service to take a lead role in managing these patients. There is always a mix of clinical, social, ethical, legal, financial and other practical difficulties to resolve. Rehabilitation's skill in analysing, formulating and then explaining the situation and its skill in developing and executing complex management plans makes a rehabilitation service well suited to the task. The trainee needs to develop sufficient self-confidence to take this on willingly.

Linking evidence to capabilities

The tables on pages 13-25 of the curriculum show the types of evidence that can be used to demonstrate particular capabilities or domains within the six generic and eight speciality Capabilities in Practice, and also the nine domains of the General Professional Capabilities framework. Again, this is guidance and not every piece of evidence is needed for every suggested domain or capability.

It does, however, remind the trainee and the Educational Supervisor that, as evidence is entered into the e-Portfolio, it can be linked to one or two generic or specialist capabilities in practice.

The following points are relevant to **linkage in the ePortfolio** (linking evidence to capabilities):

- the assessment of entrustment is based on evidence; and the Educational Supervisor, the panel at the ARCP, and the Penultimate Year Assessment assessor will all depend on the evidence linked to each capability;
- it is important not to link any one piece of evidence to more than three or four capabilities;
- it is important to ensure that every capability has sufficient evidence linked to it to allow someone to assess progress during training and to judge entrustment at the end of training;
- An excess of evidence is unhelpful, and the evidence provided should cover different aspects of the linked capability;
- the links between evidence and capabilities should be kept up-to-date; links should be made when the evidence is added;
- from time-to-time a review with an Educational Supervisor to check that links are suitable is advisable.

Presentations and conditions

Learning is primarily derived from exposure to and experience of clinical work. During training, the trainee needs to cover as broad a range of problems seen, interventions given, settings, and clinical dilemmas as possible. In this way, the trainee will be able to respond safely and efficiently to any new situation met in future, even if not previously experienced.

Rehabilitation is centred on disability – the patient’s activities that are limited as part of their illness. The table of clinical presentations that a trainee should gain experience of during training is centred on activities (as defined in the biopsychosocial model). Some of the activities are reasonably abstract, such as self-management, but all can be observed in a patient’s behaviour.

Within each of the 11 disability domains there are some additional descriptors to help make it clear, and to illustrate the range of activities included. For each of the eleven disability domains, there is, in the other three rows, a list of the common diagnoses underlying it, the common impairments underlying it, and the common more general issues raised by the disability. The intention is to illustrate the very broad range of experience a trainee should be enabled to acquire.

It should be stressed, as with other tables and lists, that this is illustrative guidance. It would not be possible for a trainee to cover every single domain, disease, impairment or issue. At the same time there are other disabilities, diseases, impairments and issues that are not listed. Moreover, it is obvious that (a) some disabilities are more common than others and (b) that limitations in some activities, such as mobility and dexterity, will also limit other activities, such as working or undertaking community activities.

Nevertheless, every trainee should expect to have clinical experience of problems in all 11 disability domains, should expect to see patients with most of the disease groups or diagnostic groups given, and to have exposure to patients with most of the impairments.

Practical procedures

The curriculum only mandates one practical procedure, unsupervised intramuscular injection of botulinum toxin as a treatment for focal limb spasticity (without necessarily using EMG or ultrasound guidance).

This is not to say that interested trainees in suitable training programmes cannot learn many other practical procedures. Many practical procedures are undertaken on patients within rehabilitation, by rehabilitation medicine consultants or by other consultants or clinicians (e.g. specialist nurses). In suitable clinical settings, it is appropriate for a rehabilitation trainee to learn some procedures that are of interest and potentially useful.

At the same time, trainees should recognise that, without continued use, skill at a practical procedure will decline and that acquisition of competence to perform independently in the first year of training does not equate to safe practice at the end of training, unless the procedure has been undertaken regularly since.

Given the breadth of experience to be gained during training, and the uncertainty as to the specific needs of the post obtained at the end of training, trainees and educational supervisors should discuss the advantages and disadvantages of acquiring a practical skill that can be learned in a particular placement. The expectation should be that training in the procedures needed in a particular consultant post will be given to the post holder after appointment, unless they have been practicing the procedure recently.

The training programme

A consultant in rehabilitation medicine needs to be able to manage almost any rehabilitation problem presented to them in any setting and with any request. This skill requires a clear understanding of the rehabilitation process and experience in using the process in a wide variety of circumstances. Thus, over the training programme, a trainee needs to garner as wide an experience as possible covering different diseases, ages, settings, stage of illness, presenting problems, possible solutions etc. Being exposed to a situation, even only once, will greatly help when a similar situation next arises.

The programme is intended to facilitate exposure by setting out the more common services and situations, ones that are likely to be available in most deaneries. No specific time or other measure of quantity is mandated. The intention is to gain knowledge (of conditions), skills and capabilities, not simply to accumulate time or experience.

Throughout their training programme, the trainee should be expected to gain experience outside the confines of the particular service employing him or her. This obviously needs to

take into account service needs and, for any significant time away, needs to be planned. However, it is important to recognise that gaining experience in a wide variety of services and situations is a training requirement and will require planned short times not present in the host service. Most of this can be fitted into the working week, for example attending a specialist muscle disease clinic once a week for six weeks in a nearby neurology department.

Every trainee should spend some time (the amount is not specified or mandated) in all the services given in the curriculum:

- Neurological rehabilitation
- Spinal Cord Injury rehabilitation
- Musculo-skeletal rehabilitation
- Trauma rehabilitation
- Rehabilitation involving and focused on assistive technology (all types)
- Palliative medicine
- Psychiatry - liaison psychiatry or learning disability psychiatry
- Paediatric rehabilitation
- Cardio-respiratory rehabilitation
- Pain services

This list does not preclude a trainee from gaining experience in other areas of rehabilitation. For example, much of Sports and Exercise Medicine clinical practice is similar to rehabilitation, and exercise is an essential component of many rehabilitation programmes. Opportunities to learn about low vision services and impaired hearing services would be two other valuable areas to learn about as visual and auditory impairments are both very common.

In many of these areas, the supervising consultant may not be specifically trained in rehabilitation, but this is not necessary provided the experience and training is concerned with rehabilitation.

A spreadsheet that might help trainees record their exposure to different problems, interventions, patient groups etc has been developed.

Teaching and learning

The majority of training arises from self-directed learning, including asking for and receiving regular feedback from others. Formal teaching is an important but relatively smaller contribution to the totality of training.

The curriculum assumes that all trainees will be responsible for patients receiving hospital-based, inpatient rehabilitation. It sets out a range of other specific situations where trainees learn through taking clinical responsibility for patients:

- Seeing new referrals in different settings

- Seeing patients for follow-up in different settings and using different methods
- Participating in larger, more complex meetings about a patient
- Participating in meetings that review a group of patients
- Participating in multi-disciplinary team meetings
- Palliative and end-of-life care
- Working in specialist clinics

The specific educational objectives associated with each of these are given in the curriculum.

The trainee should actively learn from all clinical experience, in one or more of these ways:

- Getting feedback from another person. [18][19]
 - This may be a consultant or other senior doctor, using case-based discussions or mini-CEX or, if a case conference, the cCAT tool
 - This may be less formal, for example reviewing a clinical, patient-centred interaction just undertaken with a medical or non-medical colleague or asking for informal feedback from anyone present
 - Patients or relatives can also be asked;
- Debriefing after a particularly difficult or stressful event;
- Writing a reflective entry, if there was something that stimulated thought or development; [20][21][22][23]
- Doing a quick search on some aspect of the case, in no more than 10-15 minutes; as a daily routine this can be invaluable;
- Discussing difficult cases with other trainees or team members;
- Observing how others approach a problem, and not simply how rehabilitation doctors do it.

Formal educational, learning opportunities also exist and should be used. The trainee should particularly take advantage of opportunities outside specific rehabilitation medicine teaching. The opportunities to consider include:

- Local grand-rounds and journal clubs;
- Regional rehabilitation medicine training days; these are limited as many regions are too small to sustain a programme and trainees may need to travel to training days run in other regions or nationally;
- National training courses or days; there are some recognised courses, and the British Society of Rehabilitation Medicine has an up-to-date list;
- Regional training days run by other specialities such as neurology, rheumatology, or paediatrics; these offer excellent opportunities, and encourage cross-fertilisation of ideas;
- Any regional or national meeting by a relevant speciality or, especially, by another profession closely involved in rehabilitation such as clinical psychology or physiotherapy.

In addition, it is strongly recommended that trainees read material from around the speciality. For example, trainees should consider becoming familiar with books, journals, or articles covering:

- Ethical and legal aspects of medical practice;
- Sociology of health and illness;
- Epidemiology, and health services research;
- Medical Humanities;
- Patient accounts of their disabling illness;
- ‘Structural competency’ [24][25][26] *“the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases ... also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.”* (See also: <https://structuralcompetency.org/publications/>)

Miscellaneous

Academic training is possible, and indeed will be supported and encouraged.

Out-of-programme periods are not uncommon, and may cover:

- additional training under two circumstances
 - the trainee needs to acquire sufficient medical experience to meet capability five (Able to diagnose and manage existing and new medical problems in a rehabilitation context); this may arise when someone enters from a non-medical speciality or after some time out of hospital medical practice;
 - specific training needs are identified, usually at the ARCP;
- undertaking research, including on occasion sufficient time to acquire an MD or PhD;
- undertaking some other specific training or experience, agreed with the Educational Supervisor, Training Programme Director and Head of School at the Deanery;
- periods of leave, e.g. maternity, paternity, sickness, etc.

Acting up as a consultant is possible in the last three months. This is covered in the curriculum (section 4.5) and the Gold Guide. (see resources at the end).

Assessments (of the trainee).

There is no exit examination. There is only one summative (pass/fail) assessment, the direct observation of procedural skills (DOPS) relating to botulinum toxin injection, where full independence is expected at the end of the third full year.

All other assessments are formative (i.e. intended to identify level of performance and areas needing extra training attention). The trainee and the supervisors should see these assessments primarily as a means to learn, and thus the clinical situation being assessed should usually be one the trainee is less confident in handling. It is not useful to be recorded as performing very well at every assessment. Either the clinical situations selected by the trainee are not challenging enough, or the assessor is not being sufficiently critical in a constructive way.

The curriculum gives specific information about each assessment, and suggests which capabilities are most likely to be linked to which assessment, but this is only guidance and not a set of rules.

The ARCP decision aid (see resources) outlines indicative numbers of each assessment expected for each year of training (pro-rata for less than full time trainees). These are indicative only, but if less are done both the trainee and educational supervisor need to be satisfied that sufficient evidence of good quality is being collected for each capability.

At the ARCP, the panel will also review whether assessments are being undertaken:

- throughout the year, not simply in the last two months;
- with different people, not restricted to one or two people only;
- covering different types of clinical problem and/or situation.

This is to ensure that the trainee is collecting a sufficiently broad range of evidence to allow a decision on entrustment to be made.

Two principles should be kept in mind:

- the assessments are an **educational, training** opportunity, **not** a test; and therefore:
- assessments should be spread out evenly throughout the year, in different settings, with different people, and covering different clinical topics.

Feedback from patients and from clinical colleagues is required each year (multi-source feedback). When choosing colleagues, it is important to cover as wide a range of people as possible:

- from different professions;
 - including non-clinical colleagues;
- from different services or clinical teams; and
 - not from consultants worked with, as they should be approached for a 'multiple consultant report'.

As with other assessments, these are primarily methods for identifying areas where change and improvement is needed; they are not pass/fail tests.

Although not listed among the assessments, trainees should be aware that **reflective entries** are of great importance. They are one good way to learn, and they demonstrate that the trainee is capable of self-learning. Guidance on the use of reflective entries is available.
[20][21][22][23]

More global assessments of a trainee's performance are undertaken by consultants who have worked with the trainee (the Multiple Consultant Report), and by the Educational Supervisor.

The Multiple Consultant Report should be provided by four consultants who have worked with the trainee over the previous year, and they should not include the Educational Supervisor.

Some trainees may have difficulty in obtaining a Multiple Consultant Report, because there are relatively few rehabilitation medicine consultants available. However, most trainees will have contact with consultants in other specialities, in clinics or during short-term placements, or in other ways. They can give a report. A trainee should consider throughout the year who can be asked to contribute and should approach the consultant as early in the contact as possible to discuss giving a report in due course.

Measuring progress and entrustment

The goal of the training programme is for each trainee to be fully entrustable on all fourteen capabilities at the end of the programme. The four levels of entrustment are shown in the curriculum, and a trainee is expected to progress from level 1 to level 4 over the course of training. The likely level of entrustment for each speciality capability at the end of each year is shown in the curriculum.

Four weeks before the ARCP, the trainee is expected to have completed a self-assessment on each of the 14 capabilities in practice on their ePortfolio. This assessment should indicate where evidence to support the level given can be found within the ePortfolio.

The self-assessment should be notified to the Educational Supervisor who will then review all the evidence, including feedback from clinical supervisors, to reach a decision on progress and level of entrustment. The Educational Supervisor will complete a formal report, discuss it with the trainee, and present it to the ARCP committee with a recommendation.

The ARCP panel makes the final decision on progress. During training, they judge whether progress is meeting or exceeding expectations for the grade or not. If progress is not as expected, then additional training may be recommended. If expectations are being met, the trainee progresses into their next year.

For the penultimate ARCP panel, an external advisor from a different Deanery is involved. This person will have access to and will review the trainee's e-portfolio and will have a 1:1 private discussion with the trainee. In this discussion, the external advisor will give feedback to the trainee, particularly highlighting any training that is still outstanding. The advisor will suggest both mandatory targets and recommended targets for the trainee to complete by their final ARCP meeting.

The external assessor undertaking the Penultimate Year Assessment review has another role: monitoring the performance of the training programme. The external assessor will ask the trainee(s) seen for their comments on the strengths and weaknesses of the programme and will also record how well the ARCP process is undertaken. Trainees should give honest factual feedback; although it is a confidential meeting, given the small numbers the source will usually be obvious. This information is fed back to the Specialist Advisory Committee.

In the final year, the ARCP panel decide whether or not the trainee has achieved level 4 entrustment in all 14 capabilities. If so, they can recommend that a CCT is awarded.

Learning: Supervision and feedback

There are two main classes of supervisor – educational, and clinical. The former is responsible (as the name suggests) for the trainee’s education, and guides learning; the latter is responsible for supervising the clinical work undertaken by the trainee under their supervision.

The educational supervisor may remain constant through the whole four years or may change as a trainee moves to different geographic locations. This is a matter for the Training Programme Director to decide, in conjunction with the trainees and educational supervisors. The clinical supervisor is dictated primarily by the service the trainee is working within at any particular time.

For each substantive placement, the trainee and educational supervisor should meet before or shortly after the start in post to review what should be learned while working in the post; and half-way through the post to review progress; and at the end to ensure that goals have been met.

Of equal if not more importance, the trainee should discuss with the educational supervisor and/or the consultant involved what the trainee should learn in each planned short-term period of experience, for example working in a pain service or attending a specialist clinic. The time spent identifying goals must be proportionate, and the trainee should initiate this by writing out what they hope or expect to learn. Most importantly, the trainee should write a brief summary of the main knowledge and/or skills learned from the experience.

Other matters

This part covers some matters that are not explicitly within the curriculum but are, nonetheless, of concern and interest to educators and trainees.

Adapting to changes in clinical practice

The generic and specialist capabilities remain as relevant now as they were in 2019 and will remain relevant through most conceivable changes. The capabilities are focused on the patient’s well-being, and Covid-19 has not altered that.

On the other hand, it is probable that many changes in clinical practice will affect, sometimes quite dramatically, how a doctor and a service achieve aspects of the clinical process. The training programmes will need to reflect these changes and adapt, not simply to changes due to Covid-19 but changes arising from alterations in commissioning and service provision and other unforeseen changes.

For example, tele-medicine (used as a generic term for all aspects of clinical care) will require new communication skills and new clinical processes. It raises new areas of risk and

new ethical dilemmas. At the same time, it will offer much more flexible and efficient working. The training programme will need to ensure that trainees learn what new technologies exist and how to use them, and to learn the rules that develop around their use.

Another longer-standing change which is very likely to happen over the next ten years is the delivery of more services in the community. There are currently few rehabilitation consultants working in the community. The programmes around the country should proactively be increasing exposure to community rehabilitation services. When in 2014 consultants in Trauma Rehabilitation were needed, there were very few people with any specific experience or expertise. The warning given was no more than three years, but there was no system to look for and forecast likely changes.

There are other changes that may well occur in the next five years. For example, Social Care may become part of the NHS, and even if it does not, there will inevitably be changes that undoubtedly will have an impact on rehabilitation. Rehabilitation services for people with functional neurological disorders are emerging, with an evidence-base, and consultants in Rehabilitation Medicine should be involved with such services. There are many other areas where closer integration of services may occur.

The Specialist Advisory Committee should, in conjunction with commissioners and providers, try to forecast areas where more consultant input will be required and then ensure a cadre of trainees gain suitable exposure and training to meet the need when it emerges.

In summary, the Specialist Advisory Committee in conjunction with the British Society of Rehabilitation Medicine and in consultation with all other interested parties should review, perhaps once a year, what significant changes in clinical practice are emerging or are likely to emerge. They should also consider what broader changes in service provision or delivery are likely over the next five years.

Then, they should suggest and agree what detailed changes in training might be needed to meet the needs. Most of these changes will be relatively minor, and new training will be offset by dropping areas that are no longer relevant, and all will be fully compatible with the 14 capabilities in practice.

Adapting to change in training methods

Covid-19 has also changed training methods and opportunities, though at present exactly how the future will change is quite unknown. For example, will remote and/or recorded audio-visual assessments of trainee clinical performance become used? General Practice already uses this technology, but it could become much more widely used.

Another change which may well be especially useful for smaller specialities is the use of on-line training. It is difficult to get to face-to-face training when it is several hours away, but if hospitals set up good training rooms with high-quality audio-visual facilities then most of the formal training programme could be done remotely. It may also be possible to set up

online training modules with summative (pass/fail) assessments, allowing the development of an eventual exit examination.

Whatever transpires, the individual training programmes will need to adapt, but the principles of rehabilitation will be unchanged, and the capabilities will remain as they are. The Specialist Advisory Committee will need to consider how to implement the changes, and it will need to offer guidance on the use of new training methods in this Rough Guide.

Acquiring and assessing knowledge

There are two important aspects to acquiring knowledge in Rehabilitation Medicine.

Rehabilitation Medicine is unusual, because the knowledge required extends well beyond traditional medical knowledge. For example, one needs to know about rules or procedures relating to driving licences, employment and benefits, vulnerable adults, Mental Capacity Act 2005, and Continuing Healthcare funding. It is also helpful to know something about behavioural medicine, sociology, ethics, and patient education.

Second, the essential key to increasing knowledge is always to be curious, and always to find information about anything you do not know arising from clinical work. If, each day, a trainee identifies one question he or she needs more information on, and then spends no more than 15 minutes trying to answer the question, the trainee will rapidly increase their knowledge base.

The remainder of this section covers more traditional aspects of acquiring knowledge and demonstrating successful acquisition.

There is no exit examination to test factual knowledge relevant to rehabilitation. The only easily available examination is the examination set by the Union Européenne des Médecins Spécialistes (UEMS; the European Union of Medical Specialists) who run a yearly examination in Physical Medicine and Rehabilitation. It is undertaken on-line in special centres, including one in the UK, and costs €400.00. Further information is available: <https://uems-prm.eu/board-certification-of-young-prm-doctors-by-examination-2/>

The UEMS examination has no official status in the UK, and it is not based on the UK curriculum. The Specialist Advisory Committee informs trainees about the examination but does not make any specific recommendation. Trainees who are interested should discuss the matter with their Educational Supervisor and can contact the British national representative through the Specialist Advisory Committee.

There are also no mandatory courses. There are many opportunities to receive formal teaching on courses on specific topics in rehabilitation run annually for trainees. A current list should be known to Educational Supervisors. There are also meetings run by the British Society of Rehabilitation Medicine and the Society for Research in Rehabilitation that most trainees attend when possible.

Very importantly, there are many national or international meetings run by other professions covering important multi-disciplinary topics such as trauma rehabilitation, sports medicine, management of chronic pain, traumatic brain injury and a very wide range of topics. These meetings are usually of a high quality and are additionally an excellent opportunity to learn more about the organising profession. Trainees are strongly encouraged to attend multi-professional meetings.

There is no recommended set text, but there are textbooks from the UK, such as the Oxford Handbook of Rehabilitation Medicine, which covers most aspects of clinical practice, and the Oxford Textbook on Neurorehabilitation, which covers neurological rehabilitation.

There are also many journals available, mostly multidisciplinary. Members of the British Society of Rehabilitation Medicine receive Clinical Rehabilitation monthly. The most well-known US journal is the Archives of Physical Medicine and Rehabilitation. Disability and Rehabilitation is another UK journal, with related journals focused on, for example, assistive technology. However, it should be recognised that many key rehabilitation studies are published in high profile medical journals such as the Lancet, Stroke, or Journal of the American Medical Association.

Attending grand rounds, journal clubs, lectures and teaching sessions run locally helps to keep knowledge up-to-date. It is important to keep up-to-date about the medical (diagnostic, prognostic and treatment) aspects of all the diseases commonly seen so that the doctors can answer questions from patients and can check that best medical management has been undertaken.

The key message is that trainees are responsible for actively seeking knowledge at all times. Educational Supervisors and others help through identifying areas where more knowledge might be needed, and through giving information about ways and means to acquire knowledge. The trainee needs to use advice and information given, and then to set his/her own 'learning goals', planning (if necessary) how they are going to learn and considering how they will know whether they have learnt.

The unspoken goal of the four-year training programme is to instil into the trainee the habits required for life-long learning:

- always being curious, and identifying what more they need to learn
- always seeking feedback and/or being alert to implied feedback, and learning from it
- always acknowledging uncertainty or lack of knowledge or skills when appropriate, and planning how to reduce uncertainty or increase knowledge or skill
- always recording learning systematically, a skill essential in the yearly appraisal and five-yearly revalidation processes

Societies

The specialist society for Rehabilitation Medicine is the British Society of Rehabilitation Medicine (BSRM), a learned society representing doctors who practice in Rehabilitation Medicine. (<https://www.bsrm.org.uk/>) There is representation of the trainees in most committees, and a specific trainee section with its own Facebook page which keeps trainees

in touch with training matters. (<https://www.facebook.com/RehabMedics/>). The British Society of Rehabilitation Medicine is open to other professions.

The British Society of Rehabilitation Medicine has many special interest groups cover different aspects of rehabilitation such as trauma, amputee medicine, musculoskeletal rehabilitation, prolonged disorders of consciousness, and vocational rehabilitation. Further information should be sought from the society.

The research society associated with rehabilitation is the Society for Research in Rehabilitation (<https://www.srr.org.uk/>), a multidisciplinary society with many doctors in its membership. It currently (2020) runs annual meetings in conjunction with the BSRM. Trainees are encouraged to join, because it gives a good opportunity to learn about the breadth of rehabilitation research occurring in the UK, and to meet some of the leading researchers across all professions.

Many doctors have other specific areas of clinical or research interests and join other societies such as the Association of British Neurologists and the British Neuropsychiatry Association.

Current areas of change

One important role of the Rough Guide is to identify aspect of clinical practice and aspects of training that might change in the next few months or years. This depends upon the profession highlighting to the Specialist Advisory Committee any potential or actual changes in:

- diseases or disorders coming into rehabilitation services. Trauma patients (in 2014) and Covid-19 patients (in 2020) are two examples.
- specific treatments or interventions relevant to rehabilitation. Botulinum toxin injections (1990) is an example.
- service commissioning and organisation. Introduction of commissioned trauma services (2014) and outsourcing some prosthetics and other equipment services, and services for people with behavioural disorders are examples.
- delivery of rehabilitation service. For example, the likely move to a much greater use of tele-rehabilitation (2020)
- delivery of training, for example the likely increase in virtual seminars, conferences etc.

In this version of the Rough Guide many of the areas of change were discussed in the last section, and the process of monitoring and forecasting changes is not yet set up. Nevertheless, a brief list of possible areas is given below to give an impression of what could develop.

Reduced opportunities for face-to-face contact

The restrictions associated with Covid-19 potentially alters training, limiting opportunities for some clinical activities but requiring new knowledge and skills to use alternative approaches. This will affect almost all areas of clinical practice.

Development of Covid-19 services

These may or may not be developed, but patients will be referred either way. Trainees will need to learn (alongside their consultant colleagues) about the common and uncommon problems seen and how they are best managed. This is likely to require increased knowledge about pulmonary rehabilitation, and management of fatigue and the many other longer-term manifestations of the disease.

It will also offer the trainees an excellent opportunity to be involved in service development.

Emerging technologies

The development of devices that can understand spoken words may lead to major changes in the use of technology. Other simple to use and 'intelligent' devices may transform the lives of disabled people: driverless cars, devices that monitor behaviour and activity and give feedback or warnings; ability of others to control household devices from afar, etc. It may also allow more automatic structured assessment, for example a web-based or tablet-based questionnaire prior to initial contact.

Trainees will need to keep abreast of what these technologies can offer, and also what the risks are and what they cannot achieve.

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