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CONSULTANT ATTITUDES TO 'ST' HIGHER SURGICAL TRAINEES

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The Modernising Medical Careers 2005 report on SHO training concluded that there was a need to minimise the SHO years that had, until then, involved short-term posts, poor training opportunities and indifferent career progression.[1] In response to this, 'run-through training' was introduced in August 2007. However, numerous problems were highlighted with this system, including lack of confidence in the selection process, concern about how to counsel failing trainees, concerns about staffing the wards at the junior level if all trainees were to have realistic anticipation of promotion and difficulty reconfiguring hospital services to support high-quality training.[2] Consequently, run-through training was uncoupled at CT2 and ST3, reverting back to a system of competitive entry into higher surgical training. Nevertheless, junior doctors in new core training posts could still potentially progress to higher surgical training programmes with as little as nine months of experience in their chosen subspecialty.

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In 2004 the European Working Time Regulations (EWTR) were introduced, which proposed a stepwise reduction in trainee hours, culminating in the implementation of a 48-hour week by 2009. A report published in 2006 by the Association of Surgeons in Training (ASiT) found that the implementation of a 56-hour week had resulted in a 20% decrease in operative cases.[3] In fact, 85% of trainees resorted to coming in for operating lists on their days off. Furthermore, trusts were struggling to meet the EWTR requirements and by May 2008 fewer than 20% of surgical training rotas were 56-hour compliant.

As a result, most trusts moved towards full-shift rotas, meaning trainees would spend approximately one in every seven weeks working a week of night shifts, during which time there would be no participation in the daytime activities. This led to the loss of continuity of patient care and access to supervised training. These problems were compounded by mandatory days off before and after night shifts, resulting in a loss of up to 30% of daytime clinical experience. Even if the trainee was fortunate enough to sleep at night, following the European Court ruling in the SiMAP case in 2000 (upheld by a European Parliament vote in December 2008), this time was still counted as work and so the trainee was obliged to leave the hospital at the start of the next working day, once again missing valuable training.

These changes (in core training structure, EWTR and full-shift rotas) have meant that many core trainees are unable to be supervised by a given consultant throughout a single post and consequently the mutual build-up of trust through the trainee–trainer relationship, which is at the very core of surgical training, has suffered. As these doctors inevitably progress onto higher surgical training, the net effect has been the creation of a mixed economy of trainees, namely 'old-fashioned' registrars and 'ST' registrars. We conducted a regional survey investigating whether consultants had reservations about working with the new generation of ST trainees.

Methods

We drafted a questionnaire with six closed questions and one open-ended question. These were designed to gauge consultant opinion on the EWTR and shift work on training, whether consultants felt anxious about working with ST trainees, whether they were happy to train trainees who were not formally attached to them and which of the recent changes they felt had been most detrimental to training. The questionnaire was posted to 160 consultants chosen at random working in NHS hospitals throughout London in a variety of surgical specialties. After one month, non-responders were sent a repeat questionnaire. Data were compiled and analysed using Excel® (Microsoft, Redmond, WA, US).

Results

The response rate was 60% (96/160). Table 1 shows which specialties were included in the survey. All closed questions were answered and 47 consultants (49%) left a response for the open-ended question (Table 2).

Discussion

The consultants felt that changes in

TABLE 1

SPECIALTIES REPRESENTED AMONG RESPONDENTS

Specialty	Responses (*n*=96)
General surgery	29 (29%)
Orthopaedics	21 (23%)
Neurosurgery	12 (13%)
Plastic surgery	9 (9%)
Urology	6 (6%)
Cardiothoracic surgery	5 (5%)
Otolaryngology	2 (2%)
Anonymous	12 (13%)

working patterns have made it extremely difficult to train juniors effectively. This is most likely due to loss of continuity in the trainee–trainer relationship. In fact, many consultants have more contact with trainees who are not actually allocated to them. Nevertheless, the vast majority of consultants felt that it is appropriate to teach/supervise trainees who are not allocated to them as they are aware of the steady decline in the availability of formal training opportunities. This may also be linked with concerns about their overall capabilities, which are largely attributed to changes in working patterns, and consultants are therefore tentative about being on call with them.

The vast majority of consultants felt that the 48-hour limit had reduced the operative experience of surgical trainees to a point where it may be difficult to achieve the present level of competency required for the Certificate of Completion of Training in the current timescale. In 2009 the government commissioned an independent review, chaired by Professor Sir John Temple, on the impact of the EWTR on the quality of training. This report was published in June 2010[4] and concluded that high-quality training could be delivered in a 48-hour week but not where trainees have a major role in out-of-hours services, are poorly supervised and have limited access to learning opportunities, as is the case currently. The report stated that changes need to be made to the way in which services and training are delivered to ensure that both are of a high quality.

Although many consultants feel that compensating for the reduction in working

TABLE 2

RESPONSES TO CONSULTANT QUESTIONNAIRE

Do you think that new working patterns (EWTR + shift work) are making it difficult to train juniors?	
I strongly agree	63 (66%)
I agree	31 (32%)
I do not believe this is pertinent to training	1 (1%)
I disagree	1 (1%)
I strongly disagree	0 (0%)
Do you think it is worth teaching a trainee who is attached to another consultant who happens to be taking part in your weekly outpatient clinic?	
I strongly agree	40 (42%)
I agree	42 (44%)
I do not believe this is pertinent to training	5 (5%)
I disagree	7 (7%)
I strongly disagree	2 (2%)
Do you think it is appropriate to supervise a trainee attached to another consultant in a nearby theatre who is operating alone?	
I strongly agree	21 (22%)
I agree	34 (35%)
I do not believe this is pertinent to training	13 (14%)
I disagree	17 (18%)
I strongly disagree	11 (11%)
Do you feel more tentative about being on call with new ST trainees?	
I strongly agree	22 (23%)
I agree	42 (43%)
I do not believe this is pertinent to training	16 (17%)
I disagree	16 (17%)
I strongly disagree	0 (0%)
Do you think the new generation of ST trainees are less capable?	
I strongly agree	38 (40%)
I agree	41 (43%)
I do not believe this is pertinent to training	2 (2%)
I disagree	14 (14%)
I strongly disagree	1 (1%)
Do you think the length of registrar training should be increased?	
I strongly agree	41 (43%)
I agree	32 (33%)
I do not believe this is pertinent to training	3 (3%)
I disagree	14 (15%)
I strongly disagree	6 (6%)
If you could make one change to SpR training what would it be?	
Ban EWTR	31 (32%)
Increase years of training	6 (6%)
Ban shift system	4 (4%)
Dedicated consultant to train trainees	2 (2%)
Apprenticeships	1 (1%)
Back to firms	1 (1%)
Modular teaching	1 (1%)
Simulation training	1 (1%)
No response	49 (51%)

hours by increasing the number of years in training may be the answer, this will not necessarily amount to equivalent expertise as experience is not gained at a high enough intensity. The time in training needs to be concentrated in order to focus on the acquisition of expertise, allowing the consistent application of intuition and experience at the highest level without having an impact on the provision of safe out-of-hours cover. In trauma and orthopaedics, for example, the specialist advisory committee, in conjunction with the British Orthopaedic Association and British Orthopaedic Trainees Association, has recommended an average working week of at least 65 hours based on a 1 in 7 on-call rota to provide out-of-hours cover at night and weekends, with prospective cover. A 24-hour on-call shift would enable the trainee to attend all daytime commitments, thus minimising lost training opportunities as well as facilitating continuity of patient care.[5]

Similarly, in a 2009 position statement, ASiT suggested a 1 in 6 evening and weekend on-call system that would require a total working time of 65 hours per week when averaged over a 6-week rota cycle. Ideally, trainees should have access to three half-day operating lists a week, two outpatient sessions, a special interest session (such as endoscopy) and time protected for research/audit and administrative tasks to include teaching of juniors.[6]

Full-shift rotas have been shown to reduce the proportion of overall hours spent in daytime training activities, with a corresponding increase in out-of-hours service provision. Coupled with the fact that most units do not have a sufficiently heavy workload to require full-shift rotas, a return to the traditional on-call system is strongly recommended. This would result in fewer daytime training opportunities being missed while maintaining exposure to out-of-hours emergency work, improving continuity of care and patient safety, and reducing the number of doctors required on the rota with the potential for financial savings.

Conclusions

The expertise of future consultant surgeons will be invariably inferior to the current standard. This will lead to widespread falls in standards of patient care with serious patient safety issues resulting from unavoidable clinical errors.

At present, a single ideal job plan seems almost impossible to produce owing to the inevitable differences between the working pattern and requirements of individual surgical specialties and individual units. However, in order to safeguard patient safety, surgeons must evolve strategies to deal with a reduced training timescale so that they preserve the high level of competence exhibited by current consultants. Proposed strategies include a focus on dedicated training time, the use of surgical simulators and career progression based on satisfactory completion of a defined curriculum as well as competency assessment.

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Hunterian Museum

Anatomy of an Athlete exhibition extended

Hunterian Museum
at the
Royal College of Surgeons

SPRINTING by Richard Neave and Denise Smith. Wax écorché 2012.

Current exhibition extended to 21 December

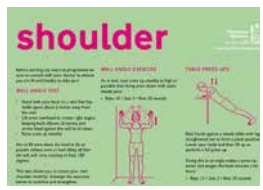
Anatomy of an Athlete: Elite sport, surgery and medical art

The Hunterian Museum has worked with the Medical Artists' Association of Great Britain to generate new artworks that explore the anatomy and physiology of elite athletics. Ranging across different media and sporting disciplines, the artists illustrate the key role played by sports and exercise medicine, and surgery in particular.

Qvist Gallery, open Tuesday – Saturday, 10am – 5pm. Free to all.

A set of five exercise cards (below) designed by a personal trainer are now available to collect as part of the *Anatomy of an Athlete* exhibition.

They feature illustrated exercises to support the knee, shoulder, ankle, heart and flexibility and are free to pick up in the Qvist exhibition gallery.



Surgical events

PROMs Summit
6 December 2012, Manchester
Chaired by Professor Nick Black from the DH National PROMs Operation Board the day will take an in-depth look at Patient Reported Outcomes Measures and Patient Reported Experience Measures (PREMs) including national and international developments and the future of PROMs and PREMs.
For further information and to book visit http://www.healthcareconferencesuk.co.uk/proms-training
or contact kerry@healthcareconferencesuk.co.uk
A 20% discount* is available to RCS members by quoting ref: **hcuk20rcs** when booking.

The Future of Day Surgery: The Streamlined Day Surgery Pathway
13 November 2012, Manchester
Chaired by Dr Mark Skues, President of the British Association of Day Surgery, this conference will discuss the future of day surgery with a particular focus on the Streamlined Day Surgery Pathway, how to shorten length of stay and how to maximise income from tariff.
For further information and to book visit http://www.healthcareconferencesuk.co.uk/day-surgery-conference
A 20% discount* is available to RCS members by quoting ref: **hcuk20rcs** when booking.

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