The MMC Inquiry

Response by

The Association of Surgeons in Training

1 Key messages

1.1 ASiT supports the original principles of MMC but the current incarnation of MMC does not reflect these sound principles.

1.2 Concerns about the implementation and structure of MMC repeatedly voiced by ASiT have been largely ignored.

1.3 We must strive for a training process that fosters *excellence*, not just *competence*.

1.4 The lack of a meaningful transition period has greatly reduced the opportunity for highly qualified trainees to compete for higher surgical training posts.

1.5 Important selection methods *in addition* to a structured CV and interview have been developed by the surgical community, but remain inadequately resourced.

1.6 The selection process must account for the relative importance of an applicant's different attributes.

1.7 Realistic opportunities must exist for those in FTSTA posts to be selected into run-through training.

1.8 Final selection to surgical specialty should not occur directly from the Foundation Programme and a second point of selection after core training is required.[1]

1.9 A CCT indicates sufficient competence to work at the consultant level – MMC must not act as a pretext to reduce this level of competence.

1.10 The early years of specialty training should include a significant generic component.

[1] There is no consensus within Trauma and Orthopaedics on this issue, but is accepted by the majority of other Surgical Specialties.

1.11 The lack of flexibility to move between specialties can be blamed largely on overly rigid curricula for early training and a lack of coordination between speciality colleges on the identification of transferable competencies.

1.12 Provision must be made for doctors to move between geographical areas.

1.13 The development of important research skills must receive appropriate emphasis.

1.14 Accurate and realistic career advice must be available to trainees.

1.15 Trainers must be positively identified and have training time identified and included in job plans.

1.16 Strenuous efforts must be made to protect training budgets.

1.17 Assessment of training doctors is often inadequate and mechanisms for identifying individuals unsuitable to progress remain untested.

1.18 Accurate workforce planning is a prerequisite of any rationalisation in the structure of training.

1.19 No further expansion of NTN posts should occur without evidence of an increase in the number of prospectively approved training opportunities and a similar expansion in consultant posts.

1.20 Specific requirements exist in different surgical specialties, but these variations can be easily accommodated within robust global structures.

2 Introduction

2.1 The Association of Surgeons in Training (ASiT) welcomes the opportunity to submit evidence to the Modernising Medical Careers (MMC) Inquiry, with particular reference to trainees in surgical specialties.

2.2 ASiT represents trainees from all surgical specialties and with over 2200 members is one of the largest specialty trainee organisations in the UK. The opinions expressed in this document have been gathered from members and agreed by the ASiT Council. A consensus has been sought from the relevant surgical specialty trainee organisations.

2.3 ASiT support the principles of MMC, particularly in the form expressed in Modernising Medical Careers (February 2003) (1). The current incarnation of MMC does not reflect these sound principles and significant reform is required to correct this disparity.

2.4 The medical profession has endeavoured to try and make MMC work. Concerns about the process of implementation and the perceived short-comings of the wider project have been repeatedly voiced, and ASiT have issued a number of statements over the last year (Appendices). These concerns appear to have been wilfully ignored by those directing policy, resulting in the chaos of the current selection process.

2.5 Overall, we must strive for a training process that selects for, cultivates and rewards *excellence*. A process designed only to ensure *competence* will engender mediocrity. Not only is this demoralising, more importantly it will disadvantage many patients and the NHS in the longer term.

3 Selection to specialty training

3.1 While we appreciate that the process by which individuals are appointed to specialist training (Medical Training Application System: MTAS) and the structure of specialist training (MMC) are separate entities, the success or failure of the MMC is dependent on a selection process that is reliable, valid, fair, practical and cost effective.

3.2 The number of surgical trainees in senior house officer (SHO) jobs has historically far exceeded the number of higher surgical training places (2). The much cited 5:1 ratio of qualified SHOs to national training numbers (NTNs) is a reasonable estimate, but higher ratios exist in some surgical specialties such as plastic surgery. The architects of MMC never got to grips with this "lost tribe" and how best to integrate them into the new training structure.

3.3 Despite what has been stated in some fora, trainees are well aware of the realities of job prospects in the highly competitive field of surgery. The "honesty" introduced by an improved correspondence between the number of basic training and higher training places is broadly welcomed, but well-qualified trainees who have "played by the old rules" have been unfairly penalised by an overnight change in selection criteria and the one-off nature of the new process.

3.4 ASiT and most surgical trainee groups called for a transition period of 2-3 years (and greater in some specialties) to ensure highly qualified trainees had adequate opportunity to gain a higher surgical training post, prior to the full implementation of new selection methodologies. These calls were largely ignored.

3.5 The lack of a meaningful transition has been compounded by the recent need to increase numbers of junior medical staff to create WTD/New Deal compliant rotas.

3.6 ASiT put forward proposals on how a meaningful transition period could be introduced, even relatively late in the process. The basis of this "inverted pyramid" model required a reduction in the numbers appointed to ST1 and ST2 this year, creating space for ST3 level applications in future years. This has not happened.

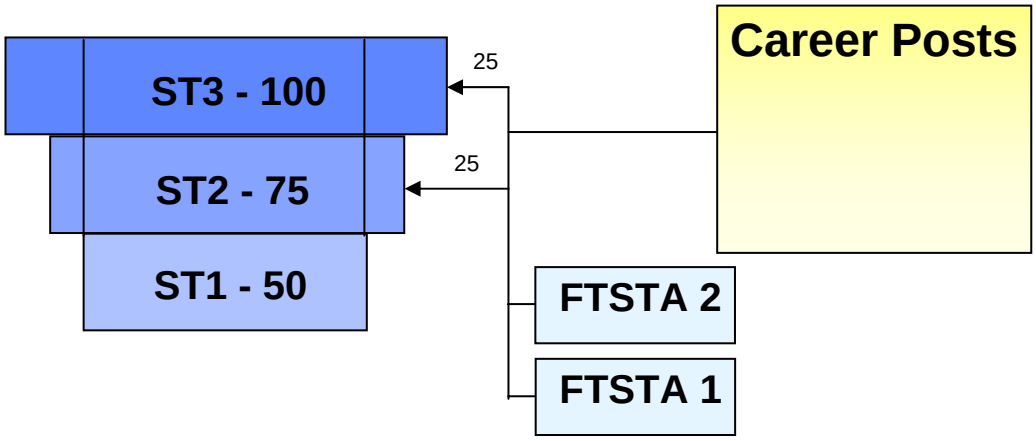

Figure 1. **Inverted pyramid model.** Worked example with 225 posts: rather than 75 per year at ST1, 2 and 3, this could be adjusted to have 50 at ST1, 75 at ST2 and 100 at ST3. This creates 25 ST2 opportunities at each of ST2 and ST3 for 2008, and 25 ST3 in 2009. This avoids a huge increase in NTNs but creates a 3 year transition. (Personal communication to Dr Sarah Thomas, Postgraduate Dean, South Yorkshire and South Humber Deanery)

3.7 Any selection process has weaknesses and is prone to error. A process that uses a number of different validated methods to build a more accurate representation of an individuals attributes is likely to be subject to less error. Processes *in addition* to structured CV and interview are likely to be important. These have been developed by the surgical community in the past but have been inadequately funded and resourced.

3.8 Short-listing is a logistical consequence of a process where the number of applicants exceeds the number that can be practically assessed "face to face". It is our view that the ability to discriminate individuals on any application form is extremely limited. No evidence has been presented to support the apparent belief that the scoring of 150 word statements, in which an individual details their abilities in a certain domain e.g. team working, correlates with objective measures of that individual's performance in the given domain. There has been no piloting of this methodology or evaluation of its discriminatory ability. For this reason, the application form must assess objective criteria, rather than the more nebulous measures common to the MTAS process.

3.9 The weighting of scores in the selection process and particularly the short-listing took no account of the relative importance of different attributes. Hence, these statements

used to assess various domains were given equal weighting to more objective measures of achievement, such as prizes, higher degrees and publications. It is accepted that the correlation between any of these selection criteria and what may be regarded as a "good consultant surgeon" remains difficult to determine, and we have to rely to a certain extent on face validity.

3.10 The desire for an online national application process has been significantly tainted by the failure of MTAS. Any rationalisation of deanery-based selection methods is based mostly on pragmatism and cost effectiveness, at the expense of individual flexibility. In some smaller surgical specialties, e.g. paediatric and plastic surgery, a national process is desirable due to the limited number places available.

3.11 There is no consensus on whether a national application process should be pursued, and if so, whether the number of applications an individual can make should be limited. Any future online application system must only be implemented following sufficient piloting.

3.12 There should be realistic opportunities for those in FTSTA posts to be selected into run-through training.

4 Structure of specialty training

4.1 A career structure allowing continuous progression without time spent "treading water" awaiting entry to higher training is welcomed. While this appears to have been a major driver behind MMC, a number of problems now exist:

- difficulties in selecting at such an early stage of training
- a lack of candour regarding the future of the consultant grade
- loss of generic/multi-specialty training
- loss of flexibility in career and geography
- loss of research training

4.2 The majority of trainees believe selection should not be directly from the Foundation Programme. In order to select those with a genuine aptitude and the skills required for a career in surgery, a second round of competitive selection following a period of core surgical training is essential. However, this is not a unanimous view, as within Trauma and Orthopaedics there has been no consensus amongst trainees.

4.3 Selection to specialty relies on:

- individuals having sufficient knowledge of a specialty, a) to wish to commit to a lifetime working in it, and b) to judge themselves capable of the specific requirements of that specialty
- individuals having the opportunity to demonstrate (potential) capability and a commitment to that specialty
- selectors having access to sufficient information be able to make an accurate assessment allowing comparison of individuals

We do not believe that Medical School and Foundation Training provide sufficient experience to fulfil the above criteria.

4.4 The Department of Health report *A Health Service of all the talents: Developing the NHS workforce* (April 2000), highlighted the concern that career decisions by doctors in training were often made too hastily, which has been used as an argument for the

creation of the Foundation Programme. However, specialty exposure in Foundation Training is extremely limited (and variable within and between individual rotations) and with applications to specialty training being completed within the first few months of FY2, significant specialty experience in this period is unrealistic.

4.5 There has been no frank debate on the future of the consultant grade. Some suggest the consultant grade will continue to be the end-point of training, while others predict its demise within five years. How can we design a structure of training when the goal remains so uncertain? Either way, the CCT indicates that a trainee has achieved sufficient competence to work at the consultant level – MMC must not act as a pretext to reduce that level of competence.

4.6 Generic training. The early years of Specialty Training should include a significant generic component. Many surgical specialties are now calling for a return to the development of generic skills in the early years of surgical training. Skills in trauma, critical care, post-op care etc., are requirements of all specialties and should form part of core training. Some training in a number of surgical specialties is beneficial to all trainees and will enhance final career selection.

4.7 Flexibility. *MMC: The Next Steps*, stated:

"Overall training arrangements must ... promote diversity and flexibility." (3)

The lack of flexibility to move between specialties can be blamed largely on overly rigid curricula for early training and a lack of coordination between speciality colleges on the identification of transferable competencies.

4.8 Curricula. Generic training and the identification of core/transferable competencies is lacking in many surgical curricula. This makes early transfer of an individual from one surgical specialty to another virtually impossible. This problem is not limited to surgery and that the ability to transfer between other areas of medicine is also limited.

4.9 Geography. It has been reported in the US that almost 50% of doctors are married to other doctors (4), and an equally high figure is to be expected in the UK. Provision must be made for this group and those with other pressures requiring them to be domiciled in a given geographical area. Increased provision for inter-deanery transfer, particularly in the early years of training must be ensured.

4.10 Research. The requirement for an understanding of critical appraisal, research methodology, statistics, ethics and educational theory is universal, together with the need to develop aptitude in audit, leadership and presentation. Many of these skills are developed during a period of dedicated research prior to higher surgical training. With the loss of this period, it must be ensured that these skills receive emphasis within the curricula or that trainees are supported in posts offering appropriate "out of programme experience".

4.11 Accurate and realistic career advice must be available to medical students and doctors and mechanisms must be introduced that ensure high quality and consistent advice across specialties and regions. Active career management with identification and redirection of those failing to progress is essential.

5 Training delivery

5.1 MMC will reduce the hours available for training, adding to the pressures of the European Working Time Directive. A number of changes must be introduced to ensure adequate training delivery.

5.2 Training is often linked to service, but specific time allocated to training must be identified and adequately resourced. Effective training will often be modular, themed and rely on adequate study leave arrangements and funding.

5.3 Training must be an active process and trainers must be positively identified. Trainers should complete courses in optimal training methods and must have training time identified and included in job plans to ensure full remuneration.

5.4 Strenuous efforts must be made to ensure the multi-professional education and training budget is protected and cannot be used (as it has been) to offset other NHS deficits. If UK surgical training is to continue to be of a world class, then sustained investment is essential.

5.5 Assessment of doctors within training schemes is often inadequate. Methods are variable and trainers reticent to recognise and manage struggling trainees appropriately. Suitably supportive environments where remedial training can take place in a non-threatening manner are lacking. Robust mechanisms for identifying individuals unsuitable to progress in surgical training remain untested and many fear they will be inadequate. The concept of failure is unhelpful in this regard and a mechanism by which individuals can "exit honourably" and move to other specialties is required.

6 Workforce planning

6.1 Has consistently failed in its goal. Appropriate workforce modelling should ensure numbers of doctors trained match future service needs. Yet, a number of surgical specialties have CCT holders well in excess of consultant job opportunities.

6.2 No further expansion of NTN posts should occur without evidence of an increase in the number of prospectively approved training opportunities and a similar expansion in consultant posts.

7 Specialty-specific concerns

Trauma and Orthopaedics

7.1 An opportunity for all trainees to apply for training posts at ST1,2 and 3 for the next three years, given certain restrictions

7.2 A small excess of trainees is desirable to foster competition, however, in the presence of a monopoly employer, this notion of true competition is fallacious.

7.3 UK trained doctors should have priority in the appointments process in advance of recruitment from outside the country. This is true for appointments to ICATs and ISTCs as well.

7.4 Existing consultants hours should be brought in line with the EWTD.

Plastic surgery

7.5 In terms of transition, the position in Plastic Surgery is extreme in many ways, though not unique amongst surgical specialties. The well worn traditional career path of 7 years post registration training prior to higher training has led to a problematic situation due to the short period of transition. Indeed, it is likely that any abbreviated transition, be it 3 or 5 years will undoubtedly lead to some trainees being disadvantaged.

7.6 The current situation of 5-7 years worth of trainees attempting to shoe horn into run through training at two different levels has caused much anguish this year. Firstly, with the expansion of ST3 numbers, some candidates may have been awarded run-through posts who may not have got them under the old system. Secondly, the best trainees at lower postgraduate years are not getting training posts and with the short transition many will be unlikely to get training places and be disadvantaged simply on their year of graduation.

Cardiothoracic & ENT surgery

7.7 Both specialties are seeing a significant over-production of CCT holders compared with consultant job opportunities.

Urology

7.8 Urology has been a pilot specialty for shorter training. Trainees on 3 year programmes are due to finish in March 2008. Training has not modified for this group, just shortened, and most are very unhappy with the standard of training. Competency based assessment on completion may result in extra training time being arranged. Other specialties will face this problem if competency based assessment/training is not carefully planned with very specific objectives.

Neurosurgery

7.9 There is strong support amongst current and "awaiting potential" neurosurgical trainees for genuine national selection with ranking of all 18 (or as many as have posts) training rotations, in order to remove the geographical lottery. It is widely accepted that this would be in principle the same process as that which has always occurred, simply occurring at one stage each year.

7.10 At the last British Neurosurgical Trainee Association meeting, neurosurgical trainees unanimously supported the suggestion of directly linking the new input of NTN or equivalent posts with the release of NTN posts which should only occur once completed trainees are appointed to substantive consultant posts (obviously with account made of the expansion in consultant posts). We accept that it is unlikely that we could win an indefinite extension to the duration of an NTN whilst consultant employment is sought, but given that a completed NTN should have passed all stages of assessment such that they are suitable for such appointment, there is little logic in casting such trainees onto the scrap heap for them to become deskilled whilst spending the same amount again employing someone who currently has no "specific neurosurgical value".

7.11 Under MMC there is increased recruitment to training posts year on year in spite of the fact of the predicted unemployment.

8 References

1. *Modernising Medical Careers*: The response of the four UK Health Ministers to the consultation on *Unfinished Business: Proposals for reform of the Senior House Officer grade*. February 2003.
2. Galasko CS, Smith K. Ratio of basic surgical trainees to type 1 specialist registrar programmes 1999/2000/2001/2002. *Ann R Coll Surg Engl.* 1999;**81**(3 Suppl):124-8
3. *Modernising Medical Careers:* The Next Steps. April 2004.
4. Sobecks NW *et al*. When Doctors Marry Doctors: A Survey Exploring the Professional and Family Lives of Young Physicians. *Ann Intern Med*. 1999;**130(4)**: 312-9