

The Cost of Surgical Training

Position Statement by
the Association of Surgeons in Training

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I Summary

- I.1 The Association of Surgeons in Training (ASiT) represents UK trainees from all surgical specialties and is one of the largest specialty trainee organisations in the UK with over 2200 members.
- I.2 Current issues relating to funding in surgical training:
- Who should fund postgraduate medical education (PME)?
 - What proportion of the costs of PME should be borne by the individual in training?
- I.3 The last ten years has seen training costs increase dramatically while funding has been cut.
- I.4 Following the principle of the “beneficiary pays”, it is equitable to share costs between all those who gain from the training of surgeons, in direct proportion to these benefits. Parties who benefit include Governmental, non-Governmental and special-interest groups.
- I.5 As beneficiaries of surgical training, the private sector and industry should contribute to training costs and it is essential that training is offered in the private sector and in particular in Independent-Sector Treatment Centres (ISTCs).
- I.6 The total cost of surgical training is over £400 000, a third of which is funded by the trainee.
- I.7 Medical graduate debt often exceeds £20 000 and is an important factor that must be taken into account when determining what contribution trainees should make to the cost of their ongoing training.
- I.8 Study leave allocations are an essential element of the surgical training budget but have been cut in most Deaneries. Training funds should be protected and not be used to offset other NHS deficits.

- I.9 The place of research in the new surgical curriculum remains unclear, with the source of funding for the majority of academic surgical pursuits being equally uncertain.

- I.10 For most trainees, inclusion on the Specialist Register requires a Certificate of Completion of Training (CCT) obtained by application to the Postgraduate Medical Education and Training Board (PMETB). PMETB should not be funded entirely through trainee fees and all beneficiaries of the work of PMETB should contribute.

2 Drivers for change in the funding of PME

- 2.1 NHS reconfiguration has resulted in challenges to the delivery and funding of PME. Foundation Trusts and independent-sector treatment centres (ISTCs) are examples of new healthcare structures in which the provision of training may be seen to be at odds with commercial pressures.
- 2.2 The implementation of Modernising Medical Careers (MMC) (with highly competitive, shortened training) and the European Working Time Directive (EWTD) have considerably reduced the time available for training. The reduction in 'on the job' learning has increased the onus on alternative modes of education, such as courses, conferences and external lectures. These tend to be costly and funded by the individual trainee.
- 2.3 Trainees have been penalised as a result of the financial pressures in the wider NHS. Training funds have been diverted to offset NHS deficits with a resulting loss of training opportunities.
- 2.4 Training costs to the individual are increasing with little in the way of return. Two recent examples of this being the significant increase in the Intercollegiate Exam and Postgraduate Medical Education and Training Board (PMETB) fee.
- 2.5 The frustrations resulting from the reduction in training opportunities, greater costs and diminished funding are leading many to ask how training is actually funded and to demand better value for money. ASiT believe the true cost of training to the individual is high yet remains largely unrecognised.

3 Who ought to fund surgical training?

- 3.1 It is a truism that education is never free and so it would seem most equitable to share the costs between those who stand to gain from the training of surgeons. This principle is often referred to as that of the beneficiary pays. It asserts that those who benefit from an action, pay for part of the action in direct proportion to the benefit they receive.
- 3.2 Table I lists the sorts of groups who have a legitimate interest in ensuring the adequate training of surgeons.

Governmental	Government NHS Trusts Armed services
Non-Governmental	Private sector healthcare providers Non-Governmental organisations Industry Individuals Patients Trainees Families of trainees
Special interest groups	Surgical Royal Colleges Other surgical specialty associations

Table I: **Groups with a legitimate interest in the effective training of surgeons**

- 3.3 The categories are for illustration only and there is much crossover, for instance patients are tax-payers and so fund NHS trusts, and Governments may pay private healthcare providers with public funds to provide a particular service (ISTCs being one example). These groups all contribute to the cost of surgical training, however some contribute a great deal more than others.
- 3.4 The analysis stalls when the essential tenet ‘in direct proportion to the benefit they receive’ is considered. This is near-impossible to meaningfully quantify. For instance, how do we balance the benefit to an individual trainee’s career prospects against that of a patient being treated for cancer? These arguments are largely irreconcilable. As such, how do we determine what is reasonable for each interest group to contribute?

4 How is training currently funded?

- 4.1 This is a complicated area and has been the subject of a recent Government consultation. The salary of a doctor in training is currently provided for equally between the employing NHS trust and the Postgraduate Deanery, reflecting the theoretical division between the service and training aspects of the job.
- 4.2 Deanery funding comes from the Multi Professional Education and Training (MPET) budget. MPET is a funding stream from the Department of Health that finances the additional costs of training in NHS. It was created by the merger of the Non-Medical Education and Training (NMET) budget, the Medical and Dental Education Levy (MADEL), and the Service Increment for Teaching (SIFT), all of which continue as separate elements.
- 4.3 The MADEL component of MPET was introduced in April 1996 as a means of providing support for PME in the NHS and to support key central initiatives in medical education. The majority of the budget funds salary and non-pay costs, which are identified as the training element of medical and dental training grade posts, as set out in EL(92)63. Additionally, flexible training, study leave and educational infrastructure, including postgraduate centres and libraries are also funded. Funding for the salary element is based on the number of training posts accredited with the appropriate educational approval. Additional posts are funded via the Workforce Numbers Advisory Board's process of projecting national consultant requirements. MADEL has been criticised as it only funds direct costs of PME, neglecting indirect costs such as consultant time spent teaching, which are subsidised by NHS Trusts.
- 4.4 Undergraduates are funded by grants from the Higher Education Funding Councils and SIFT which supports the additional costs incurred by NHS organisations in hosting medical student placements. It is not a payment for teaching as such. For example, consultants in an outpatient clinic or a GP in a surgery generally see fewer patients if students are present. SIFT is intended to meet this sort of excess cost, rather than pass it on to healthcare purchasers.

5 The role of private healthcare and surgery-related industry in the funding of surgical training

- 5.1 It is unclear the extent of the contributions made by the private sector or surgery-related industry, or indeed whether they should make any contribution at all. It is true that both entities require surgeons to exist, but when in excess and adequately trained by others, does a private company have anything to gain from such an investment?
- 5.2 Anecdotally, private companies in the medicines and healthcare product sector make significant contributions to training through the support and provision of educational courses and meetings.
- 5.3 There have been calls for training to be offered in ISTCs, but only with Government compensation for loss of productivity.
- 5.4 It is our view that, as beneficiaries of surgical training, the private sector and industry should contribute to training costs.
- 5.5 It is essential that training is offered in the private sector and in particular in ISTCs.

6 Analysis of the cost of surgical training

- 6.1 We have undertaken an analysis of the costs incurred by the public and trainees in funding surgical training (Table 2).
- 6.2 The public costs are derived from the work of Netten et al (University of Kent) [1,2] based on an analysis of the MPET (SIFT) and MPET (MADEL) contributions.
- 6.3 We have used the 2005 figures and have adjusted the specialist registrar costs to reflect a five-year training program.

- 6.4 The costs to the trainee are approximations based on a typical surgical training pathway. They allow for a five-year university medical course, a one-year pre-registration year, two years of basic surgical training, two years of dedicated research, and five years of higher surgical training with an additional fellowship year.
- 6.5 The trainee costs do not take into account the effects of inflation over the period of training so do not represent the actual total cost to an individual.

		Cost to public (£)	Cost to trainee (£)	Total (£)
University	Tuition	41,013	15,000	
	Clinical placements	142,880		
	Living expenses / lost production		39,549	
	Elective		2,000	240,442
Basic surgical training	Tuition & replacement	44,978		
	MRCS I + II + III		1,070	
	Courses (BSS, CCrISP, ATLS [®])		1,725	
	Fixed costs		1,560	
	Study leave		(1,400)	
	Tax relief		(200)	47,733
Research	Lost earnings		25,000	
	University fees		3,000	
	Attending conferences		2,000	
	Fixed costs		2,588	
	Tax relief		(800)	
				31,788
Higher surgical training	Tuition & replacement	52,937		
	Courses (HSS, ATLS [®])		1,075	
	Specialty courses		7,500	
	Attending conferences		2,500	
	Fixed costs		2,830	
	Study leave / tax relief		(3,500)	
	Tax relief		(2,500)	
				60,842
Fellowship	Arrangement / relocation		5,000	
	Lost earnings		25,000	30,000
CCT / consultant transition			2,400	2,400
Total (£)		281,808	131,397	413,205

Table 2: **Public and trainee costs at different stages of surgical training.** MRCS, Membership of Royal College of Surgeons diploma; BSS, Basic Surgical Skills course; CCrISP, Care of the Critically Ill Surgical Patient course; ATLS[®], Acute Trauma Life Support course; HSS, Higher Surgical Skills Course.

7 The cost of undergraduate medical education

- 7.1 The introduction of university 'top-up fees' means that the majority of UK students will pay around £3000 per year in course fees. This will have a significant effect on the levels of graduate debt.
- 7.2 The BMA Survey of Student finances 2004/5 [3], performed prior to the introduction of the new fees, found the average debt for those in the fifth year of a medical degree was £20,172, while those in the final year of a six year course owe £22,365, 17% more than the previous year.
- 7.3 Medical student indebtedness is certainly not limited to this country. In the United States the figures are higher, with the median debt burden of graduates being \$120,000. Yet our calculations show debt levels of £57,000 are likely in the UK in the near future, almost as high as in the US where starting salaries for doctors are much higher.
- 7.4 The importance of this lies with the appreciation that lower social classes are greatly under-represented in medical schools and rising student debt is likely to act as a further disincentive.
- 7.5 Levels of student debt are an important factor that must be taken into account when determining what contribution trainees should make to the cost of their training.

8 The cost of postgraduate surgical training

- 8.1 Surgical trainees contribute significantly to the cost of their training.
- 8.2 Pressure on the MPET (MADEL) budget has seen the study leave allocation fall in most Deaneries. The amount available for each trainee is notional but, even allowing for an optimistic £700 per year, this only covers one third of the costs to the trainee during postgraduate surgical training.
- 8.3 It is unclear what form study leave will take in run-through training, but a recent document from the Conference of Postgraduate Medical Deans (COPMedUK) [4] states it should continue “to have a place in learning in postgraduate medical education and training”.
- 8.4 The document also refers to the distinction between study leave for ‘career advancement’, which may include mandatory elements which are curriculum requirements, and study leave essential for a doctor’s ‘fitness to practice’. The difference, however, is not black and white, but a distinction certainly exists. Examples of career advancement courses would include training which, while necessary for the trainee to complete, would not jeopardise patient safety if not completed, like the Basic Surgical Skills course or the AO Principles in Operative Fracture Management course. Training deemed essential for patient safety may be the Advanced Trauma Life Support (ATLS®) course or Care of the Critically Ill Surgical Patient (CCrISP), where completion is likely to significantly improve a particular trainee’s ability to treat ill patients.
- 8.5 While NHS Trusts may have no specific duty to train doctors, they certainly have a responsibility for patient safety and we can see no good reason why essential course like ATLS and CCrISP are not funded, at least in part, by the health service.
- 8.6 The study leave allocation itself remains an essential element of the training budget and must be protected.

9 The funding of surgical research

- 9.1 The place of research in the new curriculum for the surgeon not seeking a University appointment remains unclear. Provision is being made for the small minority pursuing an academic career via Academic Clinical Fellowships (ACFs) and Clinical Lectureships (CLs) following the recommendations of the Walport Report [5]. Nonetheless, it seems unlikely that standard Specialty Training (ST) will include a dedicated period of research and less likely still that trainees will be encouraged to undertake a higher degree.
- 9.2 There have been calls to ensure that all trainees have exposure to academic surgery but current estimates of the costs of the research component of surgical training are likely to change in the future.
- 9.3 However, a significant number of trainees will still undertake research and a higher university degree. The majority of these trainees will have a specific interest in surgical research while some may do so to increase competitiveness for consultant positions.

10 The surgical fellowship, specialist registration and the cost of transition from training to independent practice

- 10.1 The transition from higher surgical training to consultant requires an application for inclusion on the Specialist Register either through the Certificate of Completion of Training (CCT) or Article 14 routes. The former, typical for UK trainees in recognised training programmes, requires successful completion of the Intercollegiate Specialty Examination (ICE). This has recently been revised with the inclusion of multiple choice and extended matching questions section which seeks to “... offer significant enhancements in terms of fairness, quality, validity and reliability ...”. The exam fee was raised to £1130 to cover the costs of these new developments, but will increase again to £1700.
- 10.2 Furthermore, to obtain a CCT an application must be submitted to PMETB. PMETB was established by the Government to oversee PME for all specialties and replaces the Specialist Training Authority (STA). Duties include issuing certificate of completion of training (CCT), standard setting for PME, ensuring standards are met and developing and promoting PME. The PMETB is seeking to become financially independent from the Government. To do this, funds need to be raised to cover costs previously funded by the Government. These are being met by increasing the fee to trainees to £500 this year and £750 next year. It is highly likely the fee will continue to rise over the next 3 to 4 years.
- 10.3 We believe the PMETB should not be funded entirely through trainee fees and all beneficiaries of the work of PMETB should contribute.

11 Summary

- 11.1 In Figure 1 we have taken the data from Table 2 and combined it to illustrate the proportion of total costs funded by the Government against the contribution of the trainee.
- 11.2 Two of the largest costs are that of research and the fellowship year. By their very nature, these often involve foregoing service work and result in a significant pay cut.
- 11.3 Grants and bursaries are available but are becoming harder to obtain.
- 11.4 It is interesting to see that the proportion contributed by the trainee increases dramatically during the senior years of surgical training.
- 11.5 Overall, we found trainees pay around one third of their total training costs. Is this a reasonable proportion? We would question whether it was.
- 11.6 There is very little published on what trainees in other professions pay for, but it is our impression it is nowhere near £130,000. Postgraduate training in law, for instance, involves high tuition fees, which, although sometimes borne by the trainee, are more often paid by employers, and ultimately passed on to the customer. Furthermore, the initial starting salaries of medical graduates' are also broadly in line with those of other comparable professions, for instance dentists, vets, accountants and actuaries.

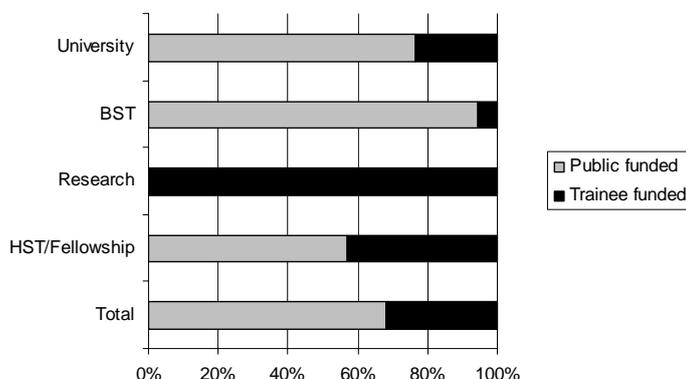


Figure 1: Proportions of public versus trainee funding in surgical training

12 Conclusion

- 12.1 There are numerous challenges facing the funding of PME.
- 12.2 There has been no debate as to who ought to contribute and almost no data on funding in the public domain.
- 12.3 Trainees are very willing to contribute to the cost of their training but the apparent arbitrary nature of fees is intolerable.
- 12.4 The covert shift of training costs from central Government to the individual needs to stop until it has been adequately debated.
- 12.5 One solution would be for trainees to pay a fixed 'training fee' to one body each year. This would cover tuition, courses, exams and fees to professional bodies, and would go a long way to providing the stability and clarity trainees seek.
- 12.6 Surgical trainees require a coherent funding policy for PME which is clear, equitable and legal.
- 12.7 We must consider whether expensive surgical training is discouraging good trainees, possibly from poorer backgrounds. Is expensive medical training discouraging talented young individuals from entering the profession at all?

13 References

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