RESPONSE TO THE SHAPE OF TRAINING REVIEW QUESTIONS

On behalf of the Council of the Association of Surgeons in Training

1. Over the next 30 years, how do you think the way patients are cared for will change?

With an aging population, the challenge in medicine over the next 30 years is going to be striking the correct balance between prolongation of life and preservation of good quality of life.

The focus will move towards screening and early detection of disease, allowing prevention, cure or even lifelong delayed progression.

The mapping of the human genome and advances in areas such as cancer genetics will lead the way to much more bespoke targeted treatments. Individuals will have their genomes mapped which will allow them to know at an early stage in their lives what diseases are likely to affect them and make the necessary lifestyle alterations.

Stem cell research is approaching a stage where it is foreseeable that individuals may be able to have replacement organs grown when their originals fail. These will still be grown in vitro in the early stages and are going to require surgeons to implant.

The increase in population density and dwindling energy sources are going to present challenges, not just socio-economically but particularly microbiologically as increasing numbers of common infections become resistant to conventional therapies.

Surgical treatments particular are becoming more and more complex and as such require an increasing level of subspecialisation to deliver them. In the future decisions will need to be made on who delivers the care of common conditions, especially those conditions that present as an emergency.

As technology improves the role of simulation in surgical training is going to crucial,
not just in technical skills but in the complex non-technical skills involved in surgery.


2. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?

Doctors are going to have to continue to have an excellent broad scientific training regardless of their chosen profession. They are going to have to become skilled learners who constantly seek to refresh their knowledge as they work to keep up to date with rapid advancements in techniques and technologies.

It would seem that the ability to prolong life is outpacing the treatments available to ensure a preserved quality of life. Whilst these aspects equilibrate there will have to be a focus on keeping care in the primary sector and avoiding overcrowding the secondary sector in all but the most essential of cases. This will require doctors’ skill not only in general practice but in domiciliary health management. It will require doctors that can effectively liaise with other health and social services to prevent patients from requiring admission to hospital and expedite their return to the community following acute illness or injury.

Careful workforce planning beginning early in medical school should be used to ensure that we have a medical workforce that considers the needs of the population whilst maintaining flexibility and choice, and continuing to produce motivated and innovative individuals.

Throughout the health services and sectors care should continue to be led and delivered by the gold standard product of clinical training, the Consultant.

3. What do you think will be the specific role of general practitioners (GPs) in all of this?

The role of the GP as gatekeeper to secondary care will continue but will become more complex as those GP’s will get much more say on where the care is commissioned from. As well as gatekeepers they will effectively become holders of the purse strings for the funding of resources. This is going to require excellent training in wide ranging aspects of health economic management.

With increasingly complex and subspecialist treatments available, it is going to become ever more beholden in GPs with their unique perspective to provide the overarching care and co-ordination of care of their patients.

4. If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors’ training (including GP training)
change to meet these needs?

There should be greater opportunities for training in the community starting at medical schools for those who wish to pursue a career in general practice and a greater emphasis placed on active career management. ASiT would be anxious however that there were no erosion of surgical foundation posts which can provide excellent experience. That said however the foundation system, with its 4 month placements has decreased the early years surgical experience found in the traditional 6 month placements. This in turn puts pressure on core and specialty trainees as they are required to take more hands one clinical responsibility during period when they would otherwise expect to be gaining operative experience. The ERAUT report of 2009 highlighted the gaps in operative training experienced by core trainees in particular.

Technical training should start early on in a doctors postgraduate training, rather than waiting for core or even specialty training. Be this in the form of formal simulation training or initiatives to free those doctors from activities that provide no educational benefit, there must be greater appreciation that the early twenties is an ideal time for an individual to acquire complex technical skills, and should not be squandered.

5. How can the need for clinical academics and researchers best be accommodated within such changes?

Training in and around academia is essential and something that continues to be neglected. This is not necessarily because its importance is not appreciated but because training of doctors in this area can be fragmented, non-regimental and often highly individualised. This does not dovetail well with initiatives such as national selection to ST3 and can make workforce planning even more complicated.

It is essential that time be taken to accommodate this area of medicine. Whilst it is crucial that we aim to produce a workforce that meets the public’s needs, without research and innovation it will not be possible to push the boundaries of what it is possible to offer. Research defines excellence in healthcare and this should always be the primary goal in the future.

ASiT believe that all surgical trainees should be able to explore the possibility of period in research. Opportunities, availability and funding for academic posts need to be improved at the various levels of training.

There is such an enormous amount of current medical practice that is performed with no evidence whatsoever; a paradigm shift in attitudes to research is required. Where safe and acceptable, every patient should be considered for inclusion in research. This is the only way that key questions are going to be answered.

6. How would a more flexible approach to postgraduate training look in relation
to:

Doctors in training as employees

Doctors are going to have to get used to working in several different environments and possibly for several different employers as commissioning care in new sectors increases. This could be very diverse and may include independent and private treatment centres and will likely vary in different areas of the country. It is important that they continue to be provided training in all arenas, that this be solidly written in to all of their various contracts and that it is overseen by local education boards and the royal colleges.

a. The service and workforce planning?

Service and training are inextricably linked and their relationship is extremely complex. There is no doubt that doctor’s gain invaluable training from service and that, in turn the health service benefits from their work. There must be measures put in place however, that protect medical staff from having to perform repetitive tasks that do not require their level of training and expertise and that keep them from activities that would enhance their skills, experience and knowledge.

b. The outcome of training – the kinds and functions of doctors?

Training in modern health care will be lifelong. We must ensure however, that the benchmark for completion of junior and middle grade training must remain the award of a CCT followed by appointment to a consultant post.

Currently the emphasis of training an individual to CCT is too focused on clinical aspects. in the future there must be additional effort directed toward non-clinical skills to encourage and develop clinicians as leaders, managers, commissioners of health, champions of patient safety and drivers of quality improvement, teachers and mentors.

c. The current postgraduate medical education and training structure itself (including clinical academic structures)?

The current postgraduate training structure has undergone a myriad of changes within the last 15 years. We believe it would benefit greatly from a period of stability especially following the prolonged turbulence of modernising medical careers.

7. How should the way doctors train and work change in order to meet their patients' needs over the next 30 years?

We must be careful to not overproduce doctors. Equally, it is important not to produce a medical workforce treated and acting like worker bees. Doctors should be trained to be innovators and advocates for change and service improvement.
Modern doctors should be trained specifically in healthcare leadership. Surgeons particularly need to be able to train flexibly and outside of the 48 hour limits in order to maximise their experiential learning as well as acquiring technical competence.

8. Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?

ASiT sees no specific problem here. Doctors are trained to introduce themselves and the general public are more than familiar with the structure of junior doctors working under a supervising consultant. If this question alludes to the potential need for uniforms for junior doctors we would strongly oppose this as it would be unnecessary, costly and would serve to further deprofessionalise and undermine the medical workforce. Smart and sensible attire is all that is required.

ASiT feel that the title ‘Surgeon’ must be reserved for medically qualified staff only, as outlined in our position statement on the subject.

*The use of the title ‘Consultant Surgeon’ by non medical practitioners. A positions statement from the Association of Surgeons in Training. Dec 2011*


9. How should the rise of multi professional teams to provide care affect the way doctors are trained?

There can be no doubt that certain aspects of training can be delivered to a high standard by non-medical members of staff but this should always be under the general supervision of a consultant in that field.

From a surgical point of view, ASiT appreciate the benefits of non-medically trained surgical practitioners but would urge that their activities should never impact negatively on the learning opportunities of surgical trainees. Moreover, non-medical trained surgical practitioners should be utilised to facilitate learning opportunities for trainees, either directly, by assisting trainee in theatre, for example, or indirectly by reducing the service burden on the trainee.

It should also be understood that non-consultant members of the medical team at all levels of training have great potential to be involved in the training of other junior doctors and medical students and are vastly under-utilised.

10. Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?

ASiT can see no evidence that modern CCT holders are not competent for
independent consultant practice. We do have evidence from our Fellowships survey that many will undertake peri or post CCT fellowships in order to grow in confidence or to learn more high end sub-specialist techniques. It is crucial that these are appropriately funded by trusts or industry and that it not fall to the individual undertaking the fellowship to foot the bill. They should have to meet criteria that ensure training to the fellow and no impact on the NTN trainees in the department.

We also acknowledge that modern practice is changing to the point that new consultants undertaking high risk/high stakes procedures will often spend a period of time operating with a colleague until they are ready to operate alone. It is important to understand that in these situations the ethos is shifting rapidly to a team-based approach being the norm in these complex cases.

11. Is the current length and end point of training right?

This is a highly complex question and will vary from specialty to specialty and from individual to individual.

ASiT feel that the current surgical training produces doctors competent for independent practice. This is largely because surgical trainees come in, in their own time and outside of the contracted working hours, in order to secure the quality of their training and the breadth of their experience.

12. If training is made more general, how should the meaning of the CCT change and what are the implications for doctors’ subsequent CPD?

ASiT believe that the CCT should remain the same in surgery. A holder of a CCT should be considered to be an expert in the generality of their specialty and in the generality of their declared sub-specialty of interest. We accept that some ‘super’ sub-specialty training may need to occur in fellowships in the post CCT period.

13. How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?

ASiT strongly support a relaxation of the EWTD and Simap/Jaeger rulings. Surgery is a craft specialty and, as such, training is both competence and experience based.

Whilst we fiercely support and develop initiatives that improve the quality of surgical training, there is no substitution to being in the hospital and operating on patients with conditions as they present.

ASiT does not, by any means, advocate a return to 120 hour weeks but there has to be some pragmatic relaxation to enable surgical trainees to get the experience they can only learn whilst on the job.
Whilst we appreciate that this may not be the case for many of the other non-surgical specialities, we feel it crucial that the voice of the ten surgical specialties is heard.


14. What needs to be done to improve the transitions as doctors move between the different stages of their training and then into independent practice?

As stated previously we feel that training to be a consultant should not just be a clinical based exercise. Modern training of a consultant should include aspects of leadership, management, health economy, research and development, teaching and mentoring to include but a few. How much each one of these feature will be down to the future career aspirations of the individual, but adequate training in these aspects should be provided.

15. Have we currently got the right balance between trainees delivering service and having opportunities to learn through experience?

Junior doctors should be tasked with activities that will develop their clinical skills but are commensurate with their level of previous training. Hours and even shifts given over to repetitive tasks, where trainees spend more time sat behind a computer screen than sat at the patient’s bedside, that often do not require an individual with a medical degree to complete, only serve to dilute the training experience.

16. Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?

The service currently relies on the work of junior doctors and ASiT do not see that changing. The work they provide must, wherever possible, be engaged in activities that develop their skills and experience.

17. What is good in the current system and should not be lost in any changes?

The best thing about the system at the moment is the people in it. You are unlikely to see a more dedicated and driven cohort in any job sector. Their professionalism must be trusted and they must be invested in. Trainees will be a short time in training and a long time in service but it must not be forgotten that their contribution to healthcare begins in medical school.

The training structure is currently laid out in front of a doctor in their foundation year. This allows for planning of extra-curricular activities such as research or
experience training abroad. When goal posts continually change, career decisions that were initially astute can become counterproductive.

As reiterated several times in this response, ASiT feels that the gold standard of completion of training and delivery of care is the consultant grade and this must remain the case.

18. Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?

For this section we would like to submit our document 'The Future of Surgical Training', which present the views of surgical trainees in relation to the changes needed to the organisation of surgical training required to improve training quality and standards.

http://www.ASiT.org/resources/articles/future