



THE COST OF SURGICAL TRAINING: who should pay for postgraduate education?

Ewen Harrison
Vice President, ASiT

I got into a heated debate recently. “*The public are not interested in overpaid young doctors complaining about how much their training costs them*”, the consultant surgeon said over his coffee, “*and what’s more, the politicians know this*”. I rocked back on my heels, “*yes, yes, but ...*”. But what? I had no answer.

This exchange ended a discussion on a problem that has always existed but is usually only referred to in low mutterings in darkened rooms, militant outbursts from trainee organisations or (I imagine) behind the closed doors of the Departments of Health. Who should fund postgraduate medical education (PME)? Or, more specifically, what proportion of the costs of PME should be borne by the individual in training? This article does not seek to answer these questions but aims to stimulate debate on an issue which the Association of Surgeons in Training (ASiT) believe has been inadequately addressed.

Why is it important that this is discussed now? It is the nature of every generation to feel ‘their time’ is subject to greater change than any other, and this is no different for the current group of trainees. While the truth behind this perception is that change is constant, there is a sense of an ‘alignment of heavenly bodies’ acting to alter surgical training beyond all recognition. The triple threat of the new market-driven NHS (with Foundation Trusts, independent-sector treatment centres - ISTCs - and non-medically qualified surgical practitioners), Modernising Medical Careers (with highly competitive, shortened, run-through training) and the European Working Time Directive leave some wondering whether training is possible at all. “*Skill to do comes of doing*”, said American philosopher Ralph Waldo Emerson. The question is, are surgical trainees going to be doing enough doing?

Disenchantment with this perceived erosion of training opportunities is compounded when training costs to the individual increase with little in the way of return, two recent examples being the significant increase in the Intercollegiate Exam and PMETB fee. Expenses are increasing while study leave allocations drop as a result of insufficient Deanery funding. Not many like to talk about it, but fewer hours spent working in hospital means smaller salaries for trainees. Less opportunity to train in hospital means trainees are seeking instruction elsewhere, usually in the form of courses, costing more money. The frustrations of fewer 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. We have undertaken to quantify this and are currently performing a survey of costs to surgical trainees. We have also performed an analysis of costs based on our own experiences.

But to start with, who *ought* to fund surgical training? 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. **Table 1** lists the sorts of groups who have a legitimate interest in ensuring the

adequate training of surgeons. The categories are for illustration only and there is clearly 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. Do all these groups contribute to the cost of training? The short answer is yes, but some contribute a great deal more than others. The analysis stalls when the essential tenet ‘in direct proportion to the benefit they receive’ is considered. How can this possibly be quantified? How do we balance the benefit, say, to an individual trainee’s career prospects against that of a patient being treated for cancer? Maybe these arguments are irreconcilable, but, if so, how do we determine what is reasonable for each interest group to contribute?

Table 1: Groups with a legitimate interest in the effective 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

How is training currently funded? This is a complicated area and has been the subject of a recent government consultation ⁽¹⁾. The salary of a doctor in training is currently split equally between the employing NHS trust and the Postgraduate Deanery, reflecting the service and training aspects of the job. The deanery money comes from the Multi Professional Education and Training budget (MPET), which was created in April 2001 by the merger of the Medical Education and Training Budget (MADEL), the Non Medical and Dental Education Levy and the Service Increment for Teaching (SIFT), all of which continue as separate elements. As well as contributing to salaries, MPET (MADEL) funds flexible training, study leave, and educational infrastructure like postgraduate centres and libraries. It 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. Undergraduates are funded by grants from the Higher Education Funding Councils and MPET (SIFT) which supports the additional costs incurred by NHS organisations in hosting medical student placements. 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 both require surgeons to exist, but when in excess and adequately trained by others, does a private company have anything to gain from the investment? There have been calls for training to be offered in ISTCs, but only with government compensation for loss of productivity. It is our view that, as beneficiaries of surgical training, the private sector and industry should contribute to training costs. It is essential that training is offered in the private sector and in particular in ISTCs.



We have performed our own analysis of the costs incurred by the public and trainees in funding surgical training (Table 2). The public costs are derived from the work of Netten *et al* (2, 3) (University of Kent) based on an analysis of the MPET (SIFT) and MPET (MADEL) contributions. We have used the 2005 figures and have adjusted the specialist registrar costs to reflect a five-year training programme. 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. The trainee costs also use 2005 figures but do not take into the effects of inflation over the period of training so do not represent the actual total cost to an individual.

Table 2: Public and trainee costs at different stages of surgical training

		Cost to public	Cost to trainee	Total
University	Tuition	41,013	15,000	
	Clinical placements Living expenses/ lost production Elective	142,880	39,549 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 Tax relief		(1,400) (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) (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

The introduction of university “top-up fees” means 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. The BMA Survey of Student finances 2004/5 (4), 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. Medical student indebtedness is 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. Why is this important? One reason is 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. Furthermore, 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.

Trainees in basic and higher surgical training contribute significantly to the cost of their training. 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 basic and higher surgical training. 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) (5) states it should continue “to have a place in learning in postgraduate medical education and training”. 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 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. 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. The study leave allocation itself remains an essential element of the training budget and must be protected.

The place of research in the new curriculum for ‘the average’ surgeon remains unclear. While provision is being made for the small minority pursuing an academic career following the recommendations of the Walport Report (6), it seems unlikely that standard specialist training will include a dedicated period of research, and less likely still that trainees will be encouraged to undertake a higher degree. There have been calls to ensure that all trainees have some exposure to academic surgery, but are the estimates we have provided for the cost of research going to be relevant in the future? Nonetheless, there are some who believe that a significant number of trainees may still undertake a higher research degree, for instance to increase competitiveness at consultant interview.

The final year of higher surgical training is often flexible and many take advantage of this by arranging time, often abroad in a specialist unit, referred to as a fellowship. This has the advantages of exposing the trainee to new techniques, greater numbers of rarer conditions, different disease patterns, or a further period of research. However, for all the benefits, it does cause significant upheaval in family life and often requires a move abroad costing a significant amount of money and reduction in salary. Very little funding is available for fellowships, particularly those of a purely clinical nature and the significant financial burden is often borne by the trainee. Most would agree that fellowships are an extremely important part of training and may result in improvements in the services available to patients. We feel more funding should be available.

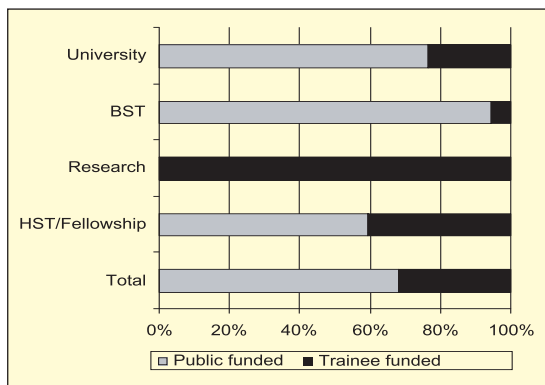
The transition from higher surgical training to a consultant job requires an application for inclusion on the Specialist Registrar either through the Certificate of Completion of Training (CCT) or Article 14 routes. The former, typical for UK trainees in recognised training programmes, requires successful completion of the intercollegiate specialty examination. This has recently been revised with a new MCQ/extended matching 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. Furthermore, to obtain a CCT, an application must be submitted to the PMETB. The 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. We believe the PMETB should not be funded entirely through trainee fees and all beneficiaries of the work of PMETB should contribute.

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. 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. Grants and bursaries are available but are becoming harder to obtain. It is interesting to see that the proportion contributed by the trainee increases dramatically during the years of higher surgical training. Overall, we found trainees pay around one third of their total training costs. Is this a reasonable proportion? We would question whether it was. There is very little published on what trainees in other professions pay for, but it is our impression it is no where 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 (7).

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



In conclusion, the funding of PME is in turmoil. There has been no debate as to who ought to contribute and almost no data on funding in the public domain. Trainees are very willing to contribute to the cost of their training but the apparent arbitrary nature of fees is intolerable. The covert shift of training costs from central government to the individual needs to stop until it has been adequately debated. 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 we seek. We need a coherent funding policy for PME which is clear, equitable and legal – until this occurs, disharmony will exist. 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?

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