

**Medical Education England, Medical  
Programme Board discussion  
document:  
‘Core Surgical Training and  
Experience in Surgical Specialties in  
England’**

A response from



August 2010



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On behalf of the ASiT Executive and Council

## **I. Introduction**

- 1.1. The Association of Surgeons in Training welcomes the opportunity to respond to this discussion document.
- 1.2. The document highlights some important issues regarding career progression that are concerning to all surgeons in training.
- 1.3. Both the training and workforce structure of Core Surgical Training are closely interlinked. ASiT has previously published a position statement outlining the preferred structure for Core Surgical Training, which this document draws on.
- 1.4. We have discussed these issues amongst ASiT Council. While a complete solution is clearly complex, we can contribute to the debate from the trainee surgeons' perspective.

## **2. The new Lost Tribe**

- 2.1. As is explained in the Medical Programme Board document, Core Surgical Training (CST) is approaching a crisis point of mismatched workforce numbers, similar to the circumstances that created the 'Lost Tribe' of Senior House Officers which precipitated the disastrous introduction of Modernising Medical Careers in 2007.
- 2.2. A 'CST bulge' of trainees without any prospect of entering Higher Surgical Training (HST) is rapidly developing and this requires urgent action.
- 2.3. It is a great shame that lessons have not been learnt and that we are seeing the same problem recurring so soon. It appears that a lack of service reconfiguration is primarily to blame and a long term solution must now be sought.

- 2.4. The figures described in the document are reflective of the situation, but do not account for surgical trainees outside of CST that are applying for Specialty Training (ST) 3 posts in surgery (such as those in research, non-career grade posts and those returning from working abroad). As a result, the attrition rate from CT2 through to ST3 is in fact likely to be far greater than the predicted 64%.
- 2.5. The excess number of junior surgical trainees does meet a service need, but using trainees in this role is not cost-effective and represents a waste of public finances. These valuable funds could be better utilised by investing them in those most likely to proceed.
- 2.6. Improved, long-term workforce planning and better alignment between trainee and consultant numbers is key to this strategy.

### **3. Natural attrition after CST**

- 3.1. We acknowledge that there is always going to be an attrition rate between CT2 and ST3. It is a natural stage for trainees to change career path.
- 3.2. There are many reasons that this may happen, including failure to pass membership examinations for the Royal Colleges of Surgery, lifestyle choices or changes in interest.
- 3.3. We also acknowledge that the surgical specialties have always been a highly competitive field of medicine and believe it is healthy to maintain a degree of competition at all levels of recruitment.
- 3.4. However, the level of competition and loss of junior trainees from the specialty at this rate is unreasonable and can not be maintained.

#### 4. Impact of the European Working Time Directive

- 4.1. The issue of trainee numbers at each level of training cannot be considered in complete isolation of other issues that are impacting on the NHS.
- 4.2. One key issue that compounds the problem is the European Working Time Directive (EWTD).
- 4.3. ASiT's opinion on the directive is covered elsewhere, but it does have a direct influence on trainee numbers.
- 4.4. Restrictions laid out by the EWTD mean that high numbers of Core Surgical Trainees, or trainees at this level of junior doctor, are required to maintain the service function of the NHS.
- 4.5. Many NHS trusts do already fill a number of 'SHO level' rotas with trainees in Foundation Year 2. It could be considered to compromise patient safety by having non-surgical trainees providing this front line service.
- 4.6. However, maintaining CST workforce levels at the current capacity is leading to the new bulge at CT2 that we are now seeing.
- 4.7. Introducing a third year of core surgical training (as detailed below) could help ease the immediate service demands and reduce the incidence of 'rota gaps' that lowering the number of trainees entering CT1 would create. However, service reconfiguration, perhaps with the use of non-training grades is inevitably required.

## **5. Training numbers at ST3**

- 5.1. We feel that it is important to determine the number of trainees employed at ST3 level in line with long term employment planning, again allowing for a small attrition rate during Higher Surgical Training (HST).
- 5.2. This has been accepted by Deaneries across the UK. As a result, numbers in higher surgical training are reducing to account for the lack of consultant expansion.
- 5.3. We broadly agree with this move, accepting that there is a real need for consultant expansion which the NHS is not currently offering.
- 5.4. Therefore, increasing workforce numbers at ST3 level and above does not offer a solution in the current climate.

## **6. Core Training Year 3**

- 6.1. The introduction of a third year of CST has a definite attraction, although this is not universally agreed by all sub-specialties of surgery.
- 6.2. CT3 could offer trainees broader experience prior to starting their higher surgical training, which is clear advantage to the patients, trainees and trainers alike.
- 6.3. If introduced as a temporary measure, CT3 is likely to simply delay the problem for future years.
- 6.4. A better option for CT3 would be for it to be introduced as an alternative to ST3 for one year (to those who would like more experience before progressing to ST3 or those who have been unsuccessful in their applications to ST3) and then to make it compulsory for subsequent years. This would

ensure that no trainees are disadvantaged by the introduction of an extra year of 'basic surgical training'.

- 6.5. If introduced, CT3 posts must have clear goals and educational value, as with all years of surgical training. These goals should complement the career of a trainee progressing from core to higher surgical training.

## **7. Acceptable competition for ST3 posts**

- 7.1. As mentioned previously in this document, we accept that there must be an attrition rate from surgical specialties at entry to ST3 level, partly as a quality control measure.
- 7.2. This acts to allow for those leaving of their free will and those who have not shown themselves to be of a suitable standard to continue in their training.
- 7.3. However, a trainee who completes core surgical training with a favourable outcome at their Annual Review of Competence Progression (ARCP) should be considered to have the skills to continue into ST3 and should have a reasonable expectation that they will progress.
- 7.4. Modest, acceptable levels of attrition must therefore be decided.
- 7.5. In Scotland a level of 15% has been set, which appears to have been introduced with some success and is perhaps a level to aspire to in England. Unfortunately for Scotland, it now seems likely that the problems that we are seeing in England could upset their balance, as English trainees start applying en masse north of the border.
- 7.6. It is vital that core trainees are aware at the beginning of their rotation that career progression is not guaranteed. This advice is currently lacking and

many core surgical trainees perhaps have unrealistic expectations of continuity as they progress through training.

- 7.7. Investigation is needed to detail the eventual career path taken by trainees that do not progress to ST3. Knowing precise numbers lost from the specialty as a result of this process would also aid in future trainee career planning.
- 7.8. It is essential that regional variability in training does not bias a trainee's chance of progression to ST3.
- 7.9. Where standards of training are very variable and trainees are disadvantaged by not receiving sufficient exposure to their chosen sub-specialty, perhaps due to the make up of their rotation, then these issues should be highlighted to the relevant Schools of Surgery.
- 7.10. We endorse the recommendation that prior to entry into ST3, each trainee should spend at least 12 months working in the chosen surgical specialty. Some surgical specialties do already expect this before entry into higher surgical training, but the lack of agreement on this has led to problems alluded to in paragraph 7.9 above.

## **8. Flexibility in medical training**

- 8.1. An issue that has been mentioned many times by ASiT and was highlighted in the Tooke report is that of flexibility in training.
- 8.2. Trainees are now expected to commit to a career path as early as Foundation Year 1 or 2. This allows little flexibility to those who are undecided and perhaps find that they have made an unsuitable career choice as they progress.

- 8.3. Many medical specialties have transferable skills, yet the current training structure fails to embrace this opportunity.
- 8.4. We believe that it is vital to revisit this issue in order to create a less rigid structure to early years medical training, which allow trainees to transfer easily between specialties of medicine where their skills can be utilised.

## **9. Non-CST trainees applying for ST3 posts**

- 9.1. As noted previously in this document, the figures presented by the Medical Programme Board do not include trainees applying for ST3 from outside a core surgical training post.
- 9.2. Some of these trainees may have been trying to enter higher surgical training for many years, usually with little or no chance of being successful. There is a need for this group to have consistent and realistic career advice.
- 9.3. ASiT council discussed numerous potential solutions to this specific issue and were unable to reach a unanimous decision. Three options became apparent during our discussions:
  - 9.3.1. A method already used by some sub-specialties in their selection process involves a calculation based on the product of number of years spent at CST level and the trainee's achievements in those years. This could level the field between high achieving CT2 trainees and those who have accrued experience through time spent at that level of training.
  - 9.3.2. An alternative suggestion was to limit the number of applications that a trainee is allowed to make into higher surgical training. This would be enforceable if national selection for ST3 is introduced, but there may be issues concerning employment law and whether trainees apply to more than one surgical sub-specialty.

9.3.3. Another option may be for a second or third failed application for higher surgical training to automatically trigger an obligatory careers advice interview. This would potentially benefit the trainee by pointing out the deficiencies in their application and offer alternative career paths that they might follow. It would also benefit the training committees by reducing the number of applicants who have little or no chance of success in the process. However, this would require the introduction of a strong mentorship programme (an initiative that ASiT would readily endorse).

## **10. Conclusion**

- 10.1. The developing bulge of trainees at CST level has been identified and must be addressed urgently.
- 10.2. Sensible, long-term workforce planning must be utilised to determine the number of trainees required at ST3 level, and these numbers worked backwards to decide the number of trainees to be employed in CST given an agreed attrition and rates of competition.
- 10.3. Solutions to the EWTD and how to staff CST-level rotas are an integral part to this process.
- 10.4. The introduction of a third year of CST is attractive to most surgical specialties for several reasons, but is perhaps not a long-term solution to the specific situation of the 'CST Bulge'.
- 10.5. We accept that there should be an attrition of trainees between CST and HST, but this must be kept to a reasonable level, probably no greater than 15%.

10.6. Ways to reduce the number of applications to ST3 posts from outside of CST or legitimate research programmes should be sought, to reduce the number of excess trainees with little chance of long term career progression congesting the application process.

10.7. The system by which trainees can change disciplines within a medical career should be simplified, with recognition of transferable skills that have been developed in their original discipline.

10.8. Careers advice and mentoring should be easily accessible for trainees at all levels of training.

## **11. Further Reading**

The Structure of Core Surgical Training: Discussion Document by The Association of Surgeons in Training. January 2008 [Click to view](#)