

The Role of the Surgical Trainee In Teaching Delivery For Undergraduate Surgical Education

by

Northern Ireland division
of
the Association of Surgeons in Training

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Northern Ireland division



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I. Executive Summary

- I.1.** The Northern Ireland division of the Association of Surgeons in training is committed to ensuring that surgical education and training is delivered at a consistently high standard, both at Postgraduate and Undergraduate levels.
- I.2.** Surgical Trainees remain enthusiastic in their support of teaching medical students and involvement in undergraduate surgical education, despite pressures of work.
- I.3.** Demonstration of, and maintenance of, the ability to teach is enshrined within *Good Medical Practice* and *Good Surgical Practice*, and is a required competency to attain a Certificate of Completion of Training (CCT). However, teaching competencies can be demonstrated in many ways by teaching small groups, such as medical students.
- I.4.** Changes to the Working Time Directive are reducing the amount of time available in Normal Working Days for Postgraduate Trainees to attain all of their required competencies which makes finding time for undergraduate teaching more difficult.
- I.5.** A Majority of surgical trainees are teaching medical students outside normal working hours, in a gesture of 'Goodwill', stating that there is no time within the normal working week in which to deliver the teaching. Monitoring of training needs robust and reproducible methods.
- I.6.** A significant proportion of Consultants are still not delivering teaching on a regular basis.
- I.7.** Postgraduate trainees are untrained and unassessed in teaching methods with the vast majority having no formal courses to verify their skills, and having received no formal feedback on their teaching ability.
- I.8.** A deficient curriculum, and lack of dissemination of a curriculum are felt to be major factors contributing to poor teaching delivery.
- I.9.** The University needs to urgently address issues of loss of trainee confidence and put in place a mechanism for recognising those people who are high quality teachers.
- I.10.** Solutions to address the problems include:
 - I.10.1.** Formal certified training on teaching methods for all postgraduate trainees delivering undergraduate teaching
 - I.10.2.** Provision of, and training in the use of, a curriculum appropriate to the level of students being taught
 - I.10.3.** Enforcement of requirement of Consultant led and delivered teaching for the 30%⁺ who are still not adhering to this

- 1.10.4.** Postgraduate trainee tutors should 'opt-in' to teaching in order that those with the enthusiasm and skill to deliver high Quality teaching are involved and recognised as delivering training.
- 1.10.5.** Postgraduate trainee tutors should have increased university support and recognition, which may be in the form of an honorarium in recognition of teaching time outside normal working hours.

2. Background

- 2.1. The Northern Ireland Association of Surgeons in Training (NIASiT) exists as a division of the Association of Surgeons in Training (ASiT) to represent the needs and views of Core and Higher Surgical trainees, in all 9 SAC defined surgical specialties, in Northern Ireland to the relevant regional training bodies.
- 2.2. NIASiT represents to ASiT council nationally, and collaborates with other regions in the UK in order to try and maintain best practice and share evidence of good practice.
- 2.3. Within the Northern Ireland General Surgical Higher Surgical Training Rotation there are a total of 44 posts, namely 38 approved training posts (34 NTN holders and 4 LAT/FTTA posts) and 8 further non-training Clinical Fellow posts.
- 2.4. Queens University Belfast (QUB) Scrubs is an undergraduate society that exists to: Develop interest in clinical or academic medicine and surgery; Interact vertically with other students and institutions around the UK, Ireland and wherever!; Interact socially and professionally with other healthcare professionals; and Promote social and professional peer interactions at an undergraduate level.
- 2.5. Undergraduate Surgical Education is delivered in the General Surgery specialty predominantly in the 3rd and 5th years of the MB BCH BAO course at Queens University, with students undertaking placements in General Surgical Units in the 3rd year, and elective placements and tutorial schemes in the 5th year of the course.
- 2.6. The Final year surgical tutor scheme has traditionally been run by Specialist/Specialty Registrars running tutorials on a weekly basis for groups of 5th year medical students allocated by QUB.
- 2.7. Anecdotal reports of 'poor' teaching by surgical units, with particular emphasis on General Surgery, has been reported by students to QUB undergraduate departments.
- 2.8. Concern over the ability of Consultants to deliver undergraduate surgical teaching has been raised and it was felt that undergraduate surgical teaching is in 'crisis' in an excerpt from the minutes of the School of Surgery meeting on Friday 19th March 2009:
 - 2.8.1. *“Professor Campbell raised this issue in a letter to Mr Campbell and indicated that there are not enough Consultant Surgeons to undertake undergraduate teaching. He then explained that the Undergraduate teaching is now in crisis. He then commented that this was a component to postgraduate’s responsibilities and that, in recent times, students had vocalised their concerns that the Trainees either do not turn up for teaching or arrive late. He then asked that if the Trainees do not involve themselves in this activity that this should be raised at the RITA process.”*
 - 2.8.2. Discussion at the School of Surgery meeting involved possible perjorative/punative action if students felt that Trainees were not

turning up on a frequent basis to deliver teaching, with sanctions available being a possible 'Unsatisfactory' grading for the Teaching component of the RITA form leading to award of a RITA 'D' or ARCP '2'.

- 2.8.3.** The maximum award available within the RITA/ARCP process is a 'Satisfactory in all respects to proceed' (RITA C or ARCP I). There is no mechanism for recognising excellence within this process.
- 2.9.** The impending full introduction of the Working Time Directive in August 2009 may further reduce the number of hours that trainees are available within the workplace, as well as the number of individual trainees that may be present at any one time.
- 2.9.1.** Postgraduate Surgical Training has already been significantly reduced due to the reduction of hours available to date. This is likely to be further compounded with ongoing hours reductions.
- 2.9.2.** Surgical Trainees are frequently underreporting hours, and rotas are experiencing 'rota gaps' due to the pressure to comply with current hours limits.
- 2.9.3.** A move towards full-shift working has seen a lack of continuity of individual trainees present on any given week, and staff within teams frequently change on a weekly basis.
- 2.10.** Funding streams for the remuneration of undergraduate surgical education are complex and poorly understood.
- 2.11.** Allocation of funding for staff time for delivery of teaching is difficult to clarify and quantify, and hence it is difficult to see where the funds for teaching are directed to, and hence responsibility for delivering the teaching at undergraduate level.
- 2.12.** Funding of undergraduate education comes partially in the form of the Supplement for Medical and Dental Education (SUMDE), which provides a supplement from the DHSS and DEL, via QUB, to NHS Trusts to provide education and training for undergraduate students. The mechanism for calculating SUMDE allocations is currently under review within the document "*Review and Modernisation of Supplement for Medical and Dental Education (SUMDE)*"
- 2.12.1.** Target numbers for recruitment to Queens Medical School are currently 250 students per annum, having increased from 154 prior to 2005.
- 2.12.2.** SUMDE has 3 main portions:
- 2.12.2.1.** Joint Appointment Funding (50% of Clinical Academics)
 - 2.12.2.2.** Dental SUDME
 - 2.12.2.3.** Medical SUDME (includes student placement funding & infrastructure funding)
- 2.12.3.** In the year 2004/05 £24,000 was distributed by the DHSS per student per year to support undergraduate teaching.

- 2.12.4.** The split of funding in models other than SUMDE is 80:20 in relation to facilities:clinical placements and teaching. This has been generally accepted.
- 2.12.5.** In Northern Ireland 85% of the funding is fixed and not related to the volume of teaching delivered, which favours some Trusts more than others.
- 2.12.6.** The review of SUMDE states *“Delivery of teaching is fundamental to SUMDE and requires compatibility, flexibility and partnership between QUB and the Trusts in order to deliver Flexible Academic and Clinical Teaching (FACT). Team job plans which support clarity should be promoted and this may be included in a new Memorandum of Understanding.”*
- 2.12.7.** It is also suggested that relevant teaching ratios are examined and considered within the future review of SUMDE funding in relation to provision of number of clinical teachers. *“The application of Teaching Units (TU) in the current model for distribution of New SUMDE uses a ratio of six students to one member of staff for clinical teaching. This is based on the premise that no more than six students can comfortably fit around a bed for teaching purposes. Some specialties (e.g. Psychiatry, Paediatrics) have a natural limitation on the number of students acceptable to a patient in a teaching situation. These are mainly, but are not limited to, Fourth Year specialties. While it is acknowledged that not all clinical teaching occurs at the bedside, it is agreed that to provide accurate student-staff ratios would require detailed and lengthy analysis of teaching styles in each specialty in each hospital, and these figures could vary on a sessional basis. The developed models continue to use the 6:1 ratio”*

3. Responsibilities of Surgical Trainees in Teaching

3.1. *Good Surgical Practice* defines that “Surgeons should be willing, as part of their professional practice, to engage in the training and supervision of students, trainees and other members of the surgical and health care team.”. Furthermore, in specific relation to Medical Students states that Surgeons should:

- 3.1.1.** encourage and support medical students;
- 3.1.2.** involve themselves actively in teaching if students are attached to their team;
- 3.1.3.** be aware of the professional competencies to be achieved by students;
- 3.1.4.** explain to patients that they have the right to refuse to participate in student teaching and reassure patients that such a refusal will not prejudice their treatment in any way;
- 3.1.5.** ensure that students are introduced to patients;
- 3.1.6.** ensure that privacy and confidentiality are maintained and that students understand and respect this requirement; and
- 3.1.7.** ensure that when a student is involved in specific examinations or procedures on patients under general anaesthesia, written consent has been obtained giving the full extent of the student’s involvement.

3.2. *Good Medical Practice*, in relation to Teaching, Training and Education states:

- 3.2.1.** Teaching , training , appraising and assessing doctors and students are important for the care of patients now and in the future. You should be willing to contribute to these activities.
- 3.2.2.** If you are involved in teaching you must develop the skills, attitudes and practices of a competent teacher.
- 3.2.3.** You must make sure that all staff for whom you are responsible, including locums and students, are properly supervised.
- 3.2.4.** You must be honest and objective when appraising or assessing the performance of colleagues, including locums and students. Patients will be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.
- 3.2.5.** You must provide only honest, justifiable and accurate comments when giving references for, or writing reports about, colleagues. When providing references you must do so promptly and include all information that is relevant to your colleague’s competence, performance or conduct.

3.3. Within the Intercollegiate Surgical Curriculum Project (ISCP) the Education and Training Competencies that must be completed prior to CCT include:

- 3.3.1. Knowledge**
 - 3.3.1.1.** Basic principles of adult education (teaching and learning theories)

3.3.2. Skills

- 3.3.2.1.** Builds on the skills acquired in the initial and intermediate stages
- 3.3.2.2.** Using his/her understanding of preferred learning methods in dealing with students, trainees and colleagues
- 3.3.2.3.** when teaching and training is being conducted using patients, Factoring in sufficient safeguards to protect the patient, when teaching and training is being conducted using patients, by adopting a structured approach, clear boundaries and briefing
- 3.3.2.4.** Planning educational activities which clearly set out aims and intended learning outcomes
- 3.3.2.5.** Preparing appropriate teaching materials which meet learners' needs
- 3.3.2.6.** Providing effective feedback to learners
- 3.3.2.7.** Optimising opportunistic teaching and learning
- 3.3.2.8.** Evaluating the use of reflective practice, learning agreements, portfolios and journals
- 3.3.2.9.** Using different methods of assessment appropriate to what is being assessed e.g. knowledge, skills, judgement and professionalism
- 3.3.2.10.** Differentiates between appraisal and assessment

3.3.3. Behaviour

- 3.3.3.1.** Shows a commitment and enthusiasm for teaching and training others
- 3.3.3.2.** Shows a willingness to supervise the work of less experienced colleagues
- 3.3.3.3.** Shows sensitivity to the needs of learner and responds appropriately.
- 3.3.3.4.** Shows a personal commitment to learning
- 3.3.3.5.** Is aware of and identifies ways in which their clinical teaching might be improved
- 3.3.3.6.** Uses his/her understanding of preferred learning methods in teaching students, trainees and colleagues
- 3.3.3.7.** Tailors the style and content of teaching to the audience and setting
- 3.3.3.8.** Demonstrates, when carrying out teaching and training activities that the safety and well-being of patients, trainees and those about is paramount

3.3.4. Practical Activities

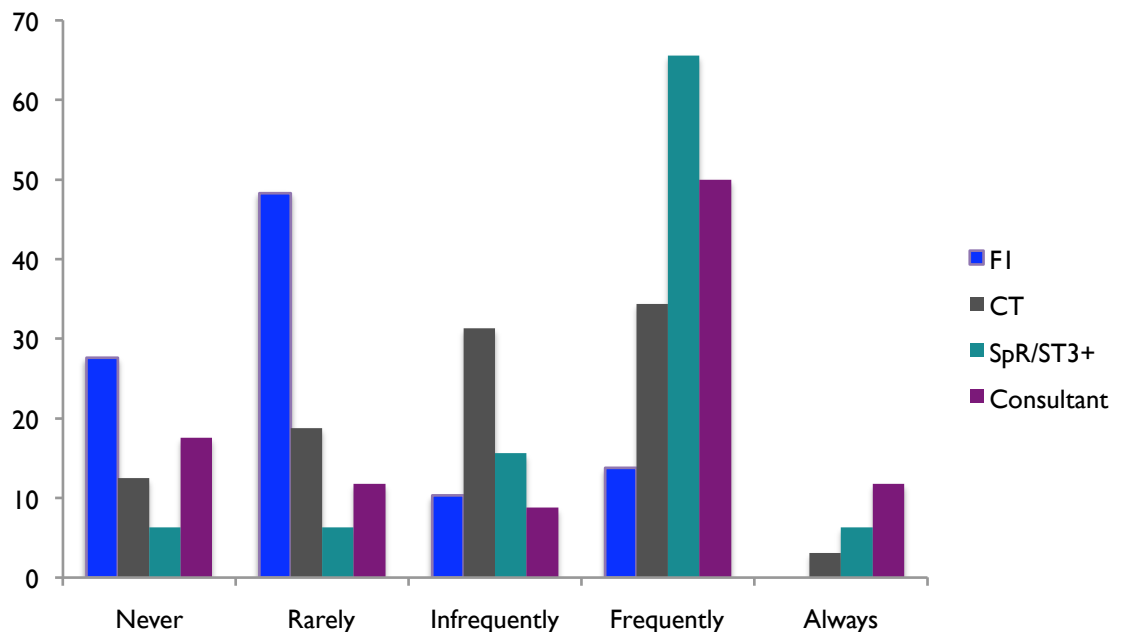
- 3.3.4.1.** Regular small group teaching of medical students, nurses **or** junior medical staff with some assessment or feedback to assessor
- 3.3.4.2.** Regular attendance at local surgical teaching sessions
- 3.3.4.3.** Organises and carries through a teaching programme or departmental meeting programme
- 3.3.4.4.** Supervision and teaching of junior surgical staff
- 3.3.4.5.** Acting as assessor for more junior trainee's assessments

3.4. Within contractual arrangements, the only relation to duties that must be performed is in sample Paragraph 3(a), which states: "3 (a) Your hours and duties are as defined in the attached job description. We may need you to carry out other duties or work in other areas to meet changing demands on service provision."

3.4.1. Within the ST3 person specifications it is stated "Evidence of contributing to teaching & learning of others"

4. HST Student Teaching – Survey Results

- 4.1.** A survey of Northern Irish Higher Surgical Trainees was carried out from Monday 8th June to Thursday 11th June 2009.
- 4.2.** Data was collected using online SurveyMonkey software and the relevant link was emailed to a targeted audience of Higher Surgical Trainees from a distribution list from the Northern Ireland Medical and Dental Training Agency.
- 4.3.** 34 responses were collected from Higher Surgical Trainees in General Surgery giving a 77% response rate from Higher Surgical Trainees.
- 4.4.** 97% of respondents are currently involved with teaching medical students within their current post, with 62% teaching medical students at least once per week.
- 4.5.** When asked about who delivers the 3rd year medical student teaching within their unit, the responses were as outlined below (expressed as percentage of responses):
- 4.5.1.** Rarely = less than once weekly
- 4.5.2.** Infrequent = once weekly
- 4.5.3.** Frequent = 2-3 sessions per week
- 4.5.4.** Always = every session students are present

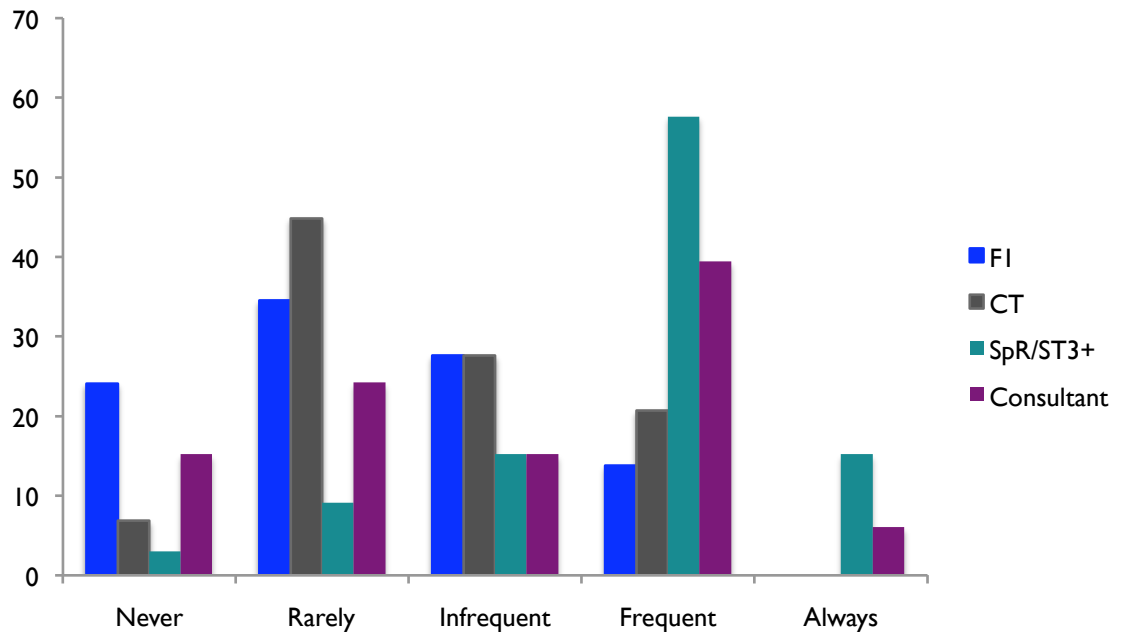


- 4.5.5.** 88% of individual SpRs teach 3rd year students at least once per week, while 71% of consultants teach at least once per week. However, 32% of Consultants teach less than once per week, and 19% Never at all, while only 12% of SpRs teach less than once per week
- 4.6.** When asked about who delivers the 5th year medical student teaching within their unit, the responses were as outlined below (expressed as percentage of responses):
- 4.6.1.** Rarely = less than once weekly

4.6.2. Infrequent = once weekly

4.6.3. Frequent = 2-3 sessions per week

4.6.4. Always = every session students are present



4.6.5. 87% of Surgical Trainees teach final year students on at least one occasion per week, while 60% of consultants teach on at least one occasion per week. However, 39% of consultants teach 5th year students less than once per week, with 15% never teaching 5th year students. Only 12% of SpRs teach less than once per week.

4.7. With regards to Quality Assurance of teaching delivery:

4.7.1. Whilst 97% of HSTs teach medical students, only **26%** have completed training on teaching methods, of which 33% were delivered by the University.

4.7.2. Only **12%** of people teaching medical students have had their teaching skills assessed.

4.7.3. Only **15%** of people teaching medical students have received, or are aware of the undergraduate surgical curriculum, whilst **74%** are unaware of any online resources that are available for use by the medical students and the contents of these.

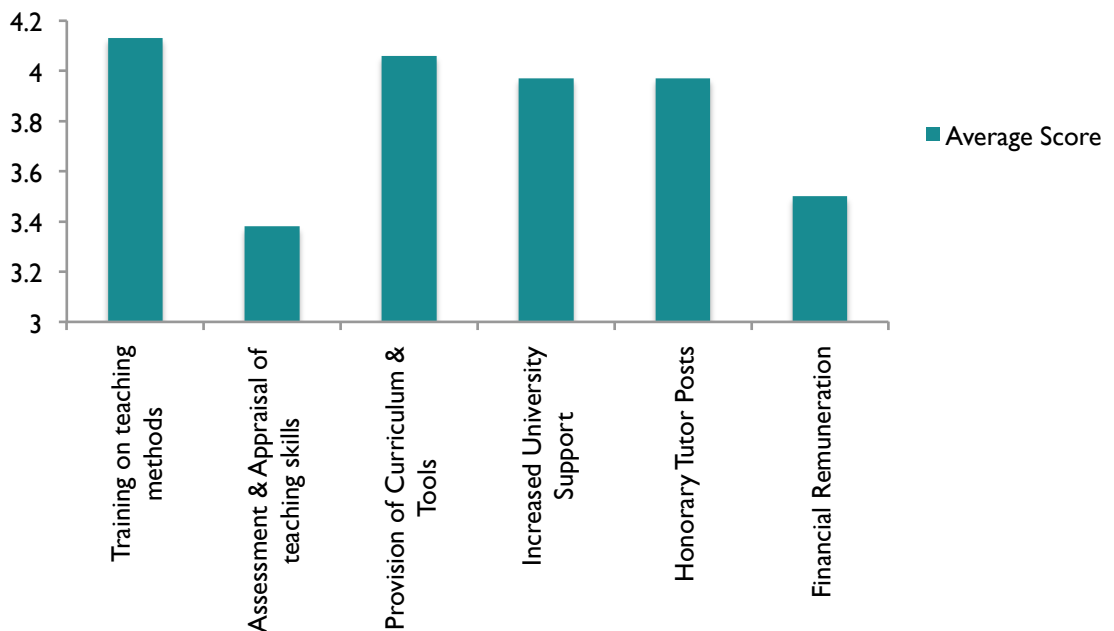
4.7.4. **17%** of HSTs who deliver teaching have ever received any written or verbal feedback on the quality of their training.

4.7.5. All HSTs who responded to the survey are currently working rota patterns which are greater than 48 hours per week, and which will be under pressure to reduce to less than 48 hours in August 2009.

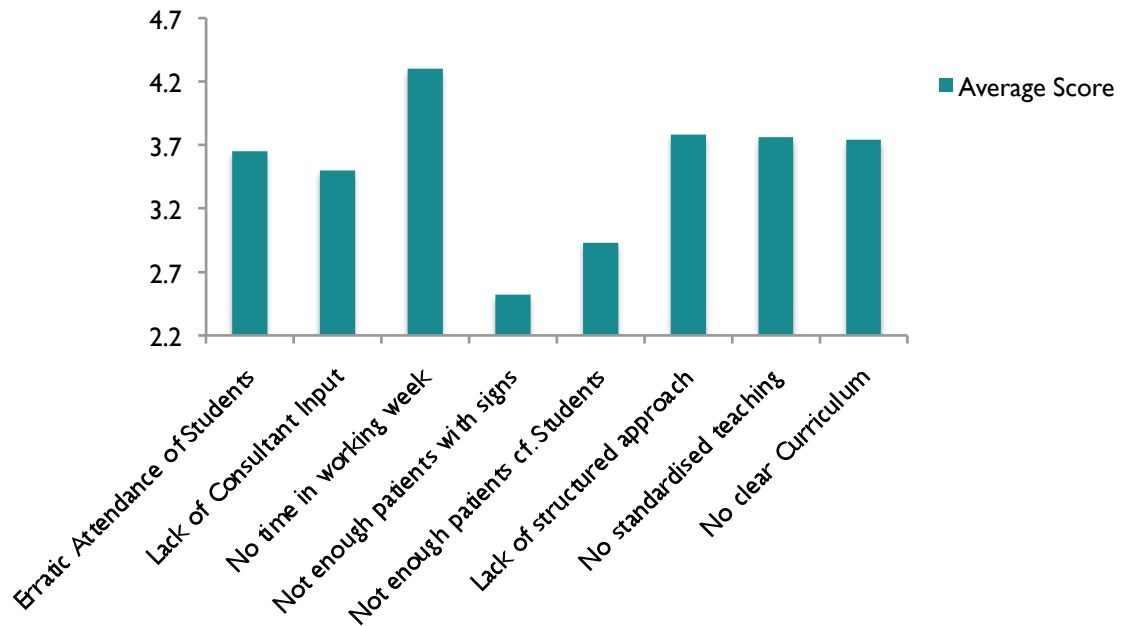
4.7.6. **94%** of HSTs surveyed have NO protected time for undergraduate

teaching within their weekly timetable.

- 4.7.7.** **70%** of HSTs teach medical students at a time when they are rostered to be off work and not present within the hospital, of whom **82%** state that this is due to no time being available in their current working week, while **57%** have also encountered problems with students not being available at times other than their 'out-of-hours' period.
- 4.7.8.** **91%** of those taking a 5th year Tutorial group ENJOY teaching the students, however only **42%** feel that they have ever received recognition for doing this. When asked if they would teach a tutorial group in the future, **42%** responded Yes, **19%** No, and **39%** Unsure.
- 4.7.9.** With regards to teaching others, and demonstration of teaching competencies through teaching at local hospital presentations, teaching on courses, or teaching other healthcare groups, **94%** of HSTs could demonstrate teaching competencies in this way.
- 4.7.10.** When asked if a further hours reduction would impact on the ability to deliver medical student teaching within the working week, **94%** answered Yes, with the remaining **6%** Unsure. Furthermore, **63%** of people would then be LESS likely to teach medical students in this setting with another **13%** Unsure what they would do.
- 4.7.11.** Only **3%** of respondents felt that the assessment of quantity of Medical Student teaching should be recorded in a RITA or ARCP process, while **75%** of people felt there was NO mechanism to 'reward' Medical Student teaching through a RITA or ARCP Process.
- 4.7.12.** With regards to the changes that are required that may encourage participation in medical student teaching in the future, the following chart outlines the responses based on their average score out of 5.



4.7.13. With regards to the barriers that were felt to hinder good medical student teaching, the responses are outlined below.



4.7.14. Invited free text responses are outlined below:

4.7.14.1. Surgical tutor scheme is very haphazard - spr's feel hard done by and students sometimes get a bad deal (by less than enthusiastic tutors). I think this is recognised by the new university setup and the tutor scheme is due to be phased out within the next 1-2 years

4.7.14.2. Usually find out on short notice. Better if known in advance to be able to prepare and structure a lesson.

4.7.14.3. Perhaps the university should recognise the input of those people who have a desire to teach and enthusiasm by supporting them through appropriate educational courses, and honorary university positions with university privileges - and leave those of us who don't enjoy it, or are not good at it, to focus on other things.....

4.7.14.4. How can the University propose chastising people for something for which there is no support, no recognition, and which consumes an awful lot more time if done properly than they ever give credit for. All this at a time when we are told that we should be working less and are constantly under pressure to reduce the amount of tie in work to give a better work life balance - when preparation time for teaching, and teaching delivery outside working hours actually make this worse. This is an insult and I may decline to teach tutorial groups outside working hours in the future.....

4.7.14.5. Teaching is often unstructured and poorly prepared due to being given very little time in which to prepare for teaching. Use of standardised presentations and a more structured approach would improve the quality of the teaching delivered, and avoid repetition. I enjoy teaching and will continue to teach, but the threat of punitive action is frankly insulting given that this is provided in my own time and impacts on family life. At a time when training is harder to come by, people need to get a grip on what is realistic, and the University needs to seriously rethink who, and how surgical teaching is delivered, perhaps by formally recognising the role of those keen to be involved in teaching, and supporting their role - only then can teaching medical students be formally assessed as part of our jobs - while teaching is provided 'free of charge' and in an unqualitative and non-

reproducible manner there can be no benefit to this.

- 4.7.14.6.** Surely the University, and the GMC, need to look at the overall standards of Undergraduate Surgical Education, its methods of delivery, and the qualifications and standards of those delivering it before it targets the poor sods who are keeping it afloat for free. Our Medical Students, and the patients that will be under their care in the future deserve better than they are getting from Undergraduate surgical teaching at the minute, but this will take a major investment from the university.
- 4.7.14.7.** teaching medical students has always been haphazard and dictated by which doctors are available, which patients are available and which students turn up. this is unlikely to change. i do not think that rita should be effected by teaching ability either in a positive way or a negative way. if a trainee has been shown not to be skilled at teaching then simply stop them teaching. i would like to see more involvement from queen's university who i would suggest are 'silent' presently. I have had no training or feedback from them (my training was at another university) rather, I received an email asking me to volunteer for a final year group, no questions asked. financial remuneration for teaching would be pleasing and given that all of my final year teaching is done in my own time out of hours then i suppose would make sense. however, remuneration or not, i would continue teaching as (aside from 'good practice' a) i find it enjoyable and b) helps me keep up to date in the various sub-specialities of surgery.
- 4.7.14.8.** To threaten to penalise individuals in their postgraduate training, when they are otherwise demonstrating that they have achieved their competencies makes no sense whatsoever. The University would be better served focusing on sorting out the standards and quality of the teaching, and providing support to achieve this, rather than trying to threaten teaching that is currently provided out-of-hours as goodwill. If there is a threat that I will be penalised, I will simply opt-out of teaching at all and will fulfill my teaching competencies in other ways.
- 4.7.14.9.** I have to admit that I am personally offended by the idea that the discontent of some students could affect my career. Within my current job there are no free sessions, teaching has always been supposedly outside working hours, which inevitably eats into my own family, study and personal development time
- 4.7.14.10.** Currently working in Daisy Hill Hospital. 2 of my final year tutorial group turned up to my first tutorial then I got an e-mail from the tutorial group representative to say that they found Newry too far away and would prefer to attend the final year tutorial groups at the hospital they were currently attached to. As not all higher surgical trainees are allocated a tutorial group each year it might be better to allocate tutorial groups to HSTs in central hospitals.

5. Undergraduate Perspective on Surgical Teaching

- 5.1.** QUB Scrubs were approached for a student perspective of the issues that they see in Undergraduate Surgical Teaching which are outlined below:
- 5.2.** As with many of our placements at undergraduate level, there does seem to be disparity between hospitals in relation to the level of attention/teaching that students get. Phase Quality Assurance Committees have been set in place to 'try to' improve on this, but it is a slow and gradual process and obviously depends on staffing, time, and enthusiasm of doctors to teach.
- 5.3.** A more structured approach would most definitely be of benefit as some doctors do talk of how they are told to teach, but have little guidance on what to teach and thus sessions can be pointless! In short, the university needs to produce a syllabus because the third year student guide is poor (very vague).
- 5.4.** Students feel that the attitude of some surgical registrars needs to change e.g. one student reported that on the first day of one of their attachment they were told by the reg that there was no set class time or topic; it was up to the students to approach the teacher with a topic and patient in mind. One of the registrars in BCH admitted to students that there might as well not be a timetable, labelling the set timetable a "unicorn"!
- 5.5.** The appointment of Clinical Teachers in Surgery, for example at RVH, is of great benefit to students as a source of contact regarding the course and these people are in place solely for the purpose of teaching which takes the pressure off staff to do so. Siva is an excellent example- he is very popular with the students who revere the high quality of his teaching.
- 5.6.** In the most recent OSCEs students we spoke to felt that they struggled most on the surgical stations, especially when asked to perform so called basic skills like writing up fluids and examining a patient's calf. The only students who were relatively happy with their performance were those taught at RVH.
- 5.7.** Students feel that a system has to be put in place whereby they can report lack of teaching on placements. This is particularly poignant as one of the third years this year had a dispute with a very senior figure in BCH over the quantity of teaching, not with the quality it must be said.
- 5.8.** Cases need to be standardised. Across the board cases were not being returned to students promptly to allow for comments to be taken on board and improvements to be made prior to submission of the next case.

6. Issues Identified in Undergraduate Teaching

- 6.1.** There are ever increasing pressures on time available for Postgraduate Training to be delivered. With reducing work hours, many trainees have to focus more on attaining their own postgraduate training within normal working hours, therefore leaving no time in normal working hours for delivery of teaching.
- 6.2.** A change in working patterns towards full-shift rotas with the implementation of the Working Time Directive has led to a break-up of the firm structure, and more erratic attendance of trainees during working hours. This makes regular scheduling of sessions impossible.
- 6.3.** Postgraduate trainees, currently deliver a substantial proportion of Undergraduate teaching with a large proportion being delivered outside normal working hours (and therefore on 'goodwill' of trainees), with no formal recognition.
- 6.4.** Postgraduate trainees ENJOY teaching medical students.
- 6.5.** Whilst the vast majority of trainees deliver teaching to medical students, most have had no formal training in teaching methods, nor been assessed in the quality of their teaching. This raises issues relating to the Quality Assurance of undergraduate teaching.
- 6.6.** Both Postgraduate Trainees, and Undergraduate Trainees have highlighted that a deficient surgical curriculum is a major factor impeding the appropriate delivery of teaching.
- 6.7.** Lack of knowledge of a curriculum, or other available resources hinders delivery of teaching.
- 6.8.** The role of Surgical Educators should be enhanced in order to incentivise people to deliver better quality training.
- 6.9.** There is a strong feeling that a lack of structured approach to teaching hinders teaching delivery, with little time available for preparation of high-quality teaching sessions, and hence students are missing valuable learning opportunities.
- 6.10.** There remains concern over the level of consultant input, and whilst a majority are delivering teaching frequently, there is still a reasonable proportion who are not delivering teaching (presumably despite having it included within job-plans etc)

- 6.11.** The formal assessment of medical student teaching within a RITA process is not felt to be appropriate, as the required competencies for training can be, and are being gained, through other means and demonstration of teaching ability and engagement.
- 6.12.** It is not felt that there is any method to 'Reward' good teaching within the RITA process, and if teaching is to be rewarded, this would need to be through other means.
- 6.13.** Increased pressure is impacting on the perception of Postgraduate trainees on their willingness to continue teaching, and ability to continue teaching. This may result in the loss of a number of postgraduate trainees from teaching medical students.
- 6.14.** Methods of enhancing and Incentivising undergraduate surgical teaching have been identified, and include provision of a curriculum, certified training in teaching methods, increased university support and honorary tutor positions with the University.

7. Solutions

- 7.1.** The main focus of solutions should be on improving the **QUALITY** of teaching that takes place for undergraduate trainees. If Quality is addressed then quantity will become less relevant.
- 7.2.** Continue current arrangement where Postgraduate trainees continue to train using 'Goodwill'
- 7.3.** Enhance consultant delivery of teaching to undergraduates and utilise the mechanisms within the Consultant Contract and SUMDE to ensure that Consultant teaching is delivered.
- 7.4.** Production of a robust and widely distributed curriculum for undergraduate trainees at 3rd and 5th year levels. This should also include details of other tools and resources available in order to avoid repetition and duplication of teaching.
- 7.5.** Postgraduate trainees should 'opt-in' to undergraduate teaching. This should be associated with formal training in teaching methods provided by the University, and assessment of teaching skills by the University. This should be recognised with increased university support for these roles, and recognition in terms of honorary tutor posts and university privileges.
- 7.6.** Other mechanisms of 'Rewarding' those who deliver teaching may be on a financial basis with an honorarium paid to those felt to be delivering good quality teaching.
- 7.7.** There must be a mechanism to recognise teaching that is delivered outside normal working hours in order that trainees remain incentivised to provide the teaching at that time.