

The Shape of Training Review 2013

A Response on behalf of the Council of



November 2013



35-43 Lincoln's Inn Fields, London, WC2A 3PE, UK

Telephone: 0207 973 0301

Fax: 0207 430 9235

Web: www.asit.org

Twitter: @ASiTofficial

Email: president@asit.org

Authors:

Mr Henry Ferguson (ASiT Vice-President)

Mr Ed Fitzgerald (ASiT Past-President)

Mr Joseph Shalhoub (ASiT Past-Vice-President)

Mr Vimal Gokani (ASiT Academic Trainee Representative)

Mr Andrew Beamish (ASiT President)

Written On behalf of the ASiT Executive and Council

Foreword

‘Securing the future of excellent patient care’, the final report of the independent review led by Professor David Greenaway (The Shape of Training Review), sets recommendations regarding the structure and delivery of medical and surgical postgraduate training for the next 30 years¹. The changes proposed within its 19 recommendations are far-reaching and have implications for both current and future trainees in the UK. This response document sets out the specific changes that surgical trainees within the UK will encounter if these recommendations are implemented, and seeks to communicate the opinions of ASiT regarding this important document.

About ASiT

ASiT is a professional body and registered charity working to promote excellence in surgical training for the benefit of both patients and surgical trainees. With a membership of over 2,300 surgical trainees from all 10 surgical specialities, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and Specialty Associations.

Executive Summary

The broad goal of delivering trained doctors that match the needs of the local population is laudable. However, patient expectations for their care continue to rise. At the same time, the complexities of surgical care together with the focus on surgeon outcomes are driving the profession towards ever more specialist care. In parallel to this, factors previously discussed by ASiT²⁻⁶ are conspiring to substantially reduce the operative experience of current surgical trainees. ASiT therefore finds it difficult to see how the generalist model proposed in this review can be reconciled against these pressures and be of benefit to both patients and trainees.

We have specific concerns regarding the potential product of the proposed training system in surgery. While it is commendable that the Review acknowledges that there is no appetite for a subconsultant grade, this is the reality of what the reforms would lead to in all but name. The Certificate of Specialty Training (CST) holder of the future will lack the depth of knowledge and operative experience of current trainees due to the shortened and broadened training structure and, while the Review intends these trained surgeons to provide the majority of generalised care, it is clear that they will be working at a lower level to that of the current consultant. This is not in the best interests of future patient care.

With regards to Post-CST training, ASiT cannot support subspecialty credentialing. The migration of subspecialty credentialing beyond formal postgraduate training raises significant financial and organisational questions, which appear not to have been given consideration.

It is our opinion that a 'one-size-fits-all' approach to postgraduate training is inappropriate. Greater flexibility must be given for craft specialties to achieve the technical, professional

and knowledge-based skills that their future consultant careers will necessitate. There should be significant clarification of a large number of the recommendations within this Review and significant thought given to the alteration of others before any movement towards changing surgical training is considered. We look forward to engaging with the profession to discuss this further.

Introduction

The Shape of Training Review proposes a new training system for all doctors in the United Kingdom. The review proposes a restructuring of current specialties into multiple 'broad specialties', one or more of which will include the current surgical specialties. The proposition is to have the trained doctors of the future specifically developed with the needs of their local population in mind. Thought has also been given to the ability for retraining within broad specialty areas, again, driven by local demand.

The following statement is laid out to mirror the format of the Review, within 5 major themes, and directly responds to the 19 Recommendations proposed in the document. It is intended to be read alongside the Shape of Training Review document.

Response to Recommendations

Theme One: Patient Needs Drive How We Must Train Doctors in the Future

Recommendation 1

ASiT supports the notion that postgraduate surgical education must be able to respond to changing demographics and patient needs. Specific note and endorsement is made of the recommendation to improve the holistic nature of care, reinforcing key aspects such as cultural awareness, patients' individual circumstances and communication skills.

However, we approach with caution the suggestion that a shift towards community working within surgical specialties carries only positive implications, as outlined in this document.

ASiT recognises a potential training opportunity presented by community minor surgery and continues to work with the Association of Surgeons in Primary Care (ASPC) to seek ways to achieve valuable training experiences in the community for junior surgical trainees in the future. However, while an increasing number of minor procedures are being performed in the community, training quality and clinical outcomes are not adequately reported in this setting. There is also significant potential for publication bias in existing outcome reporting. Furthermore, within the context of an ageing, more medically complex population, we do not foresee a reduction in the need for hospital specialists.

Surgical training, more than any other specialty training programme, is dependent upon a prolonged period of technical skills acquisition alongside the generic medical skills obtained in non-craft specialities. There are not currently sufficient appropriately approved surgical training environments in community settings in the UK to facilitate such a shift in skills

acquisition. We cannot support a shift of trainee placements without adequate, quality assured training environments, in addition to the examination of clinical outcomes.

We also believe that any devolvement of specialist care in the community must be directed and coordinated with involvement of relevant specialists rather than relying upon General Practitioners as stated in the Review. Equally, we feel it is unnecessary for trainees in a surgically orientated broad based specialty stream to undergo explicit training in general practice (as implied in point 35). Such training would be at the expense of the valuable surgical experience, which is already under pressure.

ASiT supports the Review's intention to increase the volume of acute care managed in the community. Reducing unnecessary admissions to hospital and delays to discharge from hospital or transfer of care has the potential to effect major cost savings in the Health System.

Recommendation 2

ASiT is wholly supportive of the further integration of patients into surgical training programmes. However, this is likely to increase costs and it is unclear how this would be funded. ASiT is opposed to additional training costs being imposed on surgical trainees given the pre-existing financial burden of surgical training borne by trainees themselves.

Theme Two: Changing the Balance Between Specialists and Generalists

Recommendation 3

It is clear that, both now and in the future, all prospective and current medical students need to be fully informed as to the realities of a career in surgery from the outset, in order that they can make informed career choices. We recognise that the surgeon of the future should be responsive to the shifting needs of their population. However, further clarity is needed on this point. Would this be the case of, for example, a general surgeon who predominantly performs breast surgery needing to improve their skills in laparoscopic cholecystectomy to meet service needs, or indeed is the Review suggesting a broader shift from, for example, otorhinolaryngology (ENT) to orthopaedic surgery? This latter option is clearly beset with enormous difficulties and we feel that such broad shifts would be unworkable, even if the Consultants of the future had received a more broadly based early training.

Indeed, there is another, even more worrying possibility, which is that practical operative surgery becomes credentialed. In effect this would mean that surgical trainees would have a Certificate of Specialty Training (CST) as expert diagnosticians, but the ability to operate would be gained after CST. As the representatives of the UK surgical training body, ASiT is wholly opposed to this model and we feel a shift this far might risk making surgery a highly unattractive career option, with migration of prospective surgeons to other surgical training systems abroad or other specialty or career choices. Extensive clarification is required, as we feel that its implications on surgery as a whole have not been considered in the wording of point 39.

We recognise that surgical specialties are universally oversubscribed in terms of applicants into specialty training. We also recognise that this is not the case within more general specialties, such as emergency medicine or psychiatry, and in remote geographical areas. However, the diversion of surgical specialty trainees to work in these undersubscribed areas on the basis that they are broadly trained is a thinly veiled effort at stemming a service problem. While some benefits could be gleaned from this experience, the learning goals to be achieved by a specialty trainee, for example, assessing unselected patients in an emergency department need to be strictly identified and adhered to if this aspect of training is to afford any benefit as a training experience. This is particularly important if the training programme is to be shortened, as outlined in the Review. ASiT feels that attention should be directed toward the primary problems in individual specialty areas where there is difficulty recruiting in order to attract a greater number of applicants rather than diverting trainees from surgical areas.

With reference to point 46, it must be remembered that within a finite and likely reduced timescale, an increase in the breadth of knowledge an individual possesses, will inevitably decrease the depth of this knowledge. This will increase the need for deference to specialists when managing complex patients. While a generalist may be able to take on various roles and responsibilities for a future employer, the emphasis of their practice will be service driven, with seemingly little reason for employers to encourage practitioners to become specialists, as this will necessitate employment of a further generalist.

Despite advances in surgery and imaging, operative findings often differ substantially from expectations. It will not be an infrequent occurrence that the pathology encountered in an emergency surgical patient exceeds the generalist training of a consultant of the future.

There will therefore be a requirement for a further, potentially regional, tier of emergency subspecialist cover for a safe emergency surgical take to be possible. This has significant associated financial costs to healthcare providers and needs to be addressed in any plans for reconfiguration.

Extensive consultation is needed, and significant care must to be taken when identifying the areas of the current surgical subspecialties that ought to be devolved to the generalist. It is likely that if only the 'routine', low complexity work is devolved to this pool, then it will present an unpopular long-term career option to the potential surgeons of the future and, in the opinion of the Association, is likely to lead to emigration of CST-holders, as well as a reduction in the number of young people inspired to train to become a surgeon.

Theme Three: A Broader Approach to Postgraduate Training

Recommendations 4 & 5

The competence of new medical graduates, and any changes to the point of registration with the GMC are beyond our remit to comment upon. It suffices to say that if Foundation Year One doctors are to be fully registered, then they should be as capable, both professionally and clinically, as the current Foundation Year Two doctors are. This presents significant issues for medical undergraduate training.

ASiT has concerns regarding the proposed future move of Foundation Year 2 into Speciality Training. While the emphasis in the Review is on competency based training rather than time-dependence in this respect, the removal of a further year from the proposed programme, which could in theory produce a CST-holder in 8 years from graduation, is not desirable within craft specialties.

Recommendation 6

ASiT acknowledges the merits of a Generic Capabilities framework in keeping with *Good Medical Practice*. We advocate assimilation of the Royal College of Surgeons *Good Surgical Practice* document into this framework for surgical specialties.

Recommendation 7

ASiT agrees with the sentiment that progress through surgical training should be competency-based and has in recent years made clear that arbitrary numbers of workplace-based assessments or procedures are in no way an appropriate substitute for formal apprenticeship style training which directly addresses trainees' learning needs⁷. It is important to emphasise, however, that even if sufficient competence can be demonstrated

through continued assessment, there is no substitute for repeated operative exposure in order to encounter less common pathologies, or anatomical variation. This lack of exposure in a shortened training model may well be counter-productive when the goal of the programme is to produce a surgeon who is able to independently manage a wide range of surgical pathologies. Even within the most lenient model in this document, the total length of time spent in formal surgical training would be 6 years – 2 years shorter than is currently the case. Equally, the future proposed integration of Foundation Year 2 into specialty training should only occur if there is a reciprocal year increase in the length of specialty training, so that training time is not further eroded in a political effort to stem a service gap.

A careful review of the way in which service and training requirements are balanced in surgical training programmes would be needed in order to permit the accelerated learning required to meet this shortened training period. This would have to recognise and address the clear need for experience in both technical areas of surgical practice (e.g. operative skills) and non-technical areas (e.g. outpatient and ward based clinical skills, management, leadership) in the development of the competent consultant surgeon. Without the development of such programmes, with adequate additional service provision from outside of said programmes, we find it difficult to foresee that a surgeon who is 25% less experienced than is currently the case, could offer the care that patients currently expect from a consultant.

Current evidence suggests that two-thirds of current surgical trainees plan to perform a post-CCT fellowship, primarily to develop operative confidence and competence⁸. This implies that the current training scheme is not fit for purpose as it currently stands, but we do not see that shortening the training scheme further will improve the status quo. We

recommend that the normal expected length of training within craft specialties be maintained at 8 years post Foundation Programme, with the facility to progress more quickly if mastery of the necessary skills can be evidenced.

Recommendations 8 & 9

ASiT is supportive of the proposal to make surgical placements longer to allow trainees to integrate better into their teams. This has been our position since the formal introduction of Core Surgical Training in 2007/8⁹. Four-month, or sometimes shorter placements are disruptive to the working of the multidisciplinary team, and also to continuity of care. Six-month placements could be appropriate in early specialty training to gain the breadth of experience needed, but longer placements of up to 12-months should be considered in the more senior years as short placements can undermine the relationship between mentor and apprentice when training in more complex procedures. Many procedures require significant trust on the part of the trainer, which cannot be built in a short placement.

The proposal for a closer relationship between service delivery and training opportunities is to be commended, so that service is not favoured over training opportunities. However, the notion that as trainee surgeons become more senior that they would deliver more service should be cautioned against. In the later stages of the proposed specialty training, trainees would have greater independence and would be developing their operative skills, but we have concerns that care should still be directly supervised and consultant-led, in order to improve patient outcomes.

Similarly, we are concerned over the statement that trainers' "supervision will become less hands-on" (point 84). We feel that trainers' supervision should remain hands-on throughout

training. While we encourage the development of a trainee's ability to practice independently, as will be required in consultant practice, we feel that the focus of supervision should shift according to the individual trainee's needs, rather than the level of supervision diminishing. As a trainee develops competency and independence in clinical and operative skills, other attributes, such as leadership and management skills, may warrant attention from the supervisor in an apprentice model that seeks to produce the rounded individual, competent to perform across the myriad activities required of a consultant surgeon.

There is well-recognised evidence that consultant-led care is beneficial to clinical outcomes¹⁰, but it must be borne in mind that this evidence is based upon today's consultants, who are products of previous and current training systems. In our opinion it is not possible to train to an equivalent consultant standard within the proposed framework without radical reconfiguration of the way training and service are delivered, as well as renegotiation of the European Working Time Regulations (WTR), and its current impact on service delivery.

The aim for apprenticeship-based training should be lauded and we especially support the notions of ongoing mentoring, commitment to teaching and approved trainers working in this role. We particularly highlight the latter point – not all workplaces should be involved in training, including both community and secondary care settings. However, trainees should be able to follow the training opportunities – care should be taken to ensure that high volume units are encouraged to be training centres, as well as those centres offering unusual case mixes. Equally, it may be the case that centres of subspecialty excellence are not training centres for broad-based programmes in the future. Care must also be taken within

training reconfiguration to avoid overloading successful training centres with an unmanageable volume of trainees, which could detrimentally affect a centre's ability to provide training.

Recommendation 10 & 'The Outcome of Postgraduate Training'

ASiT is keen to emphasise and echo the statement within the review that there is 'no appetite for postgraduate training to produce a less trained doctor - a subconsultant grade' (point 87). This is in keeping with the vast majority of opinion within surgical trainees¹¹. We are firmly united in the opinion that the product of postgraduate surgical training should be a professional who is able to practice independently – a consultant. There is a significant risk that these proposals will produce a clinician who is not sufficiently trained to practice independently at the level of a consultant surgeon, a fact that will inevitably lead to a subconsultant grade in all but name unless this is specifically addressed from the outset of any change in the delivery of surgical training.

The levels of competence outlined in the Shape of Training Review appear to equate to:

- a) A Specialty Registrar
- b) A Consultant
- c) A Consultant credentialed in a subspecialty

The distinction between the latter two groups should be purely in respect of their area of service provision, with equivalent seniority, pay grading and employment conditions. The future CST holder must be eligible to apply for any advertised consultant post, as is the case for a current Certificate of Completion of Training (CCT)-holder.

Significant clarification is needed to address the notion of training within a ‘broad-based specialty’. The prospect of not only shortening the overall training programme, but using some of the valuable surgical training time to gain experience in other specialties is likely to be detrimental to the overall surgical experience of CST-holders and therefore to the quality of patient care in both acute and elective settings. Similarly, the option of a single year taken within training to improve, for example, management, educational or research skills, which counts towards total training time, further compounds this issue. With specific reference to this single year of targeted training, we have significant concerns that those wishing to pursue a research degree in a specific area of interest would not be afforded the opportunity to do so within the proposed training system. Those skills gained during study for a higher degree go far beyond an ability to engage as a future surgical academic. It provides problem solving and critical analytical skills, which we feel are less likely to be gained in routine clinical practice within the proposed framework. The alternate academic training pathway would be available for these individuals, but academic training numbers would be limited in the same way that they are now. This risks stifling the pool of important surgical researchers who do not specifically want to be Clinical Lecturers.

Recommendation 11

ASiT has concerns regarding the process of transferring some clinical skills currently acquired in Specialty Training to proposed post-CST credentialing. The proposal is that the CST-holder will be equivalent to the current CCT-holder, but with less chronological experience, and consequently less clinical and operative exposure, and a narrower experience of surgical pathology. This mismatch needs to be specifically addressed and assurances gained for our patients that the ‘fully-trained’ surgeon of the future is as competent as is currently the case.

Theme Four: Tension Between Service and Training

ASiT's position with regards to working hours is well known^{2,3,12,13}. Significant relaxation of WTR would potentially allow adequate time for training within these proposals. However, we have reservations regarding the statement that broader based curricula will take away some pressure on training hours. If anything, greater training time will be needed to ensure the future surgeon has the necessary exposure and experience for diagnosis, decision-making and technical development.

Recommendation 12

ASiT acknowledges that there are deficiencies in staffing in many centres, especially in less popular specialties such as emergency medicine. The report seeks to address this deficiency by aiming to have all trainees broadly trained so that they can see 'unselected' patients in an emergency setting. ASiT do not believe that this is appropriate. It ultimately concerns the use of doctors in training to cover service provision in the emergency department. This would result in less surgically competent consultants in the future, who are less able to care for complex patients with multiple co-morbidities. However, ASiT does support specific, directed training in trauma and emergency surgical care in the early years of surgical training, which we accept could occur in the emergency department⁹.

Recommendation 13

As previously stated, there is good evidence that consultant delivered care is superior to other models¹⁰. ASiT is conscious that this will lead to a decrease in hands-on training opportunities for surgical specialty trainees, thus impacting on future patient care. The devolution of the planning of training to employers raises numerous concerns. The most obvious of these is that employers will see no direct benefit in training a doctor who will

subsequently rotate to another employer, and are therefore unlikely to be generous in their support. Anecdotally, this appears in the discrepancy between permanent nursing staff having training courses paid for by their employers, where junior doctors have to use their limited study budget, supplemented by their own funds. This raises the possibility of individual employers taking on trainees for continuous training to CST - a model similar to that of the residency programme in the United States. Assurances would have to be sought as to the quality, and hence the universal recognition of training within programmes such as this in the UK.

Theme Five: More Flexibility in Training

This section represents a paradigm shift in the way doctors are treated as professionals. The proposal is one of a dictated career structure where CST-holders could be asked to retrain to fulfil local service needs, regardless of their own career intentions. This will be unpalatable for the majority of current surgical trainees given the time and personal funds invested in training to-date. Any introduction would need to be phased in, with specific management of the expectations of the doctors of the future as early as school careers advice. Given the time and expense required to develop operative surgical skill, it is difficult to see how this recommendation is achievable in surgery.

The emphasis on improving work/life balance and restructuring training to better suit part-time working is commendable, but the review lacks any detail as to how this would be arranged or implemented.

Recommendation 14

ASiT is supportive of any modifications within clinical academic training that would allow future surgical academics to flourish. This will clearly be better managed within any future training scheme rather than in parallel to it as is currently the case. Assurances would need to be made that such academics would be able to achieve their clinical competences alongside their academic work and would not have their training curtailed by arbitrary time-related cut-offs. However, we dispute the statement that the proposed single year within training would eliminate the need for the majority of out of programme (OOP) periods. It is our feeling that current OOP periods offer a significant benefit to surgical trainees and the wider health service, and they should not detract from overall training experience. In short, such experience should remain out-of-programme, and not count towards training time.

Recommendation 15

ASiT supports the recommendation to ensure Continuing Professional Development (CPD) is a mandated requirement of terms of employment.

Recommendation 16

ASiT has significant concerns about the removal of subspecialty training from formal training programmes. The security offered by current surgical training allows surgical trainees to pursue a clinical interest, with the potential for subspecialty employment. However, the current CCT is already awarded within a general specialty rather than a specific subspecialty and we are unclear as to what benefit the proposed changes offer to the status quo.

It is our presumption that employers will bear the costs of subspecialty credentialing if the employer requires such subspecialism within their organisation. However, we have significant concerns that employers will see this differently, and in this case it will represent another costly investment on the part of the CST-holder.

ASiT cannot support subspecialty credentialing. We reiterate our ongoing belief that the proposed system would be applicable only for the acquisition of a very limited number of highly sub-specialised skills, as is the case for proposed National Fellowship Schemes in Surgery^{8,14}.

Recommendation 17

ASiT has no mandate to comment upon issues affecting non-training surgeons in the staff and associate specialist (SAS) grades. Appropriate opportunities should be given for such professionals to compete for training posts, but subspecialist equivalence through credentialing should be discouraged until after a successful Certificate of Eligibility for Specialist Registration (CESR) or equivalent future process application, at which stage the professional would be equivalent to a CST-holding consultant.

Recommendation 18

The proposed training structure advocates run-through training from the end of the foundation programme, with shortened specialty training. Some specialties have found run-through training appropriate, but many, including most surgical specialties, found that such selection, as implemented during the MMC selection in the 2007/8 training year, was inappropriate. Replication of this seems unwise. Removal of competitive hurdles seems to go against the ethos of improving standards, as this step may foster complacency rather than striving for excellence.

The Review also seeks to replace the CCT with a CST. The implication, which must be the aim of these proposed reforms, is that these two entities will be equivalent. However, common sense dictates that this will not be so if there is a reduction of at least 25% in overall training, as is proposed in the Review, without significant reform to training programmes' delivery in balance with service provision, as previously mentioned. Concerns already exist as to the adequacy of surgical training within the current structure in the face of WTR, and it is unlikely that a further modification to this system is going to be anything other than detrimental to standards. When previously attempted, changes in training

structures have led to 'lost-tribes' of trainees who are stuck between two systems. Proposals to ensure adequate transition from current to future training schemes must be secured prior to embarking on the latter.

Recommendation 19

ASiT believes that without significant clarification, and wide consultation with relevant trainee stakeholders, there should be no move towards implementation of the recommendations within this report.

Conclusions

The structure of surgical training has been under constant review for the past decade. Consistent themes from these reviews include workforce planning that is slow to adapt to changes in demographic and geographical variations within the NHS of the future. The consistent feeling is that doctors need to be more generally trained in order to provide adequate care for an ageing population with ever increasingly complex medical needs. The Review supports this notion, and proposes significant changes to the way postgraduate training is delivered.

The main issues identified by ASiT are as follows:

- 1) Run-through training as proposed in the Review has previously been tried in surgical specialties, and was rapidly withdrawn.
- 2) The shortening of Specialty Training such that a surgical trainee could be considered a consultant surgeon and independently practice, perhaps only 6 years following graduation, fundamentally misunderstands the rigours of surgical training, and the demands of being a consultant in ever evolving craft specialties.
- 3) The future plan to incorporate Foundation Year 2 into Specialty Training would further decrease training experience unless the length specialty training is consequently increased by a year. This reciprocal change must be ensured prior to alteration of the Foundation Programme.
- 4) The proposal for the insertion of a year for reasons of career development within training, as opposed to OOP period outwith training, further reduces the available specialty experience, and should be abandoned.
- 5) The award of a CST would result in a generalist who may still require limited supervision. This is incongruous with the current CCT, and there is no support for

the end-point of surgical training to represent anything other than a fully trained, consultant surgeon, capable of fully independent practice. This report should not lead to the creation of a subconsultant grade by another name.

- 6) We feel that the term Certificate of Specialty Training implies that CST-holders will be 'specialist generalists'. If this is what is intended, then these new 'specialist generalists' must be recognised as such within the future National Health Service hierarchy as of equivalent seniority to subspecialists. If a 'non-specialist generalist' is what is desired, then we offer no support to these proposals as it represents a subconsultant grade by another name.
- 7) The migration of subspecialty credentialing beyond formal postgraduate training raises significant financial and organisational questions, which appear not to have been given consideration.
- 8) The plugging of service gaps in the emergency department by broadly training surgeons seems ill thought out and will be detrimental to training.

The motivations of this review are broadly commendable, but the recommendations generally lack anything in the way of detail that allows meaningful abstraction onto future surgical training. Furthermore, in a document that seeks to improve the training of the surgeons of the future, there is disproportionate reference to the improvement of service provision. We accept that these two entities are interdependent, but feel that trainees should not be the solution to service gaps, nor should a subconsultant grade. Within the term 'subconsultant' we include the possibility of a consultant only in name, with a different contract, pay and employment opportunities to the subspecialist. We feel that these proposals will create another 'lost tribe' of surgical trainees, albeit at the level of CST-

holder, who have not fulfilled their surgical potential. Surgical trainees should not have to bear any further costs for their training as a result of the delivery system.

In many places, the proposals have merit, but it is important to remember that the last large-scale rearrangement of training in line with these principles resulted in what has come to be known as the Modernising Medical Careers (MMC) debacle, with widespread discontent among trainees. This occurred in part due to the short timescale adhered to when implementing the proposals. This mistake should not be repeated.

ASiT seeks significant clarification of a large number of the recommendations within this Review before any movement towards changing surgical training can be considered.

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