

# Association of Surgeons in Training Response to GMC framework and supplementary information regarding credentialing in postgraduate medical practice



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On behalf of  
ASiT Executive and Council  
Association of Otolaryngologists  
British Association of Oral and Maxillofacial Surgeons Fellows in Training  
British Association of Surgical Oncology Trainees

British Neurosurgical Trainees Association  
British Orthopaedic Trainees Association  
British Association of Urological Trainees Section of Trainees  
The Dukes Club  
Herrick Society  
Mammary Fold  
Mammary Fold  
National Cardiothoracic Surgery Trainee Committee  
PLASTA (Plastic Surgery Trainee Association)  
The Roux Group  
Rouleaux Club  
Trainees in Plastic Surgery

### About ASiT and this response.

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 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. Governed by an elected Executive and Council, the Association is run by trainees for trainees.

The GMC recently held a public consultation into credentialing, a mechanism for the reform of postgraduate training.

The GMC's information on credentialing can be found on their website:

<https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/credentialing>

The public consultation, which closed 25<sup>th</sup> January 2019, took the form of a series of online questions. ASiT responded, with input from the trainee speciality associations. This document presents the questions asked by the GMC, in the sequence presented by the GMC and ASiT's responses.

It is likely that each question will be considered by a different team, consequently our responses have repeated key points and are individually referenced, where appropriate.

### Question 1. Why credentials are needed

*This is for comments about ‘A case for change’ in the framework, and ‘Why we’re introducing credentials’ and ‘Impact and issues’ in the annex. We’re interested in your views on:*

- *whether credentials will enable flexibility*
- *support necessary change*
- *opportunities for doctors*
- *any other thoughts on these sections.*

### ASiT Response:

The Association of Surgeons in Training (ASiT) understands and supports the need to maintain and promote patient safety, and firmly believes that patient safety is achieved through excellent training. ASiT is supportive of the GMC’s aim to regulate areas of unregulated practice, however it is our understanding that examples of this practice would be non-medical practitioners performing cosmetic interventions such as botulinum toxin injections and injectable fillers. ASiT questions how credentialing, as it has been described in the draft framework and annex achieves this. It is perplexing to see how non-compulsory credentials aimed at the incorrect cohort of individuals, i.e. qualified doctors, will improve the safety of potentially vulnerable patients.

There is significant uncertainty regarding the synergy of credentialing with the current training and revalidation process. The principle concern for surgical trainees and surgical trainee associations is that credentialing will result in the removal of content from existing postgraduate training and devalue the Certificate of Completion of Training (CCT). This concern is magnified as the isolation of skills within the modular framework of postgraduate training has been suggested as a credential under the term “endorsed module” in the draft framework.

ASiT notes that the draft framework references flexibility to support effective service delivery. ASiT is supportive of flexibility in surgical training that allows surgeons in training to develop a higher level of clinical and academic interests. ASiT agrees that training and experience should be recognised. However, credentials, particularly “endorsed models”, as described in the draft framework and annex, serve to compartmentalise surgical training. ASiT opposes removing pre-CCT skills and instead making them a credential. This is likely to distill areas of surgical practice to single procedures and operations. This undermines the value and breadth of professional, holistic surgical training, and narrows it to completion of a technical task. For patient care and patient safety, it is important the treating doctor has a range of complementary skills to the “technical task” being undertaken. It is unlikely that an individual trained in a single or small number of procedures will have the skills to safely manage the perioperative care and potential complications of those procedures independently. Arguably, the creation of credentials could lead to attrition of the number of trained surgeons to deliver the service need and paradoxically reduce flexibility. Surgeons would now need a credential in an area, rather than developing a broad set of skills which ultimately provide holistic safe patient care.

Currently, many trainees achieve a high level of skill in niche, specialist areas of practice beyond the postgraduate curriculum in post-CCT fellowships. This includes many overseas fellowships in centres of excellence. It is imperative that the UK continues to attract these highly skilled professionals back to the UK to work as consultants to ensure we deliver a high standard of care to our patients. Credentialing risks reducing flexibility if it does not recognise equivalent fellowship training outside the UK in post-CCT fellowships. Ensuring the recognition of training is essential to ensure firstly that there is not disproportionate migration of UK trainees surgeons abroad and secondly that UK trained surgeons continue to travel to centres of excellence across the world and bring back innovative ideas and international collaborations that enrich patient care and improve standards and delivery of surgical care in the UK.

It is concerning that credentialing may be used to ask surgeons to train to work in areas outside of their normal practice to fulfil a service need. This has implications for the ongoing development of skills in the specialty left behind. This model risks leaving the original specialty more short of staff, creating an under resourced specialty that may require credentialing to cover. This reflexive approach to changes in service need is detrimental to the continuity of patient care and the continuity of postgraduate training. Patients deserve competently trained, experienced surgeons to deliver their care, who take a holistic approach to their care rather than a person trained in a certain procedure and lacking the wide wealth of knowledge and expertise in the field to deal with possible complications or difficulties faced.

### Question 2. Defining a credential

*This is for comments on 'Defining credentials' in the framework.*

*We're interested in your views on:*

- *whether we have described credentials clearly*
- *if an alternative word should replace 'credentials'- and ideas welcome*
- *any other thoughts on this section.*

### ASiT Response:

The draft framework lacks definitions of credentialing or in fact what a credential is. Without having clear explanations it is confusing and difficult to provide a robust response and we would urge further explanation and engagement before matters are taken further and sealed. It would appear that there are three broad areas of practice that are suggested by the GMC draft framework and that these are used variably and interchangeably.

1. Areas of unregulated practice.
2. Areas of the current postgraduate curriculum that the UKMERG and GMC seeks to remove from postgraduate training.

3. Areas of the current postgraduate curriculum that the UKMERG and GMC seeks to make attractive for doctors in alternative training programs, SAS doctors and other healthcare professionals.

**Areas of unregulated practice.**

As discussed in the previous question (please refer to our response above), the Association of Surgeons in Training (ASiT) does not anticipate that a non-compulsory credential for healthcare professionals will prevent non-healthcare professionals from practicing unregulated practice. ASiT is supportive of the GMC's aim to promote patient safety by reducing unregulated practice.

**Areas of the current postgraduate curriculum that the UKMERG and GMC seeks to remove from postgraduate training.**

The draft framework specifically highlights the need to move areas out of postgraduate training. By the very description this is an act to undermine the current Certification of Completion of Training (CCT). Removing skills from the curriculum, a CCT graduate will have less skills, diluting the end point of training and consultant expertise for their patients. This creates a two-tier system of consultants. In diluting CCT, surgeons will be less flexible and less readily equipped to deliver the service need creating further areas of service delivery to patients being affected. This also diminishes the ability of the surgical trainee to achieve their potential and become an expert surgeon for our patients.

There is little information regarding the funding and delivery of credentials, which is a significant concern for trainees and trainers alike. The patients deserve the best trained doctors looking after their care, which in turn means many hours spent in hospitals/healthcare settings "training at the coal-face". This provides trainees a supportive environment for query and reflective learning under the guidance of trained colleagues with years of experience of how to provide patient centred care. The patients are the centre of discussions and provide an excellent opportunity for case-based education delivery and

their input is a valuable resource in training the future generations. This method of delivery of care and training at the same time under the obligation of the NHS provides a valuable tool in perfecting learning and teaching skills for lifelong learning in the profession. To think that this element can be replaced by a short course or artificially fragmented training through obtaining credentials is concerning, especially as the robust model of apprenticeship is being highlighted in other professions as a way forward to develop expertise.

ASiT is concerned that removing the obligation of the National Health Service to provide training as part of the postgraduate curriculum for CCT, will create a business opportunity for either Trusts or private providers, and for the regulator to charge for education that is currently being provided in the current system. ASiT's concern is that this cost will then be transferred to the trainees, who are already struggling with some finding the only option to emigrate in order to develop their skills and work in a different healthcare system. This could cause a further shortage of doctors and add to an already difficult workforce planning environment, ultimately leading to a shortage of skilled professionals caring for patients. Surgical trainees are already faced with rising costs to meet their developing training needs. This varies from approximately £20,000 to over £70,000 over the course of training, dependent on specialty. (1)

In order for credentials to be appropriately considered there should be an evidence-based proposal put forward by the appropriate training advisory body (in the case of surgery; the Joint Committee on Surgical Training) and supported by the Speciality Advisory Committee and the surgical Royal Colleges and relevant, established speciality associations. This proposal should detail the definition of the proposed credential, clear entry requirements, funding strategy, educational delivery and assessment and defined outcomes to be assessed and measured. This pilot should be developed with stakeholder involvement including trainers, trainees, Trusts and patients. Each pilot should be subject to an independent evaluation, and the results of which should be freely available for stakeholder discussion prior to further implementation. It is hazardous to assume that a credential in one area of practice is an appropriate

model for widespread implementation across disparate medical and surgical disciplines and demonstrates a lack of understanding of the complexities of postgraduate training and specialist patient care.

It is possible that the changes made to junior doctors' contract Terms and Conditions in 2016 (2) has had unintended consequences. For many junior doctors it has changed the relative benefits of continuing in postgraduate training compared to opting for non-training posts or locum posts. (3) Contractual changes were imposed with a justification that reducing the payments given to junior doctors for out of hours working would promote patient safety by facilitating an increase in out of hours staffing. These changes have made postgraduate training less attractive due to increased out of hours working and in many cases a fall in remuneration necessitating formal payment protection arrangements. The result has been an unprecedented reduction in the proportion of foundation trainees choosing to apply for core and speciality training. (4,5) Efforts to improve patient safety have been negated by a rise in rota gaps (6) and an increased reliance on agency workers. Individuals who choose not to apply for training posts recognise the freedom to choose their place of work and, for those who join agencies, the potential to gain substantially higher financial rewards for similar amounts of work. By introducing a credentialing system outside of formal postgraduate training that does not rely on an individual achieving CCT for independent practice, and simultaneously devaluing the importance of speciality training there is a risk that this could lead to a much greater exodus away from formal postgraduate training pathways. Speciality training is vital in providing the holistic care for patients, in which where the surgeon has trained in both technical and non-technical skills in order to provide seamless patient care and be able to deal with any complications or problems that may arise. Hence, the CCT provide a marker that demonstrates to patient a reassurance and understanding that a minimum standard of training has been reached before independent practice is delivered. This is vital for good quality safe patient care and removing more items from the CCT and producing fragmented learning through credentials will not provide the correct learning for robust holistic patient care.

**Areas of the current postgraduate curriculum that the UKMERG and GMC seeks to make attractive for doctors and other healthcare professionals.**

ASiT is concerned that sections of postgraduate surgical training will be made available to professionals who have not received the fundamentals of surgical training, which is clearly a patient safety issue. It would be attractive for healthcare providers to highlight areas of surgery and train other doctors and professionals to complete these tasks. Given that there is little information available about the exact nature of a credential, ASiT is concerned that doctors and other professionals with limited surgical background will be trained in individual procedures or operations. This is a clear patient safety issue and clearly a well-established professional with a breadth of knowledge is able to deal with the outliers/deviations from the norm or complications more competently. ASiT is concerned that diluting expertise of the professionals providing care could place patients at unnecessary risk.

The creation of credentials from the post graduate curriculum to be made available to Staff and Associate Specialist (SAS) doctors further reduces the appeal of postgraduate training pathways, and the holistic approach to patient care that is robustly delivered through the CCT, where the curricula have been scrutinised to provide a continuum spiraling learning process. Clearly fragmenting this continuous process of skill development and delivery, and further higher learning, diminishes the work of generations of colleagues in producing a fit for purpose surgical training programme. This process undermines the current training system and erodes the professional holistic approach to surgical care, operating and the management of complications.

ASiT is particularly concerned that as the GMC makes its case for regulating physicians associates that surgical credentials will become automatically available to this group. It is likely that opportunities as such will be attractive to this group, who respectfully will not have the necessary depth and breadth of

training to fully understand the complexities of surgical decision making and skills. The concept of independent practice in these cases is false, as a consultant surgeon will still be required to supervise. We do understand why this is attractive to organisations, and again, this would create an easy revenue stream for the regulator and private training providers.

Credentialing is a term that is likely to be confusing to patients. At present it is confusing for healthcare professional and those that read the draft framework and annex. The Royal College of Nursing credentials nurses in areas of advanced practice. Patients need to be appropriately informed, and there is a risk that this crossover of term is confusing and one could argue that it is created to confuse the public, where a surgeon trained in a breadth of specialty will no longer be providing patient care, but someone with a basic medical degree could have a credential and deliver the care. This is a patient safeguarding issue and has a potential for decreasing rather than increasing standards for our patients

## **References**

1. O'Callaghan J, Mohan HM, Sharrock A on behalf of the Council of the Association of Surgeons in Training, *et al*  
Cross-sectional study of the financial cost of training to the surgical trainee in the UK and Ireland *BMJ Open* 2017;**7**:e018086. doi:10.1136/bmjopen-2017-018086
2. Junior doctors terms and conditions of service June 2016. Available at: <https://www.nhsemployers.org/case-studies-and-resources/2016/06/junior-doctors-terms-and-conditions-of-service-june-2016> Accessed 23rd January 2019
3. Spooner S, Gibson J, Rigby D, *et al*  
Stick or twist? Career decision-making during contractual uncertainty for NHS junior doctors *BMJ Open* 2017;**7**:e013756. doi: 10.1136/bmjopen-2016-013756.
4. UK Foundation Programme Career Destinations Report 2016 Available at: <http://www.foundationprogramme.nhs.uk/sites/default/files/2018-08/2016%20F2%20Career%20Destinations%20Report.pdf> Accessed 23rd January 2019

5. UK Foundation Programme Career Destinations Report 2017 Available at:[http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/2017%20F2%20Career%20Destinations%20Report\\_0.pdf](http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/2017%20F2%20Career%20Destinations%20Report_0.pdf) Accessed 23rd January 2019

6. British Medical Association. Medical Rota Gaps in England 2018 Available at <https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/medical-rota-gaps-report>. Accessed 23rd January 2019.

### Question 3. Criteria and threshold for credentials

*This is for comments on 'Identifying credentials' in the framework. We're interested in your views on:*

- *whether we've got the criteria right*
- *anything we might need to be aware of in trying to balance the criteria correctly*
- *anything we should consider regarding the risk threshold*
- *any other thoughts on this section.*

### ASiT Response

If credentials are considered appropriate to implement, they could be defined as areas of niche higher expert practice beyond Certification of Completion of Training (CCT). Thus, it is only correct that a credential can be earned by a doctor on the relevant specialist register with a full licence to practice. This ensures the doctor has been certified as competent to practice independently in that area of practice at a certain standard which is nationally accepted. This is the only way we can truly safeguard standards and more importantly safeguard patients. Patients deserve the very best of care by highly trained surgeons that can deliver holistic surgical care.

Defining a credential as prior to CCT allows the potential for a badging system for those whom are not certified as independent practitioners or those who may not have a medical licence to practice. These individuals who have not achieved CCT would not have the wide foundation of knowledge to deal with

the patients that may require extra input and potentially further care could be missed causing the patient safety issues. This problem can be compounded even further if we provide credentialing in the same areas to non-qualified doctors, as they will not have basic medical training. This deconstruction of medical training is extremely worrying as it erodes the role of a doctor as a professional, undermines medical education, patient confidence and safety.

The criteria for setting credentials is very difficult to comment on as there is no clear definition of what a credential is, nor how it will work within, alongside or instead of current postgraduate training. Without full stakeholder engagement, transparency of what is proposed a well-informed response cannot be given.

#### Question 4. The regulatory process

*This is for comments on 'Regulating credentials' in the framework, and 'How we propose to regulate credentials' in the annex. We're interested in your views on:*

- *if approving credentials as part of the postgraduate training pathway is right if credentials should be recognised on the List of Registered Medical Practitioners*
- *any other thoughts on these sections.*

#### ASiT Response:

The Association of Surgeons in Training (ASiT) has concerns that the development of credentials is likely driven by a pecuniary interest without thought of how patient care could be compromised due to a professional providing care who has not achieved Certification of Completion of Training (CCT).

Surgical trainees face significant personal financial (1) and non-monetary (2) costs and contractual changes that are making a career in surgery an unattractive choice for medical students and foundation doctors. (3,4,5) This

also risks making surgery elitist, with only those who are wealthy able to train as surgeons and providing a greater divide for social mobility within the profession. The surgical community should reflect the diversity of the populations it serves and encourage people from all walks of life into the profession. ASiT urges the GMC to consider this extremely carefully, as the cost of surgical training is a serious threat to diversity. ASiT is sure you will agree, given that the purpose of credentials is to meet the service need, it would be counterproductive to promote a training system that could further alienate young doctors from a surgical career and worsen the recruitment and retention issues the profession is currently facing. (6)

As discussed above, ensuring regulatory recognition of non-UK fellowships is essential in developing the regulatory framework. Currently, many trainees achieve a high level of pre-CCT fellowships, 62% (n=20) reported that these should be considered as out of programme training (OOPT) and therefore counted towards overall speciality training, rather than out of program for experience (OOPE), that doesn't count towards training. (7) In niche areas of expert practice post-CCT fellowships are undertaken so that expertise is brought to patient care. These include many overseas fellowships in centres of excellence around the world. It is imperative that the UK continues to attract these highly skilled professionals back to the UK to work as consultants to ensure we deliver a high standard of care to our patients. Credentialing risks reducing flexibility if it does not recognise equivalent fellowship training outside the UK in post-CCT fellowships. Ensuring the recognition of training is essential to ensure too that there is not disproportionate migration of UK trainees surgeons abroad and secondly that UK trained surgeons continue to travel to centres of excellence across the world and bring back innovative ideas and international collaborations that enrich patient care and improve standards and delivery of surgical care in the UK.

## **References**

1.O'Callaghan J, Mohan HM, Sharrock A on behalf of the Council of the Association of Surgeons in Training, *et al*

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Cross-sectional study of the financial cost of training to the surgical trainee in the UK and Ireland *BMJ Open* 2017;**7**:e018086. doi:10.1136/bmjopen-2017-018086

2. O'Callaghan JM, Mohan HM, and Harries RL on behalf of the Council of the Association of Surgeons in Training The non-monetary costs of surgical training. *The Bulletin of the Royal College of Surgeons of England* 2018 100:8, 339-344

2. Junior doctors terms and conditions of service June 2016. Available at: <https://www.nhsemployers.org/case-studies-and-resources/2016/06/junior-doctors-terms-and-conditions-of-service-june-2016> Accessed 23rd January 2019

3. Spooner S, Gibson J, Rigby D, *et al* Stick or twist? Career decision-making during contractual uncertainty for NHS junior doctors *BMJ Open* 2017;**7**:e013756. doi: 10.1136/bmjopen-2016-013756.

4. UK Foundation Programme Career Destinations Report 2016 Available at: <http://www.foundationprogramme.nhs.uk/sites/default/files/2018-08/2016%20F2%20Career%20Destinations%20Report.pdf> Accessed 23rd January 2019

5. UK Foundation Programme Career Destinations Report 2017 Available at: [http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/2017%20F2%20Career%20Destinations%20Report\\_0.pdf](http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/2017%20F2%20Career%20Destinations%20Report_0.pdf) Accessed 23rd January 2019

6. Health Education England Recruitment and retention on surgery Presentation available at: <https://www.rcseng.ac.uk/-/.../300pm-recruitment-and-retention-john-brecknell.pdf> Accessed 25th January 2019

7. ASiT Consensus Group on Fellowships in General Surgery. Structure and Quality Assurance of Fellowship Training in General Surgery: Consensus recommendations from the Association of Surgeons in Training. Submitted to *International Journal of Surgery* December 2018

### Question 5. A phased approach to implementation

This is for comments on 'Implementing credentials' in the framework, and 'Plans for implementation' in the annex. We're interested in your views on:

- any issues we need to consider in our plans for implementing credentials
- any other thoughts on these sections.

### ASiT Response:

If credentialing is deemed to be required. The initial phase must be to explain credentialing and its place in relation to postgraduate training. The Association of Surgeons in Training (ASiT) is aware that many potential stakeholders are not aware the consultation on credentialing is occurring so the first phase should be an extension of the engagement process and further engagements with stakeholders.

A slowly phased approach to implementation is essential, with pilots, 360-degree reviews, quality assurance and comment from those undertaking credentialing training and those undertaking the generic training pathway to ensure standards are improved and patient safety is not affected negatively. A fully independent and transparent evaluation needs to be conducted, which

should be shared with stakeholders thereafter engagement and comment from these organisations sought. Each phase should have risk assessment conducted pre-intervention and a review of practice built into it so that patient care is not adversely affected. There must be a mutually agreeable threshold set for stopping the process. As the nature of a credential remains undefined, it is difficult to predict the outcome of implementation. The potential impact of introducing credentialing cannot be predicted when the term is poorly understood. To build confidence in the process a clear plan for transparent, objective assessment of early phases should be a prerequisite for progression to later phases/expansion into widespread medical practice.

ASiT is concerned that there has been little meaningful stakeholder involvement in the planning of credentialing. ASiT has been privy to a number of GMC delivered presentations on the topic and has been disappointed that these presentations have provided little clarity in the proposal.

ASiT is concerned that the stakeholder involvement has been inadequate, particularly given that credentials are not defined or understood by the GMC. In order for credentials to be appropriately considered there should be an evidence-based proposal put forward by the appropriate training advisory body (in the case of surgery the Joint Committee on Surgical Training), supported by the Speciality Advisory Committee, the surgical Royal Colleges and relevant, established speciality associations. This proposal should detail the definition of the proposed credential, clear entry requirements, funding strategy, educational delivery and assessment and defined outcomes to be assessed and measured. This pilot should be developed with stakeholder involvement including trainers, trainees, trusts and patients. Each pilot should be subject to an independent evaluation, and the results of which should be freely available for stakeholder discussion prior to further implementation. It is hazardous to assume that a credential in one area of practice is an appropriate model for widespread implementation across disparate medical and surgical disciplines and demonstrates a lack of understanding of the complexities of postgraduate training and specialist patient care.

ASiT understands that there have been previous pilots of credentialing, (1) but believes there has been no transparent discussion of the results of these pilots. ASiT has concerns that the associations that led these pilots are not appropriately placed to do so. For example, is the Association of Breast Clinicians best placed to propose a credential in breast disease, seemingly without the input of the Association of Breast Surgery and British Association of Surgical Oncology?

ASiT also questions the process of implementing credentials for those whom have already been trained and are practicing independently. Will credentials automatically be assigned? Will they be achieved through the process of revalidation? Or will established consultants be asked to retrospectively demonstrate their competence at a cost to gain and maintain a credential? Again, there is no clear proposal for this implementation. There are additional questions that require answers prior to further pilots or implementation.

### **References**

1. GMC credentialing pilot studies Available at: [https://www.gmc-uk.org/-/media/documents/final-report-credentialing-pilot-studies\\_pdf-61540524.pdf](https://www.gmc-uk.org/-/media/documents/final-report-credentialing-pilot-studies_pdf-61540524.pdf) Accessed 23rd January 2019.

### **Question 6. Supporting flexibility in training in other ways**

*This is for comments on 'Other developments to support flexibility' in the framework. We're interested in your views on:*

- *Endorsed training modules in postgraduate curricula*
- *whether QA processes for additional skills areas adds value*
- *any other thoughts on these sections.*

### **ASiT Response:**

The Association of Surgeons in Training (ASiT) is concerned that endorsed modules could become a pathway allowing sections of postgraduate surgical training to be made available to professionals who have not received the fundamentals of surgical training, which is clearly a patient safety issue. It would be attractive for healthcare providers to highlight areas of surgery and train other doctors and professionals (those without basic medical training) to complete these tasks. Given that there is little information available about the exact nature of a credential, ASiT is concerned that doctors and other professionals with limited surgical background will be trained in individual procedures or operations without the full breadth of surgical knowledge. This has a clear potential to impact on patient safety given the ability of a traditionally trained professional with a breadth of knowledge and ability is able to deal with the outliers/deviations from the norm and/or complications more competently. ASiT is concerned that diluting expertise of the professionals providing the care could place patients at unnecessary risk.

The creation of credentials from the postgraduate curriculum to be made available to Staff and Associate Specialist (SAS) doctors may further reduce the attraction of postgraduate training pathways. ASiT recognises the contributions that SAS doctors make to the health service, and that SAS doctors can achieve Certificate of Eligibility for the Specialist Register, under Article 14 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. Curricula have been scrutinised to provide a continuum spiralling learning process, fragmenting this continuous process of skill development and delivery, and further higher learning, diminishes the work of generations of colleagues in producing a fit for purpose surgical training programme. This process undermines the current training system and erodes the professional holistic approach to surgical care, operating and the management of complications.

ASiT's consensus recommendations on fellowships in general surgery (1) defines a fellowship as "an optional, additional period of clinical work undertaken within a defined speciality or subspecialty area by a surgeon not

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yet appointed to a substantive consultant position, and for whom this additional period is not a mandatory requirement of their training program.” These periods of specialised practice offer the potential to gain experience beyond the scope of Certification of Completion of Training in niche areas of expert practice. It would appear that there is potential overlap between the proposed intent of credentials and what is achieved through fellowship experience.

ASiT would welcome consideration of how fellowship experience equivalent to a credential is assessed and recognised. In particular international fellowships can offer unique training with exposure to technology and practices not readily available in the UK giving surgeons the opportunity to return to the UK with innovative skills and ideas to improve the delivery of safe surgical care.

In the UK, over three-quarters of trainees across all surgical specialities state an intention to undertake clinical fellowships. In 2016, opinions on surgical fellowships were assessed at an ASiT consensus session at the annual meeting of the Association of Surgeons of Great Britain and Ireland (ASGBI). 50% of delegates expressed a preference for international rather than UK based fellowships, the remaining 50% expressed no preference for UK versus international fellowships.

Internationally, many fellowships are highly structured and regulated, e.g. USA and Canada. However, currently, there is no national regulation of surgical fellowships in the UK, with the exception of a small number of competitive fellowships that cross specialties called Training Interface Groups (TIG) fellowships.

Alignment between fellowship curriculum development and credential requirements would avoid unnecessarily increasing the length of training by duplication.

To promote flexibility pre-CCT fellowships should be considered as out of programme training (OOPT) and therefore counted towards overall speciality

training, rather than Out of Program Experience (OOPE) that doesn't count towards training. This seems the logical next step as all trainees involved in these gain valuable surgical and non-technical skills which help produce a well-rounded and professional surgeon as careers progress.

ASiT supports the GMC and the Joint Committee on Surgical Training commitment to competency-based training. At present there is little evidence to suggest that the delivery of training is sufficient to support a shorter duration of training.

It is important in the credentialing process to ensure that international fellowships are recognised and that trainees are not discouraged from seeking high quality fellowship opportunities overseas. A UK fellowship should not be mandatory to achieve a credential. Rather, presentation of logbook evidence and references from international fellowships should be recognised in order to grant recognition of equivalent qualifications and to allow a credential to be awarded.

### **Reference**

1. ASiT Consensus Group on Fellowships in General Surgery. Structure and Quality Assurance of Fellowship Training in General Surgery: Consensus recommendations from the Association of Surgeons in Training. Submitted to International Journal of Surgery December 2018

### **Question 6. Any other comments**

*If you have any other feedback on the framework, please let us know here*

### **ASiT Response:**

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 surgical trainees from all 10 surgical specialities, the Association provides

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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. Governed by an elected Executive and Council, the Association is run by trainees for trainees.

ASiT is committed to the principle that excellent surgical training is required for excellent surgical care for patients. ASiT welcomes the opportunity to be involved in the development in systems that aim to protect patients. Surgical trainees are key stakeholders in the development and reform of postgraduate surgical training and should be central in the development of change. ASiT welcomes the recognition of flexibility of working and training and maintains that the individual trainee should be the driving force for flexibility.

In 2015 ASiT and British Orthopaedic Trainees Association (BOTA) published a joint position statement on credentialing (1) which has been reviewed in light of the GMC draft framework and supplementary information regarding credentialing in postgraduate medical practice. This statement, written on behalf of the ASiT, has been informed by discussion with the ASiT Council and the ten trainee specialty associations.

The recommendations made by ASiT/BOTA in 2015 are as applicable to date and we highlight the following recommendations which continue to represent our position.

ASiT is calls for a clear, transparent, and fit for purpose training pathway that delivers the best evidence-based care for patients. At present the undefined nature of credentialing, it's target audience, it's funding and delivery pose a potential risk of diminishing existing expertise and training programmes and of diluting CCT at the likely expense of trainees and directly the patients. Clearly it is better for patient care to have a robustly trained surgeon delivering an operation who can deal with a range of complications rather than someone just trained in a procedure. We have an aging population and better advances in healthcare, which often means that we see patients with different comorbidities

and hence as surgeons we need a breadth of knowledge to competently deliver holistic care to these patients in addition to carrying out the operation/procedure.

It is important to ensure that equivalence of training between the UK and Ireland continues. Considering recognition of credentials for trainees from the Republic of Ireland is another important consideration in the introduction of credentialing. We urge the GMC to work with the Irish Medical Council to maintain this standard which is important for patient care.

ASiT trusts that the GMC will consider the views of surgical trainees, as key stakeholders, carefully and provide a clear explanation on the points identified in this consultation.

ASiT welcomes the opportunity to work with the Royal Colleges, JCST and the GMC in postgraduate education reform.

## **References**

1. Credentialing in postgraduate surgical practice a joint statement from the Association of Surgeons in Training. Available at: <https://www.asit.org/resources/archived-articles-documents/credentialing-in-postgraduate-surgical-practice/res1021>  
Accessed 23rd January 2019

## **Trainee specialty associations that have contributed to this document**

ASiT Executive and Council  
Association of Otolaryngologists  
British Association of Oral and Maxillofacial Surgeons Fellows in Training  
British Association of Surgical Oncology Trainees  
British Neurosurgical Trainees Association  
British Orthopaedic Trainees Association  
British Association of Urological Trainees Section of Trainees  
The Dukes Club  
Herrick Society  
Mammary Fold  
National Cardiothoracic Surgery Trainee Committee

**ASiT** - *the pursuit of excellence in training*

PLASTA (Plastic Surgery Trainee Association  
The Roux Group  
Rouleaux Club  
Trainees in Plastic Surgery