Credentialing in Postgraduate Surgical Practice

A joint statement from

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www.asit.org

and

British Orthopaedic Trainees Association

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About ASiT

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.

About BOTA

The British Orthopaedic Trainees' Association (BOTA) was set up in 1987 and it subsequently became affiliated to the British Orthopaedic Association. BOTA is a democratically elected professional committee. It represents Trauma and Orthopaedic trainees across England, Scotland, Wales and Northern Ireland. BOTA has a current membership of over 1000 Specialty Registrars.

1. Introduction

The General Medical Council (GMC) has outlined its plans for credentialing in postgraduate medical practice across the United Kingdom. The GMC has defined credentialing as 'a process, which provides formal accreditation of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area…' [1]. The GMC has outlined that credentials will be recorded against an individual's entry on the List of Registered Medical Practitioners [1].

2. Time Point for Credentialing

The proposals suggest that a credential will be 'comparable to the level of competence expected of a doctor who has completed formal postgraduate training, but not across the same breadth of practice.' [1]. ASiT and BOTA have significant concerns that credentialing may result in doctors with only partial training in a specialty and that those doctors may be ill-equipped to cope with complex cases or complications that unexpectedly arise.

It is essential, therefore, that credentials do not include any skill or competency already included in a surgical speciality training curriculum leading to an award of CCT (Certification of Completion of Training).

3. Scope of credentials

Staff and associate specialist (SAS) doctors work in a setting that has consultant oversight; this can be a safe, appropriate and accountable system. Patient safety should remain paramount; therefore ASiT and BOTA would not support any introduction of a clinical credentialing system that allows doctors to practice without the full range of skills covered by a CCT, or equivalent.

Furthermore, we would strongly oppose the tiered credentialing system proposed by the General Medical Council. This system suggests that there may be a number of "levels" to which a doctor can credential in a certain area, gaining increasing responsibility at each level. Recent studies have demonstrated that patients find the array of titles assigned to doctors confusing [2]. A goal of the credentialing process is to ensure that patients can be treated safely and provide informed consent. To do so requires the knowledge that the professional overseeing a procedure is appropriately trained to do so. The introduction of a tiered system would add further potential for misunderstanding in the process of informed consent and may even result in harm. It is contradictory to the statements in the GMC consultation document that credentialing would introduce "certainty for patients…about those practicing autonomously," and maintain "public confidence that patients are protected" [1].

Avoiding the use of clinical credentials in areas already covered by a CCT would alleviate the aforementioned concerns. ASiT and BOTA recognise, however, that there are potential clinical areas that are not fully defined in training programmes

and may benefit from credentialing such as remote and rural medicine or forensic and legal medicine.

However, credentialing may be useful in non-clinical aspects not already covered by a specialty training programme, such as medical education or leadership and management. We feel that attainment of a credential in these areas is less likely to negatively impact directly on patient safety and therefore could be obtained by those not on the Specialist Register but with a full license to practice.

4. Eligibility for Credentials

With the primary goal of credentialing being improved patient protection and care, ASiT and BOTA are concerned about the erosion of a complex professional role to a mutually exclusive list of basic competencies. Each competency often relies on a multitude of other competencies and requires a comprehensive medical education to fully assess a patient seeking medical attention. As such, and with concern for patient safety, ASiT and BOTA would strongly recommend that credentials (clinical or non-clinical) are not made available to anyone without an existing medical degree and registered with a full license to practice.

Furthermore, to ensure a doctor has the appropriate skills to safely and thoroughly assess a patient and to perform a task independently it is of paramount importance that clinical credentials should only be made available to those already on the Specialist of GP Register, as this ensures that the practitioner has been robustly assessed as competent to treat patients without supervision.

The GMC proposals which suggest a doctor would apply for credentials seem pragmatic, however, neither ASiT nor BOTA could endorse such proposals prior to the provision of much more detailed information, e.g. the method by which a doctor's competence would be evaluated.

5. Credentials and Organisations

We agree with the principle of improving patient safety. However, introducing credentials for "service need" undermines that principle. Under GMC proposals organisations will be eligible to submit an application to award a new credential. This is concerning. The GMC do not highlight which organisations will be eligible to submit a proposal, what safeguards will exist to ensure those organisations do not have a significant conflicts of interest (such as private healthcare organisations or the ability to make a profit from awarding credentials) and which "authorities in the field" will be appropriate for approving the proposals.

There is also a risk of project creep that would lead to a significant, unmanageable and expensive burden to doctors across the country to maintain numerous credentials covering their professional practice.

We believe, therefore, that there needs to be much stronger regulation on how organisations apply to award a credential and that these organisations should be limited to the appropriate Royal Colleges, Universities or faculties such as Joint Committee on Surgical Training.

6. Funding

The GMC consultation states that it will not expand on plans on how any training associated with credentialing will be funded. However, it does recommend that doctors pay a fee to a "credentialing organisation." This is of particular concern to ASiT and BOTA as representative bodies for trainees in all surgical specialities in the UK and Republic of Ireland.

It has been clearly demonstrated that there is an increasing cost of undergraduate training [3], with financially burdensome postgraduate surgical training [4-5] and trainees afforded minimal training budgets per year [6]. Those budgets do not come close to meeting the already-rising cost of mandatory training. Whilst the GMC states that it is not its responsibility to decide how the system is funded it must take some responsibility as the organisation proposing the systematic changes. It must consider the financial costs and funding source for a credentialing system carefully.

With less medical graduates choosing to pursue a career in surgery [7], a further financial disincentive would exacerbate the problem and would be strongly opposed by ASiT and BOTA. Even more worrying is that, regardless of the primary funding source, if independent bodies are responsible for charging for credentials there remains the potential that a mandatory credential be introduced that serves only to make a profit for that organisation.

ASiT and BOTA oppose doctors' paying a fee to gain a qualification of primary benefit to their host organisation, and would strongly encourage an alternative funding strategy. Doctors-in-training especially, are facing challenging times

regarding the cost of training. The introduction of multiple credentials paid for by doctors will inevitably increase the financial strain faced by many, wishing to remain competitive.

7. Recommendations

- It is essential to consider the funding source for a credentialing system. Its funding should not be borne by the doctor as this would add further expense to an already expensive training system and would likely exacerbate recruitment problems in surgical training.

- To maintain rigorous standards in patient safety, only Royal Colleges, Universities or Faculties such as Joint Committee on Surgical Training should be eligible to award credentials.

- Credentials should not overlap with any skill or competency already accredited in the existing curricula for award of a CCT.

- Clinical credentials should only be made available to doctors on the Specialist or GP Register, to avoid "chunking" clinical practice and devaluing the importance of a well-rounded and complete attainment of skills / knowledge in that speciality.

- Tiered credentialing has the potential to lead to patient misunderstanding and lack of informed consent, and as such we would not support proposals for a tiered credentialing system.

8. References

1. General Medical Council (UK), Introducing regulated credentials. June 2015. Accessed on 15th July 2015 at: http://www.gmcuk.org/Introducing_Regulated_Credentials_Consultation_W_form_FINAL_distributed.pdf_61589419.pdf

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6. Association of Surgeons in Training. The Cost of Surgical Training. 2007. Accessed on 15th July 2015 at: http://www.asit.org/assets/documents/ASiT_Cost_of_Surgical_Training_final.pdf

7. Peters K, Ryan M. Machismo in surgery is harming the specialty. BMJ Careers. 2014. Accessed on 15th July 2015 at: http://careers.bmj.com/careers/advice/view-article.html?id=20017462

9. Further Reading

1. General Medical Council (UK). Introducing regulated credentials. June 2015. Accessed on 15th July 2015 at: http://www.gmcuk.org/Introducing_Regulated_Credentials_Consultation_W_form_FINAL_distributed.pdf_61589419.pdf

2. General Medical Council (UK). Shape of training: securing the future of excellent patient care. Accessed on 15th July 2015 at: http://www.gmc-uk.org/Shape_of_training_FINAL_Report.pdf_53977887.pdf

ASiT and BOTA have published a number of statements that are available at: http://www.asit.org/resources/articles

http://www.bota.org.uk/home/position-statements/