

Provision of Emergency Cross-Cover Between Surgical Specialities

A statement from



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Written On behalf of the ASiT Executive and Council

Foreword

Patients are concerned that they receive appropriate treatment, delivered by doctors trained and experienced in dealing with the management of their condition.

The Patient Liaison group at the Royal College of Surgeons England would like patients to receive safe and high quality care delivered in a timely manner so as to achieve the best possible clinical outcome and that these services are provided by appropriately trained and competent doctors. ASiT have highlighted in this report the concerns in service delivery and training that need to be addressed in order to maximise good patient clinical outcomes.

RCS (Eng) Patient Liaison Group (PLG) December 2012

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 2000 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.

Executive Summary

- ECC can be defined as the provision of emergency care by a doctor trained or training in a different specialty to that which they are requested to assess or manage.
- Most commonly surgical ECC is referred to in respect of the out- of- hours assessment and management of acute surgical emergencies within a given specialty, be they new admissions or ward patients.
- The sole principle on which to base ECC must be the provision of safe, appropriate and timely patient care when needed.
- The problems surrounding emergency cross cover primarily relate to:
 - Potential variability in patient care and resource use by those providing care outside of their usual surgical specialty area.
 - Trainee's competence, experience, and confidence in dealing with surgical problems outside their own specialty.
 - The paucity of specific training opportunities (local, regional and national) for trainees required to assess and/or manage surgical problems in different specialties.
 - Variable access to senior support in the specialty being cross-covered, together with the willingness to provide this.
 - Medico-legal implications of providing such cover outside a surgical trainee's normal area of practice, particularly without previous experience or means for regular skills practice and up-dating.
- In this document ASiT set out a number of proposals to address these matters. Key points include:
 - JCST and SAC guidance on curriculum content is required to ensure robust guidance on training provision for those undertaking ECC.
 - Curriculum alignment between specialties providing cross-cover to ensure trainees demonstrate similar competencies at similar grades.
 - Improved provision of local, regional and national training opportunities for those trainees required to provide cross cover between specialties.
 - Where used, ECC should be utilised to ensure timely early emergency assessment and management only.
 - Improved senior support for those trainees delivering cross cover.

I. Introduction

- I.1 This statement discusses the issues and provision of emergency cross-cover (ECC) between surgical specialties.
- I.2 ECC is a concept that has been present between specialties for many years in order to utilise trainees to fulfil on-call service requirements. However the progressive changes within surgery have caused increasing difficulties in its provision, which need addressing.
- I.3 Questions have been raised at both the consultant and trainee level with respect to the appropriateness and also manner in which ECC is provided between specialties.
- I.4 The review conducted as part of this document was initially in response to concerns relating to general surgical and urology cross-cover, however proposals should be considered appropriate to any surgical specialties providing or receiving cross-cover.
- I.5 We hope this document will inform in regards to the trainee's position and help guide discussions with respect to the provision of cross-cover amongst the surgical specialties.

2. Emergency Cross-Cover

- 2.1 ECC can be defined as provision of emergency care by a doctor trained or training in a different specialty to that which they are required to assess or manage.
- 2.2 Most commonly surgical ECC is referred to in respect of the out-of-hours assessment and management of acute surgical emergencies within a given specialty, be they new admissions or ward patients.
- 2.3 Since the implementation of the European Working Time Directive (EWTD), New Deal (ND) and Modernising Medical Careers (MMC), surgical specialties have been exploring new ways of working.
- 2.4 The increased use of ECC between specialties is a result of numerous factors including changes to rota patterns in an attempt to maintain EWTD rota compliance and a reduction in training posts. .
- 2.5 Cross-cover relationships commonly exist between general surgery and urology, ENT and maxillofacial surgery, as well as orthopaedics and plastic surgery.
- 2.6 The implementation of MMC and EWTD has resulted in a reduction in the training hours and exposure of junior trainees being appointed to ST3 and beyond.¹⁻⁵
- 2.7 There has been a radical overhaul and restructuring of surgical training in the UK⁶, and current junior trainees may not have undertaken 6-months Emergency Department posts, nor rotated through as many surgical specialty SHO posts as in previous years (particularly Foundation Year doctors filling posts previously staffed by surgical SHOs).

- 2.8 Subsequently, their experience and ability in managing surgical emergencies across other specialties has reduced as curricula have been streamlined to meet the training requirements within their own specialty.
- 2.9 Evidence demonstrates that the care provided by trainees in cross-covering specialties differs from that of those trainees within that specialty.⁷ Such variation in practice needs to be addressed.

3. Principles of Safe Emergency Cross-Cover

- 3.1 The sole principle on which to base ECC must be the provision of safe, appropriate and timely patient care when needed.
- 3.2 Prompt and definitive decision making is critical in the outcome of patient care with delays in the correct diagnostic or therapeutic decisions carrying associated increase in both morbidity and mortality.
- 3.3 The suitability of a trainee to provide ECC can be assessed by applying guidance issued by the GMC and standards expected by the courts.
- 3.4 GMC guidance upon *Good Medical Practice* paragraph 3 states that:
“*In providing care, you must recognise and work within the limits of your competence*”⁸
- 3.5 Doctors are required to act to the required standard of care expected of them by law. The *Bolam* test⁹ requires a doctor to act in accordance with the accepted practice of a responsible body of medical opinion. Inexperience cannot be used as a defence in the event of a trainee acting without obtaining guidance from a senior.¹⁰ The law therefore expects a trainee to seek advice from experienced colleagues when appropriate. Conversely a consultant would be found negligent were he to delegate responsibility to a trainee in the knowledge that the junior was incapable of performing the duty.¹¹ Given that the actions of medical

professionals are being placed under increased scrutiny by the courts, following decisions such as in *Bolitho*,¹² medical professionals therefore carry greater responsibility to their level of expertise.

- 3.6 Both professional and legal guidance upon the provision of care centers around the competence of a doctor to provide the care required of them. Competence is of paramount importance when assessing suitability to provide ECC for a specialty in which the doctor is not training and thus may have limited exposure and experience. The GMC's guidelines and the law both defend the basic principles of patient safety and care.
- 3.7 Recent recommendations from the Royal College of Surgeons of England, have stated that surgical care should be consultant led and, where necessary, consultant delivered.¹³ It is the consultant's duty to ensure that those trainees to whom they are delegating care and management of their patients are appropriately experienced and trained.^{13,14}
- 3.8 Implementation of adequate training and induction programmes has the potential to inform and educate incumbent trainees not only on their responsibilities, but also to provide them with necessary skills and knowledge.¹⁵

4. Current Concerns

- 4.1 A recent ASiT snapshot survey demonstrates many widespread variations in the experiences amongst general surgical trainees providing ECC for urology. Representative quotes from this survey can be found in table I.
- 4.2 Evidence demonstrates that there is variation between the management of the acute scrotum when general and urological trainees are compared.⁷ There appears to be a wide variation in the degree of confidence and competence in assessing and managing the acute scrotum in the emergency setting. Such variation is likely to occur between trainees of other specialties with other comparable conditions unless they have been subject to the same training, exposure and assessment of such cross-covered conditions.
- 4.3 The degree of senior supervision, support and coverage that is available and provided by specialties requiring ECC is variable between institutions.
- 4.4 In the case of urological cross cover by general surgery registrars, trainees are expected to perform assessment and sometimes operative management of the acute scrotum with little or no experience or formal training.
- 4.5 Regarding trainees who deem themselves competent and confident in the assessment and management acute scrotal emergencies, there is often little or no exposure to elective lists to maintain on-going competence within the specialty.
- 4.6 At present early care of urological emergencies form part of the curriculum for core trainees in general surgery. Therefore exposure to urological emergencies through ECC, with appropriate supervision from seniors, can provide core trainees with learning opportunities needed to fulfil their curriculum requirements.¹⁶

Table 1: Representative quotes from a recent snapshot survey of ASiT members which asked for opinions on the provision of emergency cross-cover for urology by general surgery trainees

“Whether consultants are supportive or not, the skills learnt in the modern era are not as generic as they used to be, and the juniors not as skilled in their own specialty, let alone another one”.

“The situation in our trust is very much that the Urology service is propped up by the General Surgical SpRs with no assessment of training or competence. I feel it is entirely wrong that we are just expected to provide this cover which is outside our speciality”.

“Clarity from ASiT and the SAC would be very helpful in this matter as at present I feel General Surgical Trainees are left exposed to criticism and possibly worse such as legal action, and discussion of this now will assist in the future with further separation issues in other specialities”.

“Yes, frequently [experience problems] and I feel very under-qualified and under-trained to be providing a urology service”.

“Giving an opinion about a ?torsion will result in a scrotal exploration 100% of the time in my practice since I do not feel confident or qualified to make the decision not to explore anyone”.

“I perform approx 2 emergency scrotal procedures per month, never have any training or senior support and have not been involved in an elective scrotal procedure for 8 years”.

“My concern is that occasionally we are required to perform emergency procedures such as suprapubic catheter or scrotal exploration for torsion with no urology consultant cover. The only training I have had in these is on a "see one do one" basis as I have never worked in a urology job. While this is ok most of the time, I don't feel I have the experience or knowledge to deal with unexpected findings”.

“From my personal point of view, as a senior general surgical trainee I could manage the patients adequately, but as I had never done a urology post and was post-CCT [Certificate of Completion of Training] , there was always an uneasiness about doing this from a medico-legal point of view”.

“I have often found it difficult and at times impossible to contact the on-call urology consultant for advice or assistance. When contactable they are extremely unsupportive and resentful of the disturbance. I have been pressurised to undertake scrotal exploration when it did not appear to be clinically indicated and also to undertake it with no prior experience/ expertise in emergency exploration/ orchidopexy. My other concern is that the majority of scrotal explorations are undertaken in the under 18 if not under 16 age group i.e paediatric and this has further implications medico-legally”.

“I do not feel that general surgical registrars should be the 'catheter service' for the whole hospital”.

- 4.7 From ST3 onwards, the management of the acute scrotum in paediatric patients is included in the general surgery curriculum. However there is no mention of the management of the acute scrotum, or in fact any specific mention urological emergencies, such as urinary retention, in adult patients in the intermediate or final stages of the general surgical curriculum.¹⁶
- 4.8 The historical reliance upon the training of general surgeons in particular gave rise to the expected ability to assess and manage a broad range of conditions. This is no longer the case with the continuing subspecialisation seen in surgery. The breadth of training has reduced along with the relative experience in these fields.
- 4.9 There is often overlap between surgical specialties, both in terms of training and procedures and conditions managed (e.g. groin, hernia and vasectomy surgery in the case of general surgery and urology). Such overlap forms the historical basis of the use of cross-cover and therefore the requirement for general surgical trainees to maintain competence in the management of the scrotum.

Other Surgical Specialties

- 4.10 Issues of ECC are certainly not restricted to general surgery trainees covering urology, with head and neck services often requiring ECC between maxillofacial surgery, ENT and sometimes plastic surgery. ASiT are increasingly concerned of reports regarding non-medically qualified dentists providing emergency care out of hours for patients in specialities such as plastic surgery as a result of amalgamation of on-call rotas.
- 4.11 An out of hours telephone survey of ENT units in the UK has also raised concerns regarding inexperienced non-ENT trainees expected to provide emergency resident ENT cover. This study demonstrated a lack of training of doctors from other specialties covering ENT. Two-thirds of respondents

were cross-covering other specialties in addition to ENT, with 19% of doctors covering four or more surgical specialties whilst on-call.¹⁷ These concerns echo those from a previous study of junior doctors covering ENT which showed that of those cross-covering from other specialties only 35% had received any training on how to manage common ENT emergencies.¹⁸

- 4.12 Cross-cover of children by primarily adult sub-specialities has also raised issues regarding the assessment and management of children presenting with possible testicular torsion and acute abdominal pain. The relationship of secondary general and urological surgery with tertiary paediatric surgery also warrants comment.
- 4.13 Initial assessment and management of a child with acute abdominal pain, for example acute appendicitis, can be made at a secondary-care level by either general surgery and or general paediatrics. In the majority of cases, the initial observation period can be safely undertaken locally avoiding potentially unnecessary transfers to tertiary centres, often out-of-hours. A decision to operate locally is determined by provision of adequate resources and expertise, as outlined by the Children's Surgery Forum.¹⁹
- 4.14 Issues relating to children presenting with possible testicular torsion echo those highlighted between general surgery and urology with regards the acute scrotum in the adult services. The technical aspects of scrotal exploration are similar in children (particularly post-puberty) and thus within the competency of the surgical team providing the service to adults in the local unit. Delay in definitive treatment caused by transfer to tertiary care is inappropriate and safe practice may appropriately require greater surgical and anaesthetic consultant input.
- 4.15 Although curricula for general surgery, urology and general paediatrics include the assessment of surgical conditions of childhood, recent closure of secondary care level inpatient paediatric units threatens to divert significant numbers of children with common emergency presentations away from local

services and towards tertiary care. As a result the critical mass necessary to sustain local paediatric surgical services may be lost with few learning opportunities available for trainees working in secondary care to fulfil curricula requirements and maintain competence.

- 4.17 Prior to adoption of MMC the Gold Guide to training concluded that trainees should not cross-cover other specialties once they had entered higher training. It is noticeable that this is no longer the case in current editions of the Gold Guide, though it does allude to the GMC guidance on acting within one's competence.²⁰
- 4.18 There are particular challenges in the provision of ECC for surgical specialties where emergency cases are infrequent. In such instances there is greater likelihood that they will operate non-resident rotas, leaving other specialties to manage cases that there is little chance to gain any experience, even for trainees within that particular specialty.
- 4.19 It is important to ensure that a specialty's need for ECC due to rota provision does not impact unnecessarily upon the workload, training and delivery of patient care of another specialty's trainees.
- 4.20 Specialties such as general surgery most frequently operate a resident system for on-call cover and as such can be seen as an easy target for the provision of ECC. The requirement for a resident on-call service is usually driven by the volume and extent of the workload within the specialty in question, and as such, resident teams are often already busy prior to the addition of cross-cover responsibilities.
- 4.21 The recent separation of vascular surgery from general surgery, and with it a separate vascular training programme and curriculum, adds further complexity to the issues surrounding ECC. Vascular surgery now represents an additional speciality that will require trainees from other surgical specialities to cross-cover in order to support consultant vascular surgeons in

service delivery. How the new speciality status of vascular surgery impacts on the training of non-vascular trainees and their on-call responsibilities remains to be seen.

5. Recommendations

5. 1 In response to the issues identified with regards to ECC, ASiT suggests the following proposals as appropriate for all specialties providing ECC out of hours. Summary advice for trainees can be found in table 2.
5. 2 Where there is potential for ECC between specialties, such as in general surgery and urology, further JCST and SAC guidance on curriculum content is required to ensure robust guidance on training provision for those undertaking ECC.
5. 3 Trainees should not be expected to perform ECC for any specialty or condition which is not included within their curriculum, and thus no formal requirement or provision for training.
5. 4 In those areas where there is clinical knowledge and skills overlap between specialties providing cross cover, curriculum alignment must take place between those specialties to ensure trainees demonstrate similar competencies at similar grades.
5. 5 In departments where a surgical specialty is cross-covered by another, there is a duty upon consultants in both specialties to ensure there are adequate training opportunities and provision for trainees to gain the required level of competence to conduct their duties of ECC.
5. 6 Trainees who have not received adequate training experience or competence to provide ECC must bring this to the attention of the on-call specialty consultant in question and their educational supervisor.

5. 7 Trainees providing ECC who do not feel competent to do so must inform the consultant for whom they are cross-covering and should utilise the resultant opportunity to gain experience and competency.
5. 8 In centres where cross-cover is provided for a specialty, consultants will provide immediate appropriate support for those trainees providing ECC when asked to do so.
5. 9 Wherever possible, care of patients should be provided by those doctors trained or training within the specialty in question, thus avoiding the need for cross-cover provision.
5. 10 Where ECC provision is necessary, it should be to provide timely appropriate emergency care only, and should not include the out of hours (e.g. weekend daytime) management of ward patients including routine ward rounds.
5. 11 Once admitted, all patients should be assessed by their appropriate specialty consultant on a post-take round, and not solely by the registrar providing cross-cover.
5. 12 Further research into the required frequency and outcomes of ECC between specialties will better identify whether or not such cross-cover provisions are in fact necessary, or whether such emergencies should be managed by the specialty themselves.
5. 13 Consideration should be given at local, regional and national levels to provide specific courses addressing the training needs of those expected to provide surgical cross-cover for different specialities whilst on-call, in order to ensure trainees are emergency safe and provide consistent, up-to-date patient care.

Table 2: Summary of advice for trainees who are asked to provide ECC

- You should always work within the limits of your competence as per GMC guidance.
- Prior to commencing a training post find out in advance if you will be expected to provide ECC.
- If you have not received adequate training or do not feel competent to provide the ECC then bringing this to the attention of your educational supervisor and/or training programme director, ideally in advance of starting the post.
- Your supervisors should help with the early identification of training opportunities in order for you to gain the required level of competence to conduct ECC duties.
- If you find yourself providing any element of ECC that you do not feel competent to do so then you have a duty to inform the consultant on-call for the speciality and document having done so.
- You should then utilise any resultant opportunities to gain experience and training under consultant supervision.
- If you have any concerns about patient safety then you are obliged to raise these concerns. GMC advice on raising concerns about patient safety can be accessed on www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp

6. References

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7. Further Reading

7.1 ASiT has published a number of statements which are available at

<http://www.asit.org/resources/articles>

7.2 These include our position statements:

- [Simulation in Surgical Training \(November 2011\)](#)
- [Cost of surgical training \(April 2011\)](#)
- [Future of Surgical Training \(August 2010\)](#)
- [EWTD for Surgical Trainees \(August 2009\)](#)