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Letter to the General Surgery SAC from the Association of Surgeons in Training 1st May 2017

Re: Run-through training in General Surgery

Dear Mr. Lund,

I wish to summarise trainee concerns and views expressed by ASiT council regarding run through training in General Surgery. There has been considerable debate over the past number of years regarding the shape of training and the improving surgical training pilot(1-6).The issue of run through training is a contentious one and it is clear that there are both positives and negatives to a run-through training model. The views of trainees are heterogenous on whether it is desirable. I have sought feedback from ASiT Council and from Presidents of trainee specialty representative groups, and below is a summary of the comments received in online discussion.

Positive aspects of run-through training

Security

Security of job progression and region is described as a strong advantage for the trainee on a run-through pathway. This allows for family and personal planning, without the worry of upheaval in the ST3 benchmarking process. It has been suggested by some council members that trainees for whom run through is not an option may avoid surgery and chose other specialties which they perceive to be more compatible with their personal circumstances.

Experience not based on ST3 application

Some felt that if trainees weren't as focused on having a full logbook for ST3 applications, they may be inclined to undertake modules in related/adjunct specialties, e.g. plastics for vascular trainees, or ITU for general surgery trainees, adding to breadth of experience.

Equality with academic trainees

Some academic trainees felt that not having to be distracted by an ST3 interview allowed them more time to focus on their academic and clinical training. Run through training would extend this advantage and scope to more trainees.

Career progression

There is an advantage for the individual trainee's career progression if there is a truly run through process that does not rely on a reduction of trainee numbers between CST and HST.

Enhanced flexibility and equality

Not having a hiatus between ST2 and ST3 allows more certainty when planning maternity leave etc., and the flexibility to choose to undertake research, for example, at a time that suits their life circumstances best. This may improve gender equality and family friendly career planning.

Diminished role for ST3 selection process

As the competition ratio for ST3 positions in surgery has declined (1.6:1 for General Surgery in 2016), it is questionable whether a second selection process for ST3 plays a role except in ranking appointable candidates to choose their specialty.

Negative aspects of run-through and potential unintended consequences

Lack of exposure to surgical specialties

The exposure of doctors to surgery in foundation years has diminished. With run through training, trainees may have to choose a surgical specialty before they may have ever worked in it. Indeed, with the current under exposure to surgery at medical school and foundation training, trainees may not be attracted into surgical specialties. Moving the point at which trainees need to commit to a specialty to forward in run-through may result in early attrition, as trainees realise they do not enjoy their chosen specialty. Equally, it could lead to under-recruitment, with some specialties missing out on potential applicants who have not been adequately exposed to their specialty. Although some trainees felt run through might improve exposure to adjunct specialties, others felt that run through would diminish this and reduce exposure to the variety of specialties undertaken at core. The lack of exposure to surgical specialties may also reduce the educational value of their training and the breadth of experience obtained.

Difficult to transfer between specialties

Although transferable skills may be gained by undertaking placements in other specialties, run through as it currently stands is associated with a lack of flexibility in trying to change to another surgical specialty. A run through programme commencing at ST1 with no other entry point could also seriously limit access to training for those caught in the transition between conventional and run through programmes. This could particularly affect those not on a training program at the time of the transition, e.g. who have taken time out to pursue research or experience overseas.

Lack of flexibility in taking time out

There is less scope to take time out between core and specialty training as it would now be subject to the same stringent application process as Out of Program (OOP), with its associated time limitation. OOP can provide significant added value to training, and should not be diminished or reduced in a run-through programme.

Lack of diversity in training

The flip-side of the benefits of staying in one region for social circumstances is that it leads to less diversity in training experience and exposure.

Inevitable bottleneck

There is a bottleneck between Core Surgical Training (CST) and Higher Surgical Training (HST). Run through may, therefore, have several implications in larger specialties. One possibility is that CST and HST jobs are directly matched, which requires a reduction in CST jobs or an increase in HST jobs. This could dilute the operative experience of trainees already in the system. A reduction in CST posts would

also have significant effects on service provision and might reduce the operative exposure of those on CST due to a diminished workforce. A reduction in CST jobs could significantly increase the pressure on other trainees in the system. Although there has been promise of a wider surgical team to reduce service provision by this group, significant work remains to be done on this issue before it is anywhere near ready to ameliorate the problem.

Retention and recruitment

There is difficulty in developing an adequate selection processes for run through training at a point where trainees may have had very limited exposure to surgery during foundation programmes, let alone their chosen surgical specialty. This may lead to a higher drop-out rate. For example, when trialled in orthopaedics following MMC, run-through was associated with a 15% dropout rate.

Precedent

Some expressed concerns as run through has been tried before and failed in 2007 following Modernising Medical Careers (MMC) in general surgery and orthopaedics. The logic in introducing it again in larger specialties given its previous failure has been questioned.

Progression and benchmarking

Surgery is a challenging and difficult specialty. It is important that surgery continues to attract high calibre candidates. Some trainees felt that run through may lead to complacency due to the lack of pressure of looming ST3 interviews, and some run through trainees reported that they felt they lagged behind non run through trainees subsequently. Without the ST3 application process, there is a danger that standards could drop. Reflecting the above, it would be important to change the ARCP process significantly to ensure it is robust enough to identify and support those who are not progressing at an appropriate pace. However, there was concerns that ARCP may be more difficult to standardise than national selection.

Dual Economy and Inequality

If run through training is introduced as part of the IST pilot, this may lead to inequality in the system. If the trainees in the pilot must be benchmarked at ST3, but not achieve an ST3 post in terms of ranking, currently this is unlikely to discommode other applicants as competition ratios are so low that the majority of those who achieve the minimally appointable score are appointed. However, if surgery becomes more attractive, which as a trainee body promoting excellence in surgical training we hope it does, this could lead to pilot trainees who are benchmarked as appointable getting onto ST3 ahead of non-pilot trainees who are appointable and score higher than the run through trainees.

Stranded trainees

There is a concern that with run through, chances of progression may be more subject to yearly variability in competition for a particular specialty. For example, a small specialty may be particularly popular the year that a trainee applies and therefore they may not succeed in breaking into the specialty. Conversely, it may be less popular the following year and trainees entering that year may progress without necessarily having greater ability. For those lucky and "in the right place at the right time", the run through system can work very well, but for others it can mean never even having the opportunity to work or train in a specialty they wanted. For this reason, it is important that there is consideration on what to do with trainees that are not successful in their first attempt for their specialty, or equally who wish to change specialty so that these trainees are not lost from surgery altogether.

Examinations

It is important that there is clarity for trainees on when they can and should sit the MRCS and FRCS examinations in any new system that is introduced.

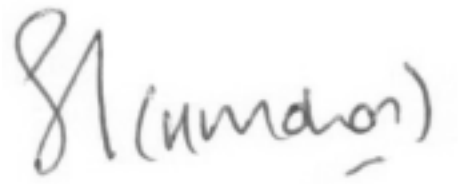
In summary, the overall view was that run through training can work very well if appropriately introduced, in keeping with the experience of some smaller specialties, e.g. neurosurgery. However, there is a significant potential for unintended consequences, and many trainees do have concerns about the introduction of run through, particularly in General Surgery and larger specialties, as well as some small specialties. Significant work must be undertaken if considering the introduction of run through training to avoid the many pitfalls and unintended negative consequences, some of which are outlined above.

If run through training is to be introduced, it is imperative that lessons from the past are learned. It should not be the only route to access specialty training, and it must not be introduced in a hasty fashion without due consideration and planning for all of the above. If run through and alternative pathways are allowed, it is important that there is fairness and equality in the division of jobs between the two pathways.

I trust you will take the concerns and views of trainees into account. No matter what system is introduced, it is imperative that trainees are not stranded between systems.

Looking forward to hearing from you,

Many Thanks,



Helen Mohan

President ASiT on behalf of ASiT Council

cc.

Miss Clare Marx, President of the Royal College of Surgeons of England
Mr. Mike Lavelle-Jones, President of the Royal College of Surgeons of Edinburgh
Professor David Galloway, President of the Royal College of Physicians and Surgeons of Glasgow
Mr. Ian Eardley, Vice-President of the Royal College of Surgeons of England
Mr. Bill Allum, Chairman of JCST
Mr. Gareth Griffiths, ISCP Surgical Director
Professor Ian Finlay, Chair of the UK Shape of Training Implementation Group

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