Letters and comments

Contributions to this section are asked to make their comments brief and to the point. Letters should comply with the notice printed on the inside back cover. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and subedit contributions to ensure clarity.

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EDITORIAL by IRVING TAYLOR

Can performance as an undergraduate assist entry selection into surgical training programmes?

IRVING TAYLOR

RESPONSE - 1 by D BIRCHLEY

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I read with great interest the editorial by Professor Taylor and would like to comment on an article by a perceived authority which, in my opinion, sets out the wrong approach to the selection of future surgical trainees.

I had a little difficulty in following the logic of the argument presented. From a criticism of the decreasing exposure of medical students to surgical specialties, Professor Taylor moves to argue that perhaps performance at this time should be used as an additional marker of suitability at the later stage of specialist training appointments. I would infer from this that, first, the dedication of students to achieve 'against all odds' should be taken as a sign of increased aptitude or productivity in later training (tying in with the points relating to decreased training time). Second, the argument is made that academic excellence equates with surgical excellence. I would question the evidence base for either of these suppositions.

I believe most would accept that the requirements for higher surgical training are at present rigorous. In addition to the mandatory examinations and courses, we are obliged to be clinically skilled, aware of governance and managerial issues, be IT competent and in possession of a further academic qualification with a suitable portfolio of papers, presentations and completed audit cycles. Should the attainment of such criteria still not be sufficient to show one's dedication to a career in surgery and the ability to profit from formal surgical training?

If not so, perhaps we should look a little closer at the practicalities of the criteria set out by Professor Taylor. I would be interested to learn the proportion of current surgical consultants who hold prizes from medical school. If one is to commit to a postgraduate degree at a time of increasing work commitments, financial obligations and (possibly) family responsibilities, where is the need for an undergraduate BSc? Does a surgical elective really act as a surrogate marker for surgical aptitude? Or membership of a medical school surgical society (should one exist)? Given that many consultants can barely recognise members of their own team (should one still exist), is the suggestion of an exemplary medical student reference really viable?

I believe that, rather than improving the quality of future applicants for surgical training, the measures suggested would prove counterproductive. Many able candidates would be unnecessarily deterred from application feeling it is 'already too late'. Perhaps more sinister, we would be lowering the level of specialisation even further. No longer would you be able to experience surgery as part of your 'career choice' process, but rather you would need to have decided on your future almost before applying to medical school. Do 18-year-olds really know their future plans with this degree of certainty?

There exist major flaws in the current training process in surgery and I do not wish to digress into this area but, if the time for training is so pressured, does the solution lie with smarter applicants or extended training? Are current SpRs by implication failing to achieve the necessary standards because they are not academic enough?

If I could set out my stall I would argue that, rather than asking us to excel at lower and lower levels (GCSE grades, anyone? Prenatal screening?), we should question the system in which we work. How many of us truly believe that submitting an arbitrary 50% of the population to higher education really increases the quality of the workforce?

What do we do when suddenly the entire of medical student exposure consists of pressured academia in order to allow for the possibility of higher surgical training? Even worse, what have we really achieved if this nirvana is reached and all students leave medical school as competent academics with little taste for the daily workload of the typical surgical consultant? We should not set ever more stringent entry criteria in order to theoretically select those who would perform best in a training system struggling to train.

The standards for entry to higher surgical training are rigorous enough. The manpower is insufficient. Appoint more consultants and give them the time to train. Allow them to foster SpRs and to teach the SHOs and PRHOs and help them to mature in their abilities and interest. Increase registrar numbers to meet future requirements without diluting the standards already in place. Students will meet a supportive, productive workforce who will spark enthusiasm. The moment for hurdles will come but the timing should not crush early uncertainty. The result? A workforce sufficiently trained to provide first-class surgical care with suitable cover and able to inspire the next generation.

CONFLICT OF INTEREST

I am a year-one SpR in surgery in the South Western Deanery. I do not hold undergraduate prizes, a BSc or, on the criteria presented, the stigmata of surgical success.

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RESPONSE-2 by J KNOWLES

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This editorial underlines the importance of encouraging students into surgical careers and identifying those students who show promise. The place of surgery in modern curricula is being squeezed by increasing community placements and other hospital-based specialties. In order to maintain surgery's status in undergraduate teaching, surgical firms must provide well-organised programmes of teaching that deliver a broad range of learning objectives. This will allow students to spend time in theatre and on the wards, absorbing and gaining enthusiasm for surgical practice and satisfying educational requirements. To staff these learning programmes, surgical departments should look at creating innovative teaching posts.

Increasingly, undergraduate surgical teaching is suffering as a result of pressure from conflicting commitments. Meeting government waiting-list targets and pressure to provide more formal postgraduate training is reducing time available to surgical staff. At the same time, student numbers are increasing at a rate of 1000 per year. In the face of this, the GMC and the government are requesting high-quality, cost-effective, medical school education. Decreases in the numbers of academic staff and the increasing numbers of students are leading to more students being taught in the community.¹ In order for surgical units to maintain their place in undergraduate teaching timetables, they must deliver well-organised, modern teaching programmes.

Clinical surgery has a crucial role in teaching the core clinical skills of history-taking and examination. It also provides insight into the teamwork, communication skills, emergency and critical care management that is everyday practice in surgical firms. The teaching of these values will be eroded unless there are the staff to supervise the necessary teaching sessions.

I have just completed a post at St George's Hospital working as a clinical teaching fellow. This newly implemented, year-long post was funded by service increment for teaching (SIFT) funds and was available to post-membership junior surgeons. The job allows you to work two and a half days a week teaching and the rest of the time can be made up with clinical or research commitments. My main responsibility was teaching surgery to the three clinical years, using varied teaching techniques, including lectures, small groups, traditional bedside teaching and clinical, problem-based learning.

There is no substitute for academic and NHS consultant teaching in terms of quality and inspiration. Most 'firm' consultants cannot deliver all the sessions required by students and curriculum, and rely on registrars and SHOs to provide some bedside teaching. The European Working Time Directive and the resultant shift patterns, as well as pressure to maintain one's own training, have reduced chances for juniors to do this. Clinical teaching fellows can provide a reliable timetable of teaching, uninterrupted by clinical commitments, to supplement teaching delivered by the firm system. They should also be flexible enough to cover teaching sessions from surgical teams that are disrupted by clinical commitments. In my experience, one teaching fellow can fulfil the teaching load required to support the surgical firms within a large teaching hospital.

These posts can be seen as a start to developing a specialist interest in medical education. If combined with a postgraduate qualification in medical education, teaching fellows can develop and implement curriculum design skills. Courses, such as the excellent certificate in healthcare education being piloted by St George's Hospital Medical School, are becoming increasingly common. Training in modern teaching skills, curriculum design, assessment and evaluation has been difficult to come

by, especially with the time constraints of hospital-based disciplines. If surgery is to remain where it belongs as a core component in undergraduate education, surgeons with knowledge of these areas are going to be crucial to champion this cause. As medical schools look increasingly to the community for teaching opportunities and course planners, the onus will be on surgeons to demonstrate that they are delivering quality, robust education. If we can provide this service, we can justify requesting adequate time for surgical teaching on clinical curricula. Teaching fellows, with qualifications in medical education, will be a number of years from having an impact on the higher levels of academic surgical units. They can become future leaders in surgical education and maintain the tireless work being done by many academic surgeons and enthusiastic NHS surgical teachers currently.

Surgical teaching fellows represent an excellent and inexpensive way of improving surgical teaching in academic and NHS surgical units. They can increase the quality and reliability of teaching programmes and ensure delivery of course learning objectives. To implement these posts, Trusts will need to be innovative in securing funding either through SIFT, which can be notoriously difficult, or via the research and clinical components that make up the other half of the job commitments. Suitable junior staff will need to be encouraged to explore this new career path, with these posts securing similar standing to evidence of research involvement at registrar applications. Those who have shown an interest in undergraduate training at an early stage in their career must be encouraged to follow this up to consultant level. Looking to produce better quality and breadth of surgical undergraduate teaching is vital if the specialty is to continue to attract the highest quality of students to enter the field.²

References

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RESPONSE-3 by S GAWNE

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I recently participated in a 'first assistant' course as part of an educational project in my Trust. This is designed to provide health professionals who work in theatre with the

skills and knowledge required to fulfil the role of a first assistant. It consisted of five half-days timetabled to fit in with the hospital's educational half days. Practical sessions consist of practising skills such as suturing. These are backed up with presentations considering theatre manners, draping and positioning patients, instruments and dangers in theatre such as diathermy. Learning methods are also addressed, raising awareness of concepts such as the value of reflection.

The course also considers reflective practice and methods of learning, which I feel should be given more attention in undergraduate learning, especially with the introduction of PBL courses. Incorporation of these in my own practice has changed my attitude to learning and reflection in a positive manner. Documentation of learning points and experiences in itself helps understanding, as does revisiting them retrospectively. Surgeons can be trained to perform procedures but being a good surgeon entails more than simply performing skills. A good surgeon uses knowledge to make wise decisions and then chooses the most appropriate skill to be beneficial to the patient.

The first assistant course gave me insight into the running of theatre and expected etiquette which may intimidate students and newly qualified doctors as they take on their new role. As an SHO with previous experience as an assistant, there was still a lot to learn. I am now more aware of what happens around me while assisting or operating. More importantly, I gained a greater insight into the roles of members of the theatre team and their differing opinions.

I believe the course might be useful to consider as an undergraduate special study module for those keen on a career in surgery. Alternatively, it could be timetabled as part of training for surgically orientated F2 posts. This would provide an opportunity to understand the theatre environment and even the chance to 'scrub in' as part of the team and perhaps the inspiration to pursue a surgical career.

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RESPONSE by the author

IRVING TAYLOR

I am pleased that my editorial induced such a robust response and I do hope this debate will continue. Few would argue with the concept of optimum exposure and the need for appropriate training patterns in the face of increasing and competing interests.

The object of my article was to highlight the importance of carefully selecting appropriate individuals into surgical training programmes in a situation where not all individuals wishing to become surgeons can be accommodated.

I propose that evidence of competence, commitment and enthusiasm for 'surgery' as an undergraduate should be taken into consideration during the process of competitive entry into training programmes.