Audit

The record of in-training assessments (RITAs) in urology: an evaluation of trainee perceptions

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Aims: To evaluate the effect of the Calman reforms on SpRs in urology with respect to their educational goals, their experience of the RITA process and its value in preparing them for their chosen consultant careers.

Participants and Methods: All urological trainees holding national training numbers who had completed at least one RITA review, but had not yet been awarded a CCST, were sampled.

Results: A total of 100 completed replies were received. Of those replying, 87% had an appointed educational supervisor with marked variation between regions. Training expectations in the four main categories of knowledge, vocational skills, operative competencies and personal development for each particular year of training were clear to only 40%, 35%, 44% and 60% of trainees, respectively. In general, trainee satisfaction with their most recent RITA review was fair with a mean of 6 (range, 4–8) on an arbitrary 10-point scale. Of the trainees, 83% felt that they would be adequately trained for consultant practice at the end of their training although this confidence varied between years of training.

Conclusions: Unification in the registrar grade has initiated an improvement in urological education for SpRs. There has, however, been haphazard delivery of that education due to a lack of objectivity in definition and assessment of the educational goals in individual training years. The RITA process should be more prescriptive in its administration and the setting of annual targeted training objectives should help to optimise the training opportunities for individual SpRs.

Key words: RITA assessment – SpRs – Training – Urology

Prior to the introduction of the specialist registrar grade, surgical training had been based upon the apprenticeship model with little objective assessment of individual trainee's performance. As a consequence of the 1992 working party directed by Professor Kenneth Calman, then Chief Medical Officer, the old registrar and senior registrar grades were amalgamated. A new grade of specialist registrar (SpR) was created with a defined

curriculum and minimum training period, completion of which would lead to admission to the specialist register.

The features of the new system were set out in *A Guide to Specialist Registrar Training*.¹ The principal aims of the system were to give greater career security, a move to an exit examination mechanism, and a reduction in the time taken to achieve a level of training consistent with consultant practice. The processes by which shortened

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training could be achieved were set out in the 'orange book'.² Implicit in the Calman system was that each SpR should receive proper induction at the start of each new placement, with set educational objectives outlined in a training agreement with their supervising consultant and the programme director.

A trainee's progress is monitored by the record of in-training assessment (RITA) review which takes the form of a compulsory annual interview, following which trainees achieving a satisfactory report are issued with a RITA C grading and continue to the next phase of training. Failure to achieve a C grade indicates either a problem with the trainee's progress or the ability of that placement to provide appropriate training. Those SpRs deemed to require targeted training receive RITA D grade. Unsatisfactory progress results in the issue of a RITA E form requiring the SpR to repeat that particular year. On completion of training, the SpR is given a RITA G notification and is entitled to apply for a Certificate of Completed Specialist Training (CCST) and inclusion on the specialist register of the General Medical Council (GMC). The RITA review process should be objective and take into account attainment of agreed educational goals and competencies that trainees would be expected to achieve for a given year in training.

We set out to evaluate the effect of the Calman reforms on SpRs in urology with respect to their educational goals, their experience of the RITA process and its value in preparing them for their chosen consultant careers.

Participants and Methods

All urological trainees holding national training numbers who had completed at least one RITA review, but had not yet been awarded a CCST, were sampled. Respondents were asked to fill in a 45-point anonymous questionnaire about their training and the RITA review process. One of the authors (IP) had sole access to the raw data for analysis.

Results

A total of 100 completed replies were received, 80 and 20 from the first and second mailings, respectively. Not all respondents answered every question.

Of those replying, 87% had an appointed educational supervisor with marked variation between regions (Table 1). Of the trainees, 48% had agreed educational objectives with their educational supervisor in their first week following rotation. Only 34% had had these objectives written down in some form of educational contract.

Training expectations in the four main categories of knowledge, vocational skills, operative competencies and

Table 1 Number and percentage of trainees responding to the questionnaire who had an appointed educational supervisor and both a verbal and written educational contract

Region	No. replies	No. with educational supervisor	No. with educational contract	
			Verbal	Written
East Scotland	4	3	1	0
Mersey	4	2	1	1
North Thames	11	7	6	3
North West	11	11	7	7
Northern	9	9	4	4
Oxford	7	7	3	2
South Thames	12	11	5	3
South West	9	7	7	3
Trent	7	6	2	2
West Midlands	9	9	4	3
West Scotland	2	2	0	0
Wales	9	9	7	6
Yorkshire	6	5	1	0
Total	100	87	48	34

Table 2 Percentage of replying trainees with known expectations or objectives in four core areas of training – knowledge base, vocational skills, operative skills and personal development

Region	Knowledge base	Vocational skills	Operative skills	Personal development
	(n)	(n)	(n)	(n)
East Scotland	0	0	1	2
Mersey	4	3	3	3
North Thames	5	5	5	6
North West	11	10	11	10
Northern	2	3	4	7
Oxford	1	2	3	4
South Thames	3	1	3	9
South West	3	4	3	5
Trent	0	1	2	1
West Midlands	1	1	0	4
West Scotland	2	0	0	1
Wales	3	2	4	3
Yorkshire	5	3	5	5
Total	40	35	44	60

personal development for each particular year of training were clear to only 40%, 35%, 44% and 60% of trainees, respectively. (Table 2). Of the trainees, 82% were sure of their most recent RITA grading; 74% received a RITA C grade and 5% a RITA G. Only three trainees received either a grade D or E, two from the North West region and one from South Thames. These were all given for a perceived lack of operative experience. Only 48% of trainees were set educational goals following their RITA interview. These were communicated in writing prior to rotating to their next post in only 38% of cases (Table 3).

Table 3 Percentage of trainees with educational goals for the forthcoming year communicated to them verbally or in writing following their RITA interview but prior to commencement of their next post

Region	Verbal (n)	Written (n)
East Scotland	1	1
Mersey	3	2
North Thames	1	0
North West	11	10
Northern	3	2
Oxford	3	2
South Thames	7	5
South West	7	6
Trent	1	6
West Midlands	4	3
West Scotland	1	1
Wales	3	2
Yorkshire	3	4
Total	48	38

In general, trainee satisfaction with their most recent RITA review was fair with a mean of 6 (range, 4–8) on an arbitrary 10-point scale. Only 36% of trainees thought that the RITA process helped in the evolution of their future training whilst 39% believed that the current RITA mechanism would not identify the failing trainee. The majority of trainees (83%) felt that the reason for a trainee being given a less than satisfactory RITA grade was due to a failure of the training establishment in fulfilling its part of the educational contract.

Most trainees (89%) intended to sub-specialise in a branch of urology with oncology (42%) being the most popular (Fig. 1).

Of the trainees, 83% felt that they would be adequately trained for consultant practice at the end of their training although this confidence varied between years of training (Table 4).

Discussion

The unification of the registrar grade heralded the most fundamental reform of specialist training since the inception of the NHS³ resulting in changes in the learning environment,⁴ feedback,⁵ and greater operative supervision for surgical trainees.⁶ It has been demonstrated that specialist registrars have felt the benefits of these changes within a single deanery,⁴ although this is not a finding common in the surgical specialities.^{7–10}

Our data suggest a very marked variation in the delivery of basic education within a single speciality in the UK in contrast to the conclusions of Paice *et al.*⁴ This is particularly evident in the setting of educational objectives, feedback and the delivery of hands-on experience, three of the four cornerstones of Calman's recommendations.

Figure 1 Distribution of intended area of sub-specialisation amongst current urological trainees at completion of training.

Table 4 Distribution by year of training of trainees and those not confident of being able to practice independently upon completion of their current training scheme

Year of training	Number responding from that year	Number not confident	% of respondents from particular year
1	4	1	25
2	22	6	27
3	21	4	19
4	18	1	6
5	35	5	14
Total	100	17	17

We have also found that, despite the prescriptiveness of the educational targets at the end of training, there are marked differences by which that objective is achieved. There appears to be a marked variation in objectivity by which the annual workplace assessment is carried out. It was disappointing that less than half of surveyed trainees were allowed to progress into another training year without any clarification of their learning objectives. This may explain why only a third of respondents felt that the RITA process helped in identifying an individual's training needs and would facilitate identification of the trainee in need of targeted help. It could also explain why the majority of trainees were given C gradings at their RITA review. Importantly, the trainees felt that the process failed to identify those training establishments failing to fulfil their part of the educational contract.^{10,11}

Whilst the majority of urological trainees felt that they were adequately prepared for consultant practice, it is extremely disappointing that one fifth did not feel adequately trained for this objective at their particular point in training. It is also unsatisfactory that current training appears to encourage trainees towards sub-specialisation which may not be appropriate to service demand.

How might these problems be addressed? Since 1999 urological trainees in the North West region have been guided by a manual of competencies set out to provide 'peer-level' expectations of their abilities within that section of their training.¹² This manual is prescriptive for the individual's expected competencies in four categories – knowledge base, technical, dextrous and vocational skills – with incrementally challenging goals across the 5 years of SpR training. We believe that these objectives may explain the disparity between the number of trainees having an educational contract, with a clear educational purpose, in the North West and those in the majority of other deaneries throughout the UK. It is recognised that competency based assessment¹³ provides a more robust means of appraisal¹⁴ and we welcome the changes that mean this is being accepted by the SAC as a central theme of the current extended 6-year training programmes.⁹

Conclusions

We believe that unification in the registrar grade has initiated an improvement in urological education for SpRs. There has, however, been haphazard delivery of that education due to a lack of objectivity in definition and assessment of the educational goals in individual training years. We feel it is essential that the RITA process be more prescriptive in its administration so that the majority of trainees felt adequately prepared for their consultant careers in appropriate sub-specialities.

The setting of annual targeted training objectives should help to optimise the training opportunities for individual SpRs, and may help with the future identification of those training establishments, or individual trainers, unable to

provide the educational support necessary for specialist registrar training. In addition, it is likely to help shape a urological workforce more suited to the service requirement demanded.

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