A STATEMENT ARISING FROM A PAN-SURGICAL CONSENSUS CONFERENCE HELD ON FRIDAY 12th OCTOBER 2007 AT THE ROYAL SOCIETY OF ARTS, LONDON

Association of Surgeons of Great Britain and Ireland

British Association of Oral and Maxillofacial Surgeons

British Association of Otorhinolaryngologists – Head and Neck Surgeons

British Association of Paediatric Surgeons

British Association of Plastic Reconstructive and Aesthetic Surgeons

Society of British Neurological Surgeons

Society of Cardiothoracic Surgeons of Great Britain and Ireland

Royal College of Physicians and Surgeons of Glasgow

Royal College of Surgeons in Ireland

THE FUTURE OF MODERNISING MEDICAL CAREERS

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This event was organised by the Association of Surgeons of Great Britain and Ireland with the support of the nine SAC defined Surgical Specialty Associations and the four Surgical Royal Colleges

Submitted to the MMC Inquiry chaired by Professor Sir John Tooke (20th November 2007)

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FOREWORD

Professor Robert Stout

It was a great privilege to be invited to act as facilitator for the Pan-Surgical Consensus Conference on the future of MMC on Friday 12th October 2007. This is a very important subject and the conference was arranged at a very appropriate time.

The conference first heard from Professor Alan Crockard who, earlier in the year, had resigned as Director of Modernising Medical Careers. He explained the process that was undertaken and the pressures and constraints under which he worked. Professor Sir John Tooke, Chairman of the MMC Inquiry, presented the findings of his interim report which had been published earlier in the same week. This set the scene for a wide ranging debate led by presentations and with interactive discussions at the end of each section.

One of the impressions of the conference was the complexity of the issues that were being discussed. Although the specific issue was postgraduate medical training, it became clear that this had to be discussed in the context of the undergraduate curriculum, the type of specialist produced at the end of training, and workforce considerations. Undergraduate and postgraduate training takes a total of 12 to 15 years and is the gateway to a career lasting three decades during which there will be enormous changes in both the delivery and organisation of medical care. It was not surprising that there was a wide range of views on how best to prepare the specialists of the future. Contributions were made with enthusiasm and sometimes passion. Time constraints legislated against complete consensus but much common ground was established. The writers of the Consensus Statement had an enormous task ahead of them and they are to be congratulated on producing a comprehensive summary of the conference and subsequent consultations.

In all of these discussions we must ensure that two areas are kept to the fore. First, all of this is to provide the best possible care for patients. We have been accused that, in the past, we have been more concerned with the interests of doctors than the interests of patients. I believe this to be unfair, and, of course, in many cases the interests of doctors and patients coincide. Second, we must be concerned about the interests of doctors in training. Medicine attracts some of the brightest of our school leavers who are not only academically gifted but are strongly motivated and have all the characteristics necessary to be good doctors. It is an enormous responsibility to be involved in their education and training. A large amount of work has been put into devising undergraduate curricula which are fit for the 21st Century. We must ensure that postgraduate curricula are just as good and that the talents and skills of doctors in training are fully utilised. We must also ensure that they have adequate time for rest and recreation and they are able also to have interesting and fulfilling lives outside medicine: this will make them better doctors.

The Association of Surgeons of Great Britain and Ireland is to be congratulated on taking the initiative to hold this Consensus Conference and I wish it well in influencing the future direction of surgical training.

Bob Stout

THE FUTURE OF MODERNISING MEDICAL CAREERS
A CONSENSUS STATEMENT

INTRODUCTION

A one-day Consensus Conference on the Future of MMC was convened by the Association of Surgeons of Great Britain and Ireland and held at the Royal Society of Arts, London, on Friday October 12th 2007. A list of attendees is given in ***Appendix 1***. Representatives of all nine SAC defined Surgical Specialty Associations were present as were senior officers and representatives of the Surgical Royal Colleges and other surgical specialty societies. The facilitator was Professor Robert Stout, a distinguished physician and former Dean of the Faculty of Medicine and Health Sciences at Queen's University of Belfast.

Like many other organisations, ASGBI has voiced grave concerns about the consequences of the recent MTAS debacle together with the related but separate issue of MMC reforms, their implementation and consequences to surgical careers.

ASGBI has been in the forefront of promulgating debate and discussion on these topics. A Consensus Conference was held in Cobham in October 2004, the conclusions of which were disseminated widely in a Consensus Statement, *Modernising Medical Careers and General Surgery*[1], and provided focus for subsequent discussion (***Appendix 2***). A debate on MTAS was held at the Association's 2007 Annual Scientific Meeting in Manchester which resulted in the agreement of a proposed 'rescue package' (***Appendix 3***) which became the baseline for the many future discussions in other Associations and Societies, Colleges and the Academy of Medical Royal Colleges.

It was against this background of previous commitment and ongoing concern about developments within the surgical profession that ASGBI, with the cooperation of the Surgical Forum (previously the Senate of Surgery) and the Federation of Surgical Specialty Associations (FSSA), decided that a pan-surgical Consensus Conference on the future of MMC would be appropriate.

KEY PRINCIPLES

1. **Surgical training and clinical service provision are inextricably linked and there must be an aspiration to excellence in both. Doctors in training make a major contribution to healthcare delivery and this should be widely recognised.**

2. **The formative years of training should be curriculum driven and underpinned by flexibility and relevance to societal needs.**

3. **Education, training and career development must be determined by the profession with appropriate educational input.**

4. **Graduates of UK/EEA medical schools should be given priority for training posts and employment in the UK.**

5. **All surgical specialties should be allowed the flexibility to determine their own destiny.**

6. **The end point of training is the gateway to a professional medical career. Learning never ends and CPD is mandatory.**

7. **All surgical trainees must be exposed to the academic components of surgery. Surgical science and education must be recognised as important components of training, in addition to clinical and technical expertise.**

8. **Entry to Medical School is highly competitive and selection on merit must underpin academic, clinical and professional advancement throughout a surgical career.**

9. **F1 and F2 should be "uncoupled" with F1 doctors affiliated to their medical schools and F2, ST1 and ST2 becoming core specialty training. Generic skills implicit in the Foundation years must be re-designated into the curriculum for core training.**

10. **PMETB has not been successful in its objectives and should be incorporated into the GMC, allowing linkage of accreditation with registration. It is essential that professional representation should predominate.**

11. **It is essential that Quality Assurance is effective and ensures the confidence of trainees, trainers and the public. Regular face-to-face interviews between trainee and trainer are vital and mutually beneficial in a craft specialty such as surgery. SAC visits are a powerful method of safeguarding the standards of surgical training.**

12. **The future of surgical training and practice will benefit from a pan-surgical approach across specialty interests and geographical boundaries. Surgery should speak with one voice and embrace examples of clinical and academic excellence, whatever their origin, that benefit our patients and the public.**

BACKGROUND

The origins of MMC lie in a consultation document entitled *Unfinished Business; proposals for reform of the Senior House Office grade*[2] written by the Chief Medical Officer for England, Professor Sir Liam Donaldson, in 2002. SHOs were referred to as the 'lost tribe' within training and he proposed that the grade be restructured, underpinned by five principles:

1. Training should be programmed-based.
2. Training should be broadly-based to begin with for all trainees.
3. Training should provide individually-tailored programmes to meet specific needs.
4. Programmes should be time-capped.
5. Training should support movement into and out of training and between training programmes.

The response to these proposals was generally positive. Reservations were expressed that some of the final recommendations were not part of the original objectives of the report and that it was inappropriate to reform training grades other than SHO. After consultation, the proposals were reviewed by Health Ministers and simultaneously the emphasis began to shift towards the concept of Run Through Training (RTT). The aim of these changes was to provide seamless specialist training leading to a CCT. The origin of this proposal is unclear, but it marked the beginnings of serious misgivings within the medical profession.

RECENT DEVELOPMENTS

1. The foundation programme comprising F1 and F2 doctors was commenced in 2005. It is a tribute to the hard work of Trust HR departments, Deaneries and Foundation School Directors that relatively few problems were encountered with this significant change in medical careers.

2. A two-year time span for the Foundation programme inevitably meant that new specialty training would commence in 2007. Despite widespread objections and the need for pilot studies, the MMC directorate continued unswayed and specialty training commenced in August 2007. Concomitant with these developments the Medical Training Application Service (MTAS) was created to provide a national on-line system to accommodate Run Through Training schemes from 2007.

3. The distinction between MTAS, the selection process, and the aims and the aspirations of the reforms proposed by MMC is often overlooked.

4. Most would agree that MTAS was a debacle, which caused huge upset for trainees and trainers throughout the UK. The careers of many young doctors were compromised and morale reached a low ebb.

5. The negative effects of MTAS are clear, but the current status of the MMC reforms generate significant debate across all specialties.

6. MMC aimed to provide structured training programmes in which progress was determined by competence, based on detailed curricula for each of the nine SAC defined surgical specialties brought together in the Intercollegiate Surgical Curriculum Project (ISCP).

7. Disquiet about MTAS and MMC resulted in professional, public and political recognition of the inherent problems. To address these concerns, the Chief Medical Officer and the Department of Health invited Professor Sir John Tooke to lead an independent inquiry, the results of which would focus discussion for selection and specialist training after 2008. The MMC Inquiry's preliminary report, *Aspiring to Excellence*[3], was published on Monday 8th October 2007. The ASGBI Pan-Surgical Consensus on the Future of MMC, from which this ***Consensus Statement*** arises, was held a few days later to facilitate debate and to develop consensus amongst stakeholders, leaders and opinion makers within the Surgical Specialty Associations and Royal Colleges. The aim was to produce a statement for submission to the MMC Inquiry as part of the wider consultation process.

CONSENSUS STATEMENT ON THE FUTURE OF MMC

This ***Consensus Statement*** is based on:

1. Presentations delivered at the Consensus Conference held on 12th October 2007, discussions arising from them and the final interactive session.

2. A number of important issues were identified in advance of the Conference and invitees with a particular expertise in these areas were asked to provide a précis of relevant points. This provided the writing group with additional information to incorporate into this Statement.

3. At the conclusion of the Consensus Conference, delegates were asked to provide a brief summary of their impressions of the day. These opinions have also been incorporated into this Statement.

The above presentations, relevant points and summaries are available, under 'presentations' or 'documentation' at:

www.asgbi.org.uk/mmc-consensus

This final ***Consensus Statement*** includes feedback from those who contributed to the Conference and those who were invited to comment on earlier drafts. The document is, therefore, a statement arising from a conference, rather than the proceedings of a conference. Not everyone will agree with all the recommendations or conclusions. ASGBI have actively encouraged ALL stakeholders to submit individual responses to *Aspiring to Excellence*, and many have done so. Some have endorsed this statement, but others have demurred. However, this document is a significant attempt to represent the views of all surgical specialties on issues which are fundamental to the future of the profession.

CONCLUSIONS

1. MODERNISING MEDICAL CAREERS

1.1 *Aspiring to Excellence* acknowledges that MMC was an honest attempt to redress perceived failures in medical training. MMC sought to provide a greater number of trained doctors. Training was to be competency based with explicit standards. These objectives were laudable and should improve patient care.

1.2 The decision, by the DoH in 2005, that a two-year Foundation Programme was essential was presented to the newly formed MMC board without prior consultation.

1.3 The implementation of MMC was undertaken too quickly and with insufficient consultation. The MMC team were prevented from influencing MTAS and the absence of a coordinated approach to recruitment and medical training was a major contributing factor to the ensuing problems.

1.4 The Government, Department of Health, PMETB, the Deaneries, BMA, the Royal Colleges and the Specialty Associations have all contributed to further confusion.

1.5 The surgical trainee organisations (ASiT and BOTA) have actively represented the views of their peers throughout a period of uncertainty and engaged in constructive dialogue about the future of MMC.

1.6 The input of independent, newly formed organisations (eg, Fidelio and RemedyUK) is recognised. These groups advocate that the medical profession must be involved in planning and assert that trainee doctors have been the victims of the worst experiment in workforce planning in the history of medicine.

2. MMC INQUIRY AND *ASPIRING TO EXCELLENCE*

2.1 Professor Sir John Tooke is to be congratulated on producing a coherent and constructive interim report, *Aspiring to Excellence*, which, after it has been refined through consultation, will, no doubt, provide a solid springboard for the evolution of medical training processes in future years. The recommendations in the report are broadly accepted, with the caveat that some details contained in the narrative have not been translated into recommendations.

2.2 The goal of medical training should be an aspiration to excellence rather than simply to be competent.

2.3 Doctors in training make a major contribution to service provision and this should be widely recognised. Reference to them as trainees only is inappropriate.

2.4 Doctors in training, working under the constraints of the EWTD, will receive a generalist training in the initial part of their career, followed by the acquisition of specialist skills leading to the award of a CCT. Opportunities for selected individuals to acquire additional specialist skills post-CCT (Fellowship Training) will require additional time and resources.

3. FOUNDATION PROGRAMME / CORE TRAINING

3.1 The Consensus Conference was generally in agreement with the proposal in *Aspiring to Excellence* that Foundation Years F1 and F2 should be "uncoupled".

3.2 F1 doctors should be affiliated to their medical schools. These "pre-registration" posts would not, therefore, be open to IMGs.

3.3 Many extol the benefits of the F2 year. It may be appropriate that the first year of core training retains the 3 x 4 month rotations before moving into themed core training programmes of 2 x 6 months.

3.4 Selection to core specialty training (F2) should include an assessment of medical school performance. This emphasises the importance of establishing consistency in marking and assessment criteria across all medical schools.

3.5 It is essential that the generic skills implicit in the Foundation years (knowledge, communication, etc) are formally re-designated into the curriculum for either the pre-registration year or core training. This should be decided before uncoupling takes place.

4. HOW TO SELECT FOR HIGHER SPECIALIST TRAINING

4.1 For the majority of specialties, Run Through (or seamless) Training is not appropriate. As such, entry into specialist training would have to be competitive.

4.2 The Conference supported the recommendations of *Aspiring to Excellence* which advocates assessment of knowledge, skills, aptitudes and experience. This will necessitate a structured examination. Ranking may be employed to determine eligibility for interview.

4.3 Interviews must include review of CVs, or structured application forms, and an opportunity for candidates to demonstrate their strengths and commitment to the specialty and their suitability for a career in surgery. Other techniques such as evaluation of clinical scenarios (OSCE) should be considered. The validity of structured references has not yet been fully evaluated.

4.4 It must be accepted that not all applicants will be successful**.** To avoid overloading of examination departments, applicants should be permitted a limited number of attempts.

4.5 Run Through Training and national selection may be appropriate for the numerically smaller specialties such as Neurosurgery, Cardiothoracic, Maxillofacial and Plastic Surgery where workforce predictions are likely to be more accurate. All specialties should be allowed the flexibility to determine their own destiny.

5. SHOULD DOCTORS CURRENTLY IN ST1 AND ST2 POSTS BE GUARANTEED PROGRESSION TO ST3 (ie. RUN THROUGH TRAINING)?

5.1 Current ST1 and ST2 trainees appointed to RTT should not be subjected to further selection to ST3. Those currently in the system who satisfy educational and training objectives must be allowed to progress.

5.2 In future, there should be careful, competitive and formal selection, using criteria determined by the profession, into ST3 for most specialties.

5.3 Run Through Training should not be guaranteed in the round of appointments for 2008 until the criteria for selection are clarified. However, it is accepted that there will be variations depending on specialty and geography.

5.4 A modest increase in surgical NTNs and training opportunities may ease the anxiety of trainees currently competing for ST3 positions. However, the consequence of this will be an increase in post-CCT competition in the future.

5.5 Surgery must look urgently at trainees with aspirations to specialty training who were unsuccessful in August 2007. The Conference supported a modest increase in ST3 posts, in those specialties where the problem is most acute, in the 2008 round.

5.6 We must determine numbers involved, surgical specialty and the quality of these disadvantaged unsuccessful applicants. Programme Directors should survey their regions for all nine SAC-defined surgical specialties to determine the number of additional training opportunities. This information will allow a constructive debate about solutions including financial and other resource costs.

5.7 All FTSTA and NTN posts should provide equivalent training opportunities. This would necessitate central funding, time limited for FTSTA trainees.

6. ACADEMIC TRAINING

6.1 Research, education or other academic endeavour should be nurtured and strongly encouraged. Existing academic placements in Foundation programmes should be incorporated into core training. All surgical trainees must be exposed to the academic components of surgery. Surgical science and education must be recognised as important components of training, in addition to clinical and technical expertise.

6.2 The suggestion in *Aspiring to Excellence* for an academic core training module was welcomed. Research and other academic activities must be an explicit part of the curriculum in order to gain PMETB approval.

6.3 Fundamental to the success of academic training is flexibility in the workforce and between programmes. The rigidity of MMC must be avoided to encourage individuals to pursue their own self-improvement programmes.

6.4 Surgery should remain an important component of the undergraduate curriculum and all surgeons (especially academic surgeons) must contribute. Role models and mentorship enhance surgical training.

6.5 Trainees (in England and Wales) wishing to pursue a full-time academic career are advised to follow the recommendations of the Walport Report [4]. However, all surgical trainees should have the opportunity of entering an academic training programme during specialist training.

6.6 It is recognised that a great deal of research occurs in the early years of training and that such research has traditionally reflected well upon candidates wishing to enter higher surgical training. Many trainees undertake research to demonstrate commitment to their chosen career and, if selection is to be based on meritocracy, this should be allowed for and recognised.

6.7 All surgeons in training should have a broad knowledge of critical appraisal, research methodology, clinical research and ethics. Evidence of satisfactory completion should be available within the trainee's portfolio or logbook.

6.8 Academia includes education and all surgical trainees should acquire experience in educational practice and theory. All trainees should be involved in the teaching of both medical students and students of the professions allied to medicine.

6.9 Further work should be undertaken to devise a suitable academic curriculum, which would be applicable to all surgical trainees within MMC, and provide courses to equip surgeons for a role in education and training.

7. WHAT IS THE END POINT OF TRAINING?

7.1 The end point of training is the gateway to a professional medical career. Learning never ends and CPD is mandatory.

7.2 No single definition exists to describe the "end point" of training. Most would agree that possession of a CCT in a SAC defined specialty indicates suitability for appointment to a Consultant post. The award of a CCT signifies the transition from formal training to independent professional practice and continued learning. It is but one significant milestone in the totality of a medical career.

7.3 The majority of NTN holders should achieve a CCT which indicates eligibility for Consultant status. In some specialties, market forces may preclude consultant appointment on gaining a CCT. The term "Specialist" is recommended for these post-CCT doctors.

7.4 In future, not all trainees will become Consultants and, for varied reasons, some may not wish to do so. However, the term "sub consultant grade" must be abandoned. The number of CCT holders in this category will increase in future years.

7.5 If a future manpower crisis occurs, the number of CCT holders without consultant posts will increase. The system needs to provide individuals with opportunities to discover their occupational niche and encourage competition for career outlets.

7.6 Possessors of a CCT may select non-consultant, specialist posts in which they add to their portfolio by developing additional competencies, eg. Clinical Fellowships or modular Masters degree programmes. During this period, which will vary between individuals, it is likely that these doctors will require careful mentoring. This flexibility is the norm for many other professions.

7.7 The constraints of EWTD will result in future CCT holders being less experienced than CCST holders of the past.

8. INTERCOLLEGIATE EXIT EXAMINATION

8.1 A robust system of assessment, linked to a curriculum, is an essential route to the preservation and maintenance of standards within surgery.

8.2 Successful completion of the Intercollegiate exit examination provides reassurance to the public and a sense of security for our patients.

8.3 Formal examinations help to focus and drive the learning of trainees and prepare them for consultant practice. The exit examination should remain an essential component of the assessment system for the foreseeable future.

9. REGULATION OF MEDICAL EDUCATION AND QUALITY ASSURANCE

9.1 PMETB was established by legal statute to set standards for the content and outcome of surgical training and to be responsible for certification. MMC was responsible for implementing those standards, whilst Colleges and Specialty Associations determined the curricula.

9.2 The majority of delegates considered that PMETB had not been successful in its objectives and there was considerable support for the *Aspiring to Excellence* recommendation that PMETB be subsumed into the GMC. This would allow linkage of accreditation with registration. The regulating body for medical education should report to parliament rather than the DoH, and it is essential that there should be more professional representation.

9.3 Concerns were expressed about the competence and commitment of the GMC to achieve Quality Assurance in all aspects of medical training and felt that regulation should reside with the profession. It is relevant in this regard that the GMC intends, in the future, to have a majority of lay members on Council.

9.4 There was unanimity about the need to preserve the RITA. A regular face-to-face interview between trainee and trainer is vital and mutually beneficial. Summative assessments based entirely on a paper exercise were deemed inappropriate, particularly in a craft specialty such as surgery.

9.5 There was strong support for the re-introduction of the peer-review SAC visits as a powerful and appropriate method of safeguarding the standards of surgical training.

9.6 Whichever organisation has the responsibility for training, it is essential that Quality Assurance is effective and appropriate. Any QA system must ensure the confidence of trainees, trainers and the public.

9.7 The Consensus Conference noted the effectiveness of the North American National In-Training Examination.

10. INTERNATIONAL MEDICAL GRADUATES (IMGs/non-UK, non-EU Doctors)

10.1 In the past, graduates of overseas medical schools had been encouraged, under HSMP, to work in the UK to alleviate staffing problems within the NHS. Some of these doctors had been successful in open competition and completed specialty training in this country. Their contribution to encouraging a competitive meritocracy is undeniable.

10.2 A significant minority of delegates recommended that HSMPs appointed on or before 1st January 2007 should be entitled to apply for training posts.

10.3 A majority of delegates thought that graduates of UK/EEA medical schools should be given priority for training posts and employment in the UK.

11. EUROPEAN WORKING TIME DIRECTIVE (EWTD), POSTGRADUATE TRAINING AND DEANERY SCHOOLS OF SURGERY

11.1 All doctors will be required to comply with the EWTD by 1st August 2009, ie. working an average of 48 hours per week with appropriate rest requirements. Consultants can currently opt out of the working hours limits of the EWTD but must comply with current rest requirements (11 hours in 24). To date, most consultants have not formally opted out.

11.2 Investment in training is essential for the future of the profession. MPET budgets reside with Strategic Health Authorities who have control over these funds. In some SHAs portions of MPET funding have been diverted to other, non-training, expenditure; this is unacceptable.

11.3 The culture of Trusts needs to change to recognise the importance of teaching and training within the confines of the European Working Time Directive. This will involve maximum use of training opportunities and a more flexible approach. Training needs to be mapped against robust workforce planning.

11.4 There are many bodies influencing surgical training (four Royal Colleges, the JCST, nine SACs, numerous specialty associations and other external bodies). There needs to be cohesion and direction so that an agreed strategy for training, education and professional development can emerge.

11.5 Deanery Schools of Surgery are, to date, very variable; some have been strong, others weak. The Heads of Schools of Surgery should play a strong leadership role and demonstrate a consistent application of educational principles.

11.6 Postgraduate Deans should be appointed by Universities. This should encourage academic excellence. Consideration should be given to reallocating the training budget (MPET) from Strategic Health Authorities to Postgraduate Deans. In Scotland, the Postgraduate Deans hold the entire training budget, and this is commended as good practice.

11.7 Not all Consultants wish to be trainers. Those who do wish to be active in the education of trainees should be given sufficient time to develop this role; receive appropriate training, particularly with regards to curricula; have their position recognised within the NHS Trust in which they work and have adequate support at deanery level for those with major responsibilities such as Programme Directors. Without such support, many good trainers will disengage.

11.8 The DoH, and individual NHS Trusts, must recognise the resource implications of training. A commitment to training may necessitate reconfiguring emergency and elective activities. The expectation that staff will support on-site service provision in excess of contracted hours is widespread and unacceptable.

11.9 Hospitals with a substantial training commitment should command additional funding to compensate for that lost under 'payment by results' because of the reduced clinical throughput necessary for training.

12. WORKFORCE PLANNING

12.1 In any competitive meritocracy not all will succeed with their ultimate career goal; there will be fall-out in the process of progression up the career ladder.

This is not at variance with the aims and ambitions of MMC principles. Entry to medical school is intensely competitive and no other career guarantees seamless training from entry to endpoint.

12.2 Surgical workforce calculations are rendered difficult, if not impossible, by three main problems:

i) The increase in medical student numbers and shifting demographics.

ii) Uncertainty over the future of International Medical Graduates (IMGs).

iii) Uncertainty about how surgical care will be administered in the future. Will this be consultant-led or consultant-delivered?

12.3 Future trainees will have different aspirations to their predecessors. Flexible working, career breaks, multiple career switches and work-life balance are all part of the current employment paradigm. This will change the structure of the medical workforce. Trained post-CCT Specialists will provide the majority of clinical services. Doctors in training will constitute a reduced proportion of the total medical workforce.

12.4 The system must have the flexibility to allow trainees to move into different specialties as appropriate. Training programmes must avoid rigidity and include an opportunity to change career direction, mitigating against potential future unemployment.

12.5 There are nine SAC defined specialties in surgery. There must be flexibility for each craft specialty to determine training and career pathways embracing skills and knowledge for effective clinical practice.

12.6 The Conference agreed with the recommendation in *Aspiring to Excellence* that the Trust Registrar position (formerly Staff Grade) must be de-stigmatised and contract negotiations rapidly concluded. Trust Registrars should have access to training and CPD opportunities. They should be eligible for a limited number of applications to Higher Specialist Training positions according to the normal mechanisms and acquisition of CESR through the Article 14 route.

13. GENERALISM VERSUS SPECIALISM

13.1 Generalists are essential to cover the emergency on-call rota in most DGHs to manage the unselected nature of emergency admissions. Generalists are trained in triage and the referral of cases beyond their expertise.

13.2 Fewer generalists are required to provide care for any given population compared to specialists. Generalists can protect specialists from being swamped by conditions within their specialty that do not need expert intervention.

13.3 Specialisation will continue to evolve resulting in centralisation of complex, technical, procedures where there is evidence that case volume has a beneficial influence on outcome. Multi-disciplinary teams are important for diseases that require complex physiological management.

13.4 There will be an increased emphasis on networked care for smaller hospitals where emergency departments may not be sustainable. However, reconfiguration has to be locally led.

APPENDIX 1

List of delegates attending the Pan-Surgical Consensus Conference on the Future of MMC (Friday 12th October 2007)

Mr Anthony J Banks	Former Chairman, SAC in Trauma and Orthopaedic Surgery
Mrs Louise Bayne	Political Liaison Officer, RemedyUK
Mr Jonathan Beard	Consultant Vascular Surgeon
Miss Anne Bishop	Chief Executive, British Association of Urological Surgeons
Mr John Black	Former Chairman, SAC in General Surgery
Professor Morris Brown	Fidelio
Professor Kevin Burnand	President, Society of Academic and Research Surgery
Mr Richard Canter	Deputy Director Department of Education, RCS England
Professor John Collins	Dean of Education, Royal Australasian College of Surgeons
Mr Allan Corder	Association of Breast Surgery at BASO
Professor Alan Crockard	Former MMC Directorate
Miss Julie Doughty	Association of Breast Surgery at BASO
Mr David Drake	British Association of Paediatric Surgeons
Mr Adrian Drake-Lee	Chairman, SAC in Otolaryngology
Mr Ian Eardley	Chairman, SAC in Urology
Mr Derek Fawcett	Vice-President, British Association of Urological Surgeons
Mr Colin Ferguson	Consultant Vascular Surgeon
Mrs Antoinette Foers	RCS Coordinator for East Midlands (North) and SYSH
Dr Nicholas P Gair	Chief Executive, Association of Surgeons of Great Britain and Ireland
Mr Robert A Greatorex	RCS England Manpower Committee
Mr A Roger Green	Vice-President, British Association of Plastic Reconstructive and Aesthetic Surgeons
Professor George Hamilton	President, Vascular Society of Great Britain and Ireland
Mr Wilson S Hendry	Vice-President, Royal College of Surgeons of Edinburgh
Professor Michael Horrocks	Vice-President, Association of Surgeons of Great Britain and Ireland
Mr Matthew Jameson Evans	Press Coordinator, RemedyUK
Mr James N Johnson	Past Chairman, British Medical Association
Professor Zymunt Krukowski	Past-President, British Association of Endocrine and Thyroid Surgeons
Mr Peter Lamont	Chairman, SAC in General Surgery
Mrs Nechama Lewis	Administration Manager, British Association of Otorhinolaryngologists - Head and Neck Surgeons
Mr John R C Logie	Vice-President, Royal College of Surgeons of Edinburgh
Professor John MacFie	Honorary Editorial Secretary, Association of Surgeons of Great Britain and Ireland
Ms Fiona MacNeill	Association of Breast Surgery at BASO
Dr Richard Marks	Legal/Strategy, RemedyUK
Mr Conor Marron	Past-President, Association of Surgeons in Training

Mr Ian Martin	Chairman of Council, British Association of Oral and Maxillofacial Surgeons
Professor Peter T McCollum	Consultant Vascular Surgeon
Dr Chris McCullough	Website Coordinator, RemedyUK
Miss Anne Moore	Vice-President, Royal College of Surgeons of England
Professor Anthony R Mundy	President, British Association of Urological Surgeons
Mr Chris Munsch	Chairman, SAC in Cardiothoracic Surgery
Mr Richard J Nelson	Chairman, SAC in Neurosurgery
Ms Sallie Nicholas	Joint Committee on Higher Surgical Training
Professor John M A Northover	President, Association of Coloproctology of Great Britain and Ireland
Mr Richard O'Hara	British Association of Day Surgery
Mr Rowan W Parks	Director of the Scientific Programme, Association of Surgeons of Great Britain and Ireland
Dr Katie Petty-Saphon	Chief Operating Officer, MMC Inquiry
Professor John Pickard	President, Society of British Neurological Surgeons
Professor John N Primrose	Director of Education, Association of Surgeons of Great Britain and Ireland
Mr Jonathan K Pye	Honorary Secretary, Association of Surgeons of Great Britain and Ireland
Professor Richard Ramsden	President, British Association of Otorhinolaryngologists - Head and Neck Surgeons
Mr Myrddin Rees	President, Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland
Miss Wendy Reid	Postgraduate Dean, London Deanery
Mr Bernard Ribeiro	President, Royal College of Surgeons of England
Mr Keith Rigg	Vice-President, British Transplantation Society
Mr Paul H Rowe	Honorary Treasurer, Association of Surgeons of Great Britain and Ireland
Professor Brian J Rowlands	President, Association of Surgeons of Great Britain and Ireland
Mr R Christopher Russell	Vice-President, Royal College of Surgeons of England
Professor Cliff Shearman	Chair of Education and Training, Vascular Society of Great Britain and Ireland
Mr James Steers	President, Federation of Surgical Specialty Associations
Professor Robert W Stout	Facilitator
Professor David Thomas	Chairman, SAC in Paediatric Surgery
Professor Sir John Tooke	Chairman, MMC Inquiry
Mr Owain Tudor	EIDO Healthcare
Mr Philip van Hille	Honorary Secretary, Society of British Neurological Surgeons
Mr Christopher C Walker	President, British Association of Plastic Reconstructive and Aesthetic Surgeons
Mr David Ward	Chairman, Intercollegiate Committee for Basic Surgical Examinations
Dr David Whitaker	President, Association of Anaesthetists of Great Britain and Ireland
Professor Howard Young	Representing CMO (Wales), Vice Dean

APPENDIX 2

Conclusions from a Consensus Statement on Modernising Medical Careers and General Surgery Association of Surgeons of Great Britain and Ireland (October 2004)

1. The implementation of the European Working Time Directive has highlighted the severe shortage of trained surgeons in the UK.

2. There is an urgent need to increase the number of General Surgeons who are fully trained to treat patients in both the emergency and the elective setting. However, there should be a diminishing reliance on Staff and Associate Specialist Surgeons to support the NHS.

3. ASGBI strongly supports the introduction of structured training programmes, in which progress is determined by competence.

4. ASGBI recognises the need to provide emergency and elective surgical cover throughout the United Kingdom. This will necessitate variations in the provision of service and different models to suit different circumstances.

5. The Modernising Medical Careers concept that most hospitals should be staffed by General Surgeons who are only "emergency safe", with relatively few specialists, is fundamentally wrong.

APPENDIX 3

ASGBI Key Principles for rescuing MMC (Manchester 2007)

1. MTAS must be discarded completely.

2. ST3 vacancies should filled by a Deanery process.

3. Appointment to seamless training before ST3 should be delayed for one year.

4. There should be a Deanery or Trust process to fill ST1 and ST2 level posts for one year.

5. There should be a replacement for MMC led by the Profession.

6. A new selection process should be agreed nationally by SACs, Colleges and Deaneries.

7. There should be renewed debate on where seamless training starts.

REFERENCES

1. ***Modernising Medical Careers and General Surgery: A Consensus Statement***
   Association of Surgeons of Great Britain and Ireland
   (October 2004)

2. ***Unfinished Business: Proposals for reform of the Senior House Officer Grade***
   Sir Liam Donaldson, Chief Medical Officer for England
   Department of Health
   (August 202)

3. ***Aspiring to Excellence: Findings and Recommendations of the Independent Inquiry into Modernising Medical Careers***
   Professor Sir John Tooke
   (October 2007)

4. ***Medically and dentally qualified academic staff recommendations for training the researchers and educators of the future***
   Academic Sub Committee of MMC and UK Clinical Research Collaboration
   (March 2005)

BIBLIOGRAPHY

Modernising Medical Careers and General Surgery: A Consensus Statement
Association of Surgeons of Great Britain and Ireland
(October 2004)

Proceedings of a Consensus Conference on Academic and Research Surgery
Association of Surgeons of Great Britain and Ireland
(September 2005)

Emergency General Surgery: The Future - A Consensus Statement
Association of Surgeons of Great Britain and Ireland
(June 2007)

GLOSSARY

ASGBI	Association of Surgeons of Great Britain and Ireland
BAOMS	British Association of Oral and Maxillofacial Surgeons
BOA	British Orthopaedic Association
BAPS	British Association of Paediatric Surgeons
BAPRAS	British Association of Plastic Reconstructive and Aesthetic Surgeons
BAUS	British Association of Urological Surgeons
ENT-UK	British Association of Otorhinolaryngologists - Head and Neck Surgeons
SBNS	Society of British Neurological Surgeons
SCTS	Society of Cardiothoracic Surgeons of Great Britain and Ireland
FSSA	Federation of Surgical Specialty Associations
AUGIS	Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland
ACPGBI	Association of Coloproctology of Great Britain and Ireland
ALS	Association of Laparascopic Surgeons of Great Britain and Ireland
VS	The Vascular Society of Great Britain and Ireland
BAETS	British Association of Endocrine and Thyroid Surgeons
ABS at BASO	Association of Breast Surgery at BASO
BASO	British Association of Surgical Oncology
BTS	British Transplantation Society
SARS	Society of Academic and Research Surgery
ASiT	Association of Surgeons in Training
BADS	British Association of Day Surgery
ASPC	Association of Surgeons in Primary Care
NAASP	National Association of Assistants in Surgical Practice
BHS	British Hernia Society
BOTA	British Orthopaedic Trainees Association
AAGBI	Association of Anaesthetists of Great Britain and Ireland

SAC	Specialty Advisory Committee
CPD	Continuing Professional Development
ISCP	Intercollegiate Surgical Curriculum Project
BMA	British Medical Association
GMC	General Medical Council
MMC	Modernising Medical Careers
MTAS	Medical Training Application Service
PMETB	Postgraduate Medical Education and Training Board
CCT	Certificate of Completion of Training
CCST	Certificate of Completion of Specialist Training
EWTD	European Working Time Directive
RTT	Run Through Training
NTN	National Training Number
IMG	International Medical Graduate
SHA	Strategic Health Authority
HSMP	Highly Skilled Migrant Programme
MPET	Multi-Professional Education and Training
FTSTA	Fixed Term Specialist Training Appointments
DGH	District General Hospital
CESR	Certificate of Eligibility for Specialist Registration
OSCE	Objective Structured Clinical Evaluation

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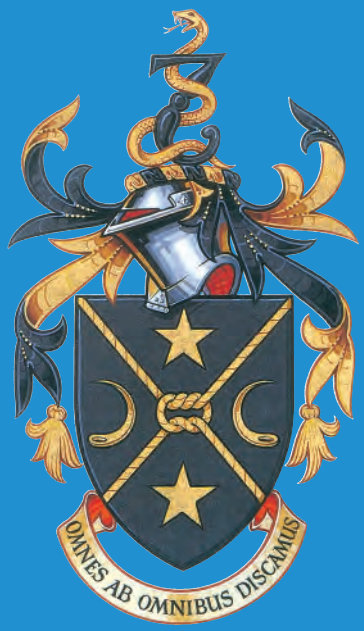

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