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Declaration of competing interests: None declared.

# The surgical trainer – are we still evolving?

> **"We need a system and we will surely have it – which will produce not only surgeons, but surgeons of the highest type"**
> **William Halsted MD**

William Halsted, a famous American surgeon, is widely credited with developing the first formal surgical training programmes at John Hopkins Hospital. Although this quote is from 1904, current surgical trainers still strive for the same goal as we train our next generation of surgeons – to produce "not only surgeons, but surgeons of the highest type".

Halsted believed that surgical training should be accomplished in a set period of time, have a progressive increase in responsibility and operative experience, and have a final period of independent activity. This 'apprenticeship' model has been the mainstay of surgical training for decades and was enthusiastically adopted in the UK. Budding surgeons would apprentice themselves to a surgical 'firm' – this firm was a clinical team usually headed by the consultant surgeon who had the ultimate responsibility for the patients under their care. The trainee progressed through a series of training posts and grades, often widely distributed across the country, assuming increasing levels of responsibility as they progressed.

Trainees could be given high levels of responsibility even at fairly junior stages, and it was expected that learning took place 'on the job' with the trainee acquiring the appropriate skills and knowledge as they went along. The learning that took place within this system was opportunistic, was usually a by-product of the clinical job, and lacked a clear educational framework. This arduous training, rather than being seen as onerous, unsafe and inefficient, was held up as a rite of passage on the road to becoming a surgeon, and indeed is often still mentioned with pride by a certain generation of surgeon.

One benefit of this was that trainees accumulated vast hours in the hospital and so collected extensive experience (although not necessarily competence), and so by the time they were appointed as consultants they were usually extremely proficient operative surgeons. While this is, in essence, a form of experiential learning, it lacked structure, rigour and any form of formal assessment of performance.

Progression within this system was strongly associated with the practice, beliefs, and attitudes of their mentor; and their judgements about a trainee's performance were unstructured and largely opaque. It would be rare to get explicit feedback on your performance as a trainee, and if you were allowed to do the next operation you assumed you had performed the previous one to a satisfactory standard. There was no formal record of progress or proficiency and no end of training assessment. In particular operative skill was never formally assessed or documented.

> **"All Changed, Changed utterly..."**
> **WB Yeats**

The environment in which we train now is very different. The WB Yeats quote from Easter 1916 was famously used as the title of a 1996 *British Medical Journal* editorial by Richard Smith. This editorial was about the Bristol enquiry, an enquiry into excess deaths in a paediatric cardiac unit that sent shockwaves through the medical profession, introduced the concept of clinical governance and threw into sharp relief the need for the profession to be accountable and transparent. From this enquiry emerged a clear need for us to be able to evaluate and ensure clinical competence and technical expertise, both in ourselves and our trainees. The days of 'muddling through' as a trainee were over.

In addition to this we have seen an increasing rise in the professionalisation of medical education, driven and demanded at least in part, by our own trainees. Rightly, they want to be well trained; by trainers who are engaged and competent. Especially in our brave new world of restricted duty hours, with shift patterns all but destroying the surgical 'firm' of days gone by, we do need to be able to train more efficiently.

As surgeons in the UK we are all subject to the current pressures of the National Health Service. A fiscal imperative to drive down costs, meet targets, yet retain quality and safety, means that operating theatres become production lines rather than crucibles of learning. With increasing demand for throughput it is unfortunately often training that is the first to suffer and to slip down the priority list for the day's achievements.

> **Good enough is not good enough. Rather, in the interests of the health and wealth of the nation, we should aspire to excellence**
> **Professor Sir John Tooke**

As trainers we need to rise to these challenges and continue to deliver the highest quality training to our trainees. We need to have a single minded focus on the final product – at the end of the day what is a competent urologist meant to look like? What knowledge, skills and attitudes do they need in order to provide safe and effective patient centred care? We then need to train our trainees in these competencies effectively and efficiently.

In this new paradigm we need to engage in a wider range of teaching and learning activities. We need to take advantage of all learning opportunities within the workplace, enhance the educational environment within that workplace, and assess and record all elements of competency within the surgical setting. We need to train not only in clinical settings but also using both low- and high-fidelity simulation models in a surgical skills laboratory. Evidence is growing that this competency-based approach is capable of improving training over a shorter course of time. Trainees can progress at their own pace and may complete the entire programme more quickly (or more slowly) than those in a traditional model. Competency-based training can thus accommodate the natural variation of learners better than a 'one-size-fits-all' timeline.

In order to move towards a truly competency-based training system we need to have reliable forms of assessment, as trainers must be able to determine when competency has in fact been achieved. A competency-based programme allows us to re-evaluate the role of assessment: rather than being a barrier which must be overcome, if we consider assessment as a stepping stone, an integral part of the learning process, then it can become a non-threatening mechanism for guiding trainees through a curriculum, allowing them to improve their performance and gauge their progress through the programme.

Our current workplace-based assessment tools are fit for this purpose. Although there is a degree of scepticism surrounding these tools, particularly with their validity and reliability questioned and disparaged. In the messy world of the surgical workplace we simply cannot standardise conditions as we would in an exam – validity and reliability of assessment in the workplace are entirely dependent on the expert judgement of ourselves as trainers. Our role as trainers is also central to the entirety of high quality surgical education and training, although this is a role that is often delivered in an almost covert fashion.

Professor Sir John Tooke did recognise and emphasise the important role of the trainer. He said that trainers need to be recognised, developed and rewarded. Trainers also need to be trained, accredited and supported, and he emphasised that we need to strive for a culture of excellence. If we are to continue to deliver high quality surgeons, we need to have high quality trainers. Much of the educational literature in medicine and surgery has a focus on the process of delivery of training, and I would argue that this focus is too narrow and puts the cart before the horse. Our first priority should be developing our surgical trainers – as you can have the most innovative training programme in the world, but it will fail if not taught and delivered by excellent trainers and educators.

As surgeons we are all well practised in the delivery of state of the art evidence-based care. As educators we are perhaps not quite so rigorous in our delivery of education and training. Expert surgeons are not by default expert teachers or educators. Educator competencies include a range of skills that differ markedly from the skills needed to be a skilled practitioner of surgery. These separate competencies need to be identified, practised and coached, just as in any other professional training programme to result in knowledgeable and effective educators. Very few hospitals or colleges provide their clinicians with a structured curriculum on teaching and learning.

This is not to say that we are doing it 'wrong'. On the contrary, we are able to continue to deliver high quality surgical training in the face of all the challenges that our current, sometimes turbulent, times can throw at us. I would argue, however, that we can do it 'better'. Surgical trainees have the dubious honour of reporting being least satisfied with their training of all the specialties, and have been in this position for the past five years according to the GMC training survey. The literature is fairly clear that we can improve our performance as trainers in the areas of professionalism and feedback, for instance. There is definitely room for improvement.

To drive this improvement, we need to see our role as trainers being held in higher esteem, being seen to be valued, recognised and rewarded. At present training is often seen as a by-product of being a consultant, a default option when you achieve your CCT. There is no acknowledgement of the work we put in to deliver high quality training; the expectation is that you will fit this in around your service delivery, in a climate with increasing pressure on throughput and fiscal scarcity. Having formal time in your day and job plan to train is the exception rather than the rule, and there is no defined trainer career path, as say compared to academic surgery. This needs to change.

It is with this thought that the Faculty of Surgical Trainers (https://fst.rcsed.ac.uk/) was conceived. The Faculty was launched in 2013 with a remit to achieve increased recognition of the role of the surgical trainer, and provide reward and support for that role. All surgeons with an interest in surgical education and training can join, regardless of College affiliation or specialty. The Faculty seeks to champion the vitally important role that surgical trainers play in the delivery of effective safe surgical care. One highly visible method of promoting the importance of surgical trainers is the faculty's tiered membership structure. Surgeons with any degree of interest can join the Faculty as an Associate. Those who can demonstrate engagement and achievement in relation to surgical training can join the Faculty as Members or Fellows. The award of Membership or Fellowship confers the post nominals MFST(Ed) or FFST(Ed), a clear badge of honour reserved for the best surgical trainers.

Surgical training is evolving, and we need an army of engaged and rewarded trainers to deliver this training. Being a good trainer is not something that can be delivered in our spare time – we need dedicated time and resources to deliver this. As surgeons we all need to stand up for quality training, and to ensure that being a trainer is valued properly, rewarded appropriately and performed with excellence.