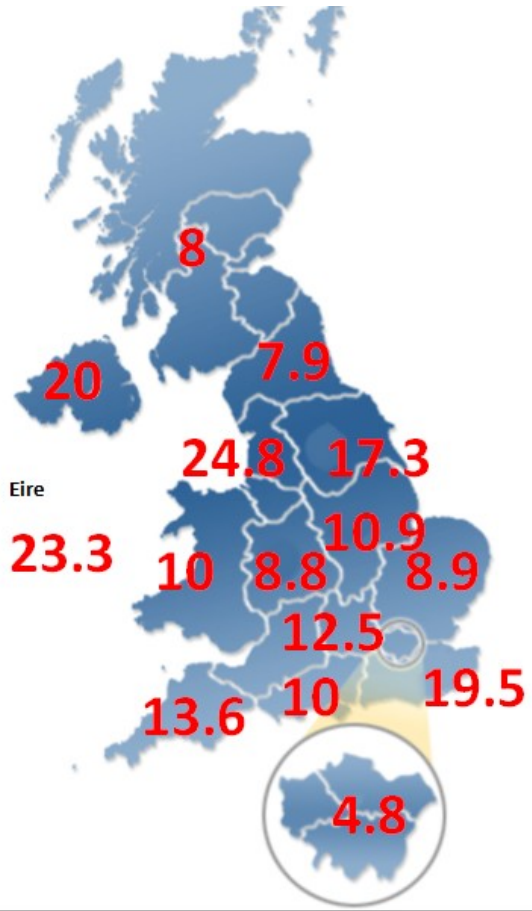
JCST
Joint Committee on Surgical Training

Specialty Advisory Committee
Trauma & Orthopaedics

As part of its routine business, the SAC receives reports from many different groups including the intercollegiate board. Mostly these reports are fairly routine, but the report that we received recently from the intercollegiate board drew our attention to a potential problem looming on the horizon.

ISB | INTERCOLLEGIATE SPECIALTY BOARDS
and Joint Committee on Intercollegiate Examinations

The exam board are getting increasingly concerned about the obstacles that are put in the way of current and aspiring examiners. Some trusts are not granting professional leave to allow examiners to attend examinations, forcing examiners to take annual leave in order to examine. The fact that people do this is a measure of the dedication that examiners have, but this is unsustainable in the long term. 9:1 contracts, and a focus on local targets, also make it difficult for examiners. The net effect is that over the last few years the exam board has had difficulty in recruiting potential examiners.



Examiners / 100 trainees. National Avg = 12

In itself, the above is clearly worrying, but the last 2 years of recruitment have seen a significant increase in the numbers of trainees appointed, and therefore in 3-4 years one can anticipate that there will also be a significant increase in the number of people all wanting to sit the exam.

Currently the exam board has difficulty in offering every candidate successful in the part one of the examination a place in the next diet of part 2. A lack of examiners, combined with a substantial increase in the number of applicants is only going to make this problem much worse.

In its report to the SAC the exam board had clearly noted a significant geographical variation in the number of examiners and had suggested to the SAC that we might wish to consider allocating trainees to regions in proportion to the number of examiners from that region. While there is a superficial logic in this approach, if enacted it would lead to significant controversy, and therefore the SAC would be reluctant to go down this line. Nonetheless the geographical variation is difficult to ignore and hard to explain. With an almost fivefold difference in the level of contribution between the least contributing and most contributing regions, the SAC believes that if we could reduce this level of variation, and bring some of the least contributing regions up towards the national average (12 examiners per 100 trainees), then we would go a long way towards addressing this problem.

Therefore, I would encourage all of you who are involved in training and who have been a consultant for a minimum of 5 years to consider putting yourselves forward to become an examiner. It's an extremely enjoyable activity that is not only intellectually stimulating, but also has a very enjoyable social aspect. Details can be obtained from the intercollegiate board website http://www.jcie.org.uk/content/content.aspx?ID=23 . Please apply, the exam is the ultimate quality assurance of training and therefore every trainer should aspire to being an examiner.

EXAM REFERENCES: While on the subject of the exam, the ISB report also updated the SAC on the pass rate in the recent diets of the exam. These showed that while the overall pass rate was 80% and 60% for parts 1 and 2 respectively, that there was a significant difference between the success rate for those in training and those out with training. There are probably many reasons for this, not least of which is the difficulty that those not following a structured training programme have in gaining clinical experience covering all areas of the curriculum. If, for example, a candidate has not gained experience in paediatric orthopaedics they cannot expect to have the same chances of success in that part of the exam as a candidate who has had such experience.

The view was expressed at our meeting that, because it is difficult to refuse to give a reference for the exam, some applicants out with training were being signed up for the exam before they were truly ready.

I would therefore encourage all those who sign exam references on applicants who are not in training to consider carefully whether or not the applicant has reached the standard of a day one consultant. They should consider this not just in relation to the areas of the applicants experience that they are familiar with, but against the whole breadth of the curriculum. No one likes to fail an exam so one really isn't doing anyone any favours by signing them up for the exam before they are truly ready. It's far better to have the difficult conversation and say that you really don't think they are quite ready and then give them guidance on how to be more ready. The number of times an applicant can sit the exam, and over what time frame, is limited to a maximum of 4 attempts at each section over an 8 year period with no right of appeal.

THE GAP BETWEEN CCT & CONSULTANT APPOINTMENT: The management and supervision of doctors between CCT and taking up a consultant appointment was discussed at the recent SAC meeting. This had been put on the agenda on the basis of an individual case that had come to the chair's attention. The SAC chair therefore wanted to know whether or not liaison members were aware of other issues in relation to doctors in this gap period. From the ensuing discussion it was clear that members were aware of some issues relating to doctors in this phase of their careers. It was agreed that some guidance was required on career management for this period.

It was felt that trainees needed to be reminded that they are re-validated at the time of ARCP outcome 6 and therefore that from that time, the clock starts counting down towards their next revalidation in 5 years' time. It is therefore important that a portfolio is maintained not just from taking up a consultant appointment, but **from the end of training**. That portfolio should include (among other things):

- A continuing logbook. (The SAC are aware that some trainees give up the chore of keeping a logbook at the point of CCT.)
- A personal development plan continuing forward from ARCP outcome 6
- Records of annual appraisal meetings. (Doctors working outside the UK in this phase of their careers, and who plan to revalidate within the UK, will find guidance about the process on the GMC website.)

LOGBOOK UPDATE: The SAC discussed a minor change to the recording of olecranon fractures in the logbook. When the logbook was set up fixation of olecranon fractures, other than by tension band wiring, was extremely uncommon. Not only that but there was no concept of indicative numbers. As it exists therefore there is only one term for olecranon fracture fixation which is: Olecranon fracture ORIF. This term maps to the indicative number for tension band wiring. Theoretically therefore if you have used a plate to fix an olecranon fracture it still counts towards the indicative number of tension band wiring. The SAC felt that the key element of the indicative number was actually the technique of tension band wiring rather than the location of the fracture, and therefore that the term "Olecranon fracture ORIF" should be separated into 2 terms: tension band wiring of olecranon fracture; & other fixation of olecranon fracture. These changes were made in the logbook in early January. All cases previously entered under the old term of Olecranon fracture ORIF will continue to map to the indicative number for tension band wiring so your totals there will not change.

The SAC has also had discussions about "unbundling " of cases in the logbook and filling a logbook with lots of small procedures such as joint injections. An example of unbundling is where, at one procedure, a patient has a 1st metatarsal osteotomy, combined with an Akin's procedure and a soft tissue correction. Unbundled, this is recorded in the logbook as three procedures rather than one. For this example, which clearly relates to the index number for 1st ray procedures, the SAC view

was that unbundling was inappropriate. In general it was felt that the appropriate principles to follow, wherever possible, were those of the private insurers clinical coding schedule development group (http://www.ccsd.org.uk) .

Similarly the SAC felt that inflating logbook numbers by the inclusion of large numbers of minor, often out-patient procedures such as joint injection, was inappropriate, and will be introducing upper limits for the number of such procedures that can be counted in a logbook.

QUALITY INDICATORS: The quality indicators for surgical posts are regularly reviewed both by the SAC and the JCST quality assurance group. As part of its review, the JCST group had identifies 2 inconsistencies between the T&O posts quality indicators and those of other specialties. They had asked us to consider incorporating the indicator used in other specialties that related to the attendance at multidisciplinary team meetings on a weekly basis. Some discussion took place in relation to what constituted MDT meetings in T&O, as in other specialties this most frequently relates to working with oncologists et cetera. The SAC agreed to the inclusion of this QI for T&O posts but this will include the phrase "MDT meeting or equivalent" as we would like people to take a broad view of what constitutes an MDT meeting, including such things as meetings with radiologists, geriatricians, and plastic surgeons.

The other QIs that JCST had asked us to look at related to the number of fracture clinics that we would expect a core surgical trainee to attend. Currently QI 15 for core surgical trainees in T&O units states that; trainees should be allocated to units that ensure attendance at a minimum of 20 fracture clinics in 6 months. This will be amended so that it reads an average of 1 fracture clinic per week.

CCT guidelines: The CCT guidelines are also reviewed on a regular basis, and we discussed a minor amendment in relation to these guidelines for research. The minor modification which was agreed relates to the 2nd bullet point in these guidelines which currently reads "evidence of the screening/recruitment of 5 patients into an RTC approved study". It was agreed that what was meant here was "screening **&** recruitment" and therefore the / will be changed to an ampersand. This change will appear in the certification guidelines from August of this year.

CLARIFICATION: Finally, I would like to apologise for publishing, in my 2nd last newsletter, a graph which, when enlarged significantly on screen, allowed the identification of individual training programmes. It should have been made clear that when the SAC received this data, the data came with a "health warning" in relation to the data concerning one programme. The methodology of the study combined with the stages in training of the trainees on that programme produced data which falsely suggested that trainees on that programme had difficulty in reaching their indicative numbers. I would wish to make it clear that the SAC has no concerns about any particular programme.