

Thereafter the technical training that takes place during higher specialist training will be devoted to acquiring experience in the use of these techniques for specific operations. The Specialist Advisory Committees (SAC) are in the process of revising their training requirements to include far more detailed descriptions of the form and extent of this experience, which will be monitored by reviews of log books, personal audit, regular formal annual trainer assessments and an examination.

Completion of this course of supervised higher specialist training will be acknowledged by the award of a Certificate of Completion of Specialist Training (CCST). This will indicate the specialty in which the trainees may practise independently as consultants and the range of technical procedures they are trained to perform – without being individual procedure specific.

New techniques and procedures that are developed after an individual's training has been completed will be dealt with by the continuing professional education programme (see Section 3).

## **2. Certification**

The certificate referred to above (CCST) will define, by reference to the SAC requirements, the experience of the trainee. It will, therefore, identify many of the technical procedures in which the trainee is competent, but cannot identify every procedure because of the enormous variability between patients and the operations they need. Thus it will be specialty-specific not procedural-specific. The profession is opposed to procedural-specific credentialling by either the Royal Colleges or employers (Trusts, Universities or Directly Managed Units) because it is impractical, bureaucratic, based on training that may have occurred years ago, restrictive of innovation and does not reduce the incidence of medical mishaps.

Certification of the ability to use the common forms of instrumentation used by all surgeons (ie technique-specific certification) will be an integral part of the basic training assessment.

We believe that the training (and therefore certification) of consultants in techniques that are developed after they have completed their training can only be effectively ensured, monitored and certified by a controlled system of continuing professional education, audit and recertification.

### 3. Continuing Medical Education

All the Colleges are introducing programmes of continuing medical education with five-yearly recertification of participation and satisfactory completion. They wish the register of this certification to be held and published by the General Medical Council.

The education will include personal study, personal audit, peer review, teaching, attendance at courses and lectures – all with guidance on learning content and self-assessment systems. The Specialist Associations will set the syllabus and provide much of the education, the Colleges will monitor and record the process, approve the standards, and advise the GMC on recertification.

The profession believes that new techniques should be dealt with in the following manner:

- a. New techniques must be detected, through literature, communication and conference reviews, when they are first made public.
- b. If a technique is considered by the profession to be sufficiently novel as to require special training and assessment before being introduced into general clinical practice, its initial use should be controlled and limited to a number of specified centres for clinical trial. The Colleges are now devising the mechanisms for achieving such control.
- c. During its trial the methods of training and the training requirements should be developed and defined.
- d. When its value is proven, all consultants who wish to use it will be required, as part of their CME certification, to show evidence (certification) of learning via the prescribed courses and by working with surgeons in the trial centres already skilled in the technique.

At the same time, a similar requirement will be included for trainees in the SACs' training regulations. Once a new technique is adopted for general use, proficiency in its use will become part of the basic surgical skills assessment.

The process described above is similar to that in current use when a new drug is developed. The problem for surgeons will be the definition of what is sufficiently new and different from existing practice to demand such control.

Most technical developments are simply minor improvements on an existing technique. Laparoscopic cholecystectomy, however, is an example of a technique that should have been treated in this way.

The Colleges do not believe that legislation is required to introduce such a system, provided that proper participation in CME is expected by all – the public and the employers – and new techniques are not introduced into general practice before the Colleges, Associations and the Department of Health's Research and Development Unit give their approval.

#### **4. Audit**

Quality is assured by constant audit of personal and group practice. The surgical fraternity has been the leader in this field and will continue to demand audit as a function of all surgeons who teach and train and as an element of continuing professional education.

One of the factors affecting quality is experience. A surgeon who performs a specific operation once or twice a year is unlikely to be as experienced, and therefore as competent, as a surgeon who performs the same procedure 30 times a year. The profession is in the process of producing guidelines that will indicate the degree of personal experience required by consultants to remain clinically competent and to ensure adequate clinical and nursing experience for their supporting team.

Personal and unit audit will reveal whether surgeons are getting the necessary degree of experience. The audit section of a surgeon's CME feedback will indicate whether or not it is right for that surgeon to continue performing certain procedures. The implication of this approach is that rare conditions and rare operations should only be seen and treated in specialist centres.

#### **5. Facilities and Resources**

Good surgery needs the correct facilities and adequate resources. The Colleges regularly inspect hospitals that train junior doctors and when necessary draw attention to any inadequacies that restrict or reduce the quality of training. We believe it is incumbent upon the management of all hospitals to supply the facilities required for training as well as the facilities needed (equipment, buildings, support services and manpower) for proper high quality surgical practice.