

Changes in surgical training in the United Kingdom and the possible consequences for African trainees

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Over the past 50 years, Britain has increasingly failed to meet the training needs of Africa's surgeons. It has always been difficult to overcome the bureaucratic hurdles of registration with the General Medical Council and the obtaining of visas. Now, even if these are overcome, I have to declare that Britain can no longer offer training in the wide generality of surgery that is required for the surgeon who will work in Africa.

Since the second World War, Britain has moved steadily towards a more specialised type of surgical practice and this has accelerated recently. This has produced increasingly distinct courses of postgraduate training whose aim is to produce surgical specialists, such as orthopaedic, urological, plastic and cardiothoracic surgeons. The 'speciality' that is now general surgery, is itself being fragmented into the subspecialities of coloproctology and vascular, upper gastrointestinal, breast and endocrine surgery. Orthopaedics is now divided into surgeons who specialise in hand, spinal or shoulder surgery to quote but a few. There are many in Britain who doubt that any improvement in the delivery of surgical services will result. Each surgeon must have a narrower range of skills than his predecessor and thus more must be appointed to deliver a full service to any region. Unfortunately, the numbers of trained surgeons are too few and the money in the health budget is too little for this to occur.

If these worries exist about the provision of services for non-metropolitan areas of a relatively rich developed country such as Britain, then how much more relevant are they to the countries of

East and Central Africa whose populations live largely in rural areas which are served by far fewer surgeons?

Africa, of course, needs all but a few of its surgeons to be generalists capable of dealing with all common pathology, broken bones, urethral strictures, skin grafting, head and chest trauma and, amongst other things, abdominal pathology. Since the second World War this wide experience has not generally been available in Britain to the surgical trainee, no matter whether he was home grown or from overseas. A few individual trainees may have been fortunate enough to have acquired successive short-term appointments in orthopaedics, urology, plastic surgery and neurosurgery but these will have been few amongst the overseas trainees for their eyes were on other prizes.

Their eyes were focused on the Fellowship (FRCS), the surgical diploma awarded by any of the four surgical colleges. In the old days, possession a Fellowship was little short of a guarantee that their employers back home would interpret that its owner was capable of independent surgical practice and worthy of instant promotion to consultant. In Britain, however, the FRCS was accorded a rather different status. There it certified to the colleges and employers alike, that its holder was qualified to BEGIN higher or advanced surgical training which in most cases would take at least another four years. If the FRCS ever had any relevance to African surgery, then it was during the last years of colonialism and in the early years after independence. Then there was no 'home-grown'

certification of surgical training and the FRCS at least provided evidence of a certain level of knowledge and, equally important, evidence of the desirable personal characteristics such as determination, ambition and the capacity for prolonged focused study. Moreover, in those earlier times, the majority of African trainees were sponsored by their governments and had earned their sponsorships only after several years of satisfactory work in supervised posts in the largest of their countries' hospitals. In such cases, the FRCS was being used to set the seal on home-based, and therefore widely-based, training that had already been judged satisfactory by the local surgical hierarchy. Those few individuals who gained a FRCS after a sponsorship gained by political or personal preferment rather than by an excellent surgical apprenticeship, tended to reveal the inadequacies of the FRCS in being the lone definition of surgical competence.

The development of the MMed programme is welcome notwithstanding its fragmented national basis at present. Though it has developed rapidly to produce a system of certification of surgical training that is more appropriate to Africa the British Royal Colleges still tempt some trainees. It is appropriate to summarise what they have to offer and to describe some of the difficulties that the trainee from overseas will face.

Postgraduate training in Britain

The British health service is hugely dependent on overseas trainees who provide the bulk of its junior doctors. Notwithstanding the fact that all training programmes are designed specifically to meet European Community (EC) objectives, the majority of immigrant doctors are from non-EC countries (Table 1).

TABLE 1 GMC registrations 1996

ORIGIN	DOCTORS
Non - EC	12,962
EC	2,679
UK	3,961

All immigrant doctors must pass the Professional and Linguistic Abilities Board (PLAB) or be sponsored by a Royal College.

In Britain in the past six years, there have been huge changes in the structure of specialist training. This has been fuelled by the bureaucratic need to obtain equivalence into the routes of entry into specialist training throughout the EC. It fell to the CMO, Dr Calman, to introduce these changes in the early 1990s. It may help this explanation if I compare the situation before these changes with the situation today.

Pre-Calman era

Until the early '90s, overseas trainees had a four-year limit on their visa. After gaining PLAB or being sponsored by a College, they then undertook a variable period of training as SHOs before, if fortunate, obtaining the FRCS. This allowed them to proceed to higher surgical training (HST), as registrars but most were able to complete only 1-2 years of this before their visas expired and they had to return home. Though the period of HST was inadequate, there were the compensations that there were plenty of suitable registrar posts available and, of course, the FRCS had been obtained. Then after Dr Calman's changes came the ...

Post-Calman era

The UK had been told by the EC that its accreditation of medical specialists was illegal. Not only did it not possess an exit exam but, since it relied on proof of satisfactory progress through approved posts, this could be thought of as being discriminatory against overseas candidates from the EC such as Greeks. Dr Calman decreed that completion of specialist training had to be defined by an exit exam that was equivalent to those in other EC countries. He asked the Royal Colleges to re-look at their exams and they decided to establish the FRCS as the exit exam, as a licence of surgical competence.

Entry to HST would be by candidates successfully completing approved Basic Surgical Training (BST) and passing the MRCS/ARCS exam. Not for the first time the Edinburgh College chose to distinguish itself from its sister Colleges. Whilst they all agreed that the BST exam should be named the Membership of the Royal College of Surgeons, (MRCS), Edinburgh chose to retain some of the allure of the FRCS by calling their exam the Associate Fellowship of the Royal College of Surgeons, (AFRCs). On one thing the colleges were

all agreed: this BST exam was not to be regarded as a diploma to certify that overseas doctors would then be capable of independent practice when they returned home.

HST now lasts for six years and leads to the FRCS examination. This is now a speciality examination, so there is FRCS (Urology) and FRCS (Orthopaedics). All HST is therefore specialised and the trainee must choose his speciality before entering HST. Time spent in one specialty HST programme will not count towards HST in another speciality. All entrants to HST must begin by entering the 1st year of training.

The overseas trainee

The overseas trainee has always had many hurdles to overcome; GMC, PLB, visas and job interviews. Most of these remain but now, post-Calman there are others;

- 1 almost all trainees, (for exceptions see next section), must do BST and at present that can only be done in the UK,
- 2 there are no Royal College sponsorships for BST,
- 3 there is a shortage of HST posts - this has been exacerbated by the college's insistence that there must be a 2:1 consultant/trainee ratio. Thus a hospital with 5 consultants that in the past had 3 training posts may now have no more than 2. Stringent criteria in the definition of a HST post further limit the number of training posts; all HST posts must contain only work in one surgical speciality. Hence, registrar posts that contain, for instance, general surgery and urology, (these are not uncommon amongst consultants who were appointed more than 10 years ago), are judged to be unacceptable as HST posts in either general surgery or urology!
- 4 entry to HST must be at year 1 - whatever the previous overseas experience.
- 5 finally the FRCS will now only be awarded by exam which will take place in the 6th year of HST.

But if, in spite of this, the overseas trainee wants to obtain the FRCS how may he achieve this?

He has no choice but to enter BST. There is no exemption from this and the colleges have decided not to sponsor trainees at this stage. Before he can apply for an SHO post he must pass the PLAB, which can be sat either in several cities of the Indian subcontinent or in London. Then he must pass the International English Language Testing System, (IELTS) and obtain a visa. Visas are now offered to doctors for five years and are extendable. Armed with all these he may now apply for a BST post, (which is always an SHO post), but he must be prepared to find that these are hotly competed for. One hears of 150 applicants for one post!

After 2-3 years of BST posts, the trainee may be fortunate enough to pass the MRCS/AFRCS examination. Then he must try to obtain, from the Postgraduate Dean, a Visitor Training Number, (VTN), which then entitles him to apply for a HST post. Unfortunately the number of VTNs is declining due to the tendency to convert them into training numbers for the home trainees of whom there are many more qualified to enter HST than there are posts available to accommodate them.

Application for the HST posts is, therefore, another very competitive area but, if the overseas trainee is successful he can be assured that he will be allowed an extension to his visa when one is required. He may then concentrate on his training and should pass his FRCS in the 6th year of HST. He will not, however, be allowed entry to the UK specialist list and may not, therefore, practice as a consultant in the UK. It is expected that the trainee will then return home. Although the possessor of a FRCS, which has been properly reinvented as an exit exam, it will, I submit, be no more appropriate for the surgeon in Africa than was its predecessor, for this FRCS is a certificate of competence in a surgical speciality rather than the 'generality of surgery'.

If the overseas trainee wishes to train in the UK but chooses not to aim at acquiring a FRCS, then other options are available to him. There is what is known as a Fixed Term Training Appointment (FTTA). This aims to be more tailored to the needs of the trainee who wants to undertake part of his training in the UK.

Fixed term training appointment (FTTA)

Candidates for a FTFA are usually nominated by their employer or head of department in the country where they have done most of their training and each must show that they have acquired a standard of training equivalent to BST, i.e. that required for entry to the specialist training programme. These posts are appointed by the postgraduate dean of the region in which training will occur and they are not appointed in competition with candidates from the UK or EC. All candidates are required to take the IELTS but PLAB is not required. Interviews are not required for overseas candidates to be selected but on arrival in the UK there will be an assessment of the candidate before he takes up the post. No FTFA can lead to the acquisition of specialist registration in the UK. Appointment to an FTFA is for a period which may be extended, on evidence of satisfactory progress, for up to 3 years.

Type IIa FTFA's are designed for very experienced trainees who require relatively short periods (of up to one year) of training at an advanced specialist level. Type IIb FTFA's are for less experienced trainees who would generally be offered an acclimatization period as an SHO prior to their transition, after a satisfactory assessment, to a HST post for 1-3 years. It can be seen that even in this area of FTFA's, which may be thought to have been designed with the overseas trainee in mind, that there are problems enough to tax all but the most determined of trainees. For instance, the Royal Colleges have not yet designated any hospital posts in East and Central Africa which they would recognise for higher surgical training, nor have they pronounced yet on whether the MMed(Surg) will be judged by them to be equivalent to completion of BST. In any event, the African trainee will definitely need the support of a departmental head who has influential surgical friends in the UK. Access to a FTFA will, I predict, only be achieved by those who can be supported by an enthusiastic reference from his departmental head, to which is added the practical support of his proposed trainer

in the UK, who must work closely with his postgraduate dean.

In closing this summary, I must emphasise that these training plans of the colleges have been evolving rapidly over the past 10 years and I do not think that a stable state has yet been reached. The changes that have occurred have been coordinated by joint committees of the four colleges and agreement has been reached on the structure of BST and HST. The exit exam, the FRCS, is awarded by all four jointly and is now known as the Intercollegiate FRCS.

But strains exist in this intercollegiate body and the Edinburgh college is beginning to pull away a little. It has recently begun holding speciality FRCS exams in Hongkong and is considering holding the exam in other countries. It, alone among the colleges, is planning to hold its BST exam, the AFRCS, outside of the UK. It is also thinking of introducing a new FRCS which is more broadly based on the non-specialized 'generality of surgery', aimed at the surgeon who is working in the developing world. They plan to make this exam open to those who may have never worked in the UK and there would be an overseas venue for the exam. Entry to the exam would be by the AFRCS or its 'equivalent'. Some in the college feel that candidates should be given the opportunity to work in Scotland but this has not yet been decided.

Though all of this may be depressing to read for the trainee wishing to obtain training in the UK, it may strengthen the argument of those who, like me, feel that East and Central Africa is the best training ground for surgeons who plan to work there. The re-invention of the FRCS as an exit exam, and a very specialised one at that, has rendered it totally inappropriate for Africa. The time is ripe for East and Central Africa to coordinate the several excellent MMed programmes with the aim of replacing them with a diploma that is recognised throughout the region as combining the best of all possible options.