The Journal of Laryngology & Otology
November 2000, Vol. **114,** pp. 817–820

The Future of ORL-HNS and Associated Specialties Series

Quality issues in otorhinolaryngology: Part I

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Key words: Otolaryngology; Quality Indicators, Health Care

A high quality, comprehensive healthcare system has been the hallmark of the British NHS since its inception over 50 years ago. However, in recent years, the public has increasingly been alerted to instances of lack of quality in service provision which, in turn, has stimulated politicians to be more pro-active in this area. Thus an apparent lack of quality, in comparison to other countries in the outcome of cancer treatment, has resulted in large sums of money being diverted to 'correct' this. This is done without first examining what the deficiencies in the service are, and then directing finance towards these aspects specifically. Gross medical malpractice of a few practitioners has also recently been highlighted, stimulating the profession, which has until now been responsible through the GMC for maintaining standards, to re-examine their system of identifying and investigating all such potential cases. It is interesting that, in some of the more recent examples, problems were identified but not dealt with during the specialist registrar (SpR) training of the consultant concerned.

Otolaryngologists, through their professional association and the Royal Colleges of Surgeons, have a duty like other specialists, to help define what quality standards should be set in training and service provision, and to ensure these standards are being met. The major caveat that has still to be accepted by politicians and managers is that achieving quality is time-consuming; specialists' time being an increasingly finite resource within the NHS. Monitoring is also time-consuming and has to be done by groups rather than individuals to avoid bias. The number of individuals who have the inclination and time to do this monitoring is limited, and they themselves have to be trained and motivated to do it. This editorial and the subsequent one in the December issue will examine quality issues in training and service provision in otolaryngology. In these the current quality standards are identified and the existing systems to monitor them are examined, highlighting their strengths and weaknesses and suggesting how they might be improved.

Quality issues in training and continuing professional development (CPD)

Selection of specialist registrars

The object is to appoint to specialist registrar (SpR) training posts, individuals with the aptitude and skills required for self-governing consultant otorhinolaryngological (ORL) practice in the UK. Currently appointments are made to a Region, on behalf of the post-graduate dean, by a committee of local ORL trainers, supplemented by University, College, and Specialty representatives depending on the region. Such appointments are taken seriously, because appointment to an SpR post is in effect an appointment to a UK consultant post, fewer than one per cent failing to complete their training satisfactorily.

The main problem facing such committees is the large number of applicants, with curricula vitae that are almost indistinguishable as the majority are within two or three years of graduation. A short-listing committee reviews the applications against a tick list of necessary and desirable qualities. These qualities can be easy to identify (for example, GMC registration), sometimes difficult to work out (e.g. length of time in ORL) or open to considerable variations in judgement (e.g. demonstration of an interest in research). Unfortunately it is this last type which usually is used to cut a bundle of over 30 applications to an interview list of five or six.

The interview committee then assesses the short-listed applicants, spending an average of 20 minutes each discussing their CV with them. This may help identify their comparative strengths but not their weaknesses which are usually only identified after two-to-three years of training within a programme.

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https://doi.org/10.1258/0022215001904130 Published online by Cambridge University Press

The problems that are subsequently identified, and which make one re-think the efficacy of the selective process, are most commonly ones of poor interpersonal relationships with colleagues and paramedical staff, lack of maturity and poor decision-making on clinical matters, rather than a lack of manual dexterity. Hence, attempting to improve the selection process by having 'certificates of competence' from surgical skills course would seem to be of marginal benefit.

One avenue to investigate is that used in commerce, where over several days of interviews and team-working, an applicant's aptitude for leadership, decision-making and interpersonal relationships are scored. Whether this expensive process would improve the selection of medical trainees has not been assessed but should be explored. It could be more cost-effective in that the expensive litigation associated with appointing a candidate who turns out to be inappropriate is avoided. This requires a long-term financial view to be taken by different budget providers which, on past experience, does not happen within the NHS.

What does require improvement is the review process during the early years of training. All appointments could initially be to a one-year LAT (locum appointment for training) post, following which more detailed references would be available from the trainee. The problem is that once appointed to an SpR post, even if weaknesses are identified early, a period of more closely supervised professional development will usually modify these sufficiently for the learning objectives set to have been achieved. Indeed, the ethos of the system is that it should not fail. However, many would still prefer not to have made the mistake in appointing such an individual in the first place.

Specialist registrar training in ORL

The object is to train individuals to a level of competence to allow the self-governing, general practice of ORL, managing patients with common conditions in ORL's component areas of otology, rhinology, phoniatrics, head and neck surgery and paediatric ORL. The national standards of competence that trainees have to achieve are continually evolving, primarily through the Specialty Advisory Committee (SAC) in ORL but also through the Intercollegiate Examination Board. These standards are now having to be rethought because of an increasing demand for sub-specialty training in years five to six. This move is being led by the Head and Neck Interface group, consisting of otolaryngologists, plastic surgeons and maxillo-facial surgeons, and set up by the surgical colleges. This group will supervise selected trainees from each of the specialties training in interdisciplinary teams managing head and neck cancer. Acceptance of this is likely to lead to the general ORL surgeon being limited to the diagnosis of head and neck cancer and to performing non-oncological head and neck surgery e.g. parotid surgery. Sub-specialty training in the other aspects of ORL is currently being instituted by the SAC. This requires clarification of those competencies required for specialists in each sub-speciality and clear distinctions of what generalists are expected to do. These competencies will not be defined surgically but in terms of an ability to manage a patient with a specific condition. Thus, for example, competence will be defined as 'ability to manage a patient with otosclerosis' rather than 'able to perform a stapedotomy'.

The *advantages* of the recent restructuring of registrar training (initially 'spin-doctored' as necessary to fit more closely with the European pattern but now quite clearly leading it) is that, throughout the UK, standards are more uniform. Regional training programmes have been clarified and a trainee's rotation between centres is now more often driven by each trainee's specific training requirements. This helps to ensure that there are no deficiencies in an individual's training. The *disadvantages* are considerable. Once appointed, many trainees soon become complacent and lack motivation. This is usually most evident by a dramatic fall in their interest in research and audit, but also by failure to attend post-graduate meetings in the evenings. Regular audit is an essential requirement for all practitioners, (this will be discussed later in monitoring of the quality of service provision) and it is relatively easy to identify whether audit is being done to a satisfactory standard. Trainees are paid, *inter alia*, to undertake audit. The same applies to research. A trainee's progress in clinical decision-making is less easy to assess but must be attempted. Progress is assessed yearly, usually by a sub-committee of the Regional training committee along with a SAC member, who has specific responsibility for that Region. The trainee is interviewed, there being an up-to-date curriculum vitae and a report from their current trainers to guide this. At the end, a Record of In-service Training Assessment (RITA) is finalized, with a grade that is discussed with the trainee. At present, failure to perform is almost invariably identified too late in training and handled in a conciliatory manner. This should change. Too often progress is reported by trainers to be satisfactory when doubts about some aspect should be raised. Even though the progress report now has to be signed by all the current consultant trainers, to suggest that there is a deficiency and that nothing has been done about it reflects poorly on the trainers. What would be better is a form that requires them to list a trainee's strengths and areas for improvement. Objectives for the subsequent year can then be better set and guided by the ensuing set of trainers. Subsequent poor performance has then to be acted upon firmly. For example, the non-completion of a satisfactory audit by a SpR during the previous year, should automatically increase the length of that individual's training. It is currently a minimum of six years. It frequently should be longer. Quality issues here should override other considerations such as the need to vacate SpR posts.

Although the standards of training throughout the regions are now more uniform, they are probably on average no better. The centres that in the past were sought out as particularly good centres in which to train are now incorporated into regional rotating programmes. This has demotivated these centres who can no longer choose their own trainees and has made it more difficult for the motivated trainee to train themselves to a high standard by being appointed to these centres. Fortunately, both these weaknesses may potentially be overcome by the SAC's development of sub-specialty training slots in years five to six.

Standards of training can still be materially improved. The SAC, in their five-yearly regional visits of hospital inspection, focus primarily on the *process* of training rather than its *quality*. Thus considerable attention is paid to the details of a trainee's weekly programme and the ratio of trainees to consultants. Whilst this is important, little or no attention is given to whether the consultant trainers are providing a quality service that can be taken as an example of good practice. This will almost certainly be easier to assess in the future with the requirement for consultants to be revalidated in their practice. In the meantime the SAC could be more pro-active in this regard and it would not be difficult to do. They could, for example, give advance warning that for a visit, consultants would each have to submit a recent audit of their practice for them to continue to be certified as an accredited trainer.

Certification of completion of specialist training (CCST)

The surgical colleges, through the relevant SAC's are responsible for the award of a CCST. Several criteria have to be satisfied; passing of the Specialty examination in Otolaryngology, completion of a minimum of six years of SpR training and satisfactory reports of progress from the local trainers. At present around 20 per cent of SpR's fail the exit FRCS exam at their first attempt. This almost invariably comes as a surprise to their trainers, who are often even more surprised to hear which component of the assessment they failed. Intercollegiate examiners are no less likely to be surprised to hear of 'their' trainees failing. There is obviously a mismatch between the examiner's assessment and the trainer's assessment which should not be put down to the SpR's performing badly in an exmination situation. Communication and decision-making under stress are important attributes for clinical practice. The mismatch is not in the academic oral, where the candidate's ability to evaluate the literature is assessed, because nobody has yet to fail the examination on this component alone. The three clinical vivas assess the candidate's basic knowledge and their ability to apply it in a theoretical clinical context. Candidates usually do not fail these vivas due to lack of knowledge alone. The 'practical' in operative surgery and audiology assess knowledge of anatomy, ear surgery skills and the ability to perform basic audiometry. It is not uncommon in the surgical skills part of the exam, for the examiners to report gross incompetence that would make the surgeon 'dangerous'. It is also surprising that this should be one of the commonest components that trainees fail. It is of considerable concern that there is currently a shortage of cadaveric temporal bones, on which trainees can hone their surgical skills, to decrease the likelihood of damaging important structures in their patients.

Could the mismatch be because of incompetent examiners? The examiners only examine on an area of their specialty which they practise. They are usually appointed as examiners because they are considered to practise quality medicine but this is by no means consistent. Attendance at a day course for examiners is compulsory, but there is no formal assessment of the quality of examination techniques displayed in the actual examination. There is the self-regulation of examining in pairs, but it is difficult to be consistent over three days of examinations. Questions that seem inappropriate to a co-examiner the first time, gradually become easier as the other examiner adapts to the answers. Subtle observation and monitoring of an examiner's marking is also done but what is done with these data is uncertain. A more formal and explicit system needs to be considered.

Despite these weaknesses, the major mismatch is probably in the trainer's assessment of a trainee in everyday practice. This is usually done informally and attitudes to clinical competence can be influenced by gender, pleasantries and getting the job done without too many calls on the trainer's time. Trainers, if they more formally assess competence by taking the time to do mock vivas, can be surprised to detect large areas of clinical practice where the trainee is deficient.

There are moves to supplement or even substitute the exit examination with continual, i.e. yearly, assessment of a trainee's progress. This would have to be done more formally than at present, over a longer period of examination time and include external assessors. Broadening the scope of the current exam to include a 'clinical' part would probably do little to improve the sensitivity and specificity with which weak trainees are detected.

Continuing Medical Education (CME) in Continuing Professional Development (CPD)

For most otolaryngologists, in the immediate future Continuing Medical Education (CME) will be the major component of their Continuing Professional Development (CPD). This will be detailed in their personal folio and will include, amongst other things, their job description, their job plan and details of personal audit. This folio will be reviewed annually to decide on the other components of their CPD, if any, which will be based on what the particular consultant sees as furthering a special interest, which may be management, teaching or research. Targeted CPD objectives, to overcome externally identified

https://doi.org/10.1258/0022215001904130 Published online by Cambridge University Press

weakness, are likely to be part of the parallel governance procedures.

With the introduction of these folios, CME will become compulsory, but will continue to be monitored by the Royal Colleges. The 'recognized' opportunities for CME, differ between specialties and between colleges. Thus for some, writing a textbook is accredited but not for others. However, for everyone, the core component of CME will remain attendance at formally approved external and internal (local hospital and not requiring approval) meetings. However, attendance at a meeting is just that, there being no need for education to have occurred. Whether an opportunity for education occurred at an external meeting is not currently assessed when the Education Committee of the BAOL HNS grants the requisite hourly credit points, this still being rather a perfunctory procedure. Retention of feedback questionnaires from participants is required for continuing accreditation of an event, but how these forms were completed is considerably biased by whether the meeting was enjoyed, rather than whether there was a relevant learning opportunity. Thus, a well-illustrated talk with a video on some details of skull base surgery may be interesting, and enhance even more the reputation of the speaker, but it is no more relevant to the education of the average otolaryngologist, who does not do skull base surgery, than a talk on embroidery. How can this be improved? At the very least, prior to the meeting, contributors should be forced to state what the learning objectives and take-home messages are from their presentation. They would therefore have these in mind whilst formulating it and help them focus on education, rather than entertainment, although there is no harm in having the latter in addition.

The contents of the presentation should be of quality, remembering that on the recognized 'levels of evidence' of clinical management, personal uncontrolled case series and opinion are at the lowest level. Unfortunately, the majority of presentations are still of this type. Whether learning has occurred from attendance at a quality presentation of quality information is another matter, and not just a question of being awake. Learning is easier to assess at practical skills courses, where the participant does something active that is observed and perhaps criticised. Such personal involvement in CME could be extended to other areas such as tutorials and discussion groups, but even if something is learnt at the meeting this has then to be used in the home hospital setting, which is the ultimate measure of something useful having been learned. To assess this is possible, and could be part of the governance structure that will be covered in the subsequent editorial, but requires highly-skilled assessors spending a considerable amount of time.

For the immediate future, traditional meetings with presentations will be the main offering of the Sections of Otology, Rhinology and Laryngology of the Royal Society of Medicine and the other academic bodies that offer opportunities for CME, as they are cheap and relatively easy to organize. They are undoubtedly popular, perhaps because 'given the opportunity, clinicians choose educational events, that fit in with what they already know'. Hopefully, consultants will be stimulated to extend their horizons beyond this in the future when their folio containing their CPD is being annually reviewed.

Disclaimer: the views expressed in these two editorials are those of the authors and not necessarily those of any statutory bodies on which they may have sat.

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