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# BMJ Open What laparoscopic skills are necessary for the certificate of completion of training? A prospective nationwide cross-sectional survey of obstetrics and gynaecology and general surgery trainees and consultants in the UK

Zaibun N Khan,<sup>1</sup> Donna Shrestha,<sup>2</sup> Abdulwarith Shugaba,<sup>2</sup> Joel E Lambert,<sup>2</sup> Elizabeth Haslett,<sup>3</sup> Karolina Afors,<sup>4</sup> Theodoros M Bampouras,<sup>5</sup> Daren Subar,<sup>6</sup> Christopher Gaffney ,<sup>2</sup> T Justin Clark <sup>7,8</sup>

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For numbered affiliations see end of article.

## Correspondence to

Dr Christopher Gaffney;  
[c.gaffney@lancaster.ac.uk](mailto:c.gaffney@lancaster.ac.uk)

## ABSTRACT

**Objectives** To explore the views of obstetrics and gynaecology (O&G) and general surgery (GS) trainees and consultants on the laparoscopic skills considered necessary to achieve the certificate of completion of training (CCT) and identify any mismatch between consultants and trainees in their expectations of these skills.

**Design** A prospective nationwide cross-sectional study in the UK.

**Setting** A national survey distributed through Health Education, England and national training bodies such as the Royal College of Obstetricians & Gynaecologists, British Society for Gynaecological Endoscopy and the Association of Surgeons of Great Britain and Ireland.

**Participants** O&G and GS consultants and specialty trainees in O&G and GS. Specialty trainees below ST3 level and consultants performing open surgery or minor laparoscopic surgery only were excluded.

**Interventions** Trainees completed a 27-item questionnaire on their training characteristics, rated their confidence and perceived importance of 10 laparoscopic skills required for CCT using a 5-point Likert scale. Consultants answered a 36-item questionnaire on their demographic details, their views on the importance of the same 10 laparoscopic skills, their confidence and the standard of laparoscopic skills they observed among trainees approaching CCT.

**Results** 345 participants responded to the questionnaire: 117 O&G trainees, 95 O&G consultants, 57 GS trainees and 76 GS consultants. O&G trainees and consultants expected similar laparoscopic skills required for CCT for all 10 skills ( $p>0.050$ ), while GS consultants had higher expectations of GS trainees for use of endovascular devices ( $p<0.05$ ), suturing ( $p<0.01$ ) and staplers ( $p<0.05$ ). Consultants in both specialties observed that trainees were performing significantly below the expected standards;  $p<0.010$  (O&G) and  $p<0.001$  (GS) for all 10 listed skills. O&G trainees reported lower confidence than GS trainees for all 10 laparoscopic skills,  $p<0.001$ .

## STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ Largest nationwide survey of UK trainees and consultants in obstetrics and gynaecology and general surgery specialties.
- ⇒ A prospective cross-sectional study design to gain insight into UK surgical training programmes.
- ⇒ Randomly distributed to minimise selection and attribution bias.
- ⇒ Population captured was heterogeneous and therefore limits generalisability.
- ⇒ De novo study design limited power calculation, thus pragmatic dissemination.

**Conclusions** This nationwide study showed that UK O&G trainees and consultants both agree on the skills required for CCT, but GS consultants had higher expectations than their trainees. Trainees in GS were more confident in their surgical skills than those in O&G. However, consultants in both specialties believed that trainees were not achieving the requisite laparoscopic skills required for CCT.

**Trial registration number** [NCT05116332](https://www.clinicaltrials.gov/ct2/show/study?term=NCT05116332).

## INTRODUCTION

Laparoscopic surgery is increasingly practised in obstetrics and gynaecology (O&G) and general surgery (GS) as a result of advances in instrumentation and evidence supporting more rapid recovery compared with traditional laparotomic approaches.<sup>1</sup> Proficiency in laparoscopic surgery therefore forms a key aspect of curricula in both O&G and GS and is required for the certificate of completion of training (CCT).

However, studies have identified that O&G trainees lack confidence in key surgical procedures.<sup>2 3</sup> Moreover, consultants have

raised concerns about O&G trainees' surgical ability and readiness to work independently.<sup>4</sup> Postgraduate training in O&G lasts 7 years comprising 2 years of basic, 3 years of intermediate and 2 years of advanced training.<sup>5</sup> The Royal College of Obstetricians & Gynaecologists (RCOG) conducts an annual survey among all the trainees on its register, and the 2023 survey showed that only 64% of O&G trainees were able to complete their training requirements for the year. Furthermore, approximately a quarter of final year O&G trainees reported inadequate opportunities in performing gynaecological emergency procedures.<sup>6</sup>

This lack of experience may therefore have an adverse impact on patient outcomes.<sup>7</sup>

Regarding training, GS lasts 8 years and includes 2 years of core surgical and 6 years of higher specialty training.<sup>8</sup> The Joint Committee for Surgical Training (JCST) oversees the quality of training for all surgical programmes including general surgery. JCST's sixth trainee survey for 2021–2022 reported that all surgical specialties saw a drop in achieving targets for time in operating theatre, with higher specialty GS trainees achieving approximately 56% and core GS trainees achieving only 48% of the expected theatre time.<sup>9</sup> Evaluation of GS logbook records has shown that elective case records for the specialty as a whole have halved (~4000 in October 2019 to ~2000 in August 2021), and the corresponding emergency work has also dropped from 1700 to 1000 cases over the same time interval.<sup>10</sup> These reductions in operative volume and breadth of exposure in both O&G and GS elicit concerns as the quality of surgical training and the quality of care are inextricably linked.<sup>11–14</sup>

Despite an increase in training structure post-Calman reforms, trainees face both reduced working hours and shortened training programmes.<sup>3</sup> As a result, those completing specialist training tend to exhibit a more limited range of experience and skills than the previous generations of trainees.<sup>4 15</sup>

Previous studies suggest that trainees feel unprepared for CCT.<sup>16 17</sup> However, the significance of these perceptions is unknown as it is not clear what standards are required to practise as an independent consultant. In this nationwide survey, we asked trainees about their laparoscopic skills and asked consultants which skills they regarded as more important from a predefined list of laparoscopic skills.

The objective of the study was to explore the views of O&G and GS trainees and consultants on the laparoscopic skills considered necessary to achieve CCT and identify any mismatch between trainees and consultants in their expectations of these skills.

## METHODS

A prospective cross-sectional study was conducted and reported according to the Checklist for Reporting of Survey Studies.<sup>18</sup> The study was approved by the O&G and GS heads of schools from Health Education England,

North-West. The study was prospectively registered at ClinicalTrials.gov Registry (NCT05116332). The survey included O&G specialty trainees from the third year of training to the seventh year of training (ST3–ST7) and O&G consultants doing regular intermediate to advanced level operative laparoscopic surgery. Consultants doing obstetric work only or open gynaecological surgery only or minor laparoscopic work were excluded. The survey also included GS specialty trainees from the third year to eighth year of training (ST3–ST8) and GS consultants with specialism in any area involving laparoscopic work such as colorectal, upper gastrointestinal surgery and hepatobiliary surgery. Consultants doing open surgery only were excluded.

The laparoscopic skills we considered integral to attaining proficiency in laparoscopic surgery were based on skills extrapolated from the O&G and GS curricula<sup>5 8</sup> and a validated survey.<sup>19</sup> The 10 laparoscopic skills included in this survey were: the ability to gain laparoscopic access, recognise anatomy, manipulate tissue, dissect tissue planes, achieve haemostasis with diathermy, use advanced energy devices, haemostatic agents and endovascular devices, suture laparoscopically and apply staplers.

We developed two separate surveys; a 27-item one for trainees and a 36-item one for consultants (online supplemental materials S1 and S2, respectively). Trainees were asked their views on the importance of 10 listed surgical skills for the award of CCT and how confident they felt in these skills. Consultants were also asked their views on the importance of these same 10 surgical skills for the award of CCT, their own confidence in these skills and asked about trainees' possession of these skills. Consultants were asked to base their answers on trainees approaching CCT and those who were doing training modules involving laparoscopic surgery. This was to ensure that consultants provided subjective assessment of trainees who were approaching the end of training in an area relevant to laparoscopic surgery. Additional demographic data were also collected; in the trainee survey, these data included gender, type of training, stage of specialty training and employing deanery. In the consultant survey, background data included gender, year and place of CCT acquisition, the proportion of surgery performed laparoscopically and their employing NHS Trust.

The surveys were piloted on trainees and consultants similar to the survey target population to refine the design, approve the face validity of the content and improve the clarity of the questions. The pilot surveys were sent digitally through Survey Monkey (SurveyMonkey Europe UC, Ireland) to O&G specialty trainees and consultants identified through Health Education England, North-West (HEENW) and to GS trainees and consultants at East Lancashire Hospitals NHS Trust.

The two surveys were disseminated using Survey Monkey to improve accessibility, ease of completion, and to ensure anonymity. The survey could be accessed through a QR code. The O&G trainees and consultants

digital survey was distributed to all eligible O&G trainees and consultants through the RCOG, Head of Postgraduate Schools, Health Education England, North-West (HEENW) and the British Society for Gynaecological Endoscopy (BSGE). HEENW sent email invites with survey links to all trainees on their register while RCOG promoted the survey on their website and BSGE advertised the survey in their newsletter.

The GS trainees and consultants digital survey was disseminated via Survey Monkey to GS trainees and consultants via the Association of Surgeons of Great Britain and Ireland, Emergency General Surgery symposium and Blackburn Research Innovations Development Group in General Surgery conference. These organisations advertised the survey on their website and in their promotional materials.

The online platform allowed voluntary participation and confidentiality while preventing duplication of responses by identifying participants' uniform resource locator. The survey was initially planned to run over 6 months. However, due to low initial response rates, it was extended to 19 months. In addition to the digital surveys accessible via a QR code, paper copies were also printed so participants could choose their preferred and most convenient method of participation. These paper data were entered by a different study investigator to minimise bias. All data collection took place between August 2021 and February 2023.

### Statistical analysis

Demographic data comparisons between specialties were conducted using  $\chi^2$  tests. Ordinal data were analysed using Mann-Whitney U tests for comparisons between different specialty groups and levels and Sign tests for comparisons between the consultants' perceived skill level and observed skill level. The Holm-Bonferroni correction was applied for multiple comparisons, and the corrected values are reported.

Finally, to examine any association between the consultant's expectation scores for each skill and their confidence in those skills, Kendall's  $\tau$  correlation coefficient was calculated and interpreted as weak if  $<0.10$ , moderate  $0.10-0.30$ , medium if  $0.31-0.50$  and strong if  $>0.50$ .<sup>20</sup>

Data were analysed using Jamovi statistical analysis software V.2.3.18.0 (The Jamovi project, <https://www.jamovi.org>). Data are presented in raw scores and as percentages. Statistical significance was set at  $p<0.05$ .

## RESULTS

### Demographics of participants

A total of 365 trainees and consultants participated in this survey. 20 participants did not respond to all questions, precluding use of their data for the questions they did answer. Data were therefore analysed for 345 participants of which 212 (61%) were practising O&G and 133 (39%) GS. The final sample consisted of 174 (50%) trainees (117 O&G and 57 GS trainees) and 171 (50%)

**Table 1** Baseline characteristics of trainees in O&G and GS participating in the survey

	O&G n=117 (%)	GS n=57 (%)	P value
Sex			
Male	28 (24%)	24 (42%)	0.014
Female	89 (76%)	32 (56%)	
Prefer not to say	–	1 (2%)	
Specialty training			
Yes	116 (99%)	55 (96%)	0.207
No	1 (1%)	2 (4%)	
Stage of training*			
Juniors	64 (55%)	31 (54%)	0.970
Seniors	53 (45%)	26 (46%)	

\*Stage of training defined as junior if ST3–5 and senior if ST6–7 (O&G) and junior if ST3–5 and senior if ST6–8 (GS). GS, general surgery; O&G, obstetrics and gynaecology.

consultants (95 O&G and 76 GS consultants). There was a significantly higher proportion of female trainees in O&G; 89 (76%), compared with GS; 32 (56%),  $\chi^2(1)=8.48$ ,  $p<0.05$ . There was also a higher proportion of female consultants in O&G 45 (47%) compared with GS 13 (17%),  $\chi^2(1)=17.3$ ,  $p<0.001$ . The characteristics of trainees and consultants are detailed in tables 1 and 2 respectively.

### Expectations of laparoscopic skills required for working independently as a consultant

O&G trainees and consultants did not differ significantly in their expectations for proficiency in any of the laparoscopic skills required for CCT (table 3). GS consultants had significantly higher expectations of their trainees in the use of endovascular devices  $U=1742$ ,  $p<0.05$ , suturing  $U=1489$ ,  $p<0.01$  and stapling devices  $U=1678$ ,  $p<0.05$  (table 4).

### Consultant views on the expected compared with the observed level of laparoscopic skills in trainees

Consultants in both O&G and GS reported that the laparoscopic skills demonstrated by trainees approaching CCT were significantly below the expected competency level across all listed laparoscopic skills (table 5). With regards to access, 60% of O&G consultants and 78% of GS consultants agreed or strongly agreed that respective trainees were achieving proficiency in laparoscopic access. Among O&G consultants, 54% agreed or strongly agreed that trainees should be proficient in using endovascular devices, 33% for staplers and 69% for suturing. In contrast, among GS consultants, 95% expected proficiency in endovascular device use, 92% for staplers and 63% for suturing.



**Table 2** Baseline characteristics of O&G and GS consultants participating in the survey

	O&G n=95 (%)	GS n=76 (%)	P value
Sex			
Males	50 (53%)	62 (83%)	<b>0.002</b>
Females	45 (47%)	13 (17%)	
Training in the UK			
Yes	89 (94%)	63 (83%)	<b>0.030</b>
No	6 (6%)	13 (17%)	
Amount of surgery done laparoscopically			
0–25%	25 (26%)	6 (8%)	0.156
25–50%	23 (24%)	24 (32%)	
50–75%	22 (23%)	28 (37%)	
75–100%	25 (26%)	18 (23%)	
Length of experience post-qualification as a consultant			0.072
5 years	19 (20%)	14 (19%)	
10 years	32 (34%)	15 (20%)	
15 years	20 (21%)	15 (20%)	
>20 years	24 (25%)	30 (41%)	
Consultants estimated the proportion of procedures conducted laparoscopically compared with overall numbers of (laparoscopic and open) procedures. P values in bold denote significant values. Data are presented as raw numbers and percentages of the respective group's sample. GS, general surgery; O&G, obstetrics and gynaecology.			

**Trainee views on their confidence in laparoscopic surgery**

O&G trainees reported significantly lower confidence than GS trainees across all 10 listed laparoscopic skills

(table 6). Only 40% of O&G trainees expressed confidence (agreeing or strongly agreeing) in obtaining access, compared with 91% of GS trainees,  $U=1219$ ,  $p<0.001$ . When analysed by training grade, confidence among O&G trainees significantly increased with seniority, from 22% in ST3–5 grades to 63% in ST6–7;  $U=1231$ ,  $p<0.05$ . In contrast, confidence levels among GS trainees remained high across all training grades, with 90% of ST3–5 and 96% of ST6–8 trainees reporting confidence, showing no significant difference  $U=312$ ,  $p>0.05$ .

**Consultant's self-reported confidence in the listed skills and its association with their expectations**

Finally, there were significant associations between the consultant's own confidence and their expectations of trainees in respect of some of the listed laparoscopic skills. However, this pattern was mixed, and where significant, the strength of those associations was not strong (table 7).

**DISCUSSION**

Our survey found that trainees agreed with the importance of laparoscopic skills required to attain proficiency in surgical training curricula and completing their certificate of completion of training (CCT). However, our survey has shown that specialist trainees lack confidence and perceive their training in both O&G and GS as inadequate to allow them to meet the expected standards by the end of their training. This contention is echoed by consultants in both specialties who reported that the laparoscopic skills of the trainees at the point of CCT were significantly below their expectations across all key laparoscopic competencies. Thus, these concerns from both trainees and consultants raise serious concerns regarding the adequacy of current surgical training and the extent

**Table 3** Perception of laparoscopic skills required for completion of training among O&G trainees and consultants

Laparoscopic surgical skill	O&G trainees n=117 Median* (IQR)	O&G consultants n=95 Median* (IQR)	P value
Ability to obtain laparoscopic access	1 (0.0)	1 (0.0)	0.132
Ability to recognise anatomy	1 (1.0)	1 (0.0)	0.375
Ability to manipulate tissue	1 (0.0)	1 (0.0)	0.431
Ability to dissect tissue	1 (1.0)	1 (1.0)	0.559
Ability to control bleeding using diathermy	1 (1.0)	1 (1.0)	0.834
Ability to control bleeding using endovascular devices	2 (2.0)	2 (2.0)	0.489
Ability to control bleeding using haemostatic devices	2 (1.0)	2 (1.0)	0.910
Ability to control bleeding using advanced energy devices	1 (1.0)	1 (1.0)	0.070
Ability to control bleeding using suturing	2 (2.0)	2 (2.0)	0.070
Ability to control bleeding using staplers	3 (2.0)	3 (2.0)	0.393
Data are presented as median (IQR). *Likert scale: 1= strongly agree, 2= agree, 3= neither agree nor disagree, 4= disagree and 5= strongly disagree O&G, obstetrics and gynaecology.			

**Table 4** Perception of the skills required for completion of training among general surgical trainees and consultants

Laparoscopic surgical skills	GS trainees n=57 Median* (IQR)	GS consultants n=76 Median* (IQR)	P value
Ability to obtain laparoscopic access	1 (0.0)	1 (0.0)	0.679
Ability to recognise anatomy	1 (0.0)	1 (0.0)	0.679
Ability to manipulate tissue	1 (0.0)	1 (0.0)	0.938
Ability to dissect tissue	1 (0.0)	1 (0.0)	0.474
Ability to control bleeding using diathermy	1 (0.0)	1 (0.25)	0.379
Ability to control bleeding using endovascular devices	1 (0.0)	1 (1.0)	<b>0.020</b>
Ability to control bleeding using haemostatic devices	1 (1.0)	1 (1.0)	0.720
Ability to control bleeding using advanced energy devices	1 (0.0)	1 (1.0)	0.071
Ability to control bleeding using suturing	2 (1.0)	2 (1.0)	<b>0.003</b>
Ability to control bleeding using staplers	1 (1.0)	1 (1.0)	<b>0.020</b>

P values in bold denote significant values.

Data are presented as median (IQR).

\*Likert scale: 1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree and 5=strongly disagree.

GS, general surgery.

to which the CCT reliably reflects surgical proficiency for all trainees.

#### Meaning of the study: implications for clinical practice, training and policy makers

Widespread concerns regarding all aspects of training have been raised by surgical specialties, especially

core and higher training for general surgery.<sup>9 21 22</sup> These have been voiced in General Medical Council (GMC) trainee surveys as well as through the JCST surveys.<sup>9 21</sup> Barriers to adequate surgical training have been attributed to reduced training hours, lack of continuity between the trainee and the consultant as well as the increasing complexity of surgical cases.<sup>23 24</sup>

**Table 5** Proportion of O&G and GS consultants who reported a drop in the laparoscopic skills they observed compared with the standards they expected among respective trainees

Laparoscopic surgical skills	O&G consultants		GS consultants	
	n=90 % consultants reporting a drop between expected and observed skills	P value	n=73 % consultants reporting a drop between expected and observed skills	P value
Ability to obtain laparoscopic access	97	<b>&lt;0.001</b>	93	<b>&lt;0.001</b>
Ability to recognise anatomy	91	<b>&lt;0.001</b>	97	<b>&lt;0.001</b>
Ability to manipulate tissue	95	<b>&lt;0.001</b>	94	<b>&lt;0.001</b>
Ability to dissect tissue	83	<b>&lt;0.001</b>	94	<b>&lt;0.001</b>
Ability to control bleeding using diathermy	78	<b>&lt;0.001</b>	83	<b>&lt;0.001</b>
Ability to control bleeding using endovascular devices	79	<b>&lt;0.001</b>	91	<b>&lt;0.001</b>
Ability to control bleeding using haemostatic devices	83	<b>&lt;0.001</b>	97	<b>&lt;0.001</b>
Ability to control bleeding using advanced energy devices	93	<b>&lt;0.001</b>	100	<b>&lt;0.001</b>
Ability to control bleeding using suturing	71	<b>&lt;0.01</b>	85	<b>&lt;0.001</b>
Ability to control bleeding using staplers	81	<b>&lt;0.001</b>	88	<b>&lt;0.001</b>

P values in bold denote significant values.

GS, general surgery; O&G, obstetrics and gynaecology.

**Table 6** Perceived confidence of trainees in O&G and GS in laparoscopic surgery

Laparoscopic surgical skills	O&G trainees n=117 Median* (IQR)	GS trainees n=57 Median* (IQR)	P value
Ability to obtain laparoscopic access	3 (1.0)	1.5 (1.0)	<b>&lt;0.001</b>
Ability to recognise anatomy	3 (1.0)	2 (1.0)	<b>&lt;0.001</b>
Ability to manipulate tissue	3 (1.0)	2 (1.0)	<b>&lt;0.001</b>
Ability to dissect tissue	4 (1.0)	3 (1.0)	<b>&lt;0.001</b>
Ability to control bleeding using diathermy	3 (1.0)	3 (1.0)	<b>&lt;0.001</b>
Ability to control bleeding using endovascular devices	5 (1.0)	3 (1.0)	<b>&lt;0.001</b>
Ability to control bleeding using haemostatic devices	4 (2.0)	3 (0.0)	<b>&lt;0.001</b>
Ability to control bleeding using advanced energy devices	3 (2.0)	3 (1.0)	<b>&lt;0.001</b>
Ability to control bleeding using suturing	5 (1.0)	3 (1.0)	<b>&lt;0.001</b>
Ability to control bleeding using staplers	5 (1.0)	3 (1.25)	<b>&lt;0.001</b>

P values in bold denote significant values.

\*Likert scale: 1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree and 5=strongly disagree.

GS, general surgery; O&G, obstetrics and gynaecology.

The results of our survey revealed that O&G trainees reported significantly lower confidence in their laparoscopic skills compared with GS trainees. Notably, only 40% of O&G trainees felt confident in gaining laparoscopic access, compared with 91% of GS trainees. However, confidence levels among O&G trainees improved significantly in the later stages of training, suggesting that the initial lack of confidence may stem from limited exposure to laparoscopic surgical opportunities.<sup>11</sup> Interestingly, only 60% of O&G consultants and 78% of GS consultants believed that trainees were achieving proficiency in laparoscopic access. This highlights a persistent gap between the expected and actual levels of competency achieved during training. Given that successful laparoscopic access is crucial for performing minimally invasive surgery and preventing complications such as vascular or bowel injury,

addressing this gap is essential for improving surgical training outcomes.<sup>25</sup>

Despite the acute nature of O&G, the volume of operative opportunities in gynaecology have decreased over time. This is likely to be multifactorial; the number of trainees has increased,<sup>6</sup> while surgical opportunities have declined<sup>24</sup> and gynaecological surgical operations are predominantly consultant-led.<sup>26</sup> Additionally, the cases that do proceed to surgery are often complex and may not be suitable for trainee involvement.

Differences in confidence ratings may be influenced by gender,<sup>27 28</sup> limited laparoscopic theatre exposure in O&G,<sup>11 17</sup> earlier surgical training in GS curriculum,<sup>8</sup> prior surgical experience,<sup>29</sup> participation in relevant surgical courses, and practice with pelvic simulators,<sup>4</sup> among others. Additionally, a higher proportion of O&G

**Table 7** Associations between the consultant's own confidence and expected scores for all the skills examined

Laparoscopic surgical skills	O&G consultants n=87 (Kendall's $\tau$ )	GS consultants n=73 (Kendall's $\tau$ )
Ability to obtain laparoscopic access	0.020	-0.086
Ability to recognise anatomy	<b>0.348</b>	0.135
Ability to manipulate tissue	<b>0.342</b>	0.183
Ability to dissect tissue	<b>0.311</b>	0.020
Ability to control bleeding using diathermy	<b>0.306</b>	<b>0.284</b>
Ability to control bleeding using endovascular devices	<b>0.470</b>	<b>0.283</b>
Ability to control bleeding using haemostatic devices	<b>0.498</b>	<b>0.393</b>
Ability to control bleeding using advanced energy devices	<b>0.350</b>	<b>0.309</b>
Ability to control bleeding using suturing	<b>0.282</b>	<b>0.461</b>
Ability to control bleeding using staplers	<b>0.404</b>	<b>0.410</b>

P values in bold denote significant values.

GS, general surgery; O&G, obstetrics and gynaecology;  $\tau$ , Kendall's tau correlation coefficient.



trainees undertake less-than-full-time training,<sup>6</sup> and their curriculum encompasses two broad specialties, in contrast to GS, which may also contribute to the observed lower confidence levels.

Previous research consistently identified clinical exposure as a crucial determinant of confidence in surgical skills.<sup>27–29–31</sup> Indeed, a recent study by Khan et al.<sup>11</sup> found that GS trainees attended the operating theatre earlier in their training, significantly more frequently and were more likely to perform procedures as primary operators rather than assistants compared with their O&G counterparts.

Similarly, a national survey conducted in Ireland revealed a decline in trainee confidence in performing major surgical procedures between 2014 and 2021, with limited theatre exposure cited as a contributing factor.<sup>2</sup> This trend has been observed in previous studies as well.<sup>3–17</sup> While our survey does not establish causality, existing evidence suggests that surgical exposure plays a key role in confidence development. It is therefore plausible that the lower confidence levels reported by O&G trainees are related to reduced operative experience compared with GS trainees.

Our survey found that haemostasis techniques varied by specialty. GS consultants had higher expectations for trainees' proficiency in endovascular devices, such as endo-loops, haemalocks and staplers. In contrast, O&G consultants and trainees were aligned in their expectations, giving higher importance to suturing than staplers and endovascular devices (tables 3 and 4). In GS, staplers are preferentially used for liver and bowel resections,<sup>32</sup> whereas suturing is the preferred haemostatic technique in O&G for hysterectomies, myomectomies and ovarian cystectomies.<sup>33</sup> Therefore, we speculate that these variations likely stem from differences in surgical practices rather than disparities in the quality of surgical training.

The COVID-19 pandemic has negatively impacted the training for most surgical specialties including O&G.<sup>34</sup> In fact, the current state of gynaecology training is regarded, by the RCOG as a serious 'educational risk' advocating its placement on the training hospital's risk register. The RCOG has generated a recovery plan centred around increasing hands-on surgical exposure through simulation, dedicated trainers and collaborative working with general surgical specialty as well as the independent sector. Similar solutions to recover training have been proposed by JCST and include 'maximising training' and 'improved surgical training' schemes.<sup>9–22</sup> The latter incorporates good training principles and advocates a 60% rota dedicated to training activity as well as developing a non-medical workforce to facilitate junior surgeons' access to all available training opportunities.

### Strengths and weaknesses

This was a nationwide survey with participants from England, Scotland, Wales and Northern Ireland. It included the views of both trainees and consultants in two related surgical disciplines, O&G and GS. We believe

that the findings of our survey are important because the laparoscopic surgical skills that consultants considered important for the award of CCT are indicative of skills needed for independent practice as a consultant. Furthermore, the assessment of trainees' skills may pinpoint any shortfalls between expectations and actual achievements.

The main limitation of this study is the response rate and external validity of our findings. We do not know the exact denominator as the survey was disseminated pragmatically, using several forums to enhance participation. Representativeness of participants may be further compromised because trainees and consultants with an interest in laparoscopic surgery may have been more likely to participate. However, we included both trainees and consultants from a generalist background as well as those focusing more on laparoscopic work in an attempt to minimise any potential self-selection bias.

We sought to evaluate the perceptions of trainees and consultants in O&G and GS in producing independent consultants at training completion. We opted to include all ST3+ trainees to capture a broader range of experiences and gain insight into the perceptions of all trainees at different stages in their training. However, future research should target O&G trainees, completing surgical gynaecology modules at the point of CCT completion for direct comparison with GS trainees.

### CONCLUSION AND FUTURE RESEARCH

Our study's finding of lower confidence among O&G trainees compared with GS trainees is likely multifactorial. While we can only speculate on the underlying causes in this study, future studies could use regression analysis to explore the impact of multiple variables such as gender, prior surgical experience, operative exposure and pelvic simulator use on confidence ratings.

Future research should target trainees at the point of CCT completion, completing surgically oriented gynaecological training. This may allow a more suitable population for comparison with GS trainees. Future studies could incorporate a more detailed assessment of baseline characteristics, review of their e-portfolios to assess the number and entrustability levels for various surgical procedures. Additionally, an objective evaluation of laparoscopic skills should be conducted and compared against trainees' self-reported confidence. Such an approach would enhance both the objectivity and generalisability of findings, providing robust evidence to inform future policy changes.

There is an urgent need for the GMC and Royal Colleges to reassess their training programmes to ensure that trainees are better equipped to meet their surgical training objectives. Proposed strategies include earlier subspecialisation, the adoption of an apprenticeship model<sup>35</sup> and post-CCT fellowships as a means of preparing trainees for independent practice.<sup>19–36</sup>

## Author affiliations

- <sup>1</sup>Royal Lancaster Infirmary, Lancaster, UK
- <sup>2</sup>Lancaster University, Lancaster, UK
- <sup>3</sup>Blackpool Victoria Hospital, Blackpool, UK
- <sup>4</sup>Whittington Health NHS Trust, London, UK
- <sup>5</sup>School of Sport and Exercise Sciences, Liverpool, UK
- <sup>6</sup>East Lancashire Hospitals NHS Trust, Blackburn, UK
- <sup>7</sup>Gynaecology, Birmingham Women's NHS Foundation Trust, Birmingham, UK
- <sup>8</sup>University of Birmingham, Birmingham, UK

X Christopher Gaffney @cgaffneyphd and T Justin Clark @TJustinC

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## ORCID iDs

Christopher Gaffney <http://orcid.org/0000-0001-7990-2792>

T Justin Clark <http://orcid.org/0000-0002-5943-1062>

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