

Association of Surgeons of Great Britain and Ireland

*MODERNISING MEDICAL CAREERS AND GENERAL SURGERY
A CONSENSUS STATEMENT*

PREFACE

The Association of Surgeons of Great Britain and Ireland embraces progress in surgery and service delivery and recognises the necessity to modernise medical careers. However, in order to provide an adequate and safe provision of patient care to future generations, General Surgical manpower, recruitment and training are of paramount importance. These have not been fully addressed by the Department of Health's proposal for Modernising Medical Careers (MMC).

General Surgery has a unique contribution to healthcare and it is vital for the health of the nation that the concerns of the profession – as outlined in this Consensus Statement – are resolved.

INTRODUCTION

- 1.1 There is a severe shortage of General Surgeons in the NHS¹, a situation which, for many years, has been accommodated by trainees who have worked excessive hours and by overseas qualified doctors who have served in a sub-consultant role. The introduction of the European Working Time Directive (EWTD) has made this situation unsustainable and the effect has been compounded by an increasingly elderly population and the heightened public expectation of specialty care.
- 1.2 It is necessary to respond to these changes so that training in General Surgery will provide surgeons best-suited to meet the needs of patients in the foreseeable future.
- 1.3 It has been proposed by MMC that, in order to provide a satisfactory emergency service in relatively small hospitals, the great majority of General Surgeons should be "emergency/judgement safe"² but should not be trained to perform complex high-risk surgery for which there is limited demand.
- 1.4 The Association's concern is that the MMC proposals are flawed and that the curriculum, recruitment, training and examination of General Surgeons of the future may fail to provide surgeons with the skills necessary for an appropriate service to patients.
- 1.5 To address these issues, the Association of Surgeons of Great Britain and Ireland (ASGBI) held a Consensus Conference at the Woodlands Park Hotel, Cobham, Surrey, on Thursday 21st and Friday 22nd October 2004. A list of all those contributing to the Conference is given as *Appendix 1*.

This document is the agreed consensus resulting from that meeting. (*Appendix 2*)

THE CONSTRAINTS

The Consensus Conference considered the following factors:

2.0 Workforce Changes

- 2.1 The European Working Time Directive is already a major concern to surgical trainees and it is unlikely that consultants will be able to opt-out of the requirements in the long term.
- 2.2 The proportion of women entering medical school has already reached 70% and this trend will, to a greater or lesser extent, be reflected in the surgical workforce.
- 2.3 Both the above factors will require a more flexible work pattern for surgeons.

3.0 Population Changes

- 3.1 It is predicted that the population over the age of 75 years will increase by 38% by 2021³. The rising age of the population has increased the volume and complexity of acute surgical admissions. This is one of the factors which has led to the cessation of all elective work for the on-duty team in many hospitals, so that senior surgical staff are readily available to attend emergency admissions⁴.
- 3.2 Public expectations for specialist treatment, especially in the field of cancer surgery, have increased. Treatment by a specialist multi-disciplinary team improves the outcome of elective surgery^{5,6,7,8} and there is now some evidence that specialisation in the provision of emergency surgery may give a better result for patients.

4.0 Epidemiological factors

- 4.1 There is evidence that the operative mortality for cancer of the oesophagus and pancreas is significantly lower for those hospitals and surgeons dealing with a high case load^{9,10}. However, the number of operable cases nationwide for these two cancers is very small.
- 4.2 On the other hand, the overall volume of other cancers which require surgical intervention is much higher. In particular, cancers of the colon and breast form a major part of the surgical workload in every District General Hospital (DGH)¹¹.
- 4.3 The pattern of disease and its treatment may change and this has already become apparent in coronary heart disease where non-operative interventions are now predominant. The reduction in smoking, the introduction of statins, the possibility of screening for abdominal aneurysm and the increasing use of stenting techniques may significantly reduce the future emergency workload of the vascular surgeon.
- 4.4 The introduction of seat belts has altered the pattern of trauma from road traffic accidents but the incidence of stabbings, gunshot wounds and the surgical complications of substance abuse is increasing.

5.0 Specialty Changes

- 5.1** The management of peripheral vascular disease has become specialised and demanding to the point where a substantial number of vascular surgeons do not practice General Surgery and provide, instead, a specialist vascular emergency rota. The relationship between vascular surgery and the provision of organ transplantation needs to be revisited.
- 5.2** The volume of symptomatic breast disease is such that most General Surgeons with “an interest” in this specialty have little or no time for elective abdominal surgery. With the exception of vascular surgery, most surgical emergencies admitted under the care of General Surgeons require the management of abdominal symptoms. With the passage of time, there is a tendency for the breast surgeon to become de-skilled in this respect and with shortened training, this process is accelerated.
- 5.3** The increasing use of oncoplastic techniques in breast surgery requires training which is more akin to the practice of plastic surgery. It is also possible that much of the out-patient breast clinic work, traditionally carried out by General Surgeons, may be taken over by breast clinicians with expertise in imaging.
- 5.4** It seems unlikely, therefore, that vascular and breast surgeons will, in future, take part in the emergency on-call rota for General Surgery.
- 5.5** The place of endocrine surgery within General Surgery is also uncertain. Thyroid and parathyroid disease, which have been the province of the General Surgeon, now attract the attention of the ENT/head and neck surgeon. Tumours of the adrenal glands and pancreas have become the concern of the laparoscopic/upper GI surgeons.
- 5.6** The above trends are likely to leave the upper and lower gastrointestinal surgeons, the “visceral surgeons”, with the major responsibility for the on-call rota in General Surgery.

6.0 Hospital catchment populations

- 6.1** A recent ASGBI national survey of hospitals showed that 65% serve a population of between 200,000 to 350,000 (median 260,000). Hospitals with a catchment of 120,000 or less, serve less than 2% of the population. (Appendix 3)
- 6.2** The suggestion that the ideal catchment population is 500,000 has led to a policy of adjacent DGH's being paired into a single Trust and being described as a single unit. More often than not this strategy has led to a fragmentation of services and manpower that is counter-productive and which has been further compromised by extended travel times between acute sites.
- 6.3** The reality is that geographical rationalisation of acute surgical services on to single large sites is often politically impossible¹².

7.0 Career Structures

- 7.1 The General Surgical service is supported by a significant cohort of Staff and Specialist (SAS)/Non-Consultant Career Grade (NCCG) surgeons most of whom qualified abroad and none of whom are on the Specialist Register. Many SAS surgeons perceive that they are given responsibility but lack clinical autonomy and ASGBI is anxious that their concerns are addressed. While some of these surgeons may gain specialist registration under Article 14 of PMETB (Postgraduate Medical Education and Training Board), this should not influence a plan for training in the future, as the UK should aim to train its own surgical workforce.
- 7.2 Current workforce calculations suggest a major expansion of the SAS grade in “Service and Access” posts, which are in parallel with the training grades but would rarely allow progression to consultant status.

8.0 International comparisons

- 8.1 The number of surgeons per head of population in the UK (1 per 37,000)¹ is roughly half that seen in most of mainland Europe and, although comparisons are not straightforward, the ratio is even less when compared with the United States.
- 8.2 Paradoxically, it is perceived that UK surgeons spend a greater proportion of their time in consultation and less in the operating theatre. Time constraints have reduced the availability of elective operating time in the UK to what many General Surgeons would regard as an absolute minimum.
- 8.3 UK consultant surgeons have, in the past, experienced a much greater autonomy than their international counterparts. This has to some extent been eroded by peer pressure, multi-disciplinary team-working and by credentialing in the private sector. However, the Clinical Director in the UK does not yet have the authority of the continental European “chef du service”.
- 8.4 In the UK all consultant General Surgeons have regarded themselves as trainers but in many countries surgical training is confined to academic centres.

THE ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND’S CONCERNS ABOUT THE MMC MODEL INITIAL POSITION STATEMENT:

- 9.1 The aim of any reform should be to meet the requirements of the population covered by the average DGH which serves a population of between 200,000 and 350,000 since it is unlikely that existing DGHs will be replaced by fewer, larger hospitals in the next 10 to 15 years¹². (*Appendix 3*)
- 9.2 The requirements of the European Working Time Directive must be met and a more flexible work pattern created. Any amendment to the EWTD is likely to be a time-consuming process and its current status may prolong training and/or remove trainees from night cover in some acute hospitals.

- 9.3** A small proportion, perhaps 5%, of General Surgery patients will require tertiary referral to a specialist centre for complex primary or re-do surgery.
- 9.4** It is likely that there will be a separate vascular emergency rota based on networking between adjacent Trusts.
- 9.5** It is likely that breast (and possibly endocrine) surgeons will not, in future, be on the on-call rota for General Surgery.
- 9.6** It is likely that acute surgical admissions to a DGH will be managed predominately by 8 to 10 upper and lower GI surgeons. This will effectively double the number of General Surgeons in most DGHs.
- 9.7** Academic surgery, which plays an essential part in the training of General Surgeons, is in crisis. The benefits of a period spent in research are clear but it may no longer be appropriate for all trainees to undertake a prolonged period of full-time research.
- 9.8** Before a surgeon enters practice, albeit under the supervision of a mentor, it is appropriate that he/she should have basic competence in one specialty (eg. colorectal, breast, Upper GI, etc) in addition to General Surgery. *(Appendix 4)*
- 9.9** Credentialing for specific procedures which have been assessed for competence is supported. Such competence should be subject to periodic review.
- 9.10** The concept that basic surgeons should enter practice and that they may subsequently be sent for further specialty training in order to meet a Trust's requirements is accepted. However, this is not seen as the normal model for Advanced Specialty Training.
- 9.11** Advanced Specialty Training should normally be in continuity with standard training to the Certificate of Specialist Training (CST). This will usually be for a further two years and should be centrally funded. *(Appendix 4)*
- 9.12** Patients now expect to be seen by a specialist and the title General Surgeon is seen to be rather less than this. The title Consultant Colorectal and General Surgeon, or similar, has been suggested but this has been a longstanding debate without conclusion.
- 9.13** Trainers should be trained and accredited on a time-limited but renewable basis. Trusts should be given incentives to actively support training.
- 9.14** Expansion of the consultant/specialist grade should not be accompanied by an increase in the number of SAS surgeons. Some specialists may be accredited for a limited range of surgery, but the number of permanent staff without any clinical autonomy should be kept to an absolute minimum.
- 9.15** The MMC term "emergency/judgement safe surgeon" suggests someone who can hold the fort and knows when to call for help. In order to be safe, the surgeon must be competent to manage the great majority of cases admitted as an emergency. Not all trainees will achieve this status within the proposed six years.
- 9.16** Surgical training can be significantly improved and shortened by targeted training but the proposed number of years should be indicative of assessed competence. Surgical training must be competence based, as opposed to time-based.

AGREED CONCLUSIONS OF THE CONSENSUS CONFERENCE

- 10.1** The Association of Surgeons of Great Britain and Ireland is concerned, above all, to ensure that surgical services delivered to patients are safe and of high quality.
- 10.2** Patient safety is paramount and emergency care involves management of the most critically ill patients which demands the highest level of surgical skill. The MMC concept of surgeons who are only “emergency-safe” is not seen as an appropriate basis for quality emergency care for patients. The management of critically ill patients must be delivered by fully trained surgeons. Furthermore, the concept is not attractive to trainees and would have profoundly negative consequences for recruitment.
- 10.3** Implementation of the EWTD has thrown into stark relief the shortage of trained surgeons in the UK. The number of General Surgeons per head of population (1 per 37,000)¹ remains far from the target of 1 per 25,000^{11,13} identified by the profession and endorsed by the DoH and is way beneath that of other European and North American countries.
- 10.4** ASGBI is particularly concerned about emergency surgical services given that up to 50% of General Surgical inpatient admissions now present on an emergency basis. The provision of emergency surgical cover is becoming increasingly onerous and ASGBI recommends that General Surgeons providing an emergency service receive proper recognition.
- 10.5** Many surgeons who currently staff General Surgical receiving rotas are expected to deal with emergency conditions that are unrelated to their elective workload. ASGBI recommends that General Surgeons should only be expected to undertake at night, as emergency provision, those services which they provide electively during the day.
- 10.6** The General Surgeon of the future should be trained in structured programmes in which training takes precedence over service requirements. Training and assessment must be competence based rather than determined by time spent in training.
- 10.7** ASGBI believes strongly that surgical services of the future should be provided by surgeons trained to the equivalent of today’s Certificate of Completion of Specialist Training (CCST) level and that there should be diminishing reliance on SAS/NCCG surgeons. ASGBI sees great virtue in moving to the situation where there are two types of surgeons: those who are fully trained and those who are in training to join them.
- 10.8** The training and work pattern of the future must be much more flexible. This flexibility needs to be explicit and operate within agreed national guidelines with appropriate infrastructure and funding. The training needs and aspirations of men and women surgeons do not differ.
- 10.9** Education and training must be seen as a process that continues throughout professional life. There is general recognition that the EWTD will result in less surgical experience for those being appointed as Consultants in future. ASGBI is attracted to the introduction of formal mentoring that would offer support and guidance for a further period of, perhaps, three years following appointment to consultant status.

10.10 Elective General Surgery is already experiencing a trend to specialisation. ASGBI supports the progress towards defined training in:

- * Breast Surgery
- * Endocrine Surgery
- * Vascular Surgery
- * Gastrointestinal Surgery
 - Lower GI (colorectal)
 - Upper GI (oesophagogastric/hepato/pancreatico/biliary)
- * Transplantation

It is recognised that any alterations in the disposition of surgical services at hospital level have to take account of the need to deliver a full spectrum of patient care. ASGBI welcomes increasing specialisation and recognises the benefits this will bring to patient care and training.

10.11 Training to CCT/CCST level in General Surgery should include training in one specialty. Any Advanced Specialty Training should be centrally funded.

10.12 The practice of surgery continues to evolve. ASGBI recognises and supports the development of disease specific multi-disciplinary specialty groups.

10.13 ASGBI accepts that increasing specialisation will produce varying pressures in different hospitals and that one model for emergency provision will not be appropriate for all.

10.14 Hospitals serving large populations (circa 500,000) have sufficient critical mass to allow General Surgeons to practise exclusively within their specialty. In such large hospitals separate specialty emergency rotas will be provided.

10.15 Most hospitals serve a population of 200,000 to 350,000. (*Appendix 3*) They require separate emergency vascular rotas provided by networking with neighbouring hospitals.

10.16 Hospitals serving small populations, particularly those in remote and rural areas, are vulnerable and have particular needs. ASGBI sees the need to address the issues of training, recruitment, retention and career development for General Surgeons working in these hospitals.

10.17 ASGBI welcomes the move to formal structured training programmes. However, there is grave concern that trainees currently spend a median of five and a half years in the Senior House Officer (SHO) grade. This problem needs urgent resolution. ASGBI remains anxious about the process of selection and criteria for entry to specialist surgical training. Furthermore, the preparation that the proposed Foundation Years of postgraduate training will provide is also uncertain.

10.18 Not every Consultant General Surgeon should be regarded as a Trainer or Mentor and there should be increasing emphasis on the value of specialty teams as the basis of training delivery. Training programmes and trainers will require a robust form of accreditation and renewal.

10.19 ASGBI encourages a move from reliance on traditional exit examinations to a system that places emphasis on the summative in-training assessment of competence. It will be important to utilise rigorous assessment procedures that provide both objective quality assurance and public confidence. The RITA (Record of In-Training Assessment) system, as it currently operates, gives no grounds for complacency but if applied rigorously to agreed standards, could have great utility. ASGBI believes strongly that due attention must be paid to the early acquisition of knowledge in clinically relevant basic sciences.

10.20 ASGBI recognises that a number of important issues facing General Surgery have not been discussed adequately by this Consensus Conference e.g.

- * The future of academic surgery
- * Advanced Specialty Training
- * The provision of surgical services for children
- * The management of trauma and the future of Military Surgery
- * The evolution of the non-medically qualified Surgical Care Practitioners

These issues will require urgent consideration in their own right.

SUMMARY CONCLUSIONS

- **The implementation of the European Working Time Directive has highlighted the severe shortage of trained surgeons in the UK.**
- **There is an urgent need to increase the number of General Surgeons who are fully trained to treat patients in both the emergency and the elective setting. However, there should be a diminishing reliance on Staff and Associate Specialist Surgeons to support the NHS.**
- **ASGBI strongly supports the introduction of structured training programmes, in which progress is determined by competence.**
- **ASGBI recognises the need to provide emergency and elective surgical cover throughout the United Kingdom. This will necessitate variations in the provision of service and different models to suit different circumstances.**
- **The Modernising Medical Careers concept that most hospitals should be staffed by General Surgeons who are only “emergency safe”, with relatively few specialists, is fundamentally wrong.**

APPENDICES

- Appendix 1* Delegate List, Thursday 21st October 2004
The demographic evidence and MMC proposals
Chair: Professor Graham Teasdale, Chairman of Senate
- Appendix 2* Delegate List, Friday 22nd October 2004
The Consensus
Chair: Sir David Carter, former CMO Scotland
- Appendix 3* Distribution of Estimated Populations Served by District General Hospitals in England and Wales
- Appendix 4* Proposed Training Pathway in General Surgery
SAC in General Surgery March 2004



Association of Surgeons of Great Britain and Ireland

APPENDIX 1

Convenor: Sir David Carter

Delegate List, Thursday 21st October 2004

Allum, Mr William	Member, Specialist Advisory Committee in General Surgery
Bates, Mr Tom	President, Association of Surgeons of Great Britain and Ireland
Black, Mr John	Chairman, Specialist Advisory Committee in General Surgery
Borthwick, Mr George	Chairman, Scottish Business in the Community (Lay Representative)
Crockard, Professor Alan	National Director for Modernising Medical Careers
Curson, Dr Judy	Director, Workforce Review Team
De Cossart, Mrs Linda	Council Member, Royal College of Surgeons of England
Dehn, Mr Tom	Council Member, Association of Laparoscopic Surgeons of Great Britain and Ireland
Duncan, Mr John	Honorary Treasurer, Association of Surgeons of Great Britain and Ireland
Finlay, Mr Ian	Council Member, Association of Surgeons of Great Britain and Ireland
Gair, Dr Nicholas	Chief Executive, Association of Surgeons of Great Britain and Ireland
Galloway, Mr David	Chairman, Joint Committee of Intercollegiate Examinations
Garden, Professor James	Regius Professor of Clinical Surgery, Edinburgh
Hamming, Dr Jaap	Honorary Secretary, Association of Surgeons of the Netherlands
Hargadon, Ms Judy	Director of New Ways of Working, NHS Modernisation Agency
Harris, Mr Peter	President, The Vascular Society
Huang, Mr Joseph	President, Association of Surgeons in Training
Hyland, Mr John	President, Association of Coloproctology of Great Britain and Ireland
Jefferies, Mrs Annie	Action on General Surgery
Johnson, Mr James	Chairman, British Medical Association
Lane, Mr Robert	Vice President, Association of Surgeons of Great Britain and Ireland

Layer, Mr Graham	Honorary Secretary, Association of Surgeons of Great Britain and Ireland
MacFie, Mr John	Honorary Editorial Secretary, Association of Surgeons of Great Britain and Ireland
MacIntyre, Mr Iain	Vice President, Royal College of Surgeons Edinburgh
Maddox, Mr Paul	Director of Education, British Association of Endocrine Surgeons
McIrvine, Mr Andrew	Chair, Specialist Training Committee, South Thames East
McKee, Dr Ruth	Specialist Advisory Committee Curriculum Sub-Committee
Neal, Professor David	Professor of Surgical Oncology, University of Cambridge (Member PMETB)
O'Higgins, Professor Niall	President, Royal College of Surgeons in Ireland
O'Riordan, Mr Dermot	Council Member, Royal College of Surgeons of England
Rainsbury, Mr Dick	Director of Education, Royal College of Surgeons of England
Reid, Miss Wendy	Postgraduate Dean, London Deanery
Ribeiro, Mr Bernie	Vice President, Royal College of Surgeons of England
Rodd, Miss Caroline	Past President, Association of Surgeons in Training
Rosin, Mr R David	Vice President, Royal College of Surgeons of England
Rowlands, Professor Brian	President, Society of Academic and Research Surgery
Rowley, Professor David	Director of Education, Royal College of Surgeons Edinburgh
Russell, Mr Chris	Past President, Association of Surgeons of Great Britain and Ireland
Sunderland, Mr Graham	Director of Education, Royal College of Physicians and Surgeons of Glasgow
Teasdale, Professor Graham	President, Royal College of Physicians and Surgeons of Glasgow
Watkin, Mr David	Past President, Association of Surgeons of Great Britain and Ireland
Wilkins, Mr Denis	Vice President Elect, Association of Surgeons of Great Britain and Ireland
Williams, Mr Gordon	Chairman, Joint Committee on Higher Surgical Training



Association of Surgeons of Great Britain and Ireland

APPENDIX 2

Convenor: Sir David Carter

Delegate List, Friday 22nd October 2004

Allum, Mr William	Member, Specialist Advisory Committee in General Surgery
Bates, Mr Tom	President, Association of Surgeons of Great Britain and Ireland
Black, Mr John	Chairman, Specialist Advisory Committee in General Surgery
Borthwick, Mr George	Chairman, Scottish Business in the Community (Lay Representative)
De Cossart, Mrs Linda	Council Member, Royal College of Surgeons of England
Dehn, Mr Tom	Council Member, Association of Laparoscopic Surgeons of Great Britain and Ireland
Duncan, Mr John	Honorary Treasurer, Association of Surgeons of Great Britain and Ireland
Finlay, Mr Ian	Council Member, Association of Surgeons of Great Britain and Ireland
Gair, Dr Nicholas	Chief Executive, Association of Surgeons of Great Britain and Ireland
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Garden, Professor James	Regius Professor of Clinical Surgery, Edinburgh
Harris, Mr Peter	President, The Vascular Society
Huang, Mr Joseph	President, Association of Surgeons in Training
Hyland, Mr John	President, Association of Coloproctology of Great Britain and Ireland
Lane, Mr Robert	Vice President, Association of Surgeons of Great Britain and Ireland
Layer, Mr Graham	Honorary Secretary, Association of Surgeons of Great Britain and Ireland
MacFie, Mr John	Honorary Editorial Secretary, Association of Surgeons of Great Britain and Ireland
MacIntyre, Mr Iain	Vice President, Royal College of Surgeons Edinburgh
Maddox, Mr Paul	Director of Education, British Association of Endocrine Surgeons

McIrvine, Mr Andrew	Chair, Specialist Training Committee, South Thames East
McKee, Dr Ruth	Specialist Advisory Committee Curriculum Sub-Committee
Neal, Professor David	Professor of Surgical Oncology, University of Cambridge (Member PMETB)
O'Riordan, Mr Dermot	Council Member, Royal College of Surgeons of England
Rainsbury, Mr Dick	Director of Education, Royal College of Surgeons of England
Reid, Miss Wendy	Postgraduate Dean, London Deanery
Ribeiro, Mr Bernie	Vice President, Royal College of Surgeons of England
Rodd, Miss Caroline	Past President, Association of Surgeons in Training
Rosin, Mr R David	Vice President, Royal College of Surgeons of England
Rowlands, Professor Brian	President, Society of Academic and Research Surgery
Rowley, Professor David	Director of Education, Royal College of Surgeons Edinburgh
Russell, Mr Chris	Past President, Association of Surgeons of Great Britain and Ireland
Sunderland, Mr Graham	Director of Education, Royal College of Physicians and Surgeons of Glasgow
Watkin, Mr David	Past President, Association of Surgeons of Great Britain and Ireland
Wilkins, Mr Denis	Vice President Elect, Association of Surgeons of Great Britain and Ireland
Williams, Mr Gordon	Chairman, Joint Committee on Higher Surgical Training

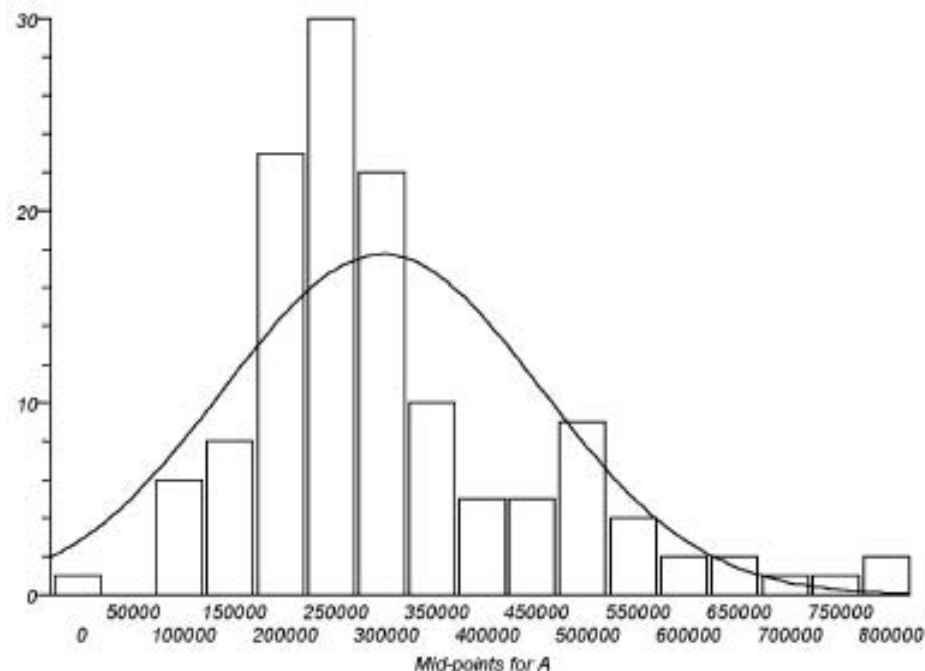
APPENDIX 3

DISTRIBUTION OF ESTIMATED POPULATIONS SERVED BY DISTRICT GENERAL HOSPITALS IN ENGLAND & WALES

Vertical axis = number of DGH's n = 130

Horizontal axis = catchment population

Histogram for A



Analysis of ASGBI Workforce Data

Of 130 hospitals in England and Wales which reported their catchment area (link-surgeons estimate) per DGH:

Population served (mean)	312,000
Population served (median)	260,000

Catchment population 200-350	85/130	=	65%	Proportion of DGH's
Catchment population < 200	14/130	=	11%	
Catchment population > 400	31/130	=	24%	

Catchment population of 120 or less 6/130 = 5%

Population in England & Wales are served
by a Hospital with population base of
120,000 or less 658,000/40,540,000 = 1.6%

Conclusion

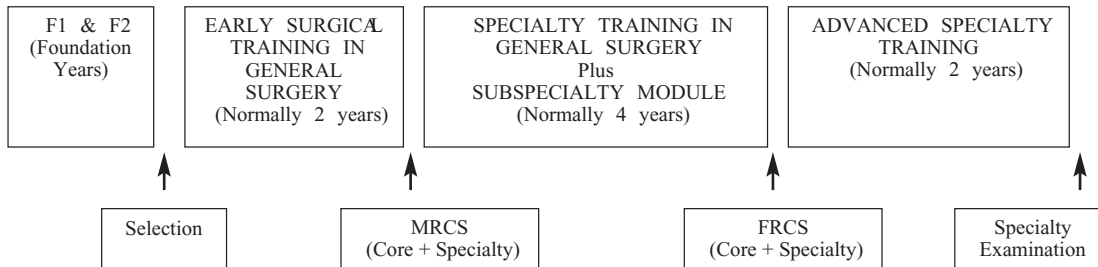
The perceived need to train a large number of surgeons to service small hospitals is not sustained.

Caveats to Workforce Survey Analysis

- Caveats:
1. Link surgeons' estimate of catchment population may overestimate or double count.
 2. A Response rate of 58% may bias results but there is no evidence of an excess of small hospital among non-responders.

G T Layer, April 2004

APPENDIX 4
PROPOSED TRAINING PATHWAY
FOR SEAMLESS TRAINING IN GENERAL SURGERY
(March 2004)



Notes:

- 1) Entry into Specialty Surgical Training will be by competitive selection. The method is not yet determined. No surgical experience or training is assumed at entry.
- 2) Progression through the pathway will be regulated by assessment. Indicative times are specified, but it is recognised that the time taken to acquire the full range of competencies at each stage will vary from individual to individual. Failure to attain a reasonable level of progress will attract scrutiny and appropriate action. The assessments carried out during the first and second years of surgical training are regarded as particularly important. All trainees proceeding beyond this point should be capable of achieving a CCT. The assessment process and regulatory framework for advanced specialty training has yet to be specified.
- 3) It is recognised that entry to and exit from the training continuum for any one of a number of reasons should be facilitated in the new curriculum. These reasons may include domestic commitments, training outside of this curriculum and research.

SAC in General Surgery, April 2004

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