Association of Surgeons of Great Britain and Ireland
EXECUTIVE NEWSLETTER
Number 7, November 2004

INTRODUCTION

The Association of Surgeons of Great Britain and Ireland was founded in 1920 with the expressed aims of the advancement of the science and art of surgery and the promotion of fellowship and friendship amongst surgeons. In the early years, this was achieved by meetings of the Association and reciprocal visits between members. The first ***Yearbook*** comprised a list of members and their addresses, together with details of the officers of the Association. In subsequent years the ***Yearbook*** expanded considerably and, in its current form as an ***Annual Report***, it now includes details of the Association's constitution, reports from the President and other officers as well an the abridged Statement of Financial Activities and the historical record of past Meetings and Presidents.

In 2002 Martin Lee, the then Honorary Editorial Secretary, and the Council recognised that it was no longer possible to use the pages of an ever expanding yearbook to keep members informed of changes affecting their profession and introduced the concept of an expanded, magazine-style, ***Executive Newsletter***. This has met with mixed success. Whilst many members have welcomed the additional news and views contained in the Newsletters some have commented upon their affection for the old-style ***Yearbook***, which provided a readily accessible source of up-to-date information on our membership. It should also be noted that our Corporate Patrons value all these publications as a means of targeting a large number of practising surgeons.

A key function of any Association's "newsletter" must be to inform and entertain its membership. Such is the pace of change in healthcare that annual or quarterly publications cannot hope to achieve this objective. We propose, therefore, that we revert to including the traditional annual reports from Honorary Officers of the association and the Presidents of the Specialty Associations and Societies in General Surgery in the ***Annual Report*** which is distributed to Fellows at each Annual Scientific Meeting. The ***Annual Report*** will, therefore, expand and, as in the past, function solely as a reference source.

In future, our ambition is to produce a regular slimmer 'non-glossy' Newsletter which will contain invited reviews on matters of topical interest to all surgeons (irrespective of speciality), comment on political issues of the day, a regular section devoted to reporting of adverse incidents and, hopefully, something entertaining. We would welcome contributions from all members and would hope to provide a sounding board for a rich diversity of opinions. In addition, we anticipate that as the ASGBI website develops, comment recorded here may also be disseminated in the pages of the Newsletter such that both means of communication are seen as complimentary. Accepting that the needs of our members are paramount it is nonetheless important to recognise our responsibility to our Corporate Patrons. We feel they will welcome additional publications from the Association, and we will continue to produce two "glossy" Newsletters a year.

This is the first of the new style Newsletters. The success, or otherwise, of this venture is entirely dependant upon feedback from the readership. This means you! Please write.

John MacFie
Honorary Editorial Secretary

MODERNISING MEDICAL CAREERS AND GENERAL SURGERY

A CONSENSUS STATEMENT
28th October 2004

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.

1.0 Introduction

- **1.1** There is a severe shortage of General Surgeons in the NHS, 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" 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.

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 longterm.
- **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 2021. 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 admissions.
- **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 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. 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).
- **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.
- **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 impossible.

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) 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 years.
- **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.
- **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.
- **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) remains far from the target of 1 per 25,000 identified by the profession and endorsed in the NHS Plan 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.

Association of Surgeons of Great Britain and Ireland
EXECUTIVE NEWSLETTER
Number 7, November 2004

- **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. 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.**

SURGEONS' TRAINING UNDER THE KNIFE

Nick Boyle

Surgical training in the United Kingdom is facing a crisis. There is a significant risk that, in five to 10 years' time, NHS hospitals will be staffed by inexperienced surgeons who have undergone insufficient training; patients will suffer and some might even die as a result. This might sound melodramatic, but many surgeons fear it is not.

For most of the past century, the British method of training surgeons was copied in most of the English-speaking world. Essentially, it relied on the concept of apprenticeship, and the acknowledgement that the skills needed to become a competent surgeon take many years of practice to acquire.

Junior surgeons, often working in excess of 80 hours a week, accrued a lot of technical experience in looking after both emergency and elective cases. Senior trainees underwent even more specialist training and were allowed increasing independence but, crucially, all patients remained under the care of a consultant who supervised senior registrars. Appointment to a consultant post and autonomous practice was usually in a doctor's mid to late 30s, after 10 to 15 years of post-graduate surgical training. Because of the length and breadth of training, at appointment consultants were equipped to deal not just with the common surgical conditions, but also the unpredictable rarities.

In 1993, this system was changed, partly as a response to the long hours junior doctors were working. Under the so-called Calman reforms, the length of training was capped. Furthermore, the Government agreed a "new deal" with the BMA that limited junior doctors' working hours to a maximum of 72 per week. To preserve on-call rotas, middle, non-training grade doctors were increasingly employed to work alongside registrars. Consequently, there has been an explosion in the appointment of so-called "staff'" or "trust" surgeons, the majority of whom are recruited from abroad. Historically, they had no prospect of becoming consultants and the Government has encouraged their recruitment, as these doctors help to preserve service provision. The inevitable consequence has been to dilute the experience gained by registrar trainees.

There is strong evidence to confirm that this is the case. In the department in which I work, surgical registrar operative experience has been progressively reduced so that it is now half what it was in 1993. Other hospitals have published evidence of similar experiences. But this process has only just started. The European Working Time Directive (EWTD) became part of British law in 1998. From this August, junior doctors will not be allowed to work more than 56 hours a week, and from 2009 the limitation will be 48. The terms of the directive, and court rulings around Europe, mean that even if a doctor spends all night asleep in bed while on call, those hours count towards the maximum total allowed.

Complicated restrictions on how many continuous hours can be worked, and what rest periods have to be taken and when, conspire dramatically to reduce the time a doctor will be able to spend working and, more importantly, training. It has been calculated by the Royal College of Surgeons that before the Calman reforms, a junior doctor worked on average for 30,000 hours before becoming a consultant, but that in the future, this will fall to 8,000.

The EWTD has other implications that further undermine the quality of learning experiences available to doctors when they are at work, let alone the quality of patient care. Instead of working a rota of a set number of days and nights per week, usually divided into 24-hour periods, they now have to work shifts to a maximum of 13 hours at a time. Most shifts include weeks where they work just at night, often not operating at all, and to conform with the law they are banned from working on elective operating lists during the day.

All surgical conditions, and particularly emergencies, change over time. For example, patients with abdominal pain who might halve appendicitis often need repeated assessment over several hours. If junior doctors cannot attend consultant rounds the morning after they have been on call, how will they ever learn if their clinical assessments were correct? And if they can't attend theatre when the decision to operate has been made, how can they ever correlate clinical presentations with operative findings?

Other systematic problems within the NHS are compounding the situation. Thanks to centrally imposed targets, consultants are being placed under enormous pressure to get through as many cases as possible. Teaching inevitably takes time and, therefore, the pressure is on for consultants to do the cases themselves.

That training is not a priority of the Government is exemplified by the introduction of "Independent Sector Treatment Centres" (ISTCs), its solution to reduce waiting times for elective investigations and minor operations. The ISTCs will be sent many of the simpler and intermediate types of cases that surgeons need to master before moving on to more complex surgery. But since the Government wants these centres to be staffed almost exclusively by foreign doctors, there may be little opportunity for experienced British surgeons to train their juniors. And since the private companies running these centres will be contracted to operate on large numbers of patients - and productivity is all important - they may have no incentive to slow down lists by allowing trainees to operate. This might seem worrying enough, but plans to introduce further changes to the structure of postgraduate medical education will make a bad situation truly terrible.

In February 2003, the Department of Health published a document called "Modernising Medical Careers" and has expanded on its intentions subsequently. Many changes are proposed but paramount is the intention to condense the period that doctors spend training before being awarded a "Certificate of Completion of Training". It is envisaged that a surgeon would be deemed a "consultant" after possibly only five or six years of surgical training. The proposals are couched in terms of being based on the need for "team working", "multi-disciplinary working" and, most pertinently, "service needs"; discussion documents talk of “dedicated learning” and “competency training”. But the truth is that in the past 10 years, despite increasing evidence of problems, the situation has

Association of Surgeons of Great Britain and Ireland
EXECUTIVE NEWSLETTER
Number 7, November 2004

only worsened. A recent survey of senior house officers in orthopaedic surgery demonstrated that a third were not trained in theatre or clinics. Many are not even able to tie knots.

It is fair to say the vast majority of surgeons view these proposals with horror. They sound the death knell for the traditional standards expected by the public of consultant surgeons. They reduce still further the total time available to complete training to only 6,000 hours.

And yet, a Department of Health spokesman was quoted recently as saying the new consultants would be "fit for the purpose". Clearly, the Government envisages being able to claim that it has created thousands of new "consultants", as it promised it would in its NHS Plan; that it has complied with European law, and that it has created a "consultant-provided service".

It may be that some of the forces influencing change are inevitable. The EWTD has been accepted into UK law. Increasing numbers of medical graduates are women and perhaps both they and their male colleagues are unwilling to spend large parts of their twenties and thirties at work. If, as appears inevitable, our traditional model of what a consultant is changes to something like the model that exists in much of Europe - where there are far more "consultants" but working under the direction of more senior specialists - then we need professional structures to cope with the limitations of their abilities. We need honesty and transparency so the public understands what these new consultants really can and cannot do. The new "junior" consultants of the future must be supervised by senior colleagues who should be available to offer advice and assistance in difficult and challenging situations.

Perhaps the public does know what is happening; or perhaps it believes the consultants of the future, because they will carry the same title as their predecessors, will share the same skills.

When the new breed of "decision-competent" consultant surgeons is appointed, and you are taken acutely unwell and need an emergency operation courtesy of the NHS, I suggest you ask two questions. How many times has your surgeon performed the operation? And, more important, who will he or she call if things are more difficult than anticipated?

Nick Boyle is a consultant surgeon in Kent and a Fellow of the Association of Surgeons

Article courtesy of the Daily Telegraph

RECRUITMENT TO CONSULTANT POSTS IN GENERAL SURGERY: A SCOTTISH PERSPECTIVE

Charles Auld
Dumfries and Galloway Royal Infirmary

Alexander Munro
Raigmore Hospital, Inverness

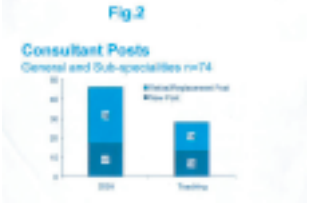
Many General Surgeons in Scotland are concerned about difficulty in recruiting consultants in their specialty. Despite advertising consultant posts on several occasions some centres have been unable to recruit surgeons and consequently have required to modify the range of services they provide.

There is a widely held view that surgical posts in District General Hospitals (DGH's) are not as popular as they used to be and even recruitment to University Teaching Centres (UTH's) is currently more difficult than hitherto. Whether this situation results from inadequate numbers of trained surgeons being produced or from migration of trainees elsewhere once they have been trained is not clear. Since firm information on the topic is not available, a survey was recently undertaken to find out about recruitment to general surgical posts in Scotland during the past five years.

Methodology
Questionnaires were sent to consultants in general surgery and its sub-specialties in all hospitals in Scotland from the Specialty Advisory Board in General Surgery at the Royal College of Surgeons of Edinburgh. The questionnaires were constructed to obtain information on the consultant posts and candidates interviewed for these posts which were advertised for Scottish hospitals from March 1998 to March 2003. A separate survey was carried out on type 1 trainees from the four Deaneries in Scotland who had completed general surgical training over a similar five year period.

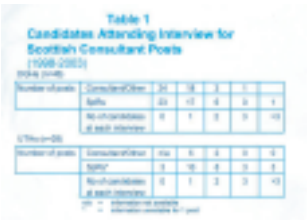
Results
Thirty seven out of 38 questionnaires were returned, a response rate of 97.4%. Information was received on 74 advertised posts. In five years 28 posts were advertised for UTH's whereas 46 were posts in DGH's. Twenty two were advertised with an interest in coloproctology, 15 were vascular, 13 were for breast surgery, 10 required an interest in upper GI/hepato-biliary surgery and 10 were advertised without a special interest.

Twenty posts were advertised on more than one occasion (*Figure 1*). In a few instances comment was made that the post was not re-advertised either because of poor previous response or a locum surgeon was in post. The majority of posts were replacement posts but some 30 posts out of 74 advertised were new consultant jobs (*Figure 2*).



There was a difference in the type of candidates interviewed for DGH posts compared to UTH

posts. Specialist Registrars accounted for 84.9% of those interviewed for posts in UTH's but this dropped to 54.4% for DGH's (p+0.005). A substantive appointment was made for 59 of 74 jobs advertised (79.7%). In the other interviews either an appointment was not made or a locum was appointed. The age of appointees is shown in *Figure 3*. Half of those appointed were 40 years or more at the time of appointment and 16 were aged 50 or more. The data on candidates interviewed for these posts was further analysed (*Table 1*). Information for DGH's was analysed separately from data for UTH's. Although the numbers of Specialist Registrars interviewed for each UTH post was low, the situation was much worse for DGH's. For 50% of posts in DGHs no registrars were interviewed. Many posts which had no suitable specialist registrar applicants were filled with candidates who were already consultants who wished to move from their current consultant post.



Data on the separate study of 64 specialist registrars who were appointed to consultant posts between 1998 and 2003 is shown in *Figure 4*. Forty nine were appointed to consultant posts between 1998 and 2003. Forty-nine were appointed to consultant posts in Scotland, whereas 11 moved to England and a further four went elsewhere.

Discussion

This study confirms the current precarious nature of consultant staffing in general surgery and its sub-specialties in Scotland. The choice of candidates available to appointed committees is very limited. Either insufficient specialist registrars are being trained or they are opting to work elsewhere after completion of Higher Specialist Training. The evidence from our survey would suggest that it is mainly a problem of too few specialist registrars in training. This issue requires to be addressed without delay since the current deficit of suitable candidates will be exacerbated further by an increasing number of new posts being advertised currently to deal with changing working conditions for consultants and trainees.

DGH posts seem to attract fewer applicants from specialist registrars than UTH posts and remote and rural hospitals are particularly difficult to staff. Why should this be? Since trainees are located mainly in the UTH environment (exclusively so during years five and six of SPR training) they feel most secure with this type of practice. In addition there is growing concern that sub-specialty based general surgical trainees are becoming less confident in coping with the general surgical on-call commitments and, perhaps, feel more exposed in a DGH environment. When there is a shortage of applicants for posts it is inevitable that those who have completed training will choose to apply for the most prestigious jobs and posts in which they feel comfortable.

Are these solutions to the current difficulties? The overall number of specialist registrars needs to be increased urgently. General surgery requires to be promoted positively as an attractive career option. This is particularly required among female medical students who now constitute 60-70% of the intake of medical schools each year. Although anecdotal evidence suggests that substantial percentages of female medical graduates are entering basic surgical training programmes, few are then moving into specialist registrar posts in general surgery. Flexible working patterns need to be established for both trainees and consultant staff to make a career in general surgery as attractive as other specialities in terms of working conditions. Furthermore, DGH general surgery with a sub-specialist interest requires to be positively marketed. The Acute Services Review for Scotland report (1988) encouraged the development of managed clinical networks and it should be possible to develop a network arrangement whereby those surgeons working in a DGH can share care of cases with those surgeons in the UTH's so that all the interesting cases need not of necessity be transferred to larger centres. If current problems are not addressed DGH's will not attract enough high quality consultant general surgeons necessary to sustain present levels of activity, thus effectively resulting in transfer of an increased number of both elective and emergency cases to university centres.

The information obtained from this questionnaire supports the concern that many surgeons in Scotland have had for some time about recruitment to consultant posts. Perhaps the time is ripe to investigate the problem further by re-circulating the questionnaire to trainees which had been used by the Association of Surgeons in Training in 1999. This would give up-to-date information on the career aspirations of surgical trainees at the present time. It is the responsibility of the Joint Committee for Higher Surgical Training (JCHST) and Regional Training Committees to ensure that training is appropriate to the environment in which the trainee intends to work as a consultant. Our survey shows that the majority of Scottish consultant general surgery posts advertised in the last five years were for DGH posts. Yet the training offered to SPR's has a bias towards UTH practice. We feel that the evidence from this study shows clearly that a major crisis in staffing consultant general surgical posts is imminent. DGH posts are already difficult to fill. Centralisation of all surgical services in major Scottish cities is neither an attractive option for patients outwith the normal catchment area of these hospitals nor is it a concept which would find favour with those working in the Scottish Health Service.

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FATIGUE AND ANAESTHETISTS

Important new guidelines were launched on July 28th 2004 by the Association of Anaesthetists of Great Britain and Ireland exploring the problems of fatigue with particular reference to the speciality of anaesthesia. The Launch coincided with the implementation of the European Working Time Directive on the 1st August 2004, which is expected to have a profound effect on the total weekly working hours, pattern of working and lifestyles of both career grade and non career grade anaesthetists in UK and Ireland.

The guidelines, written in consultation with the Royal College of Anaesthetists and the BMA, provide essential practical advice to anaesthetists that could reduce the risks for both patient and practitioner. They can be used to guide members and management of hospitals into following safe practices with a scientific background in respect of the duration of working hours and recovery from arduous duties. Guidance is also offered on better practices to be followed where handovers from one anaesthetist or team to another are necessary due to the onset of fatigue or the requirement to relieve a colleague who has exceeded safe working hours.

The guidelines have been sent to all members of the Association and interested groups. In addition an expanded version, which goes into some aspects in much greater detail, has been released on the Association's web site www.aagbi.org/guidelines (go to Fatigue and the Anaesthetist).

Dr Michael Ward, Oxford Consultant Anaesthetist, Association Vice-President and chairman of the Working Party comments: *"Association Guidelines (of which this is one of about thirty) are produced to educate members on topics of relevance to professional practice. They should be useful to the membership as references when discussing professional activities with other specialty groups or managers. These latest guidelines make a number of significant proposals aimed to protect both the patient and the practitioner. It is hoped that these will be used by anaesthetic divisions to ensure proper provision of support be it clinical, equipment, secretarial or administrative to allow safe practice"*.

Principle Recommendations:

- Every anaesthetist should be aware of the problem of fatigue and carries a personal obligation to provide a safe and effective service.
- Departments must have a plan to manage staff at all grades who have suffered an onerous duty period and consider themselves unfit to continue work. (ie: when a night on call is arduous there must be a mechanism/protocol to allow for replacement/relief of an overtired anaesthetist).
- Job plans should not be constructed which are likely to lead to predictable fatigue. (eg: Busy nights on call should neither follow nor precede a full working day in the theatre suite, intensive care unit, or similar duty).
- Job plans of career grade staff should be designed to include flexibly worked fixed theatre sessions without named lists in order to provide regular relief for colleagues.
- Routine rest breaks should be implemented. A 'Handover Protocol' should be used before even short rest breaks. When relieving a colleague a standardised check list should be introduced to avoid omitting vital information about the patient, procedure and anaesthetic technique and equipment.
- All hospitals should ensure the availability of "on call" rooms for those doctors working night shifts, to enable rest breaks. With the recent introduction of shift working many hospitals have removed the 'duty' or 'on-call' rooms as a cost saving measure. The Association believes that such facilities should be reintroduced or protected in order that anaesthetists who get the opportunity to take a rest break during their shift in a suitable environment.
- Management should provide 'Rest Rooms' adjacent to the theatre suite for napping and 'post-call' sleeping facilities.
- Good quality accommodation should be available for resident on call staff.
- All staff should have access to good quality refreshments at all times. (It is often not possible for anaesthetists to visit the dining hall/cafeteria at the fixed hours of opening due to the unusual requirements of their workload. Alternative refreshment facilities must be provided at these 'odd' hours).
- Review of on call responsibilities for anaesthetists over 45 years of age in conjunction with advice from an accredited specialist in occupational medicine.
- Private practitioners should ensure that a combination of NHS and Private work does not lead them to practice when compromised by fatigue.

The working party on Fatigue and Anaesthetists was convened in 2003, when the Association was alerted to the publication of an editorial and revue article by Howard S K, Rosekind M R *et al* in the American Journal *Anesthesiology*, on the subject of 'Fatigue in Anesthesia'. A paper with a similar message, 'Anaesthesia and fatigue: an analysis of the first 10 years of the Australian Incident Monitoring Study 1987-1997', had been published by *Anaesth Intensive Care* (Australia), in June 2000 and reported that fatigue was listed as a contributory factor to in 152 incidents, or 2.7% of all reports.

Whilst the proposals in the document are clearly aimed at anaesthetic working practices, the principles of the findings and recommendations will be just of applicable to Surgery or other branches of hospital medical practice.

Dr Michael Ward
Vice-President
Association of Anaesthetists of Great Britain and Ireland

Association of Surgeons of Great Britain and Ireland
35-43 Lincoln's Inn Fields
London, WC2A 3PE
Tel: 020 7973 0300
Fax: 020 7430 9235
www.asgbi.org.uk