27 March 2017

Dear Mr. Anderson,

In follow up to our recent phonecall, we wish to summarise the position of ASiT, and co-signatories, the Duke’s Club, AUGIS trainees and the Irish Surgical Training Group (ISTG), on Emergency General Surgery. This position is based on direct feedback and input from our members, as well as our Shape of Training survey and the wider literature (1, 2, 3, 4, 5, 6).

It is imperative that emergency general surgical services are of the highest possible quality, to ensure optimum patient care. Surgical trainees aim for consultant posts that provide job satisfaction in achieving excellent outcomes for their patients and utilising the skills they have developed in their training to drive quality improvement. We feel the goals of providing optimum patient care and satisfying consultant job plans are best achieved using a model of general and special interest surgeons, rather than moving towards replacing special interest surgeons with emergency general surgeons. We envisage that the majority of surgical consultant posts should be a combination of a special interest, e.g. colorectal, with an on-call emergency general surgery commitment, as outlined in our position statement on Improving Surgical Training (3).
Here, we outline a number of reasons that we do not feel a move towards the development of EGS consultant posts in place of special interest consultant posts is in the best interests of patients or doctors.

1. Trainees have outlined their desire to be ‘specialists’, who also provide emergency general surgery care, rather than ‘generalists’. As part of the shape of training survey we sought the views of surgical trainees on this matter. Of 3603 respondents to the cross-specialty Shape of Training Survey, 1348 were from surgeons across all 10 surgical specialties. 89% of surgeons expressed a desire to specialise, while 71% wished to specialise and provide emergency cover. Of 428 general surgery respondents, 87% wished to specialise, and 78% wished to specialise and provide emergency cover (2). ASiT has been clear on this in previous publications (1,2,3,4,5). Indeed, only 8.2% of general surgical trainees in a survey by Pearce et al listed EGS as their career plan (7).

2. Outcomes for patients are better with specialist surgeons. For example, outcomes have been shown to improve significantly with subspecialist upper GI cover in perforated and bleeding peptic ulcer disease - indeed, with dramatic results including a 50% reduction in mortality in some cases (8). Similarly, upper GI surgeons have been shown to achieve a significantly lower complication rate and mortality in emergency gastrectomy (9). Subspecialist management of diverticulitis is associated with a lower mortality and a lower rate of stoma formation (10). Similarly, oncological outcomes are better when colonic resections are performed by a specialist surgeon (11). Looking at NELA data, one could extrapolate with reference to the literature that over 50% of laparotomies would be better managed by specialists (12). Given data such as these, we feel specialists providing emergency general surgical services is in patient’s best interests, and indeed specialist specific on-call may be preferred in larger units. Some units use a “two-surgeon of the week” model where an upper and lower GI surgeon are
both on for the week in an alternating fashion. This allows them to provide the majority of emergency general cover but also to provide specialist cover where needed, for example in the event of an upper GI emergency such as a gastrectomy. This allows the opportunity to provide patients with the optimum evidence based emergency care.

3. Patients want to be treated by specialists as shown in patient surveys (13). We have asked doctors to consider who they would wish their own care to be delivered by, and it is has been made clear to ASiT that the EGS consultant model is not desired. 70% of the 3603 respondents to the Shape of Training survey reported that they would prefer to be treated by a doctor who deals with a high volume of cases within a narrow specialised range of practice (2).

4. Achieving minimum case numbers sufficient to maintain a specialist interest would likely prove difficult with the current structure of many EGS posts, relying upon the unselected emergency take (14, 15). Achieving satisfactory elective numbers while carrying out a predominantly EGS role may not be realistic.

5. ASiT feels strongly that appointing individuals as EGS surgeons, with a view to potentially moving onto more specialist elective practice after a number of years is a short-term and unsustainable option. Firstly, this appears to be a short-sighted and wasteful strategy, as it may lead to the attrition of specialist knowledge and skills developed within an individual’s training. This may lead to a subsequent need to re-learn or ensure that the knowledge and skills are sufficient for independent specialist practice once again. The case-mix of many EGS posts may not involve the complexity adequate to maintain specialist skill, and conversely the more challenging and complex cases may need specialist input and may not be done by an EGS surgeon. Appointing EGS surgeons in place of specialist surgeons’ risks eroding the diversity of the skill mix of general surgical departments over time, and thus the quality of the
service that can be provided to patients. Secondly, surgical trainees are clear that they do not want a subconsultant grade, and feel creation of a subconsultant would not be in the best interests of patients or surgical training. To this end, posts that promise several years of EGS followed by subsequent specialisation are causing alarm among trainees. Among 1365 respondents to a survey of surgical trainees, almost 9/10 (87.4%) stated that they would not consider a subconsultant post (16).

6. There are significant differences between the EGS models in the USA and in the UK. With the ongoing, and even worsening state of NHS funding, we feel it is unlikely there will be adequate investment in EGS to make it a rewarding and sustainable career in the UK, or indeed, similarly in the Irish health service. Indeed, surgeons are already at significant risk of burnout (17). We worry that EGS consultant posts, with sub-optimal and underfunded support, will create conditions highly conducive to burnout.

7. The results of the second round of the NELA audit make it clear that there are many service and infrastructural elements that ought to be changed, outside of the surgical consultant’s input, to improve emergency general surgical care. Appointing EGS consultants will not solve the crisis in emergency care. Investment in social care, radiology services, and access to elderly care services, along with a myriad of other service improvements, is needed to achieve long term improvements (12).

Trainees are in an ideal position, on the frontline of patient care, to have an informed appreciation of what the service needs. ASiT believes the service needs sustainable general and special interest jobs for surgeons that allow them to achieve excellence in surgical care provision. We foresee, as a model for the future, emergency general surgical services provided by surgeons that are both general and specialist surgeons. The exact model for service delivery may vary from unit to unit, but options include the current “on-call” model,
or other units where consultants provide a block of emergency cover alternating with elective work, e.g. a ‘surgeon of the week’ model, which may involve an acute surgical assessment unit. This model has been delivered successfully in similar settings in the UK (e.g. in Wales) and abroad (e.g. Melbourne, Australia; Limerick, Ireland) (18,19,20). Other examples of balancing EGS commitments with subspecialty practice include that employed in Nottingham, where the EGS service is arranged so that every specialist rotates through a block of EGS for a short time-period during the year, and maintains their speciality work for the rest of the year. For larger units, such as Edinburgh, specific subspecialty on-call rotas may be both feasible and preferable, like many centres in the USA, with “upper GI on-call” for example, based on the data emerging on outcomes (8, 9). This may require overnight subspecialty rotas, but more often access to subspecialist care the following day for patients who can be temporised overnight.

It is possible to improve trainee’s emergency general surgery exposure by introduction of modular blocks of EGS placements, where trainees rotate through a block where they cover the emergency theatre in the daytime (18). This does not require specific EGS consultants—instead, in the Welsh model this training is delivered by general and special interest surgeons rotating through their on-call commitment (18). What is required is sufficient infrastructure for this to be feasible, such as an emergency theatre.

There is a real danger that by not providing sustainable satisfying job plans for consultants, general surgery may become so unattractive to trainees that it struggles to recruit and retain high calibre surgeons for the future. Already, competition ratios at national selection for general surgery have dropped rapidly from 7:1 to 2:1 (21). To continue to attract and retain high calibre surgical trainees into general surgery, ASiT’s vision of the end-product of surgical training is a general and special interest surgeon who is well able to handle the demands of
an unselected emergency general surgical take, as well as their special interest practice (2,3,4,5). This model we feel is best for patients, as well as providing long-term sustainable job satisfaction for surgeons.

We look forward to your support in this matter,

Many Thanks,

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References


