Sub-specialization in general surgery – the end of the 'general' surgeon?

Sir,

As general surgeons in the UK National Health Service (NHS), we are operating in a time of uncertainty as a result of the debate on centralization and sub-specialization of our profession. The impetus for change (Expert Advisory Group to the Chief Medical Officers of England and Wales, 1995), exemplified by vascular and breast, is improvement in outcome; the rationale is that surgeons with large single-procedure workloads yield better results. However, this controversial process, together with proposed senior house officer reforms (Department of Health, 2003), has major implications on the provision of elective and emergency services.

The current organization of UK surgical services is subdivided into elective and emergency surgery. 'Hub and spoke' organization of elective services is centred on large district general hospitals (DGHs) and teaching hospitals. These high-volume centres with a large population-base, manage pathologies requiring multidisciplinary support and expensive surgical equipment; for example, oesophagogastric malignancies. Opponents of centralization claim that smaller DGHs can achieve equivalent results by 'networking' across trusts, therefore maximizing resources (Dickson et al, 2001).

In emergency surgery, some speculate on difficulties that may arise when specialists perform procedures outside of their elective repertoire; for instance, a hepatobiliary surgeon performing a hemicolectomy. Some larger centres appear to solve this problem by introducing parallel emergency sub-specialty rotas; specialists, therefore, do not operate in anatomically unfamiliar territory. Another solution is to create a separate speciality of 'emergency surgery'. Some argue that this is unnecessary as 'Calman' trainees should be competent in all emergencies.

In DGHs, the above proposals are not feasible within existing resources, and after full implementation of the European Working Time Directive (EWTD) in 2009, far greater consultant numbers will be required to run legal rotas. The Government's solution is to expand the consultant workforce by increasing the number of trainees and shortening training, leading to certificate of completion of training (CCT) within 5 years of graduation. Some feel that the product of this process is a 'sub-consultant' grade.

We propose a more rational reorganization for DGH emergency and elective services. By considering procedures on complexity, rather than anatomy, we believe that a DGH 'generalist' could manage all emergencies, and variety of benign conditions over a number of sub-specialties; for example, varicose veins to benign breast disease. A large and wide-based elective workload is maintained to yield good results, prevent boredom from an extensive single procedure repertoire and loss of emergency skills.

We consider the Government's proposals and suggest that on achieving CCT, a trainee could be employed as a DGH 'generalist'. Further post-CCT training would lead to a 'specialist' position to manage more complex pathologies as discussed above. Within existing resources, DGH surgeons cannot become true 'specialists' as emergency surgery demands a wider experience.

To maintain acute services and keep the NHS local, DGHs will need to evolve to accommodate the demands of a modern health service; quality of care, outcome, and EWTD. Otherwise, cessation of acute services and conversion to day units will occur, to the detriment of the local population. We suspect that the situation in teaching hospitals will progress to encompass a true emergency sub-specialist service. Here, the 'general' surgeon will become a dying breed, before finally facing extinction.

Prabhakar Rajan
Senior House Officer
Nasim A Din
Consultant Surgeon,
Department of Urology,
Western General Hospital, Edinburgh,
and Department of Surgery,
St John's Hospital at Howden,
Livingston EH54 6PP
(E-mail: prabs_rajan@yahoo.co.uk)

Expert Advisory Group to the Chief Medical Officers of England and Wales (1995) *A Policy Framework for Commissioning Cancer Services (Calman-Hine Report)*. Department of Health, London

Department of Health (2003) *Modernising Medical Careers. The response of the four UK Health Ministers to the consultation on Unfinished Business: Proposals for reform of the Senior House Officer grade*. Department of Health, London

Dickson GH, Waters R, Bull J, Kaul V, Sitzia J (2001) Should we continue oesophageal surgery in a district general hospital? A review of 200 consecutive cases. *Ann R Coll Surg Engl* **83**: 167–71