The future of general surgery: a global or a national issue?

Sir,

I read with great interest the editorial discussing the potential future for general surgery (vol 72(6), 2011, p. 304). I have been working as a non-governmental organization surgeon in conflict and catastrophe zones for the past 18 years or so, and I am also a general and vascular surgeon in a well-provisioned unit.

Over the last 5 years or so the interest in global health has increased dramatically, almost to the stage where panic has set in that there may not be enough surgeons to perform surgery in the developing world any more. It is true that modern-day training programmes create the specialist and surgical technology has advanced. I think it is wrong, however, to assume that the specialist is unable to operate outside of his/her field and, taking this further, I believe that there should be programmes set up for global surgery within major institutions.

The reasons for surgeons not being able to give their time to patients in the developing world are the significant constraints applied to them by their trusts, mortgages, family and private practice. Surgeons who work in the developing world are usually highly motivated with a real passion for learning skills which have probably not changed over the past 30 years. If surgeons want to learn how to do a caesarean section then they can operate with an obstetric colleague. It could be argued that any surgical procedure can usually be learnt by a bit of lateral thinking and by going on relevant courses. Talking to experienced non-governmental organization surgeons would be a good start.

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Sir,

I was interested to read the editorial by Sharma and his colleagues on the future of 'general surgery'. I qualified 63 years ago, in the very month that the NHS came into being. On my first house job, my chief dealt with everything apart from ear, nose and throat, eyes, gynaecology and orthopaedics. Indeed, he was very upset that the latter team had taken over the fracture cases.

When I retired in 1989, the year the first laparoscopic cholecystectomy was performed in London, I still practised as a 'general surgeon'. My list might include a parotid tumour, a thyroid swelling, a cholecystectomy (by open surgery), a blocked femoral artery or a patient with piles. However, even then it was obvious to me that our urologist was much better at prostatectomies using the endoscope than I was with open surgery and that the vascular surgeons were very skilled at carotid surgery; I was referring these patients to the experts.

Today, specialization is here and one thing that I have learned in a long career is that there is no going back! The authors mention military surgery – but today our seriously wounded troops in Afghanistan are being treated by surgical specialist teams, unlike previous campaigns, and the remarkable successes being achieved are the result of this.

What of the third world? Of course medical schools in developing countries must go on training generalists but, at present, I am afraid this has to be a secondary consideration to the needs of our specialists in training in the UK.

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Clarification

In the review of *Acute Adult Dermatology – A Colour Handbook* (vol 72(6), 2011, p. 357) it was not made clear that the book is also available on portable devices.