Personal viewpoint

Digestive surgery is a stillborn specialty in the United Kingdom

Gastroenterology is recognised as being one of the important subspecialties of medicine; should not digestive surgery be equally important in the specialty of surgery? Once I thought that the answer was yes; now I have my doubts. The specialty of surgery has nine recognised subspecialties while medicine has over 25. Gastroenterology has been a recognised subspecialty of medicine for 30 years whereas gastrointestinal surgery is still part of the specialty of general surgery, together with endocrine, vascular, transplantation, and oncological surgery.

In mainland Europe there have long been departments of digestive surgery; first in university hospitals and then in public hospitals. In the USA there are chiefs of gastrointestinal surgery in most large hospitals. The USA subspecialty of gastrointestinal surgery, however, has little or nothing to do with colon and rectal surgery, which is an entirely different subspecialty with its own training programme and specialty boards. In the American College of Surgeons there are 12 advisory councils of the surgical subspecialties with one in general surgery, one in colon and rectal surgery, and one in paediatric surgery; all of which participate, at least in part, in gastrointestinal surgery. The subdivisions of surgery in the UK, USA, and mainland Europe are therefore different. In the USA and UK there is no such specialty as 'digestive surgery' despite the efforts in mainland Europe to create such a unity.

The specialist associations and colleges reflect these discrepancies.

Springing from Europe was the Collegium Internationale Chirurgiae Digestivae, which aimed to unify digestive surgery but was never recognised as doing so by the hepatobiliary or colorectal specialists. In the USA there is the Society of Surgeons of the Alimentary Tract but this makes no attempt to embrace the specialty of colon and rectal surgery; although nowadays almost half their scientific meeting programmes contain papers pertaining to the hind gut. In the British Society of Gastroenterology surgeons form a numerous and powerful group. There is a single surgical section whose meetings include papers of studies on all alimentary and digestive subjects, including hepatobiliary-pancreatic, oesophagogastric, fore and hind gut, and nutrition. Is this BSG surgical conglomeration of practical contemporary value? Does it have any relation to training? At present it seems to do so but what of the future?

If, in a small district hospital, there are three or four medical specialists, it is almost inevitable that one physician will have a major interest in all matters alimentary and digestive and will be called a gastroenterologist. This is appropriate and logical. There is a common basic physiological and pathological training needed for gastroenterologists so they can treat their allotted patients. There are also similar technical skills needed to inspect or sample diseased tissues or organs in and around the gastrointestinal tract. It is to these gastroenterologists that their medical colleagues will refer difficult problems from oesophageal stricture though cholestasis and pancreatitis to ulcerative colitis and Crohn's disease. The surgeon cannot so easily be 'Jack of all alimentary trades'. Many years ago, when I was beginning my surgical training I was

appointed as a general surgeon and had the temerity to tackle all problems of the alimentary, breast, vascular, and endocrine system that came my way. I did so to convince the potential referring general practitioners that I was as affable and available as I was able. In the 1960s, the emerging discipline of regular audit and mortality and morbidity conferences soon made me realise that I should become a specialist. I decided to specialise and to become a digestive surgeon. In those days that meant becoming a gastric surgeon because, after all, that is where digestion took place! I concentrated my research interests on the nutritional sequelae of gastric operations but I also dabbled in heroic *tours de force* for cancer of the oesophagus, stomach, and pancreas; without acquiring sufficient concentration of experience to rise above the amateur ranks. All general surgeons did open cholecystectomy; some dedicated more to speed than accuracy! All of us thought that it was our right to share our carcinomas of the rectum with our senior house officers because then we all did abdominoperineal resections. The experience was wide, varied, and interesting but we dabbled.

I continued to concentrate on the sequelae of gastric surgery and in the design of physiologically elegant operations, which were so difficult to perform so that only a few of us could do them well. I thought that I was the ultimate specialist digestive surgeon. We measured acid and little else besides, we had slide rules, and sported p values. Our chief concerns were what to call our 'super operation' and how many books we could write on the subject. Then digestive surgery began to die; perhaps even before it was born. It was not killed by H₂ receptor blockers but by a declining incidence of symptomatic peptic ulcer; possibly related to better hygiene and less helicobacter.

In 1985 I did 90 proximal gastric vagotomies and 15 gastric reconstruction operations; five years later the respective numbers were five and two. Gastric surgery for non-malignant disease was evaporating before our very eyes and gastric cancer was becoming less common. Other interesting trends occurred; firstly it became possible to measure anorectal function, accurately and reliably. Mensuration and narrow margins of observer error led to more number crunching and a new wave of p values; this time related to studies of the distal hind gut. Presentations to the Surgical Research Society moved from hydrochloric acid to colonic motility and anismus. Next some talented hepatobiliary-pancreatic specialists began to show that they achieved much better results in primary and secondary surgical intervention in these alimentary appendages. At the same time other technical perfectionists began to publish figures showing much longer survival and less morbidity for resection of the distal oesophagus and of the distal rectum than we general digestive surgeons were achieving. A few surgeons were so talented as to be expert in all these fields but for most of us it was 'horses for courses'. I feel that you need to be exceptionally dexterous to be a good hepatobiliary surgeon, a perfectionist to be an oncologist but, if you are intellectually hyperactive, you can become a coloproctologist. As I perceived that digestive surgery was dying from starvation I 'upped anchor'

and drifted down the alimentary tract and finally came to rest in the hind gut. Such was the absence of specialisation that I could make this transition even though it meant acquiring new skills. Had I been in the USA or even Australasia where coloproctology was a protected subspecialty I would not have been able to cross the mid gut threshold. Perhaps today this separatism is right and perhaps digestive surgery is not a unified art.

Now that I am retired I can survey the surgical scene in my role as an interested non-combatant. It is my opinion that the technical skills and related research techniques are so different in the different branches of what was once digestive surgery that we should accept an even narrower subspecialism. I believe that surgeons, after finishing their training programmes in general surgery, should either remain as true general surgeons or take another two year training in oesophogastric (fore gut), hepatobiliary-pancreatic (appendigeal) or colorectal (hind gut) surgery.

Only then would they be true subspecialists. This might ensure that difficult cases were sent to specialist centres and that surgeons who are expert in minimal access biliary surgery do not feel that they could tackle all gastrointestinal problems from coloanal anastomoses to faecal incontinence.

Gastroenterology is a big subject and the surgical skills needed to treat it are diverse. Those specialists who claim to be expert in the difficult or complex problems should be trained and tested in one of three or more of defined subspecialties.

In Birmingham I was the first Professor of Gastrointestinal Surgery, perhaps I should also be the last!

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