Training for digestive surgery

Change, and acute change at that, is the norm for the whole of the medical profession these days. In the field of training, surgical gastroenterology is no exception to this rule. Whether one is responsible for the training or a recipient of it, the effect is little short of bewildering. Of a host of topics that could be chosen, I wish to concentrate on three. The first, and perhaps the most important because it affects all the others, is the tug-o'-war between the specialists and the generalists.

SPECIALISM v GENERALISM
It is obvious that anyone who specialises in a small area of a craft is statistically likely to achieve a higher standard in that area than someone whose range of activity is wider. For that reason, and quite appropriately, progression towards greater specialisation has been evident for some time. However, there is a reverse side of the coin: the dyed-in-the-wool specialist may render himself blinkered to material outside his speciality, even when it has a direct bearing on the treatment of a particular patient who seems to fall into his sphere. As is usually the case with a controversy, the answer lies somewhere between the two extremes. Exactly where it should lie depends on the answers to two questions. How shall we train surgeons for a particular system? Can that system work and flourish in the particular circumstances of our health service?

The present system of training of general surgeons in the United Kingdom lasts theoretically five years after basic training (at senior house officer level) is complete and the final professional examination is taken in the fourth year, and concentrates on one of several specialist fields such as urology, orthopaedics or otolaryngology, each with its specialist advisory committee to supervise and monitor all aspects of training. Gastroenterology in this context is just a part of general surgery, and moves are afoot to subdivide general surgery into (at least) gastroenterology, peripheral vascular, and endocrine/metabolic surgery. Most people would agree that this, at least, is reasonable. But this is not enough for the inveterate specialists, who want to divide gastroenterological surgery into upper (gastroesophageal, pancreatico-hepato-duodenal) and lower (colorectal) subspecialities. Presumably, if this is accepted, the training will need to split appropriately, and also the terminal examination.

To work in practice, and remembering that in any medical centre it would not be enough to have one of any particular genus of subspecialist – at least two and preferably three surgeons would be required to allow for holidays and junior staff rotas – then the number of surgical gastroenterologists on the staff of every district general hospital would need to be at least 2 x 2 = 4 or as much as 3 x 3 (if gastric and pancreatic are separated) = 9. And we have not yet considered the number of vascular and endocrine surgeons needed. Even assuming that one day we get the long promised expansion in consultant surgical numbers, it seems unlikely that appropriate staffing levels will be reached unless the average size of the district general hospital is trebled, either in fact, or at least in effect – that is, by cooperation between neighbouring district general hospitals. This last possibility has not been made easier to achieve by the formation of Trusts, which are self-governing institutions designed to increase the competition rather than cooperation between hospitals. For the purpose of the final professional examination, therefore, the subspecialties in gastroenterological surgery should remain integrated in the training programme. The resultant gastrointestinal surgeon with experience of both upper and lower tracts could subsequently focus in either direction as the manpower situation permitted.

FLEXIBLE ENDOSCOPY
Secondly, where does surgery stand with regard to flexible endoscopy?

The generation of surgeons to which I belong looked at flexible endoscopy when it arrived, and many of us decided that its practice was too time consuming, and not sufficiently attractive, to seduce us from our main love of cutting. The great disadvantage of not doing our own endoscopy is that we needed to rely on our physician colleagues for descriptions of the internal living pathology and for the provision of samples for biopsy and other investigations. All surgeons have been surprised at operation by unexpected findings, which they felt they might have been better able to interpret if they had seen the endoscopic appearances themselves. This is a natural professional jealousy, and nearly always quite incorrect, but the tendency to feel this has led an increasing number of younger surgeons to undertake their own flexible endoscopy. There is evidence that one third of the upper gastrointestinal diagnostic endoscopy is now done by surgeons, and the Association of Coloproctology of Great Britain and Ireland rightly insists on training in colonoscopy.

The really interesting point is, what about the therapeutic upper tract endoscopy? Learning the procedures is even more time consuming than is the diagnostic mode, and the operator must keep in regular practice. All this militates against a substantial surgical input, but now that much of abdominal surgery is being done with artificial vision it seems to me that there is a place for super specialised upper tract surgeons who do their own endoscopic retrograde cholangiopancreatography and therefore have only themselves to blame if a sphincterotomy produces bleeding.

LAPAROSCOPIC SURGERY
The amazing success of the laparoscopic approach to abdominal surgery, particularly with regard to cholecystectomy, has raised problems about how the training should be given. There was a tendency in the early days for the trailblazers to suggest that laparoscopic techniques should be confined to special centres, but this is today clearly unrealistic. Every surgeon who operates on the
abdomen is likely, within five years, to incorporate this technique in his armamentarium. When that becomes true, and at least for those procedures like cholecystectomy that are common, every surgeon will presumably be able to train his junior. At present, the use of the technique is already widespread but far from universal, and it is therefore important for training to be concentrated in those centres that have made good progress. It is particularly interesting that video is so important to the technique: it raises the possibility of teaching at a distance, the supervisor taking the trainee through an operation from a remote station. Apart from cholecystectomy, however, the role of laparoscopy in abdominal surgery is far from defined, although colonic resections, the repair of hiatal hernia, and proximal gastric vagotomy are promising. It is even possible that the balance of treatment in the last two conditions, so much displaced towards medicine rather than surgery at present, may be swayed back towards surgery if the operations can be done safely for a one to two day stay in hospital.

The great success of laparoscopy has raised an interesting point for the specialists to argue with the generalists. In the field of surgery, with its great emphasis on manual dexterity and skill to achieve the best results, is it possible that specialisation according to organ group is the wrong road to follow? Maybe gastroenterological surgeons should be divided into laparoscopists, endoscopists, and open operators? Although it would be a pity if the surgeon who found a contraindication to laparoscopic cholecystectomy was not competent to convert to the open procedure.

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Clinical training – back to the future

‘Experience is the name every one gives to their mistakes’
Oscar Wilde, Lady Windermere’s Fan

More than a decade has passed since our welfare state displayed a health service second to none. This distinguished era in Danish medicine came to an abrupt end in 1981, when a new agreement was forced upon junior doctors by the government against the advice of all Danish doctors, their professional associations, and their scientific societies. The authorities required that working hours, including night service and time for training, were reduced to 40 hours a week. Having reached the goal the government was forced to a further reduction in working hours to 37 hours a week as a result of a new compromise with the unions.

This offshoot of the general community policy in Denmark originated in the politicians’ ambition to improve environment and working conditions for all wage earners in the country. As predicted by junior as well as senior doctors a disastrous discontinuity in clinical work and clinical training was soon revealed. In an attempt at compensating for the reduction in working hours a structural change of postgraduate education and training has now been introduced with the purpose of speeding up the production of specialist doctors. Unfortunately, no economic resources for training programmes were allocated and no time for senior doctors to accomplish bedside education, performance feedback, and on the job surveillance was granted. Frustrations bloom, especially among junior doctors, who admit that nothing in their student careers prepared them for clinical work. The particular Danish experiment, which was carried into effect under nearly absurd conditions, may have satisfied politicians’ and hospital administrators’ wish to see specialist doctors perform patient care. By doing this at a discount price clinical training threatens to mirror H C Andersen’s fairy-tale The emperor’s new clothes. To add insult to injury the implementation of the junior doctors’ agreement has turned out to be used as a concept for calculation of wages by foregoing 150% or more to compensate for night work. One question that now remains to be answered is what challenges policy makers will face when the National Health Service reacts by squeezing still more junior doctors through the education system in still shorter periods of time? Another question to be answered is how drastic will qualifications of future consultants, in particular surgeons, decrease when the opportunity of acquiring practical skills is lost?

There is little information on the way in which politicians and hospital administrators cope with their mistakes. What we see is that they still display the principle of the greatest happiness of the greatest number of patients – other things being equal at the expense of the patients. The short working hours combined with a severe pressure from the junior doctors union explain why there has never been so many doctors employed in Danish hospitals. It is also true when politicians argue that there has never been so many permanent positions in the Danish health system. A 37 hour week, however, permits less than 50% of junior doctors to be present at all times and a future surgeon will typically have only 70–80 days during a 9 month training period to perform his practical skills during work on the day shift. This provides the important obstacle for maintaining continuity in patients’ care and junior doctors’ education. The ‘inappropriate’ use of doctors is a problem that has defied solution in Denmark, partly because the problem has itself originally been defined by doctors, produced in excess during the late 1970s, and not by patients.

A multi-level of permanent posts for senior doctors was recently introduced to obviate the lack of qualified doctors in the hospitals. The new reform of genius, converting educational posts into permanent posts threatens to eliminate the first – and ultimately the problem itself – when educational posts no longer exist. The French would say ‘après nous le déluge’, but in Denmark we are more steady – awaiting how and when qualified candidates for the new permanent posts will appear.

A third important question, which remains to be answered, is whether research makes better doctors. The short answer given by many junior doctors may be no, but