Position Statement on the management of emergency surgery at the general, paediatric and urological surgery interface

Aim

The aim of this document is to suggest a framework for collaborative working between our three Specialty Associations to achieve high standards of patient care.

Background

Professor Keith Willett, Tsar for urgent and emergency services, has stated that the next phase of the NHS Review is to develop practical solutions to deliver an urgent and emergency care system which is robust, efficient, and responsive to the needs of patients and the public. The GMC states that all doctors must adhere to the GMC's Good Medical Practice and make the care of patients their first concern, while recognising and working within the limits of their competence. Whilst these are excellent principles, there is increasing evidence that the standard of provision of emergency general surgery varies considerably across the country. In addition, there have been increasing problems with regards to provision of emergency surgery at the interface between general, paediatric and urological surgery. Potentially the same difficulties could arise within vascular surgery within the next few years. Whilst there is no evidence that such problems are in any way contributing to variation in mortality in emergency surgery, it is very clear that areas of interface are reducing the quality of care for patients.

In recent years training has become relatively more sub-specialised at a much earlier stage. Trainees now have reduced exposure to the generality of surgery; they may sometimes have ambiguity about their consultant support and become uncertain about their responsibilities.

The Shape of Training Review (SoTR) by Professor Greenaway, which is supported by the four UK Departments of Health, has identified that early specialisation and lack of experience in treating the generality of medicine is not in the interests of patients and the employers. Whilst there is concern as to how highly technical specialist surgery, for instance neurosurgery, would fit with the implementation of the review that is not the case with general/paediatric/urological emergencies. Many are common problems and can be dealt with under normal circumstances by a competent generally trained surgeon.

The interface problems have several origins.

1. There are three separate SACs dealing with the three specialist areas training scheme in general having no connection beyond CT2.
2. The General Surgical SAC have decided that general surgical ST3 and above trainees should not see urological emergencies. The reasons for this are detailed further below.
3. As a result of a previous proposal that elective GPS be provided by specialist paediatric surgical services in a hub and spoke model, there is now a reluctance amongst many surgeons to treat paediatric cases including emergencies.

There is a general view that general surgery registrars covering adult emergency take should be able to make assessments of common urological conditions. However they may not have all the relevant operative competencies needed for further intervention, and senior urologists must be available to supervise. Resistance to covering urology by general surgical trainees is multifactorial but often driven by inequity. Middle grade urology rotas are seldom complete so it is often the case that urology SpRs provide similar out-of-hours cover to those of urology consultants, such as cover from home and weekend ward rounds, and yet they commonly have identical banding to general surgery trainees for whom the emergency take can be very onerous. Adding urological emergencies with a significant time commitment and no training value makes the SpR emergency environment worse and there is a commonly stated observation that urology trainees may only take an interest in emergency patients in specific circumstances. It is these issues that led the General Surgery SAC to remove SpRs from participation in urology emergency cover.

Paediatric surgery is a small specialty concentrated in specialist centres. In these centres general surgery trainees are not normally involved in the emergency care of children, but trainees are commonly involved when working in hospitals which do not have a specialist paediatric service. Common conditions include abdominal pain/appendicitis, and testicular torsion. The current guidance is that children under five should be referred to a specialist centre. Although age five is a reasonable guide there was concern that this was insufficiently flexible. Over this age and assuming paediatric medical, nursing and anaesthetic services are present, all hospitals should be able to manage such patients but it is clear that adherence to this is erratic. Not only are there variations from hospital to hospital but there are also numerous examples of the same hospital dealing with acute surgical problems in children on some days of the week and not on others depending on the expertise of the consultant on call. Long patient transfers for conditions such as testicular torsion or acute appendicitis are well recognised and undesirable.

Emergency surgery

Foremost the provision of emergency surgery is a service issue. Although important, the training role is subsidiary to this. Ultimately Hospital Trusts must determine how they provide safe emergency care for the common surgical conditions, particularly those that cross specialty boundaries. It is then the responsibility of the SACs to set the curriculum to train the surgeons of the future to deliver these goals and have the competencies to deliver the care required. Ultimately the curricula of the ISCP will need to change in line with the needs of this service and in keeping with the aspiration described in SoTR. This paper seeks to give outline guidance on how we can make progress toward these goals.

The way forward

The two issues are training and service:

Training

The SPAs and SACs would need to agree that the direction of travel outlined in the SoTR and the three curricula should be reviewed and aligned to ensure that common competencies can be established. Solving this problem would require:-

1. The urology curriculum to include more general surgery and vice versa
2. Urology trainees up to a certain level (to be determined) to be included in a combined emergency rota.
3. GPS to become a more routine part of GS curriculum.

Detailed discussion of these proposals is likely to identify problems, most of which are surmountable. Agreement between GS and Urology is needed on the acute GS rota. Concern is expressed over dilution of general surgical experience in EGS if more trainees are on the acute rota. However as night shifts are not usually good training opportunities and most worthwhile training is during daytime, a larger rota may actually increase exposure to training opportunities.

Further discussion is needed about what competencies are needed in each specialty. In brief, all surgeons must be able to assess the acute scrotum and manage testicular torsion (general surgery and/or urology) and be able to assess abdominal pain and manage acute appendicitis (general surgery) in the over five year olds.

Service

Across the UK all significant DGHs offer acute urological services. The pressure concerns middle grade staff where, on the urology side, a compliant rota cannot be established and, on the GS side, there is antipathy towards covering emergencies in another specialty. At present Foundation and Core trainees cover urology. The changes to the structure of training outlined above have the potential to alleviate this problem, but it is essential that consultant urologists support trainees who have highly variable experience in this setting.

Consultant cover for paediatric emergencies in DGHs is presently problematic in some areas. This has resulted partly from the national drive to ensure that elective GPS only be performed by surgeons with appropriate sub-specialist training. An unforeseen and unwanted consequence of this is that many DGH consultants will decline to treat emergencies in children under 16 and hence refer on to a specialist centre, claiming lack of experience. However this division is not one seen in, for example, orthopaedics or ENT where children are a large part of the normal workload. The problem therefore lies between paediatric and general surgery. With respect to emergency paediatric surgery it could be argued that all existing general surgeons and urologists should be able to manage the common acute emergencies such as appendicitis (general) and torsion (general and urology).

Trusts therefore have to determine what services they provide. Prerequisites for a children's surgical service are medical paediatrics, appropriate nursing care and anaesthetists trained in paediatric anaesthesia available 24/7/365. In the event of a Trust providing emergency paediatric surgery it is imperative that surgical cover is available every day of the week. The situation where ambulances take children to different hospitals on different days is no longer acceptable.

BAPS have indicated the wish to support DGHs in the provision of GPS and hopefully consultants who are unwilling to undertake emergency surgery in children may be mentored. It would however be unwise to underestimate the difficulty in reversing the trend of the last two decades.

Summary

The SoTR by Greenaway gives us the opportunity to restructure training across three specialties in surgery and improve the quality of care given to patients with acute surgical conditions. However change is never easy and problems with implementation are inevitable. Detailed discussions on the curricula are required. Even more difficult may be changing the working practices of established consultants.

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