Conference Report

Problems of surgery in the European community

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Last week in the Royal College of Surgeons in Edinburgh, while over 500 young surgeons sweated and fretted over their fellowship exams downstairs, about 50 senior surgeons sat upstairs and spent a day and a half discussing some of the problems facing surgery in Europe. The problems threatened most of the young men downstairs, and yet unfortunately there was only one surgeon in training at the conference. Nevertheless, their seniors thought long and hard about among other things manpower, training, and assessment, and the ideas produced should help the young men's future, which at the moment in most of Europe looks somewhat bleak.

Working and training

To set the scene for discussion on manpower and training and to make clear the similarities and dissimilarities of practising surgery in different European countries the first sessions were most concerned to discover how surgeons from the various countries spent their time. Essentially they led similar lives: for most surgery was their life, and time was their problem. As Professor Charles Dubost from Paris said: "All surgeons get up too early, scrub too often, sweat a bit, work too late, sleep too little, and do this all year long." (Scandinavia is something of an exception, but more of this later.) Surgeons' time was divided between operating, consulting with patients, teaching, researching, and administering; all of them resented paper and committee work, but they found that with so many specialties competing for limited resources they had to do more and more of this work to protect their demesnes.

Indeed, it will comfort British surgeons to discover that their pet hates and worries are shared by other European surgeons: in most countries money was increasingly short; private practice was being eroded; and unions were becoming more militant. Moreover, although there were no waiting lists in France, Professor H Wagner of Nuremberg said that in Germany there was a three-year waiting list (for both his public and private patients) for a hip arthroplasty in his astonishingly well-equipped hospital.

The problems of established surgeons pale in significance, however, when set along side those of training surgeons. Manpower was one of the problems that most concerned the conference, and Europe is awash with training surgeons without permanent jobs to go to. Scotland, England, Ireland, France, Norway, Sweden, Denmark, and Holland all have this imbalance between

training surgeons and permanent jobs. Unfortunately, Italy, which has the worst problem and was spoken of with horror by delegates, was not represented at the conference, but Dr Knud Lockwood from Copenhagen pointed out that there were 180 000 medical students in Italy (as opposed to about 17 000 in Britain, though it must be remembered that many of the Italian students are in their first year of training, to which there is free entry, and many do not ultimately qualify).

These problems have arisen because of the impossibility of calculating how many surgeons a country needs; because of the economic, political, and social restraints working in all countries; and because of the unwillingness of the profession to be shepherded too much. Dr Graham Scott of the Scottish Home and Health Department described the failures of past committees in Scotland to predict numbers, spelt out the difficulties of prediction, and then made it clear that it was the money available that really counted in the end anyway. Nevertheless, for some time the Scottish Home and Health Department has controlled the number of senior registrar posts, has now frozen the number of junior posts, and will ultimately have to reduce them. He went on to say that he thought it inevitable that consultants would have to do more of the routine work and that some kind of subconsultant grade might be needed. (There was much unhappiness expressed about the word consultant. Some Europeans thought that consultant surgeons consulted and never operated, and another objection was that the words consultant and subconsultant set political hackles rising immediately.) Surprisingly perhaps, most of the surgeons did not find unacceptable the idea of consultants doing more routine work: they thought that it might even be fun.

France has a manpower problem in surgery that is even worse than Britain's. A recent commission set up to reorganise surgical training calculated that France needs 150 new surgeons a year, but at the moment 300 are being produced. Professor D Rignault (Sainte-Mande) explained that France does not need any new orthopaedic surgeons for the next five years. A new system of training and manpower control will be introduced in 1982, and the French think that this will do a lot to improve the image of French surgery, which has been declining.

Dr Lockwood drew attention to the gross discrepancy that exists between a Europe with too many surgeons and too few patients and the Third World with millions of patients with easily treated surgical conditions and few surgeons. There must be some way, he thought, by which Europe can help train Third World surgeons and send some of its excess surgeons to where their skills are badly needed. What is needed, perhaps, is a kind of surgical Brandt report. This gave rise to discussion of the problems of overseas doctors in Britain, and the British contingent explained how these had all too often been exploited rather than trained. Professor Michael Brady from Cork thought that European units should offer a more basic and appropriate training to overseas surgeons, and his unit is already doing this.

After manpower the conference turned its attention to the closely related topic of training, and it was here that Europe held its biggest surprises for the British. In Scandinavia, as Professor Folke Nilsson explained, the increasing number of laws governing time off and holidays (there are no fewer than 13 laws in Sweden) have presented serious problems for surgery. Swedish law dictates a 40-hour working week, and those who work more than this can be compensated with time off. Also with holidays and study leave most Swedish surgeons work only a 35- to 40-week year. With such short working hours it may be hard for surgeons to do enough operating to keep themselves competent. Worse still, training surgeons may never be able to achieve acceptable competence. Swedish surgeons have recognised these problems and have laid down that surgeons must do at least 200 hernia-equivalent operations a year. (This fanciful notion of hernia equivalents will be unfamiliar to most British doctors, but it is a system whereby a hernia repair acts as one operation, something like a gastrectomy may count as three, and cystoscopies and the like don't count at all.) Thus a limiting factor in calculating manpower needs in Scandinavia is the number of operations there are to be done. Other problems created by these short weeks are continuity of patient care and continuity of the surgeon's education: nothing educates a young surgeon better than his own complications, and it is important that he sees them.

Just as the work of a surgeon in various European countries is much the same so it became clear that the training they receive is becoming more and more similar as well. The new French system—which was introduced in part because of worries about how, for example, an orthopaedic surgeon could qualify without any experience of abdominal surgery—will be very similar to that now prevailing in Britain. There will be a “common trunk” experience of general surgery followed by several years of higher, specialist surgical training.

Mr John Cook, an Edinburgh surgeon, delivered a paper in which he raised various points about surgical training that he thought were open to debate. Firstly, he wondered about how the basic sciences are taught and examined: of course, all surgeons need good knowledge of the basic sciences, but they might best be learnt along with the clinical sciences. The

consequence of this was that they should be examined at the end of training and not at the beginning as an admission ticket to training—as happens at the moment. The whole question of how you select a surgeon for training becomes more important when the numbers entering training are controlled, and yet few delegates had a clear idea of how best to select candidates. It was for this reason among others that most thought that some competition (and its corollary, wastage) was essential to ensure high standards.

All the surgeons were agreed that it was necessary for all surgeons to have some experience of general surgery, but there was some confusion as to how this was best achieved. Was rotation through a series of specialist departments or a long attachment to a general department better? Early exposure to several specialties helped the trainee decide on his future career but it militated against his being given increasing responsibility.

Turning the focus to the problems of assessing higher surgical training, Sir Robert Wright, chairman of the General Medical Council, explained how there was dissatisfaction with the present British system. Three new ways of assessment are being considered. The first is a system whereby trainees are interviewed in their penultimate year of training by a specialist from a national committee. A second is the introduction of higher surgical exams, and the Edinburgh College has already introduced such exams on a voluntary basis. Some of the delegates were worried about what would happen to those who failed if such exams became compulsory. A third way of surveying higher surgical training is for a record to be kept of all the operations done, by both the trainer and the trainees. This is already done in Germany, the United States, Australia (where they include also information on associated morbidity and mortality), and Holland.

Dr J Th H Grond from Amsterdam told the conference about the Dutch system: various aspects in the training system had been exposed, and many training centres—even some university hospitals—had been disallowed from training surgeons for a short period. He advocated strongly that Britain should adopt such a system, and the implication was that the authorities might be surprised by what they found.

Mistletoe extract (Iscador) has been used enthusiastically in the treatment of cancer, especially for gynaecological malignancies in Germany and Switzerland for many years. What is current opinion about its effectiveness, especially with regard to treating ovarian carcinoma?

The use of mistletoe extract (Iscador) was advocated by Steiner, Koffler, and Wegman in 1958, when it was prescribed under the name of Viscum Album. So far as I am aware, mistletoe extract has never been subjected to a proper trial and is listed under “Unproven methods of cancer treatment or management” by Horton and Hill.¹ My opinion (and I think many of my colleagues') would be that this is of no value and should not be used to treat ovarian cancer when there are many suitable and effective conventional chemotherapeutic agents.

¹ Horton J, Hill GJ. Unproven methods of cancer treatment or management. *Clinical oncology*. London: WB Saunders, 1977:185.

A young woman's fiancé has recently recovered from hepatitis B and is still Australia-antigen positive. What are her chances of acquiring this disease sexually?

Most patients who recover from acute hepatitis type B eventually clear the hepatitis B surface (HBsAg) or Australia antigen from their serum, often in a few weeks—although sometimes this may take longer. In 50% of cases the HBsAg persists in the serum, and these men are likely to be infective to their female sexual partners if they also have the “e” antigen (HBeAg) in their serum. Testing for this is therefore worth carrying out. If the antibody (anti-HBe) is found then the chances of their transmitting infection are very small. The likelihood of sexual transmission of hepatitis B virus will be reduced by the

use of the contraceptive sheath, since the virus is known to be present in the semen and transmission probably occurs through small tears in vaginal mucosa. Virus particles may also be present in the saliva, although transmission by oral contact is probably rarer.

Is there any surgical contraindication to the removal of a very large pseudomucinous cystadenoma of the ovary in a healthy mobile 70-year-old woman?

It is impossible to be sure that a large ovarian tumour is benign without removing it.¹ Even a benign cyst may continue to grow and eventually prove fatal because of pressure effects. Moreover, if the patient is not healthy and mobile her problems may be partly due to her large cyst. Therefore large ovarian tumours must be removed. There is little advantage in preoperative siphonage, unless the patient's breathing is embarrassed. Operation may be difficult because of adhesions, and caval compression must be avoided. The greatest danger comes from postoperative complications.^{2,3} These include intestinal distension and perforation,¹ respiratory difficulties, and cardiovascular collapse, which may—for reasons that are not entirely clear—occur after a delay of a few days. Therefore facilities should be available for resuscitation and intensive care, including assisted ventilation and management of difficult problems of fluid and electrolyte balance. Nevertheless, complications are a serious risk only with the largest tumours, and most patients recover uneventfully.

¹ Symmonds RE, Spraitz AF, Koelsche GA. Large ovarian tumor. *Obstet Gynecol* 1963;22:473-7.

² Hoile RW. Hazards in the management of large intra-abdominal tumours. *Ann R Coll Surg Engl* 1976;58:393-7.

³ Hunter DJS. Management of a massive ovarian cyst. *Obstet Gynecol* 1980;56:254-5.