Vascular surgical training

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Invited commentary

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Driven by several factors, vascular surgery has changed significantly over the last decade, most important of which is the increasing use of endovascular treatments. At the same time, sub-specialisation has evolved within general surgery with vascular surgery having travelled further down the path towards becoming a separate specialty than most other disciplines. These developments have raised particular issues with regard to patient access to endovascular treatments across the UK and the natural concerns of current vascular trainees regarding their competence to deliver modern vascular care as future consultants. These two questionnaire-based studies help inform the debate and developments currently ongoing in these areas in the UK.

The Rouleaux Club confirms in its questionnaires that the overwhelming majority of UK vascular trainees want endovascular training to be mandatory, that they would wish to practice in a monospecialty on consultant appointment and that vascular should separate from general surgery to form its own specialty. Opinion from radiology and vascular trainers and vascular trainees in England was that there were insufficient numbers of interventional radiologists to deliver treatment, particularly on an emergency basis. Perhaps surprising was that the majority of radiology trainers would have no objection to training vascular trainees and frankly recognised that recruitment to interventional radiology continues to decline significantly. The authors conclude that integrated training of vascular surgery and interventional radiology should be implemented in England citing the example of several such successful training programmes abroad.

The Vascular Society has been working to resolve these issues over the last 4 years in collaboration with the British Society for Interventional Radiology (BSIR), the Royal College of Radiologists and the three UK Royal Colleges of Surgery. In 2006, the statement *A Joint Training Pathway in Vascular Surgery and Interventional Radiology* was issued and can be accessed from the websites of both the BSIR and the Vascular Society. The prime importance of joint training pathways is stressed with the concept of the 'Vascular Specialist' trained to provide high-quality vascular service with skills in both endovascular and vascular surgery.

During 2007, a proposed curriculum based on modular training was developed by the Joint Working Party, and is currently under consideration by the Training Committee of PMETB. There is now a real possibility that the first Vascular Specialist CCT could be issued in the middle of the next decade. The working group has also addressed the problem of current vascular trainees and, indeed, consultant vascular surgeons who wish to be trained in endovascular techniques. Over 35 trusts have been identified able to provide 1-year exchange training programmes with surgeons training in interventional and endovascular techniques, and interventional radiologists being trained in clinical vascular care and basic open vascular procedures. The implementation of these new training posts is imminent.

Because of specialisation and the European Working Time Directive, vascular treatment increasingly must be delivered by a team skilled in all aspects of vascular care – medical, endovascular and open surgical. The reality is that current

provision of vascular care is patchy with the majority of trusts unable to deliver 24-h access to interventional radiology and indeed a staggering 25% unable to provide emergency vascular surgical care. The coming together of vascular surgery and interventional radiology will provide not only high-quality service for our patients but also the wherewithal to provide excellence in training for the future vascular specialist. The need to centralise delivery of vascular services is acknowledged by the Vascular Society and the Association of Surgeons of Great Britain and Ireland.¹ The process of centralisation will be difficult but has already begun with the majority of vascular centres in England

coming together within Vascular Networks. Increasing the volume of vascular work will raise the profile of peripheral vascular disease, improve outcomes and be of vital importance in delivering training within the time constraints of the European Working Time Directive and shortened specialty training programmes. Change for the better in both provision of vascular care and training of vascular specialists will become a reality in the near future.

Reference

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Future of vascular surgical training: the trainees' views

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ABSTRACT

INTRODUCTION In the UK, surgical training includes all aspects of general surgery. Vascular surgery is not an independent specialty. We wished to assess the views of vascular trainees in UK on the future of vascular surgery and training.

MATERIALS AND METHODS Trainees were surveyed in 2003, 2004 (after introduction of the European Working Time Directive) and 2005, concentrating on four areas – future practise of vascular surgery, role of endovascular training, vascular specialisation and future training.

RESULTS The majority of trainees want to practise vascular surgery alone. In 2003, 80% thought training should include endovascular techniques. By 2005, all trainees regarded training as mandatory as endovascular techniques would represent a significant part of their future work. Opinion changed on training; from 4 years general then 2 years vascular surgery (qualification in general surgery) to 2 years general and 4 years vascular surgery (specialist qualification in vascular surgery; $P < 0.0001$). Opinion also changed, that vascular surgery should split from general surgery to form its own speciality ($P < 0.0007$).

CONCLUSIONS Trainees now regard training in endovascular techniques and endovascular aneurysm repair as mandatory. The majority wish to specialise from general surgery and achieve a separate qualification in vascular surgery.

KEYWORDS

Vascular surgery – Training – Audit

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In the UK, surgical training includes all aspects of general surgery. Formerly, trainees spent 1 year as a house officer, 2–3 years as a senior house officer, and 6 years as a registrar. In addition, most trainees undertook 2 years in

research. As a registrar, all trainees do 6–12 months vascular surgery and a similar time in other specialities of general surgery. Sub-speciality training was undertaken in the final 2 years, the exit qualification was for general