Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

COMMENT ON

doi 10.1308/003588408X285766

JK Pye. Survey of general paediatric surgery provision in England, Wales and Northern Ireland. *Ann R Coll Surg Engl* 2008; **90**: 193–7

doi 10.1308/003588409X359169

General paediatric surgery provision

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We read with interest Pye's article on general paediatric surgery (GPS) provision. This topic is of particular interest to all specialist paediatric surgical trainees: the imminent increase in the amount of GPS coming to tertiary centres has the potential to affect our training adversely, and the nature of our future consultant practice will be dictated by where GPS is carried out and by whom.

Pye rightly describes the 'tipping point' that GPS provision has reached with many consultants currently carrying out the work in district general hospitals (DGHs) set to retire in the foreseeable future and ambivalence towards the work amongst general surgical trainees. We are presented with a monopoly on GPS provision that we have not sought. Currently, this is occurring with little overt planning and our tertiary centres are at risk of being burdened with cases previously undertaken in DGHs, with no planned increase in theatre space, manpower or funding. We must, therefore, and with some urgency, devise solutions to this problem in order to ensure we can continue to pro-

vide the safe, quality service our patients expect and deserve. We also strongly believe this should be done locally if possible, a view shared by the DGHs, where both consultants and senior managers have expressed a desire to continue to offer GPS.¹

The attitude amongst specialist paediatric surgical trainees is that whilst we wish to be specialist paediatric surgeons, we recognise that GPS is a significant part of our practice and will remain so in the future. A recent survey of our peers (unpublished personal communication) demonstrates a willingness to undertake GPS in DGHs. Some 75% are prepared to do so in combination with specialist work in tertiary centres for all or part of their careers with a further 10% ready to make DGH GPS provision the whole of their consultant practice.

Pye surveyed 235 hospitals, of which 25 already had a tertiary level paediatric surgical service and a further 72 did not offer an elective GPS service. This leaves 138 DGHs that will need cover for GPS in the future. If each specialist paediatric surgeon was appointed to a tertiary centre with a day a week spent in a DGH undertaking GPS then these hospitals could be covered by specialist paediatric surgeons, particularly given the proposed optimum workforce provision of four specialist paediatric surgeons per million population.² Similarly, Pye calculated an elective case load of 22,490 cases per year. Assuming five cases on a list and one list a week for 40 weeks of the year, this would require 113 surgeons to cover the work load. This is an achievable estimate and well within the proposed target expansion in workforce numbers.

Emergency cover is rather harder to model due to its inherent unpredictability. The majority of this work will be appendicitis and acute scrotal pain. In otherwise healthy patients over the age of 5 years, both of these conditions should be well within the remit of any competent general surgeon and anaesthetist. It is hard to envisage how removal of elective day-case surgery would cause de-skilling sufficient to render them unable to manage these conditions. Indeed, the surgeon who takes on prime responsibility for the elective cases could be encouraged to take on training for the management of the emergency cases. In younger patients and those with more complex presentations, transfer to a tertiary centre may well be the most appropriate action. However, having a paediatric surgeon on call for every DGH 24 h a day will not be practical, even given expansion in paediatric surgery, and the routine transfer of all emergency cases is impractical for logistic and geographical reasons.

On balance, we therefore support the development and promotion of a 'hub-and-spoke' model of joint appointments between tertiary centres and DGHs for the provision of elective GPS, with examples of successful implementation shared

nationally to support development elsewhere. Of course, one size will not fit all and some areas, notably Scotland and perhaps the South West of England, will be better served by local general surgeons continuing to undertake the GPS. In such centres, training adult general surgery trainees to undertake GPS is a logical step. Provision should be made to enable any general surgeons who may choose to undertake this work to get the training they require in their local DGHs.

What is clear is that strong and decisive leadership is required in order that we can make use of the limited time available to plan the workforce that will be needed, put in place the necessary training systems and agree funding streams for new appointments. Accurate data will be necessary to allow correct decisions to be made. We feel discussions should be taking place between all the specialties involved, particularly between paediatric and general surgeons and we would welcome the opportunity to contribute to these discussions as future consultant paediatric surgeons.

References

1. Gomez K *et al.* *Survey of paediatric surgery in Wales*. Presented at ASGBI Annual Scientific Meeting, Manchester, April 2007.
2. British Association of Paediatric Surgeons. *Reconfiguration in Paediatric Surgery*. London: BAPS, 2003.

AUTHOR'S RESPONSE

doi 10.1308/003588409X359178

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I thank Yardley and colleagues for their interest in my paper on the future provision of general paediatric surgery. They have correctly identified that the problem has appeared in a gradual, unplanned fashion and that if it continues will not be welcomed by anyone. Their proposed solution, however, does not recognise some of the practical realities that will prevent a single provider of GPS being the answer.

Hub-and-spoke already exists as part of the provision of care. The majority is currently provided by appropriately trained general surgeons and urologists. At recent meetings of BAPS/APA and ASGBI, both in the first half of May 2008, this subject was discussed at length. There was unanimity on the fact that a problem is approaching, and that provision of care should be given locally wherever possible. The mechanism of that provision was not put in place, because it was recognised that there is no simple

solution. The problems are 3-fold. First, the volume of work is such that it cannot all be absorbed into the tertiary centres; therefore, paediatric surgeons would have to travel to the DGH. If a paediatric surgeon decided to just do GPS (as suggested by Yardley and colleagues), there is an insufficient volume of GPS work in any individual DGH to give a full week's job plan. Also, the geography, if an individual were to be employed by more than one trust, is such that much travelling would be required. In many parts of the UK, excluding the remote and rural scenario referred to, DGHs are frequently many miles apart. This constant travelling would make for a poor working life for an individual and is thus less attractive than is implied. Second, the expansion of paediatric surgeons called for by Yardley and colleagues is not a realistic proposition in the current political climate. Finally, as alluded to in their letter, the emergencies are still left unprovided for. Whilst the volume of these is relatively small, the cases that require observation is rather greater, and these children are rarely 'ill', but need treatment. Where would the children be observed, and by whom? Also, it seems unreasonable to ask parents and children to travel many miles for a minor abscess to be drained, when the capability is surely available locally.

All are agreed that safe, local care should be maintained wherever possible. The reality is that this will be provided by a variety of 'types' of surgeon. The key here is not really 'who' does it, but that this problem is pushed up the agenda of trusts and SHAs so that appropriate solutions can be put in place region by region. The essential requirement here is to establish training for sufficient individuals so that safe, local provision of care can be maintained. Agreements are needed between tertiary centres and DGHs to establish a sensible network of care. The training committees for both general surgery and urology as well as paediatric surgery need to have discussions so that a sensible training arrangement can be put in place to allow GPS to continue to be provided close to the patient.

COMMENT ON

doi 10.1308/003588409X359141

A Day, M Sayegh. Infacol to reduce the bubble effect at endoscopic ultrasonography. *Ann R Coll Surg Engl* 2008; **90**: 347

doi 10.1308/003588408X358747

Swallow the medicine

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Even easier is for the patient to swallow a dropperfull (0.5 ml) of Infacol® (Forest Laboratories UK Ltd, Bexley, Kent, UK) in 10 ml