THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

35-43 Lincoln's Inn Fields London WC2A 3PN
Telephone: 01-405 3474 Cables: COLLSURG LONDON WC2

Office of the President
Mr. Ian P. Todd, PRCS

03 March 1988

The Rt Hon Margaret Thatcher MP
10 Downing Street
LONDON SW1

Dear Prime Minister

May I first say how grateful I was to you for sparing the time to come and have lunch here at the College.

You asked me to write to you about the need for better surgical care in the National Health Service, and I enclose a Memorandum which I hope will be of help to you.

I was glad to have the opportunity to tell you something about the role of the College and its Faculties of Anaesthetists and Dental Surgery. I might also have mentioned that there is a body known as the Conference of Medical Royal Colleges and their Faculties in the United Kingdom, of which I am Chairman. All the Colleges carry out a similar function, namely the maintenance and improvement of standards for the common good. It was in this context that this College produced the documents which you took away with you. I know that the Conference would be very pleased to assist you at any time with the task you have ahead.

Yours sincerely

Ian Todd

MEMORANDUM ON SURGICAL STAFFING IN HOSPITALS

The problems of patient care in relation to surgery in the acute sector are extremely complex. Some of them have been addressed in documents published by the College's Commission on the Provision of Surgical Services:

1. General Surgical Manpower within the UK

2. The Composition of a Surgical Team

3. Guidelines for Day Case Surgery

4. Surgical Services for Small Communities

Taken in conjunction with the Report of the Confidential Enquiry into Perioperative Deaths (CEPOD), one can suggest where some of the problems lie and how best they may be tackled. All these problems influence how waiting lists and waiting times may be reduced.

The UK has fewer consultant surgeons per head of population than any other Westernised country, even taking into account the differing hospital services. We have too many junior doctors in training who have little chance of advancement to consultant status; we have a large number of overseas doctors in training posts, spending up to four years in the UK at Senior House Officer/Registrar level, and who, incidentally, help in meeting the service needs. The total number of overseas doctors may fall in ensuing years, although we hope to improve their quality through our Overseas Doctors' Training Scheme. To meet the staffing problem, a very considerable expansion of the consultant body in general and orthopaedic surgery is needed, and THEN a decrease in registrar numbers, phased over about a ten-year period. This expansion is not occurring at present, although the recommendation was set out in the Government-sponsored documents "Achieving a Balance" and "Plan for Action". In part, the reason for failure of expansion is funding, and, in part, the disinclination of unit managers to appoint surgeons, who are expensive compared with some other specialists who do not require operating rooms, specialised investigations and equipment, and anaesthetic support.

There are many obvious advantages in increasing the surgical consultant body. Patients are more likely to be cared for by a consultant and we all wish to see a consultant-based service. THe CEPOD report bears out that junior doctors should NOT be undertaking some of the surgery currently delegated to them, and that supervision is often far from ideal. With more consultant surgeons the training of these young doctors will be greatly improved and, I believe, the consultant surgeons themselves would have time to reflect upon their own service contribution.

Day case surgery and surgery carried out in small hospitals must be undertaken by consultant surgeons or under their direct supervision, as patient after-care in both these instances is minimal. Only in this way can successful results be achieved. It will be appreciated that, if carrying out a day case list, the surgeon cannot be functioning in an in-patient operating room. Thus, to maintain an adequate turnover within the hospital, further trained pairs of hands are needed. What has happened is that day case surgery has been used as a means of closing beds and saving money. If this occurs, waiting lists are not reduced unless further staff are appointed.

The CEPOD report emphasises the need for Quality Control. It is vital that this procedure is ingrained in the education of the junior doctor. The consultant surgeon must have time to take part in this programme, time to attend committees and conferences. These commitments need to be built into all job descriptions which, currently, does not happen routinely. However, there is evidence which suggests this will be so in the future.

As a subsidiary thought, I have long felt that experienced senior surgeons, at about the age of 60, could be persuaded to leave their major commitment and take on the care of surgery in small hospitals. This would benefit the small community, improve local patient care, use a surgeon's talent to the full and allow a younger person to take on the more exacting role at the major district hospital. Emergencies and complicated surgery are seldom carried out in small hospitals but are moved to the nearest centre. With this suggested scheme, the surgeon in the "cottage" hospital would not need to do more than he/she felt was suitable, given the local facilities - referring onward those cases which would be more safely dealt with at the major district hospital. The consultant surgeon from the district hosdpital, who normally services the small hospitals, perhaps once a week, could, by this means, arrange his timetable more efficiently and economically.

I have confined my remarks chiefly to the general and orthopaedic surgeons, as there is a great inbalance between consultant/junior staffing in these specialties. Although in some smaller specialties there is need for expansion, the problems are less acute and manpower difficulties can be balanced comparatively easily.

IAN P. TODD
President