

EMERGENCY GENERAL SURGERY: THE FUTURE A CONSENSUS STATEMENT Association of Surgeons of Great Britain and Ireland



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FOREWORD

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In 2006, the Executive Committee and Council of ASGBI felt that Emergency General Surgery (EGS) was a topic that warranted discussion to define clinical practice, service delivery and organisation, to ensure that all patients admitted to hospital as an emergency receive the highest quality of care. Initially there was divergence of views about the best model of future care. By debate, discussion and a Consensus Conference we arrived at this Consensus Statement, which has widespread support. This Statement addresses the problems of Emergency General Surgery, but the principles can be applied widely to all surgical specialities and others with a significant commitment to emergency work. This will encourage further debate and the principles should be adopted within the wider medical community.

I would like to thank all those who have contributed to formulating our ideas on this important topic, but in particular to Denis Wilkins, whose vision initiated this review. The Steering Committee was led by John MacFie, who ensured that a focused, coherent, document emerged from our labours; he was assisted by John Monson, John Primrose and Jonathan Tilsed.

Professor B J Rowlands

President

Great Britain and Ireland



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Introduction

For much of the past decade, the surgical Specialty Associations and the Surgical Royal Colleges have advocated the separation of acute and elective surgery. Political focus has been almost exclusively on the need to reduce waiting times. This has resulted in a target mentality to the provision of healthcare and a massive injection of resources into elective surgery. In contrast, there has been significant underinvestment in the provision of emergency surgical services for many years.

This paradox has occurred because most politicians and, indeed, many clinicians have failed to recognise that emergency general surgical admissions comprise the largest group, by an considerable majority, of all surgical admissions in this country. Despite this, many surgeons regard the care of their emergency 'take' as an inconvenient interruption to their dedicated specialist interest. This has inevitably resulted in allocation of scarce resources away from this clinical area. The Association of Surgeons of Great Britain and Ireland (ASGBI) considers that this to be to the detriment of these patients. Our view is that it is essential that there is an increased recognition of the importance of emergency care such that resources, management and training can be appropriately allocated. Emergency General Surgery (EGS) should not be allowed to become a 'Cinderella' subspecialty. All would agree that the standards of care provided to patients should be the same whatever the nature or time of their admission.

The configuration of the emergency surgical service will not develop in isolation. With increasing involvement of the private sector in the delivery of hospital care, and the consequent influence of market forces, the future shape of the NHS is uncertain. The provision of emergency surgical services is likely to remain a core NHS function and appropriately trained surgeons will be required to deliver it.

Emergency General Surgery is not simply elective surgery performed out of hours. Patients presenting with acute and elective problems are fundamentally different and often require a very different approach particularly with regard to investigation, decision-making, optimisation of clinical condition and choice of operation. This emphasises the need for appropriate training, which, at present, can only be provided within the general surgical curriculum leading to CCT.

Consensus Conference

To consider the above issues, the Association held a Consensus Conference at the National Railway Museum in York on Wednesday 28th February 2007. The purpose of this one-day conference was to explore the options for the provision of Emergency General Surgery in an attempt to inform the debate.

Consensus Statement

Immediately following the Consensus Conference a working party produced a 'bullet point' summary of conclusions. This was published in the Association's *Newsletter* and placed on the website for consultation.

This 'bullet point' statement was modified and expanded in response to comments received and an '*Interim Consensus Statement*' produced which was distributed at the Association's Annual Scientific Meeting in Manchester in April 2007 and discussed at a meeting of the ASGBI Council and Speciality Presidents. This interim statement was, again, disseminated widely for consultation.

It was agreed that a final *Consensus Statement* would be produced by June 2007, thereby allowing sufficient time for comment from all interested parties. In particular, this enabled ACPGBI, ALS and AUGIS to discuss the document with their memberships.

We received extensive feedback on the *Interim Consensus Statement*. Comments were received from all Speciality Associations, the English and Edinburgh Colleges and numerous individual responses. We have collated these and included comment where appropriate whilst attempting to maintain a consensus view.

We hope this final 'Consensus Statement on Emergency General Surgery' will educate and inform and provide a focus for future debate and deliberation.

Conclusions

- 1. There is evidence that there is wide variation in the quality of Emergency General Surgery $(EGS)^{1}$.
 - 1.1 There was unanimity of opinion at the Consensus Conference that standards of care for emergency admissions were often unsatisfactory. Many consultants described their personal experiences of avoidable poor outcomes or gave examples of unsatisfactory care of emergency admissions.
 - 1.2 The factors responsible for suboptimal care included failure to prioritise, inadequate senior input, inadequate clinical leadership, unsatisfactory resourcing of infrastructure, unsatisfactory resourcing of manpower and poor management of the service.

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- 2. Emergency General Surgery is a huge clinical service, with approximately 1,000 Finished Consultant Episodes per 100,000 population/year². It is one of the most common reasons for admission to a surgical bed in this country.
 - 2.1 The workload associated with the care of Emergency General Surgical patients is far in excess (numerically) than that associated with any of the general surgical specialty associations or societies.
 - **2.2** Despite this clinical demand, this specialty area (Emergency General Surgery) has attracted little dedicated resource or commitment to training or research.
- 3. ASGBI recognises the critical need for dedicated clinical leadership of EGS. This is not simply the 'on-call' consultant. All Trusts which receive emergency general surgical admissions should have a named surgeon responsible for the clinical leadership of this important service. Only in this way will continuity of process, policy and standards be developed.
 - 3.1 It is strongly held, by the profession and management, that services which provide strong clinical leadership fare much better than those where it is lacking. Morale, commitment, quality of care and cost-effectiveness all improve where a strong sense of identity and purpose is engendered through effective medical leadership and good team working.
 - 3.2 Leaders of EGS, as with any other clinical service, are best selected from those with a clear understanding of the clinical process who can command the respect of colleagues and are seen to be committed to the provision of high-quality services. To be effective, such leaders require the support of management, and the devolution of sufficient executive power as well as responsibility.
 - 3.3 Clinical leaders of EGS services must be provided with the necessary time and resources to develop and maintain the services which they and their colleagues are responsible for providing. This dedicated time should not simply be on a rotation basis with colleagues if the service is to be developed efficiently.
 - 3.4 A vital component of the management of any service is clinical governance. ASGBI is keen to see the development of suitable standards and markers in this respect.
- 4. ASGBI believes that the care of emergency admissions often takes second place to the care of elective patients. This will only be resolved if emergency admissions have dedicated resources and senior surgical personnel readily available.
 - **4.1** Patients admitted through an unselected emergency 'take' are often the sickest and most challenging cases. It is clearly inappropriate for the care of these patients to be under resourced.

- **5.** There must be a clear and identifiable separation of delivery of emergency and elective care.
 - 5.1 The benefits of this are generally accepted. They include more dedicated management and improvements in clinical care, training and education. This may assist in contract discussions and in liaison with primary care.
 - 5.2 The expectation, therefore, is that more resources would be directed specifically towards Emergency General Surgery.
 - 5.3 When compared to elective care, resources for emergency care are not easily identified or ring-fenced. This makes them difficult to manage and this can place Trusts in a difficult financial position. Where resources are identifiable, they do not seem to be at a level equivalent to other services. It is worthy of emphasis, for example, that the level of dedicated consultant resource for EGS is much less than for elective surgery.
- 6. ASGBI recognises that EGS cannot be delivered through the adoption of a single model, and that local circumstances will determine the arrangements. Whatever model is adopted, it is essential that the principle of dedicated resource allocation applies.
 - 6.1 The factors that will affect the model adopted include catchment population, proximity to other centres, geography, available buildings, consultant numbers and skills and, finally, local preferences. On some occasions, the model adopted will result in complete separation of acute from elective care, whilst in others an integrated solution may be preferred. It should be noted that even in the smallest centres the principle of dedicated commitment to Emergency General Surgery still applies.
 - 6.2 ASGBI recognises a tension between the aspiration of the public for rapid access to health services at local level and specialist care of the highest quality.
 - 6.3 Patient transfer arrangements in this country continue to improve. This will, to some extent, mitigate the problems of access to an appropriate level of specialist care. This might enable some smaller hospitals to continue admitting emergency surgical patients.
 - 6.4 It is neither planned nor desirable that Emergency General Surgery (EGS) will emerge as a distinct speciality, with its own training and accreditation procedures. Notwithstanding this, we recognise that one model of care for emergency general surgical admissions is the appointment of dedicated 'clinical leads in emergency surgical care to galvanise and co-ordinate the efforts of consultant surgeons in each hospital'. This model already exists and, if it proves successful, may be adopted in many more large institutions in the future where emergency surgery comprises a significant workload.

- 6.5 Job plans for consultants involved in the provision of EGS should take into account this commitment. ASGBI recognises that the constraints of the EWTD together with the impact of MMC on the experience of junior staff are such that the workload for consultants providing EGS cover may become more onerous. This is likely to lead to many surgeons opting out of on-call when the opportunity arises. The inevitable consequence of these factors will be a need for additional consultant expansion.
- 7. Timely access to diagnostic services (particularly radiology), interventional radiology and emergency theatre time is often poor and is a major factor detracting from the efficiency with which emergency cases are delivered.
 - 7.1 The delivery of quality clinical care is dependent on access to supporting facilities. Rapid access to CT imaging, U/S scanning and laboratory analyses are critical to the efficient diagnosis, resuscitation and prioritisation of these patients.
 - 7.2 Inefficient or absent diagnostic facilities will introduce delays that, at the very least, are a nuisance to patients, relatives and surgical teams and, at the worst, are life-threatening.
 - 7.3 Access to theatres can be a major problem. It is the view of ASGBI that all hospitals admitting emergency general surgical patients should have a dedicated, fully staffed, theatre available at all times for this clinical workload.
 - 7.4 It is important that there are effective arrangements for refereeing the priority of competing interests at all times of the day and night. ASGBI considers that this is best delivered by dedicated clinical leadership.
- **8.** The assessment, prioritisation and management of emergency general surgical patients should be the responsibility of accredited General Surgeons.
 - 8.1 The purpose of an EGS service is to provide high-quality care for a broad case-mix of patients presenting either directly from primary care or the hospital accident and emergency service.
 - **8.2** General Surgeons, by virtue of their training, are expected to be competent to diagnose, assess and manage an unselected emergency surgical take at the point of CCT. Manage in this context means being responsible for the patient's care from start to finish or refer on where appropriate.
 - **8.3** It is not appropriate for medical or surgical colleagues from other disciplines to assume responsibility for the diagnosis and management of emergency general surgical admissions. ASGBI recognises that there will be some overlapping of interests in, for example, urology, vascular surgery and paediatric surgery.
 - **8.4** Patients admitted via the emergency general surgical service should remain under the care of this service until formally transferred to another team and accepted by them.

- 9. A trained and accredited General Surgeon is one who has completed a general surgical training programme (is on the specialist register and/or is a CCT holder). An essential prerequisite for the CCT in General Surgery is competence to manage unselected general surgical emergencies.
 - 9.1 All hospitals admitting emergency general surgical patients should have 24-hour cover by a consultant with a general surgical CCT or equivalent.
- 10. The largest component of the emergency general surgical case-mix is gastrointestinal. This workload largely equates to the proposed 'specialist gastrointestinal surgeon' as proposed by ACPGBI, AUGIS and ALS³ and described in the curriculum as 'general GI surgeon'. It is clear that both upper and lower GI surgeons are competent in the field of EGS with occasional back-up from other specialist colleagues.
 - 10.1 Emergency general surgical practice also involves a significant caseload of conditions not directly related to adult gastrointestinal practice. For example, paediatrics, hernia surgery, urological emergencies, superficial sepsis and trauma. Competencies in these areas are already included in the current general surgical CCT.
 - 10.2 Surgeons responsible for the management of emergency general surgical admissions may be involved in the management of rare occurrences such as major incidents, stabbings, gunshot wounds and multiple trauma. This necessitates an understanding of the principles of care, but this is not a substitute for specialist trauma skills.
 - 10.3 Surgeons providing emergency general surgical cover in remote areas will need to develop their skills and competencies to suit local needs.
- 11. ASGBI recognises the case for regional trauma centres. The trauma caseload is such, however, that all emergency general surgeons should not be expected to be expert in the overall general surgical management of complex trauma. However, the Emergency General Surgeon must remain competent in trauma management to the level defined in the curriculum. ASGBI recognises that trauma is a pan-surgical problem and general surgery is committed to the care of trauma patients in cooperation with the other specialities involved with trauma care. Where trauma centres exist, the Emergency General Surgeon may, or may not, be a member of the dedicated trauma team.
 - 11.1 ASGBI recognises that trauma centres are limited to those centres where all necessary specialist expertise and infrastructure already exists.
 - 11.2 It is important that all surgeons admitting emergency general surgical patients have a working familiarity with the protocols for the management of multiple trauma and close working links with the local trauma team and the nearest trauma centre.

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- ASGBI recognises that vascular surgical practice is undergoing significant changes and will probably not be involved with EGS in the future except, perhaps, in smaller relatively isolated hospitals. EGS does not include any arrangements for the management of acute vascular problems other than their initial triage if necessary. ASGBI notes that support for emergency vascular surgical cases (eg. interventional radiology) is not available in all hospitals.
 - 12.1 It is clear from trends within the specialty and training that separation of vascular surgery from general surgical practice in the UK is inevitable.
 - 12.2 It is expected that although some Trusts will still require/offer the opportunity for dual practice in general and vascular surgery from appointment to a consultant post this is unlikely to continue for much longer. It is probably undesirable for vascular specialists whose emergency practice is not underpinned by an elective practice in general surgery, to continue to admit emergency general surgical cases.
 - 12.3 Given the prevalence of peripheral vascular and dilating disease, it remains important that the presentation and initial management of these cases remains part of the general surgical curriculum leading to CCT. Surgeons admitting emergency general surgical cases should maintain a close working relationships with their local vascular teams.
- 13. The comments made in paragraph 12 regarding vascular surgery are also largely applicable to dedicated breast surgeons.
- 14. Surgeons managing emergency surgery patients should be as committed to CME related to emergency general surgery in a manner equivalent to their elective surgical practice.
- ASGBI supports the development of outcome related standards of care in Emergency General Surgery. The care of emergency surgical patients should be delivered to equal standards as those accepted for elective surgical practice. The principle of maintaining high quality outcomes for all surgical patients, whether elective or emergency, is fundamental to modern surgical practice.



Association of Surgeons of Great Britain and Ireland

CONSENSUS CONFERENCE: EMERGENCY GENERAL SURGERY

Wednesday 28th February 2007, National Railway Museum, York

ATTENDANCE

Allum, Mr William H Member, SAC in General Surgery

Armitage, Mr Jonathan D Affiliate Representative, ASGBI Council

Bishop, Mr Hugh M President, ABS at BASO

Black, Mr John Chairman, SAC in General Surgery

Blair, Mr Stephen Consultant Vascular Surgeon

Brohi, Mr Karim Consultant Trauma and Vascular Surgeon

Brooks, Mr Adam Consultant HPB and Trauma Surgeon

Cheslyn-Curtis, Miss Sarah Member, SAC in General Surgery

Dehn, Mr Tom Council Member, ASGBI

Dunkley, Mr Arthur Consultant Emergency Surgeon

Gair, Dr Nicholas P Chief Executive, ASGBI

Gough, Mr Michael J Vice President, VS

Grant, Mr Iain Consultant in Accident and Emergency Medicine

Griffin, Professor S Michael Past-President, AUGIS

Gwynn, Mr Brian R Member, SAC in General Surgery

Hill, Mr James Past Chairman, Education and Training

Committee, ACPGBI

Horrocks, Professor Michael Vice President, ASGBI

Khan, Mr Mohib Associate Representative, ASGBI Council

Khan, Mr Zulfiqur Consultant Colorectal Surgeon

Krukowski, Professor Zygmunt H President, BAES

Lamont, Mr Peter M Chairman Elect, SAC in General Surgery

Logie, Mr John Vice President, Royal College of Surgeons of

Edinburgh

MacFie, Professor John Honorary Editorial Secretary, ASGBI

Member, SAC in General Surgery

McKee, Dr Ruth F Member, SAC in General Surgery

Mellor, Colonel Simon G Member, SAC in General Surgery

Mercer, Miss Suzy Conference Administrator

Monson, Professor John R Chair, Clinical Services Committee, ACPGBI

Nelson, Professor Rick Consultant Colorectal Surgeon

O'Sullivan, Professor Gerald C President, Royal College of Surgeons in Ireland

Parks, Mr Rowan W Director of the Scientific Programme, ASGBI

Chairman, Education and Training Commitee,

AUGIS

Primrose, Professor John N Director of Education, ASGBI

Member, SAC in General Surgery

Pye, Mr Jonathan K Honorary Secretary, ASGBI

Rees, Mr Myrddin President, AUGIS

Ribeiro, Mr Bernard President, Royal College of Surgeons of England

Rowlands, Professor Brian J President, ASGBI

Tilsed, Mr Jonathan Consultant Colorectal Surgeon

Ubhi, Mr Charanjeit S Council Member, ASGBI

Ward, Miss Ursula Chief Executive, Portsmouth NHS Trust

Wilkins, Mr Denis C Immediate Past President, ASGBI

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