Commission on the Future of surgery

Thank you very much for asking for comments. I am very proud of the College and its achievements. I am delighted that you as a practising surgeon are leading on this important initiative. The Commission has potential for a huge impact across the public, media, profession and on how healthcare is viewed in the UK and beyond.

I realise my offering comes from a different angle than most of your submissions. A committee that considers concepts from diverse viewpoints produces more robust documents, output and direction.
I am happy to have my comments shared and quoted. I have numbered them to separate out the concepts.

General comments on the Commission on the Future of surgery:

1. Surgery saves lives. It makes people's quality of life better. Although costs may seem high, a one-off intervention can often allow a patient to resume their responsibilities in society and the intervention can be highly cost-effective. We should keep pushing these messages.

2. We should use the opportunity to educate the public about research and science. New innovative techniques may be exciting and newsworthy. Some do not stand up to review over time. Some will always be un-affordable, especially if dependent on NHS I.T. systems. Everyone loves an intervention that they can understand. But evidence-based healthcare is a good aim.

3. We have a charitable responsibility to get across clear messages about health. The excitement and images of new techniques should be projected alongside other clear messages on health, what surgery can do, the importance of lifestyle, primary and secondary prevention and valuing each person's health.

4. We need to be wary of equipment companies having too great an influence.

5. There is a danger that people will equate surgery with unachievable ivory tower perfection, whereas most surgeons do routine surgery, or 'set-piece' emergency/Trauma operations that are tested, have set protocols and excellent training programmes. We need the trail-blazing publicity of innovative surgery to show that routine surgery is also of value.

Future workforce implications:

6. Fewer medical students and doctors are choosing surgery as a career. We do not wish to put off potential good surgeons because all they see is alpha driven individuals and the excitement of new expensive kit. For some that will appeal. For others, a clear message about how patients' lives are improved with routine and tested surgery and team-based care needs to go alongside the message of new techniques.

7. We need to use our influence to help other medical students and doctors to have a better understanding of surgery, to know when to refer, what the patient may be offered and how to manage patients post-intervention.

Interventions that have the most success and specific ideas for the Commission:

8. Emergency General Surgery has a success rate that varies across different units. An opportunity to save lives that would have a high impact is in improving 'failure to rescue'.

9. With planning of services, there has been an assumption from politicians that 7-day services are the best way of providing care. In reality, other groups have shown high impact from 'hot clinics'. With the current pressures on finances and staffing, a 'hot clinic' model should be tested fully. For stroke, heart attack and childbirth there is an immediate need, but for other conditions, if GPs and Emergency Medicine Consultants of Extended Scope Practitioners had access to 'hot clinics' Monday-Friday with back-up services, at least 15% of 'emergencies' would avoid admission and have better care[i]. Can the Commission trial and advertise different models of care, rather than different techniques? [My MBA thesis was on re-allocating patients with wrist fractures attending as random events over 168-hours/week into 15-hours/week of Fracture clinic.]

10. Many advances in surgical care have been through agreeing multi-disciplinary protocols of care. For example, hip fracture care is protocolised to reduce dehydration, ensure early post-op mobilisation, etc and is monitored on whether the aim of surgery within 36 hours is achieved.

11. Many operations within the last months of life have dubious benefit. This is a concern with an increasingly elderly population with multiple co-morbidities. It would be useful to extend the Commission's focus to include other interventions, such as aids to decision-making[ii].

12. Lifestyle factors have a huge influence on surgical conditions. The evidence exists. Yet is not projected as something relevant to surgery. Exercise works as primary prevention (reducing the risk of ever getting breast cancer by 25%) and secondary prevention (reducing the risk of complications, eg reducing recurrence of bowel cancer, reducing the need for amputation with type 2 Diabetes, etc)[iii]. The difficult part is translating this into practice. Is there a way the Commission could study implementation of known non-surgical interventions?

13. The future of surgery needs to include education and management. Pioneers and enthusiasts can achieve amazing results, but we need the College's educational resources to develop courses for future generations of surgeons to learn.

14. Transplantation surgery and obesity surgery have stunning results. I am astonished that we do not yet have islet cell transplantation for Type 1 Diabetes.

15. In my own specialty, Trauma & Orthopaedics, joint replacement has life-changing results for patients. It feels as though innovative Orthopaedic surgery is in decline: doubt has been cast over the efficacy of arthroscopic shoulder surgery; the public and some Healthcare Professionals can have unrealistic expectations of the efficacy of spinal surgery compared with non-operative approaches; around 50% of osteoporotic fractures are preventable with lifestyle factors (exercise, nutrition, sunlight).

16. The public has the view that screening is universally good, with the paradigm that a disease could and should have been detected earlier. In contract, many conditions are those that a person may die with rather than of. It would be useful if the Commission could improve understanding of screening or, in specific cases, reduce the impact of false positive results.

17. I suggest you start an annual prize for an innovation, to keep the work going in perpetuity. (Surgeons, potential surgeons and others could submit an idea and present it.)

18. In my view, most discoveries were serendipitous. Good ones just take off. Translating ideas across disciplines can help progress. There would be benefit from working with others (eg Interventional Radiologists, and the RCoA peri-operative medicine group). It may be worth inviting a representative of each onto the Commission.

19. Research is vital. The NHS research ethics process is very difficult to navigate, especially for surgical interventions. It would be useful if the Commission could address this.

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[i] Association of Surgeons of Great Britain and Ireland (2012) Emergency General Surgery. SECTION 6.4. http://asgbidocuments.surgicalmembershipportal.co.uk/issues%20in%20Professional%20Practice/iipp_-_emergency_general_surgery_as_gone_to_press_.pdf

[ii] Courtwright A, Karlage Ami, Gawande A, Block, S (2014) Pitfalls in Communication That Lead to Nonbeneficial Emergency Surgery in Elderly Patients With Serious Illness: Description of the Problem and Elements of a Solution Cooper Z, Annals of Surgery: December 2014 - Volume 260 - Issue 6 - p 949–957 doi: 10.1097/SLA.0000000000000721 https://journals.lww.com/annalsofsurgery/Abstract/2014/12000/Pitfalls_in_Communication_That_Lead_to.2.aspx

[iii] Academy of Medical Royal Colleges (2015) Exercise the miracle cure and the role of the doctor in promoting it. http://www.aomrc.org.uk/publications/reports-guidance/exercise-the-miracle-cure-0215/