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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

The general surgeon

SIR,—Professor Miles Irving (15 March, p 741) writes that general surgeons should remain generalists and should resist the trend towards more specialisation. He is swimming against the tide that has already carried off neurosurgery, thoracic surgery, orthopaedics, and much of urology. Increasing specialisation within general surgery is now creating specialists in vascular surgery, and who knows how long it will be before head and neck or glandular surgery becomes an identifiable subspecialty. This process is not limited to teaching hospitals: I know of one district hospital in which the vascular surgeons do not wish to participate in the general surgical take but will take all vascular emergencies.

This increasing subspecialisation is not detrimental to the service. Most would agree that a specialist vascular surgeon will probably do a better job on an acutely ischaemic limb than the generalist whose vascular repertoire consists of femoral embolectomy and amputation. Professor Irving's comments about preoperative and postoperative care emphasise how much a specialist can contribute in addition to his operative skills.

Furthermore, specialisation does not harm training, in fact it improves it. A senior registrar attached to a succession of specialist firms will surely be better trained in what is available and possible in both elective and emergency surgery than if he were to spend his time with jacks of all trades, who dilute their expertise and their trainee's experience in a wide range of techniques.

The real danger in subspecialisation lies in the decline in gastrointestinal surgery, which is regarded by most surgeons as within their competence; thus those with a special interest in urology or vascular surgery continue to remove gall bladders and colons. Consultant appointments requiring a special interest in gastrointestinal surgery are rare outside the teaching hospitals, yet if advances in sphincter saving rectal excision and the surgery of ulcerative colitis, for example, are to be made available to most of the population surgeons with special skills and training will be required in district general hospitals.

Subspecialisation is inevitable and provides better care for the patient and better training for the registrar. The corollary of the definition of vascular and urological surgery as subspecialities within general surgery must be the recognition that gastrointestinal surgery also requires specialised skills and techniques. If a hospital has room for one or two vascular surgeons, as many district hospitals do, surely there is also room for a specialist in gastrointestinal surgery.

Surgeons with an interest in gastrointestinal disorders should consider whether the referral of cases between subspecialities is working equally well in both directions and whether they should be more forceful in promoting gastrointestinal surgery as a subspecialty in defence of their own interests, and those of their patients.

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SIR,—We agree with Professor Miles Irving (15 March, p 741) that the training of general surgeons should be sufficiently broad to ensure that they are competent to deal with the range of conditions that fall within their currently recognised ambit. The present training system appears to meet this requirement. Professor Irving also rightly recognises that the best results in complex surgical cases may be expected from surgeons with a particular interest in that area. As orthopaedic senior registrars, we were therefore astonished by the suggestion that orthopaedic surgeons with a major interest in trauma should be expected to maintain skills in abdominal and thoracic surgery. Competence in performing an emergency laparotomy or thoracotomy surely requires regular operative experience in that surgical area. How is this to be achieved? Are orthopaedic surgeons to undertake elective abdominal surgery in addition to their other duties? An intra-abdominal or intrathoracic foray in the severely injured patient by the occasional operator is to be severely discouraged except in the direst emergency. It would be an unnecessary risk in British hospitals, where both orthopaedic and general surgeons are immediately available 24 hours a day.

In Britain the concept of the general surgeon dealing with both visceral and skeletal injury is both impractical and unnecessary. The combination of skeletal and visceral trauma is uncommon in relation to the overall trauma workload. The techniques of fracture surgery are allied much more closely to those of orthopaedics than to general surgery in terms of surgical approaches, instrumentation, and implants. The general surgeon would surely find it difficult to keep up to date with developments both in his own subject and in the increasingly sophisticated techniques of fracture management.

In 1986 the general public rightly expects from the surgical profession the highest possible standards of trauma management. These expectations are unlikely to be met by the surgeon who is a jack of all trades. The skills that are required for the modern management of the multiply injured