The Developing Specialty of Hand Surgery: Training tomorrow's hand surgeons

D Power

Citation

D Power. *The Developing Specialty of Hand Surgery: Training tomorrow's hand surgeons*. The Internet Journal of Hand Surgery. 2006 Volume 1 Number 2.

Abstract

Post-graduate surgical training in the UK is undergoing a period of rapid change. Time spent in training programmes is being shortened at the same time as the constraints imposed by the European Working Directive are being realised.

A number of initiatives have been introduced in the UK to optimise time spent in training programmes. Out of hours work is being reduced with the “hospital at night” project where trainees provide cross cover for a number of specialties, training is becoming competency based with performance indicators (CEX, DOPS, PBAs and OCAP) and services are becoming increasingly consultant led.

There is a real concern, however, that trainees graduating from these programmes will have less operative experience and may not be fully equipped to make appropriate management decisions for their patients. Cynics have suggested that there is a political desire to create a sub-consultant grade where newly qualified graduates will have only a general “emergency-safe” workload and operate under the supervision of senior consultants. Further entry into subspecialty training in the form of fellowships will be open to a select few.

At the same time as the introduction of these radical reforms, there is increasing sub-specialisation within the surgical specialties. Hand surgery is no different. Traditionally, most hand surgery in the UK was performed by non-specialist orthopaedic and plastic surgeons or surgeons who had a major interest in hand surgery. A study carried out at the Pulvertaft Hand Centre in Derby has estimated the future hand surgery workload and workforce requirements for the UK. They predicted that there was a need for 100 specialist hand surgeons and 100 surgeons with a major interest in hand surgery.

UK hand surgery training is accomplished through either the plastic surgery or orthopaedic surgery routes with add-on fellowship training in the latter years. Unfortunately this style of training favours the creation of a consultant with a major interest in hand surgery rather than the whole-time specialist hand surgeon.

Perhaps the time has come for a specialist hand surgery training programme to parallel that provided in the other surgical disciplines? Such a programme could run over 5 years with exposure to both orthopaedic and plastic surgery techniques and create a truly rounded training. It would still be possible to include subspecialty training in the senior years in the form of fellowships in areas such as congenital hand, brachial plexus, neuromuscular conditions and oncological surgery. Trainee numbers would be regulated at entry to match the future workforce requirements. Training would be based in the larger units with several full-time hand surgery consultants, perhaps with sub-specialisation interests, but trainees would rotate to peripheral units with specialist hand surgeons. Trauma services would be centralised, as in other areas of trauma and emergency surgery and trainees would be exposed to large numbers of complex trauma and reconstructive cases in the training centre.

Could such a model work? Could the UK support such sub-specialisation? I have recently returned from a travelling fellowship in South East Asia where I was fortunate enough to spend a few days at the National University Hospital in Singapore. The NUH Department of Hand and Reconstructive Microsurgery is such a training programme which interestingly evolved from the orthopaedic department. High quality hand surgery and training is provided that crosses the boundaries between the disciplines of orthopaedic and plastic hand surgery.

Geographically, Singapore is very different from the UK and services are amenable to centralisation, but such is the unit's reputation that a large proportion of its reconstructive workload comes from Malaysia. Perhaps also it may be suggested that regulation of trainee numbers is more imperative in a smaller country where accurate workforce planning is necessary, but this does not mean that the same style of training could not be provided in the UK. Perhaps a single unit would create complacency? This has not been my experience in Asia. The UK is very different and a number of large and specialised hand surgery units would be able to produce high quality research output based on large series of patients, highly qualified specialist surgeons and provide a future benchmark for hand surgery not only in the UK, but also worldwide.

Dominic Power FRCS
July 2007

References

Author Information

Dominic Power, FRCS
Consultant Hand Surgeon, Birmingham Hand Centre