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viewpoint

Centres of excellence verus community critical care

THE general surgeon is dead — long live the general surgeon. Sadly unlike royalty, consultants' continuity of care in communities has gone forever if you observe what is happening across the UK. Like a bad 'spaghetti western' surgeons have corralled themselves under attack into so-called centres of excellence waiting for the 'blue lights' to arrive. Patients are now starting to let politicians know how much local health care is valued by voting, and some consultants are working with patient groups and primary care colleagues to preserve local care.

The leading article in the *BMJ* on reconfiguration of critical care services in the UK[1] struck a chord with me, being full of common sense with suggestions for possible ways forward. Coming from an area where our local district general hospital (DGH) is shutting services, first maternity, then emergency surgery and now A&E, I felt the need to express my disappointment and frustration with the collapse of much valued local services. Taking a step back, the big picture is looking much the same for all small DGHs and rural communities throughout the UK.[2] All 16 general practices in Lomond LHCC have been united in attempting to preserve services for our population since June 2003. Some imaginative thinking by GP, nursing and ambulance colleagues has enabled our 'out of hours' team to expand and take over the care of minor injuries overnight. It is disappointing to find less than whole-hearted support from our health board who will only finance the service on a 3–monthly basis, while spending over £3 million on enlarging surgical services 20 miles away. Our consultant colleagues, with a few notable exceptions, now see the closure of our local high dependency unit will mean acute medicine, Xray and laboratory follow close behind. Small wonder that the local population is up in arms and hugely concerned to preserve local hospital services, as are patients in Fort William to the north.[3] Patients are the losers with local service cuts by centralisation as travel is expensive and inconvenient. Important groups, such as the police, are not even consulted over proposed changes.

The blame for centralisation is attributed to the specialism in surgical services following the Calman training scheme and the European Working Time Directive. Surgeons are now realising that the new training gives very little 'cutting time' but the latest report from the Senate of Surgery is recognising the public's concerns: at least the summary of requirements for services in the UK and Ireland states the need for more surgeons to work more flexibly.[4] The problem for GPs at present is that there are not enough of us to cover the retreating surgeons while we do our normal daily work. We will all have to wait many years for any additional GPs and surgeons to emerge on the workshop floor. So maybe the surgeons are going to 'think out of the box' but statements like 'minor injury units have no place in treating the severely ill or injured patient' are not appropriate when it takes over an hour to reach the local 'centre of excellence'. Thus all the GPs in rural Argyll have 'BASICS' (British Association for Immediate Care) training and patients should be assessed and stabilised before transfer on to major centres many miles away by 'blue-light ambulance'.[5]

Teamwork is the answer to our immediate problems. New generalists are relying increasingly on our nursing colleagues with our receptionists and managers using information technology to provide the majority of care for chronic disease management. Centralists must realise that the public will not accept the burden of travelling many miles for services that should be provided locally. I hope the new generalists can help patients to retain the local services that are appropriate to an advanced European country in the 21st century.

Patrick Trust

References

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