Gynecol Surg (2005) 2: 45
DOI 10.1007/s10397-004-0084-2

LETTER TO THE EDITOR

Kevin Jones

Delivering laparoscopic surgery in the UK

Published online: 4 March 2005

The authors [1] have highlighted the important changes occurring in gynaecological surgery. However, they have not touched on the factors that limit the widespread adoption of these innovations in the United Kingdom.

The British Society for Gynaecological Endoscopy (BSGE) and the Royal College of Obstetricians and Gynaecologists (RCOG) are collaborating in order to develop special skills modules in laparoscopic surgery. The aim is to produce consultant gynaecologists who have mastered minimal access surgical techniques. Training people is one thing; being able to provide a service is another. The stark reality of the modern National Health Service (NHS) is that many consultants find themselves working alone in theatre or at best with different members of staff each week. In most hospitals there aren't enough middle grades to maintain the traditional firm structure, making it impossible to work with the same specialist registrar on a regular basis. This presents a real difficulty for most gynaecologists because we use a laparoscopic technique that requires two people. This is particularly true for endometriosis surgery. If the first assistant is a trained laparoscopic surgeon, the operation is often faster, safer, and ultimately more effective.

There is little point in training people to be laparoscopic surgeons if they are unable to use those skills because of staffing difficulties. So how can this problem be resolved? Some gynaecologists have developed a single-handed laparoscopic technique. For the majority of us, this is not the answer. I believe the solution lies in changing the way consultants have traditionally worked together. A large number of BSGE members have now visited minimal access surgery training centres in Europe, and these countries could provide a model for the UK.

In the units I have visited, teams of consultants work together in the operating theatre. This provides everyone with the opportunity to monitor each other's performance, update techniques, expand repertoires, and reciprocate teaching opportunities. This arrangement facilitates audit, learning, patient safety, and uniformity of management. It eliminates management based solely on an individual consultant's preference, which is frequently limited by his or her personal clinical skills. In the European system, anyone can acquire new skills as part of the normal working day. It truly is lifelong learning. If it were the norm for consultants to work together in theatre, our consultant colleagues who are not trained in laparoscopic surgery could acquire these new skills. This strategy, combined with the introduction of special skills modules for trainees, would facilitate the advancement of laparoscopic surgery in the UK. Most BSGE members would acknowledge that minimal access surgery has not been as widely accepted in this country as it has been in the rest of Europe. I believe this reflects the way we work, rather than a lack of will or skill. Unless we can follow the example of other countries and "work smarter," the NHS will fail to meet both public expectations and the aspirations of the RCOG and BSGE.

Some consultants in the UK have already adopted this collaborative approach. They have introduced joint theatre lists for minimal access surgery, or they work as a multidisciplinary team with a laparoscopic colorectal or urological surgeon. I believe the BSGE and RCOG should actively promote this practice and that it should become part of our professional culture.

K. Jones
Great Western Hospital,
Swindon, Wilts, SN3 6BB, UK
E-mail: Kevin.jones@smnhst.swest.nhs.uk
Tel.: +44-1793-604020

References

1. Downes E, O'Donovan P (2004) Changing trends in gynaecological surgery—a challenge for training. Gynecol Surg 1:61–62