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## CAREER FOCUS

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### Surgery

SG Mellor

#### **Military Surgery and Modernising Medical Careers**

Medical training is changing. The avowed aim is to reduce the length of training and to provide a consultant led service – something of which we have been hitherto justifiably proud in the Defence Medical Services. However, the NHS consultant of the future will be experienced in depth in his particular specialty or subspecialty, but will not be expected to have a great breadth of knowledge or experience. The latter is, of course precisely what is required in military surgery, where individuals will often be relatively isolated and must be ready to manage patients whose injuries or illness fall outside their normal experience. Such a dichotomy in approach accompanied by ever rising patient expectation leads into a maelstrom of potential litigation. This can, however, be avoided by being entirely clear about what the military surgeon needs to be able to do, and in ensuring he or she gets the necessary support, both logistically and morally.

On the other hand, trainees can be assured that the general surgical curriculum as produced by the Specialist Accreditation Committee in Surgery remains sufficiently broad to ensure the consultant surgeon is able to manage a wide range of emergencies and blunt and penetrating trauma. Furthermore it is the intention of the Association of Surgeons of Great Britain and Ireland that all but the most specialised training will be completed by CCT. The curriculum may be viewed via the JCHST web site.

If we are able to assume that it is the task of the Defence Medical Services to get seriously ill or injured military personnel back to UK within 48 hours or so of the decision to evacuate, then the task of the military surgeon on deployment is to perform procedures which will allow safe evacuation to be undertaken. Such procedures will include life saving Damage Control Surgery, but this in itself is far from straightforward. DCS is not performed in isolation but as a considered part of the evacuation chain: the implications of performing DCS must be understood by all, especially the planners. Damage control operations in Iraq and Afghanistan in recent military operations have consumed on average 14 units of blood. Restoring core temperature in these seriously injured

patients requires considerable environmental control, and the logistical implications of achieving this are considerable. Finally, it must be made clear that it is not the task of the military surgeon to indulge in performing non urgent procedures outside his normal remit.

#### **General Surgical Training**

Until 2007 whether the aspiring surgeon wished to have a career in general surgery, orthopaedics, urology, plastic surgery or even thoracic surgery all started on the same programme. In essence this comprises two elements, one of which satisfies the requirements for MRCS and the other an additional element designed to provide the broad experience needed by the 'military surgeon'. Thus the first element is usually trauma and orthopaedics, general surgery and urology whilst the second element involves exposure to neurosurgery, thoracic surgery and plastic surgery. A not inconsiderable advantage of this system was that it allowed the trainee to make an evidence-based decision on which specialty to pursue. The Foundation programme is now with us, for better or worse. F1 involves a mandatory period of general surgery. F2 programmes for military trainees should provide exposure to emergency medicine. Specialist training commences in August 2007. Surgical aspirants (general surgery, T&O and urology) will apply for ST1 in 'surgery in general'. Selection of all military aspirants will be at the West Midland Deanery. Those currently in training and holding MRCS have been advised apply for ST2 or ST3 in August 2007 depending on their experience obtained and quality of CV to date. Competition will be fierce as about three years worth of trainees will be funnelled into one channel. The military trainee will be in more or less open competition for training slots with his NHS contemporaries, but the concept of military numbers will continue. It is to be hoped that military GDMO experience will be considered to be a positive experience and count highly in the selection process. There is assurance from PMETB that this will be the case.

The ST1 year is anticipated to be generic, with specific training in the chosen surgical specialty (General surgery, orthopaedics etc) starting in ST2. Once examinations have been passed and competencies gained

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in line with the relevant curriculum, the trainee enters the ST3 year, which is equivalent to SpR1. The final FRCS will remain in more or less its current form.

### Higher Surgical Training

If Damage Control Surgery is the *sine qua non* of the deployed military surgeon, then realistically this individual must be a 'cavity surgeon' and can only be derived from thoracic or general surgery (GI or vascular) cadres. Having said that some urologists with wide experience of major, open operative procedures may be deployable as 'general surgeons'.

### Military Surgical Training

This comprises a series of courses and attachments which run parallel to conventional surgical training. All army and most RN medical officers will now have completed six months A&E after PRHO jobs, and all should have done ATLS, BATLS and other life support courses early in training. Hopefully the F2 year will provide a similar range of competencies. Anastomosis, fracture and neurosurgical workshops for SHOs, SpRs and Consultants to refresh their knowledge of procedures they do not normally undertake are run at RCDM. In addition, there is the exercise in Denmark and the Definitive Surgical Trauma Skills course run at the Royal College of Surgeons. The aim of these courses is to equip the deployed surgeon with the skills to safely package the patient for rearward evacuation to appropriate facilities for optimum management of the condition. Several surgical trainees and consultants have been to South Africa for exposure to military type trauma: sadly this training is currently not available, and is not likely to be for the foreseeable future.

However, there is a Trauma MSc already available at Swansea University suitable for orthopaedic and plastic surgeons which we hope to modify for general surgeons. This should give all deployed surgeons a common grounding in the pathophysiology of trauma and can only be conferred if the appropriate surgical competencies have been gained.

### Life as a Consultant in Uniform

The payback for this extremely high quality training is, at present, a mere three years in uniform. My major concern at present is where the aspiring surgeon will end up as a Consultant. There are no real military hospitals apart from Cyprus and Gibraltar,

but these are not suitable for thrusting young consultants, apart from the occasional leave relief.

Whether you are posted to RCDM, one of the MDHUs or to a Trust of your choice you will spend at least 75% of your working life working in a Trust with civilian colleagues, under much the same conditions and with the expectation of performing to the same standards. However, you will probably spend 4-8 weeks of any year on deployment and some time on exercise and military training. You will also have to fit in leave and Continuing Medical Education.

As a Consultant General Surgeon on deployment you will certainly be expected to deal with major trauma of all types but equally importantly with surgical (in the widest sense) DNBI, to the best of your ability and under fairly austere circumstances. The minimum surgical team contains two surgeons, one of whom will be a general surgeon whilst the other will usually be an orthopaedic surgeon, with two anaesthetists. This allows for considerable flexibility, but does not allow for the team to be split. Timely and appropriate intervention is the rule. On many occasions you will only be required to make a decision as to whether the patient should be evacuated for definitive care rather than intervene under less than satisfactory circumstances. It is easy to operate and leave a terrible mess for someone else or even kill or maim the patient in an environment with inadequate resources when good 'packaging' and timely evacuation might have saved the day. It is not the task of the DMS to keep personnel in operational areas if it is against their best health interests.

When not on deployment, you will be part of an NHS Trust and work as part of a subspecialty team for most of your career. However, it is important to remain on the emergency rota, and learn to pass on cases to more suitable qualified colleagues and vice versa. It may be that the Trauma MSc will provide suitable background to become lead trauma and emergency surgeon for the Trust, something which seems likely to evolve as acute hospitals become more regional.

*As of 26 March 2007 Col Mellor will retire as DCA Surg and be replaced by Surg Capt A Walker contactable via [alasdair.walker@phnt.swest.nhs.uk](mailto:alasdair.walker@phnt.swest.nhs.uk)*