TRAINING TOMORROW'S SURGEONS

Introduction
A discussion paper from the Surgical Forum of Great Britain and Ireland, entitled **Training the Surgical Workforce**, was published in the previous edition of the ***JASGBI*** [Number 35, December 2011, pp 8-9]. The Surgical Forum - formerly the Senate of Surgery - comprises the Presidents of the four Surgical Royal Colleges (Edinburgh, England, Glasgow and Ireland) and the nine SAC-defined Surgical Specialty Associations (Association of Surgeons of Great Britain and Ireland, British Association of Oral & Maxillofacial Surgeons, British Association of Otorhinolaryngology – Head & Neck Surgery, British Association of Paediatric Surgeons, British Association of Plastic Reconstructive & Aesthetic Surgeons, British Association of Urological Surgeons, British Orthopaedic Association, Society for Cardiothoracic Surgery in Great Britain and Ireland, Society of British Neurological Surgeons). The discussion paper, **Training the Surgical Workforce**, was considered by the above bodies, and a resume of the consensus agreement was considered by the Surgical Forum at their meeting on 31st January 2012. The points of common accord are as follows:

- The NHS is changing; EWTR, fewer IMGs, fewer trainees, proposed changes to Deaneries, medical education and commissioning are all factors which will impact on the relationship between service and training.
- There is a need to train surgeons to meet the demands of society. Therefore, not all surgeons will be able to enter the specialty of their choice and the expectations of trainees should be managed accordingly.
- Training programmes for the nine (soon to be ten) SAC specialties must have well defined curricula with explicit entry criteria for each programme. Successful completion of a programme is marked by the award of a CCT.
- Rigorous assessment of competence at every stage in the process of training (cf. time based assessment) has to be the standard. Failure to achieve the standard will result in a change in career.
- Following the award of a CCT, some of these trained surgeons may take up posts where the emphasis is on the "generality" of their speciality. This will be particularly in the delivery of emergency surgery and routine elective work. These appointments may evolve into "acute care specialists" and, for some, would be a lifelong career choice.
- Emergency surgery is regarded by some as the 'Cinderella' of surgical specialities. A recognition of the importance of emergency care would improve standards and outcomes.
- Increasing specialisation, particularly in elective surgery, has the potential to destabilise the provision of high quality emergency surgery services.
- Those surgeons wishing to obtain (sub) specialist training in the future may need to gain this after the award of a CCT. These post-CCT posts will be funded according to service needs and appointment would be by competitive entry. These posts would be outwith the responsibility of PG deans.
- If the term consultant is to be retained, all who achieve the CCT could be termed Consultant in the generality of the specialty, e.g. Consultant General Surgeon, Consultant Orthopaedic Surgeon, etc. Once further training and specialisation has been achieved, the terminology should change to reflect that, e.g. Consultant Colo-rectal surgeon, Consultant Revision Arthroplasty surgeon, etc.

26th January 2012

John MacFie
President, ASGBI

Ian Ritchie
Vice President, RCS Edinburgh

JASGBI has been lucky enough to be allowed to publish drawings from Nick Wadley's upcoming book ***man + doctor*** (Dalkey Archive Press, 2012) which reflects *"the many and various attempts to avoid the scalpel"*. Does this sketch show an intimidating consultant, or one confident and in control?

A LETTER FROM THE NORTH WEST FRONTIER

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Consultant Surgeon
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and to the Defence Medical Services Reserve

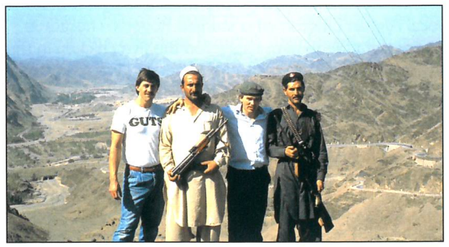

Figure 1: The Khyber Pass at Landi Kotal, looking towards Afghanistan. Geoff Macleod represents the Guildford Undetected Tumours charity

A little local history
More than 20 years, 400 British military lives and many billions of pounds ago, I was privileged to join an ad hoc charitable surgical team in Peshawar on the North West Frontier of Pakistan, working among the Afghans who had left Afghanistan during the Russian occupation. Our time there was brief, but the lessons which I learned were timeless, and of profound and unforeseen contemporary relevance, in the context of our present engagement and loss of blood in Afghanistan.

Formal British involvement on the Indian subcontinent began in 1611, with the establishment of the East India Company. British control extended across the North Indian plains of the Puinjab and Sindh to the North West Frontier by the early 19th Century, but not across the granite foothills of the mountain ranges of the Hindu Kush into Afghanistan. Kipling's Great Game for control of Afghanistan was played out in the minds of the strategists of the Russian and British Empires, such that The British invaded Afghanistan in 1839 and occupied Kabul. In the disastrous retreat from Kabul in the winter of 1841 - 1842, 16,000 British soldiers and camp followers of Lord Elphinstone's Army lost their lives, with the only survivor, Assistant Surgeon William Brydon, making it back to Peshawar.

The Second Afghan War of 1878 - 1800 took Lord Roberts' Army to Kandahar. Fortunes in this war fluctuated, before the British secured a favourable political settlement. At the Battle of Maiwand in 1880, 1,000 British and Indian troops were killed. An uneasy peace then reigned on the Frontier until 1919, when the Afghans clashed with the British along the Frontier during the brief Third Afghan War. In 1893, the Durand Line marked out an agreed border across the mountains between Pakistan and Afghanistan, but conventional political control and development was never established in the area.

An impenetrable code of obligations, economic inducements, the occasional use of force and fluid agreements kept the peace on the Frontier for much of the 20th Century. Afghanistan saw considerable economic development through the 1950s and 1960s, producing a prosperous and educated middle class around Kabul. Stability reigned until the Soviet (Russian) Army invaded in 1979, after years of political meddling. This united previously disunited tribes against the foreign invaders, as so often in Afghan history, and the fighting had a number of tragic consequences.

Educated Afghans, including most health professionals, scattered in droves to become a worldwide Diaspora, stretching from Canada, via Southall and Birmingham, to Australia, leaving Afghanistan to the mercies of the tribal warlords. Huge numbers of Afghans fled across the Frontier to long-term refugee camps in Pakistan. The warlords formed a coalition of resistance armies, known as the Mujaheddin, which, in turn, drew large quantities of covert military aid and training from the US, the UK and elsewhere. This aid contributed materially to the defeat of the Russian Occupation and the Russian withdrawal through 1988, which was completed on 15th February 1989. It also helped set the conditions for the destruction of Afghanistan after the Russian withdrawal, when the heavily armed tribesmen and religious factions, who were now well trained and versed in the tactics of modern guerrilla warfare, turned on themselves and created the conditions for the emergence of the Taliban.

Anyone who wishes to understand the history of the North West Frontier must understand the Pathan or Pashtun people. The Pathans are a fissiparous and warrior people who have occupied the Frontier, north western Pakistan, Baluchistan, Waziristan and south eastern Afganistan for several millennia. The many tribes have remained fiercely independent and instinctive survivors, defying all outside rule but bending with the political winds. The Pashtuns are linked, above all, by the code of Pakhtunwali, which mandates safety for fugitives, hospitality to all-comers, and the avenging of insults. Pathanistan extends across the boundary lines on modern maps, which is why the links between the Afghan and Pakistan Taliban, tribal warlords and regional politicians are so close.

The Guildford Afghan Surgical Mission to Peshawar, 1988
Through contacts in the Pakistani community in the UK at that time, colleagues in Guildford were invited to take a surgical team to Peshawar in 1987, and again in 1988 for a brief period of work. Concurrently, they were to undertake evaluations of local resources for Afghan medical charities. Under the administrative leadership and political negotiating skills of Mr Rupert Chetwynd, a former army officer, frontier explorer and author, the clinical team comprised Peter Stiles, Consultant Orthopaedic Surgeon; Frank Schweitzer, Consultant Urologist; John Stoneham and Kirthi Wickremasinghe as Consultant Anaesthetists, and Tony Bray, Robin Jago and Geoff McLeod as Theatre Staff. As a general surgical registrar at the time, I was the most junior clinician, on a steep professional learning curve and "beneath the radar".

Rupert Chetwynd has, subsequently, set out in his book ***Yesterday's Enemy*** how the programme came about, and how, year on year, he came progressively to observe and understand the complexities of Afghan tribal and religious politics, criminality and financial pipelines to the guerrilla groups, where all was smoke and mirrors, not as it seemed. In other words, medical provision for Afghans in Peshawar was a metaphor for normal life on the Frontier and in the Afghan badlands. At the time, I was not aware in detail of much of the political shenanigans that was going on behind the scenes. It was only when I read Rupert's retrospective account that much more became clear.

The Guildford medical team was self-funding, and deployed on an annual basis for a number of years. My own involvement was during October 1988 [1]. Rupert Chetwynd and Peter Stiles deployed a week in advance of the main party, to build contacts and establish a full programme of work and other activities over the next three weeks. We left Heathrow for Islamabad on a BA 747 on 7th October, and flew from there into the heavily militarised airfield at Peshawar on a Fokker Friendship turboprop. Peshawar was welcoming of westerners at that time, and teeming with visiting aid and government agency representatives. Peshawar is full of echoes of British colonial history, from The Lady Reading Hospital to the wide whitewashed boulevards of the garrison Cantonment, and more modern echoes of celebratory gunfire. We stayed at Dean's hotel in Peshawar, and I was free to explore the city and bazaar unhindered in local pashtun dress, the salwar kameez, on foot and by auto rickshaw. Local doctors plied their trade from buildings around the bazaar, with a proud billboard display of their UK credentials, which memorably included one "FRCS (London) (Failed)".

The work programme included outpatient clinics, ward rounds and theatre sessions at three different hospitals: the Afghan Surgical Hospital; the Jamiat –e-Islami hospital and the Ibne Sine Hospital. Of these, only the first was in a multi-storey building which was recognisably a hospital. The other two were converted villas. Each hospital was under separate political control of a more or less moderate political group. Patients were seen in a fairly haphazard fashion, and we had little idea of how they came to be with us.

There was no significant evidence of continuity of care in relation to previous visiting medical teams, although local Pakistani surgeons provided a regular supporting service at the ASH. There was an odd and eclectic mixture of Westerners working on the fringes, including US surgeons who seemed to be looking to ship suitable cases back to their US base hospitals to encourage their sponsors. This was a professional Wild (North) West. I was also able to meet various members of the International Committee of the Red Cross Medical Team in Pakistan, including Mr Robin Gray, formerly a consultant surgeon at the Greenwich Hospital.

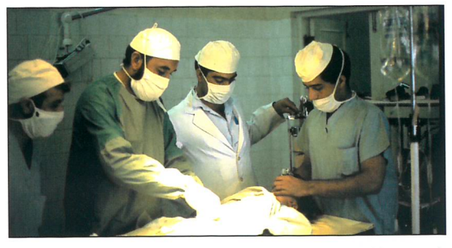

Figure 2: Working at the Afghan Surgical Hospital, Peshawar, with local staff, October 1988

The Clinical Programme and its spinoffs

My notebook indicates a busy clinical schedule in our first week in Peshawar, handicapped to a significant degree by language and cultural barriers, and a heavy reliance upon local interpreters. Outpatients with a range of simple and complex surgical conditions were seen. Easily sorted problems (hernias, abscesses, hydrocoeles, haemorrhoids) were listed for surgery, while the late and complex sequelae of gunshot injuries or paediatric cases (as with a baby with an imperforate anus) were referred to the Lady Reading. There were frustrations with equipment deficiencies, such as sigmoidoscopic lighting, but the surgical lists were populated and most problems were overcome with good humour.

The second week brought another flow of frontier pathologies, including an abdomen full of hydatid cysts, and a memorable lunch in the small apartment of a local Afghan Doctor, who studied Roget's Thesaurus every night. With him, I selected the live chicken in the livestock market on the way home, and we then negotiated our way through many back alleys and past various Mujahiddin checkpoints. Lunch was followed by a consult with his mother-in-law, mother to 14 children, while his wife was kept hidden in the kitchen for the entire three hours of my stay.

The third week saw more mature and challenging pathologies. One man with gross deformity and mummification of his left foot had found his way to Peshawar following being shot at the Siege of Khost a year earlier, when the Russian Army had relieved a garrison besieged for several years. The Mujahiddin leader, Jalaluddin Haqqani, continues to trouble occupying forces to this day.

A most interesting aspect of these clinical days was the cast of characters with whom we lunched, or who visited the hospitals on their political rounds, and who took us into their confidences. There was the individual who had just returned from the UK and the USA in negotiating a re-supply of Stinger anti-aircraft missiles for the Mujahiddin (the remnants of this stock had to be tracked down bought back when we returned to Afghanistan, lest they be used on our own helicopters).

During the long lunches, when everyone of local political significance converged on the hospital dining room of the National Islamic Front for Afghanistan, we learned a great deal about the realities of life in the region; that the main product of the Khyber economy was heroin; that the price of a seat in Government in Islamabad was at least 10 million rupees and a new AK47 for each of the 350 Chieftains voting in the Loya Jirga to elect their representative; and that local blood feuds led to the deaths of almost 100 people every year. Most importantly, in response to expressions of goodwill for the future of Afghanistan after the Russian withdrawal was complete, our naivety was met with the certainty that the coming feuding for power would be more lethal and destructive than what had gone before. These predictions by our hosts were to be brutally realised with the destruction of Kabul during the mid 1990s.

Familiarisation with Frontier

The elective working week in Pehawar was frustratingly short, and usually drifted into stalemate each Thursday afternoon. Working time and schedules were further curtailed by calls to prayer. The spinoff was plenty of time to explore the Frontier, and Rupert creditably organised a number of fascinating and memorable sightseeing trips for the team.

The first weekend permitted us a trip to the beautiful Swat Valley, via the Malakand Pass and Churchill's Picket, where many itinerant British and Ghurka Regiments had hewn their insignia in the rocks, and where the Young Winston had earned his editorial spurs as a war reporter. We climbed Mount Ilam and enjoyed hospitality at the Hotel White Palace in Swat, more recently the scenes of a cruel Taliban insurrection and battle with the Pakistan Army.

On the second weekend, we were taken along the Grand Trunk Road, passing the Attock Bridge over the Indus and passing through Abbottabad and along the high mountain roads on a wing and a prayer to Balakot, the Hazara Forest and to the lush alpine meadows of Shogran. On the Shogran mountain, I was asked to examine a 35 year old with haematemesis and melaena. A clear plastic bag substituted for an examination glove to confirm the bloody stool, and he was sent on to Barakot hospital, many miles and ravines away. We returned to Peshawar and, on Saturday 23rd October, came the touristic highlight of the trip. We were taken up the Khyber Pass to Landi Kotal, overlooking the Afghan border, with a well connected official guide named "Michael", and a soldier of the Khyber Rifles armed with a Lee Enfield. On the way up the pass, we collected another guard with an AK47 and a local dignitary, who subsequently invited us back for lunch in his fortress home and for an opinion on a 35 year old female member of the family with the late and torturous sequelae of juvenile arthritis. Our final return to Islamabad, back along the Grand Trunk Road of British India, took us to the massive and heavily guarded Tarbela Hydroelectric Dam on the River Indus, and to the ancient city and UNESCO world heritage site at Taxila.

Lessons learned

1. Clinical and organisational

In less than one month in 1988, this visit to Pakistan immersed me in a radically different social culture, and the insights have resonated with me ever since.

At the simple level, this was a well intentioned but seriously constrained exercise in medical tourism. There are severe limits as to what visiting surgical teams can achieve in a short period of time. There were minimal opportunities for teaching. Cultural contacts with patients were severely constrained by language. Contact with female patients was negligible, and only by special arrangement. There was no clear continuity of care either leading in to our arrival or after our departure. Matters were made even more difficult by the fragmentary nature of the local health systems in and around Peshawar, and the political boundaries between hospitals which increased the inefficiencies.

From my own perspective, while I learned a great deal about the circumstances and challenges of health care delivery to refugees and in challenging geo-political circumstances, my capabilities as a surgeon still in training were limited, and some cases were well outside my experience.

In these circumstances, the presence of visiting teams can be counterproductive. A number of Afghani doctors approached me for help to leave the country for employment in the West. These were requests with which I was unable to help. The impression which I developed was that visiting charitable medical teams were tolerated and assisted, at least in part, for this possible professional escape route to the West. At a deeper level, as set out in Chetwynd's book, medical aid missions and agencies work in a complex subterranean environment of local politics, criminality and worse. It would appear that at least one of the hospitals with which we were briefly associated was a front for money laundering from Arabia to the Mujaheddin and their allies.

My own belief, as established at the time, and as shared with many others who have worked in and around the charitable overseas health sector, in the UN Agencies, the ICRC and the WHO, is that medical missions should only be undertaken where continuity of care can be assured and where training and support for the local health economy are the primary aims. The aid input must be within an overall and coherent health plan, rather than ad lib and as a whim of individual charitable groups and teams. Medical tourism plays a role in the education of individuals on the larger stage, but it must be seen and understood, by those partaking, for what it is.

Figure 3: Working lunch: Staff and vistors at the NIFA Hospital, Peshawar, October 1988

Grand Strategic Lessons

These lessons are not new, and they are not original. The really important lessons of my visit resonate from those long fresh chicken biriani and nan bread lunches; those ward rounds and meetings with Mujaheddin commanders; and those brief walks among the crowds in Peshawar, where I saw briefly into the soul of the Pathan people. They are a proud, patient, hospitable, hardened and sometimes cruel race, whose culture and tribal nuances and rivalries we barely understand, but whose loyalty to other Pathans transcends all else.

Had those who led us too naively into the Fourth British Afghan War (Helmand 2005 - 2015) also been privileged to those insights, or who even now state (in public at least) that progress is being made in building governance, security and a civic society in Afghanistan, caution would certainly have prevailed. Dr John Reid and his advisors may have been party to knowledge and insights which I do not possess, but I doubt it. With the 1988 predictions of my lunchtime hosts still ringing in my ears, it would now be naive in the extreme to hope that Western plans and intentions will long survive the forthcoming drawdown of occupying forces. Afghan tribes and groupings always revert to type in a fight for the spoils of power and divided loyalties, and there is a grave danger that in training and arming the Afghan National Army and Police, we are simply pouring more fuel into the political fire.

We might expect little long-term good to come from the fighting of the last decade and the spillage of so much youthful British blood once again. However, change is afoot on the Frontier. The cultural and economic revolution is gathering pace in India and China, and its influence with gradually erode the ignorance and isolationism which has bedevilled social development in Afghanistan. Just as Afghan refugees have brought cricket from Pakistan to Kabul, so mobile phones, satellite televisions and all of the paraphernalia of the digital world are gradually encroaching upon Afghan Society. It is quite possible that, in the coming decades, the digital revolution will bring about cultural adaptations which force alone will never achieve in the region.

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