

**Report of the Short Life Working Group (SLWG) on Breast and
General Surgery to the National Clinical Advisor and Group Lead
(NCAGL) for Acute Hospitals, HSE and the Committee for Surgical
Affairs, RCSI**

1. Introduction

The Breast and General Surgery Short Life Working Group (SLWG) convened following a request from the National Clinical Advisor and Group Lead (NCAGL) for Acute Hospitals to the National Clinical Programme for Surgery (NCPS) for guidance on the provision of emergency general surgery on-call services in Ireland by Consultant General and Breast Surgeons. Following consultation with the Society of Irish Breast Surgery (SIBS) and the Department of Surgical Affairs, RCSI, it was agreed that a Short Life Working Group should be convened. Terms of reference, reporting relationships and membership of the SLWG were agreed.

After an initial exploratory meeting, formal meetings of the SLWG took place on 29th June 2020, 21st July 2020, 4th August 2020 and 1st September 2020. The draft report was reviewed at a SLWG meeting on 15th December and the revised draft circulated on 17th December for feedback. All feedback was collated by the secretariat and each submission was considered by the members of the group at a final meeting on 8th February. Although not unanimous, the following represents the consensus report and recommendations of the SLWG.

2. Terms of Reference (Appendix A)

Draft terms of Reference were discussed at the first meeting of the SLWG, circulated to all members and agreed at the second meeting. The agreed output of the SLWG is a short document outlining the current service, relevant issues and recommendations for the future.

3. Membership of SLWG (Appendix B)

The membership of the SLWG included the President and representatives from the Society of Irish Breast Surgery, the specialty of General Surgery, RCSI Surgical Affairs, and RCSI Professional Development and Practice.

4. Current service provision

There are currently 32 consultant general and breast surgeons employed by or on behalf of the HSE, working across 8 designated cancer centres (Table 1). These surgeons are registered on the Irish Medical Council specialist division as specialists in general surgery. Historically, all Consultant General and Breast Surgeons have participated in emergency general surgery rotas. At present, three of the six professorial chairs of university departments of surgery are Consultant General and Breast Surgeons. The centralisation of breast cancer surgery has resulted in all Consultant General and Breast Surgeons working in a cancer centre (model 4 hospital). It is therefore noted that the current document refers specifically to this context. A number of surgeons provide specialist breast services at the cancer centre and deliver emergency general surgery services at a separate hospital where they may be delivering that service on an onerous rota (Table 1).

Some consultant breast surgeons have additional interests, especially in the areas of academic surgery and endocrine surgery. Most breast surgeons with an endocrine interest confine their work to the thyroid and parathyroid with a small number also performing adrenal surgery.

The specialty of breast surgery has evolved in recent years. Consultant General and Breast Surgeons may have commitments to screen-detected or symptomatic breast surgery services and the majority of recent appointees have completed post-CCST fellowship training in oncoplastic surgery. The range of surgical interventions for breast cancer has changed and immediate breast reconstruction is a more common procedure than previously. These changes have resulted in fewer general surgery operations being performed by Consultant General and Breast Surgeons on scheduled theatre lists such that the majority of general surgery activity is undertaken on an unscheduled, sometimes infrequent, basis.

The field of emergency general surgery has changed too. The intensity of the on-call workload has increased, a greater proportion of operations are delivered laparoscopically and patients are older, often with greater multi-morbidity (1). Most surgeons on emergency general surgery rotas in cancer centres

undertake complex highly specialised surgery during day-time hours. Onerous out of hours rotas have the potential to impact on the quality of such services.

The frequency and intensity of general surgery on-call rotas varies between hospitals (Table 1).

Table 1 Rotas in General and Breast Surgery as of June 2020

Rotas in General and Breast Surgery as of June 2020					
Site	BreastCheck Centre	Rota	Breast surgeons on general surgery call	Breast surgeons off general surgery call	Other hospital group activity (Including on-call activity outside the cancer centre)
Cork University Hospital*	Yes	1 in 10	0	4	
			1		1 breast surgeon on-call in South Infirmary Victoria University Hospital, 1 in 4.
University Hospital Limerick		1 in 12	1	2	Going to 1 in 16, no elective general surgery.
University Hospital Waterford		1 in 7	3	0	3 breast, 2.5 colorectal, 1 vascular/general. Will be 1 in 6 in July 2020.
University Hospital Galway*	Yes	1 in 12	3*	*	
			1		Mayo University Hospital, 1 of 4.
			2		Letterkenny University Hospital, 2 of 5; 4 of these 5 surgeons also perform elective general surgery.
St James's Hospital		1 in 7	1	2	
St.Vincent's University Hospital*	Yes	1 in 14	4	1	
			1		1 on-call in Naas General Hospital, some melanoma, endocrine.
Mater Misericordiae University Hospital	Yes	1 in 9	3	1	
Beaumont Hospital*		1 in 8	2	0	
			1		1 on-call in Connolly Hospital. (1 in 6 rota).

*Note that some breast surgeons provide on-call services outside of these centres; this activity can be significant for these sites. See Cork University Hospital (1 breast surgeon on-call in South Infirmary Victoria University Hospital), University Hospital Galway (1 of 4 in Mayo University Hospital, 2 of 5 in Letterkenny University Hospital), St.Vincent's University Hospital (1 on-call in Naas General Hospital), and Beaumont Hospital (1 on-call in Connolly Hospital).

5. Challenges arising in the current model of emergency general surgery service provision

Emergency general surgical services in cancer centres are delivered by consultant general surgeons including a range of sub-specialties, namely breast and endocrine, upper gastrointestinal, colorectal, hepatobiliary pancreatic and vascular surgery. Each of these surgeons is also responsible for the delivery of highly specialised cancer and complex benign surgery within their area of expertise.

Approximately one-third of Consultant General and Breast Surgeons in the Republic of Ireland have stopped or reduced their general surgery activity, normally by local agreement with their hospital and colleagues. Among the remaining two-thirds of consultant breast surgeons, there are varying views about the optimum future scope of practice, roughly split between those who wish to retain their current scope of practice and those who would prefer to cease general surgery activity.

The SLWG was informed that the desire among some breast surgeons to leave the general surgery on-call rota originated from their concern about maintaining sufficient expertise to sustain a safe on-call service. It was reported anecdotally that some surgeons experienced an impact on their well-being resulting from continuing to deliver a service that they did not feel confident to safely deliver.

A further factor is the observation that the skill mix among Consultant General and Breast Surgeons will likely change as existing post-holders retire and are replaced. The SLWG was informed by the President of SIBS that contracts for some future surgical appointees to the BreastCheck screening programme may not include general surgery on-call commitments. Some existing BreastCheck surgeons currently perform general on-call duties, a factor that must be considered and addressed when they retire or cease practice.

Given the diverging patterns of practice among breast surgeons, Consultant General and Breast Surgeons who wish to continue delivering emergency general surgery services have identified a requirement for adequate resourcing and clarification of arrangements for cross cover, collegiate consultation, onwards referral of complex patients and quality assurance of the service.

6. Principles of Change

a. Delivery of high quality, safe and quality-assured emergency general surgery service

Patient safety was a key factor influencing the discussions and recommendations of the SLWG. The SLWG considered patient safety paramount at both individual and population levels in developing recommendations for the provision of adequate, safe and timely access to emergency and elective general and breast surgery services to the Irish population.

b. Recognising the impact of delivering emergency general surgery services on individual consultant surgeons

In the context of surgeons who work in a cancer centre, participation in an emergency general surgery rota is challenging as the emergency surgery workload arising must be balanced with cancer and complex benign surgical workload. Modern cancer care includes specific optimal time frames for surgery to take place and is normally consultant-delivered, reducing flexibility in scheduling. Historically, emergency surgery was delivered as a supplementary out-of-hours activity by surgeons and their teams, who also delivered scheduled surgery during their normal working week. It is now recommended that emergency and elective surgery should be separate, consultant-delivered activities, a policy change that has not yet been fully resourced or implemented (2).

c. Delivering sustainable proposals

The provision of emergency general surgery is a challenging commitment, and it is recognised that training is becoming increasingly sub-specialised. Any proposals must be cognisant of changes that will happen as new consultants are appointed.

7. Factors relating to the ongoing participation of general and breast surgeons in the emergency rota

a. Maintaining expertise in general surgery

The SLWG considered a number of factors in relation to breast and general surgeons who wished to continue in their current general surgical emergency practice. The discussions were wide-ranging and included ensuring general surgery activity in sufficient volumes to retain expertise, the role of laparoscopy and endoscopy skills in delivering emergency surgery and the need for continuous involvement in audit.

The necessity for defining a required indicative number of laparotomies per year was discussed. A recent Irish publication reported a relationship between surgeon volume and patient outcome in emergency abdominal surgery (3). In that paper, low volume practice was defined as fewer than 30 emergency abdominal operations over a 5 year period and was associated with worse patient outcomes. It is noted that if the number of emergency laparotomies performed nationally dictates the number of surgeons who remain on-call, this could have the undesirable effect of many Irish hospitals having insufficient surgeons to staff emergency general surgery rotas. Specifying a fixed number of required procedures could immediately affect services in a number of hospitals. Planning for the optimal configuration of emergency surgical services should be a priority to ensure a safe and sufficiently staffed service. This remains a challenge due to the large number of hospitals providing emergency general surgery services.

All surgeons including those participating in general surgery on-call rota are required to maintain their expertise and ensure that both the process and outcomes of care meet acceptable standards. It is recommended that expertise in emergency general surgery cannot be simply measured but instead should be quality assured through regular participation in morbidity and mortality meetings, participation in audit, and oversight of standards by the clinical director.

The SLWG, therefore, recommended that general and breast surgeons should have sufficient activity in general surgery, including abdominal surgery, to maintain expertise and should participate in a robust audit

and morbidity and mortality (M&M) process locally along with other colleagues involved in the emergency general surgery rota **(Recommendation 1)**.

The role of endoscopy in the provision of emergency general surgery was discussed. It was noted that endoscopy is occasionally required on an emergency basis, especially in the management of upper GI bleeding. It is further noted that although this service was traditionally provided by surgeons, a gastroenterologist can also deliver this emergency service. The SLWG recommend that it is the responsibility of the hospital to ensure that appropriate arrangements are in place for patients who require GI endoscopy as an emergency **(Recommendation 2)**.

b. Providing cross-cover and transfer arrangements for complex patients

Modern surgical practice requires teamwork (2, 4). When surgeons work as part of a group with a similar scope of practice, they can cover one another in cases of absence, such as planned or unplanned leave. In instances where surgeons work alone or are the only surgeon providing general surgery services among their breast colleagues, the same team-based care may not be available in their absence. The SLWG recommend that where cross-cover care is not available then locally negotiated arrangements for cross cover should be in place **(Recommendation 3)**.

From time to time, a patient admitted as an emergency surgical case may require specialist care that exceeds the capabilities of the admitting surgeon. This scenario may apply to any surgeon and is not specific to general and breast surgeons. The SLWG noted that, to date, appropriate and safe arrangements for such circumstances were largely dependent on good collegiate relationships with colleagues. It was reported that in some hospitals there had been endeavours to develop more formal arrangements, such as a secondary rota, however, this has not been universally successful due to the adverse impacts on colleagues participating on multiple rotas. The SLWG recommend that each hospital group must ensure that patient transfer arrangements are in place, whether formal or informal, for complex patients and time-critical emergencies that exceed the capability of the surgeon or institution **(Recommendation 4)**.

8. Factors to be considered when general and breast surgeons change their scope of practice

Participation in an emergency general surgery on-call rota includes not only delivering the emergency duties that arise while on-call but also providing continuity of care for patients admitted or seen in the ED or ASAU during the on-call period. Such patients may need an operation during their index admission, an episode of inpatient care, follow up in outpatients, or to be placed on a waiting list for scheduled surgery. As a result, a number of factors need to be considered by hospitals if a surgeon appointed to a post designated as a Consultant Breast and General Surgeon proposes a change to their scope of practice.

The SLWG reflected on lessons learned from vascular surgery becoming a separate discipline from general surgery in Ireland. Prior to departure from the general surgery rota, a significant amount of planning and preparatory work had been completed by the specialty of vascular surgery including agreement of a new division of the specialist register with the Irish Medical Council, the addition of a vascular rota (which had been in place for 10 – 15 years prior to departure from the general surgery rota) and establishment of a regulatory and training framework. It is also noted that provision of a separate vascular rota diverted a proportion of time-critical emergency work from general surgeons remaining on the rota. Despite this, in some hospitals, general surgeons remaining on the rota experienced adverse impacts on their call commitment as vascular surgeons withdrew from their dual roster commitments. The SLWG acknowledge that planning is necessary to deliver a change in post designation while minimising unanticipated consequences.

A surgeon who wishes to change their scope of practice should discuss this with the clinical director and contract holder. The clinical director and contract holder should consider the factors below along a timeline agreed between the consultant, clinical director and contract holder.

a. Maintaining a safe on-call rota frequency

The intensity and frequency of general surgery on-call duties varies from hospital to hospital (Table 1). In the circumstances of a surgeon departing the general surgery on-call rota, there will remain an additional body of work that must be performed. Planning for this change is required. It was additionally noted that a

significant proportion of breast surgeons are more recent appointees and therefore a younger demographic, so the surgeons potentially most impacted by their departure are in an older age group. Increasing the frequency or intensity of on-call activity for such surgeons may impact the sustainability and safety of the service, as well as potentially impacting the volume and safety of their scheduled surgical services, especially if the rota frequency falls below an acceptable standard. It is important to realise the impact that this may have on the physical and mental wellbeing and health of surgeons, and the consequences this may have on recruitment and retention.

The SLWG recommends that where a surgeon departs the rota, the hospital bears the responsibility to ensure appropriate resources and staffing for delivery of a safe service in a timely manner. Additional adequately resourced consultant appointments may be required to ensure a sustainable rota with safe volumes of activity. Existing consultant colleagues on the rota cannot be expected to take on this work unless they agree and are adequately resourced to do so. The impact in terms of rostering will vary depending on the scale of the roster already in existence **(Recommendation 5)**.

b. Addressing unmet general surgery need

When a surgeon is appointed as a general and breast surgeon, the activity and resources planned for that role include resources intended to deliver a proportion of general surgery services. These resources include not only the consultant's work but also the NCHD, administrative, theatre, clinic and ward allocations and other resources used to deliver care. A change in designation, while expanding the resources available to breast services, diverts resources for the care of general surgical conditions and has the potential to adversely impact access for such patients. It is recognised that this may vary from hospital to hospital. The SLWG recommends that hospitals should evaluate all such impacts of the proposed change on the general surgical services in the hospital and plan accordingly to avoid unanticipated consequences. It is essential that the changes arising as a result of re-designation are adequately resourced, including an examination and potential re-distribution of existing hospital resources **(Recommendation 6)**.

c. Impact on surgical training

A change in designation or work practices of a consultant surgical trainer has the potential to result in a change in the experience available to interns and surgical trainees working under their supervision. The SLWG recommends that surgical trainers who undertake post re-designation should inform the responsible surgical training body (RCSI) in sufficient time to ensure that any impact on doctors in training is minimised **(Recommendation 7)**.

d. Impact on specialist services

It is noted that a small number of Consultant General and Breast Surgeons also deliver complex laparoscopic procedures such as adrenalectomy. Reduced participation in general surgery by such surgeons could result in challenges in maintaining sufficient expertise to perform complex laparoscopic procedures (e.g. laparoscopic adrenalectomy) and as an unanticipated effect could reduce access to adrenalectomy. The SLWG note that the issue of adrenal surgery is being addressed by a separate RCSI working group.

e. Impact when consultants practice on multiple sites

If a surgeon changes their scope of practice, there may be impacts across their entire practice, given the necessity for sufficient volume to maintain expertise. The SLWG advises that changes in the scope of practice should be discussed and agreed with each hospital where a surgeon works if they practice on multiple sites **(Recommendation 8)**.

f. Management of emergencies arising in patients who have undergone breast surgery

There is variation nationally in the arrangements for patients who have undergone breast surgery and experience a complication or in those who present with an emergency breast problem. In most hospitals, such patients are admitted under general surgeons and referred to the specialist service the following day with a nominated breast surgeon available at weekends for urgent consultation. In a few hospitals, there is a separate breast rota. Common emergency breast presentations that previously were managed surgically are now treated medically or radiologically. The SLWG was informed that the majority of breast emergency

presentations were breast abscesses, women who had received cosmetic surgery abroad presenting with an infected implant or ischaemic flap, or existing breast surgery patients with post-operative complications. The SLWG recommend that there should be local arrangements in place to provide emergency and continuing care to patients with breast surgical emergencies that present out of hours **(Recommendation 9)**.

9. Planning for future impacts of separation of general and breast surgery

There remains strong interest in joint breast and general surgery roles, and for that reason, it is considered appropriate for this designation to remain an option. For some clinicians, it is very suitable and effective to combine breast surgery with a special interest in reconstruction, or academic surgery or general surgery duties. It is also noted that the nature of breast surgery lends itself to sessional work at a cancer centre, possibly combined with general surgery duties at a second site; each hospital group will have different requirements based on their local need and geography. Some hospitals will require a general surgeon with an interest in breast surgery who remains on the general surgery on-call rota, whereas others might be in a position to recruit breast surgeons only with no obligation to provide a general surgery service (especially in screening services). The SLWG recommends the retention of the existing designation, Consultant General Surgeon with a special interest in Breast Surgery, and the future addition of a new designation, Consultant Breast Surgeon, and further recommends that it is the responsibility of the hospital (or employer) to decide which of those designations is required in a given competition **(Recommendation 10)**.

a. Registration and Training

Irish Medical Council specialist registration is awarded as 'general surgeon', where general surgery is a mandatory component of the registration process. Should a post-change scope from general and breast surgery to breast surgery only, a doctor will no longer be in a position to maintain competence in the post to which they have been appointed. Introduction of a new designation of Consultant Breast Surgeon (without any general surgery component), will require other changes. The SLWG considers that if the role of Consultant Breast Surgeon (without any general surgery component) is proposed, this must prompt consideration of the regulatory framework within which they will work. A further challenge is how such

surgeons will be trained. The SLWG recommend that the responsible bodies should consider the impact of proposed changes on the training pathway and intercollegiate examinations for breast surgeons. If a new designation is proposed, formal interactions with NDTP and the Irish Medical Council will be required **(Recommendation 11).**

b. Future Recruitment

Hospitals should plan for the retirement of existing Consultant General and Breast Surgeons, bearing in mind that the precedent being set by breast surgeons leaving the general surgery on-call rota, may result in some newly qualified breast surgeons being incompletely trained in general surgery and therefore unable to fulfil general surgical commitments. The SLWG recommends that hospitals should clearly specify whether or not general surgical duties are required in future posts that may be advertised and plan accordingly bearing in mind that additional resources may be required to maintain the current level of service **(Recommendation 12).**

10. Recommendations of the Breast and General Surgery Short Life Working Group (SLWG)

Recommendation 1: General and breast surgeons should have sufficient activity in general surgery, including abdominal surgery, to maintain expertise and should participate in a robust audit and morbidity and mortality (M&M) process locally along with other colleagues involved in the emergency general surgery rota.

Recommendation 2: It is the responsibility of the hospital to ensure that appropriate arrangements are in place for patients who require GI endoscopy as an emergency.

Recommendation 3: Where cross-cover care is not available, then locally negotiated arrangements for cross cover should be in place.

Recommendation 4: Each hospital group must ensure that patient transfer arrangements are in place, whether formal or informal, for complex patients and time-critical emergencies that exceed the capability of the surgeon or institution.

Recommendation 5: The SLWG recommends that where a surgeon departs the rota, the hospital bears the responsibility to ensure appropriate resources and staffing for delivery of a safe service in a timely manner. Additional adequately resourced consultant appointments may be required to ensure a sustainable rota with safe volumes of activity. Existing consultant colleagues on the rota cannot be expected to take on this work unless they agree and are adequately resourced to do so. The impact in terms of rostering will vary depending on the scale of the roster already in existence.

Recommendation 6: The SLWG recommends that hospitals should evaluate all impacts of the proposed change on the general surgical services in the hospital and plan accordingly to avoid unanticipated

consequences. It is essential that the changes arising as a result of re-designation are adequately resourced, including an examination and potential re-distribution of existing hospital resources.

Recommendation 7: The SLWG recommends that surgical trainers who undertake post re-designation should inform the responsible surgical training body (RCSI) in sufficient time to ensure that any impact on doctors in training is minimised.

Recommendation 8: The SLWG advises that changes in the scope of practice should be discussed and agreed with each hospital where a surgeon works if they practice on multiple sites.

Recommendation 9: The SLWG recommend that there should be local arrangements in place to provide emergency and continuing care to patients with breast surgical emergencies that present out of hours.

Recommendation 10: The SLWG recommends the retention of the existing designation, Consultant General Surgeon with a special interest in Breast Surgery, and the future addition of a new designation, Consultant Breast Surgeon, and further recommends that it is the responsibility of the hospital (or employer) to decide which of those designations is required in a given competition.

Recommendation 11: The SLWG recommend that the responsible bodies should consider the impact of proposed changes on the training pathway and intercollegiate examinations for breast surgeons. If a new designation is proposed, formal interactions with NDTP and the Irish Medical Council will be required.

Recommendation 12: The SLWG recommends that hospitals should clearly specify whether or not general surgical duties are required in future posts that may be advertised and plan accordingly bearing in mind that additional resources may be required to maintain the current level of service.

11. Appendix A

GENERAL AND BREAST SURGERY SHORT LIFE WORKING GROUP (SLWG) TERMS OF

REFERENCE

- Working group to meet via MS Teams every 2 weeks
- Papers will be distributed via email at least three days prior to the meeting
- The SLWG will agree and develop a document outlining:
 - Description of current state of Breast Surgery in Ireland
 - How to support breast and general surgeons who wish to continue in their current practice
 - Description of the factors that should be considered by employers if a general and breast surgeon wishes to change their scope of practice
 - Proposals for future breast surgery appointees
 - Training issues to be considered
- To bring paper to NCAGL Acute Hospitals by October 2020
- Quorum for decision making is 6 of 7 core group members, which must include representation from the Society of Irish Breast Surgeons (SIBS), General Surgery, RCSI Surgical Affairs and RCSI Professional Development and Practice
- The members of the SLWG commit to:
 - Attend all meetings; where a member is unavailable and cannot attend a meeting, apologies should be sent as early as possible
 - Make timely decisions and take action to support SLWG progress
 - Notify the SLWG of matters arising which may affect the activity or output of the group
- The members of the working group expect to be:
 - Provided with timely, complete and accurate information
 - Given reasonable time to make key decisions
 - Welcomed to contribute to open and objective discussions

12. Appendix B

MEMBERSHIP

Professor Deborah McNamara (Chair; Co-Lead National Clinical Programme in Surgery)
Mr. Mitchell Barry (SIBS nominee)
Mr. Pdraig Kelly (RCSI Surgical Affairs)
Mr. Paul McCormick (Representing General Surgery)
Professor Gerry O' Donoghue (SIBS nominee)
Mr. Martin O'Sullivan (Chair SIBS)
Professor Sean Tierney (Dean of Professional Development and Practice, RCSI)

13. List of abbreviations

ASAU	Acute Surgical Assessment Unit
CCST	Certificate of Completion of Specialist Training
ED	Emergency Department
HSE	Health Service Executive
M&M	Morbidity and mortality
NCAGL	National Clinical Advisor and Group Lead
NCHD	Non Consultant Hospital Doctor
NCPS	National Clinical Programme for Surgery
NDTP	National Doctors Training and Planning
RCSI	Royal College of Surgeons Ireland
SIBS	Society of Irish Breast Surgery
SLWG	Short Life Working Group

14. Acknowledgement

The SLWG thank Ms Laura Hammond for administrative support in undertaking and completing its work.

15. References

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