EDITORIAL

ACUTE CARE SURGERY IN EUROPE: BEEN THERE, DONE THAT, STILL GOING ON

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Only ten years ago, Moore et al have published "Acute Care Surgery: Eraritjaritjaka" stating the "European model," ie, performing operative procedures in other trauma surgery fields, is an enticing proposal, and has been an enduring field in Austria and Switzerland [1]. The Swiss surgeon Martin Allgöwer [2] noted ". . . Europeans recognized trauma as the 'Cinderella of surgery' earlier than other nations, including Americans" and argued that ". . . most common limb injuries could be a field of common interest between general and orthopaedic surgeons" [3].

With today's perspective, the patients on our operating tables can be roughly classified into three categories: elective, trauma and non-trauma emergency cases. The first need not concern us here: the gallstone or reflux disease, the bunion that does not prevent the patient from walking, and the carpal tunnel syndrome that could respond to conservative treatment do not require the midnight services of a visceral surgeon, an orthopedic surgeon and a neurosurgeon, respectively. The patients who do concern us are those in the latter two categories, i.e. trauma and non-trauma emergencies requiring immediate attention. These two categories taken together can be variously called acute care or emergency surgery. Dissecting definitions should not be our concern; we all know what we are talking about here if we call it acute care surgery (ACS).

Ten years ago we published the results of a survey of a cross-section of European experts in search of a European model of acute care surgery. We had to conclude that there was, as yet, no such speciality. The European Union notwithstanding, there were too many differences, be they socioeconomic, geographic, political, educational, infrastructural, as to allow a uniform approach to the handling of patients in urgent need of surgical help. [4]

What has happened in the meanwhile? As the general population aims for citius, altius, fortius, many fall by the wayside in the race to be faster, higher, stronger and land in our surgical emergency rooms. In the developed world, the age pyramid becomes ever more top-heavy: seniors are liable to sustain injuries, e.g. from falls, and as the organism ages, its organs become more susceptible to failure and disease. We will see more ambulances arriving at our services, more gurneys traveling through the halls, more patients doubled over in pain in the waiting room.

How are we meeting the demands of our increasing workload in emergency surgery? Discussions continue, statistics are generated, papers are presented and published. Models are created and compared [5], and the conclusion is inevitably that there is still no optimal solution in sight.

As so often in the broad field of medicine, the United States seems to be leading the pack, with well- constructed initiatives that have so far produced promising results. In 2005, the American

Association for the Surgery of Trauma (AAST) and 2007, the new established European Society for Trauma and Emergency Surgery (ESTES) responded to the crisis in access to emergency surgeons by creating the foundations for the training of surgeons in ACS. The AAST conceptualized a training program that emphasized trauma surgery, surgical critical care and focused expertise in emergency general surgery conditions. The training was designed to create a versatile surgeon able to confront a host of acute surgical disease processes. This training program is now being offered at some of the premier teaching hospitals in the United States, including Massachusetts General Hospital and Yale Hospital. [6] In a similar way, ESTES has established a curriculum for emergency surgery which has been approved by the European Union of Medical Specialists (UEMS). The first exam for the European Diploma in emergency surgery was taken 2016 in Vienna during the annual meeting of ESTES. According to the curriculum ESTES in collaboration with AAST have published a Manual for Emergency Surgery.

When we did our survey ten years ago, we already had email and Internet to facilitate such efforts but advancements in IT make it ever more useful. Just as one example, there is the Orlando Regional Medical Center's forum, SurgicalCriticalCare.net / AcuteCareSurgery.net. This is an online, interactive, educational resource, open to any physician, nurse, respiratory therapist, medical student, or other allied healthcare provider interested in the discipline of Surgical Critical Care or Acute Care Surgery. SurgicalCriticalCare.net is designed to provide rapid access to essential information for caring for patients with critical illness [7]. Never before have we had such means of fast and efficient communication and it behooves us to make the best use of them that we can with the aim of improving our own practice.

As yet we do not have guidelines, models and algorithms to solve all of our problems in our day-to-day life-and-death clinical routine in our emergency rooms, shock rooms and operating rooms. We do, however, have a steady supply of seriously and desperately ill patients who depend on us. In my own experience, one of the best things the individual surgeon can do to come up to speed in ACS is to attend quality training programs such as the DSTC® courses that we have offered for more than twenty years now, supplemented in more recent years by accredited workshops in non-trauma emergency surgery. As course director, it is gratifying to me to see the progress that participants can make in just a short time, enabling them to take home skills that they can immediately implement and pass on to colleagues at their home hospitals.

At the end of the day, ACS is all about the individual surgeon with the individual patient. In that one-on-one critical situation, models, guidelines and algorithms take second place to individual information, skills, experience and judgment. And those are things that only you, the individual surgeon can work on.

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