Journal of the Association of Surgeons of Great Britain and Ireland

Number 39, March 2013

A MESSAGE FROM THE PRESIDENT

It is a great pleasure and privilege to take on the Presidency of the Association at a very challenging time for surgery in general.

To say that there is a lot going on within surgery at the moment is an understatement. The Report of the Francis Inquiry on Mid Staffs was published in February, after many delays, and although there is little new within it, it makes uncomfortable reading for us all. We are in the middle of the biggest reform of the NHS for a generation, and a time of relentless increase in unscheduled care and static funding in real terms. The "Shape of Training" review is underway and will report in the autumn. It seems likely that the outcome in general surgery (and, probably, most surgical and medical specialties) will be a move towards more generalist training as being key, in order to meet the needs of unscheduled care. This is a reversal of the direction of travel of recent years. Together, these issues provide challenges for ASGBI and surgery as a whole.

First, the Francis Inquiry. Accepting fully the dreadful medical and nursing care provided in Mid Staffs, it is important to look at the culture which produced the drivers for this disaster. As the ***Heath Service Journal*** pointed out immediately after the report was published, Mid Staffs was, in general terms, a non-viable Trust which achieved Foundation Status. There are many of these around, where the "books don't balance" in the present environment. Indeed, under the present Monitor regime, most would not get through. It is noteworthy that, although all Trusts were meant to be Foundation by 2014, this target has been quietly dropped.

With relentless pressure to meet targets and make cost improvements from the Strategic Health Authorities, it's easy to see how Trust Executives and Boards can let quality slip. Bullying at this senior level is allegedly endemic in the NHS and appears, unfortunately, to have become part of the culture. The disclosure by the ex CEO of Lincoln shows this to be the case, and there is no evidence that this has changed, or will change post-Francis. The fact is, however, that no amount of top down or target-driven pressure is actually going to achieve an NHS where quality is high on the agenda.

Clearly, funding is limited; so what should be done? It is apparent that, currently, all the risk is with the providers and none with community and primary care. It was clear, when the GP contract was changed a decade ago and the A&E wait time subject to penalty, what would happen. Hospitals have to deal with relentlessly increasing levels of unscheduled admissions and this over-performance is not funded adequately. Even if these admissions are not often surgically related, they put pressure on surgical beds and also remove funding from surgical budgets.

Although hospital information systems are not always outstanding, we do have significant data on what happens in hospitals and what the outcomes are, plus what value for money this represents. This is especially the case in surgery where, by June, unit-specific outcome data will become publically available. By contrast, the majority of the NHS spend is in community and primary care. Nobody really knows how this money is spent. Nobody really knows what GPs do, or what value to the taxpayer they represent, and cost-improvement programmes in this part of the NHS scarcely exist.

This, of course, brings me to the topic of NHS reform. Most surgeons, if asked, would have said, in 2010, that reform was needed, but practically no one would have said that it was a good idea to put most of the NHS budget in the hands of GPs! It is certainly true that the current commissioning arrangements are broken, as far as the hospital service is concerned, but the hope that Clinical Commissioning Groups will improve this seem unlikely to be realised. The architect of the whole reform process has gone, there was little enthusiasm for the changes at the higher levels of the NHS, but yet the process goes live on 1st April. The cost and opportunity cost of these reforms must be very large indeed and, for the hospital service and surgery in general, it seems likely that the new system may be worse. One potential improvement may be in Specialised Commissioning, as complex and major surgery will be controlled by a national process, so it should no longer be necessary to argue the case for these procedures locally with Commissioners without relevant expertise. We are pleased that Professor Graeme Poston, who chairs the NHS Specialised Commissioning Board for Internal Medicine (which covers major GI surgical procedures), is now on the ASGBI Executive Board as our Director of Professional Practice. What we now need to ensure is that the Executive Board has appropriate input from surgical

Continued on page 2

PRESIDENT'S MESSAGE

specialties and also that the local implementation of policy is not subject to interference.

As I mentioned previously, the "Shape of Training Review", conducted by Professor Greenaway, will report in the autumn. It covers all of medicine, but the implications for surgery will be large. Although we clearly have to await the outcome, the general expectation is that there will be a move towards generalism, rather than specialism, for most trainees, in order to meet the service needs of emergency care and routine surgery. How far this will go remains to be seen, but the Association, as the SAC-defined Specialty Association for General Surgery, has to be ready to constructively help put the recommendations into practice. The FSSA paper, authored by past President Professor John Macfie, who now chairs the Surgical Forum, suggests a way forward which may be compatible with Greenaway. What is clear is that there will be no further new surgical specialties to follow vascular in the foreseeable future and it is indeed doubtful, if vascular had not been accepted as a specialty prior to the Greenaway review, that it would have been after. ASGBI plan to hold a conference with all the general surgical specialty associations post-Greenaway to discuss the future of ASGBI and general surgery.

Moving on, the Association is also now fully established and working as a not-for-profit incorporated company and it is worth explaining what this means. Not-for-profit is a technical term which means that Executive Board members do not derive pecuniary profit from the company and there are no shareholders to do so. Your Executive is, of course, dedicated to the responsible management of ASGBI's finances and to ensuring a respectable surplus on our operations, which can be ploughed back into the organisation and into membership benefits. The Board looks rigorously at all areas of expenditure, and we are particularly focussed, at present, on a more rapid shift towards electronic rather than printed communications with the membership.

Incorporated status gives ASGBI much greater freedom than charitably incorporated bodies to undertake a range of tangible functions on behalf of members, including the provision of financial advisory services. The Surgical Indemnity Scheme is an example of this, providing highly competitive insurance for anyone undertaking a significant level of non-NHS practice. In the next issue of the ***Journal***, Graeme Poston raises the question as to whether, in terms of employment, different representation for surgery is appropriate. The BMA has been, in many ways, successful in representing doctors as a trade union, but it is inevitably dominated by the membership, the majority of which are GPs. Surgeons, and craft specialties in general, are different, and the BMA has done little to aid the aspiration of surgical trainees to have a more hours of work regimen so that training was not so disadvantaged by the EWTR and the New Deal. Nobody wishes to return to prior systems with very long hours of work, but sensible flexibility is needed if training is not to continue to be disadvantaged. Debate on this issue is needed and hopefully the article will stimulate this.

I hope that ***JASGBI*** will continue to inform, educate and entertain our members, as well as stimulate debate on the big issues which are facing us in the changing surgical landscape. Our Director of Communications, David Rew, and our Communications Officer, Jessica Pether, are overseeing the constant evolution of our ***Journal*** and I very much hope that, over my two years as President, ***JASGBI*** will become a forum of debate and sharing of information amongst our fellows. With the challenges alluded to above, it is vital that surgery endeavours to respond with a single voice.

Finally, I very much look forward to meeting as many of you as possible at our forthcoming International Surgical Congress in Glasgow (1st to 3rd May 2013), at which Robert Francis, QC will be speaking, and which I hope will be a stimulating professional and clinical conference.

With best wishes

Professor John Primrose
President

MAY YOU LIVE IN INTERESTING TIMES!

A report from the Director of Communications

It was a great privilege to have been invited to join the Executive Board of ASGBI in the autumn of 2012, to help communicate the Association's sense of direction to the membership at a time of considerable change in the professional landscape and challenge to us individually as surgeons. As the waves build and crash around the UK in the wake of the Francis Inquiry on Mid Staffs, we are all challenged to consider how our professional ethics, moral courage and compassion are channelled within the NHS in its present form.

The Professional Environment

2013 promises to be another disruptive year for surgeons. GMC directed Revalidation is now up and running, and many of our members will be going through the process this year, at significant cost to personal time and effort. The shift of service duties to consultants continues, with discussions on the form and staffing of the "Hospital at Night" and the "24/7 Hospital", and with the unwelcome prospect of a further diminution of the numbers of trained junior staff on the front line. The emergency or acute General Surgical Consultant post is now up and running across the country, posing new challenges and questions about whole-of-career management and development for those appointees.

A vigorous debate on specialisation versus generalisation is emerging and many juniors who have focussed on a specialist route may now find that they have to revert to a more general and emergency role to meet service requirements and job vacancies. The profession has yet to engage on how individuals can remain effective and focussed in an extended surgical career, with pensionable retirement dates that may well reach to 68 or even 70 years of age within a few decades.

On a personal level, for each and every surgeon, challenges to equanimity and *mens sana* continue apace. While ***The Times*** of 16th February 2013 tells us that doctors still come top of the public's list in polls on trust (at 89%), this is scant consolation for those many surgeons with firsthand experience of the complaints culture and the workings of the GMC Professional Standards investigative processes. Many surgeons are also drawn into the complaints and litigation culture as case reporters and expert witnesses. The medico-legal world remains an under-regulated Wild West for professional standards and the quality of reporting, which is a matter of considerable concern to the ASGBI Council. Whereas the best experts secure proper training and bring rigorous analysis and focussed expertise to the process of report writing, others do not. The consequences are borne by the public and by colleagues within the profession in terms of delays and irregularities in the workings of the civil litigation system, and in the fair and mature resolution of cases against surgeons.

The work and functions of ASGBI

The Association itself continues to build upon a proud history of surgical fellowship across the United Kingdom and Ireland, and to attract general and executive members from England, Wales, Scotland, Northern Ireland and the Republic of Ireland. At Executive Board level, this strength in breadth and depth brings considerable vigour and a wide range of informed perspectives to the debates in Council on the challenges before us. To this end, in acknowledging the sterling work of Professor John MacFie as outgoing President in bringing this team together, we are also delighted to welcome Professors John Primrose to the Presidency, Gordon Carlson to the Directorship of the Scientific Programme and Graeme Poston to the Directorship of Professional Practice in 2013.

Gordon Carlson

The Association is also very conscious of its relationships with the various subspecialty associations, which comprise and represent the surgical community; the Surgical Royal Colleges, international surgical associations, the wider professional community and the public in general. One matter of particular concern to us is the lack of representation of the interests of surgeons in the political arena in respect of matters such as the EWTR, which has had such a profoundly deleterious effect on the practice of surgery and the training of surgeons in the UK.

Graeme Poston

The ASGBI Executive is also exercised in matters of risk management and mitigation in respect of surgical devices, implants and equipment. We work in an increasingly complex and technological world where new risks arise for patients as new devices and equipment are introduced into practice and where the delayed or inadequate reporting of adverse outcomes is leading to unnecessary morbidity, and occasionally to media "scandals", as witnessed recently with the PIP breast implant and De Puy hip prosthesis stories. To this end, and to raise professional awareness and reporting of the problems, we will shortly be publishing an ***Issues in Professional Practice*** booklet on the subject. We have also produced a link on the ASGBI website to the DoH MHRA, to facilitate reporting of any concerns about individual devices, implants or equipments.

Communicating with and for ASGBI

And so to the communication functions of the Association. Nick Markham (Director of Informatics) and his team continue to develop the functionality of our website, the ASGBI app for Apple devices, and the digital environment of the 2013 Congress in Glasgow.

The ***Journal*** continues to be well received and a keystone of our communication with members. We would very much welcome participation in the various debates which I have outlined and the contribution of interesting, challenging, entertaining or offbeat prose (or even poetry) on any subject which may be of interest and value to the community of surgeons. Revalidation brings a demand for more reflective writing, and the ASGBI ***Journal*** provides a unique forum and vehicle through which you can reach a wide, sympathetic and interested audience, at whatever stage of your career you have attained. With a quarterly print run of around 2,500 copies, and a much wider potential online audience, you are assured of a receptive readership for your interesting thoughts and experiences. We wish you well in 2013 and look forward to seeing you at our International Surgical Congress in Glasgow, from 1st to 3rd May.

David A Rew

ASGBI EMERGENCY SURGERY INTEREST GROUP

INAUGURAL MEETING AT ASGBI'S INTERNATIONAL SURGICAL CONGRESS, 1st TO 3rd MAY 2013

Dear Fellow Surgeon

Emergency General Surgery (EGS) is a core part of the practice of almost every general or gastro-intestinal surgeon. It is an area of practice which has, sometimes, been relatively neglected and, in conjunction with other professional groups, ASGBI has produced several documents outlining the problems and some solutions.

Simultaneously, many colleagues have begun to address local problems at a number of levels with changes to rotas and systems of on-call, participation in audits and appointments of surgeons with defined clinical interest or leadership roles in EGS. Some have obtained more theatre access for emergencies. In the last English College workforce survey of Consultant Surgeons, 138 designated EGS as a special interest; a remarkable increase in a short space of time.

While problems and solutions differ between hospitals, it is clear that there are many common threads. Consequently, ASGBI is setting up an 'Interest Group' to facilitate the sharing of ideas and experiences (good and bad) and assist the development of EGS in the UK and Ireland. EGS is, and will remain, a core part of ASGBI and the annual International Surgical Congress, but this group will offer members additional opportunities to discuss EGS and to become involved in initiatives which will shape EGS practice and training. For example, ASGBI is presently involved in issues relating to EGS training, costing and remuneration, the generalist / specialist balance, standards of care, job descriptions and national audit and research.

It is envisaged that the EGS Interest Group would meet at the annual ASGBI Congress and, additionally, communicate electronically by newsletter and forum group. Subgroups will also address particular issues, and present recommendations to the larger group and to the Association's Executive and Council.

Membership of the group will be free to existing ASGBI Fellows (in whatever category – Affiliate, Associate, Full or Senior) actively involved in EGS. However, trainees should be within two years of obtaining a CCT.

The inaugural meeting of the group will take place at ASGBI's 2013 International Surgical Congress, on **Thursday 2nd May, from 3.00pm to 3.30pm**, in the Leven Room at Glasgow's SECC.
I hope you will join the group, and contribute if you are interested in continuing the development of EGS. If so please email your name, email, phone and hospital name to:
EGSinterestgroup@asgbi.org.uk

With best wishes

Iain Anderson
Consultant Surgeon, Salford
and Director of Emergency Surgery, ASGBI

A GUIDE TO PROFESSIONAL INDEMNITY

Dr Gerard Panting
Adviser to the Surgical Indemnity Scheme

You might assume that all professional indemnity cover is the same, but it's not. There are very significant differences between the various forms of indemnity available and the degree of protection they offer, both during your working life and your retirement.

The FIPO 2011 survey on professional indemnity (http://www.fipo.org/docs/indemnity) revealed that the majority of consultants did not know whether they held contractual or discretionary cover, if the cover was occurrence based or claims made, or the limit of their indemnity. Some were not sure how much they were paying or to whom.

All doctors need to have an indemnity to cover the cost of compensating patients for negligent harm and to meet the costs of protecting themselves when faced with other forms of professional accountability, such as GMC investigations. A policy of insurance is one way of securing the indemnity but there are others, such as access to a discretionary fund through membership of a defence organisation offering indemnity as a membership benefit. Getting to grips with these different forms of indemnity is not difficult: you just need to understand the basic terminology.

Insurance policy versus discretionary fund
An insurance policy is a contract between the doctor and the insurer that states the benefits that the doctor has a right to receive under the terms of the policy. Discretionary indemnity provides members of the group with the right to apply for assistance from the fund, which is available at the discretion of the fund directors.

The Surgical Indemnity Scheme (SIS), a wholly owned subsidiary of the ASGBI, provides all its comprehensive benefits through an individual policy of insurance. MDU members have a policy of insurance to cover clinical negligence claims notified during the period of membership and discretionary indemnity for all other forms of assistance, including cover in retirement. All the benefits of membership of MPS and MDDUS are discretionary.

Claims made versus occurrence
Claims made policies respond to claims that are notified during the period of insurance and the Extended Reporting Period (ERP). The ERP varies from one provider to another (see extended reporting period and retroactive cover below), but once a circumstance that could give rise to a claim has been noted in accordance with the policy, you are covered, subject to the contract terms, whenever the claim is actually brought. By contrast, occurrence based indemnity covers any adverse event which occurs during the membership period, even if the claim is only started after the end of the membership period. But occurrence based indemnity is generally discretionary, not contractual, cover.

Indemnity limit
The indemnity limit is the maximum that the policy will pay out in any one year. There may be a maximum for a single claim and in the annual aggregate, or just one total figure. Only insurance policies quote a limit, as discretionary providers cannot guarantee any level of cover.

The Surgical Indemnity Scheme offers options of £5 million or £10 million for all claims made in any one year; the MDU insurance policy indemnity limit is £10 million. MPS and MDDUS as discretionary indemnifiers do not quote indemnity limits. Most independent sector hospitals now have minimum indemnity limits for their consultants, usually £5 million in the annual aggregate, and relying on a policy with an indemnity limit below the stated requirement could result in withdrawal of admitting privileges.

Scope of coverage
This is simply what you are covered for. The GMC require all registered medical practitioners to be properly indemnified for clinical negligence claims so that patients do not go uncompensated. However, there is no requirement for doctors to be covered for the costs of defending their professional reputation in other situations, such as GMC complaints, NHS disciplinary procedures and criminal investigations, all of which pose a direct threat to your livelihood. 24/7 access to expert medico-legal advice is invaluable if you encounter any of the legal problems encountered in professional practice.

Extended reporting period (ERP)
Protection has to extend into retirement. The general rule is that adult claimants of sound mind have three years from first knowledge of having the basis for a claim to start legal action. Whilst in the independent sector, claims tend to be brought quite quickly, on average within two years of treatment, there is always the possibility that claims may be delayed, so protection must extend well beyond the statutory limitation period.

The ERP is the agreed period of time, after the end of your final period of insurance, which allows you to collate and report adverse events arising from the work that you performed prior to the expiry of your last policy. It is triggered by death, or permanent cessation of practice. SIS has an extended reporting period of 10 years. With the defence organisations, all cover in retirement is discretionary. With some commercial insurance policies there is no

extended reporting period at all, or it is short, or it comes with a significantly reduced indemnity limit.

Retroactive date
Insurance policies have a retroactive date, which may extend back many years. The policy will respond to claims arising from incidents occurring after the retroactive date, provided that the insured was unaware of the potential claim at the time of taking out the new policy. This is important because it provides continuity of indemnity when transferring from one insurer to another.

The UK Providers
Prior to 2000, the only real indemnity options in the UK were the MDU, MPS and MDDUS. All three offered discretionary benefits of membership, including cover for clinical negligence claims.

Since April 2000, the MDU have provided an insurance policy for members with an independent sector practice to cover clinical negligence claims made during the period of MDU membership only. Help with clinical negligence claims made after retirement or leaving the MDU, GMC investigations and all other assistance are covered by the MDU's "discretionary wrap around". So, a claim against an ex-MDU member for an event that occurred during the period of membership will only be covered if the MDU exercise its discretion to assist. Similarly, help with GMC and other investigations is discretionary, so when moving from the MDU you need to ensure that your new indemnifier will cover you for adverse incidents that occurred whilst you were an MDU member, but that you were unaware of when you moved to your new provider (i.e. it has a retroactive date to cover your period of MDU membership).

MPS and MDDUS continue to provide discretionary occurrence based indemnity so ex-members can apply to them for indemnity after moving to a new provider.

From 2011, surgeons in the UK have had greater choice in indemnity provision with the introduction of the Surgical Indemnity Scheme (SIS). SIS provides the full range of indemnity services through an individual contract of insurance, accessed via a 24/7 medico-legal advice service.

A few commercial insurers have also entered the professional indemnity market. The benefits available to these policy holders vary greatly and may not meet independent sector hospital group requirements or provide the range of services that surgeons need. If considering these, you need to check that the limit set for each element of the policy is adequate. Some policies offer limited legal expenses for GMC cases, leaving the surgeon to meet the cost of legal advice and representation after the limit has been exhausted. So attention to detail is required to ensure that you are as secure as you think you are if you opt for one these carriers.

Another important point is where to turn if you feel that you have been denied benefits that should have been provided to you. With the MPS and MDDUS, you can complain to the organisation itself: because they are discretionary indemnifiers, you have no comeback if they exercise their discretion not to assist you, nor are they obliged to give reasons for their decisions, although they usually will do. Insofar as the MDU provides a policy of insurance, it is subject to review by the Financial Services Ombudsman (FSO), but in respect of the discretionary membership benefits, it answers to no-one. The underwriters of insurance based indemnity fall within the jurisdiction of the FSO, who is empowered to require insurers to provide cover.

A few simple questions will help you decide which indemnifier is best for you:

- Does your provider have indemnity limits that meet all the requirements of the independent sector hospitals where you admit patients?
- Will you be covered after you have retired, and if so, for how long?
- Does indemnity extend to GMC investigations, NHS disciplinary proceedings, police inquiries, complaints procedures and all the other problems that can crop up in professional practice?
- Does the team providing the services have a proven track record in professional indemnity?
- Is there a 24/7 medico-legal advisory service?
- Will you have complete continuity of cover on switching providers?
- Does the subscription you pay reflect the risk associated with your practice? Is it used to subsidise other specialties or poorly performing colleagues?
- Have all your questions about the contractual or discretionary basis of membership benefits been answered satisfactorily?

In summary, having insurance-based indemnity provides you with contractual rights to the benefits available under the policy, as opposed to the discretionary benefits available in the main through the medical defence organisations. But before signing up to any professional indemnity arrangement, you need to ensure that it provides the security you need both in terms of financial limits, scope of benefits and adequate protection when you retire.

Dr Gerard Panting worked at the Medical Protection Society from 1987 to 2006 and, as a director of Specialist Professional Indemnity Services Ltd, has been instrumental in the development of the Surgical Indemnity Scheme and a number of other specialty specific indemnity schemes, the first of which was launched in January 2010.

INFORMED CONSENT

Mr Simon Parsons
Consultant Surgeon and Technical Director of EIDO Healthcare

Informed consent may be defined as follows:

"The *voluntary* and *continuing permission* of a *competent* patient to receive a *particular treatment*, based on an *adequate knowledge* of the *purpose, nature and likely risks* of the treatment, including the likelihood of its success and any alternatives to it. Permission given under any *unfair or undue pressure* is not consent."

Each of the words or phrases in italics are important and there are legal and practical implications attached to all of them. As healthcare professionals, informed consent of a competent patient (patient with capacity) is fundamental to our professional practice. Furthermore, understanding and performing the correct consent process when a patient lacks capacity is essential to ensure vulnerable patients are treated appropriately. Nevertheless, within the NHS, there are many examples where the practice of informed consent does not meet the standards required.

The National Health Service Litigation Authority (NHSLA) is the body responsible for managing risk within the NHS, as well as resolving claims. It creates standards of practice based on lessons learnt from claims. It has standards on patient information and consent (standard 5.2) and consent training (standard 5.3). Its standards are based on the following rationale:

"Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Analysis of data of the NHSLA database shows a significant number of claims involving the inappropriate or incorrect taking of consent. It is therefore essential that organisations have in place robust and overarching consent training programmes for all staff that are required to obtain or validate the taking of informed consent from patients".

The NHSLA and the General Medical Council (GMC) have collaborated to encourage NHS Trusts to report poor practice in consent within their institutions to the GMC using a standard form, and the extent of that reporting is one of the standards monitored by the NHSLA inspections. Although reporting individual doctors is discouraged, this new process does raise the stakes for trainee doctors and their supervisors. Ensuring that trainee doctors are adequately trained in the process of informed consent is essential to avoid being reported to the GMC in this way.

EIDO Healthcare Ltd exists to facilitate the consent process, both by helping clinicians to inform patients through their procedure specific patient information leaflets and in their consent training package. This e-learning training package has just been revised to facilitate learning about the issues in consent using case based scenarios. Training is targeted to specific groups of trainees based on their needs and incorporates documentation of what procedures or groups of procedures they are qualified to consent for. This meets the requirements of the NHSLA and so facilitates each trust to meet its obligations around informed consent. EIDO Healthcare Ltd is a corporate patron of ASGBI and will be exhibiting at the annual Congress in Glasgow on 1st to 3rd May 2013.

The Association is grateful for the generous support of the following Corporate Patrons

A FRAMEWORK FOR SURGICAL MEDICO-LEGAL PRACTICE

PART 1: THE PREPARATION OF REPORTS AND THE DANGERS OF DABBLING

David Rew
Consultant Surgeon, Southampton University Hospitals

Lynden Alexander
Forensic Writing Specialist, Professional Solutions Learning and Development

Giles Eyre
Barrister, 9 Gough Square Chambers

Medico-legal reporting is an influential yet often overlooked factor in the conduct of surgical practice. Many surgeons provide reports for the purposes of civil litigation. Medico-legal practice can be a stimulating and intellectually challenging area of professional work. Some surgeons provide medico-legal reports as a regular part of their practices, whilst others accept invitations from the legal profession to assist on an occasional basis. Whichever category clinicians come into, understanding:

The standard of care required in producing medico-legal reports, and

The role and duties of the medico-legal expert when reporting are essential to the evidential process. This is especially so since the protections previously enjoyed by expert witnesses in the production of their evidence have been removed by the Supreme Court.

The freedom of dissatisfied clients and opponents to seek disciplinary redress through the GMC, and/or financial redress through the Civil Courts, for perceived or actual harm as a result of sub-standard medico-legal reporting may lead to substantial professional sanction and awards of damages. Even in the absence of such sanction, this freedom imposes substantial costs on healthcare providers, their insurers and professional indemnity bodies, as well as the NHS Litigation Authority (NHS LA) [1]. These professional and financial pressures now affect the ways in which clinical practitioners approach their professional duties, whether these are purely medical or medico-legal in nature.

Medical and surgical expert evidence in England and Wales is presented primarily in the form of medico-legal reports. Such medical opinion has a profound influence on the conduct and outcome of cases, both for claimants and defendants. Solicitors, barristers and judges generally have a limited understanding of medicine, anatomy and the functioning of the human body, and of the nuances of individual cases and clinical circumstances. The lawyers on both sides of a case will study the medical expert evidence before making decisions on whether and how to proceed with a claim, and on what terms to attempt to settle it.

Surgeons may be instructed by lawyers to review the work of other surgeons in cases where outcomes have fallen short of that which the patient perceives to be desirable, whether or not there have been any shortcomings in the treatment of the patient. The lawyers' decision whether or not to recommend suing the operating surgeon (or the NHS Trust or other healthcare provider) will be made on the basis of the advising surgeon's report. Medical experts, therefore, have a pivotal role in the litigation process.

Medico-legal casework usually deals with claims for compensation and falls within the remit of the Civil Courts, where the only redress for a claimant is financial recompense. The system is designed (not always successfully) to contain costs and to encourage settlement within reasonable time scales and within fair and appropriate limits. The responsibilities of medical and surgical experts within this process are considerable. These responsibilities include working with the lawyers on both sides, who themselves will be operating under a court directed timetable to progress the case.

Should they come to give evidence in court, medical experts can expect to be subjected to rigorous cross-examination. Their opinions and the manner in which these are expressed will be closely considered. Written evidence in the form of a medico-legal report - and supported by meetings between the instructing lawyers and the experts in more complex cases - is the usual means by which lawyers assess the medical basis of cases; some 98% of claims involving medical experts are settled out of court.

Litigation involving medical experts may variously involve insurance companies, the NHS LA and the Professional Indemnity Societies. Whereas charges in Criminal Courts must be proved to a standard of being 'sure' of a defendant's guilt, in Civil cases the standard of proof is 'on the balance of probabilities'. This could, in theory, come down to a 51:49 decision, although such quantification of the standard of proof would be misleading and never happens in reality. Nevertheless, reaching an opinion on the basis of it being 'more likely than not', the bread and butter of the civil lawyer's diet is unfamiliar territory for a surgeon. Many problems with medical evidence arise from a misapprehension about what this basic test means and how it is applied.

Lawyers' Dissatisfaction with Medical Evidence

Lawyers often comment that the medico-legal reports that they receive demonstrate a fundamental lack of understanding of the role of the surgical medico-legal expert. For that reason, they are inadequate for their purpose. This may surprise many, as surgeons are considered to be

intelligent and responsible practitioners. To understand how it is that surgeons may be falling short of the required standard, it is useful to consider how many surgeons come to develop a medico-legal practice in the first instance. A surgeon may, for example, receive an unsolicited call from a lawyer who is seeking a suitable medical expert to instruct, or may perhaps receive an approach from a medico-legal agency. The subject matter of the request may range from the reporting of the consequences of injury in a road collision, a workplace accident, or an accident in a public place, to considering complex clinical episodes and outcomes.

With the best of intentions, many surgeons write their first report without having explored the complex issues and requirements in providing medical evidence and the sometimes difficult legal tests that have to be applied to the facts of a case. James Badenoch, QC, Chairman of the Expert Witness Institute [2], advises experts to be cautious about accepting instructions without an appropriate level of training for the role: "*There is little doubt that medical experts are often faced with very difficult medico-legal issues to address. It is essential that, before accepting instructions, experts understand the basic legal principles and legal tests that they will need to apply when expressing their opinions in evidence.*"

Medico-legal practice is essentially unregulated. The qualification to be appointed an expert witness focuses on the clinical expertise of the practitioner rather than on his or her knowledge of expert witness work. The advantage of the system as it stands is that any qualified professional can bring his or her expertise to the court and can give opinion evidence. The courts are thus able to hear from the widest possible range of professional opinions when considering cases. There is always a ready supply of experts who can fulfil the role. However, practitioners who do not have sufficient skill or training in medico-legal work may be undermining the proper outcome of cases as well as exposing themselves unwittingly to possible claims for damages.

Rules of Court

The current system of duties and responsibilities for medical experts was codified in the reforms to the Civil Justice procedural framework introduced by Lord Woolf (the Master of the Rolls) in April 1999. His Civil Procedure Rules (CPR) removed the control of litigation from litigants and their lawyers and placed it firmly in the hands of the Court [3].

The 'overriding objective' of the CPR is that the court will deal with all cases 'justly'. This objective is the basis for the discipline imposed on the parties in bringing cases to court expeditiously; in limiting the scope and duration of cases; in establishing a greater degree of equality and fairness between claimants and defendants; and in reaffirming that the overriding duty of all expert witnesses is to the Court (i.e. to the presiding judge) rather than to the party that instructed the expert. Part 35 of the CPR and its associated Practice Direction set out clearly the duties and responsibilities of (medical) experts when providing reports, and their broader responsibilities within the litigation process [3].

Removal of Experts' Immunity from Suit

The removal last year in *Jones v Kaney* [4] by the Supreme Court of the immunity from suit (in negligence or breach of contract) enjoyed by expert witnesses in the production of expert evidence has brought renewed focus on the duties, responsibilities and required quality in the provision of expert evidence. Lord Collins stated that enabling a dissatisfied litigant to seek redress against his or her expert witness '…would tend to ensure a greater degree of care in the preparation of the initial (medico-legal) report'.

Although the judgment is couched with the necessary legal understatement, expert witnesses should be in no doubt about the serious implications of this decision. In the light of this decision, all who practise as experts should pause for thought and be stimulated to improve their knowledge and skills in producing expert evidence, while ensuring their professional indemnity insurance covers this form of work.

The Acquisition of Medico-Legal Reporting Skills

Medical and surgical experts are engaged to help the Court (i.e. the judge) to decide on technical matters that are beyond its expertise. Experts need to understand the legal context and principles that guide the writing of reports and the profound differences between the medical and the legal approach to problem solving [5].

There are seven areas where a medical report written for other clinicians necessarily differs from a medico-legal report written for lawyers, vis:

1. The medico-legal report is written about a claimant and not a patient;
2. It is written for (usually) a non-medically qualified readership;
3. It is used for litigation and not for treatment;
4. It deals with medico-legal rather than clinical issues;
5. It is an independent assessment of a claimant rather than supportive of a patient;
6. It must assess all contributory factors and likely outcomes objectively;
7. It must take an independent and objective view of the actions of other clinicians [5].

There are difficulties for medical experts in developing their specialist skills 'on the fly'. Solicitors rarely provide feedback on individual reports and the outcome of cases, and an expert will rarely be told what impact his or her report has had on a case or a settlement, or even

whether the report achieved an acceptable standard. Clinicians who develop a good working relationship with individual solicitors and legal practices may secure better feedback than those who deal through medical-reporting agencies such as **Mobile Doctors**, **Premex** and **Premier Medical**.

Clearly, it is essential to attend appropriate initial training and then to remain current by attending specialist courses, combined with private study of texts and of the various web resources available. It is also essential to keep abreast of developments in the Civil Procedural Rules on the Ministry of Justice website.

The Range of Surgical Medico-Legal Reports
A surgeon in medico-legal practice may be asked to report on a wide range of different factual scenarios and in a range of circumstances. Reports are usually commissioned by solicitors, acting on behalf of claimants or defendants. Parties may be individuals, companies or other institutions. Requests may be channelled through medico-legal reporting agencies, which deal, for a fee from the instructing solicitor, with the administration of the report phase of the case, including finding an appropriate expert to report on the case.

Personal Injury Reports
Probably the commonest form of report is the Personal Injury Report, in which the surgeon is asked to provide a report on the likely causation and prognosis of injury following an accident. Such reports are particularly common in orthopaedic practice, as with alleged whiplash injuries, but also crop up in general surgical practice, as with the alleged workplace causation of hernias.

Clinical Negligence Reports
Liability and Causation (also known as Breach of Duty and Causation) Reports, and often referred to as Clinical Negligence Reports, require the expert to give supported opinions on what was the duty of care owed by the defendant clinician or health care provider to the claimant; whether there has been a breach in the duty of care; and whether the adverse outcome was consequent upon that breach of duty. The last question addresses the legal issue of causation, i.e. the causal link between the alleged breach of duty and the alleged damage or injury sustained and which the claimant must prove.

Advisory Reports
Solicitors will sometimes commission an Advisory Report at an early stage in the consideration of proceedings. This is a more informal report that is not produced for the court (and is not, therefore, bound by the CPR) but is intended to offer advice to the solicitor and client on the medical issues in the case; to consider whether there has been a breach of duty that has caused damage and hence, to allow the solicitor to weigh up the chances of a successful outcome in running the case. An instruction for a more detailed report for the court may follow this initial request.

Single Joint Expert Reports
A Single Joint Expert Report may be commissioned jointly by the parties, or be required by the court, to help resolve a relatively non-contentious or low-value aspect of a claim, especially so where there is no alleged breach of duty. As this, in effect, involves the Court in surrendering an aspect of decision making to the expert, a single joint expert will not be instructed to report on breach of duty or on aspects of the claim likely to have a high financial value.

Concepts governing the preparation of reports
In preparing reports, the expert must be aware of the legal principles that underlie the claim. The expert is required to apply the appropriate legal tests in the course of the medical report, and is generally expected to understand the requirements of such tests without guidance from the instructing solicitor. If an expert is ever unsure as to what legal test to apply, or how to apply it, on the facts of the particular case (whether considering breach of duty, contributory negligence, causation, consequential loss, life expectancy or prognosis), the best course of action is to seek advice from the instructing solicitor or to attend training that covers these points or refer to an appropriate text on the subject.

Medico-legal reports must be written with clarity, conciseness and simplicity. All necessary technical terms should be defined and the expert's opinions should be expressed with reference both to the relevant facts in the case and the medical reasoning that supports the conclusions reached. Reports must be 'internally consistent' with a logical and ordered structure that addresses all relevant facts and the range of professional opinion on all relevant matters. Reports must also be 'externally consistent', by accurately reporting all relevant facts, whether or not these support the client's case, and by clearly explaining the medical context of the issues in the dispute.

Establishing a Medico-Legal Practice
Newcomers to surgical medico-legal practice may wonder how to get established and how to promote themselves. The first step is preparation and education, following which an individual is free to advertise on a variety of databases that are distributed to lawyers. These include ***Legal Hub***, the ***Expert Witness Directory***, and the ***UK Register of Expert Witnesses*** (JS Publications). The financial resources and professional commitment to expert witness work will determine whether the surgeon runs his/her practice on an ad-hoc basis or as a formal business. The putative expert will generally be asked by solicitors to provide a CV and terms and conditions of service, including a scale of fees, which may be raised on an hourly rate or on a fee-per-case basis.

Concluding Comments
There is considerable professional danger in treating medico-legal reporting as simply an extension of clinical practice. The surgeon undertaking a successful and effective medico-legal practice must understand his or her duties and obligations as an expert witness and must follow the court rules and requirements. Not to

do so runs the risk of creating problems for the expert or the instructing party, or both. The position is the same whether the surgeon is an established expert witness or only occasionally receives instructions.

To provide a competent medical expert report the surgeon must:

- Prepare adequately for medico-legal practice by way of education, courses and reading
- Adhere absolutely to the golden rule of objectivity and independence of mind, regardless of the source of instruction and who is paying the bills
- Demonstrate a clear understanding of the legal and procedural processes and terminologies involved
- Understand the contents of Part 35 of the Civil Procedure Rules (the Rules, Practice Direction and Protocol).

The skills of medico-legal reporting can be acquired, but they are founded upon a clear understanding of the legal tests to be applied to the evidence and a good command of the English language. Words and grammar facilitate precise interpretation and the quality of the written word can have a significant bearing on the outcome of cases and upon the reputation of the report writer. Excellence in report writing often keeps cases out of court and facilitates early settlement, which should usually be the primary aim. Poorly written reports can land the writer in deep water and create profound discomfort under cross-examination if the case proceeds to court.

References

[1] NHS Litigation Authority website and reports: www.nhsla.com/publications

[2] The Expert Witness Institute is a not-for-profit membership organisation for expert witnesses: www.ewi.org.uk

[3] Civil Procedure Rules and Ministry of Justice website: www.justice.gov.uk/courts/procedure-rules/civil/rules/part35

[4] [2011] UKSC 13. A copy of the full judgment can be found on the Supreme Court website: www.supremecourt.gov.uk/decided-cases/index.html

[5] **Eyre G, Alexander L**
Writing Medico-Legal Reports in Civil Claims: an essential guide
Professional Solutions Publications (2011) ISBN 978-0-9569341-0-9

REVALIDATION OF SURGEONS IN THE UNITED STATES OF AMERICA - NOTHING NEW

John R T Monson
Professor of Surgery and Oncology
Chief, Division of Colorectal Surgery and Vice-Chairman of Surgery
Vice-Chairman of Quality and Outcomes
Director, Surgical Health Outcomes and Research Enterprise (SHORE)

Jacob Moalem
Assistant Professor of Surgery
Division of Surgical Oncology
University of Rochester Medical Center

To coin a phrase, there is nothing new in this world. For generations, the surgical profession has wrestled with the concept of demonstrating to the public that they were safe in the hands of their doctors. However, for the best part of two centuries, this reassurance has been largely based on trust alone. For their part, the various Royal Colleges played critical roles in the development of training programmes and, of course, the establishment of a process whereby an adequately trained surgeon would sit an exam to be awarded the Fellowship of an individual College. For many decades, holding such a fellowship was represented by the profession as proof of quality and, for the most part, accepted as such by patients and the rest of the medical profession. Naturally, there was some legitimacy to this process.

However, one obvious flaw was the lack of any re-appraisal of competency for the duration of a surgeon's career. In common with many professions, surgery worked on the basis of "once competent, always competent". Times change of course, and such a concept is no longer accepted by society in almost any walk of life. The challenge facing surgery around the world is actually quite simple: the patient wants and needs to know that their surgeon is safe, skilled and competent, while for their part, the surgeon needs to be able to demonstrate to their patients that these qualities exist. Perfectly reasonable expectations and desires one might suggest. However, it is somewhat easier said than done to satisfy both parties and, to be fair, efforts in this regard have existed for many years.

Board certification of American surgeons first came into being with the establishment of the American Board of Surgery (ABS) in 1937. This board was established as a direct result of Dr Edward Archibald's Presidential address to the American Surgical Association two years prior, and represented the eleventh accrediting medical professional board in the United States. Over the ensuing decades, the numbers of medical and surgical specialties grew somewhat organically and by 1970, the American Board of Medical Specialties (ABMS) was formed to oversee the ABS and 23 other specialty boards.

Board Certification requires the completion of at least five years of training in a residency programme (allopathic or osteopathic) that is approved by the Accreditation Council for Graduate Medical Education (ACGME). Following review of their operative log and attestation by their programme director as to

their satisfactory acquisition of operative skills, ethics and professionalism, residency graduates become candidates for the two-part board examination: First, candidates must pass a computer based qualifying (written) examination that consists of approximately 300 multiple choice questions. Next (and only after successfully passing the written component), the final step in board certification is the completion of the certifying (oral) examination. In this exam, candidates are questioned on their management of clinical scenarios by pairs of examiners, one being a member of the Board and the other a senior surgeon from the region where the exam is taking place. While the qualifying examination is given annually, and can be taken in any secured test-taking facility, the certifying examination is given four or five times annually in different regions of the United States, and they must be attended in person. This oral examination has naturally changed much in recent years as educational theory has introduced domains such as validity, reproducibility and objectivity. Extended matching questions derived from a centralised database is now the norm.

Until 1976, there was no requirement for recertification for American surgeons. Prior to that, the satisfactory completion of all the requirements and passage of the two-part examination resulted in lifetime certification for the surgeon. In 1976, the ABS began requiring recertification every 10 years, essentially in response to public demand. Until very recently, that process required passage of a written examination as well as documentation of the diplomates' continuing medical education credits as a testament to their commitment to practice improvement, continuing education and professionalism.

In July 2005, in response to the public's concern regarding patient safety, healthcare quality and physician competence, the ABS refined its requirements for recertification again. Consistent with the other member boards of the ABMS, the ABS embraced the concept of maintenance of certification (MOC). Under MOC, diplomates are required to report their maintenance of certification activities to the Board in three-year cycles. This allows for the introduction of real-time documentation of commitment to lifelong learning and quality improvement, and for the introduction of more relevant and meaningful measures of care. Additionally, this new paradigm allows diplomates to participate in learning and improvement activities that are customisable and reduced the burden associated with multiple redundant quality assessments.

MOC is subdivided into four parts:

- **Part 1**- Professional standing: In this component of maintenance of certification, diplomates must provide written documentation of a full and unrestricted medical license, as well as their maintenance of hospital privileges in their specialty, so long as they're clinically active. Additionally, contact information for the chief of surgery and chair of the credentialing committee must be provided to the Board.
- **Part 2**- Lifelong learning and self assessment: For this component of MOC, diplomates must provide evidence of the completion of at least 90 hours of category 1 CME credits that are relevant to the diplomate's practice. Of these, starting on July 1st 2012, 60 hours must include an element of self-assessment. A score of 75% or higher must be obtained on these CME activities for any credit to be given. Opportunities for these category 1 CME credits include a variety of self-assessment programmes and courses offered through specific surgical specialty organisations, journals and online training modules. Professional Societies are continuing to collaborate with the ABS in order to expand the resources available to fulfil this requirement within part two of MOC.
- **Part 3**- Cognitive expertise: For this component of maintenance of certification, the diplomate must pass a secure multiple-choice examination prior to certificate expiration. To qualify for this examination, diplomates must submit a 12 month operative log, a reference form and be completely up to date with all other MOC requirements. This examination may be taken starting three years prior to certificate expiration.
- **Part 4**- Evaluation of performance and practice: For this component of MOC, the Board requires ongoing participation in an outcomes registry or quality assessment programme that may be locally, regionally or nationally based. No outcome data is required by the ABS (they only require confirmation of participation).

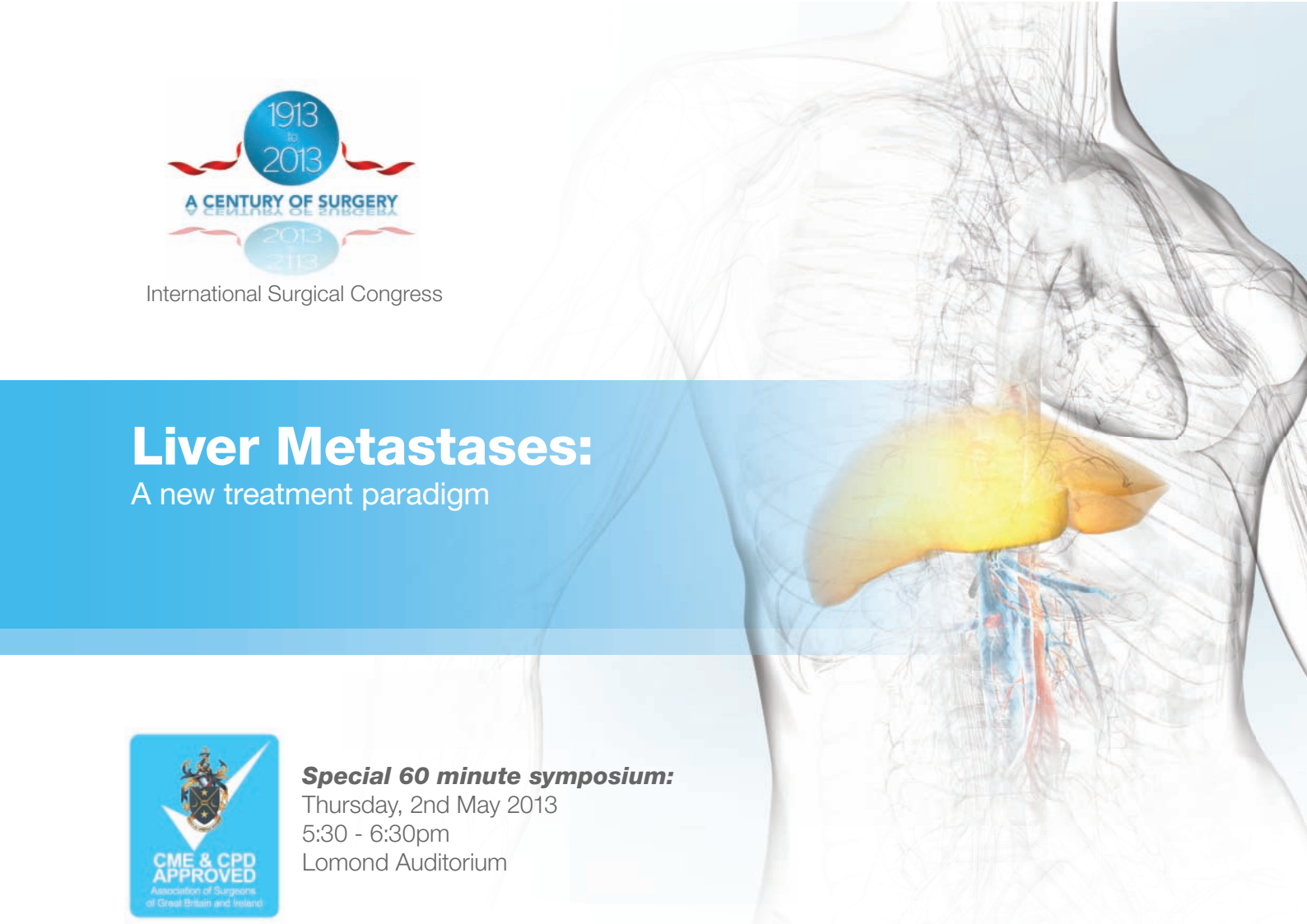
The MOC reporting cycle runs from 1st July to 30th June three years later. Following each three-year cycle, diplomates will provide the Board verification of completion of parts 1, 2 and 4 of MOC as outlined above.

As can be seen from this very brief summary of the processes in place in the United States, the drivers for change are much the same as in the UK, as indeed are the challenges in delivering a satisfactory solution to the problem. By now, education theory has been able to accurately define the minimum competencies required of any doctor. The problem is that we are still some way short of being able to measure and grade the individual competencies with equal accuracy and validity. For example, task performance, such as an operative technique, is increasingly measureable. Less so is the judgment and decision making associated with the selection of patient and named operative procedure. There remains much work to be done, with the international surgical community working together.

1913 to 2013
A CENTURY OF SURGERY

International Surgical Congress

Liver Metastases:
A new treatment paradigm



CME & CPD APPROVED
Association of Surgeons of Great Britain and Ireland

Special 60 minute symposium:
Thursday, 2nd May 2013
5:30 - 6:30pm
Lomond Auditorium

Moderated by:
Professor Andrew Biankin
Regius Professor of Surgery
University of Glasgow

5:30 - 5:45pm
Biology of Liver Metastasis
Professor Owen Sansom
Deputy Director
Beatson Institute of Cancer Research
Glasgow

5:45 - 6:00pm
Multidiscipline management of liver metastases: available therapies
Professor Graeme Poston
Aintree University Hospitals Foundation Trust
Liverpool

6:00 - 6:15pm
Practical Experience of chemosaturation in UK
Mr Neil Pearce
Consultant Hepatobiliary and Pancreatic Surgeon
University Hospital
Southampton

6:15 - 6:30pm
Chemosaturation, History and Clinical Data
Dr Mark Faries
Director, Melanoma Research Program
John Wayne Cancer Institute
Santa Monica

Delcath Systems, Inc.
Concentrating the Power of Chemotherapy™

Delcath's Hepatic CHEMOSAT Delivery System is CE Mark approved in Europe. In the United States, the chemosaturation system is an investigational product and has not received FDA approval.

AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

YOUNG FELLOWS IN ACADEMICS ENCOURAGED TO APPLY FOR ACS SCHOLARSHIP

Young fellows of the Association of Surgeons of Great Britain and Ireland who are interested in teaching or research and would like to visit medical centers in North America are encouraged to apply for an American College of Surgeons (ACS) International Guest Scholarship. The ACS is accepting applications for the 2014 International Guest Scholarships until 1st July 2013.

The ACS International Guest Scholarship, in the amount of $10,000 (U.S.), is offered annually to young surgeons from countries other than the United States or Canada. This year's selected scholar will have the privilege of participating in the College's annual Clinical Congress in October 2014, with public recognition of his or her presence. The scholar will receive gratis admission to selected postgraduate courses plus admission to all lectures, demonstrations, and exhibits, which are integral parts of the conference. Following the Clinical Congress, the scholar will have the opportunity to visit clinical, teaching and research centers in North America that are known for their work in the scholar's field of interest.

The International Guest Scholarship requirements are as follows:

- Applicants must be graduates of schools of medicine.
- Applicants must be between the ages of 35 and 44 on the date that the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for at least one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research *in accordance with the standards of the applicant's country*.
- Early careerists are deemed more suitable than those who are serving in senior academic appointments.
- Applicants must submit a completed application form, which is available on the ACS website at http://web2.facs.org/igs/. The application and accompanying materials must be typewritten and in English. Curriculum vitae submitted with a completed application will not be accepted.
- Applicants must provide a list of all of their publications and must submit three complete publications (reprints or manuscripts) of their choice from that list.
- Preference may be given to applicants who have not already trained or completed surgical fellowships in North America.
- Applicants must submit independently prepared letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment or a fellow of the American College of Surgeons residing in their country. The chair's or the fellow's letter should include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted by the person making the recommendation.
- The application form is designed to assist the Scholarship Selection Subcommittee and assists the applicant in submitting a structured curriculum vitae. Additional information (a maximum of four pages) may be attached, if desired.
- ACS International Guest Scholarships must be used in the year for which they are designated. They cannot be postponed.
- Scholarships are expected to provide a full written report of their experiences upon completion.
- An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

In order to qualify for consideration by the selection committee, all of the requirements must be fulfilled.

This scholarship endowment was originally provided through the legacy of former ACS Director Paul R Hawley, MD, FACS (Hon). More recently, gifts from the family of Abdol Islami, MD, FACS, the Stavros Niarchos Foundation, and others to the International Guest Scholarship endowment have enabled the College to expand the number of scholarship awards.

Formal American College of Surgeons International Guest Scholar applications are available on the College's website (http://www.facs.org/memberservices/igs.html). Supporting materials and questions should be directed to:

International Liaison Section
American College of Surgeons
633 N. Saint Clair St.
Chicago, IL 60611-3211
USA

Fax: 312-202-5021

Email: kearly@facs.org

Completed applications for the 2014 scholarship and all supporting documentation must be received at the office of the International Liaison Section prior to **1st July 2013.** Applicants will be notified of the selection committee's decision in November 2013. Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

100 years

THE AMERICAN COLLEGE OF SURGEONS CELEBRATES ITS CENTENARY YEAR

The American College of Surgeons (ACS) is a scientific and educational organisation of surgeons that was founded in 1913, to raise the standards of surgical practice and improve the quality of care for the surgical patient. The College is dedicated to the ethical and competent practice of surgery; its achievements have significantly influenced the course of scientific surgery in America and have established it as an important advocate for all surgical patients. The ACS has more than 78,000 members and is the largest organisation of surgeons in the world.

The Chicago-based ACS kicked off a year-long celebration towards the end of 2012, to commemorate its Centennial by unveiling an interactive online timeline that chronicles 100 years of inspiring quality in surgical care. The timeline (http://timeline.facs.org/) provides a colourful and engaging decade-by-decade history of ACS and incorporates more than 90 milestones over the past century, with more than 140 photos, images and videos.

The timeline describes how a century ago, North American physicians worked in an unregulated, over-crowded, highly competitive and sometimes unethical medical marketplace marred by high infection rates, scant blood supplies, crude tools and lax surgical practice standards. From this environment, ACS, a scientific and educational association of surgeons, was formed in 1913 in Chicago to improve the quality of care for the patient. Today, ACS has approximately 78,000 members and is the largest organisation of surgeons in the world.

"Our mission from the very beginning has been to improve the quality of care for patients by setting high standards for surgical education and practice," said David B Hoyt, MD, FACS, Executive Director of ACS. "This timeline captures, in colourful detail, the role that surgeons have played over the past century in diagnosing, treating and managing diseases and conditions once thought intractable. Many of these surgeons were pioneers in the truest sense of the word and their relentless commitment to improving surgical care continues to serve as an important example for all of us."

Aside from featuring advances such as the founding of the Joint Commission (formerly Joint Commission on the Accreditation of Healthcare Organizations), and the Committee on Trauma, the creation of the balloon catheter and the hip implant, the first foetal and robot-assisted operations and how medicine and surgery has been portrayed in popular culture such as in TV and films, the timeline also highlights the fascinating individuals instrumental in surgery and in the ACS:

- Franklin Martin, MD, FACS, the influential and controversial founder and long-time leader of ACS.
- Ernest Codman, MD, FACS, the pioneer of the "end-results idea" in surgery and a guiding light of the healthcare quality movement.
- Harvey Cushing, MD, FACS, a prominent figure in World War I medicine and "father of neurosurgery", whose patients' brains are on display at the Yale Medical Library.
- The balloon-tipped catheter, developed in 1961 by Thomas J. Fogarty, MD, FACS, while a medical student, who used his boyhood fly-tying kit to attach the fingertip of a latex surgical glove to a hollow tube.
- The first organ transplant in 1954 by Joseph E Murray, MD, FACS, transplanting a kidney from one twin to another to avoid auto-immune rejection issues - a feat that helped him win the Nobel Prize.
- The first foetal operation in 1981 by Michael R. Harrison, MD, FACS, and colleagues at the University of California San Francisco, a procedure he said was considered "shocking" at the time.
- Charles Drew, MD, PhD, who developed mass production techniques, including adapting cream separators from dairy farms for use in producing plasma, to stockpile plasma at the outset of World War II.

As a companion to the online interactive timeline, a large educational exhibit was prominent at the ACS Clinical Congress in October 2012. Called "100 Years of Inspiring Quality - An Interactive Timeline," the exhibit also featured a look at the accomplishments of the past century in surgery. The Congress also saw the launch of a new hardcover history book entitled *"A Century of Surgeons and Surgery: The American College of Surgeons, 1913-2012,"* by David L. Nahrwold, MD, FACS and Peter J. Kernahan, MD, PhD, FACS.

CONTACT:
Cory Suzan Petty - 312-202-5328
or Sally Garneski - 312-202-5409
Email: pressinquiry@facs.org

WELCOME TO GLASGOW

Glasgow, Scotland's city of style, will be a fun, exciting and welcoming host city for ASGBI's 2013 International Surgical Congress in May. As a delegate visiting Glasgow, you can experience Scotland's largest city, home to a fantastic array of over 20 museums and galleries, some of the best shopping in the UK, beautifully preserved Victorian monuments and timeless modern architecture, with some of the world's most breathtaking scenery just half an hour away.

Explore the city
Glasgow is one of Europe's most exciting destinations and has been named the number one UK destination "on the rise", by the world's largest travel site, TripAdvisor, in 2012. Glasgow was also named European City of the Year 2011 and ranked 12th in the New York Times 'The 45 Places to Go 2012'.

Compact and easy to walk around, delegates to the city will enjoy a wealth of attractions. Enjoy the magnificent Kelvingrove Art Gallery and Museum, which exhibits an internationally renowned collection of over 8,000 objects. The Riverside Museum, Glasgow's museum of transport, was designed by world famous architect Zaha Hadid and houses more than 3,000 exhibits in over 150 displays. Highlights include the Wall of Cars and the South African Locomotive. The iconic building has already become a modern landmark on the historic banks of the River Clyde.

Enjoy the many works of Glasgow born architect, designer and artist, Charles Rennie Mackintosh, who is celebrated around the world as one of the most creative figures of the early 20th century. A pioneer of Art Nouveau, he has left a legacy of his work throughout the city, including Glasgow School of Art, considered by many to be his architectural masterpiece.

Glasgow is also the perfect place to indulge in a little retail therapy. You can find high street favourites, malls and popular department stores on the city's Style Mile, an area which includes the shopping thoroughfares of Buchanan Street, Sauchiehall Street and Argyle Street. Designer delights can be found in the chic boutiques of the Merchant City and, if you're looking for something a little more quirky, take a look at the great vintage stores on offer in Glasgow's West End.

If you're looking for a great night out, Glasgow is unsurpassed. The Merchant City, once home to the traders who grew Glasgow's wealth, is now buzzing with bars, restaurants, venues and art galleries. Plus, you can check out one of the 130 live music events held every week – Glasgow is, after all, a UNESCO 'city of music'.

Also, if you're looking for some tranquillity, Glasgow means 'Dear Green Place' in Gaelic, and there are over 90 parks and gardens to explore. Or, just beyond the city lies some of Scotland's most beautiful scenery, including ancient castles, quaint distilleries, stunning lochs and miles of unspoilt coastline.

Great Selection of Accommodation
Glasgow has a great selection of accommodation to choose from, including three onsite hotels at the Scottish Exhibition and Conference Centre, offering over 550 rooms within 5 minutes' walk. The city's hotels include a variety of international brand hotels, deluxe boutique properties and quality budget and student hotel accommodation, all within close proximity of the Scottish Exhibition and Conference Centre and restaurants.

Restaurants
There are plenty of fantastic restaurants in the city to explore; every taste is catered for, from traditional Scottish fare to Italian, Indian and Thai. Whether you prefer a nice drop of malt or a fruit-infused cocktail, you will find a great range of bars close by for a post-dinner drink. Delegates will also benefit from special discounts arranged for them by Glasgow City Marketing Bureau.

Access Information

Easy to get to
Glasgow's air, rail and road infrastructure ensures excellent access for delegates to the Scottish Exhibition and Conference Centre and the metropolitan area.

Airports
Glasgow is Scotland's most accessible destination, with three international airports within easy reach of the city, offering:

- Direct flights from over 135 destinations
- Low cost direct European connections from most major cities
- Daily direct flights from North America
- Twice daily direct Emirates flight from Dubai - ideal connection for delegates from the Asia/Pacific region

Train
Glasgow has two major train stations: Glasgow Central, servicing the South, and Glasgow Queen Street, servicing Edinburgh from the North. This gives you:

- 20 direct trains from London
- A journey time from London of just 4.5 hours

Glasgow is a compact and walkable city, easy for visitors to find their way around and offers a campus feel for delegates.

Discounted Delegate Travel with Glasgow Taxis
Delegates can enjoy discounted travel to and from Glasgow Airport to the City Centre with Glasgow Taxis.

- To book your taxi call: 0141 429 7070
- Book using code CM7 - Glasgow Airport to City Centre
- Book using code CM5 - City Centre to Airport
- Each journey will be a flat rate of £16 instead of the usual fare of £19.80.

For more information visit
http://glasgowtaxis.co.uk/web-booker.html

Glasgow City Guide App
Access the latest retail, dining and leisure offers. Available from the App store and Android Market, search "Glasgow". This offers:

- Real Time Offers and Discounts
- Full What's On Listings
- Location Based Searching
- Integrated Google mapping

Connect with us
For more information on what to see and do in Glasgow, visit:

Website seeglasgow.com
Twitter @seeglasgow
Facebook GlasgowScotlandwithstyle

GLASGOW THEATRE OFFER

ASGBI have teamed up with the King's Theatre in Glasgow to offer Congress delegates a discounted rate on theatre tickets on the 1st and 2nd May 2013!

High Society at the King's Theatre, Glasgow

Tuesday 30th April - Saturday 4th May 2013

HIGH SOCIETY

Get ready for the musical event of the season, as Cole Porter's timeless classic, **High Society**, skips into town, in a dazzling new production.

Michael Praed *(Robin of Sherwood, The Sound of Music)* stars as Dexter Haven, Daniel Boys *(Any Dream Will Do)* as Mike Connor, with Sophie Bould as Tracy Lord.

Wealthy socialite Tracy Lord is in the midst of planning a lavish wedding when her ex-husband Dexter Haven turns up to disrupt the proceedings, in an attempt to try and win her back. A further twist arrives in the form of charming reporter Mike Connor, who falls instantly for Tracy, and she for him. As the day of the wedding draws closer, we're left guessing which groom the bride will choose!

Adapted from the hit 1956 film, which starred screen legends Bing Crosby, Grace Kelly and Frank Sinatra, **High Society** bubbles with a host of beautiful ballads including *You're Sensational*, *Who Wants to be a Millionaire* and the unforgettable *Well, Did You Evah!*

We are delighted to announce that ASGBI's International Surgical Congress delegates (and their guests) are entitled to a £10 discount on seats in price bands A & B. This exclusive offer is valid for the 7.30pm performances on 1st and 2nd May. Simply quote 'CONGRESS10' when booking*.

**Subject to availability. Booking fees apply*

THE KING'S GLASGOW

Visit www.atgtickets.com/glasgow or call 0844 871 7648 (booking fee) to book your discounted ticket now!

PERSPECTIVES ON THE CENTRALISATION OF CANCER SERVICES IN IRELAND

Arnold Hill
Surgical Advisor to the National Cancer Control Programme
Consultant Breast and Endocrine Surgeon, Royal College of Surgeons in Ireland

In this article, I would like to reflect on the experience in the Republic of Ireland following a government policy change in 2006, whereby all major cancer surgery was to be treated in eight designated cancer centres. This is a major change from the previous delivery of health care, whereby cancer services were delivered in any of 32 acute hospitals throughout the Republic. In this article, I have to explain my bias, in that I was appointed by the Government as the Surgical Advisor to the National Cancer Control Programme. There were many controversial aspects to the 2006 document on cancer control in the Republic of Ireland. One that was expressed by the surgical fraternity was that there was very little input from surgical colleagues in the creation of the document. I myself was not involved in the creation of the Cancer Control policy change, but in my current position, have played a significant role in its implementation.

Breast Cancer

The first major cancer to undergo reconfiguration was the delivery of breast cancer services. This was not chosen by the National Cancer Control Programme, but was forced upon it because of a number of media scandals that occurred in 2007, whereby there were a number of cases of delayed diagnosis of breast cancer, which the media took control of and demanded change. This was a significant driver of change and, indeed, one could say a factor that demanded resourcing of the changes necessary to implement the policy changes of the National Cancer Control Programme. At that time in 2007, Ireland was in the middle of a "celtic tiger" and there was no problem in appointing a plethora of breast cancer radiologists and providing 10 million in continual annual funding for a number of key positions in the clinical care of breast cancer services. Most of these appointments were for consultant breast radiologists, but all centres received a breast cancer data manager. There were other appointments made in varying units to support radiography requirements. As it turns out, there were relatively few new consultant surgeon positions in the implementation of the programme. The major challenge for surgeons was to reconfigure their clinical practices to eight designated cancer centres. This proved extremely traumatic in certain circumstances. In certain cases, the media and politicians got involved in the reconfiguration process, which made it extremely challenging on a personal level for consultant surgeons. What essentially happened was that those who were within a few years of retirement did not transfer, those who had 20 years to go in clinical practice were the first to transfer and realised that their future was in a designated cancer centre. There remained some frustrating circumstances for certain breast surgeons, who did their general surgery call in a medium-sized hospital and their specialty breast surgery in a designated cancer centre. This has not proved to be a very successful model because of the logistical challenges that arise from working on two sites frequently, up to 50 kilometres apart. It has to be said that the delivery of the reconfiguration of breast cancer services was probably made more feasible for the government by the fact that they appointed an external lead to the National Cancer Control Programme. Professor Tom Keane was recruited from Canada to lead the National Cancer Control Programme and because of his neutral status, and not being associated with any particular hospital, it was easier for him to force through the necessary changes to deliver on reconfiguration.

There were many challenges in the small geographical country of the Republic of Ireland. The government policy was to provide four designated cancer centres in the Dublin region and none in the north west of the country. This became a focus point for many political challenges, indeed, one wonders if the harsh economic reality of the collapse of the "celtic tiger", whether such geographic isolation of the north west of the country might have remained as a major political issue. Six years after the implementation of the National Cancer Control Programme, Ireland, with its new health minister, is still looking at the reconfiguration of acute hospital services. It appears that such discussions, although challenging, will be an ongoing feature of the health service for decades to come.

There were certain good things about the breast cancer transition that occurred in 2007 to 2008. It provided timely access for all patients with breast symptoms. It ensured a more likely accurate diagnosis, as all patients were now assessed by triple assessment, which was essentially consultant delivered. Strong multidisciplinary teams were established in each of the eight designated cancer centres and we now had a national programme of breast cancer care led by a team of lead clinicians. Standardised treatments were established, protocols were written down and quality key performance indicators were monitored on a monthly basis which, without doubt, has improved the standards of care for all women in Ireland with breast symptoms. It almost sounds like a perfect world; if you were to get a breast symptom in Ireland, it would be seen promptly within two weeks, it would be delivered by a consultant service, a multidisciplinary team would be in place, and all outcomes would be monitored and key performance indicators would be measured. However, there is one dreadful side effect of such a successful reconfiguration; the major problem is that we now see far too many "worried well". In 2006, there were 13,000 new referrals to the breast service for approximately 2,500 new cancers. In 2010, we have exactly the same number of cancers, but we now have

38,000 referrals seen in the symptomatic breast service. One could argue that there were 25,000 unnecessary referrals.

In 2013, this remains a major challenge for the symptomatic breast service to try to avoid seeing unnecessary referrals. The first step in reducing the 25,000 unnecessary referrals came at the annual meeting of National Cancer Control Programme for Symptomatic Breast Disease, where a resolution was passed to ensure that all referrals from primary care under the age of 25, with a symptom of mastalgia would be returned to primary care for management. However, the implementation of such a decision remains to be verified in the future. One other criticism of the centralisation of breast services was that there were far too many key performance indicators. In total, there were 27 and the majority of these related to access to the service. More challenging parameters, such as positive margins and mastectomy rates, were not recorded, but these are surely the parameters that will influence outcome for patients.

Rectal Cancer

Having dealt with the reconfiguration of breast services, the next cancer on the agenda for the National Cancer Control Programme was the reconfiguration of rectal cancer services. It was originally stated in the 2006 document that all colon and rectal surgery should be in the eight designated cancer centres. However, there was a major meeting in the Royal College of Surgeons at its annual Charter Day in 2008, when the colorectal community provided a very cogent argument to say that if colon cancer was transitioned into eight designated centres, it would lead to the closure of all other hospitals in Ireland, particularly in relation to their ability to maintain competent surgeons to do acute surgical call. There would essentially be no work left for general surgeons doing acute call in medium-sized hospitals if all colonic resection was removed from their practice. To maintain competence in medium-sized hospitals, who will provide acute care for probably many decades to come, it was determined that colon cancer surgery could stay in all acute hospitals. There was then the strange challenge of separating rectal cancer from colon cancer for colorectal surgeons. However, the international literature was very clear that rectal cancer should be provided by a small number of surgeons, doing high volume work. Such data proved very challenging. The first step in the process was to audit the practice of every surgeon in the Republic of Ireland performing rectal cancer surgery. One staggering feature of this audit was that there were over 50 surgeons who performed less than five rectal cancer resections per year. Clearly, no citizen would wish to have their rectal cancer resected by such a surgeon. The vast majority of these 50 surgeons put their hands up and walked away from doing rectal cancer surgery. It was probably fear of having their name exposed in the next rectal cancer audit that was inevitable in the years to come, that caused most sensible general surgeons to cease from doing rectal cancer surgery.

The next traumatic episode in the centralisation of rectal cancer was in those surgeons who had moderate rectal cancer practices outside the designated centres in accepting that they would have to move to perform rectal cancer surgery. In 2012, this successful transition had happened in all but a few hospitals. We expect it to be complete in 2013, but it has been a painful and traumatic experience for all involved. However, it has to be said that the treatment for patients has undoubtedly improved in that, if you have rectal cancer in the Republic, you are now going to have your case discussed at a multidisciplinary meeting by several experts. You will have a radiologist who understands and does a high volume of reading rectal MRIs. You will have your endoscopic ultrasound performed by a radiologist who has significant experience in the area and you will have a pathologist who deals primarily with colorectal cancer. The surgeon is guaranteed to do more than 15 rectal cancers per year, and your operation will be performed in a centre where nursing experience is well versed in all aspects of fast track programmes for colorectal surgery. Also you are more likely to be offered participation in a clinical trial.

However, there have been downsides to the centralisation of rectal cancer surgery. There is no doubt that the eight designated cancer centres have failed to export intermediate level benign surgery to the non-designated centres. Beds remain a constant issue for the eight designated cancer centres. Unfortunately, the transition and centralisation of cancer services happened in advance of reconfiguration of acute services within Ireland. We are now in a situation where the health budget is constantly being constrained because of the economic crisis in the country, and there is very little ability to throw money at any of these situations to resolve them.

Upper GI Cancer

This is one service that was already centralised into a number of acute hospitals, which were, for the most part, designated cancer centres. 92% of oesophagectomies at the beginning of the reconfiguration process for cancer services in Ireland were in four hospitals. Unfortunately, one of these was not a designated cancer centre, which complicated the issue of centralisation. There were only eight surgeons performing oesophagectomies in Ireland at the time of the reconfiguration. One would think that this would be relatively easy to reconfigure. However, the major challenge was if you put all the oesophagectomies in one hospital, it would deskill the rest of the country and there would be no regional self-sufficiency in upper abdominal surgery.

The new generation of breast surgeons are less and less likely to deal with a perforated duodenal ulcer or any form of upper GI bleeding. The new super specialised rectal surgeon of the future is unlikely to want to deal with a gallbladder. For a small country of four million people, with a relative degree of geographic isolation, it would seem wrong that all cases of haematemesis in the decades to come would be forced to go to one

hospital. It was challenges like these that resulted in there being four centres chosen to perform oesophageal resections. There is one lead centre that performs about 70 oesophagectomies a year. Another, in the same city, that performs approximately 40 and two other centres perform 25 resections a year. In addition to oesophageal resections, these centres will also undoubtedly perform all the gastric surgery, which equates to equal numbers of resections for gastric cancer. The main driving force behind change and reconfiguration of upper GI cancer services was a very detailed audit provided for every oesophagectomy in the Republic over a three year period. It was clear that there was a high standard of surgery being performed. Bringing the oesophageal surgeons together to know that data would be recorded on an on-going basis, and the development of key performance indicators, made the selection of centres relatively straight forward. The main learning point from upper GI cancer was that data drove decision making.

Prostate Cancer

The decision to centralise prostate cancer surgery came at a time when the disease of prostate cancer was undergoing major challenges. Firstly, there were new techniques to performing radical prostatectomy. In the first year or so of the cancer programme, many urologists were claiming that laparoscopic radical prostatectomy was the way forward and, in more recent years, the arrival of the robot complicated matters even further. In Ireland, the robot only arrived in the private sector and currently, robotic radical prostatectomy is performed in two private hospitals. As the "celtic tiger" has collapsed, thankfully, we are unable to afford placing a robot in any of the eight designated cancer centres. It would be a complete nightmare trying to select which centre should have the robot. The biggest problem in Ireland for prostate cancer was that the hospital performing the largest number of resections for prostate cancer was not a designated cancer centre. Along with the new techniques for performing prostate cancer surgery, there was also the increasing challenge from the evolving role of Brachytherapy therapy in prostate cancer. There is now a challenging literature as to the role of each of the disciplines in the management of prostate cancer. Is there too much surgery being performed for prostate cancer? These questions remain unanswered. At the moment, we have the relatively unsatisfactory state in that we cannot afford a robot in our public system, but it is being used with ever increasing numbers in the private sector. However, the precise role for robotic prostatectomy and laparoscopic prostatectomy, versus conventional traditional old style prostate surgery, versus the expanding role of Brachytherapy, remain unresolved and is a challenge for the future. The National Cancer Control Programme, having addressed the issue, has certainly challenged urologists into deciding whether they should perform high volume prostate surgery or not, and has provided a better access service for patients, in that those with an elevated PSA will get seen in a timely fashion. However, reasonable doctors will remind us that a slightly elevated PSA is not an emergency that needs to be seen within two weeks (and certainly shouldn't have a timeline of having surgery within 20 days) and sometimes we need to make sure that the disease of prostate cancer does not supersede the level of care we give for other urological cancers. We have not evolved yet to have timelines on the management of renal cancer or on testicular cancer, but clearly these are matters that will need to be addressed.

Lung Cancer Surgery

Lung cancer surgery was already relatively centralised at the start of the National Cancer Control Programme's strategy in 2006. Over 90% of lung cancer surgery was already being performed in four designated cancer centres. This is continued in that now 100% of lung cancer surgery is performed in four designated cancer centres. The major improvement in lung cancer management has been in the development of rapid access clinics, whereby those with hemoptysis or an abnormal chest x-ray will be seen in a timely fashion in a rapid access clinic in any of the eight designated cancer centres. This, undoubtedly, has been an improvement for those with hemoptysis and abnormalities on their chest x-ray.

Other Surgeries

There has been ongoing progress in the evolution of a plan for centralisation of soft tissue sarcoma surgery. Other cancers, such as neuroendocrine surgery, now have a universal agreement to be in one centre. Pancreatic surgery was a major political fight; the final solution was to have a national centre in Dublin (it was not easy to chose which site) and a satellite unit in Cork. Gynaecological services in Ireland have been traditionally attached to maternity hospitals and this area of cancer surgery has recently been addressed. Gynaecological oncology services will evolve into the eight designated cancer centres.

The Effect on Surgical Training

With the implementation of the National Cancer Control Programme, there was a significant effect on surgical training. Three consecutive audits, carried out in 2007, 2008 and 2009, demonstrated that only 20% of higher surgical trainees would take a job outside one of the eight designated cancer centres. Given that we have over 30 hospitals providing acute services, this clearly leads to problems, in that we are not training surgeons for the hospitals that we have in service. It is very difficult for any trainee to say that their career ambition is to work outside a designated cancer centre. There has been a major change in trainee attitudes, in that all trainees have a specialty interest in cancer. The concept of the general surgeon seems to have died with the advent of the National Cancer Control Programme and this probably reflects that they are less likely to get attractive jobs in well resourced hospitals if the trainee maintains the label of a true traditional general surgeon. This has implications for our training programmes as, clearly, this is not the reality. This situation continues to challenge the leaders of the Royal College of Surgeons in Ireland.

Conclusion
The National Cancer Control Programme has been a catalyst for change in Ireland. It has huge implications for the future of general surgery in Ireland. There is a concern that super specialisation may be problematic for those with some decades to work in a surgical career. There is the potential for operations to disappear, as happened with the advent of H2 receptor antagonists in the seventies and finally, we have a problem within the Republic of Ireland in that we are only training surgeons to work in designated cancer centres, despite the fact that a significant volume of our work occurs outside of these. One benefit of the National Cancer Control Programme has been to focus on data to drive decision making and there is no question that surgical volumes will be a key determination of future practices. The changes associated with the National Cancer Control Programme in the Republic of Ireland have been evolving over the last six years and there is only one certainty; that change will continue. The only question is what the pace of that change will be.

VASCULAR CENTRALISATION - A VIEW FROM THE EDGE

John V Taylor
Consultant Vascular and General Surgeon, Northern Devon Healthcare

With the emergence of the speciality of Vascular Surgery, there has been increasing pressure from both public and speciality itself to define and improve results. For British vascular surgery, the challenge arrived in the last decade. Comparing several European registries, it was found that the UK had the highest operative mortality for aneurysm repair within Europe [1], although this relied on data of variable quality and completeness. At the same time, analysis of HES data explored the relationship between increasing volumes and better outcomes for aneurysm surgery. However, there was also evidence of several small units performing a limited range and number of procedures with significantly worse outcomes [2].

Prospective models of provision were put forward [3] and, in the usual course of events, very little would have been done, and services would have continued to gradually congeal into a service that somehow worked for most. The speciality itself took up the challenge and began the process of reorganisation. First was the quality improvement framework for aneurysm surgery, which has resulted in a significant reduction in mortality in only a few years [4]. Then came the National Aneurysm Screening Programme. A criterion for approval of a screening programme was that all centres operating on screen detected aneurysms had to perform a minimum number of procedures, effectively excluding smaller units from performing aneurysm surgery. The Vascular Society then revised their recommendations regarding provision of vascular services [5], which have recently been adopted as a model for specialist commissioning, favouring large regionalised units spread across the country.

The Somerset and North Devon Network, in which I work, took a fairly pragmatic approach to these requirements for aneurysm services, centralising aneurysm surgery into a single centre. This was not without significant impact, both to the hospitals in the network and to the individual surgeons involved. The prospect of further centralisation continues to expose many fundamental difficulties in the separation and centralisation of vascular services within our network, made more acute due to our local geography, but could be reflected across several networks looking to implement the centralised model of service provision. Consequently, there may be significant unintended adverse consequences to some of the most high-risk patients surgeons deal with.

The evidence supporting larger specialised vascular units is difficult to argue against and, despite the impression I may give, I actually support it in a large part. Where a large regional unit exists, with established networks, then the work is done. Unfortunately, these units, albeit high profile, are the exception. Many areas, particularly in the more populated urban regions, may be served by several units, no more than minutes apart, with significant overlap in services and populations. Unification of services for reasons such as staffing, training and duplication of services are all well rehearsed, but there have been, and will be, many difficult discussions in where the unit is sited. Unfortunately, negotiations frequently degenerate into emotive turf wars. Often, these units will have been competing for many years, occasionally with significant personal rivalries. No organisation welcomes the removal of services. Questions arise as to whose income is whose? Who holds clinicians' contracts? What about associated services, such as interventional radiology; does that have to move? More importantly, does the proposed hub unit have the capacity to cope with the additional workload? All these questions need to be explored and resolved before any move and, no matter the evidence, no local politician with an eye on re-election will support the removal of services from 'their hospital'.

Whilst these changes within urban areas pose political challenges, they pale into insignificance when looking at a wider provision. A significant proportion of the population do not live in areas with easy access to a distant specialist centre, but rely on their 'local' hospital, where local may mean an hour travelling. Whilst there is no place for an occasional 'vascular surgeon' doing the odd aneurysm or bypass to keep his hand in, there are many small units with relatively high individual surgeon case volumes who provide an effective local service and are part of established networks to deal with patients needing complex care. Unfortunately, it is often in these smaller units that vascular surgeons also provide a significant contribution to the 'General Surgery' service and, despite the imminent separation of specialities,

the practical aspects of separating will require backfilling. With no additional funding, this could prove difficult, if not impossible. So how do those of us with continuing general surgical commitments divorce ourselves from this? Do we just walk away in the hope our colleagues pick up the slack?

Whilst the hub and spoke model is superficially attractive, the proposed model of services does not fit the entire country. This was acknowledged by Holt et al themselves [3], particularly when considering the wider workload of the smaller units, and they suggested that there may have to be a trade-off between optimum outcome and local service. Here, in the Peninsula, it is a minimum of an hour between units. Difficult road conditions can increase travel times to several hours. Not all patients have easy access to transport; what becomes of them? Do we deny intervention or increase length of stays on account of logistics? Where does any pre-op assessment occur? Do we transport patients, assessment teams and the anaesthetist for the high-risk patient? I am not aware of any modelling that takes account of these factors. However, it is clear that there will have to be a significant investment in transport systems across a network area.

A high proportion of workload in vascular surgery is emergency-driven, dealing with cases that do not figure on specialist registries. Even smaller units soak up significant emergency volumes. If elective services are reconfigured to remove routine inpatient surgery, then staff will deskill in the care of vascular patients and, in this situation, can it be justified to admit any patient with acute vascular problems to those units? Even if not considered an 'emergency', my personal experience has been that there are 'general surgeons' coming out of training programmes who have spent no time on a vascular unit. This will only become more commonplace. Increasingly, general surgeons are unwilling to make decisions on vascular patients, so will begin to insist that all emergency admissions are transferred out. If we are only returning as a 'visiting service' then we must ensure that patients do not fall between the hub and a local general surgical service, both ill equipped and unwilling to deal with these patients. Again, this will have impact on the capacity of the receiving hospital, as it is these patients who frequently need the urgent attention of a specialist but don't seem to be taken into account when we look at work load.

There are also the knock-on effects across the wider hospital; are the colorectal surgeons or the gynaecologists happy to go so deep into the pelvis with the risk of severe haemorrhage, if the safety blanket of the vascular surgeon is removed? Does day case interventional radiology follow the vascular surgeon to the hub with the inherent problems with transport or performed only when they are on site?

One aspect of reorganisation which has never been consistently discussed is the personal impact on the individual surgeons who have to move their work. The presumption is that all consultants participate in the emergency rota, but some of the existing consultants will live a significant distance from the admitting hub. Do we require resident on-call for some or all? A resident commitment will significantly impact on job plans as well as travelling between distant sites. In my own case, a single day a week at the 'hub' would require a half session of travel within the job plan. Again, this factor has never been discussed. So, do we up sticks and move? Do surgeons remove ourselves from our current base and relocate our homes and families?

Centralisation of vascular services is inevitable. With increasing specialisation, newly appointed consultants will not be trained in 'general surgery' and smaller units would have drifted into larger centres in the natural course of things. Financial pressures would have forced urban centres to rationalise. The Vascular Society document [5] describes the ideal, but even within this aspirational document is the acceptance that some smaller units may have to survive to provide adequate service to remote populations.

Surgeons in smaller units have been criticised for resisting change [6], but my response would be that for the majority of us in smaller units, our practice has adapted and developed to the challenges, improving the care to our patients, but in the current climate there is only so much possible. Even the evidence to justify the reconfiguration cautioned against moving services without first assessing the likely impact and capacity issues, but somewhere this seems to have been lost. My hope is commissioners will listen to teams on the ground to guide them towards what is achievable, rather than distant voices with little appreciation of local challenges. We must ensure that, with reorganisation, we must benefit not just those patients with vascular disease, but all those who benefit from having a vascular surgeon in the building.

References

[1] **Gibbons C, Bjork M, Jensen L P, Laustsen J, Lees T, Moreno-Carriles et al**
Second vascular surgery database report
European Society of Vascular Surgery
ISBN 1-903968-21-6; 2008

[2] **Holt P, Poloniecki J, Loftus I, Thompson M**
Demonstrating safety through in-hospital mortality analysis following elective abdominal aortic aneurysm repair in England
Br J Surg 2008; 95(1): 64-71

[3] **Holt P, Poloniecki J, Hinchcliffe R, Loftus I, Thompson M**
Model for the reconfiguration of specialised vascular services
Br J Surg 2008; 95(12): 1469-1474

[4] *The Vascular Society: Outcomes after elective repair of infra-renal abdominal aortic aneurysm*
http://www.vascularsociety.org.uk/; 2012

[5] *Vascular Society: Provision of services for patients with vascular disease*
http://www.vascularsociety.org.uk/library/quality-improvement.html; 2012

[6] **Ernshaw J J, Mitchell D C, Wyatt M G, Lamont P M, Naylor A R**
Remodelling of Vascular (Surgical) Services in the UK
Eur J Vasc Endovasc Surg 2012(5); 44: 465-467

35 YEARS

EUROPE'S LONGEST RUNNING AND LEADING VASCULAR SYMPOSIUM

WWW.CXSYMPOSIUM.COM

35th International Symposium CHARING CROSS

CONTROVERSIES
CHALLENGES
CONSENSUS

EDUCATION INNOVATION EVIDENCE

VASCULAR & ENDOVASCULAR CHALLENGES UPDATE

6 - 9 APRIL 2013

NATIONAL HALL, OLYMPIA, LONDON, UK

NEW In collaboration with the ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND

One day only - Tuesday, 9 April 2013

FOR ALL SPECIALITIES TO VIEW FULL SIZED HYBRID OPERATING SUITES OF GE HEALTHCARE, PHILIPS AND SIEMENS

Programme highlights include

- Demonstrations of the 3 systems
- Key opinion leaders to highlight radiation dangers to operators
- Procedural planning
- Medical technology briefings
- Specially invited mixed speciality faculty to show applications of hybrid imaging in lung, kidney, liver, brain, trauma and maxillofacial interventions
- Shared speciality use of sterile hybrid suites & influence on costs

Consultants:
Book now for £100 (£150 on site)

Junior doctors, nurses and radiographers:
Book now for £50 (£70 on site)

Association of Surgeons of Great Britain and Ireland members
50% registration reduction

REGISTER NOW EITHER AT

www.cxsymposium.com/cx-advanced-imaging

or, for ASGBI Fellows, at:
www.asgbi.org.uk/CX2013

GE Healthcare PHILIPS SIEMENS

Download the CX App www.bibamedical.com/apps | Like CX Symposium on Facebook | To join the conversation search @cxsymposium on Twitter | Email: info@cxsymposium.com | Symposium hotline: +44 (0) 20 7736 8788 | Fax: +44 (0) 20 7736 8283

SURGICAL OUTCOMES CLUB: AN INVITATION

SURGICAL OUTCOMES CLUB

This year, ASGBI's Congress will see the launch of an exciting new venture, The Surgical Outcomes club, UK & Ireland. The inaugural meeting will follow two important, related events.

The Surgical Outcomes Symposium, on Wednesday 1st May, introduces the Congress to Professor David Flum. From the University of Washington (UWMC), Seattle, he is Director of the Surgical Outcomes Research Center and Comparative Effectiveness Research Network. As our keynote speaker, he will share his insights and lessons from 10 years experience in building a statewide surgeon-shaped outcomes assessment programme, which more recently has helped shape the nationwide quality initiatives from the American College of Surgeons. A UK context will be provided by other experts; giving accounts of experience with specialty disease registries is Mr David Scott-Coombes, President elect of BAETS and consultant general and endocrine surgeon at University Hospital of Wales, Cardiff. A talk on clinical research perspectives on outcomes will be given by Professor Jane Blazeby, Chair of Surgery at the University of Bristol and MRC Director of Trials Methodology; and speaking about interactions between industry and the NHS to enhance learning and outcomes from innovation will be Mr Richard Carey, CEO of NHS Grampian.

Professor Flum's expertise now spans multiple work streams at UWMC and nationally. His emphasis remains on building a surgeon-led, surgeon-shaped system whereby we may choose relevant metrics to monitor our practice and outcomes. Patient reported outcomes have formed a more recent focus of work, not least through David's role as methodoligical lead for PCORI. Measurement is key and making it easy to achieve this is crucial. You can learn more from David by attending the workshop he is hosting in 'The Hub' on Thursday 2nd May at 11.15am.

If these events have captured your interest – or if you are already "signed up" to surgical outcomes, to understanding and improving the practice of surgery – we strongly suggest you attend the inaugural meeting of the Outcomes Club. This takes place on Thursday 2nd May at 4.00pm.

Paralleling the American 'club' of the same name established in 2005, we aim to build a working group of surgeons interested in advancing health services and outcomes research in surgery, in relevant and practical ways. It will, in time, provide both a virtual and real meeting place for those of us interested in addressing the most relevant clinical and policy issues facing the profession today. Through facilitating networking of established researchers and sharing resources, we can build collaborative networks for future outcomes research – within the strong subspecialty associations affiliated with ASGBI, the potential for meaningful national work is immense. Whether you are a full-time academic or an interested clinician, please come along.

This inaugural meeting will allow us to hear 'how we did it' from the USA; to agree clear aims and objectives for the collaborative and to establish a working committee.

You will find registration forms for the club at congress, at the symposium, the masterclass and at the Covidien stand. Please complete these and return them to the marked drop points prior to the meeting. If you are unable to attend the Congress this year, but wish to register your interest, an online form will be mailed out to the membership in due course.

In collaboration with

COVIDIEN
positive results for life™

ASGBI WELCOMES A NEW MEMBER OF STAFF

On 13th February 2013, the ASGBI office welcomed a new member of staff to the team. Amanda Ly will take on the role of PA to our Chief Executive, as well as becoming the administrator for both ASiT and CORESS. Originally from Greenwich, Amanda now lives in Kent. She read Anthropology at University College London and graduated in 2012. Since then, Amanda has completed internships within the fundraising department of two charities, Plan UK and Age UK. Amanda hopes that her time within these organisations will help her significantly when she begins to assist our Development Officer, Sarah Walsh, with new fundraising strategies for CORESS, aiming to help raise the profile of the charity.

Amanda Ly

Association of Surgeons of Great Britain and Ireland

A 'PULL-OUT' SUPPLEMENT ON

The 21st Century Surgeon
Challenges and Opportunities

How to recognise the opportunities and overcome the challenges of working as a surgeon in the changing health service of the 21st Century

A Consensus Conference

held on

Wednesday 12th December 2012

AN ASGBI CONSENSUS CONFERENCE

THE 21st CENTURY SURGEON: CHALLENGES AND OPPORTUNITIES

Jessica Pether
Communications Officer

Wednesday 12th December 2012 saw 60 delegates and speakers gather at the Royal College of Surgeons of England for a one-day ASGBI Consensus Conference, entitled ***The 21st Century Surgeon: Challenges and Opportunities****. As with previous Consensus Conferences, the aim of the day was to gather like-minded individuals together to address and discuss key issues currently prominent within health, relating to the day's topic. Usually, a Consensus Statement would be produced as a consequence of such a day but, due to the broadness of the topic, ASGBI have decided to produce this pull-out section in the* ***Journal****, including an overview and some of the day's talks in essay form.*

Professor Cliff Shearman, ASGBI's Director of Professional Practice, organised the Conference with the help of the Association's Development Officer, Sarah Walsh. The day began at 10.00am with an introduction from the President, Professor John MacFie, who reminded all attendees that the forthcoming discussions would be very revealing and important for all attending.

Session One was entitled 'What should patients expect from their surgeon?' John MacFie gave a introductory talk on **Surgery as a Profession** and urged those present to "not lose sight of the fact that we are all healers". This was followed by a talk from Mr David Mitchell, a consultant at Southmead Hospital in Bristol, who spoke about surgeons' results and league tables. He touched upon the very current topic of revalidation and concluded that surgeons have little to fear, and much to gain, from being open with their data. Mr Peter Lees, founding director of the ***Faculty of Medical Leadership and Management***, and journalist Christina Patterson rounded off the session with a talk on **Surgeons as Leaders**, and a personal account of an NHS experience respectively.

After a coffee break, Professor Shearman chaired Session Two entitled 'What does the NHS expect from surgeons?' He assured delegates that, although the start of the day had been full of stark and harsh messages, the afternoon sessions would be brighter, looking forward to solutions and the future.

Incoming ASGBI President, Professor John Primrose, opened Session Two with a talk on whether the NHS values research. Following this, the conference was privileged to receive a talk from Professor Sir John Temple, past President of the Royal College of Surgeons of Edinburgh. He asked delegates to question whose job it will be to train surgeons of the future. He emphasised that, when it comes to training, you must make every moment count and pointed out that the NHS has all the necessary building blocks in place.

To conclude the morning session, delegates heard presentations from Dr Mark Porter, the ***British Medical Association***'s Chair of Council, and Dr Jonathan Fielding, Medical Director of ***UCLH***. Both gave comprehensive talks which led the conference nicely into its first discussion session before lunch. The morning's speakers gathered at the front of the auditorium and were quizzed by those in the audience.

Chaired by John MacFie, session three followed lunch and asked 'What does the surgeon need from their employer?' Presentation topics ranged from **Who is my employer going to be?** to **The future of contracting and job-planning**. ASGBI's Vice President Elect, Mr John Moorehead, went through **The Bare Essentials**, raising the importance of a good secretary, a permanent office and the fact that surgeons must be given the complete set of tools necessary for undertaking their job. John MacFie concluded that the talks so far had been very instructive and full of clarity, and the day moved onto the final session.

Professor Norman Williams, President of the Royal College of Surgeons of England, was kind enough to chair the final session of the day, where he introduced the topic 'Why do things go wrong?' After he gave an overview of the category, Professor Martin Elliott, Co-Medical Director at Great Ormond Street Hospital, gave an enlightening talk on **How to Avoid Adverse Outcomes**. He linked surgery and the old adage of "prepare for the worse, it tends not to happen" with two other significant organisational structures; the constant rehearsal which Formula One teams undertake and the thorough debriefing the Red Arrows go through after every performance.

Dr Iain Simpson, a consultant cardiologist from University Hospital Southampton NHS Foundation Trust, gave a talk on **Coaching Consultants** and how this is beneficial, not only for the people involved, but also healthcare organisations. **Patient Safety** was touched upon by Mrs Joan Russell, Associate Director of Patient Safety at the NHS Commissioning Board Authority and Mr Colin Morgan finished the final session with a talk entitled **How Can Innovation and Technology Improve Surgical Services?** Mr Morgan is the Vice President of External Affairs at ***Johnson & Johnson*** and he concluded that everyone working within healthcare should take a personal responsibility to regain patients' trust.

As the Conference drew to a close, Cliff Shearman thanked all speakers and concluded that the day had been meaningful with positive outcomes and solutions. He urged those present to go forward and change the culture and ethos of what they do, as "only you hold the reigns".

After the success of this one-day conference, we are pleased to present three of the talks in this edition of the ASGBI ***Journal***, with introductions by Professor Cliff Shearman.

SURGEONS AS LEADERS

Peter Lees
Founding Director of Faculty of Medical Leadership and Management

Introduction by Professor Cliff Shearman

In his article and presentation on Surgeons as Leaders, Peter Lees, a neurosurgeon and founding director of the Faculty of Medical Leadership and Management, makes the very strong case that quality and outcomes are directly linked to good management and leadership. At a time when the problems with delivering healthcare have never been more exposed and raw, Peter argues that leadership is the solution to overcoming these problems. The logic and evidence from several examples is overwhelming and the opportunities to develop leadership skills widely available. The challenge is whether we can harness these skills to pull surgery through a very difficult time.

The big challenge facing western healthcare economies is the twin demand of overcoming the deep recession at the same time as improving quality to meet public, governmental and, indeed, professional demands. This is against the backdrop of low morale amongst many professionals, attributed variably to disempowerment, disengagement, failure to move with the times, lack of leadership, learned helplessness etc. (Depending on who one listens to!) The recently released Francis Report explores this in exhaustive depth [1].

Irrespective of the underlying reasons, it is reasonable to ask, where is the leadership? For it is a fundamental purpose of leadership 'to get results with, and through, people'. Widely attributed to Daniel Goleman, is the simple link:

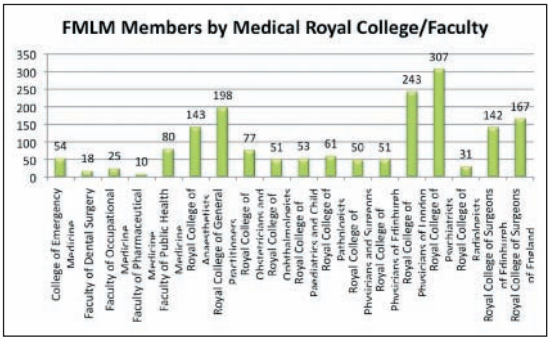
Leadership style - Climate - Results

To back this up, Harvard Business School, in a review of the turnaround of Sears, the North American department store, made the observation that growth, profitability and improved quality are the natural products of good leadership. Indeed, the inference is that sustained value (cost plus quality) for 'customers' is impossible without good leadership and good people management. The inference for the NHS in the current climate is obvious and the Faculty of Medical Leadership and Management (FMLM) has made the simple translation:

Hence, if we want to overcome the challenges of the recession and enhance quality as defined by '*Francis*', then logic would dictate that we need to address leadership within healthcare and look seriously at supporting and developing staff. Robert Francis' many recommendations about criminal prosecution hardly seem to fit this bill! None of this is new. Good human resource professionals have known this for ages; indeed, Dr Steven Boorman wrote a very impressive report for the Department of Health (England) entitled ***NHS Health and Well-being*** [2], which seems to have disappeared without trace. All that money, all that effort, all that common sense wasted!

On a positive note, in 2011, all of the UK medical Royal Colleges, faculties, and the Academy of Medical Royal Colleges made the collective decision to establish a Faculty of Medical Leadership and Management. This foresight is recognised positively in the Francis Report and strongly endorsed by the 2,000 doctors and students who joined in the first year. Furthermore, 730 delegates attended the first annual conference.

Many challenges remain but this is a most encouraging start. Equally encouraging are the breadth of specialty backgrounds and the range of career stages from student (10% of membership) and trainees (38%) through to the college presidents and chief medical officers. There is a deeply unhelpful, but widely held, misconception that leadership is something which older people with fancy titles do. Leadership exists and needs to exist at every level. The young surgeon first to attend a desperately sick patient at 3am has to lead; is that challenge, relative to experience, any less than the clinical director addressing a serious failure of clinical governance? Assuming the answer is no, why do we not routinely prepare our new recruits for such leadership challenges? Encouragingly, surgeons are very well represented in FMLM:



The numbers are an important start but the bigger prize is what those leaders do and there has never been a more important time to be 'doing' when it comes to leadership. The Faculty mission to improve the quality of patient care through better medical leadership is under-pinned by evidence. For example, we know that better teamwork lowers mortality [3]; we know that one standard deviation improvement in appraisal is associated with a reduction of 12.3% of the number of deaths after a hip fracture; we know that medical engagement correlates positively with quality in a hospital [4]. Now try to argue that such things are optional extras -

they are as optional as venous thromboembolism prophylaxis!

The Francis Report must draw a line in the sand. We must continue to resist the clamour for blame and knee-jerk reaction. The former poses the danger of the 'I'm alright Jack' mentality – it's just 'they' who have to change. The latter offers the dangerous illusion that something is being done. Although almost impossible to digest, such is its enormous length, *Francis* tells us, as any sane person knows, that there are deep and complex problems in the NHS which need to be overcome. He also tells us, as the Faculty of Medical Leadership and Management passionately believes, that leadership is vital. FMLM also shines a light on the evidence linking leadership and quality. FMLM is owned by all UK medical Royal Colleges and faculties, which offers a massive opportunity for medical leadership to be developed and for doctors to punch above their weight in the pursuit of leading the NHS out of the massive financial challenge, whilst simultaneously driving up quality. This is what we all joined the profession to do. It is time to deliver that potential and recognise this is a responsibility of the many, not the few.

References

[1] http://www.midstaffspublicinquiry.com/report

[2] http://www.nhshealthandwellbeing.org/FinalReport.html

[3] **West M et al**
The link between Management of People & Patient Mortality in Acute Hospitals
Int J HR Management 2002 13:8 1299-1310

[4] **Spurgeon P, Mazelan P M, Barwell F**
Medical engagement: a crucial underpinning to organizational performance
Health Serv Manage Res 2011 Aug; 24(3):114-20

HOW TO AVOID ADVERSE OUTCOMES - MAKING IT PERSONAL: MY 10 COMMANDMENTS

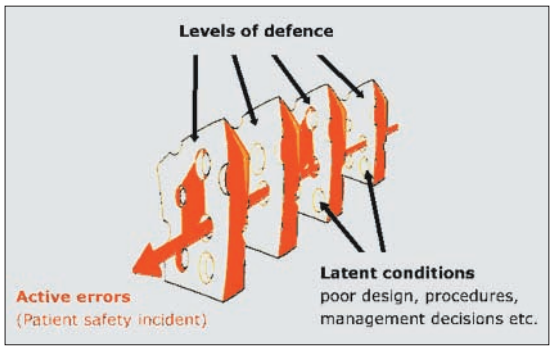
Martin Elliott
Co-Medical Director, Director of the National Service for Severe Tracheal Disease in Children, Great Ormond Street Hospital for Children NHS Foundation Trust

Introduction by Professor Cliff Shearman

It seems incredible that any surgeon is not concerned about safety and avoiding adverse incidents affecting patients they are treating. Perhaps, as Professor Elliot points out, it is not that we don't care, but that we don't often think about the problem and prepare for mistakes in a way that really engages the whole team. I would suggest anyone reading this incredibly insightful, yet simple, approach to reducing error would be hard pressed to disagree with any of the "10 Commandments". Perhaps, if we all adopted this approach to clinical practice, we would start to make a difference, not only to reducing avoidable errors but also in improving how our surgical teams work and function.

"First, do no harm" is at the core of medical practice, yet being a patient in hospital remains one of the most dangerous activities that humans undertake, on a par with mountain climbing. Over years of practice, and with a real interest in patient safety, I have identified a series of statements which help me in my attempts to avoid harm. I have grouped them together as **10 Commandments** and hope they will help readers keep patient safety at the top of their agenda, and act as a practical *aide memoire*.

I am a paediatric cardiothoracic surgeon. What I do is very complicated, not just because of the physiological and anatomical problems but because of interrelationships between people, and people and technology. The huge range of interactions produces an enormous potential for error. We are dependent on each other, the quality of our equipment and the processes we put in place to protect the patient. The hypothetical basis for the importance of processes in error protection is well exemplified in James Reason's Swiss Cheese Theory [1], which describes how processes without holes in them might protect against the concatenation of events leading to an accident.



As surgeons, we live in a world where human factors predominate. 60 to 70% of hospital budgets are spent on staff, reflecting the importance of relationships. If we consider ourselves to be 'liveware' with attitudes, stresses, cultural pressures, our own attitudes and knowledge, then we have to interact with others with the same personal factors, with various forms of hardware (monitoring etc), with the 'software' of policies, manuals and protocols and all in the context of external organisational or political pressures. These interactions make up the human factors with which we have to deal effectively to do our jobs well [2]. However, each of these interactions also has the potential to fail, resulting in poor quality care or a bad outcome.

One needs to bear the likelihood of such failure constantly in mind if one is to avoid it. I have found the following question (which I ask myself

every day and for every patient) to be culture changing and constantly challenging:

"Would this quality of care be acceptable to me or my family?"

If the answer is 'no', one should do something about it then and there, and not duck the issue. If you think from the "customer's" perspective, that is what you would expect. Run to the problem and solve it [3]. Against that background, it is always better to prevent than to treat, and so I begin my 10 commandments as follows:

1. **Adverse events are important**
   As a patient or parent, I would expect the medics to get my treatment right first time and without cock ups. As a surgeon, I need to respect that and remember the core values of providing safe care, with good outcomes, in the context of good experience for the patient. I must tell the *truth* to create *trust*, and each of these values underpin all that I do. Thus, giving weight to the existence of adverse outcomes and doing all that I can to prevent them is **core** to my work as a surgeon. By acknowledging that adverse events are important, you give them the mental space needed to avoid them.

2. **Human error is inevitable**
   No one gets up wanting to make a mistake, yet anyone working in accident investigation or organisational psychology will tell you that any human can make a mistake, even the most experienced and senior. Given that 60 to 70% of an NHS Trust's turnover is spent on staff, it is not surprising that human error is often at the root of adverse events. But we DO all make mistakes, and remembering the Swiss Cheese Theory makes us think about what we need to do to mitigate that risk.

3. **Anticipate adverse outcomes**
   There is an old adage: '*prepare for the worst: it tends not to happen*'. If you anticipate that adverse events are likely to occur, then you can do everything possible to mitigate that risk. By thinking ahead, even though you may not be able to prevent the event, you should have thought through what to do if it did happen; a get-out strategy. A clear example of this is seen week-by-week in the Formula One season. We can observe the consequences of good planning and a commitment to safety, overseen by the late, lamented Professor Sid Watkins, as drivers emerge unscathed from the most horrendous crashes. Much of that safety is due to a commitment to detail and genuine and repeated rehearsal. This manifests itself as **anticipation, preparation and practice**. All of these are so often lacking from day to day surgical practice, in which we rely largely on things going right, rather than preparing for the worst.

4. **Plan what you are going to do, with the whole team**
   You must involve them in what you are intending to do, and make sure they are up for it and have the right kit etc available for good and bad outcomes. Clearly, if you are involving them, this rule is all about *effective* communication, something which I notice, as I travel about, surgeons are not uniformly able to deliver without help. Briefings, checklists and discussion are critical to this as the WHO checklist programme has shown (and as everyone who flies recognises by their repeated survival). Medicine is changing. Our concept of professionalism used to be a doctor, with leather patches on his (and it was a he) elbows, who knew everything and was confident enough to say so. We know now that none of us can know everything, and in the digital age, especially in my field, patient and parents have grown up with smart phones and know just as well as I do how to access Google and PubMed. They *know* as much as we do, just not how to *interpret* it. We need to work with them as partners in a team, and we all need to recognise that we work in teams. Thus we must...

5. **Communicate. It is all about communication**
   Communication is not just telling; it is listening to the rest of the team and hearing what they have to say. If something or someone is missing or there is an equipment problem, don't press on regardless. Discuss with them what may happen, get their views and clearly record it was done.

6. **Respect the patient**
   I can almost hear the cries of "Duh, of course we respect the patient!". Actually, I have been horrified by how often that is clearly not the case. Someone has loaned to you their loved one for a period of time, for you to treat. They are not 'your' patient or a 'VSD'. They are a person, a child, someone's child, someone with a name, a personality and a life. Not an organ or a disease, but a person. After a terrible never event happened at the Beth Israel Hospital in the USA, despite a checklist, the CEO and CMO introduced something they termed 'the moment of reverence', a term which may not have much leverage in the secular UK, but which accurately reflects the principle. After briefing, checking and prepping, take a moment out, as a team, to remember who this person is on the table and how important they are to *others*, not to you. Such a moment's pause keeps it personal and gives the patient due respect. It aids concentration and reminds everyone of the potential and importance of avoiding error. If you want to hear how important respect and truth are listen to Clare Bowen speak at Risky Business GOSH annual conference to learn from other organisations [4]. Prepare to be moved.

7. **Check**
   It is, of course, vital to check that everything

is OK. We now know that the best way to do this is to use checklists. The WHO checklist project has worked, and lives have been saved, wrong procedures avoided and complications reduced [5]. There is **no excuse** for surgical teams not using a checklist, in the same way there would be no excuse for the airline pilot taking off without checking the situation and systems. Engage your team in checking; it is often useful to get the most junior person to read out the list to ensure it is all done. It engages them and influences the culture.

8. **Do it once and do it right**
   Don't take short cuts; think about what you are doing and check with your team, and by now you will have encouraged them to tell you if you are heading for an error. They are your friends and not your enemy. Let them protect you *and* the patient.

9. **Debrief and learn**
   This is probably the thing we do least well as surgeons. If we were the Red Arrows, we would debrief religiously, as a team, after each display and analyse minor errors in the pursuit of perfection. I have seen very few surgical teams do this after surgery, but there is so much to gain. Near misses can be identified, experiences shared and new processes and protections evolved. It induces respect amongst team members and fosters a spirit of continuous improvement; vital for a successful organisation. If we only had 'Black Boxes' in the operating room, including video and audio, we would be able even better to analyse our work.

10. **Measure, share and improve**
    Accurate data is the only way to effect rapid change and improvement. The plural of anecdote is not data, so we need to be sure that we put in place relevant quality control metrics to monitor, present and use as a basis for improvement. Good examples of such modes of presenting data are SPC (statistical process control) charts, and CUSUM charts, both of which are relatively easy to set up and can be used to monitor both success and failure of any event. Doctors and nurses are inherently competitive, so if you show them how they are performing in relation to their peers, even anonymously, they naturally try to improve, without 'management'.

I think Steve Hanson, the All Blacks coach, got it right in December 2012 when he said "Don't ask us how good we are. Just be aware that we are going to get better". We know the All Blacks are a great side, but they are never satisfied; continuous improvement is what they are about. That, too, is our responsibility as surgeons. Nobody jumps higher by lowering the bar.

References

[1] **Reason J**
Human error: models and management
British Medical Journal 320 (7237): 768–770

[2] http://www.safersurgery.co.uk/human-factors-in-healthcare.php#

[3] See Arthur Gillis of Protea Hotels talk wonderfully about this at http://www.risky-business.com/talk-31-customer-satisfaction.html

[4] http://www.risky-business.com/talk-18-story-of-bethany-bowen-2.html

[5] **Haynes A B et al**
NEJM 360:5; 2009

COACHING CONSULTANTS

Iain A Simpson
Consultant Cardiologist, University Hospital Southampton

Introduction by Professor Cliff Shearman

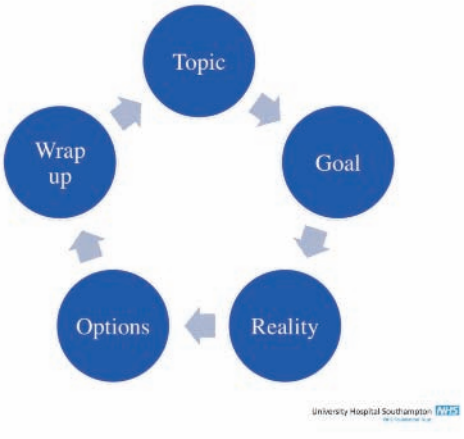
The life-time cost of employing a consultant surgeon by an institution is considerable and the performance of that surgeon is likely to have a direct effect on the success and reputation of the employing organisation. It is surprising then, at present, very little attention is paid to ways of helping and ensuring that consultant surgeons are performing at their optimum level. Likewise, most surgeons have trained and competed hard to become consultants but, having been appointed, few then plan their careers and life beyond that point. In his article on coaching consultants, Dr Iain Simpson outlines the role of coaching and how it can be used to help individuals working in organisations, such as the Health Service, to achieve success and be valuable assets to their employing organisations. Coaching is widely used in organisation around the world and hopefully its potential role for surgeons working in the NHS will be recognised.

Coaching means many different things to different people. From the sports coach to the life coach, there seems to be an increasing spectrum of coaches available to help us through many of the activities and challenges of modern life. The area of "executive coaching" has become widely established in business practice but less so in the healthcare environment, where it has largely been the domain of the manager rather than the clinician. This is changing, especially as clinical leaders discover opportunities for coaching and recognise its value to their personal development and ability to excel in their chosen field. But what is this executive coaching and how is it relevant to consultants?

Executive coaching for consultants, even if recognised, has generally been associated with failure not success, often recommended following the outcome of investigations into possible professional misconduct. Yet this could not be further from the truth. "Coaching for excellence" is about allowing individuals, already performing at a high level, to fully achieve their potential.

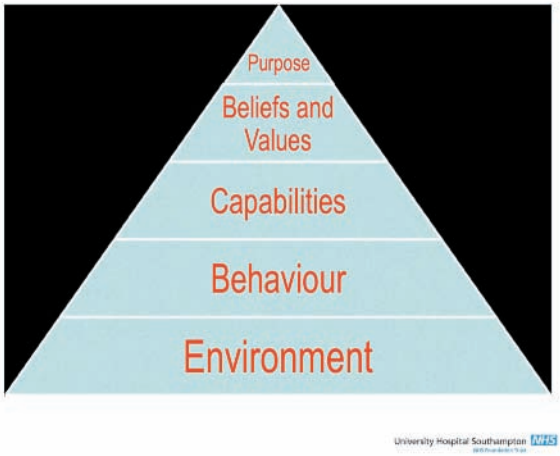
In essence, executive coaching takes the form of a structured, purposeful discussion, based around a specific topic chosen be the person being coached. This structured discussion allows the individual to fully explore the topic, define the goal or goals to be achieved and explore a range of possible options with agreed outcomes ***(Figure 1)***. Coaching is all about the person being coached, not the coach. As such, although it is important that the coach has knowledge of the healthcare industry and how an organisation and the teams within it function, it is equally important that they do not interfere with the discussion by having a close working relationship with the person being coached, where unwarranted assumptions may be made by the coach. Indeed, it is generally advised that, where possible, the coach and the person being coached have no personal knowledge of each other. In a Trust hospital, where an internal coaching programme has been established, this may not always be possible, so it is essential that the coach is aware of this potential interference and takes steps to avoid it.

Figure 1
"Grow" model of structured discussion



The coach will use a structured discussion model with tools to facilitate the discussion, exploring various levels of logical thought around the working environment, behaviours, capabilities, beliefs and values ***(Figure 2)***. The use of "clean" language, i.e. the language that the person being coached is using, is important. So, for example, if the person being coached indicates they are "upset", it is wrong for the coach to ask question about being "saddened", "angry" or "distressed", which may not be the exact meaning of "upset" to the person being coached. In this way, the discussion can progress using the language of the person being coached and the meanings attached to this, a fundamental aspect of a successful coaching session.

Figure 2
Dilts Logical Levels Model



It is important to recognise that coaching is not a form of psychotherapy or counselling, nor is it about performance management, but rather a mechanism for the person being coached to translate their own thoughts on a topic into outcomes and actions appropriate to them. Coaching differs from "mentoring" in a number of ways although there can be some degree of overlap. Unlike coaching, a mentor tends to be senior and experienced in the same field, more of a role model, with knowledge of the individual undergoing mentoring. A mentor tends to give advice and has a degree of influence on the person being mentored. It also tends to be a longer term relationship, sometimes spanning a whole career, rather than the shorter term, topic-based coaching environment. As such, whereas mentoring is often most valuable early on in a consultant's career, coaching tends to be valuable for more experienced consultants undertaking leadership roles.

The benefits of coaching for individuals in improving workplace related performance has obvious positives for the organisation, providing consistency of leadership behaviours and decisions as well as improved clinical outcomes resulting from functional teams. Consultants can benefit greatly from coaching, not only by undergoing coaching themselves but also by learning some of the skills of coaching which can prove invaluable in working with their clinical teams, assisting in education supervision, appraisal discussions and even with the difficult conversations everyone encounters from time to time with clinical colleagues and management.

This supplement is also available, as a separate off-print, at
www.asgbi.org.uk/en/publications/consensus_statements.cfm

PUBLISHED BY

Association of Surgeons of Great Britain and Ireland

35-43 Lincoln's Inn Fields, London, WC2A 3PE

Tel: 020 7973 0300 • Email: admin@asgbi.org.uk • Web: www.asgbi.org.uk

Nutrition and Enhanced Recovery in Surgery

What's new in perioperative nutrition?

Symposium at ASGBI's 2013 International Surgical Congress

Wednesday, 1st May 2013

2.15 – 3.30pm, Boisdale Room

Chaired by: Professor John MacFie (ASGBI Past President)

Programme

Pre-operative nutrition and neo-adjuvant therapy	**Professor Christophe Mariette** Professor of Surgery, University Hospital C. Huriez, Lille, France
Health economics of perioperative nutrition	**Professor Nicolas Demartines** Professor of Surgery, University Hospital CHUV, Lausanne, Switzerland
Perioperative nutrition: Looking into the future	**Professor John MacFie** Professor of Surgery, University of Hull Consultant Surgeon, York NHS Trust, Scarborough Hospital

Sponsored by

NestléHealthScience
NOURISHING PERSONAL HEALTH

ATMS
ASSOCIATION OF TRAUMA & MILITARY SURGERY
Issue 3, March 2013

THE ATMS CONFERENCE

The Association of Trauma & Military Surgery's annual scientific programme has now been published, alongside the provisional scientific programme for the ASGBI International Surgical Congress, with free papers currently undergoing the peer-review process.

The keynote speaker this year, who will deliver the prestigious Guthrie Lecture, is Professor C William Schwab from the University of Pennsylvania, USA. Professor Schwab will speak on 'Damage Control, the Odyssey'. As the surgeon who has, arguably, done more than any other to develop and popularise this concept of care for the injured patient, this will be a presentation not to be missed. Highlighting the importance of the topic and the stature of this speaker, the Guthrie Lecture will be delivered as a plenary session in the main auditorium. Our other distinguished guest speakers include Mr Rod Dunn from Salisbury, Dr Jackson Kirkman-Brown from Birmingham and Dr Harald Veen, lead surgeon for the International Committee of the Red Cross.

Mr Dunn, awarded Healthcare Civilian of the year at the 2012 Military and Civilian Health Partnership Awards, has developed a scheme that enables military patients to work closely with the most appropriate blend of specialist clinicians drawn from the local NHS, to deliver a bespoke package of care for each injured Service Person; care that is geographically accessible to the patient and their support network. He will speak on developing military and civilian partnerships in healthcare.

Dr Jackson Kirkman-Brown, a renowned fertility expert, has developed ground-breaking protocols of care for servicemen with severe urogenital injuries at the Role 4 hospital in Birmingham. Utilising techniques honed for the management of assisted fertility in the NHS, Jackson and his team have achieved hitherto unimagined results. Recently awarded a MBE, he will speak on his experience of preserving fertility after devastating genital injury.

Dr Harald Veen is lead surgeon of the International Committee of the Red Cross/Red Crescent. Dr Veen will speak about the opportunities presented by the Red Cross/Red Crescent for surgeons to gain experience in trauma surgery outside of their conventional western "comfort zone", a presentation that is sure to pique the interest of all delegates at the ATMS conference.

ATMS has received an unprecedented number of submissions of free papers this year and quality will be high; all free papers presented during the day will be eligible for the Wiseman Medal and the winning presenter will receive his or her award at the end of the conference. There is also a cash prize for the best displayed poster at the meeting.

CONFERENCE DINNER

The Association of Trauma & Military Surgery will be holding a formal black tie dinner on Wednesday 1st May at The Scottish National Piping Centre, 30-34 McPhater Street in Glasgow. The evening will begin from 7:00pm with a drinks reception in The

Museum of Piping. The museum contains artefacts covering three hundred years of Scottish musical heritage. Containing pieces from the collections of the National Museums of Scotland, this is the most complete and authoritative display of piping objects in the world. The collection contains the chanter of Iain Mackay, who lost his sight at the age of seven due to smallpox, but grew to become one of the most renowned pipers in Scotland, known as "Am piobair dall" (the blind piper). Dating from the eighteenth century, this is the oldest surviving Highland bagpipe chanter anywhere in the world.

At 8:00pm, guests will be seated in the auditorium to enjoy a three-course meal of traditional Scottish cuisine and, afterwards, guests will be entertained with live music and dancing, led by the Kilter Ceilidh Band. Kilter are acknowledged as one of Scotland's finest ceilidh bands and have been asked to play at Murrayfield this season for the Six Nations Rugby Championship. With a line-up including accordion, pipes/flute, piano and drums, Kilter are guaranteed to get the evening going with style. Whilst not strictly a formal dinner, evening dress (black tie or military dress uniforms) should be worn, with decorations as appropriate. Delegates are reminded that guests / spouses / partners will be very welcome but, as numbers are limited, please book early to avoid disappointment.

ELECTION OF OFFICERS

ATMS has evolved rapidly and is now at the point where the Association needs an elected council. In order to best represent our community of trauma care providers, ATMS will seek nominations for positions within the Association Council as per the ASGBI Memoranda and Articles for Speciality Associations. Nominations, with a seconder, will be sought for President, Secretary, Treasurer and Chair of Education and Training Committee. Only ATMS members may nominate or agree to act as a seconder. Elections will occur during our inaugural Annual General Meeting, to take place during the ATMS conference in Glasgow. Please send your nomination in advance of the meeting to the ATMS administrators on office@atms.org.uk.

WEBSITE

The ATMS website (www.atms.org.uk) is updated regularly with details of the scientific programme, electoral office bearer roles and general conference information. Delegates are also able to apply for membership to the Association online. We remind you that one of the many benefits of membership to the Association is that ATMS members receive a 20% discount on Conference registration fees. This year's conference looks very exciting and we eagerly anticipate welcoming you all to Glasgow in May.

14th European Congress of Trauma & Emergency Surgery

Working together to save lives

May 4 – 7, 2013 • Lyon / France

Organised by
European Society for Trauma & Emergency Surgery

In cooperation with
Société Française de Chirurgie d'Urgence

www.estesonline.org

PRELIMINARY SCIENTIFIC PROGRAMME

TRAUMA

- Chain of survival
- Teamwork in trauma care
- Open CPR in traumatic cardiac arrest
- War and terrorism related injuries
- Amputations for limb trauma
- Sport related injuries
- Pediatric trauma
- Trauma in the elderly
- Pelvic trauma

EMERGENCY SURGERY

- Surgical oncologic emergencies
- Bariatric surgery: complications management
- Emergency laparoscopy

TRAUMA & EMERGENCY SURGERY

- Hemorrhagic shock
- Life-threatening thoracic situations
- Life-threatening abdominal disease
- Abdominal wall reconstruction
- Non-heart beating donor organ retrieval
- New technologies
- Teaching trauma and emergency surgery
- Networks – Registries

PRE-CONGRESS COURSES

- Advanced Trauma Life Support Instructors Update (ATLS in Europe)
- Modular UltraSound ESTES Course (MUSEC)
- Definitive Surgical Trauma Care Course (DSTC)
- Medical Response to Major Incidents (MRMI)
- Vascular Injuries Course (VIC)

POST-CONGRESS COURSES

- Advanced Trauma Life Support (ATLS)
- Advanced Trauma Care for Nurses (ATCN)
- Pre-Hospital Trauma Life Support (PHTLS)
- Emergency Surgery Course (ESTES/ESC)

Journées-Rhône-Alpes-Bourgogne-Auvergne de Chirurgie

Consensus conference on pelvic trauma management

CONGRESS PRESIDENT

Voiglio Eric – Lyon, France

LOCAL ORGANISING COMMITTEE

Caillot Jean-Louis - Lyon
David Jean-Stéphane - Lyon
Fessy Michel Henri - Lyon
Gouillant Christian - Lyon
Gueugniaud Pierre-Yves - Lyon
Mabrut Jean-Yves - Lyon
Monneuse Olivier - Lyon
Porcheron Jack - St. Etienne
Rongieras Frédéric – Lyon

PROFESSIONAL CONGRESS ORGANISER, SCIENTIFIC SECRETARIAT & HOUSING

Mondial

Mondial Congress & Events
Operngasse 20b, 1040 Vienna, Austria
Tel.: +43 1 58804 0, Fax: + 43 1 58804 185
e-mail: **ectes2013@mondial-congress.com**

SPONSORING & COMMERCIAL EXHIBITION

MCO Congrès
27 Rue du Four à Chaux, 13007 Marseille, France
Tel.: +33 4 95 09 38 00
e-mail: **h.bregand@mcocongres.com**

MILITARY TRAUMA RESEARCH AT PORTON DOWN – A VIEW FROM THE BENCHES

Sarah Watts
Principal Scientist, DSTL, Porton Down, Salisbury

Introduction

Military operations over the past decade have produced major advances in all aspects of casualty care, from the point of wounding to the long-term care of survivors with a wide range of traumatic injuries. These advances have come from work in the civilian sector (ref Crash 2) and from a dedicated and wide-ranging military medical research strategy within the Ministry of Defence (MoD), as set out in the strategic and priority statement for Defence Science and Technology, and the direction of the Chief Scientific Adviser. The Defence Technology Plan (DTP www.science.mod.uk/strategy/dtplan/) describes the Research Development Objectives (RDO), which include Military Medicine, which in turn has several Research Themes.

Porton Down is a centre for research excellence on the edge of Salisbury Plain, with a long history of research in biological and chemical warfare defence, and also in the science of surgical research, to which many surgical trainees have contributed over the decades.

The Porton Down site

Military Trauma Research at Porton Down

Ballistics and ballistic injury research have a long history with publications as far back as the 1800s, but research into blast effects does not feature in publications until the mid-1900s. A review of early ballistics research can be found in the first section of ***Scientific Foundations of Trauma*** [1]. In the mid-1970s, Porton Down became established as a centre of military trauma research and a new ballistics facility.

Col W F Stevenson, the second professor of military surgery, published over 100 years ago in the field of ballistics. Current collaborations with the Academic Departments of Military Surgery, Military Emergency Medicine and the Department of Military Anaesthesia and Critical Care, of the Royal Centre of Defence Medicine (RCDM) based in Birmingham, helps ensure that the basic science research conducted at Porton Down is military relevant.

Current military medical research, as defined in the DTP, can be classified under the four broad themes listed below:

- Acute Military Medicine, including Combat Casualty Care
- The Medical Support Chain, including optimised casualty movement
- Long Term Health Care, including prosthetics, cybernetics and rehabilitation
- The Legal and Ethical Implications of Warfare, as they affect the care of casualties and military health policy

Some subsidiary subject areas, for example casualty analysis, battlefield medical care and the physical and mental aspects of major injury, share a number of themes.

Combat Casualty Care (CCC) Research at Porton Down

The collaboration between military colleagues is essential to the success and development of the CCC programme. This interaction is depicted in ***Figure 1***.

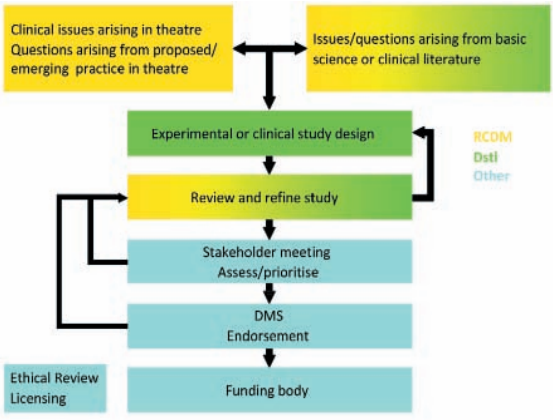


Figure 1: The process of development of research strategies between clinicians at RCDM and basic scientists at Porton Down as, for example, in prioritising research into limb injuries.

The research priorities can be broadly split into two research areas: **Acute Care** and **Reducing Long-term Problems**. These include:

Acute Care

- Treatment/prevention of acute trauma coagulopathy
- Diagnosis/treatment of Blast Brain Injury (BBI)
- Treatment of Blast Lung Injury (BLI)
- Understanding the cardiovascular effects of analgesic drugs

Reducing Long-term Problems

- Reducing the inflammatory complications of trauma
- Reducing extremity infectious complications
- Improving limb salvage and limb function.

Journal of the Association of Surgeons of Great Britain and Ireland. Number 39, March 2013
MILITARY SURGERY

Much of the research work conducted at Porton Down features blast injury as part of the injury mechanism. Current specific research tasks include:

- Biomarkers and mechanisms of brain injury
- Haemostatic resuscitation and the coagulopathy of trauma
- Mitigation of blast lung
- Vascular injuries
- Evaluation of anti-microbial dressings

Casualty Data Collection and Analysis

Military clinicians recognised the importance and value of data capture for the unique cohort of patients being treated on military operations. The Joint Theatre Trauma Registry (JTTR) was established at RCDM and it holds records on all personnel seriously injured and treated at British Field Hospitals; injured UK service personnel who arrive at Birmingham for treatment (initially treated elsewhere); and additional data is captured for those service personnel who are killed on operations. The data captured includes information on the incident, injuries sustained, evacuation time and blood product and drug usage, for example. The purpose of the JTTR is to provide DMS with information regarding clinical performance, with the ultimate aim to improve patient care via changes in doctrine, training and equipment. Interrogation of JTTR, as well as examination of post mortem findings, is an essential part of determining emerging injury patterns and to inform personnel and vehicular protection. One such example of this relates to perineal injuries, which has resulted in the development of enhanced pelvic protection for service personnel, in addition to recommendations for the treatment of such injuries [2].

Prospective data collection is just as important during military operations as retrospective review. Identification of acute trauma coagulopathy and its diagnosis in military casualties [3] has lead to changes in resuscitation practices (JSP 950 2009) as well as directing research at Porton Down (research task Haemostatic Resuscitation and the coagulopathy of trauma). Recently, a deployed research laboratory has been established at Camp Bastion which allows valuable information on early coagulation and inflammatory status, for example, to be determined in military casualties.

Animal models

The use of animals in scientific research presents many challenges, and military research is no exception. Animal research at Porton Down is done with authority under the Animals (Scientific Procedures) Act 1986. There is no Crown Immunity, and the principals of animal research, the three Rs (reduction, refinement and replacement) are extant. Wherever possible, the models used are non-recovery (the animals are anaesthetised at the start of the experiment and remain anaesthetised throughout, they are killed humanely at the end thus they never regain consciousness) and as a number of research projects examine acute effects after injury, such an approach is considered the most ethical. The animal species chosen for different projects are the least sentient, whilst still achieving the objectives of the project. For example, if a project requires detailed physiological monitoring and/or large volumes of blood, for analysis of coagulation status and inflammation for example, it would not be possible in a rodent, thus an appropriate animal in terms of size and cardio-respiratory physiology would be the pig. A large animal model, however, is not necessary for the evaluation of anti-microbial dressings for extremity injury, hence a rabbit was chosen as it is used widely for orthopaedic research.

Military trauma research at Porton Down has been continuous for approximately 40 years, therefore a number of different animal models have been utilised to replicate a wide range of traumatic injuries; many models are well established and widely published. These animal models include, but are not limited to, anaesthetised rat and pig models of blast lung injury; pig and sheep models of extremity contamination and infection; and anaesthetised pig models of haemorrhagic shock. The models are varied, reflecting the diversity of traumatic injury, the changing military environment and threat as well as the advances made in medical and surgical treatment over the last four decades. In addition, there is an ongoing requirement for models to develop and become more complex, as our understanding of mechanism of injury, the interactions of injuries and the implications for treatments, therefore, increase. One example of this is the model evolution that occurred during the programme of work for the assessment of far forward resuscitation following blast injury, and it is described in more detail elsewhere [4]. Briefly, an anaesthetised pig model of haemorrhagic shock, with and without blast lung, was developed and was utilised to determine the evidence for the use of permissive hypotensive resuscitation after blast injury, and over militarily relevant timelines (prolonged pre-hospital evacuation to surgical facilities). Results from this first study highlighted a problem for DMS in that hypotensive resuscitation resulted in very poor survival after combined blast and haemorrhage. Further research was required, therefore, to evaluate resuscitation strategies that could overcome the limitations of hypotensive resuscitation, and an anaesthetised pig model of haemorrhagic shock, with and without blast lung injury, with an incompressible grade IV liver injury (to allow re-bleeding) was developed. Following completion of these studies, the anaesthetised pig model has been developed further (addition of soft tissue extremity injury and early coagulopathy) for the assessment of the use of blood products to prevent acute trauma coagulopathy, a current problem for military (and civilian) trauma casualties.

The use of an anaesthetised animal model, whilst ethically attractive, does present its own challenges. The choice of anaesthetic used is an important factor; to ensure success, anaesthetic agents that allow observation of the physiological responses to traumatic injury, which would normally be seen in a conscious human being, are utilised. It is not always possible to use anaesthetised animal models and recently, a recovery model of a contaminated soft tissue extremity injury has been developed and

used to evaluate anti-microbial dressings in a militarily relevant setting.

Data from animal work has also lead to the development of physical models of the thorax; one to simulate the effects of blast (shock) waves on the chest and another to simulate behind armour blunt trauma. Both these models have lead to advancements in body armour for military personnel and allow armour to be evaluated without the need for live animals. These models, however, do not allow the determination complex pathophysiological processes that occur as a result of injury, nor the assessment of treatment strategies post-injury, hence the continued need for appropriate animal models. The expertise of the research group at Porton Down in complex blast models is recognised internationally as part of the UK's involvement in a five nation collaborative network (Australia, Canada, New Zealand, UK and US), and scientists from both Canada and USA have visited the facility.

Much of the work undertaken at Porton Down is published in the open literature, but there are security, political and media sensitivities making publication of manuscripts challenging and frustrating (it is demeaning to suggest that civilian reviewers do not understand; they often do so, all too well). Trauma research has not been well supported or funded until recently; the MRC's trauma research centre closed over 10 years ago. There has been resurgence for improved trauma care with the appointment of Professor Willett as the National Clinical Director for Trauma, and financial support from the NIHR, and the opening of the Centre for Surgical Reconstruction and Microbiology in Birmingham in January 2011. Funding from sources other than from the MoD, such as the MRC, the Wellcome Trust, the Department of Health and EPSRC, should encourage a range of establishments to participate in trauma research that will benefit both civilian and military personnel.

In summary, military trauma research has a long history at Porton Down. Battlefield injury research, though often of a sensitive nature, finds more general application in the management of complex trauma in civilian practice.

References

[1] **Payne L D**
Wound Ballistics Research before 1945
Scientific Foundations of Trauma (Cooper G J, Dudley H A F, Gann D S, Little R A, Maynard R L editors) 1997; 3-11
Butterworth-Heinemann

[2] **Mossadegh S, Tai N, Midwinter M, Parker P**
Improvised explosive device related pelvi-perineal trauma: anatomic injuries and surgical management
Journal Trauma and Acute Care Surgery 73[Suppl 1] S24-S31; 2012

[3] **Wollley T, Midwinter M, Spencer P, Watts S, Doran C, Kirkman E**
Utility of interim ROTEM values of clot strength, A5 and A10, in predicting final assessment of coagulation status in severely injured battle patients
Injury. Epub ahead of print 2012

[4] **Kirkman E, Watts S, Cooper G**
Blast injury research models
Philos Trans R Soc Lond B Biol Sci 2011; 366 (1562): 144-159

TAKE A DIFFERENT COURSE: WINE WISDOM AT THE WINE & SPIRIT EDUCATION TRUST®

Ed Fitzgerald
General Surgery Registrar, Chelsea and Westminster Hospital

It's a question of nature or nurture. No matter how diligent a student you were at medical school, or how prolific your PubMed citations have become since then, not all of us spent our student days scratching an academic itch. So why is it that so many of us still end up testing ourselves with new educational challenges? MBA, anyone? LLB or MSc? Perhaps the intrinsic nature of medics draws us all into the pursuit of lifelong learning, or perhaps we have all become indoctrinated into it by the system. Or both. Or perhaps some of us just really need a Consultant job. Either way, next time you feel an itch developing for a postgraduate course, why not pour some wine onto it to calm things down? Just sign up for a wine tasting course instead.

Now, I've said before to anyone who'll listen that medicine and wine are natural partners (although not necessarily at the same time). Doctors as a professional group have an unusual (or 'worrying', as my friends often say) interest in alcoholic beverages of all varieties. Whether this is nature or nurture is, again, debatable, as I fear a degree of willing indoctrination also occurs in this area at medical school. Nonetheless, learning about the art, science and culture of wine can be a challenging academic pastime. What better way to quench a thirst for knowledge than with such a pleasurable and social activity as taking a wine tasting course?

I say this with some modest experience, having recently completed 15 weeks of evening classes at the Wine & Spirit Education Trust (WSET®) in Bermondsey Street, London*. Having spent a good part of my medical school holidays driving (or rather navigating) my family crazy around the vineyards of Europe and 'exploring' (wine euphemism alert: 'exploring' = drinking) the world of wine, I fancied enrolling on what essentially amounted to a justification for opening a good bottle of wine on a Monday night. As if most of us need one.

The Wine & Spirit Education Trust is a registered charity (No. 313766) and was established in 1969, long before wine courses were as fashionable as they are now. This was an era when the UK wine trade was the centre of the vinous universe, although this hub of commercial gravity may now be gradually shifting eastwards to Asia. Founded by the historical 'Holy Trinity' of the British wine

trade, the Vintners' Company, the Wine & Spirit Association and the Institute of Masters of Wine, WSET® was tasked with developing high quality education and training for the wine trade or those planning on joining it.

Burgundy

This is the way it remained for many years and, in fact, non-industry students only started attending their courses in 1990. Since then, WSET® has developed rapidly and is now accredited by Ofqual as a UK Awarding Body within the National Qualifications Framework (NQF). Their wine qualifications are internationally respected within the wine trade, with courses in 17 languages, exams sat in 58 countries and 43,254 candidates attempting a WSET® qualification last year. Although most still hail from the UK, candidates from Hong Kong, USA and China took second, third and fourth places respectively last year.

Details of the different courses and qualifications offered are provided in ***table 1***. Timing is flexible, with many running simultaneously, and participants have the option of enrolling on day-release courses, continuous blocks or evening classes. I opted for the latter, based at the tasting rooms at the head offices of the WSET® in Bermondsey Street.

FOUNDATION LEVEL COURSES

WSET Level 1 Award in Wines
- Introductory one-day course
- Basic wine knowledge and matching food with wine

WSET Level 1 Award in Wine Service
- Entry level one-day course
- Wine service and practical skills in the restaurant setting

WSET Level 1 Award in Spirits
- Entry level one-day course
- Basic product knowledge and skills in service and marketing

INTERMEDIATE LEVEL COURSES

WSET Level 2
Intermediate Certificate in Wines and Spirits
- Major grape varieties and where they are grown
- Wine styles and the production of spirits and liqueurs
- Systematic approach to tasting with approx. 45 wines and 4 spirits
- Minimum 16 hours of teaching delivery time, with further self-study
- Assessment: 1 hour paper with 50 multiple choice questions

WSET Level 2
Professional Certificate in Spirits
- Main categories of spirits and liqueurs
- Influences of production methods on the different styles
- Systematic approach to tasting with approx. 60 spirits and liqueurs
- Minimum 12 hours teaching delivery time, with further self-study
- Assessment: 1 hour paper with 50 multiple choice questions

ADVANCED LEVEL COURSES

WSET Level 3
Advanced Certificate in Wines and Spirits
- In-depth knowledge of a wide range of wines and spirits
- Factors that influence style, quality and price of wines and spirits
- Systematic approach to tasting with approx. 76 wines and 6 spirits
- Equivalent to A-Level/AS-Level course standard
- Minimum 28 hours teaching delivery time, with further self-study
- Assessment: 50 MCQs, 5 short answer questions and a blind tasting

DIPLOMA LEVEL COURSES

WSET Level 4
Diploma in Wines and Spirits
- Internationally recognised as the premium wine and spirit qualification
- Divided into 6 units, including business and commercial aspects
- Systematic approach to tasting with over 250 wines and 50 spirits
- A prerequisite for entry onto the Master of Wine study programme
- Equivalent to university 'Certificate' course standard
- Minimum 118 hours teaching delivery time, with further self-study
- Assessment: Mix of MCQ, theory papers, assignments and blind tastings

WSET Level 5 Honours Diploma
- Attained on completing a dissertation following the Level 4 Diploma
- Includes undertaking a literature review of the subject area chosen
- Project length: 4,000–5,000 words

Table 1: Wine & Spirit Education Trust Qualifications

Before my Level 3 course commenced, I received a bulky package through the post, although my initial excitement deflated quickly when I realised this consisted solely of preparatory reading rather than the fine wine I had envisaged. Nonetheless, these course materials were excellent, with a 278-page book covering the whole world of wine from regions to regulations and production to packaging. In addition to this was a comprehensive syllabus to guide your reading and a spiral-bound study guide

including helpful practice MCQs and short-answer questions.

The following 15 weeks were great fun, perhaps more so for me as an interested amateur. The class of 20-odd students was a fantastically international group and split 50:50 between those actually in the wine or restaurant trade and others, like myself, just there to follow their passion. For those actually in the trade, many were funded by their companies, which brought obvious added pressure to their studying. There's a lesson in that for the NHS and our dwindling study leave…

Over the 15 weeks, we enjoyed a vinous tour of all the world's main wine regions, interspersed with some of the more technical and commercial aspects of vineyards, winemaking, retail and consumption. Each two hour class had a particular focus and the six wines or spirits tasted were carefully chosen to illustrate that evening's learning objectives. This ensured the classes remained 'hands-on', but also gave an opportunity to go into a detailed tasting of the wines guided by an expert in the area. Some people are naturally gifted at finding gooseberries in their sauvignon blanc and blackberries in their cabernet sauvignon. I am not blessed enough to be one of them. Thankfully, the course teaches the WSET® 'systematic approach' to wine tasting. I was relived to discover that PubMed and meta-analysis were not required for this particular systematic approach, rather a stepwise analysis of technical factors such as the clarity, acidity, tannin, alcohol levels and suchlike, in addition to the often-lampooned descriptors of taste and flavours.

The tasting didn't always end at the class either; the course was a great opportunity to meet likeminded enthusiasts (another wine euphemism: 'enthusiast' = wine nerd) and we were soon staying on for dinner locally and organising separate wine tastings together with the excuse of 'exam revision'. This proved to be a remarkably good excuse for popping the corks on some great wines!

Hard at work, revising over dinner

The end of the course came all too quickly and was accompanied by a not particularly welcome exam. For the Level 3 Advanced course, this consisted of 50 MCQs, five short answer questions and a blind tasting of two wines. Each of these required a detailed tasting note with conclusions regarding development, value and an attempt at identifying the particular wine from a range of options. A couple of sample MCQ questions are given in ***table 2***. The exam was not easy, set at an equivalent level to A-Level/AS-Level, and I was relieved to subsequently pass; a number of other students didn't make the grade.

Q. Which one of the following is the key factor in determining the quality of the wines in Ribera del Duero? a) Maritime influence b) Altitude c) Summer rain d) Cold air descending from the Pyrenees
Q. Which one of the following is a fining agent? a) Potassium bicarbonate b) Sulphur dioxide c) Kieselguhr d) Bentonite

Table 2: Level 3 Advanced Course Sample MCQs

What did I learn? For someone who thought he knew something about wine, this course made me realise that there are huge wine producing areas (mainly outside of Europe) that I really have embarrassingly little knowledge of. So for the enthusiastic amateur, that alone is a great reason to undertake these classes – just think of all those new wines waiting for you to broaden your plate and discover them! But more than that, the course gives you a solid grounding in other areas you might otherwise gloss over: the factors influencing wine quality, price and even aspects of alcohol law and social responsibility.

Was it worth it? Absolutely, yes. While these sorts of advanced courses don't come cheap, you won't be charged much more than a current Basic Surgical Skills course, and the WSET® variety tastes a lot nicer too. Put all that into context and either the WSET® sourced my 78 glasses of wine for the course very cheaply, or someone somewhere is really overcharging for pigs' trotters.

So, no matter how severely afflicted you are with recurrent medical course-itis, there's a lot of fun to be had from nurturing your vinous interests through evening classes such as these. Enjoyment of wine is what nature intended.

**Other wine courses are available. Always read the instructions before use.*

For further information on accredited courses across the country and internationally check:
http://www.wsetglobal.com/

WSET
39-45 Bermondsey Street
London
SE1 3XF

The WSET® is a Registered Charity (No. 313766)

With thanks to David Wrigley, Global Communications Director at WSET® London, for providing the background information.

miceconcierge®
meetings ▪ incentives ▪ conferences ▪ events
connecting customers

fresh!
reservations

Approved Accommodation Service
ASGBI International Surgical Congress 2013

We are proud to once again be the approved suppliers of accommodation for ASGBI's annual Congress, this year taking place in Glasgow, and we are here to provide you with the easiest and most convenient way to make arrangements for your visit at the best possible prices! Remember, by staying in one of the approved hotels, you know you'll be staying with other delegates so will have the best chance of networking and getting the most from the event.

What's in it for you?

- **Carefully selected event hotels suited to your needs.**
- **Rates negotiated exclusively for your use.**
- **Help future delegates - your booking means more buying power to negotiate better rates in the future.**
- **Peace of mind that we are experienced professionals dedicated to ensuring you have the best experience.**
- **All prices benchmarked against our competitors.**
- **Access to MICE Concierge, the new online booking software for events.**
- **Access to our team of specialists who are here to help make your experience the best it can be.**

Introducing MICE Concierge - The complete booking service

We are delighted to announce that, for the 2013 Congress, we are introducing new booking tools offered by our sister company MICE Concierge, so that you receive a more complete service.

- Visit www.miceconcierge/ASGBI2013 and for the first time, you can book everything in one place: hotels, restaurants, your annual dinner, the golf day, your airport transfers and more!
- Book your 'social' itinerary and get a separate invoice to the one you receive for the Congress itself.
- Use the MICE Concierge price comparison tool to be completely sure you are getting the lowest price available.
- Maximise your networking opportunities by sharing information with other people coming to the Congress.
- Book securely behind the MICE Concierge PCI DSS compliant servers so you know you are in safe hands.

Official Accommodation Options

HQ Hotel - Crowne Plaza

The appointed headquarters hotel has been selected as the onsite 4 star Crowne Plaza, Glasgow. This is connected to the SECC by a covered link for extra convenience. As well as being located on the tranquil river, the hotel is well known for its excellent service and facilities such as the onsite health and fitness club and beauty spa. Excellent transport links also make it ideal for travelling into the city centre. By staying at the headquarters hotel, not only will you have the ease of being so close to the Congress, but you have many opportunities to network with your fellow delegates.

Exclusive ASBGI rate including VAT & full English breakfast – £129.00

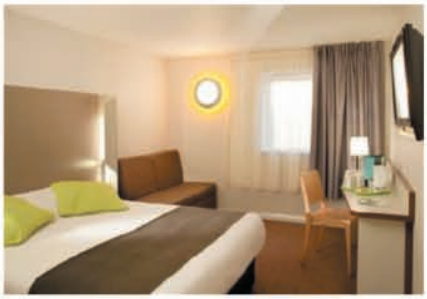
Other Onsite Options

Hilton Garden Inn

On the banks of the River Clyde, and just a 5 minute walk away from the SECC, the Hilton Garden Inn is another perfect hotel for this event. The decor is modern and fresh and there are many benefits here for you as a customer. Voted 'Business Hotel of the Year 2012', you as a delegate will benefit from complimentary wifi and a 24 hour business centre. Alternatively, relax in the hotel's 24 hour fitness centre (complimentary) or catch dinner in the 1AA Rosette restaurant.

Exclusive ASBGI rate including VAT & full English breakfast – £120.00

Onsite hotels, continued...



The Campanile

The 3 star Campanile Glasgow is a modern, contemporary hotel located just a short walk from the SECC. Spacious rooms, complimentary parking and complimentary wifi throughout make it ideal for anyone wishing to attend the Congress on a budget. An onsite traditional French restaurant gives the added bonus of being able to dine in the hotel.

Exclusive ASGBI rate including VAT & full English breakfast – £75.00

Recommended City Centre Hotels

Radisson BLU

Located in the financial district within the heart of the city, this is ideal for anyone attending the conference who wishes to be within the hustle and bustle of the city centre, but just a 5 minute taxi ride from the SECC. The hotel boasts many excellent facilities such as a fitness centre, swimming pool and restaurant.

Exclusive ASGBI rate including VAT & full English breakfast – £103.00

Hilton

The 5* Hilton Glasgow is set in the heart of the city but just a 20 minute walk from the SECC and is the perfect hotel for business and leisure. Stylish and contemporary rooms complete with high speed internet aim to make your stay as relaxed as possible. The Spa, health club and a variety of restaurants make it ideal for winding down in the evenings with other ASGBI attendees.

Exclusive ASGBI rate including VAT & full English breakfast - £120.00

Jury's Inn

Located in the centre of Glasgow, adjacent to the Central Rail Station and just 5 minutes from the Queen Street Station, Jury's is perfect for any delegate travelling into the city by rail. Being in the city, however, doesn't mean you have to travel far, as it's only a 10 minute drive to the SECC. Simple and stylish, Jury's is ideal for anyone wanting city centre location and a better value option.

Exclusive ASGBI rate including VAT & full English breakfast – £75.00

Bookings for restaurants, golf day, the Gala Dinner, airport transfers and more.

We are delighted to also be able to help you book in for the Gala Dinner, the golf day and other aspects of your visit. Full details can be found on our website so get online and book your accommodation now while we still have the best rates available... and book the other parts of your stay at the same time!

Making your booking couldn't be easier...

Visit us via the ASGBI Congress website or go to: www.miceconcierge.com/events/ASGBI2013

Alternatively, call our office on 01438 908770 and we will be delighted to help you personally.

PLEASE REMEMBER, OUR RATES ARE SUBJECT TO AVAILABILITY AT THE TIME OF BOOKING AND ARE FOR A LIMITED NUMBER OF ROOMS, SO PLEASE BOOK EARLY TO GET THE BEST DEAL

MY MIDLIFE CYCLING CRISIS: THE FRED WHITTON CHALLENGE, MAY 12th 2013

Dominic Slade
Consultant General and Colorectal Surgeon, Salford Royal NHS Foundation Trust

Mention that you are doing the "Fred Whitton" to a member of the cycling cognoscenti and you will be met with a faraway look reminiscent of Vietnam veterans discussing Saigon 1969. There is a sucking of teeth and a sotto voce comment such as: "Hardknott pass. I lost some good men there."

In three months time, I will be one of the 1,600 riders lining up in Ambleside, anticipating 112 gruelling miles and 12,500 feet of climbing in what is reckoned to be one of the toughest bike races in Britain. The obvious question is "Why?" The simple answer is to raise money for Macmillan Cancer Support and if you don't wish to read any further, please visit my JustGiving page at www.justgiving.com/Dominic-Slade and consider donating whatever you can afford. If, however, you are interested in cycling or what motivates someone with a decent day job to willingly endure such extreme forms of masochism, then read on.

Three years ago, I had never cycled more than about six miles in a day and did not possess a shred of Lycra. My brother asked me if I was interested in cycling the "coast to coast" with him and four other friends. I had never done anything like it before and 180 miles from Whitehaven to Newcastle seemed a daunting but doable challenge. This was my first taste of the camaraderie that Lycra-clad, middle-aged men find on two wheels. It was one of the most enjoyable trips I have ever taken and the feeling of achievement when we reached Tynemouth was insurmountable. Highlights included staying in a grouse-shooting lodge in County Durham and watching my brother pretend that he hadn't just drunk five pints of strong ale in front of the owners at check in. The route included the Lake District's Whinlatter Pass, which I remember at the time as being especially steep and unpleasant. Indeed, we all stopped at the visitor centre for lunch to break the climb. All my cycling to this point had been on my 13 year old mountain bike. On my return, I ordered a road bike from the cycle to work scheme. I got myself a medium price aluminium frame bike (I couldn't afford carbon fibre or titanium as I'm not an Orthopaedic surgeon). Riding that bike for the first time was like getting in a Ferrari; I couldn't believe how well it accelerated, how stable it was at speed and how agile it was.

Meanwhile my brother, inspired by our successful traverse of Britain, had entered us both in a sportive called the Lakeland loop. Sportives are the cycling equivalent of a "fun-run" where for a small fee, ordinary folk can ride a marshalled course. The loop is a 70-mile route through beautiful Lakeland scenery, which happens to include some pretty serious hills. The start at Great Langdale is beguiling because it is flat and heads away from the toughest climb of the day and our nemesis, Hardknott pass. Looking back, we were hopelessly ill-equipped in the muscle and cardiovascular department for what became the toughest feat of endurance we had ever suffered. I fell off my bike twice, once outside the feed station in Santon Bridge and the second on the lowest reaches of Hardknott, where I simply ran out of steam on its 33% gradient. We took the "walk of shame" to the top and watched as many others took off their shoes and did the same. Never in the field of human cycling had so many legs been shredded by one hill. We did, however, make it to the finish and rode over the line together. We drove our separate ways home and found ourselves talking on the phone just a few hours later. We had both independently decided that, although bloodied and bowed, we would come back next year and beat that climb into submission.

My brother and I during one of our many cycles.

At the beginning of 2012, we planned our next Lakeland loop. Our winter training involved a lot of armchair cycling and very little serious heart rate raising effort. So about a month from the loop, we entered the "perfect training" ride starting in Saltburn, on the North Yorkshire coast. This was to become yet another defining moment in our collective cycling consciousness. The route appeared to be a docile, ambling 68 miles through the moors. An easy day out and a practice run for the horrors of Hardknott soon to come, we thought. How wrong we were. It was March, not a month you would normally associate with arctic weather conditions. At the start line it was raining; when we got to the tops, it turned to sleet and then snow. My bike computer registered -6 degrees Celsius. I have never been so cold in all my life. My brother cycled on whilst I did the Captain Oates. When I got back to the car park I found my brother shivering in the driver's seat. We took half an hour to get over our hypothermia, trying not to spill our cups of tea with uncontrollable shaking. To add insult to

injury, I had forgotten to register at the finish line and was awarded DNF – Did Not Finish. We never talk of Saltburn.

So to the Lakeland loop 2012. I don't remember enjoying the hills previously but we lapped them up this time. The descents were glorious, the countryside beautiful and we had a score to settle with Hardknott. Whinlatter pass was positively tame and I managed to leave Santon Bridge without falling off my bike. Hardknott mocked us from a distance for a good half an hour before we reached its energy-sapping lower slopes. My brother cracked first with terrible cramp and I was two pedal strokes after him. We walked, hobbled and partially cycled up the 1-in-3 incline. We watched as someone pulled a wheelie and ended up on his back with bike on top of him at the steepest section. We were beaten again but proud to have taken one hour off last year's time.

I spent the rest of 2012 plotting how to conquer our nemesis. The only way was immersion therapy - to enter ourselves into the toughest bike challenge we knew - the Fred.

We are now training in earnest five nights a week. We have both purchased turbo trainers (a kind of frame that converts your road bike into a static exercise bike for use indoors) and for a month now have been sweating profusely whilst going nowhere fast. We talk to each other about intervals and power outputs and other cycling nerdity that is too embarrassing to list here. It has taught us how far we were from ever being able to take on Hardknott as we train obsessively to climb hills. It has also taught us a newfound respect for Bradley Wiggins and his achievements last year. To win the Tour de France it is estimated you need to put out 6.7 watts/kilogram of body weight. I am the fittest I have ever been and can currently sustain 3.3W/Kg for three minutes! Bradley can sustain 475 Watts for at least an hour in a time trial. To do that, you not only have to be excessively fit but also able to suffer the lashings of lactic acid and the feeling that your chest has been napalmed. 25% is fitness, 75% is sheer determination.

The Fred has created a chain reaction (excuse the pun) of 18 other riders registering with us. Several members of the team have done the Fred before and sworn they would never do it again! We have already raised a chunk of sponsorship through our team cycling jersey, upon which we have all purchased advertising space. As I don't have a business to promote, I have asked the Association of Surgeons if I can put its crest on our shirt whilst at the same time approaching the ASGBI members through this newsletter for sponsorship.

I am trying to raise a really good sum for Macmillan and am already on my way through the generosity of my work colleagues. I know there are many charities deserving of your support but Macmillan stand out for me through the contact I have had with them as a colorectal surgeon and the son of a man who died from oesophageal cancer. Please show your support and wish us luck as we try for the third time to conquer the daddy of all climbs, Hardknott pass.

100 YEARS OF WORLD-CHANGING DISCOVERIES AT THE MEDICAL RESEARCH COUNCIL

2013 marks the 100th birthday of the Medical Research Council. In that time, we have seen researchers alter the course of medicine over and over again, benefitting and extending the lives of people all around the world. Scientists funded by the Medical Research Council have played a key role in many of the most important advances of the past 100 years, have been awarded 29 Nobel Prizes and continue to dedicate themselves to tackling disease. As we move forward into the next hundred years of the MRC, we've highlighted some of the steps that have led us to where we are today.

1913 - MRC set up to tackle TB
In June 1913, a fledgling Medical Research Committee held its first meeting, to oversee the first national fund for medical research and a new national scheme for health insurance, which would provide sanatorium treatment for tuberculosis (TB) and carry out research comparing TB in animals and humans. By investing a penny per person per year from the working population, the committee evolved into the MRC, overseeing a national fund for medical research amounting to £57,000 per year, equivalent to £4m today.

1916 - Rickets caused by a lack of Vitamin D
Sir Edward Mellanby discovered that rickets, a painful and deforming bone disease, is caused by lack of vitamin D and can be treated with cod liver oil. These findings were confirmed by one of the founders of the MRC, Dame Hariette Chick, whose research showed that children who were either given cod liver oil or allowed to play outside in the sunshine could be cured of rickets.

1933 - Discovery of the influenza virus
MRC scientists proved that influenza is caused by a virus, rather than a bacterium, after studying ferrets in their laboratory that had caught the illness from researchers.

1940s - Development of penicillin as a drug
Sir Alexander Fleming originally discovered penicillin's antibacterial properties by accident in 1929 while studying bacteria. By chance, *Penicillium* mould had contaminated one of his dishes and he noticed that bacteria around the spot of mould had been killed and dissolved. It was not until Sir Ernst Chain and Lord Howard Florey's MRC-supported work that it became possible to produce the antibacterial compound, penicillin, in pharmaceutical quantities. Chain and Florey went

on to purify and extract penicillin, and enlisted the help of pharmaceutical companies to produce it in large amounts, to treat many different bacterial diseases. It was crucial for treating wounded soldiers on the front line in World War II.

1946 - First ever British cohort study begins
The MRC National Survey of Health and Development study has followed the lives of a group of people born in one particular week in 1946 for 66 years. Over six decades, it has taught us much about the influences of growth, health and environment in early life on adult chronic disease risk.

1953 – Discovery of the structure of DNA
Work by James Watson, Francis Crick, Maurice Wilkins and Rosalind Franklin revealed that the molecular structure of DNA is a double helix. Crick and Watson of the MRC Laboratory of Molecular Biology and Wilkins of the MRC Biophysics Research Unit won the 1962 Nobel Prize for this work, a breakthrough hailed as one of the most significant landmarks of the 20th century.

1956 - Smoking causes cancer
Sir Richard Doll and Sir Austin Bradford Hill studied 40,000 British doctors and showed that the death rate from lung cancer among heavy smokers was 20 times the rate in non-smokers, providing definitive evidence that smoking causes lung cancer.

1960 – Emergence of skin grafts
The NIMR's Sir Peter Medawar made the notable discovery of the ability of a living thing to overcome its normal tendency to reject another individual's organs or tissue - acquired immune tolerance. Sir Peter's finding came from his studies of skin grafting to treat soldiers with burns in World War II.

1973 - MRI invented
Sir Peter Mansfield devised a way to harness cells' natural magnetic properties to produce images of soft tissues in humans, leading to the development of magnetic resonance imaging (MRI). Today, all major UK hospitals have whole-body MRI scanners and the technique is used to diagnose and monitor cancer, Alzheimer's disease and many others.

1977 - DNA sequencing invented
At the MRC Laboratory of Molecular Biology, Sir Frederick Sanger developed a way to work out the exact sequences of bases in DNA. He used it to work out the genetic sequence of a virus, which was the first fully sequenced genome. Sanger's method was key to the Human Genome Project, which has increased the understanding of many genetically-based diseases and cancer.

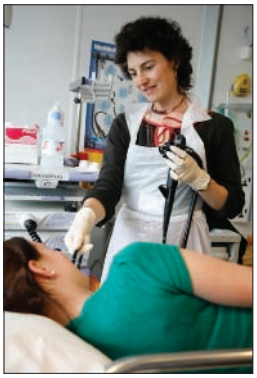
1984 - DNA fingerprinting invented
DNA fingerprinting, invented by Sir Alec Jeffreys at the University of Leicester, can reveal highly distinctive patterns of DNA fragments that are unique in everyone apart from identical twins. The technique is now used in many ways, including medicine, forensic science, paternity testing and environmental studies.

1995 - Deep brain stimulation treatment for Parkinson's disease
Deep brain stimulation involves electrically stimulating specific parts of the brain, and is able to help Parkinson's disease (PD) patients who do not respond to drug treatments. The technique was invented by MRC-funded Professor Tipu Aziz, a neurosurgeon at Oxford University's John Radcliffe Hospital. The therapy is now used worldwide and more than 30,000 people have received it.

2002 - Hib disease eradicated in The Gambia
MRC research in The Gambia led to a national vaccination programme that completely wiped out Haemophilus influenzae type B (Hib) disease, one of the main causes of pneumonia and meningitis in children in developing countries.

2010 - Cooling prevents brain damage in newborns
A brain cooling treatment trial led by Denis Azzopardi and David Edwards at Imperial College London showed that, by cooling the body by three degrees, brain damage can be prevented in newborns starved of oxygen during birth.

2010 - Markers for early detection of cancer found
MRC Cancer Cell Unit scientists discovered that proteins in the body called mini-chromosome maintenance proteins (MCMs) can flag up early-stage cancers or precancerous cells at risk of developing into tumours. MCM testing is now being developed for the early detection of cervical, lung and colorectal cancers. This could soon lead to a national screening programme to pick up cancer before it's too late to save patients' lives.



MRC-funded research continues to have a huge impact on both health in the UK and worldwide, as well as our economy and society. Throughout 2013, we'll be running a series of exciting activities and events to showcase our research successes and collaborations. Read about many more of the MRC's achievements and learn what we have planned for our centenary year at www.centenary.mrc.ac.uk.

General & Medical

Association of Surgeons of Great Britain and Ireland
COMMERCIAL PARTNER

We've taken a knife to the cost of Health Insurance!

25% Discount on Private Health Insurance for you & your family*

General & Medical began 25 years ago by providing Health Insurance to the medical professions.

To celebrate, as a preferred provider to the Association of Surgeons of Great Britain and Ireland, we are delighted to be able to offer a 25% discount on Health Insurance for ASGBI members and their families.

We have a full range of policies from those that provide only in-patient benefits to fully comprehensive schemes and we have agreements in place with hundreds of hospitals throughout the UK - one of the largest choices of any UK Health Insurer.

For a quick, no obligation quote and to claim your 25% discount* visit:

www.generalandmedical.com/ASGBI or call 0800 970 9442 and state 'ASGBI'

* The discount may be withdrawn or varied at the discretion of General & Medical Healthcare.

General & Medical

in association with the Association of Surgeons of Great Britain and Ireland

HEALTHCARE CONFERENCES UK

HEALTHCARECONFERENCESUK.CO.UK

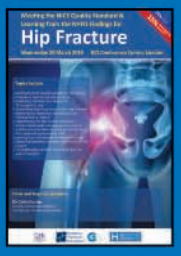
Healthcare Conferences UK organises and produces high quality healthcare conferences and exhibitions with a specialist interest in a clinical audience. Our events support knowledge sharing, professional development and take a practical approach to learning through case study based best practice.

Association of Surgeons of Great Britain and Ireland

PROFESSIONAL PARTNER

Delivering a Consultant Led 7 Day Service

Tuesday 12 March 2013
ICO Conference Centre
London



Hip Fracture

Wednesday 20 March 2013
ICO Conference Centre
London

Responding to Concerns about a Doctor's Practice

Tuesday 16 April 2013
ICO Conference Centre
London

Sepsis

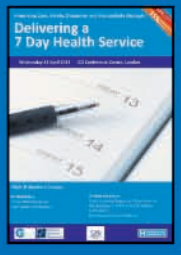
Thursday 18 April 2013
ICO Conference Centre
London

Informed Consent Masterclass

Tuesday 23 April 2013
Hallam Conference Centre
London

Reducing Medication Errors

Tuesday 23 April 2013
ICO Conference Centre
London



7 Day Health Service

Wednesday 24 April 2013
ICO Conference Centre,
London

Electronic Patient Records

Friday 26 April 2013
ICO Conference Centre
London

15% DISCOUNT FOR ASGBI MEMBERS

As a professional partner of the ASGBI we are pleased to offer ASGBI members a 15% discount which can be claimed by quoting ref: **hcukasgbi** when booking. visit **www.healthcareconferencesuk.co.uk** for a full list of conferences or please contact **kerry@healthcareconferencesuk.co.uk**.

Institute of Healthcare Management

Good Governance Institute

CPD MEMBER

The Hamlyn Symposium on Medical Robotics - Call for Papers

The 6th annual Hamlyn Symposium will be held on 23rd and 24th of June 2013 at the Royal Academy of Engineering. Workshops will be organised on 22nd and 25th of June 2013 at Imperial College London.

The Symposium is organised by the Hamlyn Centre at Imperial College London and attracts world leading scientists, engineers and clinicians from a wide range of disciplines associated with medical robotics, technology and surgery.

Topics to be addressed by the symposium include, but are not limited to:

- Co-operative Control and Perceptual Docking
- Clinical highlights in Urology, Cardiac Surgery, Thoracic Surgery, General Surgery, Gynaecology, ENT, Orthopaedic and Paediatric Surgery
- Economic and general consideration of robotic surgery
- Emerging, multi-specialty applications of robotic technology
- Flexible Robotics
- Human robot interaction and ergonomics
- Intra-operative imaging and biophotonics for robotic surgery
- Mechatronic designs for medical robotics
- Medical image computing and computer assisted intervention
- Medical robotics for NOTES
- Microbot design and applications
- Smart Instruments
- Surgical navigation and augmented reality systems
- Surgical simulation, training and skills assessment

The paper submission deadline is **20th of March 2013** and submissions are accepted on Clinical and Technical topics. To find out more about the scope of event, invited speakers involved and to register or submit a paper, please visit www.hamlyn-robotics.org.

The Hamlyn Symposium on Medical Robotics - Call for Participations

The Hamlyn Symposium on Medical Robotics is a premier event on medical robotics and computer assisted surgical technologies.

Some of the Symposium highlights are:

- *A series of invited talks by distinguished speakers*
- *Panel debate on breakthrough medical robotics and instrumentation*
- *Oral and poster presentations on a wide range of clinical and technical topics*
- *An international audience from leading research organisations and universities in medical robotics*
- *Annual international forum for clinicians, engineers and researchers*

Organised by the Hamlyn Centre, the Symposium grew out of the original Imperial College's Cross Faculty Workshops on Medical Robotics. It is now established as an annual international forum for clinicians, engineers and researchers to exchange ideas and explore new challenges and opportunities in healthcare technologies. The mission of the Hamlyn Centre is to develop safe, effective and accessible imaging, sensing and robotics technologies that can reshape the future of healthcare for both developing and developed countries.

Each year, researchers, clinicians and engineers are invited to submit papers on a range of topics. The expert Programme Committee reviews all papers by rating them against particular criteria. Papers with top scores are then invited to present at the Symposium. Best papers are selected to be published at the Journal of Robotic Surgery.

The Symposium is now held over four days, to include workshops on various clinical and technical topics and a two-day main conference with participation of invited speakers, paper authors and delegates from leading medical, science and technology institutions. The invited and keynote talks from distinguished speakers provide great insights into cutting edge developments in the fields of robotics and medical technologies.

As part of the Symposium, senior academics and young research fellows work together to organise a series of workshops on a wide range of clinical and technical topics. These workshops provide a forum for focused discussion about specific research and clinical topics of medical robotics, as well as an informal environment for academic networking.

The Symposium organisers are offering opportunities for exhibiting throughout the event. As the Symposium attracts a unique audience of interdisciplinary researchers, leading investors, policy makers, entrepreneurs and the media, the exhibitor stands are considered as excellent platforms for marketing, selling and promoting related products and services.

The Hamlyn Symposium is in its sixth year. To celebrate this anniversary, the Symposium audience will convene once again in June 2013 at venues in the heart of central London for another successful meeting. The registrations for both the Symposium and the Workshops are now open.

Contact Information

General Enquiries: hamlyn-robotics@imperial.ac.uk

Sponsorship Enquiries: sponsor@hamlyn-robotics.org

Contact Telephone: +44 (0) 203 312 5154

Website: www.hamlyn-robotics.org

Cavendish Medical

GOING SEPARATE WAYS? WHY YOUR PENSION MAY BE THE BIGGEST ASSET TO CONSIDER WHEN DIVORCING

It is a sober fact of modern times that more couples are splitting up later in life. The Department for Work and Pensions recently reported that divorce rates among the over 50s have risen five-fold in the past decade. At this age, the individuals involved are likely to have built up large NHS pension pots which, in many cases, are likely to be the biggest source of wealth to be divided, even greater than the family home.

In 2000, new 'pension sharing' legislation was introduced giving spouses (or, since 2005, civil partners) the right to a portion of the main earner's occupational pension upon divorce, when courts divide their assets. Since then, there has been an 11% rise in divorcing couples splitting pensions.

For those in their 50s, the impact of divorce on retirement provision should be a major consideration. Doctors divorcing within a decade or so of their retirement could find it difficult to secure sufficient savings to enjoy the same sort of lifestyle as singles that they were anticipating as a married couple.

Siobhan Lomasney, head of the family team at law firm **DMH Stallard**, said: "In these difficult economic times, when future property values and earnings can be so uncertain, there is increasing focus on pension funds in financial negotiations conducted in the context of divorce or separation. The ex-spouse or ex-civil partner will want to secure a significant share in the pension fund of the pension-holding spouse or to achieve an increased capital settlement to take account of the other party's pension fund. It is essential that careful thought is given by those with significant pension funds to all the options available by which to share the pension fund or to compensate the non-pension holding party and preserve the fund as much as possible."

There are three different ways of dealing with pension benefits upon divorce: offsetting, earmarking and pensions sharing. The decision on which option is chosen will be either by agreement between the divorcing couple or by court order.

Pension sharing offers the opportunity of a 'clean-break' settlement and gives the ex-spouse legal ownership and control over his/her share of the pension. In simple terms, the benefits are transferred to a plan in the ex-spouse's name in the form of a 'pension credit', for payment at the spouse's retirement age. The advantages include each party having independent pension benefits in their own right, with the flexibility to draw benefits as they choose. Neither party's rights are affected by the other's subsequent death and, unlike earmarking, any pension sharing arrangements would be unaffected by remarriage.

Crucially, the ex-spouse will be able to take benefits from age 55 in respect of the pension credit, rather than be compelled to wait until the pension scheme member retires. However, it should be noted that the normal retirement age for the 1995 section of the NHS pension is 60 and drawing benefits before this date will result in an early-retirement factor being applied. In return for the pension share, the ex-spouse will normally receive less of the couple's non-pension assets. This may result in them being in financial difficulty if they are below pension age and unable to access the pension credit rights.

Some divorcing couples opt for 'offsetting' – simply trading assets between the two parties, such as giving away the rights to a savings account in order to keep hold of a pension. The advantage is that this is easy to understand and easy to conduct. It is done at the time of the divorce and allows the couple a clean break. A significant downside is that the other assets are not always adequate to cover the amount of pension to be offset.

Finally, the 'earmarking' or attachment option allows a portion of the pension benefits to be assigned to the ex-spouse. The benefits remain in the original

member's plan until retirement and are then paid to the respective parties in the proportions stated by the earmarking order. One key point here is that no money changes hands at the point of divorce, so a former couple may need to keep in touch many years after an acrimonious divorce. Their future financial stability will be intrinsically linked and yet the pension scheme's benefits could change between the date of the original court order and the member retiring. An advantage for the pension scheme member is that earmarked benefits will revert to them if the ex-spouse dies or remarries. On the other hand, lump sum death benefits can be earmarked to protect the ex-spouse in the event of the member's premature death.

Deciding which option to take depends on the personal circumstances of both parties. External financial factors play an important role too, such as the recent reduction in the level of 'lifetime allowance' – the tax-free pension savings limit. In 2012, this fell from £1.8million to £1.5million. From 2014, this will be further cut to £1.25million with harsh tax penalties applied when ultimately drawing pension benefits for individuals deemed to have exceeded their available allowance.

Where an ex-partner has been awarded a pension debit as part of a pension sharing arrangement, this will reduce the surgeon's overall pension entitlement to be tested against the new lifetime allowance rules when drawing any pension funds in the future. Depending on the size of the sum awarded, this may have the welcome effect of bringing overall pension benefits within the lifetime allowance limits, thus reducing any tax that would previously have been due before the split.

A pension debit – the amount the pension scheme member has given away – does not count towards their own lifetime allowance except in the case of 'earmarking'. Here, any 'earmarked' pension benefit payable to the ex-spouse is treated as part of the original member's pension entitlement for lifetime allowance purposes. For some, it could be preferable to opt for a clean-break approach by handing over private pensions to an ex-spouse as opposed to a percentage of the individual's NHS pension. The NHS pension is index-linked, making a split complicated and the calculations more difficult.

It is usual practice for an independent pension actuary to be appointed to undertake calculations on the value of the NHS pension fund and any proposed share or split, based on whole time equivalent service and pensionable salary to date. As long as the surgeon is sure that overall pension benefits will ultimately be within the revised lifetime allowance of £1.25 million (or higher personal limit) then private pensions can be useful to retain when weighed against other assets because, unlike the NHS scheme, they can offer greater flexibility. For example, if a surgeon has a guaranteed NHS income upon retirement of more than £20K per annum, he or she could access flexible 'drawdown', effectively drawing out up to 100% of their private pension in any one year (subject to income tax at their highest marginal rate).

As with all things financial, the best option to take will depend on the unique situation of the parties involved but good communication and co-operation between your solicitor and your financial adviser will be vital.

Cavendish Medical is a fee-based independent financial practice helping medical practitioners in private practice and the NHS. To discuss your financial plans, call Cavendish on **020 7636 7006.**

Simon Bruce
Managing Director of Cavendish Medical
For and on behalf of Cavendish Medical Ltd

www.cavendishmedical.com



Surgical Indemnity Scheme
SIS

WRITING MEDICAL REPORTS

Medical reports may be required in a variety of circumstances. For instance, by your NHS Trust following a significant event; for the coroner or procurator fiscal following an unexpected death; for solicitors pursing a personal injury claim following an accident or medical treatment; for the police in the wake of an assault or for a patient's employer or insurance company.

The first consideration is whether you have the necessary authority to disclose confidential patient information. If you have the patient's consent, you can normally proceed, but sometimes you may want to check they are clear about the information you will be providing and why it is necessary. Patients can ask to see reports prepared for employment or insurance purposes before they are dispatched.

Even if you do not have the patient's consent, you can provide a report in some circumstances but, if there is any doubt about breaching confidentiality without justification, always seek advice before disclosing any patient details.

The GMC set out a number of requirements in paragraphs 65 to 67 of ***Good Medical Practice***, which need to be borne in mind:

- You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.
- If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.
- If you are asked to give evidence or act as a witness in litigation or formal inquiries, you must be honest in all your spoken and written statements. You must make clear the limits of your knowledge or competence.

Failing to abide by GMC guidance can result in being the subject of an investigation.

The report should start with details about you: Qualifications, time in post and relevant experience. Next, provide other relevant information about the hospital such as the availability of specialist investigations or the time it takes to get from A to B, or to take a patient to theatre.

Against that background, you can now describe exactly what happened. It's worth taking time to get the report right first time, so review the records before putting pen to paper, amplifying their contents with other details you can remember but never wrote down, and also by reference to your normal practice or the way certain procedures are always done in your unit.

Reports about patients' clinical progress benefit from a brief summary of their past medical history. You should then describe the clinical presentation, with details of the history and examination; the impression formed and subsequent management including investigations, referrals to other specialists and other arrangements made for the patient. The report should set out events in chronological order with specific times stated where possible. The chronology is the key to understanding how events unfolded, and is the clearest way to set out the facts.

The report should be detailed. To avoid confusion about who did what and when,

reports should be written in the first person singular. Where other clinicians are involved, it is helpful to give both their name and designation, for example: *"Dr Smith, the medical registrar, performed a lumbar puncture at 8.10 pm"* is clear, whereas *"We performed a lumbar puncture"* raises more questions.

Medical reports should be objective accounts of what has taken place; there is no place for exclamation marks, pejorative comments about others and in particular, the patient. If the patient did something which made matters worse, that clearly needs to be included, but there is no need to add a comment on the wisdom or otherwise of their actions. The same rules apply to the actions of other clinicians; it may be relevant for the report to include the instructions or comments of others, but a factual report should not contain judgments of their competence or conduct.

Most reports simply require a factual account of events. Sometimes you may be asked to express an opinion, for example, on the causation of a particular injury. If so, only comment on matters which lie within your expertise.

Very few medical reports result in the author giving evidence in court but, once the report is written, it is always worth asking yourself whether you would be confident if cross examined on its contents. If not, or you feel vulnerable to criticism for any reason, it's time to get further advice before submitting the report.

Other people may have a vested interest in the content of your report, to bolster their case or to avoid criticism. If you are asked to change your report, you should resist pressure to make alterations which detract from the integrity or accuracy of your report.

Finally, your report should be printed, signed and dated. Keep a copy of the report; legal matters progress slowly so it may be months or years before you need to refer to it again.

Two Medical Reports That Went Wrong

In the case of *Cornelius v de Taranto*, a forensic psychiatrist who had been instructed to complete a medical report for the purposes of litigation obtained the patient's consent to refer her to another psychiatrist for further assessment and treatment. She did not obtain her express consent to disclose her medico-legal report to the second psychiatrist and GP. Mrs Cornelius sued, complaining that there had been no consent for the report to be disclosed to the GP and was awarded damages as a result.

In *Jones v Kaney*, an expert was sued for negligent expert evidence. Mr Jones, a motorcyclist, was hit by a car, suffering physical and psychiatric injuries, and brought a claim. A clinical psychologist prepared an expert report on his psychiatric injuries, concluding that Mr Jones was suffering from post-traumatic stress disorder. The experts for claimant and defendant were ordered to prepare a joint statement on the extent of the psychiatric injuries. The psychologist signed the joint statement, which wrongly recorded that she agreed that Mr Jones had been deceitful in reporting his symptoms and did not suffer from PTSD. As a result, the claim was settled for a significantly lower sum than otherwise would have been achieved. Mr Jones won damages (to make up the shortfall) from his own expert for her negligent opinion.

Dr Gerard Panting
SIS Medico-legal Advisor

coress Feedback

Vascular surgeons, neurosurgeons and other surgical specialists often have to tunnel grafts, lines or drains subcutaneously. Whilst this is a common and routine procedure in most cases, there is significant risk of entering a body cavity, hollow viscus or solid organ if the tunnelling device is inadvertently misdirected or inappropriate force employed. The series of cases reported here remind readers of those risks. “Think before you tunnel”.

We are grateful to the clinicians who have provided material for these reports. **CORESS** is a charity, which encourages surgeons and other theatre staff to submit incident reports where there are lessons to learn. On our website, **www.coress.org.uk**, you will find a reporting form, details of how to report, and further information on how **CORESS** uses confidential reports to educate and to promote safety in surgical practice. Published contributions are acknowledged with a certificate, which can be used in the contributor’s record of continuing professional development. All previous Feedback Reports are published on the website.

Frank C T Smith
Programme Director, on behalf of the CORESS Advisory Board

TUNNEL VISION (1)

(Ref: 143)

A 61 year old man with extensive cardiovascular disease was admitted with sudden onset of bilateral leg ischaemia. Four years earlier, he had undergone axillo-bifemoral bypass for extensive aorto-iliac disease. He was overweight with a rotund abdomen and had previous extensive lower abdominal and right groin surgery in childhood with skin grafting for burns. Emergency MRA confirmed occlusion of the axillo-bifemoral bypass and he was taken to theatre urgently for revision reconstruction.

At surgery, the occluded graft was removed with difficulty, retaining the proximal patent stump of the old graft on the axillary artery. Working from the groins, a tunnelling device was passed proximally via a fresh route from the right groin incision to a small subcutaneous relieving incision just above the costal margin and thence to the right infra-clavicular region where a new graft was attached to the tunneller, and drawn down to the right femoral incision. Proximally the new graft was anastomosed to the stump of the old graft, and distally, onto the right femoral artery. A crossover limb was fashioned from the main body of the graft to the left femoral artery via a small separate lower abdominal incision. Incisions were closed and the patient returned to the ward.

Initially the patient made a good recovery with well-perfused legs. However, at 48 hours he complained of abdominal pain and distension. Bowel sounds were present, but an abdominal X-ray revealed free gas in the abdomen. The patient was taken back to theatre where laparotomy revealed that the axillo-right femoral graft component had been inadvertently tunnelled intra-peritoneally, directly through the proximal transverse colon which was adherent to the anterior abdominal wall. The bowel was neatly sealed around the graft with no evident abdominal faecal contamination. I asked my on-call general surgical colleague to attend briefly to ratify my decision to remove the graft, and undertook a temporary defunctioning transverse loop colostomy at the level of the bowel injury. Groins were washed out with copious hydrogen peroxide and saline and a new axillo-bifemoral graft constructed using the contralateral axillary artery as the inflow source. The patient made a satisfactory but protracted recovery, but has not had his colostomy reversed yet.

Reporter’s Comments:

Neither the registrar nor I were aware of penetration of the abdomen by the rigid metal tunnelling tool which has a pointed but blunt olive at its tip. Inappropriate force was not employed and by the level of the costal margin the tunneller, having skewered the bowel, had re-emerged into the subcutaneous plane. Factors contributing to the peritoneal breach and bowel injury included scarring in the groin from previous burn surgery which made it difficult to direct the tunneller; the relatively acute angle of the abdominal margin above the groin due to the patient’s habitus; and intra-abdominal adhesions resulting in attachment of the transverse colon to the abdominal wall. Vascular surgeons regularly tunnel grafts and this case highlights the need to maintain vigilance at all times to ensure that inadvertent injury to adjacent structures is not caused by careless use of an invasive instrument.

CORESS Comments:

This is a detailed account of an ever-present danger which may occur when traversing tissues blindly with a rigid instrument. Operator awareness of the risks is the key to avoiding this complication. In the presence of a clean perforation of the bowel with no faecal contamination, bowel repair may have sufficed, with placement of a new arterial graft. Although not always feasible, tunnelling from “north to south” may reduce risk of this type of injury.

TUNNEL VISION (2)

(Ref: 144)

A female child was born pre-term and suffered with a Grade 4 intra-ventricular haemorrhage. This was monitored clinically and with serial ultrasound scans of the head, but at six weeks it was noted that head circumference was increasing and the child was becoming symptomatic with poor feeding and irritability. The child was referred for a neurosurgical opinion. CT scans revealed ventriculomegaly and it was decided to place a ventriculo-peritoneal shunt to decompress the cerebral ventricles. This was carried out, as per unit practice, by a Consultant Neurosurgeon at the beginning of the operating list. The procedure was apparently uneventful and the patient returned to the ward after recovering from the anaesthetic. That evening some bogginess was noted around the wound and a simple head bandage was applied to good effect.

Overnight, the patient remained stable but on the ward round the following morning, 'surgical crepitus' was noted on palpation of the neck and scalp. X-rays were immediately undertaken to exclude pneumothorax or free gas in the peritoneum. A small pneumothorax was detected and a chest drain was placed. Free gas was also noted below the diaphragm on erect abdominal x-ray. The paediatric surgeons were consulted and an exploratory laparotomy was performed which revealed that the distal ventriculo-peritoneal shunt tubing cleanly transfixed the transverse colon. The shunt system was removed, an abdominal drain was placed. The bowel damage was repaired by direct closure of the colonic perforations. The child subsequently developed a ventriculitis which was successfully managed with intrathecal antibiotics. Finally, a replacement venticulo-peritoneal shunt was placed in-situ. The child is now making a good recovery.

CORESS Comments:

As in the previous case, care must always be taken when tunnelling through tissue planes blindly. Early recognition of the complication facilitated early correction in this case. A high index of suspicion should be maintained for potential injuries following this type of surgical manoeuvre.

TUNNEL VISION (3)

(Ref: 146)

A 73 year old man, who had undergone an aorto-bifemoral bypass for bilateral iliac artery disease and debilitating claudication four weeks previously, presented with blood streaked stools on defaecation. Proctoscopy was normal, but sigmoidoscopy revealed a length of Dacron graft passing though the lumen of the distal sigmoid. Laparotomy was undertaken (***Figure 1***).The left limb of the aorto-bifemoral graft was excised and the sigmoid exteriorised temporarily as a loop colostomy. The remainder of the arterial graft appeared well incorporated into surrounding tissues, so the proximal stump of the left limb of the graft was oversewn, and after careful groin wound irrigation, right to left femoro-femoral cross-over bypass was undertaken. The patient was maintained on long term antibiotics, but made an uneventful recovery.

Reporter's Comments:

At surgery, the initial vascular graft was tunnelled from the aorta to the left groin with the aid of a Roberts' arterial clip. This must have inadvertently pierced the sigmoid colon and the graft was tunnelled directly through the wall of the colon with a good seal which prevented faecal leakage and peritonitis. The risks of using forcible rigid devices blindly, as an aid to tunnelling a passage for a conduit, are self-evident. The patient was lucky to have avoided overt septic complications and peritonitis, although long term graft infection remains a risk.

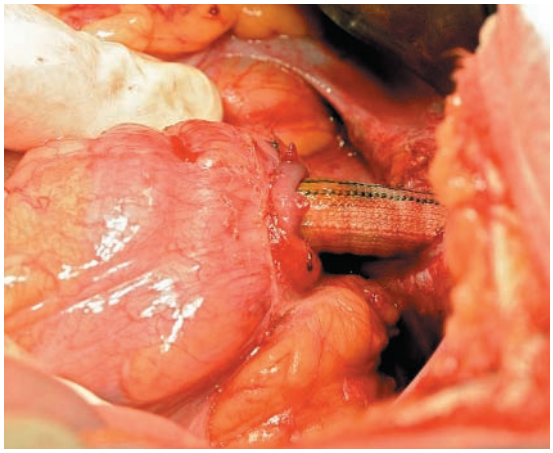


Figure1: Dacron graft penetrating sigmoid colon as seen at laparotomy.

TUNNEL VISION (4)

(Ref: 148)

A 75 year old man with debilitating left thigh, buttock and calf claudication underwent right to left femoro-femoral bypass for a long left iliac artery occlusion, not amenable to angioplasty. The graft was tunnelled over the pubis using a long arterial clip. Post-operatively he made a satisfactory initial recovery but was noted to have developed frank haematuria which was evident in the urine collection bag on the morning after surgery. The urinary catheter was removed and early cystoscopy revealed a Dacron graft passing through the vault of the bladder. The graft had been inadvertently tunnelled through the bladder whilst trying to avoid scar tissue from a previous midline laparotomy scar.

CORESS Comments:

The lessons learned from the previous cases apply equally to this case.

The Back Page

Association of Surgeons of Great Britain and Ireland

T·M·Lewin Spring Crossword Puzzle

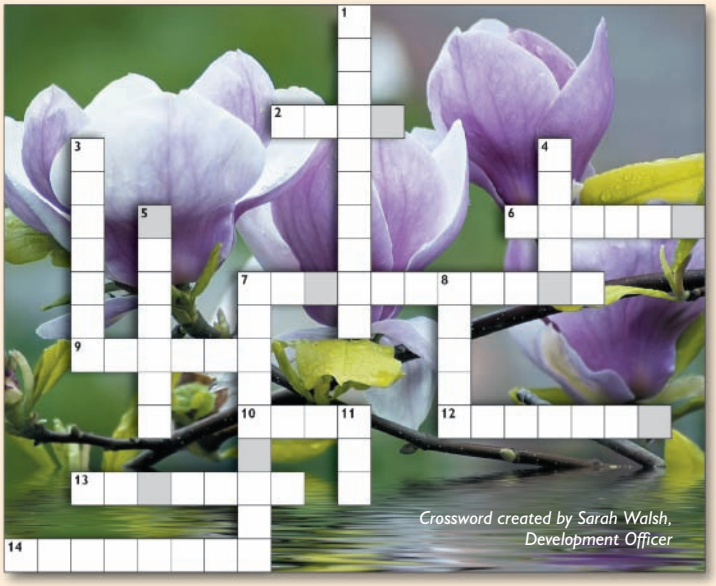
Spring into action with this seasonal crossword! Simply complete the grid below and spell a word from the letters in the shaded boxes. Send an email with your answer to **sarahwalsh@asgbi.org.uk** for the chance to win five shirts from T. M. Lewin's 2013 spring/summer collection. Entries must be received by 5.00pm on Friday 19th April. A winner will be selected at random from all the correct entries received. Good luck!

Across:

2. For every item borrowed is an item… (4)
6. Thrice an emergency (3, 3)
7. Inundated for a month (5, 6)
9. Holiday to celebrate birth and death (6)
10. You are young and mild-mannered (4)
12. Yield to hunger (7)
13. Sun and moon represented equally (7)
14. Wordsworth wandered lonely as a cloud (8)

Down:

1. A man whose death is marked; the birth of a hillock remembered (5, 5)
3. Dessert to deplete (7)
4. Sometimes viscous, somewhat less prosperous than a dragon (5)
5. Mother Earth's flourish (7)
7. Diarized trick (5, 4)
8. Contrive to lay (5)
11. A short friend (3)



JASGBI IS PUBLISHED BY

Association of Surgeons of Great Britain and Ireland
35-43 Lincoln's Inn Fields, London, WC2A 3PE
Tel: 020 7973 0300 • Email: admin@asgbi.org.uk • Web: www.asgbi.org.uk
A Company Limited by guarantee, registered in England: 6783090. VAT number: GB 944 3070 34