Journal of the Association of Surgeons of Great Britain and Ireland

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EDITORIAL

David Rew
Director of Communications

Welcome to the June issue of ***JASGBI***, the newsletter of the Association of Surgeons. This is the second issue in our new, electronic only format, which has been well received and which affords us a whole new range of publishing capabilities. Please continue to let us know what you think about it, and how we can further improve our communications with you. As usual, we seek to carry a wide and eclectic range of articles of general interest to practising surgeons, and we are most grateful to our regular, new and occasional contributors.

The Association continues to grow from strength to strength, and our recent annual Congress in Harrogate attracted the largest ever attendance, with some 1,400 delegates over the four days and the various partner meetings, including the International Congress on Surgical Education and Training (ICOSET), the Association of Trauma & Military Surgery (ATMS), the section of surgery of the European Union of Medical Specialists (UEMS), the Surgical Outcomes Club of Great Britain and Ireland (SOC-GBI), the National Cancer Research Institute (NCRI), the International Surgical Leaders Forum, the Association of Surgeons in Primary Care (ASPC), and the UK Medical Students' Association (UKMSA). Our gratitude goes to Gordon Carlson in particular, as Director of our Scientific Programme, for his hard work in putting together a sparkling academic and educational portfolio of sessions and speakers, and for heroic coordination of the submitted papers and abstracts.

Our appreciation also goes to Nick Markham, as Director of Informatics, for his foresight and vision in leading us further into the electronic future with our first ever Paperless Congress, in partnership with SpotMe, our independent service provider. There are considerable advantages to this approach, and most delegates were able to access the content of the Congress on their own electronic devices with ease. This has proved to be a very valuable learning experience in a model to which we are now committed. We will continue to explore how best to improve upon the model in future years in the most cost effective and technically attractive format.

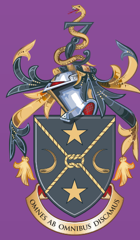
Congresses are an essential component of the professional Circle of Life. They allow us to break out of our personal employment silos and straightjackets, to meet colleagues from around the country, and to listen to and interact with a stellar cast of speakers on a broad range of subjects. For our younger members, it affords them an opportunity to present their work on a larger stage and to develop the important skills of public communication before a friendly and empathic audience.

The major Congress venues also afford a unique opportunity for a diverse collective of Subspecialty Associations and special interest groups to come together, and to reap the benefits and economies of scale and concentration which are lost in single specialty meetings. For this reason, we have been delighted to welcome the ATMS and many other groups on a regular basis to share our conferences.

Great Britain and Ireland are blessed with a diverse spectrum of thriving Surgical Subspecialty Associations, each of which value their operational and congressional independence. Regrettably, this independence leaves UK Surgery plc in a much weaker political position than it need be, as our paymasters and political masters do not always see clearly with whom to deal on matters which concern us in the workplace.

Moreover, the costs and timetabling of the various subspecialty conferences are now such that most working surgeons are unable to attend more than a small fraction of the annual meetings on offer (and usually only one). This problem is particularly acute for our juniors, for who time off work and financial support are increasingly difficult to secure.

Over Christmas 2013, I was a privileged guest of the Annual Congress of the Association of Surgeons of India,



EDITORIAL

which brought together some 7,000 delegates from regional and subspecialty associations in a single major venue in Ahmedabad in Gujarat. A striking feature of the meeting was the attendance of crowds of trainees at the educational, exam preparation and career development sessions, while the short paper sessions were relatively sparsely attended.

The conjugation of modern technology and such evidence of the continued enthusiasm of trainees for high quality didactic education thus suggests a way forward for future UK surgical congresses, founded on closer cooperation between the General and Subspecialty Surgical Associations, and placing greater emphasis on teaching curriculum content to large audiences of trainees at major venues within a framework of a UK National (General) Surgical Week. Such a venture would secure economies of scale, contain costs and ensure much greater attendance and interaction between subspecialty groups. The Subspecialty Surgical Associations will understandably defend their independence in such matters, but members will have a view on the pros and cons of an annual "National Surgical Conference Week" which you may wish to communicate to us and to the Executive Boards of our sister Associations.

For our own part, as custodians of the General Surgical Curriculum through the SAC for General Surgery, under the leadership of Gareth Griffiths and Rowan Parks as Director of Education, we will explore a range of models to deliver didactic curriculum and career advisory content through electronic media, through our publications, informatics and communications strategy, and at the ASGBI Congress and subsidiary meetings. We hope that these new models will prove attractive and engaging for members of the Association at all stages in their career, but particularly for those in their formative years who are the bedrock of the future of UK Surgery.

Your Executive Board continues to debate a wide range of subjects and issues of interest and importance to our members, and to organise the affairs and finances of the Association in a responsible and commercially disciplined manner. We will continue to explore methods for delivering membership benefits consistent with our organisational structure.

We are also delighted to continue to support the international educational work of our charitable arm, the Surgical Foundation, and to promote the work of surgeons overseas through initiatives such as Lifebox. We will continue to seek to advance safe surgical practice through initiatives such as the Surgical Outcomes Club and the work of CORESS.

We keep a close finger on the pulse of change in the Professional Workplace, and in particular, we note the impact of the introduction and development of Emergency Surgeon Consultant posts. Iain Anderson has done sterling work in this field as our Director of Emergency Surgery. We are also grateful to Ajay Kakkar as our Director of External Affairs for his sage advice and observations from his privileged viewpoint of national and international matters from the House of Lords, where he has secured a growing reputation and respect as a hard working and influential Peer; and from his seat on the General Medical Council.

We will continue to seek maximum engagement and harmony with our sister Subspecialty Associations through our Council Meetings, and through the valuable work of our Regional Reps, who double up as Regional Subspecialty Advisors for the Royal College of Surgeons, and who play a significant role in supervising and moderating new consultant job descriptions. We also continue to engage with the wider surgical community through the work of the Federation of Surgical Subspecialty Associations, the FSSA, at the Royal College of Surgeons.

We are very conscious of our unique and privileged role in British and Irish Surgery in representing a diverse and dynamic community of surgeons across national boundaries, to whom we remain committed. We also draw your attention to the opportunities to work for the Association at Council and Executive level, with advertisements carried in this issue of the ***Journal*** for new Directors of Finance and of Professional Affairs, and for a Vice President to succeed John Moorehead at the end of 2014, as John takes over the Presidential Chain of Office from John Primrose.

Finally, we are grateful for the loyal commitment and hard work of our office and administrative team, under the able direction of Nick Gair; and for the unsung work of former Executive Board Members and Presidents of the Association in advancing the interests of the members, notably John MacFie in leading the Association's Honours and Awards Committee.

My own plea, as ever, is for material of interest to the ***Journal*** for the education, information and entertainment of you colleagues. Summer is upon us. Enjoy!

David Rew
Director of Communications

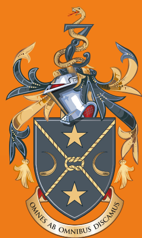
Education & Innovation

HIGHLIGHTS FROM THE 2014 INTERNATIONAL SURGICAL CONGRESS

of the Association of Surgeons of Great Britain and Ireland

Harrogate International Centre

Tuesday 29th April to Friday 2nd May



Education & Innovation

2014 INTERNATIONAL SURGICAL CONGRESS

ASGBI 2014 INTERNATIONAL SURGICAL CONGRESS, 30th APRIL to 2nd MAY, HARROGATE

A report by Professor Gordon Carlson Director of the Scientific Programme, ASGBI

Buoyed by the success of last year's Congress in Glasgow, held jointly with the Association of Trauma & Military Surgery Conference, ASGBI returned to the Harrogate International Centre for the 2014 International Surgical Congress, entitled *"Education and Innovation"*.

The collaborative format of last year's meeting proved so popular that we decided to expand it further; this year's Congress was held in parallel with, and also coordinated closely with, the International Conference on Surgical Education and Training (ICOSET), the Association of Trauma & Military Surgery Conference and the conference of the United Kingdom Medical Students' Association. We also welcomed the Surgical Outcomes Club of Great Britain and Ireland and the Association of Surgeons in Primary Care, who both held workshops and supported sessions over the three days.

With the additional attraction of keynote lectures supported by all four Surgical Royal Colleges, the American College of Surgeons and the British Hernia Society, and a taught course hosted by the British Journal of Surgery, this year's congress represented a bold attempt to provide a varied and attractive selection of high quality opportunities for continuous professional development.

And our delegates obviously agreed; the programme generated considerable interest and a record number of abstracts (nearly 1,500) were submitted. Over 1,300 delegates attended this year's congress, a record in recent years.

The Congress represented a first for the Association, with the decision to present an almost entirely paperless meeting, something that was only finalised a few months before the event. Nick Markham, Director of Informatics, and ASGBI office staff worked

Professor David Greenaway delivering his talk

furiously to make the Paperless Congress App work seamlessly for delegates, allowing them to see and comment on posters, feedback directly to presenters, and vote, in real time, on questions put to the audience during live sessions. Going "paperless" proved a little alarming at first, but delegates rapidly got used to using the App and found that it allowed a much easier, more interactive and enjoyable conference.

After initial ICOSET sessions on the Tuesday, the ASGBI programme formally got underway on Wednesday 30th April with a symposium looking at the role of surgeons as innovators, including advances in hand transplantation, intestinal lengthening, organ preservation and intraperitoneal chemotherapy.

The formal Welcome Lecture, delivered by the Rt. Hon. Andy Burnham MP, Shadow Secretary of State for Health, was followed by Atul Gawande, surgeon, award-winning author and inventor of the WHO safer surgery checklist. Atul had arrived in the UK only the night before and the Association was fortunate indeed that he was able to join us, albeit briefly. He gave the audience a spellbinding account of his personal journey in support of safer surgery then, honorary fellowship under his arm, leapt into a taxi for Manchester airport, where he caught a flight to Delhi the same day.

The opening day concluded with two symposia; a debate on the Greenaway "Shape of Training" review was led by Professor Greenaway himself, with closing words of caution from Professor Richard Reznick (Ontario), who highlighted potential concerns regarding the consequences that some of the proposed changes might have for the training of future surgeons. A fluid therapy symposium presented areas of controversy in perioperative fluid management and highlighted the recent NICE guidance in this area, as well as identifying areas of uncertainty, including optimal management of perioperative oliguria. Once again, the Association was able to attract internationally recognised speakers in this area, including Professor Can Ince (Amsterdam), Dr Mike Stroud (the Chairman of the NICE working party) and Mattias Soop (Auckland and Manchester).

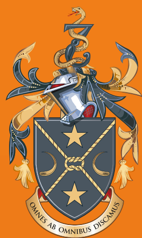
Thursday's programme was no less ambitious. A symposium on the management of anastomotic leakage (paving the way for publication of collaborative inter-specialty association guidelines next year) was followed by the BJS Travelling Fellowship lecture, delivered this year by Professor Reznick, who provided a thought-provoking overview of the state of surgical training in the UK.

The emphasis on patient safety subsequently continued, with some of the themes described by Atul Gawande the previous day being discussed by an expert panel from CORESS, the Never Events Task Force, the World Health Organization and Sir David Dalton, a Chief Executive of one of the "safest" NHS Trusts in England. The Helen Rollason Memorial Lecture was delivered by Professor Takeshi Sano from Japan, who continued the education and training theme with an analysis of training in gastric cancer surgery.

Professor Takeshi Sano delivered the Helen Rollason Memorial Lecture

After lunch there was the usual hot competition for the Moynihan Prize, with six papers of excellent quality, subjected to detailed (and, at times, rather hostile) scrutiny by the audience, who eventually judged the winner to be Mr Sreekumar and colleagues from Southampton, for their paper *"SIP1 induced activation of nucleotide excision DNA repair pathway mediates chemoresistance in colorectal cancer."*

A session on optimal perioperative care, including a lecture on perioperative feeding by Dr John Drover (Ontario) and an outstanding and detailed overview of advances in abdominal wall reconstruction, presented by Professor Mike Rosen (Case Western University, Cleveland), took delegates to the eagerly anticipated Hot Topic session.



Celia Ingham Clark and Professor John MacFie getting serious during the Hot Topic debate

This brief (and heated) topical debate is rapidly establishing itself as a firm favourite of delegates, and this year's Hot Topic, *"Seven Day Elective Surgery - Essential Efficiency or Cynical Spin?"* was no different. The main auditorium was full as Celia Ingham Clark (National Director for Reducing Premature Deaths) presented the case for provision of a 24/7 elective surgical service, and Professor John MacFie countered that the proposal is unnecessary and unaffordable. Celia put forward a strong argument for extending elective surgical services and utilising currently unused theatre time. However, she had her work cut out. The audience had already expressed, at the commencement of hostilities, a considerable degree of scepticism with Tweets from the audience, broadcast at the conclusion of the debate courtesy of the Congress App, that the proposal would require a significant further financial investment that was unlikely to ever materialise, and principally reflected a cynical attempt by the government to persuade the public that they could be offered "more healthcare for nothing", then hold the medical profession responsible for failing to do so. The audience not only remained unconvinced, but veered further to Professor MacFie's side in the debate.

The final day of the Congress was no less eventful and commenced with symposia on screening for surgical disease and the interface between surgical care in the community and the acute hospital, followed by sessions on improving surgical outcomes and the role of laparoscopy in emergency surgery. The session on improving outcomes was especially well-attended, with delegates taking the opportunity to hear Professor Carol Peden explain how the data gathered in the National Emergency Laparotomy Audit (NELA) might be used to improve outcome in a clinical setting where there are huge differences between individual units, with reported mortality varying between less than 10% and over 25%.

The ever-popular Meet the Surgical Experts session proved enormously popular last year, and a considerable amount of additional space had been allocated to it for this Congress. The session allows interactive discussion in small groups, an ideal and relatively informal environment for exploring areas of current controversy, as well as discussing individual cases. Delegates were able to get "up close and personal" with internationally recognised experts in oesophagogastric, colorectal, pancreaticobiliary and breast surgery as well as abdominal wall reconstruction and perioperative care. Feedback has again been universally extremely positive and this session seems likely to remain a Congress fixture for the foreseeable future.

The final symposia at the Congress, Bad Day on Call and Challenges in Data Collection and Risk Adjustment had been positioned in the programme to ensure that the Congress finished on strong and topical note. The Bad Day on Call session looks set to become a firm ASGBI favourite and was chaired by the ASGBI Director of Emergency General Surgery, Iain Anderson, and the Vice President, John Moorehead. Delegates heard practically relevant talks on trauma laparotomy and complicated peptic ulceration, and were updated on the National Emergency Laparotomy Audit. Professor Jonathan Fawcett, joining us again from

Brisbane, spoke on the use of topical haemostatic agents in the abdomen.

Delegates who attended the symposium on data collection and risk adjustment heard from Roger Taylor (Research Director at Dr Foster) and Jan van Der Meulen of the Clinical Effectiveness Unit of the Royal College of Surgeons of England, who spoke on the problems of ensuring that data collected to inform national audits are accurate and risk adjusted. For those of us at the "sharp end" of these audits, Paul Finan (ACPGBI) and Richard Hardwick (AUGIS) described the considerable problems that subspecialty organisations had faced in the publication of audit data. Once again, delegates at the ASGBI Congress learned that, although individual surgeons' outcome data may be accurate, they have very limited relevance for the profession or, more importantly, the public. The volume of individual activity is simply too low, the variability too great and the risk adjustment too imprecise to allow meaningful reassurance or, for that matter, concern.

It would be remiss of me not to mention the huge contribution made by delegates with regard to the scientific quality and content of this year's Congress. There were no less than 321 oral presentations and 671 posters presented, many of them of exceptional quality and clinical and educational significance. Contributors were able to view, comment on and rate posters much more easily this year because of the electronic format used for poster presentations and the Congress App.

If the standing of any society can be judged by its congress, then ASGBI has little to worry about; the 2014 Congress seems to have been a huge success. It has been the biggest Congress we have had for many years and one of the first paperless meetings held in the UK. We welcomed delegates from all over the world, to hear keynote speakers from North America, Canada, and Australasia talk on topical, controversial and practical issues of relevance to surgeons in all phases of their careers.

Your Scientific Committee is already working on next year's Congress, which will return to Manchester. The collaborative nature of our future events is set to continue and, in addition to our usual partners, we look forward to working with E-AHPBA (the European-African Hepato-Pancreatico-Biliary Association) to produce a truly world class programme. We hope to be paperless again next year, which will leave more room in your bag for your umbrella!

The Executive and Guests supper at Ripley Castle, Tuesday 29th April
Photograph taken by Professor Takeshi Sano (Cancer Institute Hospital, Tokyo)

A REPORT ON THE PAPERLESS ASPECT OF THE 2014 ASGBI CONGRESS

Nick Markham
Director of Informatics, ASGBI

ASGBI dived boldly into unchartered waters in Harrogate in April 2014. The whole of its International Surgical Congress was conducted using hardly any paper, relying almost exclusively on electronic media. ICOSET (International Conference on Surgical Education and Training), ATMS (The Association of Trauma & Military Surgery) and UKMSA (United Kingdom Medical Students' Association) were also running their conferences in parallel and they too benefited from this new paperless world.

Why did we do it?
Almost all of the mountains of paperwork normally associated with the Congress gets thrown in a bin within a very short space of time; archived material needs storage space; staff need hours of time to print off, package and distribute shed-loads of paper – and need to overestimate requirement for fear of being caught short with not enough to go around. The vast majority of delegates arrive with electronic devices of varying sorts – smartphones, tablets and laptops – and these devices can hold within them almost everything we print on paper in an electronic form. The arguments for going green were irresistible.

The European Society of Organ Transplantation (ESOT) had held a paperless conference in Vienna in September 2013, and had managed the whole process extremely efficiently. It was time for ASGBI to do its bit and venture bravely into the future.

How did it all work?
The whole process was based on an App (provided by a company called SpotMe), which could be downloaded onto an array of different smartphones and tablets. Within the 'dynamic' App, which was constantly being updated as new information and data became available, delegates could access a vast array of information. This included:

- **A 'Welcome Message' video from the President**
- **The Scientific Programme 'at a glance'**
- **A detailed Programme**
- **Oral and Poster Abstracts (searchable by topic, author etc.)**
- **DVD Prize entries**
- **Biographies**
- **Author index and list of attendees**
- **Corporate Patrons' and Exhibitor details**
- **Library of documents (AGM, meeting minutes, lists of prizes and fellowships etc.)**
- **General information, including maps, social arrangements**
- **Twitter and Facebook interaction facilities**

In addition, delegates could send a message to anyone else at the congress or request a meeting with them. Notes could be made about sessions, individual presentations, authors or exhibitors. They were able to select sessions for inclusion on their own personal schedules, and select any page from the App for inclusion in their virtual 'Briefcase', so that important relevant data could be collated in one place.

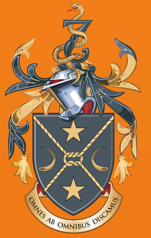
Another exciting development was the ability to vote electronically at selected sessions – moderators of those sessions were able to gauge audience opinion about certain areas of possible controversy – an exercise which, if done at the beginning of a session and again at then end, would allow comparison and an ability to see whether the talks had persuaded opinions to change!

Surveys were commissioned throughout the Congress, seeking delegate opinion about individual issues whist they were fresh in the mind, as opposed to perhaps many days after the finish of the event.

So, what happened?
Electronic glitches were seen on a very few occasions, but on the whole the wheels turned very smoothly indeed, with delegates impressed at the way pretty much everything they needed was available to them at the swipe of a screen or tap of the finger. Those who came without an appropriate device were able to rent an iPad for the duration, but in practice this happened far less than we anticipated – about 25 iPads were used from the stock that SpotMe provided.

What was noticeable was the lack of almost any paper anywhere – the litter bins contained discarded coffee cups but little else. There were no delegate bags, and little need for writing implements. Delegates' badges could be scanned through the App, to enable contact details to be swapped. Overall, the atmosphere was one of a buzz of excitement as people began to appreciate the benefits of this new digital age.

Things learned...
Dissenters and refuseniks were rare - many perhaps arriving as very sceptical but being rapidly won over once they saw how easy and beneficial it all was. The same sort of mood probably heralded the advent of PowerPoint facilities amidst the moans of those clinging rigidly to their carousels of 35mm slides. Times



changed rapidly then – one senses the same will be true for paperless conferences.

We came with many more iPads for distribution than we eventually needed – the likelihood that delegates will not already have a suitable device in the future must be diminishing all the time, and we will know better for the next Congress.

The presentation of all posters was also done electronically; large plasma screens allowed excellent views of high resolution posters, but as there were not enough screens to allow one for each, several were placed on each screen and individual posters appeared in rotation. The lack of ability to force a screen to display a particular poster was a disadvantage – we will sort that out for the future.

No going back?

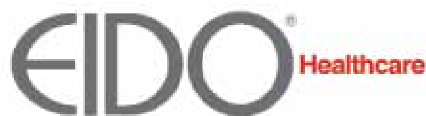
Whilst there are always ways to improve, no one seriously feels we can now go back to paper, having experienced the delights of the delivery of a top-class Congress in a digital format. The world moves on, and ASGBI, having dipped its toes in the water, has inevitably got to go for full immersion henceforth. We have glimpsed the Promised Land (or actually had some extremely good views of it) and there is no reason to turn back.

Acknowledgements

Paperless it may have been, and many hours previously spent printing and distributing huge stacks of literature were undoubtedly avoided, but that does not mean that a great deal of work did not go on behind the scenes. The ASGBI office staff were monumental in the work they put into the App, and I would like to give special thanks to ASGBI's Development Officer, Sarah Davies, for her project management skills and the large amount of time she dedicated to making sure the App was ready for Harrogate. The expertise and guidance of SpotMe and their personnel was also invaluable. Lessons learnt, we eagerly anticipate moving forward to doing it all even better next year. Come and join us!

Association of Surgeons of Great Britain and Ireland

ASGBI is grateful for the generous support of the following Corporate Patrons



TUESDAY 29th APRIL

UEMS SESSION

ANNOUNCING THE NETWORK OF ACCREDITED SKILLS CENTRES IN EUROPE (NASCE)

Anders Bergenfelz and Paul F Ridgway, on behalf of NASCE

At the recent conference in Harrogate, the Network of Accredited Skills Centres in Europe (NASCE) programme was announced. NASCE is the European Union of Medical Specialists' (UEMS) sponsored initiative to network and accredit skills centres within the European Union and its affiliates. With its origins in the surgical section of the UEMS, the NASCE project has grown since the planning phase in 2012, to be a ratified multidisciplinary joint committee (MJC) within the UEMS governance framework. This MJC encompasses the wish to network centres, with focuses not only on General Surgery, but also including Anaesthesia, Cardiology, Opthalmology, Orthopaedics and Gynaecology and Obstetrics among others. In all, 12 sections of the UEMS have so far signed up to the programme.

The roots of the NASCE programme are in the need to regularise and validate simulation-based training. The debate about the need for simulation-based training has moved from whether it is efficacious, to defining its role in healthcare training. Simulation now has specific uses in many undergraduate and postgraduate curricula. Large amounts of resources and money are being heterogeneously applied by various medical jurisdictions to skills training. This is in a relative vacuum without robust international standards or fora, where dissemination of innovative validated techniques can be readily achieved. Across Europe, there are wide variations in the application of simulation and availability of skills centres. The centres themselves range from a single room in a hospital, open for part of a week with low fidelity simulators, to supra-regional centres dealing with a variety of disciplines utilising high cost, high fidelity simulation. There is a need to support the whole range of these centres as each fulfils important, different purposes within the healthcare training environment.

The initial plan was to have three standards of skills centres to be suitable for accreditation. While the smaller focused centres will be catered for in time, the first call for NASCE seeks to accredit two centre types: **Multispecialty format and Single Specialty format**. A transparent, robust statute and governance framework has been placed around the organisation after an international consultation process lasting 18 months. All documents are available online at the NASCE tab on **www.uemssurg.org**.

NASCE principles are based around the wish to facilitate excellence in delivery of skills training across Europe within a modern, fit for purpose accreditation association. It is predominately centre based accreditation. There are other processes within UEMS for accrediting content so NASCE's major focus is around minimum standards for effective delivery of simulation in training. There are several uses of NASCE accreditation for the centre. The process of going through accreditation will allow the centre's organisational tier a chance to forensically examine their processes, identifying areas of strengths, weaknesses, opportunities and threats. While this is a useful process, particularly matching their units up against internationally developed standards, what has those of us involved in NASCE most energised is the ability of the resultant growing network of centres to gain and disseminate techniques and innovations with outcome data. This sharing of experience is a cornerstone of the network and will populate the yearly fora with the scientific endeavour, as well as evolving NASCE as its members see fit over time.

The process for accreditation is now open, with details on the above website. It is transparent and standardised, after the European consultation process hosted by the UEMS. The accreditation period lasts for four years. The process involves international survey of the centre under specified headers which include governance, administration, competencies, teacher attributes, research and development. The difference between the two levels of accreditation is predominately around the learners, those that are trained through the centre. The Multispecialty format will have many disciplines catered for, while the Single Specialty format, although no less important, will have single disciplinary focus with streamlined governance and administration requirements.

Although technological innovation has proceeded in day to day life at a pace, the diffusion of innovation of simulation in medical training has been slow over the last two decades. There has been a lot of literature reinventing or finessing the wheel. NASCE represents a potential for Skills Centres to accredit their processes, have objective international data to take to their funders regarding development and participate in a network which visibility of the marriage of innovation with pragmatic learner-centred outcomes. Those of us involved in the initial development of NASCE are very excited at the possibilities that the programme offers to the wider community of healthcare trainers. We hope you will consider growing NASCE with us by submitting your unit for the accreditation process. NASCE is now open through **www.NASCEnet.org**.

WEDNESDAY 30th APRIL

INTERNATIONAL DEVELOPMENT SESSION

THE BENEFITS OF SURGICAL VOLUNTEERING

Frank McDermott, IDC ASiT representative

Fanus Dreyer, IDC Chair

The International Development Committee (IDC) of ASGBI contributes significantly to humanitarian surgery initiatives in low income countries, where it works very closely with local surgeons. A major component of the IDC's global surgery contribution is in teaching and training in Africa, mainly through running training courses, always on invitation from local surgical trainers through the West Africa College of Surgeons (WACS), the College of Surgery of East, Central and Southern Africa (COSECSA) and/or national surgical societies. An essential component of such training is that surgeons join projects as volunteers, often taking time as annual leave and paying some expenses from their own pockets. The IDC has always had trainee members and has always supported surgical trainees from the UK to join surgical volunteer missions whenever possible and practical. The ethos and rules around volunteering from the NHS is going through a period of change after publication of the All Party Parliamentary Group (APPG) on global health's publication of their views on the benefits of volunteering, and the development of a toolkit to support medical volunteering overseas (see Brenda Longstaff's contribution below for detail).

The IDC, therefore, used its one session at the 2014 ASGBI Congress to discuss the benefits for surgical volunteering, and some key lectures are summarised in this article. Firstly, Dr Jaymie Ang Henry, who has trained in surgery, worked for the WHO, and now lectures in global surgery at Berkeley College of the University of California, writes about the ethos and personal value of volunteering. Thereafter follows a contribution by Brenda Longstaff, international programme manager at Northumbria Healthcare NHS Foundation Trust, about the evidence for the benefits of volunteering. Thirdly, four trainees who have joined a variety of volunteering projects give short summaries of their trips and focus on what they have gained from it both personally and professionally.

PERSPECTIVES ON VOLUNTEERING: CONTEXTUALISING SURGICAL CARE DELIVERY

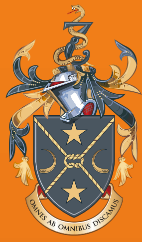
Jaymie Ang Henry
Founder, Executive Board Member and Executive Director of the International Collaboration for Essential Surgery (ICES)

Surgical volunteering
There has been increasing interest among surgical trainees and fully trained providers in volunteering for surgical care delivery opportunities in low income countries (LICs). This interest has been facilitated by the growing literature on global surgical need and the awareness on seemingly insurmountable challenges that LICs face.

The reasons for volunteering with opportunities for surgical care delivery can vary. We have a genuine desire to help other people. Others feel a certain responsibility to society, to 'give back,' while others feel it is the right thing to do as a matter of equity and social justice. For others, some emotion, accompanied by a poignant experience or a story, might have motivated them. On the more practical side, some people might simply have been invited to an event, or might have gone along with friends as a matter of activity and have found the experience rewarding. Professionally, volunteering for surgical missions in developing countries, where surgical pathology is varied, innumerable patients are not wanting, and the opportunities for hands-on work abound, seems a worthwhile investment in one's education and training. Indeed, a survey on surgeon volunteers found that international surgical experiences fulfilled the six US Accreditation Council for Graduate Medical Education (ACGME) competencies of compassionate, appropriate and effective patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice [1].

While the enthusiasm and energy directed to these efforts must be sustained, there is a need for directing this compassion into a more powerful force: compassion with competence. Growing up in a developing country with more than a decade of volunteering and observing the effects of indiscriminate charity and aid, I have come to distil the lessons I've learned into some basic tenets. Always, my thought is to extend effective energy to drive sustainable change from the ground up.

Know before you go: Clarify your real motive
It goes without saying that having a clear objective of why you chose to volunteer is essential to become more effective, to identify appropriate partners, to avoid confusion, and to



choose the opportunity well. A myriad of opportunities calls for discernment on the best ones. As surgical trainees and practitioners, two types of opportunities exist: volunteering for short-term missions or long-term capacity-building projects. Short-term missions last from three days to two weeks, involve operating on prescribed surgical cases, and have some to very little focus on teaching local providers or working with the community on any projects that involve health system strengthening. Long-term capacity building projects have increasingly gained interest, where institutional partnerships between low-income and high-income countries focus on building educational, infrastructural and systemic surgical capacity. Understanding your time commitment, level of expertise, personal passion, and outlook can help you navigate these opportunities where your skill set fits in best.

Primum non nocere

Well-intentioned though we may all be, the truth is that not all voluntary efforts create the optimal outcome [2]. In fact, a hastily put together effort is worse than no effort at all. Not taking into account the actual needs of a developing country puts an already precarious system into more jeopardy as imbalance is created by a lack of planning and awareness of the complicated socio-political, cultural, and economic climate that envelops every country.

It is therefore important to ask yourself some basic questions: *Are we doing actual good or are we doing more harm? Did we spend enough time knowing what the real needs of the situation were? Did the group establish appropriate contact with a local provider? Am I really qualified for the task at hand or do I need appropriate supervision?*

Working on the ground

Now that all the preparation has taken place, the real learning starts once you land and start working. In the same way as when you are learning how to drive, the number of hours spent practicing on empty streets only prepare you for the basics of manoeuvring a car, but getting onto a busy street or a highway is where the real learning takes place.

Listen and be open to what you will find

Surgical care cannot exist without the context of a health system underlying its delivery, which is bound to the particular climate of a country. Access to healthcare has several barriers such as accessibility, availability, cultural acceptability, affordability, and accommodation [3]. These barriers will often be one of the practical challenges you will encounter on the field. The experts at navigating these challenges are the local healthcare providers, especially those who have been working in a facility for decades. Therefore, it is important to listen more than do the actual talking to be able to apply your expertise in the appropriate context. Openness is necessary to achieve a working relationship hand in hand with local partners to achieve sustainable change.

Be fascinated with what you'll discover

In a survey of about 60 volunteer surgeons from 15 different surgical specialties with experience in 71 countries, the benefits of their international experiences ranged from exposure to varied pathology to opening their mind to efficient surgical care with limited resources. Moreover, the benefits extended to personal enrichment, self-fulfilment, and lifelong friendships [1]. In the same way, every volunteer experience is unique and has the potential to create unforgettable memories that can shape the way you practice medicine and relate with your patients. Allow it to happen.

Your expertise can be the best thing you can offer

Once you land on the ground, the complexity of providing surgical care can sometimes overwhelm. Not only does the lack of skilled providers with no dearth of patients who have been waiting for years for surgical care strike you; other more practical concerns such as lack of running water, electricity and basic supplies can present itself. You may be tempted to do everything but it is important to focus on the unique ability you have: your expertise. Technology transfer of medical and research skills takes a focused, concerted effort that may involve years of sustainable effort but expertise is the most valuable asset you can provide.

Facilitate, not dictate

It may be tempting to approach every situation we encounter in developing countries in a proactive, Western mindset where we tend to want to do everything on our own. We tend to 'take charge' and apply the technique and approach we are used to in our own practice. However, this approach does not take into account the different styles of getting things done in the country we are working in. A facilitative atmosphere, while needing more time and patience, builds trust and cultivates local ownership of the project at hand.

Be patient; it takes time to build relationships

Relationships are probably one of the most important treasures you can acquire while volunteering abroad. Making real impact takes time, but the effort invested in supporting talented local leaders will pay off, apart from strong and steady friendship that can last decades.

Have fun

Most importantly, have fun! It is a great privilege to extend a hand through one's expertise and lifelong passion. Paradoxically, we gain more through the time and effort we have given by being energised with the results.

In this increasingly global society, we are becoming more and more like global citizens. We cannot sit still knowing that next door,

simply to be a woman about to give birth or to be a child born with a common deformity, can be a lifelong sentence. We cannot sit still knowing we can do something about it. It takes a bit of thought and preparation to extend compassion with competence but at the end of the day, it is truly worth it.

Follow Jaymie on Twitter: *@JaymieClaire*
www.essentialsurgery.com

References

[1] **Henry J A, Groen R S, Price R R, Nwomeh B C, Kingham T P, Hardy M A, et al**
The benefits of international rotations to resource-limited settings for U.S. surgery residents
Surgery 2013 Apr;153(4):445-54. PubMed PMID: 23274099

[2] **Welling D R, Ryan J M, Burris D G, Rich N M**
Seven sins of humanitarian medicine
World Journal of Surgery 2010 Mar;34(3):466-70. PubMed PMID: 20063094

[3] **Penchansky R, Thomas J W**
The concept of access: definition and relationship to consumer satisfaction
Medical Care 1981 Feb;19(2):127-40. PubMed PMID: 7206846

EVIDENCE FOR THE BENEFITS OF VOLUNTEERING

Brenda Longstaff
International Programme Manager, Northumbria Healthcare NHS Foundation Trust

Introduction

Over recent years, there has been a growing understanding within government circles about the benefits that international volunteering can bring back to the NHS and its patients. This has been supported by independent research and evidence gathered by international development organisations such as the Tropical Health and Education Trust, which manages the Health Partnerships Programme funded by the Department for International Development.

At present, the National Health Service faces a period of unprecedented change, and policy makers, commissioners and NHS employers are challenged with the need to develop new ways of working to deliver healthcare services in an increasingly difficult economic climate.

Although training budgets are being squeezed, there is a requirement to continue to invest in the skills base of UK healthcare professionals to maintain the high standards of service provided by the NHS. At the same time, the workforce needs to be better prepared to deliver healthcare services to an increasingly multi-cultural population.

With this in mind, NHS employers are considering the benefits that can be gained from international work in terms of professional and leadership development opportunities for healthcare professionals.

Background

For many years, motivated individuals from the NHS have volunteered their time to undertake teaching and training of healthcare professionals in less developed countries as part of international health link exchanges. This work is often undertaken on a voluntary basis during annual leave. However, there is generally a lack of understanding among NHS employers regarding the benefits that international volunteering can bring. This is further complicated by the current operating climate, as NHS employers seek to balance service demands amid shrinking budgets and the perceived risks of supporting staff who may wish to participate in international health projects. There is an increasing need for evidence that the activity has worth in terms of professional development and benefits to the UK health system.

Across the UK, there are acknowledged to be around 200 international health partnerships between the UK and less developed countries. Some long standing health links are formally recognised as institutional partnerships by their trust board as they acknowledge the benefits in terms of workforce development and talent management that international work can bring. Others are formed between individual clinicians, from the UK and overseas, who seek to mobilise additional volunteer support and resources to target a particular health need. Some of this activity is driven by the diaspora communities within the UK who wish to 'give back' to their home countries.

Although it is generally thought that the international partner gains most from this exchange, returning UK health professionals have frequently emphasised that they also gain considerably from the experience, particularly in terms of opportunities to acquire new knowledge, aptitudes and skills. With the current drive to improve performance, and the necessity to skill-up the UK healthcare workforce in preparedness for global health threats, there is a distinct advantage to involvement in international health links as an innovative means of staff development which could not be facilitated within the UK.

The political backdrop

Since the publication of a toolkit to support international humanitarian work in 2005, the UK Government has raised the profile of international health links through a number of

successive government reports and evaluations. In 2008, the Department of Health and Department for International Development came together in a concerted effort to recognise the potential benefits of links work and the first Framework for the NHS to take forward links activity was launched in 2009 [1]. By this time, the government also acknowledged the important role that healthcare professionals who engaged in international links could play in preparedness for global health threats.

This work was further developed in 2013 when the All Party Parliamentary Group on Global Health, led by Lord Nigel Crisp, former Chief Executive of the NHS, undertook a significant review of international health links across the UK. The resulting APPG report, "*Improving Health at Home and Abroad: How overseas volunteering from the NHS benefits the UK and the world*" recognises the unique role that voluntary links can play in maintaining relationships with partners throughout the world and advocates the development of a 'movement' within the UK to further develop international links [2]. It is possible that this work may, in future, be taken forward by Health Education England with the support of the Local Education and Training Boards.

Benefits to the NHS

Although reflective accounts of international experience by returning healthcare professionals have been published in journals advocating the benefits of international volunteering from a personal perspective, it is important to recognise the direct gains to the individual in terms of knowledge and skills transfer and how this is translated to working practices in the NHS.

The need for evidence led to the development of a research report "*Innovative workforce development: the case for international health links*" which was commissioned by the North East Strategic Health Authority and later published in the Health Service Journal [3, 4].

The report was able to evidence knowledge and skills gained from international links work against the NHS Knowledge and Skills Framework (KSF) for annual appraisal, the NHS Leadership Framework for leadership development and the needs of the Royal Colleges for accreditation of project work for CPD.

The research study found that members of staff returned from international work highly motivated, with increased work ethic and renewed vocation for the health service. At a professional level, they developed better team-working skills, new ways of working, increased cultural sensitivity and awareness of the value of resources having worked in a resource-poor environment.

Since then, further work has been undertaken to develop a toolkit to evidence knowledge and skills gained from international volunteering in a format which is suitable for annual appraisal [5]. The toolkit will enable international volunteers to provide NHS employers with evidence of their professional development. Further information about the toolkit can be found on the THET website **www.thet.org/hps/news/innovative-workforce-development-the-case-for-international-health-links.** A revised version of the toolkit is due to be published by Health Education England and NHS Employers in 2014. The NHS International Group is also reviewing the Framework for international health links and new guidelines are due to be published by the Department of Health during 2014.

Figure 1: Laparoscopic cholecystectomy teaching in Tanzania

References

[1] *The Framework for NHS Involvement in International Development*
Department of Health (March 2010)

[2] *Improving Health at Home and Abroad*
All Party Parliamentary Group on Global Health (July 2013)

[3] **Longstaff B**
Innovative workforce development: the case for international health links
(August 2010)

[4] *How international health links can help the NHS workforce develop*
Health Service Journal (May 2012)

[5] *Toolkit for the collection of evidence of knowledge and skills gained through involvement in international health links*
Northumbria Healthcare NHS Foundation Trust (June 2012)

REFLECTIONS ON SURGICAL VOLUNTEERING OPPORTUNITIES

SAVING THE WORLD OR APPLYING A STICKING PLASTER?

Charlotte Gunner
Current grade: CT1, Sheffield

Location and duration: St Francis' Hospital, Zambia, 5 months

Trainee grade during placement: Surgical SHO

Organised: Through own contacts

Pre-requisites: Vaccinations, anti-malarial, registration with Zambian medical council

Current surgical training programmes are fairly restrictive when it comes to negotiating time to spend overseas. As a foundation year doctor, I opted to postpone core surgical training for a year in order to gain some personal experience in tropical surgery. Having completed a Diploma in Tropical Medicine at the University of Liverpool, I travelled to Katete, Zambia where I spent five months working as a surgical SHO in the 350-bed St Francis' Hospital. Due to its remote location, there are often difficulties in recruiting local doctors, making it a popular and welcome place for overseas volunteers.

It is important to be realistic in your expectations, particularly as a junior trainee in an unfamiliar environment. Implementing change, for example, is very difficult, particularly if you are staying for a relatively short period of time. Respecting local practice and guidelines is of paramount importance even if it is different from your norm.

By joining the surgical team, rota pressures were eased. I was able to run outpatient clinics, minor operating lists (abscesses, lumps and bumps etc.), manage the ward and assess referrals. I participated in surgical teaching, audit and research, particularly during the multidisciplinary morning meetings. In low-income settings, education, audit and research are important to help guide resource allocation. I conducted an audit of negative laparotomy rates, which I have presented at a conference.

Adequate preparation is essential; communicate in advance with the senior staff of the hospital to find out your role and responsibilities and any equipment you might need to provide for yourself. For example, I discovered that the smallest locally available sterile gloves were size 8; a generous donation of 500 pairs of size 6.5 gloves were gratefully received! Having senior support is crucial, as I would feel ethically and professionally compromised operating beyond my capabilities.

As a junior trainee, I hope to see a change in the way working overseas is viewed, with increasing support from employers and for it to be encouraged and not just permitted.

PROMOTING TEAMWORK: A MULTIDISCIPLINARY TEACHING MODEL FOR SURGICAL TEAMS

Lilli Cooper and Kathryn Ford
Current grades: Core Surgical Trainees, London Deanery

Location and duration: Tamale, Ghana (4 day course)

Trainee grade during placement: Core Surgical Trainee

Organised: ASGBI/IDC and G.A.S. partnership

Pre-requisites: Yellow fever, anti-malarials, VISA

Multidisciplinary learning in practice
A British group of consultant and trainee surgeons, anaesthetists and a senior theatre nurse designed and delivered a three-day training course, 'Safe Surgical Practice: Team Working at its Best', for Ghanaian surgical MDTs in Tamale, Ghana. The aims were threefold: 1) To deliver a cohesive and thorough outreach MDT training course for surgical staff in Ghana; 2) To provide a broader understanding of peri-operative management by the MDT through breaking down barriers in communication and sharing knowledge; and 3) To promote sustainable learning.

The 46 participants were split into MDT groups from similar hospitals and regions, with whom they rotated through tutorials and practical sessions throughout the course. The exception was the one specialty-specific day, where skills were taught relevant to the individuals' role within the team. On the fourth day, a Train the Trainer course was run for those delegates who displayed potential to be faculty in future courses. The delegates' chosen represented all members of the MDT. It was hoped that the teaching methods and resources employed on the Train the Trainer course could be used by the delegates when developing local initiatives in their hospitals as well as in future Safer Surgical Practice courses.

The feedback from the course was objective with skills-based tasks and a knowledge-based quiz. As well as subjective through a questionnaire and included free text comments such as: *"Team work is essential for positive patient outcome"*. We felt, as faculty, that the quality of the course delivered was higher because of the shared experiences that we could offer collectively. As trainees, we were able to obtain valuable feedback on our teaching

style and material from senior colleagues and MDT members. Multidisciplinary courses represent an important and underused model in surgical team training in the UK, and worldwide. The model described in Ghana is equally applicable in the UK, and MDT training should be incorporated into training for surgical teams.

Personal reflections
It can be difficult as junior trainees to contribute to global surgery. We found that preparing for and teaching on a surgical course enabled us to contribute at a level commensurate with our training and expertise. We learnt about teaching in a multidisciplinary context, and plan to use these skills and knowledge of its success throughout our careers. It was a pleasure to be involved in a well-organised, safe, transparent and sustainable project organised by two established charities and to work with such experienced and generous mentors and faculty.

WHY SURGICAL TRAINEES SHOULD VOLUNTEER OVERSEAS

Paul Sutton
Current grade: ST4 Surgery, Mersey Deanery

Location and duration: South Africa, Tanzania, Kenya, Ghana and Nigeria (short term)

Trainee grade during placement: ST3 and ST4

Organised: Through Operation Hernia website

Pre-requisites: Yellow fever (lasts 10 years) Hep A and typhoid vaccinations antimalarials. Having a sponsor in local country helps with clearing medical supplies through customs

Since graduating in 2006, I have pursued surgical training in the UK and am currently a Specialty Registrar in General Surgery in the Mersey Deanery. I have been fortunate to have the opportunity to visit a number of countries to support efforts to deliver essential surgery. Countries I have visited include South Africa, Tanzania, Kenya, Ghana and Nigeria, either visiting established institutions or contributing to temporary surgical camps with charities such as Operation Hernia.

So why might a surgical trainee embark upon such a series of short-term humanitarian missions? Dealing with the most obvious first is that it is immensely satisfying work to treat individuals who might otherwise not have access to surgical healthcare. The pathology in these areas represents both a unique spectrum of disease as well as the extremes of pathology commonly encountered in the UK. I recall hernias, goitres and abdominal masses which I have yet to encounter at home, and had the opportunity to provide emergency surgery in an area where the commonest cause of an acute abdomen is a ruptured hepatoma. I have benefited from the opportunity to extend my surgical repertoire, including crossing boundaries into paediatric surgery as well as obstetrics and gynaecology. I will never forget the first Caesarean section I had to perform – the resident surgeon had been called to a neighbouring hospital and a labouring woman became obstructed. I performed the procedure out of necessity, being supervised and assisted by a local medical officer who had performed several hundred but could no longer operate due to bilateral radial nerve palsies!

The reason I enjoy humanitarian work is that I get to be a doctor again, making clinical diagnoses without long lists of tests, instigating a treatment plan and carefully monitoring its effects. I have been involved with a number of public health initiatives, and have even found myself playing the part of a doctor in a play for local schoolchildren designed to educate them about HIV and AIDS.

I have met fantastic people, many of who have an approach to hardship I wish to emulate. On the subject of teams, the doctors and nurses I have worked with include old friends, new friends and healthcare professionals from many different countries, all with fascinating backgrounds and stories. It was easy to see in each and every one of them how their commitment to humanitarian work has enriched their lives, both personally and professionally.

Figure 2: Pre-operative assessment at a hernia camp in Nigeria

SHAPE OF TRAINING REVIEW

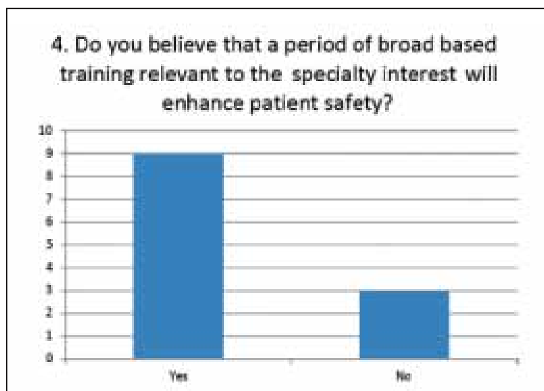
THE FUTURE SHAPE OF SURGICAL TRAINING: IMPLEMENTING THE RECOMMENDATIONS

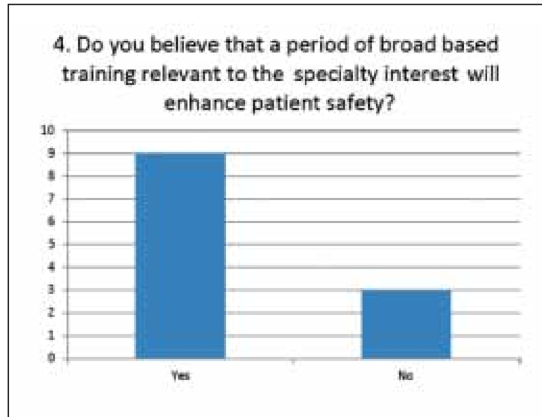
Humphrey Scott
Head of School for Kent, Surrey and Sussex and Chair of the Confederation of Postgraduate Schools of Surgery

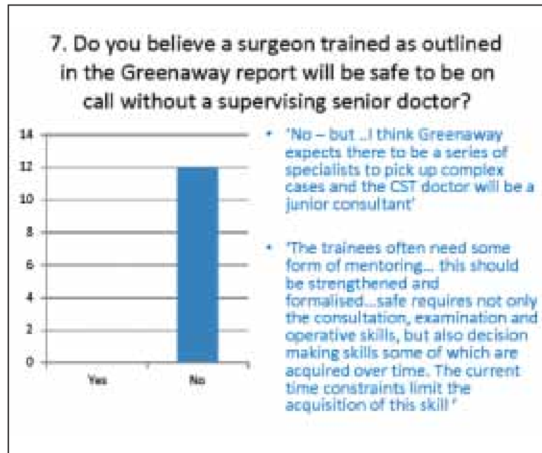
The Greenaway Report on the Shape of Training has been released. From a surgical perspective, the final picture of the implementation of the shape of training is unclear. The timeline has not been defined and an end point remains uncertain. It needs to be recognised that, as with any implemented change, it gives the profession an opportunity to improve surgical training. It is also becoming very apparent that this will not be a "big bang" but it will be a gradual evolution to the end picture.

The language for the shape of training remains confusing and the word "generalism" will require clarity. A "general" surgeon is a very different person, for example, from a "general" ENT surgeon or "general" urologist. The language and wording of "subspecialty", "specialisation", "super-specialisation", and "special interests", also requires clarity and definition. It is important to note that the General Medical Council only recognise one surgical subspecialty and that is the subspecialty of Congenital Cardiac Surgery. All other purported subspecialties and super specialisations are classified as "special interests".

In order to obtain some more understanding of the Shape of Training, a Head of School survey was conducted. Twelve Heads of School replied to a written questionnaire that consisted of some basic questions requiring tick box answers and a free text box was available for additional comments. Some of the results can be seen in the following figures:







At the time of my presentation at the ASGBI Congress in Harrogate, there had been no release of the proposed implementation plans; it was suggested that, within General Surgery, after the required 4-6 years and completion of a broad-based specialty training, the trainee would become certified and receive the Certificate of Specialty Training (CST). It was suggested that one model could be that with the CST, the surgeon would look after the sickest patients in the hospital and then through a competitive selection process, could subspecialise within their chosen area, such as colorectal, upper GI, breast and hepato-pancreatic biliary surgery (HPB). Throughout this period, robust structures for post CST credentialing would continue. It is possible that there would be some trainees who would not pass the competitive selection process and would remain with their CST, solely looking

after the sickest patients in the hospital (***Figure 1***).

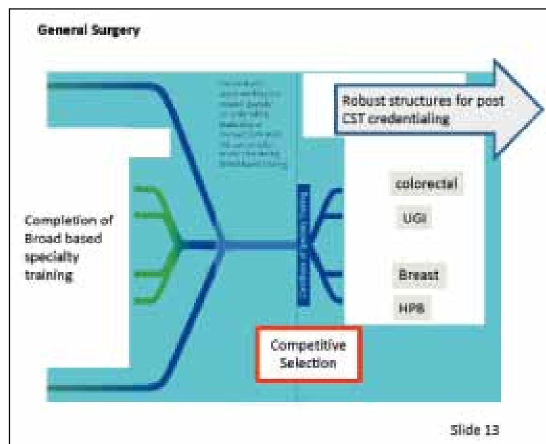


Figure 1

Another proposed model within General Surgery is that the broad-based specialty training would, within itself, have themes. These themes could include colorectal surgery, upper GI surgery, breast surgery and HPB. Therefore, a trainee reaching the CST level would already have some subspecialisation. These trainees would continue their training with their CST and continue having credentialing as they move into enhanced career development. The above two models would also be possible in urology.

In ENT, it has been suggested that, as 95-98% of ENT emergencies are treated medically, this model would not fit well. It was also highlighted that, in Trauma and Orthopaedics, there are a large majority of Trauma and Orthopaedic Surgeons who wish to stop the trauma side of their consultant role as soon as possible as they wish to develop their specialty interest, such as hips, knees or ankles. It has also been suggested that the employers should focus on this and ensure that the CST Fellows should continue their trauma expertise.

It was pointed out that the other surgical subspecialties (vascular, oral maxillofacial surgery, cardiothoracic surgery, neurosurgery, plastic surgery and paediatric surgery) do not fit well within the shape of training proposed plan. It was also felt that surgery should engage with the employers and there should be an attempt to look at some workforce modelling in order that the number of generalists fits in well with current workforce numbers.

With the reduced time to complete CST, it has been pointed out that surgeons should not become pure technicians. If this was the case, there would be no need for a medical degree. The old saying that "a surgeon knows how to operate, a good surgeon knows when to operate, and an excellent surgeon knows when not to operate" was emphasised. All areas of a surgeon's professional responsibilities, which include craft skills and communication skills, should be fully incorporated into the Shape of Training.

In summary, it was felt that there are opportunities to improve surgical training in the Greenaway Report. The surgical profession should become engaged and involved in the Shape of Training, and it is recognised that it would not be a sudden implementation but would be an evolution with an introduction of "generalism". The Shape of Training report should not be a return to run through training and it was also highlighted that broadening the foundation programme would entail trainees only having four months surgery experience within their two years of foundation training.

The profession is left with a question as to who designs the Shape of Training recommendations and who implements them. It has been suggested that the design within surgery for the Shape of Training should come from the surgical advisory committees (SACs), with involvement of the Joint Committee of Surgical Training. There may be the need to make changes in the surgical curriculum in order that surgical training fits into the Shape of Training. Once this and the curriculum (if necessary) have been changed, it was suggested that the Heads of School and the Local Education Training Boards would be responsible for the implementation of the recommendations.

THURSDAY 1st MAY

SAS DOCTORS: THE FUTURE. OPPORTUNITIES AND INNOVATION

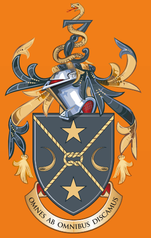
HOW TO DEFEND YOURSELF AGAINST A CLINICAL NEGLIGENCE CLAIM

Dr Stefan Maz
Associate Specialist in Anaesthesia and SAS Tutor, Rotherham NHS Foundation Trust

The key word here is "yourself". You have spent years working and studying hard to build up your professional reputation, and out of the blue you receive a phone call that a former patient is taking legal action against you. What are you going to do?

My credentials for writing this article are (1) I spent two years working as a trainee solicitor for a large firm specialising in defending NHS Trusts against clinical negligence claims, and (perhaps more importantly) (2) shortly after returning to clinical practice I found myself on the wrong end of a clinical negligence claim. Now I had to put everything I had learned into practice to defend my own professional reputation.

It doesn't matter that you are a good doctor; that you keep clear, accurate and contemporaneous



medical records; that you're always courteous to patients and that you offer an apology and take steps to put things right when things go wrong. If a patient has been promised compensation, his solicitors will come after you. Litigation has nothing to do with uncovering what went wrong; it's always about the money.

If a claim is brought to your attention at an early stage, you will receive a **"Letter of Claim"** from the patient's (Claimant's) solicitors. This outlines the facts of the case as they understand them, followed by various allegations of negligence against you. The importance of this Letter of Claim is that, although the Claimant will have had three years to prepare their case against you, you (or the Trust acting with vicarious liability on your behalf) have only thirty days to respond with a **"Letter of Defence"**.

If the case has reached an advanced stage by the time you get to hear of it (as was the case with me), you will receive an A4 lever-arch file full of legal documents and copy clinical records. There will be a covering letter from the defendant solicitors representing the Trust asking for your comments on the various documents.

Your employing NHS Trust will have reported the complaint to the NHS Litigation Authority, who in turn will commission one of the firms of solicitors on their panel who deal with clinical negligence. There will be a named solicitor assigned to your case. Get to know him/her; phone them and ask them to come and meet you to discuss your case. Unlike their high-powered "city" counterparts, clinical negligence solicitors are nice people; they are on your side and they want to help. Give them the ammunition they need to fight your corner. Minor points can be communicated by phone or email, but for substantive responses, I would recommend you communicate with your solicitor by formal structured letter, clearly explaining the points which you wish to cover.

Do not attempt to wade through this file as soon as you receive it. You will be too angry or too upset to think clearly. Arm yourself with a pencil and some Post-it notes. All you should do on the first day is identify which documents you have been given, because you will need to do a lot of cross-referencing when preparing your defence.

The following day, start with a document and read through it, making pencil notes in the margin and underlining key words and phrases. Do this for each document. The next day, read through the documents again; your subconscious mind will have processed some information overnight, and you will pick out points that were not apparent before. Do this again the following day. By now, you will probably have formed some links between the various documents. You may get the feeling that "something doesn't seem right", but you can't yet put your finger on it. This is a good sign; you may be on to something. Start putting together your comments on each document in draft form in a separate structured letter. Try to uncover links between the various documents, particularly inconsistencies and contradictions.

Against whom are you going to mount your counter-attack? You will not succeed in persuading the patient to drop their claim; they have been promised compensation, and they intend to have it. Neither will you persuade the Claimant's solicitors that their claim is without merit; as long as they continue to receive funding from the Legal Aid Board, they will keep coming after you. The object of your counter-attack should be the expert witness who has provided the Claimant's solicitors with an unfavourable report about you, criticising the standard of your care and essentially saying that you're a bad doctor.

These are the documents you should identify in your file, some of which you will be asked to comment on:

Claim Form
The first document issued by the court which names the parties involved and the sum of money claimed as damages. This signals the start of legal proceedings.

Particulars of Claim
This begins with an account of the facts of the case from the Claimant's point of view. Check these alleged "facts" against the clinical records and your own recollection. Is that what really happened? Do not allow any uncorroborated fact to pass unchallenged. The Claimant is not allowed to make up or embellish the facts to support their case.

Particulars of Negligence
Here are the specific allegations of negligence which are being made against you, usually worded as a "failure to" do this or that. These vary in number; there may be three or four allegations, or as many as twenty. If the Claimant's solicitors believe they have a strong case against you, they will limit the allegations to three or four specific "failures", otherwise they will use a "shotgun" approach and pepper you with a large number of allegations, hoping that some of them will stick. It does not matter how many allegations there are; you must have an answer for each and every one of them. If you allow even one allegation to slip through unchallenged, you have lost.

In-house clinicians' comments
Your colleagues will be asked to comment on the case; if they are supportive of your actions, you are in with a fighting chance. If they are critical of your actions, it's game over.

Expert witness reports
This is your most important target. If the report portrays you in a poor light without good reason, do not allow it to pass

unchallenged. Read each sentence carefully and ask yourself the following questions:

(1) Are the alleged facts consistent with the clinical records? If there is no supporting evidence of an alleged fact in the notes, it is not a fact.

(2) Does the expert support his opinions with any evidence? Not even an "expert" can say what he likes without backing this up with valid reasons.

(3) Has the expert made any invalid assumptions or inferences? An expert is not entitled to make up what he does not or cannot know.

(4) Has the expert put forward opinions within his own area of expertise? You know enough medicine to be able to tell if the expert has strayed outside his field.

(5) Are the opinions of the expert consistent with those of other experts? If the experts rallied against you offer contradictory opinions, then that is in your favour.

(6) Are the expert's opinions based on the clinical records or on a transcript of the notes? If there is an exact match between typographical errors in the transcript supplied by the Claimant's solicitors and the expert's report, this requires explanation.

(7) Has the expert considered all the evidence impartially? If an extract in the clinical records shows you in a good light, this should appear in the report. If not, you can demonstrate that the report is clearly biased.

(8) Is the expert talking nonsense? Some experts have been away from clinical practice for so long that some of their opinions are, quite frankly, bizarre. Do not hesitate to challenge such opinions.

Do not just defend the case which has been brought against you. Stop it in its tracks.

IDC SESSION: GLOBAL SURGERY FOR ALL

THE *ABCDE* OF SAFE RECOVERY FOR YOUR PATIENT IN A RESOURCE-POOR ENVIRONMENT

Dr Martin Clark
Consultant Anaesthesia and intensive care, Victoria Hospital, Kirkcaldy

Dr Catriona Bennett
Consultant Anaesthesia, Victoria Hospital, Kirkcaldy

"If a patient is good enough to operate on, he is good enough to look after."
Dr Andries Retief

Surgery in developing countries presents many challenges in the peri-operative period. Equipment, staffing levels and competencies that we take for granted in Western medicine do not exist in many hospitals in the developing world. Hodges et al [1] surveyed Ugandan anaesthetists in 2007 and discovered 74% did not have access to a pulse oximeter, 23% to a tilting table, 22% to suitably sized endotracheal tubes and incredibly, 22% did not have oxygen available in theatres. Anaesthetists reported intermittent shortages of electricity (80%), water (44%) and intravenous fluids (30%). This meant that 77% of anaesthetists did not have the basic equipment to safely deliver adult anaesthesia in their hospital and 94% of hospitals did not have adequate resources to perform safe caesarean sections. More recently, Walker et al [2] reported only two of 29 Ugandan hospitals surveyed had oxygen and a pulse oximeter in the recovery area.

Many hospitals are short of medically qualified staff and rely on clinical officers who will have completed a training programme of variable length but usually between one and three years. Clinical officers rarely receive ongoing training following qualification. Staffing levels on the wards are poor with nursing ratios of 1:50 patients common [3]. Unsurprisingly, with such shortages of staff, training and resources, mortality rates are much higher than in the developed world with peri-operative mortality as high as 2.57% being reported in Togo [4] (93% of deaths were identified as avoidable), although 1% is probably more typical [5]. Most of this mortality occurs in the post-operative period and is due to problems with the airway, breathing, circulation and would be largely avoidable with better care and resources. Procedures for recovery vary tremendously in developing countries but common scenarios are: No recovery with patient transferred straight to the ward; recovery in a corridor near the theatre with no monitoring or staff in attendance; recovery by the patient's relatives; recovery by a staff member, possibly with monitoring, although often staff are unable to react to abnormal readings due to a lack of knowledge; or recovery in theatre by the anaesthetist, which is safest option, but entails slower running of theatres.

Any solutions must be simple to implement and cheap, as these countries cannot afford Western levels of healthcare expenditure. For example, government annual spending per person on healthcare in the following countries is: The Democratic Republic of Congo - $4, Ethiopia - $17, Uganda - $20, Kenya - $30, Malawi - $30, Tanzania - $41 and Rwanda - $45 [6].

Recovery in Kagando Hospital; corridor outside theatre with no staff or monitoring

The ABCDE of safe recovery

Airway: Ideally, the patient should have high flow oxygen applied and be monitored with a pulse oximeter. If the patient has a laryngeal mask airway or endotracheal tube in situ, leave it in until the patient is awake enough to localise to the tube or opens their eyes and is able to stick out their tongue; this will maximise chances of them maintaining their own airway after device removal. Grunting or snoring noises indicate partial airway obstruction; usually simple airway manoeuvres such as head tilt or chin lift are enough to clear the airway as long as there is no concern over the cervical spine, in which case a careful jaw thrust should be used. Complete airway obstruction is silent as there is no airflow to generate noise, but a seesaw pattern of respiration will be visible and the patient will become hypoxic rapidly. Always check for complete obstruction if the noises associated with partial obstruction suddenly cease. Gurgling noises indicate saliva, blood or gastric content in the pharynx and these should be removed with gentle suctioning. Nursing the patient in the recovery position can help maintain the airway and encourage any secretions to drain safely.

Breathing: Assess rate, depth and symmetry of breathing. Rapid rates suggest lung pathology such as pneumonia/oedema or aspiration. More commonly, tachypnoea represents compensation for metabolic acidosis from sepsis or heart failure. Shallow rapid respiration occurs from pain. Slow respiration is usually a result of residual opiates and/or anaesthetic and should be monitored to ensure it resolves before the patient is discharged to the ward. Inadequate shallow gasping, respiration or no respiration can be caused by inadequate muscle relaxant reversal, and assessment of the patient's muscle power must be undertaken. **If ventilation is inadequate and you are unsure of the cause, simply ventilate via a bag and mask with as much oxygen as you have available until you have diagnosed the problem**.

Circulation: If available, a sphygmomanometer should be applied and regular readings taken. ECG monitoring is ideal, but is unlikely to be available. Being unable to get a pulse oximetry reading can indicate hypotension. Check the capillary refill, pulse rate and skin temperature. Check the colour of the patient's conjunctiva to get an estimate of their haemoglobin level. **Hypotension is due to hypovolaemia until proven otherwise**. Spinal anaesthesia does not cause new onset hypotension post-operatively, although it may be an ongoing cause if the duration of surgery has been short and hypotension has been present since the onset of the spinal block. Young fit adults hide hypovolaemia very well and tachycardia and hypotension in this group represents a significant loss of blood. Sepsis is unlikely as an early cause of hypotension, unless a septic focus has been found at operation. Assess as above. Give a fluid bolus of 250ml fluid and re-assess looking for any improvement. Look at any drains and consider hidden areas of blood loss such as abdomen, chest and uterus.

Disability: Muscle relaxants are not widely available in developing countries, so when used, they may cause problems as staff are unfamiliar with them. Inadequate reversal at the end of the operation will leave the patient unable to breathe and staff may not notice or react appropriately to this. If relaxants have been used, adequate muscle power and respiration must be demonstrated prior to returning to the ward, i.e. ability to lift head off the pillow for five seconds. Ketamine is widely used in the developing world as it preserves airway reflexes and respiration. Patients recovering from ketamine should be left monitored but undisturbed as emergence phenomena, including disturbing hallucinations, are not uncommon. Confusion on regaining consciousness is common with all hypnotics and patients should be nursed safely through this period.

Environment/Exposure: Keep the patient warm. Patients lose temperature with anaesthesia and need to re-warm on emergence. Shivering is not uncommon and warm blankets help to stop this. Patients who were pyrexial pre-operatively often shiver post-operatively, even if normothermic, to regenerate this pyrexia. The patient must be monitored in recovery. This does not mean the application of technology but a trained staff member who can monitor vital signs and is trained to react appropriately to any abnormality, although this unfortunately is often not available. If this is the case, it is strongly advised that further operations are delayed until the patient has been adequately recovered by the theatre staff. Alternatives used are to allow the relatives to help recover the patient with clear instructions such as "sit your baby on your lap and if their breathing changes come and get me, I am through that door". This carries more risk as obviously the ability to recognise early signs of deterioration is lost. It is important that the next theatre case does not start until the anaesthetist is happy that the patient is receiving care appropriate to their stage of recovery.

Communication

Staff may be reticent to confront or call a doctor. You need to leave clear instructions as to when you want to be called. For example: "Monitor pulse, blood pressure and respiratory rate every 10 minutes. If the airway is noisy, open the airway. If they're not breathing, then bag and mask the patient and send someone to find me. If their pulse is >100/min, systolic blood pressure <90mmHg or respiratory rate>30/min, then tell me. If there is ongoing bleeding, then tell me. If you have a concern, find me, I want to know." Hand over to ward should include written communication

regarding post-operative expectations but remember, it is unlikely staff will be able to closely monitor the patient due to staffing constraints. Relatives can be given simple instructions on warning signs with instructions to contact staff if they occur. Discern availability of blood prior to any elective operation where you anticipate large blood loss. Consider a staged procedure if resources are limited, and beware of chronic anaemia through, for example, malnutrition, malaria, and sickle cell disease.

Troubleshooting

Hypoxia: Increase/apply oxygen, attach SpO2 monitor if not already attached. Is the airway obstructed? If yes ‡ airway manoeuvres. Is ventilation adequate? If not, bag and mask with oxygen at highest flow rate, consider pain, inadequate reversal, lung pathology, acidosis. Is ventilation symmetrical? If not, pneumothorax is rare but sputum plug or endobronchial intubation leading to lobar collapse is common. Bagging with affected side up or pulling the ET tube back, usually resolves.

Hypotension: Hypovolaemia is a major cause until proven otherwise. Assess for hidden/overt haemorrhage. Give fluid and challenge and assess effect.

Summary

The post-operative period is a time of challenge and danger to our patients. Simple measures will improve patient outcomes but in view of resource constraints, Western levels of safety are as yet a far off dream.

References

[1] **Hodges S C, Mijumbi C, Okello M, McCormick B A, Walker I A, Wilson I H**
Anaesthesia services in developing countries: Defining the problems
Anaesthesia 2007:62:4–11

[2] **Walker I A, Obua A D, Mouton F, Ttendo S, Wilson I H**
Paediatric surgery and anaesthesia in south-western Uganda: a cross-sectional survey
Bulletin of the World Health Organization 2010;88:897-906

[3] International Council of Nurses/Florence Nightingale International Foundation Report 2006: Global nursing shortage, priority areas for intervention
http://www.icn.ch/images/stories/documents/publications/GNRI/The_Global_Nursing_Shortage-Priority_Areas_for_Intervention.pdf
(Accessed 14.5.2014)

[4] **Ouro-Bang'naMaman A F, Tomta K, Ahouangbévi S, Chobli M**
Deaths associated with anaesthesia in Togo, West Africa
Tropical Doctor 2005;35:220–222

[5] **Fenton P M, Whitty C J M, Reynolds F**
Caesarean section in Malawi: Prospective study of early maternal and perinatal mortality
British Medical Journal 2003;327:587

[6] ***WHO Atlas of Health Statistics*** 2011

HOT TOPIC

SEVEN DAY ELECTIVE SURGERY?

Celia Ingham Clark
National Director for Reducing Premature Mortality, NHS England

At the 2014 ASGBI Congress, the Hot Topic discussion centred around seven day elective surgery – “Essential efficiency or cynical spin?” I argued for the case and John MacFie against, and the majority of the audience agreed with John. This paper describes the continuum between acute emergency and routine surgical services and those services that support surgeons' work, and argues that, for some services in some locations, seven day elective surgery is not just an option but an important strategic goal.

Surgeons are no strangers to providing seven day services, and indeed working seven days a week. Most general surgeons provide emergency opinions and carry out emergency operations at less than 30 minutes notice where necessary at any time of the day and night. In many hospitals, surgeons have led the way in doing daily ward rounds, including at weekends. Increasingly, other services are being extended into the weekends to support the process of care for patients admitted as emergencies. For example, in many hospitals, a person admitted with acute cholecystitis on a Friday will get an ultrasound scan to confirm the diagnosis the same day, and their surgery on the Saturday, in contrast to the traditional approach where the same patient would often wait until Monday or Tuesday for their urgent ultrasound scan.

In London, we developed quality standards for acute care in 2011 that are now included in commissioning contracts and these specify an approach to providing all acute hospital services seven days a week. This was done in response to published data, showing that patients admitted to hospital at weekends were more likely to die than those admitted on weekdays [1], and in response to feedback from training grade doctors, that described a wide variation between, and indeed within, units, in the degree of consultant involvement in the care of patients admitted as emergencies.

In 2013, Sir Bruce Keogh, the Medical Director in NHS England, set up a Forum to consider Seven Day Services in England. The Forum considered all available evidence, and through a clinical expert panel, developed ten clinical standards for acute care as a seven day service [2]. These standards are being promulgated and discussed between commissioners and providers at regional events around the country and will be included in the contracts for 2015/16.

So surely this is enough? I believe that it isn’t, and there are three reasons for this.

First, many surgical services have introduced enhanced recovery for their elective patients [3]. This includes a managed pathway after surgery with the expectation of daily progress. In many cases, daily consultant review helps to move this pathway forward, and this approach is supported

by the Academy of Medical Royal Colleges [4]. In surgical specialties with relatively low rates of emergency admission, such as urology or ENT, there would be an efficiency argument for a consultant attending the hospital on a Saturday to do a routine day case list and then see any emergency admissions or in-patients, whereas simply attending for the emergency admissions would involve a very high ratio of travel time to work. The enhanced recovery pathway is also supported by other healthcare professionals, such as physiotherapists, offering a seven day service to elective in-patients. Enhanced recovery after elective surgery has been shown to improve patient experience, reduce length of stay and, in some cases, to reduce post-operative morbidity [3].

Secondly, the NHS is here to serve patients and is paid for by the tax-payer. We are trying to define the services we provide based on the values that citizens hold most highly, although we are often surprised when their priorities aren't aligned with those of the healthcare professionals providing their care. Many shops, and increasingly banks and estate agents, are opening on Sundays in response to public demand. There are good examples of routine health services such as outpatient clinics being offered on a Saturday, and generating high levels of patient satisfaction (fewer queues, access to car-parking) although clearly some of these advantages would vanish if all clinics were open every Saturday.

Thirdly, there is a continuing rise in the number of people being put on waiting lists for routine diagnostic tests and elective surgery, and a continuing rise in the number of cases being done. Most hospitals run routine endoscopy lists at weekends, and many have used ad hoc waiting list initiative weekend lists for years, to manage rising demand. Others have sent NHS patients to the private sector for their elective care, and in private hospitals, routine lists at weekends are commonplace. It makes economic sense to use the operating theatres we already have more productively, rather than restrict their use to 40 hours a week and build more theatres to meet rising surgical demand.

Why would we not do routine surgical work at weekends?

Some argue that it would force surgeons to do too many hours, especially given the significant commitment most make to emergency work out of hours already. It would be inappropriate to expect surgeons to regularly work beyond the European Working Time Directive limits, and indeed, no-one can be forced to do this. If you work at the weekend you should get time off in lieu in the week. At present, there is a surfeit of surgeons achieving CST and many of the new consultant jobs advertised are focussed on emergency work. Where a trust is taking on additional staff to meet the requirements of weekend working, they should also ensure a fair approach to the distribution of routine and emergency work between consultants.

What about financial considerations? Can the NHS afford to do weekend routine work?

Many provider trusts currently find it expeditious to run routine endoscopy and MRI scans at weekends. Endoscopy, like routine surgery, is paid on a tariff, so the more you do, the more you are paid. MRI is usually commissioned through a block contract in which the provider trust has to meet national goals for getting the scans done within six weeks of the request. Financial rewards and sanctions are set up so that it is in the Trust's interest to run lists at weekends if demand exceeds weekday capacity. Elective surgery, paid through tariff, is one of the few ways that acute trusts can generate more income, and a number of successful trusts have increased their elective work beyond their usual weekday theatre capacity. Up to a third run three session days in the week, and ten percent run routine weekend lists. For example, the South West London Elective Orthopaedic Centre, a joint (no pun intended) enterprise between three NHS trusts that only does elective hip and knee replacement operations, runs five operating lists on weekdays and four on Saturdays, and if demand required it would also run Sunday lists. For some organisations, there may also be a cost advantage of spreading routine clinics and lists over seven days instead of five and decommissioning redundant capacity.

Conclusions

The way we run our health services should be designed to optimise patient safety, patient experience and clinical effectiveness, the three components of clinical quality. Within the NHS we have already recognised what can be done to improve acute care at weekends and are implementing this around the country. Local health economies and those commissioning elective surgery have to decide how much elective surgery they want to commission, taking into account the needs of their local population. Where that demand exceeds the capacity of acute trusts to accommodate it during the week, then the choice is to commission the service at weekends or seek other providers, potentially in the private sector. Acute trusts will continue to work to optimise their productivity, and will also look to aligning weekend services they provide in the most clinically and cost-effective way. Whether or not weekend elective surgery is commissioned will be locally determined in discussions between commissioners and providers as part of agreeing their contracts. The role of surgeons is to ensure that any service with their involvement is safe and high quality. This will include ensuring appropriate staffing levels to deliver this. If a trust needs to do elective surgery at weekends, it should be doing it by thorough planning and preparation, not looking for heroes to fill the gaps.

References

[1] http://myhospitalguide.drfosterintelligence.co.uk

[2] http://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf

[3] http://www.nhs.uk/conditions/enhanced-recovery/Pages/Introduction.aspx

[4] http://www.aomrc.org.uk/projects/seven.html

FRIDAY 2nd MAY

IMPROVING SURGICAL OUTCOMES

NATIONAL EMERGENCY LAPAROTOMY AUDIT: CAN THE DATA BE USED TO IMPROVE OUTCOMES?

Carol J Peden
National Emergency Laparotomy Audit Quality Improvement Lead, National Clinical Advisor for Emergency General Surgery in the Enhanced Recovery Programme, Consultant in Anaesthesia and Intensive Care Royal United Hospital, Bath and Associate Medical Director for Clinical Quality (South) NHS England

Emergency laparotomy encompasses a wide range of procedures and is therefore difficult to study. There are over 400 ICD10 codes for which patients may undergo an emergency general surgical laparotomy (excluding vascular and trauma related surgery); the common factor is emergency presentation with an acute abdominal condition necessitating intra-abdominal surgery.

The Association of Surgeons issued a consensus statement on emergency general surgery in 2007, arguing that emergency surgical care needed more resource, management and training to avoid becoming a "Cinderella" specialty. The scale of the problem for emergency surgery is significant, with emergencies comprising more than one third of all general surgical admissions to hospitals and, in the UK, approximately 170,000 patients undergo higher risk emergency non-cardiac surgery each year [1]. Until recently, although individual hospitals had published small audits showing high mortality for patients undergoing emergency laparotomy, there was no national data on outcomes, and the degree of morbidity and mortality was hard to define.

Following the consensus statement of 2007, evidence for the poor outcomes in patients undergoing emergency general surgery, particularly emergency laparotomy, has accrued. Database studies have helped define the extent of the problem; Symons et al [2] used the HES database to define an overall high mortality of 15.6% for patients undergoing emergency laparotomy. This value was confirmed by the first major prospective study collected from 35 volunteer hospitals on 1,853 patients [3], which showed a 30 day mortality of 14.9% overall, and 24.4% for the over 80s. This high death rate has been further substantiated in recent international studies of large patient numbers with death rates varying between 14 and 18.5% at 30 days [4, 5].

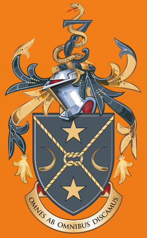
In response to these high death rates, a number of expert consensus documents have been produced, notably the "Higher Risk General Surgical Patient" report from the Department of Health and Royal College of Surgeons [1] and the "Standards for Emergency Surgery" document from the Royal College of Surgeons directed at commissioners. These documents were significant in that, for the first time, there were national standards against which future audits could be run. The 2011 National Confidential Enquiry into Patient Outcome and Death study on the High Risk Surgical Patient confirmed the real need for improvement for this group of patients.

The "Higher Risk General Surgical Patient" document [1] recommended that a National Audit of outcome should be conducted for adult patients undergoing unscheduled general surgery. Other recommendations included formalising pathways for unscheduled adult general surgical care to include the following:

- Clear diagnostic and monitoring plans
- Adoption of an escalation strategy
- Early involvement of senior staff
- Timing of diagnostic tests/timing of surgery
- Adequate emergency theatre access with appropriate prioritisation
- Post-operative location
- Risk of death estimated and documented prior to intervention and adjustments made in urgency of care and seniority of staff involved.

The 2013 position statement on emergency general surgery from ASGBI and RCS echoed the need for greater focus on the outcomes of care, with improved resources for audit and review of practice, and stated that outcomes should be in the public domain

On the basis of the developing momentum around improving the poor outcomes from emergency laparotomy, the founders of the emergency laparotomy network bid jointly with the Health Services Research Centre of the Royal College of Anaesthetists in conjunction with Royal College of Surgeons Clinical Effectiveness Unit and the Intensive Care National Audit and Research Centre to set up a national audit within the Health Care Quality Improvement Partnership (HQIP). Funding was awarded for a National Emergency Laparotomy Audit (NELA) *"to enable the improvement of the quality of care for patients undergoing emergency laparotomy through the provision of high quality comparative data from all providers of emergency laparotomy"*; this was funded for three years to commence with an organisational audit in 2013, with patient data collection from December 2013. The audit



was established to run on annual cycles with yearly reports sent back to hospitals. The audit has a quality improvement stream to try to ensure that the data collected is used to inform improvements in practice and to reduce variation between high and low mortality hospitals. Data is downloadable at any time by each individual hospital site, and for this audit to be truly successful, audit needs to be locally owned and used, rather than driven purely centrally.

The NELA organisational audit has recently been completed and published [6] with data collected on key organisational features felt to be related to quality of care, such as the number of Critical Care beds as a proportion of total beds, number of surgeons on the on-call rota, working patterns of on-call clinical staff (consultants and specialty trainees), specialist interest of surgeons on on-call rota and availability of interventional radiology, emergency theatres and routine daily input from elderly care. Perhaps unsurprisingly, the report shows considerable variation ***(Figure 1)***, which may be significant for patient care; for example, one third of hospitals do not have access to interventional radiology and endoscopy 24 hours a day. The report calls for hospitals to review the adequacy of their facilities to ensure individual standards of care are met and that the care of emergency laparotomy patients is appropriately prioritised. Far from being negative for surgical teams, this report offers clear data, which can be used to support the argument for investment in resources for emergency surgery.

What is the evidence that audit data can improve outcomes for high-risk general surgical patients? The US National Surgical Quality Improvement Programme (NSQIP) states that *"the road to surgical improvement is paved with data"*, that this data should be risk adjusted, timely and actionable. Hall et al [7] reported on 118 hospitals participating in the NSQIP programme; 66% of hospitals improved risk adjusted mortality and 82% improved risk adjusted complication rates. There was a correlation between initial observed to expected outcome ratios and the degree of improvement; initially, worse-performing hospitals had more likelihood of improvement but well-performing hospitals also improved, and variation in outcome was reduced. In the UK, the Society for Cardiothoracic Surgery in Great Britain and Ireland (2011 Report) [8] compared in-hospital mortality outcomes by hospital and surgeon, after risk-adjustment. This audit has used a methodology, for identifying and investigating mortality rates that are higher than expected; the process of collecting and benchmarking clinical outcomes has driven a cultural change to put patients at the centre of care delivery by the multi-disciplinary team and has seen a more than 50% improvement in risk-adjusted mortality. Reassuringly, the audit also demonstrated that over 99% of surgeons are performing satisfactorily.

Publication of national hip fracture data [9] has helped to drive service improvements in a previously often neglected area of patient care; 86% of patients now receive surgery within 48 hours, compared with 75% in 2009, and 49% of patients have a pre-operative assessment by an ortho-

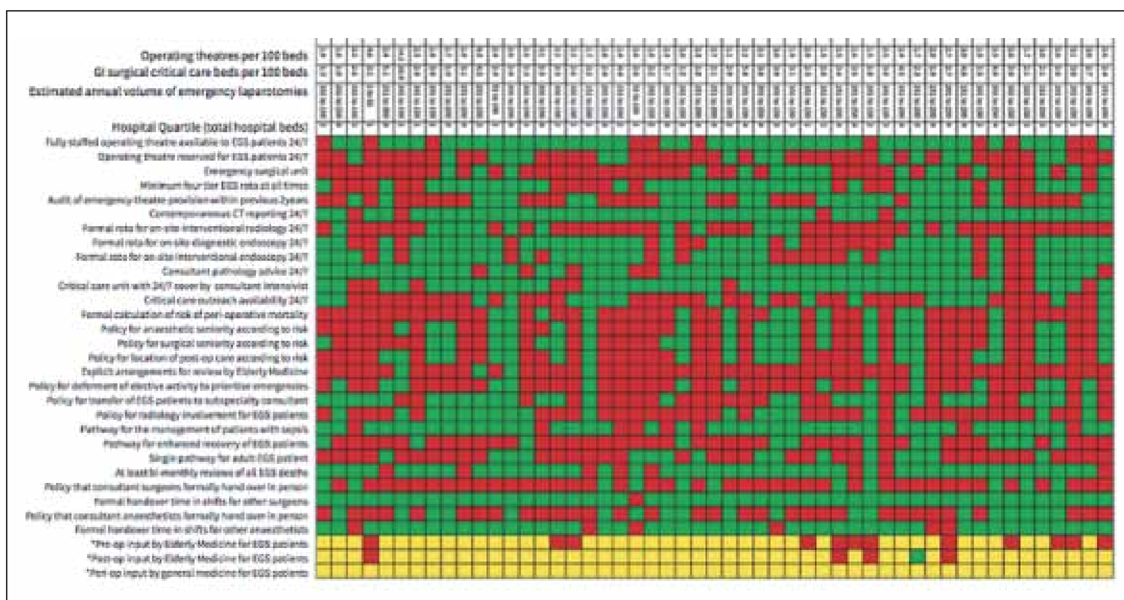


Figure 1: Patterns of variation in performance against organisational standards captured in the first organisational audit by NELA [6]

geriatrician, compared with 24% in 2009. Without process and outcome data to understand how a service is preforming, it is very difficult to create the energy for improvement and to identify areas of practice to be worked on to drive better patient outcome.

The evidence of high mortality described in prospective audits and large database analysis of emergency laparotomy patients is creating activity to improve outcome [10]. The difficulty in undertaking randomised controlled trials in the diverse, sick patients who undergo emergency laparotomy may account for the paucity of research in this patient group to date. However, the increasing recognition that quality improvement studies can lead to change, and are scientifically valid, is gaining traction. The National Institute of Health Research has given major funding to the EPOCH (Enhanced Peri-operative Care for High Risk Patients) study to use quality improvement methodology with the aim of reducing 90 day mortality in patients undergoing emergency laparotomy. The EPOCH study draws its outcome data from participating hospitals' own submissions to the National Emergency Laparotomy Audit database.

What is in it for surgeons, and their patients, if they submit more data to a central database? Mortality from emergency laparotomy has remained high for many years and emergency surgery has been an underfunded and under resourced specialty. National data of high quality will support the argument for investment and allow us to track high and low performing centres in order to learn from the former and help support the latter. With morbidity and mortality so high, even small amounts of improvement will save a significant numbers of lives. In the words of W Edwards Deming, one of the fathers of modern improvement science: *"In God we trust, all others bring data"*.

References

[1] The Royal College of Surgeons of England, Department of Health. The Higher Risk General Surgical Patient [Internet]. 2011. Available from: http://www.rcseng.ac.uk/publications/docs/higher-risk-surgical-patient/@@download/pdffile/higher_risk_surgical_patient_2011_web.pdf

[2] **Symons N R A, Moorthy K, Almoudaris A M, Bottle A, Aylin P, Vincent CA**
Mortality in high-risk emergency general surgical admissions
Br J Surg 2013;100:1318–25

[3] **Saunders D I, Murray D, Pichel a C, Varley S, Peden C J**
Variations in mortality after emergency laparotomy: the first report of the UK Emergency Laparotomy Network
Br J Anaesth 2012;109(3):368–75

[4] **Al-Temimi M H, Griffee M, Enniss T M, Preston R, Vargo D, Overton S, et al**
When Is Death Inevitable After Emergency Laparotomy? Analysis of the American College of Surgeons National Surgical Quality Improvement Program Database
J Am Coll Surg Am Coll Surg 2012;215(4):503–11

[5] **Vester-Andersen M, Lundstrøm L H, Møller M H, Waldau T, Rosenberg J, Møller a M**
Mortality and postoperative care pathways after emergency gastrointestinal surgery in 2904 patients: a population-based cohort study
Br J Anaesth [Online] 2014 Feb 24 [cited 2014 Mar 2];1–11

[6] **NELA project team**
First organisational report of the National Emergency Laparotomy Audit
RCoA London, 2014
Available at http://www.niaa.org.uk/report (accessed on 4th June 2014)

[7] **Hall B L, Hamilton B H, Richards K, Bilimoria K Y, Cohen M E, Ko CY**
Does surgical quality improve in the American College of Surgeons National Surgical Quality Improvement Program: an evaluation of all participating hospitals
Ann Surg 2009;250:363-76

[8] **The Society for Cardiothoracic surgery in Great Britain and Ireland**
Maintaining patients' trust: modern medical professionalism 2011
http://www.scts.org/_userfiles/resources/634420268996790965_SCTS_Professionalism_FINAL.pdf
(accessed on June 4th 2014)

[9] *National hip fracture database report 2013*
http://www.nhfd.co.uk/20/hipfractureR.nsf/luMenuDefinitions/CA920122A244F2ED802579C900553993/$file/NHFD%20Report%202013.pdf?OpenElement
(accessed on June 4th 2014)

[10] **Huddart S, Peden C, Quiney N**
Emergency major abdominal surgery – "The times they are a-changing"
Colorectal Disease 2013;15: 645-649

ARE PATIENT-REPORTED OUTCOME MEASURES (PROMS) A USEFUL TOOL FOR QUALITY IMPROVEMENT?

Andrew Hutchings
Department of Health Services Research & Policy, London School of Hygiene & Tropical Medicine and Clinical Effectiveness Unit, Royal College of Surgeons of England

The National Health Service in England defines three dimensions of quality in healthcare: clinical effectiveness, patient safety, and patient experience. Patient experience is, in most circumstances, best measured by asking patients about their own experience of the care they received. Patient-reported measures also have a role in the assessment of clinical effectiveness and safety. For many areas of healthcare, including much routine elective surgery, outcomes such as mortality are rare, so patient-reported measures can provide a better indication of the effectiveness of care.

The national PROMs programme for elective surgery in England started in 2009 and has been running for five years. All NHS and independent providers of NHS-funded surgery for four common elective procedures (hip and knee replacement, groin hernia surgery, and varicose vein surgery) are required to take part. Patients are asked to complete a pre-operative questionnaire before their surgery and are then mailed a post-operative questionnaire three months (hernia and varicose vein surgery) or six months (hip and knee replacement) after surgery. The questionnaires include condition-specific and generic quality of life measures, as well as items about general health and complications after surgery. Almost three-quarters of eligible patients complete a pre-operative questionnaire and around eighty percent of these patients return a post-operative questionnaire.

Results are disseminated through national publications and include analyses of outcomes by hospital. An example of this is a spreadsheet that includes an interactive funnel plot for comparing the casemix-adjusted outcomes for different providers (http://www.hscic.gov.uk/catalogue/PUB11359). Organisations with outcomes that are better or worse than expected are classified as 'outliers'.

A recent evaluation of the impact of the programme found little evidence of improvement by the third year [1]. Marginal improvements in outcomes were observed but there was no evidence that variation in outcomes between hospitals had reduced in response to the collection and publication of the data. One possible explanation is that it may just be too early to see a difference. Time lags in the collection and publication of data mean that hospitals are seeing their results many months after the surgery was done. An alternative explanation is that largely passive dissemination of results in this way does not lead to improvement.

Two alternative pathways to improvement have been suggested [2]. The first pathway operates through selection; information on comparative performance allows patients to choose where to be treated. The second operates through change; providers improve quality by changing the way that they provide care. Early outputs from the PROMs programme were aimed at selection as the route to improvement. However, there is little evidence that patients, or indeed commissioners, have substantially altered their behaviour in response to the publication of comparative data on outcomes.

A better prospect for improving quality is through the change pathway. Publication of comparative results aggregated by the provider does not tell hospitals why their performance is where it is or how they might go about improving it. If hospitals and staff want to improve care by using routine PROMs data then they will need to interrogate individual PROMs data from their own patients. The consent provided by patients completing the PROMs questionnaires has been altered to allow hospitals easier access to their own data. Hospitals can now examine data on patient-reported outcomes alongside clinical data at levels of detail that are not possible on a national scale, but this will require the involvement of the surgeons and other clinical staff providing care. It will also require an appreciation of the limitations of the data being used, for example, which patients don't participate, which patients don't complete post-operative questionnaires, and the inevitable time lags involved in collecting data on outcomes.

The full benefit of routine PROMs as a means of quality improvement has yet to be realised. The publication of comparative data on patient-reported outcomes is a start but, in itself, is unlikely to lead to substantial improvements in the quality of care. Innovative ways of using PROMs data that do lead to tangible improvements in the quality of care are far more likely to emerge as hospitals and surgeons examine their own data and share their experiences with others.

References

[1] Varagunam M, Hutchings A, Neuburger J, Black N
Impact on hospital performance of introducing routine patient reported outcome measures in surgery
J Health Serv Res Policy 2014;19:77-84

[2] Berwick D M, James B, Coye M J
Connections between quality measurement and improvement
Med Care 2003;41(Suppl):30-8

AN UPDATE ON THE INTERNATIONAL BURSARY PROGRAMME

Sarah Davies
Development Officer and Partner Relations Manager, ASGBI

"I learnt that in my capacity as a future African surgeon, I can influence change in my developing nation, by coming up with innovative ways to address the unique challenges faced by surgeons in my part of the world."
Dr Wambui Njoroge, 2014 International Bursary Winner

2014 marked the seventh consecutive year of the Surgical Foundation's popular International Bursary programme. The purpose of the programme is to give surgical trainees from poorly-resourced, low-income countries the opportunity to experience short clinical placements in UK hospitals. Bursary recipients also receive complimentary access to the ASGBI International Surgical Congress, with a substantial contribution towards their travel costs, as well as accommodation and subsistence for the duration of their stay.

Each bursary is worth a total of £2,000. This year, we were able to offer eight bursaries through the generous donations of Cook Medical, Ethicon and the BJS, as well as our very special individual donors, Mr J Pye, Mr M H Gough, Mr R E C Collins and Mr Jack Bradley, who recently passed away.

The International Bursary programme aims to improve standards of surgery around the globe, not only through developing the knowledge and skills of individual trainees, but also by encouraging them to pass on information to their colleagues.

Since 2008, the Surgical Foundation has received 184 complete applications for the International Bursary programme. Each of these has been rigorously assessed by a specialist panel made up of members of the International Development Committee. We are very proud to have hosted 58 very worthy winners over this period.

It is no coincidence that the best-represented countries are those that the Surgical Foundation has been actively involved with. In 2013 for example, we ran 'Basic Surgical Skills', 'Management of Surgical Emergencies', 'Training the Trainers' and Theatre Nurse Training Courses in Zambia, Kenya, Malawi and Uganda. You can read full reports from the delivery of these courses here:
www.internationalsurgery.org.uk/reports.

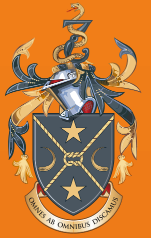
This year's winning applicants were hosted by the surgical team at St. James' Hospital in Leeds where they spent an entire day observing operations according to their surgical interests. Our sincere thanks go out to Mr Kieran Horgan who facilitated the Bursary Winners' stay at St. James' Hospital, as well as the consultants and operating teams that hosted them in-theatre. Here is what some of our Bursary Winners said about the experience upon their return:

"I observed a breast reconstruction surgery and thereafter, I watched a thymusectomy. Both procedures were brilliantly done by a team consisting of a consultant, a resident, a doctor anaesthetist, theatre nurses and support staff. I was impressed with the hospital protocols for doctor and patient safety and with the availability of CT images on a computer in the theatre. The knowledge I gathered was overwhelming and I have taken much of it back home so as to inspire my colleagues and other hospital personnel."
Dr Vanessa Msosa

"I observed resection of a tumor of the small intestine in a lady who presented with signs of obstruction and had a history of kidney resection for malignancy. Intra operatively, the surgeon realised that she had several liver lesions of variable size, and because the primary was unknown, a liver biopsy was performed using a

The winners since the inception of the programme represent 15 countries across Africa, the Middle East, the Indian subcontinent and even Eastern Europe:

Uganda: 12	Rwanda: 5	Iraq: 1
Kenya: 8	Nigeria: 3	Ukraine: 1
Zambia: 8	Ghana: 2	Tanzania: 1
India: 6	Malawi: 2	Papua New Guinea: 1
Sri Lanka: 6	Ethiopia: 1	Sierra Leone: 1



harmonic scalpel. What was interesting about the patient was the sub specialisation of the different members of staff, where the colorectal surgeon did the tumor resection while the hepatobiliary specialist did the liver biopsy. From the teamwork that I observed among the different cadres of theatre staff, I hope that someday I will implement a similar seamless working environment in my practice."
Dr Wambui Njoroge

The Bursary Winners were all very complimentary about the Congress itself and provided comprehensive details and feedback, not only of the scientific sessions and workshops they attended, but the Congress exhibition:

"One thing I understood from the conference is that surgeons of ASGBI are also concerned about improving surgical care in low income settings. The session on 'The Right to Heal' and other related ones, such as the International Development Session on the benefits of volunteering, held on 1st May and 30th April respectively, revealed this concern."
Dr Thomas Ashley

"From the exhibitions, I learnt of the advancements being made by various companies, especially in the field of laparoscopic surgery. This was exciting because the companies that I was previously familiar with seemed to have a monopoly in the market. I obtained contacts of companies that could supply high quality materials at an affordable cost especially for resource-constrained settings."
Dr Wambui Njoroge

Our thanks, once more, goes out to all concerned for another great year. In 2015, we aim to host more winners and to give them the opportunity of two days in a host hospital in Manchester. In respect of the International Bursary programme more generally, we also hope to be able to extend our outreach to other international regions, particularly South America, in the coming years.

If you would like to donate to the 2015 programme you can do so in the following ways

Follow this link to download and print a donation form:
http://www.thesurgicalfoundation.org.uk/pdf/The%20Surgical%20Foundation%20-%20A4%20Donation%20Form%20-%20Web.pdf

You can also donate £10 to the work of the Surgical Foundation by texting **SURG12 £10** to **70070**.

If you are interested in hosting some of our 2015 bursary winners in a hospital in or near Manchester, please contact **sarahdavies@asgbi.org.uk**.

You can find full details of the International Bursary Programme, along with testimonials of previous recipients, online at: **www.thesurgicalfoundation.org.uk/international_bursaries**

Our 2014 International Bursary winners. From left to right: Job Kuteesa, Parameswaran Pragatheswaran, Robert Masereka, Vanessa Msosa, Cathy Kilyewala, Wambui Njoroge, Thomas Ashley and Jack Barasa

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

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BIENNIAL INTERNATIONAL CONFERENCE ON SURGICAL EDUCATION AND TRAINING (ICOSET), 29th to 30th APRIL, HARROGATE

A report by Professor Jonathan Beard Chair, ICOSET 2014 Organising Committee

The fourth ICOSET meeting was held immediately before the 2014 International Surgical Congress of ASGBI, and what a fantastic meeting it was. The benefit of back-to-back conferences was immediately apparent, as there were nearly 300 registered delegates – 40% from overseas. Low registration fees and the central location of Harrogate, with its inexpensive range of accommodation, encouraged many UK trainees to attend, and for the first time, surgical educators from mainland Europe, Africa and Asia.

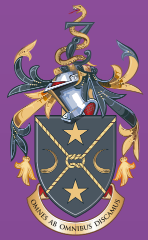
As the Chairman of the ICOSET Organising Committee, I must thank ASGBI for their organisational support, and Jess Pether (Communications Officer) in particular. Thanks also to the RCSEng and RCSEd for their financial support for keynote speakers and to ASiT and BOTA for their contributions to the programme. It was good to see the trainee organisations demonstrating their commitment to improving surgical training.

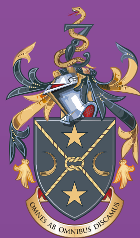
The meeting kicked off on Tuesday morning with a lively debate between Richard Reznick and Angus Wallace on the pros and cons of supernumerary (competency) based training versus the old apprenticeship (in-service training) model. Richard put forward cogent reasons for supernumerary training but Angus was concerned about the cost of completely separating training from service, which was a major reason why the recommendations of the Temple Report were not implemented. Angus suggested that supernumerary training might produce technically competent surgeons who did not have adequate decision-making or professional skills, but Richard was able to reassure us with evidence in that aspect. The general consensus of the audience was that training should be prioritised but not separated from service commitments, and that this needed to be combined with better educational supervision and a mentor/coach for the duration of training.

Professor Richard Reznick proposing his motion for the opening debate

The rest of the morning was taken up with a major session on international challenges to surgical education and training, involving the heads of education of many Colleges of Surgery, including Wolfgang Feil from Europe (UEMS), Carlos Pellegrini from the USA, Ken Harris from Canada and Stephen Tobin from Australasia. The Presidents of ASiT and BOTA chaired this session and before the conference, all speakers had been asked by Piriyah Sinclair (ASiT Education Lead) to identify and prioritise their top ten challenges. The aim of the session was to move towards a consensus on the most important challenges and how they could be solved. There was much agreement between the speakers and also recognition that the challenges for surgical training in low-income countries were very different from those in high-income countries. This was an interactive session and, towards the end, the audience were asked to vote on the top ten challenges - it was not a surprise that 80% of the audience voted resolution of the conflict between service and training as their first or second priority. The next step is to circulate the results to the Consensus Group with the aim of agreeing and publishing recommendations for surgical training.

Tuesday afternoon included a fascinating session on alternative training paradigms with presentations from Richard Hampson, the British Canoe Team psychologist, Iya



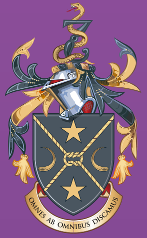


Whiteley, from the Space Institute, and Gordon Graham from the Royal Navy. This was followed by a session on integration of simulation into the curriculum, chaired by Chris Munsch from HEE and Jan-Maarten Luursema from the European Simulation Network. This identified the need for better networking of procedural skills centres and skills courses, and more investment in trainers to staff and run them. As a resident of Harrogate, Chris also produced a guide on local pubs and restaurants for conference delegates, which he says took many hours of painstaking research! The session on making assessment systems fit for purpose focussed on three areas: better use of workplace-based assessments, more research into selection methodology and discussion about the purpose and timing of examinations. The chairs, Gareth Griffiths and Isabelle van Herzeele, reminded us that Harrogate was a previous venue for the forthcoming Eurovision Song Contest. That year, it was won by Germany but fortunately the session ran out of time before they had a chance to replay the winning song!

Ex ASiT Council members reminiscing in the bar at the Majestic Hotel after the faculty dinner

The afternoon finished with presentations of Innovations in Surgical Education by trainees delivered to a “Dragons’ Den” panel. This lively session was a lot of fun and expertly compered by Craig McIlhenny from the RCSEd, whilst the audience were able to enjoy a glass or two of wine.

The Dragons’ Den panel cross-examining an applicant for the Innovations in Surgical Education Prize



Professor Eduardo Salas delivering his memorable talk on team training

The ICOSET Faculty Dinner on Tuesday evening, combined with the ASGBI Council Dinner, was a great opportunity for surgeon educators from many parts of the world to renew acquaintances, including many 'old timers' from ASiT. On Wednesday morning, I was relieved to find everyone up and ready for the three breakfast workshops: Non-Technical Skills for Surgeons, run by Simon Patterson Brown from Edinburgh; Strengthening Trainee Organisations and Developing an International Trainee Network, run by Andi Beamish from ASiT; and Educational Research in Surgery: Tips, Skills and Opportunities, run by Kirsten Dalrymple from Imperial College and Rola Ajjawi from Dundee.

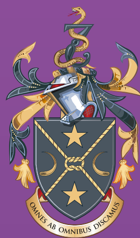
Following a reviving coffee break, we combined with the Association of Trauma & Military Surgery (ATMS) for a plenary session on team training. This kicked off with a wonderful presentation from Eduardo Salas, Professor of Psychology at the University of Central Florida, who shared with us the overwhelming evidence for the benefit of theatre team training in terms of improved patient outcomes and reduced insurance/litigation costs. Mark Midwinter and Eric Elster then gave talks on training in trauma surgery from a UK and US perspective respectively. Their talks were followed by a presentation from Bryn Baxendale, Consultant Anaesthetist and RCSEng Education Tutor, on plans for implementation of team training for all surgeons and operating theatre staff.

The session on mentorship and coaching programmes began with helpful presentations on the various models available, including OSCAR, EGAN and GROW, from Matt Driver and Lorna Marson from the London Deanery, and Nancy Redfern from the Glasgow College. Piriyah Sinclair then gave us an update on the mentoring programme for trainees being piloted nationally by ASiT. Surjait Singh from the DPA Forum and Liz Spencer from the National Association of Clinical Tutors chaired the session skilfully. Following a lively discussion with the audience, it was agreed that mentoring/coaching should be recommended for all surgeons, not just those in difficulty, but that there must be a flexible approach led by surgeons not employers.

After lunch, John Collins, ex-Head of Education at the Royal Australasian College of Surgeons and the author of the review on Foundation Training, gave the Halstead Lecture on The Future of Surgical Training – Lest we Forget, chaired by Norman Williams, President of RCSEng. John reminded us that although surgical training will have to change, we should take care not to throw the baby out with the bathwater. The ICOSET meeting then joined the ASGBI Congress for a motivational lecture on Making Surgery Safer by Atul Gawande, followed by a presentation on the Shape of Training Review by Professor David Greenaway and a lengthy discussion about the implications for surgical training.

The Halstead Lecture on the future of surgical education, delivered by John Collins

The two-day ICOSET meeting finished off with a reception in the exhibition area, the award of the RCSEng Prize for the best short paper, and the RCSEd Prize for the best innovation in surgical education; a great end to a very successful meeting. I then left for a lie down and await the evaluations with interest, as I need the evidence for my revalidation portfolio - one of the few things we didn't talk about!



SOC-GBI SUMMER UPDATE

A year following its launch at the ASGBI Congress in Glasgow, our new collaborative, the Surgical Outcomes Club of Great Britain and Ireland (SOC-GBI), successfully hosted its first half-day workshop in Harrogate. We retain one simple aim: to build a collaborative, real and virtual, of like-minded clinicians delivering quality care and outcomes at patient level, through enhanced understanding of our practice.

For an infant group, progress in the first year has been steady and significant. Having benefitted from initial ideas and energies from the American club of the same name (SOC), not least from Dave Flum's ongoing advisory role, the interim steering group has worked to define the organisation and its goals. The summary of our workshop below describes the sorts of work SOC-GBI aims to support and to learn from, whilst at the same time, providing a collaborative society of like-minded clinicians. Do consider joining us.

Our invited faculty at the Harrogate workshop were diverse and inspiring
Arden Morris, current SOC (USA) Chair, and Chief of Colorectal Surgery at the University of Michigan, provided a fascinating insight into her multi-methods research approach, whereby greater understanding of patient-clinician relationships studied qualitatively, against quantitative outcomes, could suggest beneficial interventions to breaking down barriers to better healthcare participation in certain groups of society. Some personal anecdotes of her own family's experiences of healthcare in the USA provided a human aside, but she also provided assurance of the relevance and importance of human level understanding for all of us in working to improve outcomes.

Arden Morris, current SOC (USA) Chair

Human factors were then discussed at a very different level by Rhona Flin; Professor Flin holds a chair in applied psychology at the University of Aberdeen and has produced a wealth of relevant research around human performance in high risk industries, including Surgery. We learned how our behaviours may be honed and learned from in order that our teams and our patients may be managed optimally, with scope for a wide variety of research in this area.

Mike Englesbe, also from the University of Michigan, where he is an Associate Professor of Surgery/Transplantation, introduced us to implementation science – hugely important in translating good ideas at grassroots level to meaningfully improved outcomes across whole populations of patients. The examples pertained to pre-operative 'training' programmes in Michigan, whereby an extension of Enhanced Recovery Programmes ensures patients are optimised prior to surgery, with anthropomorphic assessment providing a novel target for fitness interventions. Driving these programmes in at scale, in order to show benefit, is difficult, and Mike shared with us the lessons he has learned in the process.

Mike Englesbe from the University of Michigan

Jane Blazeby provided the context for contemporary surgical research; in order that we can all meaningfully learn lessons, we need simply to start measuring the same thing, be it from patient or clinician perspectives, but preferably both together. Jane is Professor of Surgery at Bristol and instrumental in COMET (Clinical Outcomes for Measurement of Effectiveness in Trials). Her work in developing core outcomes sets within upper GI cancer practice showed some surprise findings: patients may rate certain outcomes far higher than those considered crucial by clinicians. Within a limited healthcare system, providing the means for clinician and patient priorities to be aligned, and then ensure they are measured in any learning system, provides a huge challenge, but ultimately should ensure lessons can be learned towards evidence-based improvements for our patients.

Limited healthcare systems were again emphasised by Craig Ramsay, chair of Health Care Assessment at Aberdeen, who provided some fascinating examples of economic evaluations which did not always provide evidence that may align with clinicians' preferences, including a precautionary tale against non-evidenced innovations. Decisions on effectiveness, costs, and the broader impact of interventions need to be very carefully balanced in our current economic era.

Omar Faiz provided an insightful and relevant final talk within our workshop, tying together many key messages for the UK audience. Within

his colorectal practice at Imperial College, he has built extensive expertise in surgical epidemiology, including research and interventions at the interface with healthcare provider regulators. The importance of relevant research and measures was emphasised, examples cited around his own group's work on failure to rescue and returns to theatre in the context of laparoscopic colorectal surgery. By the end of this session, it was clear that there was both a need and appetite for this kind of meaningful clinical research within our new community.

Our guests from Michigan provided further useful input to the Congress, hosting an informal Hub session around practical approaches to data collection for enhanced surgical outcomes (in conclusion – there is no easy solution). Arden then provided a transatlantic perspective, joining with UK clinicians including our Steering Group's Ewen Harrison, to provide more insights to improving surgical outcomes in the symposium of the same name on the final day of the Congress.

As last year, there was an increasing interest and enthusiasm around the Congress for SOC-GBI's approach to surgical outcomes improvement work, and learning from practice; be it health services research, quality improvement work, or focussed collaborations, the goal now is to join forces and provide the UK with a strong core of meaningful, patient-focussed surgical outcomes research expertise.

Time at the Congress was insufficient to allow a formal AGM to be conducted, and given the Society's relative infancy, a supported decision was taken for the Steering Group to continue for another year. We shall keep the draft constitution on our website, whilst formalising the structure will be required when the Club has matured sufficiently to apply for charitable status. The Club is indebted to Covidien and Imran Farid, Commercial Partnership Manager, for their generous support of the workshops. Also, Dendrite Clinical Systems have provided an online data collection tool for laparoscopic cholecystectomy, which should prove an interesting pilot study of the process of data sharing for quality improvement.

Further mail updates will follow soon, and our new website will form the focus of discussion fora and news updates: **www.socgbi.org.uk**. In the meantime, please make note of the following events of interest:

- The SOC-USA meeting is taking place in San Francisco on Sunday 26th October. Collaboration and joint working is to be a focus, and attendance at this is encouraged.
- SOC-GBI will host a mid-year workshop, with some novel methodology talks and speakers. Date TBC in November 2014 – details to follow.
- Dave Flum's 6th biennial outcomes research course is in Chicago from 4th to 6th December; a great learning and networking opportunity.

Association of Surgeons of Great Britain and Ireland and The Surgical Foundation

2014 MOYNIHAN TRAVELLING FELLOWSHIP

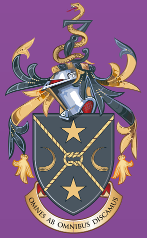
The prestigious Moynihan Travelling Fellowship, up to the value of £5,000, is available annually by open competition to Specialist Registrars towards the end of higher surgical training or Consultants within five years of appointment at the closing date for this application. The Fellowship is intended to enable the successful candidate to broaden their education and to present and discuss their contribution to British and Irish surgery overseas. It is not appropriate, however, that the award be used as part-funding for an off-service year of training.

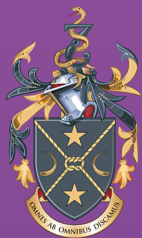
Candidates must be residents of the United Kingdom or the Republic of Ireland but need not be either Fellows or Affiliate Fellows of the Association; however they should be engaged in general surgery or in one of its specialties. A full Curriculum Vitae should be submitted giving details of all past and present appointments and publications, together with a detailed account of the proposed programme of travel, costs involved and objectives to be achieved during the Fellowship.

Short-listed candidates will be invited to attend for interview by the Association's Scientific Committee. The Committee will pay particular attention to originality, scope and feasibility of the proposed itinerary. The successful candidate will be expected to act as an ambassador for British and Irish Surgery and should be fully acquainted with the aims and objectives of the Association of Surgeons of Great Britain and Ireland and its role in surgery.

After the Fellowship, the successful candidate will be required to provide a written report of their Fellowship for inclusion in the Association's Journal, and to address a future ASGBI International Surgical Congress. A critical appraisal of the Centres visited, together with an assessment of how the experience will enhance future personal and professional development, should form the basis of the report.

Applications should be submitted online at **www.asgbi.org.uk** by the closing date of **Friday 3rd October 2014**.





THE 2014 INTERNATIONAL SURGICAL LEADERS' FORUM HOSTED BY ASGBI

Sarah Davies
Development Officer and Partner Relations Manager, ASGBI

Background to the International Surgical Leaders' Forum
On 30th April in Harrogate, and coinciding with the Association's 2014 International Surgical Congress, the President of ASGBI hosted the third meeting of the International Surgical Leaders' Forum (ISLF).

The purpose of the ISLF is to provide a platform for discussion regarding variation in international surgical practices, improving surgical standards and reaching consensus on pan-surgical issues. Discussion takes place between a changing roster of worldwide leaders in the field, each representing a national or international organisation. This is with a view to its becoming a spearhead for local, national and international action appropriate to issues arising out of such discussion. Initially it is planned that this will be enacted through reports to the World Health Organization (WHO).

ASGBI is very pleased to be recognised amongst a host of prestigious international organisations in the ISLF. We appreciate the invitation to collaborate on such an initiative, especially considering the Association's proven track record of interest in surgical safety through its development of, and affiliation with, the Confidential Reporting System for Surgery (CORESS), and its history of collaborating with surgeons in poorly resourced countries to broaden training and improve surgical standards through the work of its charitable arm, The Surgical Foundation. ASGBI President, Professor John Primrose and ASGBI Programme Director for Overseas Development, Mr Robert Lane, were in attendance at the last meeting of the ISLF, hosted on 7th October 2013 in Washington D.C. and, impressed by the scope and ambition of the Forum, suggested that the ISLF be hosted by ASGBI in the UK at the time of the Congress. ASGBI is the first organisation to host an ISLF meeting outside of the United States, taking a significant step towards broadening the ownership and shared responsibility of the forum and its activities.

The following organisations were represented at the ISLF in Harrogate

- Academy of Medicine of Malaysia: College of Surgeons
- American College of Surgeons
- Association of Surgeons of South Africa
- College of Surgeons of East, Central and Southern Africa
- Colleges of Medicine of South Africa: College of Surgeons
- European Union of Medical Specialists and European Board of Surgery
- German Society for Surgery International Relations Committee
- Pan African Association of Surgeons
- Pelican Cancer Foundation
- Royal Australasian College of Surgeons
- Royal College of Physicians and Surgeons of Canada
- Royal College of Surgeons of Edinburgh
- Royal College of Surgeons of England
- Royal College of Physicians and Surgeons of Glasgow
- Royal College of Surgeons in Ireland
- West African College of Surgeons

The agenda for the Harrogate meeting of the ISLF focused on international variation in surgical standards, sustainability in surgery and surgical organisations, evolving surgery in low-income countries as well as establishing procedure for the ISLF going forward.

International Variation of Surgical Standards
The American College of Surgeons, in collaboration with the International Relations Committee (IRC), conducted a survey of Forum attendees at the 2013 meeting in Washington D.C. to better understand variation in surgical patient safety and quality practices internationally. The initial results were presented in Harrogate. The IRC intends to follow up on the survey findings and probe further the issues behind some countries not being able to have a culture of safety in the operating room. The IRC intends to develop an additional questionnaire and submit it to international chapters for their input in order to further identify the issues and propose an appropriate action plan.

Sustainability in Surgery
The Chief Executive of ASGBI, Professor Nicholas Gair, made a presentation to the ISLF about the Association's green and sustainable agenda. In line with UN and UK Department of Health targets specifically designed to protect forests and cut carbon emissions, ASGBI has taken significant steps towards becoming a 'paperless' organisation. The ISLF also received a presentation from SpotMe, the company which delivered the app for the first ever paperless ASGBI Congress. The notion of making future surgical Congresses paperless was very well received and represented surgical organisations will explore how to implement such transition themselves. The ISLF will also consider making an official statement in support of such an initiative.

Evolving Surgery in Low-Income Countries
It was broadly agreed that the emphasis in this instance should be on collaboration rather than aid, and that a structured product should be delivered 'on a joint basis' with existing international and regional organisations. In light of this, the impact of The Surgical Foundation's existing Basic Surgical Skills courses was highlighted, and it was suggested that they could be rolled out across West Africa. In areas where the Basic Surgical Skills course has already been established, an Advanced Surgical Skills course was already being delivered. The main outcome of this part of the meeting was that the ISLF organisers should approach international representatives to collect data about what surgical assistance was required in their respective countries. The data collected would contribute to the development of ISLF strategy.

In the spirit of facilitating new connections, The Surgical Foundation's 2014 International Bursary winners, surgical trainees from around the world, were also provided with an opportunity to meet with the distinguished attendees at the International Surgical Leaders' Forum.

The Way Forward for the ISLF
It was felt that the process of co-ordinating meetings should be enacted through the international surgical organisations, rather than their Presidents as their terms of office change so frequently. It was agreed that meetings should continue to be held at the annual American College of Surgeons Clinical Congress, following the inaugural lecture. The next meeting of the ISLF will therefore be on Monday 27th October in San Francisco. It was also suggested that an additional meeting per year be held at another international location, to be determined by the group based upon upcoming international surgical meetings.

Following the success of the 2014 meeting, and the continued interest of its attendees, ASGBI aims to host the Forum once again on Wednesday 11th May 2016 at its International Surgical Congress in Belfast.

REVALIDATION FOR RETIRED DOCTORS AND THOSE PREPARING TO RETIRE

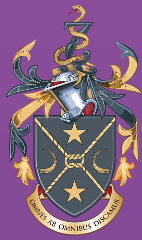
The GMC and British Medical Council have recently worked together to publish a guidance document on revalidation for retired doctors, or those planning to retire in the near future. We believe this document could be of interest to our more senior members, so as well as being available to view on our website asgbi.org.uk/en/news/detail/index.cfm/nid/DE37444C-FC83-430F-9B9D177F66D68883, the key points of interest have been summarised by the **ASGBI Journal Production Manager, Jess Pether**, in the article below.

Revalidation has been a hot topic amongst surgeons and doctors for the past 18 months and is "*part of a broad system of measures promoting improvements in the safety and quality of UK healthcare*".

If you retire, but wish to keep your licence to practice, you need to revalidate annually. This is regardless of whether you do any clinical practice and regardless of whether you're employed or contracted by an organisation. Your licence gives you legal rights and privileges in relation to practice in the UK, but if you do fully retire, you should consider giving up your licence. This will take away your need to revalidate.

As a licensed doctor, revalidation works by the process of annual appraisal. At your appraisal, you should be able to demonstrate that you have reflected on information about the whole of your practice.

There are three specific ways to revalidate, depending on your circumstances.



1) If you have a legally prescribed connection to a designated body, your revalidation will be based on a recommendation by your **responsible officer**. This is usually the medical director, and they will base their recommendations on your appraisal and other information drawn from the organisation's clinical governance systems.

   There is a clear set of rules which determine if you have a designated body, set out in ***Medical Profession (Responsible Officers) Regulations 2010, as amended***. The GMC also publishes a list of designated bodies and their responsible officers at **www.gmc-uk.org/dbtool**.

2) If you don't have a responsible officer, you can find a **suitable person** to make your revalidation recommendation instead. You can read more about identifying such a person on the GMC website (**www.gmc-uk.org/suitable**).

The role of this person, who must be approved, is basically the same as a responsible officer. The person must:

- Have a licence to practice and have been registered continuously with the GMC for at least five years.
- Have a connection to a responsible officer or another approved suitable person for their own revalidation.
- Be a responsible officer (or hold a similar post) in an organisation operating and located in the UK or the Isle of Man.
- Have a logical link to your current medical practice.

If you find such a person, and they are willing to act as your suitable person, they must apply to the GMC to have their application approved.

3) If you don't have a responsible officer or a suitable person, this does not mean that you can't revalidate. You must first inform the GMC by emailing **revalidation@gmc-uk.org**, including your GMC reference number.

   Each year, you will need to provide the GMC with information about your fitness to practice and evidence of your participation in appraisals. If requested, you will need to complete an independent assessment of your medical knowledge and skills. You will also need to pay a fee for the assessment, and so that the GMC can evaluate the evidence.

   If you pass the assessment and all your evidence shows that you are fit to practice, you will be successfully revalidated for another year. There would need to be further investigation, and your licence would be at risk, if you don't successfully pass the above criteria.

If you don't have a responsible officer or a suitable person, it may be harder for you to have annual appraisals. In this case, you will need to arrange these yourself through an independent provider of UK medical appraisals.

There is an established set of criteria for doctors in this group, to make sure that the appraisals are appropriate and robust. You are responsible for making sure that your appraisal and appraiser comply with the criteria set out in section 4.4 C of the GMC's ***A guide for doctors to the General Medical Council (Licence to Practise and Revalidation) Regulations 2012***.

If you decide to give up your licence to practice in retirement, you can still keep your good standing and registration with the GMC by paying a reduced annual fee. You can restore your licence free of charge at any point in the future, should you decide to.

In summary, there are three key things that you must do to revalidate once you are retired, to make sure that you can keep your licence to practice:

- Make sure you have an annual appraisal.
- Continuously collect supporting information to show how you are meeting the GMC's professional standards.
- Maintain a GMC online account.

For more information on revalidation, visit **www.gmc-uk.org/revalidation** or email **revalidation@gmc-uk.org**. You can also visit **www.bma.org.uk/practical-support-at-work/revalidation** or email **info.revalidation@bma.org.uk**.

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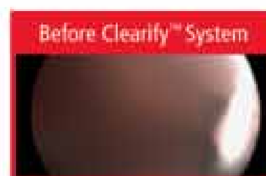

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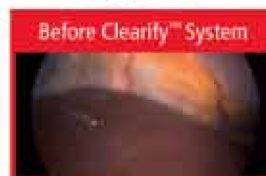

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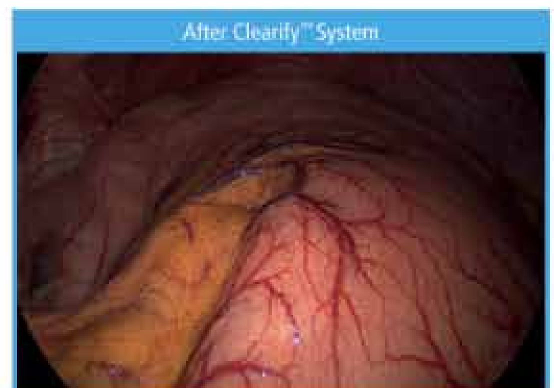

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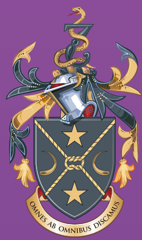


EXPERIENCES FROM THE ORGANISERS OF AN UNDERGRADUATE CONFERENCE

Ben Green, UKMSA President

Thomas Lemon, UKMSA Vice President

Lydia Burland, UKMSA Mentoring Co-ordinator

Anam Anzak, UKMSA Conference Co-ordinator

Encouraging collaboration
The United Kingdom Medical Students' Association (UKMSA) is a student-doctor collaboration aiming to unite over 40,000 medical students across the UK. Whilst the UKMSA run projects throughout the UK, the conference is the annual flagship event that aims to inspire students to support the strength of clinical and academic medicine in the UK, equipping students with the ability to make more informed choices about their careers and collaborate across borders.

The UKMSA were proud to host their third international Medical Student Conference on 2nd May 2014, in conjunction with the ASGBI International Surgical Congress and ICOSET (International Conference on Surgical Education and Training).

For the first time ever, the UKMSA opted to host a multi-professional conference with attendees including medical, nursing, physiotherapy, and pharmacy students. As changes come about regarding the way that healthcare is delivered within the UK, the promotion of multi-professional co-operation will become ever more important and, therefore, the encouragement of these practices amongst an undergraduate audience is paramount.

An exciting line up
The conference was opened and the sessions chaired by Dr Anam Anzak, conference co-ordinator and final year medical student at University College London. The morning of the conference saw host to an exciting line-up of thought-provoking lectures, delivered by a number of renowned guest speakers. In keeping with the mixed disciplinary audience, the day aimed to appeal to, and address issues common to, all future healthcare professionals.

The first talk was from Julie Cullen, registered nurse and board member of NHS Portsmouth Clinical Commissioning Group, and a former Executive Board Member for Portsmouth Primary Care Trust, who delivered an engaging talk on NHS reforms. Amanda Cheesley, the Royal College of Nursing's Long Term Conditions Advisor next provided an informative presentation on the many issues surrounding Chronic Disease. This was followed by a series of fascinating insights from Jacob Dreyer of ASGBI's International Development Committee, and Jaymie Ang Henry from the International Collaboration for Essential Surgery, describing the challenges faced by surgeons in the developing world, as well as current initiatives to combat the problems. Dr Jonathan Sheffield, OBE, Chief Executive of the NIHR Clinical Research Network next provided a personal and uniquely inspirational insight into the fast-evolving world of medical research. The Plenary Lecture was a perfect finish to the morning sessions, and was delivered on the subject of the Pharmaceutical World by Professor Humphrey Rang, long-standing member of the Royal Society and author of the world-renowned text-book '***Pharmacology***.'

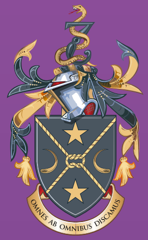
Professor Humphrey Rang delivering his highly anticipated speech to the delegates

The eminent line up of speakers helped to ensure the success of the conference, with their personal insights and expertise in their respective fields being warmly received by the delegates. Despite the presence of a multi-professional audience, the speakers maintained interest throughout and this was reflected in the unanimously positive feedback.

> *"Excellent quality of speakers and highly relevant topics."* **4th year medical student, Nottingham, UK**

Promoting research
In the past few years, the UKMSA have successfully run some of Europe's largest undergraduate medical conferences, striving to provide an experience that is both professional yet nurturing for an undergraduate audience. This year was no different and the decision was taken to allow delegates submitting highly scoring abstracts the opportunity to present orally, in addition to presenting posters. Posters and oral presentations were presented in any one of three important categories: Chronic Disease, Global Health, and Health Research. Broad categories were chosen in order to reflect the makeup of the audience and provide all delegates with opportunities to present.

Poster presentations were held during the coffee and lunch breaks throughout the day. In keeping with ASGBI, the UKMSA opted for an almost entirely paperless conference, utilising e-posters instead of the more traditional paper-



based approach. Whilst this decision was met with some initial scepticism from the delegates, we have since had positive feedback and are confident that with a few minor changes, the presence of e-posters will become normality at future conferences.

The student oral presentations were run alongside workshops during the afternoon that covered a variety of topics ranging from basic science and genomic analysis to epidemiological studies in sub-Saharan Africa. The student presentations were, overall, of an exceptional standard and well above our expectations of an undergraduate audience. It is indeed testament to the high standard of current undergraduates that the presentations were so well received by the audience, as well as being highly commended by both the UKMSA faculty and guest judges, including Dr Sheffield and Professor Rang.

Recognising achievement

Whilst providing a platform for students to present, is important that recognising and rewarding achievement remains an equally imperative part of the educational process, helping to inspire and encourage excellence. Whilst the judges were highly impressed with the standard of all the presenting delegates, we would like to recognise the contributions of a few outstanding individuals. Each of the following delegates performed exceptionally well, and topped their respective categories in their respective oral and poster categories.

- **Best Overall Presentation**
  J Buddery, University of Leeds
- **Best Oral Presentation (Chronic Disease)**
  M O'Regan, University of Glasgow
- **Best Oral Presentation (Health Research)**
  A Hayes, University of Sheffield
- **Best Oral Presentation (Global Health)**
  E Wilkinson, University of Leeds
- **Best Poster Presentation (Chronic Disease)**
  K Morris, University of Manchester
- **Best Poster Presentation (Health Research)**
  G Raghuram, University of Leeds
- **Best Poster Presentation (Global Health)**
  R Netherton, University of Manchester

Winner of the overall best presentation, Julie Buddery being presented with her certificate and prize by Dr Sheffield, Chief Executive of NIHR

Winner of the overall best surgical society, Cutting Edge, from the University of Leeds being presented with their certificate and prize, courtesy of the Royal College of Surgeons of Edinburgh

Supporting Professional Development

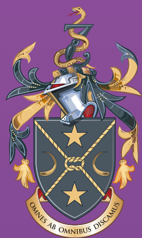
In order to provide as broad an experience as possible for the attending delegates, workshops were run in parallel with the student oral presentations during the afternoon of the conference. Themes included 'Abstract Writing and Critique,' 'Working and Training Abroad,' and 'CV Development.' All of the workshops proved to be hugely popular and were, in fact, oversubscribed on the day of the conference. The facilitators delivered the sessions in expert manner, providing a thoroughly enjoyable and highly educational experience for the delegates. This was again reflected in the workshop feedback, which was overwhelmingly positive.

> *"Very relevant to medical students - the speakers were very enthusiastic and approachable."* **Intercalator, Leeds, UK**

The UKMSA extends its sincere gratitude to both Nicholas Gollop and the Association of Surgeons' in Training (ASiT), who kindly supported and helped to secure the success of the workshops on the day of the conference.

In summary

The 2014 Conference was, overall, a resounding success and has continued to further the aims of the UKMSA in terms of promoting achievement and collaboration amongst medical undergraduates. The UKMSA would like to extend their gratitude to a host of sponsors, as well as the conference team who worked tirelessly behind the scenes, and of course to the delegates. After a series of highly successful undergraduate conferences, we are aiming to continue in similar fashion and are currently in discussions regarding our 2015 Conference.



THE ROYAL COLLEGE OF SURGEONS IN IRELAND'S COLLABORATION WITH COSECSA

Seán Tierney
Dean of Professional Practice and Development, RCSI

Eric O'Flynn
Programme Manager, RCSI/COSECSA Collaboration Programme

The Royal College of Surgeons in Ireland (RCSI) and the College of Surgeons of East, Central and Southern Africa (COSECSA) have been working together in a collaboration programme since 2007. Irish Aid has funded the collaboration programme since 2008. This collaboration has helped COSECSA establish itself as the most effective vehicle for reducing the surgical manpower deficit in East, Central and Southern Africa. Here, we will discuss the progression of the relationship and some lessons we have learnt which may have wider applicability for other international surgical training programmes.

Background

The two colleges have different histories. RCSI is an established college which celebrates its 230th birthday this year. In addition to its statutory role in providing postgraduate surgical training in Ireland, it is a university-level education facility with undergraduate and postgraduate courses, and employs nearly 1,000 staff members in Ireland, Bahrain, Malaysia and elsewhere. COSECSA was formed in 1999 and is starting from a much smaller administrative base. COSECSA offers common training programmes and examinations in ten member countries: Burundi, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe. Similarly to RCSI and the Surgical Royal Colleges in the UK, it offers membership and fellowship programmes. Fellowships are offered in general surgery, orthopaedics, ENT, urology, paediatric surgery, neurosurgery and plastic surgery. Since the first fellowship exams in 2004, 102 FCS(ECSA) specialist surgeons have graduated. As of March 2014, COSECSA has 209 surgical trainees in 33 training locations.

COSECSA has several international partners, among which ASGBI is a key partner. ASGBI and COSECSA collaborate to deliver Management of Surgical Emergencies and Basic Surgical Skills courses. Other international partners include universities, such as Oxford University, and NGOs such as IVUMed and CURE.

As with many collaborations programmes, the collaboration between the two colleges originated from a personal relationship; in this case, between the former presidents of both colleges. In 2007, RCSI, COSECSA and Irish Aid signed a memorandum of understanding to formalise the relationship. It has since developed into a cross-college collaboration involving RCSI departments as diverse as Surgery, Exams, Anatomy, Pathology, Physiology, IT, Communications, Media Services and the Leadership Institute.

Rationale

The rationale for the collaboration is to leverage the resources and expertise of RCSI to assist COSECSA in its goal of advancing education, training, standards, research and practice in surgical care in the ECSA region. Essentially, we believe that working with COSECSA in this way is:

a) a good thing to do

b) good for both partners

c) the right way to do things

Although surgery has not been a donor priority due to perceived cost, basic surgical care is, in fact, both effective and cost-effective. It is also desperately needed; 11% of the global burden of disease, as measured in DALYs, is estimated to be amenable to surgery [1]. With approximately 1,390 qualified surgeons for 265 million people, the region has a ratio of one per 190,000 people [2] compared to approximately 1 per 2,800 in the UK [3]. Of this small number of surgeons, the overwhelming majority are in the major urban areas, leaving rural East, Central and Southern Africa almost entirely without access to qualified surgeons.

Surgery is particularly needed to combat the growing tide of trauma and non-communicable diseases, which are replacing HIV/AIDS, TB and Malaria as the gravest health issues facing the developing world. In Sub-Saharan Africa, injury is the main cause of death and disability for children aged five and over [4] and road traffic accidents are the leading cause of death of 15 to 29 year olds worldwide [5].

The Copenhagen Consensus, developed by an international group of economists, found that of all possible interventions to solve all the world's

problems (including health, education, climate change etc.), surgery is the eighth most cost-effective intervention [6]. Basic surgery, when measured by DALY averted, is far more effective than anti retroviral therapy for HIV [7].

Given RCSI's mission to "educate, nurture and discover for the benefit of human health", advancing the training of surgeons in resource-poor environments is a core college activity.

Partnership

Much of the international response to the surgical manpower crisis in sub-Saharan Africa has focused on service provision or direct provision of training in surgical techniques. Training of local medical and surgical personnel by international organisations is an important contribution to meeting the unmet surgical need in the region. Train the Trainer programmes to develop the teaching skills of local surgeons are arguably more effective again. However, the RCSI/COSECSA collaboration is based on the principle that if effective local systems are not established in conjunction with these training efforts, then sustaining, developing and expanding locally relevant training programmes will be extremely difficult. Effective indigenous structures (like COSECSA), accountable to the community they serve, will be a more effective long-term solution to providing sustainable surgical training than international structures, however well intentioned. The RCSI/COSECSA collaboration, therefore, contains both surgical training activities and administrative capacity building activities.

The collaboration programme is overseen by a steering committee made up of half Irish-based and half African-based committee members. The Collaboration Programme deliberately does not try to lead in surgical training in the region, but to equip COSECSA to inhabit that leadership role. This follows best practise in the area of international development, as defined by the Paris declaration on aid effectiveness: *"Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption. Donor countries align behind these objectives and use local systems [8]."*

Programme Activities

Programme training activities have included courses such as the Train the Trainer on surgical pedagogy and leadership, which have trained 212 surgeons through 17 courses, in all 10 COSECSA countries. Through the Basic Science faculty programme, 27 surgeons completed a three-year training programme and are now recognised as the COSECSA basic science faculty. A number of fellowship level seminars and membership level basic science courses have also been delivered. The programme is training rural doctors in Zimbabwe in basic surgical techniques through the Zimbabwe Essential Surgical Training (ZEST) programme, and this is being expanded to Rwanda and Zambia.

RCSI examiners have assisted with the COSECSA exams every year since 2007. Now the exchange of examiners takes place in both directions. In late 2013, two COSECSA examiners were trained as MRCS examiners and will examine in RCSI exams in 2014. Other activities have included benchmarking the COSECSA exams against RCSI exams, collaboration on delivery of pre-exam seminars and an MCQ writing seminar and the filming of a DVD, which explains the COSECSA exams process.

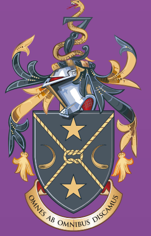
In the area of IT, an innovative and successful activity [9] has been the joint development and administration of an Africa-centric surgical e-learning platform (www.schoolforsurgeons.net). To facilitate access to this and other online resources, 25 IT labs have been equipped throughout the region and ongoing support of internet connectivity is a major programme item. A number of other training resources have also been created or adapted, and thousands of DVD copies distributed alongside the online learning.

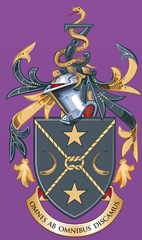
The collaboration jointly developed information management and financial systems, a website (www.cosecsa.org) and other resources. The collaboration supported the recruitment and the cost of staffing of the COSECSA secretariat in Tanzania, including a full-time international standard CEO. There has been significant administrative staff training and collaboration in administration and research. The collaboration has assisted in the promotion of COSECSA regionally and internationally. Finally, direct budgetary support has also been provided.

As the collaboration programme plans for the next three years, the emphasis on the systems building element of programme activities is expanding in importance. The collaboration is fortunate, through strong support from the RCSI senior management team, in being able to draw upon a wide range of expertise, as well as RCSI intellectual property and assets. One such asset is the mobile surgical skills education unit, which is currently being refurbished in anticipation of being transferred to COSECSA for use in delivering surgical training courses in the region.

Inherent Difficulties with Partnerships

We believe that genuine partnership is the best way that international educational institutions can help build capacity in the developing world. Partnerships are not, however, without their difficulties. Governance is a potential difficulty. In the RCSI/COSECSA collaboration, even if we do have a co-ownership model of governance,





we do have to be aware of the potential power imbalance between Western and Southern institutions and have strived to avoid a donor/recipient culture developing in the relationship.

Another difficulty is measuring impact. We think, as a partnership, we've been successful. But how do we know? In evaluating partnerships, it is hard to assign credit (or blame) for the progress made. The higher up the value chain the partnership works, the harder it becomes to measure. The cliché "what you can't count, doesn't count" often applies in international development and it is difficult for any collaboration to definitively take credit for a certain number of DALYs averted or lives saved.

Output

The difficulties of evaluation notwithstanding, there are many successes that can be attributed to the collaboration programme. At its most fundamental the collaboration has helped COSECSA dramatically increase its trainee numbers. These have increased from around 20 to 60 since 2008.

Perhaps most importantly, the programme is helping COSECSA put in place the administration needed to enable it to effectively lead surgical training in the region for many years to come.

It's a mutually beneficial partnership. The UK All-Party Parliamentary Group on Global Health's report on overseas volunteering within the health sector noted that "staff return from international work highly motivated, with increased work ethic and renewed vocation… It can revitalise people [10]." This is certainly felt to be the case in RCSI.

Lessons Learned

There is no doubt that all involved have learned an enormous amount from working on this collaboration. The lessons we have learned may not apply to every other scenario but we would urge others considering becoming involved in a development project in healthcare to at least consider these principles. While rooted and sustained by personal relationships and friendships, true sustainability requires the relationship to be formalised between institutions. If there is no institution to partner with – and there usually is - perhaps one needs to be created. It is crucially important not to nurture rather than undermine whatever capacity to provide the service that currently exists. Partnership between those institutions must be real with shared governance and true accountability for the performance of the partnership to the council or governing body of the host institutions.

In the case of education and training, the development of a sustainable indigenous service provider is more likely to be successful where the qualifications and educational structures provided are local rather than international. This does not mean that they cannot be to an international standard. In our case, the qualifications provided are COSESCA's rather than RCSI's.

Finally, there is no quick fix. These relationships require both a long-term commitment and consideration of an exit strategy. Hopefully, this exit strategy will be based on the fact that support is no longer needed and the relationship will continue to evolve into a partnership

Working within existing local structures is the most effective way to improve and expand surgical training. This is best practice in international development, and global surgery should follow the same principles.

[1] **Debas H T, Gosselin R, McCord C, Third A**
Surgery - Disease Control Priorities in Developing Countries (2nd edition)
World Bank
2006, chapter 67

[2] **RCSI/COSECSA**
A Review of Surgical Capacity and Surgical Education Programmes in the COSECSA Region
2011

[3] **NHS Health and Social Care Information Centre**
NHS Staff 2001-2011 Medical and Dental
2012

[4] **World Health Organization**
Bulletin of the World Health Organization
2002, 80:10

[5] **World Health Organization Media Centre**
Road traffic injuries Fact sheet N°358
2013

[6] **Copenhagen Consensus**
Unpublished Research
2012

[7] **Ozgediz D, Riviello R**
The "Other" Neglected Diseases in Global Public Health: Surgical Conditions in Sub-Saharan Africa
PLoS Med. 5(6):e121, 2008

[8] **Organisation for Economic Cooperation and Development**
Paris Declaration on Aid Effectiveness
2005

[9] **Goldstein S et al**
A Pilot Comparison of Standardized Online Surgical Curricula for Use in Low- and Middle-Income Countries
JAMA Surg (Online first)
2014

[10] **UK All-Party Parliamentary Group on Global Health**
Improving Health at Home and Abroad: How Overseas Volunteering from the NHS Benefits the UK and the World
2013

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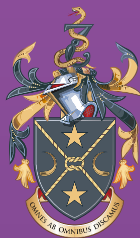

MAINTAINING GENERAL PAEDIATRIC SURGERY IN THE DGH

Jonathan Pye
Retired Consultant Surgeon and Past Honorary Secretary of ASGBI

Introduction
This is a supplementary article to follow up on the General Paediatric Surgery booklet [1], which is part of the Issues in Professional Practice (IIPP) series produced by ASGBI. In this short article, I will summarise the key issues and the main agreed ways forward to maintain General Paediatric Surgery (GPS) in the DGH.

There is a lack of "visibility" of the need for GPS, both to employing authorities/commissioners and to surgical trainees. This is leading to a lack of surgeons trained in GPS able to provide this service. I believe it is important that there is a pool of surgeons with some training in this surgery in addition to their chosen surgical subspecialty.

The overarching structure of a Managed Clinical Network (MCN) is the main practical mechanism that will allow GPS to remain in the DGH and to be performed to an appropriate standard. The full details are laid out in the IIPP booklet, ***General Paediatric Surgery***, referred to above. In this article I merely wish to lay out the main points as a reminder for those who may have missed the booklet.

What is GPS?
General Paediatric Surgery is the management of commonly occurring, non-specialist, surgical conditions that arise in children. A full list of procedures can be found in the National Services Specialist Definitions set [2], but procedures generally agreed to come under GPS [3] are for the following conditions:

Elective
- Inguinal hernia – not neonatal (less than 44 weeks corrected gestational age)
- Umbilical hernia
- Conditions of the foreskin
- Cutaneous or subcutaneous lesions
- Mal-descent of the testis
- Infantile Hypertrophic Pyloric Stenosis – usually only in a tertiary centre, depending on paediatric and anaesthetic support
- Minor anorectal conditions
- Endoscopy (If local expertise is available)

Emergency
- Acute abdominal pain
- Acute scrotal pathology
- Appendicitis
- Management of an incarcerated hernia
- Cutaneous or subcutaneous abscess
- Minor trauma
- Endoscopy (If local expertise is available)

Key Issues
Visibility
GPS used to be a normal part of the practice of general surgery. Paediatric surgeons became unhappy with the quality of the surgery carried out by some general surgeons and a swing towards paediatric tertiary centres began. The tertiary centres became swamped with GPS cases and insufficient capacity became evident. General surgeons have responded by changing practice with local subspecialisation to address the quality issue. However, in many people's minds, children's surgery became synonymous with children's surgeons and the capacity problem was not understood by the majority.

Shortened training times and the push towards early specialisation means that trainees are no longer put through GPS as part of normal training and it has thus dropped off their "radar" as a surgical avenue.

In most DGHs, the volume of GPS is insufficient for a full time appointment and is practiced in addition to the surgeon's main subspecialty. As this is provided in house, the manpower provision need is often not apparent to the hospital. Hospital job advertisements seldom make reference to GPS and thereby the stimulus for trainees to consider GPS as an additional skill is lost. Thus, GPS has become relatively invisible.

Tertiary centre capacity
Although the volume of cases in any given DGH is relatively small, many DGHs feed into a tertiary paediatric centre. The influx of several thousand additional cases annually into one centre merely exacerbates the capacity problems experienced by all hospitals nowadays.

Emergency GPS
In some hospitals, urologists and outreach paediatric surgeons do the elective surgery. This solves one problem but creates another, namely the management of emergency GPS. Children with acute surgical problems are referred to the general surgical take. The outreach surgeons will be on their own emergency rota at the tertiary centre and therefore not available locally, and many aspects of the acute abdomen are out with the normal expertise of a urological surgeon. This leaves general surgeons to manage the acute cases, but with the disadvantage of not having a locally available surgeon versed in the practice of elective GPS.

Training
Emergency general surgery is part of the general surgical curriculum [4], but elective GPS is not. GPS uses many of the transferable skills required in any branch of surgery, but does require specific training. As it is not a routine part of general surgical training it has to be specifically arranged. Because this is a change from normal, this is why so few trainees are exposed to GPS.

Agreed ways forward
The Managed Clinical Network
The Children's Surgical Forum (CSF), which brings together all parties involved in the surgical management of children, has made great progress in creating a solution and has published guidance based on the Managed Clinical Network (MCN) for GPS [3]. The MCN concept is supported by the Department of Health as well as by BAPS, BAPU, RCPCH, ASGBI and BAUS.

The managed clinical network of care is a regionally based interconnection of service providers that represents a formal support network between the nearest paediatric surgical centre and the regional DGHs. The advantages of a MCN are consistent standards across a region and readily available help and advice from the tertiary centre if required. The MCN is directed by the network lead so that education and clinical standards are such that all children can expect to receive the same quality of treatment no matter where they are seen [3,5].

The following clinical principles underpin the function of the MCN:

- Child focused
- Elective surgery stands alone as a good quality service and does not necessarily underpin emergency surgery
- Child age limits (for both surgeons and anaesthetists) should be competency based
- Personal development plans instituted, based on clinical needs
- Rigorous audit of outcomes
- Same standards in all centres

The network can also provide support, with care pathways for common conditions that can be followed in the DGH. Example care pathways for use in GPS surgical emergencies are available based on the Scottish Guidelines [6, 7]. The network lead can modify these as appropriate to suit local arrangements, but the important aspect is that the same pathways apply across the region.

Elective GPS
GPS should be provided by any surgeon competent in the management of children and their families, who have the appropriate tissue handling skills and who have had appropriate training in GPS. In practice, the majority of GPS in the UK is carried out by general surgeons who have received training. Other providers are urologists and outreach paediatric surgeons. The volume of GPS cases in the vast majority of DGHs is insufficient for the appointment of a full time GPS surgeon, and GPS must, in reality, be provided in addition to a main surgical subspecialty.

Emergency GPS
Emergency GPS cases are likely to be referred to the general surgical take. It is therefore essential that pathways are in place to manage these cases. Emergency paediatric surgery is part of the Intercollegiate Surgical Curriculum [4] and therefore all general surgeons on the on-call rota should be able to at least assess, if not to personally manage, emergency GPS patients. If the elective surgery is provided by a urologist or an outreach paediatric surgeon, discussions are essential between the general surgeons, those providing the elective service and the paediatric tertiary centre, so that appropriate care pathways can be put in place.

Training
It is vital that appropriate trainees are guided towards GPS in addition to their chosen surgical subspecialty. It is unlikely that sufficient additional paediatric surgeons are affordable to provide a nationwide network of outreach GPS services. The majority of GPS is currently provided by general surgeons and it makes sense to continue that provision as a DGH will always need general surgeons, but may not have the resources to purchase separate GPS services.

GPS requires delicacy of tissue handling. It is agreed that 6-12 months of focussed training is sufficient for those trainees with the required skills. Surgical trainers and the regional Training Programme Director (TPD) play a vital role in identifying and guiding those trainees into GPS training. Trainees who already have a leaning towards GPS should go through their TPD to negotiate appropriate training. It is also agreed that refresher training for established consultant surgeons with previous GPS training is an appropriate way forward to allow continuing GPS provision in the DGH.

Summary of Objectives
In summary, the reason for producing the booklet ***General Paediatric Surgery*** [1] was to provide a document supported by all those who manage general surgical conditions in children. The following is a summary of the objectives in producing the booklet:

- To put in place the means to provide GPS locally where it is safe to do so.
- To outline a mechanism for identifying future GPS surgeons in training.
- To highlight the relevant CPD requirements
- To raise the profile of GPS at organisational level
- To resolve the "Who" and "Where" of emergency general paediatric surgery.

References

[1] Pye J
General Paediatric Surgery
ASGBI Issues in Professional (Dec 2013)

[2] *Specialised Services National Definitions Set, 3rd Edition*
Specialised Services for Children – Definition No 23
National Specialised Commissioning Group (London 2010)

[3] Ensuring the Provision of General Paediatric Surgery in the District General Hospital
Children's Surgical Forum: 2010
http://www.rcseng.ac.uk/publications/docs/general-paediatric-surgery-guidance

[4] Intercollegiate Surgical Training Programme – Training Syllabus
http://www.iscp.ac.uk/surgical/syllabus.aspx

[5] *Standards in Children's Surgery*
Children's Surgical Forum 2013
http://www.rcseng.ac.uk/publications/docs/standards-in-childrens-surgery

[6] *Better Care, Better Health: National Delivery Plan for Children and Young People's Specialist Services in Scotland: General Surgery of Childhood: Care Pathways for Surgical Emergencies*
http://www.specialchildrensservices.scot.nhs.uk/Documents/Care%20Pathways%20for%20Surgical%20Emergencies.pdf

[7] *Example Care Pathways for Emergency General Paediatric Surgical Conditions*
http://www.rcseng.ac.uk/surgeons/working/docs/GPS%20Example%20Care%20Pathways.pdf

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Association of Surgeons of Great Britain and Ireland

CONTRIBUTE TO THE LEADERSHIP OF YOUR ASSOCIATION

VICE PRESIDENT

(2015 and 2016)

These are challenging times for the profession, and applications and nominations are currently sought for this major leadership role in UK and Irish surgery. The Vice President will serve for two years (2015 and 2016) before becoming President for 2017 and 2018. Any Full Fellow, Associate Fellow or Corresponding Fellow is eligible for nomination, which must be proposed and seconded by a Full Fellow, Associate Fellow or Corresponding Fellow.

Each nominee should also prepare a short (350 word) statement detailing their qualifications and experience for holding office, how they would deal with any competing conflicts of interest and outlining their vision for the future of the Association under their leadership.

Completed nominations must be received by the closing date of **midnight on Thursday 31st July 2014** and should be emailed, in confidence, to me (with ***"Vice President Nomination"*** as the email subject heading) at:

ngair@asgbi.org.uk

Any Fellow wishing to discuss this opportunity informally or confidentially, is most welcome to contact either myself or the Association's current President, Professor John Primrose, at:

president@asgbi.org.uk

We look forward to hearing from those who wish to help shape the future direction of ASGBI.

With best wishes

Nick

Professor Nicholas P Gair, Chief Executive

Association of Surgeons of Great Britain and Ireland

APPLICATIONS ARE SOUGHT FOR TWO EXECUTIVE BOARD POSTS:

HONORARY FINANCE DIRECTOR

The Association seeks an Honorary Finance Director who will join the Executive Board of Directors. This will either be as an accountancy-qualified lay member, or as a medically-qualified surgical member. The role will be to monitor the financial affairs of the Association and advise the Executive Board on financial matters in accordance with company and charity legislation and current best practice.

- Lay applicants will probably be a qualified accountant with experience of operating at a senior level. Previous experience as a charity trustee or a director of a not-for-profit organisation would be an advantage.
- Surgical applicants will have a thorough knowledge of accounting procedures and the responsibilities of Company Directors. Previous experience as the Honorary Treasurer of a membership society or a director of a not-for-profit organisation would be an advantage.

In either case, the position is unpaid, although reasonable out-of-pocket expenses will be reimbursed.

DIRECTOR OF PROFESSIONAL PRACTICE

ASGBI also wishes to appoint a Director of Professional Practice to be a member of the Association's Executive Board. The post holder will assume responsibility for engaging with the Association's membership across Great Britain and Ireland through the Elected Regional Representatives on Council and the Link-Surgeons Network. The successful applicant will liaise, on behalf of the Association, with the Royal College of Surgeons of Edinburgh's Regional Specialty Advisor programme, the Royal College of Surgeons of England's Professional Affairs and 'Supporting Surgeons in the Workplace' initiative and other similar systems operated by the Glasgow or Irish Colleges. The post holder will also represent the Association on a number of external committees and bodies concerned with revalidation, independent practice or other professional issues.

APPLICATION PROCESS

Both posts are for a maximum term of office of four consecutive years, and meetings of the Executive Board are generally held at the Association's offices within the Royal College of Surgeons of England in Lincoln's Inn Fields in central London. The annual time commitment is likely to be around six to ten days per annum, plus regular contact with other Directors, the Chief Executive and staff by email and telephone.

Job Descriptions for both posts are available, via the ASGBI website, at:

www.asgbi.org.uk/appointments

Initial expressions of interest in either position should be made, in confidence, to the Association's Chief Executive, Professor Nicholas P Gair, at: **ngair@asgbi.org.uk**

Letters of Application, together with a full CV, should be submitted by email to the Chief Executive, as above, by the closing date of midnight on **Thursday 31st July 2014**.

ASGBI

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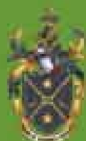
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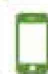
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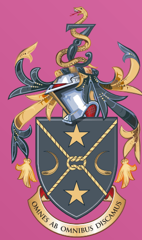

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CONFIDENTIALITY

Confidentiality is a central plank of medical ethics for good reason; if patients cannot confide in their doctors without the risk of sensitive, personal and perhaps embarrassing information being broadcast to the rest of the community, they are unlikely to be open with doctors, and so prejudice their clinical care.

On the face of it, confidentiality is very straightforward; just keep patient information secret unless the patient tells you that you can inform other people. But translating the principle into practice often proves problematic, as illustrated by the fact that confidentiality issues are one of the commonest reasons for doctors to seek legal advice.

Confidentiality is a legal, as well as an ethical, principle, finding its way into employment contracts, legal statutes and common law derived from decided court cases. The General Medical Council publishes guidance on the subject, which doctors are expected to follow, or risk investigation with sanctions on registration in serious cases.

Confidentiality requires doctors not to divulge patient information, and to keep confidential information secure by not leaving records lying around where other people may see them, not discussing patients in hospital lifts or online, or other non-secure means of transferring information. However, confidentiality is not an absolute principle. There are a number of situations where disclosure is justified.

Disclosure with the consent of the patient is routine. Insurance companies, employers and people involved in legal proceedings often need patient information. But the extent of disclosure must not exceed the authority given by the patient. There have been several instances where blanket disclosure has resulted in compensation claims.

Patients have a right of access to reports prepared by their doctors. If the report is not as favourable as it might be, you may be asked to make a few amendments. The answer has to be 'no' unless, on reflection, there is an error which needs to be corrected. At this point, patients may well wonder if it was in their best interest to have come clean over their alcohol intake, smoking and other habits, but whatever the position of the patient, their doctors cannot be dishonest.

Solicitors ask for medical information in all sorts of claims, including personal injury and clinical negligence claims. Solicitors should state who they are acting for, and provide written patient consent, so there can be no question of unauthorised disclosure. What may be unclear is exactly why they want the notes, but if looking back at the care provided there are any concerns, you should notify your indemnity provider.

If asked to prepare a report, you are not the patient's advocate and should provide an objective assessment of the patient's condition, which may ultimately result in giving evidence on oath. In some cases, a court may make an order for disclosure of specific records and if served with a court order, you must comply, as failure to do so will amount to contempt of court with unpleasant consequences, including referral to the GMC. However, the mere threat of a court order is not enough to justify disclosure without the patient's consent.

Team-based care requires all team members to have sufficient details of the patient's illness, to work with colleagues to secure the best outcomes for the patient. So there is an implied waiver to confidentiality, allowing appropriate communication between involved professionals. However, some patients will ask that their GP is not told about certain issues, and if, after counseling, they remain adamant that this information should be withheld, their wishes should generally be respected.

Because publication of case histories and photographs is about, rather than for, patient care, consent is also required, even if the case report is anonymised.

Discussing a patient's care with relatives can be problematic; ideally, the information should be given to the patient, who can pass it on to their family as he or she sees fit, but refusing to say anything to concerned relatives about a patient who cannot convey that information on would be extremely callous, so a degree of circumspection is required in these circumstances.

The police normally have no more right of access to confidential information than anybody else, except under road traffic legislation where the police may require the doctor to reveal the name and address of someone suspected of some traffic offences, or if the public interest in disclosing information outweighs the public interest in preserving patient confidentiality.

Public interest justification for disclosure usually turns on the threat of serious harm to others if the police are not notified to enable them to make an arrest. These cases are rare and well worth discussing with an advisor before deciding how best to proceed.

In cases involving the welfare of a child, the child's best interests are paramount, and may require disclosure of confidential information about the parents to Social Services and/or the police.

The duty of confidentiality does not end with death. Rights of access to the health records of a dead patient exist under the Access to Health Records Act 1990, where any person has a claim arising from the estate. In all other circumstances, the consent of all the executors or administrators to the estate should be obtained before disclosure is given.

There are some circumstances where there is a positive duty to report certain information, for example, notification of infectious diseases, so no patient consent is required and even if the patient objects, the doctor is obliged to make the notification.

The GMC cite a number of examples where the doctor should take positive action. For example, where a driver who is unfit continues to drive, having been advised that it is no longer safe to do so, or where a doctor who is unfit to practise fails to limit his practice in accordance with advice from occupational health doctors or those treating him.

Confidentiality generates some of the most difficult problems for practising doctors. The implications of getting it wrong can be serious for everyone involved, so it's best to seek advice sooner rather than later.

Dr Gerard Panting
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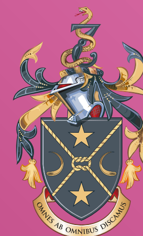

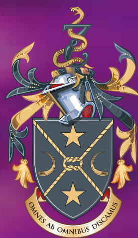

CAVENDISH MEDICAL

IT CAN PAY TO BE DISCIPLINED. SIMON BRUCE EXAMINES WHY REGULAR SAVING IS A GOOD HABIT TO ADOPT

Thanks to the new, more generous ISA rules surprisingly announced by the Chancellor in his 'Big Bang Budget' which come into force in July, it should be possible for far more people to achieve a substantial ISA savings pot.

The limit individuals can save tax-free every year will rise from £11,880 to £15,000. These changes could enable surgeons to build large, tax-proof retirement pots which can be used to top-up their NHS pension fund.

As an example, if a surgeon and his/her spouse invested the maximum deposit of £30,000 per annum every year for the next 15 years and achieved a three per cent real return (after charges and inflation), the final fund will be worth £668,222. At these same rates, it would take just under 20 years for the fund to reach £1million.

As senior medical professionals may not be able to maximise pension savings without triggering harsh tax penalties for breaching the reduced annual and lifetime allowance rates, the popularity of ISAs is continuing to grow. Many of our clients have already achieved ISA pots of around the £100K-£200K mark in a relatively short space of time as a result of disciplined, regular savings. Setting up direct debits means the money is transferred into the investment before you get used to it in your current account.

Avoiding the noise

Indeed it is the discipline here which achieves the results. Your money is drip-feeding into your ISA portfolio no matter what peak or trough the market is experiencing, forcing you to ignore the 'market noise' that can often lead to emotionally-led, poor decision making.

While it is important to understand and work within your own attitude to investment risk, a regular investor is not being held-back by any notion of when a 'bad' time to invest is. Many would-be investors were deterred by the financial crisis but the FTSE All-Share has produced a return of more than 90 per cent since April 2009. Those who invested on a monthly basis throughout this period benefited from the resulting rebound – this is commonly known as 'pound cost averaging'.

And should circumstances change, the ISA fund is accessible tax free (normally without penalty) and can also be augmented with sporadic lump-sum payments.

Other funding routes

For surgeons who have surplus income once their ISA allowances have been maximised, another investment vehicle is a General Investment Account (GIA). A well-diversified portfolio can produce gains that are not subject to capital gains tax when disposals do not exceed your annual CGT exempt allowance.

When portfolios are well managed, this allows gains to be 'harvested' annually to make maximum use of the allowance (which is also available to your partner). You can roll the proceeds into your ISA or withdraw the gains tax free as additional retirement income. Losses from previous years can also be brought forwards to offset gains in the current year.

Investment portfolios that are not managed suffer from 'style drift' and 'concentration risk'. This can be seen where certain investments are purchased and then left to accumulate substantial gains over the years, becoming disproportionately large as part of your overall portfolio or investment capital. Drift results in a portfolio with a level of risk very different to that agreed at outset and leaves you open to bigger

losses in a market decline or higher taxes when making disposals.

Proper and effective tax management of your investment accounts not only reduces this risk, it can also save a substantial amount of tax over the medium term.

Although interest/dividends accrued within the account are taxable each year, the rate of capital gains tax for higher rate tax payers is still 28 per cent, which reflects well when compared with income tax rates of 40 and 45 per cent or dividends. Although less tax efficient than ISAs, there are no restrictions to the amount that can be invested and you can accumulate substantial balances before capital gains tax becomes an issue.

Decumulation

There is a tendency to focus solely on the 'accumulation' aspect of long-term savings as this seems to attract the most attention in the press.

The 'decumulation' process – converting hard-earned savings into a retirement income – should not be overlooked. The decisions taken at this stage of life can often be one-off and irreversible. It is a complex area, shaped by the same forces as when you accumulated the funds: risk, return, inflation and taxes. However, one also has to consider what level of withdrawal to adopt to maintain a comfortable standard of living without depleting the overall pot.

While the government's radical pension changes offer a welcome freedom for savers, the relative protection from 'running out of cash' which annuities offer could be lost. Indeed, critics were quick to assume those who have saved responsibly throughout their career may have a complete change of attitude to their finances upon accessing their pension fund.

The Institute for Fiscal Studies warned: "...without wanting to be seen as patronising, it is important to point out that increased choice could lead to more mistakes. People at 60 or 65 are known to underestimate their own life expectancy, and especially the likelihood of living to extreme old age. They may over spend early in retirement."

Fears of the fast-car pension blow out – pensions minister Steve Webb famously commented that he was happy if people bought a Lamborghini with their pension pot – are of course largely unfounded but life expectancy should be considered. ONS figures suggest that average life expectancy for people in this age range is now 86 for men and 89 for women.

How long will you live?

Mr Webb has proposed providing savers with an estimate of life expectancy based on health factors and place of residence in order to help with financial planning. But these are only averages which, as actuaries tell us, are notoriously unreliable in the later stages of life where new forms of treatment can prolong life by many years.

Expenditure at this time is rarely even – there is a spike in expenditure immediately after retirement as people start to enjoy their free time which can continue for many years before reducing as mobility decreases and then increasing again to pay for care or medical expenses.

Ensuring you do not exhaust your money and can maintain your chosen lifestyle for 30 years depends on creating an adequate retirement fund through orderly saving and a good plan on how you will eventually spend it. Detailed cash flow planning should take into account not only pensions, savings and investments for you and your loved ones (adjusted for inflation) but also your general health and your position relevant to tax, inheritance tax and what happens to your private practice.

Simon Bruce
Managing Director of Cavendish Medical Ltd

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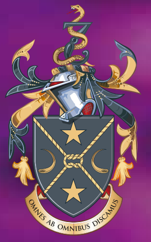

coress Feedback

This issue of Feedback has cases from disparate surgical specialties, but with generic themes. Several of the cases illustrate co-operation with other organisations concerned with surgical safety: NHS England, NCEPOD and MHRA. Sharing and dissemination of knowledge of adverse events underpins the surgical profession's determination to improve safety for our patients.

We are grateful to those who have provided the material for these reports. The online reporting form is on our website, **www.coress.org.uk**, which also includes all previous ***Feedback Reports***. Published cases will be acknowledged by a **Certificate of Contribution**, which may be included in the contributor's record of continuing professional development.

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

"SWISS CHEESE EFFECT"

(Ref: 152)

I was called to assist an ENT SpR undertaking a solo list, while his consultant was on leave, who had created a CSF fistula during elective sinus surgery. I reviewed the pre-operative CT scans before scrubbing, and found that the scans showed no evidence of sinus disease. The fistula was repaired intra-operatively and the patient made an uneventful recovery, after spending two nights more in hospital than planned. On investigation as to how the patient, whose complaint was of post-nasal drip, had been listed for surgery in the absence of sinus disease on CT, it became apparent that a different registrar had done this, on the grounds of a radiology report that stated that there was extensive disease. It appears that a radiology transcription error had occurred, which was overlooked as the CT had not been reviewed in the clinic. Furthermore, as the history did not support a diagnosis of chronic sinusitis, the CT scan should not have been requested. The patient underwent unnecessary surgery, resulting in a major complication, with no symptomatic benefit. He has declined the offer of further treatment.

CORESS Expert's Comments:

This case represents a "Never Event" [1] in which a number of circumstances contributed to the adverse outcome – the classical "Swiss Cheese" effect. An initial incorrect clinical diagnosis was made despite the patient's symptoms; there was failure to follow RCR guidelines in requesting CT at the first visit when the only symptom was that of post-nasal drip; a transcription error occurred in the radiology department; the patient was listed for surgery by a surgeon who did not have final responsibility for the operative procedure, on the basis of the incorrect radiology report (in the last issue of ***Feedback***, CORESS drew attention to the perils of pooled lists); the CT scan was not reviewed prior to surgery by the operating surgeon (as recommended in the WHO Check List).

The importance of the operating surgeon checking all of the patient's relevant investigations prior to anaesthetic induction cannot be overemphasised.

[1] The 2014 report of the Surgical Never Events Task Force can be downloaded at: **http://www.england.nhs.uk/wp-content/uploads/2014/02/sur-nev-ev-tf-rep.pdf**

coress CONFIDENTIAL REPORTING SYSTEM IN SURGERY

SYSTEMATIC DELAYS RESULT IN ADVERSE OUTCOME

(Ref: 154)

A 68-year-old man presented to the Emergency Department at 20.00, with an obstructed paraumbilical hernia. Resuscitation was undertaken and the patient was listed for surgery during the afternoon of the following day, because the on-call surgeon was undertaking an elective operating list in the morning. During the afternoon, the operation was postponed until the evening because of the need for extra corporeal membrane oxygenation (ECMO), for concomitant respiratory disease. A new on-call surgeon during the evening hours thought that the patient was now in renal failure, with no urinary output, and transferred the patient to the HDU for further resuscitation, listing him for surgery next morning. I was the surgeon on-call on the following morning and reviewed him, finding him to be in renal failure requiring inotropic support. Although the patient had a metabolic acidosis, black areas had now appeared in the patient's skin overlying the hernia. He was transferred to theatre for laparotomy.

Prior to the surgical procedure, he had three cardiac arrests from which he was successfully revived. At laparotomy, ischaemic perforated bowel with faecal peritonitis was found in a large hernia sac. Small bowel was resected, and an ileostomy and mucus fistula was created. The patient remained septic, anuric and died several hours later.

Reporter's Comments:

There was a delay in recognition of ischaemic bowel and cancellation of the original surgery as a result of ECMO. The on-call surgeon was not available on the morning after the patient's admission because he had not cancelled his elective list.

CORESS Expert's Comments:

This case provides several lessons. An obstructed, potentially strangulated hernia is a clinical indication for urgent surgical intervention. Whilst fluid resuscitation is important, intervention for the underlying cause of the patient's problems should not be delayed. In the current surgical climate, the Advisory Board recommended that an "on-call" surgeon should drop all routine elective commitments during the period of "on-call" and should be available to respond to emergencies promptly. This should be agreed as a governance principle with Trust management. The risks posed by a shift system in which no-one takes ownership for a patient are evident. A named consultant should take responsibility for the patient. Handovers should be comprehensive and should draw attention to clinical problems requiring urgent attention.

The first report (2014) of the National Emergency Laparotomy Audit (NELA), commissioned by the Healthcare Quality Improvement Partnership (HQIP), funded by NHS England and the Welsh Government, can be found at **http://www.nela.org.uk**. The following recommendations for patients requiring emergency laparotomy are made:

- Timely review by a senior surgeon following admission.
- Formal assessment of risk of death.
- Defined pathway of peri-operative care.
- Prompt administration of antibiotics.
- Ready availability of diagnostic investigations.
- Prompt access to an operating theatre.
- Surgery performed under direct care of a consultant surgeon and consultant anaesthetist.
- Admission of high-risk patients to a critical care unit following surgery.
- Structured handover of care is required at all times by all clinicians treating emergency laparotomy patients.

OPAQUE PERSPECTIVE

(Ref: 174)

Carrying out a laparoscopic cholecystectomy, after initial introduction of the laparoscope, the instrument was withdrawn, cleaned on an antifogging sponge and reinserted. The view was completely obscured and direct inspection of the scope revealed opacification of the lens, apparently within the instrument. A replacement scope was checked by myself (as the first had been), by direct vision, prepared with the anti-fog solution on the sponge and inserted into the abdomen. Again, the view was completely obscured. It was then realised by the scrub nurse that the solution placed on the sponge was not anti-fog solution, but wound glue for the end of the procedure. The telescopes were "repaired" by thorough cleaning, but this took some time. No harm came to the patient but had this happened at a critical stage then the outcome could have been different.

Reporter's Comments:

Both the anti-fog solution and the tissue glue were contained in similar bottles with twist-off caps. The bottles were opened in a theatre environment in which the lights were dimmed.

CORESS Expert's Comments:

It should be policy to check all solutions for use, either in a patient, or on equipment that will come into contact with the patient, while the lights are "up", prior to the procedure. It is the responsibility of the operating surgeon to reassure himself that any fluid potentially coming into contact with the patient is being used appropriately, is of the correct dose, and is not time expired. Where evident similarities in packaging of different substances used in the same context occurs, the procurement team and the manufacturers should be informed.

FAILURE TO CHECK IMAGE GUIDANCE SYSTEM PRE-OPERATIVELY

(Ref: 175)

A 72-year-old patient presented to the emergency department following a generalised tonic-clonic seizure, with a temporary post-ictal left-sided hemiparesis. MRI revealed a two-centimetre lesion with a cystic appearance in the right frontal lobe. CT failed to reveal an overt extra-cranial primary malignancy, and serum inflammatory markers were normal. Differential diagnoses included solitary metastasis and brain abscess. Urgent biopsy using image guidance was sought to make a diagnosis. During anaesthetic induction, an attempt was made to load the pre-operative images onto the image-guidance system. As well as a "disc error" message, the system displayed other error messages such that three further discs loaded with the pre-operative images were obtained from the imaging department. At this point, an older image-guidance system was found to function properly with the existing discs and the operation went ahead as planned. The biopsy consisted of pus macroscopically, and a smear revealed numerous leucocytes. Delay in obtaining functional image-guidance meant that sixty-five minutes elapsed between the patient being ready for surgery after intubation, and knife-to-skin time. The patient made a good post-operative recovery with no adverse effects.

Reporter's Comments:

The patient was anaesthetised before ensuring that essential equipment was functioning. The WHO Surgical Safety Checklist undertaken during the time-out asks the surgeon to check that essential imaging is displayed before skin incision, and whether any specific equipment requirements exist. However, essential equipment, including imaging kit, should be checked to ensure it is fully operational prior to induction. An ideal time to do this would be at the start of a list, as part of a team briefing, so that alternative equipment may be obtained, or a decision made as to whether to proceed, if a fault is discovered. Images should be pre-loaded onto image-guidance systems prior to induction of anaesthesia, as disc incompatibility problems are not infrequent. Where equipment is essential to perform a procedure, backup kit should be available in case of technical failure. When using new or unfamiliar equipment, the surgeon must be confident that he or she can operate it correctly, or ensure that adequate mentorship is available from colleagues or medical device company representatives. Surgeons should always have a back-up plan in the event of operative difficulties.

CORESS Expert's Comments:

The Advisory Board agreed with the reporter's comments with respect to checking functionality of essential equipment prior to induction. All relevant imaging should also be checked before inducing the patient, as demonstrated in another case in this issue of ***Feedback***. In cases of overt equipment failure, this should be reported to the manufacturer as a matter of course.

TRACHEOSTOMY TROUBLE

(Ref: 169)

A 50-year-old, acutely unwell male patient underwent laparotomy and small bowel resection for obstruction. Postoperatively, he was admitted to ICU where he remained intubated and ventilated. His progress was complicated by a spontaneous pneumothorax, requiring chest drainage, and because of prolonged intubation, a tracheostomy was undertaken to facilitate suction and respiratory care. He was improving gradually, and had been discharged to ward care, when he suddenly succumbed to a cardiorespiratory arrest in the early morning hours.

Post-mortem examination revealed that the cardiorespiratory arrest had been due to obstruction of the tracheostomy by a mucous plug. Ward night staff had not been trained with respect to tracheostomy management, and failed to notice the patient's deterioration.

CORESS Expert's Comments:

Expert ENT opinion was obtained: Sadly, death from mucus plugging of tracheostomy tubes is an avoidable but recurring event. Tracheostomised patients may be admitted under any surgical specialty, and therefore it is essential that all staff dealing with such patients are aware of best practice.

- All healthcare professionals dealing with tracheostomised patients must have adequate training in tracheostomy care and resuscitation needs.
- Hospitals should have a standardised local policy for care and a multi-disciplinary tracheostomy team where possible.

- Patients should have a double lumen tube to allow easy changes in cases of mucus plugging.
- Spare inner tube, tracheal dilators, suction cannulae and a spare smaller tube must be readily available at the bedside.
- Cuffed tubes must have pressures checked twice daily.
- Humidification and suctioning needs must be reassessed regularly.
- Timely decannulation should be undertaken in conjunction with a multidisciplinary team.

Although there is a paucity of details regarding this case, it appears that poor humidification and suctioning due to lack of adequate training resulted in mucus plugging. Perhaps simply removing the inner tube might have prevented subsequent hypoxic arrest?

NCEPOD has released their latest report, ***Tracheostomy Care: On the Right Trach?*** (June 2014). The report can be downloaded from the website at: **http://www.ncepod.org.uk**

The following case has been received from NHS England. A Patient Safety Alert has been released: (NHS/PSA/W/2014/009). The incident described was the trigger incident for a review.

SUCTION DRAINS IN SPINAL NEUROSURGERY…

(Ref: 183)

A patient with spinal metastases underwent elective surgery to stabilise his spine. During surgery, a small dural tear around a nerve root was sutured and a fascia patch applied. A RedivacTM drain was inserted near to the wound and attached to a RedivacTM bottle, with documentation in the notes that the drain should left to drain passively by gravity. (The RedivacTM drain is designed as a high vacuum wound drainage system.)

Following surgery, the patient was admitted to HDU, self-ventilating with a GCS of 15/15. During the night however, a nurse noticed that the drain was not under suction. The nurse changed the bottle to one that was vacuumed. The patient complained of back pain and requested analgesia. The drain rapidly filled with 400mls of bloodstained fluid before it was clamped to prevent further drainage. The patient deteriorated to GCS 3, with laboured breathing, cardiac arrhythmias, and developed tonic/clonic seizures before being intubated and ventilated. The spinal consultant surgeon was contacted and advised that with the small dural tear it was likely that the fluid drained was cerebro-spinal fluid (CSF). A brain CT scan was reported as showing acute intra-axial haemorrhage within the superior cerebellum, with associated mass-effect and tonsillar herniation.

Neurosurgeons were contacted and after discussion, it was decided that the patient would be managed conservatively.

The NRLS was searched for the keywords 'redivac' and 'spinal'. As a result, 23 incidents were identified. Two further incidents were found, both of which concerned patients with a spinal CSF leak following spinal surgery. In both cases, it appears a RedivacTM drain was placed, but with the intention of NO suction being applied. However, in both cases suction was applied with deleterious effects, although the patients came to no lasting harm. These cases are almost identical to the situation in the trigger incident described above.

CORESS Expert's Comments:

Surgical equipment should be used in the manner for which it was designed and licensed. RedivacTM drains are commonly encountered in all branches of surgery and perform a useful function in aspirating fluid under suction. If a surgeon modifies equipment, or uses it in a capacity for which it was not designed, that surgeon potentially assumes liability. Writing instructions in an operation note, whilst part of good practice, is no guarantee that the instructions will either be read or adhered to. The WHO sign-out check would have covered special management instructions, which should have been communicated to recovery staff and thence to ward staff in comprehensive patient handovers. Further good practice is to label drains (particularly when more than one drain is employed), with a sticky label outlining, for instance, anatomical region drained, specific drain management if unusual, and any method used to secure the drain which might not be immediately apparent, and may hinder removal (e.g. sutures). The Society of British Neurological Surgeons is to produce guidance on the use of drains in spinal neurosurgery.

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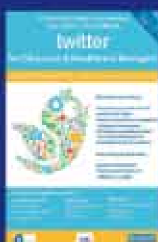
A number of industries such as the chemical or airline industries now achieve ZERO injuries on a regular basis. This has involved major changes in behaviours and culture. This workshop focuses on what health professionals can learn from these industries where a culture of ZERO has existed for some time.

Effective Clinical Director Training Course
Wednesday 10 September 2014, London
The programme will focus on developing the skills of Clinical Directors and aspiring Clinical Directors in areas including learning from patients, process redesign and improvement, delivering the standard for 7 day working at directorate level and managing directorate finances.

The New National Quality Standard for Surgical Site Infection
Tuesday 16 September 2014, London
This conference includes presentations from members of the Topic Expert Group on the Surgical Site Infection Quality Standard at NICE and through expert sessions and case studies focuses on implementing the new standard in practice in your service.

Handling, Investigating, Resolving & Learning from Complaints
Thursday 18 September 2014, London
The conference will update delegates on national developments including an update from the commons public accounts select committee and the learning from the initial Care Quality Commission inspection and new requirements for trusts such as the annual complaints report.



Developing your skills in Social Media: Twitter
Monday 29 September 2014, London
This conference will provide a practical guide to developing your skills, as an individual clinician or healthcare manager, or as an NHS Trust on twitter. With in depth interactive masterclasses for beginners to help you get started, to a more advanced stream for those already using twitter.

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JOURNAL OF THE ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND: CONTRIBUTOR GUIDANCE

(As at April 2014)

The Association welcomes and encourages contributions from Fellows, and asks that potential contributors take the following guidelines into consideration.

Aims

The ***Journal of the Association of Surgeons of Great Britain and Ireland (JASGBI)*** is a quarterly publication which has evolved from the previously named ***Newsletter***. It aims to publish material of topical or general interest to members of the Association, which will promote and advance the reputation and functions of the Association to a wider professional audience.

JASGBI is not a peer reviewed, academic publication and is not intended as a vehicle for conventional academic papers. We nevertheless welcome a wide range of subject matter which may include:

- Articles of national and strategic relevance in relation to surgical training, teaching, career development, and issues in national politics, as they bear upon surgical and professional practice.
- Articles of topical debate.
- News from the Regions, and from affiliated Speciality Associations and Societies.
- Articles on international surgical practice, as observed by members of the Association on their travels, attachments and secondments.
- Historical articles of interest and relevance to surgeons.
- Personal experiences, parallel careers, hobbies, activities and achievements which are out of the ordinary, or which would fit our popular '**Secret Lives**' series.

This list is not exclusive. ***JASGBI*** is keen to encourage and help develop standards in professional writing and to act as a vehicle for new and original material.

Publication standards

Although ***JASGBI*** is not a conventional, peer reviewed academic publication, we subscribe wholeheartedly to the highest standards in respect of Publication Ethics and the elimination of the various forms of publication malpractice, as set out by the Committee on Publication Ethics (COPE) and the World Association of Medical Editors (WAME).

Material submitted to ***JASGBI*** should thus be original to the author(s). The editors reserve the right to submit any manuscript to peer review and to seek any amendments which are deemed to improve the presentation or content of the article to meet the standards and style of ***JASGBI***.

Article length

Please submit articles in **point size 12, Calibri font**. Each page of ***JASGBI*** can accommodate around 750 words with a small picture. While we are flexible as to content, articles should usually be of 2,000 words or less, with up to four original images and/or figures. In general terms, PowerPoint graphics detract from the quality of presentation and should be avoided.

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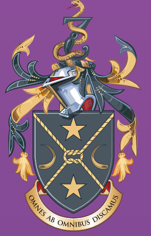
Authors must provide a 'for correspondence' email address with any article submitted. This will be published alongside your article.

References

JASGBI is not a journal of reference and we can neither encourage nor support long lists of references in the Vancouver style. In general terms, we will publish no more than ten relevant references.

Copy should be submitted electronically and directly to the ***JASGBI*** Production Manager, Miss Jessica Pether, at jessicapether@asgbi.org.uk.



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Association of Surgeons of Great Britain and Ireland

Imperial College London

Department of Surgery and Cancer

Division of Surgery

Clinical Research Fellow

Salary Range: £31,838 - £56,312 plus £1,505 London Allowance p.a.

Imperial Patient Safety Translational Research Centre (PSTRC) is welcoming applications for a Clinical Research Fellow in surgical education and simulation. The project focuses upon enhancing skills and safety in surgery based upon similar strategies used in sports. The successful candidate will be expected to undertake PhD or MD studies.

Responsibilities of the post holder will include leading this work and actively contributing to the development of novel research directions and ideas, as well as delivering the research on the ground. Applicants with previous research experience and/or an interest in education will be considered favourably.

A degree in Medicine (MBBS or equivalent), full General Medical Council registration and Membership of the Royal College of Surgeons is essential. Proven experience in an acute hospital setting with a current ATLS qualification is required. The post holder will also be required to fulfil clinical commitments and contribute to the on-call rota. Applicants should possess minimum experience up to the level of CT2/ST3 in Surgery.

The post is full-time for a fixed term of two years, and is based at the St Mary's Campus, Paddington. Clinical work within this post will be in the format of a 1 in 6 on-call on the Registrar rota at Barnet/Chase Farm Hospital.
As this post is exempt from the Rehabilitation of Offenders Act 1974, a satisfactory enhanced Disclosure and Barring Service check will be required for the successful candidate.

Further information about the DBS disclosure process can be found at http://www.homeoffice.gov.uk/agencies-publicbodies/dbs/ or by telephoning 0870 90 90 811.

Our preferred method of application is online via our website http://www3.imperial.ac.uk/employment.
Please quote reference number: SM105-14.

Closing date: 2 July 2014.

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Association of Surgeons of Great Britain and Ireland
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