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IMAGINEERING THE FUTURE OF ASGBI, SURGERY AND HEALTHCARE DELIVERY

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Welcome to the Autumn 2014 edition of the ***Journal of the Association of Surgeons of Great Britain and Ireland***. As usual, we seek to inform, interest, update, entertain and sometimes to challenge you with articles and subject matter from the broad church of general surgery in the UK and Ireland.

ASGBI is the UK national, SAC-defined representative Surgical Specialty Association for General Surgery and General Surgeons, recognised as such by the GMC, the DoH and the NHS across the four devolved nations. Education, training and curriculum issues remain at the heart of what we do and at the centre of deliberations and debate at Executive Board and wider Advisory Council meetings. Change remains the only certainty in professional life, and our discussions this year have focussed particularly on the follow-on of the 2013 Greenaway Review into the future shape of professional medical training, as it affects general surgeons.

It is still too early to see whether the Greenaway proposals will gather momentum. It is not yet clear whether they herald a transition away from early sub- and super-specialisation to a more general training, which will be directed, once again, to the production of surgeons trained primarily to manage the surgical 'take' in District General Hospitals around the UK. The GMC and the NHS Employers' Confederation have made it very clear that they do not wish to see the creation of more-subspecialty SAC Boards. We remain committed to the support of our colleagues in the flourishing sub-specialty societies within the current representational framework for General Surgery.

We are also committed to work with the Surgical Forum, which brings together the Presidents of the four Surgical Royal Colleges and the ten SAC-defined Surgical Specialty Associations in membership of the FSSA, which is presently chaired by former ASGBI President John MacFie. We are very pleased to carry an article by John in this issue which sets out the deliberations of the Forum on the Shape of Training Report.

We were also preoccupied last year with the first round of publication of surgical outcomes in certain of the general surgical sub-specialties. While this caused a considerable flurry of activity among surgeons last autumn, and understandable anxiety in many quarters, the reality as yet has been virtual silence in the national media after a very brief burst of interest.

We live and work in communities which are in a considerable state of social flux following a massive wave of immigration and cultural dislocation over the past two decades. We felt it very important to run a session at the 2014 Congress on Female Genital Mutilation, an unacceptable and hitherto under-recognised and under-reported importation to these islands. We are very grateful to Dr Comfort Momoh for following up her presentation to the Congress with an article on the subject in this issue.

Another theme of this issue is the support for The Surgical Foundation, the charitable arm of ASGBI, and its work in educating overseas surgeons, particularly from and in Africa. Bob Lane has been a steadfast champion of the Foundation, and we are delighted to acknowledge his work and fundraising for the Foundation in recent years. On the subject of distance and travel, few will have seen farther than Graeme Poston, who entertains us with his travels to some of the great mountains of the world.

2014 has been a significant transition point in the move of ASGBI towards digital services, with the introduction of the Paperless Congress in Harrogate, and with the move of our publishing operations to a "virtual reality" electronic format. These transitions bring us substantial operational efficiencies and economies, which allow us to deliver enhanced membership services at least cost.

Many members of the Association may, as yet, be unaware of the quiet revolution which is taking place nationally in the delivery online of public services. This will, in due course, have a massive impact upon the way that we work and interact with our patients, their families, their supporting agencies and the world at large. So significant and dramatic are the changes which are currently taking place in government thinking and practice about information delivery that we would be very remiss not to anticipate further change and work to embrace and shape it rather than to resist it.

In the past two decades, the health economy has broadly undergone two waves of transformational change in information technology. In the first wave, from the early 1990s, typewriters were replaced by desktop PCs in hospitals and general practices, and experimentation proceeded with a range of data systems, the introduction of email and public adoption of the Internet. The second wave, from the early 2000s, saw the maturation of many information systems in public use; in the explosion in Internet functionality; and in the widespread adoption and familiarisation of the related technologies in civic life.

EDITORIAL

By 2010, the UK Government recognised that it was falling behind commerce and industry in securing the efficiencies which are inherent in internet operations. Each and every major and minor department of government was developing its own web services to its own design and perceived needs, the result being huge inefficiency and a failure to realise the cost and service benefits of modern technology.

In 2010, following a number of large scale IT failures, including NHS Connecting for Health, responsibility for the DirectGov digital information strategy transferred to the Cabinet Office under Francis Maude, MP. The Cabinet Office commissioned a report under the direction of Baroness Martha Lane Fox, founder of last-minute.com, leading to the transformation of the way that Government should use the power of the internet. (See www.gov.uk/government/publications/directgov-2010-and-beyond-revolution-not-evolution-a-report-by-martha-lane-fox). She recommended that the Government:

1. Make Directgov the government front end for all departments' transactional online services to citizens and businesses, to set standards and to force departments to improve citizens' experience of key transactions.
2. Make Directgov a wholesaler, as well as the retail shop front, for government services and content by mandating the development and opening up of Application Programme Interfaces (APIs) to third parties.
3. Change the model of government online publishing, by putting a new central team in Cabinet Office in absolute control of the overall user experience across all digital channels.
4. Appoint a new CEO for Digital in the Cabinet Office with absolute authority over the user experience across all government online services (websites and Application Programming Interfaces, APIs) and the power to direct all government online spending.

These recommendations were accepted in full, and led to the formation of the Government Digital Service (GDS). This was underpinned by a new team of internet savvy thinkers and developers, based in London's East End around "Silicon Roundabout", and charged with implementing these changes. More insights can be gleamed from:

- gds.blog.gov.uk/
- en.wikipedia.org/wiki/Government_Digital_Service
- www.gov.uk/government/organisations/government-digital-service

The GDS is driving a transformation in Government information service delivery, according to a number of critical principles. Firstly, UK Government information service delivery will be Digital by Default, under the unifying GOV.UK brand. Secondly, the focus is entirely upon the convenience of the "Customer" rather than of the Service Provider, based upon detailed user research of "The User Story"; to the point that digital services become so good that people will always choose to use them rather than inefficient and costly alternatives. Thus, for example, we mostly now book our flights and hotels online, because the travel industry has been through a similar process of customer-centric revolution.

The current thrust of UK Government digital strategy is to give the UK "the most digital government in the world", and in the process to become a world leader in digital service transformation. Procurement is to be based upon outputs rather than detailed specification, with empowerment of small and medium sized provider companies and short term contracts. No longer will the Government be dependent upon the large branded IT organisations which have sometimes failed at huge expense to deliver the IT vision.

Fundamentally, change is to be from the ground up, driven by user experience, with continual evolution to "Good Enough" functionality, rather than through top down design of systems that do not then work as promised. The communications focus at all time is upon the use of plain English and simplicity of design, to allow users to reach and use information and processes with the least steps and inconvenience.

Change is led at the GDS by programmers, developers and "technical architects", to secure the move from process and supplier driven outcomes to customer outcomes. Buzz words include "agile development" and "sprint pathways", such that through 400 days in 2013 and 2014, massive modernisation is being secured in many government services, with the intention that transition of the work of all major government departments to the GOV.UK will be substantially complete by mid-2015. Individual services are transformed in weeks and months rather than years and decades. In the process, massive savings will have been realised in service delivery and transactional costs, with a huge uplift in public use, approval and confidence in Government information systems and processes.

Why does this matter to members of ASGBI? All who work in hospitals will have experienced the challenges in matching existing information systems to clinical needs. The end user of informatics has generally been seen as the hospital manager or administrator, and the extraction of actionable clinical intelligence from th.e mass of activity data generated in diverse hospital IT systems remains an insuperable challenge for most clinicians. Where clinical information is generated, it is often frankly wrong and it often lacks the confidence of those whose work it purports to describe. IT systems suppliers often have hospitals in contractual strangleholds which defy the clear principles as set out by the GDS and the Cabinet Office.

Francis Maude's digital revolution was informed by failures in NHS informatics, but it has been directed at functions of government other than health. The GOV.UK wave of change has yet to break over the NHS and the health and social care functions of the state. When the focus of data really shifts to empowering patients as consumers, and when the principles and skills embodied in the GDS are applied to health and social care, we may be certain of radical change in our daily professional lives. This change will shortly be coming to a computer terminal near you, and I commend early familiarisation and engagement with the principles, so that general surgeons remain at the cutting edge of radicality in the changing NHS.

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

(As at September 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.

EMERGENCY GENERAL SURGERY COURSES; TRAINING WITHOUT THE STRUCTURE OF SUBSPECIALISATION

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Introduction and Background

There has been much attention given recently to Emergency General Surgery (EGS) on account of its high mortality, long and costly lengths of stay and variable outcomes. These deficits have heightened awareness and increased trainers' and trainees' interest in EGS. Current models anticipate that all general and gastro-intestinal surgeons will continue to take part in EGS and recent surveys of trainees and trainers alike have shown that many trainers feel that trainees are light in experience of EGS. This opinion is shared by some trainees. While consultant posts in EGS have appeared, there is no current formal training programme for junior medical staff with a strong future interest in EGS either.

All trainees undergo a conventional training programme within general surgery and gain experience in managing unscheduled admissions whilst 'on call' and out of hours. The nature of emergency surgery gives this training inherent variability. Levels of trainee supervision vary between hospitals. There is an inconsistent ethos of teaching and audit of emergency surgical work amongst consultant trainers and trainees in an 'on call' capacity. In the absence of recognised emergency surgery training programmes, perhaps individual trainees should take more responsibility for their own personal and professional development and seek out other training opportunities. Many hospitals now have a dedicated EGS team of the week, but at the moment, juniors are only attached for short periods of time. While this may change in the future, supplementary training through courses seems wise.

Several national and international EGS training courses have been developed by a number of providers, including minimally invasive, advanced laparoscopic and endoscopic skills. These courses often combine elements of emergency surgery with trauma surgery and vice versa. As senior specialty trainees, with a longstanding interest in EGS, we have found such courses invaluable in developing both decision making and operative skills for EGS patients. We aim to give an overview of some of the courses currently available to those wishing to develop their skills in managing the emergency, and often high risk, general surgical patient.

What makes a 'good' course?

A 'good' course is one that provides desired knowledge at a level appropriate to the candidate. In our experience, courses that try to target too wide an audience leave people underwhelmed or confused. Ideally, trainees should opt for courses with a narrow target audience appropriate for their level of experience, training or knowledge. These courses should aim to provide new information or skills that can be used in everyday practice with immediate effect. Whilst learning new skills on courses can be stimulating and interesting, not using the knowledge and skills will soon lead to frustration as the benefit of taking time out for a course is lost and the trainee's study budget slips away.

Core Trainees

As a core surgical trainee or a foundation doctor about to enter core surgical training, a breadth of basic knowledge is essential.

Care of the Critically Ill Surgical Patient (CCrISP) is a course provided regionally by the Royal College of Surgeons of England (RCSEng). Although this course is not solely directed towards the care of emergency patients, it provides an excellent knowledge base and structured approach for dealing with the higher risk and acutely unwell patient. It is strongly recommended for all surgical trainees with at least six months' experience in general surgery. It is, therefore, suited to CT1-3 trainees. Most deaneries now consider this course to be mandatory and advise their trainees to complete the course in CT1.

ATLS is another College-led, well established, scenario-based regional course. It develops approach and clinical skills in the initial management of the trauma patient and is ideal for those attending trauma calls or working in accident and emergency. In both general surgery and orthopaedics, this is now mandatory for CCT, but some have criticised the course for not being entirely relevant to British in-hospital trauma management. That said, the course is usually very enjoyable.

If the CCrISP or ATLS candidates excel, then they may be invited to become an instructor at an appropriate stage in their career. The additional ATLS or CCrISP Instructor Courses also cover adult educational theory as well as the practicalities of teaching the course itself and are extremely popular.

ASiT provide a free Emergency Cross Cover Course to ASiT members at The University Hospital of South Manchester. This one-day course delivers a 'What you need to know' synopsis for a wide variety of specialties, delivered by senior specialty trainees. Core trainees must be able to recognise an unwell general surgical patient, implement appropriate management plans and have an understanding of their likely definitive treatments and some of the supporting evidence for these.

Donegal Clinical and Research Academy provide a one-day course in Emergency Surgery which is excellent for core/ST3 trainees. An international faculty deliver brief lectures and chair subsequent case-based discussions with an expert panel of clinicians from around the globe. This has some

similarities with The Specialty Skills in Emergency Surgery and Trauma (SSET) course run by RCSEng, in the Wolfson Surgical Skills Centre at the College. The English College course is run twice a year and takes place over two days. Candidates partake in small group discussions and lectures on the first day, before a more practical and hands on second day with porcine specimens. The Irish course does not benefit from practical sessions but is a considerably cheaper course. For more junior trainees, the Irish course compares well with the Strategies in Emergency General Surgery course, which is discussed later.

In terms of diagnostic radiology courses, Emergency Ultrasound UK provides level one and level two courses in Cambridge and Ipswich. These courses aim to improve candidates' diagnostic and management skills in the care of the critically ill or injured patient. Candidates do not have to have completed level one before progressing to level two. The level one course is ideal for core surgical trainees making the transition into specialty training, who expect to have access to, and be able to use, ultrasound in their assessment of patients e.g. in a major trauma or emergency setting. The need for this skill may expand with the development of Surgical Assessment Units, which require rapid access to basic ultrasound in order to function effectively.

Specialty Trainees

As specialty trainees, the more practical aspects of managing emergency surgical patients become more important. Many courses combine these aspects with the management of trauma patients.

The European Trauma course is similar in that it aims to provide both technical skills in trauma management and team leadership but, in addition, it aims to reflect European working practice. This course is aimed at more senior trainees and consultants and focuses on leading trauma scenarios with simultaneous assessment of airway, breathing and circulation. Most trainees tend to prefer this as it is more true to life in that a general surgical trainee on this course would not expect to lead a scenario based on airway trauma, unlike during ATLS moulages.

Definitive Surgical Trauma Skills (DSTS) and Emergency Abdominal and Thoracic Surgery for the General Surgeon are both excellent cadaveric courses. RCSEng provides DSTS in several centres across the UK for candidates who have a good understanding of ATLS and critical care principles and are ST5 level and above. The Royal College of Surgeons of Edinburgh (RCSEd), in collaboration with the Cuschieri Skills Centre in Dundee, provides the Emergency Abdominal and Thoracic Surgery for the General Surgeon course. There are two candidates per cadaver. This two-day course is recommended for trainees ST3 level and above. As both of these courses are very practical and hands-on, general surgery trainees usually speak highly of them. RCSEd also provides a similar course in collaboration with Newcastle Surgical Training Centre. Further afield, a course similar to DSTS is held in South Africa, with the incorporation of a 'wet lab' on anaesthetised animals. Wet labs are not held anywhere within the UK. This course is considerably cheaper than the UK equivalent, but obviously travel costs will be higher.

In addition, RCSEng provides a one-day course aimed at surgeons and emergency doctors alike. The Pre-hospital and Emergency Department Resuscitative Thoracotomy course aims to provide a hands on evidence-based approach to the resuscitative emergency department thoracotomy. This course uses porcine rather than cadaveric models.

The Strategies in Emergency General Surgery course is a relatively new course run by RCSEng. This course focuses solely on decision making and evidence based management of emergency general surgical patients. The cases discussed are real cases and often complex. This course is excellent FRCS exam preparation and is also recommended for consultants wishing to update their knowledge of the best available evidence and refine their decision making skills.

There are increasing numbers of patients who have undergone bariatric procedures who then present as emergencies to their local surgical team. A recommended more specialist course is Emergencies in Bariatric Surgery provided by Chelsea and Westminster Hospital. This lecture-based course aims to enable candidates to recognise and manage early and late complications of bariatric surgery, which is valuable particularly for clinicians outside of specialist centres with limited bariatric experience.

Fellowships

As well as courses, senior trainees may want to spend a focused period of time improving their skills in emergency and trauma surgery during a fellowship. The ***BMJ*** is the obvious place to search for available fellowships but there are very few fellowships advertised for emergency and 'non-orthopaedic' trauma surgery. Trauma.org (www.trauma.org.uk) provides a comprehensive list of trauma and surgical critical care fellowships. The majority of these are in the United States and South Africa. Some are aimed entirely at the care of the trauma patient although some of the described fellowships do concentrate on all forms of acute general surgery. Many of the advertised fellowships do appear to offer an amazing experience, but it is worth considering that the ratio of trauma to emergency surgery in these countries is often inverse to that of the UK experience.

Although major trauma centres able to offer emergency surgical fellowships may be the most desirable to trainees, the great majority of EGS is non-trauma and we would like to see Emergency General Surgical Fellowships offered throughout the UK at a number of centres now pioneering a dedicated emergency surgical service. At present, there seem to be very few of these trusts offering fellowships; Oxford have done so recently. Six to twelve months experience as an Emergency General Surgical Fellow would give many trainees invaluable experience and skills to build upon and take forward into their early consultant years.

Course title and provider	Target audience	Duration of course	Cost	Website and contact
CCrISP	CT1-3	2.5 days	Approx £600 (depending upon course location)	http://www.rcseng.ac.uk/courses/course-search/ccrisp.html Contact: education@rcseng.ac.uk or 020 7869 6300
Advanced Trauma Life Support	FY2 and above	3 days	Approx £600 (depending upon course location)	http://www.rcseng.ac.uk/courses/course-search/atls.html Contact: education@rcseng.ac.uk or 020 7869 6300
European Trauma Course	Anyone with an interest in major trauma care	2.5 days	Approx £750 (depending on location (various across Europe inc. UK))	www.europeantrauma.com
ASiT Emergency Cross Cover Course	Anyone on the Surgical 'SHO' rota	1 day	Free to ASiT members (Membership is £50 per year)	http://www.asit.org/events/courses/ECC
Emergency Abdominal Surgery Course Donegal Clinical and Research Academy	Core Trainees & ST3	1 day	€100	
Specialty Skills in Emergency Surgery and Trauma (SSET) RCSEng	FY2-CT2	2 days	Full Course Fee: £795.00 RCS Members/Fellows: £715.50	http://www.rcseng.ac.uk/courses/course-search/course.2007-09-11.6372285337 Contact: education@rcseng.ac.uk or 020 7869 6300
Emergency Ultrasound UK Approved by the College of Emergency Medicine	All acute care doctors	1 day	Level 1: £320 Level 2: £580	www.emergencyultrasound.org.uk
Definitive Trauma Surgical Skills RCSEng	ST5-8	2 days	Full Course Fee: £1265.00 RCS Members/Fellows: £1138.50	www.rcseng.ac.uk/courses/course-search/Dtst.html Contact: education@rcseng.ac.uk or 020 7869 6300
Emergency Abdominal and Thoracic Surgery for the General Surgeon RCSEd	ST3 and above	2 days	Full course fee: £795.00 RCSEd Member/ Fellow: £750.00	http://www.rcsed.ac.uk/education/courses-and-events Contact: C.Forrest@rcsed.ac.uk 0131 527 3436
Pre-Hospital and Emergency Dept Resuscitative Thoracotomy RCSEng	CT2 and above in Emergency Medicine or General Surgery	1 day	£485.00	www.rcseng.ac.uk/courses/course-search/resuscative-thoracotomy Contact: education@rcseng.ac.uk or 020 7869 6300
Strategies in Emergency General Surgery RCSEng	ST5-8 and Consultants	2 days	£795.00	www.rcseng.ac.uk/courses/course-search/strategies-in-emergency-general-surgery Contact: education@rcseng.ac.uk or 020 7869 6300
Emergencies in Bariatric Surgery	All clinicians involved in the care of bariatric	1 day	£25	Contact the Postgraduate centre at Chelsea and Westminster Hospital for details on 020 87465590

Additionally, for the 25% or so of trainees struggling to achieve the index numbers of emergency procedures now required for CCT, a dedicated period of emergency general surgical training would support this training need.

The Future

Emergency general surgical consultant posts are becoming more common across the UK and future candidates may benefit from a more structured training. There is a cohort of trainees with a genuine interest in the provision of high quality emergency surgical care who do not see emergency surgery posts as a 'stepping stone' or 'young consultant' post. With current training regulations, the best development of these candidates will need to be delivered by courses and fellowships.

In a recent survey, a majority of general surgical trainees indicated a desire for more structured training in EGS, so the applicability of further improvements in course availability would probably be wide. The current courses are well received, but it can be difficult to secure a place on them. This is especially true for the more practical courses where numbers are limited. Comments left on course websites are often around the issue of how long the trainee had to wait before they were given a place on the course and it is even more difficult for non-training grade doctors. In addition, most trainees find that their study budget won't cover the cost of a single course, so attending multiple courses throughout the year can be financially difficult, although professionally worthwhile. Development of locally funded regional courses with an experienced faculty chairing case-based discussions of emergency presentations relevant to local populations would complement oversubscribed national courses and be extremely valuable to all trainees.

EGS will remain an important component of every trainee's future consultant job plan, irrespective of whether their title includes 'Emergency General Surgical Consultant' or not. There has been much recent debate over the structure of emergency surgical provision within the National Health Service. We would like to see sites where service provision has been addressed, with improved outcomes for EGS patients sharing their experiences from both managerial and clinical perspectives and offering EGS fellowships for senior trainees. Trainers and trainees share the responsibility to ensure they have the appropriate knowledge, decision-making and practical skill-base to be able to provide this high quality care to all emergency general surgical patients, and we hope this article will stimulate debate as well as course uptake and development.

ASGBI Vice President, Mr John Moorehead, won Visit Belfast's Ambassador of the Year award for securing the Belfast Waterfront conference venue for the 2016 ASGBI Congress. He received his award from the Tourism Minister, Arlene Foster, in September.

FEMALE GENITAL MUTILATION

Comfort Momoh
FGM/Public Health Specialist, FGM National Coordinator

What is Female Genital Mutilation (FGM)?
The term "female genital mutilation" refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other reasons, and always for ***non-medical reasons***. Infibulation and reinfibulation are included in the definition of female genital mutilation. FGM is a violation of the rights of women and children that denies them security, personal liberty and the fundamental right to health (WHO 1997).

Why FGM?
Communities that practice FGM put forward many reasons and beliefs for the practice. Some believe that FGM promotes chastity, prevents promiscuity, and helps to secure a good marriage for one's daughter. It brings status and respect to girls and is a rite of passage. They also believe it upholds the family honour. The type and timing of FGM varies across cultures, ethnic groups and tribal affiliations. In some cultures, FGM is carried out on babies, young children or adolescents. Other cultures perform FGM on adults, often just before marriage or during the first pregnancy.

Who performs FGM?
FGM is commonly performed by traditional birth attendants, local women or men, or female family members. Such individuals do not have formal medical training and usually perform FGM without anesthesia or sterilisation. It is not uncommon for those who perform FGM to cut or damage more of the genital area than they intend. For example, an unskilled person may intend to perform Type 1 FGM, but do more damage to adjacent organs.

The World Health Organization (WHO) estimates that over 130 million women and girls in more than 28 countries in Africa, the Middle East, Pakistan, Indonesia and Iraq, have undergone FGM. It is suggested that about 2 million or more girls undergo the practice each year.

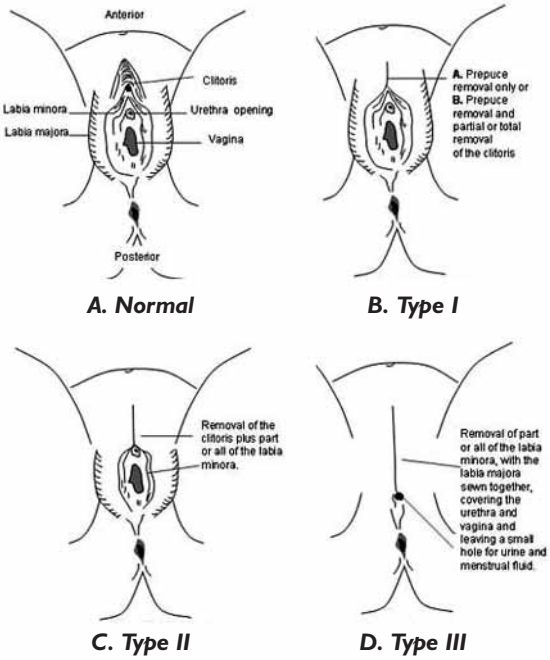
Types of FGM
There are four main types of FGM.

Type 1, also known as "clitoridectomy," is the removal of the clitoral prepuce (or "hood") and may also involve removal of all or part of the clitoris.

Type 2 is the removal of the clitoris and may also involve removal of all or part of the labia minora (the smaller, inner vaginal lips).

Type 3, also known as "infibulation," involves removal of part or all of the external genitalia and the stitching or narrowing of the vaginal opening, leaving a small opening for the passage of menstrual flow and urine.

Type 4 refers to all other genital procedures.



A. Normal *B. Type I*

C. Type II *D. Type III*

Complications and Consequences of FGM
FGM has no medical benefit and can potentially be very dangerous for women's health and psychological wellbeing; it can lead to severe health problems that last a lifetime. FGM can cause gynecological, urological and obstetric problems in women. Indeed, it doubles the risk of the mother's death in childbirth and increases the risk of the child being stillborn by three to four times.

During and immediately after the FGM procedure, women can experience significant pain and may suffer hemorrhage, shock, infection, urine retention, injury to adjacent tissue, and ulceration of the genital region. In extreme cases, girls may die from severe hemorrhage.

Intermediate complications from FGM include delays in the healing of wounds, excessive scarring and the formation of keloids (thick, swollen skin covering the scar), pelvic infection and epidermoid cysts or abscesses. Lubricating glands continue to secrete, forming sacs full of cheesy materials; the cysts may grow to the size of an orange or bigger around the excised area, which can become infected and painful, and neuromata can occur (damage or trapping of the nerves in the vulval area).

Long term complications of FGM can include haematocolpos, the accumulation of menstrual blood in the abdomen. In some cases, haematocolpos can cause extreme distention of the abdomen. This can prevent the flow of menstrual blood and lead to dysmenorrhoea (severe pain in the lower abdomen during menstruation).

It is also common for women with FGM to suffer recurrent urinary tract infections, kidney infections or dysfunction, painful intercourse, infertility and problems with labour and delivery. The use of non-sterile tools to perform FGM may also put women at risk from HIV or other serious blood borne diseases. Many women would suffer from obstructed labour, which can lead to further complications, including extreme

perineal tearing, uterine inertia, post partum wound infections (wound sustained around the vulva following delivery), and in many cases will cause foetal distress or death. A WHO study involving 28,393 women in six African countries found that women who have had FGM are significantly more likely to experience difficulties during childbirth and that their babies are more likely to die as a result of the practice.

Other complications include psychological trauma, such as flashbacks to the procedure and its aftermath, anxiety, insomnia, nightmares, depression, anger, difficulty with intimacy and establishing relationships, and phobias related to sexual relations or touching the genital area.

Women and girls with FGM living in the UK
Combining the figures for three different age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011 (City University and Equality Now, July 2014). This total is made up of the following: An estimated 103,000 women aged between 15 and 49 (compared with an estimated 66,000 in 2001); approximately 24,000 women aged 50 and over; and nearly 10,000 girls aged 0-14 (who have undergone or are likely to undergo FGM).

Of the women in the 15-49 age bracket, 53,000 were born in countries with almost universal Type III FGM, and a further 20,500 were born in countries with very high rates of Type I and Type II FGM. Women aged 50 and over with FGM are likely to continue to experience gynaecological and psychosomatic problems and these older women are also likely to create pressure to continue the practice among their younger family members. A staggering three fifths of these women were born in countries where FGM is almost universal.

Women with FGM giving birth
It is estimated that, since 2008, women with FGM have made up about 1.5 per cent of all women delivering babies in England and Wales each year. About three fifths of them were born in the group of countries in the Horn of Africa where FGM is almost universal and Type III is commonly practised.

Girls born in England and Wales to mothers with FGM
From 1996 to 2010, 144,000 girls were born in England and Wales to mothers from FGM practising countries. It was estimated that 60,000 of these girls were born to mothers who had actually experienced FGM. In both cases, well over half of the mothers came from the countries in the Horn of Africa where FGM is almost universal and Type III is practised, and slightly under a fifth came from the countries in West and East Africa where Types I and II are highly prevalent (City University and Equality Now, July 2014).

These figures may be slight underestimates as they do not take into account migration since 2011. Further analytical work will incorporate this. It will also look at the extent to which the women who migrate, especially from countries with lower prevalence of FGM, are typical of their populations in general, or whether they may come from groups with lower or higher estimates of FGM. In addition, as there is some under-enumeration of Black African women in general in the Census compared with the population of England and Wales as a whole, there may be some under-enumeration of the sub-group of Black African women who migrated from countries where FGM is practised.

The size of these provisional figures underlines the urgent need for a robust plan for services to support women who have undergone FGM and to safeguard their daughters from undergoing this too.

Conclusion
With the increasing numbers of migrants to the UK from FGM practicing countries, all concerned need to be aware of their roles and responsibilities in order to safeguard girls who might be at risk. They should also be familiar with the different guidelines, policies and pathways on FGM, given in the Multi-Agency Guideline (Department of Health 2011) which explains the complex issues surrounding the practice.

The UK law on FGM is clear; it is an offence for anyone, regardless of their nationality and residence status, to perform FGM or to assist a girl to perform FGM on herself in the UK.

Improved response would surely require that FGM is fully integrated into the safeguarding children framework and should be given equal weight and attention as other forms of child abuse.

Suggested further reading

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LEAN AND SIX SIGMA PROCESS ENGINEERING AND HEALTHCARE SYSTEMS

David A Rew
Director of Communications

Surgeons have never shied away from innovation. Forthcoming, progressive and seemingly inevitable reductions in the funding of UK public healthcare services, relative to demand, will mandate radical thinking about the delivery of healthcare, if a credible clinical service is to be sustained in a format which we presently recognise.

My reflections on this problem have recently been focussed in reading about the UK Government Digital Service, which has adopted a radical, user-centred and simplified approach to the delivery of nationwide digital information services through the web dotGov portal (about more of which later); and through a commissioned review of the International Journal of Lean Six Sigma (Emerald Group Publishing, UK), which has led me into the rich literature of lean production processes and systems in manufacturing and their translation into the service (and healthcare) sectors.

Lean production methodologies seek to secure the maximum efficiency in the use of all resources, including time, manpower and materials, to meet the user/customer/consumer needs and to minimise waste through a systematic and scientific approach to process analysis. There is nothing really new about this mental framework, without which the Egyptians could not have built the pyramids or industrialisation and mass production would not have emerged in the latter centuries of the past millennium. However, lean production as a philosophy is particularly attributed to the Toyota Motor Company, which sought to improve upon the production values and systems of Henry Ford after the Second World War.

Lean production is underpinned by a philosophy of continuous improvement, which applies to all processes within an organisation, and which embodies a philosophy of empowerment for all employees, from the top to the bottom of any organisation, known in Japanese as Kaizen (Good Change). The organisational structures which deliver Kaizen continually deliver stepwise improvements which cumulatively deliver substantial gains in productivity and efficiency, the emphasis being upon bottom up change on the basis of practical experience, rather than by more remote, top down command and control philosophies and orders.

Kaizen also describes a cycle of activity, the Plan-Do-Check-Act (PDCA) cycle, wherein a process of activity is planned and implemented in a standard format; evaluated against requirements; innovated and re-standardised in a continuous development cycle.

The PDCA cycle takes various terminological forms, including DMAIC (Define-Measure-Analyse-Improve-Control), for the improvement of existing processes; and DMADV (Define-Measure-Analyse-Design-Verify), which is applied to the introduction of new processes.

The Andon Cord
One of the more imaginative aspects of the Toyota production line has been the Andon Cord (now a wireless button) which permits any worker to pull the (emergency stop) cord and halt the production line when a defect is noted. This allows problems to be addressed before the fault becomes embedded in the unit as it moves along the production line. It might appear that this function would slow the production line. However, in practice, it improves production and economic efficiency by allowing for the early rectification of faults before more expensive and troublesome solutions are needed later in the production process.

This finds parallels in the empowerment of healthcare staff to draw attention to emerging problems, and finds an explicit parallel in the introduction of the Theatre Check List and the pre-and post-operative "time out" procedures.

Root Cause Analysis
Where a failure occurs, a robust Root Cause Analysis is undertaken to establish the cause of the failure, through an iteration of the question "Why?". Process engineers consider that "Why?" is an iterative process which can take up to five cycles (the Five Whys) to reach the true cause of a problem. There are a wide range of practical and statistical tools and methodologies to assist quality control and the associated management processes.

Wikipedia cites the following example of the "Five Whys" process in action:

Problem: The vehicle will not start.

1st Why? - The battery is dead.

2nd Why? - The alternator is not functioning.

3rd Why? - The alternator belt has broken.

4th Why? - The alternator belt was well beyond its useful service life and not replaced.

5th Why? - The vehicle was not maintained according to the recommended service schedule (a root cause).

We may wonder how often a rigorous root cause analysis of a surgical complication or adverse outcome is seen to a proper conclusion in NHS practice, when assessed against such processes; and when the simple allocation of blame for an unsatisfactory outcome is organisationally so much easier than a rigorous root cause analysis of the problem.

Six Sigma and Process Improvement
Six Sigma is a system for process improvement which was developed by companies, including

Motorola and General Electric, from the 1980s onwards. It focuses upon improvement in the quality of process outputs through standardisation and elimination of the causes of defects. The term itself originates in statistics and the elimination of error to six standard deviations (6 x sigma), or 3.4 defective parts per million.

Six Sigma focuses upon measureable improvements founded in management commitment to the process and to decision making founded in verifiable data and statistics. The emphasis upon management commitment recognises the critical role of executive leadership in successful implementation; of Champions for the process within the organisation; and for certification of those champions as Black Belts, Green Belts and so on according to their subsidiary responsibilities for Six Sigma implementation within the organisation.

Lean Six Sigma is a concept which self-evidently combines Lean Enterprise philosophy with Six Sigma methodologies. In manufacturing terms, it recognises forms of waste, which include Defects; over-production; Waiting; Non- and under-utilised talent; Transportation; Inventory; Motion; and Downtime.

The sources of waste in Lean Processes have been redefined for the service industry by John Bicheno and Matthias Holweg in their book, ***The Lean Toolbox*** (PICSIE Publications 2009) to include:

- Delay: on the part of customers (or patients) waiting for the service, which thus imposes a cost upon the customer.
- Duplication; for example in data transactions within the organisation.
- Unnecessary Movement within the system: for example, through repeated queuing, lack of one-stop visits.
- Unclear Communication, leading to duplication and error.
- Incorrect inventory.
- Loss of customers and of confidence in the organisation, and a rise in complaints.
- Errors in the transaction: to include complications and adverse (clinical) outcomes.

The principles of lean processes have been refined by Kent Bowen and Steven Spear of Harvard Business School into four clear rules for success, which are:

1. All work shall be highly specified as to content, sequence, timing and outcome.
2. Every customer-supplier connection must be direct, with an unambiguous Yes or No protocol for requests and responses.
3. The pathway for every product and service must be simple and direct.
4. All improvements must comply with scientific method throughout the organisation.

The Limitations of Lean Process Methodologies

Six Sigma attracts some criticism as an organisational development tool, in that it focuses upon the relentless and incremental improvement of existing processes and systems, and upon statistical techniques, such that it can come to dominate an organisational culture. This may, in turn, close out thinking about radical innovation and game changing strategies.

Lean Systems Engineering and Healthcare Delivery in the UK

Healthcare delivery in the UK provides huge opportunities for system re-engineering to produce service efficiency gains. At the parochial level, we can find many examples in daily surgical practice where accepted processes could be readily improved.

For example, in my own hospital, as in many others, outpatient letters are dictated in the clinic; transmitted to a remote service centre (in India) where they are typed up; transmitted back to our own secretaries, who must then match up the records and check for errors, before printing the letter, passing it on to the originator for checking and signing; and then posting it to the GP, who will then employ another administrator to scan it in to the GP's electronic storage system. Consider the benefits and savings of the clinician generating the letter on screen in the clinic at the time of patient contact, using menus and macros, and then sending it directly on to the GP's electronic in tray.

Such service gains can be investigated throughout the hospital. For example, Djoko Setijono and colleagues at Linkoping University Hospital in Sweden investigated the use of modelling systems to reduce non-value added time and total time in the system for patients in the hospital's emergency department. Modelling tools allow a wide range of variables to be tested in such systems (as reported in the ***Int J*** Lean Six Sigma, 1, 3, 2010).

We can imagine many practical applications of system modelling to examine local inefficiencies in each and every hospital; for example, in the flow of patients from referral to final outcome through the outpatient service, or in the most efficient way to optimise hospital layout and porterage services to facilitate the transfer of patients between theatres and wards.

The Impact of Information Technology upon Healthcare Delivery

Modern software and information technology tools provide the wherewithal for radical changes in the way we work. For example, paperless and paper-light data recording systems now loom on the immediate horizon to replace

traditional paper based communications. This represents a significant shift in the way in which we work, and it requires rigorous testing on the road to full implementation.

However, with a shift of focus from the convenience of the public service provider to the individual user, and given the service transformational power of well-designed software systems, as set out clearly in the dotGov philosophy (for which the following links may be of interest: https://gds.blog.gov.uk/, http://en.wikipedia.org/ wiki/ Government_Digital_Service, https://www. gov.uk/government/organisations/government-digital-service), we can now start to consider far more radical process engineering to improve the user experience in healthcare delivery.

Consider, for example, the role of general practitioners in an information rich healthcare system to which they have traditionally been the gatekeepers to access, based upon their purportedly specialist knowledge of the available services. At a time when many individuals report difficulties in securing ready access to their family practitioner, can and should we use lean service strategies to examine and to re-engineer the entire patient/user experience from first symptoms and signs to final outcome? Conversely, can we re-engineer pathways to improve the effectiveness of primary care and to reduce the load upon hospital services? Can we process, re-design and integrate the entire spectrum of health and social services provision into more efficient and effective systems?

The Implementation of Lean Process Re-engineering of the NHS

Change is, of course, a key facet of the NHS workplace. We have seen considerable rolling change in many aspects of NHS structure and organisation since its inception, along with the extensive piecemeal introduction of computerisation and information technology across the health sector. Lean and Six Sigma concepts are not unfamiliar to health planners, and a cursory search of the literature reveals a wide range of articles on the health and policy implications and applications of these concepts, although often in specialist and non-mainstream journals.

However, private sector organisations face the imperative of lean processes in all aspects of their productivity and customer facing services which have not hitherto applied to a similar degree or with the same end user focus to monopolistic and public sector organisations. The language and imperatives of lean production and service are thus not embedded in the NHS, where other pressures occupy much managerial and administrative time and energy. Efficiency objectives and processes are distorted by social, political and professional pressures and influences which are independent of the financial bottom line, and where the service user (the patient) does not have the same power and influence as in a competitive consumer market.

Nevertheless, there is much that can be done to advance the agenda and benefits of lean organisation under the pressure of shrinking budgets, and to secure the engagement of the public sector health workforce to realise the benefits. Surgeons can and should play a significant role in this process.

Lean process management starts at the top of the NHS, where surgeons in national positions of political, organisational and executive influence can help advance the benefits and practicalities of NHS-wide re-engineering. However, for most of us, organisational influence extends to the office of our local Chief Executive and Hospital Board Directors, where a transformational agenda can rapidly become overwhelmed in the daily grind of problem firefighting. Nevertheless, there are considerable opportunities for low level process re-engineering which can be developed and communicated through the system, once the language and concepts of lean methodology have taken root.

The Implications of Lean Process Engineering for the Training and Education of Surgeons

ASGBI has a key responsibility for the General Surgical Curriculum, which has itself been in a process of continuous change for several decades. General Surgery has to evolve in tandem with the realities of the workplace. We may interpret processes, such as surgical specialisation and super-specialisation, in similar terms to those seen on the lean manufacturing shop floor, where specialist functions are distilled to ensure the most efficient working of the production process.

Lean engineering of the surgical career may yet have further to run, with the widespread introduction of "physician's assistants" to assume progressively more functions which have previously been subserved by surgeons in the pursuit of economic efficiency. We are thus obliged, continually, to consider the process engineering of the surgical career and the training of surgeons, in the context of lean process development in the NHS and service requirements as, once again, for more "generalist" skills to run the takes in the District General Hospitals.

The next few decades are likely to herald profound changes in the allocation of healthcare resources in the UK, and then changes to the material environments in which surgeons work. Familiarisation with the language and concepts of organisational change, and of continuous service improvement in a resource-restricted environment, will help the surgical profession to lead and to influence the shape of things to come.

THE SHAPE OF TRAINING: *"SECURING THE FUTURE OF PATIENT CARE"*

A response on behalf of the Surgical Forum of Great Britain and Ireland, March 2014

Professor John MacFie
Chairman of the Surgical Forum

The Surgical Forum of Great Britain and Ireland (formerly known as the Senate of Surgery) comprises the Presidents and Vice Presidents of the four Surgical Royal Colleges:

- 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.

and the Presidents of the ten SAC-defined Surgical Specialty Associations:

- Association of Surgeons of Great Britain and Ireland.
- British Association of Oral & Maxillofacial Surgeons.
- British Association of Otorhinolaryngology – Head & Neck Surgery.
- British Association of Paediatric Surgeons.
- British Association of Plastic Reconstructive and Aesthetic Surgeons.
- British Association of Urological Surgeons.
- British Orthopaedic Association.
- Society for Cardiothoracic Surgery in Great Britain and Ireland.
- Society of British Neurological Surgeons.
- Vascular Society of Great Britain and Ireland.

Foreword
The Shape of Training Review (ShOT) was launched following an agreement between the key organisations that are responsible for the delivery, commissioning and regulation of medical education. These include Medical Education England, the Academy of Royal Colleges, the Confederation of Postgraduate Deans and representative health organisations from Scotland, Wales and N Ireland. A fundamental review of medical training was deemed necessary because the needs of patients in the UK are changing rapidly. It is recognised that doctors have to care for patients with chronic illness and multiple co-morbidities, which is partly a consequence of an aging population.

The final report of this independent review, led by Professor David Greenaway, sets recommendations regarding the structure and delivery of medical and surgical postgraduate training for the next 30 years. The changes proposed within its 19 recommendations are far-reaching and have implications for both current and future trainees in the UK.

Background
The Surgical Forum of GB and Ireland, formerly known as the Senate of Surgery, is comprised of the Presidents and Vice Presidents of the four Royal Colleges and the Presidents of the 10 SAC defined surgical specialties. The Surgical Forum is therefore the only truly representative voice of surgery across the entirety of GB and Ireland.

In recognition of the importance of the ShOT review and the fact that its recommendations have far reaching implications for patient care, the Surgical Forum agreed it would be appropriate to hold a one day meeting devoted exclusively to this topic. This meeting was held at the Royal College of Surgeons of Edinburgh on March 20th 2014. The Presidents and Vice Presidents of each of the four Royal Colleges attended, as did the President of the Federation of Surgical Specialty Associations (FSSA). Presidents or representatives of 9 of the 10 SAC specialties (the Vascular Society being the only absentee) were also present. In addition, written statements were received from patient liaison groups and ASiT. The Presidents of ASiT and BOTA were also present, together with CEOs of the Royal Colleges of Physicians and Surgeons of Glasgow and the Association of Surgeons of Great Britain and Ireland.

The speakers at this meeting were:

- Ms Clare Marx, Consultant Orthopaedic Surgeon and Member of the Expert Advisory Group, Greenaway Report
- Professor Rowan Parks, Deputy Medical Director, NHS Education for Scotland
- Mr Andrew Beamish, President, ASiT
- Mr Jeya Palan, President, BOTA
- Professor Nicholas Gair, Chief Executive, Association of Surgeons of Great Britain and Ireland

All participants were invited to give their views and those of their affiliated organisations.

Summary
There was broad agreement amongst the members of the Surgical Forum that:

- The broad goal of medical education must be to deliver trained doctors that match the needs of the local population with some organisational change to adapt to local requirements.
- There needs to be greater emphasis on the need for generalist as opposed to specialist skills, particularly in the care of the emergency acute patient.
- A return to apprenticeship style training and an acceptance that training times will vary between individuals and disciplines is welcomed.
- The role of the "consultant" requires revision to recognise the fact that consultant responsibilities change over career lifetime.
- Training in a defined subspecialty will require additional post CST training termed credentialing.

Introduction
For the sake of clarity, the comments, criticisms, areas of agreement or disagreement as discussed in the Forum meeting are listed here as they apply to each of the 19 recommendations of the ShOT report. This paper should, therefore, be read in conjunction with the report.

1. *"Appropriate organisations must make sure postgraduate medical education and training enhances its response to changing demographics and patient needs"*

   Agree: The Forum's paper "Training Surgeons for Future Service Requirements" was based upon this assumption.

2. "*Appropriate organisations should identify more ways of involving patients in educating and training doctors*"

   Agree: Patient liaison groups are now an integral part of Colleges and Associations.

3. "*Appropriate organisations must provide clear advice to potential and current medical students about what they should expect from a medical career"*

   - There was detailed discussion about aspirations and perceptions of surgical trainees. At present, a substantial majority of surgical trainees aspire to what they term a specialist post. Specialisation is associated with enhanced status. This needs to be addressed if trainees are to be encouraged to develop generalist skills. As such, we agree with comments in paragraph 43 which explicitly state that employers must make broader roles more attractive.
   - There is an urgent need to educate and inform surgical trainees about manpower issues throughout the specialty spectrum.
   - Notwithstanding the putative benefits to society of ensuring a medical workforce with generalist skills, the Forum agreed that there is now no doubt that volume-outcome data strongly support specialisation of many conditions. Such specialisation will inevitably result in further reconfiguration of hospitals, with only the larger centres being equipped to perform uncommon procedures. Such reconfiguration is not without dangers, as have been experienced in Ireland, where concentration of cancer services has resulted in difficulties in recruiting surgical staff to non-cancer hospitals.
   - Reconfiguration should be of services rather that of hospitals. The development of regional networks would provide a model allowing local care for general or high volume conditions, with low volume conditions being treated within the network at the most appropriate place. This does not rely on the development of supercentres, which will potentially remove the local delivery of care.
   - The regional approach means that the uncommon procedures are done where the most appropriate team is, which may be still in a small unit.

4. "*Medical schools along with other relevant organisations must make sure medical graduates at the point of registration are capable of working safely in a clinical role suitable to their competence level and have experience of and insight into patient needs*"

   See comments under paragraph (5)

5. *"Full Registration should move to the point of graduation from medical school, subject to the necessary legislation being approved by Parliament and educational, legal and regulatory measures are in place to assure patients and employers that they are fit to practise"*

The Forum recognised the potential benefits of this proposal:

- Moving the point of registration would be a catalyst to medical schools to ensure their graduates were fit for purpose in a clinical environment.
- Such a move, particularly if combined with an appropriate competency test, would ensure harmonisation with Europe.
- The mismatch between the pastoral responsibilities of medical schools between graduation and registration would cease (at present, many F1 doctors complete their preregistration year at geographic sites distant to their medical school and, as such, pastoral care transfers to deaneries which are ignorant of undergraduate career).
- At present, Foundation years are a mishmash of posts which serve trainees poorly. Often used to plug rota gaps, little attention is made to career progression or acquisition of generic learning skills. Moving the point of registration is welcomed but not if this is at the cost of moving F2 into core training.
- Moving the point of registration would absolve medical schools of the need to guarantee full employment in Foundation posts for all their graduates.

However, the Forum could not provide unanimous support for this proposal. Some of the reasons for this were as follows:

- It would result in some graduates not getting a post because of competition from the EU. Currently there are around 170 extra graduates in the UK for FY posts and we feel that additional posts should be created to ensure that all graduates are placed. This would be preferable to them applying overseas at FY1 level to systems that they have not previously experienced.
- Some form of inter deanery support should be provided to F1 doctors allocated to posts distant to their alma mater.

- This proposal is somewhat tangential to Greenaway and would be better dealt with separately. It will require significant changes in Undergraduate medical education and associated legislative changes. Greenaway is already a major challenge without this specific proposal.

6. *"Appropriate organisations must introduce a generic capabilities framework for curricula for postgraduate training based on Good Medical Practice that covers, for example, communication, leadership, quality improvement and safety"*

Agree: See response to recommendation (10)

7. *"Appropriate organisations must introduce processes including assessments that allow doctors to progress at an appropriate pace through training within the overall timeframe of the training programme"*

Agree: See response to recommendation (8)

8. *"Appropriate organisations including employers must introduce longer placements for doctors in training to work in teams and with supervisors including putting in place apprenticeship based arrangements"*

- A return to apprenticeship style training is universally welcomed.
- There was general agreement that indicative years of training are inappropriate in a craft specialty like surgery. Progression should be determined by acquisition of competencies.
- Achieving competence indicates an appreciation of safety but does not indicate experience.
- An interpretation of the schematic diagrams outlined in the ShOT suggests that completion of specialist training may be achieved within six years. This would be difficult to achieve for a craft specialty such as surgery. Acquisition of CCT takes eight years at present and there are already concerns about adequate exposure to surgical procedures to ensure trainees are emergency safe. This concern might be accentuated by a two year reduction in indicative training particularly if one of the Foundation years was incorporated into specialist training.
- Problems with training times have been accentuated by EWTR.
- Accelerated training programmes would necessitate a careful reappraisal of curriculae, a more widespread adoption of simulation and consideration of alternative training strategies (e.g. modular training in high volume units).
- A shortened training programme mandates a review of the curriculum with emphasis on the generality of care. In most surgical specialties, this will focus on the management of the emergency patient. A consequence of this will be an increased need for individuals to pursue post CST training if they are to develop "sub specialty" skills. The Forum supports this in principle.

9. *"Training should be limited to places that provide high quality training and supervision, approved and quality assured by the GMC"*

The Forum **recognised** that not all units should be designated training units. Those that are should be subject to review, and those that are not should be able to apply through a defined process.

10. *" Postgraduate training must be structured within broad specialty areas based on patient care themes and defined by common clinical objectives"*

- The Forum has no objection in principle to this recommendation.

  However, many Specialty Presidents commented upon the practical and logistical difficulties in achieving amalgamation of areas of specialist practice. For example, neurosurgery, having initiated broad-based early years training including neurology, neurointensive care, related neuroscience disciplines, emergency medicine, neurointensive care and other related surgical disciplines, has struggled to deliver that programme due to the inflexibilities and workforce limitations of current postgraduate training. Similarly, paediatric surgery would welcome closer liaison with medical paediatrics.
- The Forum also commented upon the desirable objective of common core training between, for example, general surgery, urology and paediatric surgery. Such common core training would facilitate cross cover arrangements in hospitals, often permit treatment closer to home, and be more efficient of available resource.
- The Forum recognises that the aim of encouraging more interdependent training between different specialty areas offers great benefit but poses significant challenges. We would recommend that a working party should be established to investigate these possibilities for the surgical specialties.
- The Forum is in general agreement with the suggestion that there are three "broad levels of competence" (paragraph 90). These equate to a trainee, an individual competent to perform independently and a doctor with specialist skills. This issue was debated at length by the Forum and the following observations made:

a) Competence is essential to define safety but is distinct from experience. Competence should be assessed nationally by representative organisations, not locally by employers to ensure uniformity of standards.

b) Two tiers of competence as envisaged for the consultant role would infer the early years having an emphasis of emergency care. Movement between these tiers would be by competitive selection. Trusts might opt for proleptic appointments in anticipation of a particular clinical need. This would permit targeted post CST training.

c) Such a scheme recognises that a consultant career may span over 30 years, and as such, flexibility and change are essential. The suggestion that there is a two or three tier consultant model amounts to "stretching" of the career ladder.

d) Adoption of two or more tiers of consultant appointment mandates formal adoption of mentoring for all new consultant appointments and a recognition of the importance of team work. Additionally, adoption of such a process would mandate clarity as to means of career progression.

e) The Forum recognises the concerns of BOTA and ASiT who have expressed the view that a two or more tier consultant system might result in another lost tribe of doctors. Further, they have stated "there is a significant risk that these proposals will produce a clinician who is not sufficiently trained to practice independently at the level of a consultant surgeon, a fact that will inevitably lead to a sub consultant grade in all but name, unless this is specifically addressed from the outset of any change in the delivery of surgical training".

f) A two or three tier consultant appointment already exists in a majority of modern healthcare systems worldwide and in accord with current practice in most other professions. There are suggestions that this policy is already tacitly accepted in Government.

g) A tiered consultant career progression is not a sub consultant post.

11. *"Appropriate organisations working with employers must review the content of postgraduate curricula, how doctors are assessed and how they progress through training to make sure the postgraduate training structure is fit to deliver broader specialty training that includes generic capabilities, transferable competencies and more patient and employer involvement"*

- The Forum agrees that curriculae will have to be tailored to employer requirements and involve patients (paragraph 95).
- Workforce planning should be at a national level. Employers should be involved as should patients, but it should not be governed by local demand. For smaller specialties, such as neurosurgery, this could result in gross imbalances with a culture of 'he who shouts loudest gets most'.

12. *"All doctors must be able to manage acutely ill patients with multiple co-morbidities within their broad specialty training and most doctors will continue to maintain these skills in their future careers"*

- The Forum concurs with the view that all trained doctors should be competent in emergency care and that specialist doctors should continue delivering some general care (paragraph 104).
- The Forum shares concerns expressed in the report about a crisis in emergency care (paragraph 102).
- The Forum recommends that consideration be given to dual accreditation e.g. there is good evidence of benefit from "orthogeriatricians".
- There was agreement that it is very difficult to solve the paradox posed by the management of the ill emergency patient. On the one hand, these patients numerically are the largest group needing admission to UK hospitals mandating a need to train doctors to be emergency safe. However, in reality, management of these patients demands experience. Some specialties have expressed the view that the concept that you train someone to be emergency safe and then train them more thereafter is the wrong way round, as many sick emergency patients require specialised care.

13. *"Appropriate organisations including employers must consider how training arrangements will be coordinated to meet local needs while maintaining UK-wide standards"*

- We acknowledge the concern expressed by ASiT relating this recommendation: the proposal is one of a dictated career structure, where CST-holders could be asked to retrain to fulfil local service needs, regardless of their own career intentions. This will be unpalatable for the majority of current surgical trainees given the time and personal funds invested in training to-date.

14. *"Appropriate organisations including postgraduate research and funding bodies must support a flexible approach to clinical academic training"*

There was general agreement.

15. *"Appropriate organisations including employers must structure CPD within a professional framework to meet patient and service needs, including mechanisms for all doctors to have access, opportunity and time to carry out the CPD agreed through job planning and appraisal"*

Again, there was broad agreement.

16. *"Relevant organisations including employers should develop credentialed programmes for some specialty and all subspecialty training, which will be approved, regulated and quality assured by the GMC"*

    - The Forum supports the principle of post CST training termed credentialing. However, it was unanimous in stating that there needs to be careful QA of such training and this would be best achieved through the Colleges or Specialist Associations (not the regulator).

17. *"Appropriate organisations should review barriers faced by doctors outside of training who want to enter a formal training programme or access credentialed programmes"*

    - The Forum has no disagreement with the suggestion that Staff Grade and Associate Specialist Grade doctors could avail themselves of additional training (paragraph 128). However, there was a consensus that this should be by competitive entry.

18. *"Appropriate organisations should put in place broad based specialty training (described in the model)"*

    - The section in the report on post-graduate training (paragraph 134) is comprehensive. It recommends broad based specialty training of four to six years after Foundation. The Forum agrees that the duration of training may vary between specialties and that this will need to be determined by the UK delivery group. The Forum believes that a working party should be established to examine these issues for the surgical specialties.

    - We note the recommendation that the award of CCT be changed to CST and this marks the point at which doctors are able to practice within their identified scope with no clinical supervision. As the numbers of indicative cases being performed by surgical trainees is already falling for a number of well-known reasons and is likely to fall further with these proposals, the Forum agreed that training within the surgical specialties will need to be more focussed on generic topics, particularly emergency care. Further, this proposal can only be safe if adopted at the same time as mentoring and an acceptance that newly appointed consultants will invariably work in teams.

19. *"There should be immediate consideration to set up a UK-wide Delivery Group to take forward the recommendations in this report and to identify which organisations should lead on specific actions"*

The Forum welcomes this and hopes the surgical specialties will be involved.

Other Issues

In the course of discussions throughout the day and during feedback, a number of other issues pertinent to the Shape of Training report, but not specifically referred to within it, became apparent. These can be summarised as follows:

a) That failure to accept the principles outlined in ShOT would inevitably result in massive reconfiguration of hospitals and the demise of the District General Hospital model of care.

b) Emergency medicine is a major problem. Failures of provision here impacts on all other specialties.

c) Feminisation of work force.

d) Concerns over academic training.

e) Adoption of fixed term consultant contracts.

f) Middle grade non consultant posts. There was general agreement that substantial numbers of elective surgical procedures are already performed by staff, associate specialist and specialty surgeons.

g) It is important to emphasise that within surgery in general, there is a spectrum of views. The smaller specialties, such as neurosurgery, are already handling the tension between emergency competence, generalism and specialism. Understandably, therefore, they view many aspects of ShOT with considerable concern.

h) The general feeling is that, whilst training may change, a one size fits all type policy would be detrimental. Implementation of the Shape of Training must allow variance amongst differing disciplines.

Conclusions and recommendations

- **The broad principles outlined in ShOT report were accepted.**
- **Consultant career should be tiered.**
- **The Forum suggests that a working party is established to investigate common themes between different surgical sub specialties to enhance training and facilitate subsequent cross cover. This working party should be part of the UK delivery group.**

ASGBI SUPPORTS NEW CHARITY

Ken Surridge
Chair, Porridge and Rice

Following the first ever paperless ASGBI Congress in May 2014, it was decided that the Association needed to clear its large stock of delegate bags. With the dedicated Congress app now hosting all relevant publications and leaflets, ASGBI no longer needed bags to hand out to each delegate on arrival. With this in mind, the Association selected new charity, **Porridge and Rice**, to help deliver these bags to people who could make lasting use of them, namely school children in Nairobi, Kenya.

Porridge and Rice was set up earlier this year to facilitate health education in schools in Nairobi, and in so doing, have also established a good distribution network for a variety of required materials, such as desks and even paving slabs. This made them an ideal choice for collaboration on this project. You can see images throughout the article of delighted pupils at the Excel Emmanuel Education Centre in Nairobi receiving the bags, which are a vast improvement on the plastic carrier bags they had been formerly using.

The work of Porridge and Rice

In East Africa, more children die of diarrhoea than HIV/AIDS and malaria combined, according to WHO figures. Unsurprisingly, the most affected people are the poor, especially slum dwellers. In response to this crisis, Porridge and Rice set up a health education programme for teachers and pupils, along with a water chlorination scheme targeting the worst affected in the area. Porridge and Rice received registered charity status in February of 2014.

Primary education is officially free in Kenya; however, figures suggest that there are only enough school places for around half of the school-aged children. Securing one of these places can be a difficult process, and can require money for bribes. As a result, the poorest families are often forced to send their children to fee-paying community schools.

Such schools are generally housed in tin shanties and are not in a good state of repair. It is extremely rare for them to have access to running water, and toilet facilities are rudimentary at best. Electricity and often even the most basic supplies are not commonly found. Most importantly, many teachers have no more than a secondary school diploma, and while often talented and committed, they are unable to offer a high standard of education.

After a period of fundraising at the start of 2014, Porridge and Rice secured enough money to launch a feeding programme at Excel Emmanuel Education Centre, a school with 350 pupils. A team of five people travelled to Kenya and the charity fulfilled its first objective. In July, a second school was added to the support network, raising the number of children who receive meals from the charity each day to 500.

During the July trip, through conversations with and observations of teachers and pupils, support staff became aware of the scarcity of local knowledge on key health issues, from hygiene to HIV. This initiated the Porridge and Rice health programme, currently under development, which is scheduled for launch in January 2015. The initial goals of this are to institute an annual deworming programme, to make clean water available at school, and to run classes on sanitation and hygiene for all pupils and teachers in partner schools.

Porridge and Rice are in contact with relevant organisations to establish what action to take to achieve their aims, and have a nurse who has volunteered to help launch the programme. The programme has already been discussed with teachers who are happy to participate.

Porridge and Rice are ambitious and determined to be long-term partners to the schools they support. Their goal is to provide breakfast, lunch and fruit each school day to 1,000 pupils by March 2015. If you would like to support the work of this charity, please visit their Facebook page or website and, if you can, donate some money to assist in the expansion of the work they are undertaking.

www.facebook.com/Porridgeandrice
www.porridgeandrice.co.uk

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Enhanced Recovery
Thursday 2 October 2014, Birmingham
Enhanced Recovery has been improving outcomes, patient experience and reducing length of stay for more than 5 years since the introduction of the national programme. This conference looks at enhanced recovery – how to sustain and extend improvement.

Implementing the Named Responsible Doctor in Hospital
Friday 3 October 2014, London
This conference focuses on implementing the named responsible doctor in hospital, including the new Academy of Medical Royal College recommendations, improving continuity of care through ensuring every patient in hospital has a named doctor responsible for their care.

Delivering a 7 Day Health Service
Monday 6 October 2014, London
Chaired by Steve Fairman Managing Director NHS Improving Quality this conference focuses on meeting the national clinical standards and learning from the early adopter sites to deliver a 7 day health service in practice.

Patient Experience Insight
Tuesday 7 October 2014, London
This conference will provide a practical guide to measuring, understanding and acting on patient experience insight, and demonstrating responsiveness both to individual patient feedback and to insight from patients as an organisation as a whole.

6 Sigma in Healthcare (Yellow Belt) 2 Day Intensive Training
Tuesday 21 - Wednesday 22 October 2014, London
This 2 day 6 Sigma Yellow Belt Training course for Healthcare Professionals is a hands-on interactive masterclass aimed at individuals and teams at all levels who need to develop an understanding of the power of the 6 Sigma and how the tools and methodology can make a significant impact within healthcare.

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THE NHS LITIGATION AUTHORITY SAFETY AND LEARNING FUNCTION - A VIEW FROM WITHIN

An update from Tracy Coates
Safety and Learning Lead for Surgery and Perioperative NHS LA

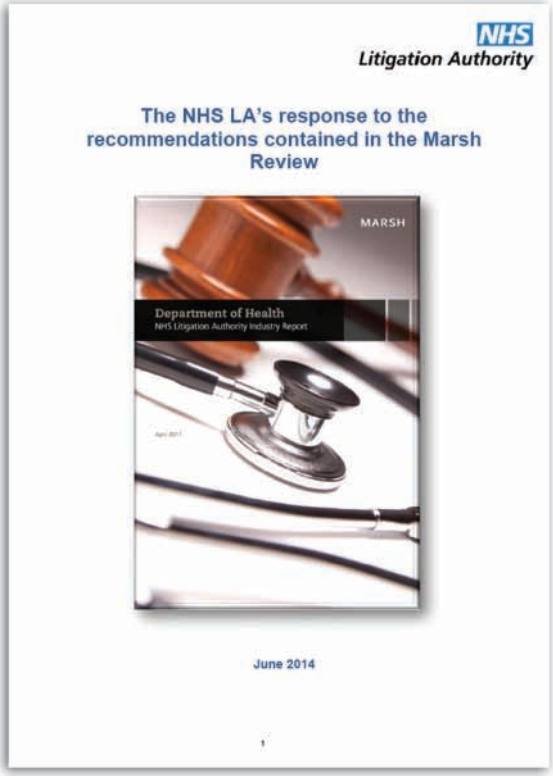
"The NHS LA's strategic objectives aim to ensure that we engage with the NHS and offer efficient and effective services which demonstrate value for money, as well as support the NHS to learn from things that go wrong, to reduce harm and improve patient safety."

Catherine Dixon CEO NHS LA
Annual Review July 2014

Background
The NHS Litigation Authority (NHS LA) is a Special Health Authority and an arm's length body of the Department of Health and was established in 1995. It provides a range of services, primarily indemnity cover for clinical and non-clinical liabilities, learning from claims, legal and professional services, and dispute resolution between commissioners and contractors. It also offers help for healthcare providers in the performance management of clinicians through advice, training and other support via NCAS (National Clinical Assessment Service) and a dispute resolution service concerning decisions made by commissioners of healthcare via the Family Health Services Appeal Unit.

Recently, the NHS LA has started a mediation service that will help support patients, families and the NHS to resolve claims quickly and cost effectively. Mediation is an independent, voluntary and confidential process which has been shown to be a highly effective means of resolving disputes.

A review of the NHS LA was conducted by Marsh, an independent insurance broker in 2011, resulting in a series of improvement recommendations that have been worked through by the organisation over the past few years. The NHS LA published a report in July 2014, detailing how it has responded to these recommendations following the review. Richard Douglas CB, the Department of Health sponsor of the NHS LA, says in his introduction: "I also recognise and firmly support the NHS LA's evolving and expanding role in the patient safety agenda and the importance it has attached to greater collaboration with clinical bodies and the wider NHS, to reduce harm to patients and staff by learning from claims."



One of the responses to the review was to discontinue the assessments that were carried out against the Clinical Negligence Standards, the final ones being undertaken in March 2014. This decision was taken after a comprehensive review in 2012/13, which included listening to and engaging with all the key stakeholders. The feedback from this review consolidated the view that the existence of a risk management system, even one complying with the NHS LA standards, could not in itself mean that a member trust was safe. There are many other factors to consider in improving patient and staff safety. The rationale for removing risk management assessment standards included: Reducing the burden on frontline staff, engaging clinicians in learning from claims and ensuring the approach is proportionate to individual claims and risk.

The NHS LA embarked upon a transition period for its members, supported through its Safety and Learning service. Four Safety and Learning leads joined the NHS LA between March and June 2014, covering clinical and

non-clinical claims. The aim of the service is to support and share learning from claims data and to align and support national patient safety agenda initiatives, e.g. patient safety collaboratives and the Sign up to Safety campaign, not duplicating them but adding value. It is important to highlight the unique role of the NHS LA and the data it holds to support learning from claims as a creative approach with trusts and healthcare organisations (our members). We fully recognise the vital importance of engaging clinicians in the process. In the post-Francis Inquiry era, this approach encompasses clinical and non-clinical claims, and the importance of human factors in patient and staff safety. The NHS LA was a signatory to the Human Factors Concordat published in December 2013. This sentinel document recognised the significance of education about and analysis of human factors in the investigation of errors and patient safety initiatives.

Current activity

We are in the process of producing scorecards for members from the claims data held on the NHS LA database. These are graphic displays that separate member organisations' claims data into four colour coded quadrants (red, amber, blue and green). These reflect a value and volume mix (high value-high volume, low value-low volume etc.) that can help support members to prioritise local safety improvement work in relation to claims. These are in the process of being developed in relation to the Sign up to Safety campaign.

Like any database, the Claims Management System (CMS) has limitations and benefits. A key function of the Safety and Learning team is to apply a root cause methodology to the data. This has proven challenging but the team are recommending improvements to the data collection and quality that will support the CMS to produce safety and learning data in a consistent and effective way. Data sharing agreements are being considered by the NHS LA in order to respond to the many requests for using/sharing the data held on CMS. We have initiated and now facilitate Safety and Learning Advisory Groups whose membership comprises clinicians and experts. Our third meeting is to be held in September 2014, where we will be sharing analysis of our review of a sample of data held within CMS with our colleagues, discuss future collaboration and determine where added value can be identified. It is also a forum to discuss how to optimise the use of this information and its potential for lessons learnt in different specialties.

The NHS LA operates an Extranet for members to access their claims information. This is the window for the Safety and Learning Team to share relevant information and there are various ways to view the claims data through this portal as well. It has an extensive safety and learning page, which we are in the process of reviewing and expanding, for any learning that we feel would benefit our members - we always welcome any ideas.

Sign up to Safety (SUTS) is a national campaign for the NHS in England which was launched by the Secretary of State on 24 June 2014, to co-ordinate safety improvement across the country. Its aim is to support the NHS in England to improve patient and staff safety by reducing avoidable harm by 50% and saving 6,000 lives by June 2017, with a focus on culture, leadership, measurement, reliability and effective implementation of safer practices.The campaign strategy asks for organisations to make pledges on safety to the campaign to achieve this vision. The NHS LA has made its own commitment to the campaign. It has pledged to support those organisations which have patient safety improvement plans which demonstrate a reduction in their high volume-high value claims. Safety improvement plans that demonstrate the local priority for reducing claims and harm using the other scorecard quadrant information will be considered if the plans are accepted through the SUTS safety criteria and submission process. This could result in an upfront, one off payment of up to 10% of that member's contribution to its schemes.

Conclusion

The NHS LA has a unique opportunity to support the NHS in England to reduce harm by learning from claims. We look forward to supporting the NHS to build on the developing safety and learning culture through our expanding work and engagement with members and clinicians in learning from claims.

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EXPERIENCE OF OVERSEAS SURGEONS WITH THE POSTGRADUATE CERTIFICATE IN MEDICAL EDUCATION FOR SURGEONS

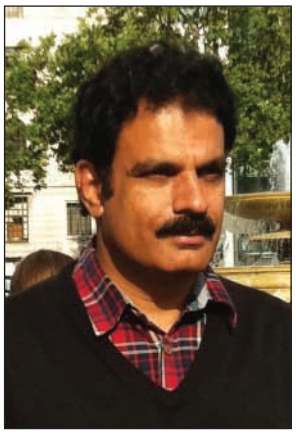
Emad H Aly
Consultant Colorectal and General Surgeon, Aberdeen Royal Infirmary

Honorary Senior Lecturer, University of Aberdeen

ASGBI Director of Surgical Education

The Postgraduate Certificate in Medical Education for Surgeons has been developed to help surgeons with the daily changes they face in teaching and training. The degree was developed as a collaborative effort between the Association of Surgeons of Great Britain and Ireland (ASGBI) and the Centre for Medical Education (CME) at the University of Dundee (UoD). The course started in 2008 and the degree proved to be extremely popular, not only to UK surgeons but also to many overseas surgeons, due to the distant learning nature of the course which allowed those surgeons to complete the degree without ever leaving their home country. The flexibility in start date with no fixed deadlines for end of module assessment submission made the degree even more attractive to most of the participants.

In the Spring 2014 issue of ***JASGBI***, we shared the experience of three surgeons from North America who had taken the degree. Clearly, the educational challenges for some overseas surgeons are different from those faced by surgeons practicing in Western Healthcare Systems. In this article, we explore if the Postgraduate Certificate in Medical Education for Surgeons was successful in addressing the educational needs of two surgeons from Saudi Arabia and Pakistan.



Professor Salman Yousuf Guraya, Consultant Colorectal Surgeon, College of Medicine, Taibah University, Almadinah Almunawwarah, Saudi Arabia

In addition to my clinical commitments, I have been involved in teaching undergraduate and postgraduate medical students since 2000. As a novice teacher, I used to apply didactic, teacher-based, knowledge-oriented strategies in my teaching sessions. Currently, being a faculty member in a medical school does not necessarily require a certified qualification in medical education; but looking back on my teaching performance, before and after getting the Diploma, I feel a great improvement in my clinical teaching, assessment feedback, mentoring, reflection, and research skills, particularly in delivering my surgical knowledge in the wards and operating rooms.

I started my MedEd certificate from the University of Dundee in 2010 when I was given the liberty to choose assignments from my areas of interest. The flexibility and convenience of distance learning allowed me to adjust my schedule in line with my workplace commitments. As my learning gathered momentum over the months, I came across a real variety of teaching and learning in medical education. Particularly, the modules on trends in teaching and learning, principles of teaching and learning, teaching methods, and small group teaching provided deep insight and new avenues of medical education. My understanding about interactive learning, reflection, lifelong learning, blended learning, and students' learning styles helped me in modifying my teaching styles. This self- awareness enabled me to diversify my teaching and learning activities towards Problem Based Learning (PBL). Knowing the students' learning styles helps the teacher to modify the teaching strategies in order to facilitate the learning process. In short, the degree helped me change.

Likewise, I understood modern trends in small group teaching in diverse formats; buzz groups, horseshoe, snowball, fishbowl, and paired group configurations. All these configurations promote interactive and collaborative learning as the tutor plays the role of facilitating the group discussions, sequence of events, reflection, and summarising. Small group teaching is an integral component of PBL, which integrates basic science knowledge into the solutions of clinical problems. The untiring efforts and scholarly advice by the assigned tutors fostered my skills in the write up and improvement of my assignments.

Another interesting area in medical education is assessment. I thoroughly enjoyed the principles and trends in assessments, self-assessment, and OSCE modules. I came across the wealth of assessment tools in surgery including their validity and reliability. How to write an MCQ, various types of test items, and the merits and demerits of each category substantially expanded my knowledge. In reality, it changed my practice as I understood the recommended composition and format of test items, techniques to write, and the 'do' and 'don't' in MCQ writing. Now that I am better equipped with the knowledge and philosophy of OSCE, arrangements and logistics, and in the role of teamwork, I am able to organise surgical OSCEs in a scientific manner. Historically, Miller's triad is used for the hierarchy of assessment of competence in OSCE. Understanding various types of checklists being used for the grading in OSCE changed my practice from using global rating scales to structured checklists. The latter are known in reducing the examiners' bias in OSCE.

Having a great appetite for research and scholarly publications, I intentionally selected a number of modules including research awareness, approaches to research, sampling, and designing and administering questionnaires. I

thoroughly understood the skills required to design and administer a self-structured questionnaire. These include the use of simple, clear, precise and focused statements addressed to a target population. I gained knowledge about the online, postal, telephonic, and net-based routes of surveys, the techniques of data collection, and qualitative and quantitative analysis of the data retrieved from the surveys. Being editor of a number of international biomedical journals, these modules have also enhanced my editorial skills. Currently, I can competently review the methodologies and designs of the submitted scholarly articles, the applied statistical analyses, and design and application of questionnaires, if used.

Some of the best parts of the course include teaching and experiential learning in the operating theatre, working in a surgical team, and learning about the teaching role of a surgeon. Surgeons teach on-the-go, whether they are in the clinics, OR, endoscopy suites, or ward rounds. The concept of inter-disciplinary surgical team-working is very well explained, which changed my clinical practice to integrate the approaches of different disciplines in patient-care. The role of surgeons as leaders is well documented, but this learning process improved my knowledge about the additional concepts of interaction with team members, maintaining good group dynamics, being a good listener, and reflection at the end of each session. It is rightly quoted that leaders have the ability to get extraordinary things from average people.

By and large, the University of Dundee certificate is a valuable academic milestone, and has the potential to provide multi-dimensional benefits to students, teachers, and the community. Sound knowledge of modern teaching and learning strategies in medical education will produce safe doctors, capable of serving the community in a more professional way.

Professor Irfan Shukr, Dean and Professor of Surgery, Armed Forces Post Graduate Institute, Pakistan

In Pakistan, there is growing awareness of medical education. An upcoming requirement from a higher medical regulatory body in Pakistan means that doctors, including surgeons, who opt for a teaching post, must be qualified in medical education.

I opted to join the PG Certificate in Medical Education course as the Pakistan Medical and Dental Council recognise the courses offered by the University of Dundee. It was not possible for me to get leave from my job to complete an degree but the University of Dundee offered the Certificate as a distant learning option. The course could be started at any time of the year and I had the flexibility to complete it in four years. This time schedule suited me as I am a busy surgeon with major family commitments.

When I started I had no intention of doing the Certificate Course for Surgeons. I had to choose 20 units out of 88, covering eight different themes related to medical education. When I was in the middle of the course, the theme "Surgery" caught my attention. Out of interest, I completed the units titled "Assessment in Surgery: Designing as assessment system" and "Teaching and experiential learning in the operation theater". Soon I realised that surgery was different form other disciplines of medicine. It was related more to the psychomotor domain of learning, compared with other specialties of medicine. Surgery required different teaching methodology and assessment tools than are conventionally used in medical education in Pakistan, like lectures, MCQs, SEQs and Long and Short cases. This insight motivated me to complete the rest of the units in the surgery theme.

Adult learners are active learners. They like to be self-directed, have a reservoir of experience, and prefer immediate application of what they learn. During the course, I had the chance to actively participate and apply all those principles of adult learning. I had the chance to decide on my own assessment project and choose from the units offered on the course accordingly. There was sufficient time available so that I could control the pace of my learning according to my busy schedule. The task-based assignments were meaningful and I could immediately relate it to my own setting in Pakistan. Each assignment made me reflect on what exists in my institution and what I can do to improve on different aspects of the curriculum. Timely, specific and constructive feedback from the assigned tutors helped me to learn and evaluate my own learning.

From the unit "working in the surgical team" I learned the importance of a surgeon having non-technical skills in addition to technical skills. Surgeons involved in training should have leadership, coaching and team working skills that can be learned and taught. This led to me attending different workshops on topics related to non-technical skills. By practicing these skills, I found my surgical unit educational environment more conducive to learning with better patient outcomes.

I was able to critically review training at my institution; we were following a model of apprenticeship in surgical training that was generally unstructured. We realised our students would better progress through seven similar stages of progression in surgical training, and they needed different approaches that are used in coaching as mentioned in the unit "Teaching and experiential learning in the operation theater". We developed a more structured approach in training with the adoption of a model of apprenticeship by coaching, resulting in better surgical training with better trainee satisfaction.

In a nutshell, the course met my needs. It has benefited my career and this reflected on my department and trainees. I am a better surgical trainer and I am participating more in educational research.

FROM PEAK TO PEAK: THE SECRET LIFE OF...

Graeme Poston
Professor of Surgery, Aintree University Hospital, Liverpool

I have been interested in hillwalking since I was a boy, and was fortunate enough to be brought up in the North West of England, close to the Lake District, Peak District and North Wales. I would frequently get away on day trips and youth hostelling weeks in the 1970s, mainly following the guide books of the late Alfred Wainwright. The only area which ultimately didn't appeal to me was the Pennine Way, which I gave up on after 80 soggy miles, and haven't returned to since. However, I still frequently escape at weekends to the Lakes, North Wales and Striding Edge; Helvellyn, Sharp Edge, Blencathra; the route from Esk Hause to the summit of Sca Fell Pike will never be boring (unlike the trek from Keswick to the top of what Avril Mansfield has christened Skiddawful!).

However, turning 50 concentrates the mind (as Dr Johnson once said of a man knowing he is to be hanged in the morning) and you start to look at your 'bucket list' while you are still fit enough to complete it. In my case, it was to extend my trekking ambitions beyond the UK and explore some of the highest mountains on earth.

I took the plunge in 2010 when one of my best friends returned from climbing Kilimanjaro and Mount Kenya. Another colleague in Liverpool had climbed Kilimanjaro twice and was of the opinion that if you could manage a round of golf then you could climb it no problem. Essentially, the only thing that prevents you from summiting is failing to acclimatise en route. More realistically, anyone can climb this if they can climb Helvellyn or Sca Fell; essentially it is just like doing six Helvellyns back to back on successive days. I stress six days, as that gives a better chance to acclimatise then the four days usually scheduled by charity walkers using the huts on the most popular route, the Marangu (known as the 'Coca Cola' route because of its popularity), in which accommodation is limited

At the Uhuru peak, the summit of Kilimanjaro, 5,896m above sea level (ASL), January 2010

and you must go forward each day to vacate the huts for the following parties of trekkers. We chose the less popular Rongai route which approaches the summit from the north side (on the Kenyan border) and since this has no huts, camping is necessary. We had five in our party, supported by two qualified guides, a chef, four other kitchen crew, and 15 other porters (including one for the toilet tent!), carrying everything we would need for the climb, and wearing an assortment of footwear ranging from flip flops to wellies. We were very quickly drilled into the Swaheli 'pole pole' (slowly, slowly) from our first steps at only 2,000m, in order to prepare for climbing from 5,000m to 6,000m. Also, we quickly adopted the Swaheli greeting of 'jambo', in addition to 'hakuna mutata': no problem! The other thing necessary to negotiate in Swaheli is that when they revert to English, if there is no y on the end of the word then it is added, so chips becomes chipsy, but if there is an I or y sound then it is deleted, so spaghetti becomes spagett! The only surgical emergency arose on the second day when one of the kitchen crew managed to auto-amputate the tip of his left index finger while trying to cut up bars of soap held in his left hand, using a machete held in his right.

We summited on the morning of the sixth day, on what must have been the busiest climbing night of the year on Kilimanjaro, the night of the full moon in the middle of the January-February dry season (there are two dry seasons, this one and a further one in June-August). The final climb to the summit starts at 11pm and the climb is through the night, they say to catch the dawn on the crater rim (which is spectacular), but I reckon has more to do with getting people on and off the mountain to keep the flow going through the huts. There must have been several hundred of us summiting that morning as we had to wait over 20 minutes to get our photo taken by the famous sign. Coming back down from the summit to 'base camp' at Kibo was probably physically the most demanding thing I had ever done. My legs felt like lead, full of lactic acid as we trudged down the fine dust of the lava field.

My next venture, the following year, was to climb Kala Pattar, at 5,600m, some 400m lower than the summit of Kilimanjaro, but situated above Everest Base Camp and just across the Khumbu Glacier from Everest, Lhotse and Nupse. Customs and language are quickly picked up, and of necessity the Nepalese greeting of 'namaste' is used generously. On this occasion, the greatest challenge was to survive the 25 minute flight from Kathmandu to Lukla, by common consensus the world's most dangerous airport (which is frequently cloud bound). The Lukla airstrip (known locally as Tensing-Hillary International Airport) is a 500m strip of tarmac stretched out over a 500m precipice with a 20° slope climbing towards a very solid brick wall at the other end. You only get one chance once the pilot commits to landing!

Having survived the landing, we then trekked over two days to the Sherpa capital at Namche Bazaar. On this occasion, we opted for the 'luxury' of Nepali tea houses, which at lower altitude included such luxuries as en suite bathrooms with European style sit down loos, but as we got higher, and the nights colder, the tea houses became more and more basic, with hole in the floor toilets to be flushed manually from a bucket of freezing cold water beside them. The food is basic but you get used to boiled eggs and porridge for breakfast, and dhal bhat (lentil curry) for lunch and dinner, which is the main meal for most Nepalis every day of the year. However, after nine days trekking (including side trip excursions to acclimatise), we summited on Kala Pattar, achieving the most spectacular views of Everest across the Khumbu.

In 2012, I was joined by my wife in returning to Nepal to trek to Annapurna Base Camp (ABC), the site of the famous 1970 UK ascent led by Chris Bonnington on the South Face of Annapurna (the first 8,000m mountain to be conquered by the French mountaineer, Maurice Herzog in 1950). ABC sits at 4,200m, in what is described as the Annapurna Sanctuary, sitting surrounded by an almost complete ring of high peaks, six of which top 7,000m, and Annapurna itself at 8,091m. This immense amphitheatre is hung with glaciers, plastered with snowfields, buttressed by enormous walls of rock erupting from a basin of moraines and streams. However, the real 'star' of the trek is Machhapuchhre, or 'Fishtail' which stands as guardian to the Sanctuary, regarded as sacred by the local people and for that reason, never climbed.

At the entrance to Annapurna basecamp within the Annapurna Sanctuary, 4,200m ASL, November 2012

We used tea houses on this trek, but the whole trek was different in every sense to the Kala Pattar trek. Firstly, we were in central Nepal, the home of the Ghurkas, as opposed to eastern Nepal, the home of the Sherpas. As with the Kala Pattar trek, everything had to be carried up the trails by porters or animals, but in central Nepal, mules were preferred to yaks. One very important trekking tip is that when passing mule or yak trains on a narrow path ledge, always stand above them on higher ground to avoid being innocently nudged over the edge to your death, hundreds of metres below; 'end of trek, end of trekker!' Also, the food served in the tea houses was different, with a strong Glaswegian influence: deep fried Mars Bars and Snickers with custard, and a Mediterranean flavour of spaghetti boneless. The scenery is more varied (as we started lower) and varied from almost tropical rainforest, through Alpine meadows, to the summit of the Sanctuary at ABC.

View of Everest, Nupse and the Khumbu icefall from the top of Kala Pattar, 5,600m ASL, October 2011

My most recent venture was in 2014, when three late middle aged couples decided to attempt the Manaslu Circuit, around Manaslu, at 8,163m, the seventh highest mountain in the world. This trek only opened up a couple of decades ago, and is still little known with only a fraction of trekkers each year compared to the very popular Everest Base Camp/Kala Pattar and Annapurna Sanctuary treks. As such, while there are some tea houses along the trek, they are few and far between, and the catering is extremely dubious! Therefore this is a camping trek, and takes 17 days to complete the circuit during which it is necessary to cross the snow covered Lakya La pass at 5,200m.

In order to get the six of us over the Lakya La, we needed a guide (who in this case was a double Everest summiteer), two Sherpas to look after us while we trekked, 10 porters headed by a Sirdar, each carrying in excess of 30kg and wearing only flip flops, a cook and three other kitchen crew (who had to run ahead of us to cook our meals in advance for when we reached each stop). The diet was very much dhal bhat most days. The trek starts in the spectacular Buri Ghandaki gorge, where the path, often only 1m wide, clings to the sides of cliff faces several hundred metres high. This is not a trek for those who suffer with vertigo. After five days, the gorge opens up onto the plains of the upper Ghandaki and the Himalaya reveals itself in all its glory. Also, the trek starts low down in Ghurka territory, mostly Hindu, but higher up comes within only a few kilometres of the Tibetan border, where the people are Tibetan Buddhists. Our major surgical problem on this trek happened to my

wife, who fell awkwardly six days in and we (the three doctors on the trek) thought only sustained a soft tissue injury to her right ankle. The trek was so isolated by then (no mobile signal for 12 days) that there was no way to summon or seek assistance. By the time we returned to Kathmandu 12 days later, her leg had swollen to twice its size, and not sure about the risk of DVT, we bought dodgy Clexane from a Kathmandu pharmacy to administer on the flight home to the UK, from which we went straight to the fracture clinic where an avulsion fracture of the tip of her fibula was confirmed!

As I mentioned earlier on, in order to do these treks, you only need to be fit enough to climb a higher Lakeland summit. One question frequently asked relates to the use of acetazolamide (Diamox) to reduce the risk of acute mountain sickness (AMS). AMS is the extreme end of altitude sickness that presents as nausea and headache, usually above 3,000m. There is a genetic predisposition to AMS, and at its worst, it is life threatening, causing acute cerebral and pulmonary oedema. Susceptibility to AMS is not dependent on physical fitness, and so training before the trek, however hard, does not remove the risk to those predisposed. The evidence for Diamox is scanty and there are certainly no randomised trials to support its use. I used it on three of these treks but not on the trek to ABC, which was only at 4,200m. I only suffered mild symptoms of altitude sickness just before summiting on Kilimanjaro, so it might have worked.

The second issue is planning; you need to choose the right time of year. For Kilimanjaro, it is either January-February or June-August, in order to avoid the rainy seasons. In central and eastern Nepal, it is either April-May or October-November, to avoid the harsh winter season and the summer monsoons, in which it rains every days and the Himalaya are obscured by dense clouds. It's also important to choose a good and reputable company to organise your trek. While it might be OK for those 18 year olds taking a gap year to turn up in Moshe or Kathmandu and negotiate a cheap local deal, you do get what you pay for. So it is advisable to look at the higher end of the market to get the most experienced guides and appropriate trekking crew to give you the best chance of achieving your objective. For all of these treks, the fully inclusive land price (from arriving to departing from Kilimanjaro or Kathmandu) from start to finish ranges between £1,000 and £1,500 per person. It is also important to respect local custom and, most importantly, generously tip your trekking crew at the end. This amounts to no more than £100 to £150 per trekker, but in countries where people subsist on only $5 a day, this is a major input into the local economy.

Lastly, if I have still not put you off trekking, then hopefully we might meet 4,000m up one of the world's great mountain ranges. We're currently considering South America for our next challenge, and while Aconcagua in Argentina might be a little beyond me, we are considering the Ecuadorean volcanoes of Chimborazo and Cotopaxi.

At the top of the Lakya La, 5,200m ASL, behind the Manaslu range, May 2014

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THE SURGICAL FOUNDATION

BJS

2015 International Bursaries

Some of our 2014 International Bursary winners being presented with their certificates and below, enjoying the Congress social evening

The Surgical Foundation is now welcoming applications for its 2015 International Bursary Scheme. A number of Bursaries will be made available to surgical trainees from poorly-resources countries in order to assist in the development of their skills and education.

Each Bursary is worth £2,000 and includes:

- Registration for the 2015 Association of Surgeons of Great Britain and Ireland 'Manchester Surgical Week'
- Six nights' accommodation near to the conference venue (19th-24th April 2015 inclusive)
- £20 per day subsistence
- £800 towards travel expenses (re-imbursement of receipts)

The 2015 Congress takes place from 22nd to 24th April 2015 in Manchester, with the theme of '**Patient-centred Care**'. Bursary winners will be hosted in a hospital local to the conference for two days prior to the event, where they will have the chance to observe and interact with UK surgical teams.

To apply, please send your Curriculum Vitae, two supporting written clinical references and a covering letter describing the ways in which you feel you will benefit from the International Bursary Scheme. Any trainee in a specialist training programme in general surgery, in a poorly-resourced country, is eligible to apply.

Please send your applications to sarahdavies@asgbi.org.uk.

For full details, feedback reports and case studies from previous recipients, please visit:
www.TheSurgicalFoundation.org.uk/internationalbursaries

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WHAT MEMBERS THINK ABOUT SIS (Surgical Indemnity Scheme)

SIS recently conducted a telephone survey to discover members' views on how SIS should develop and provide feedback on our services. In particular, we wanted to know what people thought about the medico-legal advisory service, value, SIS communications and what additional services members would like to see included in the membership benefits.

Approximately half the membership have used the medico-legal service over the past 12 months and all were either satisfied or very satisfied with the service they received. For more information on the variety of problems that the medico-legal advisory service deals with, see the accompanying short reports.

On value, the feedback was equally positive, with all respondents believing SIS to be good value for money; it would have been very disappointing to have any other response given that SIS has not increased its subscriptions since it first launched and most members save considerably by transferring to the scheme.

Communication is an area where SIS can do better. To date, we have relied on the SIS pages in the ASGBI ***Journal*** to provide information on medico-legal issues, case reports and current issues. However, amidst all the other information in the ***Journal***, the SIS messages do not necessarily stand out. As a result, a separate SIS Newsletter is to be published with the first edition planned for later this year.

There were mixed views about additional services, with some members keen on the idea of bulk purchasing producing less expensive add-on services. The core message was 'carry on doing what you do well', but alongside that response were a significant number saying that there was certainly scope for good quality services at reasonable costs. We will look at this idea further, but agree that our primary function is providing secure, comprehensive, professional indemnity with the highest service standards at realistic costs.

Dr Gerard Panting
Medico-legal Adviser to the Surgical Indemnity Scheme (SIS)

SHORT REPORTS

The range of problems surgeons face in their day to day practice is vast. Although there are common themes that emerge in the cases presented to SIS, each has its own particular twists, so there are no standard answers. Here are just a few of the issues which the medico-legal service has had to deal with over the past few months.

GMC

The GMC received a complaint from a patient about the result of her surgery. As the complaint was about clinical care, the GMC commissioned an expert review of her case, which was entirely supportive, and on that basis the GMC concluded the case. Several months later, the surgeon received another letter from the GMC saying that the patient had provided her own expert report which was critical of the surgeon and that, in light of this new information, the GMC planned to re-open the case. The surgeon was given limited time to submit any reasons why the case should not be re-opened. SIS replied with a five page letter listing the flaws in the GMC approach and the reasons why the

original decision to conclude the case should stand.

A Persistent Complainant

A patient rejected the advice provided by a surgeon because the subsequent report failed to provide adequate support for her unfair dismissal claim. Allegations were raised about the limits of her consent to disclose this information, the accuracy of the statements made and the clinical opinion and advice, despite the improvement in the patient's condition. The patient complained directly to the surgeon in offensive terms, she complained to the NHS, other agencies and claimed compensation under the Data Protection Act. The medico-legal advisors immediately took over correspondence with the complainant to minimise the anxiety and distress to the member, dealt with each new attempt to complain as it arrived and obtained expert legal advice on the Data Protection Act, which was used to rebut the claim. After many months and with all avenues exhausted, the patient fell silent.

NHS Consultant: Trust disciplinary procedure

A NHS consultant was accused of suggesting that NHS patients opt for private care contrary to national guidelines. If the consultant was found guilty of misconduct he faced possible dismissal and referral to the GMC. The Trust cited a number of cases where it was suggested that the consultant had told patients that surgery was not available on the NHS but that he could provide care in the private sector at very reasonable rates. The consultant was represented at the hearing at which a number of deficiencies in the evidence were demonstrated and speculative conclusions based on hearsay from individuals were challenged. The panel hearing the case agreed with submissions made on behalf of the consultant and found in his favour.

Private hospital action for unpaid fees leads to counterclaim against surgeon

A surgeon was bemused to discover that he had been accused of negligence in court proceedings without any prior knowledge of criticism of the care he had provided. He asked for help in discovering exactly what had happened and what he could do about it. It transpired that a patient, who failed to pay his hospital bill, was sued by the hospital in the small claims court. At the hearing, the patient claimed that the result of surgery was not as he had expected. The judge gave him time to set out his reasons for claiming that the treatment was negligent. So, the surgeon, who was not a party to the legal proceedings, stood accused of negligence. The legal position was complex. We liaised with the hospital's lawyers and worked with them to resolve the situation to the surgeon's satisfaction.

Fees refund

A private patient, unhappy at the results of surgery, complained and demanded additional treatment free of charge, so the surgeon contacted us for advice. In brief, surgery involving scar revision had failed to make the scar smaller and immediately less noticeable. Having looked at the facts of the case with the surgeon, we replied refusing his demands for free treatment and a refund as all options for treatment had been explained including a realistic assessment of the likely outcome of surgery and the potential pitfalls. Despite further threats, the case was not pursued.

CAVENDISH MEDICAL

WHAT SHOULD YOU CONSIDER WHEN DRAWING YOUR PRIVATE PENSION?

Simon Bruce, Managing Director of Cavendish Medical Ltd, examines the benefits and pitfalls ahead of next year's increased flexibility.

In the Budget, the chancellor George Osborne announced new measures coming into force next year that will give greater flexibility to those drawing their private pension. The first 25 per cent drawn will remain tax-free but instead of turning the balance into a guaranteed lifetime income in the form of an annuity, senior doctors aged over 55 and their spouses will have complete access to their pension savings – subject to their marginal rate of income tax in that year.

From April 2015, savers will have three main choices: withdraw all their pension money; keep it invested and take income when required; or buy an annuity.

The government says the latest changes will offer greater freedom so savers 'can take it how they want', with the chancellor adding that 'it was time to end the patronising view that the state knows best how people should spend their money'.

The media was quick to celebrate the changes, citing that in recent years, savers have been frustrated by poor annuity rates and an inability to access their own, hard-earned pension. Reports focused on the perceived lack of clarity regarding retirement options which resulted in many individuals being financially 'worse off' than they could be.

Weak returns

An annuity is simply an insurance product, which means you buy it to reduce risk. By converting your retirement savings, you guarantee income for the remainder of your lifetime, or possibly longer. However, rates have tumbled in recent years as the Bank of England's quantitative easing (QE) programme has pushed down returns on the government bonds that are the basis of annuity income. Many people retiring in the last few years would have been able to get a comparable return from a high-interest bank account.

One of the main problems with annuities is that individuals make decisions about their income for the next 20 or 30 years based only on immediate implications, such as the best rate at the time. So, once you have chosen the annuity, you generally cannot change your mind later.

The Financial Conduct Authority (FCA) undertook its own review last year. Despite the fact that the option to shop around has been in existence for nearly 40 years, the FCA found that 60 per cent of annuities were purchased from the pension provider with whom the individual had saved. Over 79 per cent of annuity purchasers could have been better off had they shopped around but most simply trust their existing pension provider or do not realise they have a choice.

The pensions minister Steve Webb has stated that 'the annuity market is 30 years out of date'.

But before we assume annuities will now become obsolete, it is important to note that they still might be useful for certain savers. As always with financial decisions, it is unwise to make knee-jerk decisions on the basis of media counsel alone.

There are good reasons why you may prefer the traditional route. Firstly, you will know exactly what your income will be for the rest of your life with little effort required. Without an annuity, you will need the discipline to make your pension pot last for maybe 20 or 30 years. Secondly, any prevailing medical concerns or lifestyle choices such as a '20-a-day' habit will earn a better annuity

rate boosting your income by up to 40 per cent.

Improved annuities?

As the insurance industry scrambles to adjust to the blow dealt by the new pension freedoms, we are likely to see a raft of new annuity products designed to keep savers interested. The new super-ISA has been launched but will a super-annuity follow? We could witness annuities with variable income profiles – taking into account that income needs are often greater at the start of retirement than at the end – but such flexibility will be factored into the cost for buyers and the rates offered at the outset.

Alternatives

You could consider 'income drawdown', which lets you draw an income from your pension pot while leaving the remainder invested. You choose how much lump sum or income to take and where the fund will be invested.

Doctors drawing their NHS pensions have already had more access to their personal pension pots than the general public due to their qualification for the 'minimum income requirement.' This means that, as long as you have a pension income of at least £12,000 per year from your final-salary pension, there is no limit to the income you can draw from your private fund. Not only will you keep control of your capital, you will have increased flexibility should economic or personal circumstances change.

You will need to transfer your pension fund to a scheme that permits flexible drawdown as not all do. The onus is then on you and your adviser to ensure that you do not exhaust your funds before time. This requires careful management as the art and science of sustainable investment fund husbandry come into play.

An alternative is 'phased retirement', where your pension savings are split into segments giving you control of which segments you want to turn into an income and when – useful if you don't want to retire completely. Your cash flow can then be shaped to reflect your circumstances at that time, e.g. less income at the start if still working part-time. This also has a benefit if you die as the balance of the fund segments that have not been accessed can be passed on to loved ones outside of your estate.

Tax

One key consideration when taking your pension is tax. Making large withdrawals will lead to substantial income tax payments. As savers access more of their pensions, the amount of extra tax collected by HMRC is expected to rise from £320million in 2015-2016 to £1.2billion in 2018-2019. To shield more of your retirement fund, you may need to consider staging your withdrawals carefully.

At present, if you die without exhausting your pension funds, your inheritance to your children or grandchildren can be taxed at up to 55 per cent. George Osborne is expected to announce in his Autumn Statement that this threshold will fall in line with the 40 per cent inheritance tax rate. This will make it much more attractive to keep pension funds invested, living on the interest alone, and passing these on to family members in the future.

Like most important things in life, one size will not fit all. Do you need to be certain of how much income you will have in retirement or are you prepared to accept a degree of risk in exchange for greater flexibility?

It is a significant decision because your standard of living in retirement could be restricted by the choices you make now. For many, speaking with an adviser with experience of guiding others in similar situations will give useful context and hopefully the very best peace-of-mind.

Cavendish Medical is a specialist financial planning firm for senior medical professionals in private practice and the NHS. To discuss your financial plans, call Cavendish on 020 7636 7006.

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coress Feedback

This issue of Feedback describes two cases, in which failure to make a correct diagnosis resulted in a delay in appropriate treatment for patients with acute surgical emergencies. Problems arising from inexperience when cross-covering other specialties are also highlighted. All efforts should be made by Trusts to ensure that, when necessary due to staffing considerations, those undertaking cross-cover across specialties are adequately trained, competent to do so, and are appropriately supervised.

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

THINGS CAN GO WRONG WHEN A PATIENT SAYS 'YES' *(Ref: 172)*

During an ophthalmology outpatient laser clinic, another patient came to my clinic room instead of the patient I had actually called. I think she must have misheard the name that I called out. We discussed the scheduled treatment (laser iridotomy), she signed a consent form with the other patient's sticker at the top, and I performed YAG laser iridotomies on her. Unfortunately, the patient I treated had been listed for selective laser trabeculoplasty, and so she ended up having the wrong laser procedure.

I did not check her date of birth, and the patient had answered "Yes" when I asked her if she was Mrs X. Soon afterwards, I realised what I had done - I immediately told the patient what had happened and notified this event to my Trust as a Serious Untoward Incident. Thankfully, no harm was done.

CORESS Comments:
This case illustrates the dangers of 'passive' identification of patients. It is easy for a patient to mishear a question and then inadvertently agree with the clinician. This problem would not have occurred if the clinician had actively followed the principles of the WHO pre-operative checklist. The patient should be asked 'please tell me your name', with similar open questions asking them to state their date of birth, address, planned procedure and side to be treated.

This principle applies to many other situations in medicine and surgery. Positive identification of patient, procedure, and side to be operated on is also vital in many other situations, including ordering and interpretation of tests.

"BEAR TRAP" BITES BACK

(Ref: 182)

A young woman was admitted electively for endoscopy and fitting of an 'over the scope' clip (OTSC) to manage a leaking percutaneous gastrostomy site, under the care of a gastroenterology team. An experienced registrar performed the procedure and the clip was deployed under direct vision. However, upon trying to remove the endoscope it became stuck, seemingly at the upper oesophagus. The endoscope was advanced into the stomach again and it was noted that the clip had deployed onto the scope rather than in a forward direction onto the PEG site as intended. A consultant took over the procedure but was unable to dislodge the clip from the endoscope or to remove the endoscope. A second endoscope was passed and the complication was confirmed. The general surgeon on-call was summoned and performed an upper midline laparotomy to remove the clip. The endoscope could only be removed by cutting the end off with a hacksaw and cutters. The ENT surgeon on-call attended to assess the oesophagus and found a deep laceration in the cricopharyngeus muscle. The oesophageal laceration was managed conservatively and the patient recovered after an extended hospital stay.

Reporter's Comments:

This was an equipment malfunction. None of the team had previously encountered this complication before. In using OTSCs for the management of enterocutaneous fistulae, the complication of deployment onto the endoscope can occur.

CORESS Comments:

The OTSC is a clip made of shape-memory nitinol alloy, used to close fistulae, perforations, anastomotic leaks, and to seal bleeding GI tract vessels [1, 2]. The clip is mounted onto a silicone cap (similar to a band ligation device), placed onto the tip of an endoscope, and applied by stretching a wire by means of a hand-wheel installed on the entrance of the endoscopic working channel. When the clip is released from the applicator, it closes because of the "shape-memory" effect and the high elasticity of the nitinol alloy, occluding the defect. This is similar to a "bear-trap" closure mechanism and applies a permanent force to the tissues. During introduction of the scope, migration (retraction) of the hood can occur [1]. The operator should ensure that appropriate deployment and visualisation of the clip has taken place before the endoscope is withdrawn.

[1] Diagnostic and Therapeutic Endoscopy Volume 2013 (2013), Article ID 381873 http://dx.doi.org/10.1155/2013/381873

[2] Gut 2013;62:A145 doi:10.1136/gutjnl-2013-304907.326

MISSED URETERIC OBSTRUCTION

(Ref: 155)

A 25 year old man was admitted with right iliac fossa pain, associated fever and vomiting. He had a family history of renal calculi. On examination, he was tender in the right iliac fossa and right loin. Urinalysis was strongly positive for microscopic haematuria. CRP was normal but there was a leucocytosis on full blood count and the serum creatinine was 111 μmol/L. No stones were visible on X-ray KUB. Ultrasound of abdomen and pelvis was performed on day three "to exclude appendicitis or renal pathology". Kidneys were of normal size and appearance bilaterally, with no comment about the ureters. Free fluid was seen in the pelvis. The patient was listed for an appendicectomy on day four as his fever and pain persisted. Prior to surgery, however, the anaesthetist raised concerns that the creatinine was now 140 μmol/L despite appropriate fluid administration, and that a CT KUB had not been performed. Surgery was postponed and a CT KUB was undertaken which showed a 5.5mm calculus in the proximal right ureter, causing obstruction and hydroureter. The patient was transferred urgently to the local urology services for stenting. He was discharged the following day with improved renal function.

Reporter's Comments:

A strong history and findings suggestive of renal tract pathology were not acted upon and timely appropriate investigations were not performed. The ultrasound report did not comment on the ureters despite mention of haematuria on the request form.

CORESS Comments:

This case describes a failure to diagnose ureteric obstruction. The diagnosis of appendicitis was flawed. The patient exhibited a number of symptoms that should have prompted clinicians to carry out a CT KUB, the "gold standard" investigation for renal tract stones, within 24 hours of admission. Patients with haematuria and abdominal pain should be appropriately investigated for renal stones. Worsening renal function despite adequate fluid intake should increase suspicion of underlying renal tract pathology.

LATE DIAGNOSIS OF RUPTURED ECTOPIC PREGNANCY *(Ref: 153)*

As the general surgery registrar, I was called to the Emergency Department by the on-call orthopaedic Senior House Officer (SHO) covering gynaecology and orthopaedics, to see a 38 year old woman with a positive pregnancy test and lower abdominal pain. I was told that the patient was haemodynamically stable. The SHO had discussed the patient with the on-call gynaecology consultant who had requested surgical review to rule out appendicitis before seeing the patient.

When I saw the patient at 02.30, she was in a side room in the minors section of the Emergency Department, with a blood pressure of 50/38. She had no IV access and was pale and dizzy, having been admitted at 21.00. Since admission, she had experienced lower abdominal pain, distention and a number of syncopal episodes. I immediately transferred her to the resuscitation bay, gained IV access, administered fluids, cross-matched four units of blood and inserted a catheter. Her blood pressure transiently recovered to a systolic pressure of 117mmHg before falling to around 70mmHg, with a tachycardia of 90-150 bpm. I contacted the gynaecology SHO and asked him to see the patient and to discuss her with his consultant. The gynaecology consultant eventually attended and obtained consent from the patient for emergency laparotomy, subsequently undertaking a right salpingectomy for ruptured ectopic pregnancy. The patient had five litres of blood in her pelvis. Postoperatively, she made an uncomplicated recovery.

Reporter's Comments:

The covering SHO had not been trained in cross-specialty cover and failed to recognise a critically unwell patient with clinical signs of a classical gynaecological emergency. ED staff also neglected to flag up grossly abnormal observations to other medical staff. Trainees covering specialties other than their own, in an on-call capacity, should be given adequate training in advance.

CORESS Expert's Comments:

With introduction of shift systems, inadequate exposure of trainees to emergency cases, and reduced staffing at nights, specialty cross-cover in hospitals may become dysfunctional. The patient in this case presented with classical progressive signs of hypovolaemic shock, and symptoms which should have alerted admitting clinicians to the possible diagnosis of ruptured ectopic pregnancy. A concomitant feature of this report is the element of patient "ping-pong", in which no senior clinician, including Emergency Department staff, appeared to take responsibility for the patient until she had significantly deteriorated. Adequate training and induction for trainees cross-covering other specialties should be provided by Trusts, together with clear mechanisms of expediting senior review for prioritised cases. The Association of Surgeons in Training (ASiT) has published Consensus Recommendations on Emergency Cross-Cover of Surgical Specialties [1], and reports significant demand for their recently convened courses on cross-cover emergencies (www.asit.org/events/courses/ECC).

[1] Emergency Cross-Cover of Surgical Specialties: Consensus Recommendations by the Association of Surgeons in Training

International Journal of Surgery 2013; 11: 584-588

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