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EDITORIAL

Welcome to the December 2013 edition of the ***Journal of the Association of Surgeons of Great Britain and Ireland*** (***JASGBI***). We hope that it will offer you an opportunity for relaxation and reflection at the end of a busy and disruptive year. Once again, we have sought to offer you a christmas feast of articles covering the spectrum of events which touch upon the lives of ASGBI members and staff.

Training issues are high on the agenda, and we have yet to digest in full the implications of the Greenaway report as we go to press. ASGBI is the GMC recognised representative body for general surgery through our SAC functions, and Gareth Griffiths provides a detailed and authoritative account of the current state of play in the SAC for General Surgery. None of you will underestimate the meticulous attention to detail and process, and the quietly understated efficiency which is the hallmark of Gareth's work, and which has gone in to creating this report. We are very grateful to him for this synopsis.

Trauma Centres are now finding their feet, and trauma is a major theme of this issue. Andy Eynon (Southampton), and two colleagues, describe their early experiences and observations of the establishment of a major UK regional centre, and the implications for general surgery. Harald Veen describes the surgical work of the International Committee of the Red Cross (ICRC) from his base in Geneva. ICRC surgeons work in very different and far more austere circumstances than those found in the brand leading Trauma Centre at Camp Bastion in Helmand Province, Afghanistan, which has done so much to catalyse the modernisation and practice of complex trauma care, and to educate the generation of clinicians which has been privileged to serve there.

To develop this theme, the future of Camp Bastion Hospital is now in the melting pot with the withdrawal from Afghanistan throughout 2014. No-one who is familiar with the complexity of military operations and the violence of the North West Frontier will underestimate the risks to life and limb inherent in this process, and our thoughts and best wishes go out to those colleagues who will be there to provide surgical cover. The departure from Helmand also brings closure to an extraordinary decade of military clinical activity in Iraq and Central Asia. While we await the judgement of history on these events and their consequences, we are delighted to welcome back to our pages Mick Crumplin, as our de facto Military Historian without Portfolio, with the first part of his fascinating serialisation of Six Centuries of Battle Trauma.

Members of the Association lead extraordinarily diverse lives, and we are always delighted to receive reports and reminders of life outside and beyond the workplace. In this issue, we carry Abi Walker's account of her Secret Life as an Olympian, while Jonathan Fawcett returns to these shores as the 2013 BJS Travelling Fellow to consider what has changed since he sailed away for Queensland in 1996. Michael Overcash challenges us to think in new ways about our surgical environment and Ed Fitzgerald has written another intriguing and interesting article on his passion for wine.

In a year in which GMC directed revalidation has come of age, and hopefully not too painfully for those who have already been through the process, Mark Porter provides an authoritative overview of NHS Contracts and changing the way consultants work, arising from the excellent one-day ASGBI Consensus Conference on the 21st Century Surgeon late last year. A year is a long time on the medical political landscape and surgeons are now faced with adaptation to formal seven day working contracts, with the release of detailed data on personal practices, and a host of other challenges with which we could (and hopefully will) fill the ***Journal*** with reports in due course.

We also carry in the ***Journal*** the usual mix of articles on technical matters and advertisements from our Corporate Patrons, to whom we are most grateful for help in underwriting the costs of the publication. We are also grateful to Frank Smith and his team for their continued work with CORESS and the promotion of its ideals.

Away from the ***Journal***, the informatics strategy of the Association continues to develop under Nick Markham's capable guidance. Excellence in two-way communication with our membership is central to our development strategy. The website is regularly updated, and the ASGBI App for the iPhone and iPad is proving to be increasingly popular and functional. We have developed an official presence within social media, on Twitter and Facebook, about which Ravi Vohra also writes.

As ever, I am grateful to the work of the team in the ASGBI office for making everything happen, and particularly to Jess Pether, the ***Journal*** Production Manager and your point of contact on all communications matters. It remains for me to encourage all members of the Association to use the ASGBI website and app, and to submit articles on any subject that takes your fancy within the general remit of the lives and work of general surgeons.

The ASGBI communications team wishes you all the best for the close of 2013 and for the year ahead.

David Rew
Director of Communications

AN END-OF-YEAR REPORT FROM THE ASGBI PRESIDENT: THE SHAPE OF SURGERY IN THE UK

2013 has been an eventful year for professional practice for surgeons in the UK, and for the work of the Association of Surgeons of Great Britain and Ireland. It has been particularly notable for two major developments. The first has been the publication of outcomes for individual surgeons in a range of surgical specialties, a process which developed rapidly over the summer and which is as yet incomplete. Secondly, the Shape of Training Review, from the group chaired by Professor Greenaway, the Vice-Chancellor of the University of Leicester, has recently reported. This review may yet have profound implications for general surgery and for general surgical training if it is implemented.

Surgical Outcome Reporting

Firstly, to look at individual surgeons' outcomes could be optimistically described as a "curate's egg". To take a step back, it is widely accepted that availability of surgical outcomes to the public is sensible and, hence, difficult to argue against. The caveat, however, is that the data should be meaningful and open to fair and proper interpretation. Unit outcome data, whilst having some flaws, is a reasonable measure that the lay public might understand and which the media might fairly represent. The data on outcomes for individual surgeons can be methodically unsound and statistically meaningless. Professor David Flum, from the University of Washington, Seattle, eloquently described the problems with the interpretation of such data at the 2013 ASGBI International Surgical Congress. Individual surgeon outcomes in cardiac surgery have been published for some time, and cardiac surgeons, including the Medical Director of the NHS, have been at the forefront in driving change. Their methodology covers all elective cardiac surgery. Bearing in mind the volume of cases, it is just about possible to make sense of the data, although the variation of individual surgeon outcomes demonstrates huge variation from year to year.

The difficulty arises when the same methodologies are applied to other surgical disciplines, where the spectrum of disease is more variable and where the numbers of specific case types per surgeon are consequently smaller. In my own field of interest in liver surgery, for instance, resections for colorectal liver metastases attract a perioperative mortality of less than 1% (there were no deaths in our recent clinical trial involving 270 such patients) but early mortalities in resections for hiliar cholangiocarcinoma and hepatoma are considerably higher. Within Units, it is quite common for a small number of surgeons to specialise in high-risk conditions, making their personal mortality rates appear much higher. Informed interpretation of such data is essential.

The same concerns apply across the piece in GI surgery. Outcome data at present is not robust enough for adjustment for such an array of variables. Indeed, outcome data in hepatobiliary surgery are yet to be made available. Moreover, in many conditions, and particularly in the cancer specialties, outcomes are critically dependent on the inputs of more than one clinician making significant contributions to the care of the patient and to the morbidity of the treatments.

It is clear to me that the drive to publication of individual data is political, and that the foundations of evidence of clinical benefit have yet to be solidly established. In order to address these challenges, we need to strengthen leadership within surgery in general. The Federation of Surgical Speciality Associations (FSSA), with whom we work closely at ASGBI, has taken a clear position that the publication of Unit-level outcomes is preferable at present, until the collection and interpretation of individual level outcome data matures. It has proved difficult to hold this line across all of the surgical subspecialty associations.

The initial controversy over the (mis)publication of individual vascular surgical data produced personal hurt for a small number of consultant surgeons, to whom our sympathy and support is extended. It is really unclear to me how this could have been allowed to happen. Subsequently, the publication of outcome data from endocrine, obesity, oesophagogastric, colorectal and head and neck surgery has been met, pretty much, with media silence. These releases were handled better and it may well be that this is the end of any interest, at any level, in these data. Time will tell.

The Greenaway Report

Probably a more significant event this year was the publication of the Shape of Training Review at

the end of October. This review considered medical postgraduate and undergraduate training in general, and has wide ranging implications for surgery.

The published report is very high level, and the implementation will be left to a Delivery Group which has not yet been appointed. However, the document has the full support of the four UK Departments of Health and, hence, will certainly be implemented in some form. It is the detail that needs to be worked out and discussed.

In summary, the tenor of the report is as follows: The move to specialisation within medicine in general is prevalent. The quality of elective care has improved as a result, but a highly specialised workforce does not necessarily meet the needs of the service. Serious challenges are emerging in dealing with unscheduled and emergency care; an increasingly elderly population with multiple serious co-morbidities; and the management of the "front door" of the District General Hospital.

The plan is to create a workforce which will man the emergency takes and undertake much of routine work. This will require a rebalancing between routine and specialist specialised care. The contention is that there will be more consultants with general skills and fewer specialists. Specialists will be trained post CCT (or CST, as will be) and credentialed for the work that they do. It is clear that the intent is that most consultant surgeons will remain as generalists throughout their professional careers.

Other proposals include the retention of a two year foundation programme but, more radically, the move of full registration to the beginning of F1. This would represent a massive change for Medical Schools, who would have to produce doctors who are ready to practice independently and have no necessity to undergo Foundation Training. It remains to be seen how Medical Schools cope with the change but clearly, for many, it will not be a straightforward transition.

On 2nd November 2013, ASGBI hosted a meeting which included most specialist associations within general surgery, to discuss this report. This was a highly constructive and useful meeting and a draft paper will be produced in due course. In general, it was felt that the proposals, if properly implemented, could be to the benefit of general surgery and not necessarily a threat. It was also felt that the proposals could be used to reconfigure training to produce consultants who are better able to deal with both the spectrum of the surgical take (including acute urology and general paediatric surgery) as well as pan-GI emergencies. Clearly, any such response will require a lot of thought and careful drafting, and full discussion at the Executives and the Councils of the relevant societies. Detail of the meeting itself, generously hosted by the City of Belfast, can be found elsewhere in this issue (see page 33).

We continue to work hard at ASGBI on your behalf, to promote partnership and consensus with all of the professional representative bodies for surgeons across the UK and Ireland, and further afield; to make sense and to influence change in times of upheaval; and to promote your interests as valued members and supporters of the Association in our daily dealings in a complex world. We wish you a Happy Christmas and a successful 2014.

Professor John Primrose
President

THE WAY FORWARD FOR THE INTERNATIONAL DEVELOPMENT COMMITTEE OF ASGBI

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The International Development Committee (IDC) started as the Overseas Fellowship Committee (OFC) in 1995, with the remit to award travelling fellowships to UK surgeons who wanted to go on short visits to low income countries for education or training purposes. The initial focus was on supporting individual surgeons but, within four years, the first OFC workshop on surgical skills was conducted in Ghana, with some practical skills training, with a goat as abattoir material happening in Uganda shortly thereafter. The concept of teaching basic surgical skills through structured courses became established through courses in Kampala and Dar es Salaam, followed by courses in Nakuru and Lusaka. The OFC consisted of general surgeons who were ASGBI members, as well as non-ASGBI members such as orthopaedic surgeons, members from industry, nurses and other medical specialists. That tradition still continues in the make-up of the IDC. A review of the first ten years of the OFC's work was described in the ASGBI Newsletter of March 2006 (no 13; pp 6-7).

By 2006, the OFC's goals were reviewed. The final stated goal was to contribute to sustainable improvement of surgical care in the developing world through supporting training and educational needs of health professionals who provided surgical care in such regions, but always through a collaborative process appropriate to local conditions. The OFC focused on this process through five channels:

1. Support of surgical training programmes through short training courses in essential surgical skills. This is currently the main focus of the IDC.
2. The provision of opportunities for overseas surgical trainees to acquire specific skills in the UK. This has become more difficult through changes in medical training and immigration regulations, but the IDC still support travelling fellowships for trainees from low and middle income countries (LMICs) to attend the annual ASGBI conference, coupled with a few days in a UK surgery department. Due to changes in funding, this is becoming increasingly more difficult to maintain.
3. Providing opportunities for UK trainees to work in low income countries. Due to changes in funding, support has had to curtail for this activity.
4. To foster links through related health organisations, which included UK based specialist surgical groups, non-surgical groups such as THET, regional colleges such as the College of Surgeons of East, Central and Southern Africa (COSECSA), the West African College of Surgeons (WACS), and groups that undertake research in global surgery (previously called "tropical surgery").
5. Through an annual "Surgery in the Tropics" symposium, which stopped in 2006, and through arranging sessions at the annual ASGBI conference, which remains an important showcase of the IDC's role in international surgery. IDC members also represent ASGBI every year at annual conferences of COSECSA, WACS and Bethune Round Table, a global surgery meeting of the Canadian Network of International Surgery (CNIS). At all these meetings, the contribution of ASGBI is well respected and a number of IDC members have received honorary and travelling fellowships from COSECSA and WACS.

From 2006 to 2009, it became clear that the OFC's main function was in supporting training initiatives in host countries and it changed its name to the International Development Committee of ASGBI. It became a major subsidiary of The Surgical Foundation, the charitable arm of ASGBI. The main focus of the IDC's programmes was in sub-Saharan Africa (s-SA), due to invitations to help with training, initially from university based surgeons in African medical schools, and then from surgical societies such as the Association of Surgeons of East Africa (ASEA) and national surgical bodies e.g. the Kenya Surgical Society, the Zambia Surgical Society and the Surgical Society of Ethiopia. Almost all requests for training now come through the educational committees of WACS or COSECSA. Over the last 17 years, OSF and IDC members have visited 14 countries in s-SA; five at the request of WACS and nine at the request of COSECSA. Almost 60 courses have been completed satisfactorily. An important factor has been the assessment and evaluation exercise and, as a result, courses have evolved considerably over the years. A large number of participants were trained at the same time and to the same standard irrespective of previous levels of training and experience. Teaching was mainly focused on basic surgical skills, modified for local needs.

In the last few years, the main teaching focus of the IDC has been on the development of a course in the management of surgical emergencies (MSE). Numerous requests for developing and delivering such a course came from senior COSECSA surgeons. In Africa, surgical trainees are often “at the coalface” in managing surgical emergencies. MSE was therefore developed, as requested by local trainers and guided by the learning needs of surgical trainees in East/Central Africa, to teach structured thinking processes in surgical emergencies, thoroughly assess participants’ knowledge, technical and non-technical skills, and to provide participants with robust feedback opportunities on course value. This five-day course was developed to teach on emergencies in critical care and trauma, general surgery, orthopaedics, obstetrics and urology; delivered through lectures, tutorials, and practical sessions, with individual mentoring, formative and summative evaluation. Six months after completing the pilot course in Zambia in 2011, 90% of course participants indicated that the course significantly improved their ability to manage surgical emergencies. A detailed account of the educational outcomes of MSE course has now been published online [1]. A further three MSE courses have been taught in 2013, with Training the Trainers (TTT) and a structured process to hand over teaching to local faculty in Zambia and Kenya in 2014. Through the leadership of Mr Bob Lane, a major grant was obtained from the Department for International Development (DFID) through the Tropical Health and Education Trust (THET) to fund the whole project.

Requests had already come from WACS surgeons to bring MSE to West Africa, and the IDC is keen to extend its commitment to Sri Lanka and South America, but will need a significant increase in financial and manpower resources to undertake such

projects. The aim is to provide UK surgeons with more information through a session on volunteering benefits at ASGBI 2014 in Harrogate, and through arranging a volunteering TTT for surgical trainees.

Why, then, this focus on sub-Saharan Africa? Of the global disease burden, 11% need surgery, mainly due to injuries (38%), malignancies (19%), congenital anomalies (9%), complications of pregnancy (6%) and peri-natal conditions (4%) [2]. Provision of surgical care and anaesthesia is a critical aspect of integrated healthcare delivery [3]. 80% of the surgical global burden of disease occurs in LMICs, but who will deliver surgery for these patients? In Africa, 46/53 countries are faced with a critical shortage of health workers [4]. Africa has 24% of the total global burden of disease but only 3% of the global health workforce [3]. Sub-Saharan Africa has the lowest concentration of surgery and anaesthesia providers, with only one surgeon per 400,000 people in East Africa [5].

About 800 women die every day due to complications of pregnancy and childbirth, e.g. obstructed labour, uncontrolled haemorrhage, sepsis, uncontrolled high blood pressure and unsafe abortion, i.e. mostly conditions that can be managed surgically [6]. In non-communicable diseases (NCDs), the WHO expects 16 million cancer deaths by 2020; 70% of these will occur in low and middle income countries [7]. Worldwide, 5.8 million people die yearly from injuries, which is 32% more than from malaria, TB and HIV/AIDS combined. That means that 2,300 children die daily from injuries. Road traffic crashes are responsible for 23% of all injury deaths, with 20 injured patients per fatality, reaching epidemic proportions in sub-Saharan Africa (50/100,000 vehicles compared with 1.7/100,000 in high income countries) [8]. Household surveys in Rwanda and Sierra Leone have shown that immediate surgical need is higher than the HIV rate, that 15-25% of respondents had a surgical need in the previous year that affected their ability to earn a living or quality of life significantly, and that 25% of household deaths in the preceding year were due to surgical conditions [9, 10].

The Millennium Development Goals (MDGs) have to report in 2015. Only MDG 1 (eradicating extreme poverty and hunger by >50%) is expected to be achieved worldwide. For development to be real and sustainable, it needs to be based on indigenous knowledge and solutions, not donor-led philanthropy [11].

The question is whether surgery should be part of the post-2015 development goals? The declaration of Alma Ata (1978) states in section VII.3 that primary healthcare "*includes at least: education concerning prevailing health problems… maternal and child health care... appropriate treatment of common diseases and injuries*". Within such "*prevailing health problems*" we have to ask: what is the primary care of obstructed labour, or an incarcerated hernia, or an imperforate anus, or an open fracture? There is little doubt that the provision of safe and effective surgery should form part of the post-2015 development goals, and surgeons have a responsibility to contribute to the debate around this role of Global Surgery. Since 2009, Ethiopia has trained health officers (non-physician surgeons) to do 10-12 emergency operations safely and competently. A number of other s-SA countries have similar programmes. Some are lobbying the WHO and other policy makers to support "15-by-15", a programme to enable 15 essential and emergency surgical procedures to be done worldwide to the same standard by the end of the next 15 years' development goals [12, 13].

Within this context of global surgery, the IDC has a critical role to play; the IDC remains a surgical humanitarian organisation with the primary function to serve surgical patients in low income countries. This service is provided through supporting surgical education and training, always on invitation from local surgeons' bodies such as colleges of surgery and surgical associations. It is, however, critical that the IDC concerns itself in the first place with surgery, not with surgeons. This might include supporting the training of non-physician surgeons, nurses and in pre-hospital care, depending on local need and resource availability. Traditionally training support has been provided through supporting surgical training courses and travelling fellowships, but in 2013, the IDC has lost its major source of income, a guaranteed annual grant from the British Journal of Surgery. It therefore has to look at new alliances, new ways of funding and new communication tools to support its international role. UK surgical trainees remain interested in humanitarian surgery and the rapid exchange of ideas through social media; the IDC has to support these processes to continue to attract the surgeons of the future. The IDC has always punched well above its weight on the global surgery stage and will continue to do so.

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THE JACKSON REFORMS IN CIVIL LITIGATION AND THE PRACTISING SURGEON

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Surgeons in medico-legal practice, or surgeons wishing to understand more about the medico-legal environment in which they operate, may wonder why it is that lawyers, in recent months, keep referring to the so-called 'Jackson reforms'. If they have not heard of the 'Jackson reforms', it is essential that they become aware of their impact on this field of surgical work. Introduced in April and July 2013, the reforms have radically changed the legal landscape and the lives and business practices of lawyers. The manner in which injury claims (personal injury, disease and clinical negligence) are conducted will be fundamentally changed by the reforms.

There is both a direct and indirect impact on surgeons providing reports in civil litigation. Some reforms directly refer to the use of medical experts in litigation, while others will affect the approach to the use of all medical expert evidence in litigation.

Costs

For lawyers, the principle impact of the reforms is on the costs, which will be recoverable on successfully concluding a claim. At the heart of the reforms is an amendment to the overriding objective in part 1 of the Civil Procedure Rules (CPR). It is amended to state that it is not only 'to deal with cases justly' but also now '*at proportionate cost*', that is, proportionate to the amount of money involved, the importance of the case, the complexity of the case and the financial position of each party. How the courts will interpret that requirement, and whether a ratio between the sum in issue and the 'proportionate' costs which may be incurred will develop, we wait to see. It is, however, intended to reduce the cost of litigation, and most probably to do so to a significant degree.

Budgeting

In most fast track claims (up to £25,000) the costs recoverable by a successful claimant are now fixed. In any larger (multi-track) claim commenced after 1st April 2013, the court is expected to set a budget for the whole claim at the first court hearing. Unless the court subsequently approves a variation, the costs recovered at the end of the case by the successful party will be that approved budget. The parties must provide a detailed breakdown of the estimated costs for each stage of the proceedings, including that of expert evidence. The court will set the budget for each stage, and for the whole claim, during a short hearing. Although a surgeon acting as a medico-legal expert is entitled to his contractual fee from the solicitor whether or not approved, the pressure on fees from this process is likely to be considerable.

Prior to this first hearing, a surgeon will have to provide estimates of his likely fees through to trial, or rely on the lawyers to do so for him. Particularly, in more modest value claims, the fees of the medical expert will not be recovered from the losing party in full. In that case, the surgeon's contractual right to his fees will be satisfied (assuming it is) by payments from the lawyer or by the client (out of damages).

Estimates of fees will need to cover provision for providing an initial report, re-examining the client and preparing a supplemental report, reviewing reports prepared by other experts, reviewing further documentation, replying to questions from the opposing side, attending case conference(s), attending joint discussions and preparing a joint statement and attending trial to give evidence.

Permission for expert evidence and costs estimates

CPR 35.4(2) now requires that an application for permission to rely on expert evidence must be accompanied by an estimate of the cost of the proposed expert evidence, as well as identification of the issues which the expert evidence will address. The court will then decide if the use of the desired expert evidence is "proportionate" in terms of the costs involved in the overall context of the claim being made or whether a single joint expert should be required. The order granting permission may also specify the issues which the expert evidence may address.

As with budgeting, it follows that a surgeon must be able to provide the solicitor with sufficient information as to the potential fees of all the stages of the litigation down to trial, and also, if required, assistance in identifying the issues to be addressed. This may well be before any formal instructions have been received by the surgeon.

Concurrent evidence

The Practice Direction to Part 35 has been amended to add a new paragraph 11, to provide for the court to direct the giving of concurrent evidence (or 'hot-tubbing', as it is sometimes referred to) by experts. The parties may be required to agree an agenda for the concurrent evidence, based upon the areas of disagreement identified in the experts' joint statements, made pursuant to rule 35.12.

The judge will decide the precise procedure in any particular case but it is anticipated that the experts will each take the oath or affirm and then be invited by the judge to address the items on the agenda. The judge will ask questions of one expert and then the other and may invite the other expert to comment or to ask that expert's own questions of the first expert. Only after that will the advocates ask questions, and it is emphasised that it will not be necessary or appropriate for this to be a full cross-examination or re-examination. The judge may then summarise the experts' different positions on the issue and ask them to confirm or correct that summary.

A direction for an agenda will normally mean that the concurrent evidence needs to be directed in advance of the hearing. However, the judge has the power to decide at the trial to conduct the giving of evidence by experts in this manner.

Clearly some judges will be far more comfortable and pro-active than others in their approach to, and desire to require, concurrent evidence.

The process is dependent on the judge having a good understanding of the issues and, whereas counsel may well have had a discussion with the surgeon involved on his side prior to the hearing, the judge will only have the written evidence of the two sides' surgeons to assist. Therefore it is, as ever, important that the surgeon addresses the salient issues clearly in a medical report, in language which can be readily understood by a professional with no medical knowledge.

The experts do not have to be of the same or identical disciplines, and that can, as it does in joint discussions, lead to some difficulty, for example if the surgeons are of different specialities and have a different approach to the issues in the case. It is also likely that the surgeons will be of different personalities and therefore there may well be an imbalance in the way they present their evidence in the course of this process.

Surgeons often find the adversarial approach, as demonstrated in cross-examination, alien to their normal practice in discussing differences of opinion with colleagues; however, the process of the judge discussing issues with the surgeons and seeking to summarise their opinions may be equally, although differently, alien, in particular where the judge's understanding of the issues, in the absence of any medical training, is limited.

How often 'hot-tubbing' is used in practice will depend on judicial training, the confidence of the judge to deal with a case in this manner and the nature of the dispute.

Funding arrangements

The reforms have far greater impact on lawyers' practices and the conduct of litigation than on experts directly. The success fee under a conditional fee agreement (a 'no win, no fee' arrangement), used by lawyers to fund their losing cases, will no longer be paid by the losing party, and the insurance premium on a policy to protect the claimant from a liability for the other sides' costs in the event of losing, is no longer generally recoverable. Instead, a claimant may have to pay up to 25% of the damages recovered (for the injury and past loss) to the claimant's own lawyer as a success fee (to help fund the cases the lawyer loses) and up to the whole amount of damages in satisfying a costs' claim by the opposing party. Although the starting position in an injury claim is that a losing claimant no longer pays the successful defendant's costs, this protection is lost or limited in the case of a fraudulent claim, or if an offer by the defendant to settle is not bettered.

Virtually all claims up to £25,000 will be subject to a scale of (very modest) fixed costs and will now start in an on-line portal, 'falling out' if liability is in issue. In relation to smaller value claims, many lawyers regard the maximum costs recoverable as insufficient to make such claims commercially viable to run.

Other changes

In this on-line portal, the claimant submits medical expert evidence in a standard report form provided under the scheme, or in a report containing the information required in that report form, and it is therefore necessary for a surgeon to be aware of the report form and the required information. Medical evidence is generally expected to be in a single report, with the defendant not obtaining medical evidence of its own.

To encourage a defendant to settle, in future if the defendant ends up paying no less than the sum offered as settlement by the claimant, the defendant will pay an additional sum to the claimant of 10% of the amount awarded (reducing on larger sums to 5% and capped at £75,000).

An expert does not always see a copy of a court order relating to expert evidence. By an amendment to CPR 3.9(1), if a party (and that includes a party's lawyers or experts) fails to comply with a court rule, practice direction or order, in deciding whether, for example, to extend time for the doing of something or the provision of a document, the court will take into account '*the need for litigation to be conducted efficiently and at proportionate cost, and the need to enforce compliance with rules, practice directions and orders*'. Therefore, a failure by a surgeon to comply with a court timetable may result in the claim, or the defence, being struck out, or permission to use the surgeon being withdrawn. The surgeon must therefore be aware of court timetables relevant to his involvement in the litigation, and should have appropriate insurance in place to cover such an unfortunate eventuality.

The future

Lawyers will need to deal with cases more quickly and efficiently, and often with a lower grade of fee earner, to reduce costs. There will be increased need for high quality, reliable and readily understood medical reports, which demonstrate the internal reasoning process, so that the reports can be used efficiently and with confidence within the litigation.

About the Author

Giles Eyre is co-author of a manual for medico-legal experts and those instructing them, 'Writing Medico-Legal Reports in Civil Claims - an essential guide' (2011) and co-presenter of the e-learning programme 'Medico-Legal Report Writing (Core Skills)' (www.prosols.uk.com).

He frequently gives seminars and workshops for medical experts in medico-legal report writing, giving evidence and other medico-legal issues. Giles is a barrister specialising in personal injury, disease and clinical negligence claims. He is mediator and a member of the CEDR Solve Lead Mediators Panel.

He was appointed a Recorder in 2004. Giles is a contributing editor to 'Clinical Negligence Claims - A Practical Guide' (2011) and 'Asbestos Claims: Law, Practice and Procedure' (2011), both published by 9 Gough Square.

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MEDICO-LEGAL ISSUES

AT⊕MS
ASSOCIATION OF TRAUMA & MILITARY SURGERY

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SURGICAL OUTCOMES CLUB OF GREAT BRITAIN AND IRELAND: SHAPING THE FUTURE OF SURGICAL OUTCOMES RESEARCH

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Wendy Craig
General and Endocrine Surgery, UHW Cardiff

The Surgical Outcomes Club of Great Britain and Ireland (SOC-GBI) promises to be the next significant development in influencing surgeons' outcomes. We aim to build a society, virtual and real, of like-minded clinicians delivering quality in patient care and improved outcomes through enhanced knowledge and contemporary learning. If you are not already signed up, let us explain why you should consider joining.

In May 2013, at the ASGBI International Surgical Congress, Dr Dave Flum, professor of surgery and health services research at University of Washington, Seattle, led keynote sessions around the broad theme of surgical outcomes. The original Surgical Outcomes Club (SOC) has united the key surgical outcomes researchers in the USA and Canada, including Dave Flum, John Birkmeyer, Justin Dimick and Caprice Greenberg, for nearly ten years. One intention of this year's surgical outcomes theme at the ASGBI Congress was to promote interest in forming SOC-GBI, as a sister organisation. The timing was critical and reinforced by government led initiatives publicising surgeon level outcomes data within the NHS in the United Kingdom. Any opportunity for surgeons to lead on this topic, build our own systems for quality improvement around themes important to ourselves and our patients, rather than allowing the imposition of an arbitrary system, seemed attractive. In parallel, in recent years, there has been a growing body of surgically themed health services research, health economics and quality improvement work and so the timing seemed right – evidenced by great audience numbers and interaction at the workshop sessions at the Congress.

Dave Flum at the 2013 Congress in Glasgow

The initial sign-up was impressive, and within three months of the Congress, over 150 individuals within Great Britain and Ireland had expressed interest in furthering the cause, across a wide spread of specialty backgrounds, including a number of non-clinicians, and a significant proportion of trainees – very much akin to the transatlantic SOC demographic. A needs assessment was circulated around our group, and it identified key themes:

- Surgeons want to share data for learning
- Surgeons want to understand their own outcomes better, and how practice impacts on outcomes
- Patient reported outcomes matter

In response to this survey, priorities for work streams were identified:

- Provision of tools for knowledge and learning
- Development of virtual online discussion forums
- An interactive workshop meeting prior to the 2014 ASGBI Congress, with national and international faculty
- Maintaining focus on patient-reported outcomes and core outcome set development

To launch the process, a steering group with experience and commitment to the cause, as well as cross-specialty interests, has been convened to define a constitution, prioritise arrangements for the workshop in 2014, and to generally firm up arrangements in order to function as a full society within ASGBI. The steering group members are listed, with executive advice from Dr Dave Flum, and Dr Arden Morris, current president of SOC-USA.

Steering Group Members

Tan Arulampalam
Jane Blazeby
Wendy Craig
Ewen Harrison
Zyg Krukowski
Krishna Moorthy
Paddy O'Dwyer
Derek O'Reilly
Wesley Stewart
Dan Williams

The group has been exceptionally fortunate to form significant industry partnerships at this early stage, allowing for sponsorship of sessions and the provision in the very near future of learning tools. Covidien has been key in providing time and commitment to the organisational aspects of the group, primarily through the foresight of Imran Farid, Commercial Partnership Manager, whilst Dendrite Clinical Systems have agreed to develop user friendly, online clinical effectiveness data tools for all SOC members and their hospitals. The first will be launched around common procedures and will maintain a focus on simplicity.

Other exciting developments include formalised collaboration with the transatlantic SOC group, providing expanded membership lists and expertise, virtual learning tools, including shared online learning sessions, and in turn, joint meetings. We also recognise the increase in regional and/or specialty focussed surgical research collaboratives in the UK, and will address interactions with such groups as a matter of priority.

SOC-GBI will unite specialty groups, trainees, health service researchers, academics, and practising surgeons, wherever there is a shared desire to understand better how practice impacts on patient outcomes – and to do the best for patients. The workshop next spring will be key. If you have not already signed up to this new organisation, please visit the links below to join the mailing list. Exciting times ahead!

Useful links

SOC-GBI interest page:
http://www.asgbi.org.uk/en/members/surgical-outcomes-club.cfm

SOC affiliated to the American College of Surgeons:
www.surgicaloutcomesclub.com

Follow us on Twitter **@SOC_GBI**

GREEN SURGERY - CONCEPT FOR THE PROFESSION

Professor Michael Overcash
Sam Bloomfield Chair in Sustainable Materials and Energy Systems, Department of Industrial & Manufacturing Engineering, and Department of Mechanical Engineering, Wichita State University

Professor Janet Twomey
Department of Industrial and Manufacturing Engineering, Wichita State University

Green surgery is a process by which surgeons and healthcare teams (nurses, administrators, and staff) move toward maintaining quality patient outcomes, but with lower environmental impact. That is, becoming more sustainable. How does green surgery, as a process, actually occur or unfold? Here, the answer comes from lessons learned from effecting environmental improvements in other professional areas (like new drug discovery, implementation of new biomaterials, and even manufacturing of products like wind turbines).

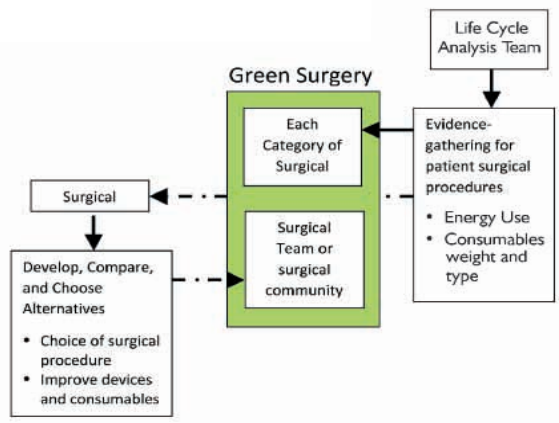

Figure 1: Schematic of Green Surgery

The green surgery process involves two steps, often in series and other times in parallel (see ***figure 1***):

1) Acquiring quantitative evidence regarding how energy and materials (consumables) are used for specific aspects of surgical interventions. Evidence acquisition is measuring and reporting, in a transparent way, the life cycle impact (in a hospital as well as downstream) of surgical practices.
2) Adapting, in an integrated effort by surgeons, healthcare teams, and life cycle specialists, to explore, try, and/or analyse step-wise improvements that maintain quality patient outcomes, but represent change to reduce environmental footprints.

Thus, green surgery is not mandated changes in clinical practices, but is a science-based process by which the surgical profession focuses on changes to lower quantitative environmental impact. This aspect of green surgery change in clinical practice would follow other recent evolutions of surgical practices, such as laparoscopic colorectal cancer surgery or sentinel node biopsy for breast cancer.

The environmental footprint of clinical practices has two distinct impacts that interact (often in complex ways):

- In-hospital energy and consumable use.
- Downstream public health impact on society (and patients) through emissions from generating electricity and the manufacturing of consumables.

Overall, green surgery is an innovative medical domain that will be grown or advanced as the surgical profession uses their creativity, medical know-how and analytical capabilities to achieve sustainability goals, as discussed at a National Science Foundation Workshop [1]. With this progress, the healthcare community will also be meeting an emerging strong demand by society to manage this very large economic sector with a lower environmental footprint. As such, green surgery is a dynamic set of changes (small and large), not a fixed set of green widgets. The National Health Service in the UK (www.sdu.nhs.uk) and the Healthy Hospital Initiative in the US (www.healthierhospitals.org) are important efforts by major healthcare providers to move toward sustainability. Green surgery is an important aspect of those efforts.

These two components of the environmental footprint for green surgery are explained in the following section (***see figure 2***). There is first an in-hospital or direct use of energy and consumables (as cost items) linked to the overall hospital budget. As healthcare evolves in the US and the UK, and reimbursement patterns change, there is a foreseeable chance that payments could be in the form of an all-inclusive payment for the patient and not a specific modality driven reimbursement. Hospitals could then utilise the reduction of in-house energy and outside consumables information to reduce costs. Every surgical procedure has an energy and a consumables shadow or profile. Select one alternative surgical procedure, change one of the steps in a procedure, choose the use of devices (such as monitors), or re-evaluate some purchased item (such as an IV bag) and the direct amount of energy and materials that are consumed can be changed. For example, shifting from MRI enterography to CT enterography is a shift in procedure that lowers energy use. These are reflected as typically electrical energy consumed or solid waste produced (after consumable use) and thus are direct hospital costs.

The second environmental footprint component is the downstream concept, in which:

1 Electrical energy is generated at power stations where fuel (typically fossil resources) is burned and emissions to air, water, and land are a result.
2 All materials (plastics, metals, liquids, solutions, chemicals) are made from a long series of manufacturing plants (a supply chain) that overall converts materials from nature (oil, natural gas, ores, etc.) into final consumables (IV bags, surgical drapes and gowns, metal sharps, etc.). This whole supply chain, across large geographic areas, also produces emissions to air, water, and land (***Figure 2***).

The concept of life cycle analysis is thus used to describe these energy emissions. Thus, each kWh of electricity or kg of consumable used creates a

downstream impact as these emissions affect public health of both patients and society.

Briefly, life cycle analysis (LCA) is the estimation of energy use and material use (and loss) of each manufacturing plant or node (such as the operating theatre) and is referred to as a gate-to-gate life cycle inventory (gtg lci). These gtgs are added together to give a cradle-to-gate, which is from the cradle (natural materials in the earth) to the gate (a final product or service, such as a gram of vancomycin, or a ganglionectomy). The energy is electricity, the use of steam (from boilers), or high temperature furnaces (for metals), while material efficiency is the mass balance on each process or service. The overall life cycle analysis is summarised in ***figure 2***.

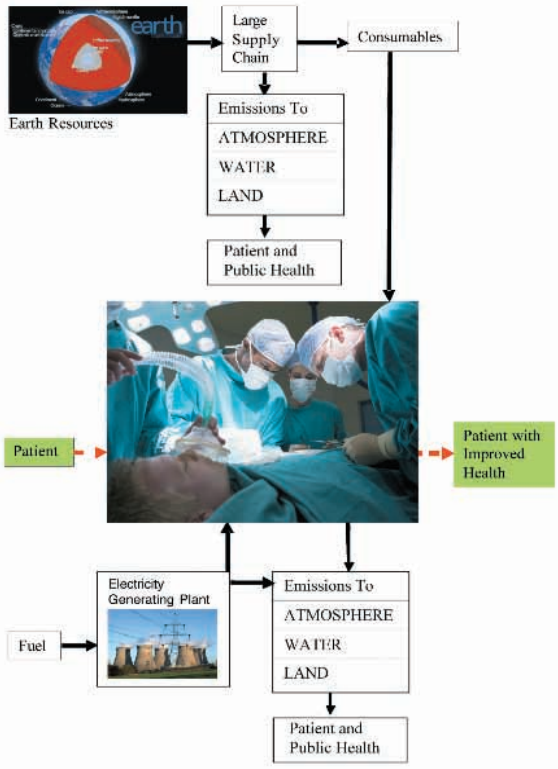

Figure 2: Representative Life Cycle and Health Impacts of Surgical Procedure

Some aspects of green surgery are already available and illustrate the first step in this process – which is, obtaining quantitative evidence of how specific patient procedures utilise electricity and consumables. In operating rooms, much of the electricity-driven equipment exhibits a common profile of power consumption that can be measured and offers concepts for green surgery improvement. This profile involves three power levels and three durations of use (***Figure 3***). First is the active power (such as power used during laparoscopic surgery, with actual results on the patient, such as a cholecystectomy). This power is used for the full time that a surgical team is engaged in the procedure and thus, varies with patient conditions. Power (kW) multiplied by time (h) gives the active energy (kWh) of a surgical procedure. Second is a lower power level in which the equipment is being positioned, programmed and tested etc, prior to actual patient use. This is referred to as idle time, since no surgery is actually in progress. This time and power are multiplied to give the idle energy. Finally, when the patient has left the operating room, the power continues to be used in standby mode. Often, these devices are on for substantial time periods in the standby mode, thus requiring standby energy use. The cumulative value of active plus idle plus standby energy is the electrical footprint of devices specific to a type of surgical procedure and also defines the downstream environmental impact (of the electricity power station). Measuring these three components of power and time for a range of surgical procedures then builds a database to allow the surgical community to explore improvements. If there are alternatives procedures which deliver equivalent patient outcomes, which have lower environmental footprints, then these can be considered for adoption. This was recently done for hysterectomies as an example of one surgical procedure [2]. If there is only one best surgical procedure, then green surgery improvement involves managing the standby energy (turn it off) or selecting equipment for which power levels are lower in the idle or standby modes. Changing the type or use of consumables would also result in energy improvement.

As a second example, surgical teams in hospitals can reduce energy use and environmental impact by changing the selection of gowns and drapes they use. All current evidence regarding the life cycle benefits of reusable gowns and drapes has been assembled [3]. From this evidence, the selection of reusable systems for gowns and drapes at a typical large hospital, using 70,000 surgical packages per year, would results in a saving in the sustainability programme goals of about 270,000 kg CO_{2eq} /year. This one decision is equivalent to removing 1,000 cars driving 4,500 km/yr from the UK highways. Again, this information represents the evidence-gathering stage of green surgery. The second step in green surgery is to use this information to influence hospital change to reusable gowns and drapes for surgery.

Existing surgical life cycle studies, as a third example of green surgery, have been conducted for child birth and hysterectomies [2, 4]. The goal is equivalent patient outcomes, although with these procedures, the predicted outcomes are not always achieved. The life cycle for vaginal and caesarean births were evaluated for multiple cases. At the level of the surgical procedure, the time or duration, the consumption of materials to achieve room sterility, and the management of wastes were part of the life cycle analysis. Overall, the life cycle factors (energy and material use) for operating room (caesarean) were larger than the patient room (vaginal) and thus pointed to impacts of these patient choices, as well as several avenues for improvement. Similar intensity differences were found for hysterectomies (laparoscopic, robotic, vaginal and abdominal). In these surgical procedures, most of the green surgery process was still devoted in the data acquisition stage with uptake by the surgical teams lagging the development of life cycle data.

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A fourth emerging concept in green surgery derives from the evidence being gathered from life cycle comparisons of materials and devices that are reusable. The alternatives are often categorised as disposables in surgical procedures. In the evidence-gathering phase, such devices as laryngeal mask airways and drug trays have been conducted [5, 6]. The results provide more evidence as to the reduced environmental footprint of reusables. Extending this concept (but currently no life cycle data) would include a number of reprocessed devices (harmonic scalpel, nasopharyngoscope, trocars etc.) [7]. From the limited life cycle data available, the reusable surgical devices hold great potential to lower the environmental footprint, while accomplishing the desired surgical outcome. The green surgery second stage would involve adoption and advocacy for these reusable devices, based on the evidence gathered. The interest in using more operating theatre recycling was captured for anaesthesiologists, as a part of a surgical team [8]. These physicians (about 95%) agreed that increased recycling in operating rooms was important and they would commit time to accomplishing such goals.

In these examples of the green surgery process, most of the current results are from the evidence-gathering stage. The involvement of the surgical team to make decisions for change that lowers the environmental footprint is critical. The Association of Surgeons of Great Britain and Ireland (ASGBI) could be an important organisation to create a forum or mechanism to stimulate change by the surgical community. ASGBI might convene a specialty conference to promote understanding and detailed discussion of green surgery, of the available evidence, collection of new evidence, and medical decision-making to assure quality patient care, but at a lower environmental footprint. These meetings might be coordinated with the National Health Service and their sustainability program.

Conclusions

The potential examination of surgical practices to identify and adopt alternatives that achieve a desired patient outcome at a lower environmental impact is an innovative chapter for the surgical profession. The steadily increasing economic role for healthcare (of which surgery is a part) to national economies has stimulated societal expectations that their input to the environment be reduced. Green surgery is a two-step process, by which the medical profession can establish evidence-based evaluation and, from that, changes in surgical practices that lower the environmental footprint. Examples of evidence-gathering (often using life cycle analysis) are now available and serve as guidance for further studies. However, the second stage by which surgical teams use this information to discuss and implement change must now be developed. This step will allow the surgical teams to use their creativity, innovation, and medical know-how to find better solutions. The outcomes of green surgery will lower energy costs and downstream public health impacts.

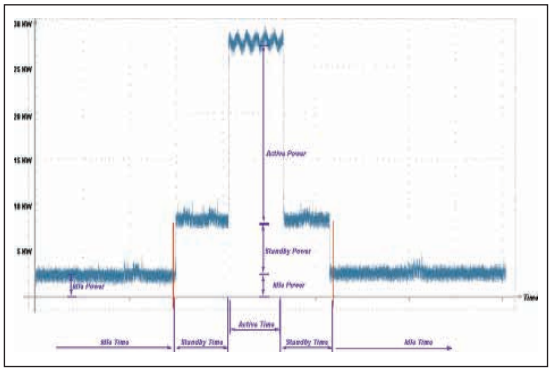

Figure 3: Electrical use profile during representative surgical procedure in OR

Acknowledgements

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SOCIAL NETWORKS, SOCIAL MEDIA AND THE SURGEON

Ravinder S Vohra
Lecturer in General Surgery, Academic Department of Surgery, School of Cancer Sciences, Queen Elizabeth Hospital, Birmingham

Mobile computing, social networks and social media platforms (SMPs) have the potential to bring about significant changes to surgical education [1-3]. Some surgical organisations and individual surgeons in the UK and abroad have already adopted Facebook, Twitter, YouTube and other social network accounts, with a variety of applications. These technologies are of particular interest and value to membership organisations such as ASGBI, because they provide for a much more interactive relationship with the membership, and they reach the younger generation of users who are the future lifeblood of the Association.

The American College of Surgeons (ACS), the Royal Colleges and ASGBI use social networks to communicate with their members and trainees, with direct feedback permitting much more active participation in the activities of the Associations. However, user engagement is still patchy among users and among healthcare institutions. One possible reason is that the disciplines and conventions of social networking are still immature, and those using public networks run professional risks from ill-judged commentary and blogging.

The ***BJS***, ***Annals of Surgery*** and ***Diseases of the Colon and Rectum*** have taken a specific approach, such that information release is controlled to different user groups on their social networks, be they surgeons, patients or the media. The information sharing is enhanced as users attach more weight to the opinions of trusted individuals and groups. SMPs also facilitate the rapid and direct distribution of news articles and videos through social networks and directly to a desktop, laptop or tablet computer or mobile phone. In 2013, more than 1.5 billion people use SMPs and 80% of online users regularly interact with social networks through SMPs [4]. The challenge for professional associations is to establish the quality, quantity and frequency of publication of such material, and the methodologies of interaction with the membership. The ASGBI Membership is one example of such a strategy in evolution.

The professional benefits of engagement with social media

Social media experts Peter Kollock and Marc Smith have postulated that the motivation for people to contribute to online communities may include altruism, but individuals also hope that the information that they share will be rewarded with valuable information in return (anticipated reciprocity); that they will gain from increased recognition; and that they will make a difference to society and gain a sense of communion.

Regardless of the underlying psychology, this form of information sharing is cheaper, more efficient and much more direct than other strategies for disseminating information. One example of the effective use of social networks to leverage valuable opinion was Ford's 2009 Fiesta Movement campaign, which selected drivers with large social media followings to test drive their new model for six months. Over this time, the drivers posted more than 60,000 items, which generated millions of shared content episodes, including 4.3 million YouTube views. This $5million campaign resulted in 35,000 pre-launch test-drives and an estimated 50,000 early sales. This would previously have cost tens of millions of dollars in advertising [6].

In surgical terms, such methods could readily be used to promote the results of an important randomised controlled trial, a new surgical technique, a seminal lecture, or the risks and complications associated with a surgical device, implant or new procedure. Such systems could be set up by public sector institutions, including the Department of Health, the NHS and its agencies such as the Medicines and Healthcare Products Regulatory Agency (MHRA); by manufacturers and retailers; by professional institutions such as the Royal Colleges and Specialty Associations; by other designated health sector charities or by publishers.

Surgical education in a digital age

Some surgeons and surgical units have already created social networking sites in the public and commercial sectors to interact and engage with their patients, such as Atul Gawande on Twitter (@Atul_Gawande) and Memorial Sloan-Kettering Cancer Center on Facebook (www.facebook.com/sloankettering). Other excellent surgical resources are in development which can be readily accessed. Hashtags (#) mark keywords by a means that is similar to the system used in scholar-based search engines, and which allow them to be found through generic search engines. In addition, there is a wealth of free content on Google and YouTube. However, the videos and text can be variable and there is sometimes no quality assurance. There are some developmental sites supported by the Associations and by the pharmaceutical industry, including the Dave Project (http://daveproject.org/) and WebSurg (www.websurg.com) which include guidelines and operative videos. Again, neither really fully utilises social networks or social media.

Schoolofsurgery.org

Schoolofsurgery.org is a not-for-profit surgical news channel which populates SMPs with the latest peer-reviewed articles, operation videos and continued medical education links. It can be freely accessed at www.schoolofsurgery.org. In thirty months, schoolofsurgery.org has acquired 130,000 followers, both medical students and trainees, worldwide. Analytical data is readily available from Facebook and from Twitter. 97% of more than 10,000 postings occur within 36 hours when information is shared on the schoolofsurgery.org Facebook site. Information is also readily rebroadcast. Over one month, 81% of all the posts that were shared on the schoolofsurgery.org Facebook or Twitter sites were shared by others on their own sites.

An objective measure of the educational value of such a site is not possible. However, of the 5,000 new followers the schoolofsurgery.org Facebook page gained in June 2013, nearly 30% joined after seeing a friend liking a post on the page. The comments and personal messages that the sites receive indicate this free sharing of information is especially useful in developing countries. This model could be developed as a valuable training resource which could encompass the Intercollegiate Surgical Curriculum Programme and the Royal College of Surgeons of England's Surgical Training Education Programme (STEP) using online operative videos and lectures.

There are various initiatives to do this, but the resources will take time to develop and are likely to be associated with subscription costs, to allow trusted organisations to vet and quality assure the content.

SMPs could be used to deliver training and course material directly to junior trainees within the Royal Colleges' and Associations' social networks. Higher surgical education could also be organised in such a manner to supplement and improve current educational programmes. High quality online surgical educational material combined with efficient methods of dissemination could gain similar traction to that seen in other free higher educational programmes [7].

Caveats to the advance of social networks in surgical education

There could be immediate benefits by using social networks and SMPs in education as demonstrated above. However, for integration of such systems into communication networks in hospitals, the technology has many hurdles. These include the Data Protection Act, the NHS Information Governance Statement of Compliance and encryption standards. Most SMPs do not currently comply with the requisite strict information governance and security standards. The General Medical Council has recently issued guidance regarding SMPs [8]. However, as hospitals and healthcare institutions adopt social network systems, so productivity in staff training cycles may rise rather than fall [9].

In conclusion, the internet has changed the face of education. It is making information more readily available everywhere. Social networks and SMPs have the ability to engage and involve individuals more efficiently than ever before and may yet transform the delivery of surgical education.

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ASGBI STAFF NEWS

Sarah Borsay

On 1st August, the ASGBI office welcomed a new member of staff to the team. Sarah Borsay has taken on the role of PA to our Chief Executive, as well as becoming the administrator for both the Association of Surgeons in Training (ASiT) and CORESS. Originally from West Wales, Sarah studied English Literature at the University of Exeter and graduated in 2011. She has moved from a role in customer services to form a vital part of the ASGBI team, becoming involved with everything from the annual Congress to the future development of CORESS. Since moving to London two years ago, Sarah has made it her mission to explore as much of the city as possible, taking in everything from West End theatre to the city's many and varied markets. Sarah is looking forward to the challenges that her new job will bring.

On a sad note, in October, we were sorry to say goodbye to Sarah Walsh, who had been the Association's Development Officer and Partner Relations Manager for just over a year. Sarah worked hard to develop the Association's relationship with our Corporate Patrons and Professional Partners and she will be greatly missed in the office. All the staff and Executive would like to wish her the best of luck in her new job.

Our IT Manager, Emmanuel, and his wife Sam were very pleased to announce the arrival of their new baby girl on the 25th August 2013. Born on her Mum's birthday, Isabelle Chinyere-Ada Amadiegwu has already been in to visit us here in the office and we can confirm that she is absolutely beautiful! We would like to offer our sincere congratulations to Emmanuel and Sam and wish them the best for the future with their little girl.

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THE EFFICACY AND MECHANISM EVALUATION (EME) PROGRAMME

Ellie Monks
Programme Manager, Efficacy and Mechanism Evaluation Programme, University of Southampton

Dr Lisa Douet
Senior Research Fellow, Efficacy and Mechanism Evaluation Programme, University of Southampton

The publication in 2013 of the ASGBI ***Issues in Professional Practice*** booklet on the 'Management of Risk from Surgical Devices and Implants' has highlighted the role of the Association in the promotion of best clinical practice through rigorous research. The Efficacy and Mechanism Evaluation (EME) Programme of the NIHR aims to advance translational research, so as to improve clinical practice. Its remit includes evaluations of new treatment strategies, disease prevention, pharmaceuticals, psychological interventions, public health, diagnostics and medical and surgical devices. It also funds the use of samples or data from clinical studies, the exploration of new scientific and clinical principles and the development or testing of new methodologies within clinical research studies.

EME will also support laboratory-based work other than animal studies, if it is relevant to the remit of the EME Programme. It will not support confirmatory studies, or trials of refinements to existing interventions. The studies must be relevant to the NHS, rather than to general issues of global health.

The EME Programme has two funding streams; these are researcher-led and commissioned. There are three rounds of calls a year in each workstream, along with NIHR-wide cross-programme themed calls. The commissioned workstream particularly encourages working partnerships and collaboration between academia, industry and the NHS. It can also include the involvement of charities. Specific information on each commissioned call is available on the EME website. The researcher-led workstream offers researchers the opportunity to submit applications on any relevant topic, with a fast-track funding process that shortens the total time from submission to receipt of a funding decision by three months.

EME invitations to surgeons

EME has funded a number of surgical studies and implantable medical device studies. Professor David Jayne, University of Leeds, is leading a surgical study evaluating the efficacy of the photosensitiser, 5-amino levulinic acid (5-ALA), to detect lymph node metastases during laparoscopic colon cancer surgery. Patients with colon cancer receive 5-ALA in oral solution 4-6 hours preoperatively. 5-ALA is selectively taken up by cancer cells and converted to naturally occurring protoporphyrin IX, which fluoresces when viewed with blue-violet light, and which can be detected laparoscopically.

We are particularly pleased to have an opportunity to highlight the work of the EME Programme in this issue of the ASGBI ***Journal*** because we are presently commissioning projects on Active implantable medical devices. We will also shortly be calling for proposals for studies on Passive and Bioactive medical devices in early 2014; both of these funding rounds may be of particular interest to practising and innovative surgical teams. Active implants are implantable medical devices that rely on a source of power other than that directly generated by the human body or gravity. Passive and Bioactive implants include devices such as artificial joints, vascular grafts, artificial valves, inert bone matrices. The EME Programme is planning a call for applications into wound healing in mid 2014, which should also be of particular interest to surgeons.

Making an application

We encourage applicants to take advantage of their loco-regional Research Design Service (RDS) and/or Clinical Trials Unit (CTU) for advice in optimising the design of their research proposals. You are strongly advised to:

- Seek our advice via the Resources link on our website (www.eme.ac.uk/resources), or by phone (023 8059 4303) or email (info@eme.ac.uk).
- Offer to peer-review for the EME Programme and see how others put together their applications.
- Speak to funded EME researchers who can be identified through the Funded Projects page on the EME website.
- Check our website. Current funding opportunities are always promoted at www.eme.ac.uk/funding. The three commissioned and three researcher-led calls are advertised each year via twitter (@OfficialNIHR), rss feed and on the EME website. We also send out email alerts to our mailing list, which you can join from the website.

We are always happy to answer any questions before you start to submit an application. We have a lot of guidance available on our website and can talk through any queries you may have about the EME Programme.

Please contact our team on 023 8059 4303 or email them at info@eme.ac.uk.

The EME Programme is funded by the MRC and NIHR, with contributions from the CSO in Scotland and NISCHR in Wales and the HSC R&D, Public Health Agency in Northern Ireland. It is managed by the NIHR Evaluation, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

AN OLYMPIC DREAM: THE SECRET LIFE OF...

Abigail Walker
CT2, ENT, Charing Cross Hospital

"You have to decide whether you're the kind of person who will regret doing something, or not doing something". Those words of advice were spoken to me as a house officer by a consultant, offering some friendly career advice. I had been agonising over the idea of taking a career break to pursue my aspirations in international hockey, and my consultant was gently letting me know that in her opinion, I would quickly regret the decision to step away from medicine. The words struck a chord; my indecision was instantly ended. I typed out a resignation letter and posted it within the hour, safe in the knowledge I would regret not doing everything in my power to chase my Olympic dream.

I started playing hockey at school, but my interest had been sparked at a much earlier age through watching my older sister play. As the youngest child of five (all of whom followed my mother into a medical career, proving that medicine truly is genetic) I was already destined for a life as a goalkeeper; as anyone with older siblings can testify, if you want to play with the big kids, you need to be prepared to spend an awful lot of time in goal. Through school, I continued to play and eventually followed my role model big sister to our local club team. This really set the wheels in motion for my future hockey career. Playing for every team, club, or knockabout side that needed a spare goalkeeper, I would sometimes play in the morning for my school first XI as a goalkeeper, the second XI as an outfielder, then for a local club team in the afternoon. Looking back over my career, I can see how incredibly important those hours of playing hockey with anyone and everyone were in my development. I would wholeheartedly subscribe to the concept of a "talent myth"; I was no more driven, coordinated or blessed with skill than my peers, but I did practise a lot more than them. Dedicated early years practise and opportunities are, I believe, what are commonly mistaken as "talent".

As I progressed through the age groups and started to move towards senior international hockey, however, my career hit a stumbling block. I suddenly encountered athletes who were willing to not just spend hours playing the sport I loved but to put in hours of training in the gym and Friday nights at home with their feet up, whilst I was enjoying all aspects of life as a first year medical student. After one training session of being roundly outplayed, outrun and outfought, I had to admit to myself that I just wasn't able to perform at that level. I resolved to start making the difficult choices instead of the easy, lazy choices. I improved my diet, signed up to a fitness programme and cut out the pub. The final piece of the jigsaw fell into place and hockey turned from being just another hobby into a way of life. The improved focus also seemed to reflect in my improved university results – I went from a middling student, to gain a First Class Honours in Physiology and a Distinction in my finals. The hard work paid off as I became a fully fledged senior international, winning my first cap for Scotland in 2003 and for Great Britain in 2006.

After graduation, I continued to combine hockey and a medical career. I moved to England to train fulltime for the Beijing Olympics. When it came to final team selection however, I didn't make the cut. That experience was heartbreaking, but it never crossed my mind to give up. It taught me some hard lessons about how I was performing poorly under pressure, and my inability to produce the consistent excellence required at the very top. It taught me exactly what I needed to do to make the final selection of 18 players nominated for the London Olympics, and I'm proud to say I learnt my lessons and I did what was needed to break into the very highest level. The selection period was unbearably tense but like everything in our preparation, it was meticulously planned. The terms of the selection announcement had been planned by the players down to the very last detail. Nonetheless, the wait for "that" email will rank as more stressful than any surgical exam results!

The actual Olympic experience would probably surprise most people in terms of the painstaking preparation and detailed planning. Every possibility and potential was discussed and a response agreed upon in advance. Kit was handed out on a timetable and each day we would have a prescribed colour for team harmony. We practised penalty shoot outs twice a week for months in advance. We would study hours of video footage of our own performances and our opponents, and then again during the tournament to detect any key tactical or personnel changes. Nutritional supplements for each day were weighed out, packaged up, and given to us in personalised, tamperproof boxes. This level of

detailed planning might seem neurotic, but it was actually aimed at coping with the uncertainty that inevitably comes with being part of "the greatest show on earth". It's almost inevitable that, at some stage of a contact sport competition, you will have to deal with injury, illness, or just plain bad luck, and it's at times like these that athletes really value having their regular routine to fall back on. "Control the controllables" became almost a cliché in the team, a way of reminding each other to optimise everything within your own power (and not to waste emotional energy on the things that aren't). A key lesson which continues to serve me well in the NHS!

The uncontrollable bad luck that comes in sport can often strike in the form of serious injury. We took pride in being the fittest hockey team at the Olympics, and probably the fittest team ever. This meant we had a very low rate of players missing games through injury, and we had an excellent medical centre hidden away in the Olympic Village if any treatment was needed, staffed with physiotherapists and doctors working away up to 18 or 20 hours a day (hidden away so that other countries couldn't spy on our superior sports science capabilities!). Unfortunately, some injuries are unavoidable and we suffered one such setback when our captain was struck in the face during the first match and sustained an open fracture of the mandible. It's an extremely difficult situation to switch off your "medical brain" at times when you see a team mate injured, and it's almost instinctive to want to help. Of course, there are sports physicians immediately on hand and our injured player was transferred to the Royal London Maxillofacial Unit where, with the aid of some astonishingly ingenious surgeons and orthotists, she made an amazing recovery to return to action just six days after sustaining the injury.

Before the Games, we had been united as a team in openly declaring that our aim was to win the gold medal. It helped us to set the standards in training and preparation. Every day, you could ask yourself, is there someone else in the world training harder than me? We knew in our hearts that over a period four or five years, the answer to that almost every day was "no". We were brilliantly prepared, confident, and at the peak of fitness. And yet, the fairytale ending was not to be. We were beaten in the semi finals by Argentina, who had become our nemesis over the previous few competitions. On the day, they simply played better than us. It's difficult to accept defeat when you set out to win gold, but when you compete with the best in the world, the margins are so fine that the opposition will occasionally outperform you. It's one of life's "uncontrollables". We recovered to win our last match and with it a bronze medal. The final whistle marked the end of my international career as I had already made the decision to hang up my sticks, and had every intention to retire from the sport entirely.

Quite simply, I had fallen out of love with the game. It's impossible to transmit the kind of existence that is required of a top level athlete. It is utterly all consuming: training on Christmas Day, missing family weddings, moving across the country to live closer to the training venue. The level of competition in the squad and the fear of missing out on selection would occupy the mind at every training session; tiny mistakes would be obsessed over. I would lie awake in bed at night thinking about a moment from the training field when I should have taken half a step forward instead of a whole step. The reason for playing hockey by the end was the drive to finish the job I had started; I couldn't live with the regret of not doing something. By the time the Olympic Games began, it wouldn't be an understatement to say that I hated hockey. I loved the team and shared a family-like bond with every member of the squad, but I felt that I had come to the end of my journey as a player.

This made it all the more surprising when, three months after the closing ceremony, I found myself signing up to join a newly promoted club team in Surbiton. Having returned to surgical training, I realised that a new part of my life was starting, where I was as an absolute beginner and not very good at the required technical skills. The frustration of that on the one hand was balanced by the sudden epiphany that, in hockey, I had an area of my life in which I was really rather good – and it was quite nice to get that ego boost once in a while! I also learnt to appreciate things I had overlooked before: coaching younger players, socialising with familiar faces, and gently easing into the role of distinguished elder!

Returning to work, I also started to appreciate more the attributes which had been developed through sport and that crossed over into surgical life. Team working, time management, and goal setting all are obvious skills required in both fields. More subtly though, I started to appreciate I had learnt other skills such as the ability to translate verbal coaching into physical skills, recognising and regulating my own stress levels, and how to extract value from technical practise. If I was asked to pick the one key trait to my success as an elite athlete, it would be one that I think all surgeons would agree is essential in our field also: resilience. To succeed in sport or in surgery, you have to be able to accept the possibility of failure. That is easier said than done – after all, with failure comes judgement, criticism, and doubt. Past experience of failure can inhibit the desire to take on further attempts. However, I have learnt that in sport (and I believe in surgery too) you must have the resilience to experience failure, doubt, and criticism but still have the strength to continue to take on new challenges and drive your personal standards higher. That, I believe, is the key attribute for success.

Education & Innovation

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CONTRACTS AND CHANGING THE WAY CONSULTANTS WORK

Dr Mark Porter
Chair of Council, BMA

The BMA is now underway negotiating both the consultants' and the junior doctors' contracts, aiming to bring them both up-to-date for 2013 and fit for purpose now and in the future. We are gearing up to work with NHS Employers to address issues such as job planning, working hours, pay and professional development.

The decision to enter into negotiations on the consultant's contract has been built around feedback from more than 4,500 doctors – consultants, medical academics, public health doctors and junior doctors – who signalled the need for a fairer and more transparent pay system, a willingness to increase out-of-hours consultant coverage for emergency and urgent care if appropriately rewarded, resourced and implemented, and strong support for retaining a national contract to ensure consistency of care and to protect time for professional development. The negotiating team have their work cut out for them over the coming year; the current contract has been in place since 2003 and any expectations from doctors must be carefully balanced against the ideals of what our patients need and a realism of what our employers will agree to.

Our aims, as specified in the negotiating agreement, are to ensure that consultants' terms and conditions continue to support consultants in providing high-quality and innovative care, are fair to doctors and good value for employers, and that they continue to attract, motivate and retain the right mix of doctors to deliver patient care. Among the most significant requirements of the medical workforce, as stated by both patients and employers, are prompt, appropriate and the best care available to all patients, at all times; no significant variation by postcode; local availability of a national health service; effective and efficient care; no barriers to reconfiguration; better rewards for demonstrably better work and overall better outcomes.

Many believe that changing the way in which the consultant workforce is structured and how it operates will lead to a better, more efficient service for patients and the national health service overall and, as senior healthcare professionals, consultants have a duty to consider how best to improve the existing system. However, it is finding the appropriate model, fitting of a public service that proves harder to agree on. Some of the key issues we will address in our negotiations over the coming months are seven day working, retaining Clinical Excellence Awards (CEAs) and pay progression. The team will also be upholding the strong support for maintaining a nationally negotiated contract as opposed to localised alternatives.

Members appreciate the importance of increasing out-of-hours consultant coverage for emergency and urgent care if appropriately rewarded, resourced and implemented. A majority of the 4,500 doctors surveyed on the future of the consultants' contract believe that increasing consultant coverage on evenings and weekends for emergency and urgent care would be beneficial, but few offered their unconditional support. Variations by speciality, for example prioritising emergency medicine coverage, and balancing the needs between elective and emergency care, need to be carefully considered before undue pressures, both financially and structurally, are placed upon the already stretched resources of the health service and capabilities and work-life balance of the individual doctors.

We, together with NHS Employers, will be carefully looking at issues relating to the scheduling of services during evenings and weekends, such as rates of pay, minimum rest periods and the resourcing of other services essential to providing a seven-day service (for example, ensuring there are enough nurses and other clinical and administrative staff and diagnostic services to provide high-quality care during evenings and weekends). Many also believe that the current system of CEAs needs to be improved, and this will, I am sure, be a core tool for the negotiating team. The way in which CEAs are currently awarded is regarded as being opaque by some, and as a result the team will be looking to improve transparency and fairness of the awards. We will work to ensure that any changes to CEA schemes continue to meet the objective of rewarding excellence.

We will also be responding to the calls for increased recognition and financial remuneration for the work already done by consultants, primarily in terms of work outside of agreed hours and at antisocial times such as evenings and weekends. The team will examine new pay progression arrangements, ensuring pay structures are fair, and that they reward, motivate and retain staff and will work to create a pay structure that will secure a fair pension, following the move from a final salary to a career average pension scheme, which comes into effect for NHS employees from 2015.

These negotiations will take time. Our aim is to agree a contract that meets the challenges facing the healthcare system and changing patient needs, and delivers fair pay and working conditions which recognise the contribution consultants make to driving excellence in the NHS.

ChM AND ASGBI JOINT BURSARIES

The ESSQ Team

The ChM in General Surgery is run jointly by the University of Edinburgh and the Royal College of Surgeons of Edinburgh. We are delighted to announce the award of four ASGBI bursaries for our top performing students in 2013.

Professor O James Garden

Professor Steve Wigmore, Programme Director for the MSc in Surgical Sciences

Mr Ewen Harrison, Programme Director for the ChM in General Surgery

The suite of surgical online distance learning programmes developed in Edinburgh was established in 2007 with the launch of an MSc in Surgical Sciences. After four years of refinement, the platform was used as the basis for the development of four ChM programmes in General Surgery, Trauma and Orthopaedics, Urology and Vascular, and Endovascular Surgery. With 300 applications in 2013 alone, the programmes have proved very popular with both UK and overseas trainees.

These innovative e-learning programmes have been structured to fit alongside professional development/examination. An e-learning platform was first developed for the MSc in Surgical Sciences, making use of virtual case scenarios based on common surgical conditions from the Membership of the Royal College of Surgeons (MRCS) curriculum. The ChM programmes built upon the success of the MSc and aim to consolidate learning towards the intercollegiate examination (Fellowship of the Royal College of Surgeons, FRCS) at the level of independent surgical practice and to recognise the subspecialty interest of the trainee.

The MSc programme delivered its first group of graduates in July 2010 and demonstrated that the format meets with strong student approval. This has resulted in increasing recruitment year-on-year and has been associated with an improved success rate for MSc students in the MRCS examination. The quality of the programme has also been recognised by the University of Edinburgh, which gave the Chancellor's Award for Teaching to its programme director in 2010, and nationally in the 2010 eLearning Awards for Best Online or Distance Learning Programme (Education).

Graduation, Class of 2010 - ESSQ graduating students with Professor Stephen J Wigmore and Professor O James Garden

The success of the programmes has led to a growing demand for continued professional development (CPD) for the consultant surgeon wishing to keep abreast of recent advances. As a result, CPD modules based on the distance learning programme format will be launched in February 2014.

The part-time postgraduate programmes were developed in direct response to the recent changes in surgical training. With reduced working hours enforced under European law and the introduction of run-through and core training programmes, trainees were starting to demand more exposure to the surgical conditions and operations that would have formed part of traditional surgical training. Although there were an increasing number of online resources available, no single platform provided learning material tailored to the needs of trainees in a flexible and readily accessible manner that enabled the student to measure their progress through the components of the MRCS/FRCS curriculum. Furthermore, no such programme provided academic recognition of their acquisition of knowledge and development. It was also appreciated that no matter how highly an MD or PhD thesis is regarded, the traditional approach of taking 'time out' for research training might not sit well with the desire to progress trainees seamlessly, and in a short time, to a high level of competence in surgical practice.

Recruitment of over 600 students since 2007 has shown that the programmes have embraced distance learning as part of the excellence of campus teaching and encompasses the aim of the University's Distance Education Initiative. Strict entry requirements and demanding assessments uphold the tradition of exemplary quality surgical training in Edinburgh, demonstrated by the increased performance of our students in their professional exams.

It was intended that these part-time programmes would support both the professional and academic development of surgeons during their clinical training. The intention was to deliver these flexibly, taking into account irregular on-call work patterns. Their online delivery and the use of asynchronous discussion boards was intended to allow participation at any time of day and to engage via any computer or smartphone. The online nature of the programmes also reaches new postgraduate audiences, supporting trainees in countries lacking well-defined training schemes and exposing them to research methodology irrespective of location.

The MSc in Surgical Sciences uses a dedicated virtual learning environment and innovative game-informed learning techniques to allow the trainee to navigate a vast, bespoke knowledge base, structured on common surgical case scenarios. We have taken great care to ensure that students are supported throughout their time on programme. Self-assessment multiple choice questions and asynchronous discussion boards direct learning towards educational objectives.

The MSc in Surgical Sciences covers the generality of surgery. In the first (certificate) year, the basic sciences are taught through the themes of Applied

Anatomy, Applied Pathology and Microbiology and Applied Physiology. In the second (diploma) year, the focus is pre- per- and postoperative care and surgical skills. Finally, the third (MSc) year is devoted to research. Students are supported through the use of discussion boards sustained by a multidisciplinary group of e-tutors, and ensuring formative and summative assessment of student interaction. Over 200 expert tutors facilitate the programmes and stimulate dynamic discussion providing trainees direct access to expert opinions. Tutors are chosen for their knowledge and experience as well as their passion for teaching. Full time academic facilitators, programme manager and administrative staff provide dedicated student support, delivering a solid administrative and academic infrastructure. Online student activities are monitored, allowing help to be offered, often before it is requested. Tutors can focus on education, whilst also providing an accessible point of contact essential for online distance learning.

All programmes deliver a strong research component, giving insight into critical assessment of research methods, and may encourage them to pursue a defined period of research but, for others, may support academic development without the need for the trainee to take time away from clinical training. This research component broadens access to academic and clinical training irrespective of the clinical base.

The ChM programmes introduce the advanced surgical trainee to management of complex surgical cases to reinforce learning in the workplace. They aim to provide a more structured and consistent approach to patient management than can be taught from a text book or limited clinical experience. To provide the trainee with a thorough understanding of these cases, expert tutors lead an assessed discussion and incorporate key research and clinical guidelines promoting evidence based practice. The ChM programmes also develop non-surgical skills to prepare trainees for leadership roles.

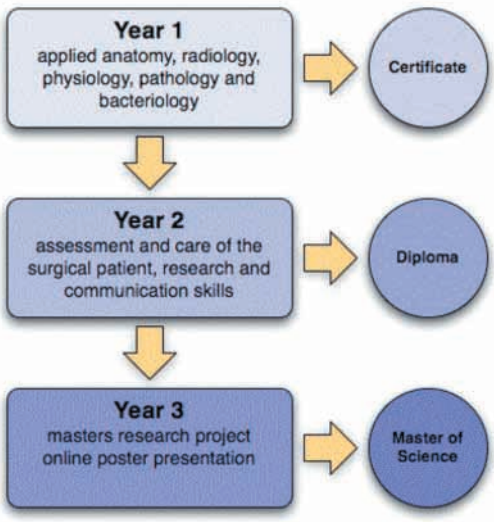
The ChM programmes are specialty specific, with individual modules that last an entire semester dedicated to covering each subspecialty. With many concurrent modules and two semesters dedicated to the development of academic skills, the two year programmes are fast-paced but compact. Bespoke, secure Virtual Learning Environments (VLEs) provide an intuitive and seamless learning experience. Their responsive design adapts to smartphone/tablet screens, facilitating the 'anytime, anywhere' nature of the course. We have found that carefully designed discussion boards can promote an active online student environment and foster a sense of community. With the University's Learning Technology Section, our platforms are improved constantly as web technologies evolve. Electronic media is further embraced with user access to over 100 surgical journals and leading eTextbooks. Course knowledgebase and learning content are updated constantly with the latest research and guidelines. Masterclass videos have been highly praised by students for allowing them to review key surgical techniques that they might not otherwise witness.

Although we have established a solid foundation for our distance learning programmes, we are working to ensure that we remain at the forefront of medical education and that we remain relevant to today's surgical trainees. We would like to conclude by thanking ASGBI for their support of our programmes.

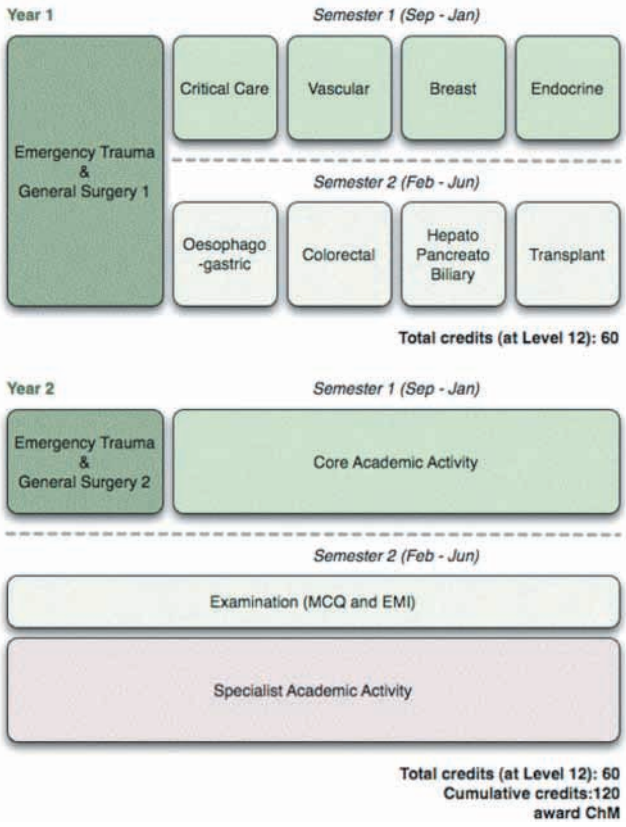
For more information please see our website http://www.essqchm.rcsed.ac.uk

PROGRAMME STRUCTURES

MSc in Surgical Sciences

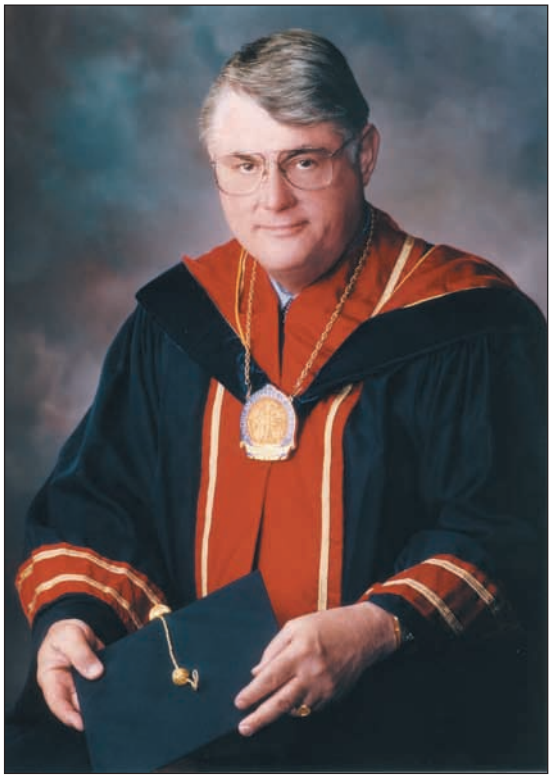


ChM in General Surgery



OBITUARY

GEORGE F SHELDON
(20th DECEMBER 1934 TO 16th JUNE 2013)



George F Sheldon, MD, FACS, passed away on Sunday, June 16, 2013 after a short illness. He spent his last days at UNC Hospital surrounded by his family.

Dr Sheldon was born in Salina, Kansas, where he grew up around medical practices. He was a third generation physician - his maternal grandfather, Dr George F Zerzan, practiced in Holyrood, Kansas, and his father, Richard Robert Sheldon, practiced in Salina, Kansas.

He married Ruth Dawn Guy in Hutchinson, Kansas on August 23, 1958. The two would go on to have three daughters and enjoy 55 years together.

Dr Sheldon had a B.A. in History and an M.D. from the University of Kansas. Following internship at KU, he performed his military service in the Uniformed Service (Coast Guard) of the United States Public Health Services, rising to the rank of Lieutenant Commander. He then did a Fellowship in Internal Medicine at the Mayo Clinic, and his surgery residency at the University of California, San Francisco, where he became Chief Resident. He also completed Fellowships at the National Heart Institute and Harvard Medical School.

In 1971, Dr Sheldon joined the University of California, San Francisco, as Chief of the Trauma and Hyperalimentation Services at San Francisco General Hospital. He then became Professor of Surgery in 1980.

In 1984, Dr Sheldon joined the faculty at the University of North Carolina at Chapel Hill as Chairman of the Department of Surgery and became the Zack D. Owens Distinguished Professor of Surgery and Social Medicine. During his seventeen years as Chair, he made many changes to the department that resulted in substantial programme growth and expansion of department services. He pushed for extensive recruitment of young surgeons, and was particularly pro-active in the recruitment of minority and female surgeons.

Dr Sheldon was one of fewer than twenty surgeons in the past one hundred years to be president of all of the major surgical organisations, including President of the American College of Surgeons, President of the American Surgical Association, President of the American Association for the Surgery of Trauma, and Chair of the American Board of Surgery. He was a Charter Member of the Council on Graduate Medical Education (COGME) when it was founded in 1985 under the Department of Health and Human Services, and was a lifelong champion of Graduate Medical Education.

He held Honorary Fellowships in the Royal College of Surgeons of Edinburgh, the Royal College of Surgeons of England, the Association of Surgeons of Great Britain and Ireland, the European Surgical Association, the British Columbia Surgical Association, the Colombian Surgical Association, and the Society of Black Academic Surgeons. He has received numerous professional awards, including the Kansas University School of Medicine Distinguished Alumna Award, the University of North Carolina Medical Alumni Association's Distinguished Faculty Award, the Distinguished Alumni Award from the College of Arts and Sciences of The University of Kansas, and was named as the Distinguished Service Member by the Association of American Medical Colleges. In 2011, he was presented with the prestigious Thomas Jefferson Award by the University of North Carolina at Chapel Hill. In 2012, he was the recipient of the Lifetime Achievement Award by the American College of Surgeons, an honour that has only been bestowed once previously.

At the University of North Carolina, Dr Sheldon was a member of the Faculty Council and the Faculty Assembly of the University of North Carolina system. He was Director of the American College of Surgeons Health Policy Research Institute and Senior Research Fellow of the Cecil G. Sheps Center for Health Services Research. His recent interests and expertise included the impact of health care reform on physician shortages and he testified before Congress on that subject. He was Editor-in-Chief of eFACS.org, the web portal of the American College of Surgeons. He authored over 400 articles and book chapters.

Along with surgery, Dr Sheldon had a lifelong love of American history. He was an authority on early Colonial medical history, writing several articles on the subject. He co-authored *The Pictorial History of Kansas Medicine* (1961) and was sole author of *Hugh Williamson: Physician, Patriot, and Founding Father* (2010). He was particularly interested in the life of Philip Syng Physick, "The Father of American Surgery," and was in the process of writing a book on Physick at the time of his death.

Dr Sheldon trained hundreds of residents and fellows, and mentored countless medical students and faculty members. He was keenly interested in knowing about others' educational goals, even during his last days in the hospital, where he would engage the staff who were assisting in his care in discussions about their lives. He also enjoyed watching sports and news, and had a great fondness for his pets, most recently, cats Theo and Ireland. He treasured family trips to the family cabin in Colorado, and was planning a visit there in August.

Dr Sheldon is survived by his wife Ruth, three daughters, Anne Sheldon Anderson, Elizabeth (Betsy) Sheldon and Dr Julia Sheldon. He also leaves behind two brothers, Richard Robert Sheldon II, Ph.D. and William F Sheldon, Ph.D. and four grandchildren.

This obituary was reproduced with the kind permission of the University of North Carolina School of Medicine, Department of Surgery (http://www.med.unc.edu/surgery/news/2013-news/dr-sheldons-obituary).

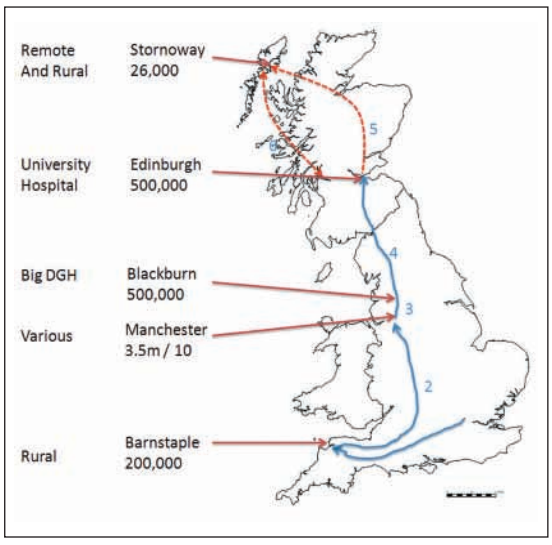
THE 2013 BJS TRAVELLING FELLOWSHIP TOUR – EMERGENCY GENERAL SURGERY AND A RETURN TO THE OLD COUNTRY

Jonathan Fawcett
Director, Queensland Liver Transplant Service;
Chairman, HPB Surgery;
Director, General Surgery,
Princess Alexandra Hospital, Brisbane, Australia

BJS

It was an unexpected surprise and a great pleasure to be invited to take up the ASGBI BJS Travelling Fellowship for 2013. I departed down-under from Oxford in 1996 after training there and, previously, in Bristol and Newcastle-upon-Tyne. Having survived the intercollegiate exam and, clutching a certificate of completion of training, I thought I would likely be back working in the old Dart by the turn of the millennium. Sixteen years later, still living in sunny Queensland, I wondered whether my nostalgia for the NHS would be crushed by nosing around UK hospitals and "rebooting" the system in my mind.

I was asked by the Scientific Committee of ASGBI to visit a range of UK hospitals, from north to south, big through small, to observe and comment on the delivery of emergency general surgery (EGS). I was assisted in my task by the people I encountered at every hospital who were willing to put aside their heavy schedules to talk me through how NHS v2013 is supposed to work, and how it actually does. I was also deeply grateful for the hospitality extended to my wife, Kate, and myself as we travelled around the country by rail (which ran excellently). In working out my itinerary, I must particularly acknowledge the help of the ASGBI president, Professor (and Head of Everything) John Primrose, Mr Nick Markham, omni-talented surgeon and Director of ASGBI Informatics, and Professor Rowan Parks, who seems to have so many jobs I wonder if he is one person. My travels have shown me that it is the people in an organisation that define its qualities more than the infrastructure. I came away reaffirmed in my belief that the current problems faced by general surgery are generating smart thinking rather than inertia (and maybe a little whingeing!).



The 2013 BJS Travelling Fellow tour map

A lot has been written about the provision of EGS, but if one were to pick out a single reference source, then the monograph on the subject by Mr Iain Anderson under the ASGBI banner would be a good choice. In it, he sets out the importance of EGS (that it encompasses perhaps a half of surgical admissions), as well as the problems (that it accounts for 20% of all operating room activity but generates 80% of the complications). These two points underscore the challenge facing EGS, which is that it is a difficult area of clinical practice in which to deliver good results, driving the need for consultant-delivered care; at a time when they are already overburdened by the incessant demands placed on them by the target-driven approach that has consumed modern NHS management, particularly with regard to elective surgery. If the mantra of patient choice in their treatment was ever to be extended to EGS, then the whole system might choke in the haze of exhaust fumes from mighty fleets of ambulances trundling from one A&E department to the next, looking for somewhere that meets the expectations of their clients, erm sorry, patients. As a looming problem for the future, trainees' depth of experience in EGS is threatened by the more abbreviated nature of training, reduced clinical exposure consequent on the EWTD, and a modern aversion in some quarters to the inconvenient, unplanned nature of EGS.

So, how are these problems being addressed in the UK? It would be difficult to summarise a subject as broad as this in a short written piece. What follows are only observations noteworthy to this overseas visitor. Any criticisms relate to resource deficiencies not to the personnel who uniformly battle through regardless. No one-size-fits-all EGS system could be imposed on all hospitals whose situations are heterogeneous – this is also a comment on the limited utility of centralised target setting. Out-of-hours protocols for managing large bowel obstruction are going to work differently in Barnstaple, where the rostered surgeon could have any subspecialty interest, compared to Edinburgh where such patients are all directed to the Western General with a large specialist colorectal unit.

The Local Champion

The core business of being a doctor is the eradication of disease and the alleviation of suffering. But unlocking one's inner manager is also useful. Delivering good EGS requires somebody to declare their determination that an area of activity is worthy of greater effort to make it better by identifying the problems, working out a fix and then examining effectiveness by developing local goals; a unit's best comparator is its previous performance. While such a person could be non-medical, in practice, senior surgeons know surgery, they know how other surgeons work and they know what patients need (which doesn't necessarily coincide with what they want). An example of such a person is Rob Watson in Blackburn. He has re-organised EGS and taken a specific interest in how it works, all to outstanding effect. As the go-to person, he is also able to focus the wishes and needs of his colleagues, so that concerted efforts can be made to win resources needed for effective EGS. No problem there with getting a daytime emergency operating theatre.

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There is also the "Hawthorn Effect" at work; the very process of examining EGS inspires positive change in delivery.

The Resources

Often identified as the biggest limitation in the NHS, it does also spawn solutions and efficiencies and my visit reminded me that the UK is a clever place. Inpatient bed days are very expensive and a patient sitting on a ward without forward progress is a bad thing. In both Barnstaple and Blackburn, there are "hot" clinics where the "semi-sick" can be rapidly referred and assessed by a consultant to determine a plan of management. To work well, this has to be supported by access to ancillary investigations, especially radiology, and this was the one really notable Achilles' heel that I saw. It is hard in contemporary practice to proceed with a laparoscopic cholecystectomy without an ultrasound first to confirm the presence of gallstones. A delay in getting the scan costs money, so you have to spend a little to save a lot. I encountered views expressed in some hospitals that access to imaging varied between awkward (*"Only the surgical registrar can order more than a plain film."*) and impossible (*"No ultrasounds over the weekend."*). This may be the result of cost containment by X-ray departments and highlights an inefficiency of "silo" funding. In Australia, any suggestion that A&E consultants shouldn't be free to order whatever imaging they chose would result in a robust response involving liberal amounts of emergency language.

Of course, access to investigations represents recurrent expenditure with ongoing cost implications, so one can understand the need to look carefully at how such resources are used. On the other hand, with regard to capital expenditure, the money only needs to be spent once, although the sums involved may be eye-watering, especially if the PFI vultures have gorged themselves. But get it right, and you have a hospital that will be easy to run and pleasant to work in for decades. To my mind, the new RIE in Edinburgh is an example of a really good new-build hospital. Sensibly laid out with good wards, offices, theatres etc, its infrastructure more than makes up for losing the prime location of its predecessor.

The new RIE in Edinburgh

I didn't feel that the same could be said in Manchester. While the MRI and the new bits of the Salford Royal are impressive, I was frankly amazed at some of the old workhouse era hospitals still open for business. To have ten-odd hospitals in a city of 3.5 million seems far too many and there must be an opportunity to replace these with a smaller number of bigger, better ones in which everything, including EGS, would be easier to do. New design hospitals are just better set up for modern clinical practice. Coming back to radiology again, one of the biggest changes in the way we look after surgical patients now is the extent to which we rely on interventional radiology. When I started as a registrar in Newcastle, there was no CT scanner in the RVI and a diagnosis of subphrenic abscess was difficult to make, and then required surgery to fix. Fast-forward to now and ask yourself when was the last time you didn't first-up order a CT-guided drainage for a post-op collection? Bigger hospitals also permit scale-up in EGS activity so that the establishment of dedicated Acute Surgery Units becomes viable. Smaller hospitals in locations such as Barnstaple, or Stornoway even more so, clearly must remain open because of their relatively isolated location but they aren't big enough to support an ASU and require a different solution. But having small hospitals in large metropolitan areas is a missed opportunity for amalgamation to make something better and more efficient. The RIE in Edinburgh has a dedicated ASU, sorting out 180–200 patients weekly in a very efficient manner, that doesn't interrupt the elective surgery workflow (but the consultant rostered for acutes works hard for their paycheque that week).

Barnstaple surgeons: Mr Mohandas Menon, Mr John Groome and Mr Nick Markham

Political considerations are ascendant in planning new hospitals. MPs defending marginal seats do their constituents a disservice, though, by promising to defend their local infirmary when it's so old and knackered, it looks like a film set for a Dickens adaptation. Patients don't like travelling but again, from an antipodean perspective - last week I did an emergency spleno-renal shunt for a patient from Mount Isa (Google Map it to see how far away from Brisbane that is) – nowhere in Britain is terribly far away from anywhere else. It was interesting to talk to Iain Anderson, Nick Lees and Gordon Carlson about the problems of developing a hospital strategy when I visited Salford Royal (formerly Hope - the hospital I was born in, coincidentally). There is clearly plenty of local medical determination to pursue a comprehensive hospital strategy across the city and this will

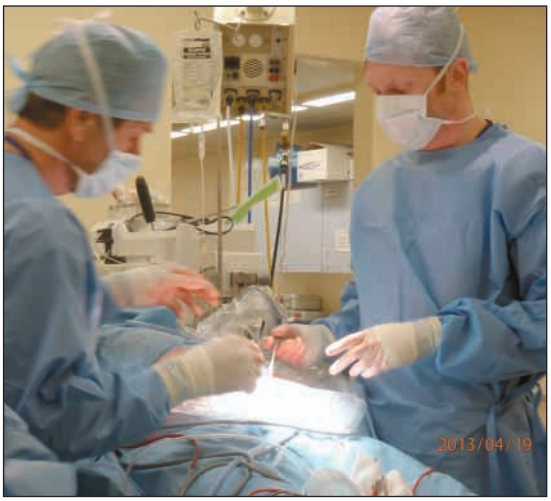
ultimately improve EGS provision. The only disappointment of my visit to Salford was to find that Gordon still looks as young as he did when we were junior trainees at the RVI in Newcastle, while my kids think I am old enough to need carbon dating to determine my exact age.

The Trainees

I enjoyed meeting surgical trainees on my tour. They seemed to be the same enthusiastic young doctors that I like to think we were at their age. When my generation went through, surgical education was probably less sophisticated and the big hurdle was capturing a senior registrar position. In every hospital, there were older registrars hanging on by their fingernails hoping to get into the SR ranks before finally running out of options. This resulted in the situation where large numbers of middle grade trainees could be described as over-experienced but under-trained. Nowadays, the education process is better developed but the training has been compressed and, quite strikingly to someone who has been away a long time, enters a terminal differentiation phase very early in the piece. So, 2-3 years into training, a registrar could, for example, be tagged as an HPB surgeon in the making. Even though they may rotate through other disciplines, they may not end up with the level of pan-competence across general surgery required to deal with emergency work, for a variety of reasons. A lack of confidence in themselves may transmute into avoidance of EGS, because surgeons don't like to undertake work they don't feel confident with. In big set-ups like Edinburgh, it is possible to restrict EGS activity to one's own specialty because of the way EGS is configured across the town, but in most small and medium size DGH settings, this isn't possible.

There are solutions to this. One is to not allow pursuit of a specialty until some acceptable level of competence in general surgery has been acquired. In Australia, the FRACS has historically been an exit exam after which a fellow is free to hang up their shingle and start independent practice. Most young surgeons will go on to some further specialty training before setting out in practice, but the common way to build a referral base in private practice is by making oneself available for EGS in the private hospitals (remember that 40% of healthcare in Australia is delivered through the private sector). There is still a strong impetus to be handy at dealing with EGS in Australia, because if you don't work you don't eat. One could apply a rewards approach in the NHS by paying salary loading for EGS activity, but it would be about as likely as the UK re-starting a nuclear power programme (oh wait, that just happened...).

The confidence factor in dealing with EGS for the newly appointed young consultant surgeon can also be improved by professional support. In both Blackburn and Barnstaple, I observed a "phone-a-friend" system where it is possible to enlist the help of a colleague when faced with a problem requiring specific specialty experience. This is an area where senior surgeons have much to offer to their younger colleagues and it was noticeable that Nick Markham and Rob Watson were "go-to" senior surgeons, with a strongly positive mentoring effect on younger members of their department. Mentoring and buddying-up is becoming increasingly common in Australia, especially in some specialties like HPB where patients commonly ask a young surgeon "How many of these have you done?" The help of an old bloke like me is useful for defusing these situations.



Nick Markham hard at work

Stornoway is a special case. A geographically isolated location with a small, but nicely equipped hospital serving a population of about 30,000 requires the provision of general surgery. A minimum of three surgeons is needed to make a roster and they need a broad skill base in EGS. One of the problems, then, is to find a sufficient caseload to prevent de-skilling. I didn't get the impression this problem has yet been addressed but periods of time working in bigger units elsewhere on a regular basis would seem helpful if a practical way of making this happen could be designed.

The Future

In Queensland, steadily increasing numbers of patients are transported around the state for care. Previously, this was for the management of rare and unusual conditions but we are now seeing patients with common problems (including EGS), in the setting of complex co-morbidity, being sent to tertiary institutions for management. This poses a strain on resources and for a while, our hospital resisted, but now it's an accepted situation. Recently, appointed RIE consultant Ewen Harrison's analysis of a volume effect in cholecystectomy outcomes may indicate the same will happen the UK. In my hospital, the influx of "peri-mortal" patients needing EGS was a driver to setting up a dedicated Acute Surgery Unit. It has two consultants, two senior and two junior registrars, and a "ring-fenced" theatre with its own anaesthetist, completely under the control of the ASU consultant of the day. Within a year, it became the busiest surgical unit in our hospital and the most sought-after registrar job. Yet, five years ago, nobody even thought we would one day even need such a service. The demands of modern medicine can change rapidly and a flexible approach to EGS service delivery is vital.

Conclusion

I would like to thank the BJS and ASGBI for the opportunity to poke around in the nooks and crannies of the NHS, still a legendary institution in healthcare. My visit was truly memorable.

SIX CENTURIES OF BATTLE TRAUMA: PART 1, 1415 – 1680

Michael Crumplin

ASGBI Archivist and an Hon. Curator, Royal College of Surgeons of England

Since time immemorial, men and women have been injured in conflict - combatting to survive, to compete for food, land or power. Although it has been disease, starvation or climate that has traditionally destroyed armies, the significant challenge to surgeons that comes with battle trauma rolls out a fascinating contest between man's ability to destroy and his skills to repair. The next two years are pivotal commemorative periods in the history of warfare; during 2014, we shall remember the end of Wellington's successful Peninsular War and the outbreak of the most terrible of the world conflicts, World War I, or the Great War (1914-1918). In the latter, terrible maelstrom, total Allied Entente Powers losses were 5.7 million dead and 12.8 million wounded (Britain 1.2m dead and 2m wounded). The Central Powers lost 4m dead and 8.4m wounded. This was the war that completely reversed the ratio of deaths from disease to injury. One hundred years previously, at the termination of Wellington's six-year Peninsular War, around 20% died from combat injury, compared with 80% who perished from disease, extreme climate or deprivation. This radical reverse between 1814 and 1914 was the result of improved understanding and treatment of disease, but also the catastrophic evolution of static trench high explosive warfare, which often overwhelmed surgical capacity. Today, in Afghanistan, we have nearly reached an impressive and almost unsustainably high level of resuscitation, evacuation, repair and rehabilitation of casualties. This has been built over six centuries of indefatigable effort by both surgeon and combatant.

This is the first of several articles, giving an overview of battle damage and its management over time, focussing on some principal or unusual developments. The first two articles deal with the darker ages of war surgery before anaesthesia and, most importantly, antisepsis. Clearly such accounts can only cover selected significant items and, in the main, British innovation. This in no way denigrates contributions of other contemporary European and transatlantic surgeons.

The real dilemma with earlier surgical data is that only works of the foremost visionary men are scrutinised. Until decent casualty records began in 1812, we remained ignorant about the 'usual' standards amongst 'ordinary' military doctors. In 2015, we remember the quatercentenary of the Battle of Azincourt, the bicentenary of Waterloo and the octocentenary of Magna Carta. Until the latter event, combat surgery was limited in scope - exploration of wounds, suturing, splinting, occasional trepanation etc. Amputation, which was regarded as a major and highly risky procedure, was probably only performed through joint spaces, at the junction of viable tissue and 'mortification' (gangrene), or as a completion operation. An inveterate American researcher into mediaeval surgery, in studying many works from the time of Albucasis (936-1013), right through to Guy de Chauliac (1300-1368), has failed to find evidence of a curved dismembering knife before 1300, inferring that amputation between joints was unusual.

The Battle of Azincourt, fought in Northern France on October 25th 1415, saw a small force of around 900 men-at-arms, 5,000 archers (all un-mounted) and numerous civilians (including surgeons), most affected with dysentery, under the iconic leadership of Henry V, completely destroy the cream of Charles d'Albret and the Dauphin's French army (of more than 30,000 men).

Figure 1: A British archer, with no breeches, since many had dysentery. His bow draw was over a 100lbs pull. (Courtesy of Richard Sullivan and Osprey Publishing).

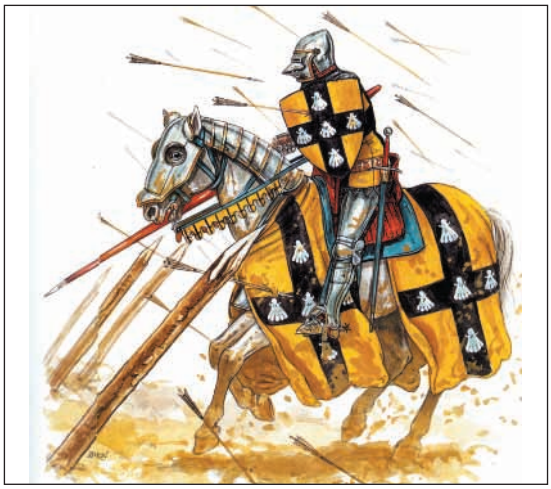


Figure 2: A heavily plate-armoured French knight. (Courtesy of Richard Sullivan and Osprey Publishing).

As we consider the diverse types of trauma that soldiers suffered at Azincourt and such evidence as was revealed at the mass burial sites of the Battle of Towton (1461), we witness severe blunt injury, bone and joint damage, also piercing and chopping wounds of the soft tissues and deep organ damage.

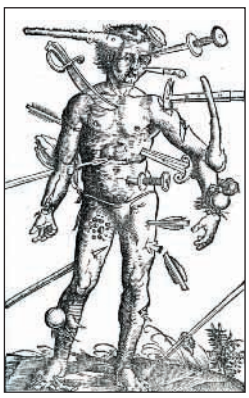


Figure 3: A 16th century 'Wound Man'.

If these injuries were survived (which many were, since there was often a smaller amount of tissue damage compared with firearms/ordnance injury), most healing was procured by nature. Apart from instantly disabling blows from

blunt or sharp weapons, there was evidence of men fired up by battle, continuing their combative role despite serious limb and torso wounding. Bruises could be dressed, cooled and compressed with all types of poultices and fomentations. Slicing incisional wounds were anointed, then sutured with linen or silk or bandaged with linen, calico or lint to obtain apposition. Joint dislocations often proved troublesome to reduce, without adequate analgesia and anaesthesia.

Figure 4: Cranial damage (blunt and sword strikes) from the Battle of Towton. (Courtesy of the Department of Archeology, the University of Bradford)

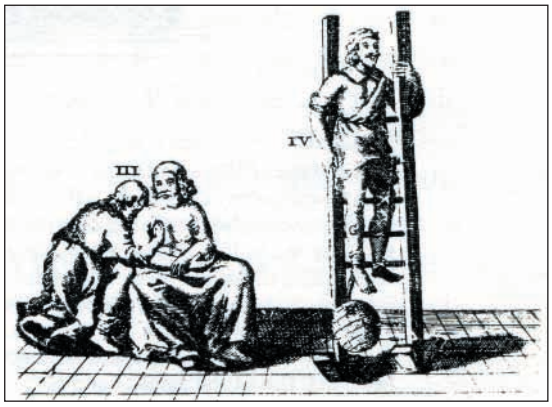


Figure 5: Early attempts to reduce dislocations.

Simple fractures were improperly aligned and 'immobilised' using short splints. Thus, many outcomes were dogged by mal- or non-union. The most troublesome sequela of bony injury was the occurrence of chronic osteomyelitis, with recurrent flare ups of sepsis, characterised by severe constitutional upsets and incomplete discharge of infected sequestra.

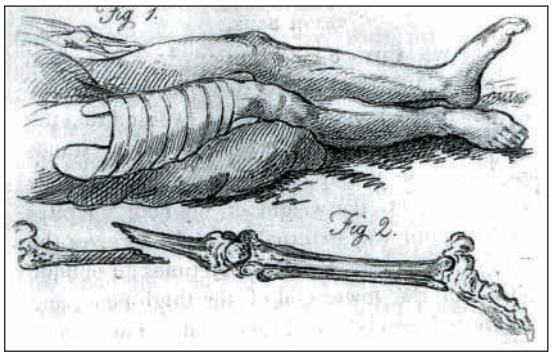


Figure 6: Short splintage for fractured femur.

At Azincourt, the effectiveness of longbow arrow penetration was to be one factor in the successful outcome of the combat on that St Crispin's Day (St Crispin being the patron saint of leather workers). Archers, often maintaining several flights of arrows in the air at once (a desirable rate of fire was 10 aimed shafts per minute), delivered a devastating shower of shafts onto the crowded and disorganised French force. So effective were the British bowmen, Henry warned his men, that if captured, the two relevant fingers of every archer would be amputated by the French. With a greater penetrating power, but shorter range, the Genoese windlass-operated crossbow was no match for the yew longbow. There was a variety of metal tips to the arrows, including some with the ability to pierce chain mail links - with a longer thinner bodkin and shorter-tipped bodkin they could penetrate plate armour - at around 100 yards. Those tips with a variety of barbs were employed in hunting or against horse.

Figure 7: Bodkin (right hand two) and barb-tipped arrow shafts - also (far left) a crossbow bolt.

Bodkin tipped arrows could be simply extracted and, provided no vital organ was damaged, would be pulled out or, as some advised (with barbs) pushed right through for extraction. Centuries before, the Romans had developed a narrow open metal sheath with rolled lip edges that, after wound dilatation, could be slipped down beside the barbs, encasing them, thus allowing withdrawal of the tip without snagging. Crossbow bolts or arrow shafts deeply embedded in bone were a challenge to extract. At the battle of Shrewsbury on 21st July 1403, King Henry IV's 16-year-old son Henry (the victor of Azincourt) received a bodkin arrowhead in his left zygoma. The wooden shaft, but not the hollow metal head, was removed. Days later at Kenilworth, John Bradmore, a London surgeon, dilated the wound with elder tents then inserted a two-limbed screw extractor which he'd had made, through the Prince's cheek and into the embedded hollow bodkin tip. Expanding the ends of the extractor with a central screw and with a gentle rocking motion, he pulled out the missile.

Figure 8: Arrow shaft in the Prince of Wales's face.

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BATTLE TRAUMA HISTORY

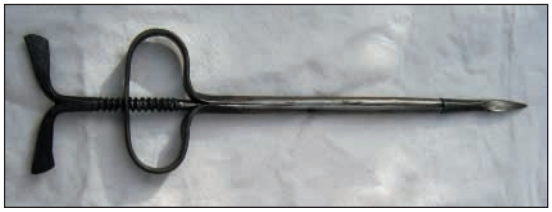

Figure 9: John Bradmore's extractor and engaged bodkin tip.

This, 12 years before Azincourt, despite the fact that Bradmore may have gleaned the idea from an earlier source, demonstrates the innovation and skill of some early surgeons. The wound was irrigated with wine and dressed with a solution of flour, honey and turpentine oil. Some recalcitrant embedded missiles were left in situ, until sepsis supervened and the missile loosened.

At Azincourt, thousands of arrows rained down on the hapless French foot and mounted knights. Crowding, panic and wounded horses and men impeded the ever-pressing rear ranks of the French assault. French knights in heavy (60-80lbs) plate armour were dismounted and crushed or even drowned in the mud. Archers ran out from their barricades and despatched surviving horses and men with hand-held weapons. Plate armour was no guarantor of protection from lead hammers, small arms and longbow arrows. The most notable casualty on the British side, The Duke of Gloucester, was injured by a sword thrust to the groin. His survival indicated that there was no major vascular or visceral damage. Surgery then was all too simple - extracting arrows, dressing non-fatal sword cuts, splinting fractures, closing and exploring wounds and often, pronouncing a fatal outcome for patients with severe head, neck or torso injuries. Armoured personel bearing heavy head protection would rarely dare to lift visors, for fear of airborne or hand-held weapon penetration. Although present, artillery featured minimally in this battle.

Figure 10: A plate-armour helmet - impairing wearer's vision - those which had visors risking injury when lifting the visor

At the time, when our intrepid soldier king engaged a much superior and healthier army at Azincourt, surgeons were attached to high ranking officers and Royalty. Senior amongst these was surgeon Thomas Morstede, who probably witnessed Prince Hal's facial surgery at Shrewsbury. He was Royal Surgeon to King Henry and took 12 colleagues and three archers as bodyguards to France. He was accompanied by another man with a royal appointment, Willam Bradwardyn, with nine assistants. Morstede was frustrated by the rivalry between physicians and surgeons and he was the driving force in the formation of the Guild of Surgeons in 1435. Based on much trauma experience, he wrote the standard text for surgery in the 15th century, the ***Fair Book of Surgery***, in which, for example, he describes in detail the operation of trepanation.

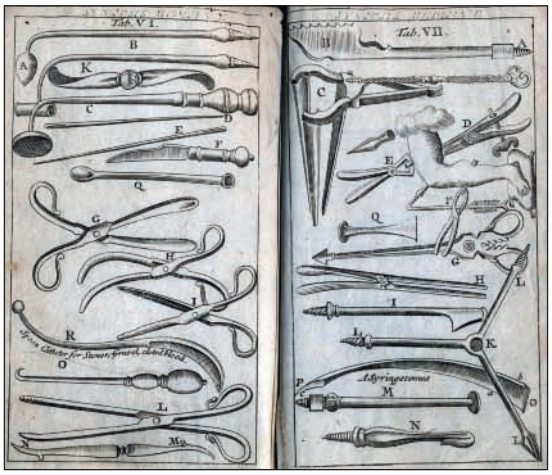

Figure 11: Early 17th century surgical instruments, including cautery irons and cranial instruments.

One of the bugbears of surgery at this times was the use of cautery - employed well into the 17th and early 18th century. This reflected the innefficient management of haemorrhage, especially with general oozing and controlling bleeding in less healthy or deeper tissues. 'Actual cautery' was the use of boiling oil or heated iron instruments to seal wounds and arrest haemorrhage, whilst 'potential cautery' was the use of chemicals (styptics), such as dilute mineral acids, for lesser degrees of bleeding. Cautery was also employed for ablation of granulation tissue or prolific lesions, such as lepromatous or malignant protrusions. With the burgeoning use of gunpowder, cautery was thought useful by removing the 'poisoning' effect of the gunshot. The experience of a French military surgeon, Ambroise Paré (1510-1590), frequently quoted is important because, just as the experience of John Bradmore more than a century earlier, this French surgeon emerges as an observant and pragmatically able surgeon.

Figure 12: Ambroise Paré

Whilst serving at Turin under the Mareschal de Montejan in 1537, he made a seminal observation on the use of heat to manage gunshot wounds. Either as an option or, because the supply of oil of elder/theriac applied freshly boiled had been exhausted, he merely applied a mixture of egg yolk, turpentine and rose oil. We share his delight on finding the wounded men he had treated thus, on the previous day, rested and calmer, with less swelling, pain and inflammation. He subsequently promoted discrete ligature of bleeding vessels, which he first employed at the siege of a French town in 1552.

Undoubtedly, William Clowes (1544-1604) was a leading light in sea and land battle surgery. He was probably the foremost surgical author of the Elizabethan age; writing in English text, he believed in the poisoning effect of black powder.

He designed a chest for military surgeons and wrote on ambulance evacuation and splinting of fractures. In one accident on board, he managed to remove a splinter of bone from a matelot's lung, in-driven by a capstan bar in heavy weather. He referred to a man thrust right through the upper abdomen with a sword, who had pulled out the weapon and asked Clowes for help. Clowes was concerned that the wound was mortal and commented: *"I was unwilling to dresse him, supposing he would die under my hand"*. Relenting his decision, the surgeon put tents into the wound, dressed the entrance and exit wounds appropriately and was surprised at the patient's recovery. This case demonstrates the ability of combatants to continue their activities with potentially mortal wounds and the difficulty of prognosis in deep pentatrating wounds.

As weaponry evolved over the 15th and 16th centuries, metallic weapons partly gave way to the advent of gunpowder, which was first used in Europe in the mid-14th century, at the Battle of Crecy in 1346 (extant since the 9th century in China, the widespread use of cannon and firearms had been slow to evolve). Gunfire radically altered the patterns of injury and delivered a variety of stone and metal missiles, projecting large amounts of kinetic energy, resulting in avulsion of limbs, decapitation and penetrating head and torso wounds. There was more tissue damage, with necrosis and devitalisation of areas traumatised, which critically led to real threat of aerobic and/or anaerobic sepsis.

Figure 13: John Woodall

John Woodall (1569-1643) was another naval surgical pioneer, providing sea surgeons with a work entitled ***The Surgion's Mate***, published in 1617. The work lists instruments and medications for use on warships. He was an orderly, conservative and 'clean' surgeon, who avoided the use of cautery. Digital control of haemorrhage was commonly in use from the 10th to the 17th century. Woodall certainly advised that strong men should be used to restrain the patient for limb surgery, one standing behind the patient, and the other to compress *"… strongly the member which is to bee taken off"*. By 1776, Richard Wiseman (***Figure 16***) had pointed out the inefficiency of this practice and recommended the 'ligature' (tourniquet) round the limb, so that, *"…the vessels are secured from Bleeding, the Member benumbed, and the flesh held steady..."*. Such early tourniquets were usually straps, twisted tight with a rod. A French surgeon named Morel had formally introduced the tourniquet in 1674. This was successfully used for femoral artery ligation in 1688. Not until the early 18th century would the screw tourniquet be introduced, for use in definitive capital surgery. Thus, on the battlefield, then as now, controlling haemorrhage using digital pressure and field tourniquets (with modern haemostatic devices and surgical interventions) continues to play a critical role in battle field survival. Woodall was notable for another important innovation - his promotion of the hand-held (as opposed to the brace model) of trephine for craniotomy, the latter employed mainly by continental surgeons. Woodall's trephine was easier to control, being turned closer to the skull than the brace trepan. He also recommended using a 'quill' or cannula to steady the skin, during the insertion of waxed silk sutures. This was the forerunner of forceps used today for skin closure. This gifted surgeon also recommended elevation of the injured hand and repair of mildly injured exteriorised intestine.

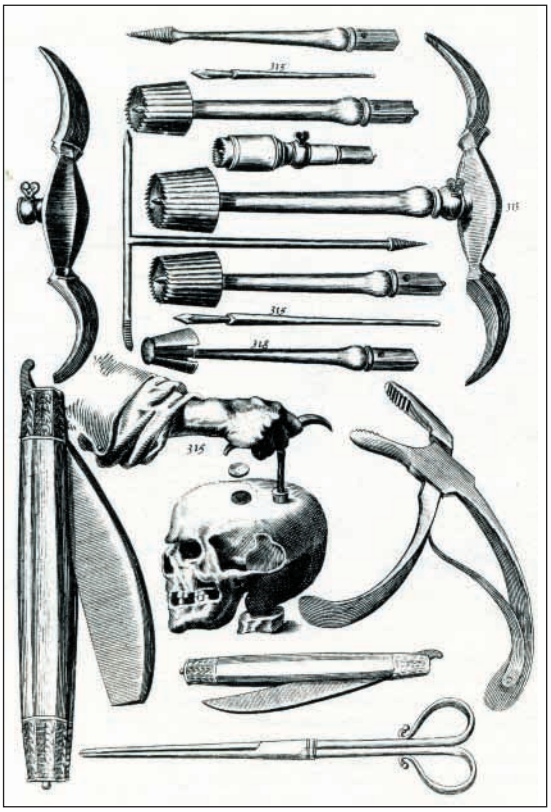

Figure 14: Woodall's trephine and other cranial instruments

In 1621, a certain Richard Wiseman (1621-1676) was born and, after apprenticeship, he served in the Dutch Navy until 1645, when the English (British) Civil War broke out. Wiseman was a Royalist and clearly became an outstanding surgeon. In his management of trauma he was meticulous with documentation and detail, honest with his outcomes and advised that failure was important, noting that: *"Those who come after me may learn what to avoid"*. He also recommended second opinions, where unsure of his own treatment options. His ***Several Surgical Treatises*** was published in 1686 and recorded 129 trauma

Figure 15: Silver cannula to push against the hand-held skin suture needle to steady the skin.

cases managed between 1645 and 1675. He was an advocate of foreign body removal and extending the wound surgically for improved exposure. Clearly ahead of his time, he recommended some excision of dead and loose tissue. An advocate of early amputation after significant limb injury, he also recognised when it was inappropriate to close some wounds primarily, and advised leaving complex wounds open. All too often at this time, injured tissues were dressed with a large variety of salves and applications, which were of little therapeutic value. Worse still, wounds were stuffed with tents and charpie (a sort of linen waste). Promoting the early reduction of fractures and closing the skin of compound breaks, he bound the fracture with roller bandages for some days and afterwards, applied external splints.

Figure 16: Richard Wiseman

Wiseman's description of head wounds and torso injury were about as advanced as could be expected for the time. His works are full of common sense, founded on a clear understanding of applied anatomy, wound 'behaviour' and herbal therapy. With much experience, he remarks on the immediate management of injuries with in-driven material: *"The part is at [the] first dressing to be cleared with what diligence you can of all such forrein bodies as have made violent intrusion into it, while the Patient is warm with the heat of Battel, and the wound frefh, and very little altered by either air or accidents: Upon which consideration lefs Pain must neceffarily follow upon the Extraction"*. He also points out that metal missiles might easily lie dormant in tissues without much harm coming to the patient but he warns: *"…let nothing of this encourage you; for the Bullet pierceth not any Part without carrying Rags (clothing) along with it, which corrupt in the VVound, and make Apostemations (septic foci), occasioning a prolonging [of] the cure…."*. After 20 years of itinerant practice, at the Restoration of Charles II, he was appointed one of three Sergeant Surgeons to the monarch.

Figure 17: Instruments belonging to Sir Francis Prujean (President of the Royal College of Physicians of England 1650-1654), typical of the mid 17th century surgical armamentarium. (© and courtesy of the Royal College of Phycisians of England)

From the 1st century AD until the 14th century, amputations were relatively infrequently performed, usually more distally in the limb, through joint spaces or at the junction of dead and healthy tissue, to minimise blood loss. But gunpowder was to change all that. Belief in a 'poisoning' effect of the powder and the burgeoning numbers of contaminated compound limb injuries during the 16th century meant that amputation, despite very real risks, was increasingly to find its way into the military surgeon's armamentarium. By the late 17th century, immediate guillotine amputation for shattered limbs was increasingly performed. Not long after Wiseman's demise, surgeon James Yonge (1646-1721) became a prominent advocate of soft tissue flap formation, to improve cover of limb bone ends following amputation. He is said to have carried out this innovative manoeuvre in 1679. It would be over 100 years before flap formation would become *de rigeur* amongst battle surgeons. The guillotine amputation had remained speedier and simpler for combat conditions and less experienced surgeons.

Figure 18: The circular or 'guillotine' amputation.

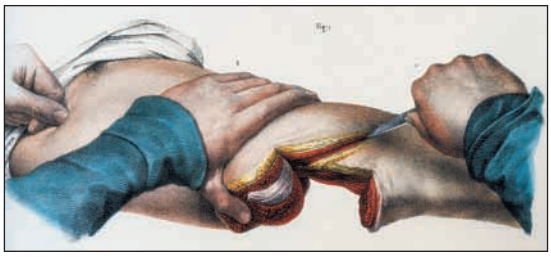

Figure 19: The flap method of amputation.

The persistence in performing any such inferior operation as the latter reflects the lack of efficient communication, regulation and information amongst poorly regulated service personnel. It also emphasises the lack of military medical training colleges, an issue not to be tackled until the mid-nineteenth century. As the world engaged with the Age of Enlightenment (c.1650 - c.1800), how much would the challenges of war injuries and altered surgical practice change and improve? As the 'Age of Reason' arrived, what legacy would this period of history leave to the injured soldiers and sailors?

FUTURE SHAPE OF TRAINING REVIEW

Professor Nicholas P Gair
Chief Executive, ASGBI

Introduction

The final report, entitled ***Securing the future of excellent patient care***, of the independent review on the future **Shape of Training**, led by Professor David Greenaway, was published at the end of October 2013. Immediately following this, the Association of Surgeons of Great Britain and Ireland (ASGBI) held a Future Shape of Training 'Think Tank' over the weekend of 1st to 3rd November 2013, in Belfast.

Attendance

In addition to the Association's Executive Board, the following specialty groupings were represented at the meeting:

- Association of Breast Surgery (ABS)
- Association of Coloproctology of Great Britain and Ireland (ACPGBI)
- Association of Upper Gastro-Intestinal Surgeons (AUGIS)
- Association of Laparoscopic Surgeons (ALS)
- Association of Surgeons in Training (ASiT)
- Association of Surgeons in Primary Care (ASPC)
- British Association of Endocrine and Thyroid Surgeons (BAETS)
- Vascular Society (VS)

The following were also represented:

- SAC in General Surgery
- Intercollegiate Examination Board in General Surgery

The following specialty groupings were invited, but were not able to be represented at the meeting:

- Association of Trauma and Military Surgery (ATMS)
- British Association of Day Surgery (BADS)
- British Transplantation Society (BTS)

Key Messages

The "key messages" of the report (taken from the Review's website) are as follows:

- Patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations.
- We will continue to need doctors who are trained in more specialised areas to meet local patient and workforce needs.
- Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties.
- Medicine has to be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers.
- Local workforce and patient needs should drive opportunities to train in new specialties or to credential in specific areas.
- Doctors in academic training pathways need a training structure that is flexible enough to allow them to move in and out of clinical training while meeting the competencies and standards of that training.
- Full registration should move to the point of graduation from medical school, provided there are measures in place to demonstrate graduates are fit to practice at the end of medical school. Patients' interests must be considered first and foremost as part of this change.
- Implementation of the recommendations must be carefully planned on a UK-wide basis and phased in. This transition period will allow the stability of the overall system to be maintained while reforms are being made.
- A UK-wide Delivery Group should be formed immediately to oversee the implementation of the recommendations.

Thus, the Association's Belfast 'Think Tank' was a timely and extremely productive meeting. A full day of debate was also made very sociable through the generous support of 'Visit Belfast', and attendees were able to continue discussions over a most enjoyable civic dinner at the Titanic Centre.

Attendees at the ASGBI 'Think Tank' and their partners enjoyed a social dinner at Titanic Belfast. *(Photo: Peter Sedman)*

Response from ASGBI

Following discussion on the above 'key messages' of the report at the Belfast 'Think Tank', the Association will, over the coming few weeks, be drafting an initial response. Once this has been seen by all those attending the Belfast meeting, and approved by the Executive Board, this will be disseminated to all Fellows.

ASGBI 2014 Congress in Harrogate

The Association is delighted that Professor David Greenaway has already agreed to lead a major symposium on the 'Shape of Training Review' at the 2014 ASGBI International Surgical Congress in Harrogate, which will be held from 4.00pm to 5.30pm on Wednesday 30th April 2014 in the main Auditorium at the Harrogate International Centre. Further information on this symposium, and the Congress, can be accessed at:
www.asgbi.org.uk/harrogate2014

Conclusion

ASGBI recognises that the Report of the Shape of Training Review is, by definition, high level and broad in scope. As such, the "devil is in the detail", and ASGBI looks forward to working with the UK-wide Delivery Group (when appointed) to refine and implement the recommendations of the Review for the benefit of the profession, successive generations of trainees and future high-quality patient care.

The final report of the independent review on the future **Shape of Training** is available to download at:
http://www.shapeoftraining.co.uk/reviewsofar/1788.asp

Acknowledgements

ASGBI is extremely grateful to '**Visit Belfast**' for hosting the Association's Future Shape of Training Think Tank over the weekend of 1st to 3rd November 2013. We would also like to thank the Hilton Hotel, The Merchant Hotel and the Titanic Centre for their hospitality, and the Lord Mayor of Belfast, Councillor Máirtín Ó Muilleoir, for his warm welcome to the city.

SURGEONS AND PRODUCT LIABILITY ARISING FROM THE USE OF IMPLANTS AND MEDICAL DEVICES

Greg McEwen, Partner at Berrymans Lace Mawer LLP

Dr Dan Kremer, MPS Medicolegal Adviser

We are very pleased to have been invited to contribute this article to the ***JASGBI***, as a follow up to ASGBI's 2013 ***Issues in Professional Practice*** booklet on *The Collective Management of Risk from Surgical Implants and Devices*.

Product liability relates to the manufacture, supply and sale of goods. The benefits of membership of medical indemnity organisations, such as the MPS, do not include indemnity for product liability claims.

Surgeons may not think of themselves as suppliers of goods. However, recent cases have highlighted the potential risks for surgeons and clinics who find themselves identified in the chain of supply. Few will have missed the publicity surrounding DePuy metal on metal hips and PIP breast implants. These examples have shown that, where there are difficulties holding manufacturers to account for potentially defective products, resourceful claimants will look to pursue other potential targets, including the surgeons that "supplied" the product at the point of implantation. In these circumstances, claims directed towards individual surgeons have included allegations not only in contract, but also in negligence. For example, when it comes to metal on metal hips, it has been argued in some cases that surgeons have failed to properly fit the prostheses and that injuries allegedly sustained by the claimants arise from improper surgical technique.

The demise of the French manufacturer PIP has been the subject of intense international media scrutiny, since regulators highlighted issues with the implants in March 2010. PIP founder Jean-Claude Mas stood trial for fraud earlier this year in the wake of the scandal. PIP's insolvency (and inadequate insurance arrangements) meant that the recipients of the implants were unable to pursue a claim against that company. How does the product liability regime operate in such circumstances and what causes of action will claimants be able to pursue against those who have acted as suppliers?

The term "product liability" has evolved to address the civil liability of manufacturers, suppliers and importers where injury or damage is caused by products which are defective and/or not of satisfactory quality. English law divides product liability law into two main areas, depending upon whether the liability relates to a contract or to a legal duty owed by one person to another. These causes of action can provide claimants with alternative avenues for redress and have the potential to overlap between different parties in increasingly complex chains of supply. Further complexity is introduced where different parties are based in different jurisdictions and subject to different laws.

The division between breach of contract and breach of a legal duty can become complex when considering the supply of medical devices, as was the case with PIP implants. To understand the reasons why surgeons may find themselves in the firing line, it is necessary to understand the development of the EU regime for ensuring redress for consumers.

Driven partly by the thalidomide tragedy, a general shift towards the adoption of a system of strict liability, in which proof of negligence was no longer required, led to the EU Product Liability Directive 85/374/EEC, implemented in England by the Consumer Protection Act 1987. The Directive was intended to balance the interests of consumers and manufacturers, and introduced a regime whereby consumers who suffered injury or loss caused by a defect in a product were able to pursue 'no fault' claims against the producer of that product (or, alternatively, other potential defendants including those who had taken steps to 'own brand' products, importers from outside the EU and a limited range of other suppliers of goods including retailers in some circumstances).

The critical test for claims to succeed under the legislation is focused on the concept of defect and is defined at Section 3(1) of the Consumer Protection Act 1987 as whether the safety of the product is "such as persons generally are entitled to expect". The legislation provides the factors which should be taken into account when determining whether this requirement is satisfied; these include the manner in which the product has been marketed, any instructions included with the product and the expected use of the product.

Interestingly, the number of cases tried in relation to claims under the Consumer Protection Act has been low and thus, there are few judgments which provide guidance on the court's interpretation of the various aspects of the legislation, including the assessment of what constitutes a defect.

As the manufacturer of the relevant implants, the French company PIP would ordinarily be the appropriate party for claimants to pursue. However, as is highlighted above, due to their insolvency, PIP was not a viable defendant. As such, the claimants' lawyers were required to find alternative causes of action against other parties, in order to preserve their clients' claims.

In reliance upon the contractual relationship and the cause of action available under the sale of goods legislation, the claimants' contractual suppliers were identified as the only alternative party to pursue (being either the clinic or the surgeon). As with the Consumer Protection Act, a significant advantage of a claim in contract is that of "no fault" liability. Liability is considered to be "strict", meaning it is determined with reference to the qualities of the

product and not the defendant's actions. A key disadvantage for some, however, is that claims for liability in contract are restricted to the immediate contracting parties.

In the PIP scenario, the claimants are therefore required to identify who they had contracted with for the supply of the implants. Some claims have been pursued against the clinics, seeking a contractual remedy under the Supply of Goods and Services Act 1982, alleging that the implants were not of satisfactory quality. For the purpose of considering whether a product is of satisfactory quality, the test of safety applied will be very similar to that under the Consumer Protection Act detailed above. In other cases, however, the party who contracted with the claimant for the supply of implants has been identified as the individual surgeon, as opposed to the clinic.

The identification of the appropriate defendant depends on a number of factors, which may include the following:

- Who the patient initially contacted to enquire about the surgery; the surgeon in their personal capacity as an independent Consultant, or the Clinic.
- The location of the initial consultation.
- The patient's records - do these consist of standard documents (e.g. consultation standard form checklists) which were produced by the clinic?
- Was the payment made by the claimant directly to the surgeon? In some cases, surgeons have 'hired' beds and theatre space from clinics or hospitals, and been invoiced accordingly for this by the clinic or hospital. This may be deemed to indicate that the clinic or hospital's only role was to provide facilities for surgery. Furthermore, if the clinic does not invoice the claimant directly, it is less likely that the clinic will be considered to have contracted directly with the claimant.
- Who sources the implants? In some cases, the surgeon may be the party who contracted with the claimant, but the clinic will have supplied the implants to the surgeon in any event.

While the doctor may have a potential contractual liability to a patient, as with any party in the chain of supply, there may also be a right of contractual indemnity from the supplier/distributor next in line up the chain. Other causes of action may also exist and the need to identify targets for indemnity should be considered at the earliest opportunity.

Inevitably, similar issues may arise in relation to a wide range of every day products supplied by healthcare professionals, from dressings to drugs to implantable devices. Where a patient or consumer enters a contract of supply with a healthcare professional, terms will be implied into the contract that the goods will be of satisfactory quality. Any breach of that implied term will provide an opportunity to claim for redress.

Doctors should, therefore, be wary of making statements to patients that could be deemed to amount to a warranty (e.g. the expected life of an implant), or the promotion of a particular product. Any blurring of the boundaries between the consent process and selling a product could provide an opening for a dissatisfied patient to argue that their consent to a procedure was conditional upon assurances given by the surgeon as to the quality or durability of the product selected. Beware of statements such as "this should last a lifetime", which begs the obvious question "whose lifetime?". The recipient of breast implants way well place a different emphasis on the expected life of the product than the recipient of a replacement hip.

KEEP YOURSELF SAFE

Although it is all but impossible in practice to completely avoid the potential for claims to be brought by dissatisfied patients, steps can be taken to keep such claims to a minimum and to assist in a robust rebuttal of those that are brought. The key, invariably, lies with thorough record keeping. As well as maintaining clear and comprehensive clinical notes, encompassing the consent process, surgeons are advised, where possible, to retain the following documentation in relation to products utilised, to protect themselves in the event of a product liability claim:

- Evidence of purchase.
- The product serial number, which can be used to identify the relevant product batch.
- Any terms and conditions.
- Express warranties and guarantees.
- Instructions and packaging.
- Correspondence regarding product specifications and any alterations.
- Where whole goods are transported by an external logistics company, relevant contracts/terms/correspondence.
- Any relevant complaints history relating to the product or similar products.
- Order forms, emails, faxes etc.

The MPS remains committed to supporting its members. Whilst not providing an indemnity for product liability claims, we will seek to prevent the development of litigation targeting individual clinicians in place of other, more appropriate sources of redress. Inevitably however, there will remain some cases where, faced with a manufacturer or supplier that is abroad, insolvent or both, a potential claimant sees their surgeon as an easier target to pursue. Surgeons are hence advised to take whatever steps they can to protect themselves and, where necessary, seek advice from their defence organisations.

LESSONS FROM ARMED CONFLICT: TRAUMA CARE OF WEAPON WOUNDED PATIENTS, THE ICRC EXPERIENCE

Harald Veen
Chief Surgeon for the International Committee of the Red Cross, Geneva

The International Committee of the Red Cross (ICRC) is a neutral, independent and humanitarian organisation, which was founded in 1863. The mandate, role and activities of the ICRC encompass the protection and assistance of the victims of armed conflict and other situations of violence. Assistance programmes are now run according to a public health approach while reassuring that the health needs of patients/victims/detainees are fully addressed at different levels of care; first aid, primary healthcare, hospital, physical rehabilitation and mental health, and psychosocial. Health activities in armed conflict and other situations of violence remain a pillar of the ICRC's identity. The ICRC implements its health programmes mainly through supports to the local health structures and ICRC independent health facilities, with a particular focus on quality of care, professionalism and proximity to the victims. In addition, the ICRC endeavours to alleviate some of the suffering through co-operation with its partners within the International Red Cross and Red Crescent Movement

The world currently agrees on the 'rules of war', as described in the Geneva Conventions and its additional protocols. In case of an armed conflict, the ICRC has the mandate from the international community to be present and engage the warring parties, to monitor and promote the implementation of these rules, and assist the victims. This engagement of ICRC in war zones implies surgical treatment of weapon wounded patients.

War surgery is different from 'regular' traumatology. Appropriate treatment of patients with gunshot wounds, or blast injuries, demands a specific approach. Rarely, our colleagues in new war zones are well prepared for this. As a result, many patients suffer infections due to inadequate treatment. ICRC tries to limit this avoidable suffering by assisting the local colleagues, or conducting substitution surgical programmes.

Over the past decades, there have been many independent ICRC hospitals, and ICRC supported hospitals. In 2012, ICRC supported the in-hospital treatment of 14,280 weapon wounded patients and 114,341 non-weapon wounded patients in 26 countries in different war zones, who underwent a total of 133,131 operations. At any time, we have around 10 surgical expat teams in the field.

The initial treatment of trauma patients has changed with the introduction of the Damage Control principles. In the past twenty years, survival chances have improved for those with immediate access to high quality care. For the wound management of these patients, old lessons apply. The most important skill that has to be re-learned in every conflict is the adequate Wound Debridement. This is the surgical removal of all the contaminated, infected, non-viable tissue. After, the Debridement wounds are left open, with a Delayed Primary Closure after about five days.

For fracture treatment in penetrating injury, there is no place for internal fixation in the initial treatment. The risk of infection has proven to be too high. Recent publications and presentations from the American [1] and French [2] military colleagues mentioned a 20-40% infection rate. The policy of the British [3] military states that there is no place for internal fixation in the initial treatment of fractures in penetrating injury, and that it will not be accepted that wounded British military personnel will undergo such a treatment in any other health facility.

ICRC started promoting these protocols around 25 years ago, with publications from the ICRC chief surgeons at that time, Robin Coupland and Robin Gray. An intensive co-operation, over the past two decades, with the Swiss Ballistic Institute under Beat Kneubeuhl, has resulted in a better understanding of the effects of bullets to the body. Recently, the ICRC experience of treating weapon wounded patients has been described in a new manual. The second and final volumes of this ICRC's new War Surgery book has just been launched. The manuals are available via the ICRC website also with a free downloadable version [4].

We all have a responsibility to deliver safe quality care to the patients in need. The WHO has now taken the initiative to define minimum quality standards via the FMT (Foreign Medical Team) working group, with ICRC's participation. An intended international register with available teams and their specific skills may improve the assistance to victims of future disasters and conflicts.

Special challenges are imposed by the circumstances of working with limited resources, in an austere environment. The surgeon is often alone, without specialist back-up, with only essential equipment. He/she needs to be a trauma surgeon with a broad variety of skills, hard to find in current practice with the trend of super-specialisation. Required skills are the full traumatology, including the stabilisation of fractures, as well as dealing with surgical emergencies such as Caesarean sections and strangulated hernias. ICRC runs a global programme of war surgery seminars and trauma resuscitation training (around 70 courses per year), to prepare the colleagues. Instructors for these courses would be welcome. A recent attempt to meet the demand for further training of surgeons before going on mission is the new Surgical Training in the Austere Environment (STAE) course at the Royal College of Surgeons of England in London. As a one week extension of the Definitive Surgical Trauma Skills course, it teaches the necessary skills hands-on in the cadaver-lab of the RCS. There is a lot of demand for this course.

Where traditionally there is a distance between military and humanitarian medicine, now mutual respect and recognition is growing, knowing that we treat patients with the same pathology. Establishment of the new Association of Trauma & Military Surgery (ATMS) by ASGBI is most welcome, and ATMS can play an important role in sharing experiences with the humanitarian colleagues, defining quality standards, and providing training.

Colleagues who would want to contribute to the alleviation of suffering victims in armed conflict should consider making themselves periodically available. They will be welcomed by ICRC or the established NGOs. The duration of ICRC surgical missions is mostly three months, however, frequently, there are shorter missions. Colleagues going for an ICRC mission have a short-term contract, with proper arrangements for salary and insurance. Applications can be submitted via the ICRC website, or via the author (contact details below).

Assisting wounded people in armed conflict is rewarding, and is also of benefit to the patients and the hospitals at home, due to the experiences and the newly acquired skills.

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[2] Presentation during the European Congress of Trauma & Emergency Surgery, Lyon 2013

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MAJOR TRAUMA NETWORKS AND THEIR IMPLICATIONS FOR GENERAL SURGERY

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Introduction

Major trauma describes serious life- or limb-threatening injuries that most commonly occur as a result of road traffic accidents, falls or assaults. In the UK, major trauma is the most common cause of death in people under the age of 40, resulting in around 5,400 deaths per annum [1]. For every death there, are 3-4 other patients who suffer life-long disability as a result of major or moderate trauma. Trauma is most commonly classified using the injury severity score (ISS), an internationally recognised, anatomical scoring system which retrospectively assigns a measure of severity ranging from zero to 75, with a score of 16 or greater signifying major trauma [2]. Mortality increases with injury severity score, and a score of 75 signifies injuries that are unlikely to be survived.

In 2007, 'Trauma: who cares?' The National Confidential Patient Enquiry into Patient Outcome and Death, found that almost 60% of trauma patients had a standard of medical care that was less than good practice [3]. The UK was estimated to have an in-hospital mortality rate for major trauma that was 20% higher than in the USA or Australia. The Department of Health appointed Professor Keith Willett as the first national clinical director for trauma care in 2009. Under his chairmanship, a Clinical Advisory Group was established to advise on the development of major trauma networks; the low incidence and high complexity of major trauma means that it is not feasible or cost-efficient to expect all hospitals to be able to manage such patients, but rather a system-wide approach is required with ready access to specialist major trauma centres (MTC) for patients with the most severe injuries [4]. Key recommendations of the Clinical Advisory Group with relevance to general surgery are shown in ***table 1***. The National Audit Office report, 'Major Trauma Care,' in 2010, highlighted the financial cost of major trauma; the cost to the NHS for the immediate treatment of major trauma was estimated to be between £0.3 and £0.4 billion. The costs of subsequent hospital care, rehabilitation, home care or informal care was estimated at between £3.3 and £3.7 billion [1].

The first major trauma networks in the UK went operational in London in 2010. Each network comprises a hub and spoke model of trauma units (TU) and local receiving hospitals (LRH) based around a major trauma centre (MTC). The MTC has all the clinical specialties that might be required to treat a patient with major trauma, with consultant availability 24 hours a day. A TU is a hospital that has more limited facilities, being able to stabilise and transfer the most serious cases, but able to admit and manage less severe injuries. A LEH is a hospital that does not routinely receive acute trauma patients (excepting minor injuries). It should have processes in place to ensure that, should this occur, patients are appropriately transferred to a MTC or TU. Networks outside of London went live from April 2012, with 12 MTCs designated for the care of both children and adults, eight MTCs for adults only, four MTCs for children only and two collaborations of hospitals in Manchester and Liverpool (***Figure 1***).

1. Major trauma teams should be consultant led. There should be a 24 hour presence on-site and immediately available. The major trauma team should comprise members from emergency medicine, anaesthesia/intensive care, general surgery and orthopaedic surgery.
2. Emergency trauma surgery should be performed by a consultant surgeon with appropriate skills and experience.
3. All emergency trauma surgeons should understand the principles and techniques of damage control surgery.
4. There should be 24-hour access to a fully staffed and equipped emergency theatre.
5. General surgery and orthopaedic surgery senior trainees should be on-site 24 hours a day. Consultants should attend within 30 minutes for the acute management of injuries.
6. Vascular and cardiothoracic consultants should be available for consultation to the Trauma Network 24 hours a day, and must attend within 30 minutes to the Major Trauma Centre.

   Within Major Trauma Centres, patients' care should be overseen and co-ordinated by a Trauma Service. All major trauma patients should be admitted under the primary care of one of the Trauma Service consultants. The Trauma Service should include a care and rehabilitation coordinator (Major Trauma Coordinator) who is responsible for coordination and communication regarding the patient's current and future care and rehabilitation.

Table 1: Key recommendations of the clinical advisory group with relevance to general surgery

Implications for the major trauma centre

Prior to go-live, trauma networks developed pre-hospital trauma bypass tools to assist paramedics in deciding which patients would benefit from bypassing a nearby hospital and go direct to the major trauma centre. In addition, in the Wessex region, an automatic acceptance protocol was developed for those patients who initially attended a hospital distant to the MTC but who required emergency definitive care not available outside the MTC. It was estimated that each hospital that was not designated as a major trauma centre within the Wessex region would see around 10-20 fewer cases of moderate to severe trauma as a result of these changes.

Measures designed to reduce severe haemorrhage have moved from the combat field to civilian practice. These include the use of scoop stretchers rather than long spinal board (thus reducing the amount of movement each patient undergoes), the use of combat tourniquets and application of haemostatic dressings. Additional training and education was provided for all paramedics in this region.

Within the MTC, a trauma team was established including senior staff from general surgery. Additional training was provided for all staff that

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were likely to be involved in the management of major trauma. This included two consultant surgical training days, monthly trauma team moulages and a trauma intermediate life support (TILS) course for nurses and allied healthcare professionals. Attendance at the Royal College of Surgeons 'Definitive Surgical Trauma Skills' (DSTS) course was recommended for consultant general surgeons.

Impact on the MTC

In the first year of operation, the MTC at Southampton saw 335 patients with an ISS >15 (major trauma) and a further 301 with an ISS 9-15 (moderate trauma). These figures reflect an increase of 16% for ISS >15 and 41% for ISS 9-15 compared to the previous year. Median time from arrival to having a trauma computerised tomography (CT) scan fell from 1.9 hours to 1 hour. There was an increase in the percentage of occasions where a consultant saw patients with an ISS >15 within five minutes of arrival, from 29% in 2011/12 to 78% in 2012/13. 10% of trauma admissions went direct to the operating theatre from the emergency department. 20% of patients went to one of the adult intensive care units (general or neurosciences). The percentage of patients going direct to a general surgical ward area was low (1.9%). Roughly 10% of patients were paediatric (<16 years).

The total number of trauma patients requiring operations increased by 37% in the first year with the total theatre time increasing by 50% for trauma cases. The median time to theatre for patients, with an abbreviated injury severity (AIS) score of ≥3 for abdominal injuries fell from 5.9 hours in 2011/12 to 2.4 hours in 2012/13. The percentage of occasions when a consultant surgeon was present during the initial operation for patients with AIS ≥3 abdominal injuries increased from 67% in 2011/12 to 86% in 2012/13.

Thirty-five patients satisfied the Wessex Trauma Network automatic admission criteria, designed to reduce the time taken for critically ill patients requiring specialist surgical skills to receive definitive care. Of these, the majority (32) were for severe head injuries. Two patients required emergency transfer for the management of intra-abdominal haemorrhage that could not be managed locally. A further 141 patients were transferred to the MTC within 48 hours for specialist but non-emergent care. The majority of these were for spinal or pelvic injuries.

Implications for consultants

Trauma centralisation and a progressive increase in the demand for emergency general surgery have promoted the earlier and closer involvement of senior surgical staff in the management of the critically ill. Within our MTC, we elected to develop a weekday, acute service with no elective commitments based on three general surgeons. The consultant is available on an extended daytime rota from 0800-2100, is the surgical bleep holder and responds as part of the major trauma team. A senior trainee provides out-of-hours cover during the week with the consultant available within 30 minutes. The gastrointestinal surgeons provide weekend cover which helps to maintain their acute surgery experience. Demand and the need to improve continuity by providing internal cover in the acute team have led an expansion to four consultants from December 2013. Separate rotas for hepatobiliary, vascular, thoracic, cardiac and neuro-surgery support the acute surgical rota and there is a separate paediatric trauma rota. This subspecialty support has helped remove a lot of the anxiety felt as a general surgeon. The DSTS course at the RCS has been universally highly rated and while the lessons taught may never be used, those who have attended the course feel less vulnerable.

Having a small, regular general surgery team has facilitated a close working relationship with the emergency department and the extended trauma team. The vast majority of major trauma patients received by a MTC outside London or a major metropolitan centre do not require prolonged general surgical involvement, with the surgical specialist being able to stand down shortly after completion of the trauma CT scan. The increasing experience and confidence within the major trauma team has enabled the vast majority of patients to undergo CT scanning. This is particularly important when there is a haemodynamically concerning patient with a severe head injury; a trauma CT scan can be helpful in avoiding an immediate and negative laparotomy/thoracotomy. Senior surgical decision-making has also allowed some trauma patients to be managed non-operatively or with increasing use of interventional radiology. Where emergency surgery is required, senior involvement ensures that this is timely and appropriate. The application of damage control surgery has become widely accepted [5, 6]. Newer developments such as REBOA (resuscitative endovascular balloon occlusion of the aorta) have helped to save patients who previously would have almost certainly died shortly after admission or of multi-organ failure on the ICU [7].

Implications for trainees

The impact of introducing a national trauma system on general surgical training is yet to be objectively evaluated. To date, there has been no published 'before and after' studies assessing the effect on trainee logbooks or competence in trauma related procedural skills. When 'on-call,' both core and specialty general surgical trainees are expected to attend trauma team activations; there are no separately staffed trauma rotas for juniors. Therefore, how the reorganisation of trauma care has impacted trainee experience has been largely determined by the designation of the centres at which they rotate through during their training programme.

Anecdotally, trainees working in TUs have reported a reduction in exposure to management of patients with life-threatening thoraco-abdominal or multisystem injuries. Patients requiring emergent general surgical intervention are now rarely received at these units and a trainee is highly unlikely to experience a trauma laparotomy or thoracotomy whilst on placement there. Whether the trainee interprets this development favourably or unfavourably will depend upon their personal interests. Regardless, they are likely to end up attending a higher ratio of cases that do not require general surgical intervention. This could become tedious, frustrating and an unproductive distraction from other emergent on-call learning opportunities. Conversely, trainees working in a MTC will experience more frequent involvement in general surgical interventions for trauma victims [8]. Importantly, because of the higher institutional commitment, these episodes are more likely to be supervised by a senior with an interest in developing the technical trauma skills of their junior. A period of 12-18 months working within an MTC during

rotation may be sufficient for a specialty trainee to acquire operative ability sufficient to meet the demands of the Intercollegiate Surgical Curriculum Programme syllabus [9]. Specifically, they must become competent to arrest haemorrhage (by packing, suture, ligation or resection) and repair or resect intestinal injury without assistance. Achieving this working solely within TUs is difficult to envisage.

At present, there is no defined training route for individuals with an interest in becoming a specialist consultant trauma surgeon. The Royal College of Surgeons of England is currently compiling a report that should illustrate the need for, and define the shape of, this cadre [10]. Such trainees could elect to rotate into a MTC towards the end of their programme as well as conducting a post- CTT (Certificate of Completion of Training) fellowship. This can be supplemented by attendance on the DSTS course and out of programme secondments. More opportunities are likely to become available and easier to access as attention focuses on developing the specialist workforce to compliment our new trauma system. However, the attractiveness of a career in trauma surgery is increasingly limited by progression of non-operative means of managing physical injuries. The North American solution to this conundrum was to combine trauma and emergency surgery into a distinct specialty called Acute Care Surgery [11]. Separation of emergency and elective surgical workload was considered and rejected by a consensus conference of the Association of Surgeons of Great Britain and Ireland in 2007 [12]. With some UK hospital trusts, including Southampton, already appointing dedicated emergency surgeons, a cohesive solution to this divisive workforce issue is urgently required to guide current and prospective trainees.

Discussion

In the first year of operation, NHS England reported that the mortality from major trauma had fallen by 20% [13]. This equates to around 1,000 additional lives saved, with many more experiencing an improved outcome. These successes have led to new challenges. Major trauma is more common at weekends and early evenings; as such, many patients continue to be received by the resident surgical registrar. There is now frequently pre-admission information and it is important that trainees anticipate when they may make a patient's care vulnerable because of their inexperience. The duty surgical consultant must be contacted if they are not in the hospital. Although our data indicates that the general surgical consultant is usually in attendance for life-saving surgery, this is not the case for all surgical specialties. The current training of trauma skills needs updating to accommodate our new model of care and new knowledge, including damage control surgery, permissive hypotension and blood replacement protocols. Outside our major cities, penetrating trauma is rare. As we are always going to be relatively inexperienced in managing these conditions, the DSTS course needs to be more widely available and perhaps mandatory before completion of training.

Centralisation of major trauma care has resulted in the biggest improvement in outcome for severely injured patients over the lifetime of the NHS. The medical workforce and hospitals will need to adapt and redistribute to allow this process to progress and excel. It is likely that all other low incidence and high complexity surgical conditions will also be candidates for centralisation.

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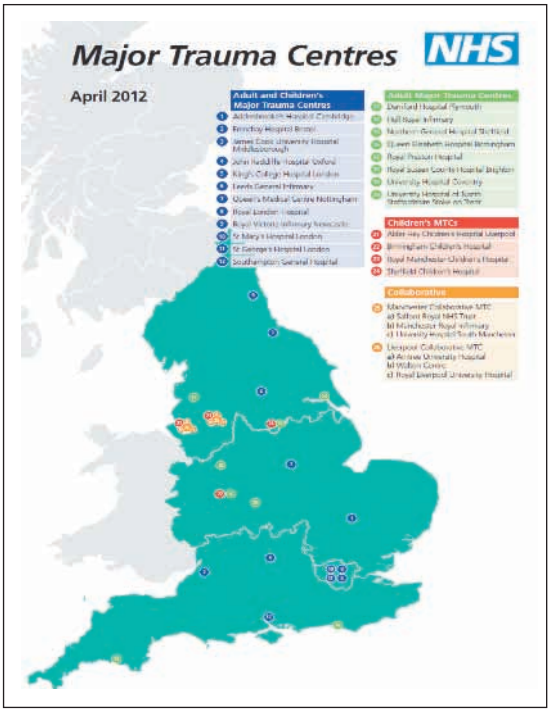

Figure 1: Major trauma centres within England (April 2012)

ATMS
ASSOCIATION OF TRAUMA & MILITARY SURGERY
Issue 5, Winter 2013

The Association of Trauma & Military Surgery (ATMS) is eagerly looking forward to our forthcoming conference, to be held in parallel with the first day of the ASGBI International Surgical Congress, in Harrogate on Wednesday 30th April 2014.

To deliver our eponymous Guthrie Lecture, we are delighted to welcome a distinguished trauma surgical visitor, Professor David Hoyt, Executive Director of the American College of Surgeons. Dr Hoyt obtained his medical degree from Case Western Reserve University, Cleveland, Ohio in 1976 and began his career at University of California San Diego School of Medicine. He was, in turn, resident, research fellow and senior and chief resident. He joined the faculty in 1984 at UCSD and immediately became involved in the Trauma Services as a Director of the Surgical Intensive Care Unit. He subsequently served as Director of the Division of Trauma, Burns and Critical Care at the San Diego Medical Centre from 1989 to 2006, prior to taking up the post of John E Connelly Professor of Surgery, University of California. Since 2009, he has been the Executive Director of the American College of Surgeons.

He has been involved with the work of the American College of Surgeons Committee on Trauma since 1980, and was chair from 1998 to 2002. He is a member of the National Faculty for the Colleges Advanced Trauma Life Support course and is a coordinator, instructor, and director of training for ATLS. Dr Hoyt was awarded the American College of Surgeons' distinguished service award in 2007.

Dr David Hoyt

An internationally recognised trauma surgeon, Dr Hoyt has been president of the Pan American Trauma Society, the American Association for the Surgery of Trauma, and the Shock Society. He has served as chair of the Trauma Advisory Committee for the State

of California's Emergency Services Authority. Dr Hoyt's research interests have involved trauma and trauma care systems, including work on cytokine regulation, the isolation of trauma active peptides, trauma registries, violence prevention, crash investigation and long-term outcomes. He has authored or co-authored more than 500 publications and has been awarded the Robert Danis lifetime research award from the International Society of Surgery. We are delighted to welcome him to our conference and look forward to him sharing his experience with us.

For this year's conference, we will also have a symposium dealing with aspects of one of the world's most vexed problems: violence against women. From the practical realities of how to assess and treat a woman who has survived rape, to the use of sexual violence in war, ATMS will confront some of these difficult issues head-on. And in the centenary year of the outbreak of World War 1, we will offer perspectives from both sides of the Atlantic on how to train the future surgeons for service in combat support hospitals.

As well as our distinguished guest speakers, there will be a host of free papers and the opportunity to display your work as a poster presentation. ATMS wishes to offer an academic home to all those with an interest in trauma care, including all those trauma care providers involved in the chain of trauma care from prevention and pre-hospital care, through the ED and surgical and allied specialities, to rehabilitation. We urge you to submit abstracts of your work; the best presentation at the ATMS conference will receive the Wiseman Medal and we would remind all trainees that they can submit for the 2014 Ian Jenkins' Travelling Fellowship, which is a grant of £1,500, to enable a trainee to attend a conference or visit a centre of excellence to further their career aspirations. More details are on the website: **www.atms.org.uk**.

As usual, we will be enjoying a convivial conference social evening on Wednesday 30th April 2014 at the Sun Pavilion. An Art Deco venue, it is idyllically located in the midst of the tranquil Valley Gardens in the heart of elegant Harrogate. An evening of good food and great company is promised and we will be entertained by a band of the Royal Marines. All ASGBI delegates and their guests will be warmly welcomed; however, spaces are limited and we advise you to book early to avoid disappointment! In the tradition of ATMS, the dinner will be a 'black tie' event.

We look forward to welcoming you to Harrogate.

UPDATE FROM THE SPECIALTY ADVISORY COMMITTEE (SAC) IN GENERAL SURGERY

Gareth Griffiths
Chairman, SAC in General Surgery

The SAC is a sub-committee of the Joint Committee on Surgical Training (JCST), which itself is an intercollegiate body to which the four surgical Colleges of the UK and Ireland devolve responsibility for the management of surgical training. There are ten SACs, one for each surgical specialty, the newest of these being in Vascular Surgery. The separation of vascular surgery from general surgery required a redesign of the general surgery curriculum. A brief description of this curriculum, the changes in the FRCS examination that it requires and arrangements for the use of the curriculum will be described in this article.

The SAC is responsible for a wide variety of other work, and other aspects of this which will be discussed include simulation training, e-Logbook development, National Selection for specialty training, the SAC's opinion on emergency cross cover by trainees and monitoring the workforce situation.

2013 General Surgery Curriculum
The GMC require all trainees in all specialties to follow a curriculum of training leading to their certification. Trainees who have completed all their training in GMC approved training programmes and who have achieved all requirements of the curriculum are awarded a CCT (Certificate of Completion of Training), which enables entry onto the specialist register. Entry onto the register can also occur through other routes, including the CESR/CP (Certificate of Eligibility for Specialist Registration/Combined Programme) or a full CESR application. Details of these can be found on the GMC website.

The 2013 Curriculum has now been introduced and the full version is available on the ISCP website in web format and as a download. Its aims include emphasising the importance of emergency general surgery for all trainees while also allowing the development of a special interest in one (or more) of the components of general surgery. It also clarifies what must be achieved in order to meet all the requirements of the curriculum.

All trainees are expected to become competent in emergency general surgery in order that they can safely manage an unselected take. Trainees are also required to develop a special interest in upper GI, colorectal, breast, endocrine or transplant surgery. Trainees may also choose to develop an additional special interest, if they wish, in the general surgery of childhood, advanced trauma surgery (for trauma centres or the military), remote and rural surgery or in thyroid/parathyroid surgery (if endocrine is not their major special interest). Trainees who already held an NTN (National Training Number) in general surgery on 1st January 2013 can, if they choose, develop a special interest in vascular surgery. This option is not available, however, for trainees appointed to general surgery NTN posts after 1st January 2013 onwards.

The terminology is important here. The GMC does not recognise any sub-specialties within general surgery and it had become apparent, as the 2013 curriculum was being written, that training to full sub-specialty level is not possible in six years alongside the essential training in emergency general surgery. Development of a special interest indicates the trainee has acquired significant skills in that area but that s/he does not have all the skills required for more complex or uncommon procedures. The trainee is well placed, however, to develop these skills as a consultant through mentoring.

The requirements of the curriculum are clearly laid out and cover clinical competence, operative competence, breadth of operative experience, research, quality improvement/audit, medical education/training, management/leadership, additional courses and attendance at educational conferences. Specific requirements are described for all these aspects of training and are listed in detail in the curriculum and on the JCST website. A checklist for use at the ST8 ARCP has been developed to ensure that trainees have met the requirements for a CCT. There is a similar checklist for the ST6 ARCP and one is being piloted for the ST4 ARCP. The aim is to be completely transparent about what is required for a CCT and for trainees and trainers to be able to assess sequential progress towards this goal.

All trainees who enter specialty training in 2013 will have to follow the 2013 curriculum. The GMC have issued guidance for existing trainees on changing to the latest version of the curriculum and this is available on their website. The GMC indicate that all trainees should change to the latest curriculum as soon as possible. The latest date by which all trainees must change is 31st December 2015 (unless their training has been extended by less than six months beyond this date and they have the support of their Post Graduate Dean to remain on the old curriculum).

Following discussion with the GMC, and in keeping with the desire for trainees to change to the latest curriculum as soon as possible, the general surgery SAC assumes that all trainees with a certification date after 30th September 2014 will transfer to the 2013 curriculum, unless the JCST office is informed in writing by the trainee, their Programme Director and Head of School that this is not the case. Trainees with a certification date before 30th September 2014 are not expected to transfer. Trainees who do transfer to the 2013 curriculum will be assessed

against the requirements for a CCT which are included in that curriculum. Those who remain on earlier versions of the curriculum will have these requirements applied flexibly as they are not included in these earlier versions.

FRCS (Gen Surg) Examination

One of the principles of education is that assessments must map to the curriculum. With the introduction of the 2013 Curriculum, it was recognised that changes were required to the FRCS. These have now been agreed at SAC, Exam Board and College level. Formal GMC approval is awaited, but it is hoped this will be gained in February 2014. If formal approval is gained, then the first sitting of the new exam (which will replace the current exam in its entirety) is expected in November 2014.

In essence, the entry requirements for the exam will be an ARCP 1 at ST6 or onwards (or equivalent knowledge, clinical and technical skill for non-trainees). This will allow Section 1 (MCQ) to be sat and once that has been passed, candidates will be able to progress to Section 2 (clinical and oral) at the next available sitting.

The curriculum describes the levels of knowledge required by all trainees for each of the components of general surgery (***Figure 1***).

	A	B	C					
	Section 1	Section 2 – General Surgery	Section 2 - SPECIAL INTEREST					
Area	All Candidates	All Candidates	Upper GI	Colorectal	Transplant	Breast	Endocrine	Vascular
Elective General Surgery	ST8	ST8						
Emergency General Surgery	ST8	ST8						
Upper GI	ST6	ST6	ST8					
Colorectal	ST6	ST6		ST8				
Transplant	ST4	ST4			ST8			
Breast	ST4	ST4				ST8		
Endocrine	ST4	ST4					ST8	
Vascular	ST4	ST4						ST8*

* Applicable to Irish surgical trainees and for UK trainees appointed to a Gen Surg NTN post before 1 Jan 2013

Figure 1: The levels of knowledge required by the curriculum and for the FRCS

The curriculum details the level of knowledge required at ST4, ST6 and ST8 for each component and the Section 1 questions are being mapped to these levels as are the general surgery clinical and orals in Section 2. Trainees' special interests will be assessed to ST8 level during the special interest clinical and orals. The academic oral has been incorporated into one of the special interest orals and reduced to the critique of one paper.

As before, there will be a clinical exam in general surgery and another in the trainee's special interest. The time spent on cases will be longer though, with one case for 20 minutes and two for 10 minutes in each clinical. This is to enable a more in-depth discussion of management options, as would be expected at consultant level. There will be four 30 minute oral exams:

a) Emergency surgery, trauma and critical care
b) General surgery principles and practice
c) Special interest clinical practice
d) Special interest basic principles and academic paper discussion
e) A knowledge of applied basic sciences and of the evidence justifying practice will be tested in both the general surgery and special interest orals.

Vascular Surgery

General surgery trainees who were appointed to an NTN post before 1st January 2013 can, if they wish, train in general surgery and develop a special interest in vascular surgery. Arrangements for these trainees were discussed at the SAC and at the TPD meeting with the SAC recently. Professor Cliff Shearman (Chair of the Vascular Surgery SAC) and Professor Mike Gough (Chair of the Vascular-General Liaison Group, a body established between the two SACs to assist these trainees) gave presentations outlining the issues and steps being taken to address them. A document outlining support for these trainees has been distributed widely.

The arrangements describing which curriculum trainees are assessed against for their certification are particularly pertinent for trainees with a vascular interest and it would be beneficial for them to stay on the 2010 curriculum for as long as the GMC allow. Trainees with a vascular interest who do transfer to the 2013 Curriculum will still be able to follow the vascular section of the 2010 Curriculum as this has been incorporated into the 2013 Curriculum for this express purpose.

It is recommended that TPDs ensure trainees have made significant progress towards their general surgery competencies before they are attached to specialist vascular units. These trainees may spend some time doing vascular-only emergency work during their final two years of training, as long as they achieve the emergency general surgery competencies.

Simulation Training

Simulation is recognised to be a valuable adjunct to clinical training and the JCST has been working to include aspects of simulation in the curricula. The GMC has now approved the simulation component of the 2013 Curriculum. This will be uploaded onto the ISCP website in the near future.

A range of technical and non-technical skills have been identified as being suitable for simulated training and are divided into those in which simulation is "highly recommended" or "desirable". No simulation components are "essential" as there are still concerns about equity of access to simulation facilities across the UK. The GMC have requested a survey of simulation facilities and will only sanction aspects of simulation as "essential" once equitable access has been confirmed.

eLogbook

By its nature, the eLogbook will continue to evolve as experience in its use increases and as clinical practice changes. There are three aspects of the logbook which have been developed recently:

1) **Supervised-Trainer Scrubbed (S-TS)**
The JCST describe S-TS in the eLogbook as the trainee performing the key components of the operation as defined by the PBA. For

procedures which do not have a PBA, the SAC have agreed this definition:

S-TS is equivalent to the trainee performing the operation while the trainer is scrubbed. To further clarify common issues which arise:

a) The trainer will be able to offer advice and carry out limited parts of the procedure (e.g. demonstrate a dissection or suturing technique) before allowing the trainee to continue.

b) A junior trainee may carry out some parts of the operation which the senior trainee is clearly competent to perform (e.g. opening or closing the incision).

c) Some operations are commonly divided into different components (e.g. Whipple's, femoro-distal bypass) and are carried out by two trained surgeons. If the trainee takes the place of one of those surgeons and performs their component(s) as described above, then it is appropriate to record the case as supervised-trainer scrubbed, even if all components were not carried out by the trainee.

2) **Definition of Emergency Laparotomy**
The SAC have agreed which therapeutic procedures, when carried out as "immediate" or "urgent", should be included in the list of emergency laparotomies. It is hoped that an eLogbook filter can be written which will automatically extract a list of emergency laparotomies following this definition.

3) **Consolidation Sheets and Operation Codes**
Some operation codes have recently been updated and a new "Operation Group" consolidation sheet has been introduced. This lists all operations alphabetically within each component of general surgery and trainees will now be asked to provide this consolidation sheet when they submit their paperwork for a CCT/CESR CP application. Updates of other operation codes are likely to take place in the coming year.

National Selection for Specialty Training
2014 will be the fourth year that selection into specialty training in general surgery has been managed nationally. Hundreds of consultants have kindly agreed to participate in the interviews over the last three years and, without their help, the process could not go ahead. As ever, the SAC and National Selection Board Steering Group are immensely grateful to everyone who has helped.

It was difficult to set the dates this year because of the need to avoid a date clashes within the relatively short window within which interviews must be held. The dates have now been set as:

22-25 April 2014

6-9 May 2014

12-13 May 2014

All these dates are inclusive and the venue will be the Events Centre within London Deanery, the same as last year.

Jon Lund, the Chairman of the Selection Board Steering Group, will be sending out the dates and a formal invitation to interview shortly. Any UK consultant who is not on the interviewer list but who would like to participate is encouraged to contact Jon directly at **jon.lund@nottingham.ac.uk**.

Emergency Cross Cover by Trainees
The JCST office has received a significant number of enquiries regarding the role of general surgery trainees in caring for patients with emergency urological conditions, such as torsion of the testis. The broader issue of emergency cross cover of surgical specialties has been examined by ASiT [1].

After discussing this at its October meeting, the SAC's guidance is that general surgery specialty trainees should not normally be expected to provide cover for urological conditions. The exceptions to this would be:

1) Undiagnosed abdominal pain or sepsis, which eventually turns out to be due to a urological condition. Such patients should be cared for by general surgery trainees until taken over by the urological team according to local arrangements.

2) Patients with suspected torsion of the testis in hospitals where this condition is managed by consultant general surgeons.

It is expected that support for urological teams may be available from Core Surgical Trainees, general surgery trainees who are Out of Programme for Experience or Research and non-trainees according to local arrangements. This view is in keeping with that of the Association of Surgeons of Great Britain and Ireland Education and Training Board, which also discussed this recently.

Regardless of this guidance, however, all doctors must adhere to the GMC's Good Medical Practice and make the care of patients their first concern, while recognising and working within the limits of their competence. It is recognised that issues such as this may change significantly after the Shape of Training Review.

Workforce Monitoring
For around a year now, the SAC have been monitoring substantive consultant adverts that appear in the BMJ under General Surgery along with the declared interests of trainees as they are awarded their CCT. These are presented opposite for information.

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Summary of Consultant Adverts and Special Interests of CCT/CESR CP Graduates

Consultant Adverts 5 May 2012 to 30 August 2013 (16 months)

		UK		Ireland	Annualised UK
CR		50			37.5
	CR		49	3	
	CR with EGS		1		
UGI		48			36.0
	UGI		14		
	benign		16		
	bariatric		3		
	bariatric and resection		1		
	OG		5		
	HPB		7		
	HPB and trauma		1		
	pancreatic		1		
General		31			23.3
	general surgery		13	1	
	general surgery, R&R		1		
	GI with laparoscopy		1		
	GI		5		
	ambulatory		2		
	emergency and laparoscopic		1		
	emergency		7		
	general surgery with vascular		1	1	
Transplant		9			6.8
	transplant		5		
	renal		1		
	renal and vascular		1		
	renal and endocrine		1		
	liver and HPB		1		
Breast		43			32.3
	oncoplastic, EGS not specified		18		
	oncoplastic, no EGS		3		
	breast, EGS not specified		9		
	breast, no EGS		4		
	breast with EGS		6		
	breast, optional EGS		2		
	breast and endocrine		1		
Vascular		7			5.3
Total		188		5	141.0

CCT Graduates 9 November 2012 to 1 October 2013 (11 months)

		UK		Ireland	Annualised UK
CR		38		1	41.5
UGI		25			27.3
	UGI not specified		4		
	OG/HPB benign		1		
	benign/bariatric		3		
	OG		10	1	
	HPB		5		
	OG/HPB		1		
	UGI+paediatric		1		
General		2			2.2
	general		1		
	emergency and laparoscopic		1		
Transplant		7			7.6
	not specified		2		
	liver and HPB		5		
Breast		22			24.0
Vascular		22			24.0
	Vascular		21		
	Vascular and trauma		1		
Total		118			126.5

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SAC IN GENERAL SURGERY

BEGINNING IN BURGUNDY

Ed Fitzgerald
General Surgery Registrar, Barnet Hospital

An old wine merchant's joke: Q. How many Burgundy winemakers does it take to change a light bulb? A. Change?!

While it might be a joke told in many different guises, it does play on the preconceptions that surround what has been described as the most maddening and yet magnificent of all the world's wines. For many people, when they imagine a wine region, they will probably picture something that looks like the vineyards and villages of Burgundy; neat rows of vines lined up across gently undulating slopes as far as the eye can see; ancient stone walled 'clos' secretively enclosing the finest vineyards; historic hamlets nestling amongst these, seemingly overlooked by modern life and linked only by a meandering network of single-lane byways zigzagging around the vineyards. Even the colour of the chardonnay wines is seemingly reflected in the soft limestone hues of the houses in these old, old communities whose livelihood is farming the vine.

There are few places so evocative, yet so ephemeral, and therein lies the problem. When I first started exploring wine, Burgundy was quickly dismissed as being hopelessly variable from one producer to the next, and hopelessly over-priced at that. The myriad place names (mostly unpronounceable) partnered with the multitude of small wine producing families, (mostly inter-related) conspires to make a truly impenetrable combination. And so it remained throughout the passage of many forgettable glasses of Burgundy, or 'Bourgogne' as it is to the French, until that memorable day that wine drinkers talk about when you taste your first great glass – that moment can send you chasing these wines for the rest of your days.

Something quite different and special separates these wines from the many other famous wine-producing regions of the world. This was famously described by Maurice Healy, the Irish lawyer and King's Council in his wine book ***Stay me with Flagons*** (1940): "*Burgundy at its best overtops claret at its best ... You will only drink four or five bottles of truly first-class Burgundy in your whole life ... I took one sip; I closed my eyes, and every beautiful thing that I had ever known crowded into my memory... The song of armies sweeping into battle... the glint of sunshine after rain on the leaves of the forest... the voices of children singing hymns, all these and a hundred other things seemed to be blended into one magnificence*". Perhaps a little over-the-top, but you get the general picture!

The Lie of the Land

Burgundy is located in mid-eastern France at the crossroads of the Mediterranean influence to the south, Atlantic influence to the west, and the continental influence to the north. A long, thin strip of land running north to south, it measures approximately 230km from the Côte de Nuit region in the north, through the Côte de Beaune and Côte Chalonnaise, to the Maconnais in the south. Outside of these, Chablis is geographically separated to the north with Beaujolais forming the southern tip of Burgundy. Both these latter regions produce quite different wines from the classic heart of Burgundy, the Côte de Nuit and the Côte de Beaune, which are together referred to as the Côte-d'Or, the "golden slope".

Chevalier-Montrachet is one of five Grand Cru vineyards of the Côte de Beaune

The grape varieties are the simplest thing to learn in this region. Whites are made from Chardonnay (with the quirky exception of small quantities of Aligoté, mainly grown around the wonderfully named village of Bouzeron). Reds are made from Pinot Noir, while in Beaujolais they are made from Gamay. Once the grapes are dealt with, the headaches start. The complexities of the vineyard classifications cause problems for many, although the underlying concept is quite simple. One geographical region, Burgundy, has 100 different 'Appellations d'Origine Contrôlée', or legally defined areas. Whilst some have almost become brand names in the eyes of consumers (e.g. the villages of Meursault or Nuit-St-George), these innumerable different names can baffle the average wine drinker.

Whilst new-world producers can simply state the grape variety on the label, Burgundy is largely 'terroir'-driven. That means that, while the grapes may remain the same, one village will produce a wine noticeably different from its neighbour due to the coming together of weather, soil and other site-specific vineyard factors that make each unique. Hence the vineyard, village or region appears on the label, not the grape variety. If remembering all of these different names wasn't complicated enough, there is a further classification based around the area of production, from recognised regions right down to individual named 'Grand Cru' vineyards. This hierarchal 'pyramid' is illustrated in ***figure 1***.

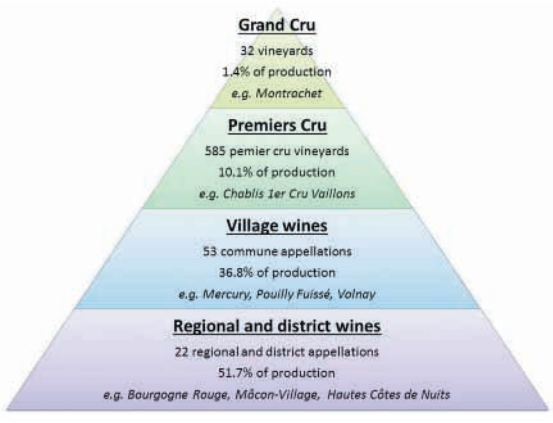

Figure 1: Wine Classifications of Burgundy

To put Burgundy in a world context, the region produces some 200 million bottles per year, which represents approximately 0.5% of world wine production, yet 5% of world wine trade by value. Just over half this is exported outside France; while the Chinese are starting to get thirsty, around 30% remains within the EU. It is sobering to consider that the 'Grand Cru' vineyards of Burgundy, on what so much of the region's international reputation is based, account for only 1.4% of the region's total wine production. Equally important to remember is that the 'Grand Cru' denomination only guarantees that the wine originated from such a vineyard; it makes no guarantee of the wine's quality itself. So while most vigneron owning 'Grand Cru' vines stake their reputation on producing something that represents the finest wine known to humanity, it can, on occasion, end up being nothing more than extremely expensive radiator fluid.

History in a Glass

The history of wine is the history of human culture and there are few places where this is truer than the gentle slopes of Burgundy. While the 'Bordelais' up-starts were still draining the swamp land of Bordeaux to plant their vineyards in the 1700s, the winemakers of Burgundy had already established an elegance and finesse that won them fame across Europe and beyond. Indeed, when Thomas Jefferson, then still America's envoy to France, embarked on his vinous grand tour of the country in 1787, he started that journey in Burgundy.

There is archaeological evidence suggesting vineyards in the region date back to the Gallo-Roman era in the first and second centuries. The first written evidence comes from 312AD, but it was the foundation of the great religious monasteries in the 11th century that secured wine in Burgundy. During this monastic period, the status of these wines rose, helped by the monasteries extensive vineyard holdings and the monk's careful cultivation of the vineyards. The Dukes of Burgundy subsequently helped their local wines become known throughout Europe in the 15th century until the French Revolution saw the redistribution and sale of these vineyards to the people. Despite the longstanding admiration of these lands, particularly the more famous vineyard sites, the first Appellations d'Origine Contrôlée wasn't created until 1936.

This profound history has helped shape the wine, cuisine, culture and people of Burgundy for generation after generation. Today, there are over 3,800 wine producing domains and a further 250 merchant houses and 23 co-operatives.

Changing Times

This modern-day Burgundy is still a region of contrasts. The gentle vineyard slopes are so peaceful and picturesque, yet many represent the world's most expensive vineyard real estate. Generic 'peasant' wine of Bourgogne is still widely available for a few Euros per litre. In contrast, Domaine de la Romanée-Conti, considered to be one of the world's finest wine estates, currently list their La Tâche Grand Cru 2001 at the bargain price of £19,500 per 12-bottle case with Berry Bros & Rudd wine merchants. (Donations welcome!) But it is the bottle's contents themselves that provide the ultimate contrast, with thin-skinned pinot noir producing wines so deceptively light in colour yet capable of such profound concentration, aroma and longevity.

Burgundy now means business, and the region has come together with the help of EU funding to embark on an ambitious promotional drive. Part of this includes a push to see the 'climats' (the Burgundian notion of terroir in terms of the unique delimited vineyard sites) included in the UNESCO World Heritage list. This is a wise move; imitation may be the greatest form of flattery, but many competing wine regions are now seeking to adopt the grapes and winemaking practices of Burgundy for their own gain. Such is the way of the world, but it is right to protect this unique origin. Chardonnays may come from anywhere, but a Puligny-Montrachet wine should only ever come from the village of Puligny-Montrachet. We should have been similarly protective of cheddar cheese!

The vineyards of Château de Chamirey outside the village of Mercury in the Côte Chalonnaise

Big business also means that many of the traditional opportunities to walk amongst the vines and taste the wines with producers have gone. Famous wineries will only accept visits by appointment, and only then with good wine tasting credentials! However, many of the well-known traditional négociants in the beautiful town of Beaune (e.g. www.vins-chanson.com or www.louisjadot.com) have tasting rooms and tours of their cellars. Another notable producer worth visiting is Château de Chamirey, whose beautiful tasting room is in the picturesque vineyards outside the village of Mercurey in the Côte Chalonnaise (www.chamirey.com).

Hard work tasting Grand Cru wines at Château de Chamirey

Good Chardonnay from outside of Burgundy is common these days, much of it offering relative value compared to generic white Burgundy, which may often be sold on reputation rather than reality. Nonetheless, Burgundy still produces some of the finest quality wines, with the steely character of Chablis or the poised elegance of whites from the

Côte de Beaune seemingly impossible to replicate elsewhere. Red Burgundy has proved hard to imitate. Some of the higher-end Pinot Noirs from New Zealand come close, and these are becoming every bit as expensive. Good bottles from top producers (e.g. www.craggyrange.com) retail from £20 upwards, with many of their limited bottlings costing considerably more. Much better value can be found in Chile (e.g. www.leyda.cl) although these can be very different in character from the classic red Burgundian style. Still, I highly recommend them as a good starting point to explore the grape variety.

Traditional Bugundian 'pièce' oak barrels maturing red wine in a Nuits-Saint-Georges cellar

Conclusions

For me, Burgundy is not somewhere to begin when you start exploring wine, but somehow all those winding French lanes seem to lead you there in the end. Initially, the complexity, variability and expense can be both off-putting and deeply frustrating. But when you taste that really special bottle – as you will perhaps only a few times in your life – that light-bulb moment arrives and you understand: when they've been doing it right for 1,000 years, why should they change?

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Recommended further reading

- The official site of the Bourgogne Wine Board (BIVB) has a huge wealth of information and downloads available, particularly for those planning visits: www.bourgogne-wines.com
- **Mah A**
  Following Jefferson Through the Vineyards
  New York Times, June 10, 2010
- **Morris J, MW**
  Inside Burgundy: The Vineyards, The Wine And The People
  2010. ISBN: 0951063219
- **Nanson B**
  The Finest Wines of Burgundy: A Guide to the Best Producers of the Côte d'Or and Their Wines
  Aurum Press Ltd, 2012. ISBN: 1845136926
- **Coates C, MW**
  The Wines of Burgundy
  University of California Press, 2008. ISBN: 0520250508
- **Norman R, Taylor C, MW**
  The Great Domaines of Burgundy
  Kyle Cathie, 2010. ISBN: 1856268128

CORRESPONDENCE

Dear Professor Primrose

I am writing to express my concern, as a member of ASGBI, about the BMA's attempts at consultant contract negotiations. I am a junior consultant, having been in the grade for only three years, so perhaps my concerns should be viewed in the light of that limited experience. I understand that ASGBI has altered its organisational premise to be able to act as a representative body for surgeons, a move I welcome. The BMA seem overly keen on a national consultant contract that takes no or little account of geographical location, specialty or organisational differences within the consultant grade. I read that, in the past, trusts have looked at making local contracts based on geography with no real advantage. However, I think this misses the point to some extent and actually, specialty differences in intensity and type of work make a degree of differentiation appropriate. As the focus of any new settlement will likely dwell on provision of acute/emergency care, this is especially relevant to surgeons. If acting on behalf of general surgeons is something that ASGBI is hoping to do in the future, then the current situation seems an ideal one to ask to be involved in any renegotiations. I am unsure if I am alone in thinking this way or if I am one of several independent voices; you'll know the answer to that and either ignore this individual concern or respond to several letters of concern. I am taking a roundabout way of asking if ASGBI would consider asking for a role in any decision to renegotiate. While most surgeons are members of ASGBI, we are not all BMA members (although I am) and so ASGBI is probably the most representative body for consultant general surgeon opinion. As a general surgeon, I fear what the BMA may consider a fair negotiation in the light of a rigidly over arching national contract.

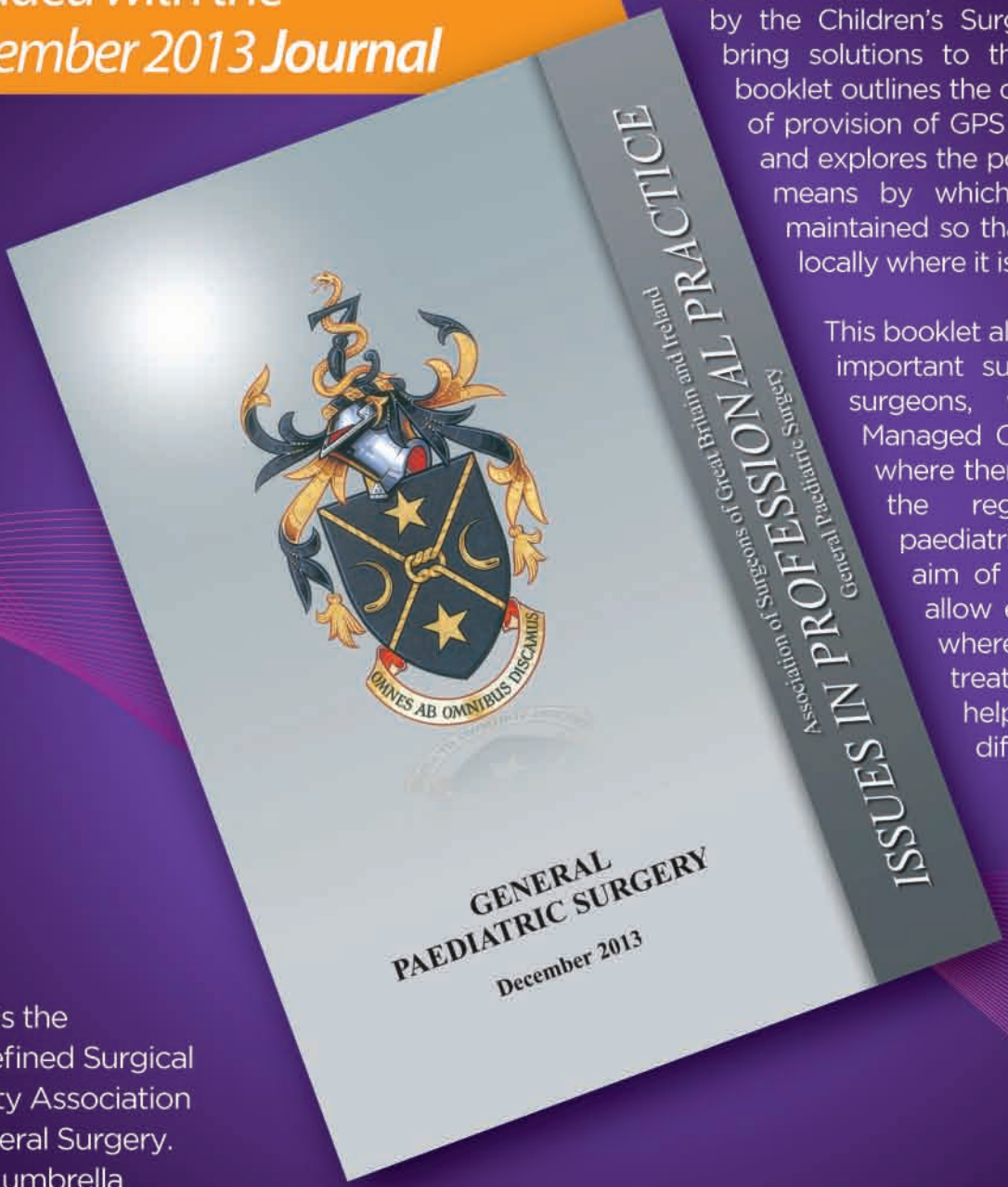
I am grateful for your consideration of my concerns and would welcome your feedback.

Yours sincerely

James Kirkby-Bott

Issues in Professional Practice (IIPP) is an occasional series of booklets published by the Association of Surgeons of Great Britain and Ireland to offer guidance on a wide range of areas which impact on the daily professional lives of surgeons.

Your copy
included with the December 2013 ***Journal***



Our latest booklet concerns the continuing provision of General Paediatric Surgery in District General Hospitals. This topic has been aired over the past two or three years, and great strides have been made by the Children's Surgical Forum to bring solutions to the table. This booklet outlines the current problem of provision of GPS into the future, and explores the possible practical means by which GPS can be maintained so that it is available locally where it is safe to do so.

This booklet also highlights an important support for GPS surgeons, which is the Managed Clinical Network where there are links with the regional tertiary paediatric centre. The aim of the MCN is to allow equality of care wherever the child is treated, and to give help or advice with difficult cases.

ASGBI is the SAC-defined Surgical Specialty Association for General Surgery. It is the umbrella association for all the general surgical specialty societies in relation to Revalidation and the accreditation of CPD.

ASGBI offer a wide range of member benefits, including frequent ***Issues in Professional Practice*** booklets distributed to all our members. You can find your copy of our latest IIPP, entitled *General Paediatric Surgery*, with this edition of the ASGBI ***Journal***.

ASGBI

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CONCERNED BY THE IMPENDING TAX CHARGES ON PENSION SAVINGS? YOU MIGHT NEED A 24-HOUR BREAK

There is still little good news to report for the senior medical practitioner. Having already faced changes to the NHS pension scheme, higher pension contributions, reforms to the NHS and an effective pay freeze, doctors will be very frustrated to be targeted again with the changes coming next April.

As a result, we have seen a rise in the number of high-achieving doctors considering '24 hour retirement' or 'retire and return'. This allows them to reduce their professional commitments, while often maintaining or even increasing their earnings. Despite a lower base salary and the loss of clinical excellence awards, doctors taking this route save on pension contributions and receive pension benefits while working. Many are better off financially. The move also caps the value of your pension pot and could provide a welcome escape from the imminent new lifetime allowance of just £1.25million, a figure easily exceeded by many senior doctors' pension savings. If you breach the new limit, you face a tax charge of up to 55 per cent on the excess.

There are other benefits too. Some consultants are concerned about further changes to the NHS pension scheme, believing it safer to lock-in their benefits now. For others, the ability to access a tax-free lump sum at a time when their dependents most need it can be a deciding factor. Most of us will need considerably more money at 60 than at 80.

In addition, you can often negotiate a more flexible working contract and cherry-pick your current position to lose less attractive parts. For instance, you may be able to reduce the number of PAs you undertake or drop your on-call commitments. It is better to achieve that elusive work-life balance while you are still fit enough to enjoy it.

To qualify for retire and return, you must effectively resign from your NHS contract of employment and take a 24-hour break in service. You stop paying pension contributions and gain access to your tax-free lump sum plus a regular pension payment. You can then return to work on the new contract, but must not work more than 16 hours a week in the first month. After that period, you can choose to return either full or part-time, without any restriction on your hours.

Consultants remaining on the 1995 pension scheme and aged 60 or over can access the lump sum without penalty, while those who have moved to the 2008 scheme must wait until they are over 65. In addition, the process known as 'abatement', which reduces your pension if your earnings are more in retirement than in previous full-time employment, does not apply after age 60.

Before you resign, you must make sure that your trust will take you back. A lingering personality clash with management will make this unlikely. Fortunately, doctors returning after a break in service are often cheaper and therefore desirable, as the trust no longer pays a pension contribution for them. You should also bear in mind that your new contract is likely to be only on a one-year renewable basis. This can lead to less career security, as well as a perceived change of status, which can be difficult for some to accept.

By giving up a long-term contract, consultants also lose some of their rights if they are subsequently made redundant. Redundancy compensation would apply only to the period of your new contract, with statutory payments applying to the rest of your NHS service. You will also lose valuable death in service payments (worth twice the relevant pensionable salary) and ill-health benefits, both of which are more likely to be useful to you as you near retirement age.

Should you opt out instead?

A minority of senior medical professionals nearing retirement could fare better by opting out of the NHS pension scheme altogether, rather than retiring. The ongoing pay freeze makes this more appealing, as pension benefits accrue on the basis of salary. If you are not in the scheme, you can choose to defer your benefits until you retire. Your benefits will continue to increase by the rate of inflation, as measured by the consumer price index, which could well be at a higher rate than your current salary growth.

Savers who already hold 'fixed protection' on their pension savings may opt out so they meet the scheme's strict criteria, which do not allow further pension contributions. In doing so, you can also retain the current lifetime allowance of £1.5million. One extra advantage of opting out is that you can remain in your current position, which you and your peers may find easier to live with. Those who have returned on a lower level after retirement have reported feeling vulnerable and no longer seen as key members of staff.

With the April deadline looming, it is vital that you consider your situation now, as retiring from the NHS can take several months to arrange. If you are concerned by the forthcoming tax changes, you should seek expert help to get the best value from your pension.

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

www.cavendishmedical.com

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SIS

WORST CASE SCENARIO

Post Stafford, there has been a marked increase in the number of concerns about individual surgeons raised within NHS trusts and, with that, more surgeons calling to say that their practice is under review. In some cases, they have been excluded (suspended) from the trust, or restrictions have been put on their practice pending the outcome of the investigation. Often, all this comes like a bolt from the blue leaving the surgeon bewildered and extremely anxious.

Some cases are resolved very quickly, with an internal or external reviewer reporting back and confirming that there are no issues requiring further action. However, in a small number of cases this is just the beginning of a long, exacting and worrying process which can culminate in the surgeon being dismissed from the trust and losing his GMC registration.

The process for investigating concerns about capability, exclusion from work, and the disciplinary process are all set out in Maintaining High Professional Standards (MHPS). This framework was developed by the Department of Health and has been integrated into local NHS trusts procedures in England since June 2005.

MHPS provides some protection to surgeons and, although coming to some informal agreement over 'special leave' rather than exclusion may seem attractive, bypassing the system can be detrimental. Exclusion is meant to be an interim measure pending resolution of the problem and should be for the minimum period necessary, reviewed every four weeks and supervised by a single non-executive board member. In practice, once excluded the surgeon remains excluded during the course of an investigation.

Exclusion should be used only to protect patient safety or other staff, or if the surgeon's presence would impede gathering the evidence. In practice, it usually works like this: An urgent meeting is requested by the medical director, where the issues giving rise to concern are outlined, together with the trust's proposed process for investigating those concerns. This will usually have been rehearsed with the National Clinical Assessment Service (NCAS) and the local GMC employment liaison officer. The arrangements and any exclusion or restrictions on practice will then be confirmed in writing.

Investigations under MHPS are overseen by a case manager (often the medical director) with the case investigator responsible for collecting and collating relevant information and statements with appropriate clinical input, as well as keeping a record of the investigation. An outside expert may be required to look at clinical issues, either because of the degree of subspecialisation or because the concerns have been raised by the only colleagues in the trust with the requisite skills to provide advice.

The idea is that the case investigator should complete the investigation within four weeks but, if the trust invite the RCS to conduct a review (Invited Review Mechanism or IRM), it is likely to be more than six weeks before this can happen, let alone report back, so slippage of the timescale is commonplace.

Meanwhile, the case investigator must 'assist the designated Board member in reviewing the progress of the case,' including the continuing need for exclusion.

Whether it is an internal trust investigation or a RCS IRM, the surgeon is usually interviewed and may be accompanied by a 'companion' (not a representative) who cannot act in a legal capacity. The real problem here is that, although the surgeon has the opportunity to answer questions, he will not know what others have said about him, his practice and the events that illustrate their concerns. The RCS IRM also involves review of a number of cases which have been identified by the Trust, however, this may not include any discussion or input from the surgeon before the review team formulate their conclusions.

From the surgeon's perspective, the result is a report tainted by the bias of all those who have spoken against him and conclusions drawn without his case being properly heard.

It's true that the surgeon can comment on the report, particularly on factual inaccuracies, but that falls well short of the opportunity to hear and challenge the evidence presented by antagonists.

A critical report may also recommend referral to the GMC. If the report raises issues of patient safety, that is likely to lead to a hearing at the Medical Practitioners Tribunal Service (MPTS) Interim Orders Panel, which does not examine the evidence in detail but can suspend, or restrict, the surgeon's practice for up to 18 months if the alleged shortcomings are serious, pending a full MPTS hearing.

Meanwhile, back at the trust, the case manager must decide what further action to take. If there are significant clinical issues, the choices are either retraining followed by reassessment or proceeding straight to a capability hearing.

At the capability hearing, the panel decide whether or not the surgeon should be dismissed or some other action taken. The surgeon can be legally represented but, by this stage, the surgeon is likely to have been excluded for months. In addition to issues of clinical ability, it may be argued that the surgeon has lost the confidence of his colleagues, making his position untenable. There is a right of appeal but these are seldom successful. Finally, cases referred to the MPTS for a full hearing will result in action on registration if significant impairment of fitness to practise is found.

This all makes grim reading, but for a few surgeons each year, it is a terrible reality. It doesn't happen unless significant problems have been allowed to develop, which have rarely been flagged up in appraisals. Interpersonal disputes, poor leadership and professional isolation within departments all militate against good patient care and can be the rocky road to the end of a surgical career.

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

coress Feedback

This issue of Feedback contains a case which underlines the importance of incident reporting in providing educational feedback to clinical staff. Four other cases illustrate the need for surgeons to maintain peripheral awareness whilst concentrating on technical aspects of surgical procedures. Potential risks of diathermy, a perennial theme in CORESS cases, are emphasised yet again, and the reader is directed to a useful educational web-based module on electrosurgery, prepared jointly by the MHRA and Royal College of Surgeons of England.

We are grateful to the clinicians 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 contributions 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

"STOP BEFORE YOU CHOP" (CASE 1)

(Ref: 151)

I was performing a colonoscopy under general anaesthetic for diarrhoea in a young boy with cerebral palsy. On entering the terminal ileum, I asked for biopsy forceps, but the forceps I was given were too short. Longer forceps were found and passed to me. Unfortunately, due to preoccupation with "torqueing" the scope to stay in the terminal ileum, I didn't check the forceps until deploying them in the terminal ileum.

The forceps were, in fact, rat-toothed alligator-jawed grasping forceps, and not biopsy forceps. The view through the endoscope did not alert me to this fact and the packaging for these is identical to biopsy forceps, except in name.

A terminal ileal perforation resulted in the patient requiring admission, although conservative management sufficed.

Reporter's Comments:
The grasping forceps are similarly packaged to biopsy forceps. Checks were not in place to ensure selection of the correct instrument, prior to utilisation of the forceps. These should be undertaken in the same manner as instrument and drug checks. Warnings should be placed on the packaging for grasping forceps to ensure they are not used mistakenly for biopsies.

CORESS Comments:
It is the responsibility of the operating surgeon to check the kit that he or she uses, and to ensure that the equipment is appropriate, just as medications or injected fluids should be checked. It is very easy during endoscopic or laparoscopic surgery to become immersed in the procedure, but part of the duty of the surgeon is to retain peripheral awareness in the operating environment.

"STOP BEFORE YOU CHOP" (CASE 2)

(Ref: 162)

During a laparoscopic cholecystectomy, a disposable sucker was opened by an agency scrub nurse assistant who was unfamiliar with our equipment. The sucker was passed to me with rubber guard on the tip still in-situ, but because I was concentrating on the televised image I didn't notice this and inserted it into patient. The rubber guard dropped off inside patient but at this point I recognised the problem. The guard was visible and was retrieved immediately.

Reporter's Comments:
The sucker had a small rubber guard which could easily be lost in a patient. Could the supplier modify this to prevent future similar events? The scrub nurse was not familiar with the equipment, but the underlying responsibility for using this equipment was mine and I should have checked it before inserting it into the patient. It is easy for a surgeon to become distracted by the operation to the exclusion of all else.

CORESS Comments:
The comments on the previous case apply equally to this case. It is the duty of the surgeon to remain aware in the operating theatre environment, and to ensure that equipment used is appropriate and serviceable.

ELECTRIFYING EXPERIENCE (CASE 1)

(Ref: 149)

Whilst I was assisting during a laparoscopic cholecystectomy, the diathermy hook was inadvertently activated whilst inside the abdomen. I realised that this had occurred because, unrecognised at the time, I had trodden on the yellow diathermy "cutting" pedal, whilst immersed in the operative procedure. Fortunately the patient came to no harm.

Reporter's Comments:

The diathermy pedals on this occasion had been placed away from the operating table rather than under the lip of the table, where the standing surgeon would usually expect to find them. As the operating surgeon takes full responsibility for the use of diathermy it is his/her duty to check the position of the pedals prior to commencing the operation, to ensure that they are not activated inappropriately. If a particular pedal is not required for a specific procedure, it should be placed out of reach of surgeon and assistant.

ELECTRIFYING EXPERIENCE (CASE 2)

(Ref: 162)

Whilst performing a laparoscopic cholecystectomy, the cutting diathermy pedal had been placed on the base of the operating table. When the table was lowered, the pedal was compressed by the descending table pedestal, resulting in the diathermy being activated constantly. Because the warning buzzer was set at a low volume, I did not hear it. When I attached the diathermy lead to the instrument I was using, there was a small spark between the lead and the terminal on the instrument. I did not appreciate the significance of this until I placed the instrument into the patient and saw smoke arising from the tip of the instrument. I was not aware of contact with an intra-abdominal organ, but assume that I must have touched the liver or falciform ligament during introduction. At that point I realised the problem and although nothing untoward actually occurred to the patient, the potential for harm is obvious.

Reporter's Comments:

Contributory factors here were: placing the pedal onto the table base; leaving the warning tone on low volume; not placing significant emphasis on the warning of the spark.

Sparks when attaching diathermy leads to instruments should never be assumed to be unimportant and must be fully investigated before using the instrument or placing it into the patient. Leave the diathermy pedal on the floor and ensure the volume of the warning buzzer is set at an audible level.

CORESS Comments:

Diathermy mishaps occur frequently. In a survey of the CORESS Advisory Board, almost all surgeons across the range of surgical specialties had been involved in similar incidents to the two described above. Education about the risks of diathermy is a fundamental component of surgical training and is taught in the Basic Surgical Skills Course and included in the ISCP curriculum.

When not in use, the diathermy pedals should be kept well out of the way of the operating surgeon. The diathermy alarm is there for a purpose and any activation-warning alarm should not be turned off or set to an inaudible level. Never leave diathermy forceps lying on a patient and always place in a protective sheath during periods when not in use. It is not good practice for the operating surgeon to delegate activation of the diathermy to an assistant, ("Please buzz..."). Although not directly relevant to this case, recent CORESS cases have also drawn attention to the risks of fire and burns due to pooling of flammable skin preparations ignited by diathermy.

The MHRA have developed an educational module on electrosurgery, jointly with the Royal College of Surgeons of England. This useful educational tool can be found at:

http://www.mhra.gov.uk/ConferencesLearningCentre/LearningCentre/Deviceslearningmodules/Electrosurgery/index.htm

The MHRA have also issued guidelines for the perioperative management of patients with implantable pacemakers or implantable cardioverter defibrillators, where the use of surgical diathermy/electrocautery is anticipated, (another area which sometimes confuses surgeons):

http://www.mhra.gov.uk/home/groups/dts-bi/documents/websiteresources/con2023451.pdf

REPORTING CONCERNS

(Ref: 150)

I am retired from the NHS, having had full experience of emergency and elective general surgery with a 1 in 4 on-call responsibility throughout my career. I was invited to take on a two-month Consultant Locum in General Surgery at a large hospital.

On two occasions when I was on-call, patients collapsed on the wards at around 10pm. The first patient was a 32 year old woman who had undergone laparoscopic cholecystectomy and whose charts showed, (in retrospect), signs of internal bleeding with gradual increase in pulse rate and a drop in blood pressure. The patient was resuscitated, brought to theatre, and I performed a laparotomy, evacuating a large volume of fresh blood, and controlling bleeding, before the patient was returned to the ward.

The second incident involved a 64 year old patient who had undergone laparoscopic sigmoid colectomy for volvulus. She collapsed pulseless on the ward, and it was only thanks to the intensive efforts of a Consultant Anaesthetist that we were able to resuscitate her, bring her to theatre, and again, to deal with haemorrhage, in this case from a branch of the inferior mesenteric artery.

Reporter's Comments:

After completing the locum post, I wrote to the Chief Executive of the hospital requesting a copy of the Serious Untoward Incident documentation on these two patients, for anonymous incorporation into my validation appraisal documentation. I was surprised to hear that there was no evidence that these cases had been reported, and it was implied that I was remiss in not completing appropriate forms.

My feelings were that, in these circumstances, it was the responsibility of the admitting Consultants (who had both been involved in the original operations) to refer the cases. I did not think that it would be professionally polite for me to "expose" the non-negligent complications of the original procedures. I believe this is a significant issue and would welcome comments from CORESS.

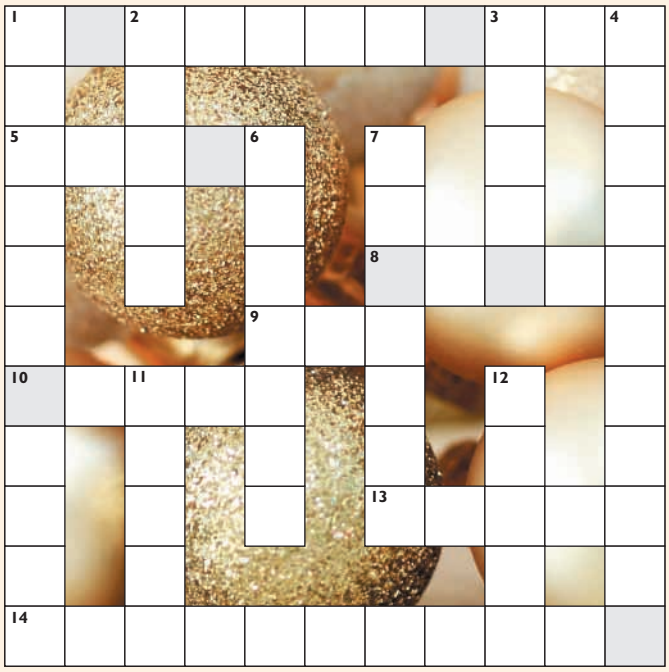
CORESS Comments:

Reporting untoward incidents and disseminating learning from such experiences is the ethical and professional responsibility of all clinical staff. The value of the morbidity and mortality meeting in a hospital cannot be overestimated in terms of the educational value to trained surgeons, trainees and ancillary staff, and underpins the existence of CORESS. It is vital that reporting should occur in a blame-, and recrimination-free environment, but cases such as those described above contain essential learning material that must be shared if we are to improve outcomes for our patients.

Journal of the Association of Surgeons of Great Britain and Ireland

Winter Crossword Puzzle

Now that you've reached the back page, put your feet up and have some fun with our seasonal crossword! Complete the puzzle (which may have a few surgical words thrown in for good measure...) and form a Christmas word from the shaded boxes. Email your solution to **sarahdavies@asgbi.org.uk** by Friday 17th January for the chance to win five shirts from T.M. Lewin's 2013 Autumn/Winter collection. Best of luck!



ACROSS

1. Composed the music for *Hark! The Herald Angels Sing* (11)
5. Directed *It's a Wonderful Life* (5)
8. Harbinger of yuletide cheer (5)
9. Animal that migrates towards the snow (3)
10. Winter constellation in the Northern Hemisphere (5)
13. "____ apparatus" – a net-like structure in the cytoplasm of animal cells (5)
14. An activity for freezing days (11)

DOWN

1. Wet weather outerwear (11)
2. Chilly (5)
3. Exceed existing efforts (in Christmas decorating perhaps) (5)
4. Let's hope this winter is not... (5,6)
6. In abundance (7)
7. Capillary action (also relevant for candles and oil lamps) (7)
11. Ice dwelling (5)
12. French cuisine, a winter game stew with rich sauce (5)

Summer 2013 crossword answers

Across: 5. Al fresco, 8. Fig, 11. Independence Day, 12. Cancer, 13. Holiday

Down: 1. Carnival, 2. Cricket, 3. Monsoon, 4. Barbados, 6. Sunflower, 7. Tennis, 9. Lei, 10. Seashell

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