



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

(As at November 2012)

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

Aims

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

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

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

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

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

References

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

REVALIDATION CANNOT BE LEFT TO GMC ALONE

Alastair McLellan
Editor of the *Health Service Journal*

Jeremy Hunt announced the final go-ahead for medical revalidation within days of his decision to ask the Independent Reconfiguration Panel to review children's heart surgery.

It is more than a decade since the Bristol Royal Infirmary inquiry highlighted the variability of medical performance and fed the debate over the creation of specialist centres. The NHS has been wrestling with both issues ever since.

Despite some progress, service reconfiguration is still often a sticky mess of conflicting clinical "evidence", thinly veiled political interference, poor consultation and local mischief-making. However, only the most optimistic can claim efforts to tackle the quality of doctors is in better shape.

It is important to state three things before explaining why this is the case. First, the quality of UK medical practice is usually good. Second, revalidation is an unarguable step forward and the General Medical Council should be congratulated for its tenacity. Third, revalidation should build on trusts' established clinical governance systems and will hopefully evolve over time.

Mr Hunt has declared that revalidation should ensure doctors are "up to speed with the latest treatments and technologies". This is important not only for patients wanting to receive the best care, but also for a system facing unprecedented demands on its efficiency. However, there remains considerable scepticism that revalidation will justify the time and effort required to make it a success.

The loudest mood music emanates from the framework which will "host" revalidation. The current clinical governance process is not considered a widespread success. While there are examples of robust and transparent systems across the country, there are also too many cases of organisations going through the motions. Too many doctors have not been convinced of the value of appraisals and, at best, treat them as an intellectual game. Too many medical directors lack the will or the support to challenge poor performance and

behaviour. The introduction of revalidation will not solve the kind of deep-seated cultural problems present, for example, at Mid Staffordshire Foundation Trust six years ago. Revalidation rightly stresses the importance of teamwork and patient involvement and seeks to gather feedback on this.

But as one commentator on hsj.co.uk remarked: "If one of my team said to a very junior staff member they were talking 'crap' and asked them 'are you stupid?' this would be frowned upon, but as it's a consultant, he is just 'having a bad day'. Is revalidation going to address this? I doubt it very much."

Another commentator - a medical director who champions revalidation - warned: "Sadly club culture and old boys' networks are all [too] common in some trusts and revalidation may give the opportunity for some leaders to punish someone from the wrong club, colour or one who is outside the network."

Then there is the question of how high the bar has been set. Revalidation, at present, appears to do little to test expertise in a doctor's chosen specialism. Finally, revalidation takes place every five years, a desperately long time to wait to deal with a poorly performing doctor.

But these problems are not insurmountable. Revalidation, and - crucially - the clinical governance process in which it sits, is a system and organisational issue, as well as one addressing the quality of individual clinicians. It is something trust boards, and those charged with improving the quality of primary care, need to convince themselves is helping deliver a consistent improvement in medial performance.

Isolated as a straightforward matter of professional regulation, clinical governance and revalidation will slide into an increasingly irrelevant box-ticking exercise, resented for the time it takes from patient care. Strong and consistent engagement by boards can ensure it saves lives and enhances effectiveness.

This article originally appeared on the Health Service Journal website on 24th October 2012

(<http://www.hsj.co.uk/opinion/leader/revalidation-cannot-be-left-to-gmcalone/5051041.article>) and has been reproduced with their kind permission.

COMMENTARY ONE: Revalidation Cannot be Left to the GMC Alone

John Moorehead
Director of Operations and Company
Secretary at ASGBI

The author of this article is quite correct in suggesting that considerable doubts exist around the whole issue of revalidation and that many doctors remain unconvinced about the appraisal process. However, some of the comments in this paper will do nothing to assuage the concerns of many in the profession. To suggest that "only the optimistic can claim efforts to tackle the quality of doctors is in better shape" is a remark with little foundation. What evidence is there that there is a significant problem with medical practice in the UK? Yes, there will always be the very occasional poor performer, but existing mechanisms have already proved adequate at weeding them out. The author's throw away remarks are on a par to those of a

COMMENTARY TWO: Revalidation Cannot be Left to the GMC Alone

Nicholas Markham
Director of Informatics at ASGBI

I think McLellan has got it about right. Success depends on engagement and enthusiasm, neither of which will be likely overflowing in abundance. There are going to be real teething issues, as well as a great deal of apathy and resentment, but like most fails accomplis, kicking against the pricks will ultimately prove to be fruitless.

We know this that legislation is coming, and there are some indisputable facts:

1. We want to see the best possible standards in medical practice.
2. Bad practice should be rooted out.
3. Underperforming doctors need identifying and thence, if possible, retraining.
4. The public need maximal confidence in doctors and the way medical services are provided.
5. Doctors' skills, interests and performance can become stale over time.

COMMENTARY THREE: Revalidation Cannot be Left to the GMC Alone

David Rew
Director of Communications at ASGBI

A license to surgical professional practice is based upon accumulated trust. Credits for that trust accumulate incrementally, in the passage from school into undergraduate medical training; from medical school into basic professional training, and so on up the ladder to

junior health official who recently wanted to highlight that 50% of doctors are below average. I think that most doctors are struggling to see how revalidation will do anything other than waste a considerable amount of time and money. An unarguable step forward? I think not. The author should also be aware that teamwork and patient involvement existed long before the concept of revalidation was ever thought of. The comments of the quoted "medical director" strike me as those of a well-balanced manager with a chip on both shoulders, irritated by the fact that no "club" would have him. To suggest that we have to wait for the five-yearly revalidation process before poor performance can be identified is utter nonsense. All the surgical units that I am familiar with have regular and robust audit meetings. These, along with weekly MDTs, have the potential to flag up performance issues very quickly. I know of no surgeons who would either tolerate or condone poor clinical practice. Revalidation will add nothing to what we already do.

The process will take years to mature. It will take almost as long for the process to have real teeth, and allow poor performers to be reliably and consistently identified, and then remediated. The robustness of the annual appraisal will need considerably beefing up as, at present, it is invariably little more than a tick-box exercise, and revalidation cannot be allowed to inherit this trait.

The evidence needed to inform will vary from specialty to specialty – for surgeons, their morbidity/mortality, cost effectiveness, records of complaints and some multisource feedback, are the most obvious.

So, yet another piece of regulation/legislation – call it what you will – with which we have to contend with these days. I must try not to be so sceptical; maybe it really will make a significant difference.

Perhaps the greatest personal worry I have is that I suspect I suffer from 'Imposter Syndrome' – having a fear that the process will reveal me for what I really am; not an apparently minimally successful surgeon, but an utter fraud. Should I jump before I'm pushed?

consultant status. At all stages during training, there are checks and balances on an individual's competence, integrity, behaviour and safety, which validate that trust.

At consultant level, these checks and balances, if anything, intensify. The individual surgeon carries a substantial burden of responsibility for his or her every action. He or she is under continual scrutiny by patients, ward, theatre and outpatient staff, administrators, family, friends and others. Perhaps the most potent form of scrutiny is

peer observation. It does not take long for a reputation to become established or undermined by word of mouth in any professional community, or for concerns to emerge about aspects of an individual consultant surgeon's practice.

Over the past decade, reporting, appraisal, risk and complaints systems, and the policies that underwrite them, have been progressively refined in every NHS and independent hospital. The days have long gone when consultants had the authority to override managements and concerns, or to act imperiously and contemptuously in the face of evidence of their own incompetence or malpractice. In a well run hospital, where there is good communication and trust between clinical and administrative colleagues, informal lines of communication will help anticipate and address many issues before they escalate into serious harm to patients or to the reputation of the hospital. Indeed, such is the sensitivity around these issues that many "course corrections" and local disciplinary actions are exercised effectively, quietly and with little overt disturbance.

Of course, seen from the perspectives of senior management and the DoH hierarchy, a large modern hospital can be a frightening place in terms of risk containment. Cosy, clubbable contacts and informal information networks begin to break down when you employ 500 consultants at all stages in their careers, in a technically complex system where new procedures and methodologies are regularly introduced; where younger consultants are being appointed with significantly less clinical experience at the coal face than once was the case; and where senior consultants are entitled by law to work into their late 60s.

Formal appraisal systems have much to offer organisations and appraisees. They provide an opportunity for regular reflection on practice in a supportive environment, and an excuse to collate documentation on one's professional life into a folder on an annual basis. Given the importance now attached to the annual appraisal process, it is a matter of some surprise to me that some 20% of the 400+ consultants in my own institution have allegedly not had such an appraisal in the past five years.

Consultants feel under considerable administrative pressure at present, with requirements to engage in annual job planning, local and enhanced appraisal, reflective writing and Stat and Mand training (50 Shades of Health and Safety), all of which are significant distractions from clinical work. Throw in time and emotional energy expended in dealing with the complaints culture, and fears of the

GMC elephant lurking in the professional waiting room, and it is small wonder that some colleagues fold or withdraw from voluntary participation in the appraisal process entirely.

And so to GMC-directed revalidation. It is already clear that this will produce a very substantial increase in workload, both for appraisers and appraisees, which will carry massive time costs and penalties for a system which is already under considerable pressure, and where the state of the nation's finances may yet oblige substantial cuts in funding for the health services. One cannot help but wonder what practical return will be secured for this call upon precious resources, when strengthening and enforcement of the current local reporting and appraisal systems would go a long way to teasing out potential problems at source.

I have a further concern on a matter which I believe will ultimately and rightly come to be tested in the courts. It relates to the enormous powers invested in the Reporting Officers, who will generally be medical directors of NHS Trusts. Given the anxieties felt by many members of the profession about revalidation, it is essential that Reporting Officers are seen to be independent of GMC pressures, which are ultimately political. They must carry the confidence and trust of those who they are revalidating.

Unfortunately, Reporting Officers carry a double indemnity. They lack true independence, in that they are both (generally) employees of the NHS Trust whose employees they are revalidating. They are also directly answerable to the GMC through their own revalidation and through the innate command structure of the health system. While the best reporting officers will approach the process with absolute integrity, there will be huge scope for deliberate or inadvertent prejudice in a system which may be perceived as fundamentally illiberal by those who have studied history and the working of autocracies.

Clearly, surgeons should take the lead in engaging with the revalidation process, in helping make it work as intended, and in helping make the concept of enhanced appraisal fit for purpose in one form or another. It remains to be seen whether GMC-directed revalidation in its present form will secure the aims which have been set with it, or whether it will collapse under the weight of additional bureaucracy and of the inconsistencies which it is likely to generate. I look forward to discussing this piece of reflective writing with my Reporting Officer in the Autumn of 2013.



THE LAST SURGICAL OUTPOST OF EMPIRE

David Vassallo
Clinical Director, The Princess Mary's Hospital, RAF Akrotiri

David A Rew
Visiting Consultant General Surgeon
Colonel, Defence Medical Services (V)



Figure 1: Painting of TPMH by Wing Commander Gora Pathak RAF, Consultant Orthopaedic Surgeon, Peterborough Hospital: by kind permission of the artist

1st November 2012 marked the closure of The Princess Mary's Hospital at RAF Akrotiri in Cyprus, the last remaining peacetime British Military Hospital overseas, after 50 years of existence. TPMH Akrotiri has been one of the most spectacularly located and beautifully appointed hospitals in the portfolio of the UK Taxpayer since its construction in the early 1960s, when the contraction of Imperial responsibilities East of Suez, and the expansion of the military presence in Cyprus, mandated a new medical and surgical facility for military personnel and their dependants in the Eastern Mediterranean.



Figure 2: The 1956 RAF Temporary Hospital at Akrotiri, courtesy of TPMH Archives

A temporary military hospital was first built at RAF Akrotiri in the mid 1950s (Figure 2), to support the large movement of troops out of Egypt after Colonel Nasser's ascent to power. Construction of the current hospital commenced in 1961 and was completed in 1963, at a time when Cold War tensions were still running high following the Cuban Missile Crisis. The modern building comprises a series of low-rise two, three and four storey ward and administrative blocks, faced in white concrete. The hospital sits in splendid isolation on Cape Zevgari at the end of the Akrotiri peninsula on the southern coast of Cyprus, surrounded on three sides by low cliffs and the Mediterranean Sea, and to the north by the open expanse of Akrotiri ranges, which remain in use for troops on general training duties and in transit to Afghanistan. It offers unsurpassed views of the coast and sea from all aspects. The tiled floors and high ceilings, to dissipate the summer heat, are reminiscent of the best of the innovative modernist architecture of the period, while the central garden courtyard, with its Koi Carp pool, provides a haven of escape and tranquillity. The earthquake-proof (and nuclear bomb resistant) structure and foundations have seen it through at least one earth tremor on its tectonic fault line with no significant damage.



Figure 3: Princess Mary inspects a model of the hospital at the opening ceremony in 1963

The 155 beds and two operating theatres have supported the wide range of elective and emergency workload generated by a local service population with dependants of up to 30,000 personnel in the peak years, and by a diverse transit population of military and civilian patients and casualties passing through Cyprus over the years. At the peak of its activity at the beginning of the 1970s, TPMH was handling 20,000 outpatients and 5,000 inpatients each year, by a purely consultant-based service (with the only junior staff being a surgical registrar, until that post was

abolished in recent years). Some 14,000 British citizens have taken their first breath in the TPMH maternity wards.

The hospital has never been surgically as busy as a UK District General Hospital, although there have been surges of activity during times of conflict [1]. CP Malpass and JS Winter reported the hospital's experience in dealing with casualties of events around the Turkish invasion of Northern Cyprus in 1974 in the BJS. 119 operations were carried out on 41 casualties of gunshot, missile and bomb blast at that time, the majority of whom were Turkish Cypriot local nationals rather than UK service personnel [2]. Tom Day and Harald Veen (from TPMH and the Royal Naval Hospital Gibraltar respectively) discussed the contemporary governance issues surrounding the working of such hospitals in 2008 [3].



Figure 4: The Princess Mary's Hospital Akrotiri, prior to closure

As reflects its presence within the boundaries of a major RAF base, the hospital has remained under RAF command throughout its life. It had been staffed primarily by RAF medical officers and members of the Princess Mary's Royal Air Force Nursing Service, until the closure of the Army hospital BMH Dhekelia in 1978 resulted in reinforcement with Army staff. It had additional support from a locally engaged workforce of Cypriot residents, and an itinerant population of visiting civilian, tri-service and Reserve specialists.

Sadly, but inevitably, as the service population has shrunk, so the costs of maintaining and staffing the hospital have grown significantly in proportion to the declining clinical activity, forcing an emotionally difficult but economically unarguable decision to close the hospital completely in 2012. Its potential utility as a transit care centre for casualties of Middle East operations has not been realised, as UK casualties of conflict in Iraq, Afghanistan and elsewhere in Asia and Africa are now flown on

well equipped strategic airframes with in-flight critical care directly from the war zone to UK hospitals. From now on, the acute clinical workload in Cyprus is being referred on to the impressively well-staffed and internationally accredited local secondary care facilities at the Ygia Polyclinic in Limassol, as a natural extension of the growing links between UK and local Cypriot clinicians at TPMH in recent years.

While the TPMH buildings themselves hold out the potential of many more years of fruitful occupancy for clinical teams, it is paradoxically the splendid isolation of the hospital on an active military base which has sealed its fate. In any other coastal location in the world, it would provide a magnificent site for a civilian medical facility to serve the large multinational expatriate civilian population, for conversion into residential apartments, or as the foundation for a top class hotel. Mothballing the buildings against future contingencies is reportedly not a realistic option, as the costs of maintenance would, in any case, be substantial.

Many surgical teams, clinical and nursing staff will have happy memories of their time at TPMH in the conducive climate of Akrotiri, where the sea breezes mitigate the heat of the island, and where the views over the Mediterranean have accelerated the recuperation of mind and body for the past 50 years. In marking the passing of an era and of a unique clinical Outpost of Empire, we are privileged to have been present as the consultant general surgeons to close the doors on the TPMH operating theatres for the last time, and to be able to record its passing from within its sunlit walls.

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(Available from the Army Medical Services Museum, Keogh Barracks, Aldershot Camberley Hants. A more comprehensive version is available as an iBook.)
- [2] **Malpass C P, Winter J S**
A report on missile injuries in Cyprus 1974
Brit J Surg 1976; 63: 482-487
- [3] **Day T K, Veen H**
Getting the best of both worlds: clinical excellence at a peripheral unit
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Useful websites

- www.qaranc.co.uk/theprincessmaryshospital.php
www.raf.mod.uk/PMRAFNS/history/rafhospitalakrotiri.cfm
www.rafacyprus.co.uk/
www.rafakrotiri.co.uk/



A GRAND DAY OUT IN SWANSEA

David A Rew
Consultant Surgeon, Southampton
University Hospitals

The Gower Peninsula, the Welsh Baritone Voice and well prepared Laverbread are among the true splendours of the Good Lord's creations. The City of Swansea is the gateway to the Gower. The grand sweep of Swansea Bay stretches from the Mumbles Lifeboat station and Oystermouth, past West Cross, The Mayals, Singleton Hospital and the University of Swansea to the steep residential terraces around Brynmill, the Brangwyn Concert Hall, the City itself and the Docks. The latter are now delicately renamed the Maritime Quarter to appease the post-industrial sensibilities of a generation who were spared the toils and memories of the copper, coal, iron and slate trades of the 18th and 19th centuries, and the explosive ordnance of the Luftwaffe, which enlivened my parents' childhood in the town.

Until the mid 1960s, the sea frontage of Swansea Bay was owned by the steam train and the tram, which would chug past one of the more curious sports grounds of the home nations. Swansea Cricket and Football Club, or the St Helen's Ground nestled in Brynmill at the foot of a steep hill, behind the Mumbles Road and enclosed by Gorse Lane, with the Cricketer's Pub to the East and Bryn Road to the North. It is a hybrid site in the shape of a truncated oval or light bulb, which doubles as a rugby club ground in the winter, and the itinerant home of Glamorgan County Cricket Club for occasional county home matches during the summer.

As a 1957 graduate of the Swansea Hospital's maternity service, with itinerant parents who would make the annual summer trek back to Swansea throughout our childhood for our annual vacation from the near abroad, be it Nottingham, Newcastle or Cheshire, I would walk for many miles around the highways and byways of the Gower.



Figure 1: A first class cricket match at St Helen's in the 1950s

On Saturday 31st August 1968, a few days before the start of the new school term and a new life in secondary education, our father decided that the time had come to initiate us with a rite of passage into the intricacies of county cricket. My six year

old brother Christopher and I were packed off to St Helen's with our sandwich lunches, to occupy ourselves for the day at the foot of the East stand, below the windows of the Cricketer's pub. Nottinghamshire were the visiting club, for the first day of a three day match against Glamorgan. The sun was shining gloriously, and most of South Wales was on the beach or anywhere but St Helens.

The history of cricket dates back to the seventeenth century, if not before, and was covered in the free press during the 1700s as a county level sport. The laws were codified in 1744, and the game spread to the colonies, including North America, the West Indies and Australia, before 1800, and to South Africa. The County game was formalised in the 19th Century, with Sussex being founded in 1839, and internal tours developed following the visit of a team of English professionals to the USA in 1859. The inaugural Test Matches with Australia were played in 1877. W.G. Grace played his inaugural first class match in 1864. Only war halted the march of cricket in the 20th century. The number of cricket matches played around the world over the three centuries before 31st August 1968 is incalculable, as is the number of overs bowled in that time.

In all of first class cricket history before the day on which we watched our first ever County Cricket match, one particular batting achievement had never been recorded. In 1967, the wonderfully entertaining Pakistani batsman Majid Khan had hit 34 runs in a six ball over, and by a twist of fate, he was fielding for Glamorgan as the overseas player that day against Nottinghamshire. No batsman had ever cleared the boundary with strikes on six consecutive deliveries in one over, scoring 36 runs.

Nottinghamshire batted at a brisk pace and piled up the runs on a ground with a short boundary and an excellent wicket. The former England cricketer J.B. Bolus scored 140 runs, striking six sixes over the course of his innings, and his opening partner R.A. White scored a further 73 runs. By tea, as the shadows began to cross the ground, Notts had amassed over 300 runs, with the Glamorgan bowler Malcolm Nash taking four of the five wickets to fall.

The fall of the fifth wicket belatedly brought the languid, loping West Indian all rounder Gary Sobers down the long flight of steps from the pavilion. Sobers was already a legend from his achievements in Test cricket over the past decade, including the then highest Test score of 365 not out. The events of the next 60 minutes or so are recorded in exquisite detail in Graeme Lloyd's book, *Six of the Best* (Celluloid Limited 2008, Cardiff). One over in particular, bowled from the Pavilion End by one Malcolm Nash to one Garfield St Auburn Sobers, has become a cricket legend. Ball after ball soared upwards, and four of them over our heads and over the East stand. As the over progressed, the crowd became increasingly animated, willing the next ball over the ropes. Knowledgeable old soaks in the rows behind informed us of the significance of the spectacle as six followed six; 36 runs in six balls!

BBC Wales were filming that afternoon. I have re-watched the grainy coverage of that over to the late Wilf Wooller's astonished commentary on many occasions. As the camera shoots its blurred black and white images from high above the

Mumbles Road end, it pans over the Cricketer's Arms and the patchily occupied stands below, where at least one small pair of blessed young boys became witnesses to an extraordinary piece of cricketing history.

Figure 2: Gary Sobers hits six sixes on 31st August 1968. Pictures courtesy BBC Wales.

