INTRODUCTION

Thanks to MMC (a disaster), MTAS (an unmitigated disaster) and Liam Donaldson et al, our trainees are demoralised as never before. Even those with posts are unhappy! One spin-off of this abject misery has been an exponential increase in the number of discussions seniors have to have with trainees seeking advice. What do you say to the FTSTA? Is this really a dead end job? What about the trainee with MRCS and some research who has failed to gain a place? The overseas doctor without right of residence, the F2 who always wanted to be a doctor, even a surgeon, but is now unsure?

For my own part, I make the following ten points emphasising one or other depending upon the circumstances of the individual trainee:

Firstly, write! Whether it be case reports, reviews, audits or - if they are fortunate - some original research, it does not matter, urge them to write! Whatever your opinions on MTAS, there was general agreement that questions on the application form were vacuous, facile and wholly non discriminatory. None of us know what will evolve in the next year or so, but I suspect one aspect of the backlash against MTAS will be a recognition that industry should be rewarded. In other words, we will return, a little, to the meritocracy. So advise your trainees to write! For some, it might be appropriate to recommend taught MSc surgical science degrees such as are available at the University of Hull and elsewhere.

Secondly, make sure the paperwork is correct and up-to-date. This means keeping the dreaded portfolio. Yes, I know that mini CEX and other modern assessment methods beloved of Deaneries are almost a complete waste of time but, unfortunately, the educationalists have won the day and without them they are sunk!

Third, I urge trainees to keep an accurate logbook and insist on regular documented appraisals and they must have proof of completed audits.

Fourth, make sure the correct boxes are all ticked for ATLS, training the trainers and appropriate skills courses.

Five, I suggest they reconsider their specialty choice. General Surgery and T & O remain extremely popular and, therefore, competitive. Why not Urology, ENT or A & E?

Six, I point out that we are on the verge of being ‘over doctored’ in this country. A total of 3749 doctors qualified in 1997, increasing to 5894 in 2005 without a proportionate increase in training and consultant posts. The discrepancy between available posts and applicants will increase as doctors from the training and consultant posts. The discrepancy between increasing to 5894 in 2005 without a proportionate increase in training capacity. Trainees must be aware, therefore, that not all trainees will end up in consultant posts as we know them today, is fundamental to future planning. Rightly, the profession will have to adapt to provide that which the trusts will pay for, and this will be determined by patient need. Also, in the context of the crystal ball, it’s worth considering what you feel the future is of General Surgery. After all, there are important lessons to be learned by the difficulties confronted by our Cardiac colleagues, which have occurred as a result of dramatic changes in therapeutic interventions. Will the same happen in General Surgery? My view is that major cancer surgery will get less in years to come, and that it only seems a matter of time before breast and vascular leave the general surgical fold. Perhaps we, like the acute care physicians, will evolve a cadre of acute care surgeons to “babysit” cases until they are referred on to appropriate specialists.

Eight, I discuss manpower planning. I appreciate that any prediction of the needs of the surgical workforce are almost doomed to failure. However, I still think it instructive to consider likely scenarios. There has been a significant expansion in the number of Consultant Surgeons in the past ten years to meet targets set in the NHS Plan. This has occurred with a concomitant increase in NTNs. In Yorkshire alone we went from 44 NTNs in 2000 to 74 in 2006. In the past twelve months we have been urged to further increase ST 3 availability to offset the introduction of MMC. This resulted in another eight posts in Yorkshire. I believe we have reached saturation point for training capacity. Trainees must be aware, therefore, that there is little prospect of a significant increase in training posts in the near future.

Foundation Trusts wanting to appoint “consultants” for life with guaranteed jobs and pensions. More probable is that they will appoint personnel if, and when, required. A (Foundation) Trust near here recently appointed a Consultant Orthopaedic Surgeon for a fixed term of two years. The same will apply to ISTCs. In future, service requirements will dictate appointments. This will mean that not everyone can be a super-specialist. This concept, that not all trainees will end up in consultant posts as we know them today, is fundamental to future planning. Rightly, the profession will have to adapt to provide that which the trusts will pay for, and this will be determined by patient need. Also, in the context of the crystal ball, it’s worth considering what you feel the future is of General Surgery. After all, there are important lessons to be learned by the difficulties confronted by our Cardiac colleagues, which have occurred as a result of dramatic changes in therapeutic interventions. Will the same happen in General Surgery? My view is that major cancer surgery will get less in years to come, and that it only seems a matter of time before breast and vascular leave the general surgical fold. Perhaps we, like the acute care physicians, will evolve a cadre of acute care surgeons to “babysit” cases until they are referred on to appropriate specialists.

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Continued overleaf
Nine, I advise trainees to consider some navel gazing. Why do they really want a NTN? Will it guarantee a consultant post? Almost certainly not. Will it guarantee a “specialist” post? Again, almost certainly not. Read John Black’s article in this Newsletter on Manpower Planning; it’s excellent and should be compulsory reading for all involved with training. He estimates that general surgery has about a 30% over provision of NTNs! Unless there is some dramatic political turn around and considerable consultant expansion, we are almost certainly looking at the prospect of unemployed CCT holders in the near future.

Ten, the above gloomy viewpoint of available posts in the future is likely to be made worse by increasing numbers of surgeons getting onto the specialist register by routes other than conventional run through training resulting in the award of a CCT. This includes both the ‘Article 14’ route as well the award of CESRs (Certificate of Equivalence of Specialist Registration). I advise struggling trainees, without a NTN and little prospect of getting one, to consider using these developments to their potential advantage. If they take up a non-training grade post, publish, ensure regular appraisals and keep their portfolio, and then take the exit exam (which is now open to all) then there is a good chance they will be successful in an Article 14 application. Incidentally, I don’t see a reformed PMETB scaling down Article 14 in deference to traditional training routes supported by the Colleges.

If aspiration to obtain a “consultant” post is the only goal deemed worthwhile, then many trainees will be disappointed. If, however, we recognise that there are other equally worthwhile career options, many of which will suit present life-styles and many of which will be forced on the profession for the reasons outlined above, then we may make some progress towards improving morale. In future, “consultant” appointments may only occur after a period of service provision during which time individuals develop their specialism. Whatever your views, I’m sure most would agree that there is an urgent need to address the issue of post CCT training.

John MacFie
Honorary Editorial Secretary

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SURVEY OF GENERAL PAEDIATRIC SURGERY PROVISION IN ENGLAND, WALES AND NORTHERN IRELAND

Mr Jonathan K Pye, Honorary Secretary

Abstract
A survey was carried out to ascertain the current provision of General Paediatric Surgery (GPS) in all hospitals in England, Wales and Northern Ireland with 100% return rate. The provision of GPS is at a crossroads with a drift of these cases to the overstretched, tertiary referral hospitals.

Methods: The regional representatives on the council of the Association of Surgeons of Great Britain and Ireland (ASGBI) obtained data from their regions. Any gaps in the data were completed by the author telephoning the remaining hospitals to ascertain their current provision.

Results: Three hundred and twenty five acute hospitals are potentially available to admit elective and/or emergency paediatric patients, of which 25 hospitals provide a tertiary paediatric surgical service. Of the remaining “non-tertiary” hospitals, 138 provide elective GPS and 147 provide emergency GPS. The ages at which GPS is carried out varies considerably, but 76% of non-tertiary hospitals provide elective GPS to those over the age of 2 years. The ages of emergency cases are 24% over the age of 2 years and 51.5% over the age of 5 years. The age at which surgery is carried out is dependent on the anaesthetic provision. Subspecialisation within each hospital has taken place with a limited number of surgeons providing the elective surgery. Only 11 surgeons provide this surgery in a “hub and spoke” fashion with a tertiary centre. An estimate of the annual elective case load of GPS based on the average number of cases done on an operation list works out at 23,000 cases done outwith the tertiary centres. Discussion: Almost ten years ago, a change in the training of young surgeons followed advice from the British Association of Paediatric Surgeons (BAPS), which suggested that training and management of these cases was in the realm of the paediatric surgeons. A subtle change in the wording of the general guidance by the Royal College of Anaesthetists also altered the emphasis on the age at which it was appropriate to anaesthetise children. This led to a drift of GPS away from the District General Hospitals (DGHs) of 30% over a decade. The volume of cases of these low risk operations in well children cannot be absorbed into the current tertiary centres due to pressures on beds. Young surgeons are now seldom exposed to this surgery, and are not being trained in it. The future provision of this surgery is at risk unless action is taken now. This survey was carried out to inform the debate, and to make recommendations for the future. The principal recommendations are: That GPS should continue to be provided as at present in those DGHs equipped to do so. That GPS training should be carried out in the DGHs where a high volume of cases is carried out. That management of these cases should use a network approach in each region. That central support is needed for this agreement. That hospital Trusts should actively advertise for an interest in GPS as a second subspecialty.

Introduction
General Paediatric Surgery (GPS) provision in the UK is at a crossroads. Cochrane and Tanner identified a swing of provision of GPS from DGHs to tertiary centres of about 30% over a decade (1). Many of the general surgeons that currently provide the majority of GPS are of an age where retirement is approaching. The training of general surgical SpRs rarely includes GPS at present as it is not a separate subspecialty and is not clearly demarcated in the surgical curriculum.
There is a crisis in the current ability of the tertiary paediatric centres in terms of physical space as well as manpower to cope with a further swing away from the DGH as the main providers of GPS. The future provision of GPS is therefore in doubt.

This survey was undertaken under the umbrella of the Association of Surgeons of Great Britain and Ireland (ASGBI) to establish the detail of GPS provision hospital by hospital, so that suggestions for the future can be made. Scotland has not been included in this survey as the Scottish Health Service is substantially different from the rest of the UK.

The worry from a national perspective is that a domino effect may come into play. When the current GPS surgeons retire, then GPS in the DGH could wither on the vine. The domino effect is that if one specialty stops doing GPS, this will impact on the anaesthetists who may not have enough cases to maintain their skills. This might mean that other specialties may have to stop doing paediatric cases. If there are no surgeons, or no anaesthetists capable (or willing) to give children’s anaesthetics, this will impact on the ability of a DGH paediatric department to safely accept emergencies with no surgical backup. This, in turn, could undermine the status of such a hospital as a fully functioning DGH. Clearly this is not a tenable situation for the NHS.

Methods
The ASGBI Regional Representatives enquired via their link surgeons as to the status of GPS to provide a report on the current provision, the number of surgeons appropriately trained in GPS, and a view of the future local provision of GPS. This gave a response that was supplemented by the remaining hospitals being telephoned by the author to enquire of the arrangements for that hospital. This has allowed 100% data acquisition for the hospitals in England, Wales and Northern Ireland.

Results
Elective GPS: In England, Wales and Northern Ireland there is a total of 235 acute NHS hospitals potentially available for the admission of elective and/or emergency paediatric patients. This survey has firm data on 100% of the hospitals relating to the provision of GPS.

Of the 235 hospitals, 25 (10.5%) have “tertiary” status with a full time specialist paediatric surgical unit able to manage the full range of paediatric and neonatal surgical conditions. A further 72 (30.5%) do not provide elective GPS and 63 (27%) do not provide emergency GPS. This leaves 138 (59%) “non-tertiary” hospitals that provide elective GPS and 147 (62.5%) “non-tertiary” hospitals that provide emergency GPS.

Elective GPS consists of herniotomy for hernia or hydrocele, orchidopexy for palpable undescended testis, circumcision, removal of minor soft tissue abnormalities and repair of umbilical hernia (2), with most conditions presenting under the age of 5 years. The age at which anaesthetists are happy to give an anaesthetic is therefore crucial. The data in Table 1 gives the age bands of the lower age limit at which the surgery is carried out in each hospital.

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<th>Number</th>
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<tr>
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Table 1: Data on elective GPS by age band

Emergency GPS consists of the management of the causes of the “acute abdomen” such as appendicitis, minor trauma including lacerations, incision and drainage of a superficial abscess, management of the acute scrotum and where the anaesthetic cover allows, obstructed hernias (2). Very few hospitals are able to provide a service that includes pyloromyotomy or the treatment of intussusception with the majority being referred to a tertiary centre. Table 2 gives the data by age band for emergency GPS. The lower age limit for emergency surgery is mostly dictated by anaesthetists, and varies quite widely. As there is rarely a specific rota, either surgical or anaesthetic, just for paediatric emergencies, the age limits are rather higher with the majority being at >5 years. There was widespread feeling that the surgery itself is often not complicated, but anaesthetic confidence is frequently the deciding factor. On talking to the surgeons, there was a strong sense of awareness of individual limitations by the surgeons, with all hospitals making it very clear that any case outside their expertise would be transferred without hesitation.

<table>
<thead>
<tr>
<th>By age band</th>
<th>Number</th>
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<tr>
<td>&gt;5 years</td>
<td>77</td>
<td>52.5</td>
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Table 2: Data on emergency GPS by age band

**Hub and spoke:** In some regions there is a functioning “hub and spoke” arrangement with either a paediatric surgeon travelling to a DGH or a joint appointment between the Tertiary centre and a DGH. This is, however, a fledgling system with only 11 individuals in place.

Future intent: Of those currently providing a non-tertiary GPS service, 86% made a firm statement that, as a consultant body in each of those hospitals, they would wish to continue to provide GPS. It was seen as a good service to their population, and that a long journey for parents and child for either a consultation or a daycase procedure was often difficult for families in deprived areas.

Emergency GPS: A greater number of “non-tertiary” hospitals 147 (62.5%) provide emergency GPS. This consists of the management of the causes of the “acute abdomen” such as appendicitis, minor trauma including lacerations, incision and drainage of a superficial abscess, management of the acute scrotum and where the anaesthetic cover allows, obstructed hernias (2). Very few hospitals are able to provide a service that includes pyloromyotomy or the treatment of intussusception with the majority being referred to a tertiary centre. Table 2 gives the data by age band for emergency GPS. The lower age limit for emergency surgery is mostly dictated by anaesthetists, and varies quite widely. As there is rarely a specific rota, either surgical or anaesthetic, just for paediatric emergencies, the age limits are rather higher with the majority being at >5 years. There was widespread feeling that the surgery itself is often not complicated, but anaesthetic confidence is frequently the deciding factor. On talking to the surgeons, there was a strong sense of awareness of individual limitations by the surgeons, with all hospitals making it very clear that any case outside their expertise would be transferred without hesitation.
Sub-specialisation: In all hospitals, apart from 3, sub-specialisation has taken place in that the elective GPS is carried out by a limited number of individuals all of whom have had training in paediatric surgery to the level required for GPS in the DGH. In 12 non tertiary hospitals the emergency anaesthetic/surgical support is able to deal with neonates at and around term. The emergency operations done in these hospitals include pyloromyotomy, intussusception and strangulated hernias with appropriate training and case volume to allow safe practice.

Case volume: One hundred and one (74%) of the non tertiary hospitals carrying out GPS have a list of approximately 5 cases per fortnight. The remaining 36 (26%) hospitals have a weekly list. This gives a total workload of 22,490 cases per year. This represents a conservative estimate of the elective case load. This survey is not able to estimate the number of emergency cases done in the non tertiary hospitals, but as many hospitals only operate on the over 5 year olds, it is likely that the biggest swing towards the tertiary centres has already happened with the emergencies. There is anecdotal evidence that the tertiary centres have problems accommodating emergencies because of pressure on beds.

Discussion
This is the first survey that has established the hospital by hospital detail of the provision of GPS in the UK. The stimulus for this is the looming difficulties for the provision of GPS in the future coupled with a diminution in the training of future surgeons able to do GPS in the districts. There has been a change in provision already as evidenced by the 73 hospitals that do not provide GPS. There has also been change in that in almost every hospital sub-specialisation has taken place with only a limited number of appropriately trained surgeons in each hospital providing the surgery.

The volume of cases done outside the tertiary centres is such that it is not possible to accommodate all GPS in the tertiary centres even if there was a desire to do so.

There is anecdotal evidence that anaesthetists have a major influence on the age at which GPS both elective and emergency is done. The Royal College of Anaesthetists (RCoA) clearly states that all their members should be able to deal with infants and neonates in the emergency setting if only for stabilisation (3), but the same guidance also states that anaesthetists should “normally be able to anaesthetise children who have reached their 5th birthday”. RCoA guidance in 1999 stated that “children under the age of 5 years will normally be anaesthetised by consultants under the direct supervision of a consultant” (4). It is clear from comments received that this change of wording resulted in a change in practice, with some anaesthetists being uncertain whether, according to this guidance, they should anaesthetise those under 5 years of age. A number of other factors are evident and these include confidence by the individual anaesthetist, support by a paediatric department, and other surgical specialties also operating on children providing a sufficient volume of operating to allow anaesthetic skills to be maintained.

The main issue that falls out of this survey is that of surgical training. Of those hospitals that provide non-tertiary GPS (137) 86% state that their consultant body has expressed a desire to continue to provide GPS. A recent survey done in Wales by K Gomez et al (5) has shown that at least one third of hospital managements also wish for their hospital to provide GPS (presented at ASGBI meeting on 20/04/07). Evidence exists from the SAC in general surgery (personal communication, J Black) that, although posts are provided for paediatric training, there is little enthusiasm by the trainees to take up these offers. In addition, there is sometimes reluctance by specialist paediatric surgeons to train general surgical trainees as many cases are of a super-specialist nature with preference being given to the paediatric surgical trainees.

A paper by Arul & Spicer in 1998 (6) questioned where paediatric surgery should be performed. This appeared to lead to a change in emphasis by BAPS as to where the training of surgeons able to carry out GPS should be done. This resulted in surgeons that used to train their registrars in GPS no longer doing so despite a statement by BAPS in a paper in 2002 (7) that training in GPS could be a combination of DGH and tertiary centre. GPS remains within the General Surgical curriculum, but as this lack of exposure has persisted for a generation of trainees, there is little perception of the need for GPS training by the trainees. Surgical sub-specialisation is now firmly entrenched in the minds of trainees and trainers alike. There is insufficient volume of cases for GPS to be a subspecialty in its own right so the need for it has dropped off the training radar. Trainees no longer see the attraction of GPS as a neat, delicate area of clinical practice that is so important to the local population. It is perceived, by the surgeons currently carrying out GPS, to be a valuable service to the local population who may otherwise need to travel up to 70 or 80 miles for either a consultation or a daycase procedure. The volume of cases effectively precludes centralisation quite apart from the question of the distances to travel. A “huh and spoke” practice is a potential way forward but is actually happening in only eleven cases across the UK.

The Future
The future must lie in the training of GPS. General Surgery can easily incorporate this training without the need for expanding the overall training numbers. It would seem appropriate that the majority of the training takes place in those hospitals where GPS is carried out on a regular basis by those with a high case volume. It is also appropriate that there could be a 6 month period in GPS training in a tertiary paediatric surgical unit so that modern practices can be learned and applied to the trainee’s future practice. There are several committed GPS surgeons who should be training every SpR (StR) that comes to them for their main subspeciality training. Those SpRts (StRts) that show aptitude and/or a desire to add these skills to their repertoire should then spend 6 months in a paediatric surgical unit focussing on the outpatient and operative work. This could be either in a DGH or a tertiary centre. The advantage of this approach would be that those units interested in GPS would feel that they have a useful function in providing for the future, and their expertise will be recognised.
training provided in a DGH will be focussed on GPS alone. The pressure will be taken off the tertiary paediatric surgical units who will not have to train reluctant trainees and will only encounter those interested, who already have appropriate skills. It would be an advantage if the trainees were exposed to GPS when they are in years 3, 4 or 5 as they will have been able to develop their tissue handling abilities. A further benefit is that paediatric tertiary centres can concentrate on training their own trainees in the complex specialist surgery that they should rightly teach.

A sensible way to provide GPS would be through networks. In each region, the solution may be different, but an overall theme could be that a high volume DGH might be able to gear up to accept the transfers that would otherwise have gone to the tertiary centre. This would need to be based on a fully functioning paediatric department and accompanying anaesthetic skills. These hospitals exist already and it would take only a small change to effect this working arrangement, which would benefit all parties and preserve the ability for the DGH to continue to provide the local service as at present.

Not all trainees will go on to provide a GPS service in their consultant practice, but effective training would allow a cadre of individuals to be produced that are capable of continuing to provide this important service for their local populations. If SpRs (StRs) trained in GPS are available this will have a dual benefit for both the individual and the employing Trust. The individual will be able to bring an additional benefit to the Trust, and the Trust will be able to continue to provide a service for their population. There is evidence that this would be attractive to some hospital Trust managements (5).

It is important that a “domino” effect does not destabilise DGHs. In order for a sufficient volume of cases to be available for maintenance of anaesthetic expertise, this requires several surgical disciplines to operate on children with the support of a paediatric department.

GPS is currently carried out by surgeons who may be looking at retirement in the foreseeable future. This survey has established that the majority (68%) of hospitals currently providing GPS can continue for 5-10 years but many are worried about the future. It is vital that action is taken now in order to have enough trainees to fill the posts that become available in the next 10 years and beyond.

**Recommendations**

General Paediatric Surgery (GPS) should continue in DGHs in order to provide a service for their local population.

Regional networks should be developed to accommodate the majority of GPS and take the pressure off the tertiary centres.

Those DGHs with a high volume of GPS should be required to train the SpRs (StRs) that come to their hospitals. This should form the bedrock of GPS training. Those trainees demonstrating either ability or intent should then spend a further 6 months refining their paediatric surgical technique either in a DGH or a tertiary centre as appropriate.

Some regions have the facility to do all the GPS training in “non-tertiary” hospitals. This could be negotiated on a regional basis as appropriate.

DGH Trusts should be encouraged to actively advertise for trained surgeons with an interest in GPS.

Obtain central support from the British Association of Paediatric Surgeons (BAPS), the British Association of Paediatric Anaesthetists (BAPA), the Royal College of Anaesthetists (RCoA) and the Children’s Surgical Forum for this proposal.

Make the Department of Health aware of the potential solutions and obtain support for this model.

**Acknowledgements**

I wish to acknowledge the contributions by those on the Council of ASGBI and those surgeons who kindly spoke to me over the telephone that allowed this survey to be complete.

**References**

5. Survey of paediatric surgery in Wales. Gomez K et al presented at ASGBI Annual Scientific Meeting (Manchester), April 2007
EUROPEAN WORKING TIME DIRECTIVE: A VIEW FROM A PROSPECTIVE SURGICAL TRAINEE

Mr Priyadharshanan Ariyaratnam

Introduction
Leo Tolstoy once remarked that every man wishes to change the world, but nobody wishes to change themselves. Over the years, the medical profession has been fairly generous in its serving of advice to the general public though sparing in its receiving. The ability of the medical profession to change itself from within is at the centre of the debate into the time restrictions imposed by the European Working Time Directive (EWTD).

Surgery is a highly disciplined speciality which involves a lot of patience and dedication. The working time restrictions imposed by the EWTD, from a 70 hr week to a 56 hour week in 2004 and thereafter to a 48 hour week by 2009, may involve a radical revision of how surgical training is conducted in the United Kingdom (UK). This essay examines three aspects of the working time restrictions on surgical training: the reasons behind initiating the EWTD; ways in which surgical training may be modified and maximised within these restrictions; and finally how working time restrictions have fared in other countries, notably in the United States of America (USA).

Arguments for a change of practice
For many, time is a precious commodity in life. The time to work, the time to spend with one’s family, the time to sleep and even the time to think. Mainland Europe places much emphasis on recreational time and, some may argue, at the expense of global competition. However, the protection of employees is fundamental in a civilised society. Such protection may, in fact, improve productivity by protecting the welfare of the workforce. For example, it has been shown that sleep deprivation due to long hours on-call may lead to an increase in the errors performed in the operating theatre. Recreational time plays a pivotal role also in both the high drop-out rates seen in surgical training and the recruitment of women to surgical training.

Drop out rates in surgery
Medicine has always been a stressful career option. It was once considered a vocation, where family and friends often came second. For some intelligent and able individuals, the choice has often been the wrong one. Between 10-20% of surgical trainees in the USA drop out for many reasons including the long working hours which have been associated with high levels of exhaustion and depersonalisation in surgical trainees. In addition to drop-out rates, the actual recruitment of trainees into surgery may be affected by long working hours. Studies in South Africa have found that long hours have contributed to the lack of recruitment to certain surgical programmes. A reduction in the proportion of the day or week spent working may, therefore, allow an increase in recruitment to surgical training whilst reducing drop-out rates.

Surgical training and women
Much has changed in Britain over the last fifty years. From the emergence of the oral contraceptive pill, society has shifted away from an emphasis on family values towards a preoccupation with individualism. The pursuit of one’s own career advancement has put considerable strain on the training doctor to balance their personal or familial responsibilities with their clinical endeavours.

The emergence of the working mother within a more liberal society has had many advantages and disadvantages. The advantages have mainly been the greater expression of the woman’s talents within the workplace. However, the disadvantages have mainly come in the form of a reduced relationship between mother and child, which has impacted negatively, in instances, on the child’s intellectual and social development. It seems that time may be the limiting factor in successful family dynamics. The increasing numbers of females graduating from medical school suggest that more attention must be given to their needs and preferences. Surgery has always had a low proportion of female trainees in comparison to the female graduates. Although discrimination within the speciality may prevent many women from entering surgery, it is also the perception of the long hours being incompatible with a family life that plays a pivotal role in the decision to embark on surgical training. Hence a reduction in the time spent working may encourage more women to enter surgery whilst also maintaining an active role in their responsibility within the family.

Training and continuity of care
Mark Twain once said that “The 20th Century is a stranger to me- I wish it well but my heart is all for my own century”. Much of the objection to the implementation of the EWTD has come from the senior levels, particularly consultants. Cynically, it may originate from an ungrounded sentimentality or it may, indeed, arise from a genuine concern for a generation who have had the ladder removed from under the feet of their superiors.

Although it may be too late to stop the train in its tracks, the path must be made smoother and safer for the next generation. Most of the objections raised involve the disruption to the patient care continuum (PCC) and the impedance of surgical training by imposing limited hours. Although two separate entities, both are inherently connected. The PCC provides the surgeon with an overall appreciation of their skills and learning by following a case through from beginning to end whilst dealing with any problems that may arise. Equally, the PCC is also enhanced by a well trained surgical team who is able to manage these various surgical problems.

Continuity of care has largely come through the traditional firm-based model of patient care. With the introduction of shift-work, there is the removal of the familiarity of the patient with the surgical team and vice versa. The inconvenience and problems posed by this removal of familiarity may not be trivial. It was found, for instance, that 44% of adverse events in hospitals relating to patient care were potentially reversible and that most of these were due to a disruption in the continuity of care especially during handover. Much effort has been made to minimise these errors. Schemes, such as the ‘Hospital at Night’ programme have provided a framework, in theory, which allows for greater flexibility in the management of patients whilst providing a system to ensure an effective handover.
However, jubilation may be premature as little research, thus far, into the effectiveness of this scheme has been evaluated.

Regarding training, it has been shown that the average time spent from SHO level to Consultant level will be less than a third of the previous pathways. The implication of this is that there is less time for training surgeons, though this may be counteracted by increasing the number of years of training. Although this may create conflicts in negotiating time spent with their families, registrars may, on balance, appreciate this necessity if they were to acquire the appropriate experience required for Consultant posts.

Other options include measures to reduce the less educational workload of trainees by appointing assistants who carry out some of the administrative duties such as writing discharge letters. In addition, the increase use of simulators to train surgeons may improve skills in a short space of time where clinical exposure will be much reduced. I would also like to discuss another method of maximising the surgical training under the limited hours and that is surgical specialisation at any earlier point in the training curriculum.

Specialisation

It is worth noting that one of the reasons for dropping out of surgery has been the lack of opportunities for earlier specialisation. Whilst general surgical training provides a solid foundation to explore a specialist area, for many this comes at too late a period where one fails to see the wood from the trees.

The advantages of specialisation are widely known. A recent systematic review of the literature concerning surgical specialisation has found that both an increase in the volume of specialist surgical procedures as well as the performance of specialist surgeons on a particular case, significantly improved the patient mortality and morbidity rates. The effect of this on the outcome of patients is not merely trivial but produces a highly significant clinical difference.

For example, in the case of vascular surgery, the in-hospital mortality rates for patients undergoing a repair for an abdominal aortic aneurysm were twice as much when performed by a general surgeon as opposed to a specialist vascular surgeon.

The argument against early specialisation would be the case of emergency surgery. Within a particular trauma case for instance, a multitude of pathologies may exist which the surgeon must know how to deal with. In addition to this, on-call registrars may not be able to handle specific pathology for lack of experience in their own specialities. For example, one study showed that much of the out-of-hours urology emergencies were inadequately covered by general surgical registrars. Although this may highlight a potential deficit in the training programme of general surgeons, it is rare to find a specialist who cannot be called for a specific emergency. For instance, another study found that mismatch was often rare in the context of abdominal emergencies except in the case of colorectal emergencies where a significant amount of the out-of-hours colorectal emergencies were performed by non-colorectal surgeons. The study may show that general surgeon training is not essential in view of emergency management as long as the common emergencies (where mismatch is evident) are identified and the appropriate training given. Thus, earlier specialisation is a real possibility in countering the reduced working hours. However, it must be supplemented by a comprehensive general surgical training that encompasses the common surgical emergencies.

A tale of two countries

It is the best of times and the worst of times. Dickens’ characters in Darnay and Carton may find much in common with America and Norway. One’s laissez-faire approach to medicine contrasts sharply with the other’s more benevolent attitude to its employees. The EWTD has been trying to move away from the US style of practice and towards the Norwegian model of guidelines for employees. The Norwegian surgeon’s average working week is 36 hours with an allowed extra 14 hours for on-call work. Norway’s neighbour, Denmark, also has a short working week where specialist training occurs at an earlier time point. Despite the shorter hours, this earlier specialisation allows surgeons to become competent in a full range of difficult specialist procedures such as aortic operations and infrainguinal bypasses in the shorter space of time. If one were trying to achieve a Nordic model of medical practice and patient care, they would not be doing too badly. Norway and Denmark boasts one of the highest standards of living in the world for its average citizen and has one of the lowest morbidity and mortality rates in the West.

USA time restrictions

An adequate model to investigate the effect of a reduction in working time would be the effect on USA surgical trainees of the Accreditation Council for Graduate Education’s (ACGE’s) proposals for an 80 hour week.

Exploring the impact on quality of life of the surgical trainees, it is found, by restricting working time, that life was made more tolerable for trainees. One study looked into the effect of a two-shift rotating system in general surgery. The system consisted of a ‘Day Continuity Care Team’ (DCT) covering 6.00 am to 5.00 pm and a ‘Night Continuity Team’ (NCT) covering 6.00 pm to 5.00 am, there being a one hour handover period between 5.00 am and 6.00 am and again at 5.00 pm and 6.00 pm. It was found that resident fatigue was significantly reduced, reading time was significantly increased and spouse satisfaction was significantly improved. Drop-out rates of surgical residents were predicted to increase as a result of the restriction, however no such differences were seen before and after the implementation of the guidelines. This may indicate that the dedication of surgical residents to their training withstands any changes to their working time.

With regards to the direct effect on surgical training, a nationwide study carried out on neurosurgical residents found that 79% of them thought that the hour-restriction had a negative impact on their training. This contrasts with other specialities such as plastic surgery where residents felt that the restrictions had a beneficial effect on their training and patients. The apparent discrepancy between these results may lie with the study design or within the difference in training between the specialities.

Possibly a more objective account on the effect of the guidelines on residency training came from a study published in 2004 which looked into the perceptions of the Faculty on the training of senior
residents. It was found that almost 100% felt that the restrictions had a negative impact on the training of their residents. In fact, it is found that, as seniority increases, there is less support for the ACGE guidelines on working hour restrictions. Objectivity may be supported by comparing the workload covered. Studies have shown that by employing the aforementioned initiatives of employing ‘physician extenders’ to occupy the less educational workload of trainees, working time restrictions resulted in little effect on the operative volume each resident undertook in his surgical speciality. However, a breakdown of the total volume revealed that emergency surgical experience was reduced, likely as a result of the reduction in on-call shifts.

The evidence regarding the impact on patient care as a result of the restrictions is very limited. Despite this, early reports are encouraging. It was found, for instance, that restrictions did not negatively impact on the complication rates in patients who underwent cholecystectomies, thus implying that resident training, in this field at least, has not been negatively affected to impact on patient care. Remaining evidence is predominantly subjective both on the part of the residents and the patients. Residents, whilst admitting that fewer fatigue-related errors exist as a result of the restrictions, more errors occurred in relation to continuity of care, in particular cross-over errors. However, most admitted that, overall, patient care had remained unchanged.

**British neurosurgical training as a result of the EWTD**

Finally in this section, I would like to discuss a study published comparing the exposure of a post- New Deal neurosurgical Registrar and a Pre- New Deal Registrar. It was found that a 1:6 rotation reduced the emergency exposure of the New Deal Registrar but did not significantly reduce the skills acquired to manage common neurosurgical emergencies such as craniotomies for intracranial haematomas or spinal decompression. Skills needed to treat rarer emergencies such as the cauda equine syndrome were also maintained. This contrasts slightly with the concerns raised by our American authors who perceived the reduction in emergency surgery as a potential drawback. This study shows that the reduction in emergency caseloads, does not necessarily equate with a deskilling in the relevant emergency procedures. However, elective procedures were far reduced by the working day restrictions. Thus, skills needed in the complex elective surgery such as skull base surgery may be put at risk. The study was important as it demonstrated that the working time restrictions did not adversely affect the overall competency of its employees but did demonstrate that assessment of the new generation of trainees needs to be much more robust due to the significant reduction in elective surgical procedures.

**Conclusion**

Whilst the EWTD has been received with much scepticism across the spectrum of experience, it may open many doors to potential trainees and newer initiatives. The introduction of the Modernising Medical Careers programme has meant that early specialisation is a very real phenomenon with the general surgeon possibly becoming a remnant of a bygone era. Moving away from a US-style of intense surgical training to a more socially acceptable Scandinavian model of training, the profession must find initiatives that will make this transition smoother whilst maintaining the high level of care which the UK has boasted for so many years.

*A fully referenced version of this paper is available at: www.asgbi.org.uk/newsletteroctober2007EWTD.htm*
THOUGHTS ON SURGICAL MANPOWER PLANNING

For the last ten years there has been significant expansion in the number of Consultant Surgeons in England, to meet targets set in the NHS Plan. There has been a concomitant increase in the number of National Training Numbers to meet this demand, to the point where training capacity is close to saturation. It seems that this expansion phase is now over, and the number of NTNs needs to be reduced to that necessary to maintain current consultant numbers.

How might this reduction in numbers of trainees be planned, particularly at a time when an expansion of NTNs is being advocated to cushion the effects of MMC? What is the ratio of numbers of Consultants to NTNs to achieve a steady state?

A trite assumption is that the ratio is 5:1, based on consultants being appointed at 35 years of age and retiring at 65, with trainees holding an NTN for six years before CCT. In fact, the mean career length of a consultant surgeon is around 22 years, not the 30 often assumed (personal communication, NHS Workforce Review Team). Reasons for this include:

- Appointment later than age 35.
- Retirement before age 65, the usual age being 61 or 62.
- Career change.
- Death in service.

The theoretical time to CCT for a holder of an NTN is six years, but many take longer for the following reasons:

- Time taken out of service for research or extra clinical experience.
- Not all trainees leave immediately on achieving the CCT. Many stay in post for the six months allowed at end of contract.

The average time an NTN is held is probably around seven years.

Hence the ratio of consultant numbers to NTNs for steady-state replenishment is approximately 3:1.

The table below has been compiled accordingly:

- Consultant numbers are the 2006 figures for England from Department of Health data.
- NTN numbers are the June 2007 figures for England obtained from the JCST.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Consultants 2006</th>
<th>NTN Holders 2007</th>
<th>Ratio of Consultants to NTN Holders</th>
<th>Number of NTNs for 3:1 Ratio</th>
<th>Excess of NTNs for 3:1 Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic Surgery</td>
<td>240</td>
<td>78</td>
<td>3.1</td>
<td>80</td>
<td>-2 (3%)</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1,756</td>
<td>867</td>
<td>2.0</td>
<td>585</td>
<td>282 (33%)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>187</td>
<td>105</td>
<td>1.8</td>
<td>62</td>
<td>43 (41%)</td>
</tr>
<tr>
<td>OFMS</td>
<td>306</td>
<td>89</td>
<td>3.4</td>
<td>102</td>
<td>-13 (15%)</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>552</td>
<td>250</td>
<td>2.2</td>
<td>184</td>
<td>66 (26%)</td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td>104</td>
<td>57</td>
<td>1.8</td>
<td>35</td>
<td>22 (39%)</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>254</td>
<td>164</td>
<td>1.5</td>
<td>85</td>
<td>79 (48%)</td>
</tr>
<tr>
<td>Trauma and Orthopaedic Surgery</td>
<td>1,710</td>
<td>768</td>
<td>2.2</td>
<td>570</td>
<td>198 (26%)</td>
</tr>
<tr>
<td>Urology</td>
<td>510</td>
<td>208</td>
<td>2.5</td>
<td>170</td>
<td>38 (18%)</td>
</tr>
<tr>
<td>All Surgical Specialties</td>
<td>5,619</td>
<td>2,586</td>
<td>2.2</td>
<td>1,873</td>
<td>713 (28%)</td>
</tr>
</tbody>
</table>

In broad terms:

- Cardiothoracic Surgery is in balance.
- OFMS does not have enough trainees to maintain present consultant numbers.
- All other specialties have apparently more trainees than are needed.
- Neurosurgery, Paediatric Surgery and Plastic Surgery appear to be in a phase of consultant expansion. If not, they have far too many trainees.
- General Surgery, Otolaryngology, Trauma & Orthopaedic Surgery and Urology need to reduce the number of NTNs by between one fifth and one third, if present consultant numbers are maintained.

John Black
A WARNING TO 
DOCTORS TAKING
THEIR NHS PENSION 
BENEFITS IN THE 
NEAR FUTURE

Dr Mark Martin, Cavendish Medical

I thought it best to write this article as we have recently come across a number of doctors whose position might be similar to yours. Forewarned is forearmed, as always.

As you might know from previous articles, pension legislation went through a process of ‘simplification’ last year. We do sometimes feel that ‘obfuscation’ might be a better description, as never before have we had so many confused medical professionals asking for help.

In many ways, pension ‘simplification’ offers a range of enhanced possibilities for those planning their retirement, but it has also thrown up a number of probably unforeseen and unintended sequelae for a large number of NHS doctors and other higher paid professionals.

To illustrate the problem, let us take the example of a consultant who is about to retire and is expected to receive a starting gross pension of £60,000 per annum from the NHS. He or she also has £400,000 in private pensions, built up on the basis of private practice income over the years.

As regular readers will know, the deemed value of the NHS pension is thus £1.38m. By ‘deemed value’ I simply mean the value ascribed to an occupational pension scheme by Her Majesty’s Revenue & Customs, which, in the case of the NHS Pension Scheme, is the starting annual pension multiplied by a factor of 20 plus the value of tax free lump sum (so, £60,000 x 20 + £60,000 x 3 = £1.38m).

It is this calculation which is used to determine whether or not the value of a Doctor’s pension is above or below the Lifetime Allowance and, thus, potentially subject to an excess tax charge. This allowance is set to rise from £1.6m this year to £1.8m by 2010, although the rate of increase thereafter has not yet been disclosed. You will appreciate, therefore, that a pension fund that may be currently over the limit may not be so in future years.

In our example, let us say that our hypothetical Consultant blithely goes forward and takes benefits from the NHS pension scheme, intending to deal with the private pensions at a later date. On this basis, he or she will have used 86.25% of the Lifetime Allowance, which is currently £1.6m - i.e. (£1.38m/£1.6m)/100.

This leaves 13.75% of the Lifetime Allowance to be used up (i.e. 100% - 86.25%).

Of course, on taking benefits from the private pensions a couple of months later, our doctor had expected to be able to release 25% of the fund as tax-free cash - £100,000 in this case.

However, due to the new rules, only 13.75% of the pension fund, ie. £400,000, is now eligible to be taken as cash. Thus, the hoped-for £100,000 tax-free cash is reduced to £55,000, with the remainder being taken as taxable income.

There would have been a solution to this matter, which, put simply, would have been to take the benefits of the private pensions prior to taking benefits from the NHS Pension. As always, no two situations are alike and, thus, professional advice is essential, but you will understand that this is a remarkably simple trap to fall into.

I should say that, in a situation where a Consultant has, say, 30 years service and no discretionary points, and perhaps only limited private pension provision, this scenario will, in all likelihood, play out quite differently and may not be cause for concern.

In such a case, a Consultant on the new contract and at the top of the payscale would earn £96,831. Thirty years service would give a starting pension of £36,311, giving rise to a deemed value in the eyes of HMRC of £832,153. As this is considerably below the Lifetime Allowance of £1.6m in this tax year, it is highly unlikely that taking main scheme benefits first would have any consequence.

If you have substantial NHS and Private Pension provision and are on the verge of retiring, please ensure you take every step to avoid being hit by the new rules. Please feel free to email Joe Clark at Cavendish Medical Ltd if you feel that you need assistance on this or any other matter:

joe.clark@cavendishmedical.com

Dr Mark Martin is a Director of Cavendish Medical Ltd

This article has been sponsored by ASGBI Ltd, a wholly owned subsidiary of the Association of Surgeons of Great Britain and Ireland
The ASGBI website looks very different today than it did five years ago, and more changes are afoot to improve its functionality and refresh the design. This should provide a better website experience for ASGBI Members and other users.

Dr Jakob Nielsen, one of the leading figures in the web industry and Consultant on software and web-design usability, has indicated that the success of a good website is based on “user empowerment”. This is clearly demonstrated in sites such as Google, Amazon, eBay and Yahoo where close attention to design and user needs contribute to success. These sites are extremely profitable and popular, mainly due to the fact that they make simple but powerful tools directly available to the user.

One of the ASGBI website’s strengths is the volume of information available. However, it is also one of its weaknesses – if the information is hard to find. Thus, the new website will offer customisation features to allow Members to filter the content they see; thus creating a more dynamic, interactive and adaptive web environment. It is hoped that this interactivity will generate, in ways that has not been possible before, a real sense of ownership for Members.

Another advantage of interactivity is ‘self-generating content’. This is achieved by allowing ASGBI Members to interact with the website so that they can actually create content for the site that is relevant to them. The new website will also provide user surveys and on-line polls which will enable users to share information with others so that this data can be used to better serve the needs of ASGBI Members.

Members will also be able to take advantage of password-protected areas. This secure member area will allow searching for, and contact with, other members as well as the option to amend and update membership records. Members will also have the ability to browse a comprehensive online publications library to read or download ASGBI documents including reports, newsletters, conference materials, minutes, etc. In addition, event and course material files can easily be uploaded into this area for viewing or download depending on member permission and rights.

In order for these and future web initiatives to come into fruition, a Website Management Group has been established, chaired by Mr Nicholas Markham, ASGBI Director of Informatics. The main purpose of this Group is to ensure that the content, on both the private and public websites, is relevant, current and provides a major interface with ASGBI members.

Latest statistics show an increasing trend in the number of visitors and hits to the website together with large numbers of users downloading documentation, registering for meetings and submitting abstracts online. This is clearly demonstrated by the record number of abstracts (1,217) submitted for the Association’s 2007 Annual Scientific Meeting in Manchester where there was an increase of 26% on the number of abstracts submitted from last year, and an all-time record for the Association.

The World Wide Web is an interactive, dynamic, and rapidly changing communications medium and our aim is to make sure that the ASGBI website reflects this by creating a more user friendly and dynamic web experience.

Nicholas Markham, Director of Informatics
Nicole Taub, Web Manager

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**BRITISH HERNIA SOCIETY**

The management of abdominal wall hernias remains within the remit of the General Surgeon. A minority of surgeons will develop a special interest in this area and undertake repair of complex recurrent hernias, closure of laparostomies and reconstructive surgery following trauma or tumour excision, often in partnership with plastic surgeons. The principle aims of the British Hernia Society (BHS) during the last three years has been to provide a forum for education and training in these areas and encourage discussion around the merits of the large number of new prosthetic implants and laparoscopic advances. As part of this commitment to education and training, the BHS - along with the EHS - has also been involved in the establishment of a humanitarian mission to treat and teach groin hernia surgery in Ghana. This is an ongoing project with groups of UK and European surgeons visiting on a regular basis.

The BHS has held three successful Annual Meetings, which include a popular Live Surgery day, updates and the highly interactive “Hernias from Hell” session. Members of the British Hernia Society now form the largest chapter of the European Hernia Society, and as part of their membership receive a copy of the journal Hernia six times a year. The Presidency has recently passed into the capable hands of Paddy O’Dwyer and Andrew Kingsnorth remains on the Board as past-President and the current President for the European Hernia Society.

We are very pleased to have achieved successful negotiations with ASGBI to affiliate into that organisation, which will enable us to have a Symposium during the ASGBI 2008 International Surgical Congress, and our own independent Annual Meeting later in the year.

The next BHS Annual Meeting will be held in Liverpool on 7th and 8th February 2008. The meeting addresses the benefits and complications of meshes used in hernia repair and will have distinguished speakers from the United States, Europe and the UK. In addition, the Hunterian Lecture will be delivered by Andrew Kingsnorth on the evening of 7th February. Live operating will take place on the first morning of the meeting and will include open approaches to incisional hernia.

The BHS contribution to the ASGBI Congress in Bournemouth (14th to 16th May 2008) will include a Symposium on “Who treats abdominal wall hernias?” The session will explore the role of General Surgeons, Specialist Hernia Surgeons, Ambulatory Care Surgeons, General Practitioners and Nurse Specialists and should provide a fascinating insight into the future of hernia surgery in the UK.

We look forward to a large audience participation in both meetings and welcome comments to our website at: [www.british-hernia-society.org](http://www.british-hernia-society.org)

For more details regarding Operation Hernia in Ghana please contact: andrew.kingsnorth@phnt.swest.nhs.uk

Paddy O’Dwyer and Andrew Kingsnorth

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ASGBI Ltd is delighted to announce the launch of an exciting on-line service for members: [www.asgbigifts.co.uk](http://www.asgbigifts.co.uk)

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Go direct to the site, or link through the main Association website ([www.asgbi.org.uk](http://www.asgbi.org.uk)) and a commission on anything you buy will be returned to the Association to use for educational and international fellowships and awards.

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BAPEN Conference 2007
26-28 November – Harrogate International Centre

BAPEN Medical
Clinical Nutrition Teaching Day
For Trainees and Consultants of all disciplines

Monday 26th November 2007
Harrogate International Centre

Programme:
10:00-11:00 Peri-operative saline: what goes in must come out
Dr Peter Gosling
11:00-11:45 The oedematous post-operative patient: case based discussion
Professor Gordon Carlson
11:45-12:00 Coffee
12:00-12:40 NICE nutrition support guidelines
Dr Jeremy Nightingale
12:40-13:15 Implementing NICE – the view from a DGH
Dr Emma Greig
13:15-14:00 Lunch
14:00-15:30 PEGs and ethics – a debate
Dr Barry Jones & Dr Simon Gabe
15:30-16:15 Biochemical reprise – the refeeding syndrome
Dr Michael Colley
16:15-16:30 Feedback and concluding comments

Cost:
BAPEN Medical Members £23.59
Non-members £47.00
Lunch & refreshments included

For those staying in Harrogate, there will be a (sponsored) meal to which delegates, faculty and all members of BAPEN Medical will be invited.

Registration:
To register please contact:
Sovereign Conference
Secure Hold Business Centre
Studley Road
Redditch
Worcestershire B98 7LG

Email: enquiries@sovereignconference.co.uk
Website: www.sovereignconference.co.uk
Tel: 01527 518777
Fax: 01527 518718

Travel information:
Full details on how to reach the Harrogate International Centre are available at:
www.harrogateinternationalcentre.co.uk/hic-65

BAPEN Annual meeting:
The Clinical Nutrition Training Day will be followed on Tuesday 27th and Wednesday 28th November by the British Association for Parenteral and Enteral Nutrition (BAPEN) Annual Conference. This is an excellent learning and networking opportunity for all professionals involved in clinical nutrition and nutritional policy. It is therefore very much encouraged for delegates to combine the Teaching Day and the BAPEN conference. Sovereign Conference will be pleased to arrange registration for either or both events (see above for contact details), or go to: www.bapen.org.uk
THE HEART OF A LION:  
Sir Gordon Gordon-Taylor (1878 - 1960)

Mick Crumplin

This great international surgeon was born in London, in 1878 in Streatham, the son of a wine merchant and a Scots mother from Aberdeen. He was educated at Robert Gordon’s School in the latter city, graduated in 1898 with honours in classics and entered the Middlesex Hospital Medical School in October of that year. Having distinguished himself with three exhibitions and a gold medal in anatomy, he qualified by the Conjoint Diploma and the London MB in 1903.

It was at his first posting as an assistant pathologist to Lazarus Barlow, that he struck up a partnership with Victor Bonney. Fortified with coffee heated over a Bunsen burner and working three nights a week, they both achieved first class honours in the new BSc in anatomy from the University of London in 1904.

Much commended for his zeal and careful attention to detail as a researcher and demonstrator in anatomy (by his Chief, Professor Peter Thompson at King’s College), he began his surgical apprenticeship in 1904. His first job was that of house surgeon to Sir Alfred Pearce Gould. After obtaining his MS and FRCS in 1906, he was appointed to the Middlesex Hospital as assistant to Pearce Gould and Sir John Bland-Sutton – also to be the Surgeon to Out Patients.

A London and Middlesex man through and through (although he also worked at the Royal Northern Hospital), he soon established a reputation as a bold and skilful operator. Such attributes would soon be called on in no small way.

The Great War broke out in 1914. After serving at first at home then at the Battle of the Somme and Passchendaele, he was soon appointed Acting Consulting Surgeon to the 4th Army. He became a legendary figure in the casualty clearing stations and contributed in many ways to the advancement of combat surgery. One of the great strides he made was his surgery of abdominal trauma. He undoubtedly bestowed much to the aggressive management of shrapnel and bullet wounds in that cavity, the surgery of which was so full of risk in the pre-antibiotic era and early days of intravenous fluids. He boldly resected and exteriorised bowel under the most unfavourable circumstances.

One of Sir Gordon’s heroes and undoubtedly a role model was that other great surgeon, so precious to this Association, Lord Moynihan. Having been examined by Moynihan and also after visiting his theatre in Leeds, one can sense the pride when Sir Gordon, having welcomed him to the Casualty Clearing Zone of the Fourth Army, was so proud to walk to the Officers’ Mess with one arm linked with Sir Harold Stiles and the other with Moynihan! Following the Great War, he returned with the rank of Major and an OBE.

After his chief, Sir John Bland-Sutton retired in 1920, Gordon-Taylor was appointed as a full
staff consultant to the Middlesex and married Florence Pegrume, who was, like his mother, an Aberdonian. In the 1920/30s, his reputation and practice as a bold and meticulous surgeon flourished. Perhaps the two operations that are associated with his heroic practice and which I feel are best known are the interinnomino-abdominal (hind-quarter) amputation and the surgery for innominate artery aneurysm.

At the age of 52, he was elected to Council of the English College and two years later, first visited Australia. At the inception of the Second World War, he was, at the age of 60, appointed as Temporary Surgeon Rear-Admiral. This post involved visits to home naval hospitals and EMS hospitals throughout Britain, wherever naval patients were admitted. He also visited the USA, Canada, Australia and Russia, later being awarded a CB, KBE and the Legion of Merit in the USA. During the blitz, his flat was wrecked and, when he and his wife had been extracted from the debris and he had seen her safely admitted, he ran off in theatre gear under a mackintosh, with an amputation set to remove a trapped barman in a damaged hotel in Great Portland Street.

He retired from his Middlesex practice in 1943, but continued to operate all over the country, whenever his skills were required. He lectured and wrote (135 contributions) assiduously. He set up, with the assent of the College, a one-man advice bureau, to help advise, place and instruct post war and foreign young surgeons.

What of him as a man? In the 1930s, he was a slim, neat figure in a brown suit, wing collar and bow tie. A Homburg hat, black boots and a pink carnation as a buttonhole completed the image of a man with a rapid, purposeful walk, full of energy. He always scorned an overcoat, no matter what the weather. There could have been no more courteous and kind surgeon, who always remembered faces, taking time and trouble with anyone, quite irrelevant to their station. He was the epitomy of a master surgeon, always supporting his apprentices, with great loyalty.

His generosity was legendary. He always gave the new house surgeon a cystoscope at the commencement of his appointment and cuff links on departure. He treated his staff to surgical visits and even defrayed the cost of patients’ blood transfusion or travel fares. Little notes of gratitude to anyone who helped, sometimes in a

Figure 4: Sir Gordon in discussion during an operating session.

Figure 5: Left - Large Innominate Chondroma (1933). Right - Patient after hindquarter amputation for an osteoclastoma of the innominate bone (1929).

Figure 6: Top - Spontaneous aneurysm of the innominate artery (1936) treated by ligation – osteofascial flap drawn on skin. Above - Ligation of innominate aneurysm – sac gently retracted (1942)
most menial way were received with great cheer by many assistants!

He proudly admitted that he had not visited a public bar or cinema, ate and drank sparingly and never owned a motorcar. He did later have a Rolls Royce, chauffeur-driven, but mostly preferred to walk. He loved cricket and was a member of the MCC. As a student, the austere attitudes then predominant in East Scotland had enforced him to change his name, when playing the game, for the disapproval that engaging in the sport might bring!

His real love was for ballroom dancing and, having become proficient in this, he engaged a professional partner after his wife had become disabled. After an evening’s dancing, he would come into the hospital and guide, assist and generally take an interest in the surgical wards at night. Sometimes, when he needed time to contemplate or just wanted a break, he would take the night train to Scotland and, for instance, walk on Rannoch Moor, before taking the train home. Suffering at one time or another post-herpetic neuralgia, the loss of his wife and a carcinoma of the colon, resected by George Grey Turner and David Patey, he demonstrated his own personal courage.

If he had any faults, they were few – pride in his achievements, his attitudes, dress and ability (well deserved!). He was intolerant of slower surgeons, an ignorance of the classics and had a disinterest in committees, at least in his early years.

What were his contributions to the practice of surgery? Foremost was his commitment to his patients and the craft. He was a pioneer of appropriate surgery for bleeding peptic ulcers, and also a bold advocate of interventional surgery for bowel injury in warfare. Combat surgery must have contributed to his expertise in amputation – latterly, he performed his hundredth hindquarter resection around the time of his eightieth year! Deeply interested in the surgery for cancer, he was as happy in the abdomen as he was with radical block dissections of the neck. Whilst shunning cranial surgery, he operated in the chest, neck and urinary system with great skill. He managed aneurysms of the innominate artery and tumours that, to many others, seemed beyond the scope of a surgeon.

He retained interests in subjects that today are often ignored or considered irrelevant - the classics, surgical history and eponyms – as to the latter, he questioned “Who has not heard of Gordon’s Gin or Taylor’s port?”

We are all the poorer for not having listened to Sir Gordon lecture or orate. He was an absolute master – not only profoundly eloquent, but also clear and well educated, with a deep knowledge of the natural sciences, classics and history.

He was one of the few British surgeons awarded an Honorary Fellowship of this Association and was President in 1944/45.

His surgical accolades, degrees, honours, diplomas and adulations were worldwide and far too numerous to mention. They included four honorary doctorates and five honorary fellowships. I feel that his greatest reward was the respect he earned for his integrity, skill, commitment and, not the least, his courage.
Executive MBA Public Sector and MBA ‘Healthcare’

Nottingham University Business School is extending its range of Executive MBA Programmes to include a programme tailored to the needs of the healthcare sector.

The Executive MBA is for managers who want to develop their management knowledge and skills to an advanced level whilst continuing their career. The programme is flexible and can be taken over two to four years enabling participants to pace their studies to match the needs of their organisation or wider commitments. The Executive MBA is available to individual applicants, those sponsored by employers, or through a formal partnership with organisations. The programme is offered as a series of 12 one-week block modules, plus a management project. The modules run Monday to Friday and involve approximately 35 hours of class-based study during the week the module runs, plus a further 65 hours of independent study for further reading, and to complete assessments. The management project can deal with a real issue in your organisation, through the application of relevant theory to practice, to produce a major piece of work with practical recommendations.

Nottingham University Business School currently offers a public sector variant of its Executive MBA that is designed for participants from the public sector and other non-for-profit organisations. Participants usually take nine core modules including two public services modules and three electives from a broad range of management areas plus a management project.

We are now also in the process of developing an Executive MBA ‘Healthcare’ programme. This programme will be designed in collaboration with the University of Nottingham Medical School to provide a general management training for all professional groups concerned with healthcare from both the public and private sectors. For many of the modules, the Executive MBA ‘Healthcare’ will enable healthcare professionals to learn alongside private sector managers from a range of industries, thereby facilitating the sharing of management insights and contextual challenges. The programme will also offer a number of specialist healthcare modules that will focus on contextual issues specific to the healthcare sector. We plan to launch this programme in 2008. To register your interest in this programme and obtain further details in due course please contact the office below.

All our MBA programmes are AMBA accredited, and Nottingham University Business School is a Financial Times global top 100 MBA provider.

For further information please contact:
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DISPOSABLE OR NOT?

We recently changed our supplier of linear cutting staplers, initially using the new stapler under supervision by a representative of the company. Our usual technique is to insert the limbs of the linear cutter into the two free ends of the bowel and activate it. This divides and staples the adjacent loops to create a side-to-side anastomosis with an open end. We then replace the cartridge and apply the linear cutter transversely across the open end of the anastomosis. The instrument is activated again and this cross staples the open end of the anastomosis, simultaneously amputating any redundant bowel.

After the change of supplier, we experienced unexpected anastomotic leaks from the cross stapled end, as well as two haematomas. The manufacturers subsequently advised us that their linear cutting replacement cartridges are not suitable for sealing the blind end and that a second knifeless stapler should be used.

Reporter’s Comments:
A linear cutting stapler is commonly used in this way to make an anastomosis. Although it is not mentioned as a contra-indication in the manufacturer’s leaflet, we now learn that, in the opinion of a major manufacturer, the linear cutter should not be re-used to cross staple the anastomosis without significant risk of leakage. We have been advised that a second knifeless stapler should be used with consequent cost implications. Also, it cannot be assumed that supervision by product representatives will ensure the use of like-for-like devices, or will avoid mishaps.

CORESS Expert’s Comments:
The Advisory Committee were most grateful for this report that raises an issue of which some surgeons will, perhaps, be unaware.

CORESS approached the two major suppliers of linear staplers in the U.K. and the following comment was agreed: - "We do not recommend stapling with a linear cutter to close the common entry point of a stapled anastomosis because of the risk of disruption of the staple line by the sliding blade of the linear cutter".

The Reporter quite correctly notes the absence of any contra-indication in the manufacturer’s leaflet, but surgeons using these instruments might wish to reflect on their technique and consider discussing the matter with the manufacturer concerned.

Surgeons are ultimately responsible for the choice and limitations of any instrument or device they use and it is essential that they are actively included in any decision to change instruments or suppliers. It cannot be assumed that similar instruments are compatible, or can be used in the same way, and it is unwise to rely solely on a product representative for safe use.

WRONG PATIENT OR WRONG LIST?

When I am on call, I am now rarely on with my own team and continuity of care is solely at Consultant level. One night recently, a girl was admitted with appendicitis and was listed for appendicectomy on the emergency list after a boy who had come in the previous evening with a similar diagnosis. Early the following morning, I informed the theatre staff that I would be available to start with the boy, who I had already seen. Before I reached theatre, I was bleeped and informed that the girl had arrived in the department as the boy "was not ready".

Although the “checklist” was complete and entirely in order, this girl had not been seen by any of the surgical on-call team operating that day, including myself. I examined the child and instructed that she be returned to the ward as appendicectomy was unnecessary.

Reporter’s Comments:
The surgical shift system that has been enforced upon us in order to comply with the New Deal and the European Working Time Directive is not conducive to continuity of care. In this case, it resulted in a night registrar listing a patient for theatre who could have been anaesthetised without being seen by the operating surgeon. The NHS checklist does not ensure that the operating surgeon has met the patient. I believe that the checklist should be amended accordingly. There was also poor communication between theatre staff and the operating surgeon, as the order of the list was changed without consultation.

CORESS Expert’s Comments:
The Advisory Committee considered that, though not ideal, in very urgent cases it can be acceptable for the operating surgeon to see a patient for the first time in the anaesthetic room.

Shortcomings with communication and handover has featured in previous CORESS Feedback (June 2007, Ref 34) and is addressed by The Royal College of Surgeons of England (Safe Handover: Guidance from the Working Time Directive Working Party; March 2007), see: http://www.rcseng.ac.uk/publications/docs/publication.(2007-0514.3777986999/view?searchterm=SAFE%20HANDOVERS)
IT’S YOUR NAME ON THE PUBLICATION

I edit a multi-author surgical textbook, which is proof read by the contributing authors prior to a final reading by the publisher. After the final publisher’s proof reading, I was sent a list of drugs which had been named differently in different chapters, and sometimes even within the same chapter, despite proof reading by the contributors. Even more serious were errors of dosage. For instance, different units of dosage were used by different authors and one contributor recommended a dose that was grossly excessive. It transpired that, quite coincidentally, the publisher’s proof reader had worked for some time in a dispensing pharmacy and had picked up potentially dangerous errors which had been missed by the contributors.

Reporter’s Comments:
Surgical authors should use generic terminology and not rely on the publisher’s proof reader to correct errors - they are responsible for the accuracy of what is published under their name. This should also be a lesson to those who use surgical textbooks to find the correct dosage of drugs - local anaesthetic, for instance.

CORESS Expert’s Comments:
The Advisory Committee agree. Although it is good practice for a medical publisher to include a statement recommending referral to the drug manufacturer’s data sheet (SPC), authors are responsible for the accuracy of their contribution. Responsibility for prescribing rests with the prescriber. In the event of a claim, evidence of referral to the SPC or the British National Formulary would constitute a reasonable defence. Relying on a single (erroneous) entry in a textbook would not normally form the basis of a defence likely to succeed.

STUCK FAST

I had been doing a hernia operation in a private hospital on a Saturday morning, and I was in a hurry to get away. We prepared the groin in the standard manner using a brand of disposable drapes with a particularly strong adherent sticky edge. The sticky edge of one of the drapes was inadvertently in contact with the shaft of the penis. The operation was uneventful and as I was dressing the groin I pulled the towels off to avoid some blood getting on to the dressing. I was not careful enough doing this and used too much force. It produced a small abrasion on the skin of the shaft of the penis because the towel had stuck to it. Fortunately it healed satisfactorily and the patient accepted the apology.

Reporter’s Comments:
Know your drapes. Some varieties of sticky drape are more adherent than others and pulling off sticky edged drapes too vigorously can result in skin damage particularly in certain areas where the skin is thin or delicate. When using these drapes in the groin, care must be taken to protect the genitalia.

CORESS Expert’s Comments:
The Advisory Committee would only add that the skin of small infants and elderly people can be damaged by adherent drapes, irrespective of the care used in removing them.

FLUSHED WITH SPIRIT? - NOT QUITE

A central venous line was being inserted, in the operating theatre, under local anaesthetic. The skin was prepared with clear surgical spirit, which had been poured into a plastic galipot. Heparin saline had been poured into a similar galipot and was nearby, but at the back of the trolley. The radiographer was detained in another theatre and this caused considerable delay before the position of the guide wire could be checked. During this time the original scrub nurse handed over to another. After the line had been inserted the surgeon asked for heparin saline to flush the line. The scrub nurse drew up the remaining surgical spirit and handed it to the surgeon who connected it and was about to flush the line when the mistake was recognised.

Reporter’s Comments:
Clear spirit preparations are dangerous as they can be confused with other fluids and, if used for skin preparation, should be discarded after use and not replaced on the trolley. Perhaps all spirit preparations should be coloured to avoid this risk. Identical containers without labels should not be used. This case also illustrates the potential risks of scrub nurses changing over during a procedure.

CORESS Expert’s Comments:
The Advisory Committee were grateful for this very courageous report and agreed with the reporter that all clear skin preparations are potentially dangerous in these circumstances, especially surgical spirit, which carries additional risks. The Committee questioned the justification for using spirit to prepare the skin when safer aqueous preparations are now available. In any case, skin preparations should be coloured and there should never be two unlabelled containers on a trolley at the same time. All unused skin preparations, of any sort, must be discarded after draping. The Committee also thought it very unusual for the scrub nurse to change over during such a relatively short procedure.

Surgeons should be aware that clear protocols exist for safe perioperative practice (Standards and Recommendations for Safe Perioperative Practice 2004; Edited by John Beesley and Susan Pirie, NATN; Published by NATN, October 2004). See also: www.afpp.org.uk/publications_list.cfm

If a patient suffers injury in the circumstances illustrated above, disciplinary and legal action will certainly follow and, at the worst, a prosecution for manslaughter can be expected.

If you are going to use it, know what it is!

FINALLY...

Durable? - MRHA has received a number of reports of the tips of spinal needles breaking off during use when the stylet is not present. Users should be aware that these needles are designed to be inserted (and moved after insertion) with the stylet in place - as highlighted in the manufacturer’s instructions.

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MEDICAL EMOTICONS

On 19th September 1982 a computer scientist at the Carnegie Mellon University in Pittsburgh, Scott E Fahlman, sent an email message to his colleagues, who had been discussing how to mark jokes in an email text:

I propose the following character sequence for joke markers :-( Read it sideways. Actually, it’s probably more economical to mark things that are NOT jokes, given current trends. For this, use :-(

This is generally agreed to be the first example of what are now called emoticons, or smileys, the little sets of symbols that are used as markers in email messages. In fact, there is a pre-history of such symbols. According to the Official Smiley Dictionary (www.smileydictionary.com), in 1972 a French journalist called Franklin Loufrani invented a picture consisting of a bubble with two dots for eyes and a curve for a smiling mouth, thus (;) he called it a smiley and used it and its derivatives to mark articles in France soir and other newspapers.

Whatever their origin, emoticons are popular and have spawned explanatory dictionaries and websites. Here are my suggestions for some medical emoticons. Remember to hold the page sideways.

a:-| Male pattern baldness :-(#) Tonsillitis
@:-| Alopecia areata :-)) Mania
8-) Myopia :-( Man
%-) Strabismus :-%( Depression
!-) Ptosis :-(#) Torticolis
::-))) Diplopia €:-)X Harley Street doctor
8-) 8 Graves’ disease €:-) :- Man
¶-( Migraine #:3 Woman
::( Coryza €:-(3 Gynaecomastia
#: Broken nose #:O Pregnancy
:: Rhinophyma €:-O Ascites
:=" Scleroderma €:-O Hydrocele
:-|= Marfan’s syndrome €:-O Impotence
:-| Coryza €:-O Viagras
:-£ Congenital syphilis €:-O Priapism
:-/ Bell’s palsy

There was a time when doctors would write abbreviations and acronyms, such as GOK (God only knows) or TALOIA (there’s a lot of it about), in patients’ notes. Now instead we can draw emoticons. I expect to see this happen before too long.

Jeff Aronson
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