The Association’s 2006 Annual Scientific Meeting in Edinburgh (3rd to 5th May 2006) has been promoted more widely than any previous ASGBI Meeting. The *Call for Abstracts* has been distributed in hard copy to 4,500 addresses in the UK and Ireland on the ASGBI database, and to circa 10,000 subscribers to the British Journal of Surgery across Europe. Additionally, through our newly established Designated Societies, the *Call for Abstracts* has been distributed electronically to all members of General Surgeons Australia, the Canadian Association of General Surgeons and the New Zealand Association of General Surgeons.

In total, therefore, around 25,000 surgeons across the world have received notification of the Meeting and this has resulted in a record number (just under 1,000) of submitted abstracts. The Association is extremely grateful to Dr Conor Shields and the iFormix on-line abstract system for ensuring that all this happens without a hitch.

Additionally, there has been unprecedented traffic – from more than 17 countries - through the ASGBI website over the past few months, as shown in the table.

**ANNUAL SCIENTIFIC MEETING**

“*The Compleat Surgeon*”

**EDINBURGH 2006**

If you treat a professional as an employee, ultimately they become an employee. I tried to point this out approximately 15 years ago when it became clear to me that this was the direction in which the then profession was headed but to no avail. Now the manifestations surround us and are plain to see.

An employee is one employed by another; one who works for wages or salary in the service of an employer, who may or may not have the freedom to enlarge or to modify those tasks. The task usually is temporarily finite. In contrast, no such temporal finality or lack of responsibility occurs in a professional’s life. One does not set timelines on when responsibility for certain tasks or, in our case, a certain patient exists or does not exist. In addition, a professional sets his or her own rules, sets their own reimbursement, and provides for his or her own working conditions within the confines of rules set by the entire organization of similar professionals (in historical England and Scotland, a guild). Professionals are usually guided by the benefit and the welfare of those individuals who the professional must serve. Professionals are available 24-

**SURGEONS: EMPLOYEES OR PROFESSIONALS?**

Josef E Fischer, MD

*Department of Surgery, Harvard Medical School and Beth Israel Deaconess Medical Center, Boston, USA*

Well folks, it’s finally happened. The total destruction of medicine, and more specifically general surgery, is upon us as a profession. It is unfortunate that it is taking place on the Quincentenary of Surgery 500 years after those who practiced our craft formed the first guild in Edinburgh, an event celebrated in June and July of 2005 where it started.

This is happening to medicine generally and to general surgeons particularly not just because of reimbursement (which is bad enough), and not because of our professional liability situation (which is worse), but because the various societal forces that began approximately 15 to 20 years ago have reduced physicians and surgeons to the level of employees. We are no longer professionals. The crux of the issue is something that has already happened in the United Kingdom, antedating the situation in the United States by approximately 30 years. The basic tenet is the same.
hours a day, 7-days a week. If they are not available, other people are available to cover for them. Professionals have an office in which a human voice is instantly available, in which the patient and their family do not have to go through a rat maze of various alternatives of buttons and guidelines, thus making it impossible for either the patient, his or her family, or anyone else for that matter to reach the physician. Professionals have obligations to society in return for the ability to set their own reimbursement, work rules, and how they wish to practice. This trade-off is intrinsic to any profession, and in the case of medicine, is now, in my view, totally gone.

And then there is the 80-hour workweek, which I will touch on later. For now, let me say this innovation was proposed as a solution to a problem of fatigue by a medical educational establishment (many of whom have spent their lives avoiding direct patient care). It is the antithesis of a profession, which comes at a time when professionalism is almost cynically set as one of the six competencies. The cynicism of this particular step, establishing professionalism as a criterion at a time when professionalism was dealt the final body blow, can only be described as brilliantly Orwellian. There was and is a problem with fatigue and impairment of performance that has been documented for apparently inadequately supervised medical services [1, 2]. For surgical services, in which continuity of care is more important, the little evidence currently available suggests that lack of continuity of care may be detrimental [3]. Regardless, the problem could have been resolved by a 24-hour limit.

A professional, in our case a physician or surgeon, takes care of the patient until the job is completed. Especially in surgery, we provide continuity of care. This is the traditional trade-off that society has expected in exchange for the rather rare privilege of assaulting a human being and doing things to a human body that, if it were not sanctioned, would land all of us in prison. As physicians, professional privileges are being eroded. Corporate medicine, corporate surgery, and lack of commitment have resulted in a call system in which patients can no longer expect their physician or surgeon to be constantly available. Did the shift (which in part aided the evolution of society’s views towards medicine and surgery) to that of temporal employees, whose responsibility was no longer constant, lead to the erosion of what the public expected of professionals?

This actually has been happening since the 1970s when the so-called leadership of medicine proposed two deviations from the traditional role of medicine: First, continuity of care and individual responsibility for patients unlimited by time, and second, intentional compromise of the knowledge base.

The first breach occurred in emergency medicine in response to a perceived failure of medicine and surgery to cover the emergency room. Since the responsibility (as defined by emergency medicine physicians) was to a patient for only a given period of time, the temporal shift mentality of emergency medicine followed naturally. Mind you, I am not being critical of emergency medicine in the way they set up their lives. It probably had to be that way, since they did not have sustained ability to care for patients by the nature of the way the specialty was set up. Consequently, they became temporal employees. It could probably not have been otherwise. Unfortunately, the second breach of professionalism, a decision also made in the 1970s, was in family medicine. This was the first time there was a significant intentional compromise of the knowledge base that was thought necessary for a medical professional.

Herefore, there had been no limits specifically set, either actually or philosophically, on medicine professionals. In family medicine, it was stated almost explicitly that family practitioners did not have to have the intellectual armamentarium that, for example, internists or surgeons had to have in order to practice. They merely take care of simple problems but refer complex problems to specialists. This seemed logical at the time given the needs of the country for primary care practitioners, especially in rural areas. The intellectual compromise was greeted not only with great enthusiasm by the so-called leadership of American medicine, but also by legislators who provided cash bonuses (like the bounty on wolf pelts) to medical schools that produced family practitioners. This, in turn, made primary care fair game for anyone who could claim the same intentionally limited knowledge bases.

For example, advanced nurse practitioners practicing independently, as has been demonstrated by the Columbia School of Nursing, demonstrate outcomes identical to family practitioners. Since access will be easier and advanced nurse practitioners are less expensive, I would suggest that in 10 years economic forces will completely gut the practice of family medicine, and primary care will be done largely by advanced nurse practitioners as 3300 are being produced annually. My point in referring to these historical events is to point out that once the profession breached its traditional boundaries, it left itself open for the changes that followed.

However, I am wandering. Let us return to the results of the loss of the profession and the fact that physicians, and especially general surgeons, have become employees. The most obvious manifestation of the loss of the profession is the failure of general surgeons to cover the emergency room and to provide emergency care. This, of course, is not solely the problem of general surgery, but of all surgical specialists. Congress has responded by passing EMALTA, an unfunded mandate, which, as usual, when one tries to deal with employees, proposes draconian punishments for lack of performance to no avail. Various surgeons and specialties, especially the scarce specialties such as neurosurgery, have simply resigned from hospital staffs rather than undertake coverage of emergency rooms that would make their lives not worth living. This effect seems to have eluded Congress.

Be that as it may, the real reason issues such as coverage of emergency rooms have now risen to a crisis situation is because having been devalued to employees, general surgeons and other surgical specialists do not feel an obligation to do a number of things that professionals do. Professionals have an obligation to care for the indigent. Employees do not. Professionals have an obligation to cover the emergency room. Employees do not.

Having thus devalued surgery, one now has the situation that employees simply do not want to compromise the one thing that still remains theirs, their leisure time, to carry out responsibility which previously was theirs when they were professional. If they were professionals, one could put in more resources and thus encourage the intrinsic obligation that both physicians and surgeons would feel as a profession. In short, they would pay physicians more and provide incentive. There are only four forms of incentive that I, now in my 27th year as a surgical chair, recognize (with apologies to Yogi Berra):

Cash Money.

Cash Money (Same as Cash).

Cash Money.

And

Anything that is convertible to Cash Money.
The lack of obligation to the needs of society are also manifest in other behaviours of general surgeons. General surgeons have become subdivided and have morphed into a series of subspecialties rather than becoming generalists. The reasons for these are complex but generally can be grouped as follows:

**Economic:** Particular expertise in a certain area will result in efficiency in office practice, as well as freedom from the economic tyranny of the third party payors, if a reputation is made in a certain area. In certain urban areas, a renowned super specialist can refuse to take insurance.

**Expertise:** Expertise in a certain limited area gives one some protection from the unfortunate tort situation in which medicine finds itself and a reputation as an expert. The knowledge base is smaller and one can develop expertise and therefore avoid professional liability.

Taking Advantage of Social Trends and Societal Needs: An example of this is bariatric surgery, currently filling a social need. In certain geographic areas of this country, patients are so desirous of weight reduction and not wanting to go through the hassle of third party payors that cash on the barrelhead without the intervention of health insurance carriers is the norm. Can you blame either them or their surgeons? I do not think so.

The problem is that there are certain areas which are not remunerated and fall far from what general surgeons wish to do, particularly areas of trauma (the knife and gun club). In addition, in rural areas, generalists are beginning to disappear, and it is the generalists who cover the emergency room. According to our current economic situation, generalists are not rewarded. One of the first things that the Center for Medicare Services did was to take a series of general surgical procedures such as hernias, gallbladders, colectomies, etc, and declare them overvalued. Who said they were overvalued? On what basis was this decision made, a decision which egregiously and singularly affected general surgeons? The result, unfortunately, is that general surgeons are a disappearing breed. The country will simply have to do without generalists. Surgeons interested in bariatric, endocrine, foregut, hepatobiliary, colon and rectal, and vascular surgery all have developed expertise in their particular specialty. They want no part of the general problems, which medicine finds itself and a reputation as an expert. A renowned super specialist can refuse to take insurance carriers is the norm. Can you blame either them or their surgeons? I do not think so.

In addition, exposure to professional liability is allegedly increased in emergency situations, as one has not developed a relationship with the patient. As a result, what we have left is a series of employees, each developing expertise in a smaller and smaller area, but with no obligation to society as a whole. Only professionals, in the trade-off that is intrinsic in granting a profession its area of expertise and governance, have an obligation to society to do the unpleasant care for all such as trauma and emergency surgery, care for the indigent, practice in rural areas where remuneration and social advantages may not be as pleasant as in the urban setting, and to cover emergency rooms. Employees have no such obligation. Employees work their shift. They are under no obligation to disadvantage their spouse and/or family, or to put themselves in harms way for professional liability. Those of us who did this, did so at the disregard and sacrifice of our family, willy-nilly. We enjoyed what we were doing. We enjoyed being away day and night; our families did not. At least there was some financial remuneration, and the tort system was not as odious as it is now. The latter two have changed and with it went the desire of our employee successors to do anything such as what we did. Do I blame them? No.

Finally, we have the 80-hour workweek. This has completed the cementing of the employee mentality that our trainees will carry with them into professional life. This is not the cause, but it is the result of societal decisions. The outcome is not yet clear and varies from training program to training program. However, it is clear that, with increased pressure, what we will be producing is a group of shift workers. There was a problem and the problem was fatigue. The 80-hour workweek was overkill. All that needed to be done was to make the 24-hour shift maximum, and residents could go home. The data which have accumulated, for example, that of Czeisler and his co-workers, was predetermined giving the lifelong work of that group with a certain point of view [1, 2]. However, this study was limited to an internal medicine intensive care unit, where interns seemed generally under-supervised. There have been very few studies concerning surgical patients and the 80-hour workweek in which the handoff of complex patients who are postoperative may result in a greater mortality and morbidity than might have resulted from a patient being cared for by a fatigue resident who actually knew the patient and had some pattern recognition of what might be going wrong. Indeed, some of the early studies that deal only with surgery, as recently presented at the annual meeting of the Southern Surgical Association [3], seemed to suggest this, although the relationship between the 80-hour workweek and the increased morbidity is not entirely clear.

Instead of fixing the problem and restoring professionalism, Congress has responded in its characteristic way by putting Band-Aids on the problem. To deal with the needs of the rural United States, they have waived the waiting period for people who come to work in research laboratories to stay immediately, so they can serve underserved areas. For example, physicians with a J1 Visa and who normally have to return to their own countries prior to returning may now avoid the waiting period by serving in underserved rural or urban poor areas. Thus, the problem of the emergency room will remain without the ability to oversee the quality of the product being produced, despite the protestations of the various organizations allegedly setting standards for international medical school graduates.

With the destruction of the profession, first and foremost the general surgeon, and as we embark in our brave new world, let us wish the public well. While all of these changes have been brought about through the elected officials, neither the elected officials nor the public that elected them had any idea of what they were doing philosophically and what the logical outcome of these philosophical changes might be. To the public I say, "Good luck. You’ll need it."

### References


SCURVY AND THE BRITISH NAVY

John MacFie

Scurvy was responsible for more deaths at sea than storms, shipwreck, combat or desertion. It has been estimated that over 2 million sailors perished from scurvy during the “Age of Sail”, a time that began with Columbus’s voyages across the Atlantic and ended with the development of steam power and its adaptation for engines on ships in the mid-19th century. Vasco da Gama lost two-thirds of his crew whilst making his way to India in 1499. In 1519 Magellan lost more that 80% of his crew whilst crossing the Pacific. He departed to India in 1519. In 1519 Magellan lost more that 80% of his crew whilst crossing the Pacific. He departed with three ships and 250 sailors to circumnavigate the globe and reached the Spice Islands by sailing west rather than east around Africa. Only one ship and eighteen men survived. Magellan himself was lost in the Philippines. One Antonio Pigafetta, an Italian mariner who kept a journal of the voyage, described “the sea scurvy was the worst of all our misfortunes, the gums of some of the men swelled over their upper and lower teeth, so that they could not eat and so died”. Two voyages made by Pedro de Quiros early in the 17th century resulted in a huge mortality from a sickness Sir Richard Hawkins called, after his adventure into the South Seas, “the Plague of the Sea and the Spoyle of Mariners”.

Scurvy came to public notice in Britain after Commodore George Anson led a squadron into the Pacific in the 1740s to raid Spanish shipping. He lost 700 out of an original complement of crew of 2000, most of them succumbing to scurvy. Richard Walton, the chaplain, who wrote up the official account of the voyage, vividly described the symptoms: “skin black as ink, ulcers, difficult respiration, rigidity of the limbs, teeth falling out and, perhaps most revolting of all, a strange plethora of gum tissue sprouting out of the mouth which immediately rotted and lent the victim’s breath an abominable odour”. During the Seven Years’ War (1756-1763) 133,708 men were lost to the Navy by disease or desertion, yet only 1512 were killed in action.

It was a trio of individuals in Britain who converged to lift the veil of obscurity from scurvy, a surgeon named James Lind, the famed mariner and sea captain, James Cook and an influential physician and gentleman named Sir Gilbert Blane. These three proved that scurvy was a disease of chemistry and food, not vapours and viruses. Nutrition rules, OK!

Scurvy in the British Navy

Scurvy was predominantly a European problem. This reflected in part the success of Europe’s navies and in particular the British navy. Increasingly voyages lasted for months, or even years. Landfall was often infrequent and, as a consequence, crews were wholly reliant on stored foodstuffs in an age when the science of food preservation was in its infancy. Scurvy reached epidemic proportions in the 15th and 16th centuries. Matters were compounded by the fact that the practice of the day was to massively over-man ship’s vessels. This led to significant overcrowding which contributed to the insanitary conditions on board all naval vessels and encouraged the spread of disease. The largest battleships, weighing over 2000 tons, could house over 1000 men. Large crews were needed because, in addition to manning the sails (no winches in those days), 8 to 12 men were required to operate each gun. Because of the high mortality rates, navy ships were often supplied with as the overpowering factor determining crew numbers at the Admiralty was the need to avoid loss or abandonment of ships at all costs (including men). Ships were colossally expensive to build, fit and maintain. It was deemed unacceptable to lose ships of the line as a simple consequence of lack of crew. So, the prevailing view was to ensure “surplus” personnel in an attempt to ensure that, at the very least, British ships could always be sailed home. Matters were made worse by the fact that many of the men recruited (more often “Shanghai’d”) were unfit or scorbutic when they were first drafted into the service.

The standard naval diet during these years differed little between countries. It was determined by what could be preserved or stored for months at a time without deteriorating. Salt beef or pork, dried peas or grains or ship biscuit were the standard fare from the time of the Spanish Armada in the 16th century throughout the period when Dutch merchants piloted their way to Indonesia to the era of great naval battles between France and England in the 18th century. A typical weekly menu for the average sailor was as follows:

<table>
<thead>
<tr>
<th>Food</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salt beef</td>
<td>2lb daily</td>
</tr>
<tr>
<td>Salt pork</td>
<td>1lb twice weekly</td>
</tr>
<tr>
<td>Dried fish</td>
<td>2oz thrice weekly</td>
</tr>
<tr>
<td>Butter</td>
<td>2oz thrice weekly</td>
</tr>
<tr>
<td>Cheese</td>
<td>4oz thrice weekly</td>
</tr>
<tr>
<td>Peas</td>
<td>8oz four days a week</td>
</tr>
<tr>
<td>Beer</td>
<td>1 gallon daily</td>
</tr>
</tbody>
</table>

This monotonous and unpalatable food was served in great quantity though and would have amounted to nearly 4000 calories per day, which is more than adequate to meet the energy requirements of these men. Their malnutrition would result as a consequence of vitamin and trace element deficiency compounded by prolonged periods of alcohol intoxication. It is interesting to speculate that this, together with the absence of John Harrison’s chronometer enabling determination of longitude, must have contributed to the frequent shipwrecks around our coasts.

Prevention and Cure

One result of Anson’s voyage when so many succumbed to scurvy was that it started a Golden Age of scurvy research in England. The voyage raised public awareness of the social cost of scurvy. Everyone now...
knew that more British sailors routinely died from scurvy than from anything else. Contemporary medical thought in these times was dominated by the influence of the Dutch physician Hermann Boerhaave. He proposed a modification of the Hippocratic explanation of disease based on the four humours: blood, phlegm, yellow bile and black bile. These, it was thought, made up the nature of the body. Disease occurs through an imbalance. Boerhaave proposed that when the body’s digestive system malfunctions the partially digested food trapped within the bowels became either acid or alkaline depending on the food eaten. Ulcers seen in scurvy were considered acid achrnomy while foul breath and rotting gums alkaline acrimony. Boerhaave’s teachings were particularly influential in the Royal College of Physicians of Edinburgh from where virtually all eighteenth Century Royal Navy Physicians were educated.

Physicians speculated that scurvy occurred owing to a salt diet, to a lack of oxygen in the body, to fat skimmed from the ship’s boiling pans, to bad air, to thickening of the blood, to sugar and to melancholy. It was recognised that once on shore the disease frequently disappeared rapidly. Such was the superstition amongst sailors, that the smell and touch of the earth gave the surest cure that one of Anson’s crew had his shipmates cut out a hole in a piece of turf and put his mouth in the hole. None had a cure for scurvy at sea but numerous recommendations were made. These included keeping the crew dry and the ship clean, serving bread and diluted wine for breakfast, sprinkling vinegar about the ship, burning tar, bleeding 8oz blood from the left arm, cooking in iron boilers instead of copper, punishing the idle sailor, lastly and most unpleasantly, eating the ship’s rats. Despite this plethora of bizarre recommendations, it is interesting to record that the benefits of fruit had been recognised by some for years. In 1601 Sir John Lancaster was commissioned to lead a flotilla of ships on a pioneering voyage to the Spice Islands. He prevented scurvy on his flagship the Red Dragon by the use of lemon juice. Why he did not recommend the same for his other three ships the crews of which succumbed to scurvy is unknown. 1602 Francois Pyrard recorded “there is no better care than citrons and oranges and their juice”. In 1617 John Woodall, a military surgeon and author of The Surgeons Mate, an extensive inventory of medicines and instruments in use in his time, described the following “we have in our owne country many excellent remedies generally knowne as namely scurvy grass, horse reddish roots, nasturtia aquatica, wormwood, sorrel to the cure of those which live at home.....they also help sea men returned from farre. At sea, the lemons, limes, tamarinds oranges do farre exceed any that can be carried from England”. In 1618 John Low during his first voyage to the Mediterranean. Between 1739 and 1746 he continued as a surgeon’s mate. In 1746 he passed examinations for a surgeon and was promoted aboard HMS Salisbury. It was in May 1747 that Lind carried out his famous experiments on scurvy. This, it has been said, represents the first prospective, randomised and controlled trial in medicine.

Lind describes how he selected 12 patients all with advanced symptoms of scurvy “as similar as I could have them. They all in general had putrid gums, the spots and lassitude, with weakness of their knees”. He provided a common diet to them all and isolated them in one part of the ship for a 14-day period. He separated the scurbutic sailors into six pairs and supplemented the diet of each pair with various anti-scorbutic medicines and foods. The first pair were given a quart of cider each day, the second were administered 25 drops of elixir of vitriol three times a day on an empty stomach, the third took two spoonfuls of vinegar three times a day, also on an empty stomach, also gargling with it and having their food liberally doused with it, the fourth pair who were the two most severely suffering patients were given sea water to drink a half pint every day, the fifth were fed two oranges and one lemon for 6 days when the ship’s supply ran out, the sixth pair were given an ‘electuary’ (medicinal paste) of nutmeg thrice daily.

The results were remarkable. By the end of the week, when the fruit supply had dwindled, one of the sailors had responded so dramatically that he was fit enough to return to duty. He was soon followed by his companion and both were then appointed as nurse to the rest of the set for the remainder of the trial. It took five years for Lind to write up his work (the absence of a vigorous RITA system probably accounts for this delay) It was not until 1753 that his Treatise on the Scurvy, Containing an Enquiry into the Nature, Causes and Cure of That Disease Together with a Critical and Chronological View of What Has Been Published on the Subject appeared in Edinburgh.

Arguably there was nothing new about his discovery. The efficiency of fruit as an anti scurbutic had been known for centuries but Lind’s real achievement was that in one experiment he had definitely established the undoubted superiority of citrus fruits over other anti-scorbutic remedies.

The immense importance of Lind’s findings on scurvy were recognised after his publication of a Treatise on Scurvy but it was another 40 years before an official admiralty order was issued on the supply of citrus fruit juice to ships. This was but another sad example of the damage done when politics neglect science and unqualified autocrats make final decisions on matters concerning health. Following the introduction of lemon juice as part of daily rations, scurvy all but disappeared from the British navy. In 1805 the navy, in a cost-cutting exercise, replaced lemons with limes (hence British seaman were referred to as Limeys). West Indian limes were cheaper to obtain than the Mediterranean lemon. Outbreaks of scurvy re-occurred on several arctic expeditions. What was not known then, but is now, is that limes have only one-third of the anti-scorbutic value of lemons.

It is interesting to speculate as to why it took so long for Lind’s experiment to gain the public and Admiralty recognition it deserved. Many explanations are possible. On the one hand, Lind in his treatise carefully discusses the many theories and proposed treatments of scurvy and is rightly critical of many. This may have offended many of his peers. On the other hand, Lind appears to have attempted to appease his superiors at the Admiralty by concocting a theory to explain the benefits of citrus based on Boerhaave philosophy. This he may have
deemed important because this did dominate medical thinking of the day. Lind's explanation, however, lacked substance. He proposed that scurvy came about because of blocked perspiration, which leads to an imbalance in the body's alkalinity. This latter was corrected by fruit.

Another possible explanation simply lies with the fact this was an era when medicine was not based on evidence based trials. Practice was dominated by experience. The more senior the figure, the more reliable the advice. Lind was a mere midshipman; little reason for the establishment to heed his words.

Of course, these days we would be critical and say the trial was unblinded and had too few numbers! Also, ludicrous to have as an end point, the ability to return to work which involved heavy manual labour and a head for heights!

A more curious explanation, to account for the deferred acceptance of Lind's work was the possibility that the establishment were more influenced by the opinions of the famous Captain James Cook. Captain Cook believed firmly in the values of malt and sauerkraut.

CAPTAIN JAMES COOK

James Cook (1728 – 1779) was a British explorer and navigator. Born in North Yorkshire, his early years were spent in Staithes from where he joined the Merchant navy. In 1752 he was promoted to Mate aboard the collier Friendship and 1755 he volunteered for the British Navy. During the Seven Years War he participated in the Siege of Quebec. He was familiar with the horrors of scurvy. In 1766 the Royal Society hired Cook (then a Lieutenant in the RN) to travel to the Pacific to observe and record the transit of Venus across the sun. This was the first of three epic voyages around the world (1768-1771, 1772-1775, and 1776-1779).

Cook is regarded as one of Britain's greatest mariners. He mapped large areas of the Pacific including New Zealand, Easter Island and the Sandwich islands. He was accompanied by scientists including botanists, astronomers and anthropologists. His contributions were colossal. However, some regarded his greatest achievement to have been the successful completion of so much sea travel without a single death from scurvy. Now some disagree with this claim, but few disagree that Cook's vessels were not plagued to anywhere near the same degree as most other ships of the day. The explanation for Cook's success was described by himself writing shortly before his death: “every innovation whatever, tho' ever so much to their advantage, is sure to meet with the highest disapprobation from Seamen: portable soup and Sour Krout were at first condemned by them as stuff not fit for human beings to eat. Few men have introduced into their ships more novelties in the way of victuals and drink than I have done. It has, however, in a great measure been owing to such little innovations that I have always kept my people generally speaking free from that dreadful distemper Scurvy.”

There is no evidence that Captain James Cook had any knowledge of Lind's work. Apart from portable soup (a preparation of dried vegetables) and sauerkraut, Captain Cook took large quantities of concentrated fruit juice (rob), vinegar, mustard, molasses and beans. He also paid strict attention to airing and drying the lower decks and keeping his men warm and well slept. He was also keen that vermin were eliminated in his vessels. In Cook's three voyages, he only identifies five cases of scurvy and no deaths from it. He was hailed as the conqueror of the sea's great plague. Which of his recommendations, however, was the most effective remained elusive. It is likely that Cook's reports to the Admiralty after his first two voyages significantly delayed the introduction of lemon juice in the Royal Navy for twenty years or until 1795.

GILBERT BLANE (1749-1834)

Gilbert Blane was from a wealthy and influential Ayrshire family. He graduated from Glasgow Medical School and soon established himself as a successful physician. In 1776 he was appointed personal physician to Admiral Sir George Rodney, whom he accompanied with the British fleet to the West Indies in 1780. In this position, despite no previous experience on board ship, he became responsible for the medical welfare of over 12000 mariners in 21 warships. He is said to have read extensively and, being wealthy, could afford whatever reading material he wished. He observed that Cook had preferred malt while Lind had recommended lemon juice and he concluded therefore that both should be used.

On arrival in the West Indies, Blane recorded that the death rate from disease in the fleet amounted to one in seven men, with scurvy the commonest cause. Of 12,019 mariners, 1518 perished from disease in his first year at a time when “only” 60 died in enemy action. By 1783 the death toll in all ships under his supervision had been reduced to one in twenty. At the end of the War of Independence in 1783, Blane took up a post in St Thomas's Hospital where he continued his investigations into the welfare of the British seamen. In 1793 he advised the captain of the 74-gun war ship “Suffolk” to supplement the daily ration of grog with lemon juice and sugar. On its return 23 weeks later no single case of scurvy had appeared. In 1795, Blane was able to persuade the Admiralty to adopt lemon juice rations for all sailors in the British Navy. Scurvy disappeared.

Blane is regarded as the father of naval medicine. His influence probably saved more British lives than any other. Indeed, such was the health of the average British seaman that some have said that the abolition of scurvy was probably an important factor in Nelson's success at Trafalgar 10 years later.

Postscript

Cook was very keen on cleanliness and the crews were keen on rats. It was their only supply of fresh meat. Whilst urging the sailors to eat rats may not appeal to our present culinary tastes, the fact of the matter is that it is now known that rats can synthesise vitamin C. A diet of rat meat might, at least, have delayed the onset of scurvy.

Another recommendation of Cook's was a prohibition against eating the fat from the boiling pans used in preparation of soup. We now know that hot salt fat coming into contact with copper produces a mixture which, if ingested, irritates the gut causing malabsorption. Certainly it would reduce vitamin intake. Avoidance was therefore definitely beneficial

The clinical presentations of scurvy were almost certainly variable depending upon the severity of other vitamin deficiencies or other aspects of malnutrition. Further, intestinal infestation with worms was common making malabsorption of some degree almost the norm.
Recent experiments have shown that vitamin C repletion of scorbutic patients results in cessation of spontaneous bleeding within a day and healing of bleeding and sore gums within 2-3 days.

Lind’s findings of a return to work within a week are, therefore, perfectly plausible. His choice of end point was appropriate!

Preoperative assessment for minor surgery can be readily managed by nurses on a protocol driven basis. The practicalities of bed availability have made this necessary in most hospitals. However, there is a risk that this might extend to decision making about whether an operation should be performed. The spread of common waiting lists and independent treatment centres has made it less likely that the decision to operate is made by the surgeon who will then be responsible for performing the surgery and dealing with either short or long term consequences.

Integrated care protocols have been useful for perioperative care in situations where progress should be predictable. They have acted as useful “check-lists” to ensure that the correct routine is followed. They tend to be very confusing when circumstances deviate from the norm.

We have realised that it is a poor use of time for every patient having minor surgery to be seen by a consultant surgeon for follow-up. Some do not need to be seen in hospital at all, while other routine follow-up can be managed by nurse practitioners. On the other hand, how are we truly to assess the outcome of our surgery if we never see patients personally?

It is not too ridiculous to foresee a situation in the future where surgeons are entirely focussed on operating. From a management perspective, this might make a lot of sense.

My overburdened outpatient clinic morning is not generally the best in my week. Some of these other aspects of care can seem less attractive than disappearing into theatre where there is the option of being “too busy to be disturbed”. However, I believe a job where operating was my sole activity would rapidly become boring. The decision with the patient to take the surgical option and the often complex decisions of perioperative care are part of the package of surgical care. These areas require professional judgement and are often more difficult to get right than the technical aspects of the operation.

So how are we to react to this situation? I believe that the first part of the solution is to be aware of the potential changes. We then need to assess what we feel our core activities consist of. Where is our input essential? There are many of these areas where we need not be involved in every detail of the routine case but it is vital that we remain in the centre of the organisation and in control of activity. We need to remain the decision maker with the patient for the “big decisions” of surgical care.

Continuing active involvement in perioperative care is necessary. It is essential for our patients’ sake that we do not take the easy way out and allow other disciplines and specialties to take over tasks which are boring when routine but where deviation from the norm must be detected early and dealt with appropriately. We must retain our role in the multidisciplinary teams, indeed, we need to increase our involvement in some such teams so that the voice of the surgical expert is heard. If the surgeon was to become purely a technician who performs operations our professional role would be seriously diminished and our jobs would become unattractive.

WHAT FUTURE SURGERY AS A PROFESSION?

Ruth McKee

What distinguishes a surgeon from other doctors? The answer is obvious; we operate. For most of us theatre days are the most attractive days of the week and, for our trainees, learning to operate seems the most important part of training.

However, we do far more than just act as elaborate technicians, performing intricate and difficult procedures. We are in danger of finding that much of the rest of our job has been taken over by others. Is this another ploy to reduce waiting lists? If we do less of other things, we would be free to do more operating.

Those of us who are gastrointestinal surgeons have seen gastroenterologists take over an increasing amount of endoscopy in the past few years and, in many hospitals, they perform more endoscopies than the surgeons. They have plenty of time to do it, we are tempted to think, so they should take the greater part of the burden.

However, the gastroenterological assessment of a proximal gastric cancer or a rectal cancer has completely different priorities than those of the surgeon who is going to operate on that patient.

Perioperative care is in danger of being taken over by the intensivists. The days of the on-call surgeon being the principal decision maker for patients on ventilators with multiorgan failure are past and there is no doubt that the fully trained intensivist is much more capable of adequate patient care in that scenario. On the other hand, HDU is being taken over by intensive care in many hospitals and our patients who have had epidural anaesthesia for major but routine surgery are being looked after there. Are we really incapable of looking after these patients? Is it right that our trainees have no responsibility for them and so gain little experience in this area? Is care by doctors used to looking after the critically ill appropriate for these patients in the era of enhanced postoperative recovery protocols?

The majority of patients who require complex nutritional support, such as nasojejunal feeding or parenteral nutrition, are in surgical wards. Yet very few surgeons are actively involved in either the British Association for Parenteral and Enteral Nutrition or the Intercollegiate Course in Nutrition. Nutrition teams usually have no problem recruiting dietitians and pharmacists and gastroenterologists have regained their involvement in some hospitals, but it is difficult to find surgeons willing to participate other than in name.

Nutritional support is an area where skills which are very familiar to us are vital - fluid and electrolyte management, endoscopy, and line insertion. The surgeon’s understanding of the anatomy of the GI tract and the likely outcome of the underlying pathology and surgery are essential for a realistic management plan to emerge.
HELLO FROM THE HONORARY SECRETARY

It is now 6 months since I took up my position as Honorary Secretary of ASGBI. It is a great honour to have been selected for the post, and I am writing to introduce myself to you. I have taken over from Graham Layer who, as you know, has done a magnificent job as Hon Sec. It will be difficult to come up to his standards. I must give him many thanks for leaving the paperwork in such good order, and for being most helpful during my settling in period.

I am a General Surgeon, well fairly general, with a subspecialty interest in upper GI surgery. I work in Wrexham in North Wales. I have just demitted office as Programme Director for Wales, and have an interest in training. I see my job as Honorary Secretary as being a conduit for information. I also see it as giving responses on behalf of the Association to external bodies. You may have read my response on the Pension proposals by the government, which was my first task for ASGBI, and was published in the August 2005 edition of the Newsletter.

I am hoping to try to get some relevant information on a range of topics that concern us all in the surgical world in the current NHS. You, the Fellows of the Association, are the embodiment of Surgery in the UK. As such, you have vital information about your working life that may not be available from any other source. I am hoping to gather information that will help to win arguments to preserve surgery as a craft specialty with the professionalism that befits the title of a Consultant Surgeon. We all recognise the potential problems that await us with the many factors at work currently. Factors such as EWTD, consultant contracts, ISTCs, unrealistic government targets, PMETB, Choose and Book, the list is endless.

There should be an ASGBI Link Surgeon in your hospital with whom I am very much hoping that you will liaise. The information on the network of Link Surgeons is a little out of date, and that is being updated as we speak. When it is in full working order, I will be working with Nick Wilson (Winchester) to gather information on behalf of the Association so that ASGBI is in a position of strength when it comes to facts and figures. Strong data is the only way to counter government proposals (if they are off beam) and to give accurate information that can be used to inform decision making.

I can be contacted at the Association offices, and look forward to meeting many of you at the Annual Scientific Meetings.

Jonathan Pye

THE FUTURE TRAINING OF BREAST SURGEONS

Hugh M Bishop
President, Association of Breast Surgery at BASO

Introduction

The breast industry is a big multidisciplinary organisation within the NHS, and Surgeons treat over 25,000 new breast cancer patients each year. As Breast Surgeons we developed and are habituated to working in complex multidisciplinary teams. The surgery of breast cancer is now interesting and technically challenging – it is the new speciality of oncoplastic breast surgery. We have differentiated away from visceral surgeons, whose practice is inside the body cavity. We are not true plastic surgeons, although we rely heavily on their techniques and skills for oncoplastic surgery. We are a new speciality. It is time to consider how the next generation of Breast Surgeons should be trained.

The National Committee of the Association of Breast Surgery at BASO met to discuss the future training of Breast Surgeons on 2nd March 2005. There was extended discussion on this, and the Committee have commented on several drafts by e-mail of what we talked about. This article is by way of background which informed the debate which took place in May 2005 at the ABS at BASO Conference at the National Motorcycle Museum.

The ASGBI Consensus, November 2004

A good starting point in this debate is the historic “Modernising Medical Careers and General Surgery” Consensus Conference organised by the ASGBI in November 2004. This was convened to consider the future configuration of General Surgery and the training of the surgical workforce. I understand, from those present, that it was agreed – in principle - that:

• Vascular • Transplant • Endocrine surgery • Breast should develop SACs, leaving General Surgery in the hands of visceral surgeons. The time has now come to recognise that breast should become independent of General Surgery.

There was full support at the Consensus Conference of the proposal that Surgeons that did not carry out elective abdominal surgery should not carry out emergency abdominal surgery and, therefore, would not take part in an on-call rota. During the extended discussion at the ABS at BASO National Committee, I twice put it to the Committee whether they felt that, in future, Breast Surgeons, who were not doing elective visceral surgery should take part in the take and, on both occasions, there was unanimous agreement that Breast Surgeons should come off the Emergency On-Call rota. Given that the Consensus Statement seems to indicate the future of Breast Surgery as being an independent speciality outwith visceral surgery, how will we train the next generation?

Foundation Years 1 and 2

The rotations within these two years are pretty fixed. I understand the second year (F2) is supposed to focus on the development of generic professional skills and emergency skills. Having said that, in the future, the aspiring surgeon, as a medical student, will probably be expected to develop a surgical based portfolio, for example, work at Imperial College suggests that Surgeons are being assessed for hand/eye co-ordination and other skills before considering embarking on a surgical career. We must hope that any aspiring surgeon will be able, in their two foundation years, to have posts that represent their interests whilst accepting that there will be some exposure to non-surgical medical work.

Surgical Training Year 1

The names for these years keep changing. There are two alternatives:

A fast track disease specific year

A “fast track” road into breast surgery via a disease specific year. The Neurosurgeons have opted for this approach, doing a variety of related topics such as Neurosurgery, Neuroradiology, and Neuroanatomy, and
Neurosciences. Selected candidates then go straight onto Surgical Training Year 2, which focuses on Neurosurgery only and does not include any training in the generality of surgery. It is possible that Breast Surgery might lend itself to a similar approach, offering a “fast track” disease specific year, including topics such as medical and clinical oncology, imaging, communication and counselling skills, principles of plastic surgery, pathology, etc. This might be a multi-professional year, as well as multidisciplinary. Those emerging into Surgical Training Year 2 could then spend the next four years learning the craft of surgery of the breast and the management of breast disease, and any other module of surgery included in the programmes below.

The generality of Surgery
Alternatively, those considering Breast Surgery could pass through the conventional Surgical Training Year 1, rotating through three or four posts relevant to Breast Surgery, and this would include general, plastic, endocrine, vascular and breast surgery posts. If selected for surgical training (Surgical Training Year 2-5), they would then have the choice of selecting Breast Surgery. This route would give those “uncommitted” trainees a further year to make up their minds in what is becoming a very attenuated training programme, which is nonetheless being supported by the four Royal Colleges and the Department of Health.

Surgical Training Year 2-5
One way of ensuring that the technical components and a variety of surgical skills are integrated into Surgical Training Years 2-5 might be to spend the second year, and possibly the third year, learning the following core topics:

- Resectional Breast Surgery
- Fundamental Oncoplastic Surgery
- Medical and Clinical Oncology
- Diagnostic interventional imaging
- Specialty specific professional skills, communication, ethics, trials etc.
- Pathology, Genetics, etc.

In addition to this, during Surgical Training Years 3, 4 and 5, the trainees could take up one, or possibly two, surgery modules that focus outside the body cavity. These might include:

- Intermediate Oncoplastic Surgery
- Thyroid surgery
- Parathyroid surgery
- Melanoma
- Day Surgery, hernia, lumps, bumps, etc.

This would mean that the CCT holder would be signed off after four years of specialty training as competent in the range of fundamental diagnostic and therapeutic procedures in relation to resectional breast surgery, as well as being familiar with the principles of reconstructive surgery. It seems likely that most trainees will choose to achieve competence in at least the fundamental aspects of breast reconstruction, and some will choose either to develop their oncoplastic skills further or, alternatively, to extend their portfolio to include endocrine surgery and other modules such as melanoma. These modules will, of course, be competency assessed so that these trainees could practice independently. Given the fact that these trainees will be doing no emergency general surgery, and the entire four years will be focused on breast surgery and its other modules, it would seem not unreasonable that, if desired, they might achieve competence at basic flap surgery, which should be perfectly possible with focused training. We need to be wary about what happens when the curriculum is structured wrongly. It is absolutely vital to get the structure and content of the curriculum covering these four years correct, as this will determine the level of interest in recruitment into the specialty. We should learn the lessons from Urology, who are now having recruitment problems into their specialty because the majority of trainees entering Urology today will be trained to a level where they can perform endoscopic urology and minor inguino-scrotal surgery only. It has been made clear that only a very few will go on to carry out complex open laparoscopic urological procedures, such as nephrectomy and cystectomy. Potential trainees appear to be voting with their feet, as few see a career in endoscopic urology as being attractive. I think we need to avoid making the same mistake in breast surgery where, ironically, with the opportunity for developing modules, in areas such as Endocrine Surgery, melanoma, and more advanced oncoplastic surgery we really do have the opportunity to make the specialty more, not less, technically challenging than it was in the past.

Post CCT Training
My understanding is that it is difficult to predict which way Post CCT Training will go. If, as seems likely, the demand for reconstructive breast surgery escalates in the United Kingdom, the demand for Fellowships in order to learn the techniques is likely to escalate as well. Competition for these posts will be considerable. On the other hand, the British Association of Endocrine Surgery (BAES) could develop advanced fellowships in endocrine surgery, or possibly soft tissue sarcoma surgery.

Breast Surgery in the New World
There are 450 Full Members of the ABS at BASO. The SAC in Plastic Surgery represents 300 Consultant Surgeons. Probably there should be many more plastic surgeons in this country than there are, but the fact is that Breast Surgery is a big specialty and has much to offer. Furthermore, breast disease is a politically sensitive topic to all consumers. Those who represent consumers are keen to see that women are able to access properly constituted multidisciplinary breast teams who have breast surgeons attached to them, who are competent and up to date. Breast Surgery sits in the middle, between Plastic Surgery and General Surgery. Effectively, General Surgery is the specialty from which we are departing. We are not plastic surgeons, though we will rely heavily on plastic surgical techniques and it will be important to develop a close association with the British Association of Plastic Surgeons, in order to ensure that oncoplastic trainees in the future are properly trained in the fundamentals of flap surgery and other plastic surgical techniques.

Conclusion
The moment seems to have arrived for breast surgeons to become independent of General Surgery, a specialty with which they now have increasingly tenuous relationships and to give up the on-call commitment, which is increasingly causing concern from a Clinical Governance point of view. We must develop the training of breast surgeons in the future. They will spend a great deal of their time in the operating theatre because they will accumulate competencies not only in breast, but also in endocrine surgery and skin cancer and who will have a major contribution to make to Oncoplastic Surgery in the United Kingdom.

I look forward to hearing your views, and am grateful to John Black, Chairman of the SAC in General Surgery, for contributing to the debate, and to Fiona MacNeill for advancing the cause of an independent specialty.
We are delighted that COOK has agreed to become the Association’s sixth, and final, Corporate Patron. They join B.Braun, Ethicon, GlaxoSmithKline, Stryker and Tyco as the major commercial sponsors of ASGBI and the Association is extremely grateful to all of them for their continued support.

Here we give a brief overview of COOK, and we look forward to working closely with them over the coming three years.

History
The story of Cook Group Incorporated began in 1963 with the founding of its flagship company, Cook Incorporated. Using the spare bedroom of Bill and Gayle Cook’s apartment in Bloomington, Indiana, as its first “factory” to build wire guides, needles and catheters, the business grew quickly. Cook Incorporated soon expanded into other fields of medicine, its success fuelled by its commitment to providing the highest quality products and the best possible working relations with the clinicians using COOK products. Cook Group manufactures products for diagnostic and interventional radiology and cardiology, critical care medicine, endovascular surgery, urology, gynaecology/IVF, endoscopy and surgery. Today, COOK is among the world’s best-known and most respected names in medical devices and supplies. Closely allied with top medical research facilities, teaching hospitals and leading specialists around the world, the Cook Group continues to provide innovative, physician-conceived, custom-crafted medical devices to health care providers who will accept nothing but the best for their patients.

SIS
Cook is working with numerous natural tissue substrates to develop advanced biomaterials. One such biomaterial that is being used extensively is small intestinal submucosa, or SIS, a strong, pliable tissue taken from porcine small intestine that provides a scaffold for host cells to replace and repair damaged tissue. SIS is a naturally-occurring, complex matrix that is easy to handle, yet strong enough to hold sutures and provide support for weakened tissue. As a naturally-derived, extracellular matrix material, SIS is neither synthetic nor chemically cross-linked. SIS is taken from a biological source and is processed to remove all cells. It is biocompatible and safe for human use. It is sterilized to eliminate pathogens and provide a long shelf life.

Biomaterials for replacement or repair of damaged tissues are utilized in a number of surgical procedures. The ideal material needs to be strong, easy to handle, and biocompatible, while supporting growth of new tissue. Existing biomaterials often lack some of these requirements and can cause complications, such as:

• Encapsulation
Many implanted biomaterials used for tissue repair produce a foreign body reaction leading to encapsulation that results in non-functional, rigid, fibrous scar tissue.

• Dissolved Support
Implanted biomaterials can be incompatible with surrounding tissues leading to breakdown of the material, tissue erosion, or adhesion formation. In an attempt to overcome these problems, complex, cellular tissue composites are being engineered in the laboratory, but these biomaterials are expensive, difficult to store, and raise concerns about cell-borne pathogens.

• Remodelled Tissue
The ideal biomaterial must allow tissue incorporation and result in remodelled, functional tissue without leading to encapsulation, breakdown of the material, tissue erosion, or adhesion formation.

Surgisis has applications in many areas of soft tissue regeneration. It has proved very successful in hernia repair where it is effective in potentially contaminated areas, eliminates the risk of erosion and reduces pain. It has applications in plastics, paediatrics, ENT and Neurosurgery, where a specific version of SIS, Durasis, can be used as a dural substitute.

For more information, visit www.cooksurgical.com or email surgical@cook.ie

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CONTACT
Lucie Lancashire
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LETTERS TO THE EDITOR

Partners’ Programme at the ASGBI Annual Scientific Meeting

Dear Sir

My wife and I were disappointed to read, in the Call for Abstracts that there would not be an Accompanying Persons’ Programme at the Association’s 2006 Annual Scientific Meeting in Edinburgh. It looks as though this decision has been made, no doubt with some thought, but I am writing in case a sufficient number of Fellows respond to persuade the organising committee to reverse the decision.

These programmes seemed to be very well supported and appreciated. They provide an opportunity for (almost exclusively) wives to make new friends and fully enjoy the visit to the host city. Whilst it is true that Edinburgh can be explored relatively easily on foot, there is a limit to how much one wants to tramp around in solitude in what is quite likely to be inclement weather. I’m sure that, for how much one wants to tramp around in solitude in what can be explored relatively easily on foot, there is a limit to the provision of healthcare throughout the land. You may be in a better position to judge the truth of this but the recent comments by the Health Secretary on failing trusts lends support to my suspicions.

The new model of acute trusts and elective DTCs may well have its merits, but I also believe that our profession should be insisting now that the work of the DTCs is undertaken by surgeons of consultant status working together with acute trusts and used as part of an accredited intensive training programme for juniors. As the Link-Surgeon for our trust, I thought I should draw your attention to our plight, as I am sure it will become a familiar story in the months to come. I would value the views and advice of the Association.

Andrew Mitchell
Milton Keynes

The Honorary Treasurer replies

Dear Mr Mitchell

Very many thanks for your letter; we are always delighted to hear the views of our Fellows. I was most interested in your thoughts on the decision not to offer an Accompanying Persons’ Programme in 2006 and would like to clarify the reasoning behind our decision.

While the programme has, indeed, attracted support in the past, our statistics show that this support has dwindled significantly over the last few years, so much so that running the programme is no longer financially viable and the Accompanying Persons Programme at this year’s Meeting in Edinburgh has returned a deficit. When planning the programme, we price the various activities on the assumption that a critical mass of partners will attend the various activities, and the losses we have experienced are the result of an increasing lack of support. As you may have seen from our 2005 Annual Report, the Association was the subject of a Review Visit, earlier this year, from the Charity Commission which highlighted the fact that, as a charity, our financial affairs must be seen to be completely transparent and, quite simply, ASGBI cannot realistically subsidise the programmes.

However, we are very grateful to you for highlighting this issue. We take such comments seriously and will ensure that we encourage partners to attend the Edinburgh Meeting by providing a comfortable room at the EICC (with all day refreshments, brochures and maps of the city, etc) where partners can meet and enjoy a day in the company of others but selecting, and paying for, their own activities. We will discuss this with the Edinburgh Convention Bureau who may well be willing to provide access to organised activities as part of their service.

We look forward to seeing you, and your wife, in Edinburgh.

John Duncan
Honorary Treasurer

Trust deficits

Dear Sir

One in five Trusts now has substantial deficit. My own Trust, the Surrey & Sussex, is apparently the worst of all and is currently under “special measures” following a Public Interest Report into its financial position. The drastic recovery programme being implemented by our interim CEO will almost certainly result in our service becoming emergency-only with elective work farmed out to diagnostic and treatment centres. This will inevitably affect our recognition for training purposes. Whilst we are assured these are temporary measures to regain financial control, I am extremely sceptical about this and, far from being unique, I strongly suspect that we are just first wave of similar exercises designed to alter radically the provision of healthcare throughout the land. You may be a better position to judge the truth of this but the recent comments by the Health Secretary on failing trusts lends support to my suspicions.

The new model of acute trusts and elective DTCs may well have its merits, but I also believe that our profession should be insisting now that the work of the DTCs is undertaken by surgeons of consultant status working together with acute trusts and used as part of an accredited intensive training programme for juniors.

As the Link-Surgeon for our trust, I thought I should draw your attention to our plight, as I am sure it will become a familiar story in the months to come. I would value the views and advice of the Association.

Adrian Ball
Link-Surgeon, Surrey & Sussex NHS Trust

The President replies

Dear Adrian

Thank you very much indeed for your letter. Your views coincide with mine exactly. Our Trust is going through the same sort of upheaval in that we have been told that our number one priority is to eliminate the deficit and number two to adhere to targets. Everything else goes by the board. There is no investment and one of the ways of reducing the deficit is to make members of staff redundant but I am told that we cannot afford to do that because we do not have the money to make people redundant! This means that when people retire or resign they are not being replaced.

The Association is well aware of what is going on in the country and I, through various publications in the press, have drawn attention to this and am going on doing so. I shall be having a meeting with the Health Minister shortly but I am afraid that they are deaf to any criticism about the running of the Health Service and this I believe is for one simple reason. In 2008 the extra money (50 billion pounds) that they have pumped into the Health Service since the year 2000 will cease and we shall be back to the same sort of treasury budget that we had then plus inflation. The Government are terrified that this enormous drop in income for the Health Service will result in terrible consequences and that is the reason why they are trying to outsource as much as they possibly can to the private sector before 2008.

It is the job of the ASGBI to publicise what is going on in the Health Service and try to make our colleagues and the public aware for at the present time there is a
This didn’t mean much really because the car was still not much good. In 1967 Honda’s Formula One budget was not the $400 million they spend every year these days – in fact they could only afford to make one car at a time and changes were not easily introduced. For 1968, in an effort to save weight, they introduced a car largely made of magnesium and tragedy ensued. Against the advice of Surtees, the car was entrusted to Jo Schlesser – father of multiple Paris-Dakkar winner Jean-Louis Schlesser – for its debut. A popular driver, Schlesser raced a Formula 2 Matra in the 1966 and 1967 German Grand Prix and, keen to become a Formula 1 driver, despite being 40, he accepted an invitation to drive the untested air-cooled Honda RA302 in the 1968 French Grand Prix at Rouen. He crashed on the second lap and was killed along with the project when the car caught fire.

In those days, however, safety wasn’t the issue it is today and drivers died on a regular basis. It was just considered an occupational hazard or the consequence of taking too many risks and although sad for poor Jo the world moved on without much comment. For Honda though it was too much to take and they withdrew from F1 soon after and would not win another Grand Prix until the era of the great Ayrton Senna many years later. All of this would convince John Surtees that the time had come to make his own cars and, back at home in Edenbridge, Kent he did what everyone did – make the chassis (monococque) from aluminium sheets, buy an engine from Cosworth (£3500), a gearbox from Hewland (£3500) and blag some free tyres from Dunlop, Goodyear or Firestone. Surtees was now following the lead of Jack Brabham and Bruce McLaren and he became a driver/constructor. All Team Surtees cars were labelled with TS chassis numbers and had a long broad arrow in their paintwork. Total budget in their best year - £110,000!

In those days F1 drivers were versatile folk who drove in all sorts of events – Grand’s Prix of course, sports cars at Le Mans and elsewhere and other formulae such as F2 and F5000. F5000 seemed like a good idea at the time and it was hugely successful in the UK, America and the Antipodes for several years. It was basically a
cost cutting exercise – sound familiar eh – and also aimed to broaden the market. The idea was to take a single seater race car like one used in F1 racing and replace the expensive and complicated Cosworth engine with a 5 litre Chevrolet V8. These engines were widely available and very cheap particularly in America – their real home. They produced the same amount of power as the F1 engine (just short of 500 BHP) and were supposedly very reliable. They also made a fantastic noise and would likely make a great spectacle – that bit was correct and they still look and sound terrific today.

So it was that the European F5000 Championship was born in 1969 and the big boys soon made cars seeing an opportunity to sell customer cars. McLaren dominated the previous year’s car – the TS5 – had been quite good and was upgraded into a virtually new design labelled TS8. It was exactly the same as that years F1 car (the TS9) save for the engine and gearbox which saved money and increased the options for spare parts etc. It certainly looked the part with a shape that looked fast and, of course, it had the required arrow down the middle. Indeed the arrow shaped nose suggested the aerodynamics of the car had been based on the paintwork more than anything else – no wind tunnels in those days of course!

What about a driver for the new car? Enter one Mike Hailwood – often known as “Mike the Bike”. Hailwood was arguably the greatest bike racer in the world having won nine World Championships on two wheels – before Hailwood left the team complaining that Surtees would not listen to suggestions about car design. He had been dabbling with car racing for many years and, by now, was full time on four wheels. The two former bikers got together and were to race together for several stormy years – before Hailwood left the team complaining that Surtees would not listen to suggestions about car design – where did we hear that before?

The works car for 1971 was TS8 Chassis No. 5 and it made its debut at Mallory Park near Leicester. And what a debut it was, as Mike started from pole position and won the race at a canter. Over the ensuing months, however, much frustration was experienced with the team plagued by unreliability. Mostly this was the Swiss built Morand Chevrolet blowing up. Mike was clearly the fastest man out there for the first half of the season and was regularly on the front of the grid. However, he broke down far too often and by the time the team dumped the Swiss built engine for one made in Derby the Championship was a lost cause. The eventual winner was Australian Frank Gardner who drove the first of a series of Lola factory cars that would soon come to dominate the formula for years to come. At the start of the season he was not quite as fast as Hailwood but always finished and by the time Lola had introduced their new faster car halfway through the year he was uncatchable. So, Hailwood came second in TS8-05, and attention was directed towards 1972 and a better car.

Before that, however, it was time for the Tasman series. Back in the ’60s and ’70s the winter break did not mean time for rest or testing as it does today. Instead it was off down under for the annual series of races in New Zealand and Australia where visiting stars mixed it with local drivers racing over successive weekends in both countries. Between the races the drivers travelled and lived together as a group having fun, sunbathing, water skiing, playing cricket and drinking far too much. The relaxation and camaraderie was very attractive to one and all along with attractive prize money and the chance of selling last year’s car for good money to some local hopeful.

The Surtees team were planning to compete in the Tasman series with their new car the TS11, to be driven by Hailwood who was also looking forward to some serious partying, as was his habit. However, days before the car was due to be shipped out disaster struck during a testing session at Goodwood. Essentially the new car was written off and the old faithful TS8-05 immediately came out of retirement and was sent to New Zealand.

The 1972 Tasman Championship was almost a mirror image of the ’71 European Championship for Hailwood and Team Surtees. Instead of the car being fast and fragile Mike now found that he was being regularly outpaced by the new Lolas that had moved design on quite a lot. However his car was now very reliable and, apart from one major crash at the third race – into a water ditch which wrote off the chassis – he finished all the races. End result? Second place in the Championship again!

TS8-05 returned home and like all old racing cars in those days was sold off. Bought by a very average French amateur driver it was run infrequently throughout 1972 before appearing briefly in the 1973 Brands Hatch 50,000 Race. Intended as a celebration of Jackie Stewart’s third World Championship, the field included both F1 cars – Hailwood was in the new Team Surtees Grand Prix contender – and F5000 cars. However, our intrepid French driver (Herve) decided to fit a 3 litre Cosworth engine to ’05 and enter as a proper F1 car. However, he soon ran out of money and talent and failed to qualify for the race proper after practice. However, this aborted venture did mean that the car is one of the few to have run as both an F1 and an F5000 car – important nowadays in historical terms for eligibility.

TS8-05 then entered a “wilderness” period and was nothing more than an old and outdated race car being passed from one amateur to another and gradually fell on hard times. However, salvation appeared in the form of one John Foulston. An enthusiastic collector of race cars with the finances to support such a hobby, Foulston had created a museum of some repute and, realising the historic significance of this car, bought and restored ‘05 back to a rightful former glory. The car rested for several years before passing through two more respectful
owners. Despite being taken to demonstration events on occasions ’05 never actually raced in anger again until 2005.

But we are ahead of ourselves at this stage. Going back to the 1971 series, the European Championship visited Ireland for the Rothmans Grand Prix of Ireland. Held at the country’s only purpose built race track, Mondello Park in County Kildare, the race was a full Championship round and the visiting contenders were joined by various local hot shoes to fill up the grid. Around that time the author was a callow youth in secondary school and a madly enthusiastic motor biker. My father had been a professional speedway rider and had introduced me to trials riding and moto cross and I had been a modestly successful rider of Spanish Bultaco bikes in various local championships. Coming from a biking family meant that the forthcoming arrival of bike legends Surtees and Hailwood was not to be missed. A kindly Godfather (really!) who was a friend of both the great men made a few calls and I was delegated to an official Team Surtees “hanger on” for the event.

The Mondello Park of 1971 was a pretty primitive place and the paddock was a grass field retrieved from the local cattle for the occasion. The weather was rather dreary and the “facilities” were very basic. However for me, none of that mattered as I mingled with legends and heroes as if I was one of them. My race programme was soon filled with autographs and many poor quality pictures were taken. The event was a mixed bag for “my” team with Hailwood once again starting from pole position. Run over two heats, the race was a different proposition and Mike soon found himself being outpaced by the dreaded Gardner and ended up third overall. Big John was not a happy man and managed to convey that feeling fairly clearly to Hailwood. For me the entire event was a dream come true although sadly that was the last time I saw Mike Hailwood in the flesh – tragically having retired from racing he was killed along with his nine year old daughter in 1981 - while driving to pick up a fish and chip supper.

Naturally I was a confirmed Team Surtees follower and fan and suffered the outrageous fortunes of the teams along with the very few triumphs until the cash ran out. Big John’s health failed and he packed it in at the end of 1978. In fact, did you know that the man he sold his F1 entry to was an unknown wide boy dealer in second hand racing he was killed along with his nine year old daughter in 1981 - while driving to pick up a fish and chip supper.

Fast forward to 2003 and your author has been pursuing a mid life crisis for some time and managed to amass a small collection of racing cars for weekend fun – and for investment purposes of course (especially if my wife is reading this). During a visit to my parents in Dublin my mother informed me that she has been clearing out a room and found box of “junk” belonging to me. Inside the box I soon found the autographed race programme from 1971 and a box of colour 35mm slides – the ones I had taken on that grey day in Mondello Park. Delighted with my new piece of nostalgia the slides were cleaned up and digitized for posterity.

Six weeks later a phone call arrives during my outpatient clinic from a vague acquaintance who says he is selling an old Surtees F5000 car and did I know anyone who might be interested. On asking which one it was I am told it was “the one that Hailwood drove in Ireland I think” - none other than TS8-05. The main thing at that point was to keep calm and not reveal any signs of interest. My (now) friend did not realise that he was talking to a sucker who had already bought this car before even asking the price. Summoning up a lot of steely nerve, a sense of disinterest was convayed and I was eventually convinced to take the car off his hands once he sent along the race records that confirmed it was indeed “my car”. And now it was for real!!

The next few months passed both slowly and in a blur. My mechanic insisted on stripping the car down to nuts and bolts and demanded a “routine” engine re-build. Slowly the car regained its looks and was put back together – including the rear wing signed by John Surtees, Jack Brabham and Hailwood’s son David. Six months after collecting the car it returned to the track for a September test session at a murky Donington Park – driven in anger for the first time in almost 25 years. However, a week later, out of the blue I received an invitation from Australia to have the car taken out there for a weekend of historic racing to be followed by three days of “spirited demonstrations” during the Australian Grand Prix weekend at Albert Park in Melbourne.

So instead of a rainy autumn day in England, TS8-05 returned to active racing in February 2005 at the fabulous Phillip Island circuit south of Melbourne – thirty three years to the month that Mike Hailwood had driven the car in the Tasman Series not twenty miles away. That’s quite a journey and life cycle for any car!

![The author races the Surtees at Phillip Island in March 2005](image)

Finally, what about the other cars taking part in the 1971 Grand Prix of Ireland? The race contained a few local stars who were mostly driving Formula 2 cars and were, therefore, at the back of the grid. Put into the shade for that weekend by the visiting celebrity teams from the UK, they were nonetheless good drivers in pretty quick cars. One of the drivers was a young Ken Fildes who was a bit of a local hero. That day he was driving a Crossle 19F Formula 2 car built in Northern Ireland on behalf of his patron – garage owner Luke Duffy. In fact the factory only ever made one of this model and when I was offered the chance to add it to my little stable there was only going to be one answer wasn’t there? So that’s two cars out of a total of 19 cars on the grid that day – only seventeen more to go!

Any other connections before we finish this story? Sitting alongside me on the 2005 grid in Australia was a McLaren M18 F5000 car. So what you say? Well that car also sat beside Mike Hailwood on the same row of the starting grid at Mondello Park. Before you ask – I didn’t buy it!

So there we have it. In the space of six months, thirty years of race history came together re-uniting three cars from the same race in a series of unconnected events that resulted in me buying two of the cars and returning one to the scene of previous glory. The world of race cars is truly a small place. We can see this again by watching the current TV coverage of the latest motor racing event – the A1 GP World Cup of Racing. The Great Britain team has an experienced chap at the helm – 71 year old Big John Surtees.
**DESIGNATED SOCIETIES**

As Fellows will be aware, the Association’s Byelaws were amended at the 2005 AGM in Glasgow to allow for affiliation with other national and international surgical and related organisations to be formally recognised as Designated Societies. It is hoped that this will provide a vehicle for sister societies around the world having a particular relationship with the Association to be formally affiliated with ASGBI for mutual benefit. This may include the promotion of each others’ scientific conferences, possible exchanges or fellowships and potential joint meetings.

We are delighted to report that the British Journal of Surgery Society should become the Association’s first such Designated Society, and the photograph below shows the President, Mr Robert Lane, presenting the certificate conferring this status to Professor Neil Mortensen, Chairman of the BJS Society.

The British Journal of Surgery Society has been an outstanding supporter of the Association over many years, and it is appropriate that the certificate proudly hangs in the recently refurbished “BJS Room” within the ASGBI offices.

We are equally delighted to report that the status of Designated Society has also been conferred on General Surgeons Australia and we hope that this will lead to many fruitful collaborations over the coming years.

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**SHOULD COUNCIL GET “LAYED”: Lay Representation on ASGBI Council?**

**Introduction**

The issue as to whether there should be a Lay Representative on the ASGBI Council has recently been raised, causing considerable discussion. Here, the Association’s Honorary Editorial Secretary, John MacFie, and Chief Executive, Nick Gair, take deliberately opposing views in a light-hearted debate.

**The argument against**

At a recent meeting of the Association’s Executive Committee, the suggestion was made that it would be to our benefit to have a Lay Representative on Council. This, it was said, would bring certain skills, knowledge and expertise to our organisation and would bring us in line with modern practice. In the spirit of debate I expressed certain reservations about this proposal but agreed further discussion appropriate. I was somewhat surprised, therefore, to receive an email from the Executive some days later confirming our decision to go ahead with this proposal, and for the proposal to be discussed at Council. I dispatched the following email, partly out of badness and partly for fun:

Dear All,

I do hate to be a dam squib on this (Lay Representatives) but may I gently remind you that the Executive did not wholeheartedly agree to this. It agreed in principle to "test" the idea for a fixed period and then review.

I appreciate that some of you feel my reticence to welcome a Lay Representative "Luddite" but I assure you it is borne of experience. Often they are single issue, self-righteous or evangelical and, as such, counter productive.

Consider, we could not and should not have an individual with a partisan political approach (that counts out MPs, the aristocracy, councillors, etc.), members of the GMC (arbitrators of the death of medical professionalism in the UK - we'll base everything on Shipman, but ignore Fred West because he was into double glazing), the BMA (representatives of the "we need more money" group - particularly for primary care, and stuff altruism, the fundamental bed rock of professionalism), the medical protection societies (who profit from our alleged misdeeds, but refrain from any independent comment on behalf of doctors), the academic institutions (universities, as these are single interest - academia - which excludes the majority of surgeons in your institution who have not put pen to paper for years), the para-medical professions who aspire to be medical but were not clever enough to get to medical school, and so on.

Also, consider, why should we as a profession be ashamed of our unique expertise. Why should we have yet another representative, for example, on our Distinction Awards Committee? They are already there. Who understands best the constraints on aspiring to excellence in a busy surgical practice? A lay person or a surgeon?

So, I agree, we should consider a Lay Representative, but not in a cuddly, politically correct fashion. If we want a Lay Representative let us define what we wish to achieve, what attributes we would wish this individual to possess, and what our end points are. Why do we have to roll over and Kow-tow to external pressures such as PMETB? They need to embrace organisations such as ours if Medicine is not going to go completely down the drain (the spelling of completely is deliberate; see next year’s Annual Scientific Meeting).

I hope, at least, that these thoughts provoke some discussion. The issue of lay representation must be discussed at full Council who should have the opportunity to hear all views.

**Kind Regards**

**John**

The responses I received to this were remarkable. Firstly, everyone on the Executive Committee expressed a view (with the exception of our President who is far too mature to enter into this banter), and secondly, without exception, everyone indicated their support for the proposal. I was advised to learn “to build bridges not walls”, to take a look outside my narrow world and see what was happening elsewhere. Didn’t I realise that such conservatism on my part was the cause of the demise of many organisations in the past. To move forward, I was told, meant engaging with the public. I should learn to be mutually inclusive to attract new skills and not exclusive. We live in a modern world. I was told (2005, one of my colleagues helpfully reminded me) and must learn to adapt to modern ways. Anyway, I, “Outraged of Scarborough” as another colleague addressed me in his reply, ruminated on this for a while and decided to commit my thoughts to paper.

The benefits of lay representation, some of which are mentioned above, include openness and transparency, which, it is said, are essential to keep public confidence and avoid accusations of running a closed shop. The acquisition of additional expertise is fundamental together with the view that lay representatives perceive matters from a different perspective. Professionals such as us live and work in a goldfish bowl and need third parties to save us from swimming in ever-decreasing circles. Finally, of course, there is the view that only lay representatives can tell us how we as a profession are viewed from outside the goldfish bowl and that’s important so we don’t become even more arrogant and opinionated.
Well, I don’t buy all of this. Take public accountability, for instance. There may be an argument for public accountability for public organisations, but we are not a public organisation. We are a club, a fellowship set up by Berkeley Moynihan to foster good relations between surgeons and to encourage the interchange of ideas. We are not publicly accountable in the same way as political organisations, patient groups or organisations like the GMC, BMA or medical defence organisations. We, as a registered charity, must satisfy the Charity Commissioners that our “mission statement” is not against the public interest, but this is perfectly compatible with working for the benefit of surgeons, which is in the public interest.

And, as many of you will know, the ASGBI just had a Review Visit from the Commission and they didn’t raise the issue of lay representation.

What then, of the argument that lay representatives bring additional skills, new knowledge or a different perception of our activities. Well, firstly we already have lay representatives - a very efficient and knowledgeable Chief Executive together with his two deputies. These individuals sit on Council and the Executive Committee and are not mute observers. Secondly, what skills do we want? Financial, so we should appoint a managing director of one of our Corporate Patrons perhaps. Great, I’m sure they would be unbiased when it comes to sponsorship. Or an accountant? Fine, except what guarantee can they offer any other expertise apart from financial. Well then, an eminent academic or educationalist? I think not. These individuals have recked havoc with our examination system and why should a Vice Chancellor or similar either want to sit on ASGBI Council or have views relevant to a surgical club?

There is a further conceptual difficulty with this issue of bringing in new skills or knowledge. If one area of expertise is required, why not another and another? When do you draw the line? Surely it would be better if, as an organisation, we feel we require specialist advice that we co-opt members if, and when, necessary on an ad-hoc basis. We could even pay them for their expertise. This is the real world after all.

Another thing, isn’t it a little insulting to our members (over 2500) to presume that the skills we need to run our organisation are not already out there. We have Directors of Informatics (a surgeon), Science (an Irish surgeon), Education (a Scottish surgeon), an Honorary Treasurer (another Scottish surgeon), an Honorary Editorial Secretary (a Geordie) and an Honorary Secretary, President and Vice Presidents from all corners of the British Isles. What a diverse group. Talk about multi-culturism.

And finally, in this rant, what about the view that lay representation would open our eyes to the outside world, would inform us narrow minded surgeons what the public really think about us and provide pearls of wisdom that would significantly influence the future of our organisation. Well, what tripe. I sleep with a lay representative who is not reserved about offering her non-medical opinions. I go to garden parties and dinner parties and am, as I’m sure you are, frequently arraigned with the opinions of potential lay representatives. And, guess what, every day I see them by the score at work. They are called patients and it may surprise you to know that I frequently listen to their opinions.

John MacFie
Outraged of Scarborough

The argument for
Wow, where do I start? M’learned colleague has already done a pretty effective demolition job on all the arguments I would propose in favour of the inclusion of a Lay Representative on Council. John’s certainly got his retaliation in first! Whatever I put forward now is in danger of sounding like political correctness, or interference in the affairs of the Association (which is, after all, an association for surgeons managed by surgeons) from a non-surgical – in fact, non-medical – meddling Chief Executive.

So how do I put the case here for lay representation; which I rashly agreed to do in the interests of an even-handed debate (which only goes to show that flattery – in the form of being called, in print, a “very efficient and knowledgeable Chief Executive” – will, indeed, get you anywhere). I could, I suppose, counter John’s arguments one by one, picking holes in his finely reasoned defence of the status quo. Alternatively, I could plead with his better nature to bow to the inevitable. Or perhaps I could get him a part on TV’s “Grumpy Old Men” with Bob Geldorf and Jeremy Clarkson?

I will, however, attempt none of these things. I will simply put the case that lay representation on the Council of the Association of Surgeons of Great Britain and Ireland somehow just ‘feels right’. As John correctly points out, ASGBI is, indeed, a charity and, as such, is required to satisfy the Charity Commissioners that they contribute their efforts. I have even, believe it or not, come across surgeons who are lay representatives on school governing bodies, and a very good job of it they do too. They bring an external and fresh perspective to discussions, derived from a different professional culture, work ethic and ethos.

So, for reference and an external perspective, let’s look to how the issue of lay representation is handled by other organisations. As we all know, the majority of Magistrates, the first level of our legal system, are lay and some of you, no doubt, contribute to society in this way. In a similar vein, Police Authorities and Probation Boards include lay representation. The General Synod of the Church of England includes lay representatives, and, of the 105 members on the Council of the Law Society, up to five of them are lay. In the medical arena, the GMC has a Council of 35 of which 14 are members of the public, and the PMETB has 24 members, 16 of whom are medical and 8 of whom are lay.

Everyone, I guess, is “lay” at something. In fact I suppose we are all “lay” at a lot more activities than we are professional – if that’s the correct opposite. As such, as we have seen above, many organisations and bodies include non-professional/non-specialist (ie. lay) representatives. Well, what tripe. I sleep with a lay representative who is not reserved about offering her non-medical opinions. I go to garden parties and dinner parties and am, as I’m sure you are, frequently arraigned with the opinions of potential lay representatives. And, guess what, every day I see them by the score at work. They are called patients and it may surprise you to know that I frequently listen to their opinions.

Nicholas P Gair
Layed back of Lincoln’s Inn
# CORESS: Confidential Reporting System in Surgery

## REPORTING FORM

Once completed, this form should be sent to:
RLTC-KCER-HLEB
CORESS (ASGBI), 35-43 Lincoln’s Inn Fields, London, WC2A 3PE

**NOTE:**
- Your personal details are required only to enable us to contact you for further details about any part of your report.
- You will always be sent an acknowledgement following receipt of your report.
- This WHOLE Report Form will be returned to you when your report is closed and no copies of the form will be made during processing.

NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT.

Please complete the following relevant information about the incident/situation.

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PLEASE GIVE AN ACCOUNT OF THE INCIDENT/SITUATION ON THE OTHER SIDE OF THIS SHEET OR ON ADDITIONAL SHEETS. DO SO IN YOUR OWN WORDS AND INCLUDING AS MUCH DETAIL AS PRACTICAL.

When completed please place the Report Form, with additional Pages if required, in a sealed envelope and post it (no stamp required) to the “Freepost” address given above. Additional copies of this form can be downloaded from www.asgbi.org.uk
A couple of interesting cases are offered this month, with thanks to the reporters as usual for taking the time and trouble to write in. We at CORESS are delighted to report the appointment of Adam Lewis as our first Programme Director. Adam will be known to many of you as a distinguished colleague who works as a general colorectal surgeon based at the Royal Free. He has held the job of Medical Director there for some years and it is of note that he is also a keen amateur pilot. He was selected from a shortlist of four excellent contenders, each one of whom was clearly capable of doing the job. Our thanks to them all for applying and we hope to use their talents in due course.

The other important snippet is the development of the project. It is clear that there is a niche to fill in the way that we capitalise on mistakes and near-misses and that an informal feedback system such as CORESS, run for and by surgeons, can do the job. Thus encouraged, we have asked the other surgical associations and Royal Colleges to join the project and all so far approached have signed up to taking this forward as a group. It will take some time to develop and organise, but all the signs are that, providing colleagues send in regular reports, we can really make this part of the fabric of surgical practice. If any local M & M meetings would like one of the CORESS team to come and set out our stall with a local presentation, please get in touch with Emma Seekings, CORESS Administrator on 020 7973 0302. Meantime, M & M chairmen, you must have something interesting to report to after the last meeting … surely?

A CORESS Reporting Form, which includes the “Freepost” address to which it can be returned, can be downloaded from the CORESS section of the Association’s website at: www.asgbi.org.uk

**CORESS FEEDBACK**

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**HE WAS SPEECHLESS.......**

Mr BS presented to my endocrine clinic with a six month history of enlargement in a long-standing goitre. He was a keen amateur singer in the local male voice choir and had noticed some changes in the quality of his voice. When I examined him, I found a multinodular goitre with a pronounced (dominant) nodule on the left hand side which was confirmed on ultrasound. TSH was 5.4 and cytology of the lesion showed branching follicular cells with scanty colloid, nuclear enlargement and vacuoles, classified as C4.

After due discussion, we agreed a left total thyroid lobectomy with frozen section, which in the event was consistent with a papillary carcinoma of the thyroid. Accordingly, we went on to perform a bilateral total thyroidectomy.

The procedure was uneventful with exposure of both recurrent laryngeal nerves and re-implantation of parathyroid tissue. I closed the wound leaving a small drain to the bed of the thyroid and completed the performance by infiltrating 20mls of Bupivacaine, as is my routine.

He was extubated in theatre while I wrote up the operation notes and all was well. We went off to have a cup of coffee, only to be called to the recovery area about 15 minutes later where the patient was in acute respiratory difficulty with audible stridor. An urgent fibre-optic laryngoscopy showed bilateral vocal cord palsy and he was re-intubated and admitted to HDU.

The next few hours were, of course, worrying although I was confident that I had left the recurrent laryngeal nerves intact. Fortunately, by 6 hours post-op on trial of extubation he was able to breath and speak normally.

When I saw him at follow-up he reported that his speaking voice was back to normal and his singing voice was ‘almost there’. We suspect that some of the Bupivacaine solution must have entered the central compartment, either via the drain or by infiltration.

**Reporter’s Comments:**

I carry out a lot of thyroidectomies and this is the first time that I have encountered this particular complication. It had me worried that I had in some way produced a mechanical bilateral neuropraxia. I now make sure that the infiltration of local anaesthetic is confined to the skin flaps.

**CORESS Expert’s Comments:**

The reporter makes an important learning point by submitting this case, namely that Bupivacaine injected into a wound at the end of a procedure may enter any of the planes opened by the surgeon and if nerves have been exposed they may be blocked. If the nerves are the recurrent laryngeal nerves then the potentially life threatening outcome described here is a real possibility. If Bupivacaine is to be used in thyroid or parathyroid operations many find it safer, and just as effective, to infiltrate the wound site before the incision is made. If premixed bupivacaine/adrenaline is used it has the added advantage of limiting bleeding from the wound edges.

This problem is not confined to thyroidectomy. There are reports of femoral nerve palsies following inguinal hernia repair under LA. These can present with the leg giving way when the patient tries to stand for the first time postoperatively and can result in injury.
MURPHY’S LAW...

We cared for an obese man on whom we undertook colectomy with ileocolic anastomosis for extensive angiodysplasia and life-threatening haemorrhage. All was well until the time came to carry out the staple anastomosis. The device used was one that involved separation of the anvil and head; purse-stringing the ends of the ileum and upper rectum onto the head and anvil respectively; re-assembly of the two components and, after tightening, firing the gun. At this point it became clear that the head had misfired and to my consternation could not be withdrawn from the patient. The reason then became apparent. Initially, we had planned to use a size X anastomotic gun but found that the head was too large to insert into the proximal bowel (ileum). The gun was, therefore, discarded but left on the scrub trolley and a smaller size brought into play. At this point it was realised that there had been a transposition of the components between the two guns. Having been fired, the incorrectly assembled gun could not be disassembled and the anastomosis had to be resected and a further one carried out - fortunately there was sufficient colon/rectum to complete this satisfactorily.

Subsequently, I am pleased to report that the patient made an uneventful recovery.

Reporter’s Comments:
This could have been worse. If, for example, we had been carrying out a totally closed procedure, we would have had to open the abdomen. If there had been insufficient rectum left after the failed attempt we would have had little choice but to leave the patient with a stoma.

We now make it a rule that disposable devices are taken off the scrub trolley once they have been tried.

CORESS Expert’s Comments:
The reporter quite rightly highlights the need for vigilance when using devices that have several components, and I agree with his/her analysis of the cause and remedy. Manufacturers should be made aware of this incident and any other similar that occur (we have done – Ed). I would guess that this danger is something that other surgical specialties routinely using similar devices such as joints, will have encountered more than us in General Surgery. When I discussed this with my theatre sister she felt that the Reporter’s solution was correct and we also went on to check and found that this could happen with several of the most commonly used brands of guns.

Again, as the Reporter states, if the one short segment of rectum/anal canal has been destroyed in this way there is little alternative to a stoma or a hand-sewn endo-anal anastomosis, now but rarely performed.

AND FINALLY...

Collectors of trivia will be intrigued to know that there really was a Captain Edward A Murphy. In Pilot 2004 he is described as an engineer working on Air Force Project MX981 in California during 1949. The project sought to discover the human body’s tolerance to sudden deceleration, by means of rocket sled tests. One day after finding a transducer was wired incorrectly, Murphy roundly cursed the technician responsible saying “If there’s a way to do it wrong, that guy’ll find it”. Hence Murphy’s Law. Shortly afterwards, a USAF doctor rode a rocket sled during a 40g deceleration (!), and at a press conference afterwards said “The good safety record of the project is due to a firm belief in Murphy’s Law, and in the necessity to try and circumvent it”. So now you know!

A SURGICAL THREAD

I studied medicine for five long years
It was mostly vain, just a few tears.
I passed my finals and received my degree
My parents were pleased, it was plain to see.

They had scrimped and saved to help me achieve
My childhood ambition, for they’d always believed
I could make the journey from secondary school
Through the University’s lecture hall.

Inspired by surgeons in my clinical years
I started my house jobs with almost no fears
That a surgical career would be there to be had
By a bright, reliable, hard working lad.

Now that my name is proudly in
The medical register, it seems a sin
That I’m having to go overseas to obtain
My post grad training- is that insane?

We are told the UK is short of physicians,
Surgeons, GP’s and paediatricians,
So having trained many hundred more docs
I say to our leaders, ‘pull up your socks’.

The nation has spent a small fortune on
My education, so what went wrong?
Was there no manpower planning to guarantee
Some seamless training for the likes of me?

I’m told it’s all down to MMC
F one, F two and ST one, two, three.
Well all I can say is an Ass in a cellar
Could probably have organised things a bit better.

I’m young, enthusiastic and willing
To bend my surgical back for a shilling,
But sadly it’s farewell to this frustrated scholar
I’m off to work for a Rand or a Dollar:
F one, F two and ST one, two, three.

I’m told it’s all down to MMC
F one, F two and ST one, two, three.
Well all I can say is an Ass in a cellar
Could probably have organised things a bit better.

So one should find, in a year or two,
A few gaps appear in your surgical crew,
I’d need to be sure that if I returned
I wouldn’t once more be used and then spurned.

I would love to return to your surgical team,
I still have a burning UK based dream.
Yet I cannot help but wonder aloud
Am I the thread of an NHS shroud?

Magnus King
GOVERNIMENTIUM

A major research institution has recently announced the discovery of the heaviest chemical yet known to science. This new element has been tentatively named ‘Governmentium’. Governmentium has one neutron, 12 assistant neutrons, 75 deputy neutrons and 224 assistant deputy neutrons, giving an atomic mass of 312. These 312 particles are held together by forces called morons, which are surrounded by vast quantities of lepton-like particles called peons.

Since Governmentium has no electrons, it is inert. However, it can be detected as it impedes every reaction with which it comes into contact. A tiny amount of Governmentium causes one reaction to take over four days to complete when it would normally take less than a second. Governmentium has a normal half-life of four years; it does not decay but, instead, it undergoes a reorganisation in which a portion of the assistant neutrons exchange places. In fact, Governmentium’s mass will actually increase over time since each reorganisation will cause more morons to become neutrons, forming isodopes. This characteristic of moron-promotion leads some scientists to speculate that Governmentium is formed whenever morons reach a certain quantity of concentration. This hypothetical quantity is referred to as ‘Critical Morass’. You will know it when you see it.

When catalyzed with money, Governmentium becomes Administratium, an element which radiates just as much energy since it has half as many peons but twice as many morons.

CAPTION COMPETITION

The winning caption to the photo of Sir John Temple, past President of the Royal College of Surgeons of Edinburgh, will receive a book token for £25 and will be published in the next edition of the Newsletter.

Please email your entries to: admin@asgbi.org.uk putting “Caption Competition” as the subject of your email.

WINNING ENTRY

Too late, you should have got your shades on faster; they’ll recognise us now!

In the last edition of the Newsletter, we invited you to submit a caption to this photo of Graham Layer and David Bouchier-Hayes. The winning entry, given above, is from Marcus Ornstein; book tokens are on their way.

Merry Christmas to all our readers

Association of Surgeons of Great Britain and Ireland
35-43 Lincoln’s Inn Fields
London, WC2A 3PE
Tel: 020 7973 0300
Fax: 020 7430 9235
www.asgbi.org.uk

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