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Letters to the editor

Clinical excellence awards

Ann R Coll Surg Engl (Suppl) **87:** 342–345

Sir,
I am writing to congratulate the *Bulletin* on the quality of the clinical excellence awards debate published in November 2005 and to support Sir Netar Mallick in his defence of the present system. I am senior enough to remember a time when the old C award was regarded as simply recognition of seniority, a reward for compliance and a boost to one's pension.

The new advisory committee on clinical excellence awards (ACCEA) system is a complete refreshment and answers the suspicions raised by consultants like Richard Rawlins (of secrecy, nepotism and 'fitness for purpose'). The presence of lay members on the local and national awards committees, together with their reflection of sex, ethnicity and specialty representation, not only make this a fairer system but one in which decisions are nearly impossible to influence or pre-determine by any one individual, however persuasive.

Mr Rawlins is correct in his application of Maslow's theory of the hierarchy of needs as being the best fit for consultants.[1] His assertion, however, that failure to achieve the highest need in this hierarchy (a sense of fulfilment) then leads to de-motivation, low self-esteem and, ultimately, depression is an exaggeration. To suggest that no patient would wish to be treated by a surgeon who has a low opinion of him/herself is spurious. This fails to recognise that patients cannot always be operated on by surgeons who have succeeded in every aspect of life in which they have competed.

Richard Rawlins states that 'the role of sycophancy in the allocation of awards has never been adequately analysed'. This is true but then neither has its role in the consultant appointment process been investigated and he does not suggest reform of that mechanism. His conclusion appears to be to scrap the present scheme since it fails to recognise and reward everyone. However, if this were to happen there would be a ground swell of opinion from my naturally competitive colleagues asking for something else to be put in its place. I suspect that the best design evolved would then not look very different from the present ACCEA model.

Reference

1 Maslow AH. *Motivation and Personality.* New York: Harper & Row; 1964.

D Hicks, Medical Director, Barnsley Hospital NHS Foundation Trust

Response by Richard Rawlins

David Hicks' contribution to the debate on clinical excellence awards (CEAs) is welcome but some facts of his letter bear correction. Nowhere in my article do I express any concern about secrecy or nepotism, only that CEAs are not fit for purpose.

I actually suggested that all surgeons would be at the apex of Maslow's hierarchy of needs and that it was the failure of some surgeons to have their worth recognised (as Sir Netar Mallick confirms is the case) that leads to loss of morale. No system of remuneration that fails to recognise all those worthy should be acceptable. Is such a system acceptable to Mr Hicks or does he share my view that it is tantamount to exploitation? A surgeon could continue with extensive and worthy contributions for five or so years after reaching nine CEAs but just miss out on the tenth (worth about £10,000 per year and about £5,000 on the pension) before retirement. The NHS would have had all the benefit of those contributions but will not have paid a penny for them. Is that fair?

I did not suggest that 'no patient would wish to be treated by a surgeon who has a low opinion of him/herself'. I simply asked 'which patient wants to be treated by a surgeon who holds such a low opinion of him/herself that they cannot be bothered to appeal?' This question is especially relevant in the case of our colleague who knows he or she is worthy of a CEA but has just missed out.

My conclusion was not that the CEA scheme should be scrapped 'since it fails to recognise and reward everyone' but because not all those who are deserving and worthy are recognised.

Trusts can and do now pay for extra work done. They can pay for any contribution 'above normal'. Perhaps Mr Hicks' colleagues are rewarded in that way at his Trust. If not, why not? The CEA system is not necessary at Trust level. At national level the funds could be used to recognise specific contributions to a college, specialist association, deanery or national body. Competition for those posts would provide the necessary stimulus to professional excellence.

No one has ever calculated the value of the contributions of all those who fail to get an award or who have an award delayed. What we should be asking is not how much is spent on awards but how much should be spent to properly reward those worthy. What is clear is that the present system is divisive, demoralising and dysfunctional. This debate will run a while yet but a better system will emerge.

The pregnant surgeon

Ann R Coll Surg Engl (Suppl) 2006; **88:** 137–139

Sir,
I am sympathetic towards the plight of pregnant surgeons. I have two medical daughters (one an anaesthetist) and both worked through their pregnancies – I have three healthy grandchildren as a result!

What does puzzle me, however, is the assertion that three months of maternity leave can be counted towards the Certificate of Completion of Training. How can time on leave possibly equate with the receipt of training? In these times of reduction in junior doctors' hours this seems to further reduce the opportunity to gain surgical experience.

EA Benson, retired general surgeon, West Yorkshire

Sir,
I read the article by Mrs Cross with interest – and some sadness. The tone about derogatory comments and harassment, and the outdated views on dangers of x-rays, will only put more women off choosing a surgical career or choosing to start a family.

On a practical note:

1. The Women in Surgical Training guidelines[1] are no longer available and the British Medical Association *Maternity Leave for Medical Staff* is better.[2]
2. A number of recent publications put the risk to the foetus of using an image intensifier with modern x-ray machines, 'as low as reasonably achievable' techniques and lead gowns as negligible.[3,4,5]
3. Wearing a thyroid radiation shield is more important when pregnant.[4]
4. The miscarriage rate for all pregnancies is 15% and the natural rate of congenital abnormality is 4%.[4] I would caution against Mrs Cross's advice to 'let the surgical directorate know as soon as possible' before the 12-week scan.
5. The work of a surgeon in the UK now, with a balance of clinics and operating lists, the European Working Time Directive and breaks for anaesthesia, is actually easier than in the past or currently in the US. It is probably easier to be pregnant as a surgeon (in training or otherwise) than as an air stewardess or an old-fashioned house officer, especially for the crucial weeks of organogenesis (2nd–8th week post-conception), when a woman may not realise she is pregnant or has had no time to make work adjustments).
6. Over the last decade many initiatives have reduced the amount of unsupervised operating performed by surgeons in training.[6] I would dispute the need for a locum to stand by in case one feels faint. For many women the nausea, lethargy and faintness settle after the first trimester. A better suggestion would be to take some annual or study leave as soon as one finds out one is pregnant.[7] The foetus should then be more robust and the mother should feel better.
7. It is important to plan ahead as there is often a waiting list for places in childcare, which would limit the options for returning to work.

We need to support pregnant women. We should not perpetuate myths that may put some women off a surgical career or cause others to delay or avoid starting a family.

References

1 The Royal College of Surgeons of England. *Women in Surgical Training: Pregnancy and Maternity Leave Guidelines.* London: RCSE; 2001.
2 British Medical Association. *Maternity Leave for Medical Staff: BMA Guidance Note*. London: BMA; September 2005.
3 Cohen-Kerem R, Nulman I, Abramow-Newerly M *et al.* Diagnostic Radiation in Pregnancy: Perception Versus True Risks. *J Obstet Gynaecol Can* 2006; **28:** 43–48.
4 De Santis M, Di Gianantonio E, Straface G *et al.* Ionizing radiations in pregnancy and teratogenesis: a review of literature. *Reprod Toxicol* 2005; **20:** 323–329.
5 Royal College of Radiologists, British Institute of Radiology. *Pregnancy and Work in Diagnostic Imaging.* London: BIR; 1992.
6 Joint Committee on Higher Surgical Training. *A manual of higher surgical training in the UK and Ireland.* London: JCHST; April 2005.
7 McNally SA. Having babies as a surgical trainee. *BMJ Career Focus* 4 December 1999; **317:** S2.

SA McNally, Consultant Orthopaedic Surgeon, Eastbourne District General Hospital

Sir,
I myself was a pregnant SpR last year and I was surprised to find that Mrs Cross received such negativity from her peers and such difficulty in obtaining information regarding working conditions. This contrasts sharply with my own experiences.

I worked at two busy district general hospitals during my pregnancy and neither hospital had previously had pregnant surgical trainees. My expanding waistline was quite a novelty with much interest from my colleagues, patients, managers and domestic staff. From discouraging night shift work to providing chairs in theatre, I received plenty of support until I left to go on maternity leave.

Well over 80% of NHS employees are female. Consequently, medical staffing and occupational health departments are used to dealing with pregnancy, even if the specific risks of operating are a little unclear. Furthermore, I found that although the majority of my registrar colleagues were male, most were fathers themselves and knew only too well the difficulties of child rearing and training to be a surgeon. It need not, therefore, be such a problem and others should not be deterred!

K McCarthy, SpR in general surgery, North East Thames rotation

Response by Katie Cross

I was delighted to hear colleagues having experienced such positive responses in their working environment. This is a rapidly evolving service and, indeed, my second pregnancy was far easier in a different working environment but also because I was clear about what I should and should not do.

I am grateful for Mrs McNally's informative comments regarding ionising radiation; this is far more relevant for the orthopod. Being a general surgeon, I was recommended to leave theatre as it was rarely essential for me to be there.

I still believe that informing colleagues and the human resources department in the

first trimester can only be helpful as the majority of symptoms occur during this time, especially with the first pregnancy. Irrespective of the outcome of the pregnancy, support from your colleagues is essential. The idea of trying to take annual and study leave during this period is a good one. However, most people like to keep as much annual leave as possible to take off at the end of the pregnancy prior to starting maternity leave.

Depending on surgical experience, it is very common to do laparotomies yourself during on-call duties and patient safety must always be paramount. If the consultant surgeon is happy to come in, then the issue may not arise but emergency laparotomies are often difficult, taking several hours, and, if the surgeon is not going to make it through the procedure, alternative arrangements need to be in place beforehand.

Having read my *Bulletin* article, the Association of Coloproctology of Great Britain and Ireland asked me to present at the regional chapter meeting as it was felt that consultant colleagues were not aware of guidelines for pregnancy. I do not believe information puts women off surgery; in fact, it often makes things easier.

OFFICERS OF THE COLLEGE 2006–2007

At a meeting of Council on 11 May 2006, Mr Bernard Ribeiro was re-elected president and Miss Anne Moore and Mr Christopher Russell were elected vice-presidents of the College for 2006–2007. They will be admitted to office on 13 July 2006.

NEW COUNCIL MEMBERS

This year four new candidates were elected to Council at the ballot held on 6 April 2006.

Professor John Stanley

John Stanley trained in Liverpool and in the US before being appointed in 1979 as consultant surgeon to Ormskirk and Wrightington hospitals. The hand surgery service at the latter was expanding rapidly, attracting a large number of upper limb rheumatoid cases. This led to his presidency of the Rheumatoid Arthritis Surgical Society and the British Association of Hand Therapists. In 1986 he was appointed *ad hominem* Chair in Hand Surgery at Manchester University. As a member of council of the British Society for Surgery of the Hand, he helped to expand the elected membership to council to make it more democratic and became president of the British Society for Surgery of the Hand in 1999. His principal concerns relate to the training of junior surgeons, who have been well educated but lack the apprenticeship side of surgery that is so necessary for the experience and confidence as a surgical consultant.

Professor Michael Horrocks

Michael Horrocks qualified from Guy's Hospital Medical School in 1970 and gained the fellowship of the Royal College of Surgeons four years later. He was appointed consultant surgeon at the Bristol Royal Infirmary in 1982, moving to Bath in 1991 to take up the Postgraduate Chair in Surgery. He has been editorial secretary to the Association of Surgeons of Great Britain and Ireland and is currently vice-president elect. He has been secretary general of the European Society of Vascular Surgery and president of the Vascular Society of Great Britain and Ireland and he serves on the Court of Examiners for the intercollegiate examinations. He is an active member of the Wessex regional training committee, having chaired it for five years. Following his election to Council, Professor Horrocks will carry on his duties as a vascular surgeon and committed surgical trainer and, through this, will endeavour to represent the views of his surgical colleagues.

Mr David Ward

David Ward is a consultant plastic surgeon at Leicester Royal Infirmary. He qualified at King's College Hospital, London, did his general surgical training in London and Brighton and was awarded his fellowship in 1980. He then trained in plastic surgery at East Grinstead and in London. He has extensive experience in examinations from the Court of Examiners and the exit examination, and in training as a College tutor, basic and higher surgical training chairman, and on hospital recognition and specialist advisory committee duties. He is on the College's staff and associate specialist committee and has just been appointed chairman of the Intercollegiate Committee for Basic Surgical Examinations, which runs the MRCS for all four surgical colleges.

Mr Robert Greatorex

Bob Greatorex trained as a dental surgeon in London, graduating in 1970. After a period in maxillofacial surgery, he gained entrance to study medicine at Cambridge. Following pre-clinical studies, he remained at Addenbrooke's Hospital and graduated in 1976, pursuing a career in general surgery. He was awarded the FRCS in 1980 and in 1983 was the College Burghard fellow, researching effects of prostacyclin in critical ischaemia. He was a council member of the Association of Surgeons in Training from 1984 to 1987 and was appointed consultant surgeon at the Queen Elizabeth Hospital, King's Lynn, in 1988, where he is currently associate medical director. He is a member of the Court of Examiners and the intercollegiate general surgical faculty. Mr Greatorex stood for election because he wishes to help the College champion the values that attracted surgeons past and present into surgery, while supporting the College's continuing development as a 21st-century professional body.