SPEAKERS' CORNER

Waiting Times in Orthopaedic Surgery

Hugh Stewart, Consultant Orthopaedic Surgeon,
Lancaster and Kendal Hospitals

I am writing in reply to Dr Jeremy Marriott's piece in Speaker's Corner in the May 1994 issue of this journal. He says "consultants . . . in orthopaedics . . . will have to accept the waiting times are totally unacceptable and there needs to be some dramatic change."

The answer to this is that we in the orthopaedic department agree about the total unacceptability of waiting times and have always done so. What must be acknowledged is that a waiting list reflects an unmet demand, assuming that the providers, ourselves, are working as hard as we can – which we are (and certainly more than our professional association recommends). More importantly, our operating capacity does not match the numbers added to the waiting list from outpatients. There is, therefore, an increasing inpatients operative waiting list.

There have been two recent attempts to reduce outpatient waiting times. The first, in Lancaster, was paid for by the region from waiting list initiative cash. Selected patients referred to the orthopaedic surgeons were given direct access to experienced physiotherapists working alongside surgeons in the clinic. Most conditions arose from the back, knee, neck or shoulder. This initiative took place over a three-month period earlier in the year and was successful in that 112 patients were seen. At the end of the period, our files contained 169 fewer letters than at the outset.

There are two very important points to make here. The first is that it is generally agreed by those who refer orthopaedic cases that demand for services is nowhere near being met. If more cases are seen and dealt with over a longer period than three months, then eventually even more referrals will be generated. That is to say, supply fuels demand and unfortunately this is shown all too clearly by the results of the other initiative, which took place between October 1994 and March 1995 in Westmorland General Hospital. This involved a consultant rheumatologist, Dr Wendy Dodds, working one day per week, funded by the Maude St practice for the benefit of everyone. Despite her seeing over two hundred patients, the numbers on the waiting list were reduced only from 443 to 428.

The second point is that both the above initiatives, if continued, would increase our operative waiting list, partly because of a certain amount of direct access to the list, but mainly because of a skew in the outpatient population. The percentage of patients needing an operation would rise and those needing an opinion but no operation would fall. Our operative waiting list is rising at the moment and the only way to cope would be to have an extra two or three orthopaedic surgeons, preferably consultants. Are the purchasers prepared to pay for this, including all the associated facilities? And are these facilities available? At present in Lancaster the answer to the last question is 'no'.

Thus the problem is an arithmetical and economic one. The arithmetic can be demonstrated further by reference to both the tables shown. It should be pointed out that several European countries have separate orthopaedic and trauma units. The inequality shown is actually worse. I make this point because there were more new casualty referrals seen in my clinics in Lancaster last year than there were new referral letters received. These casualty patients generated as much need for surgery as the non-trauma patients, they complained more, and they were operated upon when and where they could be fitted in, mostly by me. We intend this to change in Phase III. They are not counted by the trust as new patients in our department and they are not contracted for. They are generally considered to be 'non' patients and if their follow-up treatment is included, they occupy more than half my time and that of my colleagues. Furthermore, none of them ever has to wait at all.

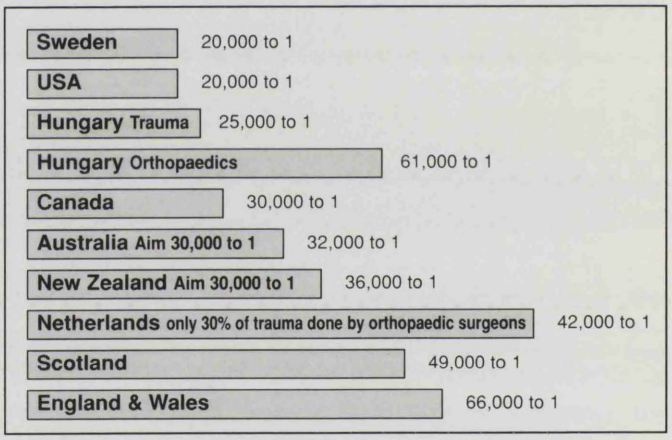


Table 1 – Population to orthopaedic surgeon ratio in various countries

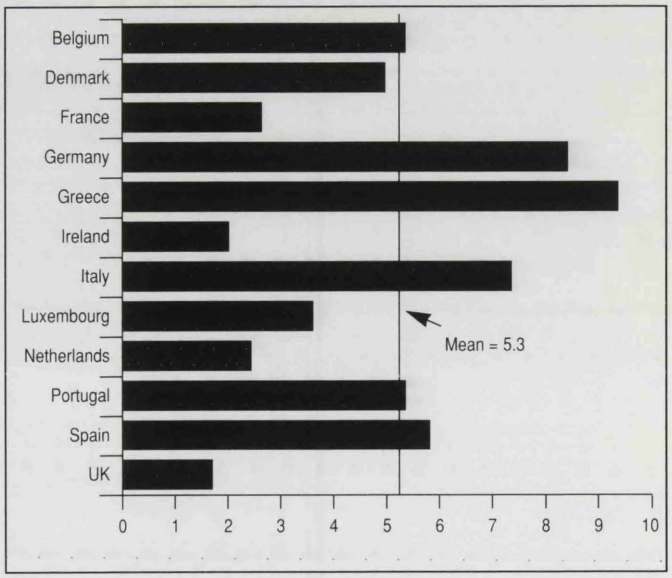


Table 2 – Orthopaedic surgeons to 100,000 population in various European countries

Watching the Workers

Pam Clark, Business Manager, Medicine

I have been around in health service management for a long time and managed throughout to avoid much contact with junior medical staff other than on domestic matters such as accommodation, bleeps and car parking.

The inception of the Trust gave some managers opportunities to work in new roles. I moved from the traditional administrative environment which had been my background to be the business manager for medicine, whilst retaining some hotel services responsibilities.

The role of the business manager developed slowly and evolved to match the new management arrangements of directorates. Each directorate had different expectations and needs and, therefore, although there had been an original template, the posts became different. In medicine, working with the clinical director, directorate nurse and accountant, we concentrated on developing the business planning process and pulling together a cohesive management unit with improved communication and management processes. This excluded junior doctors.

My relationships with the consultants have developed, perhaps built on an acquired credibility through better understanding of their aspirations and frustrations, and I think I am generally seen as a contributor to shaping future services constructively.

During this time, the drive to reduce junior doctors' hours has intensified and the directorate, conscious of its responsibilities to manage the service and the budget, has regularly discussed junior staffing issues. My lack of understanding has been evident and whilst I was not asked to contribute directly, it seemed that the junior doctors had such an impact on the overall effectiveness of the Trust that I needed a better feel for their perspectives.

An invitation to juniors to a couple of lunchtime sessions failed because of pressure on their time, although I did manage to speak to one or two individually. They were vociferous in their views. Michele Pomphrey, training and development manager, and I offered to run some slots in the juniors' educational programme both here and in Manchester. These met with varying success but again left a clear agenda for managers. The juniors felt that their issues were not recognised despite our protestations to the contrary.

The next step had to be to build on the contacts I had made and I therefore asked to be attached to one SHO for 24 hours. The consultants supported this and Dr James Brittan was good enough to put up with me.

It was a taxing experience. Like the junior, although considerably older, I did my full day's work and then started on-call at 5pm on a Monday. We had, I am told, a light night, being able to sleep undisturbed for five hours. I then stuck with James for the following day until 5pm when I was released. He was going to play football – I went home to collapse.

One night is unrepresentative, but I could begin to relate some of the previous conversations with juniors to my brief experience. Trust-wide management issues emerged, such as quality and availability of accommodation, the arrangements for acute medical admissions and the organisation of certain clinical procedures.

I found, however, the most interesting perspective to be the personal development requirements of the juniors. The dean in Manchester had asked Michele to run sessions on time management; the juniors did not see this as a need. I certainly did when I observed them; I think simple lessons could help their organisation of work considerably. Role clarification and the expectations of juniors in what they hope to gain from individual posts are important, if unexplored, areas. Generally, appraisal systems seem to be welcomed by them because they feel that some framework to their jobs could be beneficial.

I have also been surprised at the varying levels of understanding the juniors have of the market principles and the effects these may have on their career choices, if nothing else. Sessions we have run to give background about this trust and the Morecambe Bay Health Authority setting seem to have been well received.

All I am concluding is what has been said for many years: doctors and managers must work together. The role of business manager has moved closer to the clinical issues and is seen as a contributor to the delivery of service. I am now convinced that a major key to the delivery of contracts is the contribution of junior medical staff. It is very important to help them to recognise this within the context of the organisation for which they work. The process, of course, is two-way. Not only do juniors form part of the larger team caring for the patient, they also deserve investment in them by the organisation.

I do think the juniors themselves need to take personal responsibility for their own development but I am very happy, as are others, to help them to think through priorities on both the personal and the organisational level, and to prepare them for what is now a very different medical role to the traditional one. I hope there is a recognition that this would benefit both parties.

NOTES FROM THE CLINICAL TUTOR

MAKING TIME FOR POSTGRADUATE EDUCATION

Did you know that one half of a junior doctor's salary is provided by the Postgraduate Dean at the University of Manchester and that the Clinical Tutor is a paid officer of the Dean? The Clinical Tutor is responsible specifically for ensuring that doctors in training receive an adequate education with organised programmes of instruction and regular assessment by educational supervisors. This is fine in theory but difficult in practice. You see, everyone's day is full; there is little or no time to prepare, deliver or receive educational material and there is a more or less permanent tension between one's duty of service to the patient and everything else. By this, I mean that admissions, ward rounds, clinics, talking to relatives, coping with emergencies and so on take precedence over education and audit. Who wouldn't attend to a person with chest pain instead of staying in a teaching session?

The reduction in junior doctors' hours and the unrealistic talk about an expansion in the consultant numbers (intended to increase the amount of care delivered by consultants) are added strains. Education enthusiasts talk about 'protected time' and the zealots clamour for guaranteed timetabled slots for education. Some specialties, notably the surgical ones based in Manchester, have terrific programmes for registrars which result in two half days' absence from Lancaster or Kendal per week and big claims for travel expenses. This is more than a matter of internal organisation. The bottom line is money and it is expensive both to train junior doctors and to reduce the clinical load of senior doctors to allow them to teach. The whole profession shares an interest in having well-trained doctors yet the dominant force in many consultants' lives is that of providing the clinical service. Education and audit are always under threat. Some junior doctors get a raw deal some of the time, and it is easy to see that poorly trained doctors will not provide the best clinical service.

If we are serious about improving training, there has to be an acknowledgement that education is an issue for purchasers as well as providers. Purchasers have as much interest as providers do in good quality healthcare in local hospitals. Whilst the Dean may be providing half a junior doctor's salary, the other half is provided by the trusts as is most of the NHS salary of most consultants. In brief, paying for education is an issue for purchasers.

FORMATION OF A LOCAL EDUCATION COMMITTEE

Log books, educational supervision, certification, references, careers advice and counselling are all part of the junior doctor's lot. He or she is subject to the differing (and sometimes conflicting) requirements of the trust, the dean, the GMC, the royal colleges and the government. The education of an individual is a matter of importance to the whole trust, and for this reason an education committee has been formed to tackle the issues. It first met in June this year and comprised the specialty college tutors, the clinical tutor, the medical directors in Lancaster and Kendal and senior trust executives. It will meet quarterly with the expressed aim of ensuring the local delivery of the best possible education and training of doctors.

THE POSTGRADUATE LECTURE PROGRAMME FOR GPs

Getting to the postgraduate lectures is becoming very difficult. Distance, traffic, the workload, dealing with fundholding, business planning and other demands have resulted in dwindling attendances despite some good clinical topics and speakers.

Dr David Knapper (GP tutor) and I have taken the view that postgraduate education does not have to be delivered solely in postgraduate centres. Rather, we are starting to view the surgeries and other meeting places as extensions of the centres, a network of smaller locations which are more accessible. The postgraduate centres will continue to act as a hub and larger meetings and evening meetings will be held in them. GPs, however, are reminded to discuss any planned meetings with David Knapper before making arrangements. PGEA approval will not be given except through the postgraduate centres. We must avoid clashes in the timetable, yet ensure a locally accessible, self-directed programme for GPs.

The biggest change will be **Saturday seminars**. Quarterly meetings lasting two or three hours are planned for Saturday mornings. The first will be on Saturday 21st October and its subject will be myocardial infarction and its management, including ECG interpretation. Further details will be circulated shortly. We are aiming for a more participatory 'workshop' type session with fewer didactic lectures.

The lunchtime and evening lecture programme is almost complete for 1995-96. Further details soon.

AUDIT

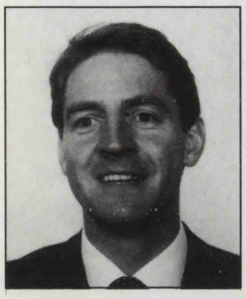
Dr Mike Bird is planning a large seminar in November at St Martin's college, which is intended to focus on the collaborative aspects of audit between different groups of health workers. It will appeal to GPs as well as practice nurses, hospital-based workers and those in the community.

It is still disappointingly true that audit has had a patchy uptake locally despite some excellent work. Perhaps it's the name. Perhaps we're too busy seeing patients to check that we are doing the right thing, a weakness at the very heart of our profession.

NEWS & NOTES

New Appointments

Consultant Surgeon



Mr John Abraham has been appointed as a consultant general surgeon with a special interest in vascular surgery. He expects to take up his post during October.

Mr Abraham was born and brought up in Lancashire, educated at Kirkham near Preston and studied medicine at Manchester. He graduated with a distinction in surgery in 1983. Following pre-registration posts in Manchester he taught anatomy in Edinburgh before returning to south Manchester for SHO and registrar posts. He obtained FRCS England and FRCS Edinburgh in 1987.

In 1989 he took up a post at the University of Louisville, Kentucky, USA to research into aspects of microvascular pathophysiology. This work formed the basis of his MD thesis. He returned in 1991 to further registrar posts in Preston, Blackburn and Salford, where he developed a particular interest in vascular surgery.

As a senior registrar at the Manchester Royal Infirmary, he further developed skills in vascular surgery including vascular access and renal transplantation. He has most recently been working here in Lancaster and Kendal, and obtained the Intercollegiate Fellowship this year.

As well as contributing to the care of general surgical patients, Mr Abraham intends to establish a specialty practice in vascular surgery including vascular access, and to expand the non-invasive diagnostic service. He will also be involved in the North Lancashire Breast Screening Programme and the treatment of symptomatic breast disease.

Mr Abraham's wife Nicky trained in Lancaster as a general practitioner. They have three young children, Robert, Andrew and Kirstin. Together they enjoy several sports including dinghy sailing, hill walking and skiing.

Consultant Ophthalmologist

Mr R K Khanna has been appointed locum Consultant Ophthalmologist to the Lancaster Acute Hospitals NHS Trust and Westmorland Hospitals NHS Trust with effect from August 1st, 1995, for a period of twelve months initially. He will cover Mr Griffith's duties and will be based at Garnett Clinic.

Retired GPs' luncheon meetings

These informal lunches have now been running successfully for two years. Any retired GP who requires further information please contact:

Dr Anderson 01524 32089 or Dr McKinney 01524 85293.

Forthcoming dates are 2nd November 1995 and 21st March 1996

The venue remains the Shrimp Inn, Morecambe at 12.30 and as tables are booked approximate number are required.

Library Matters

Welcome to the first *Library Matters* – a regular column of news and things you should know about the postgraduate medical library.

First, a brief guide . . . we are: Melanie Weeks (librarian) and Alison Harry (information assistant). You can telephone us on (01524) 583954 or fax us on (01524) 848289. Our opening hours are 9.00am-5.00pm Monday to Friday.

We have books and videos that can be taken out for three weeks, journals that can't be taken out at all and Medline that sits and hums to itself in a corner. Instructions on how to use this wonderful resource are now available and staff are always around to help, especially if you've booked a tutorial beforehand.

If you can't find what you want – ask! Things we don't have can usually be got from other places.

A self-service photocopier is available. A small charge (10p per sheet) is made for copyright reasons.

What's been going on . . . the past four months have seen frenzied activity on the book-buying front. Most of the orders have now arrived and are sitting on the shelves waiting to be taken out. Gold stars to the juniors in Obs. & Gynae. and Surgery for not only requesting books but actually taking them out when they arrive. A selection of recent arrivals are listed at the end of this report.

On the journal front, new subscriptions include The Diplomate and Medicine.

A recent audit of current journal use confirmed what we thought – they are not being used nearly enough! There might be several reasons for this:

- nobody knows they are there
- identical journals are held in hospital departments (a quick 'phone-around didn't seem to indicate this)
- they are not the most relevant journals available in their field
- nobody has time to read them anyway (not sure what I can do about that one!)

With an annual journal bill in the region of £6600 it is important that we are taking the right ones. I am happy to send out a list of what we take and a copy of the audit findings to anyone who is interested. Comments and suggestions are welcome.

We have recently subscribed to the CD-ROM version of The Cochrane Database of Systematic Reviews – an electronic journal of current research information. It is published by the Cochrane Collaboration who prepare, maintain and disseminate systematic reviews largely based on the results of randomised controlled trials.
The first issue contains:

51 reviews dealing with the treatment of problems in pregnancy and childbirth, subfertility, stroke, schizophrenia and parasitic diseases.

Protocols and titles for 134 reviews currently in preparation on these subjects and also on musculoskeletal disease, oral health, acute respiratory infections and inflammatory bowel disease.

The database is available during library hours and initial testing has proved that it is very easy to use. So come down and check it out!

Recent Additions to Stock – Lancaster

Mothers, Babies and Disease in Later Life
BMJ Publishing, 1994
Barker DJP

Physiology and Medicine of Diving
WB Saunders, 4th ed, 1993
Bennett P, Elliott D (eds)

Gastroenterology
Blackwell Scientific, 2nd ed, 1993
Bouchier IAD et al
A Handbook of Medical Teaching
Kluwer Academic, 3rd ed, 1994
Newble D, Cannon R

Diagnostic and Statistical Manual of Mental Disorders
American Psychiatry Press, 1994

Critical Reading for Primary Care
Oxford University Press, 1995
Jones R, Kinmonth A

Annual Abstract of Statistics 1995
HMSO, 1995

Management for Doctors
BMJ Publishing, 1995
Simpson J, Smith R (eds)

Dewhurst's Textbook of Obstetrics and Gynaecology
Blackwell Scientific, 5th ed, 1995
Whitfield (ed)

Whitaker's Almanac 1995
Whitakers, 1995

Aids to Postgraduate Surgery
Churchill Livingstone, 3rd ed, 1989
Meirion T, Watkins R

Caring for Older People in the Community
Radcliffe Medical Press, 3rd ed, 1995
Williams EI

Paediatric Orthopaedics and Fractures
Blackwell Scientific, 3rd ed, 1993
Sharrard WJW (ed)

Radiation Protection for Patients
Cambridge University Press, 1993
Wootton R

Essentials of Nutritional Diet Therapy
Mosby, 6th ed, 1994
Williams SR

Recent Additions to Stock – Kendal

Medical aspects of fitness to drive: a guide for medical practitioners
London: Medical Commission on Accident Prevention, 1995
Taylor JF

Practical Renal Medicine
Blackwell, 1993
Gabriel, Roger

Macleods Clinical Examination
Churchill Livingstone, 1995
John Munro (ed)

100 short cases for the MRCP
Chapman & Hall, 2nd ed, 1995
Gupta K

Royal College of Surgeons of England. College of Anaesthetists. Commission on the Provision of Surgical Services. Report of the Working Party: Pain After Surgery.
London: RCS/CoA, 1990

Royal College of Physicians
MRCP (UK) Part 1 and 2 Papers
RCP, 1994

A guide to dermatology
MBHA, 1995
Harrison PV, Blewitt RW

The new Aird's Companion in Surgical Studies
Edinburgh: Churchill Livingstone, 1992
Burnand, KG (ed)

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders: DSM-IV.
Washington: APA, 2nd ed, 1994

Pathology for Surgeons
Butterworth Heinemann, 2nd ed, 1993
Spence, Roy AJ

The Lancaster and Westmorland Medical Journal Prize

REGULATIONS

- An annual prize of £100 and a commemorative medal will be awarded for the best article by a medical student or doctor in a training grade published in the journal.
- Only the first-named author will be considered.
- All eligible published articles will be automatically considered. The winner will be announced in the January issue.
- The content, style and presentation of the original submitted article will form part of the entry.
- Judging will be at the sole discretion of the editorial board.
- The award will run for an initial period of three years and will be evaluated after that time.

LANCASTER POSTGRADUATE MEDICAL CENTRE
PROGRAMME
September–December 1995

SEPTEMBER

Friday 22nd

12.30 pm Buffet
1.00 pm Speakers: Community Midwives
Title: Supporting breastfeeding in the community
Category: Preventive medicine
PGEA: 1 hour

Thursday 28th

7.30 pm Buffet
8.00 pm Speakers: Mr VW Burton, Consultant Orthopaedic Surgeon
Dr AP Vickers, Consultant Anaesthetist
Dr JP Halsey, Consultant Rheumatologist
Dr BK Higton, General Practitioner
Mrs P Wilson, Physiotherapy Manager
Title: The management of back pain
Category: Disease management
PGEA: 2 hours

OCTOBER

Thursday 12th

7.30 pm Buffet
8.00 pm Speaker: Dr A MacDonald, General Practitioner, Bristol
Title: Transcutaneous Spinal Electroanalgesia
Category: Disease management
PGEA: 2 hours

Tuesday 24th

12.30 pm Buffet
1.00 pm Speaker: Dr DR Telford, Consultant Pathologist
Title: Bugs and Drugs
Category: Disease management
PGEA: 1 hour

Saturday 21st

9.30 pm Speakers: Dr AK Brown, Consultant Physician
Dr Valerie Anderson, Associate Specialist
Title: Workshop: adult resuscitation; interpretation of ECG's and echos
Category: Disease management
PGEA: 3 hours
12.30 pm Buffet

NOVEMBER

Tuesday 7th

12.30 pm Buffet
1.00 pm Speaker: Dr RA Coward, Consultant Physician and Nephrologist, Royal Preston Hospital
Title: Renal services in Morecambe Bay – the iceberg perspective
Category: Service management
PGEA: 1 hour

Tuesday 21st

7.30 pm Buffet
8.00 pm Speaker: Dr Pat Ainsworth, Consultant Child & Adolescent Psychiatrist
Title: Unwillingly to school in the 1990's
Category: Service management
PGEA: 2 hours

DECEMBER

Tuesday 5th

7.30 pm Buffet
8.00 pm Speaker: Professor MA Green, Consultant Pathologist to the Home Office, The Medico-Legal Centre, Sheffield
Title: The man who wanted his leg back
Category: Service management
PGEA: 2 hours

Tuesday 12th

12.30 pm Buffet
1.00 pm Speaker: Dr D Walmsley, Consultant Physician
Title: Why is diabetes suddenly important? The St Vincent declaration and related issues
Category: Disease management
PGEA: 1 hour

WEEKLY MEETINGS

Monday	1.00 pm	Medical Unit meeting
	5.00 pm	Orthopaedic Unit meeting
Tuesday	1.00 pm	Combined surgical and radiological case review
Wednesday	10.00 a.m.	GP (VTS) course, termtime only
Thursday	10.00 a.m.	Paediatric teaching in department
	1.00 pm	MRCP tutorial by Dr AK Brown
	2.15 pm	Dermatology discussion clinic, held on the fourth Thursday of the month in the department at QVH. Please check with the dermatology office for details.
Friday	8.30 a.m.	Xray tutorial, held on the second and fourth Fridays of the month in the department at RLI. Dr PM Flanagan and Dr RF Willey.

MONTHLY MEETINGS

2nd Thursday of the month

11.00 am Paediatric X-ray tutorial

4th Wednesday of the month

12.40 pm Child Health Journal Club, Ashton Road Clinic

AUDIT MEETINGS

Medical Unit audit meetings: held on a monthly am/pm rotational basis at the PGMC.

Surgical/Orthopaedic/ENT unit audit meetings: held on the same day on a monthly am/pm rotational basis at the PGMC.

Oral surgery: held on a quarterly basis at the PGMC.

Perinatal audit held on monthly am/pm rotational basis in the school of midwifery.

A&E DEPARTMENTAL MEETINGS

Held on the seven Wednesday afternoons following induction dates, at the PGMC.

EDUCATION PROGRAMME FOR PRHOs and SHOs

A series of weekly lectures following induction dates held on Wednesday at 12.30pm at the PGMC.

WESTMORLAND GENERAL HOSPITAL EDUCATION CENTRE

PROGRAMME

September–December 1995

SEPTEMBER

Monday 4th

12.30 pm	Buffet	
1.00 pm	Speaker:	Dr M Flanagan, Consultant Radiologist
	Title:	An update on ultrasound, CT scanning and angiography in strokes and TIAs
	Category:	Disease management
	PGEA:	1/3 session

OCTOBER

Tuesday 10th

12.30 pm	Buffet	
1.00 pm	Speaker:	Mr I Page, Consultant Gynaecologist
	Title:	Pelvic examination – how to make it useful
	Category:	Disease management
	PGEA:	1/3 session

NOVEMBER

Wednesday 15th

12.30 pm	Buffet	
1.00 pm	Speaker:	Dr Margaret Ellam, St John's Hospice, Lancaster
	Title:	"Nothing more we can do?" - Pain and symptom control
	Category:	Disease management
	PGEA:	1/3 session

DECEMBER

Thursday 14th

12.30 pm	Buffet	
1.00 pm	Speaker:	Dr D Walmsley, Consultant Physician
	Title:	Why is diabetes suddenly so important? The St Vincent declaration and related issues
	Category:	Disease management
	PGEA:	1/3 session

Lancaster & Westmorland Medical Journal