



Letters to the Editor

THE CONFEDERATION OF BRITISH SURGERY: A TRADE UNION FOR SURGEONS?

Sir,

I have followed the formation of the Confederation of British Surgery (CBS) with interest (*The Confederation of British Surgery: A trade union for surgeons*, March 2018 *Bulletin*), and wish to share some observations and make a suggestion.

I have been let down personally by the British Medical Association (BMA) on the two occasions that I needed strong representation. When I was made redundant from my first consultant post by Oxford Radcliffe Hospitals in 2006, the senior leadership of BMA made political capital out of the issue. The only doctor in a position of leadership who actually deigned to meet me did so for about 10 minutes. She pompously told me to be polite to the Chief Executive when I met him. Their Industrial Relations Officer was less helpful. On the second occasion when I found myself referred to the GMC and in dispute with my employers, the BMA were worse than useless again – to my great cost.

More generally, I agree with the founders of the CBS that the BMA are ineffective in representing surgeons and, indeed, all hospital doctors. I admire Professor MacFie for his pithy insight and pugnacity, but think he and his colleagues are wrong. Their CBS is not the answer to our problem with political representation.

I wish to second Sue Hill's proposal for a surgical section within the BMA. Throughout the years I have seen few surgeons on the ballot sheets for BMA elections. This must change and, when it does, the rest will follow as the BMA is transformed from within.

Simon Cole

Locum Consultant Emergency General Surgeon

ADDRESSING UNCONSCIOUS BIAS

Sir,

We read with interest *Avoiding Unconscious Bias – A Guide For Surgeons* and wholeheartedly endorse the RCS' desire to avoid such bias in surgery, as it should be avoided in all areas of medicine.

What was unexpected about the advice in the guide was the emphasis placed on bullying. Although this is clearly important, it has little to do with unconscious bias and perhaps should have been

kept separate? The theme of bullying and harassment continues in a section to do with 'Behaviour' and then in bulletpoint-list form describes what trainers and trainees should do, followed by a list of 'unacceptable behaviours'. This last list would have benefited from consideration of the word 'persistent' – for instance, attempts to belittle or undermine work are unacceptable, persistent or otherwise.

Anoopama Ramjeeawon

Nadeem Pervaiz

Final Year Medical Students

David J Wilson

Director of Admissions and Professor of Medical Education

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Response from Scarlett McNally, senior author:

Thank you for your comments. Our guidance *Avoiding Unconscious Bias* highlighted that bullying is often inadvertent and is strongly linked with discordant expectations or unconscious bias. A new edition and e-learning will be published later in 2018 with even clearer bulletpoint guidance on behaviours. The current edition is most easily found at www.rcseng.ac.uk/career

VARIATION IN PREOPERATIVE MANAGEMENT OF CARPAL TUNNEL SYNDROME

Sir,

In their article (*Variation in CCG policies for the treatment of carpal tunnel syndrome*, January 2017 *Bulletin*), Ryan and colleagues found interesting discrepancies in Clinical Commissioning Group (CCG) requirements for the non-operative management of carpal tunnel syndrome (CTS) prior to surgical intervention.

We conducted a UK-wide survey of hand surgeons, which confirms substantial variation in practice. Our survey was distributed to members of the British Society for Surgery of the Hand and the Association of Surgeons in Primary Care and yielded a 14% response rate. The majority of responders were consultant hand surgeons (84%) practising in England (88%). Current UK guidance states that nerve conduction studies (NCS) are not required unless the diagnosis of CTS is clinically ambiguous¹ – nevertheless, Ryan *et al* found that NCS were mandatory in 21 (of 175) English CCGs. We found that more than 80% of the 154 surgeons who participated in our survey reported

using NCS as part of the CTS diagnosis in the previous 12 months. Of these, 31% requested NCS for less than a third of their patients, 30% requested NCS for between one and two-thirds of their patients and 24% requested NCS for more than two-thirds of their patients.

The nature of our survey did not require information about the level of clinical uncertainty when requesting NCS; however, it seems unlikely that the diagnosis of CTS would have been clinically uncertain in all of these cases. When asked about provision of preoperative wrist splints, 10% of surgeons reported that all of their patients had been given a trial of wrist splinting before surgery, whereas 71% reported providing preoperative wrist splints for more than two-thirds of their patients. The most recent Cochrane Review of splinting for CTS concluded that there was limited evidence for night splinting (compared with no treatment) for the short-term management of CTS, but that the optimal splint type and wearing regime required further investigation.² Ryan *et al* found that steroid injection(s) were a mandatory non-operative intervention in 33 CCGs prior to referral for surgery. In practice, 49% of surgeons reported that less than a third of their surgical CTS patients had received a steroid injection preoperatively, with only 2 surgeons reporting that all their CTS patients received at least 1 steroid injection. Local steroid injection has been associated with greater clinical improvement in CTS symptoms compared with placebo in the short term,³ but it is not currently known whether steroid injection ultimately reduces the need for subsequent surgical release.

The findings of our recent national practice survey support the conclusions of Ryan *et al* that 'clinicians and commissioners must work together to come to an agreement on the referral criteria that provide the best patient care pathway'. Based on our survey, we agree that there is inconsistency in the assessment and treatment of CTS in the UK, and that a clinically and cost-effective evidence-based pathway is required.

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Professor David Warwick

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Professor Jo Adams

Professor of Musculoskeletal Health

Professor Karen Walker-Bone

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References

1. British Orthopaedic Association. *Commissioning Guide: Treatment Of Carpal Tunnel Syndrome*. London: Royal College of Surgeons; 2017.
2. Page MJ, Masy-Westropp N, O'Connor D, Pitt V. Splinting for carpal tunnel syndrome. *Cochrane Database Syst Rev* 2012; 7: CD010003.
3. Marshall S, Tardif G, Ashworth N. Local corticosteroid injection for carpal tunnel syndrome. *Cochrane Database Syst Rev* 2007; 2: CD001554.



Orthopaedic Surgeon Timaru, New Zealand

"Why not have your cake and eat it too?"

Looking for that elusive balance between public hospital work, while managing to maintain an active personal life?

If you are an Orthopaedic Surgeon with an interest in hip and knee arthroplasty in particular, then South Canterbury District Health Board, Timaru Hospital could well be the ideal place for you.

We have a genuinely rare chance for an Orthopaedic Surgeon to join our team of 4 colleagues, who seem to have found that almost elusive combination of balanced work and personal time. Initially this is a fixed term role for 3 months, but may well convert over into a permanent opportunity, so here is a chance to "try before you buy" potentially.

While this role is full-time, there is real scope to create the personal time to commit to other interests, as our after-hours expectations are not overwhelming.

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