

SLOW SURGERY?

Editor,

Some of your readers will have heard of slow medicine. This concept was born in Italy in 2011 and aims to make medicine more measured, respectful and equitable.¹ Slow medicine asks health professionals to take their time to allow for a more holistic approach and a careful consideration of new methods and technologies. The movement has expanded, particularly in Europe.²

This has got me thinking about the surgical equivalent – slow surgery. For example, my Health Board in Wales, a home nation of the UK, has introduced an orthopaedic lifestyle programme for patients who may need a hip or knee replacement and have a Body Mass Index (BMI) of 35 and over. Patients take part in a 32-week programme of exercise classes at Leisure Centres and receive support from qualified professionals such as physiotherapists and dieticians. The aim is to induce weight loss in order to reduce the complications of surgery, as well as to decrease pain to the point, in some cases, where surgery is no longer needed.

The operational standards relating to referral to treatment times in Wales are that 95% of patients should be seen within 26 weeks, and no patients should wait longer than 36 weeks.³ Trauma and Orthopaedics is the largest contributor to long waits, with 66% of total waits over 36 weeks in March 2018 being from this surgical specialty; this is followed by general surgery (9%). Therefore, could it be argued that we are practicing slow surgery by default anyway? I am sure that the picture will be similar in other home nations of the UK.

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PLASTIC AND RECONSTRUCTIVE SURGERY JOURNALS: FEASIBILITY OF ACCESS BY SURGEONS AND TRAINEES IN THE UNITED KINGDOM.

Editor,

The current surgical training system expects high levels of knowledge from trainees¹. This is especially true in plastic and reconstructive surgery which is one of the most competitive specialties. Hence, surgeons in training must be familiar with the current literature in the field.

The resources available to achieve this goal reside mainly in medical journals. Access has been widely revolutionised by the novel electronic platforms.² However, limitations imposed by subscription fees are a significant obstacle.

We conducted an electronic survey to assess availability of medical journals, in UK units to surgeons in training and analyse the pattern to make recommendation for improvement. Ten journals were selected using the Scientific Journal Ranking (SJR) index, which is a numerical value used to compare journals according to the number of citations and popularity.³ (Figure 1). A questionnaire was distributed to librarians in the respective units followed by a telephone call to units that did not respond.

We collected responses from 52 units with 100% response rate. 45(86.5%) of them were in England, five (9.6%) in Scotland and one (1.9%) unit each in Wales and Northern Ireland.

The mean was 6.48 journals per unit whilst the overall mode was nine. One (1.9 %) unit had no access while only eight (15.3%) units subscribed to all journals.

The plastic surgery units in London and Scotland had higher access to the selected journals compared with other geographical areas in the UK. The highest number of journals accessible to trainees was in Scotland with an average of 9.2 followed by London with an average of 8.5.

The journal subscribed the most was Plastic and Reconstructive Surgery in 41(78.8%) of the units. The results show significant variation in both the number and quality of journals available to plastic surgery trainees in different units. In order to provide a level playing field, all trainees should have access to at least a core number of relevant journals.

Potential solutions include migrating to free access journals or providing shared access through a central point.

Open access journals, full or hybrid, provide free navigation without restrictions.⁴ Funding can take many forms including article processing charges, institutional membership scheme, volunteer labour, sponsorship, institutional subsidies and finances from other sources.⁵

A growing trend is the conversion of subscription-based journals to hybrid open access journals where authors pay an extra charge to make their articles freely available to readers.⁴ The development of open access journals may be helped by policy makers through centralised payment



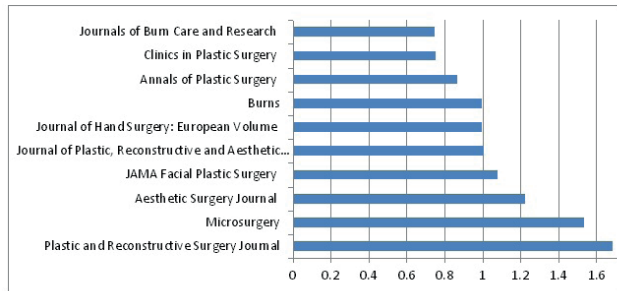
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scheme towards the article processing charge.³ A good example of institutional support is the agreement between UK institutions and Springer to provide free access to more than 2000 subscription journals and an option for open access publication in hybrid journals.⁶

Another option is to provide a themed specialty specific subscription organised by professional bodies to replace the

Chart 1: Plastic and reconstructive Journals included in the study and respective SJR indices 2016



current arrangements that provide area-specific subscription organised by the relevant National Health Service trusts. Partnership between universities and NHS trusts can increase such access.

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WHO CLEANS YOUR OCTOPUS? AN OBSERVATION OF CLEANING BEHAVIOURS AND BACTERIAL COLONISATION OF TOYS IN A NEONATAL UNIT

Editor,

Toys remain a fixture of neonatal intensive care units despite being proven reservoirs of nosocomial microbes.¹ A survey of 13 neonatal units in the UK² identified variation in procurement and cleaning procedures and testing for fomites. Washing toys is proven to reduce the bacterial load of potential pathogens.³ However there remains variation between units, regarding who has responsibility for cleaning toys, and what the interval between washes should be.

Toys within neonatal units have recently received a significant boon in press coverage. A movement originating from Aarhus, Denmark has seen knitted octopodes become an increasing fixture in neonatal units, with hospitals worldwide issuing public appeals for their procurement via social media. Despite emotive stories about the benefits of such woollen crustaceans there remains a paucity of published data proving they help regulate infant breathing, or reducing heart rate as is oft claimed anecdotally. Whilst the physiological benefits of toys in the neonatal setting are yet to be corroborated or refuted by robust testing, they are unlikely to disappear from units. Toys are often preferred by parents, they humanise an otherwise intensely clinical environment. Their presence allows parents to provide a touch of the child friendly environment, similar to that enjoyed on maternity and paediatric wards alike.

Figure 1. NICU Toy swabbing audit 2018

