SHOs attended 111 theatre sessions, 27 clinic sessions and spent 61 days on ward cover duties. With the new team-based structure, SHOs attended 189 theatre sessions, 55 clinics and spent 10 days on ward cover duties. 

**Conclusions:** A consultant based team-based structure within plastics surgery optimises the balance between service provision and training opportunities for SHOs.

### 0754: THE ANATOMICAL KNOWLEDGE OF HEALTHCARE PROFESSIONALS REFERRING TO A HAND TRAUMA CENTRE

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**Introduction:** Approximately 20% of all A&E presentations are hand injuries which equates to 1.36 million attendances per year in the UK. These injuries range from simple lacerations to mangled hands. Accurate questioning re-asked 5 questions regarding hand anatomy. We felt that the level of practitioners referring to a hand trauma centre was worse than in some medical students. We have formulated opportunities for SHOs.

**Method:** Every professional that referred a patient with a hand injury was asked 5 questions regarding hand anatomy. We felt that the level of questioning reflected knowledge that a final year medical student should possess and we tested this on a subset of them. We stopped when we had 50 answers from each set of referrers.

**Results:** A`E registrars scored a mean of 4.6 questions correct; their senior house officer counter-parts scored a mean of 3.2. Medical students scored a mean of 3.8 and emergency nurse practitioners scored a mean of 2.8.

**Conclusions:** We found that the level of anatomical knowledge in some practitioners was worse than in some medical students. We have formulated posters highlighting basic hand anatomical structures and have distributed them in order to ensure that our patients get the best possible treatment.

### 0761: DOES THE SENIORITY OF OPERATING SURGEON INFLUENCE THE LENGTH OF STAY AFTER LAPAROSCOPIC APPENDICECTOMY?

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**Aims:** To assess factors influencing the outcome after laparoscopic appendicectomy, with particular emphasis on the seniority of surgeon.

**Methods:** A consecutive series of patients who underwent laparoscopic appendicectomy between April 2010 and April 2011 were studied. Data was collected retrospectively from computerised operating theatre and histopathology records. The primary outcome measure was length of hospital stay (LOHS).

**Results:** 118 patients [median age 29 (12-81), male:female 43:75] underwent laparoscopic (n=99) or laparoscopic converted to open appendicectomy (n=18). The lead surgeon was a Core Trainee or junior SpR in 44 (37.3%) and senior SpR or consultant in 74 (62.7%). The median LOHS was 2 days (1-34). On univariate analysis the following were significantly associated with a longer hospital stay: older age (p=0.001), longer duration of procedure (p=0.001), converted to open (p=0.006), more advanced appendicitis macroscopically (p<0.0001) and histopathologically (p=0.011). Time of day of surgery (p=0.078), delayed surgery (p=0.527), gender (p=0.284) and grade of surgeon (p=0.490) were not significant. On multivariate analysis only age (HR 0.987, 95% CI 0.974-1.000, p=0.046) was independently and significantly associated with LOHS.

**Conclusions:** There was no association between the seniority of the lead surgeon and LOHS. With adequate supervision laparoscopic appendicectomy remains an appropriate training operation for surgical trainees.

### 0776: A TOOL TO MEASURE SURGICAL DECISION MAKING IN ACUTE ADMISSIONS

Zita Jessop, Michael Charalambous, Nebil Behar. Chelsea and Westminster Hospital, London, UK

**Aim:** Design a decision making tool to measure decisions by trainees, evaluate the degree of concordance with seniors and effect on patient outcomes.

**Method:** A decision making tool (10 management options), based on NCEPOD grading, was introduced into surgical clerkings and completed at SHO, registrar and consultant level. Data collected on final diagnosis, delay to operation, hospital stay, complications and mortality. Two doctors independently derived “ideal decisions” based on final diagnosis.

**Results:** Decision making tool was completed for 136 acute surgical admissions over two months. SHO’s made less “ideal decisions” compared to registrars (45% vs 56%; p=0.01, Fisher’s Exact Test) and consultants (45% vs 70%; p=0.0001). SHO’s made more “admit and observe/investigate” decisions compared to registrars (63% vs 55%; p=0.27) and consultants (63% vs 51%; p=0.01), who were more likely to decide to “operate/discharge”. There was less time to appendicectomy (21 vs 14hrs, p=0.30) and shorter hospital stay (4 vs 3 days, p=0.31) but neither was statistically significant.

**Conclusions:** Results show that as you progress up the grades there is narrowing of decision making, with seniors more likely to decide to operate or discharge patients. This may reflect a combination of better decision making skills, demonstrating the value of early senior review, and increased availability of results.

### 0791: WHY WOULD STUDENTS CHOOSE A CAREER IN SURGERY IF WE NEVER LET THEM TRY IT? A SURVEY OF PROCEDURAL EXPERIENCE IN GRADUATING MEDICAL STUDENTS

Nick Baylem, Matthew White. Queens Medical Centre, Nottingham, UK

**Aim:** One of the greatest draws to surgery as a career is the satisfaction achieved by completing a complex practical task successfully. In order to attract medical students to careers in surgery, it is important to give them a taste of this. The aim of this study was to assess the number of students being allowed to perform a simple surgical task on real patients.

**Methods:** An anonymised questionnaire was distributed to 323 graduating medical students. They were asked on how many real patients they had been allowed to suture. They were also asked to rate the major barriers to gaining more procedural experience at medical school.

**Results:** 203 questionnaires were received; a response rate of 63. 39.7% of students had not sutured a real patient. Only 10.8% of students had sutured more than 5 times. The most commonly quoted barriers to more procedural experience were lack of on-call time and lack of enthusiasm in supervising doctors.

**Conclusions:** Allowing nearly 40% of medical students to finish medical school without performing such a simple surgical procedure will not help to entice them about a career in surgery. Medical schools and surgical trainers need to be proactive in remedying this situation.

### 0811: SHOULD UROLOGY BE A COMPULSORY PART OF GENERAL SURGICAL TRAINING?

Steven Pengelly, Aled Jones, Michael Fabricius, Paul Mchneary, Anthony Lambert. Derriford Hospital, Plymouth, UK

**Background:** We aimed to determine how much of the emergency take comprises urological patients and whether general surgeons receive appropriate training to manage them.

**Methods:** A prospectively recorded database of one consultant’s emergency admissions was examined to determine what proportion was for urological pathology. The ISCP website was interrogated to see what urology competencies are required during basic surgery training. Trainees were questioned regarding their urology exposure.

**Results:** 5959 patients were admitted with emergency surgical problems between June 2000 and December 2010, with 887 (15%) for urological pathology. The SCP states that all general surgeons entering ST3 should be able to manage these patients. Seven of eight (88%) surgical trainees who had done a urology Sho job felt competent to explore a scrotum or insert a suprapubic catheter. This fell to one of four (25%) who had not worked in urology.

**Conclusions:** Urological pathology makes up a significant portion of the general surgery take. Trainees who have not had formal urology training are not achieving the required competencies laid down by ISCP. Urology should be a compulsory part of basic general surgical training.

### 0815: LEARNING CURVE IN SINGLE-PORT APPENDICECTOMY: AN EXPERIENCE FORM A UNIVERSITY TEACHING HOSPITAL

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**Aim:** To evaluate the degree of concordance with seniors and effect on patient outcomes. We aimed to determine how much of the emergency take comprises urological patients and whether general surgeons receive appropriate training to manage them.

**Methods:** A prospective collected database of one consultant’s emergency admissions was examined to determine what proportion was for urological pathology. The ISCP states that all general surgeons entering ST3 should be able to manage these patients. Seven of eight (88%) surgical trainees who had done a urology SHO job felt competent to explore a scrotum or insert a suprapubic catheter. This fell to one of four (25%) who had not worked in urology.

**Conclusions:** Urological pathology makes up a significant portion of the general surgery take. Trainees who have not had formal urology training are not achieving the required competencies laid down by ISCP. Urology should be a compulsory part of basic general surgical training.