A Personal View

Denis Wilkins
President

I have a growing unease that with the tacit acceptance of many within the ASGBI that ‘General Surgery is Dead’, we may be allowing an important surgical service both to deteriorate and, by default, to move out of the remit of the surgical fraternity.

Consider the present situation and also the likely trends in service provision during the short term. It seems clear that emergency services will increasingly be based on large district general or teaching hospitals. Those hospitals that are able to provide full cover for surgical emergency services may share with neighbouring trusts through networking arrangements but, with the new contract for consultants, EWTD, the fragmentation of service contracts, the requirement for adequate specialty backup, etc, small hospitals serving populations of 250,000 or less will struggle to recruit enough surgeons having adequate expertise to provide full cover. There is an increasing focus within the ranks of general surgeons and trainees on their subspecialty interests that is having several noticeable effects. First, there is anecdotal evidence that expertise in the management of trauma is not uniformly of the high standard required today. Ditto for urological and vascular cases. Since there is no requirement for surgeons taking part in the emergency rota to undergo CPD in trauma, urology and vascular, for example, it would certainly seem likely to be the case. There is no hard evidence one way or the other, since there is no database that addresses this - in England and Wales at any rate. The second noticeable effect of subspecialty pre-occupation is a tendency by many specialists within general surgery to regard emergency surgical duties as a nuisance and distraction rather than a core activity. Again, no hard evidence, but a strong general impression. This may well colour the attitude of surgical trainees and downgrade the attractions of a more generalist training and practice.

Within the large DGHs, serving between a half and one million population, the receiving emergency surgical services are at present provided by a number of general surgeons who have one or two of a number of subspecialty interests. Mostly these are GI related but vascular and the other subspecialties still figure prominently in the listings. In many hospitals, urology and vascular provide ‘tertiary’ emergency rotas to support the general surgeon on call. Increasingly, breast surgeons are withdrawing from emergency general surgical rotas and the same applies to a substantial number of vascular surgeons - particularly in the large conurbations.

Consider next the requirements for a surgeon covering the general surgical emergency service in a large DGH. The majority of cases relate to GI emergencies. There is, however, an important requirement to be able to deal with cases of trauma as a team leader, or as a member, able to treat soft tissue trauma in order to save life and limb. This may include traffic related trauma, knifings, gunshots, and many other accidental injuries to any part of the body including the chest, neck and limbs and even blast injuries. Furthermore, patients presenting as non-trauma ‘surgical’ emergencies do not come neatly packaged with site or specialty specific labels. Urological and vascular emergencies continue to masquerade as ‘visceral’ conditions and as a trap for the unwary or inexpert. The emergency general surgeon must, therefore, have a good working expertise in managing the emergency care of patients suffering from a wide range of acute conditions; if only to assess, save life and refer on with an appropriate level of priority. In other words, there remains a clearly defined role for a generalist expert.

A further aspect concerns the economics of overspecialisation in relation to the provision of emergency surgical care. The more that this is fragmented across the specialties, into a series of emergency rotas, the more expensive - and probably less accessible - it becomes. This argument inevitably spills over into the provision of elective surgical services, but one has to ask what will prove more attractive to the economically driven NHS and independent employers of the future? A specialist who can provide an emergency service of superb quality but within a very tightly defined area? Or one who is capable of providing an adequate service across a range of specialties? Are we pricing ourselves out of the market?

My concern is that if we, as a surgical profession, do not make clear through our actions that we are committed to providing and maintaining a cadre of properly qualified emergency surgeons, we will see this important service degrade. Furthermore, we may see the emphasis move from the provision of an holistic emergency surgical service into one of a ‘triage’ service provided by another group such as the emergency physicians/A & E doctors. If we do not train and support a group of surgeons able to provide holistic acute and emergency surgical care, the demise of the emergency generalist surgeon could become a self-fulfilling prophesy. After all, the notion that a group of emergency doctors in the admissions or A & E department would see and assess all patients suffering from a wide range of acute conditions and then refer to the appropriate specialist - urologist, vascular, upper GI, colorectal surgeon, cardiothoracic, plastic, trauma, physician, coronary care, etc - sounds quite attractive. But would this be to the overall benefit of service provision and our patients? We cannot answer this with certainty, but experience and common sense suggests that a service fragmented across several fronts is less responsive and more prone to error than one that is integrated. Perversely this may then negate the intended benefits of specialisation and lead to a reduction overall in quality of acute surgical care.

If the membership of the ASGBI accepts the general thrust of the foregoing, then we should next consider how we can respond. The Surgical Royal Colleges express standards of practice through the curricula for training and in this they traditionally defer to advice from the specialty associations. They clearly perceive a need for training in emergency care, which is reflected in the new curricula and further exemplified by a major new course in trauma management launched in conjunction with the Defence Medical Services. But to whom do they turn to for advice on the standards and breadth of an integrated emergency general surgical service? To whom do they turn for the standards of CPD? Surely a grouping of practitioners, experienced and expert in the craft is required to inform and guide. My contention is that without such a group, that has the training and maintenance of emergency general surgeons as its main focus, this will continue to be everybody’s problem but nobody’s responsibility.

In summary, I perceive that the case for the continuing provision of a group of surgeons competent to provide a
wide range of emergency surgical services is quite clear. Furthermore, that the training and CPD of such surgeons is under threat through an increasing emphasis on specialisation and an acceptance that the emergency surgeon is essentially one who deals with pathology of the bowel alone. We now have the situation within the ASGBI where the specialty elements are extremely effectively represented, but we may be neglecting the role of the emergency generalist to the overall detriment of future service provision. This is ironic, given that the Association was founded primarily to serve the interests of ‘general’ surgeons and their patients.

I wonder whether the time has come for the Association to offer a home for a further specialty association, within its present federal structure, that would comprise surgeons who provide emergency care? The new association or society would operate under much the same terms as the specialty associations who are represented on Council at the moment and would evolve to develop its own structure, officers etc in similar manner. It would work with the other specialty associations and bodies outside of the ASGBI as necessary to provide a voice and advocacy for this important service. I rest my case.

Editor’s Note:
We are extremely grateful to the President for drafting this clear and concise proposal, which has already been debated by the Association’s Executive Committee and Council. We would, of course, be delighted to receive - and publish in the next Newsletter - the views of Fellows, so please write to me at the address given on the back page.

TEST THE NATION

On the evening of Saturday 8th October 2005, a brave team of 40 surgeons, many of them Fellows of the Association, gathered in a television studio in West London to take part in the live TV show “Test the Nation” hosted by Anne Robinson and Philip Schofield. Valiantly led by the Association’s 2005 President, Bob Lane (bottom left in the photo above), they were up against stiff competition from five other teams representing Radio Presenters, Ballroom Dancers, University Freshers, Greengrocers and a panel of Celebrities.

After a gruelling and closely fought competition, the team of Radio Presenters came out as winners, scoring 53 out of a possible 70 points. In second place were the celebrities with 49 out of 70 and our gallant Surgeons came third with a score of 48. However, the highest scoring individual was a surgeon, Mr Samer Nashef, who scored a very creditable 66 out of 70.
OBITUARY

Thomas G Brennan

The surgical community within Great Britain and Ireland was saddened to hear of the death, after a long illness, of Tom Brennan, Consultant Surgeon in the Leeds Teaching Hospitals NHS Trust, on 12th November 2005. Born in Dundalk and graduating from University College Dublin in 1962 Tom came to England to continue his postgraduate training. He undertook SHO posts in London and obtained the Fellowships of the Royal College of Surgeons in Ireland, Edinburgh and England before arriving in Leeds as a Registrar and subsequently a Senior Registrar in the Leeds/Bradford training scheme. From 1972 to 1974 he was Lecturer in Surgery with the Late Professor Geoffrey Giles in the newly-established Professorial Surgical Unit in St James’s University Hospital, Leeds and was appointed an NHS Consultant post in that hospital where he worked until his retirement in 2005. Tom was an outstanding clinical surgeon and was one of the last of the breed of truly general General Surgeons whose clinical talents appeared to know no bounds. Nevertheless, he was ahead of his time when, over 20 years ago, he established a multidisciplinary clinic for women suffering from diseases of the breast and over 20 years ago, he established a multidisciplinary clinic for women suffering from diseases of the breast and was one of the last of the breed of truly general General Surgeons whose clinical talents appeared to know no bounds. Nevertheless, he was ahead of his time when, over 20 years ago, he established a multidisciplinary clinic for women suffering from diseases of the breast and he was the first surgeon in Leeds to embrace interventional laparoscopy. Skilled as his surgical talents were, it is perhaps as a trainer (both undergraduate and postgraduate) for which Tom will be best remembered professionally. Countless surgical registrars owe him an enormous debt of gratitude for his patience and legacy of clinical insight. He had that rare ability to operate via the trainees hands. It is a great reflection of the high esteem in which he was held that he was always mentioned in the annual medical students review. His knowledge was always transferred with generosity tinged with Tom’s own likable brand of Irish wit. Tom also facilitated the transfer of many Irish surgical trainees to and fro across the Irish sea, many of whom have become distinguished surgeons in their own right. He was arguably the most popular surgical examiner in Great Britain and Ireland because it always seemed that the examining bodies had conveniently forgotten that Tom’s term of office as external examiner had expired! His achievements were recognised by the Royal College of Surgeons in Ireland in 2005 by the striking of a special medal which was awarded to Tom in appreciation of his commitments in training.

Tom Brennan was an outstanding colleague. His opinions about difficult cases were always worth seeking and his wisdom was generously given. Nevertheless, beneath the skilful surgeon and teacher, there lay a compassionate man whose kindness to his patients was limitless. Tom had a very highly developed sense of humour and this came particularly to the fore when indulging in one of his pastimes as a bon viveur and oenophile. However, he and his family would be the first to admit that when it came to sporting activities, of which he was passionately fond, particularly golf, he was a ‘poor loser’, this being the only flaw in an otherwise legendary character. He will be greatly missed by his colleagues and friends but his love and devotion to his family was boundless and the fortitude and spirit with which both he and his wife Mary, and children, Jessica, Jennifer, Michael and Catherine bore his last illness was inspirational.

Professor Pierre Guillou

EIDO HEALTHCARE BECOMES CORPORATE PATRON

We are delighted that EIDO Healthcare has agreed to become a Corporate Patron of ASGBI. They join Cook, Ethicon, Stryker and Tyco, and the Association is extremely grateful to them all for their continued support. The Association welcomes EIDO’s library of information for patients and will be providing ongoing editorial input to ensure that the highest standards of technical integrity are maintained. This relationship will help demonstrate ASGBI’s commitment to providing a public benefit in all its activities.

EIDO Healthcare was established in 2000 in response to the need for high-quality information to support informed consent. EIDO is focused on reducing the risk of litigation faced by clinicians. It does this by developing information for patients that clearly sets out the benefits, complications and alternatives of hospital treatment, in accordance with GMC Guidelines and the recommendations of the Department of Health.

The NHS Litigation Authority’s liability for clinical claims currently stands at over £6 billion. Poor communication is the most-cited reason for complaints and hence litigation. That is why there are stringent regulations regarding information for patients in the clinical standards for both the Clinical Negligence Scheme for Trusts (for the NHS) and Care Standards Act (for private hospitals). EIDO’s library of information, covering over 210 hospital operations and treatments across 24 specialties, is now being used by over 240 hospitals to help them meet these regulatory requirements. Hospitals are choosing to use EIDO’s information to avoid the high costs of developing and maintaining their own information resources.

The accuracy and readability of the information is a primary concern of EIDO’s development teams which together comprise over 50 expert surgeons and physicians. EIDO encourages clinician feedback, recognising that each information document needs to be a ‘fit for purpose’ tool for clinicians in clinic. The information can be customised to reflect local practice and complication rates. Working with the ASGBI Education and Training Board will help to ensure the information, which is updated at least annually, meets the highest standards and fully reflects current clinical practice in the UK.

EIDO’s in-house team of editors is trained by the Plain English Campaign (PEC). Each EIDO document bears a unique PEC Crystal Mark. Recently Chrisie Maher, the founder of the PEC, described EIDO as a “guiding light for the entire healthcare industry”. EIDO also conducts regular patient audits, and collaborates with Patient & Public Involvement Forums and patient charities, to make sure that the information is as clear and relevant as possible for patients.

If you feel your hospital may benefit from EIDO’s library, please contact EIDO for more information. Email: info@eidohealthcare.com or telephone 0115 878 1000

www.eidohealthcare.com and www.aboutmyhealth.org

STOP PRESS

The 4th Annual Patient Communication Conference, co-hosted by EIDO and ASGBI, will be held on 23rd May 2006. For more information and to register, please visit www.eidohealthcare.com or call 0115 878 1000
Modernising Medical Careers (MMC) aims to improve patient care by delivering a modernised and focused career structure for doctors. Over 5,000 trainee doctors joined the Foundation Programme in August 2005 and are about to be placed into their F2 year commencing August 2006. In August 2007, these doctors will enter the new specialist and GP training programmes and we are expecting to announce an approved implementation plan for this training in Spring 2006.

To make the coming changes to specialist and GP training as easy to understand as possible, we have created an easy to use version of the final MMC Career Framework, with no jargon, just clear definitions. The diagram and definitions have been agreed by the four UK health authorities and the MMC Career Framework was endorsed by the health ministers in the four countries on 25th January 2006.

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F1 and F2
Foundation year 1 (F1) and Foundation year 2 (F2) make up the two-year Foundation Programme which all UK medical graduates are required to undertake before progressing to specialty or GP training. These two years effectively replace the pre-registration house officer (PRHO) year and the first year of senior house officer (SHO) training. Foundation doctors are trained and assessed against specific competences set out in the Curriculum for the Foundation Years in Postgraduate Education and Training. This curriculum was agreed with the General Medical Council (GMC) and the Postgraduate Medical Education and Training Board (PMETB).

Foundation Schools
Foundation training is managed in a way that brings together medical schools, postgraduate deaneries and health care providers to provide training in a variety of specialties and settings (acute, community, mental health and general practice). This training is supported and overseen by the postgraduate medical deaneries. This administrative body may be referred to as a Foundation School.

Specialist and GP training programmes (run-through training)
These are specialist and GP training programmes which candidates who are successful in their application can start directly after the F2 year. Once a doctor is in specialist or GP training, they will have the opportunity to gain a Certificate of Completion of Training (CCT), subject to satisfactory progress. Each programme will have a curriculum, agreed by PMETB, against which doctors in training will be assessed. The number of years that a trainee spends in training will vary from programme to programme. After a doctor receives a CCT, they will be legally eligible for entry to the Specialist or GP Register and can then apply for an appropriate senior medical appointment.

Specialty/GP training schools
As with foundation training, specialist and GP training programmes will be delivered through a range of organisations, overseen and supported by the Postgraduate Deans. Similarly, this administrative body may be known as a specialty/GP training school.

Specialist and GP Registers (CCT route vs Article 14/11 route)
Once a doctor is awarded a CCT by PMETB at the end of a training programme, they will be eligible for entry to the Specialist or GP Register held by the GMC. A doctor who has not completed a specialist/GP training programme may apply for entry to the Specialist or GP Register through PMETB. If PMETB is satisfied, they may be entered on the appropriate register. (This route is defined by Articles 11 and 14 of the General and Specialist Medical Practice (Education Training and Qualifications) Order 2003). Once a doctor is on the register, they are then eligible to apply for an appropriate senior medical appointment.

Senior medical appointments
These may cover, for example, GP principals, other employed GPs, consultants or other specialist roles. These roles will be determined by the service.

Fixed term specialist training
These appointments will be for a fixed period. They are likely to mirror the early years of training in a specialty/GP training programme and trainees will be assessed against explicit standards. The duration of such posts is yet to be determined, but they will probably be for no more than two years.

Career posts
These positions are service delivery posts with no formal specialty training elements. However, employer appraisal and relevant Continuing Professional Development will be an essential part of these doctors’ careers. These posts will only be available in secondary care.

Competitive entry
Progress through each stage of training will be through open and fair competition.
Association of Surgeons of Great Britain and Ireland

MOYNIHAN TRAVELLING FELLOWSHIP 2006

The Association’s prestigious Moynihan Travelling Fellowship, up to the value of £5,000 is available annually, by open competition, to Specialist Registrars, towards the end of higher surgical training, or Consultants within five years of appointment at the closing date for this application. The Fellowship is intended to enable the successful candidate to broaden their education and to present and discuss their contribution to British and Irish surgery overseas. It is not appropriate, however, that the award be used as part-funding for an off-service year of training.

Candidates must be residents of the United Kingdom or the Republic of Ireland but need not be either Fellows or Affiliate Fellows of the Association; however they should be engaged in general surgery or in one of its specialties. A full Curriculum Vitae should be submitted giving details of past and present appointments and publications, together with a detailed account of the proposed programme of travel, costs involved and objectives to be achieved. Shortlisted candidates will be interviewed by the Scientific Committee of the Association on Wednesday 1st November 2006. The Committee will pay particular attention to originality, scope and feasibility of the proposed itinerary. The successful candidate will be expected to act as an ambassador for British and Irish Surgery and should be fully acquainted with the aims and objectives of the Association of Surgeons and its role in surgery. After the Fellowship the successful candidate will be required to provide a written report of their Fellowship for inclusion in the Association’s Newsletter, and to address the ASGBI Annual Scientific Meeting, 21st to 23rd May 2008, in Harrogate.

Requests for information and applications (15 copies) should be submitted to: Moynihan Travelling Fellowship 2006, Honorary Secretary, Association of Surgeons of Great Britain and Ireland, Royal College of Surgeons of England, 35/43 Lincoln’s Inn Fields, London, WC2A 3PE. Deadline for applications: Monday 2nd October 2006

OVERSEAS SURGICAL FELLOWSHIP 2006

The Association of Surgeons of Great Britain and Ireland, together with the British Journal of Surgery Society, are offering to sponsor surgeons wishing to work on a short term basis, primarily in the Third World. This Scheme is run in conjunction with the Tropical Health and Education Trust to provide support for overseas medical schools in the development of their undergraduate and postgraduate training programmes and also for research, thereby establishing links with these centres.

Only Fellows including Full, Senior, Associate and Affiliates of the Association of Surgeons may apply and, if successful, a grant of up to £2,000 will be made available to individual applicants.

Further details are available from Miss Bhavnita Borkhatria, Association of Surgeons of Great Britain and Ireland, Royal College of Surgeons, 35/43 Lincoln’s Inn Fields, London ,WC2A 3PE. Deadline for applications: Monday 2nd October 2006
The Association’s Overseas Surgical Fellowship Committee (OSFC) first sat in 1995, under the chairmanship of Bernie Ribeiro. With an annual budget of £10,000, its remit was to award fellowships to UK and Irish surgeons wishing to undertake short-term projects in the Developing World. The primary purpose of these visits was to provide training and educational support for overseas health professionals and medical institutions. Since its inception, the OSFC has sponsored nearly forty such visits.

However, since 2000, the OSFC has considerably broadened its scope of activity. In 2000, four consultant surgeons from the Association ran the first Introduction to Surgical Skills course in Ghana. This ran over two days and was attended by 120 participants. It aimed to teach junior surgeons or general medical officers the theory and practice of managing basic surgical conditions and was tailored to the local environment and level of resources. The course is increasingly popular and has subsequently been run in Nigeria, Ghana, Gambia, Sierra Leone, Uganda, Tanzania, Kenya and Zambia.

The OSFC has recognised that, amongst the Association’s Fellowship, there are many surgeons with a longstanding commitment to Developing World surgery, in both service and training capacities. This has often been pursued at an individual and local level, with little reference to other colleagues or organisations engaged in similar activity. With this in mind, the OSFC has convened an annual Surgery in the Tropics Day, the first of which took place at the Royal College of Surgeons of England in London in 2002. This day aims to bring together like-minded surgeons from the Great Britain and Ireland and overseas, to share experiences and form an overview of our work in “the Tropics”. An essential part of this is the robust assessment of our limitations and the formulation of a co-ordinated approach to overcoming them.

A necessary response to the need for integration of effort has been to connect with other organisations with similar interests. The OFC works closely with THET (Tropical Health and Education Trust) which has pioneered the concept...
of formal links between UK and Developed World health institutions. The aim of these is to support the latter’s educational and training needs from the rich resources of a linked UK institution. Recent years have seen new collaborations with COSECSA (College of Surgery of Eastern, Central and Southern Africa) and the German Tropical Surgery Society. The OFC has been represented at the WHO Conference on Rural Surgery (December 2005) and the Bethune Conference 2005, in Toronto, Canada.

In September 2004, Bob Lane, then chairman of the OSFC, convened a Consensus Meeting on Overseas Training, at Balliol College, Oxford. This was attended by delegates with overseas commitments, representing the whole spectrum of medicine, from NGOs, the Royal Colleges, the pharmaceutical industry and overseas institutions. The meeting focussed on how we, in the wider world of medicine, can proceed most efficiently and coherently with overseas training.

In 2003 the OSFC set up its own dedicated website, HOST (Help with Overseas Surgical Training) as a central reference point for individuals and groups with overseas interests. This provides regularly updated information on overseas events and visits. Requests can be made, and queries raised, via the Message Forum at: www.asgbi.org.uk/host

It is clear that the remit of the OSFC has evolved considerably in a very short time. In broadest terms, the goal of the OSFC is the improvement of surgical care available to the populations of Developing World countries.

The committee recognises that training of overseas health professionals in their own countries should be its priority if improvements are to be sustainable. The practical response to this recognition has been the introduction of the surgical skills courses described above and the ASGBI is recognised as the preferred provider of such courses by the West African College of Surgeons as well as COSECSA.

Equally important, however, are the co-ordination and integration of the training activities and philosophies of the multitude of individuals and organisations involved in tropical surgery. To this end, the OFC has participated in and convened the meetings above. Producing action from discussion in this sphere will be the OSFC’s greatest challenge in its next ten years.
ART CREATES LIFE IN HOSPITALS

Ib Hessov

Amongst grown-ups - like those who work for Novo Nordisk - the encounter with art in the daily work-life is definitely contributing to keeping us young and curious, and - as for the artists - never to stop wondering, asking questions or to try finding new ways and new solutions.

(Mads Oevlisen, 1999)

In the 2002 Christmas issue of the BMJ, the chief editor Richard Smith wrote a thought-provoking paper with the heading: *Spend (slightly) less on health and more on the arts* (1). The subtitle, which also concluded this very stimulating, convincing and, for me, only slightly provocative paper, was this: **Health would probably be improved.** The assumption behind this conclusion was that health was not simply defined as the absence of illness but that the definition of health also had a spiritual content including concepts such as adaptation, understanding and acceptance. Richard Smith suggested specifically that, in addition to the Government's grants to the arts, amounting to £300 million, the NHS should use 0.5% of its £50 billion budget on art.

My paper is not going to try to argue that 0.5% of a hospital's annual budget should be used on art but, hopefully, it will inspire people to look a bit more at the rooms in the hospitals where patients spend time. In 1985 we started to look at what art could do for Aarhus Amtssygehus (a 300 bed hospital, part of Aarhus University Hospital in Denmark). We have continued to do so and here is a short version of the history.

**Art at Aarhus Amtssygehus**

In 1985 Aarhus Amtssygehus celebrated its 50th anniversary. Outside, architectural beautiful buildings in red brick, inside, a hospital which worked efficiently but with dull corridors and walking areas, dull waiting rooms and common/day rooms, and technical examination rooms which felt cold. The Managing Director of the hospital and I decided that, for its birthday, the hospital should wish for some pieces of art, which could leave their stamp on those areas in the hospital where patients were spending time. We established an arts foundation and drew up the statues for its work which, amongst other things, said that it was the board of the foundation, consisting of four people interested in art, who alone should decide what to buy for the hospital. We then wrote to all the potential donors of birthday presents saying that we wished for money to buy art and, if they wanted to donate a whole piece of art, that we wanted to be involved in the selection procedure. Great success. Small and big money gifts came to DKK100,000 (2). In addition to this we received three big presents including a painting by Lars Noergaard, measuring two by three meters.

In the following nine years it was pretty hard work to raise funds for the pieces of art we wanted to buy, but from 1995 an amount for art was included every year in the hospital budget, rising to DKK130,000 in 2003, the last year Aarhus Amtssygehus was an independent hospital. This amount was, in relation to the hospital's total budget, less than 0.3%.

So what does the hospital look like today? Well, it is characterised by art, mostly by Danish artists, bought when the artists were young. It is art, which changes its surroundings, which is not only decorative but also creates life, which provides the possibility for experiences and often provokes discussions. It is good art. You can see paintings at the entrances, where walking areas meet, in waiting rooms and in common/day rooms. Most of the wards have a series of pictures, lithographs, etchings, or paintings, which create a cohesive overall decoration. All in all, we have 160 paintings, 15 big photos and about 150 silk-prints and other works on paper. The few examples of the artistic decoration shown here are able to illustrate some of our ideas and values behind the choice of art.

The two waiting rooms in A&E were the dreariest rooms in the hospital and places where many people were waiting every day. We knew that the artist Lars Noergaard, apart from being one of the best young artists in Denmark, was able to paint with a wonderful grotesque humour and, on top of that, thrived immensely when given a concrete task. The task was: paint two fairly large paintings on the theme 'The animals' A&E', one for the smoking area and one for the non-smoking waiting room. The paintings completely changed the two rooms, created life and a waiting-time with the possibility for experiencing so much more.

![Fig.1](image1)

The waiting room in the laboratory was 'naked' but, with Dorte Dahlin's large, floating, poetic painting, it gained, in harmony with the classic, old leather chairs, an exciting overall look which radiated quality (fig.2). It was a 'indecent' cheap buy when we in 2002 could get this painting at an auction for DKK12,000.

![Fig.2](image2)
When an out-patients' ward was to be renovated it was not only decorated with four paintings by Anette Abrahamsson, but the artist also chose the colours on the walls. This created an exciting unified whole (fig.3).

On their way to the restaurant and the out-patients' clinics the staff and the visitors are confronted with a big, striking, colourful painting by Tal R. It is just immediately beautiful (fig.4). This was also how I saw it in 1999 in the artist's studio at The Royal Danish Academy of Art, where Tal R was still a student. These days you can see several of his paintings on www.Saatchi-gallery.co.uk

Which art - and who is to decide?
At all hospitals we aim to provide the best possible care. Good quality is the keyword, and we will do our very best for the patients to feel this too.

So, do the surroundings at the hospital influence a patient's view of the standard of quality? That is probably the way it is. A day/common room, full of odd pieces of furniture with worn covers, which do not match the curtains of the room, does not radiate quality. An untidy hospital corridor, where the walls are decorated with a mixture of different notices, casually hung lithographs and other pieces of art donated by grateful patients, just looks messy. A decoration, consisting of bad, easily available art, is like 'muzak' in the supermarket, perhaps entertaining but only leaving an empty space, and should hardly be the one to set the standard of quality.

What we would like to demand from our surroundings is that they convey thoughtfulness, that we are not only thinking of effectiveness but also on the way they can provide positive experiences, have an activating effect, make the patients think about something else than illness - and at the same time be inspiring for the 'white coats'. This is something pieces of good art can provide.

But who is to decide what 'good' art is and what to buy? With reference to the hospital world: Who decides what good care is? Whose responsibility is it that the methods used in surgery are the most optimal? These are the tasks of the specialists, those who have worked their whole life to perfect their knowledge of their subject. Decisions are not taken according to a democratic vote. Similarly, to decide whether art is good or bad is a decision that has to be taken by people who have used time and effort to perfect their knowledge of the art world and at best also know where to buy good art at reasonable prices. At Amtsygehuset we were four in the art-committee (which should consist of art connoisseurs and the hospital MD/the budget-holder) and we were the ones who tracked down the art, decided what to buy and where to place the art in the hospital. The last task was in cooperation with that particular ward to which the art had been allocated. Conditions were often attached, such as painting of a wall, improvement of lighting, re-upholstering of worn pieces of furniture, all in accordance with the hospital's architect, one of the four members of the committee. In this way the art becomes part of a whole.

Art at the hospital of the future
In contrast to the patient of the past, who was placed in a bed and passively cared for, the patient of the present and the future is a human being who is much more informed about his/her illness and somebody whom we expect to be actively contributing to his/her own care and rehabilitation. The hospital of the future will be adapted accordingly, with much more emphasis not only on outpatient treatment but also on the areas where those who are in hospital can be 'walking cases', training, eating, talking, on their way to recovery. These activities are dependent on suitable surroundings, and good pieces of art can, in addition to be something for the eye, perhaps help to take the thoughts away from the illness, show other aspects of life, provoke, give rise to discussions and activate the patient.

New building work gives rise to the added opportunity of being able to integrate the art, in cooperation with the architect, already in the early phases of the planning and building process. For example, one of the good painters/artists can, already at an early stage, be involved in the discussions about interior, colour-choice and decoration.

When building in Denmark under the aegis of the Government, a declaration of intent exists to use 1% of the cost of the building work for artistic decoration, and large progressive private companies have realised that good pieces of art can be inspiring for the employees and help to create an attractive workplace. May good art also be an integrated part of the hospital of the future!

References
(1) Smith Richard. Spend (slightly) less on health and more on the arts. BMJ 2002;325:1432-33.
(2) The exchange rate for DKK/£ is approx. 10/1
Fig.1 Lars Nørgaard. Oil on canvas. 110x150cm.
Fig.2 Waiting room in the lab. with Dorthe Dahlin’s 85x205cm painting.
Fig.3 The heart-clinic with four 60x180cm paintings by Anette Abrahamsson.
Fig.4 Tal R. Oil on canvas, 200x200cm.
CONTINUING PROFESSIONAL DEVELOPMENT

ADVICE TO ALL SURGEONS FROM THE SENATE OF SURGERY OF GREAT BRITAIN AND IRELAND

JANUARY 2006

- A Dossier of guidance on Continuing Professional Development (CPD) was endorsed by the Senate of Surgery and published online in November 2004. The recommendations replaced previous publications and reflect the evolving understanding and attitudes towards undertaking and recording Continuing Professional Development activities. They can be accessed on the website of the Senate of Surgery of Great Britain and Ireland:
  

  and those websites of the Royal Colleges of Surgeons and the Specialty Associations.

- The Dossier gives advice to surgeons about the needs for CPD appropriate to all fields of surgery. It recognises that CPD should encompass the clinical, professional and managerial aspects of the surgeon’s role and acknowledges how these may evolve in relative importance over the different phases of a surgical career. It is important that the different facets of a surgeon’s life are recognised and recorded as CPD where appropriate.

- The advice is directed primarily to surgeons practising in the UK. Although Ireland is a different jurisdiction, and there is also a European system for accreditation for CPD, the guidance will also inform the surgeons in these and other areas.

- Evidence of engagement in CPD is expected in the context of an annual appraisal. The requirements for revalidation of registration with the General Medical Council (GMC) are still under consideration; CPD is likely to have a prominent role and the guidance from the Senate is in accord with the principles in the recommendations produced by the GMC (Continuing Professional Development, April 2004). Evidence of participation in CPD is also important as an expression of the fundamental professionalism of the conscientious, compassionate surgeon.

- In placing the emphasis on the purpose of different CPD activities, and on reflection on the benefits of the activity, the Senate’s recommendations provide a lead for other disciplines and specialties.

- The Senate guidance recognises that the erstwhile system of central recording and analysis of “points” was neither effective nor valid and the accumulation of these into virtual credits was without demonstrable benefit. Certificates of attendance from CPD organisers therefore should not award points or credits. Instead, Colleges and Specialty Associations will advise on the merit of either a particular activity or the portfolio of activities undertaken by an individual surgeon, some of which may be time dependent. Information about CPD activities by surgeons may be sought by Colleges and Specialty Associations in order to guide the evolution of such advice.

- A proforma encompassing the components of the Dossier has been produced for use by individual surgeons and is strongly recommended (“Record of CPD Activity” below). Senate advises all surgeons to use this proforma to accumulate their personal record, in order to facilitate consistency in the presentation and analysis of information of CPD and hence support any future collaborative approaches by Colleges or Specialty Associations. Submission of this proforma to these organisations therefore might also be recommended. This proforma may be copied freely but is also available online from the Senate of Surgery website:
  
  http://www.senateofsurgery.org/Publications/CPDDecember2004.pdf and
  

Signed:

Professor Sir Graham M Teasdale
PRCPSGlasgow
Immediate Past Chairman of Senate of Surgery

Mr Graham T Layer
Chairman of JCCPD and
Senate Lead on CPD
Background
The role of Link Surgeon was proposed by Mr Bernie Ribeiro during his Association Presidency to promote the rapid exchange of information between the ASGBI Executive Committee and membership. The system has subsequently been used to canvass ASGBI Fellows’ views and to undertake surveys of manpower, training and other topics affecting service delivery and working conditions.

Link Surgeons are generally appointed from the ASGBI Fellows within a Trust following an informal approach by the Elected Regional Representative on Council. One Link Surgeon is usually appointed for each Trust but, where a Trust has multiple acute sites, more than one Link Surgeon may be appointed at the Regional Representative’s discretion.

The Link Surgeon can be any ASGBI Fellow and not necessarily the College Tutor, although this is frequently the case. Many Regional Representatives are also Link Surgeon for their Trust. Link Surgeons are asked to supply an email address to facilitate rapid communication. The tenure is undefined. There is no remuneration and no expenses are offered. There is no PA allocation available for the work involved. The role has not hitherto been accurately defined but a Job Description has recently been drawn up and discussed by Council. The list of Link Surgeons is published in the Association’s Annual Report to indicate their official status within the ASGBI.

Regional Representatives are encouraged to communicate with their local Link Surgeons who are asked to represent the views and concerns of their ASGBI colleagues and to act as their mouthpiece in responding to surveys or by conveying concerns or news of important local developments to the Association’s Council and Executive Committee.

National Link Surgeons Coordinator
The Association has utilised the Link Surgeon system successfully in the past but wishes to strengthen and formalise the system to gain deeper local insight into the rapidly changing political and surgical landscape developing in Trusts. The Executive Committee wish to canvass Fellows’ views and to be more responsive at a time when many surgeons feel professionally and politically sidelined. The Executive Committee wish, therefore, to raise the profile and standing of Link Surgeons. To this end, a National Link Surgeons Coordinator (NLSC) was appointed and took up post on 1st June 2005.

The NLSC is appointed from the elected Council membership and tenure of the post is for the duration of that membership (maximum of four consecutive years). The responsibilities of the role include the following:

• To maintain and update the central database of Link Surgeons.
• To assist the Honorary Editorial Secretary with the compilation of a comprehensive list of Link Surgeons for publication in the Annual Report and on the website.
• To assist the Honorary Secretary with any national surveys of Link Surgeons.
• To liaise with the Web Manager over the maintenance of ‘Surgeons GBI’ personal websites and e-mail addresses for all Link Surgeons.
• To communicate with all Link Surgeons.
• To provide a focus for Link Surgeons at the Annual Scientific Meeting and to recognise their contribution to the ASGBI.
• To contribute occasional articles on Link Surgeon issues to the Newsletter.
• To report regularly, in writing, to Council meetings.

Evolution of the Link Surgeon role
It is hoped to engage the Link Surgeons by defining their role, improving communication, utilising the cascade system for surveying the membership and raising their recognition whilst recognising that making substantial additional demands on their time would be unrealistic.

Proposed Link Surgeon Job Description
• To gather and reflect views and experience of ASGBI colleagues and to feed this information to Council directly or through Regional Representative or the NLSC.
• To make themselves known to colleagues within their Trust.
• To encourage membership of ASGBI amongst colleagues, trainees and medical students.
• To inform Regional Representative of new Consultant appointments.
• To keep the Regional Representative informed of local views.
• To receive ASGBI Council notes.
• To submit an email address and maintain ‘Surgeons GBI’ personal website.
• To respond to surveys/enquiries from ASGBI Council.
• To attend Link Surgeon session at the Annual Scientific Meeting.
• To encourage and mediate submission of CORESS reports from local governance/D&KC meetings.
• To encourage local undergraduate societies.

Communication
Link Surgeons are asked to communicate with colleagues and to feed local views to the Executive Committee where appropriate. Communication by email seems appropriate for most purposes and Link Surgeons are requested to provide a current e-mail address to the Association’s Secretariat.

Attempts to arrange Regional Link Surgeon meetings have proved disappointing, and a session at the Annual Scientific Meeting seems more likely to be attended. This could be one large national session or multiple smaller regional sessions, depending on the availability of space.

A synopsis of Council meetings, produced by the Honorary Secretary, should be sent to all Link Surgeons by email.

Link Surgeons are encouraged to contribute occasional articles to the Newsletter and to submit CORESS reports.
Proposed Surveys
Council and the Executive Committee will decide on topics to be circulated through the Link Surgeon network. The following topics have been suggested:

- Yearly workforce survey/new appointments.
- PA’s worked/paid.
- Hours worked.
- EWTD 48 hour opt out.
- Plans for additional colleagues.
- On-call rotas.
- Study leave/time/funding.
- Targets/2 week waits/WLI work.
- Retirement plans.
- Catchment population/area.
- Beds.
- Secretarial/administrative support.
- Adjacent ISTC’s.
- Service reconfiguration.
- Trust deficits.
- Downgrading/closure of services.
- Training: rotas/shfits; number of NTN’s.

Next Steps
More frequent and regular email communication is planned and pathways through the Secretariat are being identified to handle the flow of information and to analyse the resulting survey data identified. Contributions to the Newsletter and CORESS will be invited and a Link Surgeon session is being held at the Association’s 2006 Annual Scientific Meeting in Edinburgh (5.00pm to 5.30pm on Thursday 4th May 2006, in the Pentland Auditorium).

Finally, overlap or conflict of Link Surgeon and Regional Representative roles should be avoided and their relationship further defined.

ANNUAL SCIENTIFIC MEETING
“The Compleat Surgeon” 3rd to 5th May 2006, Edinburgh

The Association’s 2006 Annual Scientific Meeting will take place in the historic city of Edinburgh, officially the UK’s top city destination. With an impressive Scientific Programme, a varied and innovative range of taught courses and workshops and a fantastic location, the Meeting promises to be an exciting event not to be missed!

Places on the Taught Courses and Workshops are strictly limited, so book now to avoid disappointment.

The dates and venue of the Meeting have been deliberately chosen to coincide with the 500th Anniversary of The Royal College of Surgeons of Edinburgh, and many associations and societies will be taking this opportunity to be part of the Meeting including:

- Association of Breast Surgery at BASO
- Association of Coloproctology of Great Britain and Ireland
- Association of Laparoscopic Surgeons of Great Britain and Ireland
- Association of Upper Gastrointestinal Surgeons
- British Association of Endocrine Surgeons
- The Vascular Society
- Society of Academic and Research Surgery
- Association of Surgeons in Training
- British Association of Plastic Surgeons
- British Association of Paediatric Surgeons
- National Association of Assistants in Surgical Practice
- British Orthopaedic Association
- British Association of Day Surgery
- British Association of Urological Surgeons

AN EXCITING PROGRAMME
The Provisional Programme for the Annual Scientific Meeting is available to view or download from www.asgbi.org.uk/edinburgh/ and reveals a varied and stimulating line-up. Professor Murray Brennan from the Memorial Sloan Kettering Cancer Centre in New York, and an Honorary Fellow of the Association, has kindly agreed to deliver the Helen Rollason Memorial Lecture, whilst Professor Barbara Bass, Professor of Cancer Research from Houston, Texas, will talk about ‘Preparing the 21st Century Workforce: Adaptation to Evolving Challenges’ in the 2006 British Journal of Surgery Travelling Fellowship Lecture. The programme also includes Professor Richard R. Reznick, Director of the Faculty of Medicine at the University of Toronto, speaking on new models of training when he delivers the Royal College of Surgeons of England Moynihan Lecture on Wednesday 3rd May. Professor David Rowley delivers the Royal College of Surgeons of Edinburgh Lecture with Professor John R T Monson giving the Royal College of Physicians and Surgeons of Glasgow MacEwan Lecture. The Royal College of Physicians and Surgeons of Glasgow MacEwan Lecture sees Mr Alan McKay talking on the modern management of melanoma. With such high calibre speakers, the 2006 Meeting promises an exciting programme not to be missed!

ANNUAL DINNER
The Association’s Annual Dinner on the evening of Thursday 4th May 2006 is a fantastic opportunity to catch up with friends and colleagues and dine in splendour at one of the most spectacular and illustrious venues in the UK - the Royal Museum of Scotland. Tickets are £65 which includes a champagne reception and after-dinner entertainment including a ceilidh, and we look forward to seeing many of you there.

www.asgbi.org.uk
ANNUAL SCIENTIFIC MEETING 2007
“A First Class Service”

The Association’s 2007 Annual Scientific Meeting will be held from
Wednesday 18th to Friday 20th April 2007
at the
Manchester International Conference Centre
(MICC)

The closing date for the submission of abstracts will be midnight on
Friday 15th December 2006

For further information, please contact:

Association of Surgeons of Great Britain and Ireland
35-43 Lincoln’s Inn Fields
London
WC2A 3PE

Tel: 020 7973 0300
Fax: 020 7430 9235
Email: admin@asgbi.org.uk

or visit

www.asgbi.org.uk
HOW TO BE A RETIRED SURGEON

On Friday 2nd December 2005, the Association held an extremely successful one-day Meeting entitled HOW TO BE A RETIRED SURGEON. The meeting was held at the Royal College of Physicians in London and just under 100 delegates, including a number of partners, enjoyed a programme of excellent presentations. The morning session, Planning for Retirement, covered practical topics such as NHS Pension Scheme (from Mr Andrew Blake, Senior Pensions Officer, BMA), Making the most of your options (from Dr Mark Martin, a Consultant Anaesthetist and Independent Financial Advisor) and Medico-Legal Work (from Professor Roger Grace).

The afternoon session was split into two halves. The first part included sessions on Using your skills in Retirement (from Mr Robert Lane) which promoted the possibilities for working in the developing world, Training in Retirement (from Mr Denis Wilkins) which encouraged those nearing retirement to take a more active role in surgical training, and Educating and Encouraging our Successors (from Professor Jerry Kirk) which outlined the options of becoming involved with undergraduate surgical education.

The second part of the afternoon was a more light-hearted look at retirement, beginning with a superb presentation, with a lifetimes collection of slides, from Professor Harold Ellis on The Art of Anatomy followed by a thought provoking and amusing look at Staying Sane in Retirement from the inimitable Sir David Carter. Before the delegates ‘retired’ for wine and canapés, the meeting concluded with an excellent presentation on The Destruction of the Medical Profession from Dr Theodore Dalrymple. Dr Dalrymple has written extensively in the press, including publications such as The Spectator, and has recently retired from his Consultant post within the NHS. He has kindly given his permission for the Association to publish the text of his presentation, which appears below.

THE DESTRUCTION OF THE MEDICAL PROFESSION

Dr Theodore Dalrymple

Ladies and gentlemen,

I should like to thank you for the honour you have done me in asking to speak to you this afternoon. My subject, however, is not altogether a happy one, though it might perhaps give you a little consolation to those who are about to retire. Bad as things are, they can only get worse; but you, who have not yet retired, will feel them as keenly as we would feel them, or even feel them at all, is an open question.

I was having lunch the other day with a former colleague of mine - one of the advantages of retirement is the opportunity to have a decent lunch without a sense of guilt that one should really be doing something else - who told me a story of his son, who is a senior house officer in medicine.

He, the SHO, was attending a very sick patient in the ward the other day when he received a call from casualty. It was a nurse asking him to come at once to see a patient who had been waiting in casualty for almost as long as the target time permitted. He explained that he could not come, as he had an emergency on his hands. A couple of minutes later, he had a second telephone call, this time from a manager in casualty, also asking him to come, and of course for the same reason. Again he explained why he could not come. Finally, he received a call from a more senior manager to the effect that he, the manager, had admitted the patient to an available bed in a medical ward.

This was not the end of the story. The SHO went in due course to that medical ward, where he discovered that the patient had not needed to be admitted. He phoned the manager to tell him so; but the manager said that he was pleased to hear it, for it meant that the patient could be discharged immediately, which would be good for the hospital statistics. An illness treated with the maximum expedition and efficiency!

Well, you might say that one swallow doesn’t make a summer - or, in this case, a winter. But I don’t think my friend’s son is a single, isolated swallow. On the contrary, not only do surveys demonstrate that an ever-increasing proportion of young doctors regret their choice of career, and a similarly increasing proportion of senior doctors wish to retire as soon as possible, but an increasing proportion of those who obtain a medical degree do not take up the career in the first place. The daughter of another friend of mine, also a medical SHO, tells the story of how, on asking her former boss over the telephone for a reference, he asked her to send a photograph of herself to his secretary, so little had had contact with her, and so much a blur were all junior doctors in his mind nowadays. Her complaints about her training - incidentally, at the other end of the country - were exactly the same as those of my other friend’s son.

I might add here that, in the last year or two in my hospital before I retired, I found increasing difficulty in finding any junior who knew a patient thoroughly. All such doctors appeared to have been called in to attend to solve a particular problem that had arisen - a UTI, for example, or complaint of a headache - and to have had no further contact with the patient. I might add also that my aged mother, who was recently in hospital for her operation, if any, that was looking after her. And this was not because of any cognitive impairment on her part.

I suppose that people have been lamenting the passing of the old, and the deterioration brought about by the new, since the beginning of time. This fact, however, and the almost biological propensity of people in late middle age like us to lament the past, should not disguise from us
the real possibility of deterioration. Improvement is always possible, but it is not inevitable; Rome might not have declined in a day, but it did decline. And I think that the medical profession is in decline, not from any internal decay, but from external pressure applied to it mainly by unscrupulous and demagogic politicians.

So is there any single explanation for the present discontents of medicine? Since I am among friends, I think I may indulge in a little conspiracy theory. Please note that I am not saying that there has been no progress, that in all respects things were worse than they were. People live longer and healthier than they once did. To take an obvious example, from my own family history: much of my childhood fell under the shadow of my father's peptic ulceration. He would pace the floor at night in pain. For years our house smelled of fish boiled in milk, and also the peppermint flavoured...
In effect, managerialism has legalised corruption in the public service. There is no clear distinction any more between what is licit and what is illicit. To take a single example: the directors of the trust for which I worked acknowledged that they, or their families, had financial interests in consultancy firms whose sole work was provided by the NHS. (Goodness knows what went on unacknowledged.) Of course, the directors who had these interests, or whose families had these interests, would be horrified by the suggestion that they were corrupt. After all, they would say, they would ensure that their own trusts did not employ the services of the consultancies in which they were interested. But it surely takes little imagination to envisage the scope for corrupt reciprocal relationships with others in the health service who have like interests. In my opinion, much of what goes under the name of in-service training falls into the category of corruption: large sums are paid to training companies consisting largely of former NHS staff. One of my secretaries, for example, who was three weeks away from retirement after 40 years as a medical secretary, was sent on a course - compulsorily - on how to answer the telephone. Not only was this deeply insulting to her personally, but it was very difficult to imagine any reason for it but the desire to swell the numbers on the course and therefore the remuneration of those providing it. The imbrication of such interests in the management of the health service is something comparatively new and in my view sinister. It is worse in its effects than straightforward corruption of the brown-envelope-under-the-table-variety, which at least is potentially controllable because clearly illegal. The privatisation of the public service has often been remarked upon; but equally important is equality of dependence of private enterprise on the public service. Such enterprise is rarely enterprising and owes its position not to its efficiency but to favours done it by the managerial class.

All this is as nothing, however, compared with the intellectual corruption brought about by managerialism, with its culture of targets. In medicine, intellectual corruption inevitably leads to moral corruption also. And in a centralised system such as the NHS has become, as the whole history of the Soviet Union demonstrates, target-setting results in only one thing: organised lying.

Let us return to the story with which I began, that of my friend's son, the medical SHO. The hospital in which he worked had been set a target which was conjured out of thin air by politicians and their bureaucrats, for purely demagogic purposes so that they could dishonestly demonstrate an improvement in services. It was imposed upon the hospital irrespective of its other activities and irrespective of its capacity to meet it without deforming the rest of what it did. The career of people already inclined, ex officio as it were, to unscrupulous careerism were made dependent upon meeting the target. Compared with meeting the target, the fate of an individual patient, however sick, is a very small thing. One must not allow mere doctors to set priorities in their own work. (Let me interpose here that I am far from believing that all doctors are moral giants who consider only the welfare of their patients. However, I have met very few doctors who have no concern whatever with the welfare of their patients. By contrast, a manager can do evil without having directly to face the humiliated families of his actions.

We all know of the statistical manipulations which targets call forth: for example those relating to waiting lists. Trolleys are renamed beds and patients not allowed out of ambulances until it is certain that they will not breach the 4 hour rule once they have entered the casualty department. Under managerialism, information-gathering becomes not a means of inquiry into truth but a means of letting you know that Big Brother is watching you. Not long ago, I went to out-patients where I found a note asking me to bar code the patients. There was a machine on the table that was the kind of thing one sees in supermarkets. The patients entered with card with a bar code attached. I complied with the instruction as they came in and bar-coded them as they came in, but sometime I wondered whether I had done so satisfactorily and ran the instrument over them a second time immediately afterwards. What I did not realise was that I was supposed to bar code them on the way out as well, for the alleged purpose of the whole exercise, which I had not been vouchsafed, was to record how promptly the patients were seen in relation to their appointments, and for how long they were seen.

My patients, therefore, fell into a neatly bimodal distribution: those whom I saw for at most half a second and those who, according to the recorded information, are to this day still in my consultation room in the out-patient department. I need hardly tell you that no one came to me to ask how this absurd situation had arisen: the real purpose of the exercise, as against its ostensible purpose, was to let doctors know that they were being closely managed.

A corrupt system needs corrupt workers: indeed, cannot tolerate probity. An uncompromised and independent medical profession is a dangerous medical profession, and therefore everything possible must be done to corrupt it. To this end, the distribution of financial awards to doctors for outstanding work must be taken away from the doctors themselves, who would decide principally by medical criteria, and given to managers, who will decide largely (if not yet entirely, as they would prefer) by organisational ones. Doctors - and here I speak sotto voce - are only human; they will not rock the boat if by doing so they stand to lose a great deal of money.

One way to corrupt doctors (or anyone else for that matter) is to involve them inextricably in processes in which the worth in which they do not believe. It is curious how, at a time when we are enjoined to do nothing medically for which there is not sufficient evidence of benefit, we are involved in such processes as annual appraisals, whose worth has never been demonstrated and which is unlikely to exist. (Evidence-based management would decimate the bureaucracy.)

The annual appraisal form has a question about probity. When my appraiser, a fellow-consultant of course, asked me about my probity, I told him that I would reply, but only after he had answered two questions. The first was what kind of person would ask such a question. The second was what kind of person would answer it. In fact, it is a question brilliantly designed to destroy everyone's probity. To be forced to do what he does not believe in is to humiliate a man, and the higher his calibre, the greater the humiliation. I am reminded of Communist propaganda in communist states, whose purpose was not to inform, and much less to persuade, but to humiliate, by asserting patent untruths against which the population could not protest. It is no accident (as Marxists used to say) that many trusts now produce glossy news sheets telling its workforce how wonderfully splendid everything is going - at the same time, of course, as they destroy real esprit de corps and institutional pride by treating all institutions, no matter how old or well-loved, as expendable, and as having no worth beyond their contribution to statistics, which everyone knows to be bogus anyway.

In these circumstances, the medical profession must be cut down to size, and if possible proletarised, by making medicine no different in the way it is practised from the way a factory is run, with shifts and strict timetables. Nurses and others are to be allowed to prescribe after a course lasting 38 days - an implicit recognition that there is nothing really very special about prescribing, and therefore in the medical profession. Post-graduate training is to be shortened, and a special class of doctor - with a shortened training, and with reduced areas of competence, a little like fieldshers in Russia - to be
created. In my opinion, the new consultants are already less thoroughly trained and experienced than the old. General practice is to be systematically depersonalised, all for the good of patients, of course, even if the patients themselves don’t really want it.

One could go on and on - perhaps some of you think that I already have. Medicine has for two centuries been a broad church, with room for men of a wide variety of talents, from which, I think, enormous services to mankind have emerged. The masters of the new dispensation do not agree: before them, they believe, there was nothing, or nothing worthwhile. The managerial revolution that has engulfed us is the revenge of the mediocre, the careerist and the stupid upon the intelligent and the committed.

In the memoirs of the Hungarian writer, Sandor Marai, there is a very telling scene. There is Marai’s last dinner party before the arrival of the Red Army in Budapest. There is nothing much to eat, and it is cold, but there is a little wine left. One of the guests, a pro-Nazi, says that we (the Hungarians) have to support our allies, the Germans, to the bitter end.

“Why?” asks Marai.

The guest turns on him and says it is all right for him, he has talent, but men without talent need the Nazis.

Later, as he is leaving, the pro-Nazi guest turns to Marai.

“Remember,” he says, “the future belongs to the untalented.”

How right he was.

HOW TO BE A RETIRED CONSULTANT

We are pleased to announce that, following the success of the How to be a Retired Surgeon, outlined above, the first annual joint meeting with the Royal Society of Medicine - HOW TO BE A RETIRED CONSULTANT – will be held as a one-day meeting, in partnership with the Royal Society of Medicine, on Monday 27th November 2006.

The venue will be the recently refurbished main lecture theatre at the RSM, and the Registration Fee for the meeting will be £150. In addition to some excellent conference facilities and catering, the RSM will provide on-line registration and will assist in selecting some top-class speakers representing a spread of medical specialties. They will also promote the meeting to their membership.

Delegates attending the meeting will also be able to benefit from the Society’s discounted ‘weekend rate’ for accommodation so that those wishing to do so can stay at the RSM over the weekend prior to the event.

Further information on this meeting will be distributed to Fellows in the near future, and will also be available on the Association’s website at www.asgbi.org.uk

The recently refurbished lecture theatre at the Royal Society of Medicine
A lady presented to my clinic with a large recto-sigmoid carcinoma which CT showed to be involving the right ureter and causing a right hydronephrosis. A stent was inserted into the right ureter and “down staging” radiotherapy given.

Two months later, a further CT showed two small metastases in the liver, but the recto-sigmoid primary had greatly reduced in size. After MDT discussion, it was agreed that an attempt should be made to remove it prior to appropriate management of the liver metastases.

At laparotomy, the tumour was mobilised quite easily from the right ureter which was still stented. The left ureter was identified at the pelvic brim and traced proximally and distally a short distance. The inferior mesenteric artery was then separated with some difficulty from the presacral fascia and aortic bifurcation due to radiation fibrosis. The artery was divided and ligated and, at this point, I realized that the left ureter had been divided with the artery. It was apparent that the left ureter had become adherent to the artery as a result of the radiation fibrosis. The two ends of the ureter were rejoined by an urologist who happened to be in the hospital at the time.

Subsequently the patient made an uneventful recovery and went home.

**Reporter’s Comments:**

Many years ago, I assisted a registrar who divided a left ureter adherent to the inferior mesenteric artery, in similar circumstances, without either of us being aware of this until the damage had been done. I regret having made the same mistake twice but am reminded that the ureters may be very difficult to find when displaced from their normal position by fibrosis or inflammation and are then at particular risk of injury.
A large and very vascular tumour was identified pre-operatively lying between the aorta and left kidney with multiple arterial branches from the aorta and large veins draining into the left common iliac vein and the IVC. The left ureter was not within the tumour but, retrospectively, was clearly within this very vascular bundle.

At operation, the tumour was mobilised from the left kidney and arterial supply ligated. Aware of the risk to the ureter, the very large venous pedicles were ligated carefully but, on dividing a pedicle thought to be venous, the left ureter was partly transected. The injury was immediately recognised and, as no urologist was available, the ureter repaired by the operating surgeon.

The tumour was successfully resected and the patient suffered no ill-effects from the ureteric injury.

**Reporter’s Comments:**

Pre-operative ureteric stent placement would have avoided this complication. I routinely employ this technique when operating on inflammatory abdominal aortic aneurisms but did not consider it in this case. My practice has changed as a result of this experience and I now stent the ureter whenever it is at risk in abnormal tissues.

**CORESS Expert’s Comments:**

Both these cases illustrate the need for constant vigilance, particularly in difficult circumstances, when any retroperitoneal dissection is performed. The ureter is commonly tethered to the large bowel in inflammatory or neoplastic disease. It may also be displaced medially and become adherent to midline structures in the presence of retroperitoneal fibrosis, however caused. How far should the ureter be exposed to identify and safeguard it? The current view is to avoid extensive dissection, especially after radiotherapy, as the blood supply is tenuous and strictures are not uncommon in these circumstances. Many surgeons would agree that preoperative stenting is a sensible precaution when predictably difficult surgery puts the ureter at high risk of damage. Although this practice may aid identification it cannot be relied upon to prevent injury if the ureter is not recognised, for instance when buried in dense scar tissue.

Sadly, ureteric damage can occur even in the most experienced hands. The outcome then depends on proper management. These cases could be regarded as success stories!! Above all, the damage was recognised at the time. Clearly, if ureteric injury does occur, the ideal is to immediately enlist the help of an experienced urologist who can perform the necessary repair. If, of course, an urologist is not available the operating surgeon will have to resolve the situation. Every General Surgeon should be able to repair a cleanly transected ureter. Can you repair a ureter? Is direct repair always possible or appropriate? Might it be a good idea to have a cup of tea with your friendly urological colleague and agree a strategy before this happens to you!

“There but for the grace of God go I” is a powerful educational tool which, in the last few years and for understandable reasons, has not been widely used. CORESS gives us a new opportunity to share our experience of safety-related incidents from which lessons can be learned. I hope that an increasing number of reports from surgeons and trainees, irrespective of specialty, will enable CORESS to provide valuable feedback both to the individual reporter and to the surgical community in general.

*Mr Adam Lewis, CORESS Programme Director*
**APHORISMS**

- **Gardening Rule:**
  When weeding, the best way to make sure that you are removing a weed, and not a valuable plant, is to pull on it. If it comes out of the ground easily, it’s a valuable plant.

- The easiest way to find something lost around the house is to buy a replacement.

- Health is merely the slowest possible rate at which one can die.

- Be careful of your thoughts; they may break into words at any time.

- If you must pick between two evils, pick the one you’ve never tried.

**ETERNAL TRUTHS**

- Whatever hits the fan will not be evenly distributed.

- Age is a high price to pay for maturity.

- Once over the hill, you pick up speed.

- There are seventy million books in UK libraries, but the one you want is always out.

**FAVOURITE SLIDES**

- **I’m not sure that this off-site TSSU is working**

  In the last edition of the Newsletter, we invited you to submit a caption to this photo of Sir John Temple, past President of the Royal College of Surgeons of Edinburgh. The winning entry, given above, is from William Brough. Book tokens are on their way.