Association of Surgeons of Great Britain and Ireland
EXECUTIVE NEWSLETTER
Number 2, Easter 2002

IN THIS ISSUE...

HONORARY SECRETARY'S REPORT

Mr Graham Layer

Further to the ***Executive Newsletter*** and information pack which you received last Autumn, I am writing, on behalf of the Executive of the Association, to update you on various initiatives and news prior to the Annual Scientific Meeting to be held in Dublin in May. At that meeting you will be receiving a copy of this year's ***ASGBI Yearbook***, an expanded production containing a digest of recent events and work of the Association and articles of importance and interest to Fellows.

Meetings

You will have noted that we are trying to increase the number of open meetings organised by the Association, reflecting our improved and greater infrastructure within the Office, which allows more flexibility. The 2001 Autumn Meeting *"How to make a Surgeon"* organised by the late Professor John Farndon, our Vice President-Elect, was well attended and the excellent presentations were well debated and received. We have had a presence at the various specialty association meetings and many Link-Surgeons' gatherings have been held. We look forward to the regional meeting in Scotland to be hosted by our Honorary Treasurer-Elect and doubtless this will, in due course, spawn other such conferences around the nations.

ASGBI Scottish Meeting- Stirling Royal Infirmary, 19th April 2002

Last year Scottish Surgeons were asked about their concerns regarding the provision of service for their patients. Many suggested that they needed to have some form of regional meeting to air their concerns. To this end, John Ferguson and John Duncan have arranged a meeting to allow various issues to be discussed. A range of speakers will tackle training, cancer services, service provision and the tension between specialisation and general surgical provision. The Scottish Executive are sending representatives, and the speakers come from every region of the country. We hope that it will be an interesting and lively meeting.

It is vital that the ASGBI spreads its wings around the nations to represent our Fellowship. Although our offices are in London, our Association is truly one to speak for general surgery throughout our countries and you will have seen our efforts to ensure that no corner of the land is ignored!

Dublin is, for many, the highlight of the year. It is now ten years since the ASGBI meeting in Trinity College, Dublin and the programme for this year's meeting is superb, reflecting all the facets of our organisation. This has been co-ordinated by the local organising committee and Professor Paul Redmond has been in charge of the scientific programme and the electronic submission and marking of abstracts and videos. The Dublin meeting will be followed, on Midsummer's Day, by a smaller, invitational, retreat-type meeting in St George's House, Windsor Castle to celebrate the Queen's Jubilee. Our Patron, HRH The Duke of Edinburgh, was invited to attend this meeting but, due to other commitments connected with the Jubilee, has unfortunately declined.

Windsor Castle showing, bottom left, St. George's House and Chapel.

We had planned a meeting for November 8th 2002 in Bristol entitled *"How to be a Consultant Surgeon"* to have been co-ordinated by John Farndon, to bring together advice for senior specialist registrars and newly appointed consultants on contractual issues, private practice, management and the like. Our Affiliates have shown a lot of interest in this as has ASiT and I hope we may still be able to go forward with this despite the recent tragic loss of our friend and Vice-President-Elect.

This year's Autumn Meeting is in Hungary from 19th to 22nd September 2002. Bob Johnson, our incoming President, is planning a splendid concoction of academic and scientific presentations with a social programme to match. Extensions of the visit will occur before and after the core meeting in Budapest, and members of the West Midlands Surgical Society and Surgical Sixty Club will be holding synchronous gatherings so we expect around one hundred surgeons to be attending.

Consultant expansion and the SHO bulge

Grave concerns have been expressed at the Department of Health's plans to expand the number of consultants by recruiting from abroad - globally. We have been disappointed about the SHO bulge

and the increasing number of NCCG doctors. We feel that there should be more training numbers for our own trainees to proceed to higher surgical training and then consultant status. We have performed a further Link-Surgeon's survey and determined that we could double the number of SpRs in general surgical training without deficit to those already in post- whose hours of work are being statutorily cut anyway. This work has been presented to the colleges and will appear on the ASGBI website and our "e-Politix" micro-website for parliamentarians and the public. We have appended the letter, which went out to Link-Surgeons, for your information.

By early March we had received input from around 60% of our Link-Surgeons and Council members, giving us much ammunition in discussions with the Department of Health, although replies from the more dormant links and regional representatives would have given us a stronger voice! Nonetheless, we can identify at least 275 slots in the country where NTNs could be introduced for general surgery! This takes into account working time changes, enforced rotas, promotion of senior SHOs and conversion of our skilled NCCG colleagues - this would translate into many new consultants to fulfil the government's pledge of massive consultant expansion without recourse to advertising overseas and would offer bright career prospects to our able BSTs with MRCS who otherwise have only a small chance to progress.

At present there are only Department plans to increase NTNs in the whole of surgery by 38 this year and 39 next - our survey will be taken to Ministers so consideration can be given for novel new ways of introducing further training posts without producing an overshoot in terms of numbers of consultant candidates by the end of the decade. We are very grateful to all those who took part and have responded electronically to those who contacted me by e-mail – also, thanks to all of you who wrote letters or sent faxes.

The Medical Education Standards Board

The Medical Education Standards Board was described in a consultation document from the Department of Health which was issued on December 5th last year and has taxed us with its sinister undertones of destruction of postgraduate medical education, as we now know it, devolved to the Royal Colleges. For three months we were taking soundings, consulting our Fellows and Link-Surgeons and taking part in debate within the Colleges, Senate and the FSSA, amongst others, before this was taken to ASGBI Council where we were given a strong mandate to oppose the general principles outlined in the DoH consultation document. Our formal response was submitted to the Department along with those of the FSSA and Colleges, demonstrating the unity of the surgical voice throughout the land; a copy of the ASGBI response, together with copies of the responses from the FSSA and the Royal Colleges of Surgeons of England and Edinburgh, are included in the mail-out accompanying this ***Newsletter***.

Surveys and the Link-Surgeons

The Link-Surgeon cascade is a vital mechanism in this restructuring which allows the Council and Executive of the Association to make informed decisions about events. With reconfiguration of Hospitals and Trusts, it is sometimes difficult for us to ensure we have appropriate representation and our regional council members are encouraged to update the names of Link-Surgeons when necessary. A list of current Link-Surgeons will be posted in the ***ASGBI Yearbook***. We have approximately 260 Link-Surgeons throughout the UK and Ireland.

We have highlighted above the contribution of surveys to the NTN and MESB problems. However, some surveys that are proposed have been turned down - for instance, a repeat of the Private Practice Survey of ten years ago to all Fellows - this was sent out to all the members at that time and was influential in the debate over private practice with the monopolies and mergers commission. Ten years on this will be important information, but it may well be performed by another body, and be much more widespread, so this in abeyance. A further Link-Surgeons survey on cancelled elective operations was planned and may still go ahead in a simpler questionnaire form, our last survey has stimulated the Modernisation Agency to look at this problem quite carefully, although many would be concerned about the stress that has been placed on the consultant being the cause of cancelled elective surgery. There will be a fascinating session on this topic in Dublin.

Contributions from the Executive

My other colleagues on the Executive have contributed significantly to this ***Newsletter***, for example, an article by the President on the Care Standards Act - which will affect your private practice from April 1st. Our Treasurer has updated us on a successful financial story and our Director of Education has illustrated how CME points are awarded to your various meetings. Our Chief Executive, who now has his feet well and truly under the desk following an incredibly busy time in the office, has penned his remarks and our outgoing President, Chris Russell, has summarised his considerable achievements for the ASGBI for the last year.

Our future vision

We are doing our best to involve ASGBI in every strand of surgical practice and in particular you will have noticed that we have been "getting more political" - this was the one major message that we have been receiving over the last couple of years and this is being actioned. ASGBI Council in Birmingham gave a mandate for change. We believe that ASGBI should not just be the voice for general surgery, but it should also be heard and that is why we are spending our efforts on better communication transforming your organisation into one that will represent your views. We have a number of representatives on various committees and organisations, for instance Bob Johnson sits on Senate and the FSSA, I have been privileged to be an invited member on English College Council, and we have representatives on Committees of the Edinburgh College and various Department of Health working groups. I can assure you that we are working in your interests, and those of our patients, and partake fully in the meetings we attend on behalf of ASGBI. Our President is incredibly busy, networking in all areas of surgical importance and all our representatives report back to Council, keeping us fully informed. The use of the internet has been mentioned elsewhere and this will enable us to keep on top of the changing medical and political climate.

What is around the corner? Doubtless the new consultant contract proposals will appear shortly and I am sure this should be a topic for ASGBI although previously surgeons have always left contractual matters to the BMA. Private Practice is about to undergo enforced change and this must be monitored. In terms of education and training, we must continue with our own professional development and be a major influence in the development of the current and future generations of young surgeons. All this, and more, is being taken on board as ASGBI expands and flourishes as a contemporary organisation representing your views. I hope you will enjoy the package enclosed with this ***Executive Newsletter*** and we look forward to seeing as many of you as possible at the various meetings in the months ahead.

All best wishes

Graham Layer, Honorary Secretary

PRESIDENT'S REPORT

Mr Chris Russell

By now I am sure that you have all heard of the sad demise of Professor John Farndon on 6th February 2002. This was a shock and an unexpected event. Despite having no known history of heart disease, he died of a massive myocardial infarct. His death not only leaves a gap in Bristol, but also a huge gap in the Association of Surgeons and the ***British Journal of Surgery***. John was due to take over from me as Chairman of the British Journal of Surgery Society at the Annual General Meeting in Dublin. Currently there is no obvious successor to this position, for few have the knowledge and depth of understanding of the publishing process, the art of editing, and the requirements of the Journal. He will also be sorely missed by the Association which he served well as Council member for the South West, as Honorary Editorial Secretary, as President of the British Endocrine Association, and most recently as Vice President-Elect. He was due to become Vice President in May at the Annual General Meeting in Dublin and President in January 2004, if current plans go ahead. John's loss is great for surgery and, for his family so much greater. We have all sent our condolences to Christine, his wife.

Such an event casts a shadow on a Society or group, but as Professor Derek Alderson, who has taken over John's responsibilities in Bristol told me, it would be John's wish that we moved forward, and indeed this is what your Association plans to do.

One of the satisfying features of the Association in the last three months has been to see how the office has responded to the new staffing structure. Our Chief Executive, Nick Gair, has fitted in superbly, and Nechama, with characteristic charm and hard work, has supplemented him such that we have an ideal team leading forward the Association's business. To the President it seems that all works well and indeed the pleasantness, the work being put through, and the responsiveness to all demands from many Associations using the office appears to be managed efficiently. The opportunities for sharing common problems within the Associations and so reducing cost must be to the advantage of all who use the office. More and more I view the role of the Association as an umbrella organisation in which we provide certain facilities which are used by all the Associations. In the same way in our Annual Scientific Meeting we provide for all the Associations, in particular dealing with those matters which are common to all surgeons. For instance, we all run conferences and we all do it slightly differently. There must be some advantage in amalgamating our ideas and our practices and utilising modern technology to save time and money. These are areas that we hope to explore with the Specialty Societies and Associations for the benefit of all our Fellows. Cost is important to us all and we agree that we will have to reduce costs so that we can, if possible, reduce the subscriptions but this is for the new Treasurer to consider.

Stiling Old Bridge
Photo courtesy of Argyll, the Isles, Loch Lomond, Stirling & Trossachs Tourist Board.

Our Treasurer-Elect, John Duncan, has shown his worth and we have confidence that he will succeed in the difficult task of taking over, after the Dublin meeting, from Tom Bates. An innovation, along the lines I was mentioning above, that John has introduced, is to hold a local meeting of the Association at Stirling Royal Infirmary in Scotland on 19th April 2002, when

issues such as training, particularly workforce (as this is now separately considered in Scotland), cancer services (which, again, has its own Scottish nuance), service provision, and the role of sub-specialisation will be discussed. The role of the Association is to provide a forum for discussion, and this pattern of meeting can be taken elsewhere.

The Link Surgeons whom our Honorary Secretary established last year have proven of great value. The fact that Catherine Loveday can sit at her computer and provide an instant address, e-mail and Specialty interest is of great value. Recently an issue was raised at the Council of the English College. Our representative on the Council, Graham Layer, reported that the President, Sir Peter Morris, had been negotiating the number of jobs for training. In Scotland 400 new training numbers were given while for the whole of England it was little more. Apparently the impression in high places was that the SACs did not consider there to be sufficient training facilities for more. By circulating our Link Surgeons we hoped to have an answer within a short space of time to dispel this myth so that, armed with this knowledge, the President of the English College can try to increase the number of trainees within General Surgery urgently. The money is there, the training slots are almost certainly present, but the will lacking. Indeed, many have told me that to increase the numbers would actually increase the quality of training that could be provided. Your Association, through the Link Surgeons, can now provide an accurate and quick response to questions of surgical practice. Even an 80% response is of greater value than hazy thoughts of our Executive. We appreciate the Link Surgeons greatly.

Specific issues that have been uppermost in mind over the last three months have included the Kennedy Report, whose content and response was largely apparent in the NHS Plan and subsequent documents. The only outcome of note that will affect our day to day working is that, within a few years, each surgeon is going to have to know, and be able to provide, his/her mortality and outcome figures for his/her operative workload. I do not think that we can argue too greatly about this, but, of course, risk-adjusted scores must be available in order for like to be compared with like.

Many of you will have missed the Care Standards Act because it has passed silently into action and will be law on 1st April 2002. Essentially this Act enables a commission to review and inspect all places where medical practice is undertaken. The standards on which they will insist are similar to those within the National Health Service but will probably be enacted to a higher specification. There are at least two areas of importance to the practising surgeon. The first is that the place of practice may well be inspected which means that the standard in that place of practice must be similar, or higher, than in National Health Service Outpatients. No doubt the specification will be that of an 'ideal' Outpatients. The second aspect is that much more stringent rules will be required about cover, particularly emergency cover in hospitals, and the inevitable rota will be unavoidable. It is for this reason that some are discussing 'partnerships', 'chambers' or 'working agreements'. There is much sensitivity about these matters at the moment, particularly if price fixing is involved. Many of you will have been aware that PPP took the Oxford Anaesthetic Partnership to the Office of Fair Trading on account of price fixing, yet they ran an excellent service, always providing cover. Of all groups affected by this Care Standards Act, the cosmetic surgeons come off the worst. Initially it was considered that nobody could undertake cosmetic surgery or any other surgery outside the NHS unless they had a CCST; this would immediately have ruled out 80% of those who practice cosmetic surgery. Compromises have been reached but are not yet finalised.

Perhaps the most important document to reach the Association this year has been the Medical Education Standards Board Consultation Paper. This Board was promised in the NHS Plan but no details were available. Essentially, a Board is being set up, of 24 members, which will report directly to the Secretary of State for Health. That Board will consist of 12 medical and 12 lay members plus a chairman who may be either lay or professional. The Board will govern training and certification, and all matters relating to education will be dealt with by that Board. Many of the activities of the College and of the Associations were brushed aside. Education would be provided by the NHS University (yet to be established) and certification by an appropriately governed Board. The Colleges may be drawn in to help in these matters but their role will be limited. Your Council, when it considered this matter at their meeting on 12th February, was incensed at this document and felt it should be rejected outright. This message was taken to the Council of the English College by our representative. There was considerable support for a strong line to be taken, supported interestingly by the Patients' Liaison Group. The response from Sir Peter Morris is a masterly document. I think it is one that all surgeons will be able to support and indeed our own response may be entirely related to support the strong and carefully argued phrases of the English President. We have included the various documents with this ***Newsletter***, and I would well advise you to look at the Medical Education Standard Board. I do not think you will wish to be governed in this way.

There is further legislation at present before Parliament to consider a greater degree of flexibility in training times and the recognition of training elsewhere, particularly from Europe. This is good from the point of view of enabling well qualified people to practise and complete their training in the United Kingdom, but it also opens up the possibility to a further group of Mediated Entry candidates being able to take the Intercollegiate Examination without significantly more training. This will cause difficulty within the Intercollegiate Examination Board and delay the proper standardisation of that examination. Again, we wait to hear the outcome of that initiative by the Secretary of State.

There has been considerable discussion about the membership of the SAC, and the Presidents of the four Royal Surgical Colleges are keen to make this a more transparent and open committee. Many of the SAC Specialties do have elections for that committee. In General Surgery this is difficult as we are anxious that the Specialties have appropriate input into the SAC and, thus, if an election took place there would have to be a detailed person specification to find the appropriate person. The practicalities of this are being investigated and a decision will be made at the next Senate of Surgery in April.

Association Affairs

Your Executive has spent much time considering its structure over the last three years. The Committee changes were introduced at the last Annual General Meeting and we are now faced with determining whether a one-year or two-year term for the Presidency is appropriate. More and more responsibilities are cast upon the President and, in particular, the position of the President of the Association of Surgeons is likely to be a powerful position within the Council of the English College. Sir Peter Morris has done much to listen not only to the President of the Association but also to the Presidents of the Specialty Associations. This means, therefore, that the ASGBI President must be aware of current events and be experienced in representation of the Association in Council and on Council committees. This takes time. Indeed, the current Council of the English College has expressed the wish for Association representatives to be on the Council for two years so that good interchange between Council and the SAC Specialty Associations is achieved. Therefore, at the Annual General Meeting in Dublin, I will be recommending to you on behalf of Council that Bob Johnson is elected to remain in office as President until December 2003 and that the next President starts in January 2004 for a period of two years. The reason for the changeover in December is that this coincides with our subscription year, our financial year and hopefully, the presidential year. We hope you will feel this is appropriate.

Regarding John Farndon's replacement, it is planned to go through the usual election process. Council members have been asked to nominate and seek the views of their colleagues. The names have to be with the Honorary Secretary by April 12th 2002 and Council, at its meeting in Dublin on 21st May, will elect the new Vice President. This will be ratified at the Association's Annual General Meeting on Wednesday 22nd May 2002.

Finally, I am quietly confident that the local organising committee in Dublin and your Executive have provided you with an outstanding scientific meeting in Dublin, three days of varied symposia and Paper presentations, with Irish hospitality. I am looking forward to seeing you all there.

HONORARY TREASURER'S REPORT

Mr Tom Bates

The Association's finances have improved significantly as a result of the highly successful meeting in Birmingham last year and it should now be possible to build up a reserve for the future. However, the income from the Dublin Meeting will be limited due to VAT constraints and the fact that the Registration income will be shared with the Irish College. There are more initiatives to pursue than the Association can afford and it is, therefore, essential to keep a tight rein on expenditure. Nevertheless, the Fellowship continues to expand and prospects for the future are set to improve.

CHIEF EXECUTIVE'S REPORT

Dr Nicholas Gair

The success, or otherwise, or any membership organisation relies, to a large extent, on communication. Communication out to members from elected officers, communication from members at grass roots level to the secretariat, and communication between individual members.

The production of a regular ***Executive Newsletter***, such as this, is one way in which the Honorary Officers and the Association's secretariat can communicate with Fellows to keep them informed of current activities. A unique strength of ASGBI is that, through our Link-Surgeons, we have in place a valuable two-way method of communicating quickly and efficiently with our members so that, as we can see from Graham Layer's recent survey of Link-Surgeons into National Training Numbers, valuable and powerful information - reflecting the views of general surgeons throughout Great Britain and Ireland - can be readily obtained.

Together with the Executive Committee, we have, over the past few months, been looking carefully at the Association's information strategy to ensure that we can utilise modern technology to provide an efficient and professional communication service to all our members. The success of the electronic submission of abstracts for the Dublin meeting, through the tremendous efforts of Paul Redmond and Conor Shields, has shown how we can streamline processes without compromising on quality, and we aim to develop this further over the coming months.

We have, therefore, put in place exciting plans for the future including the development of a fully interactive website which will, in time, allow immediate communication with all Fellows and offer facilities such as dedicated micro-sites for individual meetings, surveys and events as well as the electronic publication of newsletters and reports, and on-line membership subscriptions and registration for conferences. This strategy, together with improving the quality of printed hard copy publications, will

play an important part in allowing us to achieve our aim of facilitating efficient communication out to members from the Honorary Officers, communication from members to the Association's secretariat, and communication between individual Fellows.

We aim to launch our re-vitalised website at the Dublin meeting and I look forward to hearing your comments and suggestions as to how we can improve the services which we provide to you, our members.

PRIVATE PRACTICE AND THE CARE STANDARDS ACT

There is a "buzz" in Harley Street that time honoured traditions are about to be changed. Consultants are crossing the street to speak to each other...

The last decade

Despite many false alarms, the last decade has been through a period of stability. There has been a slight decline in the number of patients insured, but this has been offset by the increase in self-pay patients. Stable fees, despite considerable inflationary pressures, have been offset by the promise of change subsequent upon the Newchurch Relative Values Review. A stable hospital environment with rationalisation by the bigger companies has been offset by decreased length of stay and increased day case procedures. A stable insurance market has been offset by more aggressive performance efficiency of the companies.

What then are the clouds that cause the stir? These must include:

i. the disappearance of the foreign market, such that there are no inflated fees to offset the increased cost of practising in London, where 25% of the market is undertaken;

ii. the Relative Values Review has been ignored and the insurance companies are policing the present stable fee structure with rigor;

iii. the fewer, but more powerful, hospital groups are having to police the private sector with greater vigour to deal with the issues of clinical governance - a much more powerful tool than in the NHS, consequent upon the huge difference in data quality between the sectors;

iv. the insurance companies are showing their strength by reporting miscreant doctors with fee partnership concurrence to the Office of Fair Trading. Is this the first shot in a new conflict?

Almost certainly not, as it palls into insignificance against the enforcement of the Care Standards Act, whose enactment becomes Law on April 1st 2002.

Oh, independent practitioner have you registered? If not, why not, or are you relinquishing the unequal struggle to treat patients on April 1st?

The Care Standards Act

You need to know a little background to the Care Standards Act. In June 1999, the Health Select Committee issued its fifth report, which was the culmination of a detailed review of the private health sector. The report highlighted that, in view of the range of services on offer and the increasingly complex nature of healthcare, the Government has a duty to ensure that private and voluntary healthcare is properly regulated. In particular, additional regulation was deemed necessary to reassure patients using private and voluntary healthcare that they would receive safe services. The Committee expressed the opinion that healthcare is not a service that should be bought or sold in an unregulated market.

The Government concluded that private and voluntary healthcare should be regulated by a newly formed National Care Standards Commission (NCSC). The Commission will ensure adequate facilities by a process of registration and inspection with collection of detailed information about their activities. Inspection will occur annually. In addition the Commission will regulate private doctors.

The details of this regulation can be found on the Department of Health website at:

www.doh.gov.uk/ncsc or
www.doh.gov.uk/regulate1.htm

April 1st 2002

The reason for the "buzz" is that private doctors have to be registered by April 1st 2002. A large and rather incomprehensible document landed through the post-box of many practitioners during the last week of February. To complete the document the practitioner has to provide a certificate that he has no criminal record (unavailable until June from the Criminal Records Office), tax returns for the last two years, a business case for the next five years and details about the practice and its employees. Of course there is the usual fee which makes exam fees look cheap (£1,100 plus £300 for your personal assistant).

Of even more significance is the regulation of practice and evidence of your competencies, in other words, more stringent than your NHS activities. Now the good news is that if you work within the NHS, all this does not apply - YET.

How can you justify an Honorary Senior Lecturer being free of regulation when his colleague who has no such honorary appointment, is being regulated - unless NHS appraisal subjects that person to the same detailed regulation?

There are so many problems with the enactment of this Commission that a delay is essential and, if such a delay is not granted, there are bodies willing to take the matter to court on account of the inconsistencies between individuals. Nevertheless, if you have received such a form you are strongly advised to fill in the form and state that you are, at present, excluded on account of your NHS obligations, or if you have no NHS sessions to register and add that you will provide the information when suitably advised. Like all exam fees, it is better to show your good intentions by submitting the fee.

The implications of the clinical governance issues related to this Act are enormous, and may well change practice. Can you really provide continuous cover for your patients while in hospital or can the Hospital, in turn, provide adequate specialist cover all the time? This is where the issue of chambers, partnerships and collaborations arise and are real issues which will have to be resolved in the foreseeable future in order to meet the required standards with which no one can reasonably argue.

Dublin Meeting Private Practice Forum

These matters are being discussed in Dublin at the Association's Annual Scientific Meeting, during the Private Practice Symposium, by Mr Clive Bath, Deputy Chief Executive of Nuffield Hospitals, by Mr John Fieldhouse, who is a maxillo-facial surgeon from Swindon and has developed great expertise in this area, and finally by Mr Derek Fawcett who is a urologist in Reading where he has developed a collaborative arrangement.

There is much to think about. I hope three days in Dublin will clarify these issues along with many others.

Mr Chris Russell, President

CME POINTS

This year has seen the introduction, with immediate effect, of mandatory annual appraisal for all NHS consultants. The imminent introduction of compulsory revalidation for all UK trained and overseas non-European Community trained doctors is anticipated. Our European colleagues working in the UK will, alone, be in the enviable position of being exempt under European law from UK revalidation but if they hold an NHS consultant post will be exposed to annual appraisal.

In this new environment of close scrutiny, it is essential that all consultants create documentary evidence testifying to their worthiness. The Senate of Surgery collects and certificates the CME/CPD points on behalf of all those registered with their office within the English College.

As you would expect, the Association has taken on the task of assessing the merit of the many continuing educational opportunities available to keep us all up-to-date. Suitable courses and meetings are, after careful investigation, credited with CME points to be awarded to those who attend. The organisers, having gained approval from the Association's Director of Education, will be authorised to issue certificates of attendance and CME credits. There are dozens of approved meetings each year which pass through the ASGBI Director of Education's Office in all aspects of surgery and ASGBI is happy to consider appropriate functions for points.

Essentially one CME point is awarded per hour of educational activity. Feedback is important, and it is possible that the Senate of Surgery will shortly be validating the arrangements for the collection of CME points by a sample and audit process. Naturally, professional trust is at the centre of our continued learning programme and, whatever the final arrangements for revalidation become under the new GMC Presidency, it is unlikely that a more robust system of credits for CME/CPD can be successfully instigated.

The Association is keen to continue to help in assessing and awarding credit for these activities and the Director of Education is always pleased to offer advice to meetings and conference organisers.

Mr Jack Collin, Director of Education

NEWSFLASH

Annual Scientific Meeting, Dublin 2002

The Provisional Programme and Registration Form for the Association's 2002 Annual Scientific Meeting, to be held at University College Dublin from 22nd to 24th May 2002, was distributed at the end of March. Full details are also available on the Association's website at www.asgbi.org.uk

BOOK NOW to qualify for the early booking discount, as Registration Fees will increase after 12th April 2002.

EARLY BOOKING OF FLIGHTS MAY ALSO ENSURE LOWER COST AIR FARES

CONTACTING ASGBI

Please contact us, using any of the methods below, and let us have your views:

Telephone: 020 7973 0300
Fax: 020 7430 9235

e-mail: admin@asgbi.org.uk
website: www.asgbi.org.uk

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
www.asgbi.org.uk

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