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A MEMORIAL SYMPOSIUM

FOR

PROFESSOR Dr. Med. JOHANNES-FRIEDRICH OSBORN

1946 - 1990

AT

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND
THURSDAY 31st OCTOBER 1991

PRESENTED BY

RONALD FURLONG – HON. CONSULTING ORTHOPAEDIC SURGEON TO ST. THOMAS'S HOSPITAL, LONDON

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Authors submitting original scientific papers for publication in the *Annals* should consult 'Uniform requirements for manuscripts submitted to biomedical journals' produced by the International Committee of Medical Journal Editors and published in the British Medical Journal, 6th February 1988, 401–56. These are designed to save time and expense and to enable authors to resubmit papers to other journals without extensive alterations. Only manuscripts which conform to this, the Vancouver style, will be considered.

The text of observational and experimental articles is usually—**but not necessarily**—divided into sections with the headings Introduction, Methods, Results and Discussion. Long articles may need sub-headings within some sections to clarify their content. We intend to publish articles that are short, vigorous, logically sound and contain a clear message; but case reports are not acceptable. **Three** good quality plain paper photocopies of all written and tabular material must be submitted. A covering letter must be signed by all authors. The author should retain the original for comparison with the proof. The manuscript must be typed double spaced with 3 cm margins on ISO A4 (212×297 mm) paper in the following order:

1 **Title page** with name of author(s). The International Committee recommends that the title page should contain 'the first name, middle initial and last name of each author'. We recognise, however, that this may not be the form in which the author wishes his name to appear in print. We suggest, therefore, that authors should give their names first in the required form followed in parentheses by the form in which they wish it to be published, if this is different (e.g. Augustus B Jones (A Burton Jones)). Please add 2 highest qualifications and the appointment of each author **at the time of the performance of the work reported.** If he has since moved on, his new appointment should be given as a footnote. If not self-evident, the name and address of the author to whom proofs and correspondence are to be sent, should also be given as a footnote.

2 **Key words** Three to 10 words or phrases using terms from *Index Medicus* wherever possible should be chosen by the author.

3 **Summary** This should be concise, complete in itself, outlining the aim, results and conclusions of the paper.

4 **The text** All articles should be short and to the point.

5 **References** In the text, references should be numbered consecutively in parentheses. The list of references at the end of the Article **must** conform to the Vancouver Style. Consult the January issue of *Index Medicus* for the form of title. If not listed give the full title. Note especially that 'unpublished observations' and 'personal communications' may not be used as references. 'In press' may only be used when the article has been accepted and the journal specified.

6 **Tables** Each table should be typed on a separate sheet and must have a Roman identifying number and a short descriptive title. Prefer to present as much as possible in the text and use a **simple** table to highlight the main points. A table should not duplicate the text. The number of tables **and** illustrations should not be more than ten for Hunterian lectures etc and not more than six for other scientific articles.

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8 **Pagination** All pages should be numbered in the sequence, title page, key words, summary, text, acknowledgements, references, tables and legends for illustrations.

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COLLEGE AND FACULTY BULLETIN

MARCH 1991

Reports and Comments

REPORT ON DAY COURSE IN BASIC SURGICAL TECHNIQUES

R M Kirk

Course Organiser

On November 27 1990 a one-day course was held at the College to teach basic surgical techniques to 20 surgical Senior House Officers. The techniques were demonstrated while a video-camera was used to display them on monitors. The participants carried out the manoeuvres as they watched and listened to the commentary. They then practised the techniques while the demonstrators passed around to guide and correct them.

In the morning session they were taught to handle threads, tie knots on the surface and in the depths, using hands and instruments. They were shown how to handle scissors, needle holders, haemostats, and dissecting forceps.

The afternoon session started with a demonstration of skin cutting with a scalpel, skin suturing and the removal of sebaceous cysts using freeze-dried skin mounted on plastic sponge provided by Ethicon. Fresh animal small bowel was then used to demonstrate opening the lumen and repairing it with sutures. Finally, the mesentery of the small bowel was dissected to demonstrate the methods of securing and ligating blood vessels and removing lymph nodes. The trainees were shown the value of infiltrating the tissues with saline as an aid to careful dissection.

Throughout, great emphasis was placed upon the need to avoid damage from sharp instruments and needles in order to protect patients and the operator from hepatitis and HIV infection. The need for absolute perfection in carrying out each manoeuvre, as opposed to speedy performance, was stressed.

I should like to thank Mr Michael Pietroni and Mr Chummy Sinnatamby who voluntarily gave up a day to teaching young surgeons, with great enthusiasm. As usual, we received great help from the staff of the Hunterian Institute, from Mr Jai Ramcharan, Mr Brian Eaton, Mrs Margaret Jacques, Miss Susan Spencer, Mr Ron Judd, Mr Tom Keller and Mr Sambrook. As always the support of Ethicon was essential and given generously; apart from the freeze-dried skin, they gave us disposables, ligatures and suture materials.

The course served a useful purpose and I hope that we can repeat it.

THE FRCS EXAMINATION

APPLIED BASIC SCIENCES

Philip F. Schofield
Chairman of Examiners in Applied Basic Sciences

Written examination

The written part is a multiple choice question (MCQ) test lasting three hours. There are 90 questions covering the three subjects of Anatomy, Physiology including biochemistry and pharmacology, and Pathology. Full details are sent to you when you apply to take the examination. The MCQ test is an eliminating part of the examination—if you fail it you are not called for the oral examinations.

Oral examinations

You are given instructions about attending for these and you should be present at least 30 minutes before the time of each viva voce. There are again three subjects of Anatomy, Physiology including biochemistry and pharmacology, and Pathology. The examiners are paired, one being a basic scientist, the other a clinician. You are questioned by two pairs in each of the three subjects so that 12 examiners have the opportunity to assess you.

Anatomy. You will be given three histology slides of normal structures to examine under the microscope for 10 minutes and will then be questioned on them. After this the examiners may show you bone specimens and assess your knowledge of them. You pass to a second pair of examiners who question you on structural and surface anatomy using cadaver dissections or live models. You may be shown radiographs during these vivas.

Physiology, biochemistry and pharmacology. You are examined by one pair of examiners and then pass to a second pair for further assessment on different topics.

Pathology. You are again examined by two pairs of examiners. You will not be shown any pathology specimens.

CLINICAL SURGERY-IN-GENERAL EXAMINATION FOR THE FRCS

Averil O Mansfield

Chairman of the Court of Examiners

R M Kirk

The purpose of the FRCS examination is to determine whether candidates have the basic knowledge required for further training in surgery and are able to use this knowledge competently. All examinations are a compromise since the whole curriculum cannot be tested. We have concentrated on making the examination as comprehensive, as fair and as objective as possible. We recognise that objectivity is difficult—perhaps impossible to achieve in a clinical examination.

In order to cover the field as widely as possible the clinical part of the FRCS examination is split into sections, each intended to test different aspects and allow as many examiners as possible to assess each candidate to minimise bias. The examiner's responsibility is to cover as wide a range as possible, favouring essential topics. Different examiners emphasise different aspects. Similarly, two candidates may produce the same answer to a question but one imparts the answer clearly, confidently, with well ordered priorities, and is awarded a higher mark. This is inevitable in a profession in which communication skills are so important.

In order to maintain standards as level as possible, new examiners are always partnered by a senior, experienced examiner. Many candidates believe that the Court has a 'rationing' system, allowing through a limited number on each day or during the whole examination. This is not true. The numbers passing on different days and throughout different examinations, vary widely. The standard does not.

If you accept that the ability to utilise knowledge is at least as important as possessing it, you will realise that it is not enough to merely imbibe facts. You must arrange them so that they are immediately accessible and practise using them. One of the overlooked benefits of the 'big bang' examinations over continuous assessment is that they give a stimulus to survey the whole field, identify deficiencies and correct them.

The clinical surgery-in-general section assesses competence in the basics of surgery. You are expected to possess, and be able to use, the basic knowledge that will be required in any branch of surgery that you enter. Since all candidates do not have equal experience, you will be questioned within what is accepted as of general relevance, or in areas that you have experienced by reference to the surgical procedures which you have recorded in your log book.

Written examination

Essay questions are devoted to topics of major importance, those that have undergone advances or are changing, and those in which recently instituted or newly evaluated management has been reported. The questions are selected so that reasonably knowledgeable candidates could write for three or four times the allotted period. Good answers display the ability to comprehend the question and the reason it was included, select essentials, arrange facts, discuss complex issues and communicate lucidly in writing.

Read every word of the question carefully, asking yourself, 'Why was this question asked?' Make notes but do not start writing the answer until you are sure how you will arrange it. As you start to write, remember that examiners can only mark what they can read.

You cannot write all you know so do not waste time with irrelevant or unimportant facts at the risk of omitting major points. Remember it is possible to fail even though everything you have written is correct. The reason you will have failed is because you have not answered the question that was asked or because you have failed to communicate priorities in management. Do not omit important points because you think they are obvious. It is safer to mention them.

Questions often start with the word 'discuss'. Identify all the aspects, including the contentious ones, that demand explanation or justification. You will not be expected to have great personal experience but you should be able to display the relevant arguments. You will be expected to have gained a greater depth of understanding since the MB or equivalent examination.

Short notes questions

Here your knowledge in a wide range of subjects will be examined. The essentials can be set out briefly but careful planning will be required; merely writing correct but irrelevant information will not earn marks. Your ability to organise your knowledge is also being tested.

In the first examination the short notes questions were answered badly. It was apparent that candidates were not considering the questions fully and frequently omitted important aspects of the question while including facts that had not been asked for. Each question paper—essay and short answers—is marked independently by two examiners. This was introduced because the written paper now eliminates candidates who fail badly. In order to facilitate the photocopying you are asked to write with a black ball-point pen which will be provided.

Clinical examination

It is often difficult not to view examiners as adversaries, especially in face-to-face encounters. Remember they have a duty to the public and to the profession to maintain the standard of surgeons. They are not just influenced by your theoretical knowledge but they also take account of your communication skills with the patients and with themselves, your common-sense and ability to make deductions and decisions even when the information is incomplete. This part of the examination is stressful but you should prepare yourself by seeing as many patients as possible and presenting your findings to a critical instructor.

Long case

The intention of this part of the examination is to test your ability to gather clinical information in a limited period of time, interpret it, draw conclusions, make decisions and present your findings professionally. You will spend 20–25 minutes alone with the patient and you can make notes for your own use. After taking the history and examining the patient, spend a few moments deciding how you should present the facts of the case to the examiner.

The patient may tell you the diagnosis. This does not exonerate you from the need to assess it critically and consider differential diagnoses. Consider how to test the diagnosis and how to determine its severity. Examine other systems to find out whether they are involved. Think about possible treatments. Do not be dismayed if you cannot make a diagnosis. You often cannot make a diagnosis in the outpatient clinic but you should be able to indicate how you will proceed with investigations and management.

The discussion with the examiner lasts about 10 minutes. Unless requested by the examiner to do otherwise you should

present the patient in the way you would during a ward round with your consultant. This entails introducing the basic facts about the patient and progressing purposefully towards your conclusions. Report incidentals briefly, without distracting attention from the main line of reasoning. Report only those negative findings that are relevant to the diagnostic problem. Expect to be interrupted by questions.

The presentation is followed by your conclusion. You should present your diagnosis and be prepared to justify it, together with the incidental and differential diagnoses. Continue with the investigations you would request in order to confirm your diagnosis, to exclude others, and to assess the patient's general condition. Follow this with a discussion of treatment choices indicating and justifying your selection.

Do not be upset if the examiner interrupts and guides you along another path, asks you to explain or expand a detail, asks you to justify a statement, or changes the subject of discussion entirely. The examiner needs to determine the depth and range of your knowledge.

You may be shown the patient's investigations such as X-rays and laboratory test results and asked to discuss them.

Short cases

The objective is to assess your ability to observe and elicit a variety of physical signs and interpret them. It gives your examiners the opportunity to observe your approach to patients and the way you examine them. Time does not permit you to take a full history and examine the whole patient so you will be directed by the examiner to the affected area. In case of doubt ask the patient if the part you are to examine is painful or tender. Above all else treat the patient with kindness and consideration. Do not obsessively repeat the examination. Carry it out once, carefully, making sure that you obtain all the information you need. You may ask the patient to move if this will help you to make the diagnosis.

Even though this is the short case you should observe the patient in general because the age, sex and general condition of the patient will influence your choice of management. Surgical practice depends on accurate diagnosis, assessment of the severity of the disease and choosing the appropriate management for the particular patient. Your abilities to observe and to deduce from those observations are tested in the clinical part of the examination.

Decide what is the most likely diagnosis and consider where else you should look. What differential diagnoses are possible and how can you confirm the diagnosis? What advice and treatment, if any, should you offer the patient?

Be sufficiently confident in your clinical findings to state them boldly but word them in such a way as not to alarm the patient. Do not continue to examine the patient while reporting your findings.

Oral examinations

Each of the two oral examinations is conducted by two examiners. The topics which may be included will be found in the guide to the examination and as this guide will be revised from time to time you must make sure that you read the most recent one. You will be questioned by each examiner in turn, and the examiner may cover a number of different topics.

Principles of operative surgery

There are certain essentials, such as aseptic technique, surgical access, haemostasis, effects of surgical and other trauma, handling of tissues, the effect of foreign materials, that are common to all branches of surgery.

Secondly, there are certain life-saving procedures that must be learned by anyone practising in any branch of surgery and some of these might reasonably be asked in an undergraduate examination. These include the maintenance or provision of an adequate airway, cardiac massage, chest drainage and intravenous access. There are others that should lie within the scope of any surgeon such as cranial burr holes, thoracotomy, abdominal surgery for peritonitis, intestinal obstruction or intra-abdominal bleeding. Similarly you must know the management of trauma and the principles of surgery for malignant disease.

The examiners will look at your log book and ask questions about the procedures listed in it. This will test your knowledge of particular operations in which you have participated. They will not normally ask details of operations that you have not seen except for those that they consider within the competence of most trainees and those that are life saving.

Surgical topics

Topics here are wide ranging and frequently include the application of basic sciences in clinical surgery. A pathological 'pot' may be used to introduce a surgical topic. Resuscitation, diagnostic methods, intensive therapy and terminal care are a few of the many subjects to be found in the guide. Knowledge of medical ethics, methods of evaluation of surgical practice and critical reading of the surgical literature will all be tested here.

MARKING AND ASSESSMENT

You are identified by number throughout the examination in order to reduce any bias to a minimum. If you have worked for one of the examiners you may be passed to an independent examiner. In all you will normally be examined by eight examiners. They record the questions asked and the responses given and each pair will agree a mark for that section but without any knowledge of the mark given in any other part of the examination.

The marks from the four sections are added together at the end of the day.

At this time the whole Court of Examiners meets to check and to discuss the marks under the chairmanship of the senior examiner of the day. Candidates fall into three groups. Those with a pass mark are not discussed further. Those who have failed badly are also not discussed further. However, all the candidates who have just failed are fully discussed by the whole Court. The questions asked and the responses received are individually reported by the examiners. The Chairman, who has made notes, sums up and the Court votes to pass or fail that candidate. A majority decision is made with the Chairman having a casting vote when necessary.

This method allows the Court as a body to monitor the difficulty of questions and to make allowances if it considers that a candidate has been unfairly marked down. It also allows some compensation between subjects—a candidate who has been outstanding in one part may be voted through if the failure in another part is minimal. Examiners are usually reluctant to allow a candidate to pass who has performed badly in the clinical examination. If all the candidates achieved the pass standard they would all pass. There is no quota.

THE FUTURE

It is well recognised that there are many qualities required of a surgeon that are not assessed in the FRCS examination. The Court is continuously reviewing the examination and taking advice with the intention of keeping the examination relevant and appropriate as a basic test of surgery in general. Consequently the format may change again when the examiners are convinced that worthwhile improvements can be made.

SURGICAL RESEARCH FOR ALL?

C J Rudge

Consultant Transplant Surgeon

The Association of Professors of Surgery (APS) outline a comprehensive justification of the need for surgical research to be a part of surgical training in this country *(1)*. Much of their statement is uncontroversial and deserves widespread support, but here and there can be discerned a rather anxious glance over their collective shoulder—the beginnings of an acceptance that not everything is quite as straightforward as they would wish. The statement emphasises the benefits to the individual as well as to medical science of a formal period of surgical research but makes a number of comments somewhat lacking in support from the evidence—if, indeed, there is any—and capable of an alternative interpretation. It is the purpose of this paper to make those alternative interpretations and to propose a radical alternative to the conclusion reached by the APS.

The first hint that all is not what it seems to be comes in Paragraph 4, ii, where the APS states that the importance of surgical research is recognised by trainees 'perhaps initially motivated by career advancement rather than advancement of the frontiers of knowledge'. Here is the problem—that for some, if not many, surgical trainees the completion of a research project and the attainment of a higher degree (usually, but not invariably, an MS MChir or MD) is *primarily* stimulated by the competitive nature of surgical promotion and by the (unofficial) requirement that such a higher degree is a precursor to a senior registrar post. It is not good enough to use the quoted survey of applicants for senior registrar posts, demonstrating that all short-listed candidates had a higher degree, as evidence that there is widespread recognition of research activity as a 'good thing'. It simply demonstrates that to make the grade you have to play the game, regardless of your interest in, and ability at, surgical research.

At several points in the statement the APS say something along these lines ' . . . surgical research not only contributes new knowledge to science but also confers on the surgeon a life-long benefit by encouraging a continuing process of education and hence providing a higher standard of clinical care in the most cost-effective manner'. Is this really true? It is possible to write—more cynically but with equal conviction—that surgical research teaches the surgeon from whom to request the computer literature search and how to perform laboratory tests that he will never perform again in his surgical career. If NHS Consultant chiefs cannot teach their registrars how to assess a published paper and how to review critically new data then there is something seriously wrong—perhaps their own research time was not as valuable as was thought? No, research should *not* be an essential part of training for *all* surgeons. It should be conducted seriously and enthusiastically by those with an aptitude for 'academic' surgery—perhaps resulting in higher quality publications albeit in lower quantities.

However, it is essential not to throw out the baby with the bathwater. A year or more spent away from the all-embracing treadmill of clinical surgery should allow time for a greater intellectual stimulus and the acquisition of skills and information that are impossible at other times during surgical training. The APS use one quotation in particular in their support for research that I would like to use in support of my alternative proposal *(2)*: 'Consultants . . . must increasingly consider what they are doing, why they are doing it, and for whom, and whether they ought to be doing all of the things that they do'. Whilst written in the context of continuing postgraduate training these words take on a very interesting meaning if considered in the light of the current turmoil within the NHS and the effect of it all on the management role of the consultant. What with resource management initiatives, clinical budgeting, business plans, audit, self-governing trusts and clinical directorships, who can say they have never heard the confused and embittered consultant complain that 'I was never trained to do this'. And of course he (or she) is right—medical training in general (including the training of surgeons) makes absolutely no attempt to prepare the junior doctor for the various management roles that are required of the modern consultant. We do not understand financial statements, rolling five-year plans, personnel management, interviewing techniques or any of the other things we all become involved in. To say that we learn by experience is simply not good enough because whatever one's views of the political upheaval currently affecting the NHS it is absolutely clear that the days are gone for ever when the doctors could concentrate on treating patients, leaving the administrators to administrate. All consultants—to a greater or lesser extent—are now managers and administrators also. Is it not time that the profession recognised this and began to take steps to train young doctors appropriately?

My proposal is this—that when considering applications for senior registrar posts a period of *formal* study in management, accounting, administration or whatever should carry *equal* weight to the possession of a higher surgical degree—that an MBA* should be as well thought of as an MS. In other words, let us recognise that the role of the consultant—or of *some* consultants—within the NHS has changed and set out to train people properly for the workload that they will undertake.

This in no way invalidates the argument stated by the APS in favour of surgical research. It simply accepts that while for some individuals the opportunity to undertake research may lead to a life-long interest and involvement in academic surgery —not necessarily exclusively in a University Department—for others a period of 'management' training may provide them with the background that will allow them to play a constructive and informed role in the NHS of the future. I do not think that it is over-stating the case to quote the final paragraph of the APS Statement 5 (e) with one amendment: 'A period of research activity *or management training* is an essential requisite within the training programme of surgeons. The benefits are likely to accrue throughout the professional lifetime of a surgeon.'

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2 Rhodes P. Educating the doctor: postgraduate, vocational and continuing education. *Brit Med J* 1985, 290: 1808–1810.

* MBA: Master's Degree in Business Administration.

BRITISH SURGEONS TRAINING ABROAD—AN EVALUATION

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Key words: Third World Surgery; Registrar Training; Breadth of Experience

The experience and practice of a surgeon training in Africa is reviewed. Clinical, practical and management skills are invaluable. The value of an elective period in a British training system is suggested.

Introduction

For many years there has been a tradition of British surgeons training abroad, although in recent years the pressure of domestic training programmes has made overseas experience less attractive for the British surgeon.

Does an elective year or two spent working in a Third World country still have merit? Are there advantages in current schemes, and are lessons learnt working in the Third World applicable in Britain today? Surgical practice in the Third World can be difficult and frustrating on account of limited resources and at times overwhelming need (Loeffler, 1988). However, it offers experience in a wide range of surgical fields, developing skills learnt during basic training in Britain and providing opportunities for responsibility in clinical and administrative work.

Variety of clinical experience

There are few specialists in the developing world, so that in outpatients and emergency work a wide range of pathology presents to any one surgeon (Goodacre, 1986). Pathology is often far advanced, providing an opportunity to observe the natural history of untreated disease. Illnesses that now only occasionally present in Britain, eg tuberculosis, chronic osteomyelitis, empyema thoracis, tetanus, gas gangrene, are seen. There is experience in tropical surgical disease, eg amoeboma and typhoid perforation, that, because of travel, can occasionally present in Britain. With few specialised units, the general surgeon takes responsibility for conditions such as head injuries, burns and cervical fractures, that normally are referred elsewhere in Britain.

Perhaps the most striking difference between British and Third World surgery is the dominance of sepsis. Infections are neglected and widespread so that aggressive attitudes to surgical incision must be adopted. The basic principles of debridement and secondary suture in wound management assume new significance in the tropics.

Versatility in practical skills

Versatility is the keyword in tropical surgery, especially in emergencies where the general surgeon is often expected to be involved in the primary management of orthopaedic, ENT and even ophthalmological and obstetric emergencies. Clinical acumen in the absence of sophisticated diagnostic aids is paramount. Anaesthetic support is limited and the surgeon may have to employ local and spinal anaesthesia. Conditions for surgery are not ideal, with inexperienced assistance, poor instruments and varying suture materials (Weston, 1987). Supervision may be limited and responsibility for clinical decision-making and assessing likely outcome of surgery is vital.

Management skills

Frequently basic resources need to be carefully managed. Staff morale may be low and leadership qualities assume a new significance. Establishing priorities in the use of time is a prerequisite to survival in the tropics, because of commitments to clinical work, teaching and administration. With few senior staff available, forward planning becomes important, as well as the avoidance of crisis management. The involvement of British surgeons abroad will continue to be justified as long as their teaching responsibilities are a priority. Nurses, medical students, postgraduates, all need on-going teaching programmes.

The problem

Arranging a period of work abroad can be frustrating. Red tape proliferates in the tropics and early planning is advised. The ideal time to go is after the FRCS, when critical faculties can be developed, clinical research undertaken and papers written.

Concern inevitably focuses on the risk to visiting surgeons in some parts of the world of HIV disease. Precautions, as in the UK, must be taken, but there does appear to be a minimal risk to the medical profession. In fact, the training surgeon in a developing country is seeing AIDS-related surgical disease, which may present in the UK in a few years time.

Conclusion

Some flexibility in surgical training is possible and overseas experience, often with additional teaching and managerial responsibility, is relevant to a career in British surgery and should be encouraged.

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2 Goodacre T E. Plastic surgery in a rural African hospital: spectrum and implications. *Ann R Coll Surg* 1986: **68**: 42–44.

3 Weston P M. Care of the injured in the Third World—What can we learn? *Injury* 1987; **18**: 297–303.

Assessor's comment

In Britain today we run the risk of inbreeding in our programmes of surgical training. In our emphasis on rotations between University Teaching and District General Hospitals, we forget or ignore the wealth of clinical experience in countries abroad, especially the developing ones. In countries in the latter group where surgical services are more limited than with us, a wide spectrum of clinical conditions is available for training with all stages of pathology. In many of these countries surgeons are in short supply and skilled help is welcome.

The article from Zambia on 'British Surgeons Training Abroad—an Evaluation' is a welcome reminder to us of the opportunities for enlarging surgical experience and training abroad, and of giving back surgical help in return.

At present this type of attachment must depend on individual initiative and our surgeons in training are to be encouraged to seek this dimension of enlarging surgical skills and enjoying an increased level of clinical responsibility. A term of service in a country such as Zambia should be regarded as a valuable addition to the curriculum vitae rather than a waste of time.

In due course we would hope that it may be possible to include a year abroad in a developing country as an essential component in a higher surgical training rotation.

PROFESSOR P GILROY BEVAN

THE WORK PROGRAMME AND WORKLOAD FOR A CONSULTANT GENERAL SURGEON

C D Collins ChM FRCS

Consultant General Surgeon, Taunton and Somerset Hospital

The Association of Surgeons has recently recommended that a maximum part-time general surgeon should agree a job plan containing five fixed contracted Notional Half Day (NHD) commitments: ie 3 operating lists and 2 outpatient clinics; 3 obligatory NHD commitments and 2 flexible commitments *(1)*. This is based on the guideline programme for a general surgeon proposed by the Royal College of Surgeons of England *(2)*.

Fixed commitments

Operating lists and outpatients clinics are common to all general surgical posts and the workload of both can be, and is, regulated by consultants, although monitored by management. Most surgeons work under pressure of a demand for their services from general practitioners and management. This is in excess of their ability to sustain an acceptable level of care without considerable compromise. It is therefore important that any work 'norms' agreed for these commitments should comprise a case load which is compatible with maintaining a high quality of care.

The work of a consultant general surgeon varies considerably according to his emergency commitment, his special interest and the size of the surgical unit within which he works. This variability can be accommodated by the use to which the obligatory and flexible commitments are put.

Obligatory commitments

In addition to the five fixed commitments, there are other essential tasks which general surgeons need to undertake. The Association of Surgeons has chosen to designate these as obligatory commitments; they may take place at varying times in the working week.

	NHDs
Audit, Postgraduate Medical Education/Teaching	1
2 × Ward Rounds at $\frac{1}{2}$ session each	1
Special Interest	1

Audit, Postgraduate Medical Education

The 'White Paper' requires that all surgeons be involved in formal audit of their work by April 1991 *(3)*. Further, The Royal College of Surgeons may withdraw recognition for surgical training if surgical audit involving all consultants and trainees does not take place regularly *(4)*. Audit should be regarded as an integral part of the postgraduate education programme of every general surgical department, together with joint clinico-pathological, radiological, or other interdisciplinary meetings, journal clubs and formal teaching sessions. This commitment to audit and postgraduate medical education may comprise regular weekly, fortnightly or monthly audit sessions, some of which may be multi-disciplinary, along with the other commitments, flexibly rostered into the weekly work programme. Formal recognition of time for postgraduate medical education, including audit, is necessary in the programme of both consultants and trainee surgeons in order to ensure an appropriate balance between service and training commitments *(5)*.

Ward rounds

Ward rounds are an essential component of the surgeon's work and are often compromised both in terms of their duration and in the time taken to talk to and examine each patient and to ensure that the doctrine of informed consent with regard to any operative treatment about to be offered is satisfied. Furthermore, time is required to discuss the forthcoming procedure or clinical progress of the patient, with the junior surgical staff, students, nursing staff and patient's relatives. It should no longer be expected that all ward rounds take place on an *ad hoc* basis at odd times of the day or evening when it is possible that not all members of the surgical team or appropriate nursing staff are available. At least one formal ward round should take place per week during the normal working hours of the day, in addition to which informal ward rounds should be carried out as necesesary.

Special interest

The use to which this commitment is put will vary according to the need for further flexible NHDs to cover a particularly heavy emergency commitment or the special interest of the surgeon concerned. For example, in the smaller DGH with relatively junior and inexperienced supporting surgical staff, on-take 1 in 2 or 1 in 3, a special interest NHD could be used as a further flexible commitment to accommodate the more frequent emergency involvement of the consultant. In larger hospitals where sub-specialisation has taken place to a great degree, and surgeons are committed to, for example, a vascular or neonatal surgical emergency roster of 1 in 2 or 1 in 3, the special interest NHD could be used for further operating carried out flexibly at the time of need. Other examples include the gastroenterology surgeon who may wish to carry out an endoscopy list, or a general surgeon working in a country area who might find it most appropriate to carry out either an extra outpatient or operating commitment in a peripheral hospital. In other circumstances surgeons may wish to commit themselves to undertake specific sessions of laboratory or clinical research. The special interest NHD could also be designated as 'administration' by surgeons with extensive medical advisory or management commitments at Regional, College, or national level. Certain district management duties specified in HC(90)16 *(6)* carry the option of extra remuneration but many medical advisory, educational and other obligations outside the District management structure do not. These, nevertheless, need to be accommodated within the weekly programme.

Flexible commitments

Flexible NHDs accommodate emergency work and those activities which may take place outside normal working hours, such as clinical administration, travel and continuity of care. The number of flexible NHDs in any consultant programme should reflect the immediacy of involvement required for high quality patient care. Two would be the 'norm' but in smaller hospitals in which consultants share a 1 in 4 rota or less, three might be appropriate, whereas in larger hospitals, consultants with higher surgical trainee support, on-take less frequently than 1 in 6 and therefore less immediately involved in emergencies, might designate one of the two proposed flexible NHDs as

an obligatory session for teaching, research, or further clinical work.

Emergency surgery

Between 30 per cent to 50 per cent of all general surgical admissions are emergencies *(10,13)*. They constitute the essential component of general surgery. They make the most exacting, though variable demand on surgical time, skill and resources. The time necessary for consultants to become more widely and immediately involved in the care and assessment of emergencies, both requiring immediate or early surgery or non-operative management, needs to be recognised by the allocation of an appropriate number of flexible NHDs. Calculation of the number required to meet this commitment for emergency surgery should take prior claim over the allocation of NHDs for elective non-essential surgical activity. The number of NHDs required will depend on the number of consultant colleagues sharing the emergency rota, the availability, experience and skill of the junior support staff, the emergency surgical case load and the availability of locums to cover the leave periods of both consultant and support staff. The number will generally vary between two and three, although in a hospital with a rota of 1 in 3 or less, with inexperienced support staff and a high proportion of emergencies, four NHDs may be required.

Outpatient clinics

It has been suggested *(7)* that an average of 20 minutes is required for each new surgical patient to be seen to a satisfactory standard in the outpatient clinic and 10 minutes for each follow-up. This time is necessary to talk to, examine and possibly investigate the patient, to discuss the clinical implications with him and his relatives and relieve his/her anxiety, to make notes, complete data entry sheets, dictate letters to the referring doctor and also to teach or supervise the junior medical staff or medical students. It is recognised that more time may be needed for patients seen in 'specialist' clinics in which extensive investigation or explanation and discussion are required, whilst in general clinics to which straightforward surgical conditions are referred, less time would be required for each patient to be seen satisfactorily.

With two clinics per week, one surgeon working without support staff could see 600 to 650 'new' (referral) patients per year—7 'new' patients per clinic × 2 × 44 working weeks per year with at least an equal number of 'old' patients. Consultants in general surgery, however, rarely work alone and usually have the assistance of either a higher surgical trainee or an SHO, or possibly both, in the outpatient clinic. The contribution made by surgical trainees therefore needs to be included in any work load estimate. In order to assess the service contribution of support staff, it has been recommended that a service equivalent value (SEV) be calculated for each surgical unit and that this value is used to multiply the case load that could be handled by a consultant working alone *(7)*. The SEV for any surgical unit is calculated from the Wallace formula *(8)*. It is suggested that a score is attributed to the service contribution of each member of the surgical team as follows:

Consultant	1.0
Senior Registrar	0.8
Registrar	0.7
SHO	0.5

For a standard consultant firm of two consultants, one registrar and one SHO, the composite score would be 3.2. Hence a one-consultant team would carry a score of 1.6. This SEV, which varies with the size of the surgical team, can then be used to multiply the case load expected of the consultant alone, to arrive at an appropriate outpatient case load for the consultant team as a whole. A standard general surgical team of one consultant, half-share registrar and half-share SHO could then expect to see 600–650 × 1.6 referral (new) patients each year. This equals approximately 1 000.

It would not be expected that this formula would be applicable to all surgical units in Teaching and other hospitals specialising in complicated or tertiary referrals. It could, nevertheless, form a framework for service planning for those units without a large proportion (>10 per cent) of tertiary or complex referrals.

Operative workload

Operative workload must be distinguished from case load *(9)*. Case load, or the simple addition of the numbers of cases operated on, forms the basis of all management statistics and surgical performance indicators *(10)*, but does not take into account the complexity of the operative procedure.

An intermediate equivalent (IE) value can be applied to each operation using the BUPA Schedule of Procedures *(11)* which classifies every procedure into one of five main categories which are given a value relative to the intermediate group as follows:

Minor	= 0.5
Intermediate	= 1.0
Major	= 1.75
Major +	= 2.2
CMO	= 4.0

This gives a weighted value (IE) for every operation.

For a DGH General Surgical Team, each of the four elective operating lists (3 consultant + 1 trainee list) might consist of 3–4 IEs which, with the addition of emergency work, would average out at a total of approximately 20 IEs per consultant per week. Taking into account statutory holidays and leave periods for both consultants and support staff, this approximates to a total operative workload of 900 IEs per year.

This theoretical operative workload equates with that calculated from the workload data of the four-consultant surgical unit in Taunton *(9,12)* and compares with the mean 960 IE operative workload found by the MicroMed User Group from analysis of 49 405 patients on 45 general surgical firms from all parts of the country*(13)* who work programmes often differing from the recommended number of operating commitments *(1,2)*. This operative workload needs to be compared with the expected operative 'workload' of 1 200 suggested by John Yates of the IACC based on 1984 HAA returns from 97 surgical firms in the West Midlands *(10)*.

Experience in other DGHs may be at variance with the mean found by the MicroMed User Group for a variety of reasons. The elective operative workload may be greater if the consultants are particularly fast surgeons, the operating lists are longer than usual, or the consultants carry out more than three elective operating lists per week. The workload would also be increased if the team was enlarged by the addition of extra surgical staff members including clinical assistants who can undertake independent surgery, or if trainees are carrying out additional unsupervised operating lists.

The elective workload would be less if there were insufficient resources to permit three consultant + one trainee list to be scheduled for each week or if the operating lists were curtailed or cancelled for lack of staff or frequently interrupted to accommodate emergencies.

The figure of 900 IEs per consultant per year is considered a

reasonable 'norm' for a standard surgical team of SEV 1.6 carrying out four elective operating lists per week, looking after the general surgical needs of 50 000 population of average age distribution and morbidity.

Conclusion

Over the last few years the demands and pressures on consultants from both elective and emergency clinical work, management involvement, teaching and audit have grown. These have, for the most part, been met by considerable out-of-hours commitment, delegation of work to others, or compromise on the standard of service to the patient. This is no longer acceptable. It is therefore necessary to establish optimum productivity levels or workloads for a consultant and his team for two reasons:

(1) To provide the basis of a workload agreement between the consultant and management.
(2) To enable management to plan for the necessary resources of anaesthetic, nursing and support staff, operating theatres, beds and other facilities, and the necessary number of consultant surgical teams to meet the surgical needs of the community served.

A consultant general surgeon working in an average-sized District General Hospital on a maximum part-time contract is expected to carry out 3 elective operating lists and 2 outpatient commitments per week. These 5 NHDs would be specified in the job plan agreed with the employing authority. Working with a 'standard' surgical team the consultant could be expected to see approximately 1 000 'new' patients per year and undertake an operative workload of about 900 'intermediate equivalent' operative procedures per year.

Acknowledgements

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From this paper the author provided for the Royal College the Notes for Guidance on General Surgical Workload and the Provider/Purchaser Contract, issued by the Royal College of Surgeons (December 1990)—Ed.

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AUDIT CONFERENCE FOR CONSULTANTS

May 23 1991

A wide range of issues relating to audit and surgical practice will be discussed at a one-day conference for consultants, to be held at the Royal College of Surgeons, on Thursday May 23 1991.

For details of the programme and a registration form contact the Surgical Audit Unit at the Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PN (tel 071 405 3474 ext 4181).

AUDIT CONFERENCE FOR REGISTRARS AND SENIOR REGISTRARS

July 17 1991

Following the success of the audit conference for registrars and senior registrars on July 24 1990, a further conference will be held on Wednesday July 17 1991.

The programme is under preparation and registrars or senior registrars who would like to present a paper at the conference are invited to send in details of their proposed presentation to the Surgical Audit Unit, the Royal College of Surgeons, 35-43 Lincoln's Inn Fields, London WC2A 3PN (tel 071 405 3474 ext 4181).

A DAY IN THE LIFE OF COLLEGE COUNCIL . . .

Tim Bunker's light-hearted description of a visit to College Council on behalf of ASIT

For many years the Association of Surgeons in Training (ASIT) and the British Orthopaedic Trainees' Association (BOTA) have sought representation of their views at the Royal College of Surgeons. In 1988 a far-sighted Council invited ASIT and BOTA to attend (in a non-voting capacity) five seats at the College. These five seats were Council Training Board, Manpower and two seats on Regional Training. Each year ASIT would take three seats and BOTA two, with the seat on Council alternating between the two each year. Thus it was that an orthopaedic surgeon was given the privilege of representing the trainees last year.

Privilege comes at a price, and that price is time and effort. The past year has been an eye opener for me as far as the work of the College goes. My view of our College had previously been similar to that of most trainees: a vast empty building in London where one visits a museum between collecting Diplomas. In fact, nothing could be further from the truth. Most rooms are booked solid for meetings of the subcommittees or Boards each day. The Training Board covers the Hospital Recognition Committee (HRC) responsible for checking that Hospitals are up to standard for basic surgical training, the Manpower panel, the Advisors and Tutors, the Regional Training Boards and the ODTS. The Academic Board covers examinations, research and the award of prizes. The External Affairs Boards covers audit, Europe and election of honorary and overseas Fellows. The Internal Affairs Board covers the upkeep and running of the College, while the Finance Board runs the monetary affairs of the College. Reporting directly to Council are the JCC (Joint Consultants Committee), the Joint meeting of Surgical Colleges, the JCHST (Joint Committee on Higher Surgical Training) and through it the SACs of all the specialties, the Presidential Boards of Surgical Specialties, the Board of the Hunterian Institute, the Trustees of the Hunterian Collection and the Welsh Board. This is just the generalities for upstairs are the offices for all the specialist surgical organisations, and some of their Journals (and even an office that says ASIT on the door!) The College should learn from this that they need a good PR job (that is a journalistic, not proctological term) before they lose the goodwill or even the subscriptions of their Fellows.

What happens on Council itself? Two weeks before the event a two-inch thick parcel lands on the doorstep with details of what will be discussed. This takes at least one evening to go through with a yellow highlighter picking out what is relevant to trainees. The majority of this is under the remit of the Training Board on which we have representation. The next task is to get colleagues to cover the day of Council, for a consultant may cancel his commitments or delegate to his SR, but for an SR to tell his boss to cancel clinics or to do the SR's work does strain the tolerance of even the most accommodating of bosses! Sod's Law states that Council day always falls on a take day, which has to be rearranged.

The 125 leaves Nottingham at 8.05 and I enter the hallowed portals at 10.20. This is where privilege starts. I am no longer debarred from the Council toilet, where I can leave my coat. Coffee and biscuits are served in the Council room until 10.30 and this is where the horse trading starts. Initially this can be intimidating for a new man and I am grateful to those few who put themselves out to talk to a youngster, in particular Professor Irving, Mr Kirk and Professor Hardcastle. The meeting comes to order at 10.30, those elected members of Council proceeding to their chairs at the magnificent Council table, and those invited to their chairs in the corner. One person stands for virtually the whole day, and that is the President, Sir Terence English, and it is he who conducts the day's business, for this is very much a presidential affair.

Gradually the two inches of paper are worked through with the Chairmen of each Board reporting in turn. Important topics this year have been the amalgamation of the Colleges, the change in the title of the examinations, the breakaway of the College of Anaesthetists, the closure of Downe House, the Corporate Plan, the College Appeal, the pruning of the Hunterian Institute, the Model Job Description, the Certification of Specialist Training, the Redefinition of Higher Surgical Training, the CRISP report, criteria for eligibility for Inter Collegiate exams, ACABAL, and many others.

At 12.30 business is adjourned for lunch. Drinks are served in the Edward Lumley Hall (you will be pleased to hear this is a pay bar) and the important business is discussed over the roast. With so much business to go through and 32 Council members and 11 invited members, the meeting itself has to be very much a rubber stamping affair. Indeed, to open one's mouth in Council requires strong views and a strong nerve.

At 2.00 Council resumes, this time in full regalia and gowns. Firstly the honorary diplomas and prizes are given, the speeches and votes of thanks given, and then the guests leave. Then business continues until all the work is done and Council breaks up about 3.30 to 4.00.

The responsibility does not stop there for the role of the representative is not just to stand up in Council and give voice to our views but also to report back. This means not only preparing a report for ASIT and BOTA Councils but also attending both ASIT and BOTA Councils to report back in person.

Despite the fact that Council is biased towards the Teaching Hospitals (15 Professors out of 32 elected members) and elderly (6 are retired) it is becoming quite radical, is under good leadership, and I am sure is pushing surgery in the right direction. We must continue to push for improvements in training, for training is the keystone of surgery. The College needs to convey the facts that it is changing for the better to the Fellow in the street if it is to survive. The College through the Council, the HTCs and the SACs is the guardian of our professional lives and livelihoods, and for us to survive and retain our independence it must survive.

Plarr's Lives of the Fellows

If any Fellow has a copy of this publication I would gladly purchase it at the current antiquarian price. It would be of great use in preparing the next volume of Lives of the Fellows.

Please contact the undersigned c/o The Library, Royal College of Surgeons of England, 35–43 Lincoln's Inn Fields, London WC2A 3PN.

SELWYN TAYLOR FRCS

College and Faculty Reports and Notices

MEETING OF COUNCIL

At the **Quarterly Meeting of Council held on December 13 1990**, it was resolved that:

- the Sir Alexander McCormick Travelling Fellowship for 1990 be awarded to Mr W G Bowsher FRCS
- the H J Windsor Prize for 1990 be awarded to Mr W G Bowsher FRCS
- the Robert Jones Travelling Fellowship be awarded to Mr P Laing FRCSEd
- the 1991 Annual Meeting be held on November 14 1991
- two Diplomates Ceremonies be held in future years, in July and November/December.

The following were admitted to the Fellowship ad eundem:

- Mr Robert C MacDonald FRCSEd, Consultant Surgeon at The Royal Infirmary Huddersfield. A citation was delivered by Professor W J W Sharrard FRCS
- Mr John Rae Mason FRCSEd FRCSGlas, Consultant Surgeon, Shotley Bridge General Hospital, County Durham. A citation was delivered by Mr H Brendan Devlin FRCS.

Surgeon Commander R J Leicester, introduced by Surgeon Rear Admiral D A Lammiman, Medical Director General (Navy), was admitted as Joint Professor of Naval Surgery.

Colonel James Ryan, introduced by Major-General A J Shaw, Director General Army Medical Services, was admitted as Joint Professor of Military Surgery.

Professor Priscilla Piper, introduced by Professor Sir Stanley Peart, was admitted as Vandervell Professor of Pharmacology.

Mr Anil Gill of the University of Sheffield Medical School was admitted as 65th Macloghlin Scholar.

The McNeill Love Medal was presented to Mr John Street, Engineering Supervisor, in recognition of his thirty years' service to the College.

Professor Alexander-Williams was appointed Bradshaw Lecturer for 1991; Professor Robin Ling was appointed Robert Jones Lecturer for 1991; and Mr John Goodfellow was appointed Robert Jones Lecturer for 1992.

Certificates of Accreditation

It was resolved that Certificates of Accreditation be awarded as follows:

Cardiothoracic Surgery:	Christopher Blauth
	Christopher Mark Munsch
	Robert Stuart Bonser
General Surgery:	Charles Philip Geoffrey Barker
	Malcolm Charles Aldridge
	Denis Christopher Gosling
	Asha Senapati
	Linda John Hands
	Stephen Holt
	William Stanley Lewis Stebbings
	Peter Francis Blacklay
	Kevin Roy Wedgewood
	Peter Frederick Crooks
	Frank William Cross
	John Frederick Chester
	Niall Oliver Aston
Neurological Surgery:	David Alexander Allcutt
	Richard Sidney Campbell Kerr
	John Charles Marks
	Andrè Jackowski
Ophthalmology:	Charles Frederic John Grindle
	Michael John Potts
	Brendan J Moriarty
	Philip G Griffiths
	Peter T S Gregory
	Robert J Morris
	Neil H Johnson
Otolaryngology:	Nigel Peter Warwick-Brown
	Donald Robert Clark
	Charles Antony East
	Patricia Mary Robinson
	Geoffrey Richard Stone
	Michael Jonathan Brockbank
	David Bradford Mitchell
	Neill Barry Solomons
	John Waldron
Paediatric Surgery:	Nicholas Paul Madden
Plastic Surgery:	Simon Langdon Knight
Urology:	Graeme Cooksey
	David William Cranston
	Timothy Robin Terry
	Rosemary Anne Styles
	John Barry Anderson
	Kanaiyalai Desai
	David Andrew Jones

ROYAL COLLEGE OF SURGEONS OF ENGLAND ANNUAL MEETING OF FELLOWS AND MEMBERS 1991

To be held on Thursday November 14 1991 at the College

All Fellows are invited to attend the 1991 Annual Meeting, which will be held on the afternoon of Thursday November 14.

The College is aware of the increasingly significant role it plays in the socio-political area, and of the importance to Fellows of these issues. It has therefore been decided that the Annual Meeting should follow a morning session of presentations on socio-political themes relevant to the surgical profession.

This Meeting has been scheduled to coincide with the Regional Advisers and Surgical Tutors' Meeting on November 13. Additionally, there will be a College Subscription Dinner on the evening of November 13, at which all Fellows and their guests are welcome.

Full details of the programme will be circulated to all Fellows with the July 1991 issue of the Annals, and will be available on the Computerised Bulletin Board from May 1991.

FORTHCOMING COUNCIL VISITS

Colchester: Tuesday March 26 1991

Full details of the Colchester Meeting have been circulated to local Fellows and are obtainable from the Secretary's Office at the College.

The morning session, at Colchester General Hospital, consists of a Colchester Surgical Party, in which surgeons present and discuss patients from all disciplines.

The afternoon session, at the Postgraduate Medical Centre, Essex County Hospital, comprises surgical presentations and culminates in Professor Donald Menzies' Hunterian Lecture entitled 'Postoperative adhesions, their relevance and treatment in clinical practice'.

A Dinner will be held at Le Talbooth, Dedham for those participants and their guests who wish to attend.

Liverpool: Thursday May 30 1991

The Meeting will be held at the Royal Liverpool Hospital. The programme includes a Symposium on Oncology and a Hunterian Lecture by Professor Hugh Barr entitled 'Shedding Light on Cancer: Photodynamic Therapy for Gastrointestinal Cancer'. The Meeting will be followed by a Dinner which participants and their guests are invited to attend.

Full details will be circulated to local Fellows and are available from March onwards from the Secretary's Office.

ETHICON FOUNDATION FUND

Applications are invited for grants from the Ethicon Foundation Fund, which was established by the generosity of Ethicon Limited for the purpose of promoting international goodwill in surgery by providing financial assistance to Fellows who are travelling abroad for research or training purposes.

Applicants should be surgeons in training or within one year from their appointment as consultant.

Applications are adjudicated upon by an Advisory Board which meets twice yearly. The Board favours applications which demonstrate that applicants are using their initiative to obtain experience above and beyond that which they would derive from a routine exchange or secondment to an overseas centre. On occasions, grants may be made to senior applicants who may be visiting an overseas centre to teach rather than learn. It does not, in general, favour grants to enable an applicant to attend a meeting or conference overseas, neither does it favour grants to support the travel of an applicant's family. Applications will only be considered from those who are Fellows of the Royal College of Surgeons of England. Successful candidates will be asked to submit a report on return from their visit.

Applications *must* include the following (6 copies of each):

(a) A letter of application, to include details of the nature, purpose, and date of proposed visit.
(b) Curriculum vitae, including a list of publications.
(c) A letter of support from the head of department or consultant under whom the applicant is working at present.
(d) A financial statement showing (i) expenses to be incurred, with special reference to the cost of travel, (ii) financial resources already available, and (iii) other grants or fellowships being sought.
(e) Please state where you saw the Fund advertised.

Applications for the next meeting should be sent to the Secretary of the Royal College of Surgeons of England, 35/43 Lincoln's Inn Fields, London WC2A 3PN, not later than **December 1 for the January meeting, and not later than May 1 for the June meeting.**

H J WINDSOR PRIZE 1991

Applications are invited for the next award of the H J Windsor Prize established in 1976 by the late Dr H J Windsor KSG CBE FRCS of Brisbane, Australia.

Preference will be given on this occasion to a young Fellow of the Royal Australasian College of Surgeons proposing to undertake a research or educational project in Britain.

Applications should reach the Secretary of the College **by July 31 1991** and should include a brief curriculum vitae, an outline of the research or educational project envisaged, and supporting letters from a consultant in Australia and the person in Britain under whom the work is to be carried out.

The value of the prize is £250, to which it may be possible to add a supplementary travel grant.

LIONEL COLLEDGE MEMORIAL FELLOWSHIP IN OTOLARYNGOLOGY

The next award or awards of the above Fellowship will be made for the year commencing July 1 1991. The maximum award to any one Fellow will be £3 000.

The following conditions are laid down by the Trust:

1. Applicants must be United Kingdom born Fellows of the Royal College of Surgeons of England, aged between 25 and 35 years at the closing date for receipt of applications, who are senior trainees or recently appointed consultants, or of similar status, in otolaryngology.
2. The subject of the award is head and neck surgery with an emphasis on laryngology.
3. The Fellowship is tenable for a period of study or research in the Continent of North America.

Applications for the award or awards for 1991-92 must reach the Secretary of the Royal College of Surgeons of England, 35/43 Lincoln's Inn Fields, London WC2A 3PN **not later than April 5 1991 and *must* include the following:**

(a) Name, qualifications and brief curriculum vitae, including present appointment;
(b) proposals for the tour or visit to be made during the tenure of the Fellowship;
(c) letters of support from the applicant's present consultant (or, if already a consultant, the name of an independent referee in the United Kingdom) and the head(s) of the department(s) to be visited;
(d) a statement of the expenses to be incurred and of available financial resources.

Short-listed applicants may be required to attend for interview in London, in which case necessary travelling expenses will be reimbursed.

PORRITT FELLOWSHIP

Applications are invited for the 1991 award of the Porritt Fellowship given by the Winthrop Foundation in honour of the Rt Hon the Lord Porritt GCMG GCVO CBE FRCS to encourage the study of sports medicine and injuries in sport.

The purpose of the Porritt Fellowship is to encourage study of physiology and biochemistry of sporting achievement and/or the aetiology, pathology, prevention and treatment of accidents and injuries associated with sporting activities. The work may be carried out in the UK or abroad, and should be suitable for publication or form part of a thesis for higher qualifications.

A candidate must hold the Fellowship of a Royal College of Surgeons in Great Britain or Ireland, or of one of their Faculties or be a medically qualified member of the staff of one of their scientific departments. Successful candidates will probably hold university, NHS or other salaried posts, and will use their Fellowships to travel to centres at home or abroad to study.

The value of the Fellowship is £5 000 tenable normally for a

period of one year, from September 1991, and a Porritt Fellow may be invited to deliver a Porritt Lecture by the British Association of Sports and Medicine.

Applications must reach the undersigned **not later than Friday April 26 1991 and *must* include the following:**

(a) curriculum vitae

(b) statement (maximum 1000 words) of the study or research project, including the location and facilities already available for the project

(c) particulars of the applicant's salary and of any additional financial support promised or applied for

(d) names and addresses of two referees, one of whom should be the head of the department in which the applicant is working.

R H E Duffett MA
Secretary

The Royal College of Surgeons of England,
35/43 Lincoln's Inn Fields,
London WC2A 3PN

REGENT TRAVELLING SCHOLARSHIP

Applications are invited by the Council for the 1991 award of the Regent Travelling Scholarship, founded by Regent International, part of London International Group plc. An annual grant totalling £6 000 will be awarded to enable one or two young surgeons to study abroad and to acquire surgical expertise not readily available to them in the UK.

The scholarship is open to Surgical Fellows of the Royal College of Surgeons of England who:

- were born in the United Kingdom.
- are aged between 25 and 35 years on March 31 1991
- wish to spend a period of 3 to 12 months studying abroad.

Applications must reach the Secretary of the College **not later than March 31 1991 and *must* include the following:**

(i) Brief curriculum vitae, including present appointment;

(ii) Proposals for visit to be made during the tenure of the scholarship;

(iii) Letters of support from the applicant's present consultant (or if already a consultant, the name of an independent referee in the United Kingdom) and the head(s) of department(s) to be visited.

(iv) A statement of the expenses to be incurred and of available financial resources.

LAMING EVANS ORTHOPAEDIC FELLOWSHIP

Applications are invited from orthopaedic surgeons in training, or from other medical practitioners or scientists whose work is relevant to the advancement of research in orthopaedic surgery, for grants of Fellowships to support whole or part-time orthopaedic research in the United Kingdom.

A sum of up to £24 000 is available over the next two years for a Fellowship or a number of smaller grants. Preference will be given to orthopaedic surgeons in training who wish to pursue a clinical research project, but other relevant applications will be considered.

Applicants are required to submit:

(i) a brief curriculum vitae

(ii) details of the proposed research project

(iii) a supporting letter from the Director of the unit in which they propose to work

(iv) the names of two other professional referees

(v) particulars of the financial support required and of any already available.

It may be possible, on application, to make available the facilities of the Hunterian Institute at the College.

Applications should be submitted to the Secretary's Office at the College, tel: 071 405 3474 (ext 4001), **no later than April 30 1991.**

LISTER MEDAL AND ORATION

Thursday April 11 1991

Professor Harold Hopkins FRS Hon FRCS has been awarded the Lister Medal for 1990 'in recognition of his contribution in the field of fibreoptics and its applications'. Professor Hopkins will deliver the Lister Oration on Thursday April 11, at 5 pm. Tea will be served from 4.30 pm.

This is the twenty-third occasion of the award, which is made by a committee representing the Royal Society, the Royal Colleges of Surgeons of England and in Ireland, and the Universities of Edinburgh and Glasgow.

The title of the Oration will be 'The development of the modern endoscopes—present and future prospects'.

Enquiries should be directed to the Secretary's Office at the Royal College of Surgeons of England.

THE HUNTERIAN INSTITUTE

Intensive course on Fracture Treatment

A basic course on the treatment of fractures is to be held at the Royal College of Surgeons of England, from Tuesday to Friday, July 2-5 1991 inclusive. The course convener is A Graham Apley.

The course is intended for surgeons in training and others seeking to acquire the basis of a sound technique in fracture fixation, and will consist of lectures, tutorials and numerous practicals on internal fixation with special reference to AO/ASIF techniques. There will be lecturers and demonstrators from the United Kingdom, North America and Switzerland.

The course fee of £475 will include tuition, the provision of materials and meals.

Application forms are available from The Hunterian Institute Office, Royal College of Surgeons of England, 35/43 Lincoln's Inn Fields, London WC2A 3PN, tel: 071 405 3474, and should be returned by **Wednesday May 1 1991.** (The number of places is restricted and early application is advised.)

This course has been approved by the British Postgraduate Medical Federation.

Challenges in Fracture Surgery

A two-day meeting for orthopaedic surgeons (Consultants and Certificated Trainees) will be held on Wednesday and Thursday, July 3-4 1991 at the Royal College of Surgeons of England. The course convener is A Graham Apley.

Topics will include poly-trauma, fracture healing and controversies in the management of more difficult and unusual fractures, and will be considered in lectures, seminars and, where appropriate, 'hands-on' exercises.

The course fee of £295 includes tuition, the provision of materials and meals.

In order to allow a full opportunity for exchange of views and discussion, the number of participants at this meeting will be restricted, and early application is advised.

Application forms are available from The Hunterian Institute Office at the Royal College of Surgeons of England, 35/43 Lincoln's Inn Fields, London WC2A 3PN (tel 071 405 3474) and should be returned by **Wednesday May 1 1991.**

JOINT MEETINGS IN PAKISTAN AND INDIA 1991

The President and Council of the College have accepted invitations from the Association of Surgeons of India and the College of Physicians and Surgeons of Pakistan, the Pakistan Medical Association and the Society of Surgeons of Pakistan to participate in Joint Meetings in both countries. These meetings will take place in Karachi and Delhi during the period from Tuesday October 22 to Monday November 4 1991 and it is emphasised that they are open to *all* Fellows of the Surgical Royal Colleges. It is hoped that as many as possible will attend.

Further details can be obtained from Mr Ian McMinn, Compass, 9 Grosvenor Gardens, London SW1W 0BH, Tel: 071-828 7082. Compass/Thomas Cook have been appointed as official conference agents to the College.

The outline programmes for the meetings have been agreed and all of the surgical specialties will be represented. Those wishing to contribute papers are invited to submit general titles for consideration by the chairmen of the various sessions. Further particulars of the outline programmes may be obtained at this stage by contacting Mr Craig Duncan, Secretary for External Affairs at the College (ext. 4170) to whom general titles for papers should be submitted as soon as possible.

INTERCOLLEGIATE SPECIALTY ASSESSMENT IN CARDIOTHORACIC SURGERY

Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons in Ireland

The next Intercollegiate Specialty Assessment in Cardiothoracic Surgery will be held in Dublin in the National Cardiac Surgical Unit of the Mater Misericordiae Hospital and the Royal College of Surgeons in Ireland on Tuesday April 23 1991.

The examination will consist of clinical and oral assessment in all aspects of the Specialty of Cardiothoracic Surgery, including relevant Basic Sciences.

Detailed Regulations and eligibility criteria, together with application forms, may be obtained from the Secretariat, Intercollegiate Specialty Boards, 10 Hill Square, Edinburgh EH8 9DR. **Closing date for receipt of completed applications is Friday, March 8 1991.** Fee: £250.

SPECIALTY ASSESSMENT IN ORTHOPAEDIC SURGERY

Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons in Ireland

The next Intercollegiate Specialty Assessment in Orthopaedic Surgery will be held in London on Monday and Tuesday, May 13-14 1991.

Regulations and application forms are available from the Secretariat, Intercollegiate Specialty Boards, 10 Hill Square, Edinburgh EH8 9DR. **Closing date for receipt of applications is Thursday, March 28 1991.** Fee: £250.

SPECIALTY ASSESSMENT IN OTOLARYNGOLOGY

Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons in Ireland

The next Intercollegiate Specialty Assessment in Otolarynogology will be held in the Royal National TNE Hospital, London, on Thursday and Friday, April 18-19 1991.

Regulations and application forms are available from the Secretariat, Intercollegiate Specialty Boards, 10 Hill Square, Edinburgh EH8 9DR. **Closing date for receipt of applications is Friday, March 8 1991.** Fee: £250.

INTERCOLLEGIATE SPECIALTY ASSESSMENT IN GENERAL SURGERY

Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons in Ireland

The first Specialty Assessment in General Surgery will be held in the Royal College of Surgeons of England and St Thomas' Hospital, London, on Friday, April 12 1991.

Copies of the Regulations and application forms are available from the Secretariat, Intercollegiate Specialty Boards, 10 Hill Square, Edinburgh EH8 9DR. **Closing date for receipt of completed applications is Friday, March 1 1991.** Fee: £250.

HONOURS

The *Annals* warmly congratulates the President, Terence Alexander Hawthorne English, on his award of the KBE in the 1991 New Years Honours List. Other Honours were:

KNIGHT BACHELOR
Michael Anthony EPSTEIN CBE MRCS

CBE
Peter Kynaston THOMAS MRCS

OBE
Peter Herent LORD FRCS
Mohan Sankar John PATHY MRCS

APPOINTMENTS OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

ALMOND D J FRCS
Consultant in Urology, Hull and East Yorkshire Health Authorities.

BHAVALKAR V P FRCS
Consultant Orthopaedic Surgeon, Chinley Hospital, Arizona, and to the PHS Group of Hospitals.

LLOYD-DAVIES E R V FRCS
Consultant General Surgeon, Cornwall Health Authority.

McCLAREN C A N FRCS
Consultant in Traumatic and Orthopaedic Surgery, York Health Authority.

SHRIDHARAN P FRCS
Consultant Urologist, North Warwickshire Health Authority.

DEATHS

The *Annals* reports with regret the death of the following Fellows and Diplomates:
BAILY Ralph Arthur John FRCS
CAMPBELL ROBSON Lorne FRCS
CLAGETT Oscar Theron Hon FRCS
CRADDOCK John Gwithian FRCS
DORLING George Charles FRCS
HOBBS Henry Edwin FRCS
JAMIESON James Gardner OBE FRCS
MCEACHERN Alistair Campbell FRCS
O'MARA Maxwell Lachlan FRCS
RANDLE Gerald Peter (Professor) FRCS
SANGER Bernard James FRCS

GIFTS

RESPONSE TO COLLEGE APPEAL: 25 October-24 December, 1990
During the past few weeks the following gifts have been received/promised:

Gifts available for the general funds of the College and its Hunterian Institute

3 Annual Payments totalling	£13 500.00
11 Legacies and 1 Further Bequest totalling .	£98 119.85
Donations over £500 totalling	£15 350.00
Donations under £500 totalling	£ 2 350.42

Gifts designated for special purposes within the College and its Hunterian Institute

Donation to W J Lyttle Fund	£ 1 310.20
Donation to Sir Alan Parks Research Fund . .	£ 20.00
Donation to The Jeff Westerside Cancer Research Fund	£ 100.00
Donation to cancer research	£ 10.00

CAN YOU HELP?

Mr Adrian Sollom, one of our Ophthalmic Fellows, has generously offered his copy of the Annals to a deserving centre overseas. Will Fellows let me know of any needy surgical department?

EDITOR

ENDOCRINE SURGEON WINS SMITH & NEPHEW TRAVELLING SCHOLARSHIP

The first Smith & Nephew Travelling Scholarship for the British Association of Endocrine Surgeons has been awarded to Mr Barnard Joseph Harrison MS FRCS senior surgical registrar at the Royal Gwent Hospital, Newport.

The award will enable Mr Harrison to travel to the USA in March and April this year. He will visit Professor Jon Van Herden at the Mayo Clinic and Professor Norman Thompson at the University of Michigan whose departments are centres of endocrine surgical expertise. He will also attend the second international course in endocrine surgery in the British Virgin Islands.

The Smith & Nephew Foundation was established in 1974 by the international health care group Smith & Nephew plc. The Foundation supports international training and research fellowships for surgeons, physicians and nurses from the UK and from overseas. In 1989 Smith & Nephew donated more than £360 000 to the foundation for its work.

For further information contact Barbara Bash, Smith & Nephew Foundation: 0279 426751 or the Press Office, Smith & Nephew: 071-379 6783.

Mr Barnard Harrison

Faculty of Dental Surgery

QUALITY ASSESSMENT IN THE DENTAL SPECIALTIES

Report of the Consultants Discussion Day, held on November 16 1990

Professor J P Moss

The topic chosen for the discussion day was an important one for all involved with the reorganisation of the Health Service and also for those concerned with the improvement of clinical standards. The Dean of the Dental Faculty, Mr Derek Seel, welcomed to the study day over 200 participants who packed the lecture theatre. He also gave a special welcome to the lecturers, the representatives of the profession and the invited BUPA guest lecturer Professor J F Helfrick, of the University of Texas Health Science Centre at Houston.

The programme was opened by Mr Peter Banks who spoke on 'The Faculty's Audit Initiative'. He explained the background to this initiative and the Faculty's role in maintaining quality control of training throughout the country. The Faculty's audit initiative had been set up before the White Paper was published by the Government. There was liaison between the Department of Health, the SACs, and the other Royal Colleges and a central data base had been set up with funding approved by the Department of Health. The objectives were:

1. Quality control.
2. A definition of the educational requirements for the higher Diplomas.
3. To establish a basis for the Dental specialties.
4. To review the coding of oral diseases.
5. To produce a national dataset.
6. To publish Faculty guide-lines.

This centralised activity, using nationally agreed datasets, would not only result in assessment of the training programmes, but would also stimulate research activity. It was most important to evaluate the results of our activity. Outcome audit would become increasingly important in the future.

Professor J F Helfrick, the BUPA guest lecturer, then gave the first of his two papers on 'The development of standards of care: methodology, problems and pitfalls'. He emphasised that the results of our treatment should result in the clinical improvement of the patient. We needed to build quality control into the audit process so that the outcome problems would not be there. He then illustrated this point by referring to his study on the replacement of the TMJ where, as a result of his study, one particular material was no longer being used. Ideally audit should create interest in doing a good job and help encourage people to do better. Continuous improvement needed an examination of the data received from the profession to revise and understand the process. Good standards discriminate between care which is useful and care which is useless.

The speaker then suggested that the guide-lines for the standard of care should include the potential for continuous improvement, should limit unnecessary care and limit litigation. It should also provide a blueprint for education, establish expertise and identify research areas. In certain situations it could also be a basis for reimbursement and the maintenance of hospital privileges. In order to satisfy Government and public demands the guide-lines would need to be comprehensive, specific, meaningful and clearly indicate what is appropriate and what is not. All major factors influencing treatment should be included and the guide-lines should be manageable.

Professor Helfrick then went on to describe the principles that the American Dental Association were using and some of the legal considerations.

The discussion on the two papers was opened by Mr W Simpson, Chairman of the Oral Surgery Audit Working Party. He described some of the problems that the working party had addressed, such as data collection, coding, confidentiality and simplicity. There was considerable discussion from the floor which had to be curtailed due to the pressure of time.

After the break for coffee, Mr David Bowden described some of the work of the Orthodontic Working Party. The majority of orthodontists regularly review the results of their treatment on their long-term review clinics, which is a form of clinical audit. However, there are several problems which are specific to orthodontics. These were the multifactorial aetiology, the modification of treatment objectives in the light of patient co-operation, the influence of growth on treatment, and the relationship of the occlusal result to the facial form. He then spoke about the use of the PAR and IOTN indices to measure treatment change.

The Orthodontic Audit Party had four aims:

1. To plan educational audit.
2. To provide advice and guidance on local audit.
3. To arrange interdisciplinary audit meetings.
4. To prepare a National Orthodontic database.

The working party was developing a database which was written by clinicians which he hoped would be acceptable to fellow clinicians. The speaker went on to discuss the implications of audit both at the national and local levels, emphasising that confidentiality of audit information needs to be looked at, especially if this is made available for medico-legal and managerial purposes.

Mr W F Haines, from the Royal Cornwall Hospital, then described the work of the South West Peer Review Group. This group met three times a year and each member had to present cases that were under treatment using photographic slides taken at each visit. This concurrent approach to the continuous assessment of patient management has helped to improve clinical technique, standardised the clinical approach to patient management and increased clinical turnover by reducing the number of active treatment appointments needed to treat each case.

Professor W C Shaw then opened the discussion on these two papers. He pointed out that the two most significant factors in treatment success were the operator and the appliances used. He also emphasised the importance of international audit and

described the work that is currently being undertaken with the Euro-Cleft Scheme. Once again the discussion had to be limited due to the lack of time.

Afternoon session

After lunch in the Edward Lumley Hall, the afternoon session was opened with a paper by Mr P H Jacobsen on 'Failures in Restorative Dentistry—technique or treatment planning'. He emphasised that effective objective audit is only possible if full case notes and all records are available. The quality of restorative care was dependent on many personal factors which relate to both the clinician and his patient. It was important that the correct information was obtained in order to make a correct diagnosis and that adequate diagnostic tests should be undertaken. These points were illustrated by various clinical examples and he then went on to discuss the implications of the replacement of restorations. The analysis of the quality and success rate of restorations was difficult due to the highly individual nature of operative dentistry. Personal prejudices often influenced treatment decisions.

Mr J D Strahan then gave his paper 'Controversial issues from the Restorative Dentistry Audit Working Party'. He pointed out that restorative dentistry was divided into three separate disciplines: Prosthetics, Conservation, and Periodontology. Each had their own methods of diagnosis and treatment planning and it was difficult to get a uniform system of clinical audit. Two-thirds of the consultants in restorative dentistry held honorary contracts. The working party was addressing the issues of the workload of consultants using a patient services system, and also the problems of resource management.

This paper was followed by one by Mr F J Hill on 'The Paediatric Dentistry Audit Working Party—a different approach'. There are 34 consultants in paediatric dentistry of whom 21 hold honorary contracts. It was therefore important to develop audit methods which had national agreement. Two approaches to the problem were being used. The first was a problem based indicator audit which will provide an overview of services within a department. This 'flags' patients whose care may be unsatisfactory. The second uses criterion audit in which a selected topic involving some aspect of diagnosis or treatment is discussed by clinicians in order to agree standards against which the service provided is then measured.

Local district audit committees had been set up which met for three hours every month. All the staff attended and the proceedings were recorded. He then described in detail how a topic was selected, the criteria were agreed and the records analysed. The speaker illustrated the points using data from an audit of emergency treatment.

Professor A H R Rowe then opened the discussion on these papers. He pointed out that many restorative problems can get worse following treatment if the oral hygiene of the patient is unsatisfactory. The problem lies with the patient, not with the operator. There was considerable discussion on these papers.

The next paper in the afternoon session was given by the Chairman of the Royal College of Surgeons Audit Committee, Mr H B Devlin, entitled 'Making Audit Educational'. This was well illustrated with medical problems where having agreed the criteria and then set the standards, the result of the audit was fed back in order to implement change. He then emphasised that audit should be confidential, constructive, and collaborative. The problems for dentistry were how to get access to the material, how to process the material when it has been obtained and how to use the outcome in order to implement change.

Following this interesting lecture, Professor J F Helfrick gave his second lecture 'Standards of care: a practical document to improve the quality of care—the US experience'. The purpose of the document was to improve the standards of care for various types of surgical patients. They had listed the indications for care, the therapeutic goals, the factors affecting risk, the standards of care, the indicators of a desirable outcome and the indicators of an undesirable outcome. These points were illustrated by extracts from the 'Standards of care' document produced by the American Association of Oral & Maxillo-facial Surgeons. The standard of care was care provided to a patient which meets the therapeutic goals, maximises the desirable and minimises the undesirable outcomes, based on the current state of knowledge. A clinical indicator was a method to measure a quantifiable aspect of patient care and can be used as a guide to monitor and evaluate the quality and/or appropriateness of patient care. It was not a direct measure of quality and did not necessarily indicate a problem. The quality of care was the degree to which patient care services increase the probability of desired patient outcomes and reduces the probability of undesired outcomes, given the current state of knowledge. The therapeutic goal was that which a patient should reasonably expect following the management of his disability.

Peer review was estimated to reduce health costs by 30 per cent, but we needed more information over a larger time interval. It was impossible to manage things you cannot measure, nor was it possible to chart improvement without a baseline.

The final discussion period was opened by Dr D Plamping of University College London. She pointed out that rationing of treatment does occur if it is not accessible to the patient. Since large amounts of public money were being spent on Health Services were the public being given value for their money? She suggested that the profession should throw away their godlike image and that the patients should be educated. A lively discussion ensued which had to be cut short due to the lateness of the hour.

Those that remained to the end enjoyed a welcome cup of tea before tackling the return journey home. It had been a most enjoyable and stimulating day.

Other Notices

4th International Benign Breast Disease Symposium
Manchester, April 11-12 1991

This, the fourth meeting in a series held every two years at Cardiff and Southampton, will be held at the University of Manchester. Topics will include new biological techniques in benign breast tissue, reviews of the management of mastalgia, estimation of breast cancer risk, and the role of diet in breast disease. Details from: Professor R E Mansel FRCS, University Hospital of South Manchester, Nell Lane, West Didsbury, Manchester M20 8LR. Tel: 061 447 3845, fax: 061 447 3846.

8th Basic Urodynamics Course
Bristol, April 15-17 1991

This course, to be held at the Watershed Conference Centre, Canons Road, Bristol, will be in two parts. The first day will consist of small group teaching and is designed for those without urodynamic experience. Days two and three will cover anatomy and physiology, basic techniques, urodynamic equipment, clinical applications and management in urology, gynaecology and spinal injuries. The fee for the three-day course, including accommodation, is £125 (two-day course, including accommodation, £97.) Further details from Mr Paul Abrams, Department of Urology, Southmead Hospital, Bristol BS10 5NB. Tel: 0272 505050, ext 3162.

Recent advances in Oral and Maxillofacial Surgery
Study Days August 3-4, 1991

Held under the auspices of the Royal College of Surgeons in Edinburgh and organised jointly by the Faculty of Dentistry at the College and the Department of Oral and Maxillofacial Surgery of the National University of Singapore. For further details contact Dr N Ravindranathan, Oral and Maxillo Facial Surgery, 15-10 Mount Elizabeth Hospital, Mount Elizabeth, Singapore 0922. Tel: 2359658, fax: 7375912.

Rowley Bristow Course in Orthopaedics
March 23-24, April 6-7 1991

The above course, which is suitable for final FRCS candidates, is now being held at St Peter's Hospital, Chertsey. It has been modified to meet the requirements of the new FRCS examination. The fee is £200 which includes meals but candidates must arrange their own accommodation. The course has been approved for consideration of study leave under HM 67 (27). Latest date for application is March 8 and application forms are available from: The Course Secretary, Orthopaedic Office, St Peter's Hospital, Guildford Road, Chertsey, Surrey. Tel: 0932 872000, ext 2235.

Intercollegiate FRCS (Orth)
Norwich, October 17-18 1991

The orthopaedic surgeons at the Norfolk & Norwich Hospital are hosting a two-day course designed for trainees preparing for the Intercollegiate FRCS (Orth) examination. Places are limited. Details from Mrs Irene Oswick, N.A.N.I.M.E., Teaching Centre, Norfolk & Norwich Hospital, Brunswick Road, Norwich NR1 3SR.

Basic Science Class for Part 1 DLO
April 8-26 1991

A three-week, full time course including tutorials, practical demonstrations in Anatomy and Physiology and lectures on subjects appropriate to the Part 1 examination. Course tutor: Dr K M Backhouse OBE. Fee: £435, excluding meals and refreshments.

Practical Revision Class for Part 1 DLO
May 13-22 1991

An eight day, full-time course for students well advanced in preparation for the Part 1 examination, including demonstrations of selected clinical cases, viva voce examinations and lectures on appropriate examination topics. Course tutor: Valerie Lund. Fee: £325, excluding meals and refreshments.

Details of both the above courses from: Cheryl Overington, Administrative Assistant to the Director, The Institute of Laryngology & Otology, 330-332 Gray's Inn Road, London WC1X 8EE. Tel: 071 837 8855, ext 4218.

British Association of Plastic Surgeons
Advanced Course in Plastic Surgery 4 (7)
Lower limb trauma, Lymphoedema leg ulcers
Bristol, April 8-9 1991

Advanced Course in Plastic Surgery 4 (8)
Burns
Manchester, July 17-18 1991

The above two courses are aimed at consultants and trainees in plastic surgery, to whom places will initially be offered. Other medical graduates will be offered any remaining places. The content is at an advanced level. Further details from British Association of Plastic Surgeons, 35-43 Lincoln's Inn Fields, London WC2A 3PN. Tel: 071 831 5161/2, fax 071 831 4041.

8th International Symposium, Radionuclides in Nephrourology
May 6-8 1992

The above symposium will be held at the Chester Grosvenor, Chester, in 1992. Topics will include renal function, imaging, hypertension, renal blood flow, urodynamics, transplantation, paediatrics, radiopharmaceuticals, metabolic studies, and infection. Deadline for abstracts is December 1, 1991. Further information from Mr P H O'Reilly FRCS, VIIIth International Symposium Radionuclides in Nephrourology, Department of Urology, Stepping Hill Hospital, Stockport SK2 7JE.

Rectum carcinoma 1991
Ghent, April 20 1991

An international symposium on modern trends in diagnosis and therapy for rectum carcinoma is to be held at the Bijloke Museum, Ghent, Belgium on April 10 1991. The official language will be English and further details can be obtained from Dr D Claeys, Department of Surgery, A. Z. Maria Middellares, Ghent, Belgium.

Hands-On Transoral Surgery Workshop

September 18 1991

This workshop, including video presentations, slides and dissections, will be held at University College Hospital, London. Details from H Alan Crockard FRCS, The National Hospital for Neurology and Neurosurgery, Maida Vale, London W9 1TL.

NIH Consensus Panel Reports

A National Institutes of Health consensus development statement on Intravenous Immunoglobulin: Prevention and Treatment of Disease is available from the NIH Office of Medical Applications of Research.

Also available is an NIH Consensus Development Conference report on the treatment of early stage breast cancer.

Free, single copies of both reports are available from William H Hall, Director of Communications, Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 259, Bethesda, Maryland 20892.

Medical Interchange

Medical Interchange, run by Richard J Crane MB BS (Melb) FRCS FRACS from 100 Lurline Street, Kattomba, NSW 2780, Australia, facilitates exchange of practices between the UK, Eire, Australia and New Zealand.

College Diary

MARCH 1991

Friday 8

TUDOR EDWARDS MEMORIAL LECTURE by Sir Terence English KBE PRCS entitled 'The UK Cardiac Surgical Register: 1977 to 1989' to be delivered at Kensington Town Hall during the Annual Meeting of the Society of Thoracic and Cardiovascular Surgeons of Great Britain and Ireland (2.00 pm)

HUNTERIAN LECTURE by Professor Solomon Victor FRCS entitled 'Coarctation of inferior vena cava: an operable cause for chronic Budd Chiari syndrome' (4.30 pm)

Wednesday 13

College Dinner (7.00 for 7.30 pm)

Monday 18

Symposium on 'Investigations in surgery'

Wednesday 20

BERNHARD BARON LECTURE by Professor N Crawford entitled 'Blood platelets as "God-made" transport vehicles for site-directed delivery of drugs and other cargoes in vivo' (5.00 pm)

Tuesday 26

Council Visit to Colchester, including HUNTERIAN LECTURE by Professor D Menzies FRCS entitled 'Postoperative adhesions, their relevance and treatment in clinical practice'

Friday 29

GOOD FRIDAY—COLLEGE CLOSED

APRIL 1991

Monday 1

EASTER MONDAY—COLLEGE CLOSED

Thursday 11

LISTER ORATION by Professor Harold Hopkins Hon FRCS entitled 'The development of the modern endoscopes—present and future prospects' (5.00 pm)

Tuesday 16

Last day for receipt of nominations for election to Council

Tuesday 23

ARRIS AND GALE LECTURE by Miss A Senapati FRCS entitled 'Zinc and malnutrition in the healing of wounds' (5.00 pm)

Wednesday 24

ROBERT JONES LECTURE by Professor Robin Ling to be delivered to the Spring Meeting of the British Orthopaedic Association in Brighton

Thursday 25

HUNTERIAN LECTURE by Professor N D Karanjia FRCS entitled 'Studies in Pancreatitis' (5.00 pm)

Tuesday 30

ZACHARY COPE LECTURE by Professor J Alexander-Williams FRCS (5.00 pm)

MAY 1991

Friday 3

Voting papers for Council Election issued

Monday 6

BANK HOLIDAY—COLLEGE CLOSED

Tuesday 21

ERASMUS WILSON DEMONSTRATION by Professor Alan Davison entitled 'The immunopathology of demyelinating disease and treatment of multiple sclerosis' (1.00 pm)

Thursday 23

Audit Conference for Consultants

Monday 27

BANK HOLIDAY—COLLEGE CLOSED

Thursday 30

Council Visit to Liverpool, including HUNTERIAN LECTURE by Professor Hugh Barr FRCS entitled 'Shedding light on cancer: photo-dynamic therapy for gastrointestinal cancer' (5.00 pm)

General information

College address for correspondence

Royal College of Surgeons of England, Lincoln's Inn Fields, London WC2A 3PN (tel: 071–405 3474). Cables and telemessages: Collsurg, WC2, London. Facsimile 071–831 9438, Telex 936573 RCSENG G.

Officers of the College

Secretary of the College and of the Trustees of the Hunterian Collection: R H E Duffett MA
Senior Assistant Secretary and Secretary of the Joint Committee for Higher Surgical Training: W Webber MA
Finance Secretary: N Garland MA FCA IPFA
Examinations Secretary and Secretary of the Examining Board in England: J S West LLB
Secretary for External Affairs, Secretary of Joint Meeting of Surgical Colleges and of the Board of Surgical Specialties: C Duncan BA
Secretary of the Hunterian Institute: L F Blythe BA
Secretary of the College of Anaesthetists and of the Joint Committee for Higher Training of Anaesthetists: S N Alan LLB BBA
Secretary of the Faculty of Dental Surgery and of the Joint Committee for Higher Training in Dentistry: A C de Looze MA
Assistant Secretary (Administration): M P Coomer BSc CHSM
Appeals Director: P T A B Baker FBIM MICFM

Hunterian Institute

The Hunterian Institute coordinates the teaching and research activities of the Departments of Anatomy, Pathology, Pharmacology, Physiology and Surgical Sciences, and Biochemistry with the Research Departments of the College (Dental Science, Anaesthetics, Ophthalmology and Physics in relation to Surgery). The Wellcome Museums, together with the courses run by the College, including craft workshops and advanced courses for Consultants, also come under the aegis of the Hunterian Institute.
Master: Professor Sir Stanley Peart FRCP FRS

Examinations

All enquiries relating to Examinations of the Colleges and the Faculty should be addressed to the Examinations Secretary.

College facilities

These include a common room for Fellows of the Colleges and Faculty and a cafeteria open for luncheon on weekdays to anyone having occasion to visit the College.

The Library and Museums

The Library (Librarian: I F Lyle ALA; Sub-Librarian: F K Sherwood BSc ALA MI Inf Sci) is open each weekday from 10am to 6pm and is closed on Saturdays, Bank Holidays, throughout the month of August, and on other days when the College is closed. It is a *reference* collection of both current and historical material with a stock of over 160,000 books, periodicals and pamphlets. Nearly 600 current periodical titles are received and in addition there are about 3,500 non-current periodical sets dating from the seventeenth century. The Library is particularly rich in the literature of surgery and all its specialties including anaesthesia and oral surgery, and of anatomy, physiology and general pathology. There are also large collections of manuscripts, autograph letters, engraved portraits and photographs.

All the collection is available for inspection in the Library. Items are not lent to individuals, but books, periodicals and pamphlets less than fifty years old are lent to other medical libraries. Photocopies can be supplied at a cost of 10p per sheet plus postage, subject to copyright restrictions and to the condition of the original.

Literature searches can be undertaken using MEDLINE and other databases, for which a fee of £10.00 per search is normally charged, but this can vary, depending upon the complexity of the search and the databases used. Searches of the older literature can also be made, but in all cases enquirers are recommended to discuss their requirements with the Library staff. Where requests for searches are made in writing it would be helpful to receive full details of the subject of the search, to know whether clinical or research papers are required, and if there are any date or language restrictions. Photocopies of papers retrieved by searches can be supplied if required.

Lists of books added to the Library are published from time to time and may be obtained by writing to the Librarian.
The Hunterian Museum (Conservator: Professor J L Turk, George Qvist Curator: Miss E Allen) and **The Odontological Museum** (Hon. Curator: Dr B K B Berkowitz, Osman Hill Curator: Dr C Grigson) are open each weekday from 10am to 5pm. They are closed on Saturdays and during August and on Bank Holidays and on other days when the College is closed.
The Wellcome Museums of Anatomy and Pathology are open during normal working hours Mondays to Fridays only and are closed during August, and on Bank Holidays, and on other days when the College is closed.

Down House

Down House, Downe, Kent BR6 7JT (tel: Farnborough 59119). The home of Charles Darwin in the possession and under care of the College. Visitors are welcome. Open daily from 1 pm to 6 pm (no admission after 5.30 pm) except Mondays and Fridays. Closed during February and on Christmas Eve, Christmas Day and Boxing Day. Open on Bank Holiday Mondays (except as above). Admission £1.50 for adults, 75p for pensioners and 30p for children. Taxis and buses (146) from Bromley North or South stations or taxi from Orpington. Enquiries should be addressed to the Custodian.

Nuffield College: residential accommodation

Subject to availability rooms may be booked for long or short periods, including some rooms for married couples. Enquiries to the Residence Officer (ext 2000).

College facilities for functions and conferences

All enquiries to the Facilities Co-ordinator (ext 2001).

Subscription Dinners

These are held on the first or second Wednesday in certain months of the year. All Fellows and Members and other diplomates of the Colleges and the Faculty are eligible to attend, with their guests. Details are available from Mr M Graddon, Facilities Co-ordinator (ext 2001) at the College, to whom all enquiries should be addressed. Tickets £22, including drinks at reception and wine at dinner.

Hunterian and Arris and Gale lectures

Fellows and Members wishing to apply to give a Hunterian or Arris and Gale Lecture are advised to obtain the regulations from the Secretary. Applications are invited by advertisement in the medical journals in September each year.

Examinership

Vacancies are advertised as follows:

Court of Examiners (FRCS Clinical Surgery-in-General section and Membership) *British Medical Journal and Lancet*, October; *College and Faculty Bulletin*, November.

Court of Examiners (Applied Basic Science section)—as above plus *Nature*, October; *College and Faculty Bulletin*, November.

LRCP MRCS and Diploma in Otolaryngology—*British Medical Journal and Lancet*, February; *College and Faculty Bulletin*, March.

Faculty of Dental Surgery—*British Dental Journal*, December.