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Surname
Unique membership number (if known)
Date of Birth

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President’s Letter

Mr Myrddin Rees.

September 2006 marked the 10th Anniversary of the founding of AUGIS, which was celebrated in conjunction with the International Hepato-Pancreato-Biliary Association at our annual meeting in Edinburgh. This highly successful event, superbly organised by Professor James Gordan and Rowan Parks, was a “ compiled of activity” for AUGIS. Coinciding with the official recognition of a Hepato-Pancreato-Biliary branch within AUGIS the opportunity galvanised our UK HPB surgeons to submit a record number of abstracts and fully commit to the sessions as speakers, chairmen and discussants.

The oesophago-gastric contingent were initially concerned that they may be overshadowed by the plethora of HPB input. In the event, their fears were without substance, as each of their sessions had record attendance, boosted by the many international delegates who combine both disciplines in their own work.

Mike Griffin had a permanent grin reflecting the overall excitement. Apart from the many academic highs, there can be no doubt that the climax of the meeting was the arrival and presentation by Her Majesty Princess Anne. Renowned for her meticulous preparation and masterful brief she made all of us proud to be British and the IHPBA will remember her words and our concerns regarding the need to preserve access surgery for upper GI cancers.

The weekend was reserved for a combined symposium and dinner, with the status of consultants.

This highly successful event, superbly organised by our two hosts Manuel Pera for OG and Laureano Fernandez Cruz for HPB, was reserved for a combined symposium and dinner, with the status of consultants.

Thanks to the excellent interpreters, the interaction was robust though not surprisingly they occasionally had trouble following some of the very excitable Spanish speakers.

What was clear however was the warmth of Spanish hospitality. Although there is still work to do on the website, eventually this will be our main form of communication so please log on for updates.

Finally, our annual meeting in Cardiff (27th & 28th September 07) is nearing completion. Reflecting our firm financial footing we have invited 5 guest lecturers; Professor Stein (Germany) and Professor Csender (Chile) for Upper GI surgery, whilst Professor S. D’Angelica (USA) and Professor Fawcett (Australia) will enrich the Hepato-Pancreato-Biliary symposia. These two days will incorporate didactic lectures, debates, short papers and state of the art talks.

Do come as Cardiff is a most welcoming city with none of the drams from ‘Torchwood’.

Best Wishes

Merv Rees
Message from Immediate Past President of AUGIS

Professor S M Griffin

It is extraordinary just how quickly time passes and I now find myself a past president of our Association with which I have been involved since its inception ten years ago. There have been many changes since our fledgling society began representing the specialty and we have come a long way since 1996. From our very first scientific meeting in Leeds, which attracted just over 100 delegates, we have moved regularly having over 350 members present at our annual meeting and culminated this year with a hugely successful international congress with the IHPBA in Edinburgh. Over 1,700 registrants attended our tenth annual meeting which provided our Association with a tremendous advertisement for organisation, expertise and fellowship.

Our Association has moved with the times and has listened to its membership. We have changed the format of our annual meetings to be more inclusive and representative of the different specialty areas within the society. In order to incorporate more papers as well as more specialty areas, the Scientific Committee introduced parallel sessions in Dublin in 2005. This was an unusual move. It has set the template for the next five years. Nevertheless, with our increasing membership and interest, I have no doubt that further changes will be made to accommodate our increasing nurse specialist and affiliate membership as well as the areas of Bariatric and Liver surgery that have more recently formally come under our umbrella.

The Association has taken a lead on providing support and advice on the development of new techniques and, in particular, in supporting the development of courses in specific specialty areas. AUGIS has represented our membership on a national stage in the media and has supported and provided advice to members seeking support regarding local and national difficulties.

We represent over 600 surgeons, surgical trainees and affiliated members which include specialist nurses. In order to reach such a diverse membership, AUGIS has developed a state of the art, 21st century website. This is designed to inform medical professionals, patients and industry of our plans both for the future and the present. It is constantly evolving and developing and I have no doubt will expand to represent a great sounding board for everyone involved in the care of patients with diseases of the upper GI tract.

Over the last few years I have been anxious to forge greater links with our European sister organisations. We enjoyed a quite outstanding meeting in Cambridge in conjunction with the Dutch Society of Gastrointestinal Surgery. Everyone agreed on both sides of the North Sea that this experiment was a massive success and AUGIS immediately sought to forge more links across the water. To this end, we were invited to our first overseas visit by the Association of Spanish Surgeons and, in particular, were hosted by their upper gastrointestinal surgical group. Over fifty of our membership attended the Association of Spanish Surgeons’ Annual Congress in Madrid in November 2006. The quality of the symposia and of the British Journal of Surgery prize sessions were only exceeded by the friendship and hospitality afforded us by our Spanish colleagues. This meeting was truly a great step forward in our further integration into European surgery.

There have been many changes over the last few years, some of which I have presided over. There have been crucial changes to our constitution to accommodate branch associations within the AUGIS umbrella. The Hepato-Pancreato-Biliary and Bariatric groups, in the past separate entities have joined our Society to further strengthen and develop their specific areas. AUGIS has demonstrated a total commitment to ongoing prospective audit to ensure improvement of practice. We have been successful in a 1.3 million pound grant for a national oesophago-gastric cancer audit which will run over the next three years under our auspices at the Royal College of Surgeons of England.

I must end by acknowledging the huge honour that you bestowed upon me to act as your President over the last two years. I have enjoyed every minute of it and it has been an enormous privilege and pleasure to serve. Our achievements could not have been made without a superb executive team and I must pay tribute to our past Treasurer, Sarah Cheslyn-Curtis, whose financial wizardry saw us through a very difficult time. Our financial situation is stronger than it has ever been. Successive Secretaries in Chris Stoddard and Ian Beckingham have earned enormous appreciation from our society but from me in particular. Our two Chairmen of our subcommittees have provided unstinting support in education and training and in clinical services and audit. Rowan Parks has masterminded our scientific meetings for the last two years. His attention to detail and diligence has been extraordinary. Richard Hardwick was responsible for leading the bid to the Healthcare Commission on the national oesophago-gastric cancer audit project and has worked tirelessly for our society. Finally, I wish to pass on my best wishes to my successor, Merv Rees. He has been a proactive and innovative President Elect whose diplomatic skills have been a huge asset to AUGIS over the last few years. He will provide strong and determined leadership, providing me with the reassurance that our Association will continue to grow stronger in every way.

My predecessor as Treasurer, Sarah Cheslyn-Curtis, signed off her duties at the last AGM after 6 years of service in the post. She stepped down when at the absolute top of her game, as foot- ball pundits might say. The temporary company established between AUGIS and the IHPBA to run the combined Annual Scientific Meeting in September is due to be wound up just after the New Year, and current estimates suggest this project will have left our Association with a healthy profit return, as the number of registrations for the National Programme for IT have created uncertainty about the solutions but there is no potential for slippage in the Audit and data collection will start on the 1st October 2007. All patients with oesophago-gastric cancer will be included in England and Wales. The Audit will look at process and outcomes including Quality of Life.

The new HPB Audit Sub Committee, headed by John Buckells from Birmingham met for the first time in Edinburgh and agreed a strategy for the coming year. All Cancer Centres performing pancreatic, biliary and hepatic resections are being contacted to find out what data they currently collect and to see whether we can amalgamate these to produce the first AUGIS HPB audit report. At the same time the group will work on producing minimum datasets for auditing outcomes for patients with these tumours and consult with the HPB surgical community about how best to co-ordinate and run a prospective national HPB audit. 2007 promises to be a busy year for AUGIS audit and all Association members will be involved in one way or another. Thank you in advance for your help – I hope we can generate useful data for everyone and continue to raise the profile of our specialty.

RICHARD HARDWICK
Clinical Service and Audit Committee Chair.
"It is the beginning of the end of life when we stop speaking on the subjects which matter" (Martin Luther King). With this belief I have put pen to paper to write my observations in the earthquake disaster zone within days. Pakistan Medical and Dental council has no record of any of the foreign doctors visiting and working in the earthquake disaster zone. The uncontrolled care provided to the injured by untrained doctors who were willing and meant well for these people has led to a situation which will require tremendous amount of skill and effort on the part of people who will be involved in the future care of these patients.

The Government of Pakistan is aware of the fact that they now have a large number of amputees who need further help for years to come. The decision to amputate a limb is a serious one and has to be taken by doctors who were trained for it. Historically in the western world, this is the General and Vascular surgeons who provide such treatment. In Pakistan amputations are far and few as peripheral vascular disease and old age leading to gangrene of limb is uncommon. Therefore, expertise in amputation with due considerations to the level of amputation which could facilitate successful rehabilitation is not readily available. I feel that such inappropriate and incompetent care provided to the earthquake victims has been down right callous and poor. It has happened because of non availability of leadership from the top.

A major number of young doctors from major cities of Pakistan traveled to the earthquake zone. Therefore, the flood of patients to these cities just compounded the problem. Indeed such a large number of severely injured people would have taxed and tested any good quality health service and not surprisingly the existing health service in Pakistan could not cope with it. However, the situation was managed with the help of doctors, a large number of which came from the UK. These doctors were provided space in various private hospitals and they worked tirelessly to help these earthquake victims.

This brings me to the subject of treatments given to the earthquake victims. The doctors from abroad and locally had various levels of expertise in the management of trauma. However, the majority of young doctors had no training to deal with this type of situation.

A large number of young doctors from major cities of Pakistan traveled to the earthquake zone within days. Pakistan Medical Association and Pakistan Islamic Medical Association responded with all forms of help. The first specialized rescue team from Great Britain (GB) arrived within 48 hours to help victims trapped in Margala Towers in Islamabad. Thereafter, several other teams from various countries came in to rescue earthquake victims.

The standard of health service provided by the state in Pakistan is very poor in major cities. Therefore, the flood of patients to these cities just compounded the problem. Indeed such a large number of severely injured people would have taxed and tested any good quality health service and not surprisingly the existing health service in Pakistan could not cope with it. However, the situation was managed with the help of doctors, a large number of which came from the UK. These doctors were provided space in various private hospitals and they worked tirelessly to help these earthquake victims.

An ambulance crushed under the hospital building.

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COUNCIL REPORTS

Ethics Considerations in Medical Care in Earthquake disaster zone

Mr S Y Iftikhar DM, FRCS Consultant Surgeon, Derbyshire Royal Infirmary

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**AUGIS Affiliates**

I am sure that those of you who managed to attend the AUGIS / HPBA joint conference in Edinburgh in September will agree that the packed 4 days proved a great success with fantastic lectures and stimulating debate. (The conference dinner was quite an event too, kilts everywhere!)

The only thing missing from this year’s conference was an affiliate membership section, but that is about to change! The next conference is to be held in Cardiff on the 27th and 28th September 2007 and promises to be a huge success with guest speakers, a conference dinner and for the first time a nurse / affiliate membership component within the two days.

We have given the scope to develop this section so that we can share good practice and benefit from those areas that really identify with our roles. This is a fantastic opportunity for seasoned speakers and those thinking about presenting for the first time. You will be guided each step of the way and if you require any help with abstracts etc. please get in touch. We need as many abstracts to be submitted as possible, and with the conference still some time away, you have plenty of time to put pen to paper!

Council appreciate that: in the current climate, it is sometimes difficult to find sponsorship for study leave; however, they are committed to making the conference as accessible as possible for all of us, so watch this space!

Council are also dedicated to encouraging nursing and affiliate members, to contribute to local and national projects which affect patient management across all areas. The AUGIS website has developed an affiliate members page. This will provide an opportunity to develop and influence the work being carried out by AUGIS. We will welcome any contributions, comments or queries about the website which should be directed through our specialty manager Stephanie Heaton.

Finally, I am aware of many small groups around the country which aim to support nurses and allied health professionals working in the field of UGI care. We would benefit hugely from bringing those groups together (even if it is only one a year at conference) to network and heighten the profile of UGI disease. Please spread the word and encourage those who are not already members but would like information about the association to get in touch with either Stephanie or myself.

I look forward to hearing from you!

DAWN

To view the new affiliate page please visit www.augis.org and enter the Professionals area.

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**Upper GI Trainees Barretts Club - Wessex**

I am a 4th year SpR in the Wessex region, currently working in Portsmouth. I recently took over from Peter Lamb as the trainee representative on the AUGIS council, a post which also appears to carry the role of helping run the Barrett’s club.

The Barrett’s club exists to represent the views of all upper GI surgical trainees (oesophago-gastric, hepatobiliary, pancreatic, obesity) through its affiliation to AUGIS and its seat on the AUGIS council. This role is becoming increasingly important as the rate of change in all aspects of the health service continues to spiral. Current upper GI registrars have avoided being directly influenced by the mayhem associated with MMC, but changes to the training curriculum for junior surgical trainees will certainly affect both the service and training aspects of our jobs.

Those of us too junior to have already entered the Intercollegiate exam can expect a multiple choice exam as well as the viva and clinical parts of recent years, at a new improved price of £1700 – neither of these changes has proved universally popular. Changes in the accuracy of staging and methods of treatment of oesophagogastric cancers are leading to fewer resectional operations, and the centralisation of cancer services will reduce the number of hospitals offering such operations; these changes impact heavily on our training and onto our ability to gain an understanding of consultant posts at the end of it.

Endoscopic procedures previously performed by surgeons are now being performed by gastroenterologists, and newer techniques such as EUS and EMR seem to be almost exclusively their remit. As surgical trainees, we must master these procedures in order to retain control of our profession; the Barrett’s club and the Dukes’ club have recently been granted a seat on the Joint Advisory Committee for endoscopy, which should help us achieve this.

More cheerfully, the Barrett’s club also allows trainees to meet and socialise with colleagues from other regions. A sponsored dinner is planned prior to the AUGIS meeting in Cardiff (26th September 2007), and plans are being made for a reception at ASGBI in Manchester in April. Several companies (Tyco, Storz, Ethicon) also have a history of sponsoring individuals to attend laparoscopic training courses throughout Europe, which are an opportunity to learn new techniques and meet colleagues in a relaxing environment.

Any SHO, research registrar or SpR with an interest in upper GI surgery is welcome to join the Barrett’s club; please contact me by e-mail for further information or to raise any specific training issues.

STUART MERCER
mercersurgeon@hotmail.com

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**AUGIS Regional Report North Thames**

**Abrie Botha** new AUGIS representative for the North Thames area

AUGIS are delighted to welcome Abrie Botha to the post of regional representative for the North Thames area.

Abrie completed much of his surgical training in the North Thames region and was a consultant surgeon at Whips Cross Hospital for 6 years prior to moving to Guy’s & St Thomas’ Hospitals in 2003 where he is currently an Upper GI, Laparoscopic and General Surgeon.

Abrie’s main surgical interests are oesophago-gastric cancer, gastro-oesophageal reflux disease, motility disorders of the oesophagus, large hiatus hernias and obesity. He currently performs clinical research on oesophageal cancer resection and myotomy for oesophageal motility disorders.

As head of an abdominal firm for 3rd year medical students Abrie organises the clinical training and end of firm assessment and examines in the OSCE of the final MBBS examination.

Currently Abrie is a faculty member of three educational courses at the Royal College of Surgeons of England, Definitive Surgical Trauma Skills (DSTS), Update in Emergency Surgery, and Pitfalls in Emergency Surgery. Abrie is also involved in the organisation of the Bill Owen Oesophago-gastric symposium which will take place on March 9th 2007 at the Royal College of Surgeons. The theme for this one day, annual symposium will be oesophago-gastric emergencies and surgical complications.

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**AUGIS Regional Report South West**

The interaction between medical and surgical gastroenterology was the theme of the combined meeting of the AUGIS South West region and the South West Gastroenterology Group held in Torbay in August. The format was felt to be a great success and future collaborative meetings are planned alternating with our organisation and the region chapter of the Association of Colo-rectology.

Surgical innovation featured at the UK’s first minimally invasive oesophagectomy masterclass hosted by Richard Berrisford and Sai Wajed in Exeter in June. The program of live operating, formal lectures and interactive discussion proved extremely popular and next year’s course is already being planned.

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**AUGIS News Winter 2007**

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07 AUGIS News Winter 2007
AUGIS / IHPBA Conference, Edinburgh
September 2006

The joint meeting of IHPBA and AUGIS was the most ambitious project in the history of our Association. AUGIS were required to organise the venue and front the cost of the meeting with no guarantees of a return from IHPBA in the event of a “poor turnout”. Although this was a risk, AUGIS were confident of good industry support which in the end proved to be the case.

The meeting started on the Sunday afternoon with a Welcome Ceremony with traditional highland dancing and music and welcome speeches from AUGIS out-going president Professor Mike Griffin and IHPBA out-going president Dr William Pitt. The Councils of both associations, AIGS and IHPBA, were officially allowed to wear the Kilt and the evening covered the full repertoire of the splendours of the Scottish tradition with pipers, addressing the Haggis and of course dancing to the Ceilidh band.

The facilities of the Edinburgh International Conference Centre were large enough to hold the 1650 participants from 76 different countries and 120 accompanying visitors together with the huge industry exhibition which spread from the basement onto the ground floor reception. The organisation of the meeting by Concorde Services was seamless and the attention to detail magnificent.

The meeting culminated in a Gala Ceilidh held at the National Museum of Scotland. Council members were officially allowed to wear the Kilt and the evening covered the full repertoire of the splendours of the Scottish tradition with pipers, addressing the Haggis and of course dancing to the Ceilidh band. 

AUGIS DIARY

further enhanced the reputation of AUGIS with our overseas visitors. There are few conferences that could boast an opening by a Princess, a fireworks display shared with most of Edinburgh, dinner at the oldest Surgical College in the world and a ceilidh at the national museum! The scientific meeting was overseen by Rowan Parks, who co-ordinated the mammoth task of sitting through all the presentations, organising speakers and chairman and ensuring everyone was kept happy! AUGIS council members performed much of the work of sorting and marking the abstracts and chaired many of the sessions as well as sitting on the co-ordinating committees. And of course Camilla O’Brien, Anne Walker and the team at Concorde services who were faultless in their attention to small details in what must be one of the best UGI conferences which will be remembered for many years to come.

IAN BECKINGHAM
Honorary Secretary

Oesophago-Gastric topics. The range of topics covered every aspect of HPB and OG: from the broad topics of pancreatic cancer and oesophageal varices to the detail of technical aspects of laparoscopic resections of liver and management of autoimmune pancreatitis; from the everyday management of common bile duct stones to rare neuroendocrine oesophageal tumours; from transplantation to cellular biology – it was difficult to imagine that any Upper GI topic was not covered during the extensive programme. The calibre of speakers was exceptional with 120 invited speakers representing all 6 continents – a real who’s who of the UGI surgical world. The meeting was attended by 450 trainees who are unlikely to see such a collection of famous UGI surgeons in one place for a long time!

Besides the state of the art talks and symposia there were 1242 abstracts submitted, 235 accepted for oral presentation, 913 accepted for poster presentation and 64 videos presented giving the latest scientific data and techniques as well as importantly allowing participants from smaller countries and units to show their data.

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with competition to get a place on the dance floor. Speeches were suitably brief and the new Presidents of AUGIS, Myrrdin Rees, and of IHPBA, Marcus Buchler took up office. The evening was rounded off with a full pipe and drum band “beating the retreat”.

These meetings require an enormous amount of organisation and AUGIS are indebted to many people for ensuring the success of the meeting. The process had started several years earlier with the then President, Professor James Gardens’ Scots negotiating skills and was finished by Professor Michael Griffins diplomacy skills. The Scottish experience enjoyed by the members and Councils of both associations
As the British weather changed from the unseasonal autumn warmth of October to the first frost filled days of November, the prospect of Madrid became ever more real. The Congress de la Asociacion Espanol de Cirujanos (The Spanish Surgical Association’s annual congress) joint meeting with AUGIS seemed appealing. AUGIS’s first overseas meeting had been the brainchild of Mike Griffin and Manuel Pera during a meeting at the International Oesophageal Congress, with involvement of the HPB surgeons in the guise of James Garden and Laureano Fernandez-Cruz.

The Spanish Surgical Association (AEC) was founded in 1980 and is the equivalent of our ASGBI. The association holds its major scientific and teaching meeting biannually in the Hotel Melia Castilla in the suburbs of Central Madrid. On the alternate years there is a smaller regional meeting which is used as a paradigm ground for aspiring senior trainees and young consultants looking for a more senior position. The Spanish surgical career pathway consists of a 6 year medical degree after which a national exam is held and each graduate is ranked. They then apply to their Hospital and specialty of choice with their ranking number and are appointed in order of their exam grade with success dependent on the amount of competition for the post – akin to the American draft pick for Football / Baseball. The AUGIS party met up for a pre-conference meeting on Sunday night in the Plaza Mayor a perfectly preserved and extremely beautiful 17th century arcaded square at the heart of Madrid. The square served as a central public meeting place during the reign of Felipe III who is commemorated by a huge bronze statue of him astride his stallion in the centre of the square. Later it became a theatrical stage, a site for bull fighting and public executions during the Inquisition. The Hardy Geordie contingent arrived early and braved the damp tables of the Tosca’s terrace sampling the local Tapas – boquerone, caco, Pulpo (octopus) and patatas bravas as well as the Vino Tinto. With the arrival of the more sensitive (and sensible, given the rain and air temperature of 3 degrees) southern contingent, the party adjourned to the warmth of the bustling bar.

A pre-congress surgical update day was held on the Monday. This consisted of 13 separate rooms covering all the core specialties of General Surgery from 8am – 8pm. Oesophageal and HPB rooms were well attended and delegates were given printed copy of talks and handouts of study notes. AUGIS provided 6 chairsmen for the sessions who were active in questioning and providing summaries for each session. The meeting was conducted in Spanish but all delegates were provided with headphones to allow simultaneous translation in the main auditoria. The OG day was based around 10 “difficult cases” with a panel of experts who were asked at various intervals what they would do next and to justify their actions. Classic topics of controversy debated included the management of Barrett’s dysplasia, surgery for GORD in the presence of dysmotility, and centralisation of OG cancer units. More unusual topics included management of oro-pharyngeal obstruction, esophageal oesophagitis and the value of sentinel node dissection in OG cancer. The HPB sessions followed an intensive evidence-based approach to the finer points of detail in the management of colorectal metastases, biliary obstruction, hilar cholangiocarcinoma, liver resection and carcinoma of the pancreas. There were also separate parallel session for laparoscopic surgery (in a more technically orientated format) and Obesity surgery (case-selection, surgical techniques, medical versus surgical approaches and long term results). The sessions were very informative and it was refreshing to hear from such a wide range of speakers who would otherwise not be exposed to the UK contingent. Our own chairman and speakers were well used and well received by the Spanish audience.

The main congress itself ran from Tuesday to Thursday and was attended by 1200 Spanish surgeons and 40 AUGIS members. The Spanish Organising committee concentrated the HPB and OG sessions mainly into the first day and these sessions were again provided with dual translation. Symposia were arranged to include UK and Spanish experts debating the best way to manage Achalasia, the impact of new technologies on HPB surgery, advances in oesophageal cancer surgery and pancreatic cancer surgery, radical surgery for liver metastases and Current Surgical management of GORD. These were mixed in with original scientific oral presentations, videos and posters with more than 30 from the UK. The British Journal of Surgery had generously donated 1500 euros for a prize session which was split to provide a Spanish winner (Dr Ruize Angulo from Murcia for ‘Long Term results of a prospective randomised study of medical versus surgical treatment in the treatment of Barrett’s oesophagus’) and a UK winner (Mr Tom O’Rourke for ‘Long term outcomes in patients undergoing hepatic resection for metastatic colorectal cancer with synchronous disease’). Each working day was again from 8am-8pm with a 1 1/2 hour lunch spent recuperating in the local tapas bars surrounding the conference centre providing an opportunity to mix with our Spanish colleagues. Spanish Consultant’s earn 100,000 euros rising to 140,000 for the few that rise to head of a major surgical department. Less than 10% work in the private sector. There is very much a junior/senior consultant structure within the healthcare system and Consultants come off the on call rota at 4.5 (Barcelona) or 5 (Madrid) but lose 20% of their income if they chose to drop the emergency work.

For those of us who have been to European meetings before, it was perhaps a surprise at just how smoothly and efficiently the AEC/AUGIS meeting was run. Speakers were all present, sessions ran to time and there was seamless discussion across the language barrier with the help of the superb translators. The trade exhibition featured the same representation of companies as the UK and there was little difference in the technologies and products available across the two countries. The evenings were long both because of the late finishing of the scientific sessions and because of the impossibility of eating anywhere in Madrid before 10pm! On Monday the AEC hosted a tapas reception for AUGIS and the AEC members and on Tuesday the AUGIS Chairman and speakers were entertained at the AEC Presidents dinner where Merv Rees spoke in polished Spanish (or at least Welsh – nobody could quite tell) and presented our hosting council with AUGIS medals.

Flights leaving in the early Wednesday afternoon allowed a short trip into the city centre on the way back to the airport, which provided the only opportunity that most of us had in an otherwise packed schedule to sample the architectural and cultural treasures that Madrid has to offer (the Prado with its Goya and Velazquez collections, the Thyssen-Bornemisza Old Masters collection and the Palacio Real (the Royal Palace). This rounded off an excellent educational and cultural surgical exchange which we hope we will be able to repay to our Spanish hosts in the next few years. Our special thanks go to Manuel Pera, Hector Ortiz, Laureano Fernandez-Cruz and the committee of the AEC for facilitating and organising the meeting and for their generosity in hosting AUGIS.

IAN BECKINGHAM
AUGIS Honorary Secretary
Specialist Gastrointestinal Surgical Training

Government policy and reforms, including EWTD and MMC, have led to recognition of the need for change to provide a more clearly defined, directional and formulated training and career structure for surgical trainees. The majority of patients wish to be treated close to home but with ready access to specialist services. Those colorectal and upper gastrointestinal trainees aiming for a career in the larger, regional centres will need sufficient general gastrointestinal (GI) training to become competent at managing the acute surgical take (excluding vascular) and to aspire to a higher level of expertise in their respective elective and emergency areas of special interest (colorectal, oesophago-gastric or hepatobiliary), with potentially significant laparoscopic commitment.

The future of gastrointestinal (GI) surgical practice in the smaller, peripheral and sometimes remote general hospitals will include the provision of not only a general emergency service, but also a colorectal and benign upper GI surgical practice incorporating a laparoscopic commitment. It is envisaged that up and lower GI specialists would work as a team, but an alternative or complementary approach would be Specialist GI surgeons with both a general colonic practice as well as a benign upper GI practice.

ACPGBI, ALS and AUGIS believe that delivery of upper GI and colorectal specialist can be achieved within a flexible CCT, but that GI general training should be complemented by further specialist training in the final two years of CCT in recognised specialist training centres.

**Recommendations**

**Modular training for Specialist Upper GI and Colorectal Surgeons**

A minimum of 6 modules (3 indicative years) will be completed in the area of principal interest and 2 modules (1 indicative year) in a complementary GI training post. This will include a minimum of two final years (4 modules) of CCT training in a recognised specialist training unit, in which all necessary emergency and elective surgery (sophisticated and routine) is covered to meet the demands of specialist training in either upper GI (oesophago-gastric and/or hepatobiliary) or colorectal surgery. There should be a minimum of one earlier indicative year (2 modules) in either a recognised general or specialist training unit.

A minimum of one further earlier indicative year (2 modules) should be spent in a complementary GI training post i.e. a trainee with an upper GI interest would undertake six modules in upper GI surgery and two modules in lower GI surgery to provide an acute general gastrointestinal service, in addition to a more specialist elective and emergency service. Similarly a trainee with a lower GI interest would undertake six modules of lower GI surgery and two modules of upper GI surgery (possibly one oesophago-gastric and one HPB).

**Definitions**

**Specialist Upper GI Surgeon**

Portfolio of subspecialty work.

Completion of a defined minimum number of index procedures.

Competence in diagnostic and therapeutic upper GI endoscopy (including optional ERCP), and assessment based upon performance as measured over consecutive cases (JAG guidance awaited).

Minimum of 6 modules completed in recognised upper GI units

Minimum of 4 modules completed in recognised colorectal units

Minimum of 4 modules completed in recognised HPB units

**Specialist Colorectal Surgeon**

Portfolio of subspecialty work.

Completion of a defined minimum number of index procedures.

Colonoscopy competence: assessment based upon performance as measured over consecutive cases (JAG guidance awaited).

Minimum of 6 modules completed in recognised colorectal units

Minimum of 4 modules completed in final two years in recognised GO and/or HPB specialist training units.

At least one module should be spent on an HPB unit, to meet the demand for cholecystectomy in most general hospitals.

Completion of procedure and workplace assessments.

**Specialist component of exit examination (in development).**

**Modular training for other Specialist Gastrointestinal Surgeons**

There is a need for a more general type of Specialist Gastrointestinal Surgeon. This model might well suit smaller hospitals, those in more remote areas or to work together with more specialised upper and lower GI surgeons in larger hospitals. The Specialist Gastrointestinal Surgeon might even complement other upper GI and/or colorectal specialist colleagues in a larger hospital setting to facilitate emergency rates, and manage a more general type of level 2 workload, but with equal status and no difference in seniority.

It is envisaged that a minimum of 4 modules each of upper and lower GI surgery would be completed in a flexible way at any stage of specialist training.

At least one module should be spent on an HPB unit, to meet the demand for cholecystectomy in most general hospitals.

Training in both upper and lower GI endoscopy to JAG Guidelines.

A post CCT fellowship would not normally be a requirement, although there is already in existence a fellowship in remote and rural area surgery in Scotland.

It is envisaged that the type of work would include cases such as cholecystectomy, straightforward anti-reflux procedures, right hemi-colectomy, and the majority of uncomplicated laparoscopic procedures. A portfolio of procedures should be agreed.

Adequate training in open and laparoscopic surgery would be essential. Bariatric work will be limited to centres with ITU facilities.

**Complex level 3 procedures**

(e.g. complex benign or malignant oesophagogastric, pancreatic, liver and biliary disorders, TME, inflammatory bowel resection, complex fistula) must be referred to the appropriate upper GI or colorectal specialist. The principle that GI surgery should only be undertaken by the appropriate GI specialist is fundamentally important.

**Structure for Laparoscopic Training**

The provision of an elective GI and general emergency service will necessarily require an increasing laparoscopic commitment. Trainees will be expected to participate in courses established by ALS, in
SURGICAL TRAINING

conjunction with AUGIS and ACPGBI. Core skills (three days) at F2 and F3 stages, concentrating on appendicectomy, diagnostic laparoscopy and suture of perforation. Intermediate (three days) in the early ST years, developing skills in cholecystectomy and anti-reflux surgery.

Advanced (various courses for advanced trainees, fellows and post CCT specialists) in colorectal and advanced upper GI e.g. bariatric procedures. Post CCT laparoscopic fellowships in specialist units will be increasingly available.

Training in Emergency General Surgery
All GI surgical trainees would be part of a general emergency rota throughout their training. There is currently little formal training in surgery in trauma and we envisage structured training for all Specialist Gastrointestinal Surgeons in the techniques for life-saving emergency surgery following blunt or penetrating abdominal and thoracic trauma.

Appropriate training in emergency surgery should include ATLS, CRISP, RCS courses, and training in relevant laparoscopic techniques.

Post CCT Fellowships
It will be important to differentiate the training needs of the majority of specialists who will be appointed to larger district general hospitals from the minority who will be appointed to regional teaching. Post CCT fellowships should not be a prerequisite for all because there will be insufficient fellowship posts available. These posts should remain optional for the minority who wish to become highly specialized in regional tertiary referral centres.

Mentorship
All newly appointed Consultants, wherever they work, should receive formal mentorship during the first five years of consultant practice.

Conclusions
Three tiers of Specialist Gastrointestinal Surgeons are identified, who could meet future gastrointestinal surgery demands in all types of hospitals throughout the UK. The majority will service general hospitals around the UK and spend a substantial amount of their time dealing with level 2 and some level 3 procedures appropriate to their subspecialty interest, in addition to elective and emergency general surgery. A minority will super-specialise. Specialist Upper GI or Colorectal Surgeon – a minimum of three years’ training (six modules) in upper/lower GI surgery, the last two (four modules) spent in recognised specialist upper/lower GI training units.

Specialist Gastrointestinal Surgeon – a minimum of two years each (four + four) in upper GI (including an HPB module) and colorectal surgery. This type of split training will equip those aiming for a career in the smaller or remote hospital, and in some cases larger hospitals, where a more general GI portfolio may be sought by Trusts to work side by side with more specialised colleagues.

Super-specialist Upper GI or Colorectal Surgeon – it is important to differentiate the training needs of the majority of Specialist GI surgeons, many of whom will have an Upper GI or colorectal sub-speciality interest and who will service local populations, from the minority who will be appointed to tertiary referral centres, and other general hospitals with recognised specialist expertise, which serve large regional populations. These surgeons will eventually become “super-specialists”, requiring a fellowship year to enable them to offer a more specialised type of service.

All would be part of a general emergency rota throughout their training, resulting in a substantial pool of emergency-proficient gastrointestinal surgeons throughout the UK, and compensating for the withdrawal of many breast and other surgeons from the general surgical take. All newly appointed specialists should receive formal mentorship in the first five years of independent practice.

PROFESSOR A J SHORTHOUSE,
PRESIDENT ACPGBI
PROFESSOR S M GRIFFIN,
PAST PRESIDENT AUGIS
PROFESSOR M MCMHAON,
PRESIDENT ALS

The AUGIS Annual Scientific Meeting for 2007 will be held in Cardiff on 27th & 28th September. The meeting will be held in City Hall which is located in the heart of Cardiff within 2 minutes walk from the vibrant city centre and Cardiff Castle. The venue is within 5 minutes walk from the Millennium Stadium which will host a number of Rugby World Cup matches in September / October 2007. An interesting and varied scientific programme has been drawn up with 5 international guest speakers, covering a range of topics in Bariatric oesophago-gastric and hepatobiliary surgery.

The annual evening dinner will be hosted in the International Cardiff Hilton which is located directly across the street from the meeting venue while all the major Cardiff hotels are situated close by. In conjunction with AUGIS President Mr Myrddin Rees, I encourage all the membership to submit abstracts to the meeting and look forward to welcoming AUGIS members and affiliates to Cardiff to what should be an enjoyable and memorable experience.

GEOFF CLARK
Local Organiser

The 9th
Bill Owen
Oesophago-
Gastric
Symposium...