SURGICAL PRACTICE IN THE U.K.: A PERSONAL VIEW

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PREAMBLE

One of the most interesting experiences a surgeon can obtain is to practise in the UK. Apart from the professional bits, many other features contribute to the overall experience helping to put many things in the right (or wrong!) perspectives. This essay is an attempt to relate *my own* personal experiences, views and opinions. No doubt some of the views would be controversial but I feel that the young medical student and surgical trainee would obtain some benefits from this write up before proceeding on this now familiar journey. This essay would lean heavily on *General* Surgical Practice but opinons are expressed about other branches of surgery and indeed other aspects of medical practice as a whole.

A surgeon spends *all* his (or her) professional life in the *Operating theatres, Out-patients' clinics Wards* as well as other ancillary places like the *Accidents & Emergency* room, the *Radiology department, Surgical pathology & Post mortem departments, the Radiotherapy department* and perhaps other medical departments like *physics, paediatric, obstetrics* etc. This review would try to focus on the surgeon and his practice in some of those places.

THE WARDS

Most wards are divided into small compact sizes with few patients in each bay and centrally located Nurses' stations (unlike the old 'Nightingale' long wards with eccentric nurses' stations) making for easy and quick observations of the patients. The wards are kept clean continuously and oftentimes the doctor and the cleaners compete for space with each other around the patient, each saying 'sorry I won't be long' to another. Generally, each patient has a bell to himself to attract attention but some 'special' patients also have direct summons to the sisters's office with flashing lights and mini sirens. As soon as the pre-op patient arrives on the ward, the house officer is informed either by telephone or by 'bleeping' . The latter is a type of pager which every surgeon and doctor (including consultants) is supposed to carry on his person which flashes and rings and shows the telephone extension of the place where one is wanted, and one either rings this number (from the any of the ubiquitous telephone boxes around) or one goes straight to the place. The house surgeon would clerk the patients and write up any drug(s) which the patient is taking and which must have been brought to the hospital and given to the nurses. Prophylaxis against deep vein thrombosis is meticulous and the house surgeon would write up heparin or any other pharmacologic agent indicated. In addition to (or instead of) heparin, non pharmacologic agents like TED and anti-embolism stockings are prescribed and applied to the patients immediately on admission, in patients with no contraindications. Prophylaxis against deep vein thrombosis and its most dreaded complication is taken very seriously and it can bother on negligence and serious professional misconduct if one does not attempt to prevent it. Indeed some surgeons advocate prophylaxis for every patient regardless of risk. In clerking patients, filling forms and labelling specimens, life is made somewhat easier for the house surgeon due to something called an *addressograph.* This is a piece of sticky paper (several of them) on which the patients' details (age, sex date of birth, home address etc) are generated by a word processor and which is peeled off and stuck on notepapers, specimen forms and bottles as required saving enormous time and energy in writing these out everytime. In most places and under non emergency situations the house surgeon does not have to obtain blood samples himself. This is done by *phlebotomists* who make use of the pre-labelled specimen forms. The houseman's bleep number must be written on the forms so that *urgent or grossly abnormal results* can be communicated to the doctor at once. The phlebotomists usually go round in the mornings, so the house surgeon who does not wish to spend precious time doing venepunctures would have filled all relevant forms the precious evening and deposited them in the appropriate boxes! Sometimes the phlebotomists, when they are not too keen on working, employ spurious excuses like claiming that forms are improperly filled or that the patients is 'too sick' and has to have his blood taken by a doctor. But it has to be said that many of those doing this job are in fact doctors from developing countries who are yet to obtain registration and need to make ends meet. Ward rounds are not always necessarily organsied as we have here and it is not unusual to have the consultant and just the house surgeon conducting the round with the other members of the team in the theater or casualty. Ward rounds are at times done in the Sister's office by just looking through the case notes and discussing the patients with the nurses ... the so called 'office round' . Indeed many a time the patient's notes would have been perused and discussed in the office and some decisions taken *before* the doctors get to the patient. One has to be very careful about discussing the patients's condition in his presence because of the level of awareness and it can be quite embarassing to be asked by your patient how many more days he has to live after you have relayed the histology report to the consultant at the patient's bedside. For pre-op patients, getting informed consent can be a daunting task ...the house surgeon has to go over every detail of an operation he probabaly has not even read about let alone seen ... with the patient (or more likely the relations) asking about every detail. It is much more proper however for the surgeon *performing the operation* to discuss these details with the patient himself but this is not always possible. I remember vividly on my first day at work having to describe the operation of carotid endarterectomy and its complications to a somewhat demented 75 years old man and his wife and being asked whether *I* would be the one to do the surgery. Of course the consent form does not allow you to assure that a particular surgeon *would or would not* carry out the operation and I remember the astonished looks on the faces of the patient, his wife and nurses when I calmly replied, 'Yes, it could be me - do you have any preferences sir?'. For operations on bilateral organs and structures (e.g. herniorrhaphies and limb amputations), the side of the operation has to be clearly marked with indelible ink on the patient *even*

when the lesion is quite obvious and failure to do this borders on surgical sacriledge. Sometimes the significance of this is overflogged and forgotten and it is not uncommon to see the house surgeon or even the senior house office putting a circular mark around a pigmented lesion on the left hand. The purpose of the marking is *to identify the* ***side*** *of the operation,* ***not the site.*** The site, nature and extent of the lesion would and should have been ascertained by the responsible surgeon well before booking. I suppose this can be said of the side as well but it is more embarassing and disastrous to take off the wrong breast than to take out two moles instead of one. The perfect antidote to these possible errors is to have a proper pre-operative round which is not routine in many places. Control and prevention of perioperative and post operative pain is taken very seriously and starts on the wards. For young children (and some terrified adults) it is not permissible to perform a venepuncture without putting on the skin what is called EMLA cream *(Eutetic Mixture of Local Anaesthetics)* to numb the skin, even though it is more likely that a child's cries and agitation during a venepuncture has more to do with *anxiety and apprehension* rather than to pain. It may also be advisable to insert a long acting analgesic in the form of a suppository into a patient as he is being sent for, though I prefer to let the anaesthetist do this just after induction especially in young female patients. For operations where transfusions might be necessary but not inevitable e.g. elective small bowel resection, crossmatching is not automatically done and the request form would read..'group and save' where the blood grouping would be done but the serum saved for possible crossmatching later if necessary. This saves a lot of resources and energy as inevitably one is bound to be asked - 'are you really sure you want to transfuse? Why don't you call your consultant to do the operation?' if one insists on getting a crossmatch beforehand - and it can require a lot of tact and self control in trying to explain the situation.

Medical students come to the wards freely as we have here. But due to the high level of awareness, much care and tact is needed in dealing with patients. According to the patients' charter, the patient has a right to refuse to be questioned and/or examined by students - even in teaching hospitals. This charter, drawn up in the early 90s, also gives the patient several other rights and priviledges which at times puts the surgeon on the defensive. It is well established that chaperones are essential when a doctor is undertaking procedures of a sensitivive nature on a patient of the opposite sex - but nowhere is it more so than in Britain and I always made sure to remember this - even if it's a male patient! It is not uncommon for a young lady to raise eyebrows if you want to examine the opposite breast after examining the one with the lump she complained of and one would need to patiently explain (with the help of the chaperone of course) why it is important to do so. This is even more important when the examination involves the genital region and many a time I would wait with already gloved hands for the nurse to appear. Sometimes the patients (or the relations) would urge you to proceed without the chaperone - 'oh, you can carry on doctor, it doesn't really matter' some would say, but one should politely ignore this. Instances abound when surgeons have been accused of indecent assaults most often maliciously. Exceptions would be in emergency and life threatening situations but these would be obvious. The patient should always be asked to remove all items of clothing by herself/himself and on no account should a patient's blouse be removed for her by the surgeon. Every step of the examination process should be explained to the patient in the form of a running commentary - 'by the way Mrs Jones, when I finish feeling your abdomen *(why does he want me to remove my corset when I only complained of pain in my tummy?)* I will then listen to your chest and then *I may* put a finger down below - it's important'. And both of you look over to your nurse chaperone who nods assertively and corroborates your statement. Privacy is also very important and on no account should a patient be exposed for examination without proper screening even if all you want to do is to look at the tonsils. For patients who need or already have stomas, a *stomatherapist* usually comes on the round with the surgical team. The stomatherapist is usually a nurse who has had training in the care and management of stomata and who usually discusses the pros and cons of a stoma to patients who need them. In elective situations this is virtually mandatory but may not be practicable in an obstructed geriatric who needs an emergency Hartmann's operation in the night - though in some centres facilities exist for contacting the stomatherapist at any time. There are also people known as *breast counsellors or breast care nurses* who must see and counsel every patient needing mastectomy and who usually comes on the round with the surgeons. Their duties are similar to those of the stomatherapists, even though these ones do not need to carry bleeps in the night since mastectomies are elective operations done during normal working hours. Of course the physiotherapists follow the orthopaedic surgeon as usual as well as speech therapists and other staff necessary. Contrary to the fairly routine practice here, questions are hardly ever asked from students and even junior doctors on ward rounds (any doctor below the rank of a Consultant is described as a junior doctor). Such questions are usually reserved till later - in the coffee room or the Consultant's office. This is probably to avoid embarassing the students in front of the patients. The students are only encouraged to listen to the presentation and follow commentary by the Senior Registrar or Consultant. Conversely, a lot of Consultants find it irritating to be asked questions particularly on direct patient management *in front of the patient* though I find this rather objectionable with respect to my own background and upbringing here. In some centers, *routine* ward rounds are done out of hours, sometimes at 7pm!, and every member of the team is encouraged to be present - if you know what that means. White coats are mandatory for every surgeon *except* the Consultants who almost always prefer to appear in suits while putting their fingers (and jacket sleeves!) in patients' innards. It is common practice to see house officers on ward rounds with their electonic organisers which are used to take down notes on patients to be transferred to the notes later. Dictating machines (dictaphones) are also used routinely on rounds with the Consultant recording his management outline on a tape to be given to the secretary for typing into the patients' notes later. In many centres no handwritten notes are permitted and all entries have to be typed, to be signed by the surgeon later. This is said by some to be necessary to avoid illegible note taking and inevitable errors which may ensue. Every doctor must write his/her name in full after signing at the end of each entry as this facilitates prompt identification when necessary. Sometimes some doctors carry their peronalised stamp pads bearing their names

which they stamp on the notes after each entry. Drugs to be given ***must*** be withdrawn by the surgeon himself especially intravenous drugs in order to avoid errors - should it be necessary for the nurse to withdraw for the doctor (as when the doctor is already gloved or is busy performing a cardiac message) the empty ampoule must be shown to the doctor before injecting - and the syringe is not discarded immediately. As we do here, intravenous drug administration and any form of arterio-venous punctures are supposed to be carried out by doctors but some experienced senior nurses are allowed to do this, especially if they are favourably disposed to the house surgeon and would not want to disturb him at night. The converse may also occur because some nurses may *deliberately* and unnecessarily call on doctors *they want to chat with* even if it's 3am! All needles and sharp instruments like scalpels and cannulae are disposed off in special 'sharp boxes' made of tough and impenetrable hard plastic material, preventing accidental innoculation. These boxes are available everywhere and failure to make use of them when necessary can be sacriledgious - there were instances of staff being dismissed for causing accidental innoculation of other staff due to failure to observe this procedure. There are also boxes/ bags for the disposal of soft/non sharp items in various colours - yellow, black etc according to the infectivity of the contents.
*A *ward clerk* is present on every ward. Usually a female, her duties would include the registration of all admitted patients to the ward on the computer (available in every ward), retrieving the case notes (from out patients clinics, consultants' offices etc) and notifying the patients' relations about admisssion requirements. She (or the ward sister) would also inform the house surgeon of the patient's arrival on the ward. All discharges are also handled by the ward clerk in conjunction with the house officer.

*Resuscitative duties are carried out by special teams. A **cardiac arrest** team usually made up of the *medical registrar, anaesthetic registrar and paediatric registrar* are the ones summoned via a special pager, whenever a cardiac arrest occurs.The ward nurses usually initiate the summons even before informing the surgeon and it is not common to stroll into your ward only to find a flurry of activities around your collapsed patient. My own practice, whenever the cardiac arrest bleep goes off (you can hear it too on many bleeps) and when I have very ill patients on my hands is to ring the ward immediately and inquire - and it can be quite a relief to be told you can carry on with watching the big match on TV and that all your patients are okay. A **trauma team** is also available in most hospitals, made up of the *surgical registrar and SHO, anaesthetic registrar/SHO, orthopaedic registrar, a casualty officer, a medical ultrasonographer,* and some experienced Accidents and Emergency nursing staff (the composition can be variable with different hospitals). This team is summoned immediately to the A&E department as soon as a major accident is reported and everything is made ready and in place before the victims actually arrive. Sometimes the team has to go to the scene of the accident to free victims and administer first aid treatment on the spot. The Kings' Cross underground train disaster in 1988 was a case in point, as well as the Midlands place crash in 1989. At the Royal London Hospital in Whitechapel (which is also the regional Trauma/Neurosurgical Centre for the South-East of England) a service known as HEMS (Helicopter Emergency Service) operates where surgeons and paramedics are flown by helicopter to scenes of accidents to salvage life and limb - including roadside amputations and thoracotomies. There is a team leader (usually the surgical registrar) who directs affairs and tells who to do what in the manner of securing the **A**irways - oropharyngeal airway, endotracheal tube, monitoring, **B**reathing - air entry, chest movements, ensuring an adequate **C**irculation - intravenous lines, fluids and blood replacement and cardiac massage, giving necessary **D**rugs - analgesics, inotropes, prophylactic antibiotics and so on. Blood for investigations is withdrawn by a particular individual with meticulous attention paid to labelling, in view of the all the rush and excitement pervading. The team leader usually does the initial examination with a running commentary to his SHO who writes everything down and the time. **E**xamination is made from head to toe not omitting any system. If not already started, **F**luids are begun and a urethral catheter is passed. The ultrasonographer (usually the senior registrar in radiology) does an abdominal ultrasound to rule out any major solid organ injury and any free peritoneal fluid. A hard cervical collar is put on any accident victim until a lateral cervical spine radiograph (one of three initial films taken as soon as possible) rules out any fracture/dislocation. The other two immediate films taken by portable machines in the A&E department are of the skull and the chest - the latter being absolutely mandatory irrespective of the mode of injury. By this time the major system injured should be evident and some of the members of the team no longer needed would have begun to disperse. The patient may need to be taken to theater immediately or may be taken to the intensive care or in more favourable cases the wards. Oftentimes however, the trauma team's summon is unnecessary and some patients with embarassed smiles on their faces ... 'I'm sorry for all this bother doctor, it's all my GP's fault' are discharge home. Washhand basins are available everywhere with running water at all times. Instead of bars or cakes of soap, containers containing liquid soapand detergents are positioned atop each basin. The liquid soap is dispensed with the elbow onto the dirty hand when it needs washing. This avoids having to handle a bar of soap with the dirty hand when it needs washing and reduce the risk of transmitting infection from one personnel to the other. Disposable paper towels are used after washing (located also above the basins - besides the soap dispensers) instead of cotton/ line towels, for the same reasons given above. What I do in addition is to take a cotton towel in my white coat pocket for my personal use in case the disposable towels run out - something I used to do before I ever saw disposable hand towel - and which I still do now.

THE OUT-PATIENTS' CLINICS

Every patients is given an appointment at a particulaar time, thus avoiding the coming of all patients at the same time and long waiting periods. All cold cases presenting for the first time must be referred by the patient's GP. All other cases are referred from the A&E or from the wards for follow up. There are no General Outpatients' Department (GOP) as we have here. The GP would have sent a letter to the relevant Consultant whose secretary would then telephone and write to the patient about when to come for the appointment. If the time is inconvenient the patient is allowed to reschedule it for a more convenient time. The patient is also expected to inform the clinic if he/she would be unable to keep a previously confirmed appointment so the slot can be given

to someone else. A patient who misses an appointment without informing the clinic is frowned upon, and attempts would be made by the clinic clerk to find out why. If the reasons are genuine the patient may be given an appointment for the next clinic - otherwise a patient who misses three consecutive scheduled appointments is taken off the clinic list. Clinics are usually run by the Consultants, Senior Registrar and the other junior doctors as we have here - the house officers usually staying back on the wards except on very busy clinic days. Certain investigative procedures (sigmoidoscopies) and therapeutic procedures like injection of varicose veins and haemorrhoids are routine in the clinics and the materials are readily available. In addition there are special clinics for gastrointestinal endoscopies: colonoscopies, gastroscopies, endoscopic retrograde cholangiopancreatographies (ERCP). The latter is usually done by physicians but some surgeons now do them routinely especially at the Royal Sussex County hospital in Brighton and it can be valuable experience for the budding surgeon. There are also special clinics - breast and oncology as we have here, and things like the 'bum' clinic for anorectal conditions and the vascular clinic. The idea of the special clinics is to concentrate and maximise resources for a particular clinic and to have specially trained staff in attendance. Most surgeons tend to specialise in either upper or lower GI endoscopies but for the foreigner going back to his home country the most sensible thing is to gather as much experience as possible. When attending to patients it is wise to introduce yourself and your status - 'Morning Mrs C... I'm ... Mr ...'s ... and I'II be seeing you today. From my own experience that's usually sufficient to proceed and I hardly can remember an occasion when my attention was refused. Indeed, there were many occassions when the patients preferred to see me, rather than the Consultant. This is partly due to fact that foreign doctors are seen as being more attractive and listen to the patients' compliants better. I once had a patient who told me I was the first doctor to explain her ailment properly to her in twenty years - (she had Crohn's disease). As on the wards a chaperone is essential and every step of the procedure has to be explained. In many clinics, rubber stamps depicting certain regions e.g breast, neck, chest, and abdomen are available to help the artistically challenged surgeons and to help document findings more accurately. The clinics end when the last patient has been seen but ocassionally one has to wait for a patient to bring back the result of a doppler ultrasound to determine whether she needs admission and treatment for deep vein thrombosis. After a patient is seen a letter has to be sent to the attending GP informing him of the patient's present condition and whatever treatment and procedures/investigations were done on that particular visit and when the patient is supposed to report again. Such a letter should reach the GP well before the patient's next clinic date. Many clinic sessions are held in the afternoons, and may extend well into the early evenings, particularly for the benefit of those who have to close from work before attending. In some hospitals, specialty clinics e.g. gastroenterology or genitourinary are held jointly *(combined clinics)* by the medical and surgical divisions. This facilitates easy cross-referral. There are also what are known as *"Pre-admission"* or *"Preclerking"* clinics, where the preop patient is seen, about one to two weeks before admission, in order to thoroughly evaluate the patient who may have been booked for admission and surgery several months before. This avoids having to cancel the operation when the patient has already been admitted if found unfit. All investigation results are checked, and fresh ones ordered if necessasry, well before the day of surgery. Another advantage of this system is that it allows another (fit) patient to be substituted for the cancelled (unfit) patient and avoids wastage and underutilisation of theater sessions. It is also not uncommon to have to run clinics in a neighbouring hospital in another village involving a bit of travel. These *outreach clinics* as they are called help to lighten the regular clinic loads and can provide bits of fun and excitement as well as making one know more about the countryside.

THE ACCIDENTS AND EMERGENCY UNIT

Most patients are referred by the GP, who would have informed the relevant specialty registrar/SHO about the patient on telephone before. The registrar would then advise the GP to send the patient to the A&E, and would inform the sister in charge. When the patient arrives (usually by ambulance) the specialty registrar is sent for directly. This bypasses the casualty officer and saves a lot of time and allows the doctors in casualty to concentrate on cases who are self referred. It may also be beneficial for the patient who is seen straight away by a doctor he knows very well (and vice versa) and who may have just discharged the patient only a few days before. But this may not always be as simple as it sounds especially if the surgical registrar is very busy with many patients and it is not uncommon to see directly referred patients complaining about the casualty officer reading newspapers while they lie interminably on the trolley.

In most places, there's an A&E Consultant, who is usually a surgeon, but performs all his duties in the A&E, and supervises the junior doctors. There is also usually an Associate Specialist - more often than not a foreign doctor who cannot progress professionally to a Consultant - but whose knowledge and skills may surpass that of the A&E Consultant. In many places also there are experienced A&E nurses who have undergone relevant training and are able to perform many resuscitative and life saving procedures like endotracheal intubation and chest drainage. In my own experience most cases who present in the A&E fall into the physician's realm - myocardial infarction, diabetic keto acidosis, bronchial asthma and epileptic fits can be disappointing for the surgeon who wants to gain more experience in the A&E in the management of surgical emergencies, as most of such cases are sent to the various speciality registrars directly and not to the casualty officer.

THE OPERATING THEATERS

Perhaps the most interesing place for a surgeon is the operating theater - and some interesting things do happen here. Elective theater sessions may take place in the mornings or afternoons. The team usually operates in two batches - the consultant and the senior registrar in one suite doing the very major cases, while the registrar and the SHO take care of the minor cases in another, but adjoining suite. The personnel may however be arranged in whatever manner suitable. Sometimes the registrar has his own list, with his own name printed on the operating list as the surgeon and not that of the consultant as is always the case here, on the same or different day from when the consultant operates - the so called "Registrar's List". But the Royal Colleges are somewhat averse to this as they believe that all but the most minor of operations should be supervised by a consultant. The lists are

generally short and may contain many abbreviations that are unacceptable here. It is not uncommon to see something like - Alice Davies dob 12.01 44 Kingfisher Ward SCAPER. (SCAPER is **S**ynchronous **C**ombined **A**bdomino **P**erineal **E**xcision of the **R**ectum). In some hospitals, there are theater suites dedicated solely to day cases - like at the Saint Bartholomew's hospital in East London, a world class center where as many as two hundred herniorrhaphies may be done in a month. There are also endoscopy suites with facilities to proceed to major surgery if necessary. During surgery most surgeons prefer not to be asked questions and at times it may be so boring. One may ask 'why have you tied with vicryl' and get a snappy 'that's what I always use' answer, but some surgeons can be quite jovial. All hospitals have personnel called ***Operating Department Assistants (ODA's)*** who have an initial nursing training and who have undergone special training in theater and perioperative procedures (the course is a bit more than that for our perioperative nurses here) and who can assist the anaethetist (they can intubate and induce anaesthesia under supervision) and can also assist the surgeon (as scrub nurses and in assisting at operations). They take calls like the medical personnel and are particularly useful during night surgery. The actual conduct of the operations may at times look like rituals with every step performed 'the way it should be done' and any deviation is frowned upon - never mind that 'the way it should be done' is totally outdated and archaic and obsessive. I once worked with a surgeon whose appendicectomy incisons must be a particular lengh and each incison is measured to the last milimeter. But the spirit is admirable and the foreign doctor is allowed to operate virually as much as he is able to. There are 'camps' and personality clashes as we have here but these are not allowed to influence clinical and professional judgements especially during operations when if things go wrong colleagues who are able to help are promptly sent for even if they happen to be in the wrong 'camp'. I recall an occassion at the Newham General Hospital in East London when we ran into trouble while trying to remove a liver mass laparoscopically and we had to send for an expert from Hammersmith Hospital in West London even though the two consultants who were experts in surgical hepatology hardly see eye to eye. Also when things appear not to be moving the way they should during surgery pride is swallowed and the assistant is asked to help - or take over especially if the 'assistant' is in reality a more experienced surgeon from another country and has been forced by circumstances to take up that particular job. Atimes, operating manuals are consulted *during* operations and the theater sister is asked to open to a particular page and read out - or the book is held out to the scrubbed and gowned surgeon to read himself. Photographs of the operation may be taken but must not render the patient (or any member of the attending team not wishing it) identifiable and must not show the genitals except as an integral part of the operation. A lot of hospitals now have video cameras installed in theater to monitor the operations (for teaching students in another suite) and for record purposes when things go wrong. The General Medical Council has been asked to make this mandatory in all operating theaters but some surgeons are averse to this.

Laparoscopic Surgery is the in-thing now in the western world and Britain is not an exception. It will be exceedingly difficult for a surgeon to get a job and practise successfully in the UK if he does not possess laparoscopic surgical skills. Certainly all new generation surgeons are trained in it and many older generation surgeons have gone 'back to school' for it. There is virtually no abdominal or pelvic operation that cannot be done laparoscopically now and sometimes this may become detrimental to the trainee surgeon. Many centres (Asford Middlesex, St. Mary's Paddington) remove all gall bladders and repair all hernias laparoscopically - so no experience is gained by the trainee in the open method of these operations. A trainee who has never seen an open cholecystectomy may find himself out of depth when he goes back to his home country where laparoscopic surgery is not practised. Partly becuase of this (and also because of when the need to convert to open operation arises) such centers are encouraged to have some sessions of the traditional way, but resistance is strong - particularly if the patient opts for 'key-hole surgery'. In a few places tradition still holds sway however with laparoscopic surgery hardly being done and this can be frustrating for the trainee as well for the opposite reasons cited above. Operation notes are usually typewritten and in most cases the consultant (or the operating surgeon) prefers to dictate to the secretary or write the notes himself instead of leaving it to the registrar as is the common practice here. On many occasions I find the operating notes rather too sparse and not well informative. I derived great satisfaction seeing the students poring over my own notes and muttering among themselves - 'He cleaned the skin with povidone iodine - we don't know what Mr. X cleaned with yesterday'. Some noteworthy theater practices include the use of steristrips (thin flimsy adhesive sterile papers) to close small superficial wounds and the use of tissue adhesives, thus avoiding suturing and minimising scarring - the use of povidone iodine spray in wounds just before closure to prevent infection - the use of coloured sutures (vicryl, dexon) in deep tissues (anastomoses) for easy identification at endoscopy and reoperation - the generous use of bipolar diathermy - and the use of special skin cutting diathermy knife that gives a better scar than one done with the scalpel. Other interesting practices include day case haemorrhoidectomy and day case laparoscopic cholecystectomy.

CLINICAL MEETINGS

These are taken very seriously as they form part of the auditing process which is compulsory for every clinician in Britain. Meetings are generally held within the normal working period (9a.m - 5p.m) and are almost always held between 1 and 2 p.m (lunchtime meetings) as you work your way through lunch - though I find it sometimes disconcerting trying to ask about the prognosis of the patient presented between mouthfuls of rice chicken curry. Some meeting are held early in the mornings (breakfast meetings) but these are unusual. The format may not be as formal as we have here and it is not unusual for the consultant to be the first speaker and with most of the discussion done before the house surgeon if asked to put up the X-rays and to interprete them! Interdepartmental meetings with radiology or pathology are also regular but usually the discussion proceeds straight to the findings without any clinical presentation - a situation I find amusing atimes as one may later have to ask the pathologist for the duration of symptoms who would then turn around to ask the house man who may probably have gone back to the wards to reset a drip and all you finally get is 'oh, never mind..it's probably a long time'. But these meetings are generally enjoyable and interesting.