International Federation of Surgical Colleges

The Federation was founded in 1958 in Stockholm, Sweden, with the objective of establishing a neutral institute that would speak with a single voice for world surgery on problems of common interest. Official relations with WHO began in 1960 and have resulted in collaboration in the writing and editing of the very useful book, *Surgical Care at the District Hospital*, formal endorsement of the Alliance on Patient Safety, the Surgical Safety Checklist, full collaboration with the Global Initiative for Emergency and Essential Surgical Care and the inclusion of essential surgery as an integral component of essential primary health care. The Federation is also affiliated to the United Nations and is represented on the UN Economic and Social Council as principal advisor on all matters surgical.

However, by 1992 the proliferation of surgical specialties meant that the objective of speaking with a single voice for world surgery became increasingly unrealistic. The constitution was therefore amended and this resulted in biennial meetings with the International Society of Surgery, scholarships to young surgeons from the developing world, library support programmes and clinical research projects.

The beginning of this century saw rapid changes in surgery and surgical education, increasing availability of computers and huge developments in software technology such that by 2003 Federation activities were essentially at a standstill. It either had to undergo further reform or cease to exist. The membership agreed that the Federation should continue but with a revised Constitution. The objective became the advancement of surgery in developing countries, particularly in Africa, by promoting surgical education, training and support with examinations. To this end a Memorandum of Agreement was signed with the College of Surgeons of East Central & Southern Africa (COSECSA) in 2007 and this to provide an annual Intensive Revision Course in Anatomy, Physiology and Pathology, (whose responsibility was handed over to the Royal College of Surgeons in Ireland in 2010), and a visiting Professor to attend Regional and/or Annual Meetings.

Our current aim is still to support COSECSA in their mission to promote standards of excellence in surgical care, training and research.

However, in recent years global problems in surgical education, training and service delivery have been forcing themselves back up the agenda. The diminishing attention to anatomy and surgery in many undergraduate curricula, a tendency for surgical training to become more specialised and with less time to undertake it due to working time directives in some countries, are three examples. Increased specialisation is making it increasingly difficult for some hospitals in the developed world to support emergency rotas for general surgery. At the opposite extreme there is still a huge problem with lack of capacity to undertake essential surgery in many parts of the developing world.

It is suggested that the Federation needs to return to its wider global vision and become actively involved in pursuing these issues, as well as supporting COSECSA whose members are facing many challenges at the present time.

It is therefore proposed that the Federation act as a Centre to bring together the Surgical Colleges, Associations and Societies in order to agree a way forward on a range of issues that affect us all, some more than others, across the breadth of surgery and thereafter to publish consensus statements.

For instance:-

1. ***To advocate the free movement of trained surgeons across the world with due recognition of comparable degrees and diplomas.*** If a trained surgeon from, for instance, the United States, Australia, New Zealand, Africa, India wishes to come to the UK to practice then he/she will have to undergo a rigorous assessment and examination process whereas if a surgeon in similar circumstances wishes to come from the EU to the UK there is no formal assessment or examination whatsoever!

2. ***Health care associated infections such as HIV/AIDS, Hep B, C, etc.*** There is still ignorance in the developing world, not about the infections themselves, but about adequate precautions to prevent infection and what procedures should be in place if contamination does occur.

3. ***Impact of working time directives.*** This not only affects those in training but also Consultant staff in the developed world which are, in some countries, producing great difficulties with continuity of care.

4. ***The future of medical education***. This with regard to the teaching of anatomy and surgery in undergraduate curricula.

5. ***The future of emergency general surgery.*** This will differ from country to country but with more specialisation there is a tendency to concentrate emergency surgery in larger hospitals, which may be significant distances apart. Whilst this may be satisfactory in some countries; it is causing problems in others.

6. ***How to increase the capacity of surgeons throughout the developing world.*** The problem is not so much with the number of medical undergraduates but with retaining their services after they graduate. At the present time many will be deterred from taking up surgery because of the long training, difficult examinations, poor remuneration and the added risk of developing HIV/AIDS. Others will start out on a career in surgery and then migrate into public health or administration and some will emigrate for lack of opportunity, better lifestyle and remuneration. If this situation continues, it is clear that an alternative source of providing essential surgery, particularly in remote district hospitals, must be found. A number of developing countries have adopted the principle of training non physician clinicians to undertake this role. The IFSC could assist this change of direction in a number of ways.

7. ***The future of academic surgery and research. .*** Much research in the developed world has been taken over by scientists in this micro cellular and genomic age and maybe that is right but we do need a component that translates success at this level into surgical practice and that should involve us as surgeons. In the developing world there is a great need to teach research methodology and to undertake research into the burden of surgical disease and other major issues such as evaluating changes in surgical delivery. IFSC could act as a co-ordinating focus for these activities.

All the above are examples whereby the Federation can produce consensus statements on behalf of its constituent members and bring much needed co-operation and co-ordination to our activities.

There are also issues in professional practice that affect surgeons and surgery across the world, such as how to work as a surgeon overseas, how to deal with the increased incidence of non-communicable diseases such as obesity, heart disease and cancer, the role of expanding technology and how to cope with increasing demand with diminishing resources.

We need to share data and knowledge on these issues because in some way or another they affect us all. We need to disseminate best practice so we do not forever go on redesigning the wheel. As IFSC has been in official relations with WHO since 1960, we should continue to influence WHO on matters of importance in surgery and anaesthesia.

There are many ways in which the Federation can facilitate and co-ordinate activities, such as providing external examiners for undergraduate and specialty examinations, organise and co-ordinate travelling Fellowships and arrange postgraduate courses in the developing world, as constantly requested by member Colleges.

The Federation is now housed in the office of the Association of Surgeons of Great Britain and Ireland in London and, furthermore, has been granted Charitable Status in the UK and this so that we can raise our profile and also funds as a legitimate player on the world stage.

It might now be pertinent to consider reverting to our original objective in 1958 of speaking with a single voice for World Surgery on problems of common interest. None of all this signifies that we should reduce our efforts in the COSECSA Region. Far from it because by employing many of the means outlined above we shall be enhancing our role in conjunction with others such as the Royal College of Surgeons in Ireland, who had been generously housing the Federation until its move to London.

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