



ETHICAL
PRINCIPLES
OF WORKING
OVERSEAS

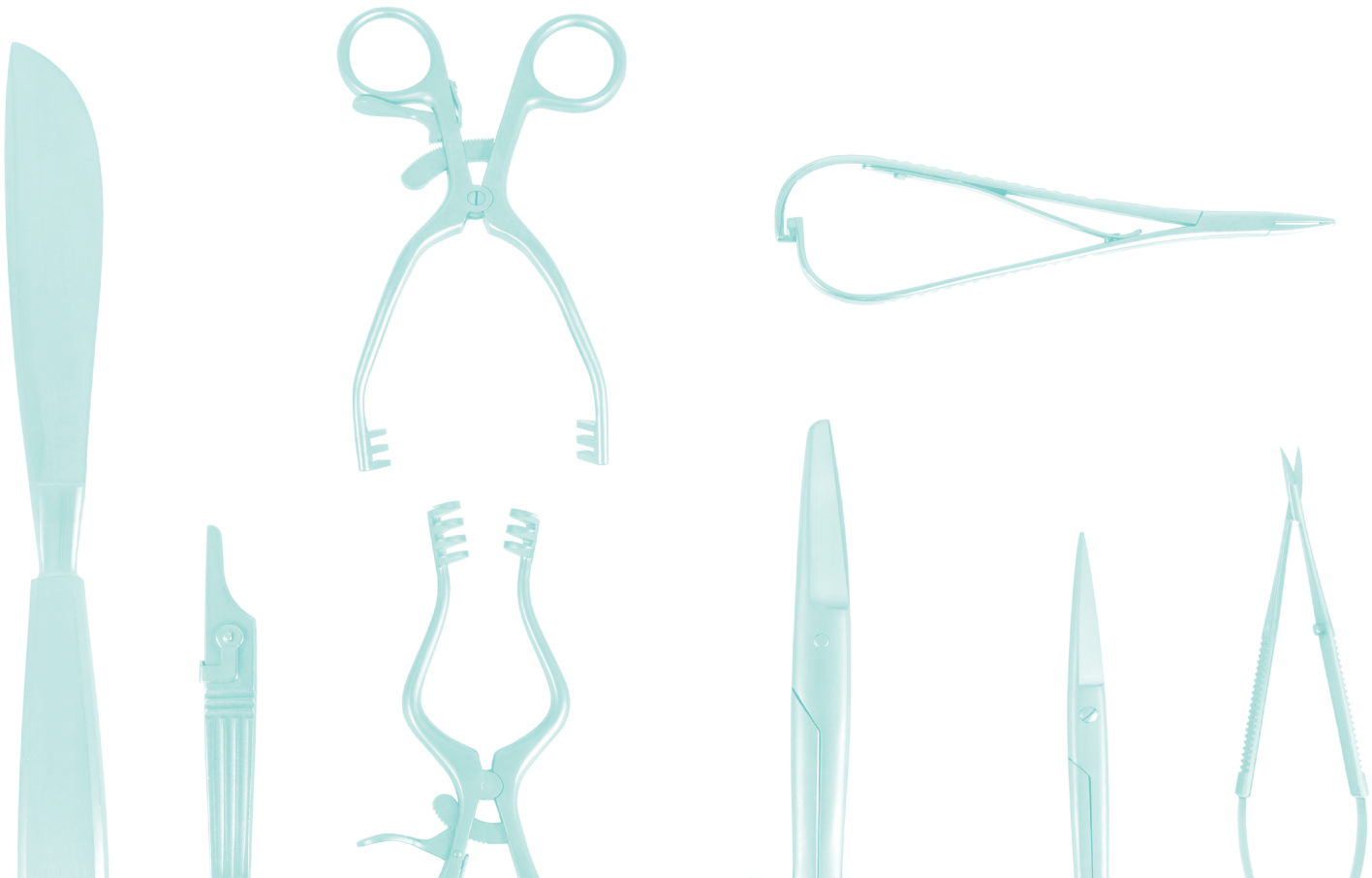


Royal College
of Surgeons

ADVANCING SURGICAL CARE

ETHICAL PRINCIPLES OF WORKING OVERSEAS

A Guide to Good Practice for Surgeons and Surgical Teams



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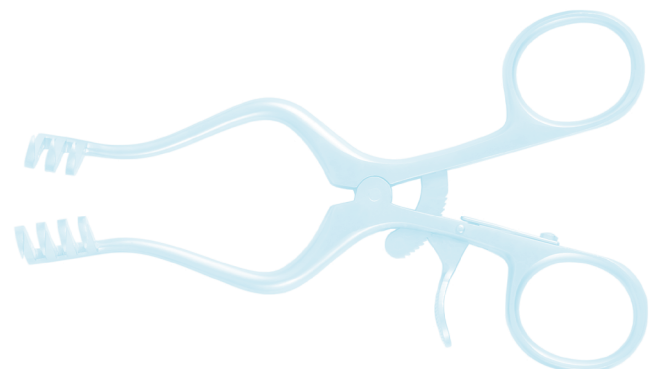
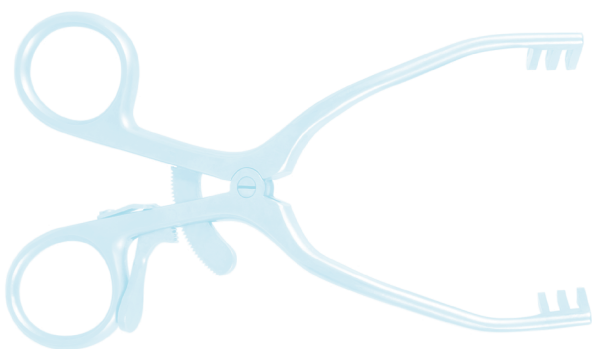
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| Introduction



Increasing global mobility has been accompanied by a great increase in the number of surgeons and teams working outside their UK practice for variable periods of time. Surgeons with varying degrees of expertise seek to work outside the domain in which they have been trained for diverse reasons including humanitarian partnership, emergency relief, experience, training and personal gain.

A wide spectrum of clinical and humanitarian standards and practices exists throughout the world. Surgeons encountering these standards frequently find themselves faced with dilemmas related to best practice and ethics.

The Royal College of Surgeons (RCS) has prepared this document as an advisory code of practice to affirm the standards to which it expects all members of the surgical team working outside UK borders to adhere.

What can I learn from this guide?

This document describes the principles of good professional practice expected of UK surgeons working abroad. It does not duplicate the principles of *Good Surgical Practice*¹ or those of *Good Medical Practice*² but it builds on these documents to address some of the key challenges in professional practice faced by surgeons and surgical teams working outside the UK, and specifically in nations where cultural and ethical perspectives might be at variance with those espoused in the UK.

This guide is not an exhaustive exploration of potential areas of surgical practice where ethical principles might

be put to the test when surgeons visit in circumstances of differing culture, resources and challenges. It does, however, seek to draw attention to aspects of practice that can present difficulties if not negotiated with wisdom and good judgement. It is an evolving document that will be enriched with future experience and contributions from visitors to less resourced parts of the world, who are encouraged to engage with this important work of collaboration between surgeons and teams from the nations of the world.

Overarching principles

All recommendations in this document are underpinned by the following overarching principles:

- **Local service focus:**
An attitude of service that aims to assist populations and colleagues overseas and makes every effort to discern what host nations wish to see in those who come to partner their own best efforts to develop and meet their needs.
- **Sociopolitical awareness:**
An awareness of the sociopolitical complexity that exists throughout the diverse nations of the world, into which the delivery of healthcare is inextricably woven, as well as explicit respect for local laws and
- **sensitivity towards different cultural and religious values.**
- **Personal conduct and behaviours:**
An expectation of adherence to the same ethical and legal standards of behaviour and conduct that apply in the UK, and commitment to being mindful of and avoiding any behaviours that might be considered exploitative of vulnerable populations.
- **Reflective practice:**
A process of constant reflection around one's activities to ensure the highest possible professional standards in each circumstance.



Building local partnerships

AWARENESS OF INTERNATIONAL PERSPECTIVES

Much work in healthcare outside the UK is motivated by humanitarian concerns for those with whom an individual or group might discern a need or receive a request for partnership. Within our world, which has such huge disparity in birthright and resources, it is easy to fall into unhelpful patterns of behaviour based on power relationships – however unwittingly they might be embraced.

While British surgeons travelling abroad to work will undoubtedly have underlying motivating principles for their activities, there is abundant evidence that the most effective periods of such activity follow considered reflection on the requests and needs of the host nation. In the past, many humanitarian ‘missions’ were designed and undertaken by those whose opinions had been formed in their own environment with inadequate consideration of heard views from recipient communities and populations.

It is important that the visiting surgeon has an understanding of the wider political and healthcare administration of the host nation. Alongside the contemporary situation, each nation also has a history that might well have past episodes of colonisation, armed conflict and a legacy that will have shaped attitudes towards the best means of improving healthcare. In some cases, this might even involve a rejection of seemingly well-designed and motivated assistance, requiring great diplomacy and listening before future direction can be determined. Surgeons are advised that the perspective of a host nation will almost invariably be more complex and nuanced than at first thought, and developing deeper understanding in partnership with hosts is one of the great rewards of such work overseas.

CAPACITY BUILDING

Best practice in development has been considered carefully by many authorities. In general, although many needs become evident in acute circumstances (such as disaster related emergencies) and require rapid action, the most valuable activities aim to support sustainable services through the development of capacity – both personnel and facility.

The RCS supports such capacity development as a principle, and urges surgeons and surgical teams to work alongside host nation services in partnership rather than in any imposed fashion, however well intentioned. Such partnership with nations involves explicit respect for local laws and requirements – most specifically registration with health ministries and appropriate professional bodies.

The ability of surgical intervention to make a very real and practical difference to individuals previously denied access to care carries the risk that surgeons and surgical teams focus too heavily on service delivery at the expense of indigenous capacity building. There is now abundant evidence of the often deleterious effect of external agencies delivering surgical care in ‘parachute mission’ fashion, when well-meaning activity can demoralise and demotivate local surgeons and their teams.

While there will continue to be some value in addressing the deficiencies in surgical services in many low- and middle-income countries by visiting teams, surgeons are asked to question each and every such activity for the balance of capacity building against service delivery. Such adverse effects are often subtle and invidious, and might only be voiced by the host nationals reluctantly for fear of causing offence or ‘biting the hand that feeds them’ despite the counter-developmental impact of repeated visiting missions.

There are occasions when circumstances determine rapid action to deliver humanitarian support when it is reasonable to adopt a pragmatic approach towards formalities and national requirements. However, these situations are rare and almost invariably will be led

by highly experienced aid agencies, whose guidance will be paramount in determining surgical practice. This aspect of care (see Emergency care and disaster support in the next section) is fraught with difficulty. The RCS expects that surgeons will constantly reflect on the circumstances of aid efforts and, while listening always to the views of host nations and colleagues, be wary of compromising their personal and corporately held standards embodied by this document.

WORKING WITH AID AGENCIES

Humanitarian aid agencies are often referred to as non-governmental organisations, or NGOs. Some focus on long-term developmental work, whereas others respond to emergencies by providing humanitarian relief and medical care. There is often great disparity in the ethical approaches of non-UK aid agencies. Therefore, before deciding on a particular organisation to work with, surgeons are advised to research its mandate and principles, to ensure its values are in alignment with UK ethical standards.

Although some NGOs and charitable organisations still operate on the basis of assuming that they understand how best to deliver better health to a given group, surgeons are encouraged to make every effort to consider the voice of the underprivileged – however difficult it might be to actually get to hear that perspective. Surgeons have a clear responsibility to be mindful of and discourage or avoid any behaviours that might be exploitative of vulnerable populations.

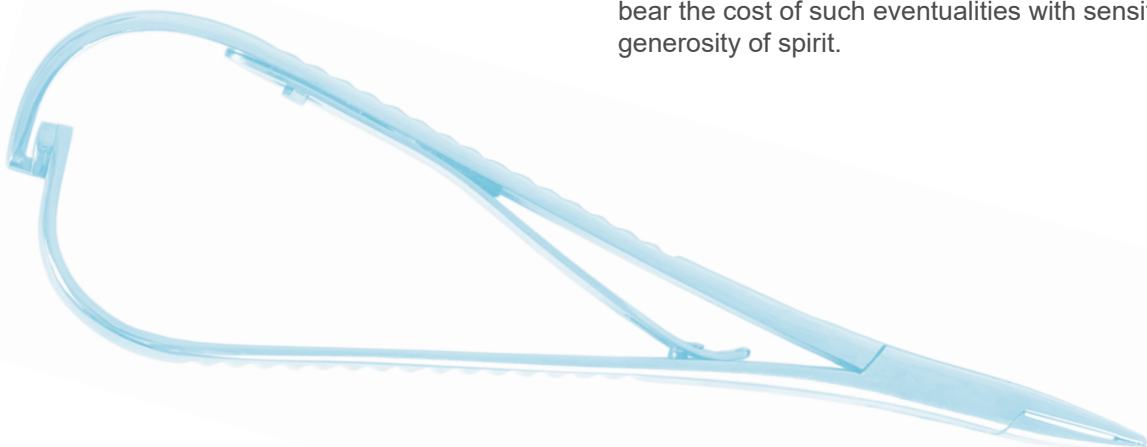
THE IMPACT ON LOCAL HEALTH ECONOMIES

Many of the most needy communities for surgical care are in very low resource settings. In such circumstances, the visiting of surgeons with inevitably more equipment and greater access to funding requires exceptionally sensitive handling as it is likely to have a significant impact.

Inadvertent distortions of local health economies can be generated by the most simple of actions. An example of this would be the effect of external funding streams to harness the services of private providers for the poor, such as is delivered by charities for cleft lip and palate surgery among those who otherwise could not access such care. While being a highly effective tool in increasing the availability of high-quality cleft care across the globe, this has created distortions in the some local health micro-economies that have been questioned by those looking at the wider development of services.

As a principle, visiting surgeons and teams should have an overriding objective of delivering benefit to those they seek to partner and not create added pressures or problems by their presence. Visiting teams that demand extra theatre resources or staff time, or expect wholly different standards of care than are usually applicable in the circumstances, can disturb the equilibrium in host facilities.

Illness or mental distress within visiting teams can also add to the burden for host nationals to cope with, and it should again be incumbent upon the visitors to bear the cost of such eventualities with sensitivity and generosity of spirit.



General standards of practice

DIFFERING CONCEPTS OF CARE AND STANDARDS

Different hospital and clinical settings can influence surgical activity. In some cases, surgeons and their teams may have to adapt to basic conditions, staff shortages and the need to take on more than one role. They may also have to take into account that there is no follow-up support or critical care support. The absence of readily accessible imaging and other diagnostic tools can also create tension in the minds of surgeons who wish to deliver assistance, but might feel compromised in the standard of care they can offer.

In such instances, awareness of local circumstances, sensitivity to local views and partnership with host national medical and nursing staff plays a vital part in maximising the impact of a visitors actions while minimising inadvertent error. Team members will need to be flexible and willing to deal with new and unexpected situations, often in situations they may not be comfortable with. The right to make comments and advise on potential changes in the host nation has to be earned by substantial experience within the local environment and understanding of local issues. Surgeons and surgical teams are encouraged to seek out means of providing missing essential services; for example, high-standard histopathological tests can be delivered using some charitably delivered resources and many newer technologies are opening up access to diagnostic collaboration with authorities across the world.

At the same time, members of the surgical team should be wary of the temptation to compromise core principles of practice when the absence of suitable facilities demands some degree of adaptation, especially when the pressure of work becomes overwhelming. No absolute standards can be set for the wide spectrum of settings within which an individual surgeon might find themselves expected to deliver care. However, the sensitive adoption of the best practical care possible by visiting surgeons and teams can sometimes leave behind a legacy of much greater overall value to colleagues in the host nation than the inevitably limited impact of individual surgical cases on the patients concerned.

EMERGENCY CARE AND DISASTER SUPPORT

While the majority of humanitarian surgical endeavour should be focused on capacity development in low- and middle-income countries, there is a fully appropriate aspect of support that is mobilised to assist in catastrophic disasters and circumstances of conflict related trauma. Surgeons involved in such care are best managed within the organisational framework of the UK Emergency Trauma Network, which has successfully coordinated UK aid efforts in emergency situations in the past decade. Individual surgeons should be aware of the serious deleterious impact of many well-meaning but poorly coordinated efforts in previous disaster relief exercises, and should make every effort to ensure that their personal contribution is appropriate and follows sufficient preparatory training.

When working in the inevitably chaotic and unstructured environment of an early post-disaster or conflict situation, it is imperative that surgeons

behave with impeccable manners, good judgement, great humanity and sensitivity. Such circumstances frequently see the arrival of many well-meaning but inadequately experienced or resourced teams with a naïve or disproportionate expectation of resources and attention. Surgeons are advised not to seek primacy for their personal or team advancement. Rather, they should lead by example and good practice, putting the best interests of the afflicted population in the forefront of their minds when planning and developing activities.

Alongside such disaster and conflict work, surgeons should be aware of their own wellbeing and potential for serious personal injury when in risky circumstances. Best practice can again not be legislated given the variety of risk that might be present, but mature and wise counsel should be sought before exposing oneself or a team to unpredictable risk. There will be frequent occurrences of situations where it is reasonable for surgical aid teams to travel to countries and circumstances that are specifically advised against by the UK Foreign Office or other advisory bodies.

Surgeons are warned that such work might not only not be indemnified, but also cannot be insured against and usually invalidates personal injury or life insurance policies. The impact of a lost breadwinner with no valid life policy to cover residual mortgage payments can be devastating to a bereaved family. Attention is also drawn to the potential emotional distress that can be generated for the families and friends of travelling surgeons, and the value of preliminary thought and management of such aspects.

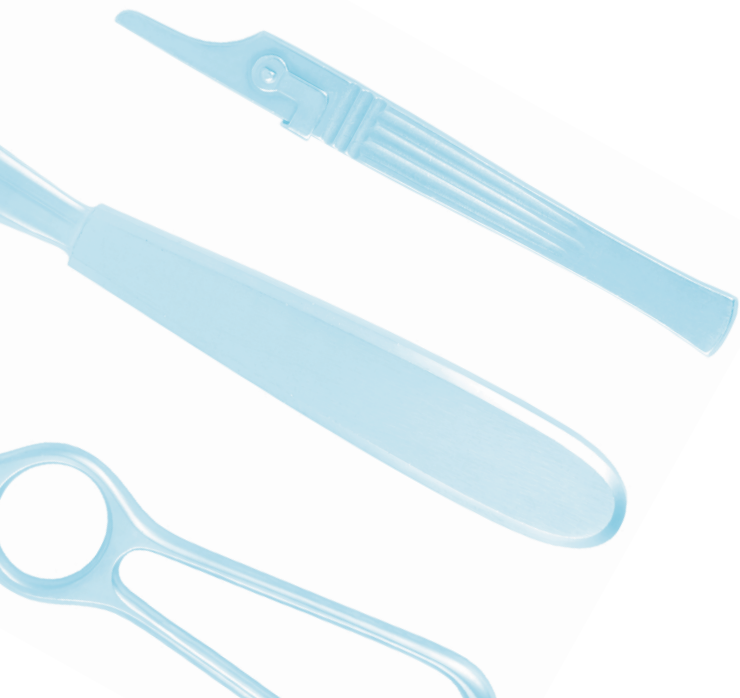


WORKING WITH CHILDREN

Compared with UK surgical practice, a disproportionate volume of surgical need relates to conditions affecting the young. Managing such cases (especially the very young) requires specific expertise, and surgeons should only step outside their usual field of practice with great consideration. To use the example of cleft repair, there are examples of adverse outcomes from inexpertly performed cleft repairs, in which it would have invariably been preferable for the child to await proper care, however old they might have been before such access to services was possible.

It is acknowledged, however, that some paediatric conditions fall within the continuum of surgical care that is embraced across all ages by many surgical teams around the globe. It is incumbent upon the visitor to make the host team fully aware of their expertise and not to be encouraged to practise outside their capabilities however pressing the need. Emergency situations frequently challenge such delineation of skills, in which each surgeon should rightly be able to make their own wise decisions on intervention should it be appropriate.

Common sense is perhaps the best guide to wise practice in such circumstances, but this should be applied with considerable cautionary judgement – especially when dealing with the young. Intervention should never be performed on elective and congenital conditions by those other than with proper expertise.



Communication and consent

COMMUNICATION

Effective and clear communication with the patient and other members of the healthcare team is essential for good care, yet this is often one of the most challenging aspects of working abroad. Language problems, illiteracy and poverty can all conspire to render communication between the visiting surgeon and patient exceptionally difficult.

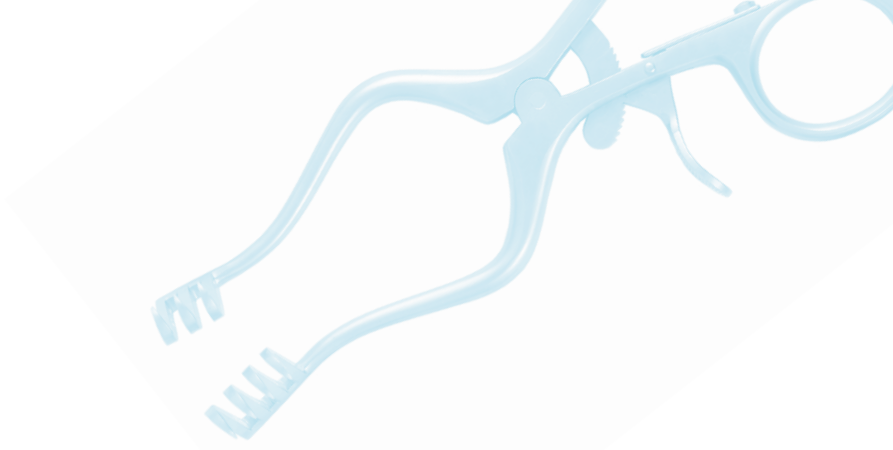
It is, however, incumbent again on the visitor to take every effort to circumvent such problems. Cross-cultural communication can, if managed well, become a most enriching experience for the visitor as well as the patient, but the nature of the power imbalance between surgeon and patient is frequently widened by such differences. Best practice for all visitors is to plan well in advance of travel to learn how to communicate well, possibly by beginning to learn some local language, exploring local customs and history, and generally adopting a respectful attitude towards the host nationals and their practices.

CULTURAL DIFFERENCES AND SOCIAL NORMS

Profound cultural differences exist in the majority of the world, and an understanding the religious and cultural context is crucial. It is incumbent on visiting surgeons to make themselves fully aware of relevant practices from the outset of their work. Simple norms such as the avoidance of expecting handshakes with patients and staff in certain Islamic nations or awareness of the impact of use of the left hand in certain circumstances, are an embedded part of many cultures. A few more strictly embedded religious practices affect the ability of male surgeons to examine and manage female patients, and such norms should be respected even in situations where the balance of harm from inaction can seem to suggest that the practices should be ignored. Well-prepared visitors will have taken the time to ascertain well before travel what such differences exist and be willing also to continue to learn from partner colleagues as practice evolves.

The spectrum of behaviour and attitudes towards gender and sexuality in particular is enormous across the globe. When seeking to practise surgery in such diverse circumstances, individuals need to be fully aware of indigenous sensitivities and respectful of attitudes, however distasteful they might appear to current 'western' thinking. The more prominent disparities between contemporary 'western' behaviour and experience overseas is likely to be in the power relationship between men and women (both at work, in theatres and as patients) and in attitudes towards same-sex and transgender sexual identity.

The visiting surgeon and team are advised that the right to comment is something that should be earned through the development of trusted relationships and engagement with the culture beyond a stereotypical characterisation that might be prevalent in media or other source of opinion. Visitors are cautioned not to rush to intervene, but rather to listen until fully aware of the circumstances into which they bring their external perspective.



CONSENT

Established procedures for consent to operative intervention vary widely throughout the world. While a degree of superficial appeal might be attached to the efficiency achieved within systems that are less encumbered by detailed processes, the visitor from developed systems bears a strong moral obligation to adopt a thorough and humane procedure to ensure informed consent in all circumstances, in line with the principles of *Good Surgical Practice*¹ and *Consent: Supported Decision Making*.³

Where the patient population has low literacy levels or linguistic communication difficulties exist, it is incumbent on the surgeon to make every effort to establish adequate informed consent. In difficult circumstances, it can be preferable to cancel or defer surgical intervention rather than to proceed.

PHOTOGRAPHY

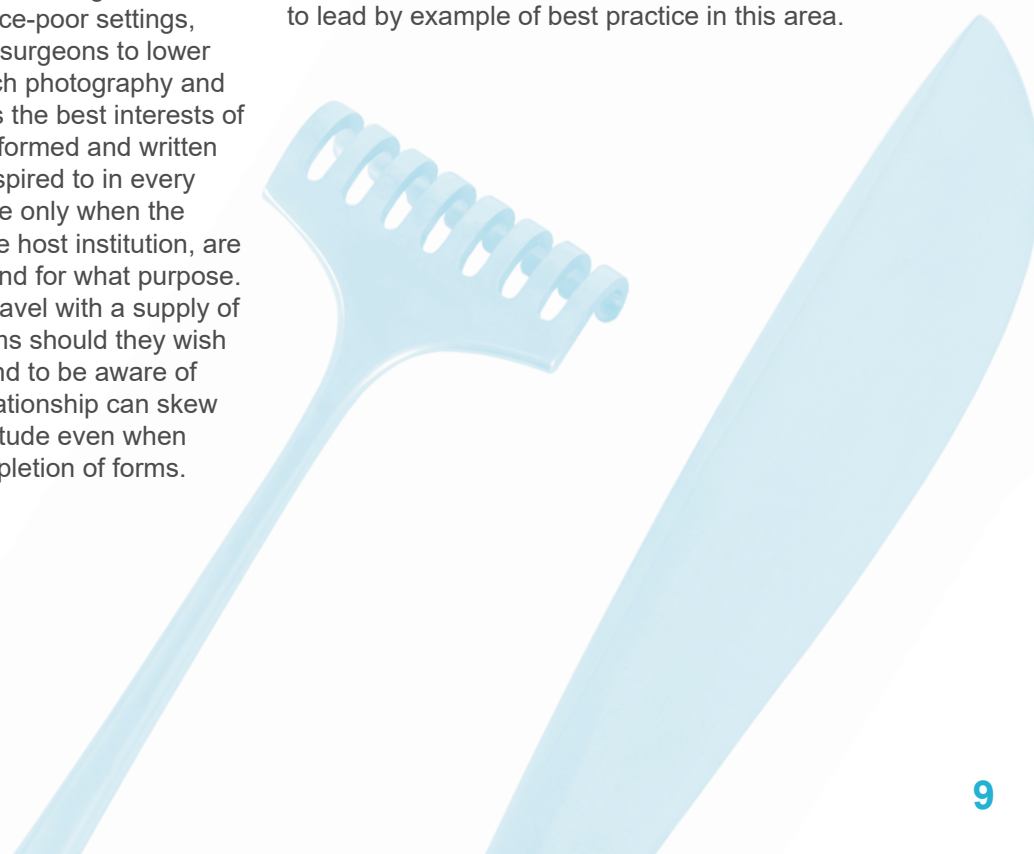
Surgeons will be aware of the current status of regulation surrounding patient-related photography and informed consent for storage, teaching use and publication. In unusual and resource-poor settings, there may be great temptation for surgeons to lower their standards with respect to such photography and compromise their ethics as well as the best interests of the patients they seek to serve. Informed and written consent should be the standard aspired to in every circumstance, with exception made only when the patients themselves, as well as the host institution, are aware of what is being recorded and for what purpose. Visiting surgeons are advised to travel with a supply of appropriately worded consent forms should they wish to collect images for future use, and to be aware of the ease with which the power relationship can skew a more caring and appropriate attitude even when fulfilling due process with the completion of forms.

PUBLICITY

All parties involved in delivering surgical care in settings that might be poor, or with caseload that has advanced pathology, will be aware of the potential impact of images and reports in home nations. Some aid agencies and NGOs encourage the collection of dramatic material to assist with fundraising and publicity, and may expect such actions to be supported by their visiting teams.

Host nations are usually well aware of how their populations and communities can be portrayed in this fashion, and many sensitivities have been adversely affected over the generations by the crass use of images and stories by surgical teams. However well-meaning or inadvertent such activities might be, it is essential that visitors only use such material in the most controlled and thought-through circumstances, and only ever in full partnership with articulate representatives of the host nation.

A mature and well-informed, culturally sensitive, approach to the use of such material can be beneficial to overall development. However, a strong case can be made that more harm has been done to the image of low- and middle-income communities over generations than good, and surgeons and surgical teams are urged to lead by example of best practice in this area.



Training and research

TRAINING AND EDUCATION

The breadth of experience that the diverse pathology and the heavy caseload of international work can deliver to visiting surgeons and teams is considerable. It is therefore perhaps inevitable that the potential of such visits to enhance training is thought by many to be a resource that should be used to the full. There are examples of both good and bad practice in such matters, and this code cannot detail the arguments that continue to be generated in support of one or other position.

Trainees should not be prevented from taking advantage of suitable training opportunities abroad, but there are two overarching ethical principles that this guide proposes as a basis of surgeons' work with trainees abroad:

- education of local nationals
- practising within your own competence.

Education of local nationals

The most important aspect of capacity development in low- and middle-income countries should be the education of local nationals, who will generally form the future workforce of the host nation. It is therefore critically important that those with expertise seek every opportunity to transfer their skills to nationals and avoid deflecting energy towards their own trainees, should they be accompanying the team. It cannot be stressed highly enough that taking a trainee on a visit, however well prepared and structured, can affect the ability of the lead surgeon to form local relationships and teaching opportunities for host nationals – whether overly or unconsciously. Such 'unconscious bias' is very difficult to prevent and is sometimes only something that a surgeon engaged in humanitarian work becomes aware of when they elect to visit alone. Thus, while the potential benefit for UK trainees of experience in low- and middle-income countries is significant, such opportunities should only be exploited and developed with the greatest of care and forethought, and only ever in full partnership with a host nation. RCS members are also advised to be wary of inadvertently playing into the hands of local political and medical conflicts by establishing projects with one party, who might not


be wholly representative of the host institutional policy or have appropriate authority to authorise programme development. An example of this would be some of the well intentioned cleft missions that have been established around the world in partnership with aspiring local 'empire builders' in the face of already established and properly constituted facilities and trainers. There is simply no excuse for those who have contributed to additional professional conflict in low- and middle-income countries simply by dint of ignorance or deliberate lack of acknowledgement of the wider political and healthcare administration in the host nation.

Practising within your own competence

There is an overarching principle that surgeons should not engage in activity overseas that they would not normally be managing in their home training institution. Thus, for junior surgeons, it is wholly unacceptable for them to perform procedures that in the UK they would only be permitted to perform under highly controlled and defined training circumstances within the confines of a specialist training fellowship. Surgeons should not seek to establish training for junior surgeons outside their normal programme using case material from less-privileged nations, even if this takes place with the collusion of host national surgeons. This practice is unethical and is fully censured by the RCS. It opens the door to the accusation that patients from outside the UK are used as 'training fodder' and cannot be advanced in any acceptable way.

MEDICAL STUDENTS

A period of time in a resource-poor facility with greatly differing pathological presentations can be exceptionally valuable for UK medical students towards the conclusion of their training. Such students will require careful nurturing and support in new circumstances, and the ability to communicate crossculturally and to offer support can be beneficial. Visiting surgeons and teams need to be aware of how stressful such attachments can be for students and how demanding they can be. Balancing appropriate support while avoiding the temptation to invest more in the visiting student than the host nationals (often seen



due to the cultural differences encountered in bridge building with local staff) is a matter of judgement. RCS members are advised, however, that during such periods of intense new experiences, their behaviour will be closely observed and time for developing good patterns of practice and communication among local and visiting students should not be missed.

RESEARCH ETHICS

Low- and middle-income countries have been recognised as providing fertile ground for investigative activities which many visiting teams and surgeons recognise as valuable both for better long-term understanding, as well as (potentially) their own career development. Such activity can begin early in a doctor's career, with medical students undertaking visiting electives to resource-poor settings frequently being encouraged by charities and funding agencies to set up or run a project while in a new environment. This drive to generate published output frequently is not driven by the best outcome for the host community, but rather the better interests of the visiting individual or team.

All major research agencies now have rigorously developed ethical frameworks for undertaking research overseas, with great awareness of the imbalance of power again present in many such situations. RCS members are urged to make themselves fully aware of the existing ethical guidance on research conduct in low- and middle-income countries, while also availing themselves of every opportunity to partner enthusiastic colleagues abroad in good-quality research projects that will eventually deliver better care for the poorest.

USE OF ANIMALS FOR TRAINING AND RESEARCH

The UK has arguably the most ethical and best crafted regulatory framework in the world regarding the use of animals for research and teaching. There is wide variation in the principles adopted across the world for such matters, and the RCS urges that surgeons who travel adhere fully to the UK guidance in all circumstances. Members are reminded that research publications invariably require evidence that studies using animals have been subject to best practice and ethics. Akin to the use of host national caseload for research purposes, members are advised to be fully aware of the error of exploiting differing circumstances to advance their personal research or training agenda.



| Health

CHALLENGING LIVING CONDITIONS

When working in countries with limited resources, living conditions can often be challenging and work practices may be very different to what is the norm for the visiting surgeon. This can generate significant stress – both physically, mentally and socially – despite the most diligent preparatory process, affecting all from the most experienced as well as the newcomer to such activities.

Stress management cannot be explored in detail in this ethical summary, but travelling surgeons and their teams are advised to both be aware of the potential for stress to distort judgement and behaviour in many forms, and also to make themselves aware of available resources to deal with such eventualities either in themselves or those with whom they may be working and witness stress generating circumstances.

PERSONAL HEALTH

Travel to low- and middle-income countries and emergency situations carries an inevitable risk of adverse health for the surgeon. Falling ill can generate major demands on both the visiting team as well as the host facility, and surgeons are obliged to ensure they have done everything possible to minimise such occurrence before embarking on the visit. Members of the surgical team must be completely immunised prior to travelling and attention to personal hygiene and care assiduous throughout the visit. Surgeons are advised to consult the many resources currently available to ensure health while abroad, and to support teams by ensuring that adequate personal resources are available such as protective gloves, emergency drug supplies, and access to evacuation facilities should they be required.

Probity



HONESTY AND INTEGRITY

Whether they work abroad or in the UK, surgeons must demonstrate probity in all aspects of their professional practice and must ensure that they do not abuse their patients' trust in them or the public's trust in the profession.

When working abroad, UK General Medical Council registration and membership of a royal college often confers kudos and respect from populations throughout the world. It is therefore essential that practitioners visiting resource-poor surgical settings maintain the highest standards of personal probity and integrity in behaviour – both professional and personal. Diminished standards in behaviour and surgical practice in overseas situations can reflect poorly on both the individuals and the national organisations with which they are affiliated. Surgeons should be aware that the reach of rapid communication and social media is vast, and all aspects of behaviour should be maintained to the level that would be rightly expected in the UK.

AMBASSADORIAL ROLES

Members of the UK surgical establishment practising abroad in whatever context will assume an element of ambassadorial status. This might be inevitable but should not be courted and all interactions with nationals from the host nation must be managed with due recognition of their perceived sensitivities.

PRIVATE GAIN AND COMMERCIAL OPPORTUNITY

In circumstances of resource inequity, it is inevitable that opportunities will present themselves for commercial activity and potential personal gain (or even gain for organisations such as the RCS). There is no doubt that entrepreneurship has a part to play in the development of surgical services across the globe, and members of the surgical team must ensure they adopt a position that avoids conflict of interest or any potential exploitative action of those who will be vulnerable and open to abuse – of which economic abuse is but one aspect.

Indemnity and registration



INDEMNITY

Litigation for malpractice and inadvertent adverse outcomes exists worldwide, and humanitarian work is no exception to this, however unreasonable it might appear. When selecting the country to work in, surgeons should consider the professional and legal risks of practising in that particular region.

The mandatory indemnity cover that is required by the General Medical Council for UK-based surgeons undertaking non-NHS Litigation Authority indemnified work cannot be expected to cover independent work abroad. The long established mutuals (the Medical Defence Union, Medical Protection Society and the Medical and Dental Defence Union of Scotland) have differing policies related to this, but all advise specific consultation with them before any activity is undertaken overseas. Similarly, the newer insurance-based companies have specific requirements regarding practice abroad, and members are advised to take great caution in being assured that they have adequate indemnity cover at all times when working abroad.

MEDICAL REGISTRATION

In some countries medical registration is not always organised on a national basis as it is in the UK and it may be carried out at the regional level with requirements varying from region to region. Where registration requirements are prescribed, those should be seen as mandatory regardless of the expense and duration of intended practice.

Surgeons should consider expectations of registration for every aspect of surgical practice in the light of what is expected within the UK. Honorary contracts in hospitals and other institutions might convey certain privileges in specific circumstances, but should not be assumed to afford a right to practise in a given nation.

REVALIDATION

Surgeons who continue to hold a UK licence to practise while practising outside the UK will need to be revalidated, as does every other surgeon working in the UK. This means that they need to connect to a UK organisation and responsible officer to support them with their appraisal and revalidation. For guidance on how to confirm their designated body, surgeons can refer to the *RCS Revalidation Guide for Surgery*⁴, or the *General Medical Council's Guidance for Doctors: Requirements for Revalidation and Maintaining Your Licence*.⁵

References

- 1 Royal College of Surgeons of England. *Good Surgical Practice*. London: RCS; 2014.
- 2 General Medical Council. *Good Medical Practice*. London: GMC; 2013.
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- 4 Royal College of Surgeons of England. *Revalidation Guide for Surgery*. London: RCS; 2014.
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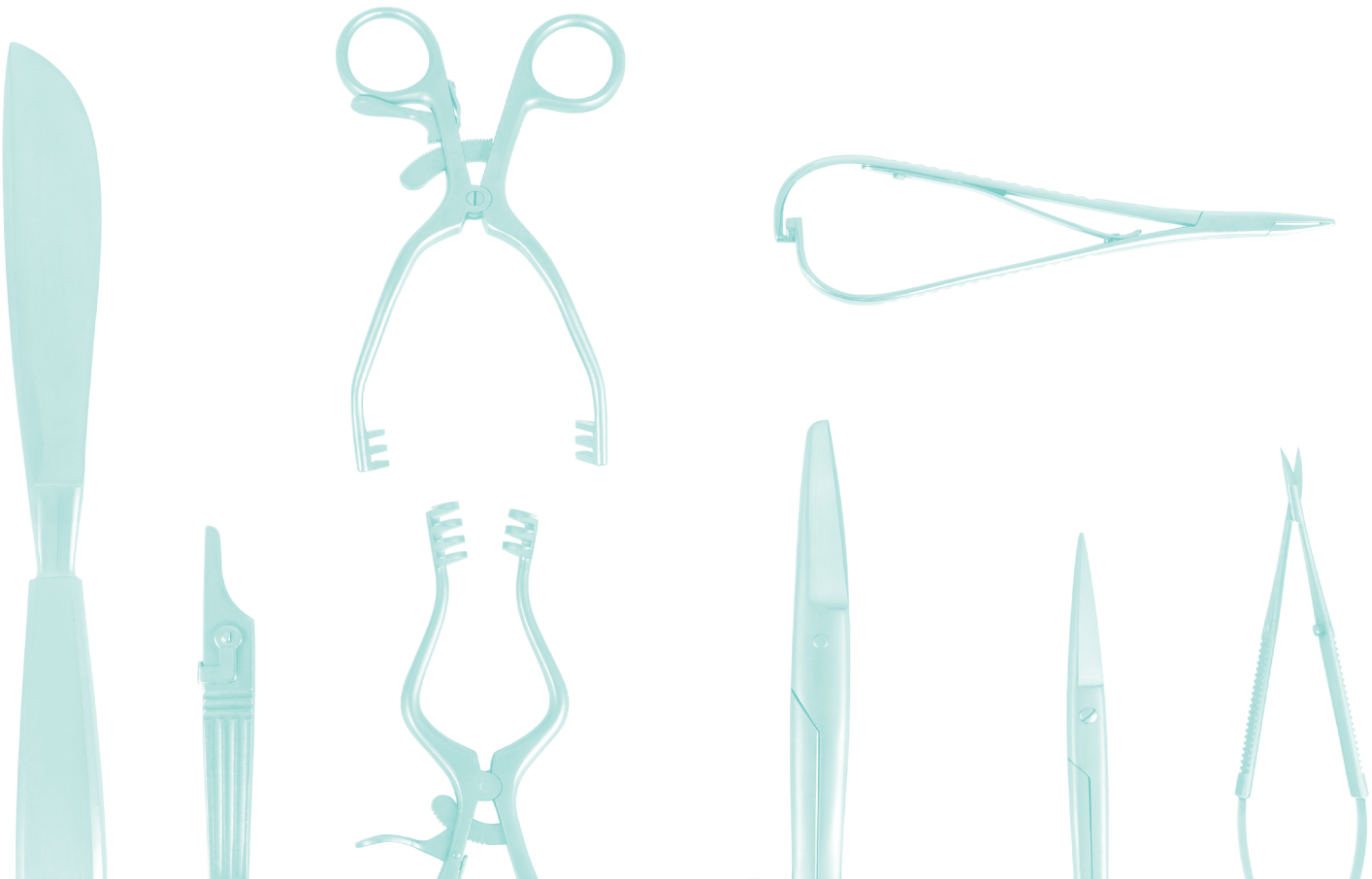
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The RCS produces a wide range of standards and guidance to support the surgical profession within the areas of team working and leadership, legal and ethical concerns, personal development and service improvement. To find out more about our work visit www.rcseng.ac.uk/standardsandguidance.

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