THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL NEWS

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April Highlights:

The Conjoint Annual Scientific Congress, in Hong Kong, May, page 7

The College of Surgeons of Australia and New Zealand

College Foundation

Foundation for Surgery

Encouraging a culture of giving by offering the usual taxation incentives

The Collections

Over the years, the College has acquired very substantial collections of objets d'art, mainly through the generosity of Fellows and their families. The range includes works of art, rare and historic books, surgical instruments. Besides paintings, there a number of sculptures in stone, wood and bronze, significant pieces of Georgian and Victorian furniture and silveware, fine china and glassware. In the Cowlishaw collection there is a number of rare and historic books on medicine and surgery. It is one of the foremost collection of rare books in Australia in its own right. The College also has a very extensive collection of surgical instruments, dating from the mid-18th to the late 20th century. They form an integral part of the museum.

Surgeons Art Gallery and Museum

To showcase the collection and offer curatorial care, the College has established the College of Surgeons Art Gallery and the College of Surgeons Museum within its Melbourne headquarters. The Council Room, President's Meeting Room and Hailes Room house the College's most impressive paintings, sculpture and silverware. Both the Art Gallery and Museum are open to the public during standard working hours.

The Cultural Gifts Program

The Cultural Gifts Program (CGP) is a philanthropic program managed by the Australian Government (Department of Environment, Water, Heritage and the Arts). Its principal aim is to encourage a culture of donations by offering the usual taxation incentives to those who donate to approved public institutions. The College of Surgeons Art Gallery and the College of Surgeons Museum have both gained endorsement from the Australian Taxation Office as Deductible Gift Recipients, which enables them to participate in this program.

Felix Behan, Andrew Sutherland, President & Bruce Barraclough, Chair of the Foundation for Surgery, in front of the painting by H.J. Johnstone, 'Waterfall Gully Panorama, generously donated by Felix Behan as a tribute to Benny Rank, his mentor in plastic surgery

The procedure of donating under this scheme is simple and straightforward, and is explained in the CGP Guide. It includes obtaining two independent expert valuations for prospective donations. These valuations are the basis of determining the level of tax concession available to the donor. Donors may elect to spread the value of the gift over one to five years. More information can be obtained from the CGP website at: www.arts.gov.au/arts_culture/tax_incentives/cultural_gifts_program

Donations to the College

The College encourages such donations and gifts, of all kinds of art works and historic books for the Art Gallery, and of surgical instruments for the Museum. The College is looking to expand its art collection, and gifts of art work are especially welcome. All donations to the College's collections are subject to guidelines set out in the policies on Cultural Gifts Program Donations and Donations, Gifts and Bequests.

If you would like to know more about giving to the College, please contact the Curator, Geoff Down, on +61 3 9276 7447 or e-mail geoff.down@surgeons.org

Rooster one day, feather duster the next

Andrew Sutherland, President

In my last article as President, I would like to thank those who have helped me in my role. It has been an honour to serve you.

As surgeons, we are accustomed to patients and their families placing their trust in us as we embark on a surgical journey often associated with risk and possibly an uncertain outcome. This trust is particularly remarkable when your patients are mostly children, like mine. I felt the same responsibility on my election as the President of our College. Although the President's job is primarily to preside over Council as it defines the work and sets the strategy for the College, there is also an expectation that the President will be the public face of the College and have a day-to-day role in partnership with our Chief Executive. Together they ensure the College functions effectively and reflects the views and aspirations of our Fellows. Serving as your President has been a great personal honour which I know will not be surpassed in my lifetime. There will be a new leadership team after the Annual General Meeting in May, led by your President-elect, Ian Gough. I congratulate Ian on his achievement and am confident the College is in capable hands.

The College must be relevant

As I enter the last few weeks of my term, it is interesting to reflect on the year and its highs and lows. My aspiration to serve on Council was driven by a desire to see the College become relevant to all surgeons regardless of specialty or special interest. Within the surgical community there are those who take the view that we are "surgeons" first and "specialists" second. It is clear to me that regardless whether or not this was true in the past, it certainly is not so now. If asked his or her profession a neurosurgeon almost certainly replies neurosurgeon, not surgeon. The same applies to all of our nine recognised specialties and a number of the emerging subspecialties who identify strongly with their own association or society. Each group believes strongly that they should be in charge of training and standards for their specialty.

This transition has been occurring for many years but has been most problematic within general surgery where there are serious concerns about the specialty's future. For historical reasons general surgeons still tend to look to the College for support in a way that no longer occurs in the other eight specialties. During my time on Council there have been a number of occasions when a subject such as colonoscopy has been discussed at a level of detail not accorded arthroscopy. Fortunately this is now a rare occurrence. All specialty specific issues are now referred to the specialty for resolution.

> "We have a responsibility to ensure we stand up for surgical standards and not allow heavy handed and misguided bureaucratic intervention affect the care we provide."

This leaves the College with an important role as leader and coordinator in regard to broad surgical issues. It provides a forum and a source of management and educational expertise for all surgical groups. It presents them with an opportunity to influence the surgical issues of the day in concert with their colleagues. There is now an agreed model in regard to activities such as Surgical Education and Training (SET) program and Continuing Professional Development (CPD) which will undoubtedly undergo constant review and modification through the appropriate committees. This is evidenced by the successful conclusion of the negotiations around the new service agreements for SET which have now been signed off by all specialist societies and associations. For the first time General Surgeons Australia will be taking a tangible role in the delivery of SET for their specialty, levelling the playing field. If the College wishes to exist in the future it must develop and consolidate this role and ensure it adds value to the independent specialties, the sub-specialties and its Fellows rather than acting as a constraining force and potential mill-stone around their necks.

Essential Communications

A highlight of the past few years has been the continuing improvement in communication between the College, its Fellows, their specialties and the Regional and National Committees. The Relationships portfolio has been responsible for this important work and has provided an increasingly important role for the Vice President. Regular meetings are held with the Presidents of the specialist societies through the Surgical Leadership Forum. The most recent was held during the February Council meeting. A vigorous debate occurred particularly around the controversial issue of post Fellowship education and training. The meeting determined to continue the discussions lead by an expanded Board of Post Fellowship and Education and Training (BPFET) Working Party. The Vice President also meets regularly with the Regional Chairs as the most effective way of ensuring that State Health Departments know and understand about current surgical issues and concerns.

Communication with State, Federal and New Zealand Health jurisdictions has always been a difficult balance. This is important as it is the only way surgical organisations including our own can effect change in the delivery of surgical services. The Australian Medical Council (AMC) expressed concerns about the College's effectiveness in this area. ➔

President's Perspective

"I am confident that the College will continue to evolve and remain a major voice in surgical matters particularly in the areas of education and standards."

I am pleased to say the obstacles to a frank and productive exchange of views have been largely overcome. The College now has channels into the highest level of Government making it clear that we desire a productive relationship but reserve the right to criticise and oppose any initiatives we believe are not in the interests of our patients. Council will be reviewing the roles of the jurisdictional representatives on our committees to ensure that they are appropriate. We have a responsibility to ensure we stand up for surgical standards and not allow heavy handed and misguided bureaucratic intervention affect the care we provide.

A Stable and Confident College

The College continues to face great challenges but is now better equipped than ever before. It has a new educationally valid model for surgical training. It has shrugged off much of the interference by external bodies such as the Australian Competition and Consumer Commission (ACCC) and New Zealand Commerce Commission and has the management expertise to ensure it remains within the law in all of its activities. It is financially sound despite the recent downturn in the equity markets. It has a governance and management structure that is effective in deciding where the College should go in the future and how it should get there. By the time you read this, Council will have concluded its retreat held in Adelaide in March. This is designed to set out the direction for the College over the next decade. Council will then sign off on the new strategic plan in June and the budget to pay for it all in October.

I am confident that the College will continue to evolve and remain a major voice in surgical matters, particularly in the areas of education and standards. It will nonetheless have to deal with a number of challenges.

Surgical Education and Training

The first challenge is to ensure that we not only impart highly prized surgical skills but also the other competencies accepted by the College and all of its specialties as necessary for surgical practice. Professional surgical educators will become increasingly important and an increasing number of our colleagues will achieve additional qualifications and careers in this important area. Surgical supervisors already need additional skills to perform well in the new era of competency based programs and continuing assessment. The continuing professional development of our "surgical faculty" is a challenge as is the issue of teaching time and remuneration.

Non-technical competencies such as communication, professionalism and ethics are difficult to teach and assess but improvements in these areas will help dispel the old image of the arrogant, bad-tempered surgeon and keep us out of the courts. Modern surgery is a team sport and the ability to function and lead in a multidisciplinary environment will be essential. These competencies were initially developed in Canada after a survey of the public's expectations of their doctor. Some of our teaching settings are not easily adapted to the acquisition of these skills particularly when Trainees have limited exposure to ambulatory practice settings, such as well-resourced and supervised outpatient clinics. Appropriate experience in the private sector may remedy some of these deficiencies. It may also redress the imbalance in case-mix and experience between the public and private systems.

Sub-specialty vs Broad-based Skills

Another major issue for the future will be how to handle the conflicting requirements for 21st century super-specialties and the need for surgeons with the broad skills and experience essential for our emergency services and remote and regional practice. The College should support both sub-specialty aspirations and the need for innovative solutions for emergency and rural surgery. There is a danger of the College becoming irrelevant if it does not acknowledge the aspirations of surgeons who choose to work in narrow scopes of practice. Their post-Fellowship education

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and training needs are real. There is no doubt that these groups will continue to provide dramatic improvements in surgical techniques and knowledge with or without College involvement. Where the retention of broad skills is required for rural, regional and emergency surgery, the establishment of career paths, improved conditions and increased remuneration will do a lot to ensure young surgeons will choose these important areas of practice.

Safety and Quality

The final issue is the safety and quality debate. The public no longer has total confidence in the medical systems across our two countries. Almost all published data suggests there are avoidable incidents and unsatisfactory processes that result in unnecessary injury and poor outcomes in both the public and private sectors. They do not understand or accept why this is the case in the sophisticated medical environments of Australia and New Zealand.

All other industries have improved the safety and quality of their processes over the last two or three decades. Hospitals and in particular surgeons have not yet fully grasped this challenge. Most of us think that it does not apply to us or our hospital. An example is the slow adoption of the College's Correct Patient, Correct Procedure, Correct Side policy. If we do not engage in the quality improvement process others will impose solutions which will be inappropriate and ineffective. In most hospitals the Quality Improvement and Risk Management Departments are dominated by skilled enthusiastic nurses and managers who require input and leadership from surgeons.

Thank you

As this is my last appearance in print, I would like to thank Council and the Fellows of the College for giving me the opportunity to serve as your President. My Council and committee colleagues have come from disparate specialties, age groups and political views but all have contributed to the welfare and future of our patients and our profession in the most amazing way. This makes the job of President a pleasure and an honour.

The College is a complex organisation across two nations that could not function without an expert and hard working management staff. I wish to pay particular tribute to the two staff members with whom I have worked the most.

Ian Burke, the Director of Resources, leads the Honorary Treasurer through the complexities of the College resources. Ian and his staff ensure the College remains financially stable and that Council is well informed and advised about financial risks and opportunities.

Many Fellows will have limited knowledge of the excellent work of Chief Executive David Hillis. David is a medical practitioner and senior medical administrator and understands surgeons probably better than we do ourselves. He has the unenviable task of reminding both Council and staff about what is possible, and more importantly what is not, within the resources available. The current stability and effectiveness of the College is in no small way due to his skills and diligence in carrying out the wishes of Council. By necessity he works very closely with the President with contact virtually on a daily basis. The role of President would not be possible without the support of an excellent CEO. I can say unequivocally that working with David Hillis has been all that a President could want or need.

I would like to acknowledge Margaret Rode, Council Secretary, whose extensive experience and hard work ensures that Council and the Executive are efficient and effective. I would also like to thank my PA, Jan Palich, for her meticulous attention to the running of the President's office and diary.

As other Presidents have discovered, Presidential responsibilities impinge on one's lifestyle to an extent that requires a commitment from colleagues, spouse and family. I would particularly like to thank my wife, Sibylle (Sibby) for her unending patience and support during my twenty years involvement in College activities, especially over the last twelve months.

The National Breast Cancer Audit

Once all requirements have been fulfilled, we anticipate a full-cycle audit will be implemented by the Breast Section in the future

James Kollias, Clinical Director, National Breast Cancer Audit

The National Breast Cancer Audit (NBCA) is an initiative of the Breast Section of the College. It began as a pilot in 1998 and now involves around 70,000 episodes of breast cancer, submitted by over 300 surgeons from Australia and New Zealand. The NBCA has an established governance structure, principally involving breast surgeons but includes input from supporting professional groups such as medical oncology, radiation oncology, medical epidemiology, breast nurses, consumers (Breast Cancer Network Australia) and the National Breast and Ovarian Cancer Centre (NBOCC). The day- to-day management of the NBCA is administered by the Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S). It has become a potent tool for auditing and research. The aim of the audit is to assess an individual surgeon's management of breast cancer according to several key performance indicators and to inform surgeons whose performance standards are below recognised minimum thresholds.

Auditing surgical practice can be controversial. At the 2007 Annual Scientific Congress of the College, there were a number of criticisms levelled at the audit. Constructive suggestions included the provision of a minimum dataset with the aim of reducing the complexity and time required for data entry; improved retrieval of data from the online system for surgeons; and integration of established institutional datasets with the NBCA dataset.

Resources were put into each of these areas:

(a) A one-page minimum dataset was drafted after extensive consultation with surgeons and other stakeholders. Once approved by the Steering Committee (May 2008), paper forms will be made available to participants. Changes to the online data entry system will be made as quickly as possible. Surgeons will then be able to choose whether to provide the minimum or full dataset.

"Surgeons who submit their data using the online system can already see whether their practice is meeting the acceptable minimum standards."

(b) Data downloads have changed to enable surgeons to import their online data into an Excel workbook. This allows surgeons to analyse their own data independently and to import their data into a relational database such as Access or a statistical package such as SPSS.

(c) Progress has been protracted with importing data from various institutions into the NBCA database. Initial efforts concentrated on the Strathfield Private Hospital (NSW) and Royal Melbourne Hospital (VIC) datasets. Contact has been made with a number of other institutions regarding their datasets. Mapping the data requires time and attention to detail. It is also important that the data items and response format do not change once they have been mapped. Uploading the data requires specific programming for each institution and this is undertaken by our system providers. Some unanticipated problems were discovered during this process, with changes (transformations) occurring to data that were not consistent with the original data source. An intermediate stage was implemented, where the transformed data was checked and approved by the institution prior to it being uploaded into the online database.

Surgeons who submit their data using the online system can already see whether their practice is meeting the acceptable minimum standards. Ongoing effort has been put in to ensure that this information is accurate and reliable. Surgeons are informed if data is missing or inconsistent.

The next stage in the clinical audit cycle will take place when the Evidence and Performance Subcommittee review a non-identifying report describing how well individual surgeons are meeting the standards. If this process is found to be satisfactory, a full audit cycle will be implemented by the Breast Section in the future.

Developing and implementing a clinical audit on the scale of the National Breast Cancer Audit has been a difficult challenge. Significant input and commitment has been undertaken by a number of stakeholders: the Breast Section Executive, members of the Breast Cancer Audit Steering Committee, the NBOCC and Breast Cancer Network Australia. The National Breast Cancer Foundation has shown considerable support in financing the audit through the NBOCC. The audit has been dutifully managed by its committed staff members, Dr Jim Wang, Ms Claire Marsh, Ms Louise Kennedy and Ms Maggi Boult. The Breast Section is thankful for the contributions made by those mentioned.

CASC
2008

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Conjoint Annual Scientific Congress

Hong Kong Convention & Exhibition Centre

12 – 16 May 2008

www.surgeons.org/casc2008

Scientific Program available online

John Graham, Chair, Fellowship Services

Technology: a surgeon's best friend

Thanks to innovations on the internet, it's easy to keep up-to-date with the constant stream of surgical and medical developments

Keeping up-to-date with new developments, articles and evidence is vital in the surgical field. There are several ways to monitor new publications and information, and the most efficient of these are via a computer with access to the internet.

Really Simple Syndication (RSS)

Keeping up to date via RSS (Really Simple Syndication) technology is convenient and easy. RSS requires two key elements: an RSS reader and RSS feeds. A reader is the software that you use to view RSS feeds and may be free or purchased. The RSS feeds (containing the update information) are sent from selected websites to the RSS reader in a similar fashion to email alerts, but your feeds remain in your reader and do not clog up your email account. RSS technology removes the tedium of staying up-to-date as there is no need to check website after website or read through all of your emails just to catch up on recent publications.

To take advantage of RSS technology, you will need to obtain an RSS reader. Some readers can be installed on one computer whilst others are internet-based, enabling you to access your information at any time and from any location. Two free internet-based readers are Google Reader www.google.com/reader and Bloglines www.bloglines.com.

Generally, RSS feeds work better through the Firefox Mozilla internet browser so if you run into any problems using RSS through Internet Explorer, Firefox is a good alternative.

Once you have a reader, you can begin subscribing to RSS feeds from various sites of interest, including medical news, journals, and database searches.

- After locating a useful site, click on its RSS feed button to subscribe.
- A new window will open with the feed's URL in its address bar. Select and copy this feed URL.

Photo courtesy Benis Arapovic

- Open your reader and look for the option to "add a new subscription" or "add a new feed" (the terminology will differ between readers).
- Paste the feed's URL to begin receiving alerts from this site.

When you have time to review updates, you can open your RSS reader and be sure that you are looking at the latest information from websites and journals that you have selected. More information on RSS readers is available from the Library on request to College.library@surgeons.org

To really take advantage of RSS, combine it with other strategies for staying up to date, to ensure that you will not miss anything.

Table of contents subscriptions

Subscribing to journals' tables of contents (TOC) allows you to browse recently published articles in the journals which you regularly read or refer to. Useful surgical journal RSS feeds may include *ANZ Journal of Surgery or Annals of Surgery* or journals in your specialty area such as *Journal of Bone and Joint Surgery*. Subscribe to the journal's TOC feed from the journal's homepage to receive the latest feeds. By aggregating these through your RSS reader, they will be available to you at a convenient time rather than cluttering up your email box as individual emails.

Podcasts

Podcasts (or audio files) provide a way to listen to information without being tied to a location. If you wish, you can listen to your MP3 player while exercising, commuting or driving distances. A small MP3 adaption tool allows the downloaded podcasts to play through your car or any other radio.

The website Journal Junkie at www.journaljunkie.com/ has free MP3 downloads to a number of major medical journals such as *Lancet, New England Journal of Medicine* and *Journal of the American Medical Association*. These provide a summary of the contents of the articles in each new issue. Specialty journals like Plastic and Reconstructive Surgery also have summaries of the most recently published articles available as separate audio downloads, for a more detailed outline of the contents. The link to PRS podcasts is available through the College online Library.

Information overload?

The internet is a rich research tool but lack of time is an issue for all surgeons. RSS is a convenient tool which may be used together with other current awareness methods such as saved searches and TOC auto-alerts to help you keep up with the latest in surgical literature. Your RSS aggregates and podcasts will help to ensure that your work time on the net is focused and rewarding.

This article is the first in a two part series by Anne Casey, Manager, Library and Website and Caryn Perera, Research Officer at ASERNIP-S. In the next issue we will be looking at evidence based databases, slideshare utilities and other internet resources that can save you time while helping you stay absolutely up to date on the latest research in your field of specialty.

New to Council

International Medical Graduates

It's not easy being an International Medical Graduate if you have been out of training for 10-15 years

I.M.A Newfellow

The name of Dr. Jayant Patel is known to most persons in Australia and possibly also New Zealand. He is an IMG. The acronym has changed from OTD to FMG now to IMG (Overseas Trained Doctor, Foreign Medical Graduate and now International Medical Graduate) but it is the same person - someone who has obtained their primary medical qualification somewhere other than Australia or New Zealand. In the case of surgeons, there is also the situation where the qualification has also been obtained overseas.The assessment of IMG's has been controversial.

A few months ago my Board Chair asked me to stand in for him in the assessment panel of IMGs. There has been (and possibly still is in some circles) a perception that the College's role has been to erect barriers to surgical immigration. Mr Narrow Mind was present in the tea room when the invitation came and later remarked, "they all want to take our jobs".

I was really quite ignorant about the assessment processes. Surgeons who come to Australia with overseas surgical qualifications go through a two phase process. First, they apply to the AMC (Australian Medical Council) who assess and certify the validity of the overseas qualifications. They then pass on the application to the College for the second stage which is to determine if the person is not comparable, partially comparable or substantially comparable to an Australasian trained surgeon.

The interviews were very interesting. The panel was three surgeons including the Chair or deputy of the specialty group and a jurisdictional representative. The Curriculum Vitae was reviewed and discussed and the applicant asked a number of questions relating to ethics and professional behaviour.

The thing I found most interesting was the enormous variation in backgrounds of the applicants. There was an American who wanted to come to Australia for a better life style, several Indians and Sri Lankans who were married to Australians, some IMG surgeons from war-torn countries simply wanting to survive and one man who was trading a very comfortable life in private practice in South Africa for a rather remote solo surgeon in (safer) Australia.

One of the applicants was a gentle, unassuming man whose grandfather had started a Charity Hospital in his developing country. He had run it when he became a surgeon, using money from his private practice to pay the costs of the charity aspect of the work. Now the lease had expired and the owner wanted a large rise in rent which was beyond his capacity so the Charity Hospital had to close. He wanted to be able to work in Australia as his Australian wife had moved here with their child.

Very few applicants are granted an FRACS without examination (Article 21 as it is called). Most applicants will have to take the College Fellowship exam and spend 12 - 24 months of "oversight" where their surgical practice is evaluated by senior colleagues, or "supervision" which is a stricter degree of supervision akin to Trainee supervision. If that sounds easy let me give all you 40-something-year-olds a trial exam:

1) What are the current concepts of the genetics of (insert here your specialty enigma e.g. inflammatory bowel disease, glioma etc) disease?
2) Describe in detail the anatomy and surgical approaches used in (insert here an operation that you saw once in your training).
3) Make brief notes on the Howard-Costello syndrome (this is a self-deception syndrome of being unable to recognise the truth. A similar syndrome, the Rudd-Gillard syndrome, will probably be described in the next 12 months).

Do you see what I mean? It is not so easy if you have been out of training for 10-15 years. The aim of the assessment process is to ensure that surgeons who are trained overseas will be substantially equivalent to an Australian and New Zealand trained surgeon. It is all about standards.

When I saw Mr Narrow Mind a few weeks' later, he asked if we had "kept them out". The rather lame reply I managed was, "It is not that simple". Maybe Mr. Narrow Mind has the Howard-Costello syndrome.

Monday, 12 May, 2008, 2.00-3.00 pm
Convention Centre, Hong Kong

A Multifaith Meeting

Contributions from practitioners of various faith traditions including fellow surgical colleagues on

Surgery and Spirituality

All delegates and friends welcome

TASM Update

Guy Maddern, Chair, Research, Audit & External Affairs

A collaborative initiative between surgeons and anaethetists

The Tasmanian Audit of Surgical Mortality (TASM) has released its second annual report since its inception in 2004. TASM is now part of the Australian and New Zealand Audit of Surgical Mortality (ANZASM) overseen by the College, but maintains its own dataset and degree of independence. Tasmania is the only audit within ANZASM which currently includes an anaesthetic audit as part of the surgical mortality audit process. This article highlights some of the major findings from the report.

Participation in TASM has increased to 96 per cent of surgeons associated with reported deaths. Fourteen percent (n=69) of deaths were associated with non-participating surgeons since the audit's inception, however, this has decreased to three per cent within the last year. The total number of reported deaths stands at 509 with 350 cases completing the audit cycle. With greater numbers, the data becomes more reliable and valuable.

Patients reviewed by TASM are often elderly with significant co-morbidities. Despite this, the number of adverse events reported is small, in only three cases (one per cent) assessors thought that an area of concern or adverse event caused the death. This compares favourably with similar figures from Western Australia (1.8 per cent). It gives reassurance that surgery in Tasmania is very safe, with the number of surgical deaths due to a defined adverse event being very small. Participating surgeons should recognise this and be able to reassure the public that cases where death has occurred have been independently audited and reported.

Nevertheless, there is always room for improvement. For example, in patients who received deep vein thrombosis (DVT) prophylaxis (72 per cent of cases), the assessors noted that this was appropriate in 95 per cent of these cases. We should aim for 100 per cent. Assessors also reported areas of concern or adverse events in 26/298 (nine per cent) of cases, although the overall proportion of cases associated with areas for consideration, of concern, and adverse events decreased over the audit period.

The effect of theatre cancellations on patient outcome is not documented in this audit process and it is an issue that needs to be considered in the future. Delays have been shown to cause adverse events, but the specific reason for these delays is not yet detailed in the audit, nor is the reason for the lack of ICU/HDU use in five per cent of assessed cases. Both of these issues may be resource-related rather than related to clinical decision-making processes. Surprisingly, in only 80 per cent of cases were consultants present at the second operation. The TASM Management Committee would have expected this to have been closer to 100 per cent. This needs to be better understood and, if appropriate, efforts need to be made to increase the percentage. Improvement in the return of proformas, speed of return, details on the forms, and legibility are important to help improve the accuracy of the audit.

Overall, the audit is beginning to provide information that will be useful in the improvement of surgical care in Tasmania. With all states having started similar surgical audits, better comparison is possible and with larger numbers of cases reviewed will come more statistical power. Those surgeons involved in the audit, and their future patients, can now be assured that an important aspect of surgical care is methodically and independently audited, and the experience to date has not revealed any significant systemic deficiencies in the standard of practice.

Written by Rob Bohmer (Clinical Director, TASM) & Lisa Lynch (Project Manager, TASM)

PROFESSIONAL DEVELOPMENT ACTIVITIES 2008

There are exciting learning opportunities on offer designed to support Fellows in many aspects of their professional lives. PD activities will earn you CPD points and assist with the maintenance of knowledge and skills in training and interviewing as well as strengthening your communication, business, leadership and management abilities.

Specialists as Teachers Workshops
Dates: 5 April Coffs Harbour, 12 April Darwin, 24 May Townsville, 7 June Orange
Cost: Free to registered participants
CPD: 5 in Category 7

These free workshops for rural surgeons have been developed as a means of providing important information to rural supervisors and trainers operating under the new Surgical Education and Training (SET) program. The course enables participants to proficient in using in-training assessment tools being adopted as part of the SET program, managing underperforming trainees and developing performance management plans. There will also be an opportunity to gain insight into College policies, legal issues and the expectations.

Proudly supported by SSRS

SUPERVISOR AND TRAINER COURSE (SAT SET)

Dates: 4 April, Bay of Islands NZ & 15 May, ASC Hong Kong
Cost: Free to registered participants
CPD: 3 in Category 7

The SAT SET course aims to enable supervisors and trainers to effectively fulfil the responsibilities of their important roles. Participants will learn to use the more common of the workplace assessment tools such as the Mini-Clinical Examination exercise (Mini CEX) and Direct Observation of Procedural Skills (DOPS). Participants will also explore strategies to improve their management of trainees and develop understanding of College training policies, supervisor and trainer responsibilities, the appeals process and legal support provided by the College. See the SAT SET Course webpage for updates on dates.

NEUROTRAUMA WORKSHOPS FOR RURAL SURGEONS

Dates: 12 April, Brisbane & 28 June, Melbourne
Cost: $100 (incl. GST) for Members of the RACS
CPD: 25 in Category 4

At these workshops, surgeons will gain the skills to deal with cases of neurotrauma in the rural setting; where the urgency of a case, or difficulties in transporting a patient, demand rapid surgically-applied relief of pressure on the brain. Importantly the workshop teaches these skills using equipment typically available in smaller hospitals, including the Hudson Brace.

Proudly supported by SSRS

BEATING BURNOUT
Date: 27 May, Perth
Cost: $242 (inc. GST)
CPD: 3 in Category 7

Are you at Risk of Burnout?

This evening workshop helps you identify and address risk factors of 'burnout' before they affect your career and personal life. Proven time and stress management strategies are explored as well as simple techniques to manage the effects of burnout. You will leave the workshop with practical simple steps that can be applied immediately to restore balance to your life.

PRACTICE MANAGEMENT FOR RACTICE MANAGERS

Date: 3 June, Melbourne
Cost: $325 (inc. GST)
CPD: 3 in Category 7

Need to improve your time management skills? Want strategies and tips to deal with the challenges of running a busy surgical practice? Learn all this and more at this exciting workshop designed for surgeons and managers of surgical practices. This is an opportunity to develop and update your skills. Participants share the challenges and solutions to running a successful surgical practice while developing a network of professional colleagues. Fellows are encouraged to attend with their practice managers.

Proudly supported by BLUE CHIP

WINDING DOWN FROM SURGICAL PRACTICE

Date: 14 June, Gold Coast
Cost: $187 (inc. GST)
CPD: 6 in Category 7

Thinking about retiring from surgical practice? This whole day workshop will explore issues relevant to those retired, semi-retired or contemplating retirement in an interactive discussion format. Topics will include the psychosocial implications of changing roles, implementing lifestyle change, post-operative career options and the legal and financial issues associated with closing a surgical practice, to name a few.

Proudly supported by Odyssey

FROM THE FLIGHT DECK – IMPROVING TEAM PERFORMANCE

Date: 13-14 June, Melbourne
Cost: $1210 (inc. GST)
CPD: 13 in Category 7

From the operating theatre to the skies, join your colleagues for an exciting and inspiring weekend that will challenge you as no other PD activity has before! Learn more about risk management and team dynamics. 'From the Flight Deck' is a challenging, fun and valuable learning opportunity for any surgeon who wants to know more about minimising their risk and developing positive team dynamics.

WRITING REPORTS FOR COURT

Date: 21 June, Melbourne
Cost: $633 (inc. GST)
CPD: 7 in Category 7

This workshop offers skills-based training in preparing medical reports for use in legal matters, focusing on the fundamentals of an excellent medico legal report. Gain valuable individualised feedback on your own medico legal reports as well as an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective on form and content (Please note prior to the workshop participants are expected to submit a report based on a designated case study).

2008 PROFESSIONAL DEVELOPMENT CALENDAR

QLD
- 26 April, 24 May, 28 June, 26 July, 23 Aug – Northern Australia Surgeons Network Videoconferences
- 24 May – Specialists as Teachers Course, Townsville
- 14 June – Winding Down from Surgical Practice, Gold Coast
- 9 Aug – Mastering Difficult Clinical Interactions, Brisbane
- 3-5 Oct – Surgeons as Managers (SaM), Cairns

NSW
- 15 April – Interviewer Training, Sydney (by invitation from Specialty Training Boards)
- 7 June – Specialists as Teachers Course, Orange
- 29 July – Mastering Intercultural Communication**, Sydney
- 8 Sept – Mastering Professional Interactions**, Sydney
- 10 Oct – Winding Down from Surgical Practice, Sydney
- 23-25 Oct – Surgical Teachers Course (STC), Sydney

VIC
- 3 June – Practice Management for Practice Managers, Melbourne
- 13-14 June – From the Flight Deck: Improving Team Performance
- 21 June – Writing Reports for Court, Melbourne
- 28 June – Neurotrauma Workshop for Rural Surgeons, Melbourne
- 19 July – Expert Witness, Melbourne
- 22-23 Aug – From the Flight Deck: Improving Team Performance
- 8 Nov – Risk Management Foundation: Informed Consent, Melbourne
- 15 Nov – Communication Skills for Cancer Clinicians, Melbourne

SA
- 26 July – Mastering Difficult Clinical Interactions, Adelaide
- 19 Sept – Practice Management for Practice Managers Adelaide

WA
- April 26, May 24, June 28, July 26, Aug 23 – Northern Australia Surgeons Network Videoconferences
- 29 April – Interviewer Training, Perth (by invitation only from Specialty Training Boards)
- 27 May – Beating Burnout, Perth
- 3-5 July – Surgical Teachers Course (STC), Perth

NT
- April 26, May 24, June 28, July 26, Aug 23 – Northern Australia Surgeons Network Videoconferences

NZ
- 4-6 July – Surgeons as Managers (SaM), Queenstown

ASC in Hong Kong
- 15 May – Supervisor and Trainer (SAT SET) Course

**New Workshops for 2008

PLEASE NOTE: Additional Supervisor and Trainer Courses (SAT SET) will be offered in each region; visit the PD section of the College website for more information.

FURTHER INFORMATION
Contact the Professional Development Department on +61 3 9249 1106, by email at PDactivities@surgeons.org or visit the website at www.surgeons.org select the Fellowship and Standards menu and then click on Professional Development. Easy online registration is available for all workshops.

Conference Diary Dates

Here are some dates for some of the surgical conferences coming up. If you are aware of any other meetings that you would like to see added to the College website Conferences page, please let us know by email to College.library@surgeons.org

AUSTRALIA / NZ

43rd World Congress of Surgery of the International Society of Surgery ISS/SIC International Surgical Week ISW
6 - 10 September 2009 / Adelaide, SA ,Australia
http://www.sapmea.asn.au/isw2009/

OVERSEAS

Conjoint Annual Scientific Congress of the Royal Australasian College of Surgeons
12 - 16 May 2008 / Hong Kong, China
http://www.surgeons.org/casc2008

The Association of Surgeons of Great Britain and Ireland (ASBGI) Annual Scientific Meeting
"The making of a surgeon" / 14 - 16 May 2008 / Bournemouth, England
http://bournemouth.asgbi.org.uk/

The Royal College of Physicians and Surgeons of Canada Annual Conference
25 - 27 September 2008 / Ottawa, Canada
http://rcpsc.medical.org/meetings/index.php

American College of Surgeons 94th Annual Clinical Congress
12 - 16 October 2008 / San Francisco, CA. USA
http://www.facs.org/

17th Asian Congress of Surgery
20 - 22 March 2009 / Taipei, Taiwan
http://www.asiansurgassoc.org/

CARDIOTHORACIC SURGERY

AUSTRALIA / NZ

CSANZ 56th Annual Scientific Meeting
7 - 10 August 2008 / Adelaide, SA, Australia
http://www.sapmea.asn.au/conventions/csanz2008/index.html

ASCTS Scientific Meeting
October 2008 / Noosa, QLD, Australia
http://www.ascts.org/sections/Annual_Scientific_Me/index.html

OVERSEAS

World Society of Cardio-Thoracic Surgeons 18th World Congress
30 April - 3 May 2008 / Kos Island, Greece
http://www.wscts2008.com/

World Congress of Cardiology
18 - 21 May 2008 / Buenos Aires, Argentina
http://www.worldcardiocongress.org/lp/WCC08/BA2008?1=1

13th Congress of the Asian Pacific Society of Respirology
19 - 22 November 2008 / Bangkok, Thailand
http://www.apsr2008. org/

Society of Thoracic Surgeons 45th Annual Meeting
26 - 28 January 2009 / San Francisco, CA, USA
http://www.sts.org/sections/annualmeeting/

Society of Thoracic Surgeons 46th Annual Meeting
25 - 27 January 2010 / Fort Lauderdale, Florida USA
http://www.sts.org/sections/annualmeeting/

GENERAL SURGERY

AUSTRALIA / NZ

Queensland State Wide Trauma Symposium
20 June 2008 / Herston, QLD, Australia
http://www.qldtraumasymposium.com.au/

2nd Postgraduate Course in Endocrine Surgery (Section of Endocrine Surgeons RACS & AES)
28 - 29 June 2008 / Darling Harbour, NSW, Australia
info@endocrinesurgeons.org.au

SWAN XVI Trauma Conference
25 - 26 July 2008 / Sydney, NSW, Australia
http://www.swsahs.nsw.gov.au/livtrauma/

XXII International Congress of the Transplantation Society
10 - 14 August 2008 / Sydney, NSW, Australia
http://www.transplantation2008.org/home.php

Endocrine Society of Australia Annual Scientific Meeting
25 - 27 August 2008 / Melbourne, VIC, Australia
http://www.esa-srb.org.au/

ACORD - Australia and Asia Pacific Clinical Oncology Research Development Workshop
31 August - 6 September 2008 / Sunshine Coast, QLD, Australia
http://www.acordworkshop.org.au/

General Surgeons Australia Annual Scientific Meeting
"Acute Care and Oncology for the General Surgeon"
26 - 28 September 2008 / Coolum, QLD, Australia
http://www.generalsurgeonsaustralia.com.au/

Provincial Surgeons of Australia Annual Scientific Conference
"Updating General Surgery"
2 - 5 October 2008 / Wagga Wagga, NSW, Australia
psa@surgeons.org

Trauma 2008
17 October 2008 / Sydney, NSW, Australia
http://www.atsoc.com.au/

Australian Gastroenterology Week
22 - 26 October 2008 / Brisbane, QLD, Australia
http://www.gesa.org.au/

Clinical Oncological Society of Australia (COSA) Annual Scientific Meeting
18 - 20 November 2008 / Sydney, NSW, Australia
http://www.cosa.org.au/ASMEvents/ASM2008.htm

Trauma 2009, Combined Australasian Trauma Society and Trauma Association of Canada
5 - 7 March 2009 / Auckland, New Zealand
http://www.trauma2009.co.nz/

OVERSEAS

The American Society of Breast Surgeons 9th Annual Meeting
30 April - 4 May 2008 / New York City, NY, USA
http://www.breastsurgeons.org/Annual_Meeting.htm

9th European Congress of Trauma and Emergency Surgery
24 - 27 May 2008 / Budapest, Hungary
http://www.eurotrauma2008.org/

American Transplant Congress
31 May - 4 June 2008 / Toronto, Canada
http://www.atcmeeting.org/2008/index.cfm

Tripartite 2008
7 - 12 June 2008 / Boston, MA, USA
http://www.fascrs.org/displaycommon.cfm?an=9

Traumacare 2008
11 - 13 June 2008 / Yokohama, Japan
http://www.itaccs.com/

25th Annual Meeting of the American Society for Metabolic and Bariatric Surgery
15 - 20 June 2008 / Washington, DC, USA
http://www.asbs.org/

Society of Laparoendoscopic Surgeons Annual Meeting and Endo Expo
17 - 20 September 2008 / Chicago, IL, USA
http://laparoscopy.blogs.com/ee06/

American Association for the Surgery of Trauma 67th Annual Meeting
24 - 27 September 2008 / Maui, Hawaii, USA
http://www.aast.org/AnnualMeeting/dynamic.aspx?id=866

Annual Meeting of the Society of Surgical Oncology (SSO)
5 - 8 March 2009 / Phoenix, AZ, USA
http://www.surgonc.org/default.aspx?id=39

NEUROSURGERY

AUSTRALIA / NZ

Spine Society of Australia Conference
18 - 20 April 2008 / Adelaide, SA, Australia
http://www.spinesociety.org.au/

NSA Annual Scientific Meeting
25 - 28 September 2008 / Auckland, New Zealand
http://www.nsa.org.au/annual_meeting/2008_annual_meeting.php

Spine Society of Australia Conference
17 - 19 April 2009 / Brisbane, QLD, Australia
http://www.spinesociety.org.au/

OVERSEAS

American Association of Neurological Surgeons Annual Meeting
26 April - 1 May 2008 / Washington, DC, USA
http://www.aans.org/annual/2008/default.asp

ORTHOPAEDIC SURGERY

AUSTRALIA/NZ

Spine Society of Australia
18 - 20 April 2008 / Adelaide, SA, Australia
rcarey@kew.hotkey.net.au

Arthroplasty Society of Australia
1 - 3 May 2008 / Canberra, ACT, Australia
smithadmin@co.net.au

Australian Orthopaedic Foot and Ankle Society
August 2008 / Australia
http://www.aoa.org.au/foot.asp

Australian Orthopaedic Association Annual Scientific Meeting
12 - 17 October 2008 / Hobart, TAS, Australia
http://www.aoa.org.au/

AOA Medico-Legal Society
16 - 17 October 2008 / Hobart, TAS, Australia
drewdix@people.net.au

New Zealand Orthopaedic Association Annual Scientific Meeting
19 - 23 October 2008 / Napier, New Zealand
http://www.nzoa.org.nz/meetings.html

ANZORS AGM
16 - 17 November 2008 / Brisbane, QLD, Australia
david.haynes@adelaide.edu.au

OVERSEAS

AOA / COA 2nd Joint Meeting
4 - 7 June 2008 / Quebec, Canada
http://www.aoassn.org/AnnualMeetings.asp

24th Annual AOFAS Summer Meeting and Pre-meeting Course
25 - 28 June 2008 / Denver, CO, USA
http://www.aofas.org/i4a/pages/index.cfm?pageid=1

British Orthopaedic Association Annual Meeting
16 - 19 September 2008 / Liverpool, England
http://www.boa.ac.uk/

63rd Annual Meeting of the American Society for Surgery of the Hand
18 - 20 September 2008 / Chicago, IL, USA
http://www.assh.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=11881

Orthopaedic Trauma Association Annual Meeting
16 - 18 October 2008 / Denver, CO, USA
http://www.ota.org/meetings/08_annualmeeting.html

American Academy of Orthopaedic Surgeons
25 February - March 1 2009 / Las Vegas, NV, USA
http://www.aaos.org/

OTOLARYNGOLOGY HEAD AND NECK SURGERY

AUSTRALIA / NZ

Australian and New Zealand Head and Neck Society 10th Annual Scientific Meeting
4 - 6 September 2008 / Melbourne, VIC, Australia
http://www.surgeons.org/Content/NavigationMenu/ExternalAffairs/ConferenceandEvents/HeadAndNeck/Default.html

61st Annual General and Scientific Meeting of the New Zealand Society of Otolaryngology Head and Neck Surgery
14 - 18 October 2008 / Auckland, New Zealand
http://www.orl2008.org.nz/

OVERSEAS

American Laryngological Association 129th Annual Meeting
1 - 2 May 2008 / Orlando, Florida, USA
http://www.alahns.org/

7th International Conference on Head and Neck Cancer
19 – 23 July 2008 / San Francisco, CA, USA
http://www.ahns.info/meetings/

PAEDIATRIC SURGERY

AUSTRALIA / NZ

Australian Paediatric Orthopaedic Society Paediatric Instructional Course / 2 - 3 October 2008
APOS Meeting / 4 - 5 October 2008 / Gold Coast, QLD, Australia
petercundy@senet.com.au

60th Annual Meeting of the Paediatric Society of New Zealand
29 - 31 October 2008 / Paihia Bay of Islands, New Zealand
http://www.confer.co.nz/paediatrics08/

Australasian Paediatric Endocrine Group (APEG) Annual Scientific Meeting
17 - 19 November 2008 / Canberra, ACT, Australia
http://www.willorganise.com.au/apeg08

OVERSEAS

Australasian Association of Paediatric Surgeons Annual Scientific Meeting
12 - 16 May 2008 / Hong Kong, China
http://www.paediatricsurgeons.org/AM/Template.cfm?Section=AAPSHome

American Pediatric Surgical Association 39th Annual Meeting
29 May - 1 June 2008 / Phoenix, AZ, USA
http://www.eapsa.org/surgeons/

Pacific Association of Pediatric Surgeons
29 June - 3 July 2008 / Jackson Lake Lodge, WY, USA
http://www.paps2008.com/

PLASTIC AND RECONSTRUCTIVE SURGERY

AUSTRALIA / NZ

Australian and New Zealand Burns Association Annual Scientific Meeting
16 - 19 September 2008 / Melbourne, VIC, Australia
http://www.cdesign.com.au/anzba2008/

ASPS 2008 Plastic Surgery Congress
2 - 5 October 2008 / Gold Coast, QLD, Australia
http://conference.plasticsurgery.org.au/

ASAPS
17 - 21 October 2008 / Adelaide, SA, Australia
http://www.asaps.org.au/

OVERSEAS

American Burn Association 40th Annual Meeting
29 April - 2 May 2008 / Chicago, IL, USA
http://www.ameriburn.org/

EURAPS 19th Annual Meeting
29 - 31 May 2008 / Madeira
http://www.euraps.org/

Canadian Society of Plastic Surgeons Annual Meeting
25 - 28 June 2008 / St John's Newfoundland & Labrador, Canada
http://www.plasticsurgery.ca/

BAPRAS Summer Scientific Meeting
9 - 11 July 2008 / Liverpool, England
http://www.bapras.org.uk/

14th Congress of the International Society for Burn Injuries
7 - 11 September 2008 / Montreal, Canada
http://isbi2008-montreal.com/

Canadian Society for Aesthetic Plastic Surgery 35th Annual Meeting
12 - 13 September 2008 / Quebec, Canada
http://csaps.ca/

63rd Annual Meeting of the American Society for Surgery of the Hand
18 - 20 September 2008 / Chicago, IL, USA
http://www.assh.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=11881

American Society for Reconstructive Microsurgery Annual Meeting
10 - 13 January 2009 / Maui, Hawaii, USA
http://www.microsurg.org/meeting.html

American Burn Association 41st Annual Meeting
24 - 27 March 2009 / San Antonio, TX, USA
http://www.ameriburn.org/

UROLOGY

AUSTRALIA / NZ

Renal Society of Australasia National Conference
26 - 28 June 2008 / Sydney, NSW, Australia
http://www.rsa2008.com/

Urological Society of Australia and New Zealand 62nd Annual Scientific Meeting
8-12 March 2009 / Broadbeach, Gold Coast, QLD, Australia

OVERSEAS

The American Urological Association Annual Meeting
17 - 22 May 2008 / Orlando, FL, USA
http://www.auanet.org/

British Association of Urological Surgeons
23 - 27 June 2008 / Manchester, England
http://www.baus.org.uk/

VASCULAR SURGERY

AUSTRALIA / NZ

Australia and New Zealand Society for Vascular Surgery - Vascular 2008
11 - 14 September 2008 / Adelaide, SA, Australia
http://vascular2008.com/

OVERSEAS

Vascular Annual Meeting
5 - 8 June 2008 / San Diego, California, USA
http://www.vascularweb.org/Annual_Meeting/index.html

OPHTHALMOLOGY

AUSTRALIA / NZ

RANZCO 40th Annual Scientific Congress
22 - 26 November 2008 / Melbourne, VIC, Australia
http://www.ranzcomel.com/

OVERSEAS

ISRS/AAO 2008 Annual Regional Meeting
29 - 31 May 2008 / Cancun, Mexico
http://www.aao.org/isrs/meetings/annual/08cancun/index.cfm

American Academy of Ophthalmology
7 - 11 November 2008 / Atlanta, GA, USA
http://www.aao.org/meetings/annual_meeting/

Ian Dickinson, Chair, Professional Development & Standards Board

CPD Program

Fellows using the CPD online diary will not be required to complete the hard copy recertification data form

CPD Online

Data collection for the 2008 Continuing Professional Development (CPD) Program is available online via the College website (www.surgeons.org). Fellows are able to access a personal CPD Online Diary using usernames and passwords to maintain CPD records in a real time format. Fellows using the CPD Online Diary for 2008 will not be required to complete the hard copy recertification data form issued at the conclusion of 2008, however Fellows are encouraged to continue keeping evidence of CPD activities for verification purposes. CPD Online training and telephone assistance is available through the Department of Professional Standards on +61 3 9249 1282.

2007 CPD recertification data forms overdue

Fellows are reminded that the 2007 CPD Program recertification data forms were to be returned to the College by 31 March, 2008. Fellows who are yet to make a return for 2007 will be issued a reminder letter in April.

Please contact Maria Lynch, Department of Professional Standards, on +61 3 9249 1282 or email at cpd.college@surgeons.org if you require assistance completing your data form or require another copy.

Lost Fellows

The College has been unable to contact a number of Fellows during the year

Dr G U Ahmed	*Australia*	*Urology*	Mr E C Lai	*Hong Kong*	*General Surgery*
Prof T G O'donovan	*U.S.A*	*Cardiothoracic*	Mr J P O'brien	*United Kingdom*	*Orthopaedic*
Mr E Vlahakis	*Saudi Arabia*	*General Surgery*	Mr W S Wong	*Hong Kong*	*Urology*
Mr P J Mcgrath	*U.S.A*	*Orthopaedic*	Dr M E Hassall	*Australia*	*Plastic & Reconstructive*
Mr G K Darby	*Australia*	*Orthopaedic*	Mr J Raman	*U.S.A*	*Cardiothoracic*
Mr A G Corkill	*Australia*	*Neurosurgery*	Dr A M Di Marco	*Australia*	*General Surgery*
Mr R C Edibam	*Australia*	*Orthopaedic*	Dr P A Barry	*Australia*	*General Surgery*
Mr P H Chow	*Singapore*	*General Surgery*	Mr J C Woodfield	*Zambia*	*General Surgery*
Mr M R Arnold	*U.S.A*	*Cardiothoracic*	Mr M J Muscio	*Australia*	*General Surgery*
Prof G M Lawrie	*U.S.A*	*Cardiothoracic*	Dr A R Houston	*Australia*	*Orthopaedic*
Mr N Husseini	*Israel*	*Orthopaedic*	Mr P J Laniewski	*Australia*	*Plastic & Reconstructive*
Mr J H Kagi	*Australia*	*Orthopaedic*	Mr P C Jansz	*Australia*	*Cardiothoracic*
Dr C Asirvatham	*India*	*Paediatric*	Mr D P Rimmington	*Australia*	*Orthopaedic*
Mr L F Glen	*Australia*	*General Surgery*	Mr M J Callahan	*Australia*	*Orthopaedic*
Miss M P Leela	*Malaysia*	*General Surgery*	Mr W P Lam	*Hong Kong*	*General Surgery*
Mr M C Robinson	*U.S.A*	*Cardiothoracic*	Dr P Moroz	*Australia*	*General Surgery*
Mr D C Mcgiffin	*U.S.A*	*Cardiothoracic*	Mr Z Moaveni	*New Zealand*	*Plastic & Reconstructive*
Mr S G Coleman	*Australia*	*Orthopaedic*	Mr E Heineman	*The Netherlands*	*Paediatric*
Prof K Bose, Ed	*Singapore*	*Orthopaedic*	Dr T F Choi	*Hong Kong*	*General Surgery*

If you are the Fellow or know the whereabouts of any of the Fellows listed above, could you please contact Fabricio Silveira on +61 3 9276 7438 or email fabricio.silveira@surgeons.org so the College can ensure that all Fellows can continue to be informed.

International Conference on Surgical Education and Training

John Collins, Dean of Education

One hundred and ninety delegates from 12 countries attended the recent two day conference on surgical education and training organised and hosted by the College in Melbourne. A number of important challenges and opportunities relating to the education and training of the future surgical workforce were addressed. In particular, the following five major topics were discussed in depth:

- Teaching and learning anatomy for surgical practice
- Equipping and supporting surgeons as educators
- Selection of Trainees – reaching an international consensus
- Implementation of workplace-based assessment
- Identification and aiding the underperforming Trainee
- Simulation in surgical education and training

The President, Andrew Sutherland, in opening the conference referred to the remarkably similar challenges being experienced across the globe by those responsible for surgical training. He reminded delegates that standards must be established and maintained by the surgical profession and highlighted the importance of this meeting, the first of its kind, which brought together leaders in this field in an attempt to achieve a common understanding and possible consensus on important issues.

Teaching and learning anatomy for surgical practice

The current status of anatomy was discussed from the perspective of "the professor" and the "student" and a way forward agreed which will improve the teaching and learning of clinically relevant anatomy. An exciting new multimedia package developed in Melbourne to assist in the teaching and learning anatomy was demonstrated and delegates heard of the new focus on anatomy for surgical trainees in different countries.

Equipping and supporting surgeons as educators

The second session discussed the need for appropriate recognition, support and educational preparation of the surgeons involved in the delivery of education and training programs. Presentations from surgeons, medical educationalists and the CEO of a major hospital jurisdiction outlined developments across the world including Australia and New Zealand. It was agreed that a major focus is required to equip and support this valuable resource without which no training can take place.

Selection of Trainees – reaching an international consensus

A major goal of the conference was to reach an international consensus on the selection of surgical Trainees. Presentations by experts from Australia, New Zealand, Canada, England, Ireland and the USA covered the major issues involved including the benefits of having a consensus statement. What the employer seeks from the selection process was clearly described. Unanimous agreement was reached on ten principles and these will serve as "guiding principles" for surgical educational bodies in preparing their selection. This statement or "The Melbourne 2008 International Consensus Statement on Selection of Surgical Trainees" was presented at a plenary session of the co-badged Ottawa International Conference on Medical Education and will be published in the international medical literature.

Implementation of workplace-based assessment

New and more robust forms of workplace-based assessment are needed to monitor the performance of Trainees and to provide career advice to the few for whom surgery may not be an appropriate career. This has become even more important with early selection into surgical training. This session included presentations from international experts on the assessment of technical and non-technical competencies. The ensuing discussion which included experts from the Australian Medical Council, the Confederation of Postgraduate Medical Education Councils and the Medical Boards, stressed the importance of these assessments in providing feedback to learners as well as monitoring their progress. Failure to equip and support surgeons to undertake these assessments has been a stumbling block in their implementation in some countries.

"A major goal of the conference was to reach an international consensus on the selection of surgical Trainees."

Identification and aiding the underperforming trainee

The factors which impact on Trainees' performance, the management of unprofessional behaviour and the legal issues involved were addressed by local and international experts including employers. The importance of being aware of the internal and external factors which might account for poor performance in such high achievers as medical graduates was highlighted. Furthermore, the importance of proper documentation of unprofessional behaviour was reaffirmed as well as the need to ensure future employers and teachers (surgeons) are made aware of significant issues at the commencement of the next rotation. ➔

"Presentations by experts from Australia, New Zealand, Canada, England, Ireland and the USA covered the major issues..."

Simulation in surgical education and training

The final session addressed the role of simulation in training, an appraisal of the tools currently available, and the challenges of designing an appropriate environment for teaching and learning surgical skills. Important considerations covered in the ensuing discussion included the number and level of sophistication of such facilities, the place of mobile facilities and their use of in assessment.

Where from here?

Achieving an international consensus has to be the highlight of this conference and signals the willingness of surgeons to work together to improve the education and training of tomorrow's surgeons. Delegates unanimously agreed a place exists for a biennial international conference on surgical education and training rotating between the major surgical educational institutions. An international steering committee is currently being formed to oversee the future development and location of these conferences.

The organisers of this conference acknowledge the significant part played by the many expert speakers involved and the contribution of the international and local delegates to its success. This conference would not have been possible without the generous support of Medtronic.


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1. John Windsor & Abdul Chaudhry
2. Mary Lawson, Adrian Anthony & Graeme Campbell
3. Heather Fry, Imperial College London, speaking about the Masters programmes in education for surgeons
4. Richard Rainsbury, Royal College of Surgeons England
5. Julian Smith Chairing the opening session
6. Damian Amato
7. Martin Burton & Elisabeth Paice
8. Oscar Traynor from Ireland speaking to Marytn Fields
9. Delegates enjoying lunch

10. Andrew Sutherland, Harjit Singh (Rowan Nicks Scholar) & Siew Kheong Lum
11. Bruce Barraclough & David Rowley, Royal College of Surgeons of Edinburgh
12. John Collins, David Rowley, Richard Rainsbury, Susan Standring, Kings College London, sitting behind Timothy Flynn, American Board of Surgery & William Thomas, Royal College of Surgeons England
13. Maxine Papadakis, Michael Gorton, Lee Hamley and Elisabeth Paice during a panel discussion on managing the underperforming Trainee
14. Susan Standring, Mike Larvin, John Primrose & Chris Chilton
15. Ian Civil
16. Richard Reznick
17. John Collins & Jonathon Beard, Royal College of Surgeons England

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

General Surgeon required for Hospital Nacional Guido Valadares (HNGV) Dili, Timor Leste (East Timor)

FULL TIME POSITION FOR 6-12 MONTHS TO COMMENCE ASAP

The College manages several donor funded health projects in the Asia-Pacific Region. Since 2001 the College has been providing surgical services to improve the availability and quality of general and specialist surgical services to the people of Timor Leste through the training of local Timorese doctors and nurses and assisting with the delivery of tertiary health care services. The program currently employs four full-time clinical advisors (general surgeon, anaesthetist, intensive care nurse and operating theatre nurse) at the HNGV and co-ordinates approximately 12 specialist surgical team visits per year.

The HNGV as the national hospital for Timor Leste is responsible for the provision of a wide range of surgical and non-surgical specialist services and it is the national referral hospital for the 5 district hospitals in the country. The hospital provides a range of surgical services such as general surgery (including paediatric), obstetrics and gynaecology, orthopaedic, ENT and oro-maxillo-facial surgery. The hospital has 268 in-patient beds including 70 surgical, 35 paediatric, 10 neonatal and a five - bed intensive care unit, and a staff of 60 doctors (40 specialists) and 150 nurses. The hospital is currently undergoing extensive rebuilding with the construction of a new theatre, wards, emergency and ICU complex.

The Ministry of Health has requested the College to provide a second general surgeon. This position is especially intended to assist in the development of surgical services in the whole of Timor, including models of training. The College is therefore looking for a suitably qualified general surgeon with an interest in helping this young nation improve its surgical services capacity.

For a detailed position description and other enquiries please contact Ms Tanya Edmonds, Program Manager, International Projects, Royal Australasian College of Surgeons ph: +61 3 9276 7413 or Dr Eric Vreede, Team Leader ATLASS in Timor Leste, teamleeader@mail.timortelecom.tp, ph: +670 725 7125.

Please send your application including a covering letter and CV at your earliest convenience to tanya.edmonds@surgeons.org

Victoria's new credentialing and scope of practice policy

Bruce Waxman, Victorian Regional Committee & DHS Credentialling and Scope of Practice Advisory Group

The Department of Human Services has recently developed a new statewide policy to assist hospitals and clinicians to undertake credentialling and scope of practice processes for all senior doctors appointed to public health services.

All public hospitals in Victoria will now need to utilise this policy. The work builds on the Australian Council for Safety and Quality in Health Care's National Standard for Credentialling and Defining the Scope of Clinical Practice 2004, and work done previously in rural Victoria. The policy has been developed with considerable input and support from clinicians, medical managers and the Colleges. Credentialling and scope of practice issues have received considerable publicity in recent years, with concerns over patient safety. A robust and appropriate credentialling and scope of practice process for surgeons is a central plank in the provision of high quality patient care. The policy is available at www.health.vic.gov.au/credentialling/

What does this mean for our patients?

Our patients will be able to be reassured that patient safety is being supported through ensuring that:

- Surgeons appointed by public hospitals have been through a thorough process of ensuring that their skills and experience match the patient's clinical need.
- That hospitals providing clinical services are properly supporting their medical staff in the provision of services.

What does this mean for surgeons?

The policy is strongly supportive of Surgical Practice, and indeed, recognises that surgeons are central to care delivery and the development of clinical services. The policy does this by:

- Ensuring that credentialling and scope of practice processes are medically led. The policy is strongly supportive of surgeons in Clinical Leadership positions.
- Ensuring that, where surgeons have a scope of practice to undertake a certain activity, the surgeon is properly and fully supported by the organisation in the provision of that activity.
- Ensuring that surgeons are actively involved in service planning and development, by ensuring that clinical services match both community demand and medical skill sets.
- Ensuring that surgeons interests are represented in credentialling and scope of practice processes, by ensuring appropriate independent peer involvement in committee and other organisational processes. In addition, the policy entrenches appropriate independent appeals processes.
- The policy supports ongoing professional and clinical development in that jointly agreed expansion of scope of practice requires organisational support.
- Where surgeons work across a range of hospitals, the credentialling element should be able to be shared. Scope of practice issues will however need to be clarified at each organisation, as an individual's scope of practice may vary in organisations of varying capability.
- Surgeons who wish to introduce new techniques will need to take those techniques through organisational credentialling and scope of practice processes, to ensure that the technique is appropriate for that organisation, and to ensure that the organisation has the staff and other capabilities required to undertake that technique.

What does this mean for organisations?

Hospitals have a range of processes for Credentialling and Scope of Practice. This policy will provide a baseline or standard for hospitals to follow. The policy will provide benefits to organisations through:

1. The active engagement of senior medical staff in service planning and service development.
2. Ensuring that service delivery is a shared activity, supported by both hospital and medical staff.
3. Reassurance that surgeons appointed to the hospital are appropriately skilled for the task
4. Reassurance that surgeons appointed to the hospital undergo regular review to ensure that their scope of practice continues to match organisational need and capability.

For further information, please contact Jeannette Bell, Department of Human Services, Quality and Safety Branch on (03) 9096 9030 or jeannette.bell@dhs.vic.gov.au

This article is a modified version of a document prepared for DHS by Dr Grant Phelps, MBA, FRACP, Gastroenterologist and Clinical Leader, Department of Human Services with the permission of DHS and Grant Phelps

Law Report

The medical profession and the Trade Practices Act (Part 1)

Michael Gorton, College Solicitor

The application of the *Trade Practices Act (TPA)* to the medical profession produces a unique viewpoint. Doctors are no longer carers, they are simply service provicers. Hospitals are no longer charitable institutions, they are purchasing authorities. Medical care no longer has its altruistic and ethical elements. It is simply a commercial service.

Application of the TPA

The relevant provisions of the *TPA* prohibit certain anti-competitive practices. These include:

1 Agreements which have the purpose or effect (or likely effect) of substantially lessening competition in a market.
2 Agreements which contain an exclusionary provision (a boycott or restriction on dealing with particular suppliers or customers).
3 Agreements to fix, control or maintain prices.
4 Misuse of market power by a body or group of people with a substantial degree of power in a market.
5 Exclusive dealing, limiting or restricting the supply or acquisition of goods or services to or from particular customers or suppliers.

Where a professional organisation may potentially breach provisions of the *TPA*, they can seek authorisation from the ACCC, which would then permit the otherwise prohibited practice, so long as it can be demonstrated that the practice involves public benefit.

The consequences of a breach of the *TPA* are substantial. In some cases, it can lead to civil remedies. Criminal penalties can also apply. Interested parties could seek an injunction preventing the conduct from continuing (unless previously authorised by the ACCC).

Issues for the Sector

Some of the practical examples where the new *TPA* provisions may apply include:

1 Agreements to set fees or prices by health professionals or their professional organisations may breach the provisions of the *TPA*. (Some doctors in Australia and New Zealand have been challenged under these provisions.)
2 Boycotts or group arrangements in dealing with health insurance funds or hospitals - either to fees, prices or in relation to other issues in "managed care" agreements - may potentially infringe the *TPA*. (Such issues were raised in a case in WA for a referral hospital and the AMA and has been heard in the Courts.)
3 Agreements between professionals for strict referral arrangements, which would prevent referral of patients outside a particular group, may infringe the *TPA*. (A recent case in SA determined that 2 surgeons had breached these provisions.)
4 Advertising restrictions imposed by professional bodies, restrictions on the ownership of medical practices, etc. may be restrictive agreements in breach of the *TPA*.
5 Agreements with pathology services, radiology and blood testing services for restrictive referral arrangements or requirements that certain patients can only obtain these services from particular groups may infringe the *TPA*.
6 Agreements between hospitals to share particular markets - either a geographic area, or some other division - may breach the *TPA*.

Not all cases of the above will necessarily breach the legislation. However, they are broad examples of the types of conduct that will be examined by the ACCC under the new legislation.

The Medical Market

In general terms, medical practitioners, particularly general practitioners, will operate in the "medical market". Patients or customers will pick and choose in a freely competitive environment. No doubt patients will choose on the basis of convenience, bulk billing, service, hours of practice, as they do at present.

However, referral practices will also come under scrutiny to determine whether any links between the referrals between practitioners and specialists have entered into any anti-competitive agreements. Also radiology, blood and other testing will be closely reviewed to determine whether any of those services are tied or whether the patient really has a choice as to which of the referred service providers they may choose.

Arrangements where health funds contract with doctors may interrupt the traditional referral pattern between general practitioners and specialists. These arrangements particularly will need special review to determine whether the health funds are engaging in anti-competitive practices, or monopolistic practices, in developing links with their own "in-house" doctors.

Advertising restrictions have been lessened in most States. The *Trade Practices Act* requires that any advertising should not be false or misleading.

Industrial Matters and Representation

Many medical professional societies (including the AMA) have traditionally played an industrial representation role. The ability of doctors to combine to negotiate terms of their services has not been under such threat until recent changes in this legislation.

There is the potential for the Trade Practices Act to apply where doctors collectively negotiate with a hospital or employer in relation to terms of engagement. However, it must be clear that there has been collusion in negotiation between the doctors, rather than doctors separately negotiating their contracts or terms.

"The ability of doctors to combine to negotiate terms of their services has not been under such threat as is now represented by the changes in this legislation."

The legislation poses a risk for many of the societies and associations representing specialties, particularly those which generally negotiate terms and fees.

The ACCC intervened in a dispute involving a regional Hospital in Victoria and the negotiation between the Hospital and its attending doctors in relation to new contracts. In what has been seen by many as a very heavy-handed intervention, the ACCC warned doctors their actions may constitute a breach of the Trade Practices Act on the basis of their collective negotiation strategy. In its correspondence, the Commission noted:

"The Commission does not claim that an individual refraining to renew a contract for service is necessarily in breach of the Competition Code. However, if such a decision is made collectively between competitors, conduct is *prima facie* unjustifiably in the interests of competition."

The ACCC issued a warning to individuals representing the doctors in the negotiations with the hospital. The Commission alleged the representatives may also be in breach of the legislation "by counselling, inducing and being knowingly involved in any breach".

Following submissions, the ACCC appears to have softened its stance and withdrawn its threat of action. However, the intervention dramatically displays the potential power of the ACCC and intrusive nature of the new legislation on traditional arrangements.

In Part two of this Article, the role of the medical colleges and effect of the TPA will be considered.

Michael Gorton,
Partner, Russell Kennedy Solicitors

Working in Wagga Wagga

Mr Kirkby enjoys the the country lifestyle and hopes more city surgeons give a tree-change some consideration

The ageing of the surgical workforce, while of concern across the nation, is having a flow-on effect in attracting surgeons to rural and regional centres, according to the Convenor of the Provincial Surgeons of Australia Annual Scientific Conference.

Mr Brian Kirkby, a general surgeon with a vascular interest from Wagga Wagga in New South Wales, said that as local provincial surgeons headed toward retirement, fewer younger surgeons were willing to take up positions in the area for fear that they would be left to cope with an unmanageable workload.

He said the Government needed to provide incentives such as the pay and conditions for surgeons working in rural and regional areas to attract young surgeons which in turn would attract more.

"Unfortunately the health departments and heath services across Australia are not exactly rolling out the red carpet. But if state governments were serious about the workforce issue they would understand that rural and regional surgeons have higher expenses that need to be taken into account, particularly overheads in visiting neighbouring towns" Mr Kirkby said.

"On-going education is more expensive, the cost of relocation is expensive and if they want to attract surgeons with families then the cost of education for children needs to be factored in.

"It is already clear that we need a major influx of younger surgeons over the next five to ten years in regional areas or we are going to have a big problem."

Mr Kirkby moved to Wagga Wagga four years ago and works out of the local Base Hospital with his private practice at the Calvary Diagnostic and Consulting Centre and the Calvary Riverina Hospital. Prior to this he had been working at the Mount Gambier Hospital until a dispute with hospital administration caused all specialists to resign on the one day.

He said one of the central attractions of Wagga Wagga was the fact that it had both a private and public hospital.

"I looked at a number of jobs when I left Mount Gambier but in particular I wanted to move to a centre with both a private and public health system so that I was not beholden to only one. I also looked for a town that had a reasonable number of other younger surgeons," Mr Kirkby said

Mr Kirkby said while his workload was considerable, and that Wagga Wagga like many other rural centres, could accommodate another surgeon, it was not unreasonable. He said he did a full range of general and vascular surgery along with the full range of endovascular procedures.

"One in seven weekends I am on call, with no formal on-call for vascular, and we basically do what-ever comes through the door including trauma from motor accidents, industrial accidents and general and vascular surgery as required."

Mr Kirkby, who grew up in Adelaide, said he enjoyed the country lifestyle and hoped more city surgeons would give a tree-change some consideration.

But he said he understood that such a lifestyle change could seem dramatic.

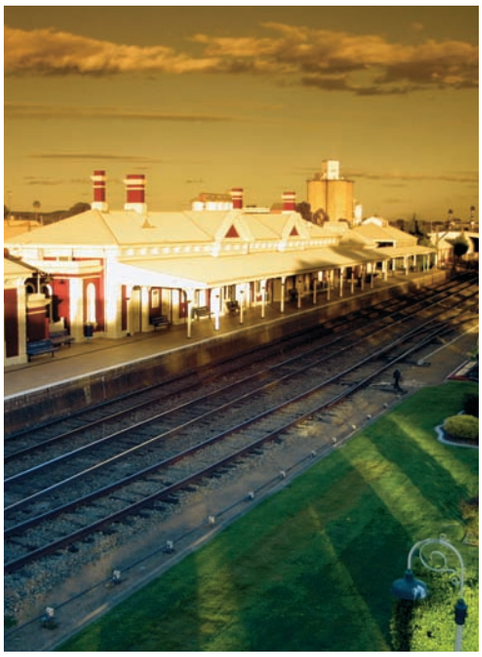
"I much prefer living and working outside the city. There is less traffic, less noise, there is a different pace to life here and I enjoy the attitude of country people," he said.

"But there are considerable difficulties facing people wanting to move out of the city such as taking into account the needs of partners. Most people, by the time they have established their own practice, are married and may have children and it is not easy for surgeons to uproot the members of the family for such a move.

"And still figures show that those surgeons who grew up in the country are more likely to come back whereas city people don't often give it a thought. You can have a great lifestyle outside metropolitan centres and a great professional life too but again the specific needs of rural and regional surgeons should be better catered for.

"If government agencies took this workforce issue seriously they would be prepared to offer attractive remuneration packages rather

"You can have a great lifestyle outside metropolitan centres and a great professional life too..."



than continuing to rely, with all the consequent ethical issues, on taking the medical staff from developing countries."

The Provincial Surgeons of Australia is the official educational component of the Divisional Group of Rural Surgery (DGRS), the peak body representing surgeons in rural, regional and remote areas of Australia and New Zealand. The DGRS has 380 active members.

The Provincial Surgeons of Australia Annual Scientific Conference is held annually in a regional centre with the conference this year to be held at the Charles Sturt University in Wagga Wagga from October 2 to October 5.

Mr Kirkby said the conference was always well attended and supported.

"Continuing professional development programs are adequate in rural and regional centres but we have extra travel time that needs to be taken into account. We often cannot just take an afternoon off to attend a workshop but rather have to leave our practice for days at a time," he said.

"That is one of the reasons why the Provincial Surgeons of Australia is so strong because it does cater for on-going education for those of us in regional and rural areas.

"As an organisation is it focussed on education, particularly in terms of passing on tips and techniques, but it also provides a supportive, collegial environment within our professional that can sometimes be hard to access for those working outside metropolitan areas."

Mr Kirkby said the theme this year is to be Updating General Surgery. He said representatives of a range of specialties including Upper GI, Vascular, Breast and Colorectal would be presenting papers in the developments that have taken place within each discipline. He said up to 130 registrants were expected.

Blue Hand

The science of glass sculpting

There is a synergy between glass blowing and surgery, as both have technical and scientific aspects

Randall Sach admits that when he first took up his now-consuming passion of glass sculpting, he was concerned about the possibility of sustaining burn injuries to his hands. It was a reasonable fear: glass sculpting requires working with molten glass melted in ovens set at more than 1500 degrees Celsius. An injury to his hands would be seriously detrimental to his professional life as a plastic surgeon.

"I was initially a bit worried, but then I found that with skill and time and care the risks were not that great," Mr Sach says.

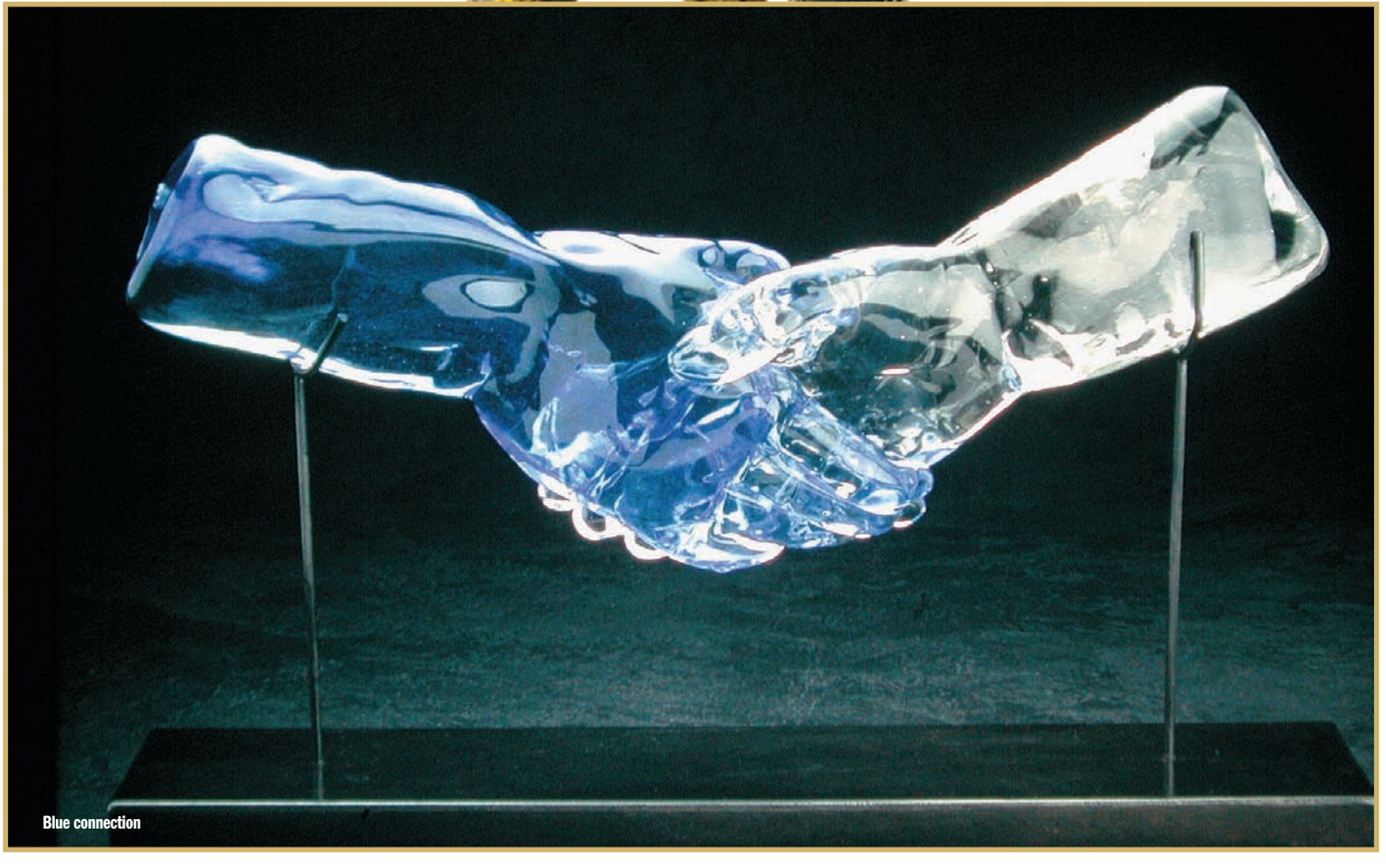
Fortunately, he has escaped any injury, but has taken on an additional role as surgeon to the glass blowers, treating other people's burns, cuts and crush injuries.

Sisters

"The other glass artists kind of like having me around though they think I'm a bit eccentric as a surgeon/glass-artist, and surgeons think I'm a bit eccentric as a glass artist/surgeon."

Mr Sach says he first became interested in working with glass after reading a *National Geographic* article about the American Studio Glass movement and then seeing some examples of that work while on a skiing holiday in Aspen, Colorado. Everything came together when his wife bought him a weekend workshop course as an anniversary gift in 1993.

"I thought the kind of work produced through the Studio Glass movement was inspiring, and I became fascinated by the process. I wanted to learn how such work was made and how it could be crafted. The tech-



Blue connection

nical skills required sparked my interest just as much as the artistic side" he says.

Although he only works in the glass studio on weekends, he has managed to hold several major exhibitions, and his work is now also found in galleries around Australia.

Elegant and subtle, most of his pieces are based on the human form – hands, heads, skulls and figurines - a theme that allows him to use his detailed anatomical knowledge. He says this is only one of the many links between his professional life and his art.

"I have found a great synergy between surgery and glass sculpting since I began. Both have technical and scientific aspects, both require manual dexterity, learning by repetition, attention to detail, precision, lateral thinking and teamwork. You can't make a glass piece by yourself, both disciplines require knowing how to get out of trouble, and both require some creative flair," Mr Sach says.

"And of course we have a bag of tools for working with glass that includes scissors, pincers, tongs and spatulae. As a sculptor, I think it helps me in the three-dimensional aspects of surgery, but while I don't think it has made me a better surgeon, it certainly makes me a happier one."

Most years Mr Sach undertakes a workshop to increase his skills and knowledge, even visiting Venice, the home of glass art, and learning from some of the maestros in the field such as Lino Tagiapietra and Dante Marioni.

"The glass community itself is similar to the surgical community in terms of hierarchy and learning. Each state has its own organisation, and at the top of the tree, anywhere around the world are the super-heroes, followed by those with particular expertise, then the people working under them, much like our registrars, perfecting their skills," he says.

"That takes some time because the key is understanding the nature of glass. Timing and heat control are critical, because if the glass is too hot it will not hold shape, and if it's too cool it will break.

"It is a wonderful substance to work with, and the more I learn the more I understand that what you can do with it is only limited by skill and imagination."

Mr Sach, who works at the Royal Adelaide Hospital with his private practice run through the Sach Day Surgery and St Andrews Hospital, keeps a cabinet of his sculptures in his office, selling pieces to his patients upon occasion. Most retail for between $200 and $1500.

"It's very flattering that people like the pieces and want to own them," he says. "It also means that I have a hobby that pays for itself."

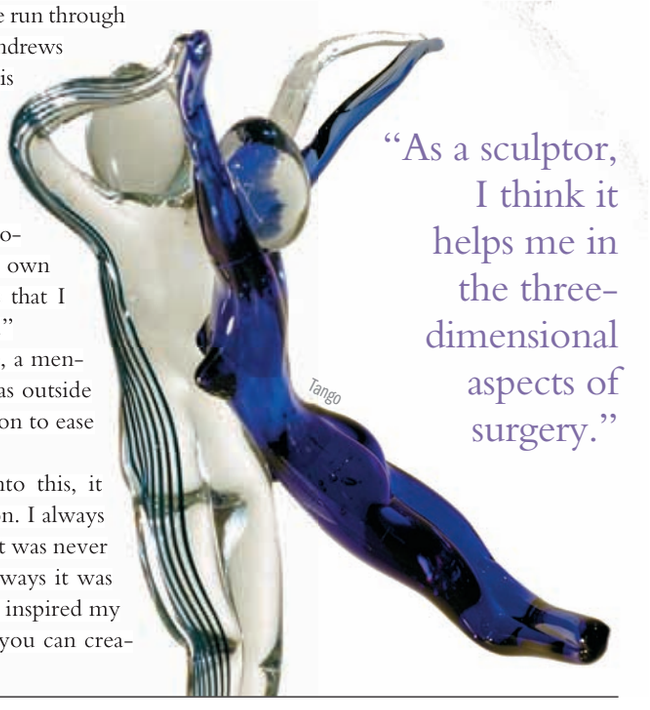
Mr Sach said that years ago, a mentor advised him to develop areas outside his professional work as a surgeon to ease his transition into retirement.

"Although I sort of fell into this, it has become a consuming passion. I always liked sketching and drawing but was never seriously artistic, and in many ways it was the technical process that really inspired my interest, how it happens, how you can creatively manipulate the process," he says.

Mr Sach now works out of the Adelaide Jam Factory glass-blowing studios.

"I enjoy being a member of the glass art community and believe it makes for a more fulfilling life getting to know people with different interests. My wife enjoys that, too, and while I have tended to become very focussd and busy in the lead-up to exhibitions, I don't think she regrets paying for that initial course all those years ago."

Mr Sach's favourite piece so far is a pair of hands called "Blue Connection", which he describes as both "strong and subtle".



"As a sculptor, I think it helps me in the three-dimensional aspects of surgery."

Notice to Retired Fellows of the College

The College maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College.

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve.

We will acknowledge your donation and place your name on the gown, if you approve.

If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.

Alternatively, you could mail the gown to Jennifer C/o the Conferences & Events Department, Royal Australasian College of Surgeons, College of Surgeons' Gardens, 240 Spring Street, Melbourne 3000.

The College would like to acknowledge the late Mr Ian A. Shumack FRACS on the generous donation of his academic gown.

Ian Dickinson, Chair, Professional Development & Standard Board

Emergency Surgery

The College Council approved an Emergency Surgery Position Statement in February 2008, which is now on the College website

A position statement was developed by the College's Emergency Surgery Working Party (July 2007 – February 2008) in response to growing concerns about the provision of emergency surgical care, including trauma care. The working party was a broad based group from most specialties and included anaesthetist and emergency physician input. The statement was developed in consultation with the Specialty Societies and Regional Committees.

The position statement includes discussion on appropriate facilities for accepting emergency patients and the need to increase resources and funding. The statement calls for strong leadership and encourages credentialling and privileging processes in public hospitals to include the provision of emergency care.

Issues such as pre-hospital care and triage,

inter-hospital transfers and models of care are addressed, in addition to the provision of safe working hours and ongoing professional development. The statement also emphasises the need for junior staff to be given adequate time to learn new skills and senior clinical staff to be given time to teach as part of their hospital appointment.

It is important that the College sets standards for surgery and is involved in policy development in relation to the provision of emergency surgical services to the communities of Australia and New Zealand. To this end, the position statement will be sent to all Federal, State and Territory Departments of Health to aid discussion of the problems in emergency surgery and initiate action.

The position statement is available online on the College's website at www.surgeons.org/Position_Statement_Emergency_Surgery.pdf.

Your comments and feedback on the position statement are welcome. Please send all comments to Ms Sylvia Daravong, Emergency Surgery Working Party Secretariat via email at sylvia.daravong@surgeons.org.

WE WANT YOUR BRAS!

Disadvantaged indigenous Fijians get much of their clothing from second hand Australian clothes shops. Bras are rare in these shops, particularly in sizes to suit the Fijian build. A new bra costs $40, and wages range from $1.50- $4.50/hour.

With the humidity, fungal infections and abscesses occur between the breast and the chest wall. Bras will help.

Since 2005, Uplift Fiji, through Rotary International World Community Service, has sent bras through secure channels, making sure they get to the women who need them without compromising their dignity.

All second hand bras size 14 or bigger are welcome. The biggest sizes are the most needed and the hardest to get. Every bra donated will become the only bra a particular woman owns. Worn out bras can be used for spare parts and strap extenders! Rotary has an import duty exemption for second hand goods taken into Fiji for charitable purposes, but not for new goods.

WEBSITE:
http://lizbaker.customer.netspace.net.au

NATIONAL & VIC PROJECT ORGANISER:
Liz Baker, (03) 9718 2883
lizbaker@netspace.net.au

SA PROJECT ORGANISER:
Maxine Jones: 08 8294 8612
maxchris@adam.com.au
6 Wyatt St Glenelg East, 5045,

POST BRAS TO: Liz Baker, 9 Steven St, Hurstbridge, Vic, 3099

TRUCK BRAS TO: Sth Morang Chiropractic, 82 Reid St, Sth Morang. Vic 3752

DROP OFF BRAS AT :

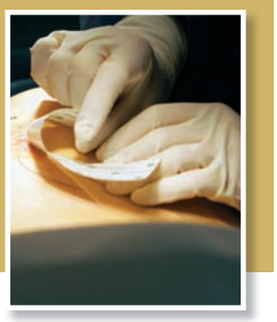
Metro Melbourne

Seaford, Lisa's Lacies, 42 Hartnett Dve
Reservoir, Lisa's Lacies, 44 Johnson St
Prahran East, Brava Lingerie: 487 High Street
Montmorency, Contours Gym, Were St
Surrey Hills, Curves Gym, 1109 Riversdale Rd
Ivanhoe, 100% Health Chiro:33 Ivanhoe Pde
Eltham: Rohini, 173 Scenic Cres
Viewbank: Leah, 23 Robern Pde
Vermont Sth Frances, 28 Stradella Ave,
Highett Lisa, 3 Donald Street
Hurstbridge, Liz 9 Steven St.
Sth Morang Chiro, 82 Reid St.
Mernda, Maureen, Brendan St

Regional Vic

Shepparton: Valley Accounting Services
20 New Dookie Road,
Maffra Sandra, 7 Pearson Street
Maffra St John's Op Shop Johnson St.
Heyfield Anglican Op Shop
Stratford Anglican Op Shop
Wallan Kathy, 140 Queen St
Simon Yu pharmacy
Uniting Church Op Shop
Broadford Salvos Op shop,
Kilmore Hospital Op shop,
Highton: Ron, 2 St Georges Crt

UPLIFT FIJI!
BRAS TO LET BREEZE UNDER BREASTS



Rowan Nicks Scholarships

The scholarships have given surgeons from developing countries the opportunities to increase their skills under the guidance of mentors

One of the Colleges' most generous benefactors, retired cardiothoracic surgeon Mr Rowan Nicks is to be honoured at this year's Conjoint Annual Scientific Congress to be held in Hong Kong in May. Mr Nicks, one of the oldest surviving Fellows, has been a major benefactor of the College since 1987 and has funded four College scholarships.

They are the Pacific Island Scholarship, the International Scholarship and more recently, the Rowan Nicks United Kingdom and Republic of Ireland Scholarship and the Rowan Nicks Australian and New Zealand Scholarship.

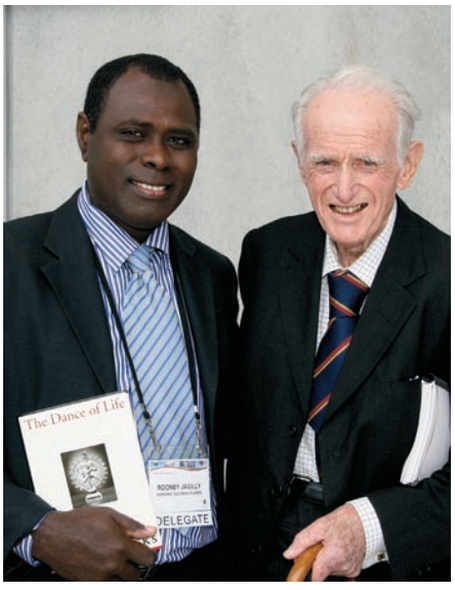
Since the establishment of the scholarships, scores of talented surgeons from developing countries in particular have had the opportunity to spend time in Australia, under the guidance of mentors, increasing their skills and gaining access to science and technology unavailable in their home countries.

Cardiothoracic surgeon and Associate Professor of Medicine at the University of Queensland, Alan Gale, is one such mentor, having nominated international scholarship recipients from Vietnam and Myanmar. He described Rowan Nicks as an "outstanding and unique individual" and said his contribution to improving medical care in emerging communities was deserving of great honour.

Associate Professor Gale recently visited Vietnam and said the progress made there in recent years, through the efforts of two former Rowan Nicks Fellows, Dr Viet and Dr Anh, had been extraordinary.

"It was a great thrill for me to visit Cho Ray Hospital in Ho Chi Minh City in February to witness the huge progress that has occurred there since my first visit in 2000 when I performed the first coronary bypass surgery in the public sector of South Vietnam," Associate Professor Gale said.

"Rowan Nicks should be acknowledged for his immeasurable contribution to the progress of this institution which, since the return of the two Rowan Nicks Fellows, has now performed 3000 cases.



Rooney Jagilly (a 2007 Rowan Nicks Scholar) with Rowan Nicks

"One memorable case that I assisted at was a ruptured thoraco-abdominal aneurysm in a 36-year-old woman who presented in extremis six hours after the birth of her sixth child.

"She was found to have ruptured her aneurysm and Dr Anh operated without CP Bypass using a shunt to the visceral arteries and replaced her aorta from thorax to lower abdomen. Six hours later she was passing urine, was wide awake and had bowel sounds. She left hospital one week later. It was an extremely dramatic case and was quite brilliantly done.

"In Myanmar, Dr Khin Maung Lwin, another Rowan Nicks Fellow, is now head of the Yangon Hospital unit.

"These wonderful surgeons feel an immense gratitude for the privilege of having the opportunity to train in Australia and the skills they have returned, particularly in Vietnam, are beyond imagination as they develop a further skills transfer for younger surgeons in the Cho Ray unit.

"Both the countries I visited have been wickedly disadvantaged by sanctions over the years which in my opinion only serve to punish the undeserving so to see the progress made was even more rewarding.

"These surgeons are highly intelligent, hugely enthusiastic and enormously technically competent and Rowan Nicks and the College should take great delight in the fact that the skills transfer made available through the Scholarship has been so wonderfully effective."

A recent Rowan Nicks scholar, Dr Anagha Zope from India, spent three months at the Alfred Hospital's breast surgery unit in Melbourne under the supervision of Professor Jonathan Serpell in 2007.

She said the scholarship had allowed her to develop competency and proficiency in the management of the full range of breast disease, from screening to diagnosis to surgical management to post-surgery rehabilitation.

"The use of isotope-based sentinel-node biopsies and breast conserving procedures are not performed routinely in most of the centres in India and I was happy to learn them. Although I could only have a limited exposure to breast reconstructive procedures it helped me greatly to understand the selection of the right procedure for each patient," she said.

"The scholarship means that I am now able to impart better and more refined surgical skills to my patients and I shall be able to participate in and offer multidisciplinary care to breast cancer patients.

"I also hope that by being able to rise above prevailing dogmatic views in the local medical fraternity that I may be able to develop a cost-effective but efficient breast cancer screening module suited for my community."

Dr Zope said she was now also in the process

John Masterton, Kondwani Chalulu, Anagha Zope (2007 Rowan Nicks Scholars) and Rowan Nicks

of establishing a department of Breast and endocrine surgery at a tertiary care medical hospital in India but was unwilling to identify the hospital until the department was fully functioning.

"The clinical experience I gained during this scholarship was immense and varied and the richness of my experience lay in the amalgamation of my visits to the different hospitals in Melbourne," Dr Zope said.

Rowan Nicks, who just celebrated his 95th birthday, grew up in Auckland and graduated from Otago University in 1937. He travelled to England to continue his studies but upon the outbreak of war he enlisted in the Royal Navy serving in West Africa, the North Sea and the Mediterranean and gaining a military OBE.

He trained in cardiothoracic surgery in England, Scandinavia and the US and in 1948 he joined the fledgling surgical unit at Green Lane Hospital in Auckland. In 1957 he was approached to establish a heart unit at Royal Prince Alfred Hospital in Sydney becoming an international pioneer in heart surgery.

Having been left a considerable inheritance, Mr Nicks chose to help young surgeons from developing countries, first focussing his generosity on those in Africa but then deciding to help those closer to home in South East Asia and the Pacific Island nations.

"These wonderful surgeons feel an immense gratitude for the privilege of having the opportunity to train in Australia..."

During the Conjoint Annual Scientific Congress, three speakers will present papers outlining the contribution made by Rowan Nicks including Mr John Masterton, the Chair of the Rowan Nicks Committee.

Mr Masterton said that more than $1 million had been spent so far on supporting the various Rowan Nicks scholarships and agreed with Associate Professor Gale that he deserved wider honours and recognition outside the medical profession.

"While the College has honoured him for his contribution, he has not been given public honours in Australia because he is still a New Zealand citizen," Mr Masterton said.

"A campaign in New Zealand should be run to honour him there I believe because his contribution to the care of patients around the world has been extraordinary."

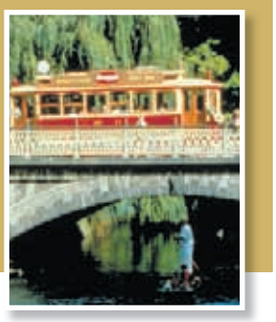
Mr Masterton said that although his age was placing limitations upon him, Mr Nicks still liked to travel (economy class) and delighted in meeting the scholars he had helped.

"The opportunity is given to scholars to come to one College meeting during their tenure or afterwards if that is impossible so they can meet other surgeons and Rowan Nicks," he said.

"They are presented at the Convocation and it is one of Rowan Nicks' great joys to meet them and he also maintains some correspondence with some of them too."

Mr Masterton said two recent additions to the Rowan Nicks Scholarships had been designed to encourage a one-year transfer of surgeons from Australia and New Zealand and to encourage surgeons from the European Union to work in New Zealand or Australia.

"We are delighted to be giving Rowan Nicks the tribute in May. He is extraordinarily generous, he has had a huge impact on the skills of surgeons in various countries and therefore the quality of care available to patients all because he has had an ambition to help young people," he said.



Toast to the Royal Australasian College of Surgeons

John Collins,
Dean of Education

During the Congress Banquet of the Annual Scientific Congress a distinguished visitor is invited to give a Toast to the College in reply to the Toast to the Visitors. The Visitors' Toasts are of great interest to delegates and can be highly entertaining as can be seen from this superb example delivered at the 2007 ASC in Christchurch by Professor Gerald O'Sullivan, President of the Royal College of Surgeons in Ireland.

Gerald O'Sullivan Russell Stitz & Andrew Sutherland

On Sunday noon your President was in a sweat
I'm a speaker short, who will I get?
Get the Irishman – they're so full of Blarney
Wordsmiths of tall tails and all that malarkey.

It will be no trouble – speak for minutes ten or so
But of course I lied. Will there be slides, oh no.
There will be no need for rhyme, he said
Blank verse or prose or simple words will do instead.

A friendly man advised – make it late and twill not matter
There'll be plenty wine; my mates and I'll be on the batter.

I called my wife – What will I do?
Your on your own boy – I can't help you
But tonight when you stand up obey a simple rule
Be brief, be clear and clean, and don't playact the fool
And remember that while we both are strangers in this fine place,
The other guests command respect, and don't you them disgrace.

We, your guests, have come from far and near; guests we're glad to be, you make us welcome here
From China, Hong Kong and from far away Japan
Malaysia, Thailand and sun drenched Pakistan.
France, UK, Scotia and Hibernia
From places nearer here and far flung America.

We join together and here salute your fine College
Your members programs – your resource of knowledge.
We admire your noble tenets and your dedicated sense
Equity, standards and tolerance

Yesterday at dawn we together sat
Exchanging new ideas, problems, this and that.

We talked about assessment, training, competence
Common global issues – miserly intrusive governments.
We proffer new techniques, advance care for patients
But from earnest bureaucrats, just cold indifference.

Manpower needs, projections – what a confused state
To solve those issues we all agree we must collaborate.
For as yet there is no size to fit us all
No programs designed to meet tomorrow's call.

But for us your guests there has been more to savour
New countries, people, cuisine - altogether a grand flavour.
Mountains, deserts, reefs and restless oceans
Define your psyche, physique and independence.

Outdoor sport, track, pool, golf, wind and surf
You excel in teams in arts and science, and all the other stuff.
At rugby now you have no peers, and cricket's just the same
For us to win again we'll invent a brand new game.

And now your guests when we go home and all this relate
We'll be back in bigger crowds at every future date.

2009
ROWAN NICKS SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the 2009 Rowan Nicks Scholarships and the 2009 Rowan Nicks Pacific Islands Scholarships. These are the most prestigious of the College's International Awards and are directed at surgeons who are destined to be leaders in their home countries.

The 2009 Rowan Nicks Scholarships are offered to surgeons from Asia, Africa or the Middle East. It is intended to provide an opportunity for the surgeon to develop skills to manage a department and become competent in the teaching of others in their home country. It is emphasised that the scholarships' objectives are leadership and teaching and it should not be used solely to develop surgical skill. The scholarship is usually awarded for a period of between three and twelve months.

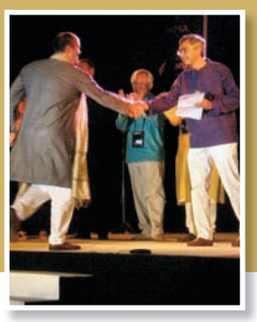
The 2009 Rowan Nicks Pacific Islands Scholarships are reserved for surgeons from Pacific Island countries. It is aimed at promoting the future development of surgery in the Pacific Islands by providing a period of selective surgical training with the specific purpose of fostering the scholar's potential to provide surgical leadership in his/her home country. The scholarship is usually awarded for a period of between three to six months.

These scholarships cover the scholar's travel expenses between their home country and Australia or New Zealand. A living allowance will be provided equivalent to AUD$36,000 for up to twelve months or appropriate pro-rata for a scholarship in Australia and NZ$36,000 for up to twelve months or appropriate pro-rata for a scholarship in New Zealand. The scholarship is tenable in a major hospital (or hospitals) in Australia or New Zealand, and appointees will attend the Annual Scientific Congress of the College if they are in Australia or New Zealand at the relevant time.

Applicants should be under 45 years of age, fluent in English (an English proficiency test will be requested) and be a citizen of the country from which the application is made. Applicants must undertake to return to their country on completion of the scholarship programme.

Closing date for these Scholarships is **5pm Monday 14 April 2008**
A copy of the application form for either Scholarship is available at www.surgeons.org.
For additional information please contact:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street
Melbourne VIC 3000 Australia
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211
Fax: + 61 3 9276 7431



New music, ancient instruments

The 8th World Congress of the IHPBA provided an energetic forum for surgeons and surgical scientists to exhibit their research

Benjamin Loveday & Anubhav Mittal, Department of Surgery, University of Auckland

"The surgeon is like a musician, playing new music on ancient instruments," stated Markus Buchler, President of the International Hepato-Pancreato-Biliary Association (IHPBA), drawing parallels between the conference delegates and the musicians who had delighted us with their skills on the electric sitar, Indian drums and wooden flute at the opening ceremony of the 8th World Congress of the IHPBA. Over 1600 delegates from 65 countries were in attendance, bringing together surgeons and surgical scientists from around the world to showcase their research.

Mumbai's Powai Lake was the backdrop for the conference, with black buffalo wallowing in the shallow water a stone's throw away. The Marriot Renaissance Hotel, on the lakefront, provided a relatively tranquil setting on the outskirts of one of the world's megacities. With six concurrent sessions running from 8am until 8pm, there was an abundant choice in content. The cutting-edge research was often found in the smaller free paper and poster sessions, while the main sessions were used to cover broader topics with more direct clinical relevance.

The Pancreas Research Group, headed by Professor John Windsor, ensured New Zealand remains relevant in the field of surgical research. During the conference Professor Windsor was inducted as Secretary General of the IHPBA, a position he will hold for four years. He was also an invited speaker, presenting on minimally-invasive pancreatic necrosectomy, use of the Harmonic WAVE endosurgical instrument and new frontiers in management of pancreatic necrosis. Professor Windsor headed a breakfast tutorial on intraoperative decision-making in pancreatic necrosectomy.

The five members of the Pancreas Research Group at the closing ceremony of the 8th World Congress of the IHPBA, Mumbai 2008 (From left: Nichola Thompson, Anthony Phillips, John Windsor, Benjamin Loveday, Anubhav Mittal)

The other members of the group made their contribution to the conference by delivering three oral and two poster presentations. Dr Anthony Phillips presented his paper "Acute pancreatitis severity is exacerbated by intestinal ischemia reperfusion conditioned mesenteric lymph", for which he received one of five awards for oral presentations.

Dr Benjamin Loveday presented two papers entitled "Lymphatic connections between the pancreas and intestine: do they exist?" and "Minimally invasive pancreatic necrosectomy: trends and barriers". Dr Anubhav Mittal demonstrated his recent research with two posters: "The proteome of rodent mesenteric lymph in fasted and fed states" and "The antioxidant status of an inflammatory disease as measured by cyclic voltammetry: a rodent study to assess the severity of acute pancreatitis". Dr Nichola Thompson, a research scientist who joined the group in late 2007, attended the conference to help formulate future experimental strategies.

The conference was a success, providing an occasion for the Pancreas Research Group to showcase some of its recent research on the world stage, and a setting for its members to meet researchers from Europe, Asia and North America. The Department of Surgery has given surgical Trainees like Anubhav Mittal and Benjamin Loveday an excellent opportunity to learn vital research skills for their future careers in surgical academia.

Dr Anubhav Mittal and Dr Benjamin Loveday are Trainees in General Surgery, currently completing PhDs in Surgery at the University of Auckland. Dr Mittal is supported by the Royal Australasian College of Surgeons Foundation New Zealand Research Fellowship. Dr Loveday is supported by a Clinical Research Training Fellowship from the Health Research Council of New Zealand. PhD positions are available in the Department of Surgery, University of Auckland from January 2009.

For further information contact Professor Windsor on j.windsor@auckland.ac.nz

Top right: Dr. Anthony Phillips runs onto the stage to receive his prize for best oral presentation

CASC
2008

The things I will see and do in Hong Kong in five days

Gordon Low

I will get myself an Octopus Card from an underground railway station - this is called an MTR (Mass Transit Railway). With this card, I can go on all public transport: bus, tram, train, ferry and anything except taxis.

Monday

- Explore Hong Kong Island
- Take a Peak Tram Ride
- Take a trip to Stanley Market
- Do some shopping at Pacific Place
- Tonight, I will go to Lan Kwai Fong – the good fun place

Tuesday

- Take a trip to Ocean Park
- Go to Cat Street (Upper Lascar Row) to look for Chinese curios

Wednesday

- Explore Kowloon:
- Take the "Star Ferry" to Tsimshatsui and walk to the Ocean Terminal and
- Ocean Centre to see all the merchandise
- Walk to Lock Road and visit the Swindon Book Company. This is a book store like no other book store
- If I am still there after dark, I will go to the Mongkok Women's Market.

Thursday

- Go outside Hong Kong: - I can go to only one of the following:
- Disneyland
- Po Lin Monastery and Tian Tan Buddha on Lantau Island
- Fishing Village of Cheung Chau
- A New Territories Tour

Friday

- Go to the Chi Lin Temple and Nan Ling Garden at Diamond Hill or,
- Take a trip to Sai Kung Village and have a seafood lunch
- Go to all the places I had missed out

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Welcome to Timor

I spent six weeks in East Timor in August/September 2007 as an AusAID surgeon, this is a modified version of my report

Emma Lang

It was easy to develop a strong affinity for this small struggling nation on my first visit to Timor Leste. The initial plan was to stay for three weeks, but due to unforeseen circumstances (and to my great benefit), this was extended to six weeks working as an AusAID surgeon.

I felt a little apprehensive before I left, so I consulted the Australian Department of Foreign Affairs and Trade website, only to read that "we advise you to reconsider your need to travel to East Timor at this time because of the volatile security situation and the risk of violent civil unrest. The situation could deteriorate further without warning…"

They were prophetic words. Shortly after I disembarked from the Nicolai Lobato International Airport, riots erupted across the country in the wake of the recent parliamentary elections. Buildings were torched and lives were lost. My heart skipped a beat when driving to work on the second day. Three locals hurled rocks at our vehicle, striking the windscreen specifically hardened to withstand such attacks. I caught a glimpse of my assailants from the side window. They were just kids, really; young and defiant like the country itself.

In a particularly precarious hot spot surrounded by internally displaced people's camps is the 260 bed Hospital Nacional Guido Valadares, undergoing reconstruction.

Initially, I was struck by the lack of unity between the various contingents of the medical community. It is a curious fact that Cuba and China, two of the world's last communist strongholds, have both sent in significant teams of medical specialists. In particular, the Cubans are an independent force, with their ready-made referral base throughout the hospital. Later I was to learn the rather complex political and social forces behind this segregation. Defections have been known to occur.

English is not the common language and it pays to be fluent in one or more of Tetum, Indonesian, Portuguese or Spanish, none of which I could speak. Reading the patient files is an exasperating exercise in deciphering entries in all of the above.

Destruction in the aftermath of the riots

The disease profile and operations are not the typical spectrum of an Australian metropolitan teaching hospital, not to mention the lack of the customary investigations such as Cat scan (CT), endoscopy and laparoscopy. In fact, anyone who needs a CT has to be airlifted out of the country at a formidable cost, which is only rarely affordable. One of the highlights of the trip was the intrigue involved in chartering a direct UN flight to Darwin for an urgent Cat scan on a six year old boy who presented in a persistently drowsy state with a third cranial nerve palsy. This revealed a large temporal lobe mass that had bled acutely. His case was later picked up by a charitable organisation and he successfully underwent a temporal lobectomy for a benign tumour.

Whilst much of the surgery is not complex, the challenge comes from relying on one's clinical acumen and applying generic surgical principles to a vast range of conditions. Infectious diseases are legion – in particular the cold abscess – necessitating a variety of drainage procedures. Burns and trauma are commonplace, including arrow wounds and the occasional gunshot wound. On the other hand, gallstones and obesity are comparatively uncommon.

The training program

The surgical training is vastly different from Australia, where there is cutthroat competition amongst a large pool of highly qualified candidates for a limited number of training positions. As is appreciated by everyone (particularly the Trainees), the opposite is true in Timor. It is difficult to know the impact of this on training, but what can definitely be said is there are varying levels of commitment demonstrated by different Trainees.

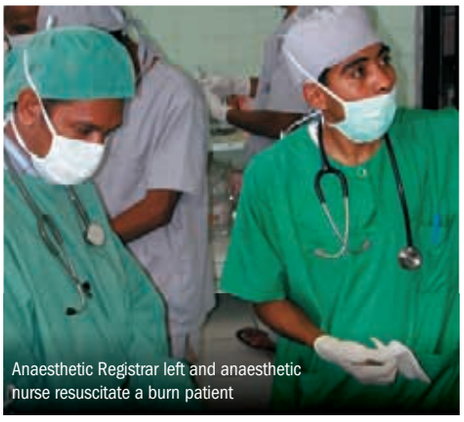
Surgical training took place in theatre, on ward rounds, in outpatients and by way of a formal tutorial program. The later was a particularly challenging exercise as the three trainees were at different levels, with different comprehension of English.

One area that was conspicuously absent from the program was the concept of Surgical Audit. Some of the cases I found most disturbing were the preventable deaths, in particular the young trauma victims. The establishment of a regular Morbidity and Mortality meeting may be a useful way of highlighting some of the systems failure or indeed, systems absence.

Trainee attendance at the 7.45am Intensive Care Unit (ICU) ward round was an ongoing issue, as was punctuality in general. As a result, the sickest patients were often overlooked by the registrars, along with important concepts in post-operative care such as electrolyte management and pain relief. It was clearly important to try and inculcate a sense of responsibility amongst the registrars by way of delegation and autonomy but unfortunately the system would often fall apart due to absenteeism and lateness.

Hospital Politics

The morale within theatre was relatively high which appeared to be largely due to a cohort of young and dedicated theatre nurses, some of whom were very impressive indeed. Unfortunately, much of the equipment was of such poor quality as to be an actual impediment to operating. Initially I kept telling the Trainees



Anaesthetic Registrar left and anaesthetic nurse resuscitate a burn patient

Emma Lang operating with surgical registrar Dr Joao Ximenes

Emma Lang in Theatre

Timor Road Safety is yet to come

Photos courtesy of Prof Hamish Ewing, Dr Orysia Sandry & Mr Dan McKenzie

to use the instruments; that is, until I tried them myself. I was surprised to find that the abdomen was routinely closed with vicryl because the pds had run out some time ago and not been replaced. This seemed to be a recurring problem as during my tenure the supply of sterile gloves also faltered and x-rays were reduced to an emergency service, and finally ceased altogether, because the developing solution was depleted. Tragically, it was not appreciated that stocks of tetanus immunoglobulin had ran out until a young boy was admitted with tetanus and died.

Why is a crisis routinely required in order to initiate supply? It is extremely difficult to pinpoint responsibility, particularly as it is extremely difficult to ascertain who, if anyone, is in charge. It is perhaps salient to remember this is a country that has lurched from one crisis to another for the past 30 years and it suffices to say that forward planning is not yet their forte.

Caring for surgical patients on the wards was a major concern as there was no guarantee that basic nursing care, such as routine observations, would take place. This was in part due to the overwhelming patient to nurse ratios and in part due to a lack of education. As a result it was difficult to send anyone even vaguely unstable to the surgical ward unless it was a palliative admission. ICU provided a far more reliable nursing environment, partly due to the inroads made by Daniel McKenzie into ICU nurse education.

Similar issues beset the Emergency Department, and in particular the early management of trauma broke most rules in the EMST guidebook. Active leadership is desperately required in this area and perhaps the establishment of a trauma team, run by the surgical registrar/surgical consultant could be a driving force in trauma care.

The role of the AusAID surgeon is a complex one. At all times it was important to try to work with rather than for (or even against!) the Timorese. I am convinced that learning the language is the key to engaging the locals and not just being seen as another occupying force. Like most ambassadorial roles there is often a fine line between exasperation and objectivity. Yet at the end of the day as a visitor to this country, the privilege was undoubtedly mine.

Cry Timor:

Fast Facts On The World's Poorest Country

- East Timor has the world's smallest economy
- Most of its 1 million people live on less than $US 1 a day
- 40 per cent of children are malnourished
- 60 per cent of the population is illiterate
- 40 per cent of the population is unemployed
- Approximately 100,000 people are internally displaced
- The birth rate is 7.8 per cent, one of the fastest-growing populations in the world

Peter Coupland,
Bereavement Counsellor,
Pictured: Graham Coupland

Graham Coupland Lecture

A tribute to prominent surgeon Graham Coupland, this lecture focuses on surgeons' responses to dying, death and bereavement

The following lecture is an edited version presented to the College 18 August, 2007 at the NSW Annual Continuing Education meeting. The full version can be obtained from the author (peter.coupland@acenet.com.au)or online at www.surgeons.org

It is with great pride that I present the 25th Graham Coupland Lecture. In preparing for today, I spoke at length with 22 surgeons over the the past six months. You told me about your memories of my father; what he was like as a surgeon and what he was like as a man. On my request, you also told me of your experiences with dying, death and bereavement.

If he could be here today, he would have much to say. He would be excited about the many surgical advances that have occurred over the past 25 years; he would be fascinated with the advances in technology. He would lament changes to the things he was most attached to and he would probably give you an ear full of the "good-old-days".

Although a private domain for him, he would express his gratitude and appreciation for the hard work that fell to his wife, Robyn Coupland, to raise our large family, maintain records for his practice and provide the love and support that enabled him to work in the way he did. In mentioning this, he would be implicitly acknowledging the support you all receive that enables you to achieve in your careers.

He probably would have challenged you on many dimensions too, such as the fees some of you charge, the inflexibility and isolation created through surgical specialisation and he would push and prod individuals and the College where he perceived there to be any complacency or laziness. Like most of you, he would be dismayed and angry where patients suffered due to incompetence.

Finally, he would comment on the critical role mentors play in one's surgical career and in so doing, he would acknowledge and pay respect to his mentors, particularly Professor John Lowenthal, Professor Lewie Lowenthal, Dr Harry Cumberland and his close mentor and ultimate friend Emeritus Professor Tom Reeve.

However, his untimely death at 47 cut short his life and in an effort to remember his contribution to surgery, plus remind yourselves of his values, his role modelling qualities and his friendship, the college pays tribute to Graham through this lecture.

In your words, Graham Coupland was a gifted surgeon and leader. A talented anatomist, a dedicated paediatrician, innovative vascular surgeon and dedicated teacher. You told me that ward rounds were a workout: from the physical: moving quickly up and down countless flights of stairs; to the intellectual: you needed to be on your toes to discuss the condition and treatment plans for anything up to 40 patients each round. Although his method could be politically incorrect and his bluntness could be intimidating, many of you are grateful for the pivotal role he played in your development as a surgeon.

He was a committed researcher and prolific writer and his reputation extended beyond Australia. In all his undertakings he was an uncompromising task master, an efficient administrator, a loyal colleague, a team player and for a few, a deeply trusted and valued friend

For many years it has been a source of curiosity as to what my father would have to say about the subject of dying, death and bereavement. The closest I could get to understanding this was to ask his colleagues and the following is what you had to say.

Surgeons' reflections on dying, death and bereavement

Exposure to Death

Surgeons are exposed to a wide range of deaths from emergency situations to those occurring during palliation. Over the course of your careers, actual numbers of deaths you are directly exposed to range from less than 30 to more than 300.

For many, their first experience of coming face-to-face with death was in the anatomy lab or on your first block as a med student. Some of you had personal experience prior to this event. Some of you told me your first encounter with a patient who died corresponded with you, having to give the news of this death to the patient's family: a practice you said was most inappropriate.

It seems the more experience you have with death, the more prepared and resilient you are in dealing with the various challenges that follow. Many of you indicated that you build up a tolerance to the emotional effect of this exposure but you were clear in saying that if tolerance ever becomes indifference then you should stop doing what you are doing. Additionally, those of you who have suffered personal loss through death report that you are more able to combine tolerance and resilience with understanding and empathy.

Circumstances of death

You indicated that from a surgeon's point of view, not all deaths are equally confronting but your reactions differ in relation to a subjective scale depending on the cirucmstances.

The least confronting of circumstances is where death is anticipated and where the

patient has lived a relatively long life. For some of you, an important part of this situation is having the opportunity to discuss issues with family members. Important elements of this situation include good communication, effective teamwork, time to consider options and where appropriate, quality palliation.

More confronting are unexpected deaths and emergency situations. Confrontation is higher when the person is young; even worse when death occurs in childhood. It hits harder when you have established rapport and trust with a patient and their family - particularly when you genuinely believed that death, although possible, was not likely.

However, the most confronting of circumstances, at both professional and emotional levels, are deaths where you question what you might have done differently or not done. This was explained to me in several ways: either as an act of omission, commission, or the result of an overall failure of the system to provide adequate patient care.

Emotional reactions

You said that on a case-by-case basis, surgeons are generally well-placed to cope with the emotional effects related to death. You are trained to be objective and you are professionals with a defined role to perform – that is, to treat illness and to save lives.

However, each surgeon interviewed recounted the details of at least one patient death that has had a profound effect on their experience with death. For many of you, even if it occurred over 20 years ago, the experience is burnt into your memory and for some these experiences resurface from time to time.

At an emotional level, most of you indicated that over time things can build up. As mentioned before, the impact is greater when it is personal with the death of a either family or friend being the most difficult to cope with. For some of you, the combined effect of these things has led to various degrees of shock, fear, guilt and lack of concentration.

At these times, you do not question the wisdom of returning to work, rather, most of you seem to dig deep and work even harder. Some of you find solace in your interests, a couple of you talk to your partners and, very rarely, you talk to each other.

One description of the cumulative impact of this type of exposure was that you experience a type of "creeping paralysis" which is characterised by emotional withdrawal. This pattern influences you differently, it can affect the choices you make regarding surgical procedures. It can also factor in your decision as to when you stop practicing surgery, or at least, some forms of surgery.

Challenges

The first challenge you described was the need for, and complexity of, communication. This was at professional, peer, team, patient and family levels. With respect to patients and families, you said that an honest appraisal of the situation using non-technical language is required. Some of you are able to be present in other peoples' distress and pain and whilst many of you limit your exposure. Finding the right words, saying them in the right way and at the right time is a challenge in most settings.

The second challenge relates to family dynamics. As someone is dying and at the time of death, family dynamics are unpredictable and challenging in many ways. You encounter the full range of our multicultural society and the vast expressions of grief within this. You indicated some individuals and families can hang onto and remember every word you tell them, whilst others are not able to take in any information. You never quite know how a family will respond to the news of death therefore a key challenge is to be flexible and honest in your response to their needs.

The third challenge you highlighted was that of personal and professional support. At the personal level, you kept very close counsel when talking about death. For some, I was the second person in their life that they had talked to about their experiences; the other being their wife or partner. One or two of you said you had a colleague with whom you would feel comfortable discussing the emotional effects of a death on you, but in fact, you rarely did that. On the whole, you do not seek support in understanding and reflecting on your experience of death…." we don't talk about that sort of thing".

However, when burden is very high and you believed you were not at your best, that support from a understanding peer could be extremely helpful. Most of you saw this as a concern and a challenge to the profession generally, but you were not sure on the best way to meet this type of support need.

Coping strategies

The presence and frequency of these challenges have a direct bearing on your experience and satisfaction as a surgeon. These challenges impact on the way you react to death and how you relate to others at this time.

You indicated that the key coping strategy is drawing on your strengths, such as your natural decision making abilities, adherence to standard protocols, and remaining objective. This helps you to stay focused and to be honest in your judgement of the factors that led to a patient's death. Communication is critical in all aspects of your work and you mentioned it also as a core coping strategy. Surgeons cope better with negative outcomes where your communication has covered all contingencies.

Receiving good news related to your work from patients is always satisfying and this helps to recharge the batteries. Finally, you said that team work and peer support is critical and that a healthy balance between high and low pressure case loads can make a big difference. At the end of the day, you said that you cope best when you spend enough time in "life" - enjoying your friends, family, faith and interests. →

"My view is as a surgeon, your experience and your personality have an important role to play for those who are dying and those who are bereaved."

Bereavement Counselling Point of View

Current thinking is that dying, death and bereavement are separate but overlapping experiences which have highly personalised and often unpredictable responses for people. There may be familiar patterns in grief but there is no "standard" way of grieving as age, personality, cultural factors and factors related to the death combine to influence one's reaction.

Some people are passionate grievers - covert, passive, or active. Yet the most reliable predictor is that we are a more exaggerated form of our pre-grief state; that is, cautious people will be more cautious, sensitive (more sensitive) and so on. We can be vulnerable: for example, the high level of emotional intensity that occurs in grief can affect our cognitive ability, therefore influencing concentration and one's capacity to take in and process information.

Added to this is the effect of regression where both adults and children revert to a younger version of themselves. This process is an unpredictable process which is seen as a natural psychological defence mechanism that aims to solicit care or protection from others. Also, contrary to previously held myths, kids also grieve. They experience similar reactions to adults but they show it in different ways.

To help live through and adjust to the reality of a death, involvement in the dying process, being present at the time of death, viewing the person who died and active participation during the course of bereavement assists with understanding and adjusting to life without the person who has died. The length of time it takes to integrate this experience varies significantly and usually corresponds to the significance of the relationship.

In terms of a challenge to this group - being at the nexus between life and death - surgeons have a unique opportunity to assist people through this most difficult period of adjustment. With respect to your role, both dying and bereaved people require honest and understandable information given in a sensitive manner. Platitudes and euphemisms are not helpful. They need to know they are in a safe pair of hands, technically, and to varying extents, also emotionally. If you show you are averse to strong emotions, or hesitant on the topic of dying and death, you are creating a barrier to communication and this will ultimately affect the extent to which they trust you.

If you are a poor communicator, this may contribute to their distress and maybe cause enough to blame you for a death irrespective of the actual cause. You will be seen as an antagonist in their grief if you cannot acknowledge their distress and pain. They may take action to show you this in their anger or frustration. If you are a good communicator, you are likely to become an ally in their grief. A trusted advisor who can provide them with much needed information at different points along their road to understanding the death of someone they loved. At a practical level, there are several things to keep in mind. Your beliefs and attitudes are visible and will affect your interaction with the bereaved family. For example, it will show in the respect you display through your actions in the way you treat the body of the person who has died and it will be most obvious when you have to give bad news. Importantly, all these things will also be observed by those you work with and your behaviour will be cues for others to follow.

My view is as a surgeon, your experience and your personality have an important role to play for those who are dying and those who are bereaved. Your emotional resilience, your knowledge and experience with death and your ability to assist those in despair are important enablers for you to succeed in this role.

Close

It is my hope this talk will encourage you to pause and reflect on the extent to which you integrate the experience and challenges of dying, death and bereavement into your life in a healthy way so you can enjoy a long-term and successful career.

As an advocate for bereaved people, I encourage you to update your skill set, expand your coping strategies and strengthen your support resources. This, of course, is an individual, team and organisational challenge. Ultimately it is a cultural challenge. Maybe one day, instead of hearing: "We don't talk about that sort of thing", you might hear: "How about we grab a coffee and talk through how your patients death has affected you."

In returning to the purpose of this tribute, I respect your view that in life and also in memory, Graham Coupland's character, values and behaviour provided an important role modelling influence to those in the surgical field. He would want this opportunity to be a reminder of a couple of principles that guided all his work as a surgeon; first was to go out of your way to be available to help patients; and second, to always do your absolute best. In surgery, near enough is not good enough.

In closing, my family and I appreciate the honour extended to my father through the existence of this memorial event.

Peter Coupland, Bereavement Counsellor, National Centre for Childhood Grief & Bereavement CARE Centre

Acknowledgements

Emeritus Professor Tom Reeve, Mr Phillip Truskett, Interviewees (20), Bev Lindley, The Coupland and Merrington Families and Friends, Colleagues at the NCCG and BCC, Lorraine Merritt, Greg Hutchinson.

Bibliography

Please visit the College website or email peter.coupland@acenet.com.au

Websites

Bereavement Care Centre:
www.bereavementcare.com.au
Association for Death Education and selling:
www.adec.org
National Association for Loss and Grief:
www.nalag.org.au

The Surgeon Scientist Scholarship

Dr Joseph Ischia, the recipient of a College scholarship, is making exciting discoveries about the causes of renal cancer

The current recipient of the Surgeon Scientist Scholarship, Dr Joseph Ischia, is participating in a unique research project that could mean the development of an effective treatment for renal carcinoma. Dr Ischia's research, part of a PhD conducted through a collaborative project between the University of Melbourne's Department of Surgery and the Urological Unit at the Austin Hospital, is investigating the role of a growth factor called gastrin releasing peptide (GRP) in the development of renal cell cancer.

"Many cancers produce their own growth factors and receptors, but the role of GRP in certain cancers has only been investigated in recent years. While it was first noted to stimulate the release of gastrin from the stomach, this is far from GRP's main role. We are now beginning to understand its role in metabolism, release of regulatory peptides, gastrointestinal and pancreatic secretions, and carcinogenesis," Dr Ischia said.

"Since then, GRP has been found to be an established growth factor in certain lung and bowel cancers, but little is known about its role in tumours of the kidney.

"But our research so far indicates that GRP is made by kidney cancers and stimulates their growth, which is a significant advance in our understanding of the disease. Renal cancer is one of the most notoriously difficult cancers to treat. It is often detected late and there is no effective radiotherapy and no effective chemotherapy, which means the only way to treat it is to cut out the tumour, but if it has metastasised there is little we can do.

"In Australia, 2500 cases are diagnosed each year and of those 1500 people die, so to find an effective treatment is of world-wide interest."

Dr Ischia said his research involved understanding the production of GRP and its receptors, the ability of GRP to stimulate proliferation, and the potential of antagonists to modulate the growth of renal cell cancers.

Dr Joseph Ischia

"We are working on this through three stages. First, we are looking at kidney cancer cells in the flask, then kidney cancer cells in mice and the production of GRP and its receptors in resected kidney tumours," he said.

"So far we have definitely proved that GRP is affecting the growth of cancer cells in the flask, and that is a huge advance. We have also shown that GRP and its receptors are found in resected kidney tumours."

Dr Ischia's research is being conducted under the supervision of Associate Professor Damian Bolton, the head of the Urology Department at the Austin Hospital, and Professor Arthur Shulkes and Associate Professor Graham Baldwin of the Department of Surgery, University of Melbourne, also based at the Austin Hospital.

"This work could mean that we can design chemotherapy that targets the growth factors to limit the spread of the disease. Much of the leg work has been done and the research being conducted at the Austin Hospital is now of great interest to researchers around the world.

"We have discovered something completely new – that is that the structure of the GRP receptor is different in kidney cancers compared to that found in other organs, such as the stomach. That was a Eureka moment, and you don't get many of those in research, which makes it very exciting, and we hope to publish within the next few months," he said.

The first year of Dr Ischia's PhD was funded by a scholarship made possible by a donation from the late Eric Bishop that supports applicants who wish to take time away from clinical positions to undertake a full-time research project. He is currently on a Surgeon Scientist Scholarship.

"One of the central benefits to having such a scholarship is the time that it gives, in that I now do one half day assisting each week, which allows us still to live comfortably. That in turn means I have more time to plan experiments, read the relevant literature and think about what needs to be done," Dr Ischia said.

"I'm grateful for the support of the College and think the whole range of scholarships now available is making research far more attractive and possible for more surgeons."

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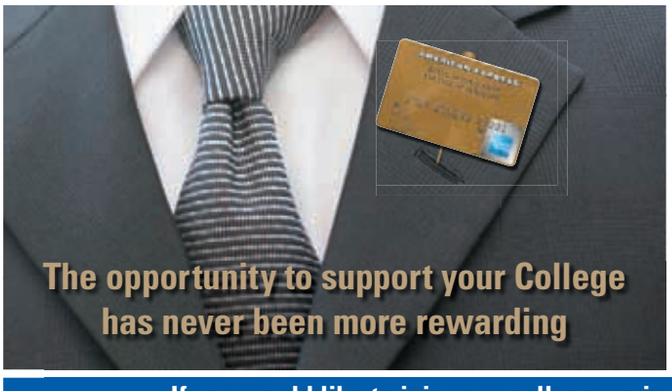

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New College Accredited Patient Information Leaflets

A significant number of all complaint and litigation cases specifically cite 'lack of informed consent / failure to warn', and this figure is significantly higher as a contributory factor. If we consider patient communication and consent lightly, we do so at our own peril.

Increasingly the teaching of communication skills has been included as part of the undergraduate and postgraduate curricula, as the doctor-patient relationship has moved from paternalism to partnership. Effective communication is a two-way process, but how do we know if we or our clinical teams are doing this well?

We may be more aware when our communication is not as good as it might be, when we receive informal or formal feedback. Informal feedback may come directly from the patient, from colleagues or from other members of the healthcare team. Formal feedback from patients is usually through the complaints system, an experience that many surgeons rate as the most aversive they could imagine.

One quarter of complaints by hospital patients cite problems with communication as a cause (source: Office of the Health Services Commissioner, Victoria, Annual Report 2006).

One area where communication is particularly important is in obtaining informed consent. Communicating benefits, risks, alternatives and expected outcomes of surgery is a legal requirement. Best-practice guidelines suggest that we should be sharing this information in an open and honest manner which promotes involvement of the patient in the decision-making process, so called 'shared decision making'.

The National Health and Medical Research Council 2006 guidelines on what information should be provided ("Making decisions about tests and treatments – principles for better communication between healthcare consumers and healthcare professionals") state:

- "a consumer cannot make informed decisions if their professional uses medical terms that they do not understand, or provides written information that is beyond their literacy or numeracy skills."
- "Almost every health decision, including the choice not to have a treatment or test, has some associated benefits and risks. Healthcare consumers need comprehensive information on these risks and benefits, given in a way that they can understand."
- "Using a decision aid can make weighing up the pros and cons of each option easier. It can also help consumers to prepare for a consultation, so that the professional can spend less time giving facts and more time on discussing things that matter to the consumer."

Communicating complex aspects of surgery and possible complications in a form that patients can understand is challenging for any clinician, as patients do not readily understand medical terminology and may struggle to retain any information if the clinician has just broken bad news. Enough time must be set aside to gain proper consent prior to surgery as the clinician will be judged to be negligent if he or she fails to provide information that the litigating patient considers would have affected their decision to go ahead with the procedure.

So what help is there for the surgeon? Considerable work has been carried out in Australia by a company called Specialist Management Services developing a set of procedure-specific patient information leaflets to assist the consent process. Each leaflet is written by a specialist in the field and goes through a rigorous development process that includes incorporating consent guidelines from regulatory bodies and specialist colleges. Each leaflet is edited by the Plain English Campaign and involves lay review to ensure the information is readily understood by most people at first read. A local peer expert and an editor of a major Australian medical journal authorise all text. Each leaflet bears the College Coat of Arms which acknowledges the quality of the processes that create this material. The leaflets are provided electronically in PDF format and can easily be printed when doctors need to give them to patients.

Written information is a key adjunct to the doctor-patient consultation - and to the process of consent - and should be provided as early as possible in the patient's journey. High quality written information can inform and remind patients of key points required for decision making and can be given either before they are seen by the surgeon or at the same time. Patients should have time to read and digest the information prior to giving their consent in order to make that consent valid. When this happens, the time the surgeon needs to spend consenting the patient is reduced because the patient is already aware of the important information and the time can be used to clarify, answer questions and emphasise the important points.

Specialist Management Services is the principal supplier of patient education leaflets to the Western Australia Department of Health and one of Victoria's largest public health networks, Southern Health.

If you would like further information regarding these leaflets you can contact Specialist Management Services on 0400 090 436 or by email at info@smservices.net.au. More information is also available on the web at www.smservices.net.au

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Nominations for College Awards

Nominations are called for College Awards to the 2008 Awards Committee Meetings

Distinguished Awards (Alphabetical Order)

Colin McRae Medal – Contribution to Surgery

Approved by Council in 2001, the Colin McRae Award commemorates the life and work of the late Colin Ulric McRae. It recognises and promotes the art and science of surgery and surgical leadership in New Zealand and honours those who have made outstanding contributions in this way.

ESR Hughes Award – Contribution to Surgery

Inaugurated in 1998, the E S R Hughes Award is designed to recognise distinguished contributions to surgery by Fellows of the College and others.

Gordon Trinca Medal – Contributions to Surgery

Approved by Council in October 2002, this award commemorates Gordon Trinca's contribution to the prevention of road trauma and trauma education. It is a prestigious honour that recognises and promotes contributions to trauma care with particular emphasis on trauma education and teaching.

Heslop Medal – Contributions to Surgery

Approved by Council in June 2004, this award remembers the contributions of Barbara and John Heslop to basic surgical training and acknowledges the contributions of others to the Board of Basic Surgical Training and its committees.

Prince Henry's Medal – Contributions to Surgery

The award shall be for distinguished contributions to plastic surgery in the broadest sense and will include original contributions to the literature and to scientific meetings, academic achievement including research, undergraduate and postgraduate teaching, intellectual leadership and the encouragement of others to the overall advancement of the highest ideals of plastic surgery.

RACS Medal – Service to the College

The RACS Medal was inaugurated in 1976 to recognise singularly valuable and dedicated contributions to the College by Fellows and others. Its sole criterion shall be distinguished service to the affairs of the College.

RACS International Medal– Education / Research / Clinical Performance

Established in 1998, the RACS International Medal is awarded to a Fellow who has provided a lasting contribution of an exceptional nature over a long period of time in the delivery or development of surgery for underprivileged communities overseas.

RACS Surgical Research Award– Education / Research / Clinical Performance

Established in 2000 the RACS Surgical Research Award is an honour created to recognise the contribution of a pre-eminent surgical scientist who has made significant contributions to surgical research.

Rural Surgeons Award – Contributions to Surgery

The Rural Surgeons Award acknowledges significant contributions to surgery in rural settings in New Zealand and Australia. The contribution will be in the form of conspicuous continued involvement of at least 10 years to the development of a high standard of surgery and commitment to quality assurance and ongoing education and training for the individual and other health care staff.

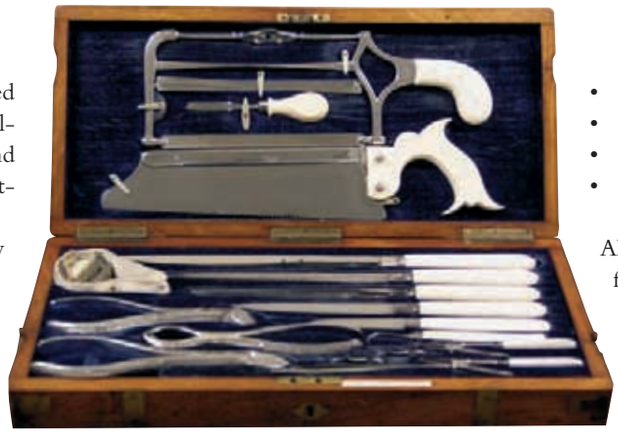
Nominations for an award must be made accordance with the appropriate policy which can be found on the College website www.surgeons.org.au. Nominations must be received by the Chair of the Awards Committee 6 weeks prior to an Awards Committee Meeting.

The Awards Committee meet in February, June and October

Heritage Report

Keith Mutimer,
Honorary Treasurer

Presentation/Exhibition set of Surgical Instruments



Among the finest of the old boxed sets of instruments in the College's collections is a large and impressive amputation set made by Matthews, London.

The case measures 46.5cm long by 21.5cm wide by 8.5cm deep. It is made of mahogany with brass mounts, bands, hinges, escutcheon plate and name plaque (left blank). The interior is lined with blue velvet. The instruments are secured in a fitted base, and on the inside of the lid. There is no lift-out tray. The case and the instruments are all in excellent condition, and the case key is still in its compartment. A label attached to the front lower lip of the case reads "MATTHEWS. 8 PORTUGAL ST LONDON . W.C". The set dates from the mid-19th century, probably the 1860s.

The instruments are made of steel plated in silver. The handles are of ivory, finely machined in a lozenge pattern to provide a good grip. Most of the instruments are engraved with Matthews' name and address, except for the large Liston knife, which has "Skidmore Sheffield" engraved on the shoulder. This knife does however belong to the set, being fitted with the same ivory handle as the others. It would seem that Matthews merely sourced the long blade from another manufacturer, in this case William Skidmore, a leading surgical instrument maker in Sheffield, who won a prize for his cutlery at the Great Exhibition of 1851. Despite their fearsome appearance, the large knives are not particularly sharp.

The set consists of:

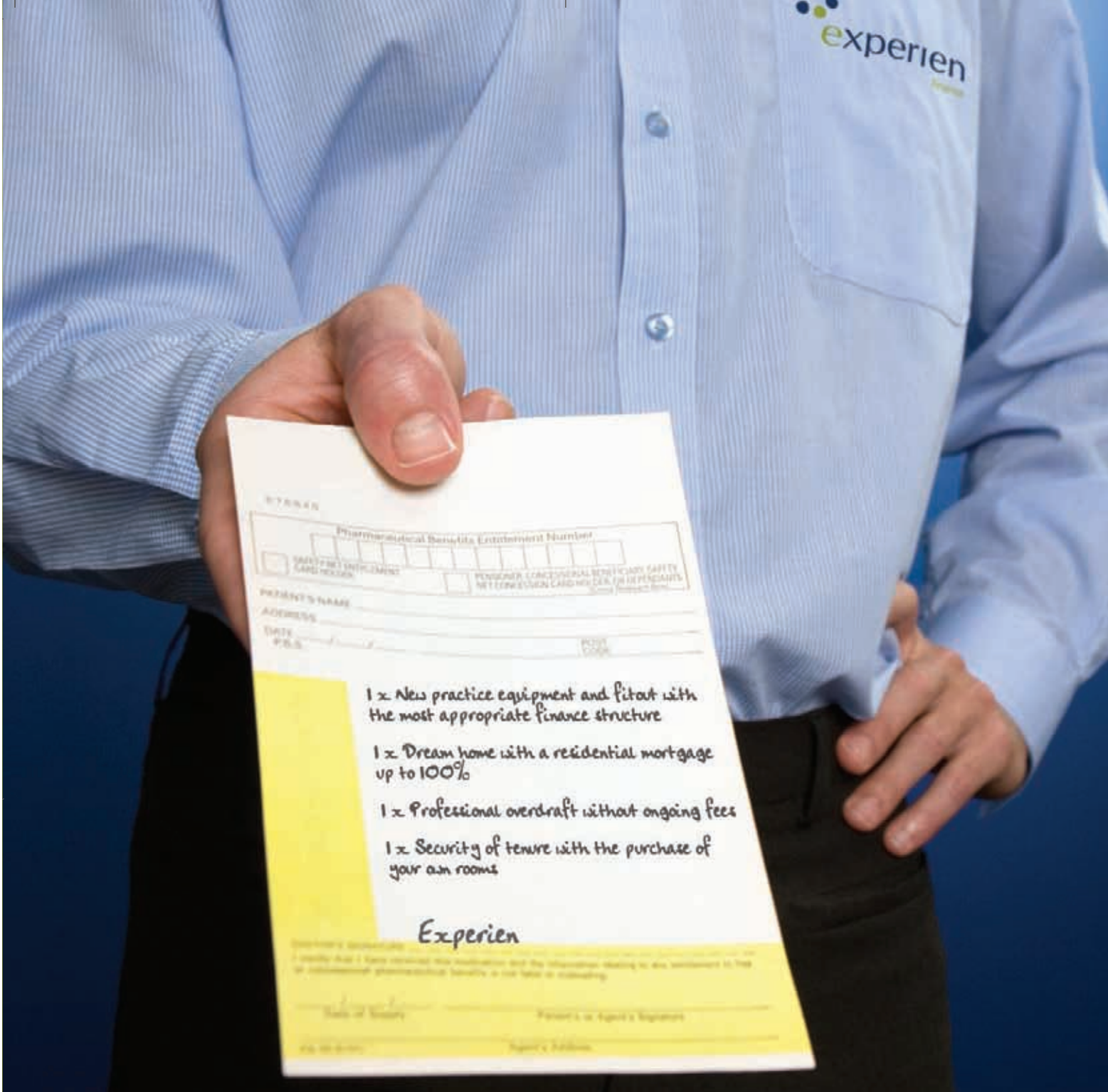
- Tenon saw
- Butcher's amputating saw with two spare blades
- Gouge
- Four amputating knives
- Scalpel
- Tenaculum
- Two bone forceps
- Lion forceps
- Dieffenbach's artery forceps (pair)
- Assalini's artery forceps (pair)
- Dressing forceps
- Petit's spiral tourniquet.

The instruments show no sign of use. Although the plating on the upper surfaces has deteriorated through exposure to the atmosphere, the undersides are in near perfect condition. This set is obviously a showpiece, designed to exhibit the quality and skills of the manufacturer. Its purpose would have been either presentation as a prize or honour, or display in the shop window and at trade fairs.

Matthews were a prominent firm of surgical instrument makers, founded in 1846 by William Matthews at 10 Portugal Street, London. In 1851 they expanded into the building next door, and from 1851 to 1878 their official address is 8 Portugal Street. They moved out of these premises in 1894. Portugal Street W2 runs behind Lincoln's Inn Fields, at the back of the Royal College of Surgeons. The site of Matthews' premises is now occupied by the Lionel Robbins Building, part of the London School of Economics.

This very fine set was donated to the College by D. Palmer.

Written by Geoff Down



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