SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:3 April 2009

The Annual Scientific Congress, next month, page 22:

The scientific program can now be viewed online asc.surgeons.org

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

Surgical Leaders Forum

The forum is one of our most profiled meetings, happening at least three times a year

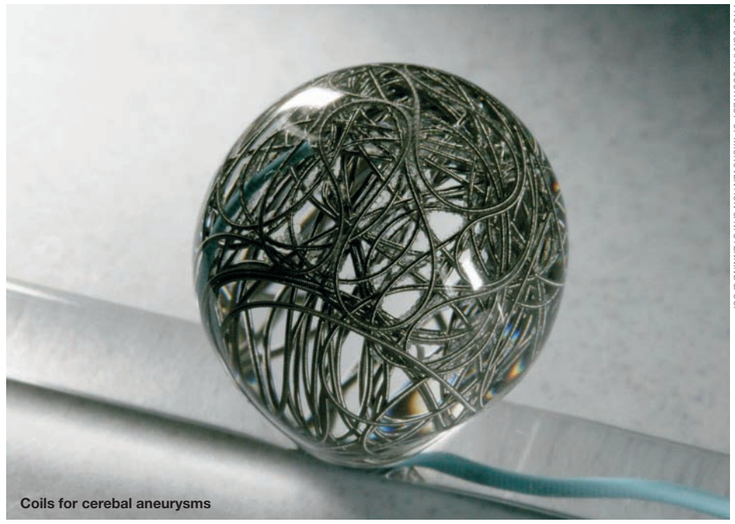
Ian Gough
President

The College continues to advance its key strategy of being the unifying force for surgery. As specialisation and sub-specialisation progresses in our technologically driven surgical careers it is vital that we effectively co-operate across many areas. This is important not only in the clinical environment but also through the action of the College and the various Specialty Societies and Associations.

The Surgical Leaders Forum is one of our more profiled meetings. It is now happening at least three times a year between the College Council and the Presidents of the various Specialty Societies. The focus is to discuss the key issues of the day and establish common positions wherever possible. Highlighted recently have been national registration and accreditation, national health and hospitals reform commission with presentations by Dr Christine Bennett and interactions with the medical technology industry with presentations by Ms Anne Trimmer who is the CEO of their association. Position papers are prepared, discussed and, as appropriate, distributed more broadly. This forum will increasingly become the driving forum of our shared surgical endeavours.

Interactions with the Medical Technology Industry

Featured in this *Surgical News* (page 32) is the new section of our Code of Conduct that deals with the medical technology industry. I encourage you to read this carefully. There is no doubt that the public perception of the industry interactions with the medical profession is open to very scathing interpretations. The surgical profession has often cast critical comments on the pharmaceutical industry and the links with medical oncology, cardiology and psychiatry amongst others. However, the same concerns can be raised about the association of surgical groups with the manufacturers or distributors of surgical equipment and prostheses. There is no doubt that much patient benefit is derived from these interactions. Many clinical advances have been achieved through useful collaboration. The challenge is to make sure the interactions are appropriate through the various training initiatives, education and developmental research. The Code of Conduct will now cover that in greater detail and the College, with the Specialty Societies, is committed to an ongoing educational campaign to ensure everyone is made aware of the changed expectations.



Coils for cerebal aneurysms

PHOTOGRAPH COURTESY OF MICROVENTION & N. STENNING & CO.

The importance of professionalism - a new College pledge

Our Surgical Leaders Forum continues to focus on issues of professionalism. We are all conscious that as our hospitals may be pushing us to focus on being a technician our patients and the broader community are becoming more insistent on our role as professionals. We need to state and affirm this more regularly. Council and the Surgical Leaders Forum have recently confirmed the new College pledge that all new Fellows will state at the Convocation when they formally receive their diplomas.

The agreed pledge is:

I pledge to always act in the best interests of my patients, respecting their autonomy and rights.

I undertake to improve my knowledge and skills, evaluate and reflect on my performance, and to continue learning for the benefit of my patients and my community.

I will be respectful of my colleagues, and readily offer them my assistance and support.

I will abide by the Code of Conduct of this College, and will never allow considerations of financial reward, career advancement, or reputation to compromise my judgement or the care I provide.

I accept the responsibility and challenge of being a surgeon and a Fellow of the Royal Australasian College of Surgeons.

Rural Surgery – the tension of increasing sub-specialisation

There is no doubt the focus of the greatest health workforce crisis is in regional and rural areas. Both Australia and New Zealand have issues of access to surgical services that are compounded by worsening regional infrastructure and the increased requirements for critical mass to justify the presence of a surgical service. However one of the ongoing concerns is how the specialties of general surgery and orthopaedic surgery handle the training of "generalists". The work-load of rural and regional centres and in particular the on-call requirements of being familiar with a broad range of clinical conditions are most important. The College and the Specialty Societies are committed to addressing these training requirements. We must keep pressure on governments and health providers to ensure regional infrastructure, regional support and regional remuneration are also fully addressed.

"The challenge is to make sure the interactions are appropriate through the various training initiatives..."

Annual Scientific Congress (ASC)

I do look forward to welcoming Fellows of the College to Brisbane for the ASC. Again there is substantial emphasis on ensuring the plenary sessions are relevant to all surgeons. Even if your own specific sub-specialty has a limited program, the ASC should add considerably to your understanding as a surgeon, as a professional and in your response to the requirements of the community.

Trauma management

The College has recently produced a position statement on emergency surgery

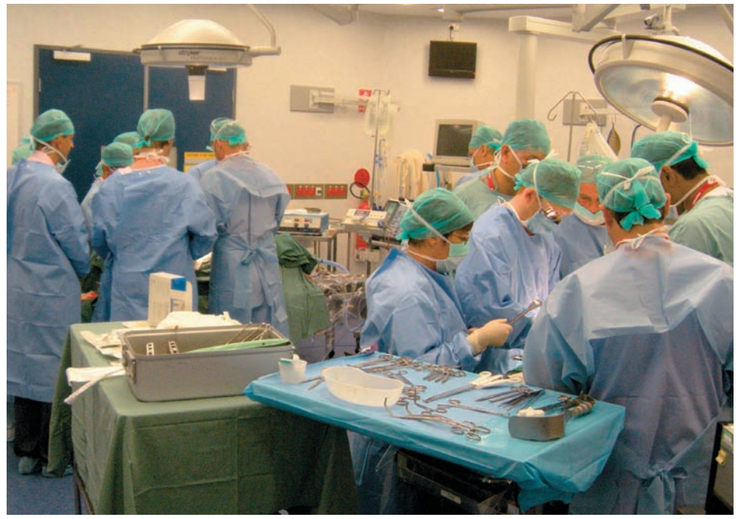
Ian Dickinson
Vice President

The management of trauma continues to be a major issue for hospitals around Australia and New Zealand. It is important to revisit this matter from time to time, so I propose to examine some of the issues related to trauma management in this month's issue of *Surgical News* and, next month, to consider the role of advocacy in improving our systems, and some of the lessons that can be learnt from systems in place around the world.

To help meet the challenges of trauma management, the College recently produced a position statement on emergency surgery which addresses such fundamental issues as facilities, funding and leadership. The College has continued to advocate for better trauma care, and has done much work over the years to help define the most appropriate and effective systems for use in hospitals.

Definitive Surgical Trauma Care courses (DSTC)

I was privileged to attend part of the recent round of Definitive Surgical Trauma Care courses at the Prince Charles Hospital in Brisbane, run by the Princess Alexandra Trauma Services.



Learning in the Medical Engineering Research Facility

The course was excellent, offering not only definitive lectures and interactive sessions but use of the Medical Engineering Research Facility (MERF). Participants were able to learn surgical techniques including cardiac and lung repair, subclavian and neck exposures, fasciotomies, abdominal closures, pelvic stabilisation and craniotomy.

While most of the participants in the course were young surgeons, others were at later stages of their careers and undertaking outreach services. Some were embracing a new challenge in their professional lives, taking on leadership roles in trauma management for the first time in their surgical careers. →

Cover photograph courtesy of Brisbane Marketing

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

Letters to the editor should be sent to:
letters.editor@surgeons.org

or The Editor, Surgical News,
Royal Australasian College of Surgeons,
College of Surgeons Gardens
250-290 Spring Street, East Melbourne Victoria 3002.
Tel:+61 3 9249 1200; fax: +61 3 9249 1219;
Internet: www.surgeons.org

ISSN 1443-9603 (Print) ISSN 1443-9565 (Online)

Surgical News Authorised by Dr David Hillis

Published by Fairfax Community Network Ltd ACN 92 007 412 008

Specialisation

One of the key issues in the development of better surgical care is the pronounced trend towards specialisation and super-specialisation. Some have called this latter category "sub-specialisation", in that surgeons are doing more and more sophisticated surgery in a much narrower field of interest.

While individual patients benefit with better care, there remains the real danger that when the unexpected arises there may not be the necessary breadth of expertise in a surgeon's scope of practice, or in a hospital's staffing, to deal with it.

Education

All surgeons now presenting for the Fellowship of the Royal Australasian College of Surgeons (FRACS) final examination must have participated in the Early Management of Severe Trauma (EMST) course. This means that skill in, and understanding of, the emergency management of severe trauma is now a core competency of all surgeons.

This is a very positive development, ensuring an increasing number of surgeons are perfectly competent to perform emergency surgery, or at least lead a surgical team in obtaining the best outcome for the patient. However, many surgeons are limiting their scope of practice very early in their careers and leaving emergency surgery to others.

Silo mentality

The emergency care of trauma patients has often been left to the emergency room physicians, and often surgical leadership has not been evident. As a result, the emergency surgical patient is presented to the surgeon after initial triage assessment and management, leaving the surgeon to deal with a particular part of the body, or a particular system, rather than the patient as a whole.

This silo mentality of surgical care, in which the focus is on a particular part rather than the whole patient, can put the patient at risk of having no particular surgeon assume responsibility for his or her overall care.

Surgical Systems

It is clear that not every hospital can be equipped and staffed for high level trauma care. The ideal situation, where there is a level one trauma centre with all necessary facilities, is simply not possible in smaller communities. And in our larger communities, resources need to be managed in such a way that there is a sensible concentration of services and these services intermesh in an efficient way.

Appropriately established level one centres provide high level services across a whole range of specialties, and achieve measurably better outcomes in terms of fewer deaths and fewer complications.

There remain, of course, difficulties in determining who will provide the level one trauma service in particular cities. This decision should be made by a community's political and medical leadership, ensuring that appropriate facilities are provided within the designated hospital, and that any waste of scarce resources is avoided.

There needs to be both a general surgical and orthopaedic roster which is complete. Specialties such as plastic surgery and neurosurgery need to be available in the hospital, even if surgeons from other hospitals are on the roster. This arrangement can apply to other specialties as well, such as ear, nose and throat surgery and urology. The extent to which surgeons have to travel from other hospitals will depend of course on the local environment.

Irrespective of local circumstances, it is important to avoid a silo mentality in which surgeons will treat only "their" particular part of the body rather than the whole patient. And there needs always to be a designated person in charge. Initially, the emergency physician may be in charge but he or she should hand over relatively quickly to the surgeon who is used to handling emergency care. Primacy in care may well rest with the general surgeon, or perhaps the orthopaedic surgeon, who can then direct traffic in terms of the other specialties. Whatever the system, it must work in such a way that someone takes care of the whole patient, and the situation is avoided where a ward nurse or an intensive care physician is left wondering how best to handle a patient.

Hospital Systems

Of course, none of the above can be achieved without proper medical and hospital support. There needs to be the appropriate hospital facilities, as well as appropriate working conditions, so that patients can be cared for in a way which reduces their risk of a poor outcome.

Competencies

It is obvious that surgeons managing trauma patients need to be competent within their own area of specialty. Surgeons, by the time they have received their FRACS and are practising, will be technically competent to perform most of the work within their own specialty. But they need to stay up to date with areas in which they do not regularly practice but in which they could be called upon to practice in an emergency or trauma situation. It is also crucial that they be made aware of the importance of teamwork and leadership, and understand that these are as important as technical competence in achieving the best outcomes for trauma patients.

Acknowledgements

I would like to thank and commend those at the Medical Engineering Research Facility. This $13 million facility is part of the Biomedical Engineering Department of the Queensland University of Technology and provides significant research and training opportunities for young engineers and doctors. I would like to acknowledge the Head of Department Mark Pearcy, Professor of Orthopaedic Research Ross Crawford, and Michael Schuetz, Professor of Trauma.

Pictured top: DSTC Faculty Brisbane March 2009. Back row from left to right: Vijay Kanagarajah, Noel Garvin, Tom O'Rourke, Martin Wullschleger, Russell Gruen, Ming Terk Chui, Zsolt Balogh, Damian McMahon, Patrick McCartan, Stephen Deanne, Donald Trunkey, Ken Boffard, Peter Bautz, Jeffrey Rosenfeld, Cliff Pollard, John Crozier Front row from left to right Michael Schuetz, Daryl Wall, Kellie Gumm, Susan Nielsen, Peter Danne

Deaths of Fellows

Giving due recognition to the Fellows who have left indelible legacies

I.M.A Newfellow

This month I am going to talk about death – your death. Everyone knows that rather hackneyed saying that the only things certain in this life are taxes and death. I would suggest that the former is not certain for some high flyers but that latter is true for all.

At the start of each Council meeting there is always an item on the agenda "Deaths of Fellows". The names on the agenda papers are noted with respect and (at least for my part) the obituaries read quietly. Often a friend is on the "Roll of the Deceased". Indeed I looked at the last three years and see that 16 surgical friends have so appeared. I see two former presidents that I have known and respected. I note a fellow councillor.

I bet that you did not know that on the College website there is an "In Memoriam" section for the deaths of Fellows. If the College has received an obituary it is linked to the name. This has been the practice since 2006. Already there are 90 listings. Have a look at (http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/Inmemoriam/default.htm).

One of the things that strikes me in reading the obituaries is how little we know about our fellow Fellows. The medical student that I taught but did not know he had followed a GP-surgeon career in a rural area, the co-registrar who was a highly respected ear, nose and throat surgeon in a large rural centre, the young colleague with leukaemia who spoke nothing of his illness, the general surgeon with parkinson's disease – all are on the list. Many of the "In Memoriam Fellows" do not have an

"One of the things that strikes me in reading the obituaries is how little we know about our fellow Fellows."

accompanying obituary. I am ashamed to say that there is a friend in this category – I should have written an obituary for him as a mark of respect.

Now I know that this is all rather more sombre than my usual somewhat flippant musings but there is a purpose to my ramblings. One of the very encouraging web pages is the page of scholarships and donations. Have a look at (http://www.surgeons.org/Content/NavigationMenu/Research/Scholarshipprogram/default.htm) .

There you will find the names of John Mitchell Crouch, Reg Worcester, Eric Bishop, Francis & Phyllis Thornell Shore, Margorie Hooper, Paul Mackay Bolton, Sir Roy McCaughey, Roy and Marjory Edwards, Peter King, John Loewenthal, Louis Waller, Hugh Johnston, Murray & Unity Pheils, Stuart Morson, the Lumley, Ramsay and Morgan families. Who were (and indeed are – as some are still very much alive!) these generous people?

The John Mitchell Crouch Fellowship was named after a promising neurosurgeon who sadly died at 36 from a brain tumour. His mother, Mrs Unsworth, chose to award the Fellowship to those making an outstanding contribution to the advancement of surgery or anaesthesia or to fundamental scientific research in the field.

This Reg Worcester Fellowship arose from a gift by the late Alan Worcester, to memorialize his brother, Reg, a great educator, doctor and humanitarian. The Fellowship is to be awarded to undertake research with relevance to the surgical care of patients.

The Ramsay Fellowship was established through a bequest following donations made in 1986 and 1993 by Mr James Ramsay, AO, and Mrs Diana Ramsay, AO. This Fellowship is only available to provincial surgeons in Australia or New Zealand and is designed to enable such surgeons to spend time developing their existing skills or acquiring new skills away from their provincial practice.

The Louis Waller Medico-Legal Scholarship was established to honour Professor Louis Waller's contributions to the Monash University Faculty of Law and medico-legal issues for more than 35 years. He was Chair of the Appeals Committee for many years.

It seems to me that if you are not going to be able to quietly slip away from this mortal existence and disappear from the rolls of the College without a little fanfare you might as well do it in style with quite a bit of fanfare. If you are going to be in the "In Memoriam" pages, and may well have a friend attach an obituary, why not join the ranks of the above persons and make a donation for a scholarship. The recently re-vamped Foundation for Surgery is an excellent way of establishing a scholarship. As for me I quite like the idea of the Newfellow Fellowship – it has a nice ring to it don't you think? Of course the name implies that it is not available to curmudgeons.

VASM - one year on

Victorian Fellows and hospitals are invited to participate in the audit of surgical mortality

Julian Smith
Chair, Research, Audit & Academic Surgery
Colin Russell
Clinical Director, VASM

The Victorian Audit of Surgical Mortality (VASM) has now been operational for a year. VASM is part of a national audit (Australian and New Zealand Audit of Surgical Mortality ANZASM). ANZASM is managed by the Research, Audit and Academic Surgery (RAAS) Division of the College and is supported and funded by the state governments. The audit process is designed to highlight system and process errors. It is intended as an educational rather than a punitive exercise. Participation in a peer-reviewed surgical audit is an annual requirement of the College's Continuing Professional Development (CPD) Program. Participation in VASM provides credits towards satisfying the criteria for recertification under this program.

Participation in the audit is voluntary. When taking part in the audit, you are protected under the Commonwealth Qualified Privilege Scheme. All data and reports are de-identified and securely stored in the VASM office.

Although data collection is standard across all states, there are some regional idiosyncrasies in the structure and processes. In Victoria, VASM has a close association with the Victorian Surgical Consultative Council (VSCC). The VSCC was established by the Minister of Health in 2001 to review causes of avoidable mortality and morbidity associated with surgery, and to provide feedback to the medical profession on any systemic issues identified. VSCC reviews issues associated with Coroner's cases and "Sentinel Events" reported to the Victorian Department of Human Services. To support this VSCC role, de-identified reports from VASM cases that have required second-line assessment will be sent to the VSCC for further review.

Of the 92 public hospitals known to perform elective surgery in Victoria, only nine hospitals have yet to agree to participate. The majority of these nine are small rural hospitals. By the end of January 2009, 66 per cent of Victorian Fellows had agreed to participate. Only eight per cent of the 955 Fellows have refused to participate, and another five per cent have informed us that they have ceased clinical practice. This leaves some 21 per cent of Fellows who have yet to respond to our invitations.

"Of the 92 public hospitals known to perform elective surgery in Victoria, only nine hospitals have yet to agree to participate."

VASM has received 824 notifications of death from participating hospitals. We have only as yet received completed case record forms on 430 (51 per cent) of these 824 cases. The full audit process, including first- and second-line assessments, has been completed on 238 (55 per cent) of these 430 deaths. We therefore only have 'clinical information' on 430 deaths and the outcomes of peer review on 238 deaths. The results presented are a reflection of those cases.

Completion of case record forms providing clinical information on events leading to death is pivotal to the success of the audit process. Currently the return rate of case record forms from Victorian surgeons is a disappointing 51 per cent. Other states report return rates around 80 per cent.

We are pleased to report that the case record forms are generally completed by the consultant and returned promptly. We have been impressed with the diligence of first and second-line assessors. However, individual fields in the case record forms are sometimes left blank when they should be completed.

In this small sample of 238 cases, the assessors have concluded that in the majority of cases (82 per cent) death was a direct result of the disease processes involved and that no issues of patient management were present. Issues of patient management were perceived to have occurred in 87 instances. These included 59 (25 per cent) areas of consideration, 16 (7 per cent) areas of concern and 12 (five per cent) adverse events.

In 86 per cent of the reported cases the risk level reported prior to surgery was moderate, considerable or expected. Of the cases reported 63 per cent had two or more significant co-morbidities. The adequacy of preoperative investigations and critical care management were facets of care to draw comment.

Of the issues identified in the audit process (area of consideration, area of concern or adverse event), assessors felt 28/87 (32 per cent) probably did not contribute to the death of the patient, 48/87 (55 per cent) may have contributed to death and 11/87 (13 per cent) probably contributed to the death of the patient. The review process only determined that seven deaths out of 238 could have been prevented. These assessments have been directly fed back to the treating surgeons. No surgeon receiving such feedback has indicated dissatisfaction with the assessment.

The mean age of all deceased patients was 73 years, the mean American Society of Anaesthesiologists grade was greater than four, and 77 per cent of the deaths that have been reviewed occurred in patients admitted as emergencies for acute problems. This is perhaps circumstantial evidence that the majority of deaths were most likely to be due to the disease processes involved rather than the treatment the patients received.

Although there has been a major gain in the participation rate of surgeons and hospitals, the number of peer-reviewed cases is still too small to infer any trends in surgical mortality in Victoria. The return rate of case record forms (currently 51 per cent) is disappointing.

Simulated Surgical Skills Program

New simulated program helps to develop and maintain surgical skills

Julian Smith
Chair, Research, Audit & Academic Surgery


Skills Centre, Adelaide

The Simulated Surgical Skills Program (SSSP) has been funded by the Commonwealth Government of Australia through the Department of Health and Aging to improve the evidence base and develop a program for simulation skills training in laparoscopic surgery. The SSSP based at the Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S) will design, implement and assess a new training program to develop the skills of Trainees and help them, and experienced surgeons, maintain their skills.

The program has undertaken a comprehensive analysis of training needs for laparoscopic surgery in Australia, which has been completed and reported on to the Department.

The SSSP will recruit Surgical Education and Training (SET) Trainees and Post-Graduate Year (PGY) medical staff to assess the acquisition and maintenance of skills using surgical simulators. We will assess whether participants trained on different fidelity simulators display different skill levels. Additionally we will investigate differences in the skill levels between participants who receive simulation plus traditional training and participants who receive traditional training alone. Data will be collected on whether fatigue alters a participant's laparoscopic ability. We will assess if there are differences in skills acquisition between participants trained by a surgeon and those trained by a skilled lay trainer.

The SSSP will run at various locations in Sydney, Brisbane, Melbourne, Perth and Adelaide. To enable many Trainees to participate, it is proposed to fit-out a mobile surgical simulation unit in a large commercial van. If approved, the van will be equipped with the low and high fidelity simulators necessary for SSSP data collection, and will travel to metropolitan centres in NSW. The unit would be staffed by a skilled lay trainer and supported by experienced surgeons - this would pilot the use of a mobile unit in the provision of training outside the metropolitan area.

Recently SSSP commenced the pre-trial phase of data collection at the Surgical Skills Centre in North Adelaide. The Skills Centre houses a range of low and high fidelity surgical simulators. The pre-trial is designed to test the methodology for data collection used prior to the introduction of the SSSP throughout Australia during the latter half of 2009 and into 2010.

In January 2009, 12 experienced laparoscopic surgeons volunteered to participate in the program in SA. They were randomised to either simulator and after a short familiarisation period were assessed on their proficiency. Tasks involved transfer of pegs, pattern cutting, intra- and extra-corporeal knot tying, and placement of a ligating loop. Their scores have assisted us in setting proficiency guidelines for participants relevant to the Australian surgical environment.

For more details on ASERNIP-S, contact Professor Guy Maddern, Surgical Director, by telephone +61 8 8363 7513 or email College.asernip@surgeons.org or visit our website at www.surgeons.org/asernip-s, or Meryl Altree, Senior Project Manager, SSSP, by telephone +61 8 83637 513 or email meryl.altree@surgeons.org

INVITATION TO NOMINATE FOR THE SIR ARTHUR SIMS COMMONWEALTH TRAVELLING PROFESSORSHIP 2009

Nominations for the prestigious Sir Arthur Sims Commonwealth Travelling Professorships are now open. Designed to establish closer links between scientific workers in the Commonwealth, one or two Commonwealth Professors are appointed each year - generally a prominent physician, surgeon or scientific worker residing in Great Britain, Australia, New Zealand or South Africa.

The appointed Professor is required to travel to any country within the British Commonwealth, of his/her choosing, for the purpose of assisting in the advancement of medical science by lecturing, teaching or engaging in research.

The exact duration of the visit, and the centres to be visited, are determined by each Professor, in accordance with his/her own interests and commitments.

Please forward nominations with supporting documentation including a covering letter and CV to Professor Guy Maddern guy.maddern@surgeons.org by no later than Thursday 30 April 2009.

PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

In 2009 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities will assist you to strengthen your communication, business, leadership and management abilities.

Practice Made Perfect: Successful Principles for Practice Management

26 June 2009, Auckland | 28 August 2009, Brisbane

This new whole day workshop focuses on the unique challenges of running a surgical practice. Learn more about planning, promotion, purpose, people, performance and problem solving. Practice managers, practice staff and surgeons are encouraged to join these workshops for a valuable learning experience.

Making Meetings More Effective

27 June 2009, Melbourne | 21 August 2009, Sydney

Explore the ten principles for effective meetings and the roles and responsibilities of the chair and individual committee members. Improve your skills for chairing outside and inside meetings as well as develop strategies for gaining consensus. This workshop is a 'must' for anyone who sirs on a committee or a board.

Mastering Difficult Clinical Interactions

4 June 2009, Sydney

This is a practical skills development workshop designed to give you confidence in handling difficult patient interactions. Practice specific communication skills to avoid arguments and learn a proven step-by-step approach for dealing with problems that keeps both patient and surgeon focused on a solution.

Leadership in a Climate of Change

19-21 June 2009, Sydney

This workshop can help you to understand what it takes to be an effective leader in the 21st century. It uses the DISC model to examine the nature and practice of organisational leadership through the exploration of issues such as organisational communication, influence and power and styles of leadership. You will also learn more about working as a team and gaining team commitment. These issues will be discussed in the context of organisational change and management.

Australian Indigenous Health Program

This online program focuses on educating rural Fellows on the issues encountered when treating Indigenous patient such as patients taking their own leave from hospital and not showing up for appointments. Strategies for better communicating with Indigenous people will be provided. The eight modules use reading material, case studies and a discussion forum to increase the interaction. This project is in partnership with the Royal Australian College of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and proudly supported by the Support Scheme for Rural Specialists (SSRS).

Further Information

Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development. Easy online registration is available for most workshops.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: APRIL - AUGUST 2009

ACT

30 July – 1 August	Surgical Teachers Course, Canberra

NSW

1 April	Interviewer Training, Sydney (videoconference)
28 April	Supervisors and Trainers (SAT SET), Sydney
4 June	Mastering Difficult Clinical Interactions, Sydney
19-21 June	Leadership in a Climate of Change, Sydney
29 July	Mastering Intercultural Interactions, Sydney
5 August	Supervisors and Trainers (SAT SET), Sydney
21 August	Making Meeting More Effective, Sydney

QLD

2-4 May	Younger Fellows Forum, Brisbane (pre ASC)
5 May	Supervisors and Trainers (SAT SET), Brisbane (ASC)
5 May	Writing Reports for Court, Brisbane (pre ASC)
28 August	Practice Made Perfect: Successful Principles for Practice Management, Brisbane

SA

16 June	Supervisors and Trainers (SAT SET), Adelaide
31 August	Mastering Professional Interactions, Adelaide

NT

13 June	Building Towards Retirement, Melbourne
27 June	Supervisors and Trainers (SAT SET), Darwin
29 July	Management of High Risk Diabetic Foot, Alice Springs (PSA)

WA

29 May	Risk Management: Shared Decision Making, Perth

VIC

2 April	Mastering Intercultural Interactions, Melbourne
29 April	Interviewer Training, Melbourne (videoconference)
26 May	Supervisors and Trainers (SAT SET), Melbourne
13 June	Building Towards Retirement, Melbourne
27 June	Making Meetings More Effective, Melbourne
4 July	Supervisors and Trainers (SAT SET), Ballarat
8-9 August	From the Flight Deck, Melbourne
14 August	Polishing Presentation Skills, Melbourne
22 August	Expert Witness, Melbourne

NZ

26 May	Supervisors and Trainers (SAT SET), Christchurch
26 June	Practice Made Perfect: Successful Principles for Practice Management, Auckland

Bi-National Colorectal Cancer Audit

The audit can help advance knowlege and understanding for the treatment of cancer

Julian Smith
Chair, Research, Audit & Academic Surgery

The Bi-National Colorectal Cancer Audit has been established through the continued collaboration between the Colorectal Surgical Society of Australia and New Zealand (CSSANZ), the Research, Audit & Academic Surgery Division (RAAS) of the College and the BioGrid Australia.

The aim of the collaboration is to create a large dataset containing Australian and New Zealand data for research and quality improvement purposes. This data could be used to advance knowledge and understanding of the optimum treatment for colorectal cancer and help ensure best practice.

Data is being contributed from a number of regions, including South Australia, Victoria, Tasmania and Queensland. There are approximately 2000 patient episodes within the database.

All episodes entered onto the College server are entered from a paper form sent to the College. In Victoria episodes are entered onto the Australian Comprehensive Cancer and Research Database (ACCORD) at the local institution and linked into the BioGrid Australia data repository. With the anticipated development of web-based data entry, which will be hosted on the existing CSSANZ website, there will be three ways to contribute data to the audit:

- paper forms are completed and sent to the College for data entry
- data is entered onto the ACCORD database, at the site, linked to BioGrid Australia
- web-based data entry.

Recently, a survey was sent to all CSSANZ members to ascertain the levels of contribution to the audit as well as the expectations of contributors in the areas of communication and reporting. The survey was delivered using an online tool with questions in three sections: profile, contribution and communication.

To date one third of CSSANZ members have responded; however, these initial results are positive. We encourage members to provide this feedback so that further improvements in these particular areas can occur. The results indicated that 45 per cent of the respondents are contributing to the audit, 32.5 per cent are progressing the provisions in order to contribute, and 15 per cent of respondents require further assistance to contribute. The remaining respondents indicated they are not currently contributing.

"The aim of the collaboration is to create a large dataset containing Australian and New Zealand data for research and quality improvement purposes."

The communication section of the survey identified that 78.4 per cent of respondents had received updated information regarding audit activities, and 79.4 per cent of respondents indicated they would like to receive further information about current research projects.

As this project is a collaboration, communication plays a key role in the establishment and development of the activity. There are a number of methods of reporting used to ensure that all key stakeholders and participants receive the information they require. The feedback obtained though this survey, including the identification of these specific needs, will ensure that strategies are developed to provide a comprehensive approach to reporting, sharing of information and communication.

The audit also was declared a Quality Assurance (QA) activity under Part VC of the Health Insurance Act 1973 by the Australian Government in October 2007. In New Zealand an application has now been accepted and a notice drafted, which would see the activity declared as a Protected Quality Assurance Activity.

Across Australia and New Zealand, there are a number of existing colorectal cancer databases which can be used to minimise duplication of efforts and provide a source of comprehensive colorectal cancer data. In South Australia there are a number of these databases. To enable surgeons to contribute data to this initiative as well as maintain their existing collections and reduce duplication, data collection processes have been reviewed. In one example this has resulted in the establishment of a combined data form which is a conglomeration of an existing form and the CSSANZ minimum dataset. This has benefited both data collections, as the data entered on this combined form can be entered into the two separate projects. The priority in this area will continue to be the provision of opportunities for data linkage.

Data collection commenced in South Australia in July 2007 (paper-based) with the installation of ACCORD onto the College server. Since then the minimum dataset has been reviewed, resulting in the inclusion of data on stents; the new form was recently circulated to all CSSANZ members. In addition, the ACCORD database has been updated to include:

- Department of Veterans Affairs number
- primary, secondary and tertiary procedures
- the ability to record distal and radial margins as < (mm)
- the ability to record up to three metastatic sites.

In South Australia the colorectal surgeons are working towards data linkage into the BioGrid Australia platform. This is being achieved through a new collaboration with the South Australian Department of Health, Information, Communication and Technology Department. A proposal is being prepared for submission to the Department of Health so that the department will provide the necessary approvals for the BioGrid Australia infrastructure in South Australia.

Research and reporting will be based on the data; hence, the quality of the data must be of the highest standard. This will require a comprehensive approach to quality control, including the provision of clear definitions for data fields, adequate validity checks, and methods to ensure data completeness and accuracy of data entry. This will be undertaken in collaboration with data contributors. Development and investigation of research questions will also be an important aspect of the audit. CSSANZ members are encouraged to submit these questions for consideration.

For further information on how to participate in the Colorectal Cancer Audit, please contact the Colorectal Cancer Audit Project Officer by telephone + 61 8 8363 7513 or email colorectal.audit@surgeons.org. You can also contact Mr Andrew Hunter, Chair, Colorectal Cancer Audit Committee.

For more details on ASERNIP-S, please contact Professor Guy Maddern, Surgical Director, on +61 8 8363 7513 or email College.asernip@surgeons.org, or visit www.surgeons.org/asernip-s.

Younger Fellows Opportunity

The president of the Royal College of Surgeons of Thailand has once again extended a warm invitation for five Younger Fellows to attend the 34th Annual Clinical Congress of the Royal College of Surgeons of Thailand.

The Annual Clinical Congress of the Royal College of Surgeons of Thailand will be held on 4-7 July 2009 at the Ambassador City Hotel, Pattaya. The theme of the Scientific Program is set to fit with the recession or Hamburger Crisis, "Surgery and Technology in Self-Sufficient Economy".

The Congress program promises to be both stimulating and challenging. In addition to the conference, Younger Fellows will also have an opportunity to visit a local hospital.

As part of the President's generous invitation, your registration, accommodation and all in-country costs will be covered by the Royal College of Surgeons of Thailand.

Please note you will only need to arrange and cover the costs for your airfares.

If you would like to take part in this great opportunity please forward the nomination form, and a brief paragraph outlining your interest in this program for consideration of the selection committee by **Friday 29 May 2009**:

Submit your nomination to the attention of the Younger Fellows Secretariat by **Friday 29 May 2009**:

Post: Royal Australasian College of Surgeons
College of Surgeons Gardens
Spring Street
MELBOURNE VIC 3000

Telephone: +61 3 9249 1122

Facsimile: +61 3 9276 7432

Email: glenda.webb@surgeons.org

> Delegates will be required to pay for the cost of their transport to Thailand.

> Accommodation, meals, transfers and activities during the meeting **will be complimentary**

> More information will soon be available on the ASM website: http://www.rcst2009.org

2009 ROYAL COLLEGE OF SURGEONS OF THAILAND ANNUAL SCIENTIFIC MEETING

Name .....

RACS ID .....

Contact Address .....

.....

.....

Home Phone .....

Bus Phone .....

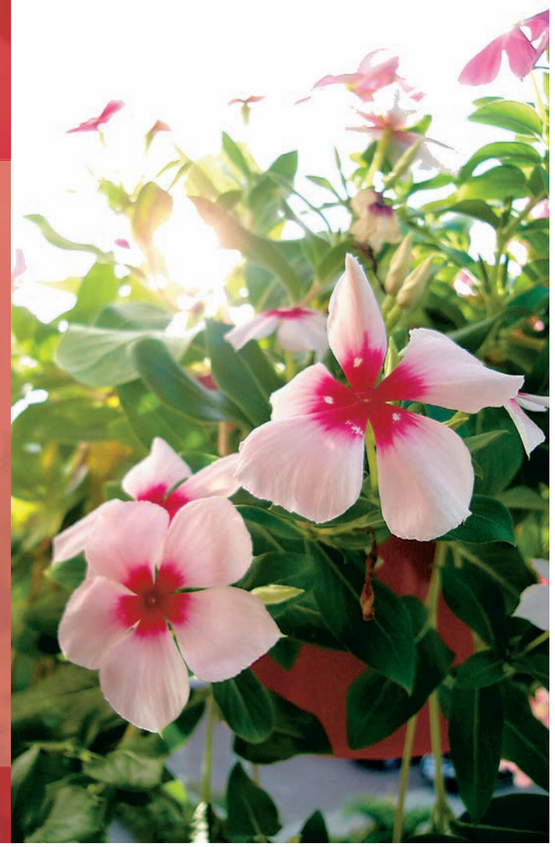
Mobile Phone .....

Email .....

STATEMENT (please tick): ☐
I am a Younger Fellow of the Royal Australasian College of Surgeons (within ten of gaining Fellowship)

Signature .....

Date ..... / ..... / .....



An inspirational runner

Mr Arun Mahajani won two gold medals and five silver medals, at the Alice Springs Masters Games last year! He recently, also ran a half marathon in Mumbai amongst 35,000 people and he was the oldest man there. The next big marathon will be next year in Alice Springs. Good luck!

Wish list

The Children's Surgical Centre in Cambodia has the following wish list for donated equipment which obviously needs to be in good working order, in order of priority:

1. **Gastroscope/colonoscope/arthroscope**
2. **Instruments**
3. **Operating microscope**
4. **Slit lamp**

If you can help please email Dr Jim Drum, on:
jimdrum@bigpond.com or
Emma Levy, Stakeholder Relations Officer,
at the Children's Surgical Centre on:
info@csc.org

Travelling Fellowship Grants

The Younger Fellows Committee and Tyco have established two travelling grants

Richard Page
Chair, Younger Fellows Committee

As a means of recognising the challenges Younger Fellows face when travelling overseas to further post Fellowship studies and experience, the Younger Fellows Committee has been assisted by Tyco Healthcare to establish two Travelling Scholarships.

The Tyco Healthcare Travelling Fellowship Grant is open to all Younger Fellows of the College (within ten years of gaining Fellowship) and is designed to actively support surgeons who pursue post doctoral studies overseas and gain experience in areas that may not have available in Australia.

The grant offers $7500AUD of assistance for accommodation and living costs whilst they are overseas. This year, the College received an unprecedented number of high calibre applications for the two grants available.

After an involved and lengthy selection process the 2009 Tyco Travelling Fellowship grants have been awarded to Dr Mark Porter and Dr Frank Wang.

Dr Mark Porter will be attending surgical skills course in practical foot surgery in Geneva in 2009. He will then be completing an Orthopaedic fellowship at St Gallen, in Switzerland. Dr Porter will have the opportunity to work under leading world specialists in this field, to focus on:

- Foot and ankle - hind foot reconstruction and paediatric trauma
- Knee and shoulder - special interest in the management of ACL injuries
- Knee - special interest in the management of septic arthritis

Dr Porter anticipates the fellowship will consolidate his orthopedic training he completed in Australia, and allow him to further his research as well as offer specialised teaching skills to the surgeons, teachers and the community.

Dr Frank Wang will undertake a fellowship in Hepatopancreatobiliary & Liver Transplant at the Chang Gung Memorial hospital in Taiwan.

He will be studying liver transplantation under eminent Professor MF Chen. Participating in rotations including attachment to the liver, pancreatic surgery, biliary surgery and liver transplantation, he expects to improve his clinical competency and gain invaluable surgical experience in a major HPB centre. Dr Wang will also complete the thesis component of his Master of Clinical Epidemiology.

The College and the Younger Fellows Committee would like to like to thank Tyco Healthcare for their generous sponsorship and wishes both recipients every success in their Travelling Fellowships. The College and the Younger Fellows Committee anticipates that the valuable experiences gained during these Travelling Fellowships will benefit the surgical and wider community in Australia and New Zealand.

Please contact Glenda Webb at glenda.webb@surgeons.org or +61 3 9249 1122 for information about the 2010 Tyco Healthcare Travelling Fellowship grant.

tyco Healthcare

From Mongolia to Australia

The scholarship provides aspiring surgeons with the opportunity to study in Australia and promotes international friendships between countries

Rowan Nicks & Tumennasan Magsar at the CASC in Hong Kong

Dr Tumennasan Magsar, from Mongolia was awarded the Rowan Nicks scholarship in 2007 and took it up in 2008. Since the establishment of the scholarships, 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.

Dr Magsar is a general paediatric surgeon and is head of the Paediatric Surgery Department in Maternal and Child Medical Research Centre in Ulaanbaatar, Mongolia. The Maternal and Child Medical Research Centre, established in 1922, is the largest medical centre in Mongolia for children's and women's health care, research and education. It has 600 beds and is the teaching hospital of the Mongolian Medical University.

For most of the Rowan Nicks scholarship he worked at the Children's Hospital in Westmead, NSW. Professor John Harvey was the supervisor of the scholarship program. According to Dr Magsar "He generously gave me opportunities to gain knowledge, engage in clinical training and operative experience. I also worked closely with widely recognised paediatric surgeon Professor Albert Shun."

"The primary goal of the scholarship was to satisfy my own expectation in a way that would improve my ability to undertake expert surgical care of my patients in Mongolia," said Dr Magsar. With the requirements in his home country and his interest, it was proposed to train on:

1. Neonatal surgery, surgical treatment of oesophageal, biliary atresia, omphalocele, gastroschisis and anorectal malformation etc
2. Modern surgical management in general paediatric surgery
3. Paediatric hepatobiliary surgery
4. Paediatric oncology problems, thoraracic surgery, urology
5. Paediatric laparoscopic surgery

Dr Magsar had the following objectives in promoting surgery in his home country:

1. To introduce modern diagnostic and treatment methods and surgical techniques for the most common paediatric surgical disease. Thus improving the quality of care and decreasing the mortality of paediatric surgery patients.
2. To approach world standards of the treatment of neonatal and congenital defect surgery.
3. To introduce progressive methods of performing surgery on the most common paediatric tumours, thus improving the quality of life and leading to a cure.
4. To establish paediatric laparoscopic surgery.

"At the end of my scholarship I felt that my goals were achieved successfully with significant all round experience in paediatric surgery. One of the major gains from this scholarship is the clinical experience which was achieved primarily through participation in surgical work and attendance at the outpatient clinics and ward rounds," said Dr Magsar.

"The variety of surgical work allowed me to have a good different experience in entire range of paediatric surgical conditions including day surgery cases, neonatal, chest, gastrointestinal, colorectal and hepatobiliary surgery."

Dr Magsar said that Professor David Croaker invited him to stay at his house and work at Canberra Hospital for ten days to share with Professor Croaker a different working environment. Working there helped him understand the differences of rural paediatric surgery services.

"I was able to have an extensive experience as I participated in many meetings. Spending some time at the Clinical School and introduction to the medical student curriculum, textbooks, lectures, and tutorials was productive to learn the teaching procedure here and compare to Mongolia. I understand the importance of the bedside teaching to medical students and their participation at department educational meetings," Dr Magsar said.

"I am proud that I had the opportunity to work at the Children's Hospital in Westmead and I understand that modern surgery is a well organised team sport and the ability to function and lead in a multidisciplinary environment will be essential.

"The visit to Australia with my family made it more enjoyable. I really appreciate the following people who supported and helped me and my family during the scholarship: Mr Rowan Nicks, Mr John Masterton and the Rowan Nicks committee, Professor Paddy Dewan, Profesor John Harvey, Professor Albert Shun, Professor David Croaker, Professor Nick Smith, Professor Ralph Cohen and Dr Thomas Gordon."

One of the scholarship highlights he said was meeting Rowan Nicks. "I had the opportunity to meet Mr Rowan Nicks at the College Conjoint Annual Scientific Congress in Hong Kong. It was impressive to meet him, I enjoyed talking to him. Participation in an international meeting is almost impossible for surgeons from developing countries, and the opportunity given to Rowan Nicks scholars is unique.

See page 51 for Rowan Nicks' advertisement.

What's on for Trainees at the ASC

A packed four-day program ends with the inaugural Trainees forum, held on the Saturday morning

Matthew Peters, Grant Fraser-Kirk & Diana Kirke
Section Conveners, Trainees program


The Story Bridge Climb

COURTESY OF BRISBANE MARKETING

The 2009 Brisbane ASC, running from the 6 - 9 May, has a packed program for Trainees. The usual specialty-specific scientific sessions are taking place, with hard-working conveners presenting an excellent program of relevant and novel topics. Local and international experts have been secured, and research sessions are a plenty for those seeking the latest developments.

For Trainees there are a number of scientific and social sessions available. Masterclasses will be taking place every morning of the ASC. These are free for Trainees. Please refer to the program for further details.

The Younger Fellows' Committee has developed a one-day workshop on Tuesday 5 May with the Association of Academic Surgeons from the U.S. This will provide Trainees (and Fellows) with the necessary insights to developing a career in academic surgery.

On Tuesday night, General Surgeons Australia (GSA) has arranged a Trainee dinner at Era Bistro in South Brisbane. This immediately follows the General Surgery training day and is open to all General Surgery Trainees.

Scheduled for Wednesday night is the Younger Fellows and Trainees Dinner at Gianni's Portside. Renowned for its amazing food and service, this venue provides the ideal backdrop for what should be a memorable night. A diverse entertainment program has been finalized. The after party will be held at 'Cloudland,' the newest 'superclub' in Australia. With the generous support of Johnson and Johnson (gold sponsors), and Ramsay Health and Covidien (silver sponsors) this night will be awesome. Please register for this event ASAP – tickets are capped at 350 in total, with every previous year selling out well before the night.

Thursday sees the majority of the specialty dinners take place. These have all been heavily subsidized by industry representatives and are positioned in top restaurants throughout Brisbane.

On Friday the Royal Australasian College of Surgeons Trainees Association (RACSTA) Annual General Meeting will be held. Commencing at 17:30, this provides an open forum for all Trainees to discuss issues of concern with each other and their RACSTA representatives. Only current Trainees are able to attend. Following this will be casual drinks and food at the Emporium Hotel in Fortitude Valley.

Commencing at 8:30 on Saturday morning is the inaugural Trainees' forum. Covering two sessions, the first explores issues of concern to those still in training. Professor Spencer Beasley, Chair of the Board of Surgical Education and Training (SET), will provide an overview of the SET program and what the future may hold. Associate Professor Julie Mundy will then run through the generic and specialty-specific SET1-2 examinations, with Dr Mark Edwards, Chair of the Court of Examiners, then leading a discussion about the Fellowship examinations. The second session, commencing at 10:30am, explores 'post fellowship planning.' Following an introduction from Dr Chris Que Hee (Younger Fellows Committee), and presentations from relevant industrial and healthcare bodies, Dr Ravi Huilgol (Vascular – Sydney), and Dr Sam Baker (General Surgery – Townsville) will provide learned advice about life post-fellowship. Dr Andrew Barbour (General Surgery – Brisbane) will then finish the session with a presentation discussing his fellowship experience in both the U.S.A. and the U.K.

Further details regarding the above events are available on the RACSTA website. Additionally, RACSTA Board members, identifiable by a 'RACSTA' ribbon attached to their name-tag will be present at the ASC. Please do not hesitate to approach them for information or to discuss issues relevant to your training.

See you there.

For information about RACSTA please head to:
http://tinyurl.com/RACSTA
To contact RACSTA please email:
RACSTA@surgeons.org

This year brings exciting challenges

RACSTA –The Royal Australasian College of Surgeons Trainees Association

Matthew Peters
Chair, RACSTA

Whether it be via word of mouth or a cursory visit to the Trainees' association page on the College website, most Trainees have in some way heard of RACSTA. RACSTA was established in 2005 following the 2002 Australian Medical Council accreditation review of the College. A recommendation from this review was the development of a mechanism to increase Trainee representation within the College.

The Younger Fellows Committee, with the support of Council, travelled across Australia and New Zealand, gathering a group of young and energetic Trainees together for a weekend in Melbourne in November of 2005. Mr Ian Civil, the College Censor in Chief convened this meeting, handing those in attendance an open forum to create a body to represent the Trainees. Under the helm of Dr Deb Ahmott (Otolaryngology Head and Neck Surgery VIC) as Chair, this group of Trainees set forth as the RACSTA 'Interim Training Committee' to establish RACSTA as the group responsible for Trainee representation within the historical College framework.

The RACSTA Interim Training Committee had a busy first year. They developed terms of reference, reporting lines within the College's governance framework, and election processes that saw the first formally elected RACSTA representatives take office in January of 2007. They gained Trainee representation on the College Education Board, Council and various other College and Specialty Boards. They held the first Younger Fellows and Trainees' dinner at the ASC in Sydney in 2006, developed 'welcome' packs for new Trainees, and commenced Trainee involvement in the development of the current SET program and safe working hour guidelines.


Dave Moss & Estella Johns dancing at the Younger Fellows & Trainees dinner in 2007

"The ASC in Brisbane sees the inaugural Trainees' Forum take place. This will provide current Trainees with insight into the SET program..."

By the start of 2007, with formally elected Trainee representatives and the RACSTA structure in place, the 'Interim Training Committee' had fulfilled its role. 'RACSTA' was now a stand-alone association. Dr John Corboy (General Surgery - NZ) was elected as the RACSTA Chair, providing leadership to representatives from each of the nine specialty groups and the Basic Surgical Training program.

The year saw the transition from the previous two stage Basic Surgical Training (BST)/ Specialist Surgical Training (SST) scheme to the new SET program, the publication of the College Safe Working Hours guidelines, and the infamous 'dancing with the stars' Younger Fellows and Trainees' dinner at the ASC in Christchurch. The year was marked with tragedy however, with the unfortunate passing of Dr John Corboy in late December. His talent as a leader and his nature as a person and Trainee will be forever remembered with the creation of the John Corboy Medal, to be unveiled at the upcoming ASC in Brisbane.

Dr Damian Amato (Neurosurgery - SA) was the Deputy Chair at this time, and provided leadership until February of 2008 when Dr Matthew Peters (PRS – QLD) was elected as Chair.

Two thousand and eight saw the formalisation of RACSTA into a National RACSTA 'Board' with Regional RACSTA Committees. The introduction of SET required restructuring to cover specialty, regional and BST representation. The RACSTA Board was subdivided into Education, Training, and Support and Advocacy portfolios, each headed by a dedicated Chair. The implementation of the SET program and its selection processes were critiqued. Training fees, safe working hours, bullying and harassment, relocation, training agreements, interaction with industry, and post-fellowship planning were all discussed and reviewed. The relationship with the Australian Medical Association's Council of Doctors in Training (AMA-CDT) and the New Zealand Medical Associations' equivalent trainee body was formalised, and the Australian Medical Council (AMC), Confederation of Postgraduate Medical Education Councils (CPMEC), and the Federal Government Department of Health and Ageing were informed of RACSTA's existence and role within the College.

Two thousand and nine brings forth exciting and novel challenges. Whilst work is still progressing in many of the fields previously mentioned, inroads to the development of an international surgical Trainees' association are underway. →

Any of the concerns faced by our Trainee body have been experienced elsewhere in the world, the clearest example being the impact on surgical training of the European Work Time Directive in the UK. Closer collaboration with our international counterparts will enable us to actively avoid many of the mistakes and mishaps they have experienced.

The ASC in Brisbane sees the inaugural Trainees Forum take place. This will provide current Trainees with insight into the SET program and the College examination processes, and an overview of what to consider when you gain your Fellowship. This 'post-Fellowship planning' session, presented by younger fellows from metropolitan and regional centres, will discuss professional and personal issues of relevance when establishing one's practice, including a presentation exploring time overseas undertaking further fellowship opportunities.

As you can see, RACSTA is making progress. Quietly, in the background, your representatives are taking Trainee views to the College. Please take the time, and the initiative, to provide them with your views and opinions. Your elected representatives' contact details are available on the Trainees' association weblink from the College home page. We are your association, and welcome and appreciate your input. If you have the energy to contribute to surgical training, please consider standing for a position on RACSTA in the future.

See you at the ASC.

For information about RACSTA please click: http://tinyurl.com/RACSTA or email racsta@surgeons.org

RACSTA Office Bearers and Contacts

Matthew Peters	Board Chair
Damian Amato	Past Chair
David Choy	Education Portfolio Chair
Greg O'Grady	Training Portfolio Chair
Mitchell Nash	Support & Advocacy Portfolio Chair
Chien-Wen Liew	Communications Portfolio Chair
Derek Buchanan	NZ Representative
Tony Palasovski	NSW Representative
Grant Fraser-Kirk	QLD Representative
Jacob McCormick	VIC/TAS Representative
David Choy	WA Representative
Amy Jeeves	SA/NT Representative
Phuong Markman	Cardiothoracic
Ruth Blackham	General Surgery (AU)
TBA	General Surgery (NZ)
Jacob Fairhall	Neurosurgery
Brett McClelland	Orthopaedic (AU)
Michael Rosenfeldt	Orthopaedic NZ
Claire Iseli	OHNS (AU)
James Wood	Paediatric
Broughton Snell	Plastic and Reconstructive Surgery
TBA	Urology
Jim Iliopoulous	Vascular

The influence of RECK

Undertaking basic research such as this, has been a highly rewarding experience

Research now being conducted by surgical Trainee Dr Jonathan Clark into the influence of a protein known as RECK on the growth and metastasis of primary bone tumours could lead to new treatments that might limit the need for cytotoxic agents. Although only discovered less than ten years ago, it is now known that RECK, found in healthy cells throughout the body, can inhibit tumour invasion and sprouting blood vessel networks.

It is thought that if this protein, which is down-regulated in common cancers, can be delivered effectively, tumours could be starved of a developing blood supply and so potentially be treated without chemotherapy or radiotherapy, or at least allowing reduced doses.

While a body of research exists on the influence of RECK in common cancers, such as those arising in the breast and prostate, little work has been done until now on its role in modifying osteosarcoma and chondrosarcoma progression. Dr Clark's research has demonstrated that RECK is down-regulated in human osteosarcoma and chondrosarcoma samples compared with normal tissue.

"The main function of this protein is to inhibit matrix metalloproteinases (MMPs) and thus control tissue remodelling processes. Angiogenesis in both physiological and pathological states is partly dependent on MMP-2 action to break down collagen in extracellular matrix and allow passages for new vessels," Dr Clark said.

"From previous studies we understand that by binding to MMP-2 and inhibiting its action, RECK can control this process, promoting vessel wall maturity and limiting cancer-related tissue destruction".

"In sarcoma, and indeed most other cancers,

Johnathan Clark

the RECK protein is down-regulated and MMPs are secreted in excess, creating a net imbalance favouring invasion. If this imbalance can be reversed it may be possible to control cancer invasion, angiogenesis and metastasis."

In Australia, the incidence of bone sarcomas over one year is approximately two cases per 100,000 in the population. Many of those diagnosed still have a relatively poor prognosis and subtypes like chondrosarcoma are generally resistant to current adjuvant therapies.

Dr Clark is undertaking his research as part of his PhD and with the support of the College through the Foundation for Surgery Reg Worcester Research Fellowship awarded to him for 2008.

The scholarship provides $52,500 stipend plus $5000 in departmental maintenance.

Accepted into the orthopaedic training program last year, Dr Clark has deferred the training post until 2010 to allow him to finalise his research which he is undertaking through the University of Melbourne at the Department of Orthopaedics, St Vincent's Hospital, Melbourne.

"We already have some definitive findings and expect more by the end of the project," Dr Clark said.

"Until now there have been no published animal studies on the role of RECK in modifying primary bone tumours but our in vitro and in vivo studies have already shown that it does have some controlling effects on osteosarcoma and chondrosarcoma cells, which is very exciting."

However, Dr Clark said that while his findings were an advance on existing knowledge, should human trials in bone sarcoma eventuate they would be at least ten years away. The goal now is to develop effective delivery systems for treatment.

"This is now a major challenge. At the moment it is not clear how stable the protein is, and we don't know if it will be broken down by the body before acting on the tumour, so we still need to explore a number of delivery techniques. Complex genetic mutations are involved in the down-regulation of the RECK protein so there is much we need to understand before RECK is fully utilised as a treatment option," he said.

"Still, it is satisfying to experiment with a novel agent and see definitive results."

Dr Clark is working under the supervision of Professor Peter Choong and laboratory scientist, Dr Crispin Dass, and is planning to present his findings later this year and early in 2010. He is in the process of submitting abstracts of his research data for an international sarcoma conference.

As well as the financial support provided by the College, he has also received the Peter Ryan Prize for Surgical Research (St Vincent's Hospital) in 2008, and a scholarship from the National Health and Medical Research Council for 2009.

He said that he was honoured to have received such support and had enjoyed the opportunity to focus on basic science.

"Undertaking basic research such as this has been a highly rewarding experience. It not only improves your analytical skill and understanding, in this case, of sarcoma biology and histopathology, but provides the opportunity to acquire practical laboratory skills and delicate handling of human and animal tissues.

"It has been extremely satisfying to study an area of orthopaedics in such depth and I would now be interested in combining clinical work and research throughout the rest of my surgical career."

Don't miss the ASC next month!

Register on-line now for the Brisbane Annual Scientific Congress, www.asc.surgeons.org

Campbell Miles
ASC Co-ordinator

Stradbroke Island

PHOTOGRAPHS COURTESY OF BRISBANE MARKETING

For the last two years, the Brisbane Executive under the direction of the Congress Convener, Mark Smithers and 28 section conveners have been working to produce the best ASC, in recent years. All the work is now complete and the ASC will be held in the Brisbane Convention & Exhibition Centre from 5 to 9 May.

The full scientific program can be viewed on the ASC website: asc.surgeons.org

Tuesday program

The Convocation will be held at 4:30pm on Tuesday 5 May and music at the Convocation will be provided by members of the Queensland Youth Orchestra. In addition to honouring 10 surgeons, and now including Professor William Coman who will be presented with the ESR Hughes Surgical award, some 80 new Fellows will convocate.

The Convocation will be held after a busy day of Workshops. Twelve Workshops will be held on Tuesday and they cover a broad range of topics from Ultrasound to Dermatoscopy.

Richard Hanney has assembled an outstanding program on 'Developing a career in academic surgery' with leading surgeon-scientists from Australia, New Zealand and the USA. The program has been generously sponsored by the Gold Sponsor of the ASC, Johnson & Johnson Medical. The program runs from 7am to 4pm and includes Undertaking Research, Writing and Presenting, Building a career in academic surgery. The program is being presented in partnership with the Academy of Academic Surgery of the American College of Surgeons.

However, that is only one topic of the 12 being held. Check the full details in the program that can be viewed or downloaded from the conference website – asc.surgeons.org

Over the last several years the College has worked to increase the appeal of the program to Trainees and to young surgeons. This is now reflected in the Masterclass program of breakfast sessions that commence each day. That said, the sessions have been well attended by Fellows as well.

The Trainees now have their own Annual General Meeting (AGM), at the same time as the College AGM and this year, they have a scientific program on Saturday morning. The full details are available on the website.

Younger Fellows & Trainees dinner

The third aspect of the conference is designed for both Trainees and Younger Fellows – the Younger Fellows and Trainees dinner on the first night of the conference. The Younger Fellows and Trainees dinner is to be held at Gianni's Portside which sits on the top floor of the new Portside development on the Brisbane River at Hamilton. The venue is striking in design and has received numerous accolades for its food, service and atmosphere.

The night will commence with canapes on its deck, overlooking the Brisbane River and the City, and a three course meal from award-winning chef Owen Lacey will follow. Later, there will be entertainment from a well-known Brisbane institution. The night ends with an after party at the newest, largest, and most imaginative nightclub in Brisbane, Cloudland. This club has taken 18 months to build and opens only weeks before the YF&T dinner.

The Younger Fellows and the Trainees Association are very grateful to the sponsors of the Dinner – Johnson & Johnson Medical, Ramsay Health Care and Covidien.

Scientific program updates – HPB program

Since the last edition of *Surgical News*, we have received confirmation that Professor John L Cameron, will deliver a Keynote lecture on pancreatic cancer in the Hepatobiliary program.

Brisbane beckons!

Dr. Cameron is the Alfred Blalock Distinguished Service Professor of Surgery at The Johns Hopkins University School of Medicine, Baltimore and a world authority on pancreatic cancer. We are fortunate that Professor Cameron is attending the conference in his capacity as President of the American College of Surgeons.

Military and Trauma program

Peter Sharwood, convener of the Military Surgery program has confirmation that Major General Paul Alexander, Surgeon General, ADF Commander, Joint Health Command (Canberra) will be able to attend the conference and on Saturday morning he will deliver a Keynote lecture 'Disaster relief: lessons learned by the Australian Defence Force'.

Vascular surgery program

A British surgeon well-known to Australian and New Zealand vascular surgeons, Mr Mike Horrocks, is attending the conference in his capacity as the President of the Association of Surgeons of Great Britain and Ireland. Mike has kindly agreed to contribute to the Vascular Surgery program with two presentations – 'Critical issues for vascular surgery - where to now?' and 'Endovascular aneurysm repair for the treatment of markedly tortuous AAA'.

So, all is ready and the Brisbane conveners look forward to welcoming all Fellows, Trainees and Associates to their city. Registering online has never been easier.

2009 Brisbane Annual Scientific Congress

TUESDAY 5 MAY

WRITING COURT REPORTS (9:00am to 2:30pm)

Facilitated by 'Leo Cussen Institute' barristers and members of RACS Medico-legal Section, this workshop provides unique one-on-one training in the preparation of medical reports for use in legal cases. Participants receive individualised feedback on their medico-legal reports and gain an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective.

9:00am	**Session 1**: "The role of the medico-legal surgeon"
10:30am	Morning tea
10:50am	**Session 2**: Working with legal counsel
12:20pm	Lunch
1:00pm	**Session 3**: Individual report assessment

Register for this Workshop Masterclass when you register online for the 2009 Brisbane Annual Scientific Congress: **asc.surgeons.org**

Further details may be obtained from Merrilyn Smith at the College (merrilyn.smith@surgeons.org).

Building Towards Retirement

Have you ever met a retired surgeon and tried to imagine what retirement will be like for you?

Andrew Roberts,
Convenor

"Experience has shown that surgeons who have a happy and rewarding retirement start planning early and carefully consider the issues..."

Our work is a major part of our lives and is not only stimulating but rewarding in many ways. It helps us to feel valued and gives us an identity, status, income and, most of the time, is immensely satisfying. It connects us to the rest of the world and those around us, including our patients, colleagues as well as the local, national and international community. When we stop full time work, or are approaching retirement, there can be a fear of loss of identity or loss of meaning to our lives.

To help overcome these fears, it is important that as much thinking and planning is undertaken for life after surgery as was given to building your career in the first place. With help from your friends and family, retirement from surgical practice can be amongst the most challenging and enjoyable years of your life.

There are many things you can plan for in order to make a successful transition from surgery to the next stage of your life. For instance, you can investigate volunteering opportunities or consider various International projects through the College. Re-invent yourself through a new career, take up a hobby, play more sport or consider enjoying a mix of a number of these activities.

Experience has shown that surgeons who have a happy and rewarding retirement start planning early and carefully consider the issues.

A Building Towards Retirement workshop will be held on Saturday 13 June at the College in Melbourne. The workshop offers a comprehensive program that covers some of the key issues facing potential retirees. Learn from industry leaders including Mr Kevin Bailey who will be speaking about financial matters and retirement planning. This is particularly relevant in the current economic climate. Kevin is recognised as an expert in the financial planning industry.

Professor Rob Moodie will be speaking on health and wellness issues. Rob is Professor of Global Health at the Nossal Institute for Global Health at the University of Melbourne. Between 1998 and 2007 he was the CEO of VicHealth.

Dr Taffy Jones will be stimulating and thought provoking by drawing on his considerable experience as a prominent hospital administrator and involvement in the Victorian Doctor's Health Program that he helped to establish.

Mr Bob Dickens, a Fellow of the College and a current member of the Board of the Medical Indemnity Proctection Society, will focus in the indemnity issues associated with retirement. Mr David Goldberg, senior advisor/solicitor with the Australian Medical Association Victoria, will address practice closure obligations.

Aviation authority Dr David Newman will be illustrating the similarities between the aviation industry and surgical practice by exploring the experiences of senior aircrew and surgeons as retirement approaches.

Recently retired surgeons Mr Andrew McLeish and Mr Peter Field, along with their wives, will be sharing insights into the changes of family dynamics and work/life balance.

The Building Towards Retirement program promises to engage and inform surgeons and their spouses or partners with a lot of relevant and up to date information that is crucial for planning a successful and fulfilling retirement.

Please contact the Professional Development Department at +61 3 9249 1106 or PDactivities@surgeons.org

PLANNING FOR RETIREMENT CHECKLIST

Issue	Time Before Retirement			
	15-20 years	**5-10 years**	**1-2 years**	**6 months**
Health	Have regular health checks with a GP and review any health insurance			
	Maintain a healthy weight and lifestyle with regular exercise and a healthy eating plan			
	Have regular eye sight checks			
		Be aware of work performance issues relating to hand motor function, memory and posture/balance		
Work Life		Consider your current skill set that may be applied to a new career as your current career winds down. Do you need to update these skills?		
		Investigate opportunities for an alternative medical career, eg researcher, surgical assistant, consultant, medico legal work		
		Develop a transition plan for gradually scaling down your surgical activities		
		Decide on general timing of retirement with your partner/family	Consider modifying your operative workload by reducing your operating list, complexity of operations, number of emergency calls, etc	
			Consider working part-time or other flexible work options.	
			Investigate opportunities for College voluntary work eg international projects, instructor on skills courses	
			If intending to close or sell a practice, investigate business and legal requirements plus risk management issues	
			Investigate medical registration and medical indemnity options when not operating full time	
Work/Life Balance	Develop interests and activities external to your workplace		Try some new activities you may enjoy in retirement and make some new friends/contacts	
	Attend a course, eg RACS Beating Burnout			
Finance	Develop financial plans (in consultation with financial adviser) based on your personal and financial goals, including: • Strategies to decrease any gap between the amount of money you require to live on and the amount of money you will have available for retirement • A possible retirement age for your circumstances • Retirement investment options • Superannuation plan • Tax issues		Review your financial plans/budget and make any adjustments	
			Review your life insurance situation	
Retirement Expectations	Collect information about planning for retirement	Discuss retirement expectations with your family, friends and colleagues	Set goals for your retirement and discuss with your partner	If you're planning to travel in retirement, investigate travel options
			Attend a course to help you plan for retirement, eg RACS Building Towards Retirement	
			Consider where you want to be living in retirement. Will your current home meet your needs in retirement?	
Estate Planning	Prepare or revise your will	Review your will		
	Make arrangements for an Enduring Power of Attorney; financial and medical	Review Enduring Power of Attorney		
	Keep important information up to date and store in a safe place			

PNG surgeons learn surgery success

The program is a triumph for ENT surgery in PNG and for the College


Operation in progress

Late last year, Queensland ear, nose and throat (ENT) surgeon Mr Frank Szallasi spent a week in Port Moresby operating alongside ENT local surgeons and registrars undertaking procedures that would even challenge surgeons working in first world conditions. Five patients suffering from head and neck cancers were treated during the week, the surgeons operating for up to ten hours on each to reconstruct faces disfigured after the removal of tumours.

The microvascular free flap transfers, involved the use of leg bone to reconstruct jaws and the transfer of tissue from the arms to rebuild parts of the tongue, mouth and throat. Despite the pressure such complex procedures placed on the staff and hospital facilities, all the surgeries were successful.

It was, in its quiet way, a triumph for both ENT surgery in Papua New Guinea (PNG) and for the College program established in 1991 to help train local surgeons. At that time there was only one ENT surgeon for the entire country, Mr Ardesh Gupta, who himself was the first to work there since 1982. Now there are nine local ENT surgeons and registrars operating out of five ENT centres spread across the nation treating more than 500 people each week.

Mr Szallasi, who operates out of the Ipswich Hospital and the St Andrew's Private Hospital, has been visiting PNG to help train the local surgeons for the past decade. He said he was impressed by the skill levels of the local surgeons as well as their determination to learn new procedures.

"There are no hospitals in Australia where this many microvascular flaps would be done in a week, so I think that the local staff and hospital coped admirably. It does point to the success of the program both in terms of the number of surgeons now working and the complexity of the work now being done," Mr Szallasi said.

"While I think there remains a need for visits such as this, you could say they are almost self-sufficient now with their skills increasing all the time. And that is a significant achievement given that the country has a growing, decentralised population of more than four million, which presents major challenges in providing the surgical services needed, where they are needed."

Mr Szallasi's visit took place in November last year under the banner of the Pacific Islands Project funded by AusAid. There, he worked alongside Professor SP Dubey, the Chief ENT surgeon at Port Moresby General Hospital.

Five ENT surgeons, three registrars and one maxillofacial surgeon took part with some surgeons travelling from the regional ENT centres based at Angau Memorial Hospital in Lae, Mt Hagen General Hospital, Goroka General Hospital and Nonga Base Hospital in Rabaul.

The first Australian ENT surgeon sent to PNG in 1990 to assess the local training needs, Mr Chris Perry, is now the College's Specialty Co-ordinator for the PNG program.

He said that after his initial visit to confer with Mr Gupta about the assistance required, he was then appointed overseer of training, a position which necessitated two trips a year to PNG as well as mentoring the local trainees during their training visits to Australia.

"When Mr Gupta was originally appointed, one of his central aims was to develop a local ENT surgical service for PNG. Then, general surgeons did everything and there was a debate about which should come first – primary health services or specialist services," Mr Perry said.

"But Mr Gupta was determined to provide specialist training to local surgeons and contacted the Australian ENT society to seek assistance. We were very keen to help but we had to start from the basics.

"At the outset there were some early difficulties because Mr Gupta had trained in India, then worked in Zambia for six years which meant that while he was a great ear surgeon, he had missed out on learning more recent endoscopic sinus surgery techniques while CT scans were relatively new to him. This in turn meant that to provide comprehensive ENT training we had to take the trainees back into the anatomy department and then put together a training program."

Mr Perry said this involved the development of a syllabus for a one-year Diploma of Otolaryngology and then three years of further training for a Masters of Medicine Degree, Part Two.

Port Moresby Hospital

After less than 20 years the country has the local surgeons it needs to provide treatment.

"We started a Diploma of Laryngology & Otology (DLO) program so that those doctors who did not wish to complete the training would still be recognised for time spent and skills acquired."

He said that until recently, each trainee spent up to six months at the Princess Alexandra Hospital in Brisbane but that now trainees were visiting Australia on month-long rotations at different hospitals in Perth, Sydney, Melbourne and Adelaide.

Able to name each trainee and surgeon trained, Mr Perry is clearly proud of the program and cross cultural surgical co-operation.

"Most of the registrars have stayed at my house. One of them, James Naipao was the vice captain of the national PNG rugby league team and given that rugby league is almost a religion up there he was considered a national hero; a surgeon and a tough front-row forward," he said.

"All of them, however, have been great to work with and get to know and have proven themselves to be excellent surgeons.

"Yet despite the enthusiasm both in Australia and PNG, it has not always been easy to provide this training. At one stage, even though the program was proving highly successful, we had difficulty securing funding but the Australian ENT society was so committed to it that we raised funds ourselves and through various private and corporate donations to allow the trainees to continue their training visits to Australia.

"There is no doubt in my mind that this is one of the most successful training programs ever run in PNG and as a specialty we are justifiably proud of that achievement."

Mr Perry said there was now work being done to determine the feasibility of setting up a new ENT centre at Wewak to tie in with the school for deaf children, run by the Christian Brothers, while local ENT surgeons were also keen to support the surgical service provided there by Sr Mary Joseph, a Passionist nun and the only general surgeon for a population of 500,000. He said that throughout the history of the PNG program, training and financial assistance had been willingly offered by a variety of surgeons and organisations.

"A few years ago, University of Queensland medical student Rachel Nugent, went to Goroka to work alongside local surgeons and came across a small boy who had inhaled a coffee bean," he said.

"The highlands surgeons then didn't have the equipment needed to remove it which meant that the child was likely to die from pneumonia over months or a year.

"Upon her return to Australia she raised more than $4000 from convent schoolkids which was matched by the ENT Society of Queensland which was then further matched by a Lions Clubs in Bundaberg and Port Moresby.

"This allowed for the purchase of $30,000 worth of bronchoscopes, light sources and foreign-body forceps for four ENT centres so that now such children don't have to die from a simple coffee bean. It is efforts like this that have made the ENT program so rewarding."

While PNG has an increased rate of unusual nasal disease such as ozaena and rhinoscleroma, and with leprosy still found there, the main ENT surgical needs relate to the treatment of sinusitis, ear infections, cancers of the throat and mouth and disorders of the thyroid. Yet now, after less than 20 years, the country has the local surgeons it needs to provide treatment.

"This program has been hugely successful in terms of now having five ENT centres and nine surgeons treating hundreds of people each week. I think it shows how programs like this should be developed and delivered and I think it shows, at last, that the days of the great white doctor are over. We don't go there to do cases so much anymore but rather to leave skills on the ground with local surgeons," Mr Perry said.

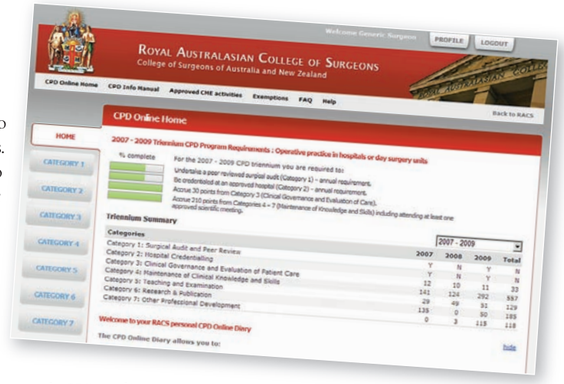
New CPD online diary

New and improved 2009 version gives Felllows user-friendly access

Michael Grigg
Chair, Professional Standards

A new version of the Continuing Professional Development (CPD) online diary was launched in January 2009. Participation in the CPD Program is mandatory for all active Fellows of the College and is an important means by which Fellows demonstrate commitment to maintaining their competence as surgeons. Fellows are encouraged to use CPD online to record their CPD program activities for 2009 in a real time format.

The CPD online diary is the ideal method for Fellows to maintain an accurate record of their CPD activities as they occur. The diary allows Fellows to view their CPD Program requirements for the 2007 - 2009 triennium and have immediate access to annual and triennial totals. This allows Fellows to more effectively plan their professional development activities to meet the CPD program requirements.



In response to Fellows' feedback, both the functionality and the design of the CPD online diary have been greatly improved. CPD online now includes the ability to record a recurring meeting/activity, thereby reducing the amount of time required to maintain the online diary. Other features include a user friendly screen design and a visual progress bar indicating how a Fellow is tracking against the triennial requirements of the CPD program.

Fellows using the CPD online to record their 2009 CPD activities will no longer be required to complete the 2009 hard copy recertification data form. Fellows can enter their CPD activities for 2009 into CPD online until 31 March 2010 and will be issued their 2009 Statement of Participation in April 2010.

Fellows who require assistance with the CPD online diary including login details, training and support are encouraged to contact the Department of Professional Standards. Please contact Ms Maria Lynch on + 61 3 9249 1282 or by e-mail at cpd.college@surgeons.org. We welcome your feedback and queries regarding the CPD Online Diary.

Occupational Bridging Course

The goal is to enable surgeons to communicate more effectively on industry issues with patients

Mr Edward (Ted) Schutz
Member, Medico Legal Section Executive

Bridging Course

A practical bridging course in Occupational Medicine is being developed for surgeons involved in the management of patients who are expected to return to work. The course will be available later this year and aims to provide surgeons with a greater understanding of workplace demands and concerns of workers and their employers which can be of value in writing certificates and assessing structured return to work programs.

From an occupational medicine as well as a surgical perspective, there can be aspects of care and overall management of patients returning to work that become a cause of concern.

Medical conditions can be effectively treated by either conservative treatment or surgery and ongoing care can often be managed by the referring GP or a physiotherapist without further specialist input, which is important for time-poor surgeons. However in some cases there could be a substantial benefit to patients if surgeons have the knowledge and are in a position to provide timely targeted advice and if necessary, continuity of care during the return to work.

The bridging course will comprise a series of factory visits enabling surgeons to gain a greater understanding of factory structures, processes, hazards and resources for managing workers health issues. Each visit will aim to provide an overview of how the factory works. Case-based discussions will include concerns of factory personnel who manage returning to work employees and explore medico-legal issues relevant to the workplace. Participants will be develop a framework of knowledge on which they can build on over time. The goal is to enable surgeons to communicate more effectively on industry matters with patients, workplaces and insurers. Participation is likely to make interactions with returning to work patients easier and improve their overall management as well as saving surgeons time by reducing disruption in their practice.

If you have relevant knowledge, skills or industry contacts that can assist in the course development, I would be most appreciative if you could contact me on the details below.

ASC Presentation

The College's Medico-Legal Section is launching the course with an inaugural session on Occupational Medicine at 4.00pm on Friday 9 May 2009 at the ASC in Brisbane. The session will be presented in conjunction with the Australian Faculty of Occupational & Environmental Medicine (AFROEM). It will include an illustrated "walk-through" of factories with case examples of factory situations and factory based injury management. There will also focus on job analysis, accident situations with photographs and a discussion of factors relevant to the factory and its personnel regarding return to work.

On behalf of the Medico Legal Section I would like to extend an invitation to all Fellows who are interested in attending the course to call + 61 3 9249 1106 or email PDActivities@surgeons.org

A national centre of excellence

Lifehouse will feature world leading clinical care, research, complementary therapies and psychological counselling

Chris O'Brien with his wife Gail

After six years of planning and now having survived five operations to treat a recurring brain tumour, Professor Chris O'Brien from Sydney is this month to make an announcement he has longed dreamed of. On Friday, April 17, with the Prime Minister beside him, Professor O'Brien will launch Australia's largest fully integrated research and clinical cancer centre to be known as Lifehouse at Royal Prince Alfred (RPA).

With $60 million already promised by the Commonwealth Government and more to follow and with NSW state government support, Professor O'Brien will also use the occasion to launch a national fund-raising appeal. Expected to cost $250 million, a business plan has now received state government approval, a project director is about to be appointed and architectural firms are soon to be invited to present design proposals.

"The brief to architectural firms will quite explicitly state that we want the centre to look and feel different from the orthodox style of hospital," Professor O'Brien said.

"We want areas where clinicians and researchers can meet both formally and informally, we want patients to feel they are in a friendly and safe environment as soon as they walk in and we want a design that encourages the people who work there to want to stay after 6pm. They are the challenges."

Lifehouse at RPA is to be built upon the site of the current Sydney Cancer Centre and will feature world leading clinical care, research, complementary therapies and psychological counselling. It is to be financially self-sustainable, expected to treat up to 12,000 in-patients and 140,000 out-patients each year and will treat a range of cancers, building on the expertise of the Sydney Cancer Centre in areas such as melanoma, lung cancer, colorectal cancer and head and neck cancer.

"The benefits of such a centre, the largest of its kind in Australia where clinical care is totally integrated with research, are that the entire organisation will be dedicated toward discoveries and innovation," Professor O'Brien said.

"We want to see much greater participation by patients in clinical trials and develop links with other cancer centres around the world so that information and new discoveries can be shared swiftly and effectively.

"As a national centre of excellence we also expect to be able to attract and retain the best clinicians and researchers from Australia and around the world for the benefit not only of New South Wales but for the whole country."

Professor O'Brien, the former Clinical Director of Cancer Services for the Sydney South-West Area Health Service, had his fifth operation to beat the recurring brain tumour in January. He has lost some of his sight, co-ordination and the ability to recognise faces but remains intellectually sharp and focussed.

Told that he only had months to live when first diagnosed in 2006, he ascribed his continuing survival to the excellent clinical care provided by his neurosurgeon, medical oncologist and the "incredible care, devotion and love" of his wife Gail.

Last year, he published his autobiography, launched by Prime Minister Kevin Rudd, called "Never Say Die" which has now sold more than 75,000 copies. As a believer in meditation and diet, Professor O'Brien is particularly enthusiastic about the Wellness Centre which will be central to the project.

"Lifehouse at RPA will not be so much a building as an organisation. As part of that concept, the Wellness Centre will offer alternative and complementary therapies as well as educational and psychological support services. Part of that will be designed around the issues involved in survivorship, aimed at people living with the psychological and physical effects of cancer which can at times feel overwhelming to people whose lives have been so radically altered by the disease," he said.

Professor O'Brien said working on bringing the project to fruition had itself helped keep him optimistic and determined.

"I was very committed to this project before I developed cancer but there is no doubt that it has given me greater moral authority when lobbying for support now that I am both a clinician and a patient," he said.

"It is very exciting to now be at this point, to be almost at the moment of moving from discussion to design and I feel very lucky to have been well enough, particularly in the last two years, to be able to continue my advocacy for the project."

While the demolition of the old building and work on the new is expected to begin in September, Professor O'Brien said he not only expected to be there to see the bulldozers go in but to also see the doors of the new building open to the public.

"I'd like to be there, sitting outside the new building, when the doors open in 2012," he said. Statistically that's a big ask after five operations and four recurrences but I remain optimistic. But even though my state of health is now clouded with uncertainty to get to this point, to see the project almost come together, has been intensely gratifying."

Medical Industry Interactions

Surgeons interactions are subject to greater scrutiny, now more than ever

Michael Grigg,
Chair, Professional Standards Committee

The relationship between doctors, surgeons in particular, and the medical industry has come under increased scrutiny in recent times both in Australia and overseas. It is important that patients have complete confidence that the choice a surgeon makes about which prosthesis is implanted or which technique is used is governed by what is best for the patient.

In response to these challenges, College Council approved a statement on *Surgeons and Trainees Interactions with the Medical Industry* in February 2009. This is an important initiative that will receive considerable focus and external scrutiny. It has implications for every surgeon.

The statement describes how surgeons should relate to the medical industry and covers a number of practical scenarios. Extensive consultation has taken place to develop the statement, with feedback received from Specialty Societies and Associations, individual Fellows and a number of College committees.

To support the surgeons' interactions with the medical industry statement and the broader Code of Conduct, the College is currently developing a sanctions policy.

The statement is available on the College website at: www.surgeons.org/positionpapers.

If you have any questions about the statement, please contact Dr John Quinn, Executive Director of Surgical Affairs, on telephone +61 3 9249 1206 or email john.quinn@surgeons.org.

Surgeons and Trainees Interactions with the Medical Industry

1. Background

Interactions between medical practitioners and the medical industry are subject to greater scrutiny by government, the media and society than ever before. There is a perception that the relationship between surgeons and industry can, and is, corrupting the relationship between surgeons and the patient. Real or not, the perception needs to be addressed.

It should be recognised that interactions between medical practitioners, particularly surgeons, and the medical industry can be both mutually beneficial, and beneficial for patients. One example of this is the development through collaboration of new or improved devices or technology borne out of innovation and meeting the needs of patients. In addition, medical industry interactions with surgeons have evolved to include the conducting of clinical trials, serving on scientific advisory boards and proctoring the introduction of new technology. The medical industry has also played an important role in supporting and collaborating in educational activities for surgical trainees and surgeons.

The community (society) has entrusted medical practitioners with certain rights and privileges. One of these is to recommend medication and the device or prosthesis that best meets the requirements of their patients. In this sense, the "consumer" from the medical industry perspective, is the medical practitioner. But the medical practitioner is not the "consumer" in the sense of payment. The principle of cost-benefit or value for money is not immediately clear. With the increasing cost of medication, devices and prostheses, there is increasing attention on the way in which decisions regarding the use of prostheses are made.

Medical industry wants to sell its product. It is their business and there is not unreasonably a requirement for it to be profitable. Any money spent is spent in the expectation of a financial return through the sale of product. This money is spent in a variety of ways – some direct and some indirect – but the aim is the same – product sale. Sometimes the financial return is not through the individual on whom the money is spent but through individuals who might be influenced, possibly inadvertently, by the recipient. Doctors receiving financial benefits from industry must realise that they are recipients of a gift, purely and simply because industry believes that it will increase sales. This is the perception of the community and it is difficult to refute. Practitioners who receive direct or indirect material benefits universally report that the received benefits do not influence their choices. If this was a correct reflection, then industry would no longer offer such benefits, yet they continue to do so. The industry is fully aware that there are significant commercial gains to be made by engaging with surgeons.

Ultimately, the cost of producing a product, which includes the cost of "marketing", is borne by the patient and the community.

2. General Principles

Surgeons interactions with the medical industry must be governed by three over-riding principles:

1. The best interests of the patient(s) are paramount
2. Transparency
3. Acknowledgement of perception as an issue.

The decision to recommend medication or a device or prosthesis for use or implantation into a patient is made by the clinician. The primary consideration in making this recommendation must be "what is best for the patient".

Whenever a choice is made by a clinician on behalf of the patient, the possibility of "self interest" or even the possibility of perception of "self interest" must be considered by the clinician. The potential of a "conflict of interest" exists whenever a clinician, or any organisation with which they are associated, receives remuneration from the supplier – no matter the form of remuneration, reason or justification.

3. Specific Issues

3.1 A surgeon must not accept financial remuneration, either by way of money or goods or services, based solely or partly on the use, or expectation of use, of medication, devices or prostheses (subject to considerations of 4.3.2).

3.2 A surgeon must not approach the medical industry as an individual for payments, either direct or indirect, during the marketing phase* of a device or technology.

3.3 A surgeon must not enter into any financial arrangement that could influence, or be reasonably perceived to influence, the decisions they make on behalf of their patients (subject to 3.6).

3.4 A surgeon must declare to the patient or their legal guardian, any arrangement with medical industry that results in benefit, financial or non-financial, before any recommendations or decisions with respect to medication, prostheses, devices or technology on behalf of patients are made.

3.5 A surgeon must disclose to the patient any possible self-interest and must make such issues available for scrutiny - particularly by patients, but also by colleagues, professional bodies and the general public.

3.6 Except where he or she has been involved in the creation or development of a medical product, a surgeon shall not promote or endorse that product other than (whether or not for remuneration) by demonstrating or training others in the use of that product (subject to 4.5.2).

3.7 A surgeon must ensure that any relationship with the medical industry is transparent and publicly acknowledged if a medical product is, either directly or indirectly, endorsed.

3.8 A surgeon must distance him or herself from financial grants obtained from medical industry e.g., educational grants should be directed to organising bodies, payment for specific fellowship training should be by way of the specialist organisations.

3.9 Surgical organisations must not accept grants from medical industry if there are any conditions stipulating that the funds be directed towards a specific individual or individuals.

3.10 A surgeon shall not permit any member of their family to accept benefits from the medical industry.

3.11 Potential conflicts of interest, or even the possibility of a perceived conflict of interest that cannot be resolved, should be addressed by consultation with relevant institutional authorities or with the College.

4. Interactions with Medical Industry - Specific Scenarios

4.1 **Consulting rooms**

Meetings with medical industry representatives are encouraged for the purposes of education and obtaining information. A fee must not be charged for such meetings nor should gifts be accepted.

4.2 **Operating theatres**

Although the attendance of medical industry representatives during procedures can be useful, the overall responsibility for the treatment of the patient resides with the clinician and decisions regarding the patient must be made by the clinician.

4.3 **Education**

4.3.1 **Education development**

Educational development should, whenever possible, be through specialist groups/ training boards that are accountable to the profession. Education should be free of commercial bias for or against any company, device, product or service. If an activity contains reference to commercial products and/or services, objective information based on generally accepted scientific methods must be presented. The educational content, faculty, venue and format should be determined by the convening body and not compromised or necessarily constrained by an industry's brand or product.

If medical industry has convened an educational meeting, the venue should not be excessive or extravagant i.e., the reason for a surgeon deciding to attend should be the educational content, not the venue.

4.3.2 **Training sessions**

Learning new techniques or becoming familiar with new technology may require training. Such training may require travel and accommodation. Reimbursement for reasonable expenses is appropriate but compensation for lost income is not appropriate. A surgeon must not accept from medical industry any financial support, direct or indirect, in excess of reasonable travel and accommodation expenses.

4.3.3 **Attending meetings**

A surgeon, or surgical Trainee, must not accept any financial support, direct or indirect, from medical industry for attending educational meetings. Any such support from industry must be directed to the organisers of the meeting to defray or disseminate payments as deemed appropriate.

4.3.4 **Presenting at meetings**

Any payment for presenting at surgical meetings should be made to individuals by the organising committee of the meeting, not directly by industry. If organisers accept a grant from industry for payment of a speaker, this must not be dependent upon a specific speaker. The organising committee must retain autonomy for the arrangements of the meeting.

Any travel or accommodation expenses met by industry should be declared at the beginning of any presentation, demonstration etc. Any such expenses or reimbursement should be reasonable and not excessive.

Intermittently, a surgeon is paid by a medical industry company to attend a meeting in order to represent that company. In this situation, a surgeon must disclose that he or she is a paid consultant to, or an employee of, the company during any discussions involving that company or its products, formal or informal. Subsequently, a surgeon must disclose to a patient or their legal guardian that he or she is or has been a paid representative of the company before making any recommendation about the use of that company's products for the patient.

4.3.5 **Arranging meetings**

A surgeon must not approach industry directly as an individual for educational support for meetings. Any approach should be clearly understood to be on behalf of the organising committee.

A surgeon acting on behalf of, or as a representative of the College, should have the expressed permission to do so.

Sponsorship of educational meetings and events (preferably directed through →

"The community (society) has entrusted medical practitioners with certain rights and privileges."

the relevant specialty organisation/ training board) should be appropriate, in accordance with professional and community standards and expectations. Venues and hospitality should be appropriate and not excessive or extravagant.

4.4 **Funding fellows**
Industry funded fellows should be organised through the relevant surgical specialty board rather than directly through individual surgeons. A surgeon must not accept financial support directly from medical industry for the purpose of funding their own personal fellow.

4.5 **Publications**

4.5.1 Any industry arrangement or involvement pertaining to a submitted paper for consideration for publication should be accompanied by an appropriate declaration of interest. In addition, any reviewer for a journal should declare any potential conflict of interest with respect to a paper to the editor of the journal.

4.5.2 A surgeon may publish (or present) their experience with a device or technique in a peer reviewed journal (or meeting).

4.6 **Demonstrations**
A surgeon undertaking to demonstrate a technique or the use of prosthesis to colleagues must be aware that they are in fact endorsing the technique or prosthesis. Any direct or indirect payment indicates that the surgeon is a paid consultant or an employee of the company involved. This must be disclosed prior to the demonstration and subsequently to patients prior to recommending that company's devices and prostheses.

4.7 **Direct remuneration**
Surgeons may have direct financial relationships with industry for a number of reasons. These include involvement with the creation or development of a prosthesis, undertaking evaluations and serving on advisory boards. These involvements must not prejudice decisions regarding individual patients and must be transparent to patients, hospitals and colleagues. They must be able to withstand public and professional scrutiny and conform to professional and community standards, ethics and expectations.

4.8 **Research**
Any funding arrangements, direct or indirect, for research must:

- be transparent and fully declared in all reports, papers or outcomes arising from the research
- for genuine research purposes
- not inhibit or restrict publication or dissemination of reports, papers or outcomes arising from the research
- be reasonable, having regard to the nature of the research.

Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2010

Applications are invited for this two year Program and the three year academic Notaras Fellowship for 2010.
The program is organised by a Conjoint Committee representing the Section of Colon & Rectal Surgery of the RACS and the Colorectal Surgical Society of Australia and New Zealand.

For details please see website.
Information and Enquires:
http://www.cssanz.org
Professor Michael Solomon:
msolomon@med.usyd.edu.au

Applications:
Applications are to be made by letter, including Curriculum Vitae and the names and addresses (inc email) of three referees.

Closing Date:
Friday 15th May 2009

Please send to:
Professor Michael Solomon,
Chairman
Training Board in Colon & Rectal Surgery
Level 2, 4 Cato Street, Hawthorn VIC 3122
AUSTRALIA
Email secretariat@cssanz.org

HOMESTAY ACCOMMODATION FOR VISITING SCHOLARS

Through the College International Scholarships Program and Project China, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to 12 months.
Due to the short term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. The International Scholarships Department and Project China are seeking expressions of interest from those willing and able to provide homestay accommodation for our visiting scholars. If you have a spare room, and are interested in learning about another culture and language, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a nominal stipend.

If you would like to help or require further information, please contact the International Scholarships Secretariat on the following details:

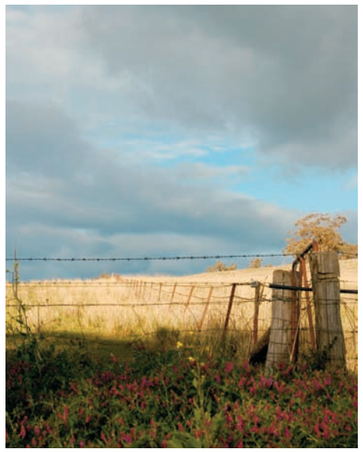
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street, Melbourne, Victoria,
Australia, 3000

Telephone: + 61 3 9249 1211
Fax: + 61 3 9249 1236
Email: international.
scholarships@surgeons.org

Well done on your achievements

Dr Tony Green received a Rural Award which was presented at the Provincial Surgeons of Australia Conference held at Wagga Wagga, NSW in October 2008

Michael Sexton
New Zealand Fellow



Dr Anthony John Green – Rural Award

For many years Tony has practised both in a solo practice in Atherton and also with attachment at Cairns Hospital. He was for many years the main voice for rural surgery on the College Council. He served simultaneously as Chair of the Divisional Group of Rural Surgery (DGRS) and College Councilor and was very active in the Provincial Surgeons of Australia.

Tony was a founding member of what became the Surgical Audit Committee, and remains solidly committed to surgical audit. The committee developed the data sets which are now an important part of the audit and peer review principles in our CPD program. Tony went to great lengths to show how audit was applicable to rural surgery and he vigorously promoted the CPD program in rural practice.

Tony has also been an important voice for surgery in the area of training for GP proceduralists surgery and is currently the Chair of the GP Proceduralist Conjoint Committee with the College of GPs and ACRRM.

Tony was a strong contributor in the early days of the DGRS and was instrumental in assisting with the early development of the Rural Surgical Training Program. He has published several articles on rural surgical matters in Australia and remains an active contributor to committees, including Professional Development and Standards Board. He is held in high esteem in rural surgical centres throughout Australia.

Dear Fellows,

The recent bushfires has caused significant trauma to many Victorians. One such family (the Nilssons) in particular has probably been the worst affected. The two parents Isaak and Kirstie died in Marysville leaving behind three young children.

Mr Mal Steel and his wife are these children' godparents and have taken over the very onerous task of caring for them. The Steel household doubled overnight and several logistic issues had to be resolved. Most of the Victorian Fellows would know Malcolm Steel as a colorectal surgeon who has been practising in the eastern suburbs for some years. To resolve some of these issues Malcolm has taken some leave from his practice.

This represents an outstanding act of generosity on his part and I hope that fellows in Victoria and interstate will join me in applauding him for this. We can be assured that these children's welfare are in good hands. However I would also hope that fellows would see fit to help Malcolm deal with the long term implication of his action. To that end, a trust account has been set up for the children.

Further details are available by contacting me at ashassen@hotmail.com

Mr Sayed Hassen
Chair, Victorian Board in General Surgery

Corpus Medicorum

Now considered one of the best amateur orchestras in Australia, Corpus Medicorum includes lawyers, psychologists and dentists

Melbourne Cardiothoracic surgeon Mr Phillip Antippa amusingly notes that despite receiving a bursary to study music at the prestigious Conservatorium of Music at the University of Melbourne in his youth, he suffered no existential angst opting for a future career in medicine.

It was, in the end, quite easy, he explains. "I think most people tend to steer toward what you think you could be really good at. I realised pretty early on that if people came to describe you as a competent surgeon who looks after his patients well, works well in a team and knows what he is about, that would be a pretty good place to get to," he says.

"However, if people said he's a competent musician that is not the same thing. Also, although I was obsessive about both I was very conscious that you couldn't find two more disparate careers than surgery and music.

"If you want to be like Hawkeye, which I did all those years ago, there is a structured and definite career path. You work hard, you study hard and there's a job at the end of it all. Music on the other hand is a moveable feast involving teaching, a professional solo career, becoming an orchestral player, it means moving around and sometimes it means desperately waiting for the phone to ring.

"I decided I liked knowing where I was going and cardiothoracic surgery just seemed like a good idea at the time."

But despite that early turning point, not for a minute has Mr Antippa abandoned his beloved viola. Having played with the Australia Youth Orchestra while at school, he continued to learn and practice despite his medical studies and later, in 1993, jumped at the chance to play with the Australian Doctor's Orchestra.

As a further sign of his self-confessed obsessive streak, however, he found their one performance a year too meagre and so, having noted that the majority of the players in the string section were to be found in Melbourne, he set up the smaller chamber orchestra, Corpus Medicorum, in 2000.

"For us to play with musicians of this calibre is simply amazing. They help take us to a different level..."

Now considered one of the best amateur orchestras in Australia, Corpus Medicorum is less specifically medical than the Australian Doctor's Orchestra and includes lawyers, psychologists and dentists. The group performs three times a year at the Iwaki Auditorium at the ABC Building in Southbank and raises money for the Royal Melbourne Hospital.

So far the ensemble has raised $100,000 through both ticket sales and donations, which has been spent on emergency cardiac equipment and a music system designed to pipe different music through individual theatres and recovery areas to reduce patient stress and enhance the concentration of the surgical teams.

"I always operate to music, as do many other surgeons. It helps my concentration, it relieves boredom and it helps cut out background noise which can at times become quite distracting. And while we haven't done any specific research here, other studies conducted indicate that music can help reduce patient anxiety, lowers awareness and therefore reduces pain," Mr Antippa said.

Mr Antippa said the orchestra was now aiming to raise the funds to buy more diagnostic equipment for the treatment of lung cancer and later to purchase computer data systems for the hospital.

Since its inception, Corpus Medicorum has gained such prestige, with many members playing at such a high level, that a number of renowned professional musicians have agreed to play along. So far the 70-member orchestra has attracted the support of professional musicians such as Chris Martin (conductor), baroque violinist Libby Wallfisch, renowned pianist Ben Martin and Hartmut Lindemann.

"For us to play with musicians of this calibre is simply amazing. They help take us to a different level which is great fun. The whole experience of forming the Corpus Medicorum has been great fun actually and I have the fabulous luxury of getting to play what I want to play with people I want to play with," Mr Antippa said.

This year Corpus Medicorum will hold performances on April 19, July 26 and November 29 and will be performing works by Bach, Mozart and Schubert (April), Bartok and Beethoven (July) and Haydn and Brahms (November).

"We have to be reasonable in the pieces we choose to perform because all the members of Corpus Medicorum are fairly time poor so we can only have three or four rehearsals before the performance. That is often a trap for amateur musicians, to be so passionate and/or obsessive as to become way too ambitious. But our regular conductor, the very accomplished Chris Martin thankfully helps steer us away from danger both before and during performances," Mr Antippa said.

The Australian Doctors Orchestra will also be performing at the Melbourne Town Hall this year on September 13 with funds raised to go to the Cystic Fibrosis Foundation Victoria.

Sunday April 19th
Bach JS *Concerto for Piano and Orchestra*
Mozart *Symphony 36 "Linz"*
Schubert *Symphony 8 "Unfinished"*
Liszt *Hungarian Fantasy for Piano and Orchestra*
Conductor – Christopher Martin
Piano – Benjamin Martin

Sunday July 26th
Brahms *Hungarian Dance no. 5*
Vieuxtemps *Elegie for Viola and Orchestra*
Bartok *Concerto for Viola and Orchestra*
Beethoven *Symphony 2*
Conductor – Warwick Stengards
Viola – Hartmut Lindemann

Sunday November 29th
Haydn *Symphony 98*
Brahms *Variations on a Theme by Haydn*
Brahms *Concerto for Violin and Orchestra*
Conductor – Christopher Martin
Violin – Natsuko Yoshimoto

Tickets $40 or $30 concession/staff

All concerts at 5.00pm at
Iwaki Auditorium, ABC Southbank Centre
120 Southbank Blvd, Southbank VIC

For further information April Law, RMH Foundation
+61 3 8387 2645 or april.law@mh.org.au

Australia needs more surgeons, now

We should question the wisdom of post-graduate only medical courses at University

Hung Nguyen
Chair, Tasmanian Regional Committee

I ran into one of my previous residents in intensive care unit (ICU) a couple of nights ago. He was a good surgical resident a few years back. He expressed interests in a career in surgery and I expected to see him as a surgical registrar one of these days. However, he told me that he is working as an ICU registrar as part of his rotation in anaesthetic training. He cited the long training time that it would take to become a surgeon as the main reason for his change of heart.

"I have kids to feed! You know," he remarks

While that is a scenario we all face now and then, it seems to be happening more frequently in the last few years.

One of the impetuses of changing into the Surgical Education and Training (SET) program is that we can enable the Trainees to 'fast-track' through what has traditionally been a longish program. There were community and jurisdictional concerns about how long it takes to train a surgeon. Not withstanding these concerns, a number of universities have moved to post-graduate medical courses, effectively lengthening the time it takes to train a medical graduate by about two years, and by logical extension, the time it takes to train a surgeon by two years. From a surgical trainer's viewpoint, this must be one of the more inept and regressive steps ever taken. Two years' time span does not seem very much but the point is that it occurs right in the middle of people's most productive time in life, when they establish family ties, get married and beget children.

Take your average school leaver at the age of 18 and put him in a five-year undergraduate medical course, he will be an intern (which is when most of us actually learned anything) around the age of 23. By the time he gets onto an advanced training post (or SET2 or whatever else we will call it) he will be about 27. He will finish his subspecialist training at 33, assuming there is no year off. To add two years to this means that he will have to consider advanced surgical training at the age of 29.

"We spend one third of our state budgets in health yet so much of our problems are self inflicted and avoidable."

There is an increased chance that he will have married, will have had children, and he will have had major shifts in his life's priorities. There is an increased chance that he will not take up that offer of a SET2 position after all. And, of course, if he were a she, and if she has not yet had children, then she would have already worked out that, if she delayed child bearing until after 35 when subspecialist training is finished, she would be called an 'elderly primigravid' at the prenatal clinic, and that both maternal and foetal risk start to climb steeply after this. There would even be fewer women from the post-medical course taking up offers in the surgical training program.

What will be the net effect? We might find out that our surgical training programs will not be as full of applicants as it used to be when an older group of junior doctors hit the scene. This shortage will especially affect the programs that produce surgeons involved in acute care, which is deemed to be rather family unfriendly. The programs least affected will be those specialties that are perceived to be less involved in acute care but still producing a comfortable income. There will be a shortage of the very kind of surgeons that the public expect to look after them when they fall ill.

What can we do about it? As a nation, we should question the wisdom of post-graduate-only medical courses at universities. How about courses that take both undergraduates and post-graduates of sufficient merits? How about teaching ample anatomy again? So that surgery becomes a natural extension of their knowledge.

As a College, we should move to enable suitably qualified candidates to get on to SET1 and SET2 earlier. There are hospitals all over the country, which have jobs fulfilling SET1 criteria. They have good residents, who would have become good registrars and good surgeons, in these jobs, and yet they are not SET1 accredited because there is a bottleneck before the SET1 year.

As departments of health across the country, we should devote resources to opening more beds, more operating time, more patients, for there is no short cuts to training a surgeon therefore the only way we will manage to train more surgeons is to train them 'in parallel' and that requires resources beyond the perennial bickering and blame-shifting over funding that currently happens.

We spend one third of our state budgets in health yet so much of our problems are self inflicted and avoidable. As health consumers, it is high time for us to look after ourselves. We could stop smoking, drinking and fighting, driving fast cars while intoxicated, getting ourselves, and other people, strung up in tractions in hospital for broken limbs from unnecessary accidents, all the while wondering why our grandmothers haven't yet been called in for her hip replacement she had waited so long for.

Wowser! I know, but unless we work together out of desire and necessity it is always going to be a failed, fragmented and half-hearted response to a global problem. And the sad thing is that, if we don't get it right, it will be a lack of willingness and not a lack of resource in this bountiful country of ours.

Peace
an Anzac day reflection

"When you go home, tell them of us and say, for your tomorrow, we gave our today" – *John Maxwell Edmonds*

Felix Behan,
Victorian Fellow

I went into the executive office of David Hillis at the College recently, and saw a drawing of Bertie Coates above his desk. David said to me "He is one our unsung hero", which stimulated me to review his contributions to surgery, the war and to humanity in a spirit of an Anzac Day reflection

On borrowing a copy of The Albert Coates Story from the College library (donated by Professor Rowan Nicks in 1977 shortly after its publication), I was surprised to find no previous borrowers had been listed. It contains recollections by Bertie Coates of his war-time experiences and the late Kenneth Russell summarises these experiences "he served as an unwilling guest of the Japanese", yet as Trevor Jones, source of the kohima quote, rephrased it "an unwilling guest of the emperor".

WW1 Experience

The book covers his experiences in WW1. He failed by two inches to meet the minimum height requirement yet was able to enlist in the ambulance core. As Churchill decided that the Australian forces needed seasoning to condition our troops for war, the whole contingent ended up at the Mena camp outside of Cairo. Brian Fleming revealed to me years ago, at the Peter MacCallum Cancer Institute, that this solar therapy cured all skin ailments and replaced the "parasols, peaches and cream" concept, which was part of our earlier migrant heritage, what a legacy.

Coates' commitment in the ambulance personnel meant he stayed off shore. He was one of the last to leave on 27 December, 1915 when Lord Kitchener completed the Gallipoli campaign. He continued his duties as a medical orderly right to the eleventh hour.

In France in 1916 in the trenches before the battle of the Somme his flair for languages resulted in his being part of the army intelligence service as well. Coates was a keen observer (a later hallmark of his clinical success) and was told by a local Frenchman, who used to give the allies coffee, that he had seen a stranger once in a British uniform and another time as a Scottish officer, which could not be explained. Coates investigated and had him arrested. He turned out to be a spy and was revealing information to help the German bombing of the Australian barracks at Allonville.

At the conclusion of the war with the marshalling of the German prisoners, he collected the caps and badges from the prisoners, then these were given to Sir John Monash to end up in the War memorial in Canberra. Sir John was one of the few people to be knighted in the field, went to Scotch College; we have a plaque outside the College headquarters in Spring St, which indicated the circa 1851, location of Scotch.

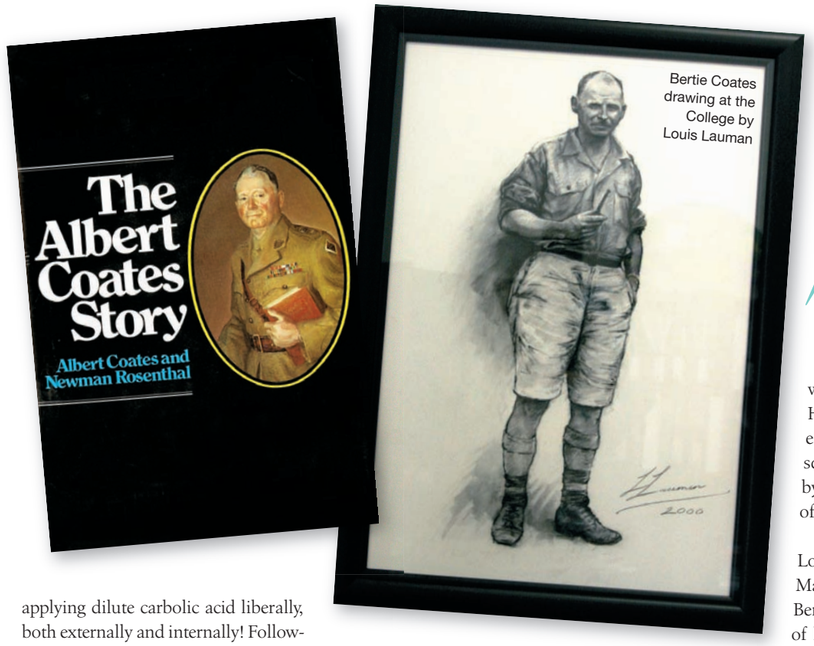
Sir John Monash was the engineer in charge of the eighth battalion who recognised the importance of motorised army units called tanks. This became the key ingredient after the battle of the Somme, resulting in the ultimate allied victory some say attributed to the Monash input. In 1916, Churchill, at the Horse Guards Parade, saw a mechanised caterpillar excavator moving across the field. He said to his entourage "we could put a gun on that and use it in the war". The boxed casing, was labelled "tank", for such machinery, as a disguise used in the transport to Europe.

Coates left France in October 1918. Then commenced medical studies in Melbourne. He lived in a bed-sit in Fitzgibbon Street, Parkville. It was in this very street, opposite the post office, when walking through Parkville recently that I stopped to admire and photograph a beautiful Peace rose in one of the terrace gardens.

Bred genetically by Meilleand's and their botanical team in France in the late 1930s, it is an aphid-resistant bloom with luscious green foliage. The petals of the bloom change in colour, initially from golden yellow and develop to a soft pink blush over a seven day period, with a most inviting fragrance.

Why is this rose now known as "Peace"? It was placed on the table at Potsdam when Churchill, Stalin and Truman met to organise the peace settlements in July of 1945 at the conclusion of European hostilities.

Coates married in 1921 and moved to a flat in Royal Parade, opposite the Conservatorium of Music and Grainger Museum. The Royal Melbourne Hospital was his "home" for the next 33 years and his teaching ability enriched many students. He was one of the foundation members in the establishment of the College. Adhering to Listerian principles he insisted on



"Memory is a man's most precious possession"
– Bertie Coates

applying dilute carbolic acid liberally, both externally and internally! Following his experience in the Nakom Paton Japanese POW camps - some recognise this as his major contribution to surgery. Coates publicly acknowledged his debt to his mentor, Hamilton Russell at the Royal Children's Hospital, who used alcohol as a disinfectant, particularly in knee surgery (Coates said "an infected knee joint is a stiff joint" another aphorism). In the Japanese prison camp he had to revert to rice alcohol to provide some semblance of sterility. Besides his many post graduate degrees he went to America to investigate neurosurgical techniques and establishing such a unit in Melbourne at Royal Melbourne Hospital (RMH); in 1940 he became a foundation member of the Neurosurgical Society of Australia.

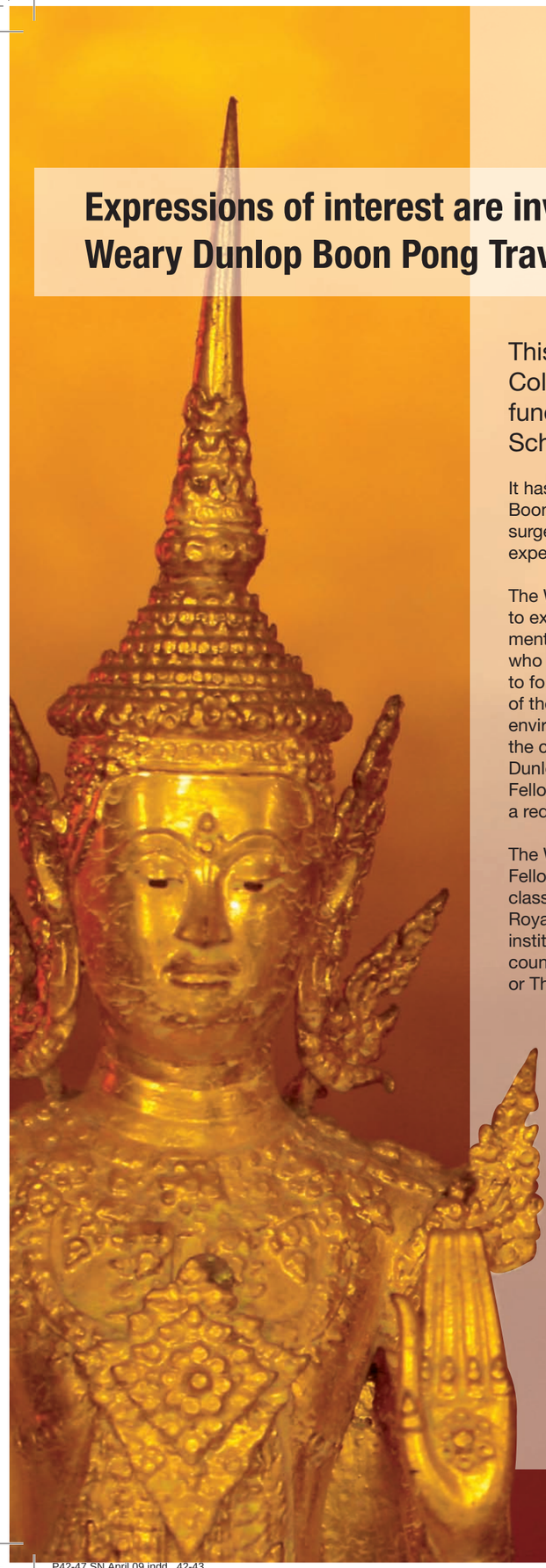
The book recounts stories of the Singapore campaign, which began in January 1942. War stimulates the need for surgical techniques and development as we have seen historically from the experiences of Ambros Paré in the 16th century, John Hunter in the 18th century and Gillies in the 20th century. Concurrently with these surgical improvements, intravenous plasma and blood transfusions and the use of chloroform for anaesthetics were an inseparable part of this picture. He even mentions on page 108 the words "weapons of mass destruction" and interestingly enough, I penned these words almost on the sixth anniversary of the Iraq invasion. Complicated amoebic dysentery, treated normally with emetine, precipitated the development of the double-barrelled ileostomy (called the Paul-Mikulicz procedure). It was the only way to solve colonic perforations. Unfortunately since I commenced this, two more Australian soldiers have been killed in foreign conflicts.

The Burma railway built by the prisoners from October 1942 to December 1943 had the medical support of two of our eminent soldiers: Weary Dunlop, Bertie Coates' second-in-charge, attended to the forces at one end of the Burma-Thailand Railway, the Kohima memorial site, while Bertie himself was at the other end. This railway was part of the relentless concept following the European onslaught to include the Japanese effort joining India and China as part of the axis development.

I first met Bertie Coates when I was a young plastic surgeon in 1974 by way of introduction from the great Stuart Archbold. He was a young trainee who joined the Royal Air Force (RAF) as a fighter pilot, taking part in the Battle of Britain. Interestingly enough he was part of the squadron to engage the Luftwaffe, preventing the bombing of the Vatican in the final stages of the war when Hitler ordered the destruction of Paris and Rome. He said "Felix, I bet you haven't met Pius XII", and given my own religious background I was rather stunned to hear his account. He said "In recognition of our fighting efforts, in saving the Vatican, the whole squadron was entertained graciously by His Holiness in the latter stages of the war."

When I returned to Melbourne from London, Stuart took me out to dinner, at Maxim's in Toorak Road, with Bertie Coates. Bertie was involved in the surgical treatment of his son who was suffering from chronic ulcerative colitis; regarded as others beyond surgical salvage. He eventually became a senior academic at the Melbourne University department of Geology. Bertie offered me a pearl of wisdom, which I still apply today in my surgical oncology work. In essence he said "tumours that grow towards you are usually favourable, while those that grow away from you are usually sinister (like people)", a principle borne out of my experience even now. Bob Marshall who was one of the last residents of Bertie at the RMH considers this poetic twist characteristic of him. It brings to mind the Tolstoy quote "learn the good thoughts of wise people."

Quoting from Bruce Barraclough's account of Bertie Coates' life, on the opening of the Ballarat Memorial, he concludes with this tribute by Weary Dunlop who said of him "he was a master surgeon, soldier, teacher, orator, ambassador to our nation. In another text, Weary also said "the profound and extraordinary results of his work were due not only to his clinical genius but a mind filled with diverse knowledge, a spritit of unquenchable enthusiasm, and a fortitude and a body as tough as an old oak tree. It is hard to imagine a man more fitted to the image of a true Australian or a more suitable ambassador for our nation". As Sir Arthur Conan Doyle said, "mediocrity knows nothing higher than itself, but talent instantly recognises genius".



Expressions of interest are invited from Fellows for the Weary Dunlop Boon Pong Travelling Fellowship – Thailand

This is the first invitation of a new, annual College Travelling Fellowship to Thailand funded from the Weary Dunlop Boon Pong Scholarship Fund.

It has been established to complement the Weary Dunlop Boon Pong Scholarship Fund activity that brings up to six Thai surgeons to Australia each year for four months of surgical experience.

The Weary Dunlop Boon Pong Travelling Fellowship is open to expressions of interest from Fellows who have supervised / mentored a Weary Dunlop Boon Pong Scholar in Australia and who volunteer to travel to Thailand for a period of two weeks to follow up their protégé and to help with the implementation of the skills gained in Australia in the protégé's clinical environment. This would ideally occur six to 18 months after the completion of the Australian experience of the Weary Dunlop Boon Pong scholar. Fellows interested in this Travelling Fellowship will need to include with their expression of interest a request to visit, from their Thai scholar.

The Weary Dunlop Boon Pong fund subsidises the cost of the Fellow's travel to and from Thailand by providing an economy class air-fare to Bangkok and one night's accommodation. The Royal College of Surgeons of Thailand and local Thai health institutions may, on occasion, contribute to costs of local (in country) travel and accommodation. Costs not met by RACS or Thai organisations will be met by the Fellow.

Up to three Weary Dunlop Boon Pong Travelling Fellowships may be awarded in the one year.

The Travelling Fellows are expected to act as ambassadors for the College during the Fellowship and will provide a report of their activities to the RACS International Committee and to the Royal College of Surgeons of Thailand within two weeks of their return.

Eligible fellows are encouraged to indicate their interest in this Travelling Fellowship to enhance our College's outreach activities

Bruce Barraclough AO
Australian Convener,
Weary Dunlop / Boon Pong Scholarship program.

For more information please contact International Scholarships Officer, Sunita Varlamos on +61 3 9249 1211 or sunita.varlamos@surgeons.org

Through a mirror, darkly

The collection focuses on the influence and achievements of the great figures of medical history

Keith Mutimer
Honorary Treasurer

"…to instil a little culture into the average Australian practitioner, who at present, owing to the absence of proper library facilities, is in danger of becoming merely a skilled artisan and lacking any knowledge of the great profession to which he belongs."

Leslie Cowlishaw, 1938

Borometz or Tartary lamb

Breede of Barnacles

Leslie Cowlishaw, physician, bibliophile and advocate for the discipline of medical history, would approve of how easily we now can research medical history

This was not always the case. One of the prime movers in the establishment of the Medical History and Literature sections of the NSW Branch of the British Medical Association in the 1920s, Cowlishaw who would have liked all Australian Medical Schools to have a medical history department, vigorously campaigned for medical history and the need for access to research material.

By 1938 Cowlishaw's advocacy had borne some fruit and in that year he was made Honorary Lecturer in Medical History at the University of Sydney, delivering a series of 12 lectures to final year medical students. The lectures were illustrated by glass lantern slides and a display of books from his library.

The same glass lantern slide collection, complemented by a glass lantern projector in the museum collection, is one of the hidden gems of the College's archive. Numbering some 1450 units and accessible through a comprehensive index of their subject matter, the black and white slides measure 80 millimetres square and, except for some surface dirt and deterioration of the edging tape, are in very good condition.

Although the collection focuses on the influence and achievements of the great figures of medical history, Cowlishaw's interests appear somewhat eclectic. Hospitals, universities and cities vie with ancient civilisations such as Sumeria, Assyria and Crete. There are slides reflecting indigenous cultures, particularly those of America and Australia and examples of Arab, Jewish and Icelandic medicine and culture. Philosophers, diarists, inventors, collectors and artists all form part of Cowlishaw's world.

But there is a rationale behind the collection. Some of the material - such as the portrait of René Descartes, philosopher and author of the physiological text, *On Man*, or paintings by the 17th century Dutch artist, Jan Steen whose oeuvre with its moralizing overtones, includes genre scenes of the medical profession - reveals obvious links to medicine.

Cowlishaw also saw the history of medicine as part of a broader history and by focussing on the social and economic underpinnings of a particular time period, effectively contextualizes his subject matter.

This can be illustrated by looking at slides that depict strange or fantastic creatures. The legend of the Sciapodes – surprisingly agile men with one huge leg who reputedly lay on their back and used their large foot to protect them from the sun; the Borometz or Tartary lamb – a lamb with sweet flesh and blood like honey, attached to a plant by its umbilical chord or the *Breede of Barnacles* – geese that hatch from pods on the barnacle tree.

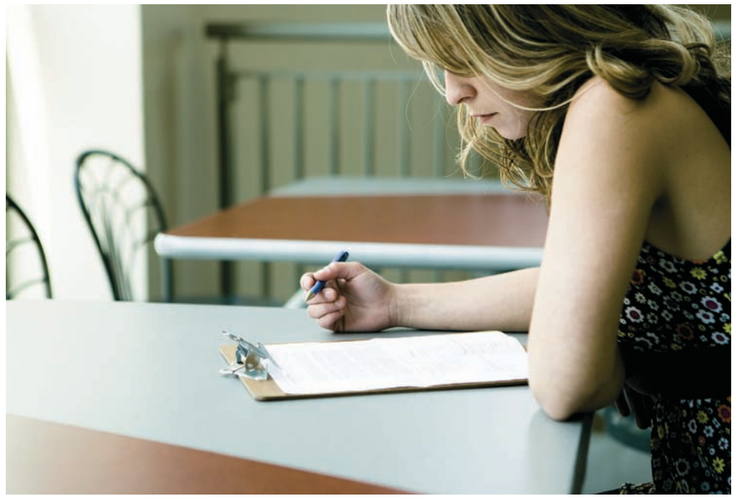
How would Cowlishaw have interpreted these images? Scientific rationalism could see the Sciapodes as having elephantiasis or link them to the yogic practice of standing on one leg. Perhaps the Borometz and barnacle geese can be seen as an aberration, a singular perception of reality that has long since flowed into myth.

But the fact remains that these creatures, often originating in the ancient world and referenced in herbals, literature and the art of the time, were part of Medieval and Renaissance culture. It is no coincidence that many of Cowlishaw's slides belong to this period for paralleling such 'fantasy' was an emerging and perhaps equally 'fantastic' science - the discipline of medicine.

Formal complaints procedure

A step-by-step guide to the process of a formal complaints procedure

The Victorian Equal Opportunity & Human Rights Commission



A formal internal process is one of the options available to a person needing to make a complaint. A 'formal complaint' refers to a process where there is:

- a formal statement made by the complainant to someone in authority when they believe there has been a serious breach of policy
- an impartial investigation by a senior manager, human resources staff or independent investigator. The investigation will include interviewing the respondent and considering other evidence (possibly including witnesses) to determine...
- a finding that there was or was not a breach of policy; and
- a recommendation on what discipline or other non-disciplinary action should be taken as a result of the finding.

Using a formal procedure to resolve complaints should be relatively rare. Formal procedure may be most appropriate when one of the following applies:

- matters have not been satisfactorily resolved through self-management or at the informal level
- self management or informal resolution are impossible for some other reason
- matters involve serious allegations which, if proved, would warrant workplace discipline or legal action (for example assault or sexual assault)
- the respondent denies the allegations
- the respondent is significantly more senior than the complainant
- the complainant has decided that a formal process is how they want the matter dealt with.

How formal complaints are handled

The handling of formal internal complaints will be spelt out in your organisation's EO or bullying policy and procedures documents. It is important that complainants familiarise themselves with the organisations procedures before they lodge a formal complaint.

Common questions about formal complaints

How do I make a complaint?

Most formal complaint procedures require the complainant to make a written statement of complaint. This can be a short outline of what happened, when, how often, who was involved and what the effects of it have been on the complainant. This statement will be shown to the respondent so they can respond. If a complainant has difficulty writing their statement, it can be written for them by someone (eg the Investigation Officer) interviewing them.

Who do I give the statement of complaint to?

The statement of complaint first goes to the Investigation Officer. Contact human resources to find out who your organisation's Investigation Officers are. Investigation Officers are normally senior managers or human resources personnel. It is important that the complaint be investigated by someone who:

- is impartial
- has sufficient authority and respect in the organisation
- has enough time to conduct a fair investigation as quickly as possible
- has no conflict of interest (eg has no direct professional or personal relationship with either the complainant or the respondent).

How will the complaint be investigated?

The Investigation Officer will interview the complainant and the respondent. Any witnesses may also be interviewed. All of these interviews are confidential.

Can I lodge a formal complaint anonymously?

No. The respondent (person you are complaining about) will be told what the complaint is so that they can put their side of the story and get a fair hearing, but they will be told not to gossip about it. Witnesses may also be interviewed, and they will also be told not to gossip. If the complaint is upheld, the respondent's manager will be told.

"All complaints will be treated seriously. The complainant and the respondent will be treated respectfully."

However, the investigation will be confidential to the extent that only those people in the organisation who need to know will know, and they'll only know what they need to know. It is important that neither you nor anyone else involved in a formal investigation gossip about the allegations or the progress of the investigation.

Can the complaint be proved if I don't have witnesses?

The standard of proof for discrimination, harassment, sexual harassment and bullying investigations is 'the balance of probabilities.'

This means that a reasonable person, taking account of all the available evidence (including what people say happened), concludes that it is more likely than not that something occurred.

There does not have to be eye-witnesses to the incident, but obviously having credible witnesses will affect the balance of probabilities. Even unco-operative witnesses can be helpful in confirming important elements like times, places and events. Unreliable, inconsistent or biased witnesses are often of little use one way or another.

How do I know the process will be fair?

Your organisation's policies and procedures, and the training provided to Investigation Officers, will normally ensure that the investigation will be conducted in a fair way and reach a fair outcome. Investigation procedures are normally designed according to principles of procedural fairness which are measures to ensure they are:

- **Sensitive** – all complaints will be treated seriously. The complainant and the respondent will be treated respectfully.
- **Confidential** – only the people who need to know will know: that a complaint has been made, what the complaint is about, what stage the investigation is at, what information has come out during the investigation, including personal information.
- **Timely** – the investigation will begin as soon as possible after the complaint has been made and proceed as quickly as the steps will allow. Two weeks is a good target to aim for.
- **Impartial** – the investigation will not reach a conclusion about what has happened until all the interviews have been completed and all the evidence considered. No record of an allegation will be kept on the respondent's file unless the complaint is proven.
- **Relevant** – only the complaint and information that is relevant to the complaint will be considered, and all the evidence relevant to the complaint will be considered.
- **Consistent** – All formal complaints will be treated seriously and according to an understood process. Outcomes (such as discipline) will be applied consistently according to the severity of the policy breach and the record of the respondent, regardless of who the complainant or respondent are.
- **Safe** – complainants, witnesses and respondents will not be threatened, punished or victimised in any other way for their participation in the process. Such victimisation is automatically grounds for discipline.
- **Appropriate** – Disciplinary action will only be taken against a respondent if the complaint is proven. Any such action will be measured and appropriate according to the nature of the complaint. It may involve performance counselling, disciplinary action, changed workplace arrangements, training and development or other measures.
- **Appealable** – if either the complainant or the respondent is unhappy with the process or the outcome of the investigation, there will be an opportunity to appeal and have either or both the investigation process or its outcome reviewed for accuracy and fairness.

Can I withdraw my complaint?

Complainants may ask to withdraw their complaint at any stage, but the decision to stop a investigation once it is underway does not rest with the complainant.

If the complainant asks for an investigation to be suspended, the Investigation Officer will interview them to find out why they made the request. If the complaint is about a serious breach of policy or the law, or if the complaint is being withdrawn because the complainant is being victimised, the Investigation Officer or managers at a higher level may decide to continue investigating.

Making a false ('vexatious') complaint is a serious breach of policy and will usually incur some disciplinary action.

Advantages of formal complaint procedure

Organisations and individuals benefit from some complaints being handled through a formal internal process because:

- complaints can be handled by a uniform step-by-step process that everyone understands and that applies to everyone equally
- a formal record is kept that can be produced, if required, to an external agency (for example if the matter ends up in court)
- outcomes of the investigation are clear, well-documented and more easily monitored and enforced
- 'hidden' problems become visible, allowing (and requiring) management to take action (eg workplace culture, training and development needs)
- a complainant can feel 'taken seriously' and regain her or his self-esteem if the complaint is proven
- a respondent can be made to understand the seriousness of their misbehaviour if the complaint is proven.

Disadvantages of formal complaint procedure

Formal complaints procedure are unlikely to be the best option for complainants if:

- the time and resources necessary for the investigation and potential for a punitive outcome is out of proportion to the seriousness of the allegations
- it is important to the complainant that they keep some control of the complaint process
- an informal approach is likely to be quicker and / or more effective
- the complainant and respondent are required to maintain a close working relationship in the future
- the complainant is likely to be severely emotionally damaged or demoralised if the complaint is not proven.

Next month, Surgical News will explore external resolution options.

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Pioneering Surgery in PNG

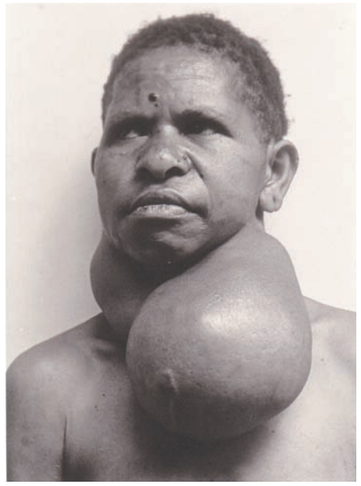
Frank Smyth was a pioneer in head and neck surgery in PNG in the late 1950s

Frank Smyth
Queensland Fellow

When I arrived in Goroka in May, 1957 as the first qualified surgeon in the Eastern Highlands of Papua New Guinea (PNG) the question was "Would people come for operations?" At first there were only recent injuries – wounds, fractures and burns. Delayed injuries followed, then lumps and bumps with a preponderance of multinodular goitres which were endemic in certain areas. The larger ones, up to six or seven centimetres were removed at the insistence of patients. Wounds of the head from axes, mostly in women and sometimes with badly depressed skull fractures, were better done with general anaesthetic, as were some other head and neck cases. The tubing of an anaesthetic machine brought out of storage was all perished; so it was back to open ether which is too long a story for this article.

Then, everybody was astonished by the size of a nodule in a multinodular goitre. Again the patient was a woman as were most of the early elective cases. The size of this nodule was extremely intimidating and I remember hurrying past her on ward rounds to avoid admitting that I was too cowardly to take on the challenge of removing her goitre. The nodule was 19 x 15 centimetres.

My procrastination made me aware of my lack of courage and confidence to operate. Clearly, I needed more than my own resources, and though I believed in prayer in an unobtrusive way, and should have had enough faith to believe Psalm 121 which says "My help comes from the Lord," I kept wondering "Could it work?" I thank God that it did work, not



A multinodular goitre, 19x15 centimetres

only in this case but in many other instances. Although the veins were as thick as ropes the operation went well and the patient was very happy with the result. I wondered why I had been so fearful.

Ameloblastoma

The next shock was the arrival of an Eastern Highlands woman with a large tumour occupying and considerably expanding the central mandible. Radiologically it was cystic and her biopsy revealed an ameloblastoma.

As there was virtually no library, urgent requests were made to Health Headquarters for information from the literature and I studied the anatomy of the area intensively. The lesion was then removed with a margin of healthy mandible. This was the first of a long series of ameloblastomas which continued over the years. Some were very huge.

Cancrum Oris

A further surprise for a young surgeon accustomed to lists of varicose veins, haemorrhoids, inguinal hernias etc. which just didn't seem to occur in PNG was a young woman Wagep, about 30 years old from the Eastern Highlands, with full-thickness-loss of cheek tissue from Cancrum Oris. She was keen to have the hole closed and was prepared to wait until I found out how to do this which meant going to Port Moresby where I was to be transferred. On leave in Australia I questioned a few reconstructive surgeons and eventually was given a plan. This was to tube a pedicle of neck skin to be attached to the back of the defect. Later it would be spread to provide both lining and cover.

SCC of Tongue

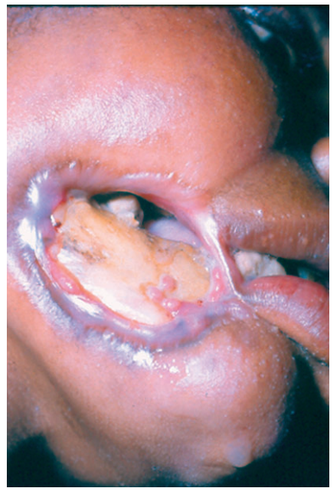
Somi raised the possibility that advanced cancers of the mouth might remain localised for some time and that a radical excision could possibly be curative. He came from Lae, and was probably about 30 years old. He was employed as a driver at the Goroka Hospital and one of the medical orderlies accommodated near him complained of the offensive smell in his mouth. Although the whole tongue was destroyed there were no palpable lymph nodes. There was absolutely no remaining mucosa.

It was thought that spread was likely to occur and if radical resection were done it would be palliative to relieve his pain and remove the offensive odour as well as lessening the risk of aspiration pneumonia. He required a feeding tube post operatively. When able to swallow again he preferred to use the tube and declined any reconstruction. He returned for four years to his job as a driver for the Health Department located near the Port Moresby Hospital where we saw him frequently. He was fit and could make himself understood. He died after four years from pneumonia with no signs of local recurrence, nor of metastases to lymph nodes or distant organs.

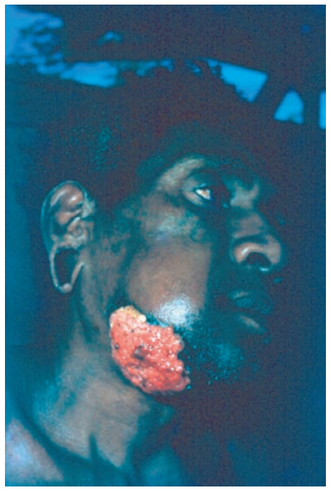
Buccal Mucosa Cancers

Once Wagep's defect had been closed I started to think about patients with Buccal Mucosa Cancers seen in Madang and later in Port Moresby.

When patients with Buccal Mucosa Cancer were admitted to my unit in Port Moresby General Hospital a regime of surgery without pre-operative irradiation was commenced. Amongst the early cases was this Papuan Coastal man, Gamoa. He is presented because his case illustrates a few important points and he is the first patient we could regard as a five year cure. He was probably over 40 years old, and biopsy showed a Squamous Celled Cancer arising in the buccal mucosa, with a large area of radiological involvement of mandible and in-continuity destruction of the overlying skin.



Cancrum Oris



A gentleman with Buccal Mucosa Cancer

"When patients ... were admitted to my unit in Port Moresby General Hospital a regime of surgery without pre-operative irradiation was commenced."

Radical excision was performed including a large part of the mandible. Following practice at the time the wound was closed mucosa to skin leaving a defect similar to that of Wagep, but with no visible mandible.

Later the defect was closed with a pectoral flap. The patient was not seen for another seven years, when he returned with a second cancer at the back of the pectoral flap. Gamoa had continued to be a betel-chewer and he had leucoplakia in the middle of the lining flap.

A second radical excision was performed (with a wider margin!) and a forehead flap was immediately transferred into the defect.

This article is based on a key note address by Dr Frank Smyth delivered at the 43rd Annual PNG Medical Symposium in 2007.

International Medical Graduates

I read with interest the article on International Medical Graduates (IMGs) in Vol:1, No:1, 2009 *Surgical News*. As an IMG myself I had to endure the process of assessment, interviewing and finally examination.

At the time I must say I was disappointed with the College's decision not to give me an article 21 Fellowship, as I felt I was at a more senior level than recently graduated fellows and I interpreted this as a lack of understanding of the depth of my training. Be it as it may, I was to be married with an Australian and it was her choice to stay in Australia, so I did not really have a choice.

I must say I hated going back to study basics than are not that essential to practice, but I also updated knowledge from fields that I do not often see these days. It is good for a surgeon willing to practice in Australia to have the FRACS part II under their wing because it implies that he or she has an equivalent level of knowledge and an understanding of the Australian system. It also provides the IMG (and the College) with some legal backbone in case of a lawsuit.

The Americans have long ago moved to a retraining program, all surgeons willing to practice in the US must retrain. This decision is probably excessive and somewhat discriminatory. But an exam, such as the part II, is a valid and fair way of assessing someone's ability to practice independently.

To conclude I feel that all surgeons willing to practice in Australia should sit the exam. This will save time with the assessment process and minimise speculation as to who is eligible for an article 21 Fellowship, making the process easier. I consider that the article 21 Fellowship should only be granted in very specific and exceptional cases.

Regards,
Nicolás Oddone-Baridon
Killara, NSW

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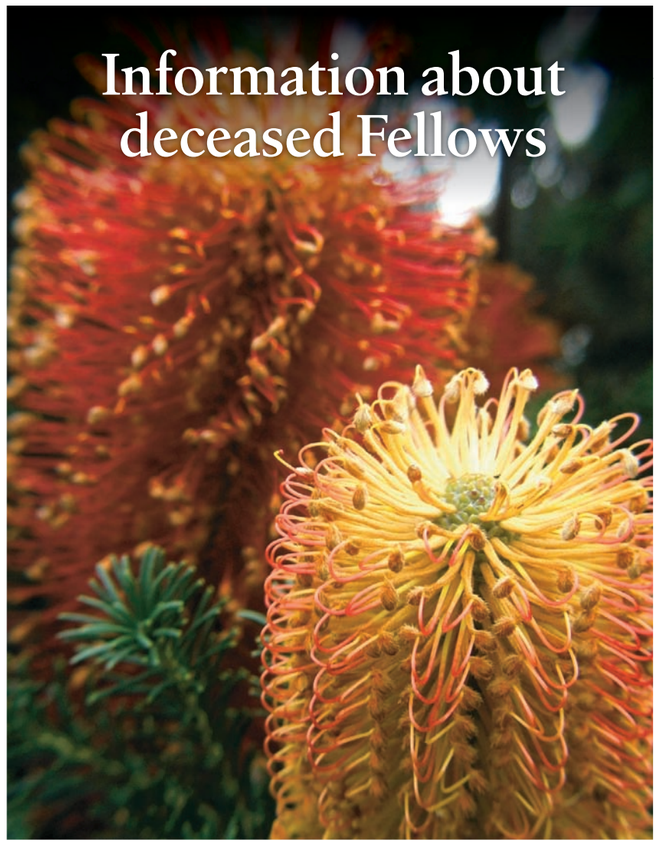

Our condolences to the family, friends and colleagues of the following Fellows whose death has been notified over the past month:

Thomas Rupert Manyard Furber NSW
Donald Lochinvar Glen NSW
Geoffrey Alan Jose SA
John Raymond Lipert SA
Harold Roberts Thompson TAS
Chester Alan Troy VIC

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website http://www.surgeons.org/Content/Navigation-Menu/WhoWeAre/Inmemoriam/default.htm

Informing the college

If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office. They are:

ACT	Eve.edwards@surgeons.org
NSW	Beverley.lindley@surgeons.org
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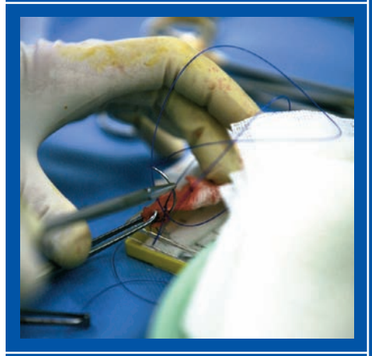

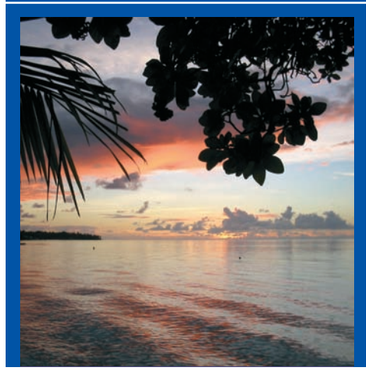

2010
ROWAN NICKS SCHOLARSHIPS
PACIFIC ISLAND SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the 2010 Rowan Nicks Scholarships and the 2010 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 **2010 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, teaching and research 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 **2010 Rowan Nicks Pacific Islands Scholarships** are reserved for surgeons from Pacific Island countries. It is aimed at promoting the future development of surgery and research 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, six or 12 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 Australasia. The scholarship is tenable in a major hospital (or hospitals) in Australia or New Zealand, and appointees may 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 program.

Closing date for these Scholarships is to be extended to 5.00pm Monday 30 April 2009

A copy of the application form for either Scholarship is available at www.surgeons.org.

For additional information please contact:

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