Surgical news

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2010

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The Perth Annual Scientific Congress is next month

4-7 May

The College of Surgeons of Australia and New Zealand

ROWAN NICKS FELLOWSHIP AUSTRALIA AND NEW ZEALAND

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of New Zealand to apply for the 2011 Rowan Nicks Australia and New Zealand Fellowship. Rowan Nicks Scholarships and Fellowships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country.

The 2011 Rowan Nicks ANZ Fellowship is offered to a surgeon from New Zealand to take up the Scholarship in Australia . The Fellowship is intended to provide an opportunity for the surgeon to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The aim is to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base. The Fellowship will be awarded for a period of between six and twelve months.

Applicants must be under 45 years of age and have completed a Fellowship of the Royal Australasian College of Surgeons at the time of application. Applicants must undertake to return to their home country on completion of the Fellowship program.

The Scholarship is valued at up to $75,000 AUD pro rata in addition to airfares, depending on the circumstances prevailing for the candidate and provided sufficient funds are available.

APPLICATIONS MUST INCLUDE THE FOLLOWING:

1. A covering letter that outlines the aspirations and intended program*
2. Curriculum Vitae
3. Copy of basic medical degree and Fellowship
4. The names and details of two referees who will be contacted separately

*A Sponsor in Australia is desirable (from the candidate's point of view) but is not essential and will not detract from the application.

The Rowan Nicks Committee will determine the successful applicant in November 2010. The application form and instructions are available for download via the College website: www.surgeons.org.

FORWARD APPLICATIONS BY 28 JUNE 2010 TO:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons Gardens
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Advocacy and the role of the College

With a keen understanding of our patients' needs, advocacy is something that surgeons do naturally

Ian Gough
President

This will be my last article for *Surgical News* as the President. After the Annual General Meeting in May, Mr Ian Civil will assume this role. The article covers the key elements of advocacy and the College's increasing activity in this area.

Over recent years all surgeons would be have been concerned to see the corporatisation and bureaucratisation of health delivery that has diminished or removed many of the traditions of altruism, professionalism or "primacy of patient care" in our clinical areas. Sometimes clinicians' responses have been withdrawal from the debate or alternatively a vigorous industrialisation that, although warranted, could easily be misconstrued as substantially based on self-interest.

At the same time there have been rising expectations for medical practitioners and specific groups such as surgeons to focus on the requirements of the communities we serve. We are increasingly required to meet the demands of regulatory and accreditation bodies such as the competition commissions and the medical councils.

Advocacy is something that surgeons do naturally. We have a keen understanding of what our patients need and we are readily frustrated by the lack of response from the broader health system in focusing on quality patient care. The role of the surgeon will always demand an active interface with hospitals to ensure surgical standards are maintained.

In my time on Council there has been a deliberate and strong endeavour to evolve the College into a position of advocating on behalf of the health needs of the community. The competencies for which we train our surgeons now have a distinct component of health advocacy so the College Council has progressed this. It is interesting to look at the key attributes of this competency. These include identifying points of influence in the health system and advocating for improved resources and organisation in the environment where they are employed.

"We are now the first point of contact for much of the media when they seek comment on issues of education, training and health service delivery."

It takes a lot of time and pressure to turn coal into diamonds. Just as the approach to the brilliant-cut of diamonds developed by Marcel Tolkowsky in 1919 had 58 facets, the approach to solutions in the health system will have multiple perspectives. Health care exists in a complex political and economic environment and all individual groups and stakeholders have strong passionate views of what is "right". When the College is involved we try to see the "big picture" and offer workable solutions based on important principles.

We need to accurately identify the determinants of health and the barriers to access for care and resources. The College has developed, and will continue to develop a series of thought through position papers that clearly state what the College believes in.

The College has contributed fully to the debates about National Registration and Accreditation as well as the National Health and Hospital Reform and taken active roles in Senate sub-committee debates, Prime Ministerial and Ministerial briefings as well as frequent interactions with the various Departments of Health.

We are now the first point of contact for much of the media when they seek comment on issues of education, training and health service delivery. Politicians and journalists often need considerable education to assist their understanding not only of the clinical or system issues, but also our proposed solutions.

Could our message be more clearly heard

> *"Clinician involvement and leadership through local structures is a strong position for the College and decision making should be delegated to these levels to ensure responses can match requirements."*

and understood? Always, of course, but that is the challenge of being in the debate. Currently the agenda is changing significantly as the Prime Minister has made health sector reform a major political topic over the next 12 months. It appears that hospitals are the first "plank" of reform following the National Health and Hospital Reform Commission report.

The issues that the College wants to highlight include:

• There is enormous opportunity in federal funding and national standard setting.

• The funding will need to be increased to meet the demands of the community. Activity based funding should cover not only clinical care, but also reflect the requirements of teaching and research. Efficiency and productivity should be rewarded.

• Measures of performance need to not only include activity numbers, but also measures of clinical outcomes and quality. This must include audit and peer review such as with the Mortality Audits that have now been established across Australia. Risk-adjusted peer reviewed audit of all surgical activity should be encouraged and adequately supported.

• Assessment and monitoring of new procedures, technologies and devices is critical and a new agency with broad responsibilities in this area should be considered. The College via the Australian Safety and Efficacy Register of New Interventional Procedures–Surgical or with the Australian Orthopaedic Association-Joint Registry have substantial experience in this regard and these proven activities need sustainable ongoing funding.

• Supervision of training is critical and dedicated support for this must be recognised and increased. The College along with other colleges strongly supports training in the private sector, but this will only be successful with dedicated infrastructure and funding. As the differences in the case-mix of public and private surgery continue to broaden, the need to train in the private sector is more significant.

• Separation of surgical care in hospitals between emergency and elective surgery brings benefits in access and delivery for both groups of patients. Evidence is now clear that standards of patient care are improved if emergency surgery is undertaken "in hours" as much as possible.

• Clinician involvement and leadership through local structures is a strong position for the College and decision making should be delegated to these levels to ensure responses can match requirements. The size of central health departments is an ongoing worry to the public as well as to health professionals. The growth in central departments has substantially outpaced that of health professionals actually providing the care. The country does not need more bureaucracy, it needs enlightened and efficient bureaucracies.

Within this broad set of initiatives there is enormous scope for improvement in surgical education and training, delivery of surgical services and the quality of care that is delivered. The "devil in the detail" will always be an issue. Given the complexity of the health sector and the multiple views that we need to understand, there will never be complete agreement for all positions. However, it is critical that we are in this debate at a meaningful level.

During my tenure as President, the College has made substantial progress in a large number of areas. Amongst the many, I would like to highlight the stronger relationships between the College and its Surgical Specialty Society and Association partners, the implementation of the new Surgical Education and Training program and the establishment of the Academy of Surgical Educators.

It has been a pleasure and a privilege serving on the Council. The College, as always, is in good hands with the incoming Council and we may be confident of the future.

Congratulations

to the new office holders, these positions will be in place after the May Annual General Meeting.

Mr Ian Civil President
Dr Keith Mutimer Vice President
Dr Mark Edwards Censor in Chief
Dr Mike Hollands Treasurer
Professor Guy Maddern Chair, Professional Development & Standards Board
Professor Spencer Beasley Chair, Court of Examiners
Dr Simon Williams Chair, Board of Surgical Education and Training
Dr Phil Truskett Chair, Skills Education Committee
Professor Michael Grigg Chair, Professional Standards
Associate Professor Marianne Vonau Chair, Professional Development
Dr Graeme Campbell Chair, Fellowship Services
Professor Julian Smith Chair, Research, Audit and Academic Surgery
Professor David Watters Chair, External Affairs
Dr Sam Baker Deputy Treasurer
Associate Professor Vincent Cousins Deputy Chair, Relationships Portfolio

The Surgical Leaders Forum

Discussions range from the specifically surgical to broader issues of public health

Ian Dickinson
Vice President

As the unifying force for surgery in Australia and New Zealand, the College works in partnership with 13 specialist societies and associations, facilitating the delivery of surgical education and continuing professional development.

In 1999, under the presidency of Professor Bruce Barraclough, the College decided to establish a regular forum, which would bring together the presidents of the societies and associations to consider and discuss issues of importance to them. The Surgical Leaders Forum, which also included the Executive of College Council, has therefore run for more than a decade.

It now meets on the Thursday morning of weeks in which the College Council meets – three times a year in Melbourne – and once a year as part of the College's Annual Scientific Congress. Its membership has expanded, with most councillors now attending, as well as the executive officers of the societies and associations and senior College staff.

Issues for discussion cover a range of matters, from the specifically surgical to broader issues of public health. Each meeting follows a particular theme; these have recently included such issues as proposed reforms to the public health system, relations between surgeons and the medical device industry, and the developing crisis in medical workforce numbers due to the increased output from medical schools.

Recent guest speakers have included the federal Opposition's health spokesman, the Hon. Peter Dutton, the Chair of the National Health and Hospitals Reform Commission, Dr Christine Bennett, and the Department of Health and Ageing's Chief Medical Officer, Professor Jim Bishop.

Addresses of about half an hour by these keynote presenters have been followed by question and answer sessions in which concerns and ideas are exchanged in an informed and constructive manner.

The most recent meeting of the Forum, in Melbourne on 25 February, is a case in point. The theme of the meeting was surgical training in the private sector, an issue which the College proposes to pursue this year. The guest speaker was Dr Michael Walsh, Chief Executive Officer of Cabrini Health, who examined the issue from the perspective of private hospitals. His was a particularly interesting presentation, detailing the level of risk involved for those private hospitals committing to the training of surgeons. We were reminded that even a not for profit network like Cabrini (and others like it), which believes the training of the next generation of surgeons is the right thing to do, must respect the bottom line.

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"At a time when health systems in both Australia and New Zealand are under increasing pressure, it is important that surgeons can come together to consider ways of helping improve the system."

Dr Walsh noted that governments have traditionally taken little interest in the private sector so they, like surgeons and patients, will need to be convinced of the benefits that could flow from a commitment to training in private hospitals. He emphasised one concern that was repeated by subsequent speakers, namely the drop in theatre productivity which occurs when a Trainee does a procedure. Private hospitals also fear that training would draw them into a new area of the health bureaucracy with, potentially, a loss of autonomy. And the question of the quality and consistency of supervision was raised. Could a Trainee be assured of the necessary workload and the appropriate case-mix? Would the Trainee be allowed to operate? What do the patients think?

Subsequent speakers considered the practicalities of the issue and addressed it from the specialties' perspective, the regional perspective and the Trainees' perspective. It was a thoroughly informative meeting, providing much of the groundwork for a planned workshop on this issue later in the year.

Another highlight of February's meeting was a short address by the Hon. Jim McGinty, former Western Australian Health Minister and the recently appointed chair of Health Workforce Australia.

As a key part of the federal government's new arrangements for the registration of health professionals, and with a budget of $1.6 billion over four years, Health Workforce Australia aims "to produce more effective, streamlined and integrated clinical training arrangements and to support workforce reform initiatives". As such, it is likely to have extensive dealings with the College and this was an excellent opportunity to meet its new chair.

At a time when health systems in both Australia and New Zealand are under increasing pressure, it is important that surgeons can come together to consider ways of helping improve the system. And, at a time when a relatively new federal government in Australia is implementing new registration and accreditation arrangements – and is proposing further sweeping reforms to the nation's health system – it is vital that these proposals be assessed and debated by those at the health "coalface".

The Surgical Leaders Forum provides just such an opportunity.

On a parting note, this is my last article for *Surgical News* as Vice-President. I have very much enjoyed my various roles at the College including for the last two years as Vice-President. In recent times we have expanded the advocacy role of the College and particularly have been active in the area of National Registration where although we have not achieved everything we wished, we did gain many solutions where none seemed to be available.

Among other areas where I have been fortunate to be able to lead include the development of the College's Competence and Performance Guide, the Emergency Surgery Consensus Statement, and the Census which is about to be released. The new College Constitution was the brief of the Governance and Advocacy Committee which the Vice-President chairs.

Thankyou for the opportunity to participate i n the College Council and its Executive. It has been a great privilege.

Fellows can access the PowerPoint presentations from this meeting, and other meetings of the Surgical Leaders Forum on the College's website, www.surgeons.org After logging in, go to About the College > Governance > Council > agendas and minutes.

Sweeping changes

Surely there are more than nine persons in Australia and New Zealand who want to be involved in the running of surgery in our two countries

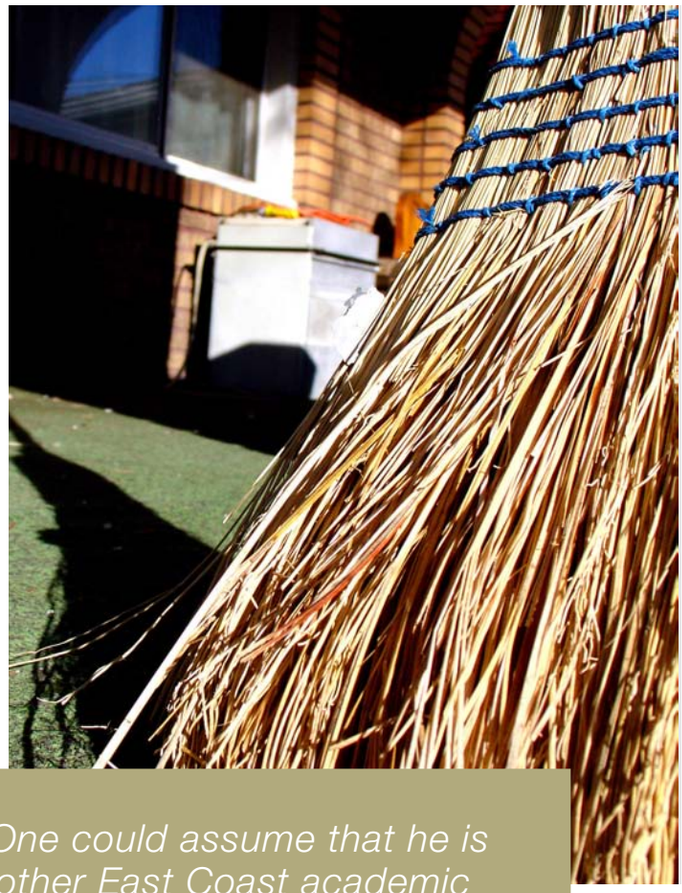
I.M.A Newfellow

The brooms have been busy – the new brooms, I mean. I am sure that you know the old expression, "A new broom sweeps clean". Well, that has happened in the Council. After the elections in the February Council meeting we have a new President, a new Vice President, a new Treasurer and a new Censor in Chief.

Well, they are actually not new. The new President was the Censor in Chief, the new Vice President was the Treasurer, the new Censor in Chief was the Chair of the Court of Examiners and the new Treasurer was the Deputy Treasurer. Do I hear someone saying "deck chairs on the Titanic"?

Readers of this column know that I have a great tendency to wander from the point of the article – so here we go again! I had thought that the expression, "A new broom sweeps clean" meant that when someone took control of an organisation they make many changes. This is actually the definition in the *Cambridge Advanced Learner's Dictionary*.

This is what I meant, that the Council, as a new broom, swept in new office bearers. However, another sense of this expression is that persons new to a position attack it with great enthusiasm. This is the definition from a web page dedicated to the meaning of expressions which concludes with the words, "Metaphorically speaking, it's much less fun sweeping a floor you know well!" So I assume that the new office bearers will sweep their new floors vigorously.



> *"One could assume that he is another East Coast academic general surgeon as Council is full of them, isn't it?"*

As I said earlier the new office bearers are not new. However, one of the replacements of their old positions is new. The new Deputy Treasurer is Sam Baker. Now he looks too young to me to even be a Fellow let alone a Councillor, and now we have appointed him Deputy Treasurer. I have heard from a reliable source that he is barely 40.

One could assume that he is another East Coast academic general surgeon as Council is full of them, isn't it? Well he is an East Coaster, but not from Sydney or Melbourne. He can't saunter across from Collins Street or fly from Sydney on one of the 50 daily flights. He hails from Far North Queensland; Townsville to be precise and it takes him a day to get to Melbourne.

He is a General Surgeon with a special interest in Upper GI and Hepato-Biliary Surgery, but not an academic safely ensconced in an ivory tower. He is a "Newfellow" to the Council, having been elected in 2008 – no, he is not a relative. He is a young man with lots of enthusiasm and thoroughly deserves his new position.

The arrival of the Council Election papers a few days ago set me thinking. Of the four specialty-elected Councillors due for re-election all were elected unopposed. Come on, surely there are more than four Cardio-thoracic, Paediatric, Vascular and Orthopaedic surgeons who want to be Councillors? (However, on reflection the orthopods are such a turbulent bunch, maybe not).

What is worse is that of the eight vacant general elected Councillors, there were only nine nominations. Surely there are more than nine persons in Australia and New Zealand who want to be involved in the running of surgical training and surgery in our two countries. Of those nine only four were new candidates, the others being serving Councillors. Where are the other Sam Bakers of the world?

As for me, I sit quietly in Council, not noticed, not heard, trying to keep off the "difficult" committees such as Resources and Governance; listening, observing and writing; avoiding jobs with real responsibility. But I can hear the brooms coming and I hope they are being pushed by an army of Sam Bakers.

Shareholder agreements

Planning for the unexpected death of a business partner

Daniel Kelliher & Adam Colabufalo
Russell Kennedy Solicitors

It makes good business sense to have a shareholder agreement in place. A shareholder agreement should be an integral part of the commencement and ongoing operation of any business venture, new or existing, small or large, where the interests or investments of different parties or ownership participants are involved, even if they are members of the same family, or regard themselves as trusted business partners or friends.

Proper consideration, agreement and documentation of how the business venture is to be managed, and how decisions on key business issues are to be made and by whom can avoid disagreement and business failure. Well considered arrangements can also save time, money and resources being unnecessarily expended in the future. An equally important consideration is what is to happen in the event that a principal behind a shareholder or unitholder unexpectedly dies or becomes permanently disabled.

There are a number of options that business principals can consider, including permitting the deceased principal's estate to continue to hold the interest in the business venture. However, this may not always be in the best interests of the parties, especially if the deceased was a key employee of the business venture. It should be noted that the executors of the principals will usually be outsiders to the business and often spouses will be executors.

Consideration should be given as to whether the business principal should enter into a critical event agreement or include similar provisions in their shareholders agreement.

Critical Event Agreement

A critical event agreement is a business succession agreement utilising insurance funding, to address the death, disability and trauma risks facing the business principals. The agreement can be broadened to address other risks, where the business relationship between the principals is so sophisticated that these can be negotiated.

For tax reasons, the critical event agreement will either be a mandatory agreement, triggered by the occurrence of a particular event with that event being a condition precedent, so that a binding contract does not arise until the event occurs. Alternatively, the agreement can be option based (hence the term "buy/sell"), with the triggering event giving rise to call options (giving rights of acquisition to the continuing principals) and put options (giving rights to require acquisition by the continuing principals, to the exiting principal or his or her representative). The option based agreement lends itself to easy disposal of interests by will.

> *"Well considered arrangements can also save time, money and resources being unnecessarily expended in the future."*

Consideration will usually be the market value of the exiting proprietor's interests, with market value defined in the agreement. The agreement will usually provide an arrangement for annual revaluation by agreement between the principals or, failing agreement, determination by an independent valuer.

Conclusion

A properly drafted and tailored critical event or shareholder agreement should serve to ensure that each participant in the business venture knows where they stand in relation to each other upon the unexpected death or disability of the other, and what mechanisms exist to deal with the deceased or disabled's interest in the venture.

Attention to documenting each participants' rights and obligations in the harmonious stages of a business venture may well avoid costly and time consuming disputes in the future.

College Conferences and Events Management

Contact Lindy Moffat / lindy.moffat@surgeons.org / +61 3 9249 1224

GSA ANNUAL SCIENTIFIC MEETING AND TRAINEES' DAY

Emergency Surgery: The Cutting Edge

17-19 September 2010

Hyatt Regency Sanctuary Cove, Gold Coast, QLD

Invited Speakers:
Associate Professor Daryl Wall
Professor Michael Cox
Dr Michael Von Papen
Dr Ian Martin

Contact:
Emma Thompson
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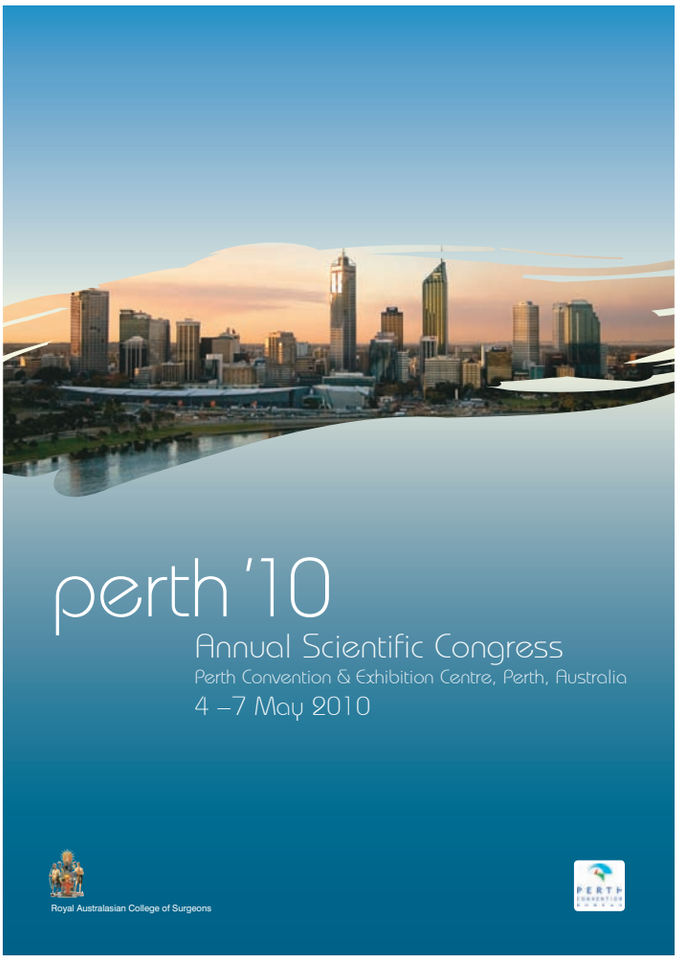
General Surgeons Australia



perth '10

Annual Scientific Congress

Perth Convention & Exhibition Centre, Perth, Australia

4 –7 May 2010

Royal Australasian College of Surgeons

46TH ANNUAL SCIENTIFIC CONFERENCE

1-4 SEPTEMBER 2010
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PROVINCIAL SURGEONS OF AUSTRALIA

"WORK – LIFE BALANCE"

Conference Convener **Mr Andrew Thompson**

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NOVARTIS ONCOLOGY

All is ready…all programs are completed and to attending the 79th Annual Scientific Congress

Local surgeons have completed two years' work to bring together and internationally. Over 400 research abstracts were submitted

You can register online now

The plenary program presents an opportunity to discuss vital matters for the entire profession

Michael Levitt, Convener &
David Oliver, Scientific Convener

It is vital that the College and the ASC remain innovative to ensure the best educational resources are being used within the format of the program. Participation enhances the educational benefit for delegates and this year several conveners will make use of audience polling units to collect audience responses to questions posed by speakers.

Following the successful trial in Brisbane, there will be prizes for 'best research paper from a Trainee' in 13 specialties. In addition, there are research prizes for Fellows in Breast surgery, Colorectal surgery, Endocrine surgery and Surgical Education - funding for these prizes is provided by the College and several of our industry partners to foster surgical research. Surgical research is the mainstay of our profession and the Congress is an excellent forum to remain current with research that in many instances has yet to be published.

The two major components to the surgical program are the plenary sessions and the scientific sessions although in the last five years the Masterclass program has also become increasingly popular for interactive learning.

Plenary program

The plenary program presents an opportunity to discuss vital matters for the entire profession, matters in which the College is frequently central to discussion. The program proper begins on Tuesday when session one will be a plenary session titled 'Are surgeons losing the fight to control surgery?' Mr Tom Dehn (Reading, United Kingdom) will open the session with his British Journal of Surgery Lecture on this topic, followed by Professor Frederick Moore (Houston, United States of America) who will address the issue of the

all College and Congress Visitors are looking forward (ASC) at the Perth Conference Exhibition Centre. an outstanding invited faculty from Australia, New Zealand and reviewed for the research paper and poster sessions.

at www.asc.surgeons.org

impact of healthcare reform on the practice of surgery, an extremely pertinent topic. Dr Jim Bishop (Canberra) is the Australia's Chief Medical Officer and he will expand on contexts and inputs for planning surgical services. Ample time has been allowed for discussion and the panel will be joined by Russell Stitz.

Wednesday's plenary, sponsored by St John of God Health Care, will be an attempt to see what may await surgeons in 2020, well within the practice lifespan of many delegates. Sue Jeffries is a clinical psychologist and she will address 'How do today's Trainees differ?' then Mike Daube, a former Director, General of Health in Western Australia, will consider how surgical health care will be delivered in ten years time – it is certain to differ from the current model. The presentations will conclude with 'Will we actually be able to afford it?' from Lachlan Henderson, Director of Medical Services at St John of God Health Care.

The Thursday plenary is sponsored by Ramsay Healthcare and the topic is "Professionalism in surgery and behavioural issues for surgeons and Trainees." The BJS Lecturer, Tom Dehn will speak again on facing up to our problems; he will be followed by Kingsley Faulkner, former College President, discussing recruitment and who will want to be a surgeon in 2020. Linda De Cossart is a UK surgeon and surgical educator who spoke with such authority at last year's ASC that she has been invited back as the RACS Surgical Education Visitor. Linda will address 'What does "professionalism" mean in daily practice?'

The concluding plenary on Friday addresses the fraught topic of sub-specialisation in surgery. Chaired by Mark Edwards, four speakers will address this potentially divisive topic of sub-specialisation – Chris Pyke: 'The Fellowship of the Royal Australasian College of Surgeons Part 2 is no longer enough'; Hugh Martin: 'Who should be accrediting post-Fellowship courses?'; Phil Truskett: 'The general surgeon is not extinct!' and Owen Ung: 'Emergency surgery – who is doing the work?'.

The President of the Australian Society of Plastic Surgeons, Peter Callan and Chip Farmer, President of the Colorectal Surgical Society of Australia and New Zealand will join the panel of speakers for the discussion.

Photo courtesy of Binh Nguyen

Surgical Oncology – Christobel Saunders

Christobel has created a program of interest to both the surgeon in general who may deal with cancer and to those who spend the vast amount of their time dealing with cancer and thus call themselves surgical oncologists.

The Congress Visitor is Professor Laura Esserman from University of California, San Francisco. Professor Esserman has a particular interest in the management of breast cancer and in particular, how we use new technology such as MRI and intra-operative radiotherapy, molecular techniques and new targeted treatments to treat breast cancer.

Tuesday looks at how we should be delivering cancer services. Professor Jim Bishop (himself a medical oncologist) will address this topic and the session will view the story from a specialist cancer unit versus a regional hospital. Additionally, the program will canvas the view from trauma surgery to see if centralising services in a specialist tertiary unit really does improve outcomes. We hope this will be informative, thought provoking and get some debate going! With other sessions on breast cancer, gastrointestinal stromal tumours, melanoma, colorectal liver metastases and the controversial subject of peritoneal resection there is something for almost everyone in surgical oncology.

Military Surgery – David Read

This year's Military Surgery program features three surgeons from the Lackland US Airforce Base, San Antonio, Texas, 'armed' with a multitude of talks. The RACS Visitor, Lieutenant Colonel Todd Rassmussen is a vascular and general surgeon who will speak on wartime vascular injuries in Iraq and Afghanistan, including endovascular management, as well as the response to mass casualty events. His colleague, Colonel David Smith is a trauma surgeon with a hepatobiliary interest and he will speak on haemorrhage control in liver injuries. Their research resident Captain Shaun Gifford will present research on ischaemia/reperfusion on a large animal model in combined sessions with Vascular surgery. The Wednesday morning session addresses the training of military surgeons with input from both local and US surgeons and the program concludes on Friday with a session of military research papers focussing heavily on recent experience in Afghanistan.

Section dinners

Please be reminded that the Plastic and Reconstructive Surgery dinner is on Wednesday night and the Medicolegal and Pain Medicine section dinner is on Friday night. You may book for section dinners and the Congress dinner (Thursday night) when you register for the meeting.

Ansell World Launch

Ansell will launch their innovative new Gammex surgical glove incorporating antimicrobial activity (AMT) at the ASC. The glove has been developed to provide additional protection for the wearer. Ansell will host a breakfast session on Thursday to explain the development of the glove and the anti-microbial activity profile of the incorporated agent. Please book for the breakfast session at the Ansell booth in the Exhibition area or email to pretection @ap.ansell.com. See page 39.

See you in Perfect Perth for the 79th ASC 4-7 May.

International English Language Testing System

How many people in Australia and New Zealand speak two languages to a sophisticated level?

John Quinn
Executive Director of Surgical Affairs

Recognised internationally by universities and employers, immigration authorities and government agencies the International English Language Testing System ™ is now the standard by which International Medical Graduates are assessed before working or training in Australia.

The International English Language Testing System ™ has been designed to assess the language ability of candidates who need to study or work where English is the language of communication. It is now jointly managed by the University of Cambridge ESOL Examinations, British Council and IDP:International English Language Testing System™ Australia. In its structure it covers the four language skills of listening, reading, writing and speaking.

It is actually available in two versions being Academic and General Training. The General Training version is applicable for the health sector purposes in Australia, Canada and New Zealand.

The IELTS ™ provides a profile of a candidate's ability to use English on a Band Scale from 1 to 9. The most pertinent bands are [1]

(9) Expert User: Has fully operational command of the language: appropriate, accurate and fluent with complete understanding

(8) Very Good User: Has fully operational command of the language with only occasional unsystematic inaccuracies and inappropriacies. Misunderstandings may occur in unfamiliar situations. Handles complex detailed argumentation well.

(7) Good user: Has operational command of the language, though with occasional inaccuracies, inappropriacies and misunderstandings in some situations. Generally handles complex language well and understands detailed reasoning.

(6) Competent User: Has generally effective command of the language despite some inaccuracies, inappropriacies and misunderstandings. Can use and understand fairly complex language, particularly in familiar situations

Obviously there are views of how expert one's command of the English language needs to be. One of the concerns of the public is the communication of culturally and personally sensitive information in the clinical setting. Consumer groups often reflect on language issues and challenges in all communication. Many consultants in the health sector could give accounts of struggling to effectively communicate in the clinical situation even when Expert English is shared by all.

However, if English is a second language then becoming a good user may be an outstanding outcome. How many people in Australia and New Zealand speak two languages to a sophisticated level? However, the requirements across the four skills of listening, reading, writing and speaking have been set at a level of 7. It is interesting to note that the level of 7.5 is regarded as being required to actually study medicine, law or linguistics in Australia. No doubt there could be much discussion over what level of English is needed in a number of clinical roles and the cut-off levels do differ with lesser standards apparently being required in Britain itself.

As these standards have become more firmly adhered to over the last five years, one of the inadvertent outcomes has been to make it more difficult to bring surgeons from the Pacific and Asian communities to Australia and New Zealand for training opportunities or exchanges. When temporary registration is required for clinical attachments where the opportunity is to see some procedures of special interest and assist then there is clearly a different set of expectations. Patient care and responsibility stays with the treating surgeon and not with the international medical graduate. The requirement to pay for and then sit the assessment to meet the high levels of the International English Language Testing System™ do not seem to be clinically required. However at the administrative and regulatory level the differentiation is not clear and the importance of these exchange programs is not apparent. The advice given is all encompassing with limited understanding of the clinical situation.

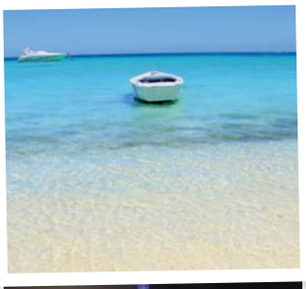
It would be a great shame to see this important interchange stopped. The College does have success in seeking exemptions for the International English Language Testing System™ for exchange programs and candidates for the Rowan Nicks, the Weary Dunlop-Boon Pong and Project China scholarships are still able to access these important opportunities. If you are having difficulty negotiating these administrative issues with the various medical boards then please contact Dr John Quinn, Executive Director of Surgical Affairs (john.quinn@surgeons.org)

1. Handbook 2007. Canberra: International English Language Testing SystemTM English for International Opportunity, 2007. at www.ielts.org

2010 professional development workshops

This month, we would like to highlight the workshops that are being conducted in conjunction with the ASC in Perth.

In 2010 the College is offering ***exciting new learning opportunities*** designed to support Fellows in many aspects of their professional lives. PD activities can assist you to strengthen your communication, business, leadership and management abilities.



Neurotrauma Workshop
2 May CTEC Perth: 10- 4

This full day workshop is facilitated by two neurosurgeons and aims to equip rural surgeons and trainees with the skills to deal with acute neurotrauma cases that demand rapid surgically-applied relief of pressure on the brain. You will learn how to use equipment typically found in smaller rural hospitals, primarily the Hudson Brace. Case studies will be used to focus on the decision-making process that rural surgeons may be faced with in trauma situations and the clinical procedures that can be performed with equipment on-hand. You will have the opportunity to practise these procedures on human cadaveric material.

Understand Your Patients Better: Become Culturally Competent
3 May, ASC Perth: 9.30-12.00, 1.00-3.30

Miscommunication between clinicians and patients in hospitals can have serious consequences. Patients often have trouble understanding the language of medical practitioners. According to a recent NSW health report, ineffective communication was identified as the major cause of critical incidents in hospitals. This three-hour workshop provides a framework to analyse the ten dominant communication styles and explores some central communication channels and cultural values that affect communication with people from different cultures. It will enable you to develop effective strategies for communicating with people from different backgrounds and reduce potential surgical errors.

Polishing Presentation Skills
3 May, ASC Perth 9.00- 3.30

Want to develop an attention grabbing presentation to deliver your message more effectively? Whether you are a beginner or an experienced presenter, join this whole day workshop to advance your presentation skills. You will learn a step-by-step presentation planning process and practical tips for delivering your message. It is equally applicable to presentation sessions in hospitals, conferences and international meetings.

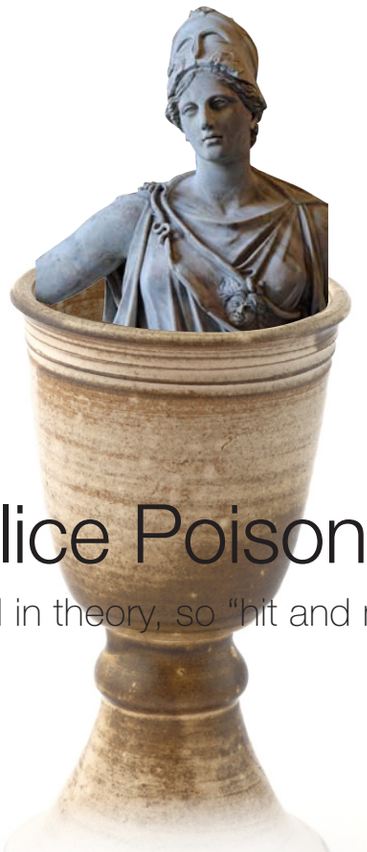
Supervisors and Trainers for SET Course
3 May, ASC Perth: 9.00-12.00, 12.30-3.30

The free SAT SET course has attracted very positive feedback from 1000 Fellows who have attended. Developed for supervisors and trainers, the 3-hour SAT SET course clarifies the roles and responsibilities within the Surgical Education and Training (SET) program and teaches you how to use workplace assessment tools, specifically the Mini-Clinical Evaluation Exercise (Mini-CEX) and the Directly Observed Procedural Skills (DOPS). You also explore management strategies for trainees and discuss legal issues associated with surgical training.

SET Selection Interviewer Training
3 May, ASC Perth, 1.00-3.00

Fellows involved in the SET selection interviews are encouraged to attend this revised 2 hour course to effectively prepare for their role as an interviewer. The activities and discussions focus on developing interview skills and explore the steps described by the FORCE acronym; Familiarise, Observe, Record, Classify and Evaluate. The legal and ethical issues pertaining to selection are also discussed. Please note that participants require their Specialty's nomination to attend.

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.



Chalice Poison'd

Mentoring – so good in theory, so "hit and miss" in practice

Professor U.R. Kidding

It has been a long day. I have arrived home and the household is asleep. For some reason I am in a reflective mood, not yet ready for sleep. Perhaps a glass of wine to aid both – reflection and sleep. Ah yes, a Curley Flat pinot, Australia's answer to those blasted Central "Otagians" - how do they keep producing exceptional pinots!

Glass 1

The day began with the Minister – he was in a reflective mood. Somewhat disconcerting, but at the same time comforting – at least I did not have to tactfully suggest that the latest wild scheme may not be achievable. But don't misunderstand - reflection is good, at least in moderation (excess is a sure sign of approaching dementia). Indeed, I am coming to realise in my role as a Surgical Director that reflection is the key ingredient for insight - and insight, or lack of it, is the major characteristic displayed by poor clinicians. More of that another time. Tonight, I am reflecting on my training – a long time ago, but in so many real ways, not so long ago. Of course these reflections have been stimulated by a letter from the University requesting that I set up a mentoring program within the Surgical Department.

Glass 2

Mentoring – so good in theory, so "hit and miss" in practice.

I had an "official" mentor when a student. He was an elderly physician; I decided to become a surgeon. Clearly a failure of the system and yet, during my training, I had "unofficial" mentors – surgeons whom I admired and wanted to emulate. These were men (and a woman) whose values I adopted and who have been supportive throughout my career. And indeed I have had mentees – now surgeons whose successes I take pride in and who have taught me more about myself than I might otherwise not have realised. Indeed, they have added a value to my career that tips the balance positively with regard to my career choice.

Glass 3
(good nose, good length this wine)

Of course, my parents ensured that mentoring would plague my life. Dear old Mr and Mrs Kidding – what were they thinking with my name Ulysses Reginald? Ulysses – a name made famous by the American Civil War General and eighteenth President of the United States, Ulysses S Grant, and by James Joyce's novel. Ulysses is also the Latinised version of Odysseus, the hero of Ancient Greece. When Ulysses left for the Trojan War, he left his son, Telemachus, in the care of his trusted friend, Mentor. The goddess Athena took the form of Mentor in order to develop Telemachus and help him reach his potential thus beginning a tradition and a new word in our language – mentoring. I wonder why she bothered with the disguise. I think she would have had my full attention without it! But then again, we would have had a different word – "athenering".

Glass 4
(this wine is getting better)

Mentoring is often confused with coaching. A mentor is meant to be wise and experienced whose major aim is to foster potential without a predetermined plan. He is meant to be supportive, communicative and help avoid pitfalls that others have fallen into. A non-judgmental debriefing agent – a wise friend. Someone who can reflect on their own experiences. Mentoring was viewed as a key component of the apprenticeship model of training, but has evolved so that one can have many mentors. I still catch up with my original surgical supervisor – still a mentor, but now much more. Come to think of it, he encouraged me to apply for this job! Well just goes to show that mentors aren't always correct.

Glass 5
(okay, I have opened a second bottle!)

Is formalising mentoring the way to go? It is clearly good for Trainees for support and for nourishing those clinical standards we wish to see endure. But it is hard to tell people to have an informal catch up. It really depends how they get on. Perhaps it is better to foster an environment where mentoring is encouraged. Clearly the senior person will have to be the one to go out of their way to open the door to dialogue and interaction. And being an effective mentor might require some training – didn't the College have a course for "would be" mentors. I will make a note to raise this with the Heads of Unit when next we meet. Strangely, I think they may need encouragement to initiate positive and rewarding discussions, to build social capital – did I say that? Social capital – that is "dark side speak", managerialism gone mad – did I say that also? Perhaps I am doomed – making up words, excessive reflection.... But I must remember them – the Minister does seem to like made up catchy words that somehow seem to mean something without actually meaning anything.

I wonder who the Curley Flat's winemaker's mentor was. I bet he was from Central Otago!

To be continued...

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Operative Management of Liver Trauma

A multidisciplinary course

ADVANCED CLINICAL SKILLS CENTRE

Auckland, 25 June 2010

Convened by:

Mr Jonathan Koea

The course is designed for general surgeons and theatre nursing staff and is designed to up skill both surgeon and theatre nurses in operative techniques for the management of severe liver trauma.

Ideally a surgeon attending will bring a member of the theatre nursing team.

For further information contact:
Administrator ACSC
Phone: +64 9 373 7599, ext 89304
Email: acscadmin@auckland.ac.nz

Registration

Registration fee, $1158.75, GST inclusive. Registration closes on 25 May 2010. A course manual and full catering are provided. Please register online at: www.acsc.auckland.ac.nz

Accommodation

Within walking distance or short taxi drive from the Centre & Auckland City Hospital.

Alpers Lodge **
Tel: 09-523 3367

Domain Lodge ****
Tel: 09-308 0161

Langham Hotel *****
Tel: 0800-616 261

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Open Hernia Repair

A Foundation Course

ADVANCED CLINICAL SKILLS CENTRE

Auckland, 28 June 2010

Convened by:

Mr Alf Deacon,
General Surgeon, Nelson.

The course is designed for SET Trainees and general surgeons wishing to update their knowledge on inguinal surgery, & will provide a thorough review of relevant anatomy & an in depth understanding of traditional & modern approaches to inguinal hernia repairs.

Topics include:

- Cadaveric dissection
- Surgical techniques by experts
- Surgery simulation in the Surgical Lab.

Registration

Registration fee, $1395.00, GST inclusive. Registration closes on 28 May 2010. A course manual and full catering are provided. Please register online at: www.acsc.auckland.ac.nz

If you require help in finding suitable accommodation please contact ACSC.

For further information contact: Administrator ACSC
Phone:
+64 9 373 7599, ext 89304
Email:
acscadmin@auckland.ac.nz

2010 professional development workshops

In 2010 the College is offering ***exciting new learning opportunities*** designed to support Fellows in many aspects of their professional lives. PD activities can assist you to strengthen your communication, business, leadership and management abilities.

Making Meetings More Effective
26 June, Melbourne

This whole day workshop helps you to understand the characteristics of effective meetings and develop a greater awareness of the roles and responsibilities of committee members. It also explores the latest problem solving strategies for making your meetings more productive.

Mastering Difficult Clinical Interactions
23 July, Wellington

Difficult people and situations are often the biggest stressors for healthcare professionals yet the responsibility of many clinical jobs makes these encounters unavoidable. This whole day workshop examines the cause of difficult interactions and presents a proven step-by-step approach for dealing with these situations. This master class is designed to give you confidence in handling difficult patient interactions and focus on finding effective solutions. You get to practise the specific communication skills required to avoid arguments in a safe, role-play environment with a trained actor.

Building Towards Retirement
30 July, Sydney

Work is an important part of life so when you stop full time surgery or are approaching retirement, you need to take time to plan for the next stage. It is crucial that as much thinking and planning are undertaken for life after surgery as was given to building your career in the first place. This full day program covers key issues including maintaining health and well-being, career options after surgery, superannuation and legal advice, community involvement, building relationships and networks. It provides an opportunity for Fellows and their partners to share experiences and plans for winding down from a full-time operating career.

From the Flight Deck: Improving Team Performance
30-31 July, Melbourne

This interactive 2-day workshop explores the lessons learnt from the aviation industry in relation to minimising errors, incidents and adverse outcomes and identifies how error analysis models can be applied to surgery. The program combines analysis of real airline accidents and medical incident case studies with group discussions. More importantly, you also have the rare opportunity to experience a full-motion training flight simulator – a chance not to be missed!

AMA Impairment Guidelines Level 4/5: Difficult Cases
19 August, Sydney/26 August, Melbourne

The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This new evening workshop provides surgeons with a forum to discuss their difficult cases, the problems they encountered and the steps they applied to satisfactorily resolve the issues.

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.

professional development workshops

DATES: APRIL – JULY 2010

ACT
29 June, Canberra
Supervisors and Trainers (SAT SET).

NSW
30 July, Sydney
Building Towards Retirement

QLD
21 July, Brisbane
SAT SET Course

SA
3 June, Adelaide
Supervisors and Trainers (SAT SET).
23 June, Adelaide
Practice Made Perfect.

VIC
20 April, Melbourne
Supervisors and Trainers (SAT SET).
27 May, Melbourne
Risk Management: Drafting a Consent.
18-20 June, Melbourne
Leadership in a Climate of Change.
26 June, Melbourne
Making Meetings More Effective.
30-31July, Melbourne
From the Flight Deck

WA
(please see page 13)

NZ
24 May, Wellington
Supervisors and Trainers (SAT SET).
23 July, Wellington
Mastering Difficult Clinical Interactions

Digital Diagnostic Imaging Guidelines

The guidelines provide recommendations on the delivery of access and viewing of diagnostic quality digital images for clinicians

Michael Grigg
Chair, Professional Standards Committee

In 2008, the College hosted a Digital Diagnostic Imaging Forum which was attended by a wide range of stakeholders. Participants included the Royal Australian and New Zealand College of Radiologists (RANZCR), the Australian Medical Association (AMA) and the Commonwealth Department of Health and Ageing (DoHA).

Forum participants discussed practical solutions for managing the transition to digital imaging. It was agreed that tackling the difficulties involved in a transition to digital imaging is a dilemma which needs to be addressed by all levels of government, hospitals and clinicians. A Consensus Statement on managing the transition to digital diagnostic imaging was a drafted as a result of the forum.

One of the results of the forum was the formation of the Digital Imaging College Working Party. The working party was multidisciplinary and included representatives from RANZCR, the AMA, the Australian Diagnostic Imaging Association (ADIA), the Spine Society Australia, the Australian Private Hospitals Association (APHA) and Fellows from various specialities. The working party's goal was to develop a set of guidelines to facilitate a successful transition to digital imaging for all clinicians, with the parallel aim of ensuring that patient care and turnaround times were not compromised. I would like to take this opportunity to sincerely thank all of the participating Fellows and organisations for their input and efforts, particularly Bernard Bourke who chaired the working party.

The College recently published the Digital Diagnostic Imaging Guidelines, which outline recommendations on the delivery of, access to and viewing of diagnostic quality digital images for clinicians. The guidelines provide the technical information necessary for progression to digital diagnostic imaging, and enable clinicians to choose the most suitable digital imaging hardware and software for their practice. The guidelines are a useful reference for surgeons, doctors, hospital administrators and governments.

The guidelines are available on the College website at www.surgeons.org/dirwp

Ear disease in Far North Queensland

Dr Vibhuti Mahanta was awarded the best paper on ENT services Far North Queensland

Richard Turner
NASN Project Leader

The annual Northern Australia Surgeons Network (NASN) Conference was held in Cairns, 27 – 29 November 2009 and was proudly supported by the Support Scheme for Rural Surgeons (SSRS). As well as providing an excellent networking opportunity for often isolated surgeons, it also served to showcase various research and clinical activities taking place in regional locations.

A panel of judges awarded the best free paper to Dr Vibhuti Mahanta for his presentation titled 'The Impact Of Ear Nose and Throat (ENT) Specialist Services In Improving Ear Health Within Aboriginal And Torres Strait Islander Communities Across Far North Queensland', which he co-authored with Dr Conroy Howson, Dr Philip Jumeau and Ms Tammy Statendan.

Otitis media is a major health problem in Australian Aboriginal and Torres Strait Islander communities and may well impact negatively on their health, education and employment outcomes. As per WHO, a prevalence rate of chronic otitis media above four per cent is a public health emergency requiring urgent attention, and unfortunately our aboriginal children definitely fall into this crisis situation with various prevalence rates reported between 10 – 68 per cent.

Two crucial factors in the pathogenesis of otitis media are Eustachian tube dysfunction and adenoids acting as a reservoir of infection in the post nasal space. Other extrinsic factors such as overcrowding, passive smoking, seasonal variation, poor hygiene certainly play important roles.

Otitis media is common in indigenous communities possibly due to certain peculiarities in the pathogenesis of otitis media in this sub-group which are:

- Colonisation of the nasopharynx by multiple bacterial species and subtypes resulting in persistent disease
- Early onset in infancy with reduced capacity to recover
- Indolent type of otitis media without significant otalgia

The early and persistent colonisation of the nasopharynx results in continuous vicious cycle of cross infection in the community. Due to the high prevalence rate, access to specialist services is urgently required to reduce the incidence of ear disease and hearing loss during the stage of language acquisition in these children.

Funding was available to Cairns Base Hospital in 2005 for the ENT outreach services to supplement and complement the existing remote Primary Health Care facilities across Far North Queensland. Since then two trips are made every year to each of the hospitals at Thursday Island, Cooktown and Weipa with an endeavour to improve ear health. A multidisciplinary team made up of ENT surgeons, anaesthetists, nurses, an audiologist and an Aboriginal health worker travel to these remote hospitals providing outpatients, surgical intervention and education to the staff and the community.

The surgical procedures performed are:

- Myringotomy and ventilation tube insertion (MVTI)
- Adenoidectomy and ventilation tube insertion
- Adenoidectomy
- Myringoplasty

So far 1284 patients have been consulted and about 208 surgical procedures were carried out.

Results of operative procedures are:

- Adenoidectomy and MVTI: More than 75 per cent of patients undergoing MVTI alone had ear discharge as a cumbersome complication, whereas postoperative ear discharge following combination of MVTI and adenoidectomy was 28 per cent.
- Myringoplasty: Various graft techniques were used for closure of the tympanic membrane including temporalis fascia, tragal perichondrium, composite graft (tragal cartilage with a layer of perichondrium) and butterfly graft (tragal cartilage with perichondrium on each side). Butterfly myringoplasty was least successful (33.3 per cent) whereas 69.2 per cent of myringoplasties using composite graft (perichondrium and cartilage) and 64.7 per cent using temporalis fascia were successful.

The salient features of our outreach services are:

- Only 11.7 per cent of the ENT consultations were offered surgery. Screening needs more emphasis and streamlining coupled with community education. This may be facilitated by introduction of specialist ENT nurse practitioners in these communities.
- The overall success rate of our myringoplasty was 56 per cent with composite graft and temporalis fascia graft being the most successful (69.2 per cent and 64.7 per cent). The challenge ahead is to improve the outcome in the indigenous group.
- The combination of adenoidectomy with MVTI as a primary procedure resulted in reduced incidence of post operative aural discharge when compared with MVTI alone (28 per cent vs. 76 per cent). Would this be an ideal primary procedure in children with recurrent otitis media or otitis media with effusion in these communities? The answer to this question is still controversial and needs further clinical trials and research.
- Most of the data collected during the outreach was manual and a better framework and collection technique are needed to reflect prevalence and incidence of ear disease prior to and after the ENT intervention phase.

Due to the extremely high prevalence of otitis media and a distinct aboriginal pathological model, the communities of Far North Queensland need timely specialist intervention and audiological rehabilitation to improve hearing at the stage of language acquisition. More emphasis is required on preventive strategies and interventions to improve poor socio-economic conditions like improving housing, education and, possibly in the future, the introduction of a vaccine.

Until then, the journey will continue through Cape York Peninsular and Torres Strait to alienate the burden of ear disease in these communities.

Code of Conduct Breaches Policy

Any potential breaches of the Code will be dealt with quickly and fairly

Michael Grigg
Chair, Professional Standards Committee

In October 2009 Council approved a policy which outlines the ways in which the College deals with potential breaches of the College Code of Conduct. This was developed to support the position paper on surgeons' and Trainees' interactions with the medical industry, and the broader College Code of Conduct. The policy also addresses complaints about Trainees and international medical graduates. For a complaint to be entertained, it must be in writing and not be anonymous.

The process is:

- A written complaint is submitted to the office of the Chief Executive Officer (CEO)
- If the complaint involves a serious allegation of misconduct, particularly if patient safety is at risk, it is referred to the relevant Medical Board or Medical Registration Authority
- If the complaint does not involve a direct threat to patients, it may be handled and investigated through the Office of the Executive Director of Surgical Affairs (EDSA). The Fellow, International Medical Graduate or Trainee is invited to respond to any such complaint
- No further action is required if the CEO and EDSA are satisfied with the response
- If the complaint is substantiated then the following course of action is undertaken.

If the person in question is a Fellow, he/she may be asked to complete a Statutory Declaration indicating acknowledgement of the Code of Conduct and undertaking to comply with the Code. If a Fellow refuses to complete a Statutory Declaration, the CEO and EDSA will recommend to Council that Fellowship be rescinded.

Under certain circumstances, the College may require a Fellow to stand down from any College appointments and positions (including as a member of any committee, a course instructor, a College supervisor or mentor, or any other College role or position). Such 'stand downs' will not be construed in any way to be indicative of guilt and in no way should prejudice the relevant investigation/review. Stand downs shall remain in place until all appeal processes have been exhausted. Following completion of the investigation/review, the Fellow may be entitled to resume all previously held positions and appointments.

If a further complaint is received about a Fellow who has completed a Statutory Declaration, it is again considered by the CEO and EDSA. If they believe there is substance to the complaint, the complaint is referred to the Professional Conduct Committee.

This Professional Conduct Committee is chaired by the President (or Vice President), and membership includes the Chair (or Deputy Chair) Professional Development and Standards Board, two other Councillors, one member of the Appeals Committee who is not a Fellow and other members deemed appropriate by the Chair. Committee members must have no conflict of interest regarding the surgeon or the matter involved.

If the Professional Conduct Committee determines that extraordinary circumstances exist, it has the power to confirm the ongoing Statutory Declaration. If there are no such circumstances, the Committee may recommend to Council that the Fellowship be rescinded. Only Council has the power to rescind a Fellowship.

Any potential breaches of the Code of Conduct will be dealt with quickly, fairly and consistently.

The Code of Conduct Breaches Policy demonstrably strengthens the College contention that it is seriously involved with standards and will enhance the professional status of Fellows.

Any comments please direct to Michael Grigg on mjgrigg@bigpond.net.au

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Dr Max Baumwol, General Surgeon and MDA National Council Member

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MDA National
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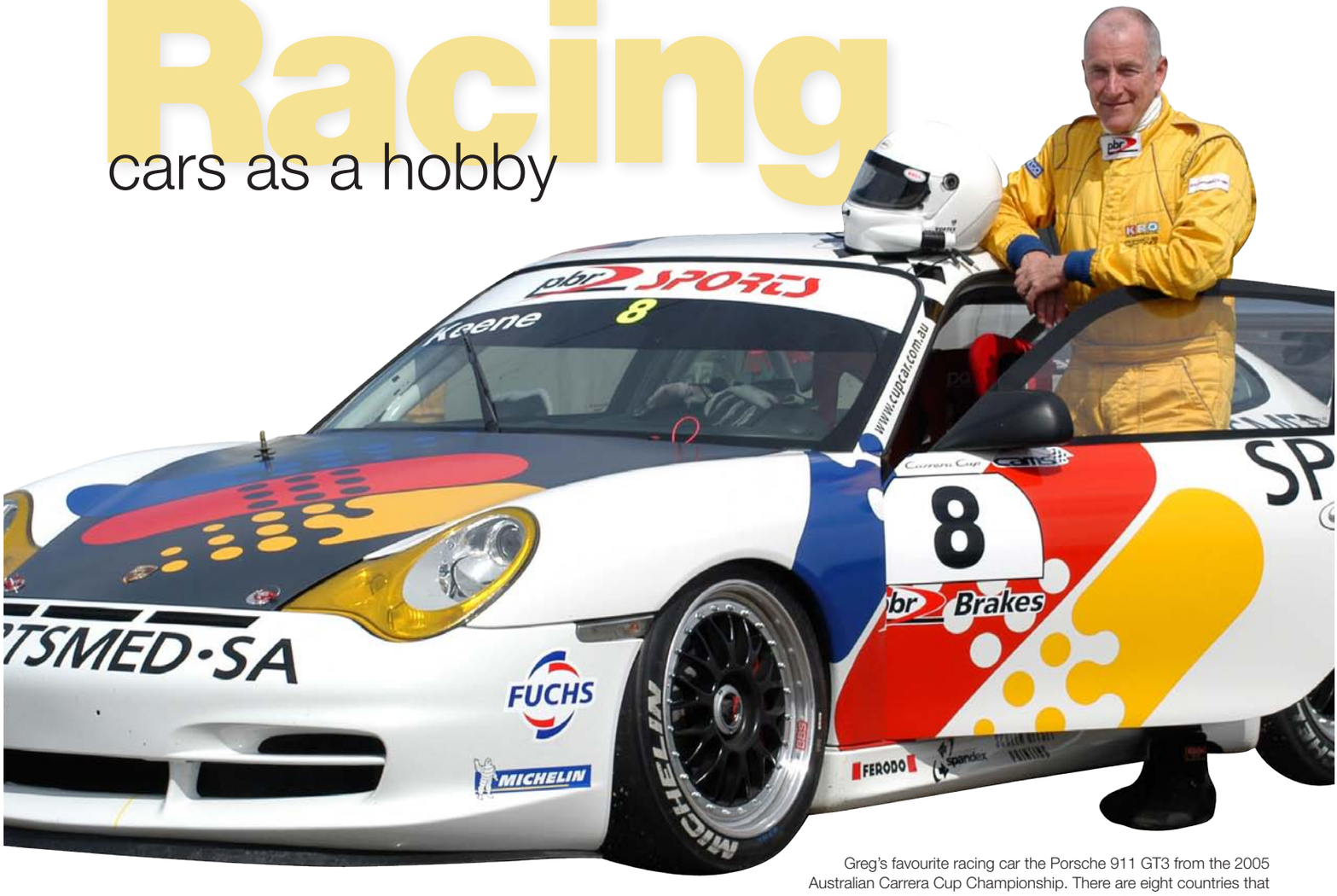
Racing
cars as a hobby



Greg's favourite racing car the Porsche 911 GT3 from the 2005 Australian Carrera Cup Championship. There are eight countries that run such a Championship, all running identical factory built cars.

Greg Keene has found many similarities in doing endoscopic surgery and driving at a high speed

Mr Greg Keene, a director and former joint managing director of Sportsmed SA, said his late father once told him that when he was only five years old he announced his lofty intention to become either a doctor or a racing car driver.

Then, in primary school a burgeoning love of carpentry muddied the waters of his scheme somewhat until that was resolved later via the decision to become an orthopaedic surgeon. And much later still, having established his successful practice, the dream of the boy became the achievement of the man when Mr Keene found the time and the money to take to the race track. Now he has been racing on the national circuit for 15 years.

"It took a long time to make it happen which is probably one of the reasons I find it such great fun. We were not a particularly wealthy family when I was growing up but I loved the sport so much I used to collect coke bottles to pay for my entry tickets and I'd ride 10 kilometres to Rowley Park Speedway," he said.

"When you come from a background like that you don't think you'll ever get the chance to race and that you'll always be the spectator not the competitor so I relish every minute I can get on the circuit."

Mr Keene, a knee specialist, said he began racing in earnest in 1995 after having won a Go-Cart race at the 1994 Australian Grand Prix.

Since then he has competed in the Australian Porsche Cup, Nations Cup and Carrera Cup Championships, and currently in a Porsche in the Touring Car Masters Championship and in an open-cockpit West sports car as part of the Supersports Racer series.

Two years ago he won the Dutton National Tarmac Spring Rally Championship but says his greatest personal achievement was beating his "hero" Jim Richards in a Grand Prix Rally in 2001.

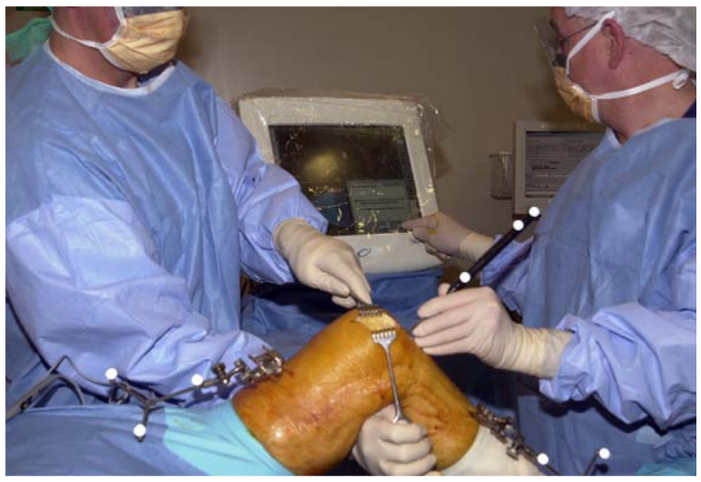
"That felt wonderful. Jim Richards is 'Mr Motorsport' in Australia which means that very few people have the experience of beating him," Mr Keene said.

"My second most satisfying achievement was winning a rally with my 16-year-old daughter Katie as navigator in the Three Peaks Rally in Victoria. That was great fun for a dad, particularly given that she had never done it before."

Mr Keene said that when he first decided to go hurtling around racetracks at speeds of more than 200km/h he took lessons from professional racing car drivers and bought his first racing Porsche for the quality of the engineering.

"Because I began at 40 years of age, it was clear that I could never be as good as someone who started at 15 so I flew to Sydney and Melbourne if there was someone available to coach me and help improve my skills," he said.

"While my number one love, apart from my family, is knee surgery, racing does come a very close second."



Right: Greg was on the design teams for both the partial replacement and the Computer Assisted Surgery technology.

Greg currently races this car in the Touring Car Masters series which runs as a support race to the V8 SuperCar series. It runs at tracks all over Australia.

The West SuperSports is a new series that Greg and his wife have joined this year.

"And I decided to race in a Porsche because even though traditionally they have been considered hard to drive they are reliable which makes them cheaper to maintain and I'd prefer to be surrounded by German steel than driving around in a less solid vehicle."

Now the boy who once collected the coke bottles, competes in a 1973 Racing Porsche 911 RS, a 2001 Rally and Racing Porsche 911 GT2 and a Cayman S for sprint racing and tarmac rallies. Mr Keene said he found a great many similarities in doing endoscopic surgery and driving at high speed.

"In the car your feet, hands and eyes are all focussed on different aspects of the task," he said.

"That's exactly the same as doing arthroscopic surgery with the foot controls, the left hand and right hand doing different things while I'm looking at the screen like I'd be looking down the road in the car.

"It requires precise psychomotor co-ordination, the independent co-ordination of four limbs while looking somewhere else and both involve the need for fast decision-making that can have important consequences. Since I took up the sport, I have never been sure if driving improves my surgical skills or if my surgical skills improve my driving."

Mr Keene said that despite his years working in the field of sports injuries, the dangers of the sport were sufficient to keep him alert but not enough to dampen his enthusiasm.

"If you take up car racing you have to accept two realities. You could have a big accident and write off the car or you could be injured or killed. If you don't accept that you're a bit foolish but if you're crippled by the fear of that you shouldn't be out on the track," he said.

"In 150 national-level races I have only ever suffered a sore neck when I was punted into the wall head-on at 100km an hour at Bathurst."

Mr Keene said one of the great delights of his motorsports career had been the chance to race with his wife Amanda Sparks.

"Hasn't she got a great name for a lady racer?" he laughed.

"Our mutual interest makes for great fun.

"Sometimes I race and she's my mechanic, then we reverse the roles and she takes to the track and I am her mechanic. In the Supersports Series, where we rent the open cockpit cars, we compete against each other which is very interesting!.

"I beat her the last time but only just."

While it is hard to imagine car racing as a relaxing way to spend time, Mr Keene said that to him it was just that.

"We go away for a weekend racing and I don't think about medicine. It might sound odd but I find it relaxing and refreshing. While my number one love, apart from my family, is knee surgery, racing does come a very close second. It's an enormous amount of fun and a huge adrenaline rush – that's what it's all about," he said.

There must be something about the atmosphere in the Sportsmed SA rooms that drives a hunger for competitive sport for Mr Keene's fellow director, Mr Andrew Saies, made history in January when he skippered his yacht Two True to victory in the Sydney to Hobart race.

His handicap win, to take home the coveted Tattersall's Cup, was just the fourth time a South Australian boat had triumphed in what is one of the world's greatest ocean races.

"We've both got a great love of sport and a desire to improve and do well," Mr Keene said.

"That's what we've done in our business and in our sports though I can say that while I've been out on his boat, he hasn't yet had the courage to get into my car."

Child with repaired bilateral cleft lip

Photo of a young girl in a remote village taken 18 months previously

Healing Timor

Dealing with the people is the highlight for us; they are the moments that we enjoy

When respected surgical philanthropist and plastic surgeon Mr John Hargrave first began his medical aid missions to East Timor, he was not only one of the few outsiders to find a way in to the politically isolated country, but one of few surgeons willing to brave the dangers of social unrest to treat those in need.

The East Timorese, then under Indonesian control, were wary of strangers, yet over time, through the consistency of his visits and his determination to assist the local population, Mr Hargrave built a relationship of trust and welcome with some of the most disadvantaged people in the world.

In those early years, Mr Hargrave worked under the banner of, and with funding from, the charitable organisation he established called the Australian South East Asia Rehabilitation Service. Then upon his retirement in 1999, the program was renamed the Overseas Specialist Surgical Association of Australia (OSSAA) and the reins were handed to South Australian plastic surgeon Mr Mark Moore.

This year marks the 10 year anniversary of that hand-over, when Mr Moore, Sr Margaret Flemming and Mr Hargrave signed an agreement with the International Committee of the Red Cross to provide plastic surgical services to Dili National Hospital. Funding for the work that is now done in both East and West Timor and Flores is provided through the College co-ordinated Australian and Timor Leste program of Assistance for Specialist Services (ATLASS) with attached funding from AusAid and through private donations given to OSSAA.

“Dr Ximenes has very good technical skills and is himself a living symbol of East Timor’s recent history having lived in the mountains as a young boy following the Indonesian takeover.”

Above: Dr Joao Ximenes and Mr Mateus (theatre nurse) performing a cleft lip repar. Right: Dr Joao Ximenes, Mr Bernardo, Dr Mark Moore and Dr David Sainsbury at Los Palos clinic

“When I first went to East Timor with John Hargrave it was clear how valued he was by the people, not only for his surgical skills, but for the consistency of his visits and his care,” Mr Moore said.

“The country had gone through such great upheaval in the years since he began visiting with the Dili Hospital, for instance, starting out under Indonesian control, then passing to the International Committee of the Red Cross, to various Non-Government Organisations, to a United Nations structure to finally now being run by the East Timorese government.

“We remain one of the most consistent services to visit East Timor and that means we have been able to build a system in which people have come to know what skills and services we can offer.

“At the beginning, people brought in children with colds or polio or cerebral palsy because they were desperate for whatever help they could get, but over time they came to understand what conditions and injuries we could treat and when we could do it.

“With such monumental change in their recent history it’s understandable that consistency has been the key to establishing the necessary relationships to allow us to help the people we can help as effectively as possible.”

Since that hand-over 10 years ago, Mr Moore has undertaken 27 clinical visits to the region, conducted more than 2,500 consultations and performed 981 surgical procedures including 540 cleft lip and palate surgeries and 160 operations to treat burn contractures.

In the past year, the program has taken another crucial step in its development with the decision to train an East Timorese general surgical trainee in cleft surgery.

“Some time ago a few of us involved in OSSAA sat down to discuss what we could do to get more of this work done in our absence and we came up with the idea of following the model of the eye teams who visit the region who train people to do cataract surgery,” Mr Moore said.

“We agreed that we should come up with a variation on that in terms of training a local general surgeon to perform cleft lip and palate repair. Dr Joao Ximenes was identified by the resident team as the ideal person for this, so we got to work.”

Dr Ximenes’ formal training commenced in March last year and since then he has accompanied and worked with plastic surgical teams on three visits to Timor Leste (funded by AusAID) and one visit to West Timor (funded by OSSAA).

“Dr Ximenes has now performed 20 unilateral cleft repairs in that year, the last four cases as surgeon with me there watching, but not scrubbed,” Mr Moore said.

“He has also assumed control of post operative management and follow-up and we hope soon for him to start performing such surgery when the team is not available and to gradually increase his range of surgical procedures over the next two years.

“This is a very pleasing development because there are so many people in need of this surgery in the region, yet it can take a generation for a country to produce the specialists needed so we felt that if there was a way to speed this up in one area of urgent need that would be most worthwhile.

“Dr Ximenes has very good technical skills and is himself a living symbol of East Timor’s recent history having lived in the mountains as a young boy following the Indonesian takeover.”

The program managed by the College will continue to fund Dr Ximenes to go to Australia and other appropriate countries for short-term training attachments over the next few years.

Mr Moore who works out of the Women’s and Children’s Hospital in Adelaide and the Royal Adelaide Hospital, said working in the region remained, even after so many visits over the past ten years, a pleasure and a privilege. He enjoys the camaraderie that has grown over time within the core group of team volunteers including other surgeons, anaesthetists and nurses as well as the opportunity to experience such a vastly different way of life as that lived by the people of East and West Timor.

“There is a hospital on the east end of Flores which is run by nuns and that has been there for 70 years, which is not only the cleanest and best run hospital in the region, but a little paradise in the middle of nowhere,” he said.

“We started working there last year, again through the generosity of the couple from the UK, and it was a marvellous experience. There is a nursing school attached to the hospital with the nurses wearing their starched white uniforms and caps and it was like stepping back in time.

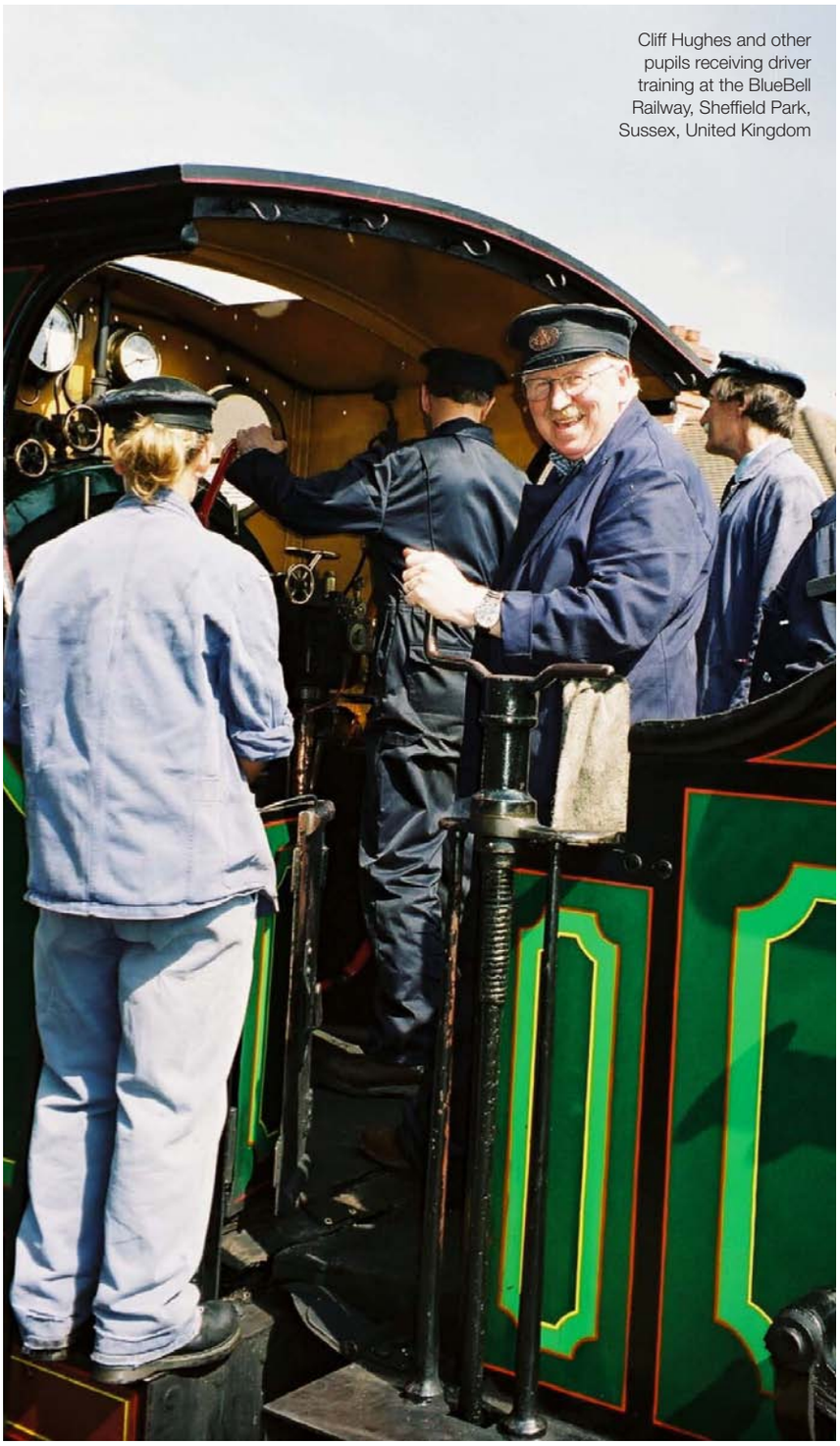
“The entire region is quite beautiful and most of us who attend these visits have fallen into a pattern of going for a walk in the early morning through the streets and markets, absorbing local life.

“I take photographs and on one recent visit I took a beautiful photo of a girl in a paddy field and on my last visit in March I took it back, went back to the same area and showed it to the people I met. Everyone knew her and ran off to find her and she was delighted when I gave it to her.

“Dealing with the people is the highlight for us; they are the moments that we enjoy and even help ease the burden of seeing people in great need that we have only a limited capacity to help.”

Passionate for promoting change

Promoting quality care for patients and improving the lives of surgeons remain at the heart of Cliff Hughes' professional interests



Cliff Hughes and other pupils receiving driver training at the BlueBell Railway, Sheffield Park, Sussex, United Kingdom

Professor Cliff Hughes, former cardiothoracic surgeon and current chief executive officer of NSW's Clinical Excellence Commission (CEC), says his father gave him two pieces of advice as a boy that have guided him well throughout his life. The first: When you argue with a fool, make sure they are not doing the same. The second: Any fool can learn from their own mistakes, but a wise person learns from the mistakes of others, and a great person explains their own mistakes to ensure they are not repeated.

Professor Hughes says it was the latter guidance from his father that tipped the balance when he was asked five years ago to take on the leadership role of the CEC, the first such organisation of its kind in Australia.

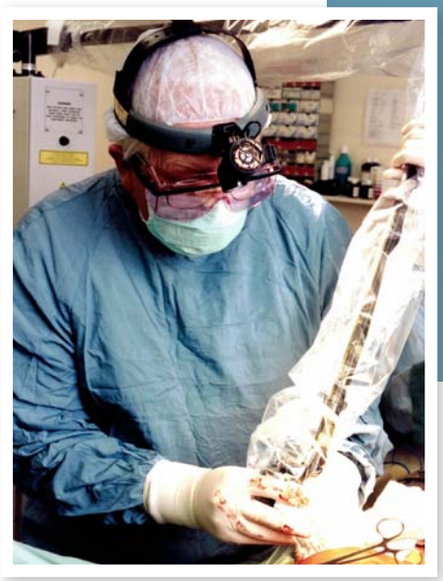
"I have always loved my surgery and was asked to take on the role when on my way into theatre actually, so at the time I didn't give it much thought. But over the following days I came to think that it might be time to put down my scalpel and pick up a pen because I believed the work of such a commission to be both important and necessary and I have never regretted that choice," he says.

The former lay president of the Baptist Churches of New South Wales and Canberra, the current chair of a charity that works with the poor and homeless of Sydney, a committed committee-man at the College and a lifelong steam train buff, Professor Hughes describes his life, both inside and outside the operating theatre, as rich in its variety.

Yet promoting quality care for patients and improving the lives of surgeons remain at the heart of his professional interests. Having recently committed himself to another five years at the helm of the CEC, Professor Hughes places the effective use of blood products and improvements in hygiene at the top of the list of the organisation's achievements since its inception.

"Our research, which formed the basis of an information campaign about the use of blood transfusion in elective non-bleeding patients, has reduced the wastage of blood products in NSW by eight per cent. This is a great outcome that has not only improved patient care, but boosted the supply of blood products for those that need them," he says.

"We have also designed and run an effective hand hygiene program and audit in which alcohol-based hand rubs are available to all health professionals close to every patient and already we have seen indications of a reduction in the incidence of blood-stream infections.



"We have also been working with the Intensive Care Units across the state to design and introduce an evidence-based bundle of care programs aimed at reducing incidences of central-line-associated bacteriema. This involves guidance on the wearing of gloves, hats, gowns and masks and prescribed insertion techniques. Already we have reduced the problem from four in 1000 line days to one in 1000."

Professor Hughes says the CEC also runs a leadership training program for doctors, nurses and allied health professionals to help bridge the growing divide between hospital administration and medical staff while also giving them skills to better manage their units, practices and staff. And lastly he cites the development of the Incident Information Management System on the CEC's list of achievements.

"This reporting system allows any staff in any hospital to make a report of an issue of concern and we are now receiving 17,000 reports per month. The vast majority, around 94 per cent, are incidents that have caused no residual harm or are a 'near-miss' with only half of one per cent causing a serious outcome," he says.

"This data gives us a tremendous understanding of the overall standard of quality of health care in NSW with the information provided both to the health system and the public every six months. It also identifies critical issues which become the subject of Clinical Focus Reports, advised and written by expert clinicians and made widely available to all health staff."

Yet while it is clear that Professor Hughes places the work of the CEC at the heart of his current professional endeavours, it is of a piece with his lifelong commitment to improve and enrich the lives of others. Within the College he is a member of the International Committee and the Project China Committee and is co-facilitator for the College leadership course with the University of New England.

Outside, he is Chair of the Board of Hopestreet Urban Compassion, a church-based ministry to the homeless and disadvantaged based in the Sydney suburbs of Woolloomooloo, Darlinghurst and Glebe.

The charity provides a refuge and support for street workers, short-term accommodation and support for homeless men, an employment training program, homework assistance programs and support for problem gamblers, while also running a restaurant in Darlinghurst that has become a hit in the local community.

"The restaurant is called Table for Twenty and that's exactly what it is, with people sitting at large tables as a way to make friends, to connect with their community and it's very hard to get a booking now," he says.

Professor Hughes says Hopestreet had grown since the church renewed its focus on outreach and the care of the disadvantaged in recent years.

"In 1987 I became the lay President of the Baptist Churches of NSW and the Australian Capital Territory and as I travelled around I came across these services which were more fragmented then, and came to believe they deserved the utmost support," he says.

"At that time we were also focussed on two central pressing issues – aboriginal reconciliation and the recognition of the rights of women in ministry. Very soon after my time as president we ordained the first female pastor of a Baptist church in NSW, which was groundbreaking stuff and something of which I am honoured to be associated."

Professor Hughes says he has never felt a tension between his spirituality and surgery, but rather that his commitment to both has enriched both.

"The two to me are part and parcel of the same thing, a focus on reaching out to others and in both cases, whether it be a patient in theatre or a homeless man at one of our refuges, I always think there, but for the grace of God go I, so that whoever is in need has my entire focus," he says.

"Yet all of this enriches me and I have the great good fortune of living a full and interesting life with tremendous support from my wife, Elizabeth, our three children, their spouses and to our great delight five grandchildren."

Professor Hughes also took something else from his father's influence along with the advice; a passion for steam trains that grew from listening to his father's stories of life on the railways as a fitter and turner.

He is now in the process of building a new model stream train layout in his back shed, replicating stations near Birmingham in the UK where he has driven full-size heritage steam locomotives.

This hobby, which he says has given him hours of calm enjoyment, does not mean that he is a slave to the past. On the contrary, he is passion about the promotion of change including change to improve patient outcomes and change to make the lives of surgeons more rewarding, more sustainable and more enjoyable.

As part of this, he was a member of the College's Safe Hours Project and says surgeons should think about the merits of group practice over the stress of individual endeavour.

"When I first came back to Australia after working overseas, I joined a group cardiothoracic practice that has worked wonderfully well for over 35 years, but which many of our colleagues said could never last," he says.

"There has already been some recognition that the old ways of working were flawed, like operating in the middle of the night when not absolutely necessary, yet still there is more that can be done to allow surgeons more time for relaxation and more opportunity for family life in whichever form that family takes.

"Group practice is part of this in my mind; it is a nourishing way to work, it provides support to the individual as a person and professional, it spreads the stress and multiplies the problem solving and I'd advise all surgeons to give this way of working some deep consideration."

What's on for Trainees at the 2010 Perth ASC?

Tuesday night is the Younger Fellows' and Trainees' Dinner on the Crystal Swan

Mary Theophilus
Section convener, Trainees program &

Matthew Peters
Past Chair, RACSTA

The 2010 Perth Annual Scientific Congress, running from the 3 to the 7 of 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. Master-classes 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 called Developing a Career in Academic Surgery on Monday, May 3, with the Association of Academic Surgeons from the United States. This will provide Trainees (and Fellows) with the necessary insight into starting an academic surgery career.

Commencing at 12.30pm on Tuesday is the Trainees' forum. Panel discussions concerning flexible training, and modern communication strategies and technological advancements in surgery occupy the lunchtime session. The 2010 John Corboy Medal recipient will then provide the inaugural John Corboy Medal lecture. The keenly awaited result of the RACSTA Working Hours Survey, completed recently by the majority of Trainees is scheduled to follow. How much Trainees are working, the presence of fatigue in Australia and New Zealand, and the balance required to train, learn and live will be presented.

The Cyrstal Swan

Robust discussion is expected. Spirited debates on safe working hours, the future of training, and training in the private sector close out the afternoon. The audience will have a chance to have their say and vote with the use of the College's new polling units.

Scheduled for Tuesday night is the Younger Fellows' and Trainees' Dinner on the Crystal Swan. Renowned for its amazing food, service and views of the Swan River by night, this venue provides a changing backdrop for what should be a truly memorable night. A diverse entertainment program has been finalised, with entertaining speakers, music and table performers.

As usual there will be an after party to head on to for the really hard-core party goers! With the generous support of Johnson and Johnson (gold sponsors), Baxter Healthcare (silver sponsor) and Avant (bronze sponsor), this night will be awesome. Please register for this event ASAP – tickets are capped, with every previous year selling out well before the night.

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

On Thursday the 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.

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

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Tasmanian News

Changing policy has not been as easy with a very strong and extremely well staffed Department of

Greg Harvey
Chair, Tasmanian Regional Committee

As I sit down to write my first report for *Surgical News* I find my mind filled with ideas I wish to pen. The result may well end up as a disorganised mess, but I hope that with proof reading some sense may come of this.

Before I comment on our State issues for surgery, I would like to tell you something of myself. I am a New Zealand and an Australian citizen schooled in both countries. I completed my medical degree at the University of Melbourne and trained as an orthopedic surgeon in Victoria and Tasmania, completing my Fellowship in 2002.

I moved to Hobart as soon as I was qualified, having fallen in love with this city over many years of travel here. I am involved in both private and public practice. I spend two half days a week at the Royal Hobart Hospital to assist in the training of our future workforce and to provide a public service to the community. I have five children aged from two to 13 and my wife and I have recently started a trampoline club in Hobart.

I was able to join the State Committee four years ago and was involved with the Younger Fellows Committee for a year also. With the retirement of Hung Nguyen, I accepted the Chair late last year. The task in Tasmania is not an onerous one. Very little happens on a political level in such a small state. Access to the Minister of Health has been easy while Lara Giddings has been in politics. Changing policy has not been as easy with a very strong and extremely well staffed Department of Health and Human Services.

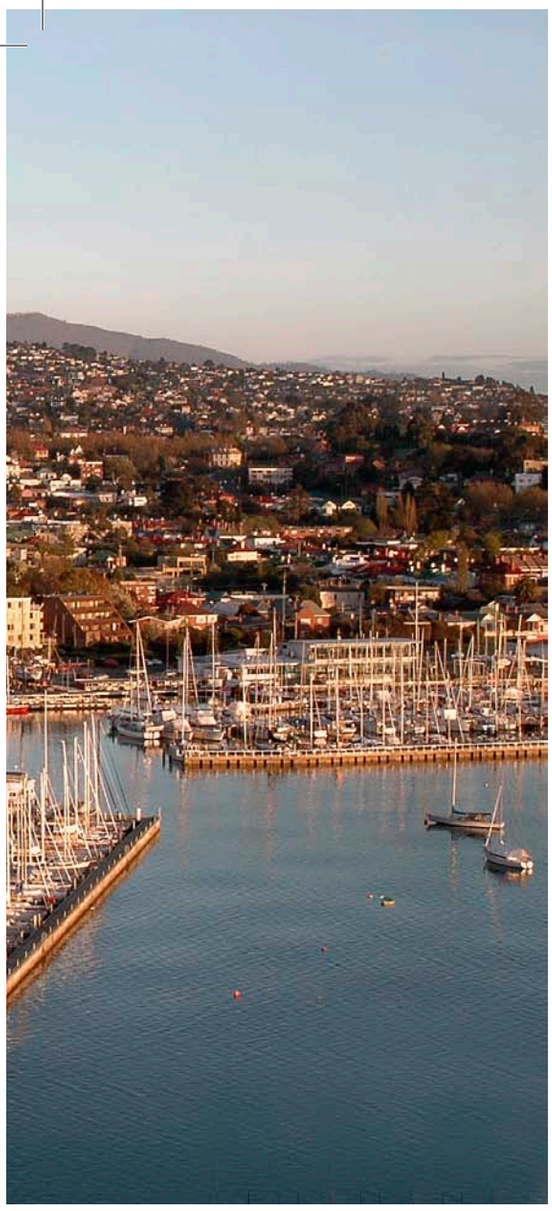
We have been in election mode here in Tasmania. We went to the polls on March 20 and we have been bombarded with promises. Health was a pivotal issue in the election once again. Our Prime Minister is on nightly extolling the commitment of Labor to Public Health and that a vote for State Labor is a vote for Australia's health care future.

I had planned to write a satirical or cynical overview of our three major party's policies with regard to public health. I then felt this would be a waste of time to do and a waste of your time to read, as it is the same every election in every state comprising a mixture of the blame game and unrealistic promises for the future.

However, I would like to highlight some local issues

Over the last year the people of Tasmania were promised a new hospital in Hobart. The current hospital is in a serious state of disrepair structurally. A year of planning and consultation for a new hospital on a new site saw millions of dollars wasted as the cost of the project became apparent and under the convenient timing of the world economic crisis, all plans were shelved.

The political bun fight then started in ear-



Health and Human Services

nest with more momentum given the recent election. We were since promised a new hospital on the same site, but consultation will have to start again. In the meantime I work in an outpatient clinic with a roof that is falling in and walls that have not been painted in ten years. We also use laptops cabled to benches as the plans to install desktop units with large screens - promised the year before last - has not occurred yet.

I am sure this is a story repeated Australia-wide by the majority of surgeons who still give time to an ailing public sector.

In a recent election announcement, our premier planned to 'take back' the Hobart Private Hospital and create a Public Women's and Children's Hospital. This was despite a 20 year contract for Healthscope to use the building and despite redeveloping the old hospital DEM into a new pediatric clinic at a cost of millions. This was reputedly to show the State Labor Government's commitment to "Public Health". I understand the plan was dependent upon Federal Funding which I understand is dependent upon other promises and plans coming to fruition in the country.

I would like to challenge the "Public Health" benefits of this plan. The Hobart Private Hospital treats thousands of people in Hobart each year, I understand over 10,000 surgical procedures are performed there each year. It has a busy cardiology unit. It has a busy medical unit. How would the removal of this service be in the interests of "Public Health"? Are the people who take it upon themselves to make the necessary sacrifices to pay health insurance not part of the "Public Health"? Should we really be talking about the State Health Service and the lack of service provision within the State Managed facilities rather than use the term public health?

It is not hard to predict what will happen if this hospital is taken back as part of the Royal Hobart Hospital. The office space will expand as there are no longer enough offices in the Royal for the administrative staff there. Bed numbers will have to decrease as there are not enough nurses employed in the Royal to staff currently empty beds. Theatres will not be used as there are currently not enough nurses employed in clinical roles at the Royal Hobart Hospital to run the nine operating theatres available in the operating suite.

I believe it is time the College took a stance to protect private practice and surgery for the good of the people of Australia. Without this service, many more thousands of Australians would not get health care. We know the facts with more than 50 per cent of surgery occurring in the private sector. This is due to the poorer performance of increasingly expensive public hospitals and the more efficient practice of private hospitals and their surgeons. I have elected to add a section to our State Meeting to discuss private surgery and the needs of its surgeons. Not surprisingly there was only one small concern about the purchase of cutting edge technology in one of our state private hospitals. This was far out-shadowed by the continued laments about the provision of services in the state run public hospitals.

Another "Promise" made by our State Liberals was that all people on the public hospital waiting list for elective surgery would get their treatment in a private hospital and not have to wait more than six months. I believe it has been funded to five million a year over two years to fix the problem.

I know of no contact made to a surgical unit to ask the true extent of the problem. I know of no surgeon in private practice who has been approached to ask if they are able or willing to assist in this plan. Those of us who have given our time to public surgery at the Royal Hobart Hospital have also not been consulted on this plan. I expect none of my colleagues in the State have been asked either. If we had been it would have been possible to set the politicians straight as to the increased hours and theatre sessions that are required to fulfill this promise. Hence it is an empty promise using the private sector as the carrot to bail out the ailing public health sector to encourage votes, knowing full well the promise cannot be delivered!

"I find it an amazing circumstance in our country that health ministers and prime ministers appear to have very little knowledge of the machinations of private sector medicine. This became apparent when the Hospital Reform Commission Document only had three recommendations mentioning the private health sector out of 173!"

This has been followed by our Prime Minister's plans to fix the ailing health sector with a planned shared funding model. I have not read the plans in detail as with a busy family and professional life, wading through this has not been high on my agenda. I do recall our health minister Lara Giddings' comments when we spoke about the reform package that a takeover of primary care was the easy thing and the lack of full funding commitment to the hospitals would perpetuate the blame game.

She was happy to hand over 100 per cent of the issue, but not part. I must say I would agree with her assessment, but I claim ignorance of the nuances of the plan. I trust this matter will be examined in detail at a Federal Level in College.

On a more positive note, I would like to confirm the $30 million upgrade of the Launceston General Hospital is underway.

I would also like to announce the appointment of Richard Turner as the Professor of Surgery at the University of Tasmania. He shares a clinical load at the Royal Hobart Hospital with this position.

Emilio Mignanelli has returned to Hobart as a Colorectal Surgeon. Mr John Oakley has retired and we were saddened by the passing of Mr Jim Cartledge in June, 2009.

In all, our state has a busy surgical workforce. We are well provisioned with private hospitals in which to treat the people of Tasmania. Many Fellows maintain a commitment to state services. As I write, we wait for the results of the State Election with interest, but I expect very few of the plans will take effect for some time yet.

Prostate cancer is a silent disease

A silent shroud covers this whole disease because only at the end do you get symptoms

In Australia, 20,000 men are diagnosed with prostate cancer with 3,000 dying from the disease every year, yet still it remains cloaked in silence and confusion, according to Urological surgeon Associate Professor Prem Rashid.

Treatment options and testing protocols remain controversial, leaving many men bewildered when presented with choices to make following diagnosis, while a reluctance to display anxiety or ignorance can prevent some men from accessing information. Now Associate Professor Rashid has published a new book designed to help navigate both men and their loved ones through the process of dealing with the disease called *"Your Guide to Prostate Cancer"*.

"Prostate cancer is a silent disease," he said.

"The gland is silent in that most men don't know where it is or what it does, the cancer is silent in that there are few symptoms until end-stage disease, the blood test is just a number, then if the biopsy shows cancer, the man is bombarded with information about treatment options even though he feels well.

"Then the fear of, or the actuality of erectile dysfunction or incontinence can remain shrouded in secrecy and shame. A silent shroud covers this whole disease because it is only at the end do you get symptoms, but there are so many choices as to treatment following diagnosis that men need to know as much as possible to be empowered to make those choices."

Associate Professor Rashid has been attempting to fill the information vacuum since 1999 when, with a sleepless newborn, he worked to fill the night time hours putting together a pamphlet providing answers to the most pressing questions many men were reluctant to ask.

This led to a book in 2003 going into greater detail on the biology of prostate cancer and the issues surrounding the disease, which in turn developed into this new edition which has been endorsed by the Urological Society of Australia and New Zealand, the Prostate Cancer Foundation of Australia and Andrology Australia.

David Sandoe, David Malouf, PeterCosgrove, Prem Rashid and Graeme Johnson

"I have written the text aimed at the bloke who might have prostate cancer who perhaps didn't know he had a prostate to begin with," Associate Professor Rashid said.

"Yet that's not to say it is simplistic. It deals with the scientific controversies that still exist, but outlines them in such a way that men can understand the choices they confront."

Associate Professor Rashid listed the PSA blood test as one such controversy with one side of the debate claiming it is not definitive, can be misunderstood and can lead to unnecessary surgery, with others saying it remains a good diagnostic tool if analysed accurately. Any good urologist can read the PSA test with intelligence, experience and insight and I support the recommendation that men over 40 are offered the test even if it merely raises awareness of the disease," he said.

"However, there is an argument that it can merely increase anxiety, which is also one of the reasons I have written the book, to empower the average bloke to know what the issues are, what the risk factors are in terms of his genetic line so the test is useful rather than confusing.

"The majority of men remain reluctant to discuss their health, given that they are more likely to have experience with cuts, bruises and broken bones, yet prostate cancer is one of the most common cancers and just like women have to know about breast cancer, men need to know about this."

Associate Professor Rashid said the other central controversy surrounding prostate cancer related to treatment options given that some tumours display a relatively slow progression to end stage disease which gives rise to more choices given the time factors involved.

"This problem has arisen in particular in the past ten years because people are now living considerably longer than they did in the past. This raises the question then of how long we expect to live and in what condition of health," he said.

"Prostate cancer is not like a melanoma or a breast lump that simply has to be treated as soon as possible because it can take up to a decade to cause symptoms. That means that a 50-year-old will have to consider treatment options, but for a man of 75 years it may not be such a problem.

"Then if you do decide on treatment do you go for surgery or radiation therapy? These are the choices that men face and most would prefer to have their urologist tell them what to do, like an accountant giving advice, but it just isn't that simple with prostate cancer."

Associate Professor Rashid said part profits from the book, launched in February by General Peter Cosgrove AC MC (Retd), would be given to the Prostate Cancer Foundation of Australia to support further research.

He said he was particularly pleased with this edition, given that it extended the informa-

"The gland is silent in that most men don't know where it is or what it does, the cancer is silent in that there are few symptoms until end-stage disease, the blood test is just a number, then if the biopsy shows cancer, the man is bombarded with information about treatment options even though he feels well."

tion offered to men with chapters written by sex therapist Dr Rosie King offering advice on sex after treatment and another by psychologist Dr Addie Wootten outlining the psychological impact of the disease.

He said that while the "Movember" campaign run by the Prostate Cancer Foundation of Australia had proven to be a great success in raising funds and increasing public awareness of the disease, there was still some way to go to encourage men to both discuss and deal with health matters.

"Many men still find it hard to admit their ignorance so hopefully they can use this book, take it and read it in private, so that they know what questions to ask and they don't feel so vulnerable when confronted with something they have never had to think about before."

Associate Professor Rashid works out of the Urology Centre and operates at the Port Macquarie Private and Base Hospitals. He is the Deputy Chair of the College Board of Urology and is the New South Wales Chair of Urology Training, Accreditation and Education. He has been honoured by the local Rotary club for his services to men's health and is a Conjoint Associate Professor at the University of New South Wales.

He said he hoped within the next few years that research into prostate cancer leads to a better understanding of which men are most at risk, to better testing methods and to a more accurate identification of aggressive tumours.

While this latest edition of his book has been a rewarding experience, however, Associate Professor Rashid said the highlight of his career had been his role in establishing the Port Macquarie Urology Unit.

"When I first came here more than a decade ago there was no urology unit in Port Macquarie and I intended to stay for only one year. Now there are three of us here, providing high level clinical services and surgical training while also conducting research and writing publications," he said.

"I believe it is a model for specialist units in regional centres and proves that you can do high quality work and have an academic involvement and great collegiality outside the city."

Copies of the book "Your Guide to Prostate Cancer" can be obtained through the websites www.prostate.org.au and www.prostatebook.com.au

Homestay Accommodation for Visiting Scholars

Through the RACS 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. If you have a spare room or suitable accommodation and are interested in helping, send us your details. We are seeking people who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a reasonable rental and eternal appreciation.

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

Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring St, Melbourne Victoria 3000, Australia
T: + 61 3 9249 1211 F: + 61 3 9249 1236
E: international.scholarships@surgeons.org

Please see the following listing for some of the surgical conferences coming up. Links to the conference websites for further information can be found on the Conferences page on the College website (under Fellows, Resources for Surgeons). Please let us know by email to College.library@surgeons.org if there are other conferences you'd like to see added

Australia/NZ

Royal Australasian College of Surgeons Annual Scientific Congress
4 - 7 May 2010
Perth WA AUSTRALIA

Inaugural Australian Emergency Surgery Conference
22 - 23 July 2010
Penrith NSW AUSTRALIA

SimTecT HEALTH Simulation Conference
30 August - 2 September 2010
Melbourne VIC AUSTRALIA

10th Rural Critical Care Conference
20 - 21 August 2010
Orange NSW AUSTRALIA

Provincial Surgeons of Australia 46th Annual Scientific Conference
1 - 4 September 2010
Broome WA AUSTRALIA

Overseas

2nd International Conference on Surgical Education and Training
13 - 14 May 2010
Dublin IRELAND

American College of Surgeons 96th Annual Clinical Congress
3 - 7 October 2010
Washington DC USA

CARDIOTHORACIC SURGERY Australia/NZ

Winter Meeting Perfusion Downunder
5 - 8 August 2010
Queenstown NEW ZEALAND

CSANZ 57th Annual Scientific Meeting
5 - 8 August 2010
Adelaide SA AUSTRALIA

Overseas

World Congress of Cardiology
16 - 19 June 2010
Beijing CHINA

GENERAL SURGERY Australia/NZ

3rd Postgraduate Course in Endocrine Surgery
19 - 20 June 2010
Melbourne VIC AUSTRALIA

Second International Trauma Conference
3 - 8 July 2010
Queenstown NEW ZEALAND

SWAN XVIII Trauma Conference
30 - 31 July 2010
Liverpool NSW AUSTRALIA

Endocrine Society of Australia Annual Scientific Meeting
29 August - 1 September 2010
Sydney NSW AUSTRALIA

ACORD – Australia and Asia Pacific Clinical Oncology Research Development Workshop
12 - 18 September 2010
Sunshine Coast QLD AUSTRALIA

General Surgeons Australia Annual Scientific Meeting
17 - 19 September 2010
Gold Coast QLD AUSTRALIA

ANZHPBA and ANZGOSA, two day annual Symposium
28 - 29 September 2010
Queenstown NEW ZEALAND

Australian and New Zealand Burns Association (ANZBA) Annual Scientific Meeting
5 - 8 October 2010
Darwin NT AUSTRALIA

Combined Colorectal CME Spring Meeting
14 - 16 October 2010
Launceston TAS AUSTRALIA

Australian Gastroenterology Week
20 - 23 October 2010
Gold Coast QLD AUSTRALIA

OSSANZ Conference
10 - 12 November 2010
Hobart TAS AUSTRALIA

Overseas

American Transplant Congress
1 - 5 May 2010
San Diego CA USA

Trauma Association of Canada Annual Scientific Meeting
6 - 7 May 2010
Halifax Nova Scotia CANADA

American College of Colon and Rectal Surgeons Annual Meeting
15 - 19 May 2010
Minneapolis MN USA

11th European Congress of Trauma and Emergency Surgery
16 - 19 May 2010
Brussels BELGIUM

18th International Congress of the European Association for Endoscopic Surgery (EAES)
16 - 19 June 2010
Geneva SWITZERLAND

27th Annual Meeting of the American Society for Metabolic and Bariatric Surgery
20 - 25 June 2010
Las Vegas NV USA

15th Congress of the International Society for Burn Injuries
21 - 25 June 2010
Istanbul TURKEY

Modern Concepts: Breast Aesthetics and Reconstruction
9 - 10 July 2010
Coventry UK

XXIII International Congress of the Transplantation Society
15 - 19 August 2010
Vancouver BC CANADA

Society of Laparoendoscopic Surgeons Annual Meeting and Endo Expo
1 - 4 September 2010
New York NY USA

NEUROSURGERY Australia/NZ

Neurosurgical Society of Australasia Annual Scientific Meeting
30 September - 2 October 2010
Sunshine Coast QLD AUSTRALIA

Overseas

American Association of Neurological Surgeons Annual Meeting
1 - 5 May 2010
Philadelphia PA USA

ORTHOPAEDIC SURGERY Australia/NZ

Australian Paediatric Orthopaedic Society Meeting
9 - 12 September 2010
Noosa QLD AUSTRALIA

Australian Orthopaedic Association Annual Scientific Meeting
10 - 14 October 2010
Adelaide SA AUSTRALIA

ANZORS 2010 with AHMRC Congress
15 - 18 November 2010
Melbourne VIC AUSTRALIA

Overseas

AOA 123rd Annual Meeting
9 - 12 June 2010
San Diego CA USA

Elbow and Shoulder Meeting
27 - 30 June 2010
Corfu GREECE

Canadian Orthopaedic Association Annual Scientific Meeting
9 - 11 July 2010
Edmonton AB CANADA

12th Meeting of the Combined Orthopaedic Associations
13 - 17 September 2010
Glasgow SCOTLAND

ASSH Annual Meeting
7 - 10 October 2010
Boston MA USA

Orthopaedic Trauma Association Annual Meeting
14 - 16 October 2010
Baltimore MD USA

OTOLARYNGOLOGY HEAD AND NECK SURGERY Australia/NZ

ASMS meeting for 2010 Stem Cell and Tissue Engineering
19 - 20 June 2010
Gold Coast QLD AUSTRALIA

ANZHNS 12th Annual Scientific Meeting
2 - 4 September 2010
Sydney NSW AUSTRALIA

Overseas

Canadian Society of Otolaryngology to Head and Neck Surgery Annual Meeting
23 - 26 May 2010
Niagara Falls ON CANADA

4th World Congress of the International Federation of Head & Neck Oncologic Societies (IFHNOS)
15 - 19 June 2010
Seoul KOREA

PAEDIATRIC SURGERY Australia/NZ

ANZAPS Annual General Meeting
5 May 2010
Perth WA AUSTRALIA

Australasian Paediatric Endocrine Group (APEG) Annual Scientific Meeting
2 - 4 August 2010
Adelaide SA AUSTRALIA

Australian Paediatric Orthopaedic Society Meeting
9 - 12 September 2010
Noosa QLD AUSTRALIA

Overseas

American Pediatric Surgical Association 41st Annual Meeting
16 - 19 May 2010
Orlando FL USA

43rd Annual Meeting of Pacific Association of Pediatric Surgeons
23 - 27 May 2010
Kobe JAPAN

British Association of Paediatric Surgeons (BAPS) Annual Conference
22 - 24 July 2010
Aberdeen SCOTLAND

3rd Congress of the European Academy of Paediatrics to EAP
2 - 5 October 2010
Copenhagen DENMARK

PLASTIC AND RECONSTRUCTIVE SURGERY Australia/NZ

ASPS Annual General Meeting
5 May 2010
Perth WA AUSTRALIA

Overseas

EURAPS 21st Annual Meeting
27 - 29 May 2010
Manchester ENGLAND

Canadian Society of Plastic Surgeons Annual Meeting
15 - 19 June 2010
Halifax CANADA

BAPRAS Summer Scientific Meeting
30 June - 2 July 2010
Sheffield ENGLAND

Modern Concepts : Breast Aesthetics and Reconstruction
9 - 10 July 2010
Coventry UK

20th Biennial Congress of ISAPS
14 - 18 August 2010
San Francisco CA USA

15th Congress of the International Society for Burn Injuries
7 - 11 September 2010
Istanbul TURKEY

ASSH Annual Meeting
7 - 10 October 2010
Boston MA USA

UROLOGY Australia/NZ

ANZSN Annual Scientific Meeting
13 – 15 September 2010
Perth WA AUSTRALIA

Overseas

25th Annual EAU Congress
16 - 20 April 2010
Barcelona Spain

The American Urological Association Annual Meeting
29 May - 3 June 2010
San Francisco CA USA

VASCULAR SURGERY Australia/NZ

Australia and New Zealand Society for Vascular Surgery - Vascular 2010
2 - 5 October 2010
Gold Coast QLD AUSTRALIA

Overseas

Vascular Annual Meeting
10 - 13 June 2010
Boston MA USA

www.surgeons.org

An opportunity at academia

I encourage all Fellows to channel their inner academic and attend the DCAS course

Richard Hanney at the Leadership Exchange commemorative plaque

"Julie Ann Sosa, an endocrine surgeon and surgical oncologist at Yale, is attending the upcoming Forum in Perth. She will be a valuable and dynamic contributor at the Forum."

Richard Hanney
AAS Leadership Exchange recipient

Having left the ranks of Younger Fellows five years ago, I was honoured and privileged when asked to represent the Younger Fellows Committee (YFC) at the recent Academic Surgical Congress held in February in San Antonio. The conference is held in partnership with the Society of University Surgeons and is a valuable opportunity to maintain and strengthen our strong links with the Association for Academic Surgery (AAS). The YFC invites Younger Fellows to nominate for this opportunity in August each year and unfortunately this year's nominee became unavailable at short notice.

The three day conference attracted over 1000 registrants and I was warmly welcomed and graciously hosted as a Visiting Professor of the Younger Fellows Leadership Exchange. I joined international visitors from 11 countries, with 45 international abstracts amongst almost 800 presentations. There were several highlights including:

- Professor John Windsor delivered one of four State of the Art plenary lectures on 'Cognitive Simulation'.
- Abstracts for 11 presentations were submitted from Australia and New Zealand.
- Recognition was given to the AAS as a dynamic organisation with nearly 3,000 members and total assets approaching $USD 1 million.
- Adam Fowler, a neurosurgical Trainee from Sydney, spoke in a showcase session for six international Research Societies partnering with the AAS. He is an exchange winner from the Surgical Research Society of Australasia; this exchange was re-established in the last 12 months in part due to the success of the Younger Fellows Leadership Exchange.
- Many social opportunities with senior representations of the AAS Executive Council who are highly valued friends and who are delighted with the developing relationship between the AAS and our College.

A further benefit of this relationship is that the Younger Fellows Forum welcomes an international guest from the AAS each year, initiated through the ANZ Chapter of the American College of Surgeons. This opportunity is a highly valued and competitive process amongst AAS members. Julie Ann Sosa (pictured above), an endocrine surgeon and surgical oncologist at Yale, is attending the upcoming Forum in Perth. She will be a valuable and dynamic contributor at the Forum.

The relationship between the AAS and our College continues to develop through this exchange initiative, with still further opportunities existing for senior Trainees and Younger Fellows to explore US-based post-Fellowship training. Eight AAS faculty will participate in this year's 'Developing a Career in Academic Surgery' (DCAS) course (see page over) run by the Section of Academic Surgery, which is sure to be of interest to all Younger Fellows.

I encourage all Fellows to channel their inner academic – we all want to improve our own surgical practice – and attend the DCAS course in Perth on Monday, May 3. The AAS faculty is a diverse and fascinating group who, together with inspiring ANZ colleagues, represent seven of the nine surgical specialties of our College. The course is structured to provide something for everyone, come along and see for yourself.

The College now has a **FACEBOOK** page, we welcome you to become a fan.
www.facebook.com

Developing a Career in Academic Surgery

Monday 3 May 2010

(The day preceding the ASC)

Perth Convention and Exhibition Centre

7.00am – 4.00pm

The 2010 DCAS Course is set to intrigue and inspire participants with evolved themes and presenters, as well as several faculty returning from last year's successful inaugural course.

Designed for surgical trainees, research Fellows and early career academics, this inspirational course contains elements of interest for those from the stage of medical students to that of any surgeon who has ever considered involvement with publication or presentation of any academic work.

Key Note Speaker: Winthrop Professor Fiona Wood AM

"The highs and lows of a successful career in surgical research"

Topics addressed by an outstanding local and international faculty will include:

- Where do good ideas and research questions come from?
- How to design a study to get an answer
- What makes surgical research ethical? (and how to survive ethics applications!)
- Submitting and revising your work (including abstract writing)
- Private practice and research
- Finding the money for research
- How to integrate Clinical and Research interests into a rewarding academic program
- Why a trainee should consider doing full-time research
- Starting and planning a research career
- Why every surgeon could and should be an academic surgeon
- Creating and managing a clinical database
- How do you fit it in? - Work/life balance

But wait... there's more!

Two interactive workshop sessions with the experts, one to address individual career pathways, and the second to brainstorm challenges in any current research project. For the latter, registrants should bring their problems with them eg: the insoluble statistical dilemma, the unachievable ethics application, the project idea that won't come together.

The Association for Academic Surgery in partnership with the RACS Section of Academic Surgery

Proudly sponsored by Johnson & Johnson Medical

2009 Comments

"excellent talks"

"the sort of talk that every research Fellow needs to hear at the outset"

"challenging topics were covered extremely well"

Registration

Cost $150.00 inc. GST
Register on the ASC registration form or online at http://asc.surgeons.org.

Complimentary registration for interested medical students, contact dcas@surgeons.org for a separate registration form.

Further information

Conferences & Events Department,
Royal Australasian College of Surgeons

T: +61 3 9249 1273
F: +61 3 9276 7431
E: dcas@surgeons.org

NOTE: New RACS Fellows presenting for graduation in 2010 will be required to marshal at 3.30pm for the Convocation Ceremony.

Maximum 100 registrants, register early to avoid missing out.

The above themes/topic were correct at the time of printing however the Organising Committee reserve the right to change the themes/topics without notice. Email dcas@surgeons.org for updates.

The Course has been submitted to the RACS for approval within the CPD program. The CPD point allocation will be available at a later date.

The Mobile Surgical Simulation Unit

The mobile unit will be making an appearance at the ASC

Julian Smith
Chair, Research, Audit & Academic Surgery

The Simulated Surgical Skills Program (SSSP) staff traveled to Melbourne for College Council week in the Mobile Surgical Simulation Unit, which was parked at the front of the College. The two day, 1454 kilometer return journey from Adelaide to Melbourne was a relatively simple task when compared with the 12 month journey that the unit took moving from conception, to design and then to reality.

Its purpose is two-fold; to assist the SSSP to access Surgical Education and Training (SET) participants across New South Wales (NSW), and also to generate data on the applicability of a mobile skills training centre more broadly. By accessing NSW SET participants using the mobile unit, we can examine a range of learning outcomes resulting from laparoscopic surgical simulation training.

Those who came in to view the unit would have seen two different simulator types, one computer based and the other a desk-top model. Both teach participants the same range of basic laparoscopic skills, but through different tasks, and it was pleasing to see so many College Fellows and staff came in to give it a try!

The mobile unit is also being assessed to see how effectively it can be used to provide surgical training. An analysis of the effectiveness of the mobile unit will be included in the SSSP final report to the Commonwealth Department of Health and Ageing.

It is anticipated that the mobile unit will be appearing at the ASC and other College events. However, the novelty of the mobile unit, the simulators and their respective tasks belies their serious purpose, the foremost of which is to collect laparoscopic surgical training and assessment data for the Simulated Surgical Skills Program in NSW.

Full-time data collection begins in June. In the meantime, SSSP staff will be taking the van from one side of the country to the other, and to a whole lot of places in between! If we pop up at a site near you please come in and say hello, as we would be more than happy to show you around.

Enquiries to Prof Guy Maddern, Surgical Director, college.asernip@surgeons.org

NEW ONLINE ASSESSMENT TOOL FOR BREAST DIAGNOSTIC SERVICES

National Breast and Ovarian Cancer Centre (NBOCC) has developed an online tool to assist breast diagnostic services to self-assess their practices against the NBOCC Standard of care for breast diagnostic services. All facilities offering the triple test (clinical examination, imaging and fine needle aspiration/core biopsy) to investigate a new breast symptom as part of the one episode of service are invited to participate in this quality improvement activity. Services who complete the online tool will receive a confidential summary report of their results, which can be incorporated into an existing risk management framework to support ongoing quality improvement. The Standard of care for breast diagnostic services was developed by NBOCC to promote quality assurance and service improvement.

There are five core components of the Standard of care for breast diagnostic services:
1. Continuity of care
2. Clinical staff with appropriate training
3. Supportive delivery of service
4. Informed patient consent and communication
5. Safety and quality care

Encourage your breast cancer diagnostic service to assess their service online. For more information, visit http://nbocc.org.au/health-professionals/standards-of-care/standards-of-care.

For further information about NBOCC's Standard of care for breast diagnostic services or the online tool, please contact Katie Allen (Ph. 02 9357 9409).

NBOCC is funded by the Australian Government and works with consumers, health professionals, cancer organisations, researchers and governments to improve care and cancer control in breast and ovarian cancer.

Project China Rotary Award

Over the years the Martins have greatly assisted participants in Project China

Gordon & Rosie Low
Coordinators, Project China

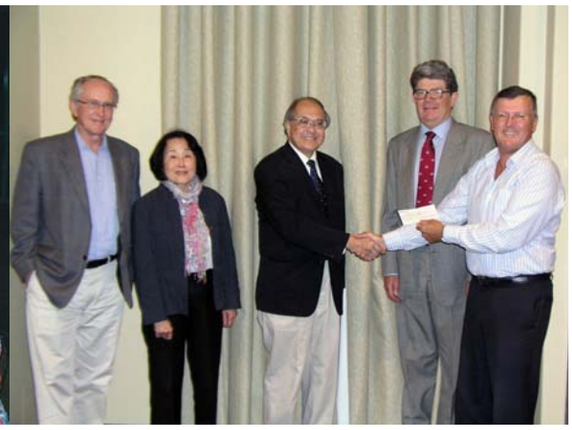
In memory of Mr Colin and Mrs Dorothy Martin, the Rotary Club of Balwyn (Victoria) will donate $4000 per year for three years to Project China of this College. The Martins were stalwarts of their Club and Rotary International, and great benefactors to Project China from 1997 until their deaths in the early years of this decade.

The purpose of this gift is to assist the work of Project China in its efforts to improve the standard of oral English among the medical personnel of Chinese hospitals, so as to enable these colleagues to travel to English speaking countries with confidence.

Between 1997 and 2001, Project China had to find funds to assist a number of Chinese doctors and nurses who wished to further their knowledge and experience in Australia. Colin Martin heard about the difficulty and offered to help. At that time, he was a past-president of the Rotary Club of Balwyn, and the 1990-1991 Past District Governor of Rotary International District 9800. He successfully applied for two International Rotary Scholarships through the Rotary Clubs of Balwyn and Flemington.

The money from these scholarships was used to assist in the partial sponsorship of seven doctors and two nurses from various parts of China to enable them to take up training positions in Australian hospitals. The beneficiaries were two plastic and reconstructive surgeons, an orthopaedic surgeon, an anaesthetist, a nephrologist, a medical research scientist, an orthodontist and two nurses. Their appointments varied from one month to one year.

Colin & Dorothy Martin



Rotary presentation of the cheque

Colin would be at the airport to welcome them and, when they went home, he would farewell each doctor or nurse in the same way. During their stay, the weekends and holidays were often taken up by Dorothy Martin, who showed them the sights of Melbourne and welcomed the visitors to their home in Balwyn for barbeques and other activities.

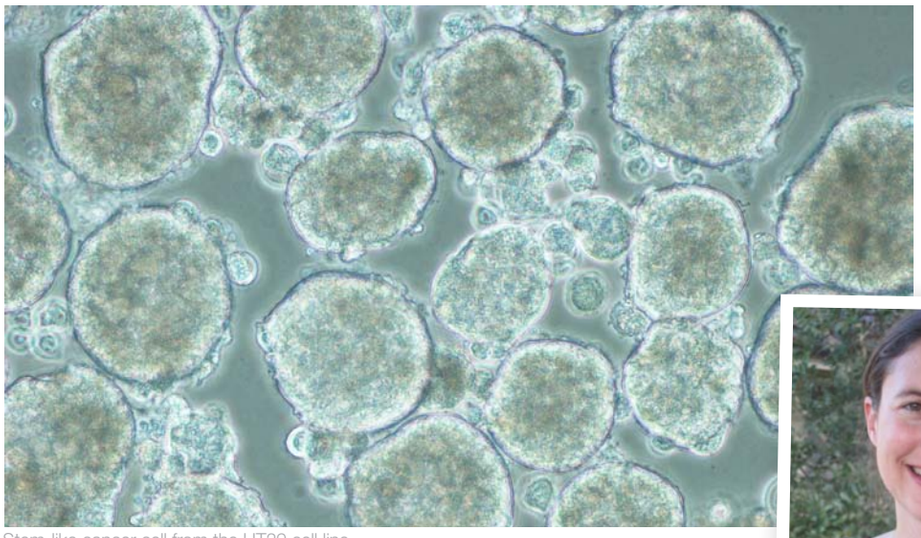
The Martins and the Balwyn Rotarians even taught our guests the art of cricket on the village green! To these visitors, the Martins were affectionately known as "Uncle Colin" and "Aunt Dorothy." On their departure, Colin was able to present expensive reference texts for them to take back to their home institutions. Funds from the Rotary Club of Balwyn also assisted in the purchase of small autoclaves for use in the operating rooms of three hospitals in Guangzhou.

Sadly, Dorothy died in 2004. Since 1995, Colin was a member of the Project China Committee. He never missed a Committee Meeting and his advice and contributions to Project China were enormous. He died from cancer in 2006. The Martins left a legacy of kindness, friendliness and magnanimity which is unequalled. Their lives were examples of selfless service to the benefit of their fellow men and women, and truly expressed the tenor and essence of Rotarianship.

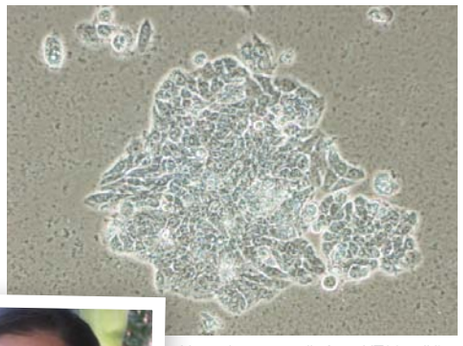
Project China is deeply grateful to the Rotary Club of Balwyn for perpetuating the memory of Colin and Dorothy Martin for their contributions to Project China in the establishment of this Award.

Cancer Research

Oesophageal cancer is a significant clinical problem around the world which carries a poor prognosis



Stem-like cancer cell from the HT29 cell line



Normal cancer cells from HT29 cell line

In the past ten years, a significant shift in thinking has taken place in the world of cancer research that postulates the existence of cancer stem-like cells in some tumours. These cells, some believe, which may comprise only one per cent of the cellular mass of certain tumours, could be the drivers of cancer cell replication rather than each cell within the tumour as was previously thought.

According to the new theory, if such cancer stem-like cells could be identified, targeted and killed, recurrence rates of certain tumours could be dramatically lowered. Surgical Trainee Dr Jodi Hirst (pictured) is one of the worldwide army of researchers investigating the new theory.

With funding from the College's Paul Mackay Bolton Scholarship for Cancer Research, Dr Hirst spent 2009 investigating both the outcomes of treatment for oesophageal cancer and the identification and profiling of cancer stem-like cells in oesophagogastric tumours.

She said she chose to study this tumour type because oesophageal cancer remained a significant clinical problem around the world which continued to carry a poor prognosis.

"The rate of rise of adenocarcinoma is greater than any other cancer and in Western countries adenocarcinoma has overtaken squamous cell as the most common type of tumour. At the same time, mortality rates from oesophageal adenocarcinoma, often linked to risk factors such as obesity and reflux disease, are rising with only modest improvements in survival rates," she said.

"The mainstay of treatment is oesophagectomy with or without neo-adjuvant therapy and recently chemoradiotherapy alone has also been proposed as a definitive treatment.

"Yet long-term survival following any of these treatments is poor with most series reporting 20 – 30 per cent of patients surviving for only five years.

"I thought my research could help lead to a better understanding of oesophageal cancer both in terms of the outcomes linked with various treatments as well as its genesis and progression."

As part of her Masters of Philosophy research, Dr Hirst used tumour lines to extract DNA, RNA and microRNA to characterise possible cancer stem cells. She found that they presented as a discrete population, with different DNA copy numbers, within the tumour.

"This is very exciting science because it looks at cancer in a different way," she said.

"The old theory held that all cancer cells can divide, but now there is increasing evidence to suggest that cancer stem cells may be responsible for tumour development in some cancers.

"In the tumours that I looked at, I found two different genetic populations, but still the science remains complex. We don't know which type of tumours may involve the cancer stem cells and we don't know what triggers them into action.

"However the identification and profiling of cancer stem cells in oesophageal tumours may one day lead to a breakthrough in therapy for patients with this otherwise devastating disease."

Dr Hirst, now back working at the Logan General Hospital in Queensland to continue and complete her general surgery training, conducted her research through the University of Queensland under the supervision of Associate Professor Andrew Barbour.

She said she was now in the process of writing up her thesis and three papers for publication and said she had been greatly honoured to receive the Paul Mackay Bolton Scholarship for Cancer Research, established by Harry Bolton in memory of his late son, which carries a $55,000 stipend and $5,000 departmental maintenance.

"In some ways it was a difficult decision to take time out for research, but I sought advice and most people I spoke to were very encouraging," she said.

"To have the opportunity to spend a year conducting scientific research was extremely valuable in terms of learning research methodology, gaining experience in giving presentations at conferences and writing up scientific papers for peer review publication.

"Such scholarships as this one are very important and a great initiative to encourage academic surgeons."

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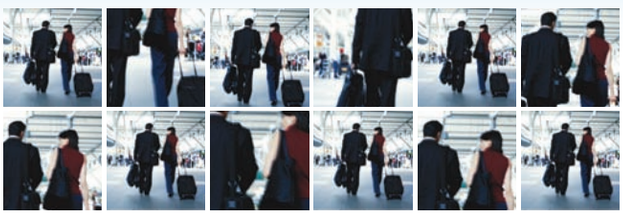
FLY IN STYLE ▶▶▶



The Qantas Club

RACS Fellows and Trainees can enjoy specially negotiated rates on Qantas Airline Lounge Memberships.

- New member 2 year membership $855* (**save $255**)
- FREE enrolment in Qantas Frequent Flyer program (**save $82.50**)
- Rates for 1 year new membership, renewals and partners are also available

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or visit www.memberadvantage.com.au/login/racs

*Rates quoted are in AUD and include a once off Qantas Club joining fee of $230 and a Member Advantage management fee of $55.

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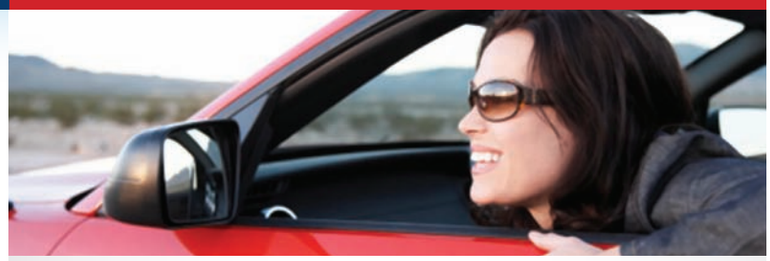

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(Use RACS AWD number **P203701** to access your discount.)

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or visit www.memberadvantage.com.au/login/racs

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The new compliance framework

Changing relationships between medical technology companies and surgeons

Interactions between medical practitioners and the medical industry are subject to greater scrutiny 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. The College and the Medical Technology Association of Australia (MTAA) have worked closely, as each body has developed its own codes of practice and ethics. To view the College's position paper on the subject go to www.surgeons.org and click on members of the public and you will be taken to the position paper - Surgeons and Trainees interactions with the medical industry.

Anne Trimmer
Chief Executive Officer
Medical Technology Association of Australia

The compliance framework within which medical technology companies engage with healthcare professionals has changed dramatically over the past two to three years, and continues to evolve. This has been driven in part by changed expectations of corporate behaviour and concerns about the ethics of previously acceptable corporate activity following the recent global financial crisis. It has also arisen as a result of the concentrated focus on relationships between the industry and doctors pursued by Senator Chuck Grassley in the United States of America (USA). Senator Grassley is the ranking Republican on the Senate Committee on Finance which has oversight of the Medicare and Medicaid programs.

An analysis of compliance activity in the USA in 2009 indicates there were more enforcement actions, increased financial penalties and settlement terms, and attention to individual action, including prison terms, than at any time previously.

The impetus for Senator Grassley's attentions derives from what he perceives as conflicts of interest which contribute to unnecessary increases in healthcare expenditure. He is also concerned that incentives, however described, drive inappropriate or questionable selection or use of medical technology products.

The Medical Technology Association of Australia (MTAA) represents the manufacturers and suppliers of a broad range of medical technology products, including many devices which are used in surgical procedures. MTAA's Code of Practice has evolved over the past two to three years to reflect the changing global compliance setting. In October 2009 further changes were adopted which focus on consulting arrangements between medical technology companies and doctors, training and education, and educational and research grants. The Code now also prohibits the provision of entertainment or gifts of any type or value, including branded promotional items of minimal value (from 1 April 2010).

Of relevance to surgeons are the following provisions in the Code:

- Compensation paid to a clinician must be documented in writing, specifying all the services to be provided and compensation paid. The compensation must be fair market value.
- The selection of the consultant must be on the basis of the consultant's qualifications and expertise in dealing with the subject matter of the engagement and not be based on volume or value of business generated.
- A consulting arrangement that involves clinical research must have a clinical research protocol to ensure there is a legitimate subject matter for investigation.
- The calculation of royalties paid to a clinician in exchange for intellectual property arising from the consulting arrangement must be based on factors which preserve the objectivity of medical decision-making and avoid the potential for improper influence.
- A company may make a grant for the advancement of medical education through programs which have a charitable or academic affiliation.
- A company may grant funds to an organisation accredited by a professional association to deliver speciality education for a clinician or trainee.

It is instructive to look at the way in which similar requirements for transparency and accountability have been dealt with in the United States, which has taken the lead in setting the compliance framework.

In pursuing an agenda of more open disclosure, Senator Grassley introduced the Physician Payment Sunshine Act of 2009 (Sunshine Act). The bill mandates online disclosure of physician investments in, and ownership of, medical facilities and medical products. It requires manufacturers to report all consulting fees, honoraria, gifts, entertainment, travel, meals, research, charitable donations and other benefits given to physicians and teaching hospitals – but not nurses, biomedical researchers or professional medical associations. It also establishes an online registry for all industry payments of $100 or more to physicians. There are significant penalties for failure to comply – up to $1 million.

Industry in the USA has supported the legislation in principle, but with higher threshold reporting requirements. Importantly all of the elements of the Sunshine Act have been incorporated into both the House and Senate versions of the health care reform bill. Some States in the USA have enacted even tougher legislation .

Limited support

While there is limited support for a similar disclosure regime in Australia , the Parliamentary Secretary for Health, Mark Butler, is currently examining the therapeutic industry codes of practice with the stated intention of creating more level standards for all the industry sectors. This may also impact the doctors who benefit from arrangements with companies.

Some companies in the USA have begun making voluntary disclosures of payments to healthcare professionals. Predominantly the disclosures have been by pharmaceutical companies although from 2011 they will be joined by medical technology companies reporting consulting fees, royalties and honoraria.

Senator Grassley has more recently turned his attention to medical groups ranging from the American College of Surgeons and the American Medical Association to the Ameri-

can Cancer Society, asking for details on the amount of funding that they and their directors receive from drug and device makers.

Achieving a balance between financial support by industry, often the only source of research funding, and the need to ensure that there are no conflicts of interest, continues to be a challenge. There is evidence in the USA that company-funded research is declining . A survey over three years of the life sciences departments at the top 50 US National Institutes of Health-funded universities, showed that industry supplied an average of $33,477 in research funds, constituting 8.7 per cent of all research funds received by the faculty. Clinical faculty members received a greater proportion than did non-clinical faculty members (10.5 per cent versus 2.5 per cent). Industry funding was also significantly higher in clinical departments than non-clinical departments (47.3 per cent versus 26.3 per cent). The percentage of research faculty which received industry funding had dropped from 28 per cent in 1995 to 20 per cent in 2006.

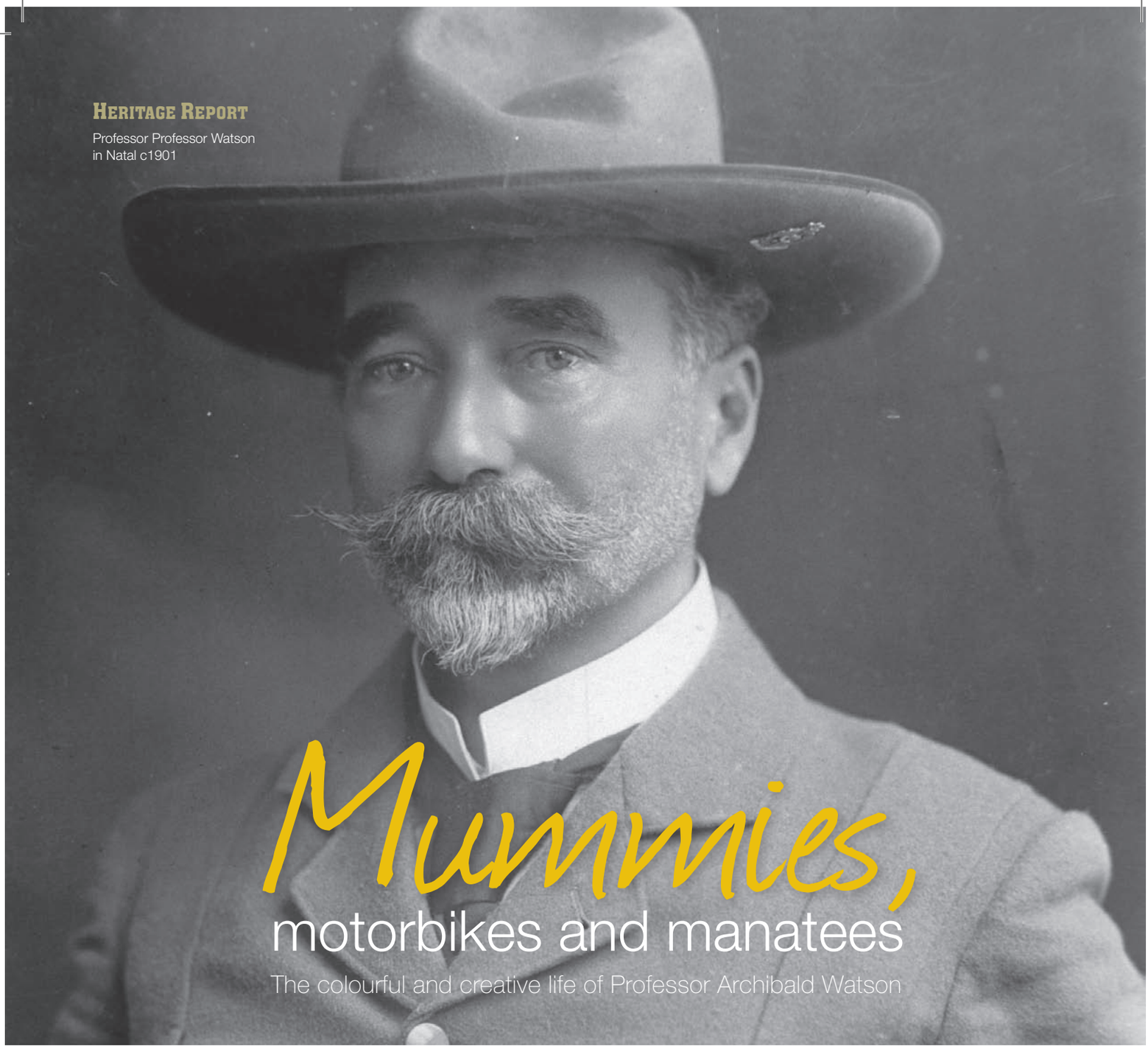
Conflicts of interest

Potential conflicts of interest need to be managed by disclosure and transparency. A report published in November 2009 by the USA Department of Health and Human Services states that more than 90 per cent of universities rely on their academics to make their own disclosures. The US Institute of Medicine has called on health research centres, journals, professional societies and others to strengthen their conflict of interest policies through greater transparency by rejecting gifts and by insisting that advisory boards do not have members with industry ties . Some of these restrictions would be challenging in the considerably smaller Australian market.

More recently the HHS Inspector General, Daniel Levinson, has called on the Food and Drug Administration and the National Institutes of Health to increase their oversight of conflict of interest policies and procedures in research institutions with the likelihood that external regulations will increase if they do not.

The push for increased disclosure is not limited to the USA. The medical school at the University of Sydney is more proactively vetting employee's commercial links with a policy requiring full-time and part-time staff to declare all outside interests which will then be examined by a committee which will judge the potential for conflict .

MTAA has worked closely with the College as each body has developed its own codes of practice and ethics. The issues are challenging for both companies and clinicians. The relationship is very symbiotic with each valuing the contribution of the other in the development of safe and effective medical products. However, the new compliance environment requires a much greater level of accountability and transparency to ensure that the interests of patients are always at the forefront.



Professor Professor Watson in Natal c1901

Mummies, motorbikes and manatees

The colourful and creative life of Professor Archibald Watson

Keith Mutimer
Honorary Treasurer

Brilliant, eccentric and audacious, Archibald Watson is a complex character who made a significant contribution to the study of anatomy and physiology. Watson was always close to scandal – his most ignominious period was when he was arrested for blackbirding in the Pacific in the early 1870s. Before he could be tried for murder and kidnapping on the high seas, Watson 'jumped' bail and went to New Zealand and then to Europe.

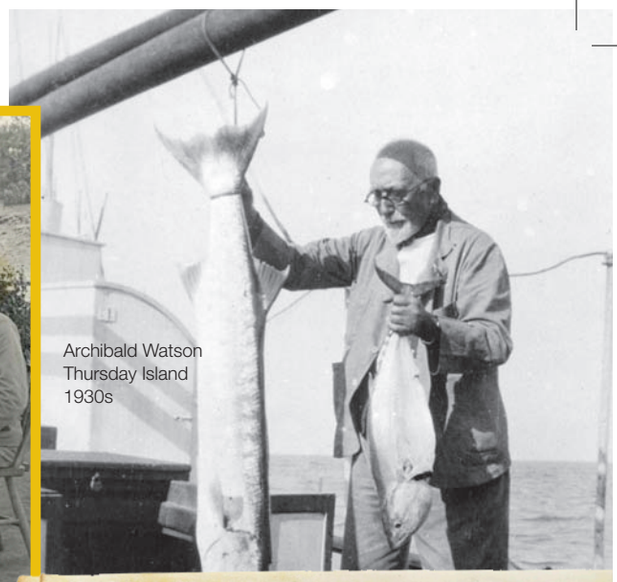
Deciding to study medicine, Watson, cognisant of his sordid past, avoided England and obtained medical degrees from Göttingen (1878) and Paris (1880). A clever linguist who by the end of his life could speak six languages, Watson seems to have easily adapted to study in Europe. He also had some significant teachers and dedicated his MD thesis in Paris to one of them, the physician, anatomist and anthropologist, Paul Broca.

Arriving in England in 1880 and obtaining his Fellowship of the Royal College of Surgeons in 1884, Watson attended the wards of Jonathan Hutchinson at the London Hospital. Always a keen diarist, Watson, probably inspired by Hutchinson, started to make comprehensive notes that culminated in the medical notebooks (1883-1937) held in the College Archive. It was in London too that Watson, like others before him, obtained corpses by somewhat dubious means for dissection, thus satisfying an abiding curiosity about anatomy.

In 1885 Watson, who had recently returned to Adelaide was selected from a group of 16 applicants to become Professor of Anatomy at the University of Adelaide. His choice was an interesting one. Despite his abilities and excellent referees (Jonathan Hutchinson was one of them), what of his blackbirding past? It has never been ascertained whether or not the warrants had simply lapsed or the incident been forgotten or overlooked. Apart from being briefly dismissed in 1895, a sojourn at the Boer War (1900-2) and World War I (1915-16), Watson remained at Adelaide University for the next 34 years. References to Watson's blackbirding past did not resurface until 1928 with an article (Daily Telegraph, 13 April) entitled 'Grim Stories of a Blackbirder'.

There are countless anecdotes about Watson. A controversial and difficult character, he alienated many, but was revered by others, especially his students. J B Cleland says that he gave "...no set lectures in anatomy, but his demonstrations and talks, illustrated by sketches, on points of anatomical and particularly surgical importance impressed us more lastingly than could any lecture or textbook."

Watson and Hospital Staff South Africa c 1900



Archibald Watson
Thursday Island
1930s

College stalwart, Sir Leonard Lindon also told the following story. A medical student, he was strolling in front of Adelaide University one day when Watson appeared on his motorbike. Summoning him to accompany him, Lindon got into the wicker sidecar and was driven to a stable outside the city where a horse with an abdominal wound was hobbled. He was then told to remove his trousers – Lindon refused - so Watson took off his own trousers and before stitching the wound, used them as a mask to anaesthetise the horse.

Pilfering of Middle Eastern cultural artefacts has a long history. In 1915 when Major Watson was stationed at Heliopolis, he obtained what was believed to be a mummified priest from the Ptolemaic-Roman period. Nubian mummies from this late period were numerous and typically, the body had been soaked in resin and wrapped in red (signifying a male) dyed linen.

The mummy was kept in the military camp until stolen by a practical joker who propped it up against the wall of Watson's tent. Challenged by a sentry, it gave no answer and was promptly bayoneted. The mummy, which ended up in the South Australian Museum, still bears the scars of this undignified encounter. Significantly, Frederic Wood Jones who succeeded Watson at Adelaide University co-authored a Report for the Archaeological Survey of Nubia 1907-1908, Vol II Human Remains, which references Watson's mummy.

Always the observer, experimenter and innovator, Watson took every opportunity to enhance his knowledge. In 1888 as Honorary Pathologist at the Royal Adelaide Hospital, he and a colleague performed an autopsy on a man suffering from generalised myositis ossificans. The two surgeons removed most of the skeleton from the body and then stuffed the skin with whatever could be found including spade handles and a partly opened umbrella to simulate the rib cage. The skeleton was retained for study, but what remained of the body was cremated, posing some interesting questions for the mortuary staff.

Watson's medical notebook of 27th May 1911 lists 12 operations performed by Charles Mayo, Dr Beckman and D Judd and viewed in the morning of that day. Reflecting Watson's interests – he had written numerous dissertations including his 1878 thesis on hysterectomy – the operations, which were mostly performed by Mayo, included a 'Hysterectomy and appendix (fibroid) and incisional hernia in the same case', 'Removal of a cricket ball myoma through uteris (submueous)' and 'Vaginal hysterectomy (senile bleeding), clamp operation, uteri.'

As this entry from Watson's detailed notebooks from Heliopolis (July 1915) indicates, his observations could also be brusque:

Corporal Quail aet. 26 No. 1349 15th Bat.

Hit with shrapnel (six others hit all in bunch by a shell) Monday July 5th. 1915 admitted July 9th Friday.

Was kneeling on ? [sic] knee when hit bullet entered from right. Thurs. July 15th unknown to me the surgeon cut down from outside the Sartoreus and burrowed to neck where he said he found perforated across its front. He then cut through Gluteus max from behind and passed a director from front wound – the end of which he said he felt. He then put the unfortunate but trusting fool of a patient on a long Liston (splint). What for? Did he drain it? Surgeon told me above "sua sponte"

(Written across diagrams in pencil) This case did not die.

Possessing a scientific interest in the natural world, Watson investigated diverse areas of study throughout his life. In the College archive there are photographs of Watson examining the wildlife on Thursday Island or a manatee at the mouth of the Amazon River. He had earlier experimented with the use of kangaroo tendon as sutures (an example is in the College museum) in surgery and devised an untried scheme to exterminate Australia's rabbits.

Archibald Watson's extraordinary life influenced many – a friend and correspondent of Julian Romaine and his son, Julian Ormond Smith, the postscript from a letter sent from Thursday Island to 'Juliano' (J R Smith) on August 16th 1935, is characteristic of Watson's style: That was an interesting photo of a N.S.W. Swordfish from 'Bermagui' – I had no idea that such monsters existed at Bermagui – though it was there that the only Pacific specimen of the Luvarus imperialis of the Atlantic Ocean, was washed ashore in the late Edgar R Waites' time. (Waites was appointed Director of the South Australian Museum in 1913)
Watson was also Sir Henry Newland's teacher and although their relationship was not always amicable, Newland remembered him with respect; hardly surprising when we consider this man with his curiosity for the world and his multitude of interests — truly homo universalis.

By Elizabeth Milford, College Archivist

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