

# Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **APRIL 2012**

**Includes post op 14 page special  
Lifestyle section**

- > Presidential view of South America
- > The classic car collection
- > Surgeon's tour of Wellington
- > Wine, sailing and surgery

**Extract from  
ANZASM Annual  
Report inside,  
p 29**



The College of  
Surgeons of  
Australia and  
New Zealand

*Welcome*  
to Malaysia

Convenors have an exciting program in store for the 2012 ASC



## If you're a doctor in training interested in a research placement, would \$25,000 or \$50,000 help?

Avant is delighted to announce the launch of the Avant Doctor in Training Research Scholarships Program.

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“As a recipient of grants in the past, I would encourage you to put as much detail as possible into the application, it's worth the time and effort to get it right.”

Dr Gareth Crouch

Cardiothoracic Registrar (SA)  
Member, Avant's Doctor in Training Advisory Council

Applications open at 9am on 13 February 2012 and must be received by 5pm on **31 May 2012**.

For more information or to download the application form, please visit [www.avant.org.au/scholarship](http://www.avant.org.au/scholarship)



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ON THE COVER:  
Petronas Towers in Kuala Lumpur, the setting for the 2012 ASC p 14



President's Perspective

## Professionalism – Is it important to you?

The room was hushed. The audience highly attentive. In many ways physicians and surgeons are used to high quality presentations and outstanding orators. But there was something about Sir Liam Donaldson that immediately captured our attention. As the Chief Medical Officer for England from 1998 to 2010 his reputation is truly international. His reforms and reviews are of critical and ongoing importance. His reports as Chief Medical Officer have had profound effect on policy and legislation in a wide range of areas including stem cell research, quality and safety of health care, infectious disease control, patient empowerment, clinical performance, temperance legislation, organ retention and medical regulation. He was in the 'hot seat' for much of the major events over the past 15 years – the Bristol, the Shipman, and for the Mid Staffordshire enquiries.

His ongoing commitment to patient safety is unquestioned through his role as Chair of the World Alliance for Patient Safety within the World Health Organisation, and his commitment to education equally unquestioned through his role as Chancellor of the University of Newcastle upon Tyne. Perhaps most importantly, he began his career as a surgeon. He was indeed someone we should all listen to.

The event was the Conjoint Medical Education Seminar entitled 'The Medical Professional in the 21st Century: Competent, Fit and Safe'. Sir Liam was addressing the issue of 'The Challenge of Professionalism'.

How would you respond to the key questions of:

1. Do you think professionalism has relevance today?
2. If you believe that professionalism is a relevant concept, then what are the challenges?
3. What can be done to strengthen those aspects of professionalism?

Since the mid part of the past decade these have been underlying themes confronting the medical profession and the various learned Colleges in United Kingdom, and were specifically asked in official enquiries. Someone with the experience, expertise and resources available to the Chief



President Ian Civil and Sir Liam Donaldson at the recent Conjoint Medical Education Seminar.

Medical Officer could produce volumes about these issues. Instead he emphasised the critical and ongoing nature of these issues across the centuries. His response was to quote Sir William Osler, the 'Father of modern medicine'.

His response to the first question was, 'You are in this profession as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow-men.' This quote from 1907 is as relevant more than 100 years later.

To the second question he replied, 'Physicians, as a rule, have less appreciation of the value of organisation than members of other professions.' This was certainly a reflection I have had both in my role as a Director of Surgery and as President.

To the third question he highlighted, 'The hardest conviction to get into the mind of a beginner is that the education upon which he is engaged is not a College course, not a medical course, but a life course, for which the work of a few years under teachers is but a preparation.' Lifelong learning is not a concept of the past decade.

I had always been an admirer of Sir William Osler. He is one of the most erudite medical writers. However, the use of his words by Sir Liam gave gravity to them that spellbound the 200 people in the audience. Sir Liam continued and his outstanding presentation highlighted the major components of professionalism being mastery of a body of knowledge, service and vocation, autonomy and the privilege of self-regulation, and being accountable to those we serve.

He brought into the 'everyday' the issues of being a reflective surgeon. If the major strands of being a professional surgeon are being compassionate and patient centred, knowledgeable and skilled and with an urge to constantly improve, then how should I reflect those strands?

Was I really compassionate?

Did I listen and explain?

Did I share the decision making?

Was I aware of the most up to date evidence about this clinical situation?

Is my technique as good as ever?

Questions that perhaps I need to ask of myself and others around me more frequently.

Sir Liam's presentation prefaced the Conjoint Medical Education Seminar which included a consensus statement on professionalism drafted by contributors from RACS and RACP as well as the Royal College of Physicians and Surgeons of Canada. This statement embodied the current views of leaders in all three Colleges and I was reassured to see that it sat well within Sir Liam's framework.

The Tripartite consensus statement on professionalism noted that traditionally the characteristics of medical professionalism involve a duty to patients that embodies professional competence and performance. It includes honesty and integrity, confidentiality, altruism, respect and compassion. The statement also noted that the modern age has placed some additional demands on professionalism. Contemporary medical professionalism must also include,

- demonstration of continuing professional development and lifelong learning
- maintenance of patient confidentiality and professional boundaries
- clinical leadership, including health advocacy
- intra and inter-professional communication team skills
- responsibility for one's health and fitness to practice
- a collective duty to meet societal needs

Taking this statement and integrating it with Sir Liam's presentation, what was the over-riding message on professionalism? What is the driving ethos of such an outstanding individual and contributor? His last slide was both an answer and not surprisingly a statement of enormous challenge.

'Keeping the flame of compassion burning.'

This drove Sir Liam through difficult times and really traumatic issues. It could drive us all.

**Mr Ian Civil**  
President

If you are interested in Professionalism, attend the NOTSS course. See p 37 for details.

## Australian & New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2013

Applications are invited for this two year Program.

The program is organised by a Conjoint Committee representing the Section of Colorectal Surgery, Royal Australasian College of Surgeons and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ).

For details & eligibility criteria of the Training Program, please see [www.cssanz.org](http://www.cssanz.org)

Closing Date:  
**Friday 11 May**

Please include -  
**1.** A covering letter  
**2.** Curriculum Vitae  
**3.** The names and addresses (including email addresses) of three referees.

Please email to:  
Professor Frank Frizelle  
Chairman, Training Board in Colon & Rectal Surgery  
E: [secretariat@cssanz.org](mailto:secretariat@cssanz.org)  
P: +61 3 9853 8013



## How we are governed

Council meets three times a year, but Executive meet a further eight

As many Fellows and Trainees would be aware, the College, in conjunction with presidents from the Specialist Societies, is undertaking a thorough review of governance of both the College as a whole and also within our Education portfolio.

It is important that the College review its governance structures from time to time to ensure that we retain an effective, transparent, responsive and representative governance model. In this case the review is focusing particularly on the governance interactions between the College and the Specialist Societies.

Last month, with the election for Councillors underway, I wrote about the role Councillors play on Council and the various backgrounds and experience our Councillors bring. I also highlighted the importance Council places on ensuring that fresh ideas and new approaches are brought to bear on the various office holder positions.

With all that in mind, I thought that this month I would highlight the current College governance arrangements, paying particular attention to the relationship between Council and Executive, as I know from my many discussions with Fellows that this is an area not widely understood.

The role of Council is spelled out in section six of the College's Constitution which I would encourage you to review. Principally, Council is there to manage the business of the College, to wisely invest the funds of the College and to make regulations "for the proper conduct and management of the College, the regulation of its affairs and the furtherance of its objectives" (Clause 6.2.1, College Constitution).

The 'regulations' referred to above are the many College policies which govern our activities in education and training, Fellowship, disposition of the resources of the College and the way in which Council is elected and governs the College.

All these policies have been considered by – and approved by – Council or the Executive of Council. One of the most important powers of Council is the power to delegate. Council has delegated all of its powers (with the exception of the power to elect office bearers) to the Executive of Council.

In practical terms, this means that the day to day oversight of the College business is managed by Executive. This is because while Council meets only three times per year (February, June and October), Executive meets a further eight

times a year (in all the other months except December).

So who are the members of the Executive? The Executive is made up of the five office bearers (President, Vice President, Treasurer, Censor in Chief and Chair, Professional Development and Standards Board) and three other Councillors elected by Council.

Most of the decision making regarding issues affecting the day to day running of the College is made by Executive at its meetings. This means that decision making can be faster and more nimble than having to wait for the three regular meetings of Council.

Having said that, however, it is my experience that Executive will never make a decision it believes should be considered by the full Council. Executive's record is laudable in recognising those issues which require broader consultation and the deliberation of the full Council.

Council can also reserve matters it wishes to be considered by Council only and not by Executive. These include matters such as approving the budget of the College and its strategic plan. Executive will, however, do much preparatory work in the lead up to the meeting at which Council makes its decision.

### Fiduciary responsibility

While this arrangement has served the College well for a number of years, it is not without its challenges, particularly for those Councillors not part of Executive.

Any Fellow who has served on a board would be familiar with the term 'fiduciary responsibility'. Fiduciary comes from the Latin *fiduciarus*, meaning "holding in trust". In modern business terms, fiduciary responsibility or duty means to act honestly and in good faith in the best interests of the organisation you represent as a director.

The fiduciary responsibilities of a board's members include:

- avoiding conflicts of interest;
- acting in the interest of the company rather than the member's personal interest;
- providing oversight to ensure that all company business is transacted legally; and
- making decisions to protect the assets of the corporation.<sup>1</sup>

All College Councillors are directors of the company, but not all Councillors are members of the Executive. This can make exercising their fiduciary responsibilities a much greater challenge. While all Councillors receive all the papers for both Council and Executive, those Councillors not on Executive don't have the benefit of attending the meetings and engaging in the decision making process.

DECLARE YOUR  
**LOVE** FOR THE  
**CITY**

Melbourne Open House  
Saturday 28 and  
Sunday 29 July 2012



A major public event in  
the calendar of Melbourne.

Last year the College opened its doors to the general public as part of the Melbourne Open House weekend.

Some 75 buildings not normally open to the public participated. Over 106,000 people from Melbourne, regional Victoria, interstate and overseas attended. The College received about 750 visitors over the weekend.

***This year we plan to do it again.***

The areas of the College which will be open to the public are: Council Room, Hailes Room, Hughes Room, Council Corridor, Foyer and Gallery Skills Lab.

For more  
information  
please contact  
Megan Sproule or  
Geoff Down  
at the College.  
+61 3 9249 1200

MELBOURNE  
**OPEN  
HOUSE**

*“Executive meetings mean decision making can be faster and more nimble than having to wait for the three regular meetings of Council.”*

In my experience, Councillors are extremely diligent in keeping up with the progress of matters at Executive meetings between Council meetings and many will contact a member of Executive to ensure that their view can be considered in the discussion at the meeting.

The Constitutional review of 2008/2009 attempted to redress this by proposing a small board with full fiduciary responsibility drawn from a larger representative Council, or Senate.

The proposal suggested that the Council/Senate would retain certain “reserve powers” such as setting the budget, determining the strategic plan and electing the board, but in all other matters the board would have full power.

Ultimately this proposal failed to win support. As the then Vice President, Ian Dickinson wrote to Council:

“By separating the Board from its members, especially those who have strong specialty affiliations and by depowering the Council, it may achieve the opposite of the gains of recent times. It may be seen as the triumph of executive power over representative power.”

As a Collegiate organisation, it has always been my belief that College Council should be as representative of the Fellowship as possible, but this must be balanced by Council’s capacity to deliver good corporate governance.

Over the coming months the working parties reviewing the College’s governance arrangements will be putting various

proposals to Council. Some of these may require a change to our Constitution and a ballot of Fellows. I trust this article will be of assistance to Fellows in considering any governance ramifications for the College in any referendum that flows from this process.




**Keith Mutimer**  
Vice President

**REFERENCE.**

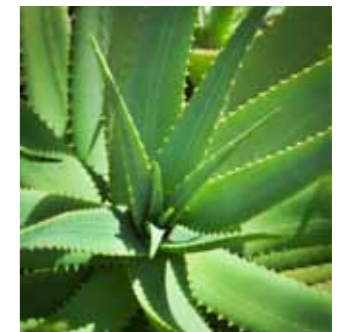
1. <http://biztaxlaw.about.com/od/glossary/f/g/fiduciary.htm>

If you are interested in leadership, attend courses ‘Strategy and risk for Surgeons’ or ‘Leadership in a Climate of Change’. See p 37 for details.



**Saved by a thumb**

Surgeons managed to reattach a thumb of a man who cut it off during a wood work session. Ali Arezi was preparing himself for life without full hand function after he lost his thumb while using a circular saw. His wife was able to find the thumb and reached the Calvary Hospital quickly where Fellow Ellis Choy worked at re-attaching the thumb through surgery. Surgeon Muhammed Ali Hussain said it was a very delicate procedure. “Mr Arezi was very fortunate that on the day he came we had the theatre available straight away,” Mr Hussain said. *Canberra Times*, 19 March




**Homeopathy crackdown**


Authorities are re-examining the claims of Homeopaths with the National Health and Medical Research Council set to claim that the work is baseless and unethical. This may have serious effects on the industry with insurers possibly evaluating the rebates on some treatment.

The statement is claimed to say that although “homeopathy was not harmful in its own right, it might pose a risk to patients if safe and efficacious conventional treatments were delayed in favour of homeopathy treatments.”

*The Age*, 14 March



**GENERAL SURGEONS AUSTRALIA ANNUAL SCIENTIFIC MEETING**  
BUILDING THE FUTURE OF CANCER CARE  
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HOBART  
21 - 23 SEPTEMBER 2012  
[www.generalsurgeons.com.au](http://www.generalsurgeons.com.au)



**2012 NSA Annual Scientific Meeting**



Sheraton Mirage Resort and Spa Gold Coast, Queensland  
4 – 6 October 2012  
Further Information  
T: +61 3 9249 1273  
E: [nsa.asm@surgeons.org](mailto:nsa.asm@surgeons.org)  
[www.nsa.org.au](http://www.nsa.org.au)




Provincial Surgeons of Australia



**48th Annual Scientific Conference**

1 - 3 November 2012  
Mount Gambier

**Save the Date**

Invited Speakers:  
Mr Glenn Guest  
Associate Professor Tim Price  
Dr Frank Voyvodic



[www.vascularconference.com](http://www.vascularconference.com)



**VASCULAR 2012 CONFERENCE**  
20 – 23 OCTOBER  
CROWN CONFERENCE CENTRE, MELBOURNE, AUSTRALIA  
‘Solutions to Challenges in Vascular Surgery’

**SAVE THE DATE**

AUSTRALIAN & NEW ZEALAND SOCIETY FOR VASCULAR SURGERY  
COMBINED WITH THE  
ASIAN SOCIETY FOR VASCULAR SURGERY  
AND THE  
WORLD FEDERATION OF VASCULAR SOCIETIES

# Fracture Management Course

Supported by the Foundation for Surgery

As part of the ongoing work of the Foundation for Surgery there is a focus on building partnerships with related groups within the College umbrella.

The inaugural Pacific Islands Fracture Management Course was undertaken in Suva in late 2011.

The course was an initiative of the Orthopaedic Outreach program and was put together at the request of local medical staff in Fiji. Much of the funding for the course was made available by the Foundation for Surgery due to a generous grant from the Kimberley Foundation.

The Kimberley Foundation is administered by the Williams family. Many of the readers would be aware of the tremendous work of the late Dr Peter Williams, a paediatric orthopaedic surgeon in Melbourne who established the Kimberley Foundation. One of his great passions was education and training.

The course was undertaken at the Fiji School of Medicine in Suva. Suva is the home base for the Masters of Surgery program which is a four year course designed to give Pacific surgeons a wide

variety of surgical skills that they will require in their home countries. Whilst some of the participants in the course have a sub-interest in orthopaedics, many of the surgeons on the course will be required to undertake all manner of surgery in a truly generalised sense.

The course had nursing and medical modules to help build the necessary team expertise to deliver high quality orthopaedic care. The trauma burden is enormous in all societies, but this is especially so in the developing world.

Our colleagues in the Pacific are often required to deal with high level road and industrial trauma with relatively limited equipment and training.

Therefore, Orthopaedic Outreach with the support of the Foundation for Surgery through the Kimberley Foundation has embarked on the establishment of training courses to help build this expertise.

The course concentrated on principles associated with correct use of screws and basic fixation devices such as compression plates. Equipment maintenance lectures and equipment planning lectures were delivered to the nursing staff.

The course then focused on the practical

management of common fractures, and case discussions were undertaken on both simple and complex trauma. The importance of developing audit systems was also addressed and all lectures were interspersed with a heavy practical component; the practical component of the course was only made possible by the generous support of Dotdash Australia who provided equipment and staff to help with setup and teaching.

There were 20 medical staff and approximately 15 nursing staff attending. Instructors on the course were delighted with the enthusiasm and the gains in knowledge that were evident. At the request of the local Pacific Islands medical staff, we will be looking to increase the number and complexity of these courses over the coming years.

The course is an excellent example of the work being undertaken by the Foundation for Surgery and demonstrates the value of developing partnerships between various groups within the College.

**Michael McAuliffe**  
Course Coordinator



## Poison'd Chalice

“What’s done cannot be undone”

Macbeth Act 5, scene 1, 68.

I stared at my desk and slowly exhaled. I looked out the window and winced at the intensity of the sunlight coming through. I was obsessing and I knew it. It felt indulgent and I wondered whether this is how dementia begins, the first steps into the prison of oneself.

I was having one of my existentialist moments. I had actually studied Existentialism as my first year elective at university. Very deep thinking I had been as an idealistic 18-year-old. My older brother had been drafted into the Vietnam War. I was walking the streets with placards, wearing my half white coat that medical students wore in those days, so long ago.

As I handed a pamphlet to an elderly lady on the pavement, I heard her mutter “Whatever next? Now the ice cream sellers are on strike!” However, at that age, the individual was unique and isolated in a hostile world. Our freedom of choice and the consequences of our actions needed to be clear, decisive. There were imperatives.

There was good and there was bad; it was black and white back then. Yes, they were the days of placards, expressing our primal concerns and urges...

What is the path from Vietnam War objector to Director of Surgery? Each virtually unrecognisable to the other, yet one and the same. Perhaps a theme of idealism carried through – at least at the beginning. When I had been approached to be Director of Surgery, it was with words of “you can make a difference”, and “we need the voice of surgeons at the highest levels”. Yes, I can!! Thoughts of surgical service development and expansion had occupied my mind. What benefits the hospital would bring to the community with these additional resources. Amazing opportunities.

However, so cleverly are we carried to the ‘Dark Side’. One step at a time becomes a slide down an ever increasingly steep slope. With increasing velocity, black and white becomes grey! Freedom becomes chained by responsibility.

“Chains” have been on my mind recently. Voltaire, from a country that knows a thing or two about bondage, wrote “All our lives we live in chains and never even know we hold the key”. And then there was Rousseau with “Man is born free and everywhere he is in chains”. No wonder they needed the French Revolution and the guillotine!

The sunlight again flashes through the window and I am sure that I see the chains around my ankles, chains around my desk.

I had sat at the Minister’s budget announcements when the adjustments to Casemix funding were announced. It was a wonderful technical explanation with an immovable bottom line. Less money, but increased opportunities for productivity improvement! I had sat in the Hospital Executive meeting as this was slowly analysed and digested. Less money equals fewer services.

I had raised my hand; what about those benefits to the community from the additional resources, those expanded services, that better equipment? That had been last year’s promises, last year’s budget, and last year’s ambitions. We now have this year. And our ambition? At least keep Treasury happy. Our budgets will be back in surplus by 2013!

Less money and fewer services equal less beds, less operating theatres and less access. The path had been taken one step at a time. Unwillingly, but like the guillotine descending, there was a finality about the closure of the ward. My colleagues had been harsh. My ambitions dashed. My aura punctured.

How was I part of this? I was obsessing again and back to my quotes from Shakespeare. “There is the tide in the affairs of men. Which taken at the flood, leads on to fortune. Omitted, all the voyage of their life is bound in shallows and in miseries. On such a full sea are we now afloat. And we must take the current when it serves, or lose our ventures”.

How was I to move this surgical service, the enthusiasm of my peers, the requirements of the community back to the ‘full sea’? Maybe Shakespeare was wrong? Maybe what is done, can be undone. Maybe I needed to become French – know the chains and have them removed. Perhaps we do need a revolution...

**Professor UR Kidding**



Fracture Management Course participants

# More than paper

Sometimes we need reminders that we are more than paperwork

Paper is strewn around me. Like jettisoned confetti, it haphazardly lies festooned on the floor, occasionally flickering in a reaction to my passing hand. There are piles of it. I pretend that there is some semblance of order to the chaos, that it was once organised into piles associated by topic, clinical relevance or date of writing. But it may as well have been arranged according to shape and colour of the paper, or how many creases each one has upon it.

This is my life. Correct that. This has been my life, for some years. And like that box full of yellowed and ageing paper files that was sitting on top of the cupboard until yesterday, it has all recently come crashing down around my ears, leaving a pile of mess and paper for me to clean up. The house is large and quiet. The

silence waits expectantly for me to fill its gaping emptiness with the gentle rustle of paper. Dry crackling, like autumn leaves scuffled by my feet. Words jump out at me, like sprinters from their stocks at the crack of the gun; Inhibitor therapy, Motivational techniques, Oncological resection, Salvage surgery, Reconstructive options.

I work laboriously, cataloguing each one into a topic, a time, a trial, a treatment. The passage of time goes unheeded for a change. I do not have anywhere else to be right now, except here. I shift my weight, leaning over the pile of Surgical News issues to make a deposit on the smaller outer orbit of fatigue management. Somehow, my head bumps the edge of the desk and a hailstorm of flash cards rains down

around me. The final few hundred pepper down with a last clump into my lap. Oh well. At least they were numbered; all two thousand, four hundred and eighty-three of them.

I stand up to collect the remaining four or five cards still left sitting on the desk, and underneath these there is a discovery. A small surprise waiting just for me. The ever growing pile of flashcards must have eclipsed and concealed another smaller pile of cards on its rapid, exponentially-expanding journey to dominate my desk space.

This smaller pile of cards is brightly coloured, with pictures of teddy bears, flowers, ribbons, and bunnies. I gently, carefully pick them up, scared that they might suddenly cease to exist. I open the first. "Dear Dr \_\_\_, Thank you so much

for the care you gave me during my op. Regards, B\_\_T\_\_."

Another, "Dear Dr \_\_\_, Thank you so much. M\_\_A\_\_."

And another, "Dear Dr \_\_\_ Thank you for looking after my mum for the last few months. Sincerely K\_\_ B\_\_."

There are dozens of them. When they were given, I remember being embarrassed. I did not need reward or favour more than that which I already had from doing all that I could do. But now, I am thankful for their gratitude, for these cards.

They remind me that I have touched people's lives and made a difference in their world. That it is not about how many pieces of paper I have amassed or how many piles there are, but that what I do is what matters.

Dr Ina Training

*This smaller pile of cards is brightly coloured, with pictures of teddy bears, flowers, ribbons, and bunnies."*



## North West Private Hospital

People caring for people RAMSAY HEALTH CARE

### Breast & Endocrine Surgery Fellowship 2013

Since 2002, North West Private Hospital has offered a one year Fellowship in Breast & Endocrine Surgery in conjunction with the Royal Brisbane & Women's Hospital. The Fellowship is offered under the supervision & guidance of Professor Ian Gough & other surgeons working at both hospitals. Professor Gough has more than 30 years experience in Breast & Endocrine Surgery.

The Fellowship offers an outstanding training in Breast & Endocrine Surgery with a substantial clinical work load in dedicated out patient clinics, operating sessions & weekly multi-disciplinary meetings. All previous fellows are now continuing in successful consultant careers. The holder of the fellowship will also be encouraged to participate in clinical research programs & will be offered the opportunity to initiate clinical/collaborative research study.

**This fellowship in Breast & Endocrine Surgery is to be offered again for 2013.**

The Fellowship is for one year at North West Private Hospital. This Fellowship provides exposure to the private hospital sector at

**Further information regarding the Fellowship & application requirements may be obtained from:**

**Professor Ian Gough - North West Breast & Oncology Service**  
North West Private Hospital, 137 Flockton Street Everton Park QLD 4053

**Applications close on Friday 28th June 2012**

**07 3870 2450**

Fax: (07) 3371 6143  
Email: goughmed@bigpond.com

NORTH WEST PRIVATE HOSPITAL

North West Private Hospital in conjunction with public care at the Royal Brisbane & Women's Hospital. The fellow will also work in the Centre for Breast Health at the Royal Women's Hospital & in the Endocrine Surgery service at the Royal Brisbane Hospital.

You will hold a FRACS; be eligible for registration with the Medical Board of Australia; have recently completed advanced training in general surgery, & be seeking further experience in breast & endocrine surgery. You will work under the supervision of three specialist surgeons & assist with private surgical operations.

You will require personal medical indemnity cover, but employer indemnity will be offered by Ramsay Health Care Hospitals & Queensland Health respectively.

The remuneration provided by the Fellowship is \$75,000 AUD per annum. Income will be supplemented from private surgical assisting & for some duties at Royal Brisbane & Women's Hospital.

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## 2012 Annual Scientific Congress

All the programs are finished, section dinners booked, session chairs appointed and all is ready for the 81st Annual Scientific Congress at the beautifully sited Kuala Lumpur Convention Centre. Registration is easily achieved on the congress website – [asc.surgeon.org](http://asc.surgeon.org)

### Convocation & Welcome Reception Sunday 6 May

The official beginning of the meeting is the Convocation on Sunday afternoon when more than 100 new Fellows will formally join the College. During the Convocation a number of surgeons and three non-surgeons will receive Honorary Fellowships – the recently retired and inaugural Community advisor, The Honorable Geoffrey Davies AO and the inaugural financial adviser, Mr Brian Randall each of whom has contributed so much to the College. Honorary Fellowships will be awarded to two surgeons who have contributed to the College and its international relationships

– Dr Nopadol Wora-Urai (Thai College of Surgeons) and SK Lum (Malaysian College of Surgeons).

Professor Robert Sutherland, Director of the Cancer Research Program, Garvan Institute of Medical Research and the inaugural Director of The Kinghorn Cancer Centre, St Vincent's Hospital, Sydney, whose reputation for research on breast cancer has made him a figure of international repute will also receive an Honorary Fellowship.

The Louis Barnett medal for services to surgical education will be presented to John Hall who recently stepped down from the editorship of the ANZ Journal of Surgery. John Harris and

John Graham will receive ESR Hughes medals, Graeme Richardson and Richard Bennett the RACS medal for service to the College and David Scott will receive the International medal. Finally, Professor Marcus Stoodley will be presented with the 2012 John Mitchell Crouch Fellowship. The venue is the spectacular Plenary Hall at the Conference Centre.

Immediately following the Convocation, the President will host the Welcome reception from 6-7pm. Situated in the east foyer overlooking the gardens and the twin towers of the Petronas Centre, the night-time views will rival the fireworks display at the Adelaide Congress.

### Scientific programs

At this Congress, 28 section and special interest programs have been convened. The conveners are to be congratulated on an outstanding educational program over the four days of the meeting. Well over 700 research abstracts were submitted and the conveners have selected 689 for the meeting. Three hundred will have podium presentations and the remainder have been accepted as electronic posters. The posters can be viewed on the screens at the eastern end of the Exhibition area; follow the instructions on the screens.

### Head and Neck Surgery

This program is convened by Jonathan Clark, Carsten Palme and David Veivers. They have compiled an innovative and exciting multidisciplinary program reflecting the evolving and multidisciplinary nature of head and neck surgery.

The international invited speakers come from two leading North American cancer centres – Professor Douglas Chepeha, from Ann Arbor, Michigan, and Professor Ian Ganly from Memorial Sloane Kettering, New York. Dr Chepeha is the director of the microvascular

program and head and neck oncology at the University of Michigan. Dr Ganly's clinical focus is on minimally invasive head and neck surgery and he has research interests in molecular therapeutics and gene expression profiling. The local faculty is made up of distinguished speakers from all major Head and Neck Centres in Australia led by Professor Gary Morgan, Sydney and Professor William Coman, Brisbane. The Head and Neck section is fortunate to have Professor Khee Chee Soo from Singapore as the invited speaker for the Surgical Oncology section and he will speak on the challenges of conducting clinical trials and basic science research as a surgeon.

The program's theme focuses on the clinical application of biomarkers, overcoming the impediments to translational head and neck cancer research, assessing competency and training in head and neck surgery and revisits trans-oral laser microsurgery for early larynx cancer with several mini-symposia to address these topics in additional depth. There are also combined specialty sessions with Endocrine surgery, Surgical oncology and Plastics

on the topics of advanced thyroid cancer, melanoma and reconstructive head and neck surgery, respectively. The Head and Neck section dinner is on Tuesday night.

### Medico-legal section

Neil Berry has brought a wealth of experience to the convening of the Medico-legal program. The Medico-legal section program will be conducted over one day. The day commences with a Masterclass aimed at surgeons who are asked for the occasional medical report. Neil and Leigh Atkinson will show you how to correctly structure a report and provide the evidence without having to attend court.

The major theme of the program is multidisciplinary teams and meetings.

Dr Mark Sidhom (radiation oncologist who has published in *The Lancet*) is the section visitor and he will give the James Prior lecture on the legal pitfalls associated with multidisciplinary teams. Mark will also direct a major combined session that includes Breast, Rural, General and HPB surgery on the issues arising in such teams – where does medico-legal responsibility lie? ▶





We are fortunate to have Peter Semmler QC discussing expert witness issues and Justice Mai Weng Kwai of the Malaysian High Court talking on the Malaysian approach to Medical Negligence. This should be an entertaining and informative day for any surgeons who have an interest in the medico-legal aspects of surgical practice. The Medico-legal dinner on Tuesday night is combined with the History, Military and Trauma programs.

### Vascular surgery

Ravi Huilgol has convened the Vascular program that will run for three days (Tuesday-Thursday). The program will cover many of the key areas in Vascular surgery. Highlights will include the Tuesday masterclass session on endovascular repair of type B aortic dissection and the following morning, a second Masterclass on strategies for percutaneous arterial access. The International and Australasian invited speakers, headed by Professor Jon Matsumura (US) and Professor Nick Cheshire (UK) will keep delegates fully informed across a wide range of the latest research and innovations in Vascular surgery. Professor John Harris will address aspects of the medico-legal issues that affect Vascular surgeons.

The final session on the program will involve presentations of challenging cases in Vascular surgery with the opportunity for the audience to vote on the best presentation. This will be an excellent way to finish what will be an educational, entertaining and informative Vascular program. The Vascular dinner on Tuesday evening is at the highly regarded Cilantro Restaurant.

### Evening functions

On Monday evening there is the opportunity to experience 'Malaysia in miniature' at the Cultural and Culinary evening. This will be held in the foyers of the Conference Centre so will be easily accessible. A range of Malaysian foods demonstrating the cultural influences in Malaysia will be served, as delegates take in Malaysian cultural events. Dress is very casual and bring your camera.

All the section dinners are on Tuesday night and a number of leading Kuala Lumpur restaurants have been booked to host these dinners.

Wednesday night will be the superb Congress Dinner at the Mandarin Oriental hotel. An outstanding banquet is planned, again with a Malaysian flavour and spectacular Malaysian dancing.

Book for each of these events on the registration site 'asc.surgeons.org' and click on registration, or on the registration form.

### Transport from KL Airport to the conference centre hotels

Traffic in Kuala Lumpur can be hectic and especially around peak hours. Travel from KL International Airport (KLIA) is best by the high speed rail link – KLIA Ekspres. The trip is 28 minutes; cost is between RM35 and RM70 and operates from 5am to 1am. The train terminates at the central railway station (KL Sentral). Additional transport is required to reach the conference centre and the recommended hotels. This would be by taxi or by the metropolitan railway from KL Sentral to the station at the shopping centre at the base of the Petronas Towers. This is the KLCC stop on the Green line (direction 'Putra'). Further information is available on the website [www.KLIAekspres.com](http://www.KLIAekspres.com)

We look forward to seeing you in Kuala Lumpur.



By **Philip Truskett**  
(Congress Convener)  
and **Raffi Qasabian**  
(Congress Scientific Convener)

# RACS ASC 2012

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# Online Logbook

A new way to track your logbook

Like many Trainees I thought (or rather hoped) that I had managed to leave the paperwork and forms associated with residency training, only to be confronted by the avalanche of new paperwork that constituted my surgical training program. According to many colleagues one of the most detailed, time consuming and often frustrating of these tasks is the end of term logbook. I have often seen colleagues traipsing the halls of our hospitals, clutching what can only be labelled as a non-descript book, sometimes a black leather-bound pad, sometimes a more humble paper notebook, often just a wad of papers filled to the brim with stickers.

Details ranging from the number of laparotomies in March or the number of lap choles in February fill the pages. Was it a major or minor? Was the boss scrubbed or available? Or was it the fellow on that list? These details and the like are seen scrawled in the paper margins, smudged and smeared by the entry below. Compiling it all at the end of a six month period takes an endless trawl of the paperwork, reading over the notes and compiling the numbers and arranging them by consultant so they all make sense.

This somewhat archaic system has finally been replaced by a new, modern, time saving and effective electronic web based system; The Online Logbook.

The summary is this: The new online logbook is good, available, in the process of regular improvements, and it is a far superior method for tabulating our surgical experience.

The College has spent years conceptualising and developing a web based logbook which aims to streamline the preparation of logbooks for Trainees as well as provide the opportunity for audit. It was released for use by Trainees and supervisors from the beginning of this year and is available for Trainees from:

- General Surgery,
- Neurosurgery,
- Cardiothoracic Surgery,
- New Zealand Orthopaedic Surgery.

The process for using the logbook is simple! After logging on (all Trainees in the above specialties can do so), an account is simply set up by selecting the hospitals at which a Trainee is based, then allocating a term supervisor followed by other consultants the Trainee works with. If a consultant is not on the list, their details can be added by emailing the logbooks team the relevant details of the consultant (logbooks@surgeons.org).

Adding a case is intuitive and involves:

- Adding patient details.
  - Selecting if the case is an operative procedure or non-operative management.
  - Selecting the specific details of the case/operation from a drop-down box.
- Finally, the supervisor for the case is allocated, and the Trainee's role is selected (i.e. primary operator with boss scrubbed, assisting other surgical registrar etc).

Additional data can also be added (i.e. M&M data, ASA criteria etc).

When the file is completed it can

be saved (this allows alterations at a later date) or "referred to a supervisor" for approval when the case details are complete.

Supervisors can approve all cases en masse or individually.

The main advantage with the logbook is that with the above simple steps, an electronic entry is created and subsequent entries can be made to compile an entire term's worth of a Trainee's experience.

The data can also be used to form an electronic means of audit and M&M data. As the term progresses, a list of the cases can be viewed and arranged based on date, procedure type, major/minor status etc. In addition the functionality of exporting lists to PDF is an added benefit as the data is tabulated and exported as a PDF document.

### What's good?

The new online logbook negates the need for a paper based system. In my hospital most Trainees add each case to their logbook online immediately after typing their operation report. It saves time and allows overall training data to be compiled early on in a term. Some major benefits are:

- No need to carry a hard copy of a logbook around.
- Can be accessed from work, home, laptop.
- Simple to use.
- Intuitive menus.
- Can use online logbook for end of term evaluation and assessment.
- Ability to use for auditing processes.

### What needs work?

The logbook has been in development for a long time, but like all new electronic systems which aim to solve a paper based system, there are some teething problems. Overall the benefits of a universal logbook for surgical Trainees are obvious, however, some things worth noting are:

- If the internet or server is down, you won't have access.
- Not yet on Iphone, Ipad, android.
- To gain access to the logbook, you need to pass through a few portals until the program opens.
- Not yet able to export data to other programs (such as Microsoft Excel).
- Unable to alter a file after it is "referred to a supervisor".
- Slightly clunky in design if adding a few different procedures for one patient.

### What's in the process?

The above issues and many of those already raised by Trainees are being addressed. In fact, a new and upgraded version of the current logbook is not far away! Although the current version has just been released to Trainees, it has been undergoing development for quite some time and the new upgrade will be released later in the year. The new version will carry on with the same format of the new RACS website and have a better user interface with more functionality – the main aim being to make the software more user-friendly. Excitingly, the iPhone and iPad version is also in current development!

### What to do?

The most useful thing is to log-on and start using the software. If stuck, there are a few instructional documents and

quick reference guides available from the login page (accessible through RACS). Alternatively ask a colleague or contact the logbooks team for help (via logbooks@surgeons.org or on +61 8 8219 0900).

The most valued input to the logbooks committee is from us (the users) and hence any feedback or suggestions are always valued. Since we are still in the pilot stage, we have the opportunity to make changes. It is an exciting transformation and a promising path down a more efficient and paperless way of dealing with our surgical audit and data.

**Hamish Urquhart**  
 RACTA NSW Trainee Representative  
 hurquhart@med.usyd.edu.au

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# Emergency Medicine for Myanmar

A collaboration between Colleges helps Myanmar healthcare grow

Health authorities in Myanmar have requested international expertise and input to develop emergency medicine skills and systems in the lead up to the South East Asian Games to be held there in 2013.

In response, the College Council has approved a proposal by the International Committee for the RACS to work in collaboration with the Australasian College of Emergency Medicine (ACEM) and the Royal Australian and New Zealand College of Anaesthetists to provide initial training later this year.

The College's new involvement in emergency medicine builds on the successful provision and delivery of 19 Primary Trauma Care (PTC) courses to Myanmar medical staff following the devastation wrought by Cyclone Nargis in 2008.

Professor David Watters, a College Councillor and Chairman of the International Committee and External Affairs, represented the RACS at the Myanmar Medical Association meeting held in January where the request for international assistance was made at an Emergency Medicine workshop opened by the Deputy Minister for Health.

He said the request represented a golden opportunity to help develop healthcare in a country that has no emergency medicine specialty and where the vast majority of the population live on only \$1 a day.

He said the College would seek AusAID funding to support the training program with financial support also being provided through the RACS Foundation.

"Myanmar has a population of 59 million yet there is no specialty of emergency medicine, no training and no specialty position in any hospital which is quite typical of a developing nation given that the specialty is relatively young, even in countries like Australia," Professor Watters said.

## More than trauma

"Yet we believe the College can help in the development of emergency medicine as a natural progression from the provision of the PTC courses which began in 2009.

"That program, which was designed to train the trainers, has been extremely successful. So far 130 local faculty members have been trained under international supervision who have, in turn, trained more than 700 other medical staff.

"We believe we can use this collaborative platform to expand our role in teaching the skills of emergency medicine."

Professor Watters said the aim of the training would not simply focus on trauma, but would cover heart attacks, snake bites, burns and strokes.

He said it had now been decided to offer a five-day induction course to be held in June which would include

a component on emergency surgery with the Myanmar Medical Association selecting suitable candidates in May.

"We are now planning the provision of a range of courses in collaboration with the colleges involved including the ATLS course, the EMST course and the Management of Emergency Surgery (MOSES) Course," Professor Watters said.

"I also envisage the provision of an Early Management of Severe Burns course, a course on the emergency treatment for snake bite and a Paediatric Life Support course.

"Some of these will be provided by Australasian specialists and some by Fellows from Hong Kong.

"The Myanmar Medical Association and Health Authorities are also planning to introduce a Master of Medical Science degree in Emergency Medicine by 2014.

"This too will require international input because providing the course will require the services of visiting surgeons and specialists to teach and support students until Myanmar has trained its own faculty."

Professor Watters said the roll-out of emergency medicine training would occur in phases with an initial focus on providing senior hospital staff with the skills to run an emergency department followed by the training of family doctors and rural specialists.

He said that while the Foundation for



Surgery had raised funds to support the PTC courses in Myanmar, extra financial support would be needed if the emergency medicine collaboration was to have a swift and effective impact.

## Coordinated response

"While at the conference in January we had a promising meeting with the Australian Ambassador, Ms Bronte Moules, and I believe that if we were able to obtain Australian government funding the College could offer a more coordinated and larger response to Myanmar's needs with regard to emergency patient care and emergency medicine," he said.

Professor Watters said the international push to develop the specialty was being led by Mr Tai Wai Wong, an emergency medicine specialist from Hong Kong, Mr James Kong, a RACS Fellow and PTC Project Director, Professor Peter Cameron, President of the International Federation of Emergency Medicine from Melbourne, Dr Steven Swallow, an Anaesthetist from Hobart, and himself.

He said Professor Zaw Wai Soe, the local orthopaedic surgeon and traumatologist leading much of the emergency medicine development, had strong ties with Australasian Fellows following a 2011 visit to Melbourne and Sydney emergency departments which was supported by

the Surgeons International fund.

He said the RACS had chosen to lead the collaborative project because it was the only College to have a dedicated International Development department and because of the interest and commitment expressed by a number of Fellows wishing to help develop surgery and quality health care in Myanmar.

"A number of Fellows have gladly offered their skills and time over recent years to provide the PTC courses and that contribution has been warmly received by local medical specialists," Professor Watters said.

"The RACS was invited to the annual meeting of the Myanmar Medical Association for the first time last year with Michael Hollands attending on behalf of the President and it was an honour to represent the College at the meeting this year.

"I think if this project to boost emergency medical care gets the necessary financial support it will involve a large number of Fellows providing their skills and expertise over the next ten years.

"Myanmar is now undergoing rapid change as it opens up to the world and this project represents a wonderful opportunity to support local surgeons, doctors and health workers in the development of Emergency Medicine which will be of great and lasting benefit to their people."

**With Karen Murphy**



## 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 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 twelve months.

Due to the short term nature of these visits, it is often difficult to find affordable accommodation for visiting scholars. If you have a spare room or suitable accommodation and are interested in helping, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a modest rental and eternal appreciation.

If you would like to be contacted by the College if the need for accommodation in your area arises, please register your details by contacting the International Scholarships Secretariat on the details below. We are currently seeking accommodation in Melbourne (near Royal Melbourne Hospital and The Alfred), Brisbane (near Princess Alexandra Hospital), Sydney (near Westmead Hospital) and Adelaide (near Royal Adelaide Hospital) for visits in 2012. We would love to hear from you.

**International Scholarships Secretariat**  
 Royal Australasian College of Surgeons, College of Surgeons' Gardens  
 250 - 290 Spring St, East Melbourne, Victoria 3002  
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*“But how to juggle a family life ... a private surgical practice, pro bono work like College roles, and working at a public hospital?”*



How do we continue our role in the public system?

I am coming to the end of my term as State Chair of the Tasmanian branch of RACS with mixed feelings. I was surprised to find that I had been on the committee for nine years (I only qualified 10 years ago). I have enjoyed the experience, but my role on the committee has been tempered by a shortage of that precious commodity called time.

As in all states, Tasmania's public health system is in crisis, but it may arguably be in the worst condition. I understand our bed numbers have been halved! So I will take this last opportunity to provide a personal take on a system in crisis. What follows is only my opinion, written to provoke thought and discussion in our surgical community.

I recently saw an advertisement for “Head” of the Department of Surgery at the Royal, brought about by the pending resignation of Bob Linacre. You should talk to Bob some time about his experience in this job and why he has resigned. Part of me looks at that role and thinks it would be a great challenge. But how to juggle a family life, five children all of whom do sport and other activities, a private surgical practice, pro bono work like College roles, and working at a public hospital?

I forgot one other thing – self or own time – that gets swamped so easily. What has to give?

At the moment self time, family time and College time is lost first. Which means my work for the College is not as thorough as I would like it to be. The volume of emailed material to be read for regional committee meetings is such that I am guilty of not reading it all in the detail I should.

Strength in numbers

### Little respect

I currently find public hospital work difficult, frustrating and time consuming with little personal reward. This has been brought about by management's attitude towards VMO surgeons. There is little respect for what we do as a group and even less understanding about how this work is effectively an act of altruism.

The role gets harder, given recent demands to further cut our hours, and to privatise outpatients and funnel the money into general revenue. And we alone are responsible for every decision made in the management of patients admitted under our bed card, despite our only being employed five hours a week.

When I was in my last theatre list (I only do one a fortnight now) I was approached by my anaesthetist and shown graphs of increasing trauma load for orthopaedics and dropping elective numbers.

I indicated that I was well aware of the situation. I indicated that despite only having 1.85 FTE for our whole unit to cover all in hour lists, clinics and trauma work, we had been asked to further reduce our hours.

I indicated that we had been cut to 17 beds for all inpatient work, including trauma and elective work.

I indicated that it was very clear why elective surgery is suffering and it was obvious how the situation could be fixed. But that solution involves money and power, and management would give neither away.

But back to the head of surgery job at the Royal. The job description is laughable. It was advertised as a two day a week job and the successful applicant will report to a senior non-clinical nurse who will then report to the CEO. Of note, the senior nurse position was on the same reporting level as the head of surgery until a year ago. Down one more rung on the decision making ladder!

Who in their right mind is going to give up two days of their week, knowing the role is powerless to affect change and will in the end involve their time and energy for seven days a week, as the job in

all honesty should have been advertised? The answer of course is that no surgeon will do this job. I suspect this position will go unfilled, and the surgical community will be excluded from decision making processes that affect their own roles within the hospital.

If the authorities genuinely wanted our engagement, this job would have been a full time position, well remunerated, with the expectation of lots of meetings five days a week, and multiple out of hours phone contacts to put out the inevitable bush fires, making this the senior position in the division with a direct line of communication to the CEO.

I salute people like Bernie Einoder in Launceston and Stephen Wilkinson and Craig Quarmbly in Hobart who have in the past donated an extraordinary amount of time and effort to help save the system (and to all others who have tried in vain to save the system in this and other states). Their work constitutes much more than a full time job.

Up until three years ago I remained an interested provider of public medicine. At that time we had a CEO who showed us courtesy and respect. We were able to effect some change, working alongside Craig Quarmbly. Since that time cost cutting has led to an inefficient and profoundly frustrating system, and when asked to reduce hours it led me to question my involvement at all.

If I were to leave public practice I would be able to rearrange my working life and have time to spend with family, and even have self time. This is an extremely attractive proposition.

I meet colleagues who are now engaged only in private surgical practice. Their common theme is that public work had provided 90 per cent of their grief and less than 10 per cent of their income.

But I want our system to continue.

### Lack of understanding

I believe Australia had the best health care model in the world for many years, with a good mix of public and private care. I am concerned that our politicians and health

departments do not understand the importance of this symbiotic relationship.

They do not understand that a busy private practice allows surgeons the opportunity to donate their time to the public health system, and that our VMO roles have become completely degraded. We are now just “FTEs”, dismissed as a cost rather than valued as an asset.

I want to continue teaching Trainees. I want to help those in our society who need care in the public setting.

What I do not want is to be treated like a number, told to do even more with less, take all responsibility, be available seven days a week, and have my clinic 50 to 100 per cent overbooked each fortnight despite repeated requests to cap numbers.

When training is taken into private hospitals what will there be to keep VMO surgeons in the public system? I for one will struggle to continue to donate time if this occurs and no changes are made to the management of our public hospitals.

Five years ago I submitted a plan to the then head of surgery to take account of our teaching role and separate it from a service role. Nothing came of this. We are employed to cut a waiting list; other functions are deemed unimportant.

On a more positive note I look forward to passing the baton on in a couple of months and returning to an easier role on the committee. I will always find time to stay involved in College work as I feel this is important to our future. The provision of quality surgical care is being challenged by many self-interested groups. I would encourage all Fellows to give some of their time to the work of the College,



**Greg Harvey**  
Chair, Tasmanian  
Regional Committee

# WAASM 10 Years On

The first Australian audit continues to improve outcomes

The Western Australian Audit of Surgical Mortality (WAASM) is an independent, external peer review audit of all deaths that occur under the care of a surgeon. It was established in 2001 and is based on the Scottish Audit of Surgical Mortality (SASM).

The prime purpose of WAASM is educational. Regular feedback is provided to surgeons through an individual case report, a compendium of important case reports, newsletters, an Annual Report and regular multi-disciplinary symposia of important issues.

The annual number of deaths under a surgeon has fallen from 692 to 586 (a fall of 15%). When adjusted for population growth this is a fall from 35 to 27 (a fall of 23%) deaths per 100,000 (Figure 1). The pattern of this fall is typical of that seen with audit – that is minimal change initially and then an improvement as the audit influences practice.

While audit sceptics will argue that there have been many improvements in surgical care over this period, WAASM can clearly demonstrate some areas where it has undoubtedly influenced practice.

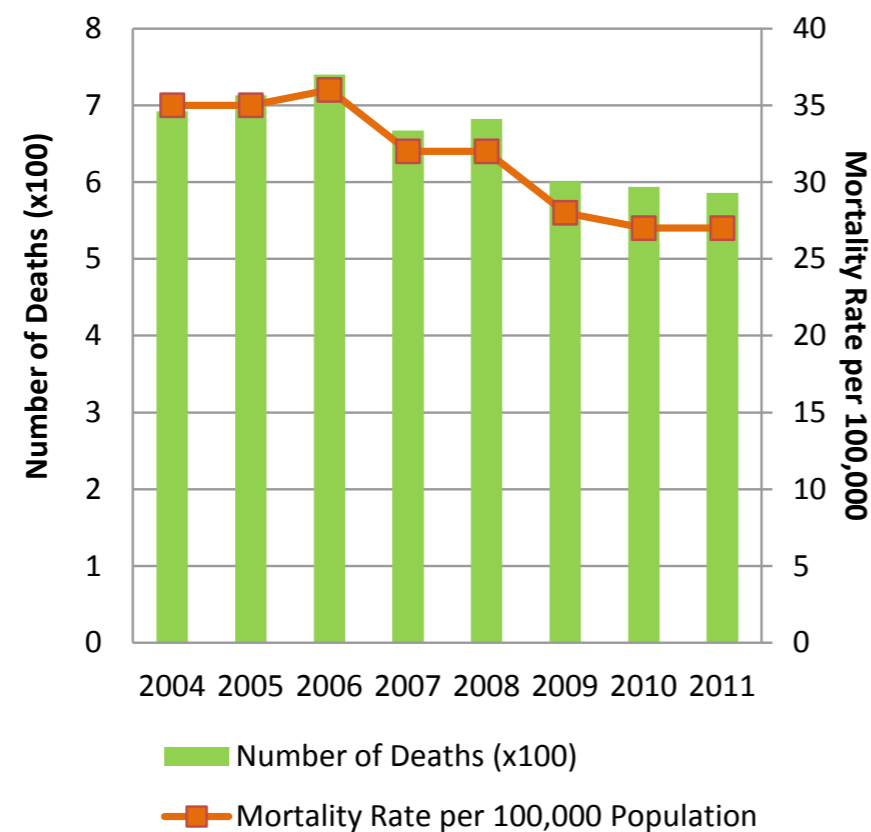
The following examples illustrate some of the areas where WAASM has influenced surgical practice.

## Deep Vein Thrombosis (DVT) Prophylaxis (2002)

An early observation was the failure to prescribe DVT prophylaxis, or the failure to administer it appropriately. A symposium was held in 2002 and subsequent data has demonstrated that there have been measurable improvements (an increase of ~15%) in patients receiving DVT prophylaxis.

## Anticoagulation in the Peri-Operative Patient (2005)

An increasing number of surgical patients receive some form of anti-coagulant. WAASM data showed that the management of this in the peri-operative period was problematic and there appeared to be a clear need for guidance on the risk of thromboembolic events when anticoagulation therapy



is interrupted, and the risk of bleeding associated with a procedure. Cardiologists, physicians and anaesthetists addressed a well-attended multi-disciplinary symposium. Since that symposium there has not been a death secondary to anti-coagulation mismanagement.

## Fluid Management in the Surgical Patient (2008)

WAASM reported a number of preventable deaths that were directly related to post-operative fluid load. This was a problem that was also of concern to SASM. By chance, one of the Scottish anaesthetists directly charged by SASM to produce guidelines for the Scottish Intercollegiate Guideline Network (SIGN) was undertaking a sabbatical in WA and contributed to a very well attended symposium in Perth. A subsequent report with recommendations was

disseminated to all WA surgeons. There has subsequently been a significant improvement and whereas some 52 deaths were associated with fluid balance issues in 2007 this had fallen to 9 in 2011.

## Whipple's Procedure (2008)

In 2007 and 2008 WAASM became concerned that the number of deaths in WA following a Whipple's resection appeared to be greater than expected. In association with the WA Health Department, WAASM obtained detailed data for all Whipple's resections in WA. This analysis confirmed WAASM's concern. A working party chaired by the WA Chief Medical Officer reviewed the process of care for all WA patients undergoing major upper GI resections. These are now managed in major teaching hospitals by surgeons who have the appropriate training, skills and support. There subsequently has been only one death following a Whipple's resection.

## Recognising the Deteriorating Patient (2011)

This is an area of both national and international interest. Unlike other WAASM symposia this was open to all members of the medical profession and senior nurses. The attendance was overwhelming. The important feedback was that as a direct consequence of this symposium nurses better understood the very detrimental impact of delay and felt that this symposium gave them the information they required to empower them to escalate care if they were not happy with the initial response. Such was the positive feedback that the Australian and New Zealand Audit of Surgical Mortality (ANZASM) through other State mortality committees, organised similar

workshops and symposia across Australia.

Much harder to evaluate is the 'halo' effect that comes from audit. In a survey surgeons indicated that WAASM had influenced and changed their practice and this is in keeping with a recent report from SASM<sup>1</sup>. So the halo effect may be substantial.

Given the undoubted improvement in care that WAASM has generated, it is disappointing that some surgeons still do not participate, and others complete proformas in a less than satisfactory manner. Participation is now a mandatory part of CPD and having a current CPD certificate is essential to register with the Medical Board of Australia (MBA).

The MBA regulations state that medical practitioners who do not complete their registration requirement by the due date risk

suspension after one month. Non-participating surgeons thus face the very real risk that they will not be able to work. WAASM is not the only state mortality audit facing this problem, and lack of participation was specifically highlighted in the first Annual Report of the National Vascular Audit<sup>2</sup>. College Council needs to provide clear guidance and leadership in this matter.

**James Aitken**

WAASM Clinical Director

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# The edge of research

The John Mitchell Crouch Fellowship has allowed for more experimental research

One of the great benefits of receiving the College's prestigious John Mitchell Crouch Fellowship – apart from the honour of peer recognition – was that the attached funding could be used to support more experimental research than that stipulated by other funding organisations, according to 2011 recipient Professor David Little.

Professor Little said that while some NHMRC grants were larger than those provided by the College, most were only allocated when significant pilot data had been generated.

Yet the funds attached to the John Mitchell Crouch Fellowship – one of the most generous grants offered by the RACS – could support research that either threw up some surprises or that could provide the data needed to secure further funding.

"It was a great honour to be awarded the JMC Fellowship and also of great value because it helped fund higher risk experiments which other grants don't allow," Professor Little said.

"The monies attached permit researchers like me to push our work forward which would otherwise be extremely difficult in Australia's scientific funding environment."

Professor Little is head of Orthopaedic Research and Biotechnology and Senior Staff Specialist at the Children's Hospital at Westmead, Sydney.

As the head of a 10-person research unit, Professor Little has been investigating cellular contributions to bone repair, particularly in relation to open fractures and high energy injuries which have a high risk of delayed union and non-union.

He said that even with agents such as bone morphogenetic proteins that can generate significant amounts of new bone, the treatment of serious fractures remained challenging, with direct hospital costs estimated at \$12,000 per non-union with a far greater socio-economic cost.



profile

## Professor David Little

> AOA Award for Orthopaedic Research, 2010.

> Stuart Weinstein Basic Science Paper Award for the Outstanding Paper by the Pediatric Orthopaedic Society of North America, 2010.

> ABC Travelling Fellow, AOA, 2002.

He said that in open fractures, the periosteum was destroyed yet some of these fractures heal while others attempt to, pointing to other secondary sources of bone-forming cells.

His research has been focused on developing mouse models to identify the cell population most critical to successful repair to allow for future therapeutic interventions specifically designed to advance the process and improve outcomes.

"What we are trying to do is to find which cells and which systems can promote bone growth and then develop a mechanism to encourage them and to do that we need to understand the history of particular cells, where they have come from, where they have been and what

triggered them into action or to change," Professor Little said.

"In the transgenic mouse strain we have bred cells that have at any time expressed the master muscle commitment transcription factor MyoD can be tracked, even after trans-differentiation into another cell type.

"We have also shown and published that myogenic cells do not directly contribute to the repair of closed fractures, but appear to be involved in open fracture healing where the periosteum is absent.

"In addition, we have sourced and bred reporter mice that enable us to track the contribution of vascular endothelial cells to fracture healing in a similar system."

Professor Little said the ultimate aim of the tissue engineering research was to develop a porous polymer system in which scaffolds could be used to stimulate bone growth or even injectable systems that could do their work rapidly before being absorbed by the body.

His work has received significant recognition both in Australia and overseas. As well as the John Mitchell Crouch Fellowship, Professor Little has received the Australian Orthopaedic Association's Award for Orthopaedic Research in 2010, the Stuart Weinstein Basic Science Paper Award for the Outstanding Paper by the Pediatric Orthopaedic Society of North America 2010 and was the ABC Travelling Fellow as chosen by the Australian Orthopaedic Association of 2002.

Professor Little said further trials in animal models were now being planned while the clinical use of the research was possibly a decade away.

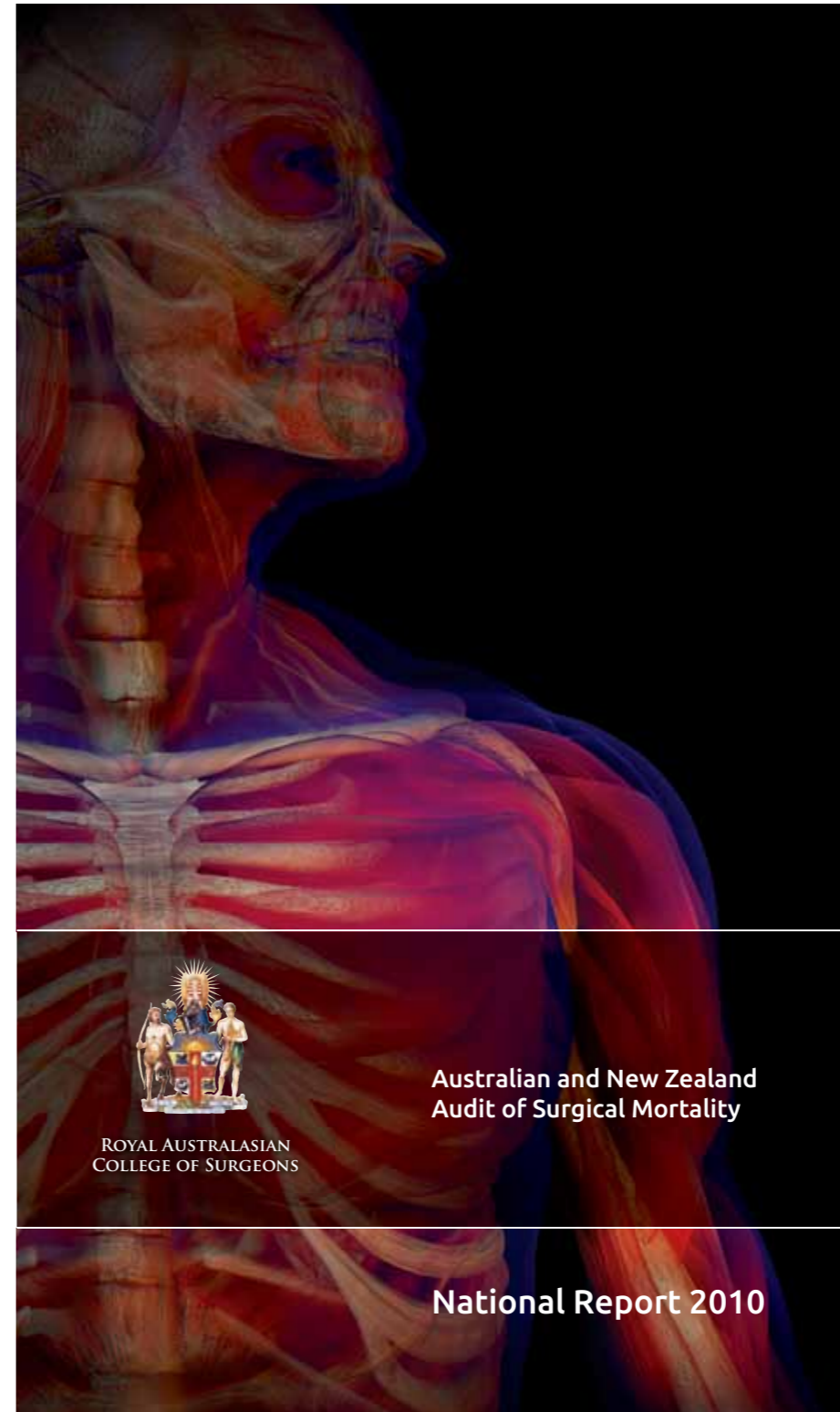
"There is a very big barrier to human trials," he said.

"One is the difficulty of scaling up the technology so that it can benefit humans and the other is that any new technique has to be extremely good to outdo the wonderful things that orthopaedic surgeons can already do."

With Karen Murphy

# Surgical Mortality National Report –ANZASM

A full copy of the report can be found on College website



## Chairman's Report

This year sees the production of the second annual report of the Australian and New Zealand Audit of Surgical Mortality. At the time of writing, all states and territories within Australia are participating and have now produced 24 months of data. This is an abbreviated summary of the full edition of the second national report using 2009 to 2010 data. To now have standardised data being collected across Australia represents an enormous achievement for the audit, which started out as a state-based audit in Western Australia. The considerable financial commitment made to the audit from all the states and territories is a great vote of confidence in the value of such an enterprise. It is now our responsibility to deliver on its promise.

One of the challenges that remains to be dealt with is the number of private hospitals that are not participating, or have yet to participate, in the collection of data in Queensland and New South Wales.

There may be a perception by those state governments that the audit process and participation in the private sector is not an important requirement. In the other remaining states, however, this collection is funded by the state governments and encouragingly, their participation levels are very high. Similarly, private hospitals should wish to ensure that the standards they deliver are at the highest level; a national audit process would only benefit the hospitals and their patients in maintaining the highest standards of care.

The feedback to surgeons of problems, the careful analysis of their genesis and change in practice can all lead to a reduction in surgical deaths. The recognition of deep vein thrombosis prophylaxis is making a significant impact on surgical mortality and has been clearly demonstrated by the audit. Management of the deteriorating patient and appropriate fluid resuscitation are other areas that have now been brought to the attention of surgeons from their own data, rather than from reports emanating from overseas centres.

While there is every reason to be delighted with the progress of the audit to its current stage, there are considerable challenges yet to be met. I look forward to resolving these important issues over the next 12 months.

### Summary

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) is an independent external peer review of surgical mortality in all states and territories of Australia. Each audit of surgical mortality (ASM) is funded by its state or territory department of health (Western Australia, Victoria, South Australia, Queensland, Tasmania, Australian Capital Territory and Northern Territory). New South Wales provides comparable data to ANZASM, but is independently managed by the Clinical Excellence Commission (CEC) of New South Wales. Denominator numbers vary throughout the report due to the variation in completion of all questions on the surgical case form.

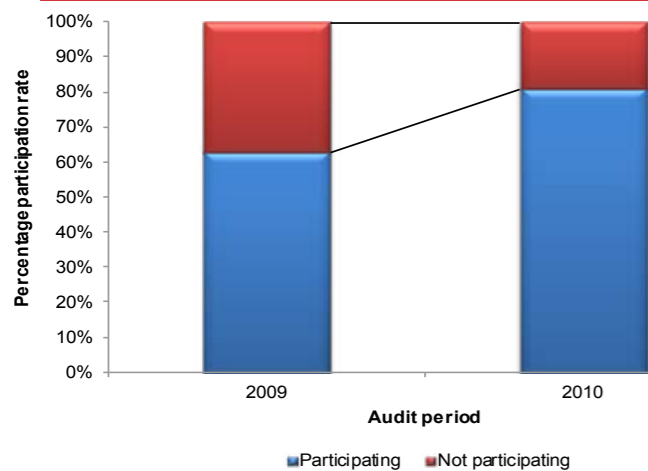


Figure 1: Participation by surgeons (n=6,892)

### Audit participation

There has been increasing participation in the ANZASM process by Fellows. Participation has risen from 60 per cent in 2009 to 81 per cent by the end of 2010. (as seen in Figure 1).

### Audit numbers

Of the 11,303 deaths, 6,507 (57%) had proceeded to, and completed the audit process by the census date. The clinical information from these 6,507 surgical cases forms the basis of this report. The remaining 4,796 cases were not included in the audit for the following reasons: excluded due to admission for terminal care, inappropriately attributed to surgical care, treated by non-participating surgeons or had not completed the audit process by census date. This latter group of 2,919 cases will, of course, be available by the next census date.

### Demographic and risk profile

Of the 6,507 cases which have been peer-reviewed, the majority (91%) of audited deaths occurred in patients admitted as emergencies with acute life threatening conditions and with significant coexisting illness. The most common comorbidities were cardiovascular, age and respiratory (as seen in Figure 2).

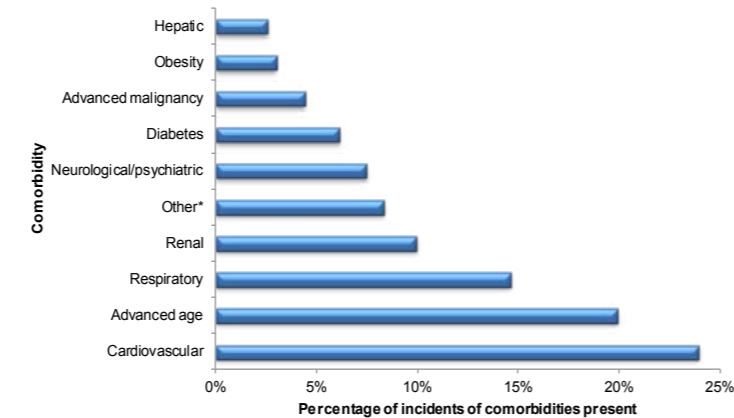


Figure 2: Frequency of specific comorbidities (16,736 comorbidities in 6,285 patients)

Missing data: 222 cases (4%).

\*Other comorbidities covered a wide range and included alcohol abuse, anaemia, anticoagulation, bowel ischaemia, cachexia, cellulitis, coagulopathy, dementia, human immunodeficiency virus/acquired immunodeficiency syndrome, malnutrition, motor neurone disease, polymyalgia rheumatica, rheumatoid arthritis, sepsis and systemic lupus erythematosus.

Death was most often adjudged by assessors to be not preventable in 85% of cases (data not shown), and to be a direct result of the disease processes involved rather than of the treatment provided.

### Risk management

Risk management strategies for this generally elderly, sicker group of patients are especially important. In this segment, the report looks at three parameters: venous thromboembolism (VTE) prophylaxis to reduce the likelihood of pulmonary embolus, use of critical care facilities and fluid balance management.

- **VTE prophylaxis:** prophylaxis was provided in 77 per cent of audited deaths. A conscious decision to withhold prophylaxis was the reason given for non-provision in most of the remaining patients. This was generally necessitated by some clinical contraindication to prophylaxis. Inadvertent omission of prophylaxis was rare, only occurring in 3 per cent of cases.
- **Use of critical care facilities:** In the majority of instances (92%), those patients expected to benefit from critical care support did receive it. The review process suggested that some 8% of cases who did not receive treatment in a critical care unit would most likely have benefited from it.
- **Fluid balance during treatment:** this may have been an issue of management in only 10 per cent of cases reviewed.

### Operative profile

A total of 6,512 separate episodes of surgery occurred in 4,735 patients. Surgery was not performed in 25 per cent of all patients. The most frequent operative procedures described were for trauma or acute abdominal pathology. This reflects the high percentage of patients admitted as emergencies in this series. Across all the regions, a consultant performed the surgery in 66 per cent of instances and made the decision to proceed to surgery in 93 per cent.

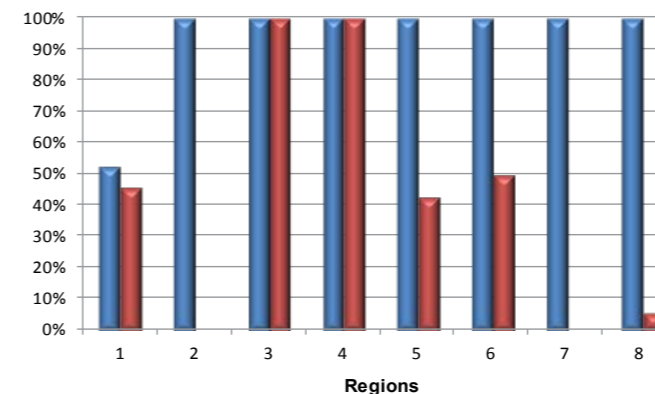


Figure 3: Participation by hospitals by region

Nationally since the end of 2010, there has been an increased recruitment drive into both the public and the private sector to join the audit process, and generally private sector participation is positive.

*“The feedback to surgeons of problems, the careful analysis of their genesis and change in practice can all lead to a reduction in surgical deaths”*

### Inter-hospital transfers

Despite some improvement, there are still issues around transfer of patients to other hospitals.

Insufficient clinical documentation (16%) is a concerning criticism. Inappropriateness of transfer (32%) and transfer delay (32%) were the most common criticisms. These are concerns as it is essential that all clinicians involved have a complete picture of the patient's issues upon presentation. However, since 2009, the frequency of inappropriate transfers has decreased by 4 per cent (see Figure 4).

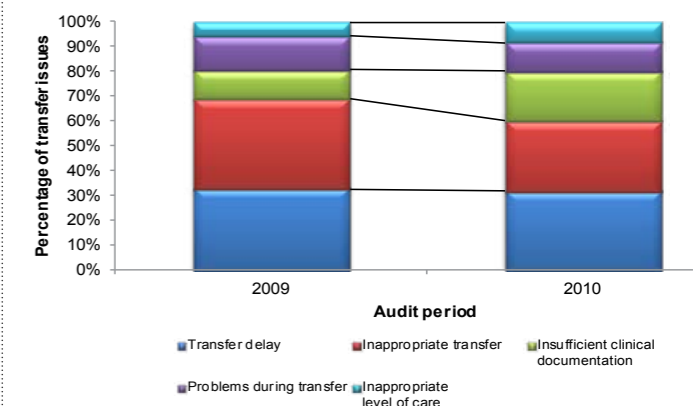


Figure 4: Care of patient during transfer to another hospital (580 issues in 1,741 transferred patients)

### Delay in diagnosis

The treating surgeons identified delays in establishing the diagnosis in 565 (9%) of the 6,507 audited cases. Delay in establishing a diagnosis is one facet of the concerning rate of delay in implementing definitive treatment shown later (Figure 5). It is important to note that such delays are not always attributable to the surgical team. These include geographical issues, diagnostic problems in the emergency department, inappropriate diagnosis, need for transfer, availability of theatre and communication issues.

### Peer review outcomes

Assessors involved in the audit process appraise the appropriateness of the clinical care provided to each case reported to ANZASM as all cases undergo first-line assessment.

**Expressions of interest are invited from surgeons to participate in the delivery of a multidisciplinary Perioperative Medicine Course in Hangzhou, China.**

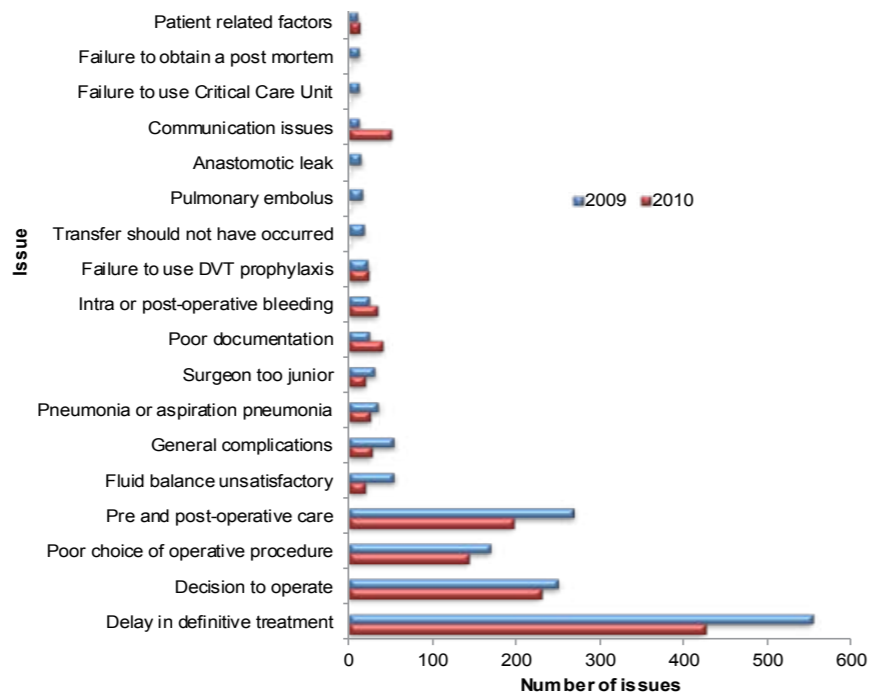
The course will be held at the Sir Run Run Shaw Hospital in Hangzhou from 2nd – 4th November 2012 and will focus on rehabilitation techniques and post-operative medicine to address needs identified during previous visits by Dr Alex Konstantatos FANZCA and his colleagues, in relation to post-operative care. The faculty will consist of surgeons, anaesthetists, physiotherapists and pain liaison nurses. The course will be taught in English with simultaneous written Chinese translation.

**Interested surgeons should contact Dr Alex Konstantatos on E: [a.konstantatos@alfred.org.au](mailto:a.konstantatos@alfred.org.au) or phone the External Affairs Division, RACS: (03) 9249 1211.**

**ANZASM Annual Report**

**EXTRACT**

- Second-line assessments (SLA): SLAs are requested for cases in which the clinical care needs to be looked at more closely or the treating surgeon did not provide sufficient information to reach a conclusion. Such assessments were required in 12 per cent of audited cases. SLA was most commonly required because the clinical information provided by the treating surgeon was inadequate, which is disappointing, but remediable with further education.
- Clinical management issues: In 87 per cent of audited deaths no, or only minor, issues of patient care were perceived. However, in 13 per cent of cases more major issues of care were identified (areas of concern and adverse events). The incidence of more major criticisms of clinical care is similar among the surgical specialties. There has been a significant reduction in the frequency of more severe criticism of surgical care (adverse event, area of concern) between 2009 and 2010. The most common issues surrounding clinical issues of management are shown in Figure 5. (below)



**Figure 5: Frequency of specific clinical issues of management**

DVT: deep vein thrombosis.  
Note: Total issues n=3,171.

It should be highlighted that in 2010 there has been a notable drop in the number of cases where a delay in definitive treatment was an issue.

**Comparison of data between the 2009 and 2010 audit periods**

When data are compared between the two audit periods, trends start to emerge. On a positive note:

- Surgeon participation has increased from 60 per cent to 81 per cent.
- VTE prophylaxis utilisation went up from 72 per cent to 76 per cent.
- There was an apparent reduction in some postoperative complications (particularly anastomotic leak and vascular graft occlusion).
- The overall frequency of issues related to patient transfer fell from 36% to 32%.
- The frequency of adverse events remained low at 5%.
- There has been an apparent increase in some postoperative complications (e.g. endoscopic perforations)

- There has been an increase in the frequency of poor communication of clinical information during patient transfer between hospitals from 12% to 20%
- There was an increase in 2010 of cases where critical care support was not being provided to patients. This apparent increase in patients not receiving critical care does not necessarily indicate a lack of critical care facilities.

**Recommendations**

The recommendations are as follows:

- Continue to increase participation of surgeons and hospitals towards 100%
- Introduce participation by the private hospital sector in both Queensland and New South Wales
- Introduce the audit program in New Zealand
- Look for emerging trends in mortality and address these where possible through ongoing educative and interactive seminars
- Improve on the quality and effectiveness of communications within the clinical teams
- Procedure-related sepsis is an ongoing issue and needs to be addressed
- Prepare and deliver a national case note review booklet twice a year for distribution to surgeons, Trainees and other clinical staff involved in patient care
- Ensure greater completeness and accuracy of the SCFs. The failure to fully complete the forms substantially detracts from data quality. Missing data in the SCF prevents assessors from reaching a conclusion regarding the need for further investigation and greatly reduces the amount of data available for analysis by ANZASM. Increased clinical information could lead to a reduction in requests for SLAs being carried out due to a lack of information in SCFs.

**Conclusions**

The Audits of Surgical Mortality are in an excellent position to utilise the extensive information learned to promote safer health care practices. There is significant value to the Australian health consumer community at large in the audit continuing as a quality assurance activity, in order to maintain the forthright participation of surgeons and in order to grow and enhance the existing data on surgical mortality.

**Achievements:**

- The workshops and seminars have been facilitated based on reports, plus more in-depth investigations of the issues. These activities have increased the quantity and quality of information disseminated on issues that have greatly affected clinical governance and patient care across the country. Further workshops are scheduled in Tasmania, Victoria and South Australia in early 2012.
- Roll-out of the 'Fellows Interface' web-based tool is a new initiative which provides users with a dynamic, user-friendly tool to enter SCFs and complete FLAs online.
- Production and delivery of national case note review booklet twice a year for distribution to surgeons, Trainees and other clinical staff involved in patient care, serves to educate on issues of relevant importance.

A greater national awareness and acknowledgment of the value of the audit amongst health professionals should see increased surgical participation and data completeness of forms and thus enable further, in-depth trend analysis and informative reporting.

The College and the state Departments of Health can be rightly proud of this important initiative to promote best practice across the nation.



**Guy Maddern**  
Chair, ANZASM

For a full downloadable version of the report, please go to:- [www.surgeons.org/for-health-professionals/audits-and-surgical-research/anzasm.aspx#national\\_report](http://www.surgeons.org/for-health-professionals/audits-and-surgical-research/anzasm.aspx#national_report) or contact your local audit office.

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# National E-Health Record System

Fellows should be aware of what e-Health means



The Federal Government is continuing its rollout of the national e-health record system. The system will help transform the electronic world of healthcare and facilitate a more efficient delivery of health services to rural and remote communities by establishing a single national healthcare identifier system for patients, healthcare providers and healthcare organisations.

E-health is the combined use of electronic communication and technology in healthcare; moving away from paper-based records to secure e-health data. It is noted that the new system means surgeons and other healthcare professionals will no longer have to rely on patients to accurately recall past treatment and will be able to take a multidisciplinary approach to provide better care and ultimately save lives and money.

## General background

In 2005, the Australian, State and Territory governments formed the

National E-Health Transition Authority (NEHTA) to develop better ways of electronically collecting and securely exchanging health information. One such development was a Personally Controlled Electronic Health Record (PCEHR), which is a secure, electronic record of a patient's medical history, stored and shared via a network. A PCEHR will contain the key health information and records from a number of different systems and present it in one view.

There are however significant risks and challenges that need to be overcome and must be considered prior to implementation.

## Risks and challenges

Reliability of patient data and liability

The notion of patient consent and autonomy preserves one's right to self-determination. With a PCEHR, the patient has the power to alter access controls, potentially allowing certain healthcare providers not to have access to some records. Power is also given to the patient to decide who can alter the

shared health summary, a vital piece of information about the patient.

This gives the patient great power in deciding what is relevant and what information a particular healthcare provider can see, and could potentially lead to healthcare providers not getting a complete patient history and records. There may be liability implications regarding access to hidden or undisclosed data, and obligations on healthcare providers to read all patient data available in the PCEHR.

Surgeons may need to add disclosures to their case notes and patient files to cover situations where the patient has declined access to their entire record. Doctors may need to ask and confirm whether all information has been disclosed to them; and if not, warn the patient of the risks of non-disclosure.

## Privacy

Patients' access to their medical records has come a long way since 1996, when the High Court held that patients did not have a common law right of access to their medical records.<sup>1</sup> Such access is now governed by a legislative regime.<sup>2</sup> Any information downloaded from a PCEHR onto a providers' system will be subject to the already existing privacy law, which will cover the potential consequential sharing of such information.

This should be of little concern for healthcare providers as it is in line with current practice. What is of concern is the use and disclosure of such records. Surgeons need to be aware that their report is potentially open for all to view, captured via the patients control over the content and the use of the record.

Surgeons should be aware that their records are currently able to be disclosed (for example under the Health Records Act (Vic)) and in pre-trial procedures of discovery. With the introduction of the PCEHR, it is a good time to remind

surgeons that they should be writing their reports and case notes with the knowledge that the patient has full access to them and they should be mindful of objectivity in expression of their clinical judgement. Surgeons should also check and update their privacy statements to ensure that they are covered for electronic patient records.

## Conclusion

With an 'opt-in' system, the Federal Government is still unclear how many people will sign up with individuals able to register for a PCEHR from July this year. Regardless, surgeons and other

*Patients' access to their medical records has come a long way since 1996, when the High Court held that patients did not have a common law right of access to their medical records.*

health professionals need to be aware of upcoming changes and the need to further protect themselves from potential liability. Although some studies<sup>3</sup> suggest surgeons perceive little workflow benefits from e-health, benefits may be seen by practice assistants and the access to digital images and accurate health records.

NEHTA is currently testing pilot sites and software, and it is a timely reminder for surgeons that the system will soon will be operational and doctors need to ensure that their privacy and disclosure statements are up to date and protect them from potential liability that may arise with the new e-health system.

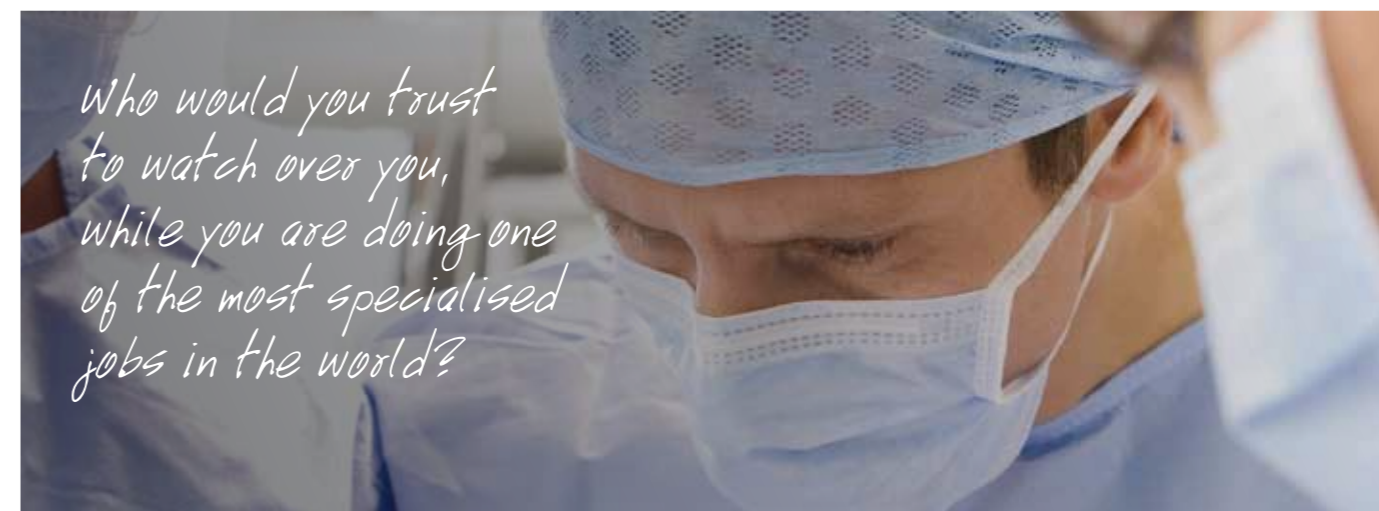


**Michael Gorton,**  
College Solicitor

With Richard Laufer, Law Clerk

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2. For example the Privacy Act 1988 (Cth); Health Records Act 2001 (Vic).
3. *The eHealth readiness of Australia's medical specialists*, Department of Health and Ageing, 30 May 2011.



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*“Trauma is the most significant disease in terms of young lives lost. However, unlike cancer or heart disease, this is a disease we can prevent.” \**

## Trauma Committee priorities

Trauma care professionals are passionate in their mission of trauma prevention and improved care

Our vision is to be the leading advocate for the surgical health and well-being of patients. The Trauma Committee gives effect to this through the engagement of the committee members with the community and carers to advance trauma prevention and care. Passion is the common link found in trauma care professionals. It provides the unity and strength in their mission to pursue trauma prevention and improve care in all communities. Passion illuminates minds to find, through partnerships, a better and safer world.

**For five decades, members of the College Trauma Committee have focused their energy on:**

- identifying areas of trauma prevention
- improving trauma care
- developing trauma training and education and
- developing trauma systems

Trauma Committee members are honoured by their association with the success of the Committee and its influence on road safety legislation including effecting legislation on seat belt wearing, blood alcohol testing and bicycle helmet wearing. The book *Blood Belts Booze and Bikes – A history of the response of the Royal Australasian College of Surgeons to the epidemic of road trauma* by Dr Alan Gregory documents this admirably.

Trauma Committee members continue to find ways to make an impact and save lives – on the road, on the farm, in the home, in the workplace, on the sporting field and in local, national and international disasters.

One of the priorities for the Trauma Committee members over the next 24 months is to develop necessary trauma-related position papers and then communicate those positions to policy

makers, politicians, the media and the community to reduce trauma.

Last year the media took great interest in the College position on Quad Bike injuries and alcohol-fuelled violence, two areas of increasing concern for the community, both of which are totally preventable. Associate Professor Daryl Wall, Chair Trauma Committee, called on governments to tighten regulation around the use of Quad Bikes which had caused 17 deaths in Australia between 2000 and 2005. He also called for consideration to be given by governments to a tightening of licensing hours, in line with the College position paper on alcohol related trauma.

Members of the Trauma Committee, in particular Trauma Directors, call on their first-hand experience of trauma care and their understanding

of trauma data to interpret trends and identify risks to the community. As well as involvement from other specialties and disciplines, efforts are made to collaborate with leaders working in other institutions active in trauma prevention.

At its face-to-face meeting in November 2011, Trauma Committee members expressed unanimous support for the development of further trauma-related position papers especially those containing strategies to prevent trauma.

Trauma Committee members are keen to continue to review and develop College positions on trauma related-issues and seek input and support from Council and the Fellowship at large in their efforts to coordinate a cohesive and united voice to advocate for the prevention of trauma.

The following areas were identified as possible fields for trauma injury reductions.

### Sharing the road:

A main focus for this year will be the 2012 Trauma Committee workshop on 22 November ‘Sharing the Road – Vision Zero for all road users’. Mr Garry Grossbard, Associate Professor Robert Atkinson, Dr Tony Joseph and Ms Monique Whear form the working party for this workshop. Participation is being sought from road traffic experts in Europe where ‘vision zero’ is an accepted aim in government policy development.

Interest from road user groups is expected (trucks, cars, bicycles, pedestrians as well as input from public transport users). Shane Warne’s call for bicycle registration after his altercation with a cyclist caused much twittering earlier this year and will most likely be a hot topic for discussion at the workshop.

Fellows are welcome to provide advice or offer submissions for presentation and are welcome to participate in the meeting. [Contact Monique Whear Monique.whear@surgeons.org or telephone +61 3 9249 1259]

### Falls from ladders/falls in the elderly:

Professor Jeffrey Rosenfeld, Trauma Committee member and neurosurgeon for Molly Meldrum, cautions the elderly – anyone over 60 – against using ladders. Sixty per cent of Emergency Department trauma admissions are the result of falls. What can be done to better prevent this type of trauma?

### Compulsory first aid taught in schools:

Professor Jeffrey Rosenfeld has called for every Victorian child to be trained in first aid [Herald Sun 25.1.12]. A trained first aider can make the difference between life and death. It has been evidenced that young people trained in first aid have a lower incidence of suffering traumatic injury mainly due to their raised awareness of consequences.

### Falls from windows by toddlers:

Associate Professor Brian Owler has identified the risks of children falling out of windows and warned society against dithering and complacency regarding the implementation of safety and building regulations to restrict the opening the windows. [SMH 16.2.12]

### Other identified risk areas include:

- Dog Bites
- Neurological injuries in sport
- Helmet wearing in sport
- Driver distraction and fatigue

Trauma Committee members welcome input and support from the Fellowship. Email contact Trauma@surgeons.org – or telephone +61 3 9276 7448.

\*Dr Jeffrey Augenstein, University of Miami pioneer trauma doctor, who sadly died prematurely early this year after giving 37 years of his life to the ‘trauma cause’. He was responsible for improved highway safety and the treatment of wounded soldiers on the front lines in Iraq and Afghanistan.



**Daryl Wall,**  
Chair, Trauma Committee



## In Memoriam

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

**Douglas Harry Cohen,**  
NSW General surgeon

**John Ridley Solomon,**  
Vic Paediatric surgeon

**Keith Jones,**  
NSW General surgeon

**William Alexander Dott,** Vic Otolaryngology surgeon

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website [www.surgeons.org](http://www.surgeons.org) go to the Fellows page and click on In Memoriam.

### Informing the College

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

- ACT:** Eve.edwards@surgeons.org
- NSW:** Beverley.lindley@surgeons.org
- NZ:** Justine.peterson@surgeons.org
- QLD:** David.watson@surgeons.org
- SA:** Daniela.giordano@surgeons.org
- TAS:** Dianne.cornish@surgeons.org
- VIC:** Denice.spence@surgeons.org
- WA:** Angela.D'Castro@surgeons.org
- NT:** college.nt@surgeons.org

# Project China – The Future for the College

Become involved in cross continental exchange

**P**roject China, one of the College's longest running international outreach programs, is entering a new phase. Expressions of interest are invited from Fellows with a particular interest in or connection to China to become involved in the new China-ANZ Project.

Project China began as Project Guangzhou in 1988, as a vehicle for exchanging surgical skills and knowledge. Political complications hampered progress and an initial visit by Australian surgeons did not take place until 1993 when Melbourne spine surgeons Dr Ian Torode and Dr Peter Turner spent a month at the Second Affiliated (Memorial) Hospital of the Sun Yat-sen University of Medical Sciences in Guangzhou. However, successes gradually came and by word of mouth the Project became known to more hospitals in other provinces in China. Of necessity, Project Guangzhou evolved into Project China.

Project China has been driven by the enormous energy of Gordon and Rosie Low (its founders and coordinators) and funded by generous donations from their friends in Hong Kong and Australia and from their own personal resources. Many Fellows have made Project China visits over the years, on some occasions with nurses and other medical practitioners.

In return, there have also been many Chinese visitors, both surgical and other, who have come to Australia and New Zealand to gain experience and exposure to our health system. More recently, English language teachers have been spending three month rotations in a number of Chinese hospitals teaching junior medical staff, with the aim of helping them secure short term training attachments in Australia.

After their long and rewarding



Vincent Cousins (second from right) in Ear Microsurgery Course with Professor Liu Wei, Memorial Hospital, Guangzhou

commitment, Gordon and Rosie are planning to scale back their involvement. The College now plans to coordinate, consolidate and further develop our engagement with China under a new name: the China-ANZ Project.

Australasian surgery is only known in selected centres in China. Hong Kong surgeons have a strong teaching commitment across the country, while American surgeons have also contributed greatly in many centres. The China-ANZ Project aims to raise the profile of Australasian surgery and to find new ways to exchange our knowledge and skills. Apart from its economic success, China has begun to attract attention in many spheres of scientific

and technological endeavour including medicine and healthcare. Both the China and ANZ sides of the project have a lot to offer and teach the other.

Several College Fellows have been engaging with China for many years outside the auspices of the Project. The new China-ANZ Project hopes to consolidate these activities, and to draw on their knowledge and connections.

## Vincent Cousins

Associate Professor Vincent Cousins has been the Chairman of the Project China Committee since 2005. He has visited China seven times under the auspices of the Project, and another five times on personally arranged engagements.



## Department of Thoracic Surgery – 4th Hospital of the Hebei Medical University (Hebei Provincial Tumour Hospital) – clinical case discussion with Chinese Surgeons.

This Department is world famous, since the publication in the British Journal of Surgery of clinical outcomes for a series of 20,000 oesophagectomies for oesophageal cancer – a paper which overnight increased the number of reported surgical cases by 200% (from 10,000 to 30,000). This Department undertakes 1200+ oesophagectomies each year, double the national workload of Australia!

Dr Cousins reports that he did perform some surgery on his visits, but that there has always been great demand for lectures and teaching of operative skills in the laboratory. From 2003 to 2009, Dr Cousins was Visiting Professor to the Department of Otolaryngology at the Sun Yat-sen University in Guangzhou.

From 2003 to 2007, he was Co-Director of the annual Temporal Bone and Ear Microsurgery Course at the Memorial (2nd Affiliated) Hospital, Sun Yat-sen University. He has also given lectures and taught with Live Middle Ear surgery at the Sir Run Run Shaw Hospital in Hangzhou; been Guest Lecturer and Temporal Bone Course Demonstrator at the Shanghai Eye & ENT Hospital, Fudan University and lectured at the Hong Kong University, at the People's Liberation Army (PLA) General Hospital in Beijing and at the Chang Gung Memorial Hospital in Taipei, Taiwan.

Most recently, he has co-edited the English edition of the "Stereo Operative Atlas of Micro Ear Surgery", co-written in Chinese by Professors Han D and Dai P from the Otolaryngology Department at the PLA General Hospital. This book is currently in press.

Dr Cousins has seen first-hand the existing disparities across Chinese medical services. Big hospitals, he says, are well equipped and generally need international involvement only for teaching initiatives and training, whereas small hospitals may have very limited facilities, and only basic ongoing training.

Senior staff in Chinese hospitals are travelling more frequently than ever before, however, middle and lower-ranked staff are not often provided the opportunity. An expanded exchange program would be an excellent avenue for young surgeons to access training, as well as providing valuable exposure to different surgical cultures. Working and learning in Australia also provides further English-language training and this will facilitate contact between Australasia and China in the future.

## David Watson

Adelaide and China have been 'exchanging' surgeons and skills since 1998, when Professor Liu Junfeng received a scholarship enabling him to spend a year in Adelaide. Professor Liu is now Head of Thoracic Surgery at the 4th Hospital of the Hebei Medical University, and is an on-going

supporter of Chinese and Australian surgical engagement. Many connections were formed on this initial visit and Professor Watson's own trips began in 2004 with a visit to Tianjin, China's fourth largest city, with a population of around 12 million. The Head of Thoracic Surgery at the Tianjin Chest Hospital, Zhang Xun, who is the now Vice-President of the Chinese Cardiac and Thoracic Surgery Society, visited Flinders University in the early 2000s.

Professor Watson reports that about 12 Chinese surgeons have now visited South Australia, each for around a year's duration, and he made six visits to China between 2004 and 2009. From July 2011 to January 2012, Professor Watson spent his six months Sabbatical in China.

Visiting Chinese surgeons do not, with a few exceptions, have an adequate command of English to be registered for clinical practice in Australia. Instead, they have been facilitated to participate in research – an opportunity which is warmly welcomed.

"They want international engagement, and writing English-language research papers is really important exposure for them," Professor Watson reports. "Clinically, they are as good if not better than we are in Australia. Their diagnostic equipment, for example, is better and their caseloads are huge. However, they have some way to go in research training, especially with issues around quality management."

Professor Watson has been studying Mandarin for the past five years through evening courses in Australia, and more intensively while recently in China – enough to 'survive'. He reports that many older surgeons in China have limited English language skills. However, new graduates and students are often quite fluent and, most importantly, keen to learn. Communication issues shouldn't, therefore, serve as a disincentive to anyone wishing to visit China.

If you are engaged with surgery or medicine in China or if you are interested in becoming involved, the College would like to hear from you! Please contact the External Affairs Division on the contact details below.

T: + 61 3 9249 1211  
F: + 61 3 9276 7431  
E: [stephanie.korin@surgeons.org](mailto:stephanie.korin@surgeons.org)

# Happy 5<sup>th</sup> Birthday

April marks the 5th birthday of the Supervisors and Trainers for the Surgical Education and Training (SAT SET) course. This is a significant milestone as a staggering 2000 Fellows have attended the course and it is now also available online.

## What has happened in five years?

The SAT SET course was launched to support Supervisors and Trainers during the introduction of the new Surgical Education and Training (SET) program in 2007. The aim of the course was to explore how supervisors can effectively fulfil the responsibilities of their very important roles.

At the time many Fellows were concerned about SET, competency based training and workplace assessment and the course was a call to action to relieve some of this angst. To represent the general feeling at the time, the course logo was a mouse with a hard hat... it didn't want to be caught in the mouse trap!

Since 2007 the course has remained relevant and popular with many supervisors and trainers embracing the changes introduced as part of SET. The course continues to focus on the effective use of the workplace assessment tools; the Mini Clinical Examination (Mini CEX) and Direct Observation of Procedural Skills (DOPS).

It also offers an opportunity for supervisors and trainers to explore strategies to improve the performance of Trainees, especially those who are not yet competent. What's more, the course is an excellent opportunity to gain an insight into the College's policies and processes, including legal requirements and the appeals process.

In 2011, as a result of participant feedback, the 'Keeping Trainees on Track (KTOT)' course was launched. Participants had indicated that they wanted more professional development in supporting inexperienced and underperforming Trainees. Specifically, they requested more strategies for encouraging Trainees to be self-direct learners. KTOT focuses how to provide effective feedback and encourage goal setting.

The SAT SET course continues from strength to strength



## Creating behavioural change

In 2009 SAT SET participants completed an online survey<sup>1</sup>, to determine if participation in a SAT SET course resulted in a behavioural change in surgical supervisors and trainers. It concluded that the course has been well received and better informed surgeons about their roles and responsibilities.

Out of the 943 surgeons who had completed a SAT SET course at that time, 332 completed the survey representing a response rate of 35 per cent. As a result of completing the course, a clear majority felt more comfortable with the use of the new in-training assessment tools and were confident that they had a more structured approach to analyse their Trainee's performance. More importantly, most indicated their role as supervisor had improved since attending the course.

In addition, informal feedback to Trainees had increased although structured feedback rates remained low. In regards to fears of an increased workload, most respondents said that this had not occurred and just under half considered that objective assessment of Trainees had improved without fear of legal implications. Other participants indicated a positive change in their management of Trainees.

See p39 for course dates.

## SAT SET is going virtual!

With the launch of the new College website, the SAT SET course is now available in an online format. The e-course consists of four modules and can be used as a refresher or introduction to SET assessment and training. There are also plans to offer an online module to Trainees, which focuses on their responsibilities and how to get the most out of work-based assessments.

The success of SAT SET has been a team effort, with College staff and Fellows working together to deliver high quality professional development to the Fellowship. I would like to thank the SAT SET facilitators who have delivered more than 100 courses on a pro bono basis. Special thanks also to our working party members; Robert Rae, Sharon English, David Fletcher and Peter Sharwood as well the Surgical Teachers Education Program Committee.



**Bruce Waxman**  
Chair, SAT SET Working party

## REFERENCE

1. Copertino, N., Blackham, R. & Hamdorf, J. M. (2010). A short course for surgical supervisors and trainers: effecting behavioural change. *ANZ Journal of Surgery*, 80, 896-901

# Workshops & Activities

Life long learning through professional development can improve our capabilities and help us to realise our full potential as surgeons as well as individuals.

## Keeping Trainees on Track (KTOT)

21 April, Launceston; 6 May, Kuala Lumpur (ASC), 5 June, Adelaide

This 3 hour workshop focuses on how to manage Trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

## Management of Acute Neurotrauma

2 June, Brisbane

You can gain skills to deal with cases of acute neurotrauma in a rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, you can learn these skills using equipment typically available in smaller hospitals, including the Hudson Brace.

## Strategy and Risk for Surgeons NEW

8 June, Brisbane

This practical whole day workshop is divided into two parts. Part one gives an overview of basic strategic planning and provides a broad understanding of the link between strategy and financial health or wealth creation. Part two focuses on setting strategy; formulating a strategic plan, the strategic planning process, identifying and achieving strategic goals, monitoring performance and contributing to an analysis of strategic risk.

## Supervisors and Trainers for SET (SAT SET)

30 April, Melbourne; 29 May, Brisbane; 14 June, Perth

This course assists supervisors and Trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support Trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues.

## Non-Technical Skills for Surgeons (NOTSS) NEW

16 June, Auckland

This workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues.

## How Well Do You Know Your Practice? A game plan for success NEW

22 June, Perth

This whole day workshop focuses on how gathering data and information, in a systemised manner, through analysis and a willingness to challenge the status quo, can lead to effective decision making and improved customer service. Practice staff as well as Fellows are welcome to attend.

## Leadership in a Climate of Change

26-27 July, Sydney

This 2½ day workshop explores how to be an effective leader in the 21st century. It focuses on leadership styles, effective working relationships, managing the performance of others and dealing with conflict. You will complete an online behavioural inventory (DiSC profile) which generates a specialised report on your leadership attributes so that you can explore a range of leadership behaviours in the workplace.



MARCH - JULY 2012

## KUALA LUMPUR (ASC)

6 May  
Keeping Trainees on Track

6 May  
SAT SET Course

## NSW

4 July, Sydney  
AMA Impairment Guidelines, 5th Edition: Difficult Cases

26-27 July, Sydney  
Leadership in a Climate of Change

## NZ

16 June, Auckland  
Non-Technical Skills for Surgeons

## QLD

29 May, Brisbane  
SAT SET Course

8 June, Brisbane  
Strategy and Risk Management for Surgeons

## SA

5 June, Adelaide  
Keeping Trainees on Track

## TAS

21 April, Launceston  
Keeping Trainees on Track

## VIC

30 April, Melbourne  
SAT SET Course

## WA

14 June, Perth  
SAT SET Course

22 June, Perth  
How Well Do You Know Your Practice

**Contact the Professional Development Department**  
on +61 3 9249 1106,  
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Professional Development.

Kuala Lumpur Convention Centre, Malaysia  
Sunday 6 May 2012

## Provisional Program

7:00am Registration and Breakfast  
7:15am Welcome . . . . . *Ian Civil (RACS President)*  
Introduction . . . . . *Melina Kibbe (Chicago, USA) and Andrew Hill (Auckland)*

### SESSION 1: STARTING AND PLANNING YOUR RESEARCH CAREER

**Moderators: Scott LeMaire (Houston, USA) and Arthur Richardson (Sydney)**  
7:30am Why every surgeon can and should be an academic surgeon . . . . . *Mark Smithers (Brisbane)*  
7:50am Research pathways: Outcomes, Translational, Educational, Basic science – which one is right for you? . . . . . *Allan Tsung (Pittsburgh, USA)*  
8:10am Where do good ideas and research questions come from? . . . . . *Russell Gruen (Melbourne)*  
8:30am Critical ethical issues in medical and surgical research . . . . . *Timothy Pawlik (Baltimore, USA)*  
8:50am Understanding statistics for clinical research and trials . . . . . *Lillian Kao (Houston, USA)*  
9:10am Panel discussion and questions from the floor . . . . . *Moderators and speakers*

### 9:30am MORNING TEA

### SESSION 2: PRESENTING YOUR WORK TO PROGRESS YOUR CAREER

**Moderators: Timothy Pawlik (Baltimore, USA) and Raffi Qasabian (Sydney)**  
9:50am Writing an abstract, choosing your journal . . . . . *Malcolm Brock (Baltimore, USA)*  
10:10am Submitting and revising your manuscript . . . . . *Melina Kibbe (Chicago, USA)*  
10:30am Delivering an effective research presentation . . . . . *Greg Kennedy (Madison, USA)*  
10:50am Networking and building academic collaborations . . . . . *Daniel Anaya (Houston, USA)*  
11:05am Building a research group/program (who is right for the roles and how to manage them) . . . . . *Leigh Delbridge (Sydney)*  
11:20am Panel discussion and questions from the floor . . . . . *Moderators and speakers*  
11:50am **KEYNOTE LECTURE: Training, academic surgery and private practice** . . . . . *Michael Solomon (Sydney)*  
12:20pm LUNCH – faculty at tables with registrants as small group discussions

### CONCURRENT SESSIONS:

#### SESSION 3: EARLY ACADEMIC CAREERS

**Moderators: Melina Kibbe (Chicago, USA) and Julie Howle (Sydney)**  
1:00pm Building a career pathway: opportunities, obstacles and getting past them - *Daniel Anaya (Houston, USA), Erica Jacobson (Sydney)*  
1:20pm Timing research projects – how much time is right, and when to fit it in? - *John Windsor (Auckland)*  
1:40pm How do I get started as an academic surgeon - *Michael Vallely (Sydney)*  
2:00pm Why a trainee should consider doing fulltime surgical research - *Zoe Wainer (Melbourne)*  
2:20pm Panel discussion

#### SESSION 4: CAREER PATHWAY DEVELOPMENT

**Moderators: Greg Kennedy (Madison, USA) and Russell Stitz (Brisbane)**  
1:00pm How do Post-graduate degrees lead to promotion? Choosing a pg degree, nil v Masters v Doctorate *Guy Maddem (Adelaide)*  
1:20pm Why should surgeons be into genomics? – the essentials *Andrew Biankin (Sydney)*  
1:40pm Writing a successful Ethics application *Jane Young (Sydney)*  
2:00pm Building and presenting an academic CV/ promotion as an educator - *Andrew Hill (Auckland)*  
2:20pm Panel discussion

#### SESSION 5: WORKSHOPPING CURRENT RESEARCH PROJECTS

**Moderators: Diane Simeone (Michigan, USA) and Marc Gladman (Sydney)**  
1:00pm Study design workshop to brainstorm current issues – attendees to bring current research and study challenges for discussion - *Allan Tsung (Pittsburgh, USA), Timothy Pawlik (Baltimore, USA), Cas McInnes (Melbourne), Jonathan Serpell (Melbourne)*

#### SESSION 6: GRANT WRITING WORKSHOP

**Moderators: Malcolm Brock (Baltimore, USA) and Robert Thomas (Melbourne)**  
1:00pm *Scott LeMaire (Houston, USA), Sue Stott (Auckland), Wayne Morrison (Melbourne)*

### 2:40pm AFTERNOON TEA

### SESSION 7: PLANNING A SUSTAINABLE CAREER

**Moderators: Lillian Kao (Houston, USA) and Andrew Hill (Auckland)**  
3:00pm Doing an overseas Fellowship – how to choose wisely . . . . . *Warren Hargreaves (Sydney)*  
3:15pm Putting it all together and remaining sane – observations from outside the club . . . . . *Richard Hanney (Sydney)*  
3:30pm Questions from the floor to all faculty  
3:45pm The future of academic surgery, and closing remarks . . . . . *John Windsor (Auckland)*  
4:30pm CONVOCATION AND SYME ORATION followed by ASC Welcome Reception

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RACS Section of Academic Surgery



Royal Australasian College of Surgeons,  
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# Experiences of an early career

The chance to exchange ideas can build great relationships

At the 2011 Australasian Surgical Research Society Meeting I was awarded the SRS Young Investigator award for my research into a novel agent's ability to attenuate cardiac ischemia reperfusion injury. This afforded me the honour of presenting my research at the 7th Annual Academic Surgical Congress (AASC) held jointly between the Association for Academic Surgery (AAS) and the Society of University Surgeons (SUS) in Las Vegas, USA.

I have attended a number of international scientific meetings and I found the AASC to be an excellent surgical meeting, with the presented research being of an exceptionally high standard.

I was humbled to find that my presentation discussant was the legendary Alden Harken, Professor of Surgery, University of California, San Francisco-East Bay Surgery Program. He provided an insightful review, supportive critique and an opportunity to visit his institute – a highlight of the congress for me.

My research had identified an agent that reduced microvascular obstruction; and cardiac necrosis by blocking an apoptotic marker. Discussing my work with Professor Harken raised several new, pertinent questions into the mechanism of action for my agent and within a short time span Professor Harken helped me create an exciting new hypothesis to explore upon my return home

Collegiality and mentorship were the fundamental principles of the congress. Residents and Medical Students were proactively included and had the opportunity to meet leaders in their field of interest. These leaders, with their wealth of experience, are able to provide invaluable guidance and advice, and potential opportunities to advance one's career.

The meeting also has a strong sense of friendship and loyalty. At one function I met

Professor Creighton Wright (Cardiothoracic Surgeon), who laughed at the fact that he was President of the AAS in 1980 (the year I was born); he has attended every meeting since.

The congress explored many of the issues that we face in the Australasian surgical community. From the provision of surgical education to medical students, residents and surgical Trainees; to the challenges of developing a surgical research group and applying for research funding. Operating on the elderly, safe working hours and minimally invasive surgery were also important topics.

One of my most memorable lectures was that of Professor Norman M Rich (AAS Founders Lecture), a Vascular Surgeon who described his experience as a Military Surgeon during the Vietnam War and the development of vascular surgery through history.

This meeting was inspirational and I will be attending the 2013 ASC in New Orleans. For anyone planning to pursue a career in Academic Surgery, attending either the RACS AASC, or the AAS AASC, would be exceedingly beneficial.

The AAS, in collaboration with RACS, will be providing the 'Developing a Career in Academic Surgery (DCAS) Course' at the 2012 ASC in Kuala Lumpur. This course is directed towards SET Trainees, prevocational doctors, medical students and younger Fellows who intend to develop their research and teaching competencies. An extremely enthusiastic and experienced faculty will host this course.

I would like to thank the members of the Australasian Surgical Research Society for presenting me with their Young Investigator Award and supporting me to attend the ASC. It has been a privilege and I am grateful to have had the opportunity.

**Connor O'Meara**  
2011 SRS Young Investigator

A letter from Professor Harken: ▶





## Minimally Invasive Surgery

Myth Marketing or Major Advance?

Graham Coupland was a medical student and surgical resident at Royal North Shore Hospital, obtaining his FRACS in 1964. After an overseas clinical fellowship he returned to Royal North Shore where he worked as a surgical academic until his untimely death in 1982 at the age of 47.

Coupland will be remembered as both an extraordinary surgeon, as well as a surgical innovator, the latter demonstrated by his approach to what has subsequently become known as “minimally invasive” surgery.

As a surgical registrar at Royal North Shore, I was privileged to have been trained by Coupland who was Supervisor of Surgical Training throughout my time there. It was he who first introduced me to the concept of “minimally invasive surgery”. Before that term had ever entered the surgical jargon, Coupland had already included in his surgical armamentarium the procedure of “peritoneoscopy” by

adapting the gynaecologist’s scopes and techniques for exploration of the general abdominal cavity.

Indeed the very first procedure I ever performed as an unaccredited surgical registrar – case no #001 in my College Surgical Case Log Book – was a peritoneoscopy supervised by Coupland. By 1981, Coupland had already published on the assessment of liver metastases by peritoneoscopy (Surgery 1981;89:645), and by then his tentative approach to formal “peritoneoscopic cholecystectomy” was really only limited by the available instrumentation. Given that the first documented laparoscopic cholecystectomy was not performed until 1985 by Eric Mühe, it is likely that but for his untimely death, Coupland would have been the first to publish in this field.

Perhaps the most important lesson I learned from Coupland about “minimally invasive surgery” was his assertion that it was “just another tool for all surgeons

to use”. He would have been appalled at the marketing and media hype that now surrounds much of “minimally invasive surgery”.

For example, Hardy recently reported the media frenzy that surrounded the first laparoscopic cholecystectomy performed in Australia in 1990 (ANZ J Surgery 2011; 81:866). He describes “a deluge of enquiries from press, radio and media about this new operation” with journalists and cameramen clamouring to be allowed into the operating theatre. To this day minimally invasive surgery is an area where marketing remains a significant factor in many surgical practices.

Within my own interest area of thyroid and parathyroid surgery, minimally invasive and endoscopic procedures were relatively late appearing, with the first “endoscopic parathyroidectomy” not being reported until 1996 by Gagner. However, it was not long before “minimally invasive parathyroidectomy”

(MIP) became marketed as the “gold standard” of parathyroid surgery offering significant benefits such as increased success rates, reduced complication rates, less pain and discomfort, shorter hospital stay.

Furthermore, it was claimed that achieving these outcomes required a range of new (and expensive) technological adjuncts, including modified endoscopic equipment, radioguided probes, and facilities for rapid intra-operative measurement of parathyroid hormone (IO-PTH). Of course, none of these claims were supported by published evidence, but nonetheless they could be found on websites around the world.

### Exaggerated claims

Particular emphasis was often placed upon the technology, implying that those who did not utilise such techniques could not achieve the same results. We published a study of websites related to “minimally invasive parathyroidectomy” (World J Surg 2010; 34:1304) and found exaggerated, misleading or false claims were present in over 27 per cent, with many such statements clearly aimed at marketing rather than providing patient information.

Nonetheless, propelled by the wave of enthusiasm for MIP around the world, a number of endocrine surgical units including our own, supported by the RACS Section of Endocrine Surgery, started performing the procedure in 1998.

Our initial operative approach utilised all the available technology (endoscopy, radioguided probe, and IO-PTH) with our first series of endoscopic MIP procedures being published in the British Journal of Surgery soon thereafter (Brit J Surg 1999; 86:1563). We then successively abandoned all the technology: the endoscope was thrown away when it was realised that the adenoma would often pop out the 2cm lateral working space incision. Initially it was pushed back to facilitate several hours of tedious dissection with the endoscope to achieve an MIP. Since simply removing the adenoma through the incision took 15 minutes, thus was developed the lateral

mini-incision (2-3 cm) MIP approach used today.

The radioguided probe lasted six cases before being dropped as an expensive, time consuming, logistic nightmare. IO-PTH was abandoned after we undertook a sham study demonstrating its use increased the success rate by only 1 per cent (from 98 per cent to 99 per cent) while leading to a significant rate of false negative conversions to open surgery.

MIP in our hands now consists of a very straightforward procedure requiring nothing more than a small lateral incision and removal of a localised adenoma, with our first 1,000 cases having been recently published (ANZ J Surg 2011;81:362).

It is of note that a number of more conservative endocrine surgeons around the world refused to embrace the technology of MIP, continuing with the “gold standard” of an open four gland exploration. What is interesting is that, in their hands, open parathyroidectomy changed significantly over the decade: incision lengths have progressively reduced to 3-4 cm, routine localisation has allowed the procedure to commence on the side of the abnormality, such that only a unilateral exploration is required in most cases (after finding a normal and an abnormal parathyroid gland) and most cases are done in an ambulatory or day only setting.

Any differences in outcome between MIP and open parathyroidectomy, such as scar appearance or success rate, are essentially non-existent (other than the name) and are certainly imperceptible to the patient. MIP as it is practiced is thus one of the greatest surgical myths of the past decade – it is also certainly one of the best marketed!

MIP has become widely adopted around the world and has proved hugely popular with referring endocrinologists. In our unit referrals for parathyroid surgery have increased over 100 times, from three to four a year in the early days to over 400 cases in the past 12 months. There are good published data to show that the principal reason for such increased referrals relates very largely to the availability of “minimally invasive” parathyroid surgery as an

alternative to what had been perceived by endocrinologists as excessively invasive “open parathyroidectomy”.

There certainly has not been a major change in acceptance of the benefits of parathyroid surgery over that period, with the revised NIH Guidelines still recommending, overall, a conservative approach to offering parathyroidectomy to “asymptomatic” patients.

However, the explosive growth in parathyroid surgery (despite the NIH guidelines) has facilitated extensive research into the potential benefits of parathyroidectomy for so called “asymptomatic” patients (although most in retrospect have a host of symptoms).

The recent PEARS study of mild primary hyperparathyroidism shows the disease to be associated with a significant increased rate of deaths from cardiac disease and cancer (SMR 2.36).

Parathyroidectomy has now been shown to benefit “asymptomatic” patients” leading to an increase in bone mineral density and reduction in fracture risk, a reduction in renal stone risk, improvements in neurocognitive functioning and quality of life, and an improvement in a number of cardiovascular risk factors including insulin resistance.

There are also Swedish population studies indicating a possible improvement in survival, although it would appear that parathyroidectomy is required early in the disease process to achieve this outcome.

Overall there is increasing evidence that this is an operation that appears to offer very substantial health benefits. Thus, although MIP is largely a surgical myth, albeit a very well marketed one, its enthusiastic adoption by endocrinologists for whatever reason has led to significant health benefits for large numbers of patients who had hitherto been labelled as asymptomatic – as such MIP can also be regarded as a major advance!



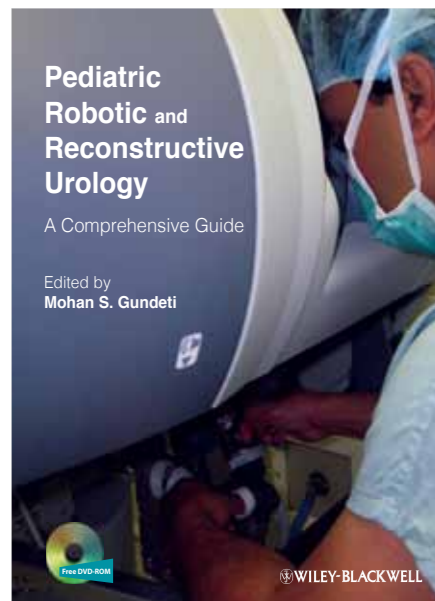
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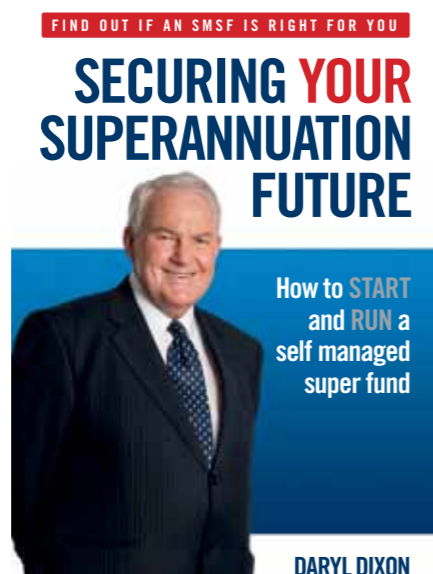
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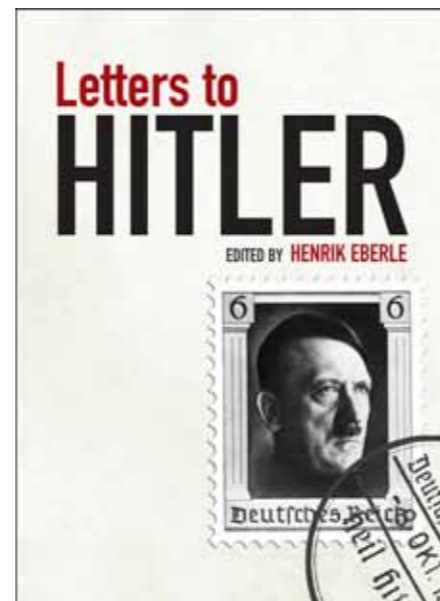
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