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# SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:7 August 2009

## Foundation for Surgery, Page 17:

Thank you to Hazel Westbury for her generous donation to the Foundation.

**Regional News, Page 15**
Australian healthcare has had an explosion of managers and administrators.

**Green Fellows, Page 22**
"Inversion: One Mans Answer for World Peace and Global Health."

**Trainees Association, Page 30**
A College medal has been named to honour the life of Trainee, John Corboy.

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

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# The new 50% tax deduction is approved

For practices with an annual turnover of under $2 million, the Federal Government has approved a TEMPORARY 50% tax allowance on eligible, new business cars and equipment purchases.

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RACS Surgical News.indd 1 13/07/2009 9:58:43 AM

# The First 1,000

## Not a re-run of an epic from the times of ancient Rome, however, still a glorious achievement

**Ian Gough**
President

The College professional development course – Supervisors and Trainers for Surgical Education and Training (SAT SET) – has now trained 1000 Fellows of the College. Those who have gone through the course know that it very effectively delivers a program aimed to enhance skills in undertaking the role of being a supervisor for SET. The College has made this course freely available in recognition of the substantial contribution that is made by Fellows involved with our training programs.

The topics covered have included the workplace assessment tools that are now required in our educational programs, including the Mini-Clinical Evaluation eXercise (Mini CEX) and the Directly Observed Procedural Skills (DOPS).

These are discussed and analysed with experience gained in their application. Importantly strategies to improve the management of Trainees, and in particular the Trainee who has areas to improve, are highlighted with adequate time for discussion.

The Course has been specifically designed by the College for busy surgeons and is only three hours long. It has also revealed a need for educational updates.

The College is now being approached by other health related groups to allow customisation of the course for the benefit of other professional groups.

The Academy of Surgical Educators has been formed to develop these types of initiatives and activities further. Last year the survey of Fellows involved in our training and educational areas revealed the priority areas for additional professional development should include

- Management of the under-performing Trainee
- Effective assessment of Trainees
- Providing constructive feedback
- Effective mentoring
- Communicating effectively

With the Academy now starting to take shape one of its priorities will be to address these key areas and other important areas like selection processes, interviewing and the background of educational theory that supports our training. Given the outstanding success of the SATSET course the model can be used to progressively make a number of professional development modules available.

Beyond the requirements of professional development the Academy will be an important interdisciplinary resource to surgeons involved in our education, training and professional development programs at multiple levels. It is important that these surgeons have very broad skills and that the College supports their endeavours to provide advice on our educational strategic direction and to ensure that the culture of commitment to surgical education is enhanced. The Academy will encourage innovation as well as promoting the ongoing pursuit of excellence in surgical education.

External to the College there are a growing number of educational courses, particularly at University level, that are designed to support medical educators and the University of Melbourne is launching a formal degree specifically in surgical education. The Academy will provide very strong links to the formal university environment to ensure that courses and degrees provide curricula that are appropriate. A pathway will be available for Fellows and Trainees to explore and then fully develop an interest in aspects of surgical education. Importantly, by having more formal links with the University sector, opportunities to improve the strength of academic surgery and educational research will improve.

> *"Beyond the requirements of professional development the Academy will be an important interdisciplinary resource."*

However, partnerships will always have our Fellows, and the training programs of the College and Specialty Societies as the central platform. Collaborative arrangements are the essential theme.

### Future models of training

Most Fellows can recall the time where consultants were far more involved in the public sector and actively encouraged to undertake supervision of Trainees and educational activities. It has been a tragedy over the past ten years that, as funding in the public health sector has decreased, this vital component of our activities has been compromised. It is not surprising that reports and reviews are now appearing almost monthly highlighting the importance of supervision of Trainees, the active involvement of senior medical staff and the →

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formal recognition of the time that is spent in these roles.

I mentioned in the previous edition of *Surgical News* that 62 per cent of elective surgery is now undertaken in the private sector [1]. The challenge for the College and the Specialty Societies is to ensure that governments identify funding for training in the private sector.

The models of the past contributed well to the standards of surgery that the community enjoys. The models at the moment are stretched and are not going to provide the educational opportunities or the workforce required by Australia and New Zealand into the future. It is vital that our ongoing advocacy continues to focus on the sustainable education of our surgical workforce.

1. AIHW. Australian Hospital Statistics 2007-2008. Canberra: Australian Institute of Health and Welfare, 2009.

David Watters & Ian Gough with a gift of appreciation from the Myanmar Medical Association to the College for its assistance in supporting the Primary Trauma Care course in Mayanmar


# Bullying is Banned

No more

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- Vexatious Reports
- Malicious Rumours
- Threats, yelling, screaming, offensive or inappropriate language
- Undermining work performance

Refer to College policies on Discrimination/Harassment at www.surgeons.org

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# Time for a new Constitution

Almost eighty years on, the College must take a more modern approach

**Ian Dickinson**
Vice President

On 22 October, 1930, Robert Russell, Augustus Kenny, Hibbert Newton, Alfred MacLure and Henry Newland put pen to paper and brought into existence the Memorandum and Articles of Association of the Royal Australasian College of Surgeons.

Whilst this document has served the College well for almost 80 years, I believe we would all agree that the College, and indeed the world, are now very different places. The existing memorandum and articles have some deficiencies with regard to compliance with modern corporations law, with the modern operations of the College and are, to some extent, a patchwork of amendments which have been required over the years.

In recognition of this fact, Council charged the Governance and Advocacy Committee (GAC) with reviewing the memorandum and articles with a view to developing a modern constitution more in line with the needs of today's College.

GAC's initial step was to approach Mr Michael Gorton of Russell Kennedy solicitors to undertake a legal review and supply GAC with a first draft of a document which complied with current corporations law and provided the College with a sound platform for the future.

Over the next several months, GAC revised this draft, working on the principles that it should be written in plain English and with a minimum of "legalese". GAC also consulted widely during this time, seeking feedback from Council, the surgical specialties, the Court of Honour and all Regional Committees.

The draft constitution was approved by Council at its June meeting and is available on the College website for Fellows to review.

## What's changed?

The first thing Fellows will notice is that the language has been thoroughly modernised and that the draft constitution is written in plain English. Terms belonging to an earlier era such as "thereupon" and "forthwith" have been removed from the draft version.

The draft constitution has also been reduced in scope. Operations of the College and this constitution will be underpinned by a set of strong regulations dealing with many day to day matters while still ensuring that sufficient protections are built into the draft to care for the overall College and the rights of Fellows.

This has been done to ensure the College has sufficient flexibility without the need for frequent reference to Fellows through referenda to change the constitution to deal with altered circumstances. Rest assured however, that central matters such as the composition of Council and the rights and privileges of Fellowship are enshrined in the constitution and can only be changed by a referendum of the Fellowship.

Regarding alterations to the constitution, the draft document proposes that the number of Fellows required to change the constitution be reduced from three quarters of those voting to two thirds. The further protection of only allowing change to the constitution by a vote of the whole Fellowship has, however, been added. This is an important protection as the existing articles allow for alteration of the articles by a vote of those present at an annual general meeting or special meeting. So while it is proposed to reduce the number of Fellows required to change the constitution, we do ensure that it will always be at a ballot of all the Fellowship.

Fellows will note that the draft constitution commences with a series of clauses outlining the purpose of the College and the manner in which the College will effect this purpose. This was largely covered by Clause 2 of the Memorandum of Association. This section however, also contained a number of mechanistic clauses relating to the land and property of the College and the College finances. →

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These are now contained elsewhere within the body of the draft constitution.

The new constitution expands on the concept of the College purpose and how to effect it, focusing more on surgical standards, education and training and various forms of advocacy. This is a conscious decision by GAC to separate the ambitions of our College from the more routine operational aspects.

Articles 19 and 21 have been removed from the draft constitution and will be handled by regulation. This proposed arrangement will allow Council to make the necessary alterations to the regulations without the requirement of a constitutional referendum.

The draft constitution provides Trainees with a voice on Council for the first time. It is proposed that there would be a Trainee Co-opted Councillor who will have the same rights and privileges (excepting the right to vote for office bearers and other Council positions) as other Councillors. This elevates the standing of the Trainee representative from an observer to a co-opted Councillor and will give Trainees a greater say in the decision-making process of Council. After all, for most Trainees this will be their College in the future.

There have been two small, but significant changes to the terms of Councillors and the President. The draft constitution caps the number of terms a Councillor may serve as President to two and ends the practice of a potential 10th year on Council. In future, no Councillor will be able to serve more than nine years. GAC and Council viewed this as an important step in ensuring new blood and fresh ideas were regularly being injected into Council.

*"In future, no Councillor will be able to serve more than nine years. GAC and Council viewed this as an important step in ensuring new blood and fresh ideas were regularly being injected into Council."*

## What's stayed the same?

While the elements outlined above are some of the more significant changes, a number of fundamentals have been retained from the articles and are reflected in the draft constitution.

For example, the balance between Council and the Executive has been retained. It was viewed as important that a Council, which fully represents the specialties and Fellowship should retain the fiduciary responsibility for the College. Therefore, there will be 16 Fellowship elected Councillors (formerly known as generally elected) and nine specialty elected Councillors.

Executive will remain as a committee of Council of eight Councillors (the five office bearers and three Councillors elected by Council) with the full powers of Council delegated to it.

The current names of all office bearers: President, Vice President, Treasurer, Censor-in-Chief and Chair of the Professional Development and Standards Board will be retained.

The draft constitution also ensures that there will continue to be a minimum of two New Zealand resident Councillors, however this Clause has been expanded to ensure that there will also be a minimum of two Australian resident Councillors.

## Regulations

GAC, in conjunction with College staff will conduct a thorough audit to ensure that sufficient regulations exist to cover any gaps which may arise should Fellows vote to adopt this new constitution. While the College already has over 600 policies, these may require slight modification or more substantial redrafting to reflect the new arrangements. In some cases whole new policies/regulations will require drafting.

For example, Clause 7 of the articles defines the manner in which Councillors are elected. No College policy exists to mirror this clause and therefore one will need to be written.

## Next Steps

Both the President and I will be visiting as many Fellows as we can in coming months at your various annual scientific meetings and other College fora. We will be endeavouring to explain the benefits of this draft constitution over the old Memorandum and Articles of Association, answer any questions and respond to any concerns you may have.

Ultimately, the draft constitution will be put to a vote of the Fellowship in 2010 at the same time as voting for Council. If three quarters of those Fellows voting support the change, the new constitution will become the new governance document for our College.

I urge you to support this change and ensure the rules governing our College reflect its role in a modern society.

## Census update

The Census is now closed and the results will be available in coming weeks. Thank you to all who participated. Six Fellows were randomly selected from among the first 30 to complete their census in their region after my recent email. They have won a $100 voucher redeemable from Borders stores across Australia and New Zealand. The winners are:

**New Zealand:** Mr Edward Yee
**New South Wales & Australian Capital Territory:** Mr Adam Rapaport
**Victoria & Tasmania:** Dr Andrei Cornoiu
**Western Australia:** Mr Sudhakar Rao
**Queensland:** Dr Daniel Rowe
**South Australia & Northern Territory:** Mr Paul Carney

**Correction**

Surgical New Vol: 10, No: 6, page 28 incorrectly named Andrew Cochrane as the Chair of the Victorian Regional Committee (VRC), the current Chair is Michael Dobson. Glenn Guest was the author of the article.



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# Who is the new Fellow?

## Our new Councillor is not naïve, silly or ignorant

I.M.A Newfellow

He is trying to usurp me, you know. Last Council meeting there was a new Councillor who said that he was a "new Fellow". I was a bit offended that this "Johnny come lately", this blow-in from the West (well actually the East relative to Melbourne College building as he works at the Alfred Hospital) would take my good name in vain. Make no mistake, there is only one Mr. Newfellow on Council and that is me, Mr. IMA Newfellow, so do not be deceived by pale imitations.

You see, to be a Mr. Newfellow you have to be fairly ignorant about College affairs, have stumbled into Council as none of your specialty colleagues wanted to give up the time, and be a bit naïve, willing to ask silly questions and show your ignorance. Mrs. Newfellow says that ignorant and silly are certainly my adjectives. However sometimes one finds that one accidentally exposes that the Emperor has no clothes.

Well our new Councillor is not naïve, silly or ignorant, so I find out. He is a former President of the ASOHNS (this long acronym stands for an even longer name – Australian Society of Otolaryngology Head and Neck Surgery). He has been involved in various positions in this important surgical specialty organisation for over 20 years. He is Head of the Ear Nose and Throat-Otoneurology Unit, The Alfred Hospital, Melbourne and Clinical Associate Professor, Department of Surgery, Monash University, Melbourne. As if this is not enough he is also an Honorary Visiting Professor at Sun Yat Sen University, Guangzhou, China.

One of the surprising things is that this new Fellow (at least new to Council) is not a general surgeon from the East Coast. We all know that the real power in the Council and the College lies with the East Coast General Surgeons. This is common knowledge – but there is an inconvenient truth.

If you look at the current Council there are generally elected Councillors who are from the specialties of vascular surgery, paediatric surgery, orthopaedics, cardio-thoracic surgery and plastic surgery. Indeed of the 16 generally elected Councilors only eight can be described as general surgeons. Oh yes, I hear the general surgeons saying "What is a general surgeon? There is no such thing. We are colo-rectal, breast, upper GI surgeons etc." So the common conception that the College is run by East Coast general surgeons is not true. Of the four office bearers, only the President is a general surgeon. Well he might actually say that he is a breast and endocrine surgeon but I would rather that he take out my appendix than the Vice President (who you will recall is an orthopaedic surgeon).

The odd thing about Council is that often I forget who is what and am surprised when, say a paediatric surgeon, knows about the workforce issues relating to cardiac surgery – it may well be that he has chaired a committee on the issue. So many Councillors have other skill sets – education, finance, business contacts and political influence. Of course I am not surprised that our past three treasurers have been a plastic surgeon, an orthopaedic surgeon and a vascular surgeon. My survey in the hospital car park shows that they know a lot about money. Two of them have other financial qualifications and talk with the best of them about market indicators, linked investments, and can waltz around balance sheets.

So there you go Vince Cousins – welcome to the College Council and welcome to your special talents, whatever they may be. But please don't usurp me. You may be a new Fellow but you are not a Newfellow – that honorable name belongs to me and my ancestors.

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# The 2009 ASC evaluation results

Congratulations to everyone involved in making the Brisbane ASC so successful!

**Rob Atkinson**
Chair, Professional Development Committee

For more than 80 years the College has been organising an Annual Scientific Congress (ASC). It is now a major educational activity and is the largest multi-disciplinary surgical meeting held in Australia and New Zealand.

This year the ASC was held in Brisbane. The delegate attendance figure was approximately 1700, including 1300 Fellows and Trainees from our College plus 400 other health professionals. This figure compares very favourably to the conjoint ASC in Hong Kong, which was attended by approximately 1200.

The College is extremely appreciative of the 270+ delegates who took time to complete the conference evaluation. Evaluation is an integral component of the planning and delivery of educational activities such as the ASC. Your feedback helps to design its educational content and helps to ensure that your learning needs are met.

Evaluation is also an important reflection tool that can stimulate you to make refinements in your practice. For this reason I would encourage all the delegates who did not complete an evaluation to take the time to do so next time.

Overwhelmingly delegates felt that the Congress enabled them to improve their knowledge, skills and competence. All scientific programs received a positive rating in regard to their educational value. However, some sessions were singled out for praise including the Surgical Oncology session 'Controversies in Melanoma' and the Breast Section session 'Difficult Concepts and Techniques'. The Trauma Surgery session 'The Message from Alice' and the Endocrine Surgery sessions relating to thyroid issues were also well regarded. Many respondents indicated that they gained a lot from the two plenary sessions: 'Surgery to the Needy at Home and Abroad' and 'Major Challenges in Surgical Education and Training'.

Spencer Beasley, winner of the 2009 ASC evaluation prize looking happy with his new iPod

Delegates were generally satisfied with the scientific program; it was balanced and allowed a choice of sessions. Some respondents expressed frustration about 'clashes' in the program when two concurrent sessions targeted the same interest group.

Unfortunately, this may be inevitable given the complexity of the ASC program and the reduction of the conference to a four day format. This reduction in the number of days is the result of consistent feedback from delegates over the last several years.

This year over 400 presentations are available on the Virtual Congress (VC) with both PowerPoint slides and audio. If you missed a session due to a program clash, please check the VC website, since the session may well be available. Presentations are only available if the presenter has agreed to their slides being uploaded on to the web. You may access the VC via 'asc.surgeons.org' and follow the links.

As in other years, there were a number of recommendations for the 2010 ASC in Perth. Some delegates requested more sessions addressing non-technical competencies and broader lifestyle issues. There were also calls for a greater number of sessions addressing topics of interest to Trainees.

The College booths were popular and most found the College staff enthusiastic and helpful. Some delegates wanted to know how to become involved in College activities and suggested that this could be a focus for future booths.

Some of the more IT savvy delegates again suggested providing presentations in an electronic format that could be downloaded to a laptop or mobile. These recommendations and the others will certainly be considered for 2010 and beyond.

Our thanks also go to Mark Smithers (ASC Convenor), Andrew Stevenson (ASC Scientific Convenor), Michael Hollands (Chair, ASC Planning and Review Committee) Campbell Miles (ASC Co-ordinator) and the scientific session chairs for their efforts in promoting the evaluation.

Obtaining feedback from delegates in relation to the ASC is an ongoing challenge. The 2009 evaluation return rate was 16 per cent, significantly less than 2008 when 23 per cent of delegates responded. The College is keen to hear your ideas about how to improve the response rate and is willing to 'think outside the square'. For example an electronic evaluation form on the ASC webpage will be available in 2010.

Please contact Merrilyn Smith on +61 3 9276 7441 or merrilyn.smith@surgeons.org with your suggestions.

# College Conferences and Events Management

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

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

## QLD REGIONAL COMMITTEE

## ANNUAL STATE MEETING

Hyatt Regency Sanctuary Cove
Friday 30 October – Sunday 1 November 2009

Convener- **Dr Maurice Stevens**

**Dual Theme:**
Changing Surgical Culture in the Public Hospital Sector
Surgical Outreach and Retrieval Services

**Program highlights:**

- Deputy Premier and Minister for Health Mr Paul Lucas will be in attendance on Saturday morning of the conference
- Free welcome BBQ (pig on the spit along the beach front) on the Friday evening
- Neville Davis Prize presentations
- David Theile Lecture
- Honoured Guest – Mr Glen Merry and Saturday Gala dinner
- Trainee activities and presentations on the Friday program
- Outreach programs such as Deadly Ears and Operation Smile
- Panel discussions with the Deputy Premier and Minister For Health
- Panel discussions on topics including: Fatigue Risk Management (safe hours), Surgery Connect and Cultural and Leadership issues between hospital administration and departments of surgery.

Provisional program and registration forms will be available in the coming weeks, costs for the meeting will be:

**REGISTRATION $AUD**
Inc GST STANDARD EARLY REGISTRATION
By 15 September 2009

**Fellows** $260 $200

**Trainees & IMGs** $130 $100

**Medical Students/Other Health Professionals** $60 $40

*Accommodation will be available at Sanctuary Cove for $235 per night, accommodation can only be booked through registration forms available from the College, please email qldasm@surgeons.org*

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# A Web-based Logbook

The logbook will allow training boards and the College to better track the progress of Trainees

**Julian Smith**
Chair, Research, Audit & Academic Surgery

The College is developing a web-based Logbook, which aims to streamline the preparation of logbooks for Trainees as well as provide the opportunity for audit. Although initially aimed at the Trainee, the logbook will be equally useful to Fellows who wish to maintain a full practice audit throughout their professional career.

Consultation is being sought from the nine specialty groups to devise specifications for a web logbook system. A process to incorporate specialties was adopted, and general surgery was the first to participate. Ongoing consultation with the Board of General Surgery led to the development of the initial version. Since then, the application has been refined to include a reporting module and a minimum approach to data entry for trainees.

The web logbook contains a common dataset for all specialties, as well as specialty specific variables. To promote data consistency in the recording of procedures, a revised approach has been implemented to include the Line Entry (as per individual specialty) as well as the more comprehensive Commonwealth Medicare Benefits Schedule (CMBS) descriptors.

The web logbook provides Trainees with immediate feedback regarding training goals, facilitates communication between Trainees and supervisors using technology such as short message service (SMS) or email, and allows training boards and the College to better track the progress of their Trainees.

Beta testing is currently being undertaken by Trainees and supervisors from a variety of specialties, as well as the College Council Executive. The next pilot phase will see a number of specialties involved encompassing both metropolitan and rural surgical Trainees.

In the first instance this will primarily involve three groups which will include general surgery, cardiothoracic surgery and neurosurgery. These groups are represented on the Logbooks and Clinical Audit Oversight Committee and have provided leadership and direction in the continuing development of the logbooks application. The logbooks management group in collaboration with the committee have developed a rollout plan which would see the logbooks available to users in 2009.

A comprehensive approach to communication with all stakeholders will be a focus of this rollout and will include userguides and documentation, web-based information available on the College website, presentations at both the College and within specialties where possible and an approach to develop e-learning tools will be utilised.

The Trainee Logbook component is established as the first phase of rollout. This will be achieved through the provision of a logbook with a minimum data entry approach enabling Trainees to continue to meet their current specialty logbook requirements.

The structure of the logbook has been recently updated and now provides three levels of interaction between Trainees/supervisors, Fellows and the Training Board. This includes a minimum data approach for the Trainee logbook, an expanded dataset enabling expanded data entry, and an additional dataset enabling specialty audit for Fellows.

An information sheet has been developed to provide updated information on the current activities, goals and the development and implementation of the system.

You can download copies from the website: www.surgeons.org/Content/NavigationMenu/Research/Logbooks/default.htm.

## HOMESTAY ACCOMMODATION FOR VISITING SCHOLARS

Through the College International Scholarships Program and Project China, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to 12 months.

Due to the short-term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. The International Scholarships Department and Project China are seeking expressions of interest from those willing and able to provide homestay accommodation for our visiting scholars. If you have a spare room, and are interested in learning about another culture and language, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a nominal stipend.

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

International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street, Melbourne, Victoria,
Australia, 3000
Telephone: + 61 3 9249 1211
Fax: + 61 3 9249 1236
Email: international.scholarships@surgeons.org

# Younger Fellows Leadership Exchange

Richard Page had the opportunity to meet like- minded colleagues in the USA

**Richard Page**
Chair, Younger Fellows Committee

From 4 to 6 February 2009 I had the pleasure of representing the College Younger Fellows at the fourth Combined Association of Academic Surgery Congress in Fort Myers, Florida. The Leadership Exchange between the College's Younger Fellows and the Association for Academic Surgery (AAS) grew out of the 2007 Australian Scientific Congress (ASC) when leaders of both groups identified key common areas of interest. Johnson & Johnson generously provided an educational grant, which enabled a Younger Fellow to travel to the AAS Congress and the AAS sponsored their representative to attend the Younger Fellows Forum.

The AAS has a dual role in representing younger academics as well as inspiring and supporting medical students, residents and younger surgeons in the pursuit of surgery – academic surgery in particular. A key membership criterion is to be within ten years of undertaking the first academic appointment. This demographic creates a natural synergy with our Younger Fellows and a lot of common ground despite some different geographic nuances in the issues and challenges that each group faces.

The 2009 AAS Congress was held over three days. It was an opportunity to renew growing friendships with the AAS Executive hierarchy as well as develop new associations within the leadership group.

On the first day there were excellent presentations, including the Society of University Surgeons (SUS) Presidential Address by Dr. Dianne Simeone. At the end of the day the AAS Outstanding Medical Student's Quick Shot papers was presented. This was an impressive array of research presented by medical students involved in academic surgical departments. Both the scope and quality of these presentations was excellent, highlighting the strong mentorship ethos the group has developed that is attracting the best and brightest to surgical training.

That evening I was a guest at the Association of American Women in Surgery meeting where three inspiring talks were given by senior academic surgeons. Professor Julie Freischlag, Chair of the Department of Surgery, and John Hopkins of the Medical Institute, presented a ten-point "P" plan for success in leadership in academic medicine: Possibilities, Patients, Perform, Push, Preserving, Politics, Peace, Pride, Pot Luck and Passion. Diners were encouraged to add their own 'Ps' to the list.

The following day in addition to excellent scientific presentations, the AAS research section gave out awards with one award going to an Australian paper. This was followed by a plenary session and then an excellent presidential address by the outgoing president, Professor Herb Chen, with a key focus on mentoring and interacting with medical students. He has an impressive research program, with students engaged at various levels and takes obvious pride in this activity. A joint social event was held that night between the SUS and the AAS at the AAS presidential reception, which was a chance to relax and spend time with American counterparts.

The next day had a focus on career-building and included a session on setting up and running a surgical skills lab and simulation centres. These sessions were designed to provide information and skills to surgeons wanting to establish strong roots for a research programme.

The Leadership Exchange was very rewarding on a number of levels; personally and professionally. It provided opportunities to interact with some of the finest emerging academic surgical researchers within the United States. It gave me insight into the structure and support required to develop a research outlook and leadership at a national and international level. I have no doubt the relationship between our Younger Fellows and the AAS group will provide exposure to the future leaders in surgery at an international level.

> "The Leadership Exchange was very rewarding on a number of levels; personally and professionally."

I would strongly recommend that any Younger Fellow with an interest in leadership, international relations and research, consider taking up this opportunity. I would like to thank the AAS and the Younger Fellows Committee for this great opportunity.

**Would you like to attend next years AAS meeting in 2010 as the RACS Younger Fellows representative?**

The 2010 Academic Surgery Congress will be held in San Antonio, Texas, February 3-5, 2010. Please download a form from the Younger Fellows Committee webpage found under Fellows/Interest Groups and Sections on the College website and return by September 30 or email glenda.webb@surgeons.org for more information.



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# Hereditary Diffuse Stomach Cancer

Dr Vanessa Blair witnessed the death of a 16-year-old from stomach cancer in her first year of training

Jimmy, Vanessa and Marco Blair

Almost thirty years ago, doctors in the New Zealand town of Tauranga became concerned at the strangely high incidence of diffuse-type stomach cancer afflicting a local Maori family.

With patients as young as 14 found to have the disease, it was apparent that the cancer was hereditary but before the more recent advances in gene science, not much more was known. Since then, however, a number of projects have been established to understand the disease process and establish optimum treatment procedures.

The 2008 recipient of the Raelene Boyle Scholarship, Dr Vanessa Blair, is one such surgeon/scientist to have studied the disease.

Working in Tauranga at the outset of her surgical training, Dr Blair witnessed the death of a 16-year-old from stomach cancer. The year before she arrived, a mutation in the gene called CDH1 had been identified as the cause of the predisposition to gastric cancer in the original Maori family, a breakthrough published in "Nature".

When the opportunity later arose to pursue research, Dr Blair chose to study Hereditary Diffuse Stomach Cancer (HDGC) and has now completed her PhD thesis undertaken through the University of Auckland's Department of Surgery, co-supervised by Parry Guildford from Otago University (who discovered the mutation) and Professor Ian Martin, the current Dean of the Auckland Medical School.

"This was a fascinating field of research to get into and a wonderful project because it was unique in that I got to meet the patients before surgery and then examine their stomachs after surgery. There are now ten families in New Zealand known to carry this gene and approximately 100 in the world, which indicates how rare it is but it has a devastating impact on those family members" Dr Blair said.

"What we found in the human stomachs is that there were up to 300 to 400 tiny spots of very early cancer with a preponderance of them found in the transitional zone between the body of the stomach and the antrum. "We found there was a greater density of the cancer foci in this area and that they were larger which is a useful finding to help doctors know what to look for and where to look at gastroscopy.

"The early cancers in HDGC are extremely subtle pale areas and are actually picked up through an appreciation of a colour change in the lining of the stomach. This became evident from comparison of the findings from the gastrectomy mapping study with the findings at gastroscopy. Gastroscopic surveillance is recommended to HDGC patients who decline prophylactic gastrectomy.

"We wanted to understand more about the disease, particularly the molecular pathways causing stomach cancer to progress.

"The goal is to develop treatments that defer the need to have the stomach removed because it would be much better for patients if we could take the stomach out at say, 40 years of age rather than in the late teens or early twenties. Obviously the optimal outcome is to work out a way to keep the normal copy of the gene working, but that is many years away yet."

The Sporting Chance Cancer Foundation established the Raelene Boyle scholarship in honour of the athlete in 1997 to support trainees or Fellows undertaking research in a cancer related field and carries a stipend of up to $55,000. Dr Blair, a mother of two young boys, has also recently passed her Part Two exam and will soon receive her Fellowship. She said the support of the scholarship made a huge difference as she balanced motherhood, training and research in the past year.

"I had my youngest son in August last year and the generosity of the College, in terms of being selected for this scholarship, meant that I could afford to employ a maternity nanny to allow me the time to write up my thesis," Dr Blair said.

"It really made a tremendous difference. It is a very special time when you have a newborn baby and a little help goes a long way and the scholarship allowed me to afford that help."

Dr Blair is now planning to specialise as a breast and endocrine surgeon and continue research in hereditary breast and stomach cancer. She is now completing the last six months of her training at Auckland City Hospital.

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Preliminary Notice –

## Surgical Research Society Annual Meeting

The Surgical Research Society 46th Annual Scientific Meeting will be held in Adelaide on **Friday 20th November 2009.**

The meeting will be titled

*"Australasia's Got Talent – in Surgical Research".*

This meeting is open to all who are involved in or who are interested in research, including surgeons, surgical or medical trainees, researchers or scientists.

Call for Abstracts:
Abstracts must be submitted no later than Wednesday 30th September 2009.

Convenor:
Professor Guy Maddern

For further information contact:
Jessica Jeffery
Administrative Officer
Tel: +61 8 8363 7513 / Fax: +61 8 8362 2077
Email: jessica.jeffrey@surgeons.org



## AFL INJURIES CONFERENCE

MELBOURNE, VICTORIA

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# ASC Surgeons as Educators Prize

A good surgeon has the ability to recognise the sick patient, decide the most appropriate course of action, and implement this action

**Sarah Rennie**
Winner of the ASC Surgeons as Educators Prize

'The Surgeons as Educators Committee would like to congratulate Dr Sarah Rennie for winning the ASC Surgeons as Educators Prize for her paper entitled *'Generating a model to explore decision making in an acute surgical setting'.* '

As a medical student I observed that one aspect of practicing surgery that distinguished those that seemed to be really good surgeons, or even really good trainees, from the others was their ability to recognise the sick patient, decide the most appropriate course of action, and implement this action. It struck me that although there was a move to assess surgical trainees in many domains other than knowledge, that I was not taught explicit decision-making skills or assessed in this area.

I began to research decision-making skills – initially I thought that there would be assessment techniques in other fields that could be applied in medicine. However, our understanding of decision-making is relatively lacking. I have been exploring decision-making in the surgical setting, with particular reference to how surgical trainees make decisions, so that we can improve and develop learning and assessment of this important aspect of practice.

The paper I presented at the ASC considered what constitutes good and poor decision- making and detailed the generation of two conceptual models for surgical trainee decision-making. A qualitative web-based survey was completed by global experts in the domains of Surgery, Medical Education and Cognitive Research. Half of the experts were asked to describe the features of a good decision, characteristics of a good decision-maker and the essential factors in developing good decision-making skills. The other half of the experts were asked to consider the same areas but related to poor decision-making. Experts were asked to give free text responses to ensure that they were not cued or biased in their thinking. Twenty-nine experts (52 per cent) responded to the survey.

> "I have been exploring decision-making in the surgical setting with particular reference to how surgical trainees make decisions..."

The free text responses were analysed using a qualitative analytical framework methodology; they were clustered and categorised under major theme headings that encompassed the interpreted meaning of the expert statement. The categories were compared by two researchers and disagreements in the clustering discussed and consensus reached.

The relationships between these themes were explored and from this a model developed that illustrates decision-making for the surgical trainee. The model is in the shape of a globe with three major layers – the decision process at the heart surrounded by the decision-maker who, in turn, is surrounded by their decision environment. Each of the three major layers has sub layers, composed of the categories described by the experts, which are dynamic and interact with each other. In the optimal setting all the layers in the model would be complete.

However in reality all of these layers are very rarely complete – they will all have some degree of holes in them. This leads to the conceptual model of the decision- making globe model being like a Chinese puzzle ball with layers that are dynamic. There is the potential for the holes in the layers to line up – when this occurs a poor patient outcome may be more likely to result.

The models have many potential applications. With regard to Trainees the models could be used:

- to enhance learning – a model which the learner can consider and reflect upon when making decisions
- as a diagnostic tool – to explore a Trainee decision-making when a problem has occurred, to enable the sub-layers to be mapped and holes to be identified
- as a preventative tool – to map a Trainee's strengths and identify potential weaknesses in them and their current training environment and ensure that these holes don't align
- as a framework for developing assessment tools of the key factors involved in decision-making.

If you would like to look at the model please email PDactivities@surgeons.org

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# Parkinson's Law and Healthcare

Work expands so as to fill the time available for its completion

**Rob Davies**
Chair, Western Australian Regional Committee

"Parkinson's Law" was first articulated by Professor Cyril Northcote Parkinson, Raffles Professor of History at the University of Malaya, in a humorous article published in The Economist in 1955. Three years later he published a series of essays as "Parkinson's Law or The Pursuit of Progress", a book that remains as germane today as it did more that 50 years ago. Drawing upon his experience in the British Civil Service (and with merciless satire), Professor Northcote dissected the very nature of public and private bureaucracies and of how administration works along with irreverent observations about, amongst other things, elections and rule by committees.

What has become known as Parkinson's First Law states that "Work expands so as to fill the time available for its completion." The corollary to the First Law is that "there need be little or no relationship between the work to be done and the size of the staff to which it may be assigned." In his book Parkinson used two examples. First he showed that while the number of capital ships in commission in the British Navy between World Wars I and II declined by 67 per cent and officers and men in the Royal Navy declined by 31.5 per cent, dockyard workers increased by ten per cent, dockyard officials and clerks grew by 40 per cent and Admiralty officials grew over the same period by a staggering 78 per cent. The result was "a magnificent navy on land" and was "unrelated to any possible increase in their work". Similarly between 1935 and 1954, the British Colonial Office increased from 372 to 1,661 officials, all while the British Colonies were undergoing a significant contraction as successive colonies achieved self-government. When the Colonial Office was finally folded into the Foreign Office because of a lack of colonies to administer, it had grown to contain the greatest number of staff in its history. Using these examples Parkinson calculated that bureaucracies grow at between 5.1 per cent and 6.5 per cent per annum, irrespective of their volume of work. This was because, according to him, "(one) An official wants to multiply subordinates, not rivals and (two) officials make work for each other".

Had he been alive and writing an updated edition of his book, Parkinson could have included The British National Health Service (NHS) as a modern day example. As of March 2009, out of a total staff of 1.36 million, 39,900 are managers and 34,900 are medical consultants. That's right: there are 5,000 more managers tending to the organisation than senior Doctors tending to the sick. As noted by Sir Gerry Robinson in the Telegraph earlier this year, "It is the starkest of all illustrations of just how far the pendulum has swung from medicinal to managerial".

Within the Australian healthcare system we too have witnessed an explosion of managers and administrators. The Australian Centre for Health Research last year released data that showed more than a third of NSW's 90,997 health staff were classified "administrative or other". It was noted that in the NSW health system, there were more clerks than there were nurses. In Tasmania 45 per cent of the 8,992 full-time equivalent staff was classified as administrative or other. Data from Victoria, South Australia and Western Australia was incomplete or non-existent.

Middle management is the main offender. They generate e-mails, memos, reminders, directives, operational circulars, meetings and committees. They invite input into such intangibles as "developing innovative healthcare policy, setting of meaningful targets and monitoring patient outcomes" from "key stakeholders". In my own hospital they generate correspondence about how the problem of a three month delay in typing outpatient correspondence is to be addressed. As Parkinson noted, managers beget managers. The trouble is that no middle manager suddenly wakes up, realises that the problem is that there are too many of them and then sets about cutting themselves out of the system.

When managers do multiply, Parkinson theorised that to self-preserve they appoint staff that are non-threatening to their own position. Thus second-rate managers appoint third-rate immediate staff who will in turn "... see to it that their subordinates are fourth-rate." Such organisations are doomed to "organisational paralysis".

> *"Within the Australian healthcare system, we too have witnessed an explosion of managers and administrators."*

The "Peter Principle" also comes into play here. This states that "In a hierarchy every employee tends to rise to his level of incompetence" and was formulated by Dr. Laurence J. Peter and Raymond Hull in their 1968 book "The Peter Principle". It theorises that a person will continue to be promoted whilst they work competently. Eventually they are promoted to a position that they cannot fulfill (their "level of incompetence") and, once there, they will stagnate. Put more succinctly, Dr Peter noted that "The cream rises until it sours". Peter's Corollary states that "in time, every post tends to be occupied by an employee who is incompetent to carry out his duties" and that "work is accomplished by those employees who have not yet reached their level of incompetence".

Scientific validation of Parkinson's Law was the subject of a New Scientist editorial earlier this year. Physicists Peter Klimek, Rudolf Hanel and Stefan Thurner of the Medical University of Vienna in Austria published a complex mathematical model that confirmed Parkinson's anecdotal observations. They needn't have bothered. They could have just visited an Australian public hospital.

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# Simulated Surgical Skills Program

## Do participants trained on different fidelity simulators display different skill levels?

**Guy Maddern**
Surgical Director, ASERNIP-S

The Simulated Surgical Skills Program (SSSP), funded by Australian Government through the Department of Health and Ageing, is charged with the development, implementation and assessment of a new laparoscopic surgical skills training curriculum. The new curriculum will incorporate the use of laparoscopic simulators alongside traditional training techniques to provide a new mode of surgical skills training for Australia.

The SSSP has five core aims:

- to produce a report examining international laparoscopic surgical simulation training and its implications for Australia
- to develop a training and assessment program suited to the Australian education and healthcare systems
- to implement this curriculum
- to assess this curriculum
- to develop a 'Train the Trainer' program.

In order to assess the proposed curriculum, research will be undertaken in the following areas:

- laparoscopic skills assessment – acquisition and maintenance of skills
- laparoscopic simulator assessment – low versus high fidelity
- simulation and traditional training versus traditional training alone
- laparoscopic skills assessment – effect of fatigue on surgical simulation skills.

The Simulated Surgical Skills Program (SSSP) plans to operate simulators in New South Wales (NSW) between August 2009 and September 2010 to examine the research question 'Do participants trained on different fidelity simulators display different skill levels?'

Key participants will be year one and two Surgical Education Trainees (SET 1/2) and Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) trainees. NSW presents a logistical challenge for SSSP as the key targeted cohort are based at 34 accredited Basic Surgical Training (BST) hospitals throughout metropolitan and country NSW including 21 metropolitan sites and 13 rural, (RACS Activities Report Dec 2007).

The concept that simulators should travel to participants rather than participants travel to a simulation centre has arisen from past experiences where long travelling times in Sydney have made the participation of medical officers in other scientific trials difficult. To this end a mobile simulation unit has been proposed. This unit would be incorporated into a light commercial vehicle with simulators and equipment permanently set up. The vehicle would be used in conjunction with SSSP simulators accommodated at two existing simulation centres in NSW. This combination has the potential to increase the number of health units which participate and consequently the number of participants.

Furthermore the use of this unit would facilitate the assessment of a mobile facility for future use in rural centres around Australia.

Annual Scientific Meeting Coalface Updates

**Controversies & Current Techiniques**
**30-31 October 2009 Sebel Hotel, Albert Park**

A ½ day meeting for general surgeons presented by the Alfred Hospital, Melbourne.

- Sessions on inguinal hernia repair, reflux surgery, right hemicolectomy laparoscopic mesh and incisional hernia repair
- How I do it sessions on closing the unclosable abdomen; sentinel node biopsy for breast cancer; thyroidectomy; and damage control laparotomy
- Update yourself on botox® injection for anal fissures

The Conference dinner will be held at the MCG with famous Australian sports personalities; Phil Anderson, Mike McKay and Linley Frame and Tony Charlton as the MC. Pianist Alan Kogosowski and violinist Sally Cooper will be performing.

*Book now as it is Melbourne Cup Weekend*

**Workshops**
**Thursday, 29 October, 2009 at the University of Melbourne Veterinary Clinic in Werribee**

- Two workshops will be held on Advanced Laparoscopic Skills and Neck Surgery.
- Attendees will rotate through five stations including small bowel, upper GI, hepatobiliary, small bowel, thyroid, colorectal, ventral and incisional hernia.
- The morning and afternoon sessions will be identical and each can accommodate a maximum of 15 attendees.

*Early registration is recommended.*

CME approved by RACS

Further information and if you would like a provisional programme please contact
Lindy Moffat, Conferences & Events at RACS
+ 61 3 9249 1224 or lindy.moffat@surgeons.org

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# A generous gift to the Foundation

Thank you to Hazel Westbury for her support to the Foundation for Surgery

**Bruce Barraclough**
Chair, Foundation for Surgery

Ian Gough, Hazel Westbury & Bruce Barraclough in front of one of the donated John Dollery paintings

Hazel Westbury, a keen artist, gallery owner and philanthropist has kindly donated her collection of four John Dollery paintings to the College for the Foundation of Surgery. Hazel has over 20 years with the arts and philanthropic arena both in Australia and overseas. Her passion for creativity coupled with her design and development of strategic plans for sustainable advancement has ensured organisations like Royal Flying Doctors, National Heart Foundation, Royal Children's Hospital, Victorian Eye specialists, St Michael Grammar School, Essendon football Club and Monash University continue to grow and flourish.

Hazel has been the director of DMT Arts International where she operated a regional gallery and dealership as well as creatively directing the Wonthaggi Italian Festa, Churchill Island Cinema Under the Stars. Many artists were represented during that period: David Millis, David Williams, John Adams, Ronald Greenaway, Joyce McGrath. Today we are proud to accept Hazel's donation of art works from the artist John Dollery. These can be viewed hanging in the foyer outside the Council Rooms.

John Dollery was born in London in 1933. As a child he became interested in drawing, and frequently visited the National and Tate Galleries. He is entirely self-taught in art. He migrated to Australia in 1957, settling in Queensland in 1965. He took up painting in oils after receiving third prize in the London Open Exhibition for drawing in 1965. While living in Queensland he painted only from life.

In 1977 he moved to Melbourne, where he established himself as a full-time artist. He is very interested in Australian history, and paints scenes from the goldfields, sailing ships and the life of Ned Kelly. He is member of the Queensland Artists Society, the Victorian Artists Society and the Australian Guild of Realist Artists. His work is represented in many private collections in Australia and overseas.

Hazel is also herself an artist and is currently working with a group of artists to exhibit their works later on in the year and has generously agreed that a percentage of profits from this exhibition will be donated to our Foundation for Surgery.

On behalf of our Councillors, Fellows, and staff we thank you for your support and encouragement of our Foundation, and College. We look forward to a shared vision and commitment to improve surgical care, clinical research and education in disadvantaged communities.

WE'RE LOOKING FOR SOMEONE TO BUILD ON A STRONG FOUNDATION

The College Foundation for Surgery enables the broader community to support projects to promote research that fosters progress in surgery and particularly promotes the health and wellbeing of those in disadvantaged communities in Australia, New Zealand and in the Asia-Pacific region.

**Expressions of Interest for Foundation for Surgery Board Membership**

We would appreciate it if you will canvass your network of Fellows, colleagues and friends, as well as corporate contacts to find suitable candidates who to nominate to serve on the Board of our Foundation.

The Board position being filled is a pro bono activity.

We are seeking someone

- Who understands the need for continued research in a rapidly changing surgical environment
- Who is willing to play a key role in developing innovative fundraising initiatives in a competitive environment, and will work to develop a network of supporters across a range of industry groups
- Who is passionate about providing surgical care to disadvantaged communities
- Who appreciates the educational value of surgical exchange programs
- Who has relevant skills and contacts that will assist the Foundation in both attracting and providing philanthropy in order to make a real difference

**For further information on the Board position please contact the Office of the Foundation for Surgery on (+61 3) 9249 1205 or email foundation@surgeons.org**

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# Working Together to Bridge the Divide

A workshop to explore better relationships between surgeons and administrators

**Rob Atkinson**
Chair, Professional Development Committee
**John Harris**
Workshop Convener

The challenge for health in the 21st century is to develop a mutually respectful partnership between medical administrators and clinicians for the betterment of patient care. Sustainable clinical improvement is a critical issue in the light of recent concerns about the state of health care in Australia and New Zealand. Experience suggests that in order to achieve such improvement, clinicians and administrators must work together to lead the improvement process.

Since 2006 the Royal Australasian College of Medical Administrators (RACMA) and the College have been offering joint professional development activities focusing on a better understanding of the surgeon-medical administrator working relationship and development of more cooperative health service management. The first joint project targeting rural Fellows aimed to achieve sustainable clinical improvement and promote collaboration by teaching quality improvement and team skills.

Building on this success, RACMA and the College are designing a new workshop with the help of Dr Lee Gruner, RACMA Dean of Education, and Professor John Harris, an ex-College Councillor. As a first step, 240 administrators and surgeons across Australia were asked about their working relationship. The following is a summary of their responses:

## Fiscal priorities ahead of patient care

When asked to rate their level of interest in patient outcomes 65 per cent of administrators felt that they shared surgeons' high level of interest in patient outcomes, yet 80 per cent of surgeons felt that administrators did not often prioritise fiscal imperatives ahead of patients' health care needs.

## Misalignment of goals

When asked to comment on the extent to which they agreed on hospital goals, 62 per cent of administrators and 39 per cent of surgeons felt that they 'usually' or 'often' agreed, with the remainder feeling that they only 'occasionally' or 'rarely' agreed.

## Misunderstanding of each others priorities

When asked to comment on their counterparts' understanding of their priorities:

- 83 per cent of surgeons felt administrators had a 'fair' to 'poor' understanding of surgical priorities compared to 62 per cent of administrators feeling that they had a 'good' to 'high' level of understanding;
- 84 per cent of administrators and 77 per cent of surgeons agreed that surgeons' understanding of hospital priorities was 'fair' to 'poor'.

## Poor feedback processes

When asked to comment on their communication with one another:

- 90 per cent of surgeons and 87 per cent of administrators agreed that administrators only 'occasionally' or 'rarely' gave surgeons effective feedback;
- 77 per cent of surgeons and 82 per cent of administrators agreed that surgeons only 'occasionally' or 'rarely' gave administrators effective feedback.

## Low levels of confidence in management

When asked to comment on their level of confidence in each other as leaders and managers, 41 per cent of administrators stated that they 'often' had confidence in surgeons as leaders or managers while only two per cent of surgeons felt they 'often' had confidence in administrators.

## Relative influence in decision-making

When asked to comment on their level of influence over hospital management decisions, 81 per cent of surgeons felt they 'occasionally' or 'rarely' influenced hospital management decisions. In contrast 72 per cent of administrators felt they had 'good' or 'sufficient' influence.

When asked to comment on administrators influence over patient care, 66 per cent of surgeons and 69 per cent of administrators agreed that administrators had 'sufficient' to 'high' levels of influence over patient care.

## Low level of involvement in management activities

When asked to comment on surgeons' involvement in management activities:

- 43 per cent of surgeons and 59 per cent of administrators felt that surgeons were 'occasionally' or 'rarely' involved in management activities;
- 36 per cent of surgeons and 30 per cent of administrators felt they were 'frequently' involved in management activities;
- Only six per cent of administrators and four per cent of surgeons felt they were 'always involved'.

## Missing out on effective teamwork

Given the perceived misalignment of priorities and limited understanding of each other's roles and responsibilities and poor communication, it was not surprising to find that 95 per cent of surgeons and 78 per cent of administrators agreed that they only 'occasionally' or 'rarely' worked effectively as a team.

When asked to identify the top five priorities for action to improve their working relationship here is what administrators and surgeons had to say, in order of the most frequently reported:

1. Establish a shared vision, priorities and goals;
2. Improve communication;
3. Improve understanding of each other's roles and responsibilities;

4. Increase leadership and management training opportunities for surgeons;
5. Increase collaboration/cooperation in service planning and decision making.

## Next steps

The joint workshop aims to give surgeons and administrators the opportunity to further explore the issues highlighted in the survey results and develop strategies to turn differences into opportunities to achieve better patient outcomes.

## Further Information

Please contact the Professional Development Department on +61 3 9249 1106 or by email PDactivities@surgeons.org. The workshop will be held on Monday, 9 November in Sydney.

## Wish List

**Medical administrators wish that surgeons would:**

1. See the big picture instead of having a specialty specific and individual patient focus;
2. Approach things with a constructive attitude – not arrogant, demanding, impatient;
3. Increase interest and involvement in administrative matters (incl Visiting Medical Officers);
4. Be mindful of resource expenditure;
5. Improve adherence to policies and procedures;
6. Contribute to service planning activities;
7. Improve management of waiting lists;
8. Increase participation in peer review;
9. Increase participation in quality and safety activities;
10. Improve their communication with administrators;
11. Become more target/KPI orientated.

**Surgeons wish medical administrators would:**

1. Align their priorities – become more patient oriented and less business oriented;
2. Improve communication/consultation with surgeons;
3. Be less bureaucratic;
4. Listen to surgeons;
5. Not impose change without fully understanding the clinical and workforce implications of their decisions;
6. Take direct responsibility for patient outcomes;
7. Improve access block (beds/theatre, pre-post-operative requirements);
8. Improve waiting list management;
9. Value the large amount of un-paid work done by surgeons;
10. Respond quickly to problems, complaints, demands.


# SYDNEY UPPER GASTROINTESTINAL SURGICAL SOCIETY

**Saturday 5th September 2009**
**9.00am-3.30pm**
Novotel Hotel, Olympic Boulevard, Homebush Bay

International Guest **Peter F Crookes, MD,FACS**
Interstate Guests **Andrew Barbour (Q'ld), Lillian Kow (SA), Ian Martin Q'ld, Robert Padbury, SA**

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# Rowing down the river

There are huge benefits not only in getting fit but having a good work/life balance

Aiden & James rowing at Henley

As quintessentially English as Royal Ascot and Wimbledon, the Henley Royal Regatta has been attracting world-class rowers and sun-starved spectators since it began in 1839. Held on an idyllic 2.2km stretch of the Thames in Oxfordshire, the Regatta has been held in July each year for every year since, with the exception of the duration of the two world wars, luring both amateur and Olympic-level rowers from around the world.

This year, two Australian surgical Trainees who have rowed together since high school, took on the course, the Pimms and the strawberries and cream. Dr Aidan Burrell now working in Adelaide and Dr James Ledgard now in regional New South Wales, set their sights on competing in the Regatta more than a year ago when the two were both living in Sydney and members of the Sydney Rowing Club.

Yet when their surgical training posts took them in opposite directions, the two continued to train in preparation for the event; Dr Burrell flying to Sydney to row with Dr Ledgard on Sydney Harbour and Dr Ledgard flying to Adelaide to train with his rowing mate at Westlakes.

Yet after so much physical and logistical effort, the two amateur athletes found they were unable to compete in the elite race. Instead, they rowed the course and measured their time against the best of the best and were pleased with the results.

"Rowing at the Henley on Thames Regatta is a very serious affair, very traditional and very elite. While we are good club crew level, most of the competitors are Olympic class and unfortunately the only event in the men's pair was at that level which meant that we were not allowed to compete," Dr Burrell said.

*"Rowing at the Henley on Thames Regatta is a very serious affair, very traditional and very elite..."*

"That was a bit of a let-down but it was a great experience. We rowed the course ourselves with all the crowds still mingling by the river and the atmosphere was wonderful and our time wasn't bad, we would have come somewhere in the middle, which at that level is pretty good.

"Henley is the oldest regatta in the world, everything is steeped in tradition, it would have to be one of the most beautiful rowing courses in the world and the whole experience gave me a hunger to have another try. And even though we did not get to compete, we took some satisfaction from the fact that at least we met three of our four goals which were to get fit, to get fast and to go to Henley, and given where we were both working in the past year they were not easy goals to achieve."

Dr Burrell, a vascular Trainee now in his second year of training at the Queen Elizabeth Hospital, was an elite junior rower, winning a gold and silver medal in the World Junior Rowing Championships in the late 1990s before being forced to give away international competition to concentrate on medicine. Dr Ledgard, a general surgery Trainee with an interest in plastics, took up the sport in high school and represented South Australia in national competitions.

The two men met through rowing at high school and then again at medical college where they became members of the same rowing club.

"Before Christmas last year the two of us were both in Sydney so setting our sights on the Henley Regatta wasn't then as challenging as it turned out to be. We intended to go to Henley and try to qualify but just as competition began, the stewards said our event was too elite and given that the first three or four crews were previous Olympians they had a point, so if we try again we'll have to do things differently," Dr Ledgard said.

"Yet it was great fun and the course is beautiful though I'd have to say that if Aidan

and I aren't in the same city next year we probably won't row together again because it became a very complex exercise to keep up our training."

Dr Burrell said the two of them would not know until October where they would be posted.

"It was great last year when we both lived in Sydney because we trained on the harbour, around the bridge, down by the fish market, dodging the ferries and the pleasure boats and it was wonderful," he said.

"Then we were training twice a week but in the past year we have had to train alone in the boat or by keeping fit in the gym, by running and cycling and then meeting once a month to train together. But we had to make sure we were staying at the same fitness level because otherwise the stronger rower can turn the boat around.

"Yet while it is difficult at times to commit yourself to outside interests as a Trainee surgeon and easy to give them up, there are huge benefits not only in getting fit but having a good work/life balance.

"James and I are of the generation that see that as important, I suppose, surgeons who want to have a role in raising their kids, being at home more and having outside interests."

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# Make a real difference

## General Surgeon for Dili, Timor Leste (East Timor)

**FULL TIME POSITION TO COMMENCE ASAP**

A general surgeon is required to lead the development and delivery of surgical training in Timor Leste as well as assisting with service delivery in Hospital Nacional Guido Valadares (HNGV). This unique and rewarding role is best suited to an experienced surgeon keen to use his/her surgical, teaching and leadership skills to improve the surgical services in this young nation. A major aim of this appointment will be to provide support to the Timorese Head of Department of Surgery

The position is open to qualified general surgeons in Australia or New Zealand. Individuals applying from outside Australia and New Zealand will need to possess equivalent qualifications to be considered.

Short-term locum opportunities for qualified general surgeons are also available.

Managed by the Royal Australasian College of Surgeons (RACS), the Australia Timor Leste Program of Assistance for Specialist Services (ATLASS) aims to improve the availability and quality of general and specialist surgical services to the people of Timor Leste through the training of local Timorese doctors and nurses and assisting with the delivery of tertiary health care services.

As the national hospital for Timor Leste, HNGV is responsible for the provision of a wide range of surgical and non-surgical specialist services and it is the only referral hospital for the 5 district hospitals in the country. The ATLASS program currently employs 3 full-time clinical advisors (general surgeon, anaesthetist, emergency department physician) at HNGV and co-ordinates approximately 12 specialist surgical team visits across Timor Leste per year.

**Please direct enquiries on conditons of the appointment to:**

Ms Karen Moss
Program Officer RACS International Projects
Ph: +61 3 9276 7436

OR

Dr Eric Vreede
ATLASS Team Leader
teamleader@mail.timortelecom.tp
Ph: +670 725 7125

**Please send your application including a covering letter and CV at your earliest convenience to karen.moss@surgeons.org**

**Only short listed applicants will be contacted.**




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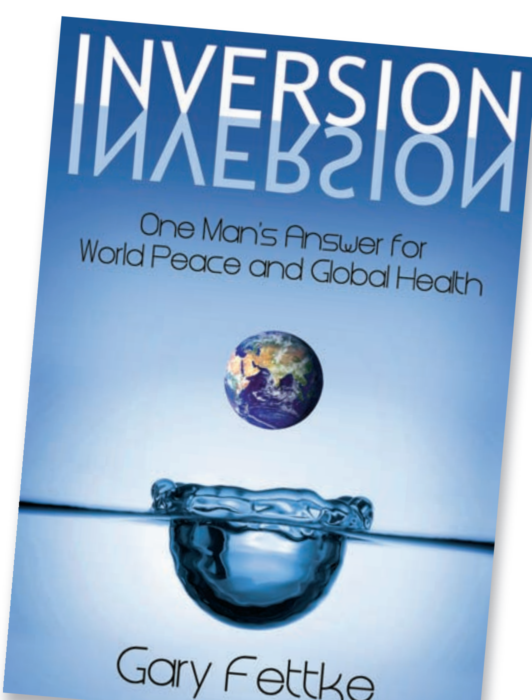
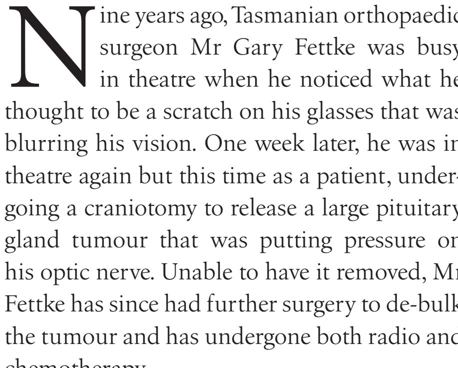
# A different perspective

There is an urgent need for the global community to find common ground on many issues



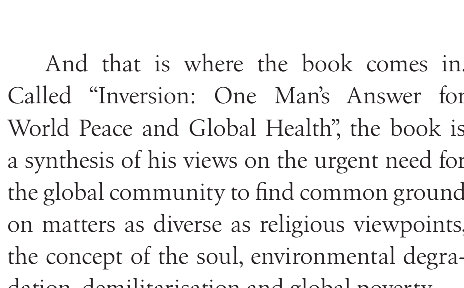
Nine years ago, Tasmanian orthopaedic surgeon Mr Gary Fettke was busy in theatre when he noticed what he thought to be a scratch on his glasses that was blurring his vision. One week later, he was in theatre again but this time as a patient, undergoing a craniotomy to release a large pituitary gland tumour that was putting pressure on his optic nerve. Unable to have it removed, Mr Fettke has since had further surgery to de-bulk the tumour and has undergone both radio and chemotherapy.

Yet, while the first operation in particular was a traumatic and painful ordeal – requiring him to relearn how to walk and causing short-term memory loss – he is now not only back at work but has written a book, launched a website, finished a research project that he will soon present to the Australian Orthopaedic Association and designed and is building an energy efficient house outside Launceston.

"That initial surgery was a very unpleasant experience and I can attest that they hurt, those neurosurgeons," Mr Fettke laughs.

"And when I first returned to work afterwards I was acutely aware of the pain patients might be experiencing and I felt quite remorseful for having caused it. I kept feeling the need to apologise."

Mr Fettke says that initial surgery and the experience of cancer has changed his life not only in a practical sense – he has reduced his working week from ninety hours – but has considered his thinking from life in a physical context to life as a metaphysical force.



And that is where the book comes in. Called "Inversion: One Man's Answer for World Peace and Global Health", the book is a synthesis of his views on the urgent need for the global community to find common ground on matters as diverse as religious viewpoints, the concept of the soul, environmental degradation, demilitarisation and global poverty.

In the book, he writes that he uses the term "Inversion" to explain the notion of looking at issues from an opposing viewpoint.

"My first physical inversion occurred whilst bushwalking in the South Island of New Zealand. Hanging upside down off the end of a rock enabled me to see the mountains from a different perspective. What I had been seeing for days looked totally different from upside down. The colours were brilliant, the shapes and outlines more distinct and the reverse perspective made me gaze in wonderment at what had been in front of me for days," Mr Fettke writes.

"The next step is a mental inversion. Invert your thoughts and opinions – look at things with a different perspective. It just might be what we need to do to alter the course of the planet."

Speaking about the book, Mr Fettke says that while he was not "naive enough" to believe he can solve the world's problems, he chose to publish his ideas as a means of demonstrating both personal responsibility, and that an individual can have a voice and an impact.

"There is nothing like waking up in the intensive care unit and being very unwell to focus the mind not only on things that matter on a personal level, like family, like loved ones, but also on how to make the most of the time available and how to make a difference," he says.

*"Invert your thoughts and opinions – look at things with a different perspective. It just might be what we need to do to alter the course of the planet."*

"Many, many people seem to feel that most of the major issues are beyond them, that they are powerless but I believe solutions can begin in the home, in the family, in the neighbourhood and grow outward into the world if we look for common ground and if we take personal responsibility for our own actions first."

"Even now, even after my own experiences, I have great empathy for those patients who are taking responsibility for their own wellbeing, who are not just expecting doctors, surgeons and the health care system to make them well. I take this, in the book, into a global context."

"We are in it together whether we like it or not and the book is simply about planting that seed, to encourage people to think about the big and small and take what action they can."

Gary Fettke and his wife Belinda

"I think the key, actually, is simply to work out where you stand on many issues, to mentally and philosophically engage with the world. I wanted to keep this book as short as possible in the belief that with so many people time poor it is better to read for an hour and think for a week than to feel overwhelmed."

Since the initial surgery, Mr Fettke has concentrated more on his teaching commitments and research and is soon to present his findings of a five-year study into the use of straight arm casts for broken forearms over the traditional method of bent casts.

"Someone once said that in life you should write something and count something and now I have done both which makes me feel quite fulfilled at the moment. I read a paper from China some years ago on the use of straight arm casts and we decided to give it some rigorous investigation. If you had visited Launceston in recent years you would have seen all the kids with broken arms all walking around with a different style cast from that traditionally used," he says.

"The findings have been remarkable; none of those kids had to go back to theatre

because the bones had lost position, thus the straight-arms casts had a significant impact on morbidity. We will be presenting this research to the forthcoming state meeting and then at the national meeting later this year."

Mr Fettke says the Launceston community had shown him great support during his recovery from surgery and his ongoing treatment. He said that working in a smaller city meant that his health status was common knowledge but that he had decided to be as open as he could be to prevent misinformation.

"In a smallish community I think it is much better to be as open as possible, an opinion I formed after hearing rumours that I was dead," he laughs.

"I kept my patients informed and wrote to GPs to explain where I was up to and in the process got infinitely more support than if I had kept it a closely guarded secret. It also meant that I could continue with my idiosyncrasies. I've written to the Federal Health Minister proposing funding solutions for the health system and I have put my mind to solving problems that face the automotive industry in Australia, all the time knowing that if I say something that people don't like I can always say I have had brain surgery."

"And my patients in particular have shown great support. I performed a hip replacement operation on one patient prior to my original surgery - she was happy with the result and came to me to have her other hip done. I said I would do it for her, she was pleased, and on her way out of the office, turned to my secretary and asked: 'Is Mr Fettke still blind?'

"Now that's loyalty."

For more information on Gary Fettke and his book, visit his website at www.onemansanswer.com



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# Interplast inroads into surgical care

Interplast has made incredible achievements that make a real difference, both now and for the future

Interplast volunteer, Sydney nurse Michelle Skrivanic teaching in the Philippines Baguio City Nov 2008

**Interplast Australia & New Zealand**

At this time it is opportune to reflect on the successes and inroads Interplast volunteers have made to improving lives by increasing access to surgery in the Asia Pacific Region. In total 31 service and training activities and supporting resources were undertaken in 15 countries during the last financial year.

In October 2009 Interplast sponsored nine surgeons from five countries, Sri Lanka, Indonesia, Burma, Nepal and Papua New Guinea to attend the inaugural Australian Society of Plastic Surgeons Congress. Interplast has been working with these international delegates for several years and watched each of them develop to now become trainers in their own country. The Interplast sponsored surgeons had the opportunity to present a paper at the Congress, and mix with their peers from Australia and across the world.

Interplast continued its training and development work in Laos by sponsoring two Laotian anesthetists to attend three months training at the Princess Margaret Hospital for Children in Perth.

To further the development work of Occupational Therapy (OT) in Bangladesh, two Bangladeshi OTs were sponsored to attend the Hand Therapy Conference in Melbourne and spent some time in Victorian hospitals before returning home to pass on their new found knowledge and experience.

Early Management of Severe Burns (EMSB) training courses continued in Papua New Guinea and Bangladesh and commenced in Fiji for the Pacific based health care professionals. These programs are conducted in cooperation with the Australian & New Zealand Burns Association (ANZBA) and draw together health professionals from local and surrounding areas. Following each training program a number of delegates are also selected to participate in an Instructors Course to build the Faculty of EMSB trainers in that country with the view to self sufficiency. The enthusiasm for these courses and thirst for knowledge continue to excite the Interplast medical volunteers who are involved. Many courses have also had the favorable affect of building camaraderie of the medical fraternity in that country.

Last financial year Interplast began work in its 24th country, Mongolia, with the Australian Society of Anaesthetists. Mongolia has recently established a critical number of enthusiastic, young, advanced trained anaesthetists who, with the assistance of Australian anaesthetists, have the capacity and dedication to develop and maintain anaesthesia training in Mongolia. A more detailed article on this venture will be available in the next edition of *Surgical News*.

In June 2009 over 100 Mongolian anaesthetists attended an 'Airways Management' course in Ulanbataar. With the assistance of AusAID, Interplast funded more than 30 from outlying provinces to attend, and training was delivered by six Australian anaesthetists. Importantly, this course also educated senior Mongolian anaesthetists to become future trainers.

The activities discussed above are in addition to the more traditional Interplast service and training programs providing life changing operations to indigent recipients and hands on training to local medical teams. Our list of activities for the 08/09 financial year includes

- Papua New Guinea, Rabaul/Bougainville — Jul 2008
- Samoa, Apia — Aug 2008
- Fiji, Taveuni — Aug 2008
- Nepal, Kathmandu — Sept 2008

Interplast volunteer Mr Darrell Nam and local nurse at the National Hospital, Solomon Islands

Melbourne surgeon Mr James Leong, Philippines

Melbourne surgeon Mr Russell Corlett  training Nepalese surgeons in micorsurgery

- Papua New Guinea, Port Moresby — Sept 2008
- Papua New Guinea, EMSB Training — Sept 2008
- Nine surgeons (five countries) to ASPS conference — Oct 2008
- Two Bangladesh OTs to Hand Therapy Conference — Oct 2008
- Sri Lanka, Colombo — Oct 2008
- Sri Lanka, Hand Surgery Educational CD—Oct 2008
- Kiribati, Tarawa — Nov 2008
- Philippines, Baguio City — Nov 2008
- Bangladesh, EMSB course — Nov 2008
- Philippines, Cagayen de Oro — Jan 2009
- Vietnam Quang Nam needs assessment — Feb 2009
- Laos, Xayabouly outreach program — Feb 2009
- Vietnam, Ho Chi Minh City — Feb 2009
- Laos, Vientiane—Feb 2009
- Two Laotian doctors training (Perth) — Mar to May 2009
- Tonga, EMSB assessment — Mar 2009
- Papua New Guinea, Madang EMSB Course Apr 2009
- Bangladesh, Dhaka OT — Apr 2009
- Bangladesh, EMSB Course — Apr 2009
- Solomon Islands, Honiara — Apr 2009
- Nepal, Kathmandu — May 2009
- Tonga, Nuku'alofa — May 2009
- Bangladesh Needs Assessment — May 2009
- Bangladesh, Dhaka OT — May 2009
- Indonesia, Balikpapan — Jun 2009
- Fiji, Pacific Region EMSB course — Jun 2009
- Mongolia, Ulanbaatar — Jun 2009

These incredible achievements, that make a real difference both now and for the future, would not be possible without the passionate support of Interplast volunteers. We were pleased to welcome a number of new volunteers to the Interplast family this year and thrilled to welcome back those who have volunteered before.

Of course none of this would be possible without the financial support of our donors. Rotary Clubs from around Australia and New Zealand continue to fund approximately one third of our annual activities in addition to the other support they provide. The Eureka Tower Climb held in Melbourne, and the Black and White Ball held in Sydney were successful fundraising events held last financial year, with plans afoot for more. Interplast continues to receive significant financial support from Cabrini and KCI Medical and is pleased to welcome Johnson & Johnson and Avant to our family of supporters among others.

As the need for the assistance of Australian and New Zealand medical volunteers remains high, and Interplast continues to expand, we depend now more than ever on donations to deliver these services. Please consider improving the lives of those in need in our region by improving their access to surgical care by making a donation to Interplast. All donations are tax deductible, change lives now, and build health systems for the future.



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# Tomorrow is another day!

The Hamilton Russell Memorial lecture continued from last months *Surgical News*

**David McNicol**
Australian Capital Territory Fellow

Further, the flow of international medical graduates (IMGs) into Australia, orchestrated by Government, to prop up our manpower needs will have a deleterious effect on those already impoverished countries from which the IMGs migrate. These countries too, have communities that need doctors and surgeons, if they are to survive and prosper in the global village.

In my role as chairman of the Orthopedic Outreach Fund, and project Director for Timor Leste, I see first hand, how essential it is in third world countries to support and grow their community health structures. Good community health, including surgery, is an important arm in eliminating poverty, lifting individual self-worth and growing the country as a whole. We as surgeons can play a decisive role.

The International Committee and External Affairs Department of the College, does a Herculean job in this respect. Education, resourcing and long term support are the ingredients to grow these communities, rather than poaching their people for our own needs.

Subtly I feel that there has been a change in Australia with respect to commitment to the community by the medical profession.

The pledge I took in 1963, as a first-year medical student, reciting the Hippocratic Oath and the Geneva Conventions, was as a new member of a proud and respected profession. I pledged to put my patients' needs ahead of my own material and personal needs.

To me the commercialisation of medicine, is a real and worrying shift to materialism ahead of our fiduciary duty to our patients.

The registrars I have worked with over the years, in a teaching hospital environment, have been dedicated and very hard-working to a man and a woman. They remain to be tested however in the outside world of surgery.

Generational change may also have an impact. To generalize about Generation X and Y's commitment to the community would be fallacious other than to say they have grown up in affluent times and the tough and demanding years of tomorrow, working in the health sector, I think will be testing for them, as indeed they would be for my generation. It will be interesting to see how much importance they will put on social responsibility and professional freedom or whether they will see themselves as technicians, for hire, to the highest bidder.

But what are the challenges for orthopedic surgery for tomorrow? There are and will continue to be shorter hospital stays. Minimally invasive surgery to some extent caters for that. In day surgery arthroscopy of the knee came first, but now this technique applies to the foot, ankle, hip, shoulder, elbow and wrist.

Disabling degenerative joint disease comes pari pasu with an aging population. Joint arthroplasty is increasing exponentially. Hip and knee replacements have altered the lives of thousands of Australians. Research on materials and implant designs has prolong the lives of these implants to more than 30 years. Almost every joint has a replacement option available -- some still to be tested but with a guarantee that they will be improved with time and clinical trial.

Last year in Australia 32,000 hip and 39,000 artificial knees were implanted. Joint replacement operations have more than doubled since 2001, mainly in the over 60's.

The National Joint Replacement Registry, set up and run by the Australian Orthopaedic Association (AOA) in 1999, collects data, on a voluntary basis, from 100 per cent hospitals, public and private, where arthroplasty surgery is performed. This is an outstanding achievement and provides information, which shapes what we do today and provides advice for tomorrow.

Obesity, for example, has been identified as an issue leading to poorer outcomes, including higher wear rates in the implants. So the challenge today is to confront obesity if outcomes are to be better for tomorrow.

At the other end of the age spectrum, pediatric and adolescent orthopedic conditions may be diagnosed prior to birth. Genetic counseling and prenatal maternal care have eliminated many of the severe deformities and conditions that have consumed much Orthopaedic time and care in the past.

Research into the growth plate of bones has taught us how to manipulate this fantastic structure and correct deformities, and limb length inequalities, once again often by minimally invasive techniques. Postnatal screening for hip dysplasia, clubfeet and other conditions has allowed us to treat early with less invasive techniques requiring less hospitalization and use of resources.

Trauma continues to pour into and Emergency Departments and is managed more aggressively by internal fixation, shortening hospital stays and allowing for earlier mobilization and rehabilitation. However open reduction and internal fixation of fractures has its downsides and is not without its complications. For example, an infection in bone by Methicillin Resistant Staphylococcus Aureus is a disaster for the patient, the surgeon and the health care system.

The management of bone tumors has also changed dramatically using a combination of chemotherapy, radiation and often-aggressive surgery, frequently sparing limbs by interposition allografts, internal fixation and custom-made prostheses. Interestingly one of Hamilton Russell's innovations in the early 1900's was the use of cadaveric bone grafts. Today, bone now comes from human bone banks establish right around the country.

Basic science research related to orthopaedic is focused on connective tissues, bone formation, the stem cell and genetic modification. Today this research has increased our clinical success with, for example, the use of bone morphogenic protein, isolated and characterized yester-year, and now produced

> “Education, resourcing and long term support are the ingredients to grow these communities, rather than poaching their people for our own needs.”

commercially and used to enhance bone healing. An example of research of yesterday that has widespread clinical use today.

So as surgeons how do we deal with the health issues that confront us? Our concerns are, and should also be the concerns of the community we serve.

I believe that it is a “given” that as a profession we will always teach and train our younger surgeons. We will always engage in research. Our minds are too enquiring about what we do to not do so! Of course there will be differences in the way we go about things – that is inevitable and evolutionary anyway.

The difficult issue is how we can continue to serve the community best, providing high standards of care. Our community expects that also as a “given”.

Ranged against us however, are politicians, bureaucrats and economists who do not understand that continually reaching for higher standards is the essential ingredient of professional life. They see us as “commodities” they unfortunately have to buy to make the system work. They want control and they want to have these commodities at the lowest price, irrespective of quality.

Whilst we must continue to engage with Government at all levels, in my opinion, as surgeons we must also focus on engaging with our community, also at all levels, now, today. Our professional image of elitism and self-interest has to be changed.

Surgeons advocating community needs, be it “bread and butter” local issues, or larger issues at state or national level, must be part of our role and seen to be so. We must get close to our communities again as individuals and as a group! Here the College and the Surgical Sub-specialty Groups and Associations have a critical role to play.

For example, right now we see the tricky, underhand way Government is attempting to sideline the Colleges and take control of standards of training and accreditation under the guise of National Medical Registration. Do you think that the community wants less competent doctors caring for them when sick? I think not! But the wider community does not know what is at stake and has not been brought into this debate effectively.

The Profession making reasoned submissions to Government and thinking the job is done is not enough. The community must be shown by us that these issues are theirs and that they must take ownership of them in partnership with us. As surgeons we should not under-estimate the power and authority that partnership could have.

And what would Hamilton Russell do if he were alive today? I suspect he would see this as a “call to arms”, fighting for both surgeons and patients rights!

In conclusion, to survive and prosper as a proud and independent profession, we must look beyond our daily surgical commitments.

We must develop strategies to engage the community, and in partnership with the community, make it clear to those who would try to diminish us that we will spare no effort in continuing to provide high quality surgery for the community, as is our right and our responsibility.

My message is that we have no time to waste if we are to survive and prosper in the changing world, and if we do not act now, today will be overcome by tomorrow, and tomorrow will surely become yesterday.

Thank you Mr. President for the great privilege of being invited to deliver the 2009 Hamilton Russell lecture.


## THE GARNETT PASSE AND RODNEY WILLIAMS MEMORIAL FOUNDATION

AWARDS FOR 2010

### PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2010.

Project Grants are for a period of up to three years and must be conducted in an Australian or New Zealand institution. *Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2010, is ineligible.*

The annual level of support will be up to AUD100,000 and, within this cap, grants must include the salary of the applicant and/or research assistant(s), on-costs, equipment, maintenance and all other costs. Usually commitments will not be made in which continued support over many years is implied.

**Closing Date:** 28 August 2009

### GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2010.

Grants-In-Aid are for a period of up to two years and must be conducted in an Australian or New Zealand institution. Otolaryngologists or Trainees in the Specialty are eligible to apply. *Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2010, is ineligible.*

The annual level of support will be up to AUD50,000 and grants are restricted to equipment and maintenance only. Usually commitments will not be made in which continued support over many years is implied.

**Closing Date:** 28 August 2009

Further details concerning the above awards together with the current application forms can be obtained from:-

The Secretary
The Garnett Passe and Rodney Williams Memorial Foundation
PO Box 577
EAST MELBOURNE VIC 8002

**Telephone:** 61-3-9419 0280
**Facsimile:** 61-3-9419 0282
**Email:** gprwmf@bigpond.net.au




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# International Scholarships

## The Rowan Nicks Scholarships and Surgeons International Award helps surgeons from overseas further their knowledge

Two of the College's most generous benefactors, Mr Rowan Nicks and Professor Dick Bennett, are this year funding the continuing professional development of young surgeons from Papua New Guinea, Malaysia, United Kingdom and New Zealand. The surgeons, who are the current recipients of Rowan Nicks Scholarships and the Surgeons International Award, are working in the fields of breast cancer surgery, urology, head and neck surgery and ophthalmology.

Rowan Nicks currently funds four scholarships designed to enhance the skills of surgeons who have the ability to become leaders in their fields. They are the Pacific Islands Scholarship, the International Scholarship, the Rowan Nicks United Kingdom and Republic of Ireland Fellowship and most recently, the Rowan Nicks Australian and New Zealand Fellowship.

The current holder of the Rowan Nicks International Scholarship, Dr Zamzuri Zakaria, is a general surgeon from Kuching General Hospital in Malaysia who has spent the majority of his time since his arrival in Australia late last year at the breast cancer units of both the Royal Melbourne and Royal Women's Hospitals.

Working under the supervision of Professor Bruce Mann, he is particularly interested in the management of breast cancer in Australia, the dynamics of the breast multidisciplinary team, Victoria's breast screening programme and the use of sentinel node biopsy (SNB) for both melanoma and breast cancer.

"Most women in Malaysia undergo axillary dissection rather than sentinel node biopsy so I am very interested in working in this field and am hoping to spread this technique when I return to Kuching," Dr Zakaria said.

Rowan Nicks & Zamzuri Zakaria

"SNB causes less morbidity for the patient and there are no studies that show women have a better overall survival with axillary dissection. However where I work in Kuching, we don't have the current best capacity to do SNB because you need a nuclear medicine unit although I could do it with just using blue dye to identify the node. Yet I am hopeful that within two or three years, we will have access to that technology so the skills I am learning now will be of great benefit.

"The Royal Melbourne Hospital has an excellent breast multidisciplinary team which is led by Professor Mann. It consists of experienced surgeons, medical and radiation oncologists, pathologists, breast care nurses and other important support groups. Weekly meetings are held to discuss the best treatment options for patients diagnosed with breast cancer which I found to be extremely effective. I hope to run a similar team when I return to Kuching."

Dr Zakaria said a highlight of his trip so far had been the opportunity to meet Rowan at the recent Annual Scientific Congress held in Queensland.

"He is a lovely caring man and it was good to have a chat with him at the ASC," Dr Zakaria said.

"Rowan said that he wanted the best surgical knowledge to be spread around the world and I felt very pleased to be part of that. This is a very prestigious scholarship to receive and I am only the second surgeon from Malaysia to be chosen and I am very proud of that."

Mr Daniel Timperley from Auckland was awarded the Rowan Nicks ANZ Fellowship which has helped him to complete a new unfunded Fellowship in advanced rhinology and rhinoplasty. Based in Sydney, he is working out of St Vincent's Hospital as well as the Concord and Bondi Junction hospitals and is under the supervision of Mr Richard Harvey, Associate Professor Ray Sacks and Mr George Marpells.

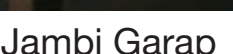
"I was very honoured to receive this Fellowship. I have a particular interest in the surgical treatment of nasal tumours and we have done some really interesting cases in the past few months," Mr Timperley said.

"They are excellent surgeons to work with and the funds that were attached to the scholarship meant that I could bring my wife and small daughter with me which has added to the enjoyment of being able to live, work and learn here."

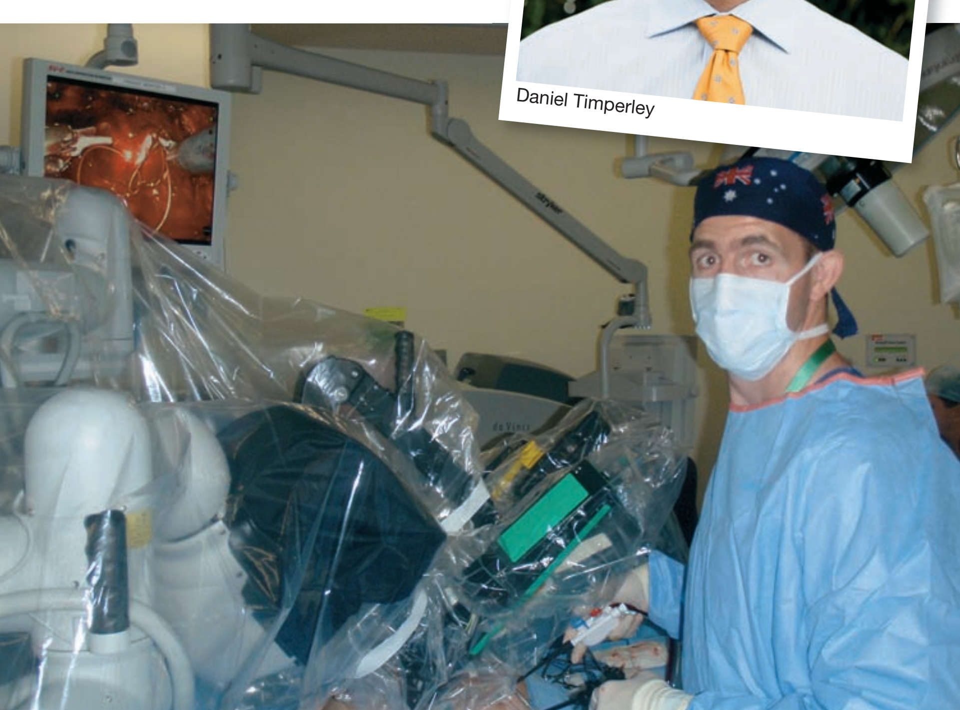
British urological surgeon Mr Ben Challacombe was already in Australia to advance his skills in robotic surgery when he heard of the Rowan Nicks United Kingdom and Republic of Ireland Fellowship and decided to apply. Working out of the Royal Melbourne and Epworth hospitals, he is undertaking a one-year Urology Fellowship to allow him to concentrate on the procedure of robotic-assisted radical prostatectomy.

"This procedure is technically challenging and ideally requires a surgeon with a sound background in laparoscopic and urological cancer surgery who has been fully trained on the da Vinci robotic system," Dr Challacombe said.

Daniel Timperley



Jambi Garap



Ben Challacombe operating with the robot at the Royal Melbourne Hospital

"However, at present there are only a small number of the da Vinci systems in the UK and consequently there are relatively few training centres for this demanding technique. Having a sound basis in laparoscopic and robotic procedures prior to my arrival in Melbourne enabled me to rapidly advance onto the da Vinci console and begin performing elements of the operation independently.

"Working under the supervision of Professor Anthony Costello, an internationally renowned urologist has been a great experience and by the end of my fellowship here I hope to be accredited as an independent robotic prostatectomist, having worked on more than 100 cases.

"I've also learnt skills to enable me to pass on what I have learnt when I go back to the UK, in particular how to teach, how to encourage independence to junior surgeons while maintaining control, how to encourage enquiry."

Dr Challacombe said one of the personal highlights of his trip was not only meeting Rowan in Queensland but developing close professional bonds with other scholarship recipients.

"I was hugely honoured to both receive the Fellowship and have the opportunity to meet Rowan Nicks, at the ASC who has done such an enormous amount to help trainee surgeons from around the world", he said.

"I have also had the great good fortune to work with a wonderful group of people and have made friends in urology who will be friends for life – surgeons from the US, Canada and the UK – and that has been an unexpected highlight of this Fellowship year."

*"This is a very prestigious scholarship to receive and I am only the second surgeon from Malaysia to be chosen and I am very proud of that."*

Dr Jambi Garap, an ophthalmologist from Papua New Guinea is now working at the Melbourne Eye and Ear Hospital through the support provided through the Surgeons International Award established by Professor Richard Bennett and his wife Enid in 1989.

The Award provides for short-term visits to Australia by outstanding doctors, nurses or other health professionals from developing countries to work in one or more Australian hospitals to gain the knowledge, skills and contacts needed for the promotion of improved health services in their own country.

Attached to the hospital's retina unit, Dr Garap is working under the supervision of Dr Robert Buttery and is focusing her work on medical retina with some exposure to vitreoretinal surgery and the diagnosis and treatment of retinal disease using state-of-the-art equipment like the Fluorescein Angiogram and Optical Coherence Tomography (OCT).

"The technology available here is quite amazing. Most of the work we do in PNG is centred on our clinical findings and it is very interesting to see disease in the retina at the microscopic layer being illustrated in the Fluorescein Angiogram and the OCT machine" she said.

"I attend operating sessions and am amazed at the post-operative outcome of patients with retinal detachment. The visual outcome is so much better than what my colleagues and I do at home.

"However, the first thing I will be doing when I return home is to advocate for more space in our unit for more equipment to help us undertake more diagnostic procedures. It would be really good if we could get a vitrectomy machine for the vitro-retinal unit in Port Moresby, although I know very well that the machine is very expensive.

"While here I am also advocating for this as well as trying to do some networking with Australian surgeons who might be interested in coming to PNG regularly to help with our patients and transfer of surgical skills."



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# A first for Trainees

The John Corboy Medal will be awarded to a Trainee who demonstrates selfless service and leadership

**Matthew Peters**
Chair, RACSTA

Traditionally the College has recognized outstanding members of the Fellowship through the naming and awarding of College medals. For the first time, a College medal has been named to honour the life and memory of a Trainee. It will be the first such award to be conferred on a Trainee.

The John William Corboy Medal was unveiled at the Annual Scientific Congress of the College in Brisbane, Australia on Friday the 8 May 2009. Nominations are now open for the 2010 inaugural award.

This distinguished award honours the life of Dr John Corboy (1969-2007) who gave selfless service to the College and its Trainees. Not only an inspiring leader and role model, he showed great tenacity in pursuing a career in surgery despite personal adversity. It is appropriate to honour his memory through an award that will recognise the qualities of this exceptional Trainee in others.

Being pivotal to the development of Royal Australasian College of Surgeons Trainees Association (RACSTA), the award was established by his friends and colleagues within the Trainees' Association in acknowledgement of the leadership that John gave to the emerging Trainees Association.

The John Corboy Medal shall be awarded annually to a Trainee of the College of Surgeons who demonstrates some of the characteristics for which John was admired – outstanding leadership, selfless service, tenacity or service to Trainees – and will be an opportunity to recognise exceptional individuals from among our trainee cohort.

Fellows and Trainees of the College may nominate an individual, who must be a current Trainee of the College.

Details on how to submit nominations can be found on the RACSTA webpage or by contacting Fiona Bull, RACSTA Executive Officer at fiona.bull@surgeons.org

*John Corboy's obituary was printed in Surgical News Vol:9 No:2 March 2008]*

## Are you interested in becoming an accredited permanent impairment assessor with WorkCover?

Only medical practitioners accredited with WorkCover are able to assess permanent impairment.

To be eligible to apply, you must be: registered with the Medical Board of South Australia; currently in practice (either in clinical or medical-legal work) at least two sessions per week; able to demonstrate that you are active in continuing professional development; and covered by medical indemnity and public liability insurance.

Successful applicants must undertake training in the *WorkCover Guidelines for the evaluation of permanent impairment*. The training includes a compulsory introductory module that provides background to impairment assessments. Applicants must also choose one or more modules (eg, upper extremities, spine etc) depending on their area of clinical practice.

The introductory module is $286 and the other modules are $396.

To be accredited by WorkCover, medical practitioners will be required to successfully complete competency assessments for all body system modules undertaken.

Participants will need to purchase a copy of the American Medical Association's *Guides to the evaluation of permanent impairment, 5th edition.*

If you would like an application package, please email pia@workcover.com and specify if you want the pack emailed or posted to you.

Applications must be submitted to WorkCover by 15 September 2009.

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Get more for your money with a secure, Government guaranteed deposit account, earning **5.25%p.a** – that's an extra 1% interest p.a. in addition to our already premium rate for the first 90 days (bonus interest available for a limited time only).

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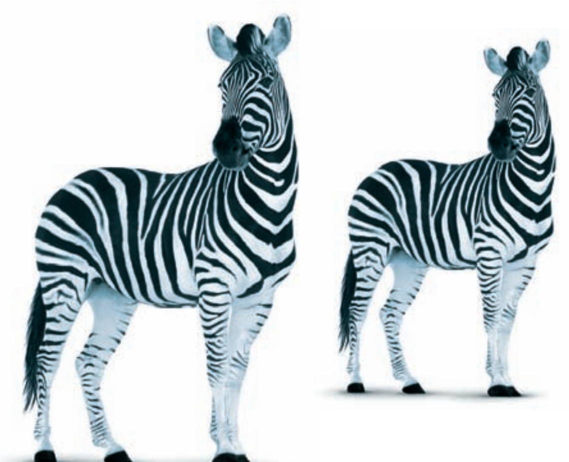

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# RACS 2009 Virtual Congress

**The enhanced 2009 ASC Virtual Congress, sponsored by Ansell, is now available online at 'http://asc.surgeons.org', click on the link.**

This year, 500 presentations are available with audio capture in addition to the PowerPoint slides.

Video content within the presentations may be viewed.

All Keynote scientific lectures are available.

All posters can be viewed.

All other presentations and e-posters are available.

*Note: Some presentations may not be available due to lack of consent from the presenter.*




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# Minister for Health visits the College

The Honorable Mr Daniel Andrews was given a demonstration of tying knots before being led to the virtual world

**Michael Dobson**
Chair, Victorian Regional Committee

Ian Faragher, Michael Dobson, Chair, Denice Spence, VRO Mgr, Hon Daniel Andrews Health Minister, Michael Grigg & David Watters

The Victorian Regional Committee Executive was pleased that the Honorable Mr Daniel Andrews, Minister for Health, accepted their invitation to meet with them at College on 13 July, 2009. Councillors Professor Michael Grigg and Professor David Watters also joined the meeting.

Understanding there had not been a visit of a Health Minister for some years, and with the knowledge that the Minister is keen on technology, the evening commenced with a brief visit to the Skills Laboratory where there was a laparoscopic suturing workshop in progress. Under the guidance of Mr Donald Murphy and his team, Minister Andrews was given a demonstration of tying knots before being led to the virtual world. Here he was able to gather an overview of the intricate procedural steps necessary to perform a bronchoscopic examination of the upper airway with the full senses of touch and sound and with visualization of the tracheobronchial tree via a screen.

The new aspiring surgical trainee Minister Andrews retired from the skills lab and joined the Victorian Regional Committee (VRC) Executive where the evening shifted from practical surgical skills to political skills. Deputy Chair, Mr Ian Faragher presented the outcomes of the National Bowel Screening Project and demonstrated how this could be used to provide further data on a State level and deliver a full screening program that would improve participation and optimise delivery. Whilst this is a National project the Minister offered to advocate on a State level with the Commonwealth Government.

The Executive were also keen to draw attention to an Inquiry into Public Hospital Performance Data for which a submission had been placed by the VRC to the Commonwealth earlier in the year.

This submission concentrated on acute surgical services, especially the timely performance of emergency surgery and the relevant data recorded in Victorian public hospitals and proposed that Key Performance Indicators be developed for the following:

(i) Acute appendicitis, acute cholecystectomy, and compound fractures.
(ii) Serious deterioration in a patient's condition whilst awaiting urgent surgery be deemed a sentinel event.

The VRC believes that management of 'time to surgery' in acute cases will provide a valuable standard which Health Networks and DHS can employ to more effectively measure, manage, report and compare hospitals. The use of such a standard will result in a better outcome for patients and hopefully less arduous conditions for those providing acute services.

The Minister agreed that these issues should be discussed and developed in consultation with the Victorian Consultative Council for Surgical Morbidity and the Emergency Surgery Committee. The VRC is looking forward to further communication and more regular meetings with the Minister.

AGSFM
Victorian Annual General Scientific & Fellowship
**Meeting**
**Scientific Program October 23 -25**
Cumberland Lorne Resort • 150 Mountjoy Parade • Lorne VIC 3232

## Definitive Surgical Trauma Care Course (DSTC )

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) is pleased to announce the courses for 2009.

The DSTC course is an invigorating and exciting opportunity to focus on surgical decision-making and operative technique in critically ill trauma patients. You will have hands on practical experience with experienced instructors (both national and international). The DSTC course has been widely acclaimed and is recommended by the Royal Australasian College of Surgeons for all surgeons and Trainees.

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.
Please register early to ensure a place!

To obtain a registration form, please contact Sonia Gagliardi on 02 9828 3928 or email: sonia.gagliardi@sswahs.nsw.gov.au

### 2009 COURSES

**Adelaide**
3 & 4 September 2009

## Director of Orthopaedics
## The Townsville Hospital
## Townsville Health Service District

The Townsville Health Service District is a dynamic organisation committed to providing a range of services aimed at achieving good health and well being for all North Queenslanders. The Townsville Health Service District offers the wider North Queensland community modern health care encompassing primary, to tertiary and emergency services in a setting of committed excellence. The primary purpose of the position is to lead the development of, and provide on-going management to, the Orthopaedic Service at the Townsville Hospital, and across the district.

**Person Specifications/ Key Selection Criteria**

To be eligible for appointment to this position a Candidate must have

- an excellent knowledge of Orthopaedic Services, and have worked in one or more tertiary hospitals
- a demonstrated involvement in continuing education in Orthopaedics
- the ability to demonstrate a commitment to research in Orthopaedics
- a thorough understanding of the relationship between clinical decisions and resource utilization
- Fellowship of the Royal Australasian College of Surgeons- Orthopaedics, and,
- registration, or eligibility for registration, as an Orthopaedic Surgeon with the Medical Board of Queensland.

**Key challenges to be met in the position include:**

- ensuring that an effective supervisory model is in place for Orthopaedic Registrars
- recruitment of staff specialist Orthopaedic Surgeons to the number allowed for in the service
- having measures in place that identify that a safe and efficient Service is being provided.

For further information contact Kevin Hardy at khardy@hardygroupintl.com / Phone +61299649099/ +61412131334

## The Financial Markets Charity Sailing Regatta - 2009

**Enter a yacht or come as crew and join the after party**

**Benefiting** over 20 Children's and Medical Research Charities, **including the Foundation for Surgery**, the 4th Financial Markets Charity Regatta will take place at Middle Harbour Yacht Club on **Friday 16th October 2009**. The race will be followed by a BBQ and party on the MHYC beach for 600 guests dancing to a Caribbean steel band and sipping complimentary champagne.

Competing for the Financial Markets Charity Cup the three hour sailing race takes place on Sydney Harbour. Prior entrants have included a number of well known Class 1 Ocean Racing Yachts including 'UBS Wildthing' (UBS), 'You're Hired' (Talent 2) and 'AFR Midnight Rambler' (Australian Financial Review). Sponsors included Nab Capital, Westpac, CBA, Morgan Stanley, Telstra, BT Global, ASX, Thomson Reuters, Fosters Group and some 40 more. (See last year's results.)

All competitors receive a regatta Polo Shirt and Cap, Lunch Box, Bottled Water and tickets to the after party with free beer, wine and sparkling. A substantial BBQ is also served. Events include a raffle with over $6,000 in prizes and a stunning auction with prizes such as luxury overseas holidays, exclusive tickets to top tennis, golf and rugby tournaments, luxury watches and jewellery.

If you prefer, you can follow the race and mingle with the rich and famous aboard the VIP spectator boat whilst sipping fine wines and enjoying a gourmet seafood buffet.

Corporate Yacht Entries start at $2,000. Individual Crew entries are $200 (we will place you on a racing yacht) and VIP Spectator Guest entries are $300 – with all profits to charity.

**For entry forms please email david.brocklehurst@thomsonreuters.com**

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# Congratulations on your achievements

## Professor Michael Gleeson: Honorary Fellowship Royal Australasian College of Surgeons

Michael Gleeson is Professor of Otolaryngology and Skull Base Surgery at the Institute of Neurology in University College London. His academic appointments and clinical practice are extensive.

Michael began his career in Otolaryngology. A chief residency in Otolaryngology was undertaken in Seattle, USA and two years later he became skull base fellow at the University of Zürich in Switzerland. He was appointed Senior Lecturer to the United Medical and Dental Schools of Guy's and St Thomas' Hospitals in London in 1987and was made Reader in 1991. In 1993 he completed his MD at the University of London on quantitative and ultra-structural features of the human peripheral vestibular system.

He was appointed Hunterian Professor to the Royal College of Surgeons of England (RCS) in 1994 and has been involved in the development of cranial nerve monitoring and neuro-navigation equipment and continues with his basic and clinical research.

Professor Gleeson's clinical practice is almost entirely devoted to skull base and parotid surgery. He has lectured worldwide on these topics and has written five books, numerous chapters, research papers, and reviews on clinical problems.

Professor Gleeson has received many notable awards including the Watson Williams Lecture (1998), an Honorary FDS from Royal College of Suegeons of England and in 2008, he was elected President of World Federation of Skull Base Societies (International Skull Base Society).

Professor Gleeson is a leader in otolaryngology head and neck surgery practice, teaching and research in Europe and has contributed in a major way to their development in Australasia.

*Citation kindly provided by Vincent Cousins*

## Mr Robert James Aitken ESR Hughes Medal

The ESR Hughes Medal is awarded to Mr James Aitken for his pivotal role in establishing the Western Australian Audit of Surgical Mortality (WAASM); since 1999, he has been Chair of the WAASM Committee. James Aitken was born in the United Kingdom and gained his undergraduate degree from the University of London in 1977. He achieved Fellowship of the Royal College of Surgeons of Edinburgh in 1982 and Fellowship of the College of Surgeons of South Africa in 1984. In 1994 he was awarded a Master of Surgery for his thesis on assessment of non-palpable mammographic abnormalities. James worked as a Consultant General Surgeon in the United Kingdom before taking up residency in Australia in 1998, when he was appointed Senior Lecturer in the University Department of Surgery at the University of Western Australia. He was admitted as a Fellow of the Royal Australasian College of Surgeons in 2000. He is Secretary of the Western Australian branch of the Royal Australasian College of Surgeons, a member of the Board of General Surgery in Western Australia and is widely published in the areas of colorectal surgery, surgical audit and surgical training.

It is fitting that James Aitken's important contribution to Australian surgery is recognised by this award. He has been, and continues to be, a driving force in advocating for rigorous surgical audit with peer review of outcomes and feedback of information to inform, educate, facilitate change and ultimately improve quality of practice. His extraordinary efforts are poised to improve surgical outcomes across all of Australia and New Zealand.

*Citation kindly provided by Robert Davies*

## Professor James Semmens RACS Medal for Service

The RACS medal has been awarded to Professor James Semmens MSc in recognition of his service and work to the College in developing the WA Safety and Quality of Surgical Care Project (SQSCP), the Western Australian Audit of Surgical Mortality (WAASM) and his role in establishing the NSW Collaborating Hospital Audit of Surgical Mortality in NSW with the NSW Branch of the College.

Professor Semmens is a distinguished scientist, gaining his BSc in 1979, followed by a Masters and a Diploma in Education, culminating in a PhD in 1994. He won an Australian Post-Graduate Research Award for his PhD and joined the University of Western Australia as a Research Officer in 1996. He was promoted to Research Fellow in 1998. In 2002, he was awarded the New Independent Medical Researcher Award by the Western Australia Medical and Health Research Infrastructure Council. Within the University he rose to the level of Associate Professor and was promoted to a Chair in 2007 at the School of Public Health at Curtin University where he is currently Director at the Centre for Population Health Research.

James maintains a keen interest in safety and quality of surgical care and is the Director of the SQSCP where he collaborated with Mr James Aitken to introduce and develop the WAASM in 2000. Professor Semmens was the project manager of the WAASM from 1999-2005. The project established a pilot program in June 2001 under the management of the University of Western Australia and has grown to become an important bi-national project in the form of the Australian and New Zealand Audit of Surgical Mortality (ANZASM). In 2004 he was appointed as a national advisor for the national roll-out of the audit model.

*Citation kindly provided by Robert Davies*

**Peter MacCallum Cancer Centre**
**Department of Surgical Oncology**

## Section of Colon and Rectal Surgery
## Colorectal Fellow 2010

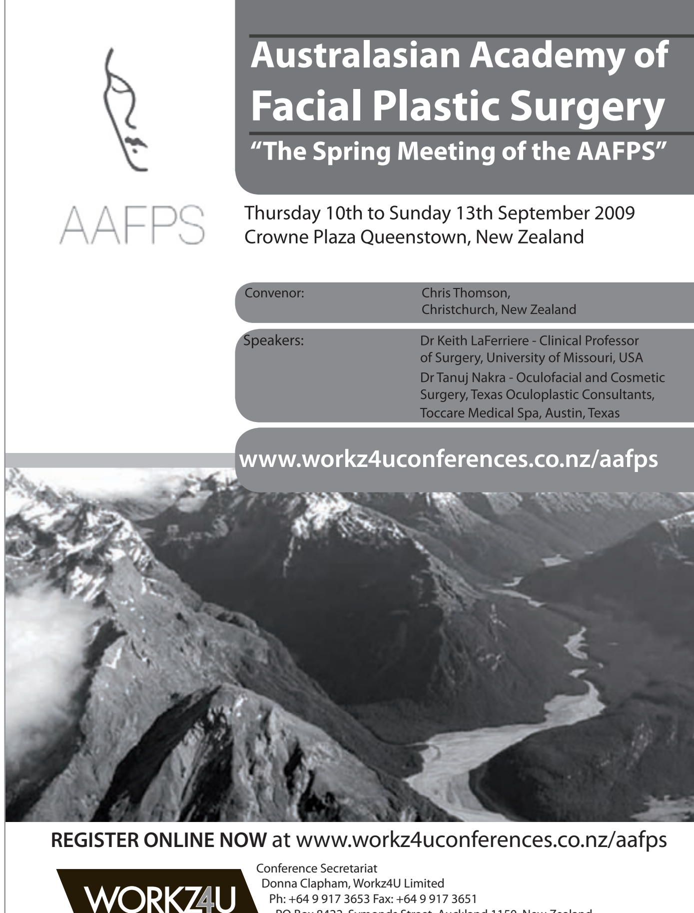
Applications are invited for the position of Colorectal Fellow in the Section of Colon and Rectal Surgery within the Department of Surgical Oncology at the Peter MacCallum Cancer Centre for the period 2010.

Applicants should hold a Fellowship in General Surgery of the Royal Australasian College of Surgeons or one of the affiliated Colleges, and be committed to a year of dedicated colorectal training, particularly in the management of colorectal cancer and other pelvic/intra-abdominal malignancies.

The Colorectal Section is supported by three Consultant Colorectal Surgeons, two Surgical Oncology Nurse Coordinators, a Stomal Therapy Nurse, a Rotating General Surgical Registrar and a Surgical Resident.

Applications including a CV and covering letter should be forwarded to Jodi Lynch on email Jodi.Lynch@petermac.org.

Informal enquiries should be made to A/Professor Jack Mackay on 0407 456 362. Formal applications close Friday 21st August 2009.



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# Changing places

The exchange program between the College and the American College of Surgeons is building networks

**Richard Bold**
American College of Surgeons Travelling Fellow

Congressional dinner at the ASC. Back row left to right: Richard Bold, Kristine Bold.
Front row left to right: Rob Finch, Raechelle Finch, Irvin Modlin.

'Each year for 20 years, the College has welcomed a Fellow of the American College of Surgeons (ACS), to participate in the Annual Scientific Congress (ASC). Funding for the visit is provided by the ACS and Australian & New Zealand Chapter of the ACS. As well as participation in the ASC the Travelling Fellow visits hospitals and research institutions for further professional exchange. Recently, the College established the Hugh Johnston ANZ Chapter of the ACS Travelling Fellowship. This provides support for an annual visit by an Australian or New Zealand surgeon to the ACS Congress. Further information regarding this new Travelling Fellowship will be featured in *Surgical News*.'

It is with a tremendous amount of honor and pleasure that I provide the report as the American College of Surgeons (ACS) Travelling Fellow of the Australian/ New Zealand Chapter for 2009. It was indeed a memorable experience to travel to Australia, meet a variety of our Australian colleagues, and visit with them as part of the Annual Scientific Congress (ASC), as well as travel throughout the country for further professional interchange. I had the opportunity to experience first-hand the surgical environment within Australia and develop, what hopes to be, long-lasting friendships. This opportunity demonstrated that many of the issues that we are facing within the profession span international boundaries, as we struggle with the same complex circumstances in practice and delivery of quality surgical care to patients.

The initial part of my travels was centered around the ASC in Brisbane. Working with the three conveners Rob Finch (Hepatopancreatobiliary and Upper GI Surgery Section), Andrew Barbour (Surgical Oncology Section) and Daniel de Viana (Breast Surgery Section) I was integrated into the Scientific Program of the meeting. In addition my host, John Buckingham (President of the ANZ Chapter of the ACS) facilitated my travel as well as welcoming me to the meeting. A topic of the ANZ Chapter meeting was potential mechanisms to foster young surgeons joining the Chapter; Buckingham asked that I offer my view of a surgical career from the perspective of a young surgeon. Some of the sessions I was involved with and the presentations included:

- Hepatopancreatobiliary Session including three lectures on pancreatic diseases including pancreatic neuroendocrine tumors, pancreatic adenocarcinoma
- Surgical Oncology section including presentations on the implementation of telemedicine resources at UC Davis Cancer Center to facilitate community based interaction in the multidisciplinary care of cancer patients
- Sentinel Lymph Node Biopsy for the breast cancer session

I particularly enjoyed the spirited debate and discussions, realising we struggle with the same difficulties in treating disease and similar complex circumstances in practice and delivery of quality surgical care to patients.

From Brisbane, I travelled to Sydney for a visit that was coordinated by Andrew Biankin, from the Bankstown Hospital as well as the Garvin Institute, a free-standing facility of biomedical research. I first visited the hospital participating in their Gastrointestinal Tumor Board, presented a lecture entitled "Clinical Management of Pancreatic Cancer" and participated in their ward rounds, noting that we struggle with the same issues; for example, I saw patients who had undergone futile exploratory laparotomies for presumed pancreatic cancer that was unfortunately found to be unresectable at exploration. Furthermore, issues of outpatient hospital care, whether in skilled nursing facilities or residence-based sights, paralleled the complexity of discharge management that I

encounter on a weekly basis. At the Garvin Institute (my arrival coinciding with the announcement that the Federal Government had awarded $70 million to the Institute to enable construction of an expansion of their biomedical research facility) I provided a research seminar entitled, "Autophagy in Cancer" to the community of biomedical investigators at the Garvin Institute. This high-quality group of researchers demonstrated their excellence by the interaction during that seminar as well as throughout the time that I visited the Institute.

From Sydney, I travelled to Melbourne where I was hosted by Bruce Mann, of the Royal Melbourne and Royal Women's Hospital. Speaking on "Current Controversies in Breast Cancer" to a group of breast cancer surgeons from throughout the Melbourne area it became apparent that despite attending this meeting in a foreign country, I had often had the same discussions with my surgical partners as well as breast cancer colleagues at UC Davis Cancer Center. Mann was a most gracious host in that he opened up his home to me and allowed me to visit with his lovely wife (Julie Miller) as well as family during my visit in Melbourne.

I had the opportunity to discuss with Mann the importance of examination of surgical outcomes. The practice of general surgery in Australia is undergoing evolution, and it was most apparent in Melbourne and Sydney in which the surgeons related their ongoing struggles of balancing elective practice with emergency practice, coordination of academic effort with private practice, and striving to do so while maintaining optimal patient outcome. The National Surgical Quality Improvement Project, coordinated by the ACS, allows for the infrastructure of evaluation of individual patient outcomes in subsequent benchmarking. This concept is currently not implemented in Australia but throughout my discussions, could be broadly embraced.

As I left the United States, the state of California was struggling with an increasing budgetary deficit with consequences of reduced payment to health care providers through the state funded health care program of Medi-Cal as well as reduced support for academic medical institutions within the University of California. In addition, many universities throughout the United States have suffered a reduction in funding which supports various aspects of academic medicine. Upon my arrival in Australia, the impact of the recession was similar although while not quite as severe or as prolonged, it will clearly impact the practice of academic surgery. Therefore, this allowed some shared commiseration of the impact that the change in the economy has on our surgical practice with an increasing number of constituents losing health insurance coverage.

Top: ACS lecture at the ASC. Left to right: Richard Bold, John Cameron, John Buckingham
Above: Pancreatic Cancer Research Group at the Garvin Institute. Front row left to right: Chris Scarlett, Emily Colvin, Amanda Mawson, Mary-Ann Brancano. Back row left to right: Andrew Biankin, Johana Susanto, Mark Pinese, Emily Stoddard, David Chang, Richard Bold.

Despite all of these similarities, there are dramatic differences to the way our Australian colleagues practice surgery, at least compared to my current practice at UC Davis. While I am an academic surgeon with a single site of practice, it is much more common for our Australian colleagues to practice at multiple site hospitals, even though maintaining an academic affiliation. With Australian health care essentially a two-provider system, I noted that many academic surgeons will engage in a parallel private practice to supplement their income, but also ensure sufficient clinical volume to maintain necessary competence. I met one surgeon in Melbourne who was affiliated with 11 different hospitals which he would frequently travel between within a week and even within a day. While this type of practice would ensure proximity of clinical care to the patient residents, we are confronting the possibility that outcomes may be improved through the regionalisation of resources, especially within the cancer arena and complex surgical procedures.

After a whirlwind tour of Australia it is with the most sincerity that I report that this experience was a once-in-a-lifetime opportunity. I am tremendously gratefully to the ACS and the Australia and New Zealand Chapter for the opportunity to serve as the 2009 ANZ Chapter Traveling Scholar. It is clear that many of the issues facing the delivery of surgical care, the finances of health care delivery, and the impact of the economic recession transcend our national borders. It is with fondness that I reflect on the long-lasting relationships that I have developed with the surgeons in Australia, most notably, Rob Finch, Andrew Biankin, Bruce Mann, and John Buckingham. As an Ambassador of the ACS, I hope that I have served its constituents well in representing American surgery to our colleagues in Australia.



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# Volting the big three

The day when we drive quietly in electric cars is closer than we think

**Richard Blackburn**

While Tesla's electric cars grab headlines across the globe, a country town of Armidale is developing its own contribution to carbon-free motoring.

The eveMe doesn't have the sleek looks or rapid acceleration of the Telsa roadster, nor the Hollywood client list. It looks like a normal Mazda2, on which it is based.

But flip the petrol cap open and you'll find a humble domestic power point, which means its owner will never have to visit a petrol station.

The evMe electric car project is led by Armidale academic and organic cattle farmer Dr Phil Coop.

Coop and his small team of software experts, engineers and mechanics have spent between $2 million and $3 million developing the evMe for commercial use.

This week, the first car was handed over to retired Glen Innes businessman Howard Eastwood, who paid a premium of about $50,000 to have an electric, rather than petrol, version of the Mazda2.

Coop's company, Energetique, plans to build 100 evMe a year priced at $70,000, and claims to have more than 100 expressions of interest for the vehicle, mainly from corporate fleets looking to score "greenie" points.

Before it was handed over, Drive got the opportunity to steer the first evMe around the streets of Armidale.

At first glance, the unique badge is the only sign there is something different about this Mazda2. But climb into the cabin and there a couple of tell-tale signs this is not your average car.

The first is a silver lever on the floor near the handbrake – a kill switch that allows technicians to cut the electricity while they work on the vehicle. Just above the lever, the automatic gear selector is also different. As the evME has no gearbox, there are only three selections available: park, drive and reverse. A trip computer-style readout in the instrument panel next to the speedo tells you which mode you've selected. It also give information about battery voltage, remaining charge and range (up to 280 kilometres).

Eventually, the evMe will have three more modes: performance, normal and limp home.

It can take some getting used to and feels as if you're somehow missing out in the power stakes but if you look at the speedo it is making the same progress.

The car excels at climbing hills, which is no surprise given its big torque — or pulling-power — advantage over the petrol Mazda2. While the standard Mazda puts out 76kW of power and 137Nm of torque, the evMe put out 89kW and 220Nm.

On a long, steep freeway inkling, the evMe kept pulling effortlessly when a conventional petrol engine would have been revving hard.

> *"To switch on the car, you simply turn the key and select a gear. The only sign the engine is running is noise made by some auxiliary systems."*

Today, we only have access to normal mode. To switch on the car, you simply turn the key and select a gear. The only sign the engine is running is noise made by some auxiliary systems. You can hear the faint hum of the break booster pump but apart form that everything is silent.

Backing out of the small workshop, the evMe feels a lot like the Prius, which can crawl silently at low speed before the petrol engine kicks in.

The comparisons end when you plant the accelerator. The evMe gathers speed without any of the usual aural and tactile sensations you'd expect from a car. There's no kickdown through the gears, no gradual build-up of noise as the revs get higher (even through though the engine reaches a sports car-like 11,000rpm). All you can hear is the whine of the conventional differential.

You immediately become more aware of noises you would never have heard in a normal petrol car. A warning to manufacturers: customer complaints about rattles and squeaks are likely to soar when a car goes electric.

Acceleration feels on par with the normal Mazda2, although when you plant the pedal to overtake, there is none of the immediate conventional automatic gearbox. Rather than give you a shove in the back, the evMe continues to push seamlessly ahead.

Because the car was being delivered to its proud owner at the end of the week, we didn't test the handling limits but in normal driving it seemed to retain the original Mazda2's control through corners.

The designers have gone to great lengths to ensure the car's weight balance is no upset. The 69 kitchen tile-sized battery packs are mostly stored beneath the floor to keep the centre of gravity low.

They weigh about 200 kilograms but once you replace the petrol engine with an electric motor, the car weighs almost the same as the standard one.

Charging takes 14 hours from a standard plug or four hours from heavy duty outlets.

Coop doesn't expect the evMe to become a volume seller. In the fist instance it will appeal to early adopters prepared to pay for what is essentially a city commuter car.

It is still a long way from a success story but this innovative electric car from the New England tablelands is enough to make Detroit's big three blush.

For more information on electric cars go to drive.com.au/electric_cars

*Reprinted with kind permission from The Sydney Morning Herald, Drive, Saturday, March 21, 2009*

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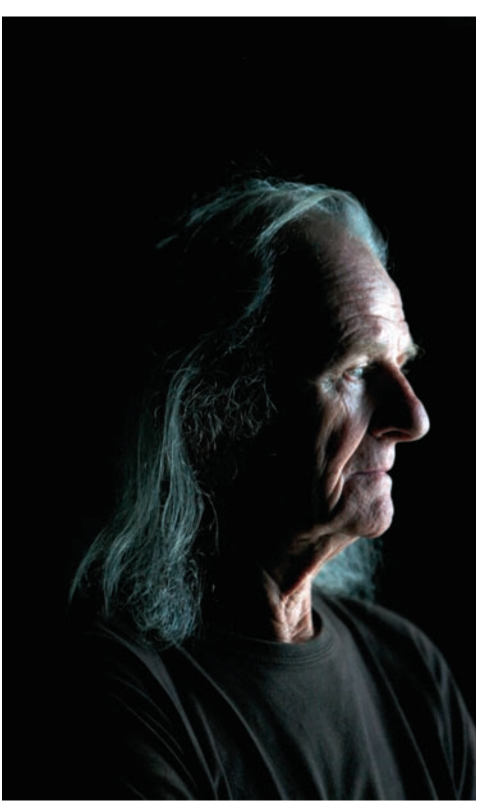

# A Ringing Glass

Ken Unsworth's latest exhibition celebrates the life and work of his late wife, Elisabeth

At the height of the Second World War, Cockatoo Island was the largest shipyard in the southern hemisphere, with hundreds of allied ships undergoing repairs after being damaged by Japanese torpedoes. Today, the island has a distinctly abandoned feel about it, with the wind off Sydney Harbour whistling through rusting machinery and long disused workshops. A modest procession of visitors makes the short journey by ferry from Circular Quay, to tour what is essentially an historical curiosity.

Recently, however, there was a rise in the number of visitors, with people drawn to the island by the installation art of Ken Unsworth. "A Ringing Glass" celebrated the life and work of Ken's wife, Elisabeth, who died late last year but whose commitment to the causes of surgery and art endures.

After the death of her son, neurosurgeon John Mitchell Crouch, at a tragically young age, Elisabeth Unsworth established the Fellowship which bears his name and which remains the College's most prestigious scholarship. The list of the Fellowship's recipients reads like a who's who of surgeons and surgical researchers.

Elisabeth was also a passionate supporter of the arts, not least of the work of husband Ken, who would go on to exhibit at galleries around the world and win numerous awards. He was made a Member of the Order of Australia in 1989.

Housed within a large marquee erected inside a cavernous workshop, the exhibition drew visitors through a series of four rooms. The first was a spacious ballroom, in which a gala dinner and dance was held in Elisabeth's honour on the evening of 28 May. In the weeks following the event, video footage of it could be viewed in the ballroom, enabling visitors to savour the incongruity of guests in evening dress arriving by boat at an abandoned shipyard to dine and dance by candlelight.

Three further rooms contained items of significance in the life of Elisabeth Unsworth. These included her grand piano and, in the last two rooms, pieces of musical instruments, model pianos and boating paraphernalia suspended from the ceiling. This was an exhibition of a distinctly encouraging tone – here was a life lived to the full.

Featured in the Weekend Australian Magazine of 23-24 May, Ken said of the installation: "It is all various aspects of my life with her, our relationship, or aspects of her personality. I just wanted to do something to honour her, and to do it without speechifying."

So successful was Ken at achieving this goal, the exhibition was extended for another month.

Top left: Ken Unsworth Top right: One of the works from the exhibition

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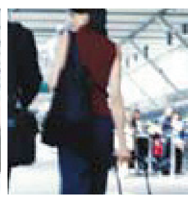
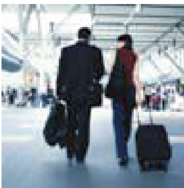
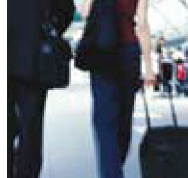

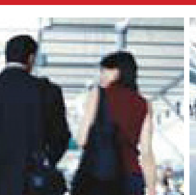

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# Information about deceased Fellows

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

James Macpherson Cartledge **TAS**
James Morrison Ellis **NSW**
Ian Jeffery Isaacs **NSW**
Douglas Malcolm Ritchie **VIC**
Olaf McClure Spence **NSW**
Harold Frederic Rowe Story **VIC**
Raymond Che-Wai Wong **Hong Kong**

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries.

Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website 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 | Penny.anderson@surgeons.org |
| NT | college.nt@surgeons.org |


ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
YOUNGER FELLOWS COMMITTEE

## PREPARATION FOR PRACTICE WORKSHOP

FAX MENTIS INCENDIUM GLORIÆ

Convenors: Dr Chris Que Hee and Dr Darren Marchant
Date: Saturday 29 August 2009
Time: 8.30am - 5.00 pm
Venue: RACS Building, 50 Water St, Spring Hill, Brisbane 4000
Fee: $110 (incl GST)
Suitable for: Final year registrars and junior consultants in all surgical specialties.

Overview:
The Younger Fellows Committee is offering a one-day workshop to assist final-year registrars and junior consultants to transition into private surgical practice. The course will cover all those things that being a registrar doesn't teach you!
Topics include:

- Getting started – the essentials
- How to set up your business
- Your responsibilities as an employer
- How to find staff
- Understanding the Medicare Schedule
- Understanding the Private Health Funds
- Computerisation in surgical practice
- Consent issues and Medical Indemnity
- Solo vs group practice
- How to pay for everything

Small Group Discussion:
Delegates will be able to speak to a surgeon, who has recently started a private practice, to get getpractical tips and advice.
Topics will include peculiarities for each surgical specialty, how to avoid problems and how to survive this challenging time.

**For more information** contact
Virginia Kelly +61 7 3835 8600 or
Virginia.Kelly@surgeons.org OR
Chris Que Hee +61 7 3831 4400 or
chris@quehee.com

# PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

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

### Practice Made Perfect: Successful Principles for Practice Management

28 August – Brisbane
16 September – Perth

This new whole day workshop focuses on the unique challenges of running a surgical practice. Learn more about the six principles of running a surgical practice. Practice managers, practice staff and Fellows are encouraged to join these workshops for a valuable learning experience.

*Proudly supported with an educational grant from Health Communication Network*

### Beating Burnout

1 September – Sydney

Tired? Stressed? Overworked?
Sometimes the demands of clinical life appear to be ever increasing and unavoidable. Not surprisingly, clinicians are at a higher risk of depression and substance abuse. This evening workshop offers advice and practical strategies for achieving a better work/life balance given the competing priorities surgeons face.
You will be able to discuss important stress management issues with your peers and be introduced to proven techniques to manage the effects of burnout.

### Acute Neurotrauma Management (Rural)

11 September – Adelaide

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

### Surgical Teachers Course

17-19 September – Auckland

The Surgical Teachers Course, consisting of two and a half days of challenging and interactive activities, enhances the educational skills of surgeons responsible for the teaching and assessment of surgical trainees. Experienced faculty members employ a range of teaching techniques and presentations to deliver the curriculum including Adult Learning, Teaching Technical Skills, Feedback and Assessment and Change and Leadership.

### From the Flight Deck

16-17 October – New Zealand

This two-day workshop is facilitated by an experienced doctor and pilot. It examines the lessons learned from the aviation industry and applies them to a medical environment. The program combines rigorous analysis of actual airline accidents and medical incident case studies with group discussions and an opportunity to use a full-motion airline training flight simulator. You will learn more about human error and how to improve individual and team performance.

*Proudly supported with an educational grant from Kimberly-Clark Australia*

## PROFESSIONAL DEVELOPMENT WORKSHOP DATES: AUGUST - NOVEMBER 2009

### NSW

| | |
|---|---|
| **15 August** | Supervisors and Trainers (SAT SET), Sydney |
| **21 August** | Making Meetings More Effective, Sydney |
| **1 September** | Beating Burnout, Sydney |
| **17 November** | Supervisors and Trainers (SAT SET), Wollongong |

### NT

| | |
|---|---|
| **16 September** | Supervisors and Trainers (SAT SET), Alice Springs |

### QLD

| | |
|---|---|
| **28 August** | Practice Made Perfect: Successful Principles for Practice Management, Brisbane |
| **29 August** | Preparation for Practice Workshop, Brisbane |
| **3 October** | Supervisors and Trainers (SAT SET), Brisbane |
| **28 October** | Mastering Professional Interactions, Brisbane |
| **30 October** (QLD ASM) | Mastering Intercultural Interactions, Sanctuary Cove |
| **1 November** | Supervisors and Trainers (SAT SET), Sanctuary Cove (QLD ASM) |
| **15 October** | Supervisors and Trainers (SAT SET), Cairns |
| **5 November** | Supervisors and Trainers (SAT SET), Noosa (ASCTS) |

### SA

| | |
|---|---|
| **31 August** | Mastering Professional Interactions, Adelaide |
| **11 September** | Acute Neurotrauma Management (Rural), Adelaide |

### VIC

| | |
|---|---|
| **8-9 August** | From the Flight Deck, Melbourne |
| **14 August** | Polishing Presentation Skills, Melbourne |
| **22 August** | Expert Witness, Melbourne |
| **24 October** | Supervisors and Trainers (SAT SET), Lorne (AGFSM) |
| **10 November** | Supervisors and Trainers (SAT SET), Melbourne |
| **13-15 November** | Providing Strategic Direction, Melbourne |
| **14 November** | Communication Skills for Cancer Clinicians, Melbourne |

### WA

| | |
|---|---|
| **16 September** | Practice Made Perfect: Successful Principles for Practice Management, Perth |
| **25 November** | Supervisors and Trainers (SAT SET), Perth |

### NZ

| | |
|---|---|
| **3 September** | Supervisors and Trainers (SAT SET), Napier |
| **17-19 September** | Surgical Teachers Course, Auckland |
| **16-17 October** | From the Flight Deck, Auckland |
| **20 November** | Supervisors and Trainers (SAT SET), Auckland (NZAPS) |

### Further Information

Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org – select Fellows then click on Professional Development.

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