Surgical news

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The College of Surgeons of Australia and New Zealand

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Post Fellowship Training

Where appropriate, the College will acknowledge post Fellowship training programs

Ian Civil
President

Most Fellows would be aware that it is common these days for newly qualified surgeons to spend some time doing additional specialised training after completing their Fellow of Royal Australasian College of Surgeons (FRACS). Indeed it has been common for many years for young surgeons to spend time overseas in formal or informal positions before coming back to work in Australia and New Zealand.

Over recent years, increased surgical specialisation within the major urban areas of Australasia and decreased access to the job markets of particularly United Kingdom and United States of America has meant more post-FRACS training is undertaken here. When surgeons have completed this add-on experience they usually highlight this as a component of their scope of practice when being credentialed for their definitive appointments. What can be quite difficult, given the extent and diversity of post-FRACS training, is determining the real quality of that additional education and training and ensuring that it is appropriately understood, particularly in credentialing and employment processes.

Realising that "post fellowship (FRACS) training" was a reality, the College determined that it would be helpful for Fellows and Trainees completing their training, the surgical community and potential employers if such training was to be accredited and then, if the standards were appropriate, to be co-badged with the College's quality standard.

This is a very similar approach to the College now working with a number of educational providers particularly Universities, where Memorandums of Understanding (MOU) will govern the relationship between the two (or more) organisations and the specific courses will be accredited and co-badged by the College. It is a key component of the College effectively partnering with other educational providers to ensure increased educational opportunities for all of us within a framework of educational standards and reliable delivery.

"As with the University relationship, the College has no interest in restricting the availability of any post-Fellowship training"

Determining quality

As with the University relationship, the College has no interest in restricting the availability of any post-Fellowship training. Rather the College purely seeks to determine the quality of the programs that are submitted to it and accredit and co-badge those that meet the required standard. These relationships need to build on the strengths of the College and so the relationships with Universities work under the oversight of the Education Board through the Skills training area or for a specific specialty through that Specialty's Training Board.Recognising the crucial relationship the College has with the nine disciplines that comprise its Fellowship, any post Fellowship program has to have the support of at least one of these disciplines. Sometimes if the surgical program impacts a number of disciplines they may have the support of more than one discipline. However, that is not essential to proceeding for accreditation. While a number of subspecialty groups run post Fellowship training programs, the College has no wish to enter into independent relationships with them. On the other hand, where proposals originate from a subspecialty group and are supported by one or more societies representing the nine disciplines then, if they meet the standard, the College will accredit them. ▶

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Johnson & Johnson MEDICAL

The Sir Edward Hughes Memorial Clinical Research Prize in Surgery 2010

The Cabrini Monash University Department of Surgery together with the Cabrini Institute - Education and Research and Johnson and Johnson Pty Ltd are pleased to advise that the competition for the prize will be held at Cabrini Hospital, 16th October 2010. The prize is open to application by all surgical residents and registrars who have entered or intend entering an accredited surgical training program.

Successful completion of the Primary examination of the RACS (or equivalent) is a prerequisite for application. The trainee must be the principal author, and have contributed the majority of research work for the project. Papers must relate to a topic of predominantly clinical significance in surgery. The abstract should be arranged as follows: Purpose, Methodology, Results and Conclusions.

An abstract of no more than 250 words will be required to be submitted by 5pm Friday 27 August, 2010. The ten finalists selected will be contacted and names listed on this web site by 20th September 2010.

Ten finalists will be selected for presentation of a seven-minute paper with three minutes to respond to questions. An objective pre-formatted point system will be employed to determine the winner. Judging will be along the guidelines of the Surgical Research Society, with special emphasis given to the clinical significance of the topic. The panel of invited judges will be selected from clinical surgeons, physicians, academics, basic researchers and ethicists. The prize is sponsored by Johnson and Johnson Medical Pty Ltd and consists of AUD$6000 and a shield.

PREVIOUS WINNERS

2009 Dr Tarik Sammour: Warming and humidification of insufflation gas in laparoscopic colonic surgery - a double-blinded, randomised, controlled trial.

2008 Dr Michael Wyatt: TOUGHEN UP – too high a price to pay for the best lamb in the world?

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2005 Dr Sebastian King: Colonic Manometry in Paediatric Slow Transit Constipation Shows Consistent Deficiencies in Propagating Contractions: Manometric Evidence of a New Disease

2004 Dr Mehrdad Nikfarjam: Hyperbaric oxygen therapy improves survival and reduces severity of acute severe pancreatitis

2004 Dr Naeem Samnakay: Morphology & Apoptosis In The Ovine Fetal Kidney In Prenatal Bladder Outflow Obstruction

2003 Dr Adam Stewart: A pain control infusion pump for post-operative analgesia following inguinal hernia repair: a double-blind, randomized controlled trial.

2002 Dr Shomik Sengupta: Butyrate delivery to the distal colon suppresses colorectal tumorgenesis in rats.

2001 Dr Paul Moroz: Targeting liver tumors with hyperthermiz: arterial embolisation hyperthermia in a small animal model.

2000 Dr Marins Pirpiris: Iatrogenic crouch gait: an avoidable complication of calf lengthening.

1999 Dr Charles Douglas: A randomised trial of ultrasonography in the diagnosis of acute appendicitis incorporating the Alvarado score.

Abstracts and/or presentations must be submitted by disk or email with a contact phone number and address to:

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Cabrini Monash University
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Increasing pressures

The standard is determined by a post Fellowship training program assessment committee. This is comprised of a majority of surgeons from non-interested specialties, but crucially involves representatives from not only the sponsoring discipline, but also the other disciplines with potential crossover interests in the area of the proposed subspecialty training program.

The College recognises the increasing and conflicting pressures of generalism and specialism in surgical practice and is not driving surgery towards specialism. In fact, the College recognises that both effective generalism as well as skilled specialism is needed to deliver quality surgical care in each of the nine disciplines. Post Fellowship training has long been with us and, because of various pressures on the training process and the workplace, seems to be increasing. The College does not intend its post Fellowship process in any way to drive specialism, but rather to put such post Fellowship training as does exist into a quality framework, if the providers of such training so prefer.

It is on this background that the information about the College accrediting courses and more importantly newly accredited post Fellowship training programs must be considered.

Firstly that, in line with the College policy, the program must have the support of at least one of the nine specialty groups. Secondly, the quality of the proposed program has been assessed as adequate and that required reports which will be defined in the subsequent Memorandum of Understanding will ensure it is delivered effectively. Finally, in those areas where there are overlapping areas of interest from more than one specialty group, the College will approve more than one post Fellowship program if suitable quality applications for such programs are received.

Politicians face the hard questions

The College has asked the major parties to respond on health policy issues

Keith Mutimer
Vice President

In the last several state elections, the College has written to the major political parties seeking their responses to key health policy issues relevant to surgery.

We are now expanding this concept to the forthcoming Federal Election. To provide guidance to the parties, the College prepared a document which highlights the important health issues pertaining to the practice of surgery. The issues canvassed were by no means exhaustive, but are those the College believes will, if addressed, deliver the best outcomes for patients through improved surgical practice.

As has been our custom in state elections, the College will assess the political parties' responses and make them and our commentary publicly available to our Fellows and Trainees in the last week of the campaign. The aim is to ensure that Fellows and Trainees have a clearer understanding of the policies and drivers of the major parties and can cast a more informed vote on election day. The College's 2010 Election Manifesto identified five key areas in the election campaign.

Future Workforce

This covered key issues such as the need for more training posts and the extension of training into the private sector. We argued that government must support trainers, ensuring protected time and appropriate remuneration for the training function.

We also argued that government must work with the College on a sustainable model for the adequate funding of the College's role in assessing and accrediting new and established training posts.

Patient safety

The Manifesto reminded the Government and Opposition that the College has been at the forefront of patient safety initiatives including the Correct Patient, Correct Procedure, Correct Side and Correct Site Surgery protocol and, more recently, the Surgical Safety Checklist. These initiatives, among many others, demonstrate the College's commitment to this vital issue.

The College asserted that the recognition of surgical specialties is a critical patient safety issue, and only those with a medical degree and specialist surgical training can safely perform surgery.

International Medical Graduates (IMGs) are key to addressing workforce shortages. It is therefore imperative that IMGs seeking employment are thoroughly assessed, properly supported and adequately resourced and that government strongly supports the College's assessment processes.

Recent tragic events in Bundaberg illustrate what happens when trained clinicians do not have the opportunity to determine who is, and who is not, capable of operating safely on Australians.

However, it is not just in the assessment of IMGs that clinician advice is being overlooked. The College is opposed to the recognition of cosmetic medical practice and podiatric surgery as medical specialties, believing that they constitute a serious risk to patient safety.

The document also stresses that systematic auditing of processes and outcomes in Australian health systems is fundamental to ongoing improvement in patient care, as is peer review of health professionals' work. Among our recommendations is that government work with the College on a nationally coordinated and properly resourced approach to audit and review processes to enable comparisons of performance within and between health jurisdictions.

We also called on the Government to ensure certainty of funding for the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). This unit is ideally placed to assist the Government in establishing and maintaining rigorous and transparent methodologies to ensure that the healthcare dollar is spent in the safest and most effective manner.

Regional and Rural Australia

As Australia's population ages and demands on the health system increase, Australia's surgeons also age, with an increasing number of surgeons contemplating retirement. An already critical situation in regional and rural Australia is about to deteriorate further. Measures must be implemented to address this developing crisis.

The relatively insufficient funding of regional and rural hospitals resulting in inadequate ▶

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infrastructure and leave arrangements has rendered them an unattractive workplace for younger surgeons. Inefficient management structures within hospitals, and the often top-heavy and overly bureaucratic management of Health Areas by government, has exacerbated the problem.

It was also noted that educational and training arrangements are such that the option of working in regional and rural Australia is inadequately encouraged.

Support for the further development, career coaching and mentoring of IMGs working as surgeons in regional and rural Australia is essential if they are to be a sustainable resource to Australia. The Commonwealth should facilitate access by IMGs to educational up-skilling opportunities either through existing College training programs or specifically developed IMG education/up skilling programs.

There needs to be greater provision of allied medical services, such as nursing, anaesthetist, pathology and radiology services, in rural and regional areas in order to attract the interest of younger surgeons.

Where possible, increased resourcing of regional and rural hospitals should include personnel to recruit surgeons and help manage their transition into the hospital and local community.

The accreditation of base hospitals as registrar training posts would have a beneficial effect on surgeon numbers in regional and rural areas. Experience suggests that surgeons trained in a regional or rural hospital are more likely to remain there once their training is complete.

Access to Care

The Manifesto argued that elective surgery waiting lists are symptomatic of longstanding problems in Australia's public health systems. While some of these problems can be addressed by a commitment to greater efficiency, there can be no denying the need for greater investment in our public hospital system, and in its workforce.

No matter how well governments resource commitments to preventative health, integrated primary care, and aged care, this decline in bed numbers represents a dangerous under investment in the health system. The problem will only become more pronounced as our population ages.

Following on from its work on the Emergency Surgery Consensus Statement, the College sought Government support to begin the process of reviewing and redesigning emergency care. The College also stated its support for the establishment of separate structures for elective and emergency surgery. This may involve physically separate facilities or, at the very least, separate streams within the one facility.

Funding

The parties were reminded that the College has long been on the record as a supporter of a single funder health system. It remains so.

Previously, blame and cost shifting between federal and state governments was rife. With both tiers of government providing some funding for the health and hospital system it was inevitable that each would blame the other when things went wrong.

The Rudd Government was elected with a mandate to "end the blame game". While the College recognises that the reforms introduced in this term of Government are a step in the right direction and have many laudable aspects, they do not go far enough to deliver the certainty of funding and the transparency and accountability which patients and tax payers require.

The current Federal Government's health reforms fall short of the single funder model. Rather, they have merely rebalanced the proportions of health funding provided by the state and federal levels of government. This will not end the so-called blame game.

While the College acknowledges that single funder is a longer term objective, we would support any sensible reform that indicates that this model is its ultimate goal.

The Election Manifesto represents an excellent opportunity for the College to put forward its position on a range of important surgical issues in the context of an election campaign.

I look forward to sharing the parties' feedback and the College's response to it closer to polling day. In the meantime, the full Election Manifesto is available on the College's website, www.surgeons.org

RAMSAY FELLOWSHIP - PROVINCIAL SURGEONS - 2010

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

The Fellowships can be taken for a period of two weeks (one Fellowship of $5,000); or a period of one week (three Fellowships each of $2,500); or a combination of the above.

The Fellowship grant is intended to contribute substantially to:

- Return airfare to city (cities) of choice;
- Daily living allowance (travel, meals, accommodation, ongoing practice costs);

No additional amounts are payable for travel or accommodation for family, locum costs, insurance, or any other unspecified costs.

The Fellowship does not incorporate payment for or arrangement of a locum. However, assistance in arranging a locum, if required, can be obtained from the Rural Services Department at the College on +61 3 9276 7407.

The Fellow must spend a major part of each week at the appropriate institution and give a guarantee to continue in practice in his local area on completion of the Fellowship. There is no application form. A letter of application should be forwarded before the end of September 2010 to the Scholarship Coordinator, PO Box 553, Stepney SA 5069, or by email to scholarships@surgeons.com.

The following details should be included:

- The intended Fellowship duration;
- An outline of the experience or skills you aim to gain through the Fellowship and how this will benefit your current practice / hospital;
- The locations to be visited in order to achieve your aim;
- A written confirmation from the institution where you are to gain your skill or experience.
- A brief outline of the costs associated with acquiring the skills & experience.
- Two written supporting references.

NB: This Scholarship is open for travel in 2010.

Long service to the College

Some proper respect to people with special talents

I.M.A Newfellow

I have been discourteous, disrespectful, impolite and inconsiderate. I have shown a lack of praise where praise is due, I have not acknowledged achievements and I have ignored them all too long. They are largely female, so I have also been a chauvinist. This is a little of what Mrs Newfellow said to me after my entirely innocent remark following the last Council meeting.

My error was that I had mentioned that some staff members were acknowledged for their long service to the College during morning tea on Friday. I think that I may have said that a few of "the girls" had had a bit of a function. "Girls, they are not girls! They are a mature group of women with special talents and you should show them due consideration and respect."

So here I go with due respect and consideration. The "girls", as I so wickedly named them, were Toula Panagopoulos, Justine Peterson, Kylie Mahoney and Kathleen Hickey. Many Fellows may only vaguely know these names, but in some areas their names are well known and perhaps invoke a slight amount of fear. Between them they have 50 years of service to the College. That is 50 years of experience, more than five times what any Councillor can achieve in his/her allotted nine years (did you all notice the "her" in there showing that I am not a chauvinist). Each of these persons has more experience in their area than any councillor.

Now Toula is usually known as Toula, as her last name can challenge some of us to pronounce it properly, although the President did make a valiant effort at the morning tea. Unless you are an International Medical Graduate (IMG) you may not know her. She is the person who organises the Australian Medical Council assessments of IMGs, runs the assessment and supervision process of the College. About 100 such assessments are done per year and about 70 active assessments are being followed at any one time.

If you are a New Zealander, the name of Justine Peterson may strike a little fear into your soul, but always respect. Justine has run the New Zealand (NZ) office for 15 years and there is not a thing that happens in NZ that she does not know about. If you are a NZ based Trainee and think that you can fudge your log book – don't. She knows about it before the thought even reaches your consciousness. If you are a NZ Fellow and need some information about the College, just ask Justine – she will know.

Two and half per cent of College Fellows should know the name of Kylie Mahoney as she has been involved with the running of the Continuing Professional Development (CPD) program and that is the percentage of Fellows who are asked each year to verify the data that they have submitted. In her 10 years of service she has probably contacted a quarter of the Fellows to ask for verification. I hope that you could do so if she phones you!

Lastly Kathy Hickey – she is master of all. Her official title is Director of Education, Development and Assessment. In essence, this is exams and courses. This area of the College activities is the very core of our functions.

So there we have it – 50 years of service in four persons. But there are others in our employ who have given two years, five years, 10 years or more. There are 180 of them all over our two countries doing the many tasks that we set them, running our organisation. It is they who really run surgical training and education, surgical outreach and international programs, surgical CPD. Many are women, but some are men; many are younger, but some are older; many are in Melbourne, but some are elsewhere. We acknowledge and thank you all.

So you see, Mrs Newfellow, that I am not a chauvinist. Indeed I could never have been one as the meaning of the word has been corrupted. Nicholas Chauvin was a semi-mythical soldier who was said to have served under Napoleon Bonaparte in the French Revolution and the Napoleonic Wars. This means he was on active service for at least 26 years. The French word "chauvinsme" meant a blind and unwaveringly zealous devotion to a nationalist cause, and not a gender based bigotry. But then along came those chauvinistic feminists and hijacked the term.

Preventing another Patel incident

Jayant Patel should have been assessed by the College and the Australian Medical Council

John Quinn
Executive Director, Surgical Affairs

Last week's verdict in the criminal trial of former Bundaberg surgeon Jayant Patel is not, regrettably, the end of this tragic matter. There will most likely be an appeals process, much of it turning on questions as fundamental as criminality within clinical care and the liability of a surgeon who has obtained the consent of a patient to operate. It is premature to say that victims and grieving relatives now have closure.

Irrespective of the outcome of any appeals process, however, there are clear lessons that can and must be drawn from the Patel case so far.

First, trained clinicians should determine who is, and who is not, capable of operating safely on Australians. In the Patel case, it was bureaucrats, answering to politicians in search of expedient solutions, who oversaw the appointment of the surgeon to Bundaberg Hospital.

As a foreign-trained surgeon, Patel should have been assessed by experienced surgeons as part of a thorough and proven process conducted by the College and the Australian Medical Council.

International Medical Graduates, or IMGs, with a specialist surgical qualification may apply to the college for assessment to determine their comparability to an Australian or New Zealand-trained surgeon.

If the assessed IMG is deemed comparable, he or she is supervised for a period of time before achieving a College Fellowship. Sometimes passing the College's Fellowship examination may be required to demonstrate comparability to an Australasian Fellow. If the IMG is assessed as not comparable, it is recommended that he or she apply for the College's Surgical Education Training Program, just as an Australian or New Zealand (NZ) medical graduate wishing to become a surgeon does.

This process of assessment acts as a safeguard, ensuring that IMGs seeking to work or train as surgeons have achieved the same required standards as their Australian or NZ counterparts.

Unfortunately this process of assessment is not mandatory and can be avoided by government. This is what happened in the case of Patel. So precipitate was the process of his appointment, his CV and references were not thoroughly checked; had they been, this whole sorry mess might have been avoided.

The second lesson to be drawn from the case is the importance of clinical governance in our hospitals. It is the responsibility of employing hospitals to ensure that surgeons when appointed are correctly credentialled; that their appointment is to an appropriate position at an appropriate level of experience and seniority; and that the range and scope of their clinical privileges are clearly defined.

Hospitals must also ensure that the performance of their surgeons is formally and regularly monitored by way of continuing clinical audit and peer review.

Anthony Morris QC, who chaired the original commission of inquiry into the Bundaberg Hospital affair, which was brought to an end before delivering its findings, notes that Queensland Health's quick-fix became seriously problematic when Patel was appointed director of surgery. As highlighted by Morris, this was in direct contravention of an express condition of Patel's registration by the Queensland Medical Board that Patel be supervised by the director of surgery.

So Queensland Health's credentialling process was also flawed. Not only was Patel appointed without restriction of his scope of practice, but the condition that he be supervised was apparently ignored. The presence of a more experienced surgeon would have meant a second opinion was always available before surgery.

Readers may not be aware of the fact that a new national system for registering doctors and accrediting health-related training courses came into effect last week. Essentially an attempt to centralise the process by which health professionals are registered, it will facilitate the movement of these professionals across state borders.

While the College of Surgeons has been generally supportive of the reforms, it did campaign successfully for some key amendments. One of these was to ensure that clinicians, not bureaucrats, sit on the committees that decide who does, and who does not, become a registered doctor. Another was to ensure that experts, not politicians, decide which teaching institutions have developed medical courses of sufficient rigour to be accredited.

Interestingly, however, one of our proposed amendments was met with stony silence by the politicians. This was to do away with the mechanism whereby politicians or their delegated bureaucrats can, without reference to clinicians, declare a given area or hospital an "area of need".

Such a declaration enables the appointment of a surgeon who has yet to be deemed fully comparable with a locally trained surgeon. While declarations of area of need are sometimes a necessity, the College of Surgeons believes they should be made in consultation with clinicians.

It is sadly ironic that existing arrangements, and the threat they pose to patient safety, were enshrined in a supposedly new and improved system of registration in the very week that their potential to do harm was brought home so forcefully.

This article appeared in Brisbane's Courier Mail, 7th July 2010. .

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Mandatory Reporting

Mandatory reporting requirements now apply nationally

Michael Gorton
College Solicitor

A new national regime for mandatory reporting of health professionals will apply from 1 July 2010. The Health Practitioner Regulation National Law makes all health professionals liable to make mandatory reports in relation to the conduct of other health professionals.

For the first time, mandatory reporting requirements apply nationally. Additionally, it applies across the 10 health professions regulated under the new legislation (doctors, nurses, dentists, optometrists, osteopaths, pharmacists, physiotherapists, chiropractors, podiatrists and psychologists).

Mandatory reporting is not new. Existing legislation in Queensland and New South Wales requires mandatory reporting by doctors in relation to the conduct of doctors. However, the significant difference under the new law is that any health professional in the 10 professions may be required to report in relation to any other health professional.

Notifiable conduct

The trigger for reporting is if "notifiable conduct" occurs. This is where a registered health practitioner:

- practices while intoxicated by alcohol or drugs;
- engages in sexual misconduct in connection with practice;
- places the public at risk of substantial harm in his or her practice because of impairment;
- places the public at risk of harm in his or her practice in a way that constitutes a significant departure from accepted professional standard.

When to report

A registered health practitioner is required to report another registered health practitioner if the first person forms a reasonable belief, in the course of his or her practice, that notifiable conduct has occurred. That is, if you are a registered health practitioner you must report if you believe that another registered health practitioner has behaved in a way that constitutes notifiable conduct.

Under these circumstances you are required to notify the Australian Health Practitioner Regulation Agency (AHPRA) as soon as practicable. There is no set time limit, but clearly reports of notifiable conduct should be made at the earliest practicable opportunity, once a reasonable belief has been formed that notifiable conduct has occurred.

Notification is also required in relation to students. Students, who are required to register under the new law, must also be notified if they are placing the public at substantial risk of harm because of impairment.

What if i don't notify

It is not an offence or criminal act if a health practitioner fails to make a mandatory report. However, the failure to make a mandatory report can be referred to the relevant Board for consideration as to whether the failure constitutes misconduct, and the relevant Board would decide what, if any, sanctions apply.

Exceptions

General exceptions apply to information which is obtained in the course of actions relating to insurance claims for professional indemnity insurers, if the information is obtained in relation to legal proceedings or providing assistance or advice in legal proceedings. An exemption applies for a health practitioner who is a lawyer, for providing legal assistance.

An exemption applies to registered quality assurance committees or bodies, registered under State or Territory legislation or under Commonwealth legislation. These statutory schemes provide statutory confidentiality for information obtained pursuant to the registered activities. If statutory confidentiality applies, then a mandatory report is not necessary.

A report is not required if a health practitioner knows or reasonably believes that AHPRA has already been notified in relation to the conduct. Thus if another health practitioner or the employer of the person involved has already notified AHPRA, then no further report is required.

What is not excepted

There is no exception for information which comes to a health practitioner as a treating doctor or treating health professional or for information obtained in the course of a health program for health practitioners (unless the program is registered under the statutory schemes referred to above).

"The significant difference under the new law is that any health professional in the 10 professions may be required to report in relation to any other health professional"

Employers

If an employer reasonably believes that an employee health practitioner has behaved in a way that constitutes notifiable conduct, a mandatory report to AHPRA must be made. Many health professionals are not employees of hospitals or aged care facilities, and accordingly the report is only required in respect of health professionals who are employees.

If AHPRA becomes aware that an employer has failed to make a mandatory report, AHPRA is required to report that failure to the responsible State or Commonwealth Minister for consideration and action.

Education providers

An education provider is required to notify in relation to its students, if the education provider reasonably believes that the public is at substantial risk of harm arising from impairment of the student.

Voluntary notification

As with existing legislation, members of the public and health professionals can make voluntary notifications if they believe that there has been any misconduct or any cause of concern in relation to a health practitioner.

Voluntary notification can certainly be made for a range of expanded grounds, for example:

- any impairment of a health practitioner;
- conduct of a health practitioner that is of a lesser standard than expected;
- if the health professional is not a fit and proper person;
- if there is any legal contravention.

Protection

Section 237 of the new law gives protection from civil, criminal or administrative process where a notification is made to AHPRA "in good faith". If a notification is made for malicious or vindictive purposes, this protection may be lost. The protection would prevent any action for defamation, and the protection applies whether the notification to AHPRA is made on a mandatory or voluntary basis, so long as it is made "in good faith".

Can I be sued if I fail to report

There is some case law which suggests that if a person fails to make a mandatory report, which they are required to make, and other people are injured after that time, the injured parties could sue the person who failed to make a mandatory report. This issue is not clearly determined, but leaves open the question as to whether a civil claim of this nature could arise.

General

There is much more information regarding the new national registration and accreditation scheme on the AHPRA website http://www.ahpra.gov.au AHPRA is also maintaining telephone advice lines during this period to assist all health professionals, employers and health bodies to understand their rights and responsibilities under the new scheme.

Michael Gorton is a Principal of Russell Kennedy Solicitors, and is a member of the Agency Management Committee of AHPRA

Specialist Training Program (STP)

The STP provides funding to support accredited surgical training rotations beyond traditional public teaching hospitals

Simon Williams
Chair, Board of Surgical Education & Training

There is growing recognition that specialist training in Australia needs to adapt to changes in the way health care is delivered, as more services are now provided outside the public sector. This has resulted in procedures either not being performed in the public sector or performed rarely, therefore depriving surgical Trainees of important learning experiences. To facilitate the expansion of training the Commonwealth Government has made funding available to create posts in the private sector.

The College has signed an agreement with the Commonwealth Department of Health and Ageing to engage in the Specialist Training Program (STP) Administration and Support Project. There are two components to this Project.

Assessment of Private Hospital Posts for Surgical Training

The STP provides funding to support accredited surgical training rotations in an expanded range of settings beyond traditional public teaching hospitals. The aim is to increase the capacity of the health care sector to provide high quality training opportunities which provide the required educational experiences for surgical Trainees.

Private hospitals may apply for Commonwealth funding of up to $100,000 (excluding GST) per FTE for each post. To be able to be considered for funding, the post must be accredited as suitable for training by the College, on the recommendation of the relevant Specialty Training Board. The College makes an assessment of each post that has applied for funding and advises the Commonwealth regarding the suitability of the potential post, including its accreditation status. Surgical training positions funded under the STP are approved by the Department of Health and Ageing, the College and Jurisdictions and are therefore fully integrated with and complement training at the major public teaching hospitals.

The College recently assessed 90 applications from training facilities seeking Commonwealth funding in 2011. Of these, 17 applications could not be supported by the College, as the training facilities did not submit an accreditation application. All of the remaining 73 applications were supported by the College, and 53 of these have been short-listed by the Commonwealth to receive funding in 2011. Forty-five applications are for existing training positions which had previously received funding in 2010, while the remaining eight applications are for new training positions commencing in 2011.

Infrastructure Projects to Increase Doctors Progressing to Fellowship

In addition to establishing specialist training positions, the STP also provides funding for the development of infrastructure projects that support the expansion of training into non-traditional settings, particularly in rural areas, and improve service delivery to Trainees and International Medical Graduates (IMGs). The Commonwealth has provided over $500,000 in funding for the College to develop and implement projects which meet these objectives and are achievable by the end of 2010 (the conclusion of the Project Period). A College Steering Committee, consisting of the Censor in Chief, the Treasurer and the Chair of the Professional Development and Standards Board has approved seven projects for implementation this year.

Train the Trainer -Introducing the Non Technical Skills for Surgeons (NOTSS) System to Australia

This project is part of the suite of Supervisors and Trainers for Surgical Education and Training (SAT SET) courses provided by the College for Supervisors and Trainers to enhance their skills in teaching and assessing the non-technical competencies.

Self-paced Online Learning Program in Anatomy

An@tomedia is an anatomy resource available to members of the College via the website as a reference, or to assist in their exam preparation. This project has been developed in response to the continuing concerns about the anatomy knowledge of surgical Trainees.

Online Training in Goal Setting and Self-Assessment

This project has been formed in response to the demand from Trainees, IMGs, and Supervisors for the College to provide more online learning resources. It will develop the resources to improve knowledge and skills associated with goal setting and self-assessment.

Rural Career Coach/Advocate

This project is a package of career support and pastoral care designed to secure Trainees and IMGs working in rural areas or contemplating a surgical career in a rural area to commit to rural surgery.

Process Communication Model (PCM) Workshops

This project involves piloting two 'Introductory PCM' workshops to assess whether PCM can assist rural surgeons to communicate better with clinical colleagues, hospital administrators, and patients in order to improve morale and performance.

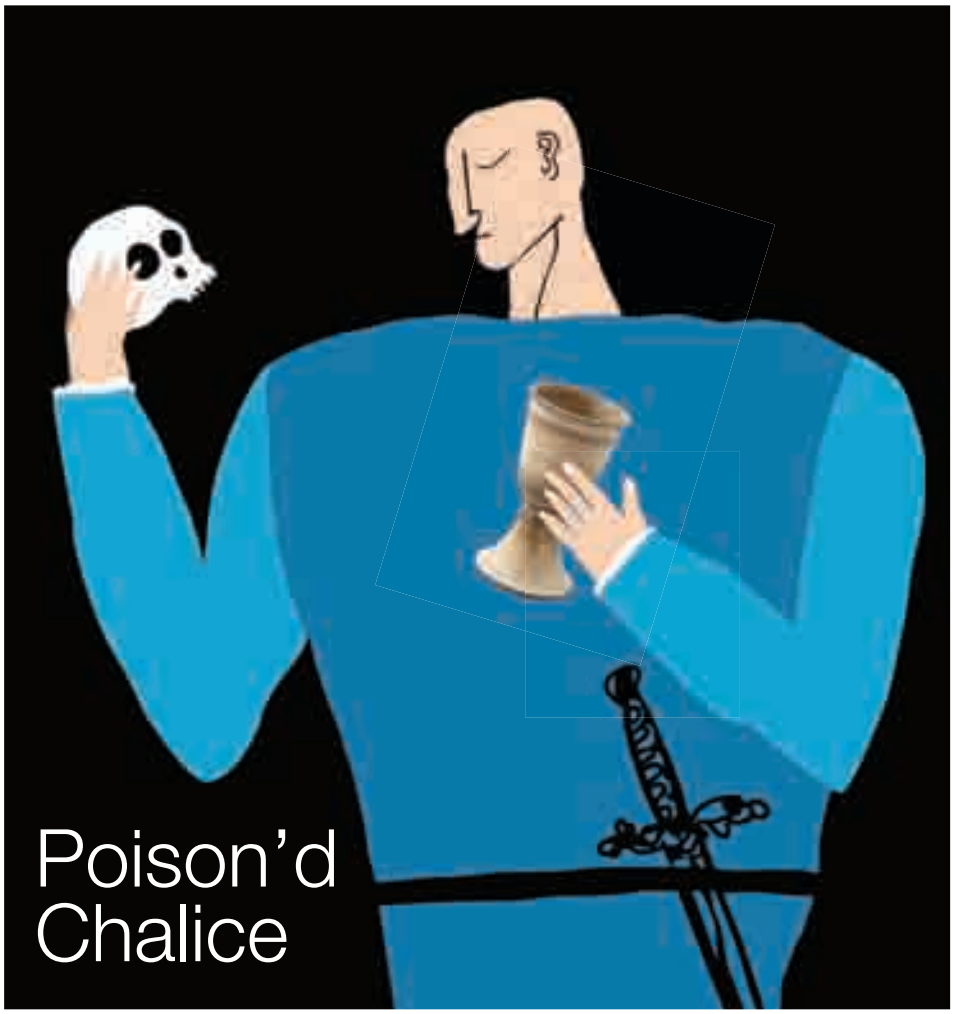
Establish a Network of IMG Surgical Educators/Coaches

This project involves sourcing a network of Fellows to act as Surgical Educators/Coaches for IMGs undergoing specialist assessment. It will also include the development and delivery of a program for Surgical Educators/Coaches including a background in the content of the Fellowship Examination and methods used to assess surgical competencies.

IMG Clinical Assessor & Mentor Workshop

This project involves preparation and delivery of two half-day workshops to instruct and assist Fellows involved in IMG and/or Area of Need specialist assessments. All seven proposals have recently gained final approval and College staff are now working to implement the projects. The current Agreement with the Commonwealth is in place up until the end of 2010, however, it is hoped that further funding from the Commonwealth will continue for future years.

For more information on PCM workshop please contact the professsional development department on +613 9249 1106



Poison'd Chalice

My words fly up, my thoughts remain below: Words without thoughts never to heaven go." Hamlet (III, iii, 100-103)

Professor U.R Kidding

I may have made a slight miscalculation today, or rather yesterday. She was a rather attractive lass, a reporter with the major daily newspaper. My comments were "off the record" or so I thought. I was wrong.

My first inkling of the issue was the 6am phone call was from the Chief Executive Officer (CEO) – "Do you realise that you are the page one story in the newspaper today!" As if to verify the veracity of this statement other news outlets, radio and television stations were ringing at minutely intervals - no doubt hoping for further sensationalism.

It had begun innocently enough. The newspaper had prepared an article on waiting list manipulation by surgeons and hospitals. They decided, at the last minute to "run the story by me" before publication. Alas I thought that they had got it wrong – and said so. That killed the article, but now they had page one space reserved but no story. So they wrote another story based on my comments of inadequate beds in the public hospital sector. It was not intended as a criticism of the Minister, but the juxtaposition of his comments and mine clearly placed us at odds. It might not have been so bad if it hadn't been an election year and as the CEO pointed out, funding negotiations between the Government and our health service were at a rather delicate point.

She rang of course – my attractive contact, to apologise. Her defence was that I had killed her article and she needed another one in a hurry. She would make it up to me (?).

The Shadow Health Minister rang to congratulate me on my courage. I was reminded of the "Yes Minister" episode when Sir Humphrey congratulates Jim Hackett on his courage! – a comment which reduces poor Jim to a sniveling mess wondering what on earth he has done.

What courage? I didn't mean to be courageous. Suddenly I remembered media training – why hadn't I enrolled to do that workshop at the College?

> *"I procrastinated and rushed out to buy the newspaper & read what it was that I had 'said'"*

The Minister's office rang – an urgent meeting was required. Alas I had a busy operating day ahead of me and the Minister's availability was limited. Do I cancel my operating, thus compounding the situation I was "complaining about"? And did I really want to meet with the Minister today?

I procrastinated and rushed out to buy the newspaper and read what it was that I had "said".

Describing elective surgery as the "soft underbelly" of the Health Service didn't seem too bad to me and was in fact accurate. Challenging the assumption that elective surgery equates with optional surgery was also in line with my everyday thinking. And blaming surgeons for inadequate throughput when cancellations for admission due to lack of beds was a daily occurrence was clearly missing the point. The sticking point was the Headline – "Surgeon accuses Minister". The sub-editor responsible for the headline had landed me in the proverbial. And it wasn't accurate – I knew the Minister wanted the Health system that he presided over to be the best, I knew that he went to Cabinet and Treasury and argued for more money. No, my divergence from the Minister and other politicians was more subtle – constant side stepping to deflect criticism and unrealistic promises to a voting public. On one hand telling them that they had the right to access whatever they wished or required and on the other, telling health care providers to cut costs – sorry, achieve productivity increases!

Of course the furore eventually blew over, but it did cause me to reflect on the power of words and the role of the press in health care. Alas, only bad news sells newspapers – the sensational, the medical mistake, etc. And waiting lists – perennially. But the press does catch the attention of politicians. Unfortunately, I am not convinced that it motivates better outcomes. More likely it creates a shoring up of entrenched positions. Advocacy for improvements requires the provision of positive opportunities rather than mere negative criticism.

I wonder how the reporter plans to make it up to me...

A Trainee Voice on College Council

It is no secret that Trainees perceive the College as an intimidating organisation

Greg O'Grady
Chair, RACSTA

The June meeting of the College Council was a historic one for Trainees, being the first time that we have held a voting position at the highest level of our College. This followed the successful change in the College constitution at the Perth Annual General Meeting this year, when the Chair of RACSTA (Royal Australasian College of Surgeons Trainees' Association) was elected as a co-opted College councillor.

This achievement represents a major milestone for RACSTA. Now nearing our fifth birthday, it is great to see how our Association's profile has grown, earning the respect of the Fellowship, and the credibility to assume a significant role in the College leadership.

What value does a Trainee voice bring to Council? At 1200 members, the Trainee body comprises a substantial portion of the College, and we certainly absorb a disproportionate share of the College's time, energy and attention. Surgical training in Australasia continues to undergo change, and Trainee input is vitally important to ensure that the best decisions are made for training, and that transitions are managed well.

Accordingly, Trainees are increasingly being looked to for leadership in managing the challenges facing our training, especially with regard to modern generational issues, including working hours, standards and flexible training. With Trainee representatives now established in every specialty, region and level in our College, RACSTA is ideally positioned to present the perspective from the training coalface, and to facilitate dialogue between the College and the Trainee body. So, Trainees, don't hesitate to be in touch and contribute.

Perhaps most important is the symbolism associated with a Trainee being able to vote at the Council table. It is no secret that Trainees perceive the College as an intimidating organisation. However, having represented Trainees for three years in several roles within the College, including now at the Council table, I have observed a very different reality, which is perhaps lost on most Trainees. At every level and on every board within the College, you will find a dedicated group of Fellows devoting substantial time and energy pro bono, because they are passionate advocates of Trainees and training.

While Trainees may not always agree with the outcomes, there is no dispute that College decisions are made with the highest standards of fairness, with a relentless focus on maintaining standards, and with the Trainee body's interests in mind.

Overall, our College has much to gain from a Trainee voice on Council. Besides the insights we can provide, I hope that the move to engage Trainees at the highest level will further help to dissolve the perceived barriers between Trainees, the College and its Fellows.

The Sir Edward Huges memorial Clinical research Prize in Surgery 2010 is open to application by all surgical residents and registrars who have entered or intend entering an accredited surgical training program. For more information see page 4.

Well done to Associate Professor Robert Pearce AM RFD

ASSOCIATE PROFESSOR PEARCE RECEIVED THE CELEBRATED WA CITIZEN OF THE YEAR, PROFESSIONS AWARD.

Associate Professor Pearce is a highly qualified and experienced reconstructive plastic surgeon. He is currently a consultant plastic surgeon at Hollywood Private Hospital where he has had a private practice since 1975.

A clinical lecturer in Surgery at the University of Western Australia and Clinical Associate Professor since 2007. He is also an Adjunct Associate Professor at Edith Cowan University and a foundation member of the Western Australian Melanoma Advisory Service. He is the Director of the Perth Melanoma Clinic which has treated over two thousand patients in WA.

Robert exemplifies integrity and commitment to his patients. He inspires those under his guidance to maximise their potential. He always finds time for his students and patients and is happy to assist colleagues and friends at all times.

Mr Peter Mott, Chief Executive Officer, St John of God Hospital Murdoch and Associate Professor Robert Pearce.

PHOTOGRAPH COURTESY OF CELEBRATE WA

2010 professional development workshops

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

AMA Impairment Guidelines Level 4/5: Difficult Cases (NEW)

19 August 2010, Sydney

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

Polishing Presentation Skills

20 August 2010, Darwin

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

Practice Made Perfect

8 September 2010, Melbourne 14 October 2010, Adelaide

This whole day workshop is a great opportunity to improve your business outcomes by developing your practice staff, giving them the tools for building strong practice processes. They will learn about the six P's of sound business and practice management; purpose, planning, promotion/marketing, people, performance and problem solving. Participants will take away a practical action plan to apply what they have learnt to their workplace.
Proudly supported by Health Communications Network

Surgical Teachers Course

21-23 October 2010, Adelaide

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 to deliver the curriculum including Adult Learning, Teaching Technical Skills, Feedback and Assessment, Change and Leadership.

From the Flight Deck: Improving Team Performance

29-30 October 2010, Melbourne

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 by Kimberly-Clark

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

professional development workshops

DATES: JULY – OCTOBER 2010

NSW
19 August Sydney
AMA Impairment Guidelines Level 4/5: Difficult Cases,
3 September, Sydney
Supervisors and Trainers for SET (SAT SET),
29-31 October, Sydney
Process Communication Model
19 November, Sydney
Occupational Medicine: Industry site visits
20 November, Sydney
Writing Reports for Court

NT
19 August, Darwin
Polishing Presentation Skills,

QLD
17 September, Sanctuary Cove
Supervisors and Trainers for SET (SAT SET)

SA
14 October, Adelaide
Practice Made Perfect
21-23 October, Adelaide
Surgical Teachers Course
17-19 November, Brisbane
Process Communication Model

VIC
8 September, Melbourne
Practice Made Perfect
11 September, Melbourne
Supervisors and Trainers for SET (SAT SET)
25-26 September / 11 November, Melbourne
Preparation for Practice (see page 16)
29-30 October
From the Flight Deck
12 November, Melbourne
Occupational Medicine: Industry site visits
13 November, Melbourne
Communication Skills for Cancer Clinicians
19-21 November, Melbourne
Leadership in a Climate of Change

WA
20 October, Perth
Supervisors and Trainers for SET (SAT SET)

Code of Conduct Breaches

The College will not process or investigate anonymous claims

John Quinn
Executive Director of Surgical Affairs

Following formalisation of how the College deals with breaches of the Code of Conduct, there have been a number of notifications of potential breaches. These have been investigated and whilst some have resulted in requests to sign a statutory declaration to agree to abide by the Code of Conduct, others have been dismissed.

Recently a notification of a potential breach of the Code of Conduct was received making very serious allegations against a Trainee. The Trainee was named, but the notification was anonymous. The College will not process or investigate such anonymous claims no matter how serious.

One of the concerns in this process has been around malicious, vexatious or frivolous complaints. This is always a danger as notifications of such matters may come to the College from various sources ranging from patients (or their relatives), nurses or other hospital staff, or doctors from all levels. However, if notifications are anonymous they will lapse. Nevertheless if a complaint is made then the identity of the notifier will not be circulated or made known, but the issue concerned will be followed up and proceed in the normal way.

Of note also is the commencement of the Medical Board of Australia (MBA) as the regulatory authority in Australia and as part of that, the legal requirement to notify to the MBA if doctors know, or ought to know, actions or behaviours whereby doctors endanger patients or break the medical practice code of conduct (more generic, but essentially the same as the College Code of Conduct). However, there are some exemptions which may be viewed at www.ahpra.gov.au/en/Health-Professions/Medical.aspx

The MBA has formally announced that they will not identify "whistleblowers", but will not look kindly on malicious claims. It should be noted that the MBA has regulatory and registration powers. It can deregister, place conditions on practice and control doctors' performance and practice overall. The College has no such regulatory authority. However, it may rescind Fellowship for serious breaches of the Code of Conduct and is bound by the regulations of the MBA concerning mandatory reporting of surgeons if practice is dangerous or harmful to patients.

The landscape with respect to monitoring of practice is changing in line with community expectations. However, whilst those notifying genuine concerns will be protected, those who make malicious or vexatious complaints will not be so treated. Those who make anonymous complaints will be ignored.

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(TGA Bulletins No.29, Apr 2006; No.28, Oct 1995)

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Easily visible markings

Disposable bulb & tubing

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2011 Professional Development Opportunities

Steven Leibman
Chair, Younger Fellows Committee

Covidien Travelling Fellowship Educational Grant, 2011

Younger Fellows face many challenges when undertaking post Fellowship studies or training. The Younger Fellows Committee in partnership with Covidien offers two Travelling Scholarships annually which can help to offset the cost of studying overseas. You are eligible to apply if you are planning to train overseas within the next 12 months, but returning to Australasia to practice. Applications will be accepted from 1 August – 30 September 2010.

Younger Fellows Leadership Exchange: AAS Academic Surgical Congress, 1-3 February 2011, Huntington Beach California

I am sure that you would have read Richard Hanney's article in previous *Surgical News* issue about his experiences in America as a delegate for the Leadership Exchange between the College and Association for Academic Surgery (AAS).

The purpose for this exchange is to provide professional development for a Younger Fellow, particularly in relationship to leadership. The goal is to promote an exchange of ideas and possible solutions for common issues affecting Younger Fellows in both organisations. It also aims to identify opportunities for our Younger Fellows to access International Clinical Fellow positions in the United States.

The Exchange covers airfares, accommodation, transfers and conference attendance expenses for the College representative. Interested Fellows are encouraged to apply from 1 September to 30 September 2010.

Younger Fellows Forum, 30 April – 1 May 2011, Adelaide SA

Last, but not least, I am pleased to inform all Younger Fellows that the development of the program for 2011 Younger Fellows Forum is well underway. Christine Lai, the South Australian/Northern Territory representative on the Committee, will convene the Forum in Adelaide with Robert Whitfield, a recent Younger Fellow.

The Forum is a channel for extensive discussion on 'hot College topics' and a chance to relax and network with your colleagues. With both convenors' enthusiasm and input from the Younger Fellows Committee, I am sure this unique opportunity to share ideas and experiences will affect your professional and personal lives. Applications are open from 1 September to 1 December 2010.

If you have any further inquiries or require more information, please contact the Younger Fellows Secretariat at Younger.Fellows@surgeons.org or on +61 3 9249 1122.

A new resource for learning anatomy

An@tomedia, a new resource for learning anatomy in a clinical context, is now available to Fellows and Trainees via the web

Mark Edwards
Censor-in-Chief

The development of this learning resource – originally published in text format – has taken many years of detailed work by Associate Professor Norm Eizenberg and his team. Beginning in 1988 with the development of a new program for teaching anatomy at Melbourne University, Norm aimed to put together a program that would encourage his students to develop an understanding of anatomical principles which could be utilised in future clinical contexts.

Through researching the education literature of the time, plus evaluation feedback from his students, he recognised the limitations of using a textbook as a learning resource. By 1991, he had begun to prepare his first CD-ROM. More recently his materials have been made available on-line.

Throughout development, the critical design factors in the content and organisation of an@tomedia is that the linking between anatomical details and clinical perspective has been extended and enhanced. This has been done by the use of:

– high quality images (e.g., radiographs, detailed dissection images from real human bodies, and graphics with coloured overlays highlighting key anatomical details),
– integration of clinical questions and answers, and
– the facility for the student to examine anatomical concepts from multiple perspectives using multiple pathways.

In the *ANZ Journal of Surgery 2006 (76; 709)* Peter Field described it as a "fresh approach to anatomy" and as a "dissection-based learning resource" which, whilst not a substitute for dissection experiences, provides medical students and surgical Trainees with access to multi-layered information through which they can learn to understand and appreciate the complexity of the human body.

An@tomedia has received highly sought awards in Australia and overseas. These include awards for their conception and development as a teaching and learning package as well as the quality of the images and as a multi-media resource.

As it is now available on the College website, the on-line application is a comprehensive, self-paced learning program that explores anatomy from four perspectives. These perspectives teach how the body is constructed (regions and systems) and how to analyse and visualise the body (with dissection and imaging techniques). The user can navigate between these four different perspectives:

REGIONS: includes surface and functional anatomy
SYSTEMS: includes conceptual and clinical anatomy
DISSECTION: includes practical procedures and post-mortem
IMAGING: includes sectional and endoscopic anatomy.

So far six of the planned nine modules have been completed. They are: general anatomy; back; abdomen; thorax; pelvis; and upper limb. The other three – lower limb, head and neck – are currently in different stages of development. The lower limb module being scheduled to be released this year.

Each module provides:

– detailed serial dissections of real human bodies
– coloured overlays of individual structures
– multiple perspectives to explore anatomy and compare
– flexibility for each individual to choose their own approach, rate, sequence and depth of learning
– interactive text, labels and clinical questions
– new concepts in anatomy and relevant clinical applications
– capacity to "build" systems, "map" regions, "dissect" layers and "trace" images
– a self learning resource with a solid educational basis, and
– a simple and consistent navigation system.

For many years Norm has been a member of the Anatomy Committee, the group which has been responsible for preparing the anatomy component of the basic sciences examination for Basic Surgical Training and, more recently, for the generic component of the early Surgical Education Training examinations. He is currently Associate Professor in the Centre of Human Anatomy Education at Monash University, Adjunct Professor of Anatomy at the University of Notre Dame and Honorary Associate Professor at the University of Melbourne.

Norm has kindly offered to work with College educational advisors, and the Speciality Boards, to further enhance the learning and teaching of anatomy, avoiding rote learning and guiding Trainees to employ a clinical, deep approach to their learning.

Protection of College intellectual property

Michael Gorton
College Solicitor

In years gone by, medical colleges have freely shared educational materials without regard to security and ownership. They were simpler times. Today, the educational environment is more complex and the need to protect the creative work of the College has assumed greater significance. "Competition" from universities, government and the private sector has increased. The College's intellectual property (IP) has greater value and commercial appeal.

The College now has a sophisticated IP Policy dealing with contributions from College staff, College communities, individual Fellows and the Specialist Surgical Societies.

The fact that the College operates a bi-national training program, and the fact that the College is answerable to the Australian Medical Council, the Medical Board of Australia and government generally, necessitates the need for the College to have control of its intellectual property relating to the training program. This intellectual property is within all our educational material including curriculum, policies, processes and all types of assessment.

The College has developed a number of policies dealing with intellectual property rights in materials created by and for the College. The latest College Intellectual Property Policy has been well circulated, and forms the basis of the relationship between the College and the Specialist Surgical Societies.

In the past, the College (and the Societies) have been less clear about intellectual property rights, and the division of ownership. Some of the material is clearly created by employees of the College or the Specialty Societies, and vests with their employer. Some material is created by Fellows, potentially as representatives of the College and/or the Societies, and issues of ownership are therefore less clear. However, the current IP Policy of the College makes it clear that the College is either the owner of, or is entitled to use, all intellectual property rights relating to education and training materials.

Intellectual Property Rights

At law generally, ownership of copyright vests with the creator. In the first instance, this is the particular individual who has created the material; although if they did so as an employee, then ownership will vest in their employer.

College Contractual Arrangements

Intellectual property rights are also governed by contractual arrangements:-

1. Under the Memorandum of Understanding (MoU) between College and the Specialist Surgical Societies, the College is the principal body for training and education (including continuing education) of surgeons in Australia and New Zealand. The Societies are "the agent responsible for the development of curriculum, instruction and assessment in the Specialty for approval by the College in accordance with the Statement of Principles".

The MoU repeats the Statement of Principles, including that "the College and the Society will respect each other's autonomy".

Clause 10 of the MoU confirms that "The Society will be responsible, through the College, for the development of agreed programs in education, training and standards of practice, health policy and any other agreed areas in relation to training and education ..."

2. The Service Agreement between College and the Societies also reflects the philosophy of the MoU and, in particular, provides:

2.1 that the "Material relevant to the Training Program owned by the College at the time of entering this Contract remains vested in the College"

2.2 that the "Material relevant to the Training Program owned by the Society at the time of entering this contract remains vested in the Society"

"The fact that the College operates a bi-national training program, and the fact that the College is answerable to the Australian Medical Council, the Medical Board of Australia and government generally, necessitates the need for the College to have control of its intellectual property relating to the training program."

2.3 that ownership of intellectual property in material (being material created pursuant to the contract) shall vest in the party or parties responsible for its creation, unless otherwise agreed expressly in writing;

2.4 that each party in whom intellectual property vests grants to the other party a perpetual, royalty free, irrevocable and licence fee free, non-exclusive licence (including the right to sub-license on the same terms) to use, copy, modify and exploit such Intellectual Property in Australia and New Zealand for the purpose of this Contract, and for the ongoing training and education activities of the other party, or as otherwise agreed.

3. As an annexure to the Service Agreement, the College's Policy on intellectual property is included as applicable to the contractual arrangements between the parties. In that policy:

3.1. The College acknowledges that the Society may wish to express and develop its own position or policies relating to its own intellectual policy. This policy is expressed to deal with the College's intellectual property.

3.2 It provides that Fellows of the College, through the College itself, or through the Society, provide pro-bono assistance and input into a range of work produced by the College. This work includes the development of curricula, policies, position statements and the development of other educational assessment material.

3.3 Work provided under the umbrella of the College means that the College (and where agreed and appropriate, the Society) has a right to publish and use these materials as required, provided such use is within the parameters defined by its key direction statement and the values and in accordance with its other agreements with the Society.

This includes work developed by Fellows of the College working within their Society when such work is developed under the direction of, or when acting specifically as an agent of, the College. Such work is described as being for the College, and therefore owned by the College.

The position is that both the Fellows who develop educational material, and the Society in the development of educational material, act as agents for the College in that development and such material therefore belongs to the College.

College's Power To License

The College is able to sub-license the intellectual property rights in its training and education materials, including curriculum materials, to others involved in the training program in Australia and New Zealand. The College has a general right to "sub-license" in connection with the College's training and education activities.

Conclusion

Accordingly, the College's need to ensure that it has control of its intellectual property rights in its training and education materials, is fully supported by the contractual arrangements currently in place.

Fellows can access the College IP Policy on the College website (www.surgeons.org). It is reassuring that the College has taken these steps to ensure that its educational and training materials are protected, and appropriately are available to all of those involved in the College's important role of training and education in Australia.

Michael Gorton is a principal at Russell Kennedy Solicitors

Happy to hear again

Deadly Ears Program

Ninety per cent of indigenous children are suffering from some form of middle ear problem

A health program in Queensland designed to reduce the incidence and severity of chronic ear disease in indigenous communities recently received State Government funding to allow it to continue to operate until 2013.

The program, called Deadly Ears, grew out of a combined push from Queensland ear, nose and throat (ENT) surgeons and Aboriginal and Torres Strait Islander (ATSI) health workers to develop a fully-funded state-wide system to tackle ear disease which is believed to affect up to 90 per cent of ATSI children.

The only one of its kind in Australia, Deadly Ears not only provides surgery for the children who need it, but also provides audiology testing to pick up impairment earlier, speech and occupational therapy for children who already have irreversible hearing loss and training for teachers of hearing impaired children.

Since its expansion in 2008, more than 3,500 children have been screened for hearing impairment, with Deadly Ears staff now having worked with 70 health services across 20 indigenous communities to provide ear health training and support. The Director of the Program, Mr Matthew Brown, said news of the continued funding had been welcome.

"Ear disease is the most significant chronic disease affecting the indigenous community with up to 90 per cent of children suffering some form of middle ear problem," he said.

"The World Health Organisation has stated that a rate of four per cent in any community is of concern, so this is very significant. Deadly Ears not only provides screening, support and education, we offer a service, at the invitation of communities, called Hospital Walking Country in which ENT surgeons, anaesthetists and nurses visit various towns to conduct the required surgery.

"So far we have assessed, repaired damage and restored hearing to more than 2000 children.

"As well as that we work with children, parents and teachers to provide strategies to help the kids make the most of the hearing they still have by advising on how classrooms can best be arranged in terms of boosting the acoustics so that children remain engaged."

Mr Brown said a key element of the program's success was both the number of ATSI staff employed and the need for an invitation by communities.

"One of the reasons for the invitation is that ear disease has become such a common problem in some places it has been normalised as a fact of life rather than as a problem that can be entirely prevented," he said.

"That is easy to understand when a number of generations have been affected, but if a community asks for our assistance they understand that it's a problem that can be tackled.

"That allows us then to work with everybody interested in dealing with the problem from kindergarten teachers, to mums-and-bubs groups, to local councillors, teachers and nurses."

One of the driving forces behind Deadly Ears is Associate Professor Chris Perry who has spent years lobbying both State and Federal Government's for the funding to address ATSI ear disease which he describes as a national disgrace.

Yet, he said, there were many pioneers before him who tried their utmost to help affected children in past decades including John Quayle, who made his first trip to the remote township of Cherbourg in 1971, Professor Bill Coman, Alan Dugdale, the Head of Paediatrics

Deadly Ears' Coordinator Sarah Boyne and Arnold Cobbo

Speech Pathologist Andrea Coleman and Aileen McKinley in Woorabinda, Queensland.

at the Mater Hospital and Dr Gerry McCafferty, a driving force behind the original outreach.

Associate Professor Perry began his visits to remote communities in 1982 and still makes two such outreach surgical visits each year.

"There have been a number of incarnations of Deadly Ears with many committed ENT surgeons participating, but each time the funding was either insufficient for the task or ran out when we'd only had a chance to scratch the surface of this massive problem.

"Ear disease and hearing impairment are the most pressing health issues confronting indigenous communities with the widest social and educational ramifications for the most vulnerable at the most important time in their lives, so that has been frustrating to say the least.

"But finally we seem to be getting somewhere and now Deadly Ears has the services of around 30 surgeons from across Queensland conducting around 17 to 20 volunteer ENT trips into remote towns each year.

"Yet it remains a complex problem because of the 90 per cent of children that have suffered hearing loss, we can only operate on five to ten per cent of the most serious cases and after careful selection because otherwise they can be made worse.

"We can't put grommets in for example if the children are then going to play in contaminated water for then they'll become deaf because of a discharge so we had to find ways to help the greater proportion of children that surgery isn't suitable for."

Associate Professor Perry said the reasons for the high incidence of ear disease in indigenous children included the presence in remote towns of tropical bacteria, overcrowding and contaminated water and said the main culprit was a suite of infections of the middle ear called otitis media, some of which cause no symptoms until the damage has occurred.

"Whenever you talk to people in these communities it's all about ears, ears, ears with daylight between ear disease and other pressing health concerns," he said.

"There you have kids screaming with pain at night and others just going quietly deaf and if they can't hear, they can't learn which adds profoundly to the lifelong impact of these diseases.

"Deadly Ears works to teach parents about hygiene, teachers to teach hearing impaired children and health workers to know how to screen and the ideal time to send these children to the ENT surgeons."

Associate Professor Perry is now in the process of lobbying the Federal Government for more on-going funding and said those Queensland ENT surgeons involved in Deadly Ears would be happy to pass on their knowledge to other surgeons or health authorities wishing to establish a similar program in other states.

One such ENT surgeon is Kelvin Kong from NSW, the first Aboriginal surgeon in Australia. He called on both State and Federal Governments to fund programs across Australia based on the Deadly Ears model but appropriate to each state's needs.

"We now know that many ATSI children have an otitis media infection by the time they are 12 months old," Mr Kong said.

"If you think of the ear drum as a musical drum, these children have ear drums filled with fluid or pus and that is what their hearing is like, like a drum filled with fluid.

"If that is not treated early, the children grow up knowing only that muffled sound, then it worsens, they can't hear at school, they become disengaged and frustrated and the rest of their lives are affected by this preventable and treatable infection.

"There is a great dichotomy in health service provision in Australia, but if there was the political will and sufficient funding this could be changed. We need to make sure the infrastructure and medical supports are in place so that kids don't slip through the net and the model of Deadly Ears, with its ATSI staff, its allied health professionals, surgeons and nurses all working within and for a community is what makes it so special.

"It would be great to see specifically funded projects in each state that follow the lead of Deadly Ears in recognising the enormous severity and impact of ear disease in indigenous communities across the country."

Mind, body and soul

How to manage when you are at the end of your tether

Dr Ina Training

There are times in our careers where we lose focus on what we are doing and forget why we became doctors. Often it is because we no longer enjoy what we do, or don't get the satisfaction from a job well done anymore. If you have read Samuel Shem's "The House of God", you'll know exactly what I mean. You get tired, frustrated, even blasé or cynical with the constant merry-go-round of the public hospital system. Disillusioned, disenfranchised, disenabled; you start to question your own sanity because you CHOSE to train in this particular vocation, in this particular system.

I am in the first few days of a two week stretch of holidays, and all I have thought about so far is why I am not enjoying my career anymore. I have been finding it difficult to concentrate at work lately, forgetting patient details for the first time in my life. We get sent on fool's errands – to get a test arranged you write form one and take it to one department, who give you form two to take to a second department on the other side of the hospital, they then give you a third form to fill in and return to another department, who then give you form one and ask you to take it back to the first department again. "There's a hole in my bucket, Delilah, Delilah...." I might as well go searching for a set of fallopian tubes.

My surroundings are blissfully beautiful; the resort I am staying in is in the rebuilt area of Patong Beach in Phuket, after the Tsunami came through and razed everything. The people are friendly and pleasant, but not pushy as I had previous experienced in Asian countries. I haven't been sleeping that well for the last few months, and have become an early riser. Each morning at 05:30, I get up and run along the beachfront, before the weather gets too hot. The humidity makes you sweat profusely, but the gentle breeze at this hour feels like the soft soothing caress of a protective parent. My arms and legs burn, and my lungs ache, but I feel more alive now, recharged. I shower, then lie on the bed to dry under the cool flow of the air-conditioner, before dressing and heading downstairs.

Patong Beach

PHOTOGRAPH COURTESY OF DEVIN KHO

"Each morning at 05:30, I get up and run along the beachfront, before the weather gets too hot. The humidity makes you sweat profusely, but the gentle breeze at this hour feels like the soft soothing caress of a protective parent."

Breakfast is supplied in the hotel, and I sit drinking bottomless cups of tea while looking out at the expansive, opulent and luxurious pool. My mind drifts and again I am thinking about running around in meaningless circles. The pool plays on my subconscious and I slowly become aware of the ripples traveling over the water. They are driven by the same gentle breeze. Initially, it looks quite chaotic with one set of ripples going one direction, and several others in different areas of the pool going others. A pattern emerges, you can't quite predict where the ripples will go to next, but you can see the flow when you follow each set. You can see that they are meant to go where they do.

This is exceptionally reassuring. I feel myself relax a little bit more. I contemplate the relationship between the ripples and the invisible guidance of the breeze. One of the last satisfying things I did at work was on a very busy cover shift; there were several sick admissions and reviews, a patient taken to emergency theatre, urgent stressful phone calls to senior staff, etc. During all of these pressing issues, I stopped to put on an anxious little old lady's slipper, which had fallen off while she was lying in bed. This is not in my job description. I do not get paid for this. But it was the most rewarding experience of my evening, a highlight in the sea of my personal hypertensive crisis. And I remember why I chose this particular vocation, this particular burden.

I thank the attentive breakfast waiters and slip out the door, back up to my room. I thank Phuket for reminding me of the resilience and beauty of humanity in the face of adversity. And I vow to continue to let the omniscient breeze guide me.

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Email: WACHSDoctors@health.wa.gov.au

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AWARDS FOR 2011

PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2011.

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 2011, 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: 27 August 2010

GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2011.

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 2011, 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.

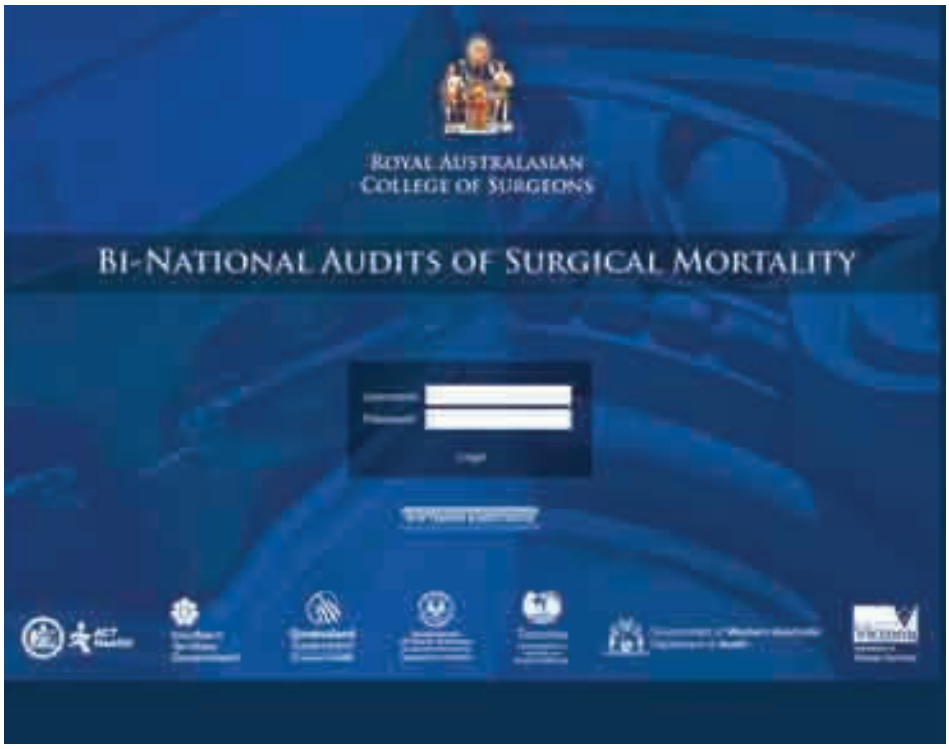
Closing Date: 27 August 2010

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

THE GARNETT PASSE AND RODNEY WILLIAMS MEMORIAL FOUNDATION



Audit of Surgical Mortality

I would like to thank you for your ongoing commitment to the mortality audit process

Guy Maddern
Chair, ANZASM Steering Committee

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) program has been operational for over eight years, beginning in Western Australia and now is operating nationally, with all states and territories contributing from 2010.

The College has a strong commitment to improve the quality of health care. I would like to make you aware of the imminent introduction of the 'Fellows Interface', an extension to the existing in-house Web-based Mortality Audit IT system (BAS). Current project staff enter audit information into BAS for case assessment purposes.

The new interface will provide Fellows with the means to enter information directly into an electronic template of the Surgical Case Form, as well as first-line assessments. This has been configured for both PC and Mac users.

The web-based Audit and Fellows Interface system ensures data security. All access to the system is controlled by user name and password. Each user's access to data is limited to their operational needs. All communication is encrypted using current industry security standards (HTTPS). All you will require is internet connection (preferably Internet Explorer 8, Safari 4 or Mozilla Fire fox 3.6) for optimum security.

Development of the interface is now complete and each regional office has undertaken rigorous testing of the system, which will shortly be deployed into a pilot phase where small groups of Fellows will begin to enter live data. You will be notified when the system is available for general use.

This new initiative will provide users with a dynamic, user-friendly tool to enter Surgical Case Forms and complete First-line Assessments online. Completing audit forms will be more convenient. The process will be more streamlined with less paperwork.

I am hoping that this initiative will benefit you as a user and will encourage your input of cases through the online system.

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The Four Hour Rule in Western Australia

Only one hospital in Western Australia has achieved its target

Jessica Yin
Western Australian Regional Chair

In an attempt to improve Emergency Department (ED) waiting times, ramping and ambulance bypassing the Department of Health Western Australia (DOH WA) introduced the four hour rule based on a model used in the National Health Service (NHS):

Definition of the Four Hour Rule:

Ninety-eight per cent of patients arriving at the ED are to be seen and either admitted, discharged or transferred within four-hours from the time of triage.

"The Four Hour Rule Program is based on a similar model used in the United Kingdom, which has been successful in delivering benefits to patients and staff" – DOH WA Gov

A group of health clinicians from WA Health visited 12 NHS sites to look at how the system worked in the United Kingdom (U.K). The policy commenced in April 2009 in the four major teaching hospitals and was progressively rolled out to the rest of the state.

The policy was to be achieved using the following strategies:

- Review and overhaul of the five tier Australasian Triage Scale (ATS) [triage system used to determine the priority for treating emergency patients].
- Enhanced use of discharge lounges
- Increasing 24 hour coverage
- Earlier consultant/senior registrar review at triage
- Increased use of General Practioners (GP) in Emergency Departments
- Enhanced roles for nurses with more 'defined' nurse practitioner roles
- Utilisation of allied health services

It has potential advantages:

- The issue of access block is formally addressed and burden shared by the whole hospital
- Theoretically speeds up delivery of specialised care by fast tracking to the appropriate unit
- "Enhancing the use of clinical judgement rather than waiting for test results

How successful has it been?

In the UK:

- Fundamental concerns still exist with the time and percentages of the 'Four Hour Rule'. The College of Emergency Medicine in the UK has suggested that 'a 95 per cent six hour target would be more sustainable, and cost effective
- Evidence suggests it may actually increase admission numbers overall and cost to health care: two million extra patients admitted through ED in England over the five year period that the 4HR was introduced with >25 per cent discharged the same day[1]

Competitive Health Knowlege System (CHKS): "there is no obvious clinical reason why growth in emergency admissions should differ between UK countries… the four hour target in England has clearly had an impact and potentially cost the taxpayer more than £2 billion"

Other concerns:

- Reduced relevance of Emergency Medicine as a profession. Rapid patient processing, less diagnostic evaluation and procedural intervention all leads to poorer training of emergency personnel.
- Reduction in the standard of emergency care delivered. "Stay and play" becomes "load and go".
- The setting of 'targets' has lead to 'gaming' of figures and the creation of "virtual beds " in CDUs (clinical decision units). These are often poorly staffed areas .
- Left to Surgical registrars to "finish the job" – to confirm the diagnosis and either commence treatment (after they emerge from theatre) or re-refer to a more appropriate specialty
- Patient perception of faster care will contribute to more presenting to ED than the GP
- Time in ED has a higher priority than patient care

"Patients are no longer known by their names or by their conditions, they're not even known by a number…patients are referred to by their time. By this I mean how long they've been in the department…as soon as a patient

ticks past three hours their name lights up like a Christmas tree…If their stay approaches three hours 30… the managers start to appear… they don't actually care…about Mr Jones who is having a heart attack…he's got to go, wherever it may be, as long as it's not ED…"(UK Medical Student 2008)

In Western Australia:

Despite the statement that the policy will be more successful in WA due to better resourcing we have seen the following:

- Only one hospital (Princess Margaret Hospital for Children) has achieved its target
- Admissions have increased (as have discharges of patients the next day)
- Patients are often admitted before results of investigations are known
- The workload for Surgical Staff has increased significantly
- Surgical Registrars are particularly disadvantaged since they often cannot see a patient within the prescribed time frame and often emerge from theatre to face a barrage of admissions
- If they are on call for a number of hospitals (as are the smaller surgical specialties) they are often woken several times a night as patients approach the four hour limit.
- If admissions are inappropriate or badly managed the surgical team will have to "tidy up" or re-refer patients themselves. There is no avenue to feedback to ED directly and patients cannot be returned to ED if a mistake has been made.
- A culture of clock watching is already pervading EDs
- There is a growing alienation between ED and surgical staff
- In WA both the immediate past and current State Presidents of the AMA are ED physicians supportive of the four hour rule.
- WA has a liberal government. The four hour rule is considered by the National Labor Health department as a good thing. Therefore we have seen little criticism of the policy from the Opposition Health Spokesman

The Final Word:

As many may be aware the four hour rule has recently been scrapped in the UK following the report on the Stafford Hospital showing multiple failures of the trust with associated increased morbidity and mortality. [2,3]

We can only hope the same resolution occurs in WA before we too see the same increase in poor patient outcomes.

1.Emerg Med J 2006;23:2 doi:10.1136/emj.2005.031948

2. www.cqc.org.uk/_db/_documents/Investigation_into_Mid_Staffordshire_NHS_Foundation_Trust.pdf

3. www.guardian.co.uk/society/2009/mar/17/nhs-hospital-mid-staffordshire-findings

Kelvin Kong speaking to students about surgery as a career

Surgery as a career

Interest in the College's Indigenous program to explore surgery as a career has already attracted 24 Aboriginal medical students and doctors

Kelvin Kong
Chair, Indigenous Health Committee

Thanks to fundraising by Foundation Board for Surgery member Dr Michael McAullife, Aboriginal and Torres Strait Islander doctors and medical students will learn more about surgery as a career at the annual symposium of the Australian Indigenous Doctors' Association (AIDA). The Foundation for Surgery is providing funds to support the efforts of the Indigenous Health Committee (IHC) to promote surgery as a career to Indigenous communities at the AIDA symposium.

A College surgical career expo will inform Aboriginal doctors and medical students attending the annual symposium of AIDA in Launceston in October., Members of the IHC and local Fellows will be available to talk about surgery and the Mobile Surgical Simulation Unit will be on site for students to trial their laparoscopic surgical skills.

The funding was made possible by the efforts of Dr Michael McAullife who conceived and organised the inaugural Foundation for Surgery Bike Ride. The ride was held in Ipswich, Queensland in April and the 66 riders, mostly Fellows, raised an impressive $9,000.

The College's program to promote surgery as a career to Indigenous communities has already attracted 24 Aboriginal medical students and doctors from across Australia. Many of these students and doctors will be in attendance at the career expo, providing the first opportunity to engage as a group and with the Committee.

The Committee is very grateful to the Foundation for Surgery and especially to Michael McAuliffe, for his support of this program and to the College for its commitment to advancing the status of Aboriginal and Torres Strait Islander people in the medical profession. It is hoped that our programme will be successful in converting Indigenous interest in surgery as a career into Trainee applications and future surgeons.

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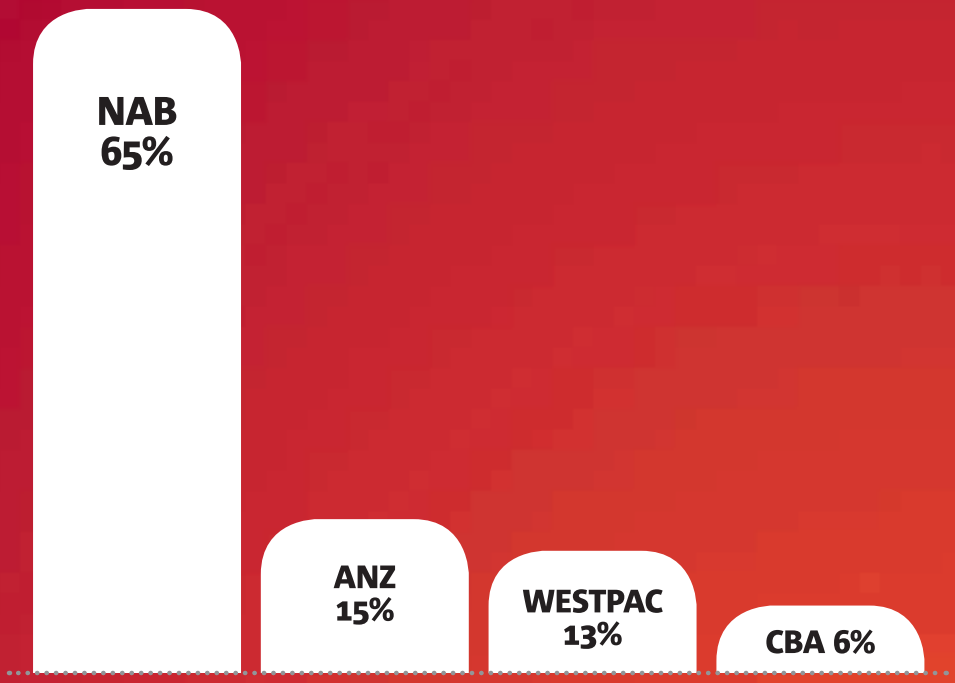

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Congratulations on your achievements

Erwin Thal - Honorary Fellowship

Citation by Michael Hollands

Erwin Thal receiving his Honorary Fellowship from Ian Gough

Erwin Thal is a great friend of this College and has made an enormous contribution to the care of injured patients in Australia and New Zealand. He is Professor of Surgery, Trauma, Burns and Critical Care at the University of Texas, Southwestern Medical School.

He studied medicine at Ohio State University School of Medicine and served his internship and general surgical residency at Parkland Memorial Hospital in Dallas, Texas. He joined the staff as an instructor in the Department Of Surgery and a year later, in 1970, was appointed Head of the Surgical Emergency Room. He became Associate Professor of Surgery in 1975 serving in this capacity until 1982 when he was appointed Professor of Surgery. He chaired post-graduate education in his department from 1981 until 2001.

Erwin's list of publications is extensive. His first paper, on arterial injuries, appeared in 1971. Erwin has contributed to over 40 book chapters and authored four books. He has served as a consultant reviewer for the *Journal of Trauma* and *Archives of Surgery* and was Editor of *Postgraduate Surgery* from 1989 until 1992.

Erwin has served on many university, hospital and college committees over the years, reflecting his interest in surgical education and trauma/acute care surgery. Erwin joined the American College of Surgeons Committee on Trauma in 1981, remaining a member until 1994 and served as Chair between 1986 and 1990. He was Vice President of the American Association for the Surgery of Trauma, and of the Western Surgical Association. In 1980 Erwin joined the Advanced Trauma Life Support Faculty serving in various capacities up to the present. He was Governor of the North Texas Chapter of the American College for six years between 1998 and 2004.

He has received many honours throughout a long and productive career. These include a Distinguished Service Award from the American Trauma Society and an Outstanding Service Award from the American College of Surgeons. He was appointed the Scudder Orator in 1992, his presentation was entitled "Out of Apathy". In 2000 he was the Minnie Stevens Piper Professor recognising "superior teaching" at college level. In 2000 he was the visitor for the Military Section at the Annual Scientific Congress (ASC) presenting four excellent papers on the care of injured patients.

He has made substantial contributions not only to surgical education and trauma but also to his community especially the American Red Cross.

Training in trauma care

It is Erwin's many contributions to trauma care in Australia and New Zealand that this Honorary Fellowship seeks to recognise. Many Australasian surgeons have visited Erwin's unit at Parkland. As Chair of the Committee on Trauma (CoT), Erwin played a major role in the successful negotiations between the CoT and the College which led to the promulgation of the Advanced Trauma Life Support Course in Australia and New Zealand. Erwin was a member of the faculty of initial Provider Course and the subsequent Instructor Course in 1988. Locally known as Early Management of Severe Trauma (EMST) it is now an integral part of the training of all surgeons in Australia and New Zealand.

A decade on, Erwin worked with a multinational faculty including Stephen Deane to develop the Definitive Surgery for Trauma Care Course, a course devoted to teaching advanced surgical techniques in trauma care. He continues to teach the course all over the world with his Australian and New Zealand colleagues. Now run by International Association for Trauma and Intensive Care (IATSIC), the course is taught in nearly 20 countries around the world.

Erwin's other major contribution to the care of injured patients in Australia and New Zealand was to trauma verification. Erwin was committed to the holistic care of injured patients. This meant not only their surgical care, but also a full understanding of the trauma system, and the hospital trauma service. He played a major role in developing a verification program for trauma units attesting to their overall ability to care for injured patients. He was a member of the CoT's trauma verification committee from 1988 until 1995 and remains a senior reviewer for that program. Working closely with Peter Danne and Damien McMahon Erwin, he assisted in developing a trauma verification program here in Australia and New Zealand.

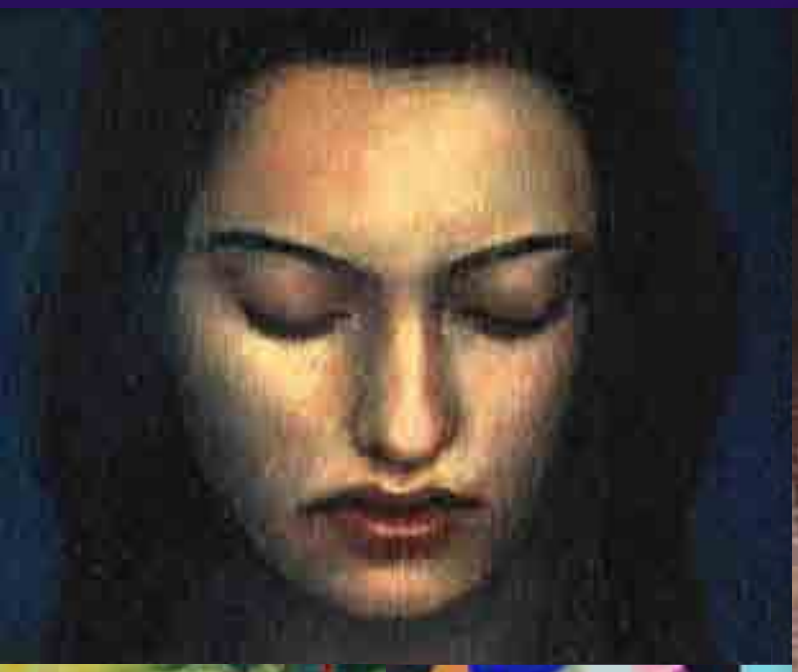
Erwin's many contributions to the care of injured patients worldwide, and especially his contribution in Australia and New Zealand, make him a worthy recipient of Honorary Fellowship of the Royal Australasian College of Surgeons.

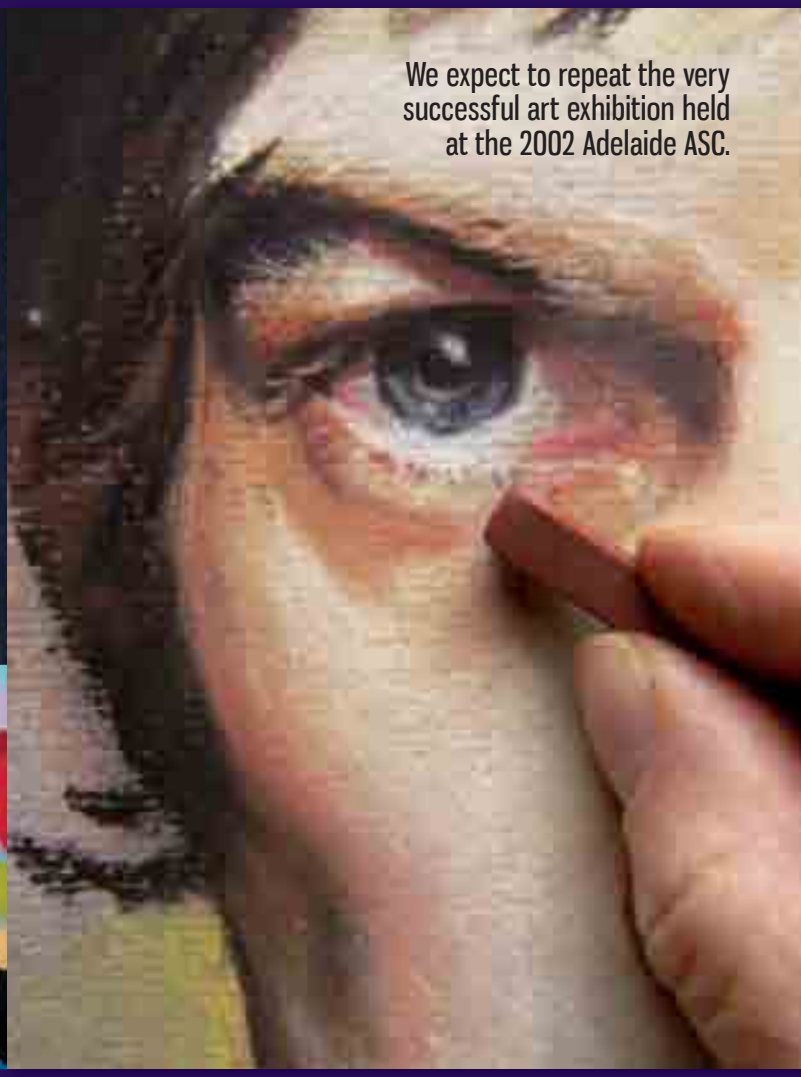
CALLING CREATIVE SURGEONS

Do you have an *artistic* hobby?

Like painting, photography, glass blowing, sculpture, woodwork, ceramics or jewellery making. If so and you'd like to take advantage of this opportunity please contact Lindy Moffat

lindy.moffat@surgeons.org





We expect to repeat the very successful art exhibition held at the 2002 Adelaide ASC.

Space has been reserved at the Adelaide Convention Centre for Fellows to display artworks for purchase or for display.

THE ASC RETURNS TO ADELAIDE IN 2011 – *a city with a fine reputation for the arts.*

ADELAIDE ASC & THE ARTS

Nominations for the John Corboy Medal

It is once again time to invite nominations for the prestigious John Corboy medal

Greg O'Grady
Chair, RACSTA

The John Corboy medal is the only College medal for Trainees, and is awarded up to annually at the Annual Scientific Congress. The award is named for Dr John Corboy (1967-2007), who selflessly devoted his time and wisdom in energetic services to the College, despite personal adversity.

All current Trainees are eligible for the medal, and nominations are welcomed for any Trainee having demonstrated outstanding achievements inside or outside of surgery. It is desired that the nominee will show some or all of those qualities for which John was particularly admired: leadership, selfless service, tenacity, and service to fellow Trainees.

In addition to awarding of the medal, the recipient will also be invited to present at the Trainees Forum at the College Annual Scientific Congress (ASC). This tradition was started in fitting fashion by the inaugural recipient of the John Corboy medal, Dr Matthew Peters, a plastic surgical Trainee in Brisbane. Dr Peters was awarded the 2010 John Corboy Medal at the Perth ASC for his five years of outstanding service to the College, in which time he has become a forthright and highly respected advocate of Trainees within the College. Dr Peters has played an integral role in improving the profile of Trainees in the College, particularly through his substantial contributions to leading the Royal Australasian College of Surgeons Trainees' Association (RACSTA) from 2008 to 2009.

We are looking forward to hearing reports about all those highly talented Trainee achievers out there, so please do not hesitate to nominate a Trainee who you think might be deserving of this award.

Please contact Fiona Bull (fiona.bull@surgeons.org) for details on how to make a nomination.

Extended format for Occupational Medicine Course

Edward M Schutz
Convener, Occupational Medical (Bridging) Course for Surgeons

The Occupational Medical (Bridging) Course for surgeons is proving very successful. Building on the success of visits to the Ford Assembly Plant, Melbourne and the Coal Services Training Facility, New South Wales, the half day program is being expanded to a whole day format. Participant feedback has indicated that this format is preferable as it will enable surgeons to visit two or three factories in one day.

During the visit, participants observe first hand the challenges that patients face when returning to work. In addition return-to-work co-ordinators and worksite doctors provide a comprehensive overview of the return-to-work issues that are experienced by each industry.

Site visits are being organised for 2010 so note these dates in your diary:

- Melbourne, Friday 12 November
- Sydney or Wollongong, 19 Friday November

The location of the visits is currently being finalised and details will be available soon. If you would like to register for the course, have an industry connection or would like to help organise a visit, please contact the Professional Development Department. Email: PDactivities @surgeons.org or call +61 3 9276 7441.

Surgical training overseas

Mr Eng Hooi Ooi enjoyed the chance to work within a different culture and health system

Learning the skills to be able to conduct both endoscopic and open surgery to treat tumours arising from the sinuses and brain was the greatest benefit to flow from a University of Toronto Rhinology Fellowship according to Adelaide Otolaryngology surgeon Mr Eng Hooi Ooi.

Mr Ooi spent a year in Toronto from June 2009, an opportunity made possible through the financial assistance provided via the College's Margorie Hooper Scholarship which funds Fellows and Trainees from South Australia wishing to further their training overseas.

Mr Ooi worked in Toronto under the supervision of Professor Ian Witterick, a rhinology expert and vice-chair of the Department of Otolaryngology Head and Neck Surgery at the University of Toronto. He also spent time with Dr Allan Vescan, another experienced endoscopic skull base surgeon.

Over the course of the year he divided his time between Mount Sinai Hospital, Princess Margaret Hospital, Toronto Western Hospital and St Joseph's Health Centre, each of which specialised in either a particular type of surgery or technique.

"Toronto has become renowned in recent years for the Head and Neck and Skull Base surgery conducted there through the dynamism of the department of Otolaryngology surgery at the University and the leadership of Professor Witterick," Mr Ooi said.

"It has an active academic program with weekly grand rounds for the entire department with a topic comprehensively presented by residents, faculty staff or invited visiting academics.

"There are also weekly head and neck tumour board meetings where difficult cases are discussed from various hospitals and it seemed to me that it would be a significant advantage to follow such a system in Adelaide with staff from the Royal Adelaide Hospital and the Flinders Medical Centre meeting to discuss complex cases."

Mr Ooi said that over the year he performed anterior craniofacial resections, orbital exenterations, and treated a large number of other head and neck cancers including thyroidectomies.

Eng wtih his family at Niagara Falls

His endoscopic skull base surgery involved the repair of brain fluid leaks and the removal of sinus cancers, pituitary tumours and brain tumours such as meningiomas and craniopharyngiomas.

"It was this combination of rhinology and head and neck surgery that was of greatest value in that generally rhinologists are experienced with endoscopic approaches whereas the head and neck surgeons are experienced with open approaches and I thought it would be valuable to have experience in both," Mr Ooi said.

"Working alongside both specialists meant that I was able to learn the skills needed to be able to tailor the surgical approach to the patient's pathology rather than offering only one type of surgery."

Mr Ooi said that while he had particularly relished the chance to learn new skills he had also greatly enjoyed teaching and mentoring the Otolaryngology residents and acting as a faculty member for several sinus surgery courses.

"It has an active academic program with weekly grand rounds for the entire department with a topic comprehensively presented by residents, faculty staff or invited visiting academics."

With the support of Professor Witterick, Mr Ooi also attended a number of meetings including those of the American Rhinology Society, American Academy of Otolaryngology Head and Neck Surgery, the North American Skull Base, World Congress on Thyroid Cancer and the World Congress of the International Academy of Oral Oncology.

He said he had enjoyed the chance to work within a different culture and health system and said he would not have been in a position to take up the Fellowship and support his wife and children in Canada without the Scholarship provided through the College.

"The support of the Margorie Hooper Scholarship was extremely valuable in allowing me to take up this opportunity as the salary of a fellow there is not sufficient to get by in Toronto," he said.

"I was both delighted and surprised to receive it and we had a great time, my two sons enjoying the experience of going to school in a different country and climate and we have agreed that this was the best year of our lives," he said.

The Scholarship has been made possible through a generous bequest from the late Margorie Hooper of South Australia and carries a stipend of $65,000.

Donald Murphy giving a tour of the skills lab

Discussing the Australian health system

Young American leaders visit the College

Fostering international ties between younger politicians, political staffers and lobbyists

Keith Mutimer
Vice President

Eight delegates from the United States, touring Australia as guests of the Commonwealth Government, visited the College on 21 June to learn about Australia's health system and, in particular, the advocacy efforts of the College.

Part of a global program to foster international ties between younger politicians, political staffers and lobbyists, participating countries also include the United Kingdom, Japan, Vietnam, New Zealand, Papua New Guinea and the Philippines.

The visiting Americans were addressed by the College's Director of Relationships and Advocacy, Mr James McAdam, himself a former delegate to the United States. The College CEO, Dr David Hillis, also spoke to the delegates.

The visitors were given a broad overview of Australia's political system and the ways in which it resembled, and differed from, that of the US. They were also told that, like its political arrangements, Australia's health system is something of a hybrid, with features reminiscent of disparate systems around the world.

The meeting then explored the structure of Australia's health system as well as the many advantages and challenges it faces. These included closing the life expectancy gap between indigenous people and the broader Australian population, the inadequate provision of mental health and the sometimes long delays patients face in accessing emergency or elective care.

The delegates were interested in drawing comparisons between their own health system experiences and that of Australia with a view to understanding potential solutions that may reap benefits in their own jurisdictions. The discussion was lively and engaging and many perceptive questions were asked.

After the presentation, delegates were given a guided tour of the College and its Skills Centre by its Clinical Director, Don Murphy.

The College was pleased to host:

The Hon. Vicki Englund, Missouri House of Representatives (Democrat).
The Hon. Michael J. Moran, Massachusetts House of Representatives (Democrat).
The Hon. Rahn Mayo, Georgia House of Representatives (Democrat).
The Hon. Anna Tovar, Arizona House of Representatives (Democrat).
Ms Alicia Hughes, Alexandria City Council, Virginia (Republican).
Mr Jeffrey Rabren, Office of the Governor of Alabama (Republican).
Ms Jennifer Spall, Senior Public Affairs Manager, Wal-Mart Inc. (Alaska, Oregon and Washington).
Ms Jessica Monroe, Director, State Government Affairs, Johnson & Johnson (Alabama, Louisiana, Mississippi and Tennessee).

Surgical workforce 2009 – a call to arms

Dear Editor

Keith Mutimer's article in *Surgical News* (Vol:11 No:5, Page 5) and the College 2009 census of surgeons makes for sobering reading indeed, especially for paediatric surgeons likely to be in practice for the next 10 to 20 years.[1, 2]

Whilst the Vice President highlights some of the key issues confronting paediatric surgery in particular which arise from the report, there remain several important additional points. First, paediatric surgery remains the College's smallest speciality, representing just two per cent of the Fellowship compared to 34 per cent for general surgery and 26 per cent for orthopaedic surgery. Disappointingly, the situation would appear to be further exacerbated by the fact that paediatric surgery was the only one of nine specialities by examination which has failed to increase its workforce per 100,000 population in the last five years. In New Zealand, the number of surgeons has actually declined.

That two per cent of the Fellowship will not be able to provide all general surgical, urological, trauma and burns care for 20 per cent of the population would appear self evident.[3] Indeed, to achieve the same population ratio as general surgery to those aged over 15 years would require an immediate, but equally implausible quadrupling of the number of paediatric surgeons. [2, 3]

These statistics should alert our colleagues with a general surgery fellowship, especially in metropolitan areas, of the need to continue to provide at least a proportion of the standard surgical care required for school-age children and adolescents. This issue has already been clearly identified in the United Kingdom, with moves to incorporate a period of paediatric surgical training for general surgery trainees as one approach to promoting the surgical care of children in district and non-paediatric teaching hospitals.[4] Within their own institutions our colleagues need to be convincing advocates for the local surgical care of older children and adolescents with appendicitis, minor lacerations and abscesses. Surgeons need to counter the administrative temptation to transfer these patients, together with the costs and responsibilities of their care, 'elsewhere', for their paediatric surgical colleagues to manage.

Secondly, our speciality enjoys a far higher proportion of female consultants, 22 per cent in Australia and 27 per cent in New Zealand, compared to just 11.6 per cent and 3.6 per cent in general and orthopaedic surgery respectively. As some may chose to work part-time, perhaps more than their male compatriots, this has clear implications on the actual number of potential new consultant colleagues that need to be trained and then gainfully employed.[5] Anecdotal data from current students and residents suggests that our future consultant colleagues will expect a more even approach to balance between life and work, with the need to modify traditional work patterns and practice styles.[6] Perhaps the next census could better address this issue by reviewing current and preferred full time equivalent employment status of fellows rather than focusing on the split between private and public work?

Finally, that 57.8 per cent of paediatric surgeons perceive their level of on-call work as heavy or extremely heavy, compared to 30.4 per cent and 25.7 per cent of general and orthopaedic surgeons, should serve as a clarion call to the College and Fellowship for urgent action if the high standards of surgical care provided for our children are to be maintained.

Yours sincerely,
Andrew Holland
New South Wales Paediatric Fellow

Relationships & Advocacy

The 2009 Census Findings… enclosed

Keith Mutimer
Vice President

As you are aware the College census of the Australian and New Zealand surgical workforce was conducted in 2009. An excellent response rate of just over 80 per cent was achieved, providing a robust data set and a valuable tool for advocacy. Under the strong leadership of my predecessor as Vice President, Dr Ian Dickinson, the data was refined to provide illustrative findings in an easy to read format. I would like to take this opportunity to thank you for taking the time to participate in this important project and I am pleased to release the findings in this edition of *Surgical News*.

The Surgical Workforce 2009 report covers Fellowship, Working Patterns and Aging and Retirement Plans. Your responses regarding the issues of work-life balance and workplace stressors will be explored through *Surgical News* articles. For example, you may recall that a census related article, "Threat of Litigation – An Unavoidable Stress?" was published in the last edition of *Surgical News*.

Key Findings

Workforce

Key findings in the Surgical Workforce 2009 report included an overall increase in the number of surgeons per population across Australia and New Zealand. In Australia the ratio has changed from 1:6000 in 2005 to 1:5000 in 2009. In New Zealand the ratio changed from 1:7000 in 2005 to 1:6000 in 2009.

These ratios are attributable to increased numbers of active surgeons in both Australia (up 167 per cent) and New Zealand (up 150 per cent) between 2005 and 2009. Of note is the increased number of women in the surgical workforce (up 61.5 per cent in Australia and 42.9 per cent in New Zealand). On a yearly average, one female entered surgical practice for every 36 males between 2005 and 2009.

On a more sobering note, nearly a quarter of Fellows intend to retire from public on-call within the next five years.

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Correction

The Younger Fellows article (Vol: 11, No: 6, page 20) last paragraph should have read – "I hope at least some of our recommendations will appear in future editions of council highlights."

Dear Mr Andrew Holland
I concur with your summation of the escalating problem which exists in both metropolitan and regional Australia and New Zealand in respect to the management of children and adolescents with surgical problems.

There are many complex inter-related issues which exacerbate this work force problem. General surgeons and urologists, despite having a training syllabus containing significant sections on the surgical care of children and adolescents appear reluctant to be involved in this area. This is due in part to the increasing work load for these specialities in caring for the ageing population. In addition some of the training positions previously reserved for general surgeons in paediatric units are now being used for training paediatric surgeons. Many recent Fellows from these specialities have no confidence in managing common paediatric and adolescent problems. Paediatric units have become the after hours repository for many older children and adolescents whom could and should be managed by general surgeons and urologists.

A classical example is a recent report where a urology registrar refused to see a 95 kg 16-year-old with an acute scrotum and demanded that this patient be transferred to a paediatric unit some distance away where the patient was assessed and managed by a paediatric surgical registrar who had in fact no experience in a "child" of this size.

Despite increasing the number of paediatric surgical Trainees (there were eight Trainees in 2000 compared to 24 in 2010), there has been no significant increase in the number of consultant positions in the public hospitals. The surgical workforce figures demonstrate that paediatric surgeons give more time to the public hospital system than any other speciality spending more time in public consulting, public ward work, public administration and teaching. In addition there are now less paediatric surgeons to provide greater supervision for the increasing number of surgical trainees and medical students.

I am encouraged by Keith Mutimer's comments in the June Surgical News where he explained that "The College now has a clearer awareness of the current gaps in the surgical workforce and areas of current and future need." The Australian and New Zealand Association of Paediatric Surgeons look forward to being invited by the College to assist them "to develop plans that can be taken to the Australian and New Zealand Governments.

Yours sincerely,
TONY SPARNON
President
Australian New Zealand Association of Paediatric Surgeons

Order of Australia

Congratulations to Rowan Nicks who was appointed an honorary Officer (AO) in the General Division

"For service to medicine in the field of cardiothoracic surgery and by providing training and education opportunities for young Indigenous and international surgeons in Australia."

Dr Rowan Nicks, respected cardiothoracic surgeon, pioneered many operations for congenital and valvular heart disease, and in 1957, was involved in the first case of open-heart surgery in New South Wales. In the early days of open-heart surgery, he established safe use of cardiac bypass techniques and assisted in developing pacemaker surgery in Australia. He designed the first automatic pacemaker.

Following his retirement from clinical practice in 1973, Dr Nicks spent much time and energy teaching and working in Africa, India and South-East Asia.

Dr Nicks is a highly respected member of the Royal Australasian College of Surgeons. In 1991, he established and financed a scholarship program that provides opportunities for young surgeons from developing countries, who show surgical ability and leadership qualities, to learn skills alongside Australian surgeons before returning to their communities to develop and promote their knowledge.

Recently, in association with the University of Sydney and the family of the late Russell Drysdale, he established the Rowan Nicks Russell Drysdale Fellowship. This has been an inspirational scheme to encourage the development of future leaders in Australian Indigenous health and welfare.

The beginning of an eye program in Samoa

Given the small population it is possible to set up an efficient and effective eye program

Tasmanian ophthalmologist Dr Nitin Verma, recently awarded an Order of Timor Leste and an Order of Australia for his work in establishing the East Timor Eye Program, has entered preliminary negotiations to establish a similar project in Western Samoa.

Dr Verma and a volunteer team of eye specialists including his optometrist daughter Miss Surabhi (Sib) Verma, worked in Samoa in June as part of the College's Pacific Islands Project, following a request from the National Health Service. While there the team saw more than 100 selected patients and conducted 83 operations to treat cataracts and pterygium, a growth over the surface of the cornea caused by exposure to sunlight and wind and the consequent drying of the eye. Dr Verma said all surgeries were successful and gave particular praise to the local eye care nurses who assisted the team at the Apia hospital, Mrs Line Auriese and Mr Sua Mailie.

"The eye Clinic at the General Hospital in Apia was very well organised and the level of pre-screening conducted by both Mrs Auriese and Mr Mailie was excellent. Their choice of patients for surgery was appropriate and the advice they gave to patients post-operatively as well as their plans for follow-up care for these patients was very satisfactory," he said.

"I have seen eye-care nurse practitioners in many countries and have found that those in Apia were perhaps the best and because of their efforts we had some spectacular results like those that we'd expect to achieve in Australia."

Dr Verma said that many of the patients who attended for treatment were suffering advanced disease with some people made completely blind from either cataracts or pterygia. Therefore, he said, the impact on the sight-restoring surgery upon their quality of life was considerable.

"One of the patients was a local general practitioner who was having problems carrying out minor surgery and he underwent phacoemulsification with insertion of a flexible intraocular lens with a very good result. He had been referred to New Zealand for surgery so we were pleased to be able to carry out his treatment in-country," he said.

"Cataract surgery is known to be one of the most effective interventions in medicine and given the fact that most of the disease was advanced, with patients virtually or totally blind, it was greatly rewarding to do this work to help the people of Samoa."

Pterygium causing blindness as it has grown over the cornea.

Dr Verma said that plans were now underway in consultation with the Samoan Ministry of Health to establish a comprehensive eye program linked to the limited services which currently exist, possibly based on the model established to help the people of East Timor.

"The basic principles would be the same. We would offer training to assist with manpower, volunteers from Australia to provide a regular presence to make sure the backlog of patients does not become insurmountable, while advising the health authorities on the infrastructure required," he said.

"Western Samoa has a population of about 180,000 people. The prevalence of cataracts and pterygia as well as diabetic eye disease is high but given the small population and easy accessibility to health care facilities on both islands of Samoa, it is eminently possible to get rid of the backlog of cases and help set up an efficient and effective program.

"We would help set up the equipment needed and offer training in the use of it and then, as in East Timor, step back and allow them to provide the surgeries and eye care to their own people."

Other members of the team who participated in the June visit to Samoa included Dr Michael Haybittel, an ophthalmologist from Burnie, Tasmania, Mrs Andrea Shuurmans, a nurse from the Royal Hobart Hospital and Dr Robert McDonald, an ophthalmologist from Sydney. The team was supported by Mrs Jane Haybittel and Mrs Anu Verma. Dr Verma said the team took over consumables generously provided by pharmaceutical companies Alcon, Bausch and Lomb and praised the international projects team at the College for the well organised visit.

Well-oiled machine

When asked what it was like to work alongside his daughter Dr Verma said: "We've done this many times now so it is no novelty for us. It simply means we work together like a well-oiled machine."

Sib Verma said she enjoyed working with her father on such outreach visits given that she now lived on the Australian mainland while her father worked in Hobart.

"I started going on dad's outreach trips when I was still in my teens and have participated as a team member for the past six years. His volunteer work has always been an inspiration to me so it was probably not surprising that I ended up deciding on optometry given that it combines my interest in public health and eye care," she said.

"It could be tricky working alongside a member of the family but we work well together and it's nice to have the chance to spend time with each other while helping other people."

The 8th Cowlishaw Symposium

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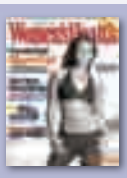

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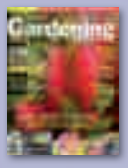

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Memorabilia of Sir Sydney Sunderland

In 1952 Sir Sydney was elected to Honorary Fellowship of the College

Mike Hollands
Honorary Treasurer

Late in May 2010 the College was presented with two pieces of memorabilia relating to Sir Sydney Sunderland. Sir Sydney was one of the most eminent men in Australian medicine, and for an older generation of Fellows he will need no introduction.

Sir Sydney is best remembered as a brilliant medical administrator. He was a member of numerous government and academic boards, most prominently as Dean of the Faculty of Medicine at the University of Melbourne 1953 - 1971 and as a member of the University Council 1951 - 1967. But in practice he was a neurologist, with a special interest in the peripheral nerves. In taking up this field of research he was influenced by several outstanding identities, most notably Frederic Wood Jones, Hugh Trumble and Sir Hugh Cairns.

Sydney Sunderland was born in Brisbane on 31 December, 1910. He began a science course at the University of Queensland in 1930, but came to Melbourne in order to pursue a degree in medicine. His undergraduate career was stellar, coming top in every year and graduating MBBS as top in medicine in 1935, having been awarded numerous prizes and exhibitions along the way. He joined the Faculty of Medicine at the University of Melbourne in 1939, when he succeeded Wood Jones as Professor of Anatomy, a position he held until 1961. In that year he was appointed Professor of Experimental Neurology, holding this position until 1975.

He was at Oxford when war broke out in 1939, but managed to return to Melbourne. During the War, in addition to his academic duties, he was put in charge of the Peripheral Nerve Injuries Unit at 115 AGH Heidelberg. The results of his work on gunshot wounds to the nerves were published as a series of clinical studies in 1944 - 45. His classic work *Nerves and Nerve Injuries* was published in 1968. He gained his Fellow of the Royal Australasian College of Physicians (FRACP) in 1941.

He was awarded many honours and distinctions in the course of his long career. In 1952 he was elected to Honorary Fellowship of this College. He received honorary degrees from the Universities of Melbourne, Monash, Queensland and Tasmania. He was appointed CMG in 1961, and created Knight Bachelor in June 1971. In the early 1980s the international Peripheral Nerve Study Group renamed itself The Sunderland Society in his honour. Sir Sydney died on 27 August, 1993.

The two pieces of memorabilia, a plate and a bowl, were donated to the College by Don Grant, a psychiatrist and Adelaide graduate. He acquired them several years ago at a suburban auction in Melbourne. Neither piece had attracted any interest, but Dr Grant felt that items associated with someone as eminent as Sir Sydney should not be left to languish, so he bid a modest sum and claimed them. On 6 May, Dr Grant attended a lecture by the Curator on the College of Surgeons Museum, one of a series of lectures on the medical collections of Melbourne presented at the University of Melbourne. As a result he decided to offer the pieces to the College, feeling that this would be a more appropriate home for them, and the offer was gratefully accepted.

The plate is a plain circular dish 27.7cm in diameter, made of pewter. In the centre is inscribed:
Sir Sydney Sunderland
Visiting Professor in Hand Surgery
to the Raymond M. Curtis Hand Center [sic]
The Union Memorial Hospital
Baltimore, Maryland
In Recognition of Your Contribution to
Surgery of the Hand
1981

“His undergraduate career was stellar, coming top in every year and graduating MB BS as top in medicine in 1935, having been awarded numerous prizes and exhibitions along the way.”

The bowl is also plain, 23.1cm in diameter and 11.4cm high, made of pewter. On the outside is the inscription:
ToSir Sydney Sunderland, M.D.
With Appreciation,
Tenth Anniversary
Surgery and Rehabilitation of the Hand Symposium
Philadelphia, Pa., March 1986

It is interesting to note that in his later years he was acclaimed as a leader in the surgery of the hand, even though he was not a surgeon. His major contribution to the repair of the hand was his long-term studies of the recovery of sensorimotor function.

These significant pieces, associated with an Honorary Fellow of the College, will be put on display in the Hailes Room.

By Geoff Down, College Curator

Prepared for trauma

Samoa was able to set up an effective system after the tsunami due to the skills learned at the Primary Trauma Course

Last year, the serendipitous timing in the provision of AusAID -sponsored, College-managed trauma training to Samoa assisted local medical staff to cope with the unprecedented stresses caused by the September 30 tsunami that devastated the small island nation.

The emergency response plan that grew out of the trauma course - now known as the "Savaii model" after the Samoan island upon which it was developed - enabled the Samoan health authorities to set up an effective triage and management system before international aid arrived.

It was defining moment for the local people as it represented the first time that international medical teams could start work immediately within a crisis management system already in place.

Such has been the enthusiasm in Samoa for the success of the Savaii model, that this year two more Primary Trauma Courses (PTC) have been held there to provide further training to a broader range of emergency responders such as fire officers, police and remote clinic nurses.

The wider professional selection was made this year because medical personnel are not always the first on the scene at many accidents, given that Samoa does not have a national ambulance system.

The main course presenters this year were Dr Loudeen Lam and Dr Tapa Fidow, both local surgical registrars, and Dr Bryce Curran, an anaesthetist from New Zealand, with the training provided at the Tuasivi Hospital on Savaii.

The PTC program was developed to provide affordable emergency and trauma skills to health workers in developing countries, presenting similar principles to the Advanced Trauma Life Support (ATLS) program.

Dr Curran said it was particularly effective because the skills taught could be applied to any situation, and any patient, and gave people a common language of emergency response through-out the world.

He said this was his third international trip to teach the course, and his second to Samoa.

"The best part of this education package, is that the PTC combines both knowledge and experience for the participants who get a chance to practice the theory of resuscitation in a range of well-developed scenarios.

"People's imaginations were captured in Samoa by their capacity to cope with the tsunami so this year we provided an hour-long disaster simulation session on how to manage mass casualties."

Dr. Curran said the main techniques presented in the course were in stabilising patients, managing air-ways, breathing and circulation, otherwise known as the ABC of trauma care.

He said that in the absence of a national ambulance service, the transport of trauma patients was mostly undertaken by nursing staff while remote clinic nurses were also frequently the prime responders.

"This year we particularly focussed on their needs in terms of teaching the participants how they can start to treat patients from the minute of their arrival," he said.

"We go into that in great detail; what to look out for, how to treat shock, how to recognise internal bleeding.

"We also looked more broadly at what local disaster management plans might look like.

"Both aspects empower people and give them the skills and the confidence to know they can cope with what can be infrequent but frightening events."

Dr Curran said the PTC course was also of great value in that it encouraged team building and boosted networking opportunities between local health workers in different parts of the country.

"The people of Samoa are fantastic and hugely enthusiastic and keen to learn," he said.

"It's all very well for overseas aid programs to come in and build a hospital or a clinic but education and training are the key and I like being involved in that.

"It's particularly rewarding to help people introduce systems that they can then finesse to fit within their own geographical and social framework like the Samoans did with the Savaii model."

This year's provision of the PTC course was a joint effort between the College-coordinated Pacific Islands Project (supported by AusAID) and the Health Ministry of Samoa.

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