



THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL NEWS

Vol:9 No:1 January/February 2008

January/February Highlights:

PAGE 10 CASC

Early registration is available through the new online program www.surgeons.org/casc2008

PAGE 18 RURAL SURGERY

"I learnt that the thing that makes you part of the community is not what you do for them, but what they do to you."

PAGE 40 ARTISTIC FELLOWS

Associate Professor Richardson said a great bonus of taking up singing is sharing the experience with his family.

Caring for Africa, page 26



The College of Surgeons of Australia and New Zealand



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Ansell





President's Perspective



Andrew Sutherland,
President

Post Fellowship Education and Training

The College provides the professional resources to support a modern education program

A number of groups within the College have or wish to develop post Fellowship courses in their areas of special interest. Council is presently considering mechanisms for this to occur within the College structure that would be acceptable to the present nine surgical disciplines and to the Fellowship at large.

It is appropriate for the College to consider such a concept given its principal role in surgical education across our two nations. Our College's responsibility is to provide the structure and common standards for the education and training of the future surgeons of Australia and New Zealand. It was the lack of common and acceptable standards that led to the foundation of the College in 1927. Since then much of the direct responsibility has moved to the specialist societies and associations. However they act in partnership with the College which is the forum and the authority for the development of common standards and the agreed model for delivery of the programs across all specialties. The College also provides the professional resources to support a modern education program.

In more recent times the College has also responded to the needs of our profession and the community by providing the model for life long learning through our Continuing Professional Development program. This is also run in many cases in partnership with the specialist groups.

Successful compliance leads to re-certification of the Fellowship of our College.

Our educational capability is now of a high standard as evidenced by the recent accreditation by the Australian Medical Council.

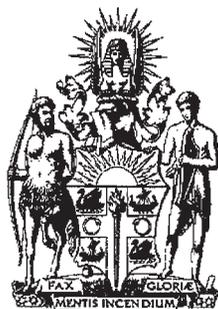
In 1944 the College offered final examinations in general surgery, orthopaedics, gynaecology, thoracic surgery, neurosurgery, otolaryngology and urology. Paediatric, plastic and vascular surgery have been added over the years and gynaecology has departed. This grouping of specialties has served the College and our patients well over the years and there is no current proposal to change this situation. The College has a process for any group to apply for a new specialty specific Fellowship but there are no current applications. This process sets the bar quite high with good reason; a proliferation beyond our present nine specialties would not necessarily be in the best interest of the profession or our patients.

On the other hand, most metropolitan surgeons confine their practice to a narrower area than that described on their Fellowship diploma. This has undoubtedly led to advances and improved standards which are then available to those with more generalised scopes of practice. A more specialised scope of practice is also attractive to many surgeons in terms of professional satisfaction, lifestyle and remuneration.

There seems little advantage in holding back

the ambitions of groups who wish to practice in narrow or cross-disciplinary areas. There are many such areas in surgery such as spine, trauma, transplantation, hand, colorectal and craniofacial surgery, to name but a few. They not only want to improve their standards through education and research but also to provide a certificate that their program has been completed. They have all without exception looked to the College as the principal surgical education body to assist them in the first instance. The College has the resources and the expertise to ensure educational validity for such programs as it already does in partnership with the mainstream specialty societies and associations. If the College is unwilling to assist in this way it is inevitable that some groups will proceed rapidly to the development of their own programs and assessment processes.

If there is an accelerated move to subspecialisation, how do we provide surgical services in areas where more general skills are required? These include rural and regional surgical services and the emergency rosters in our metropolitan general hospitals. The solution to these important questions is for authorities to ensure that the rewards in terms of lifestyle, professional satisfaction and remuneration are sufficient to attract surgeons to these areas of practice. This is a matter of job descriptions, better contracts, professional support, appropriate rostering and improved salaries rather than coercion →



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President's Perspective

“If there is an accelerated move to subspecialisation how do we provide surgical services in areas where more general skills are required?”

or moral suasion. If there is a satisfying career available more surgeons will make the choice to obtain and maintain the appropriate skills and experience to enable them to function in these important areas.

Council fully understands the political and policy minefield that it has entered by even attempting a solution to these issues but feels that to try and hold back the tide would also be unproductive. Council has had experience in recent years with proposals such as the admission of medically qualified oral surgeons into the College and the General Surgical “2+3” program both of which were eventually rejected. History will judge whether these decisions were correct. The draft proposal before Council is designed to avoid the errors of the past by ensuring that all issues, both political and practical, are sorted out before any applica-

tion can come to Council for approval.

The proposed post-Fellowship qualification has been purposely defined as a “certificate” to ensure that it ranks behind the Fellowship in importance and denotes completion of a course of study rather than superiority to those who also practice in the area. It would be only one of many factors considered by an institutional or jurisdictional credentialing body. It should rank alongside other experience and training and be judged on its merits by appointing authorities as will other diplomas awarded by bodies outside the College system. It would be hoped that involvement with the College will be ensure that the quality of the program is recognised.

As President it is impossible to ignore the ongoing requests by groups of Fellows for such a system. Council through a working party chaired by Guy Maddern has therefore put for-

ward a draft proposal. Important issues such as the support of the relevant specialty societies and associations, the public need, the impact on present services and any political implications would have to be dealt with by the sponsoring society or consortium prior to submission to the College. The arrangement with the sponsor will be through a service agreement similar to the present agreements with surgical societies governing pre-Fellowship education and training. The College would not consider any application unless it was widely acceptable to all parties. This policy is currently being considered by regional and national committees and the specialty societies.

In 2008 Council will also be considering solutions to the current challenges in the provision of rural and regional and emergency surgical services.



Royal Australasian College of Surgeons

Rural Locum Service

Become a Locum!

The Rural Locum Service is an information database of Locum Vacancies and a register of surgeons who are available for either long or short-term appointments in rural areas of Australia in all relevant specialities. Your colleagues in non metropolitan practice need a break from time to time - for CME, refresher training, or just to take a holiday from a busy practice.

It has been recognised that specialist surgeons in nonmetropolitan areas have difficulty in arranging locums. This is especially so for surgeons who are sole practitioners in smaller regional towns. This causes significant difficulties for specialist surgeons wishing to undertake further education or skills training.

The Rural Locum Service database helps alleviate this problem. Please register your interest in registering as or engaging a locum today by contacting Rural Services for more information.

For queries please contact Louisa Tesimale, Project Officer Rural Services on +61 3 9249 1284 or email rural@surgeons.org.

Supported by the Commonwealth Department of Health and Ageing.



Royal Australasian College of Surgeons

Rural Surgical Training Program

Are you interested in Rural Surgery in Australia?

Have you applied to the Surgical Education and Training Program in General Surgery this year? Or are you a current General Surgery Trainee?

The program enables trainees to undertake flexible training, which includes hands-on, broad surgical experience and responsibility in regional and rural hospitals. The program also offers access to College facilities such as the RSTP Mentoring Program, and financial assistance to attend courses, conferences and workshops relevant to your training.

For more information about a surgical experience in rural Australia please logon to the Fellowship Services web page at www.surgeons.org and select Rural Services.

For enquiries please contact Sabina Stuart, Project Officer Rural Services on +61 3 9276 7407, email rural@surgeons.org

Supported by the Commonwealth Department of Health and Ageing.





Relationships



Ian Gough,
Vice President

Preparation for the 2008 Census

Too busy to complete this? Consider the benefits of completing your census

The periodic census which Fellows are invited to complete every few years provides the association with valuable hard data with which to advocate on behalf of all Fellows. As this is an essential component of the work the College undertakes, it is opportune to discuss both the upcoming census, and the advantages per se, that census data can provide.

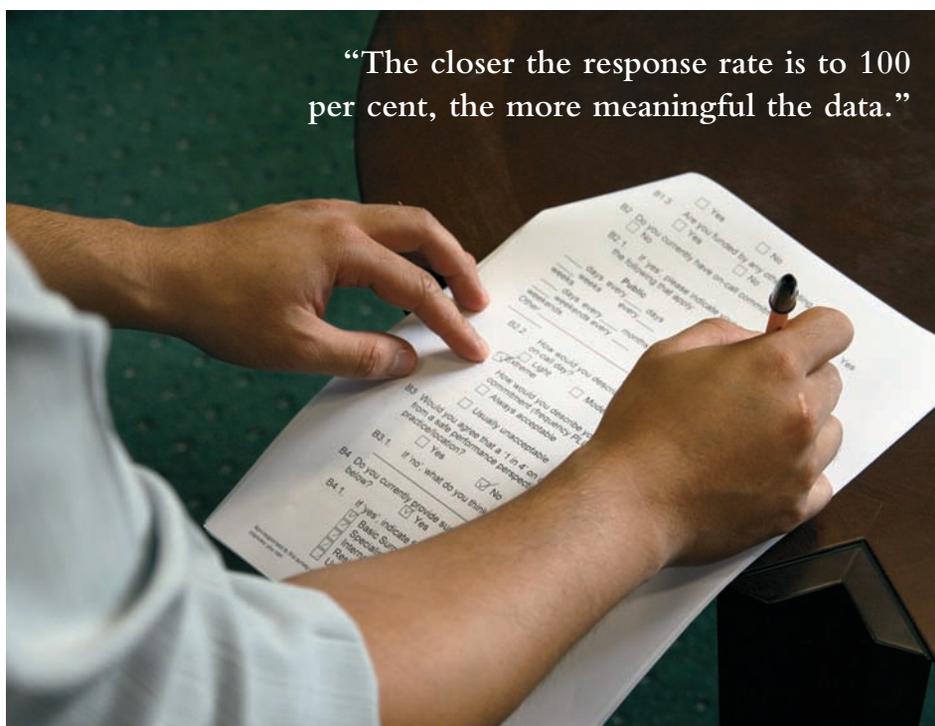
The College is one of only a handful of medical associations globally that offers all its Fellows the opportunity to provide feedback on a range of work and lifestyle factors. Historically, other associations have only carried out surveys, where a sample size is chosen to best represent the population.

As Fellows and regular readers of *Surgical News* know, the College is committed to improving surgical services in Australia and New Zealand by representing its member surgeons effectively.

To be in a better position to advocate to Governments, and to also best serve our members, we ask each Fellow to take the short amount of time required to fill out this year's census.

Never before have we encountered the current challenges that exist in the surgical profession. Factors such as the following:

- an acutely inadequate supply of vocational places at a time when there will be a doubling of medical graduates by 2015 and increased numbers of surgical graduates from 2013
- where features of the public health system are increasingly unattractive in comparison to private sector health work
- where waiting lists continue to expand
- where operating rooms do not appear to be effectively utilised
- where rosters and red-tape need to be better managed, and
- where surgeons should not be placed in positions of work overload, frustration, and conditions that have the capacity to cause high levels of stress and/or burnout.



“The closer the response rate is to 100 per cent, the more meaningful the data.”

With the 2007 change in the Federal Government, we have an opportunity to present data that allows us to better advocate for improvements in surgical areas, as well as to ensure that the College is properly informed to represent its Fellows interests accurately.

For this reason, this year's census will not only cover matters of workload and demographics, it will include questions about job-satisfaction, work-life balance, and space for airing of anything Fellows wish to raise under the confidential umbrella of the privacy conditions provided in this census.

High response rates allows the College to forward plan accurately for each speciality

Most professionals are stretched for time and it is an easy option to ignore things that are not critical to their work. However, there are

occasions when something unfamiliar in the email inbox is not spam or extra work, but rather a vehicle that can have a significant impact on work and quality of life. The 2008 census for our Fellows is such a vehicle.

The higher the response rate, the more confident we are of addressing Fellows needs. Why? Because this is not a survey where persons best placed to represent a profession are selected. With the latter, a response rate of 30 per cent can often be considered 'good'.

With a census the same cannot be said as the following example of a Canadian census demonstrates in the latter a low census response rate played havoc with the reliability of data.

Canada – low response rates can effect reliability of findings

A December 2004 census of Canadian plastic surgeons revealed that on average their →



Relationships

“A high response rate will allow the College to better advocate for change.”

patients were waiting between 32 and 33 weeks for their procedures. The reasons for this were made apparent when it was found that 23 per cent of graduates in this specialty from, 1995 to 2005, practiced outside of Canada. Meanwhile, 28 per cent of other respondents reported their intention to retire by 2009, and 3.2 per cent stated their intention to emigrate by 2010.

This information was a significant finding for the surgeon's association and policy makers. However, because only 40 per cent of members responded, there were methodological problems associated with the reliability of the data. With such a high rate of intention to quit there was a strong possibility that those intending to depart formed unusually high numbers of respondents as they were able to signal their future intentions without surrendering confidentiality.

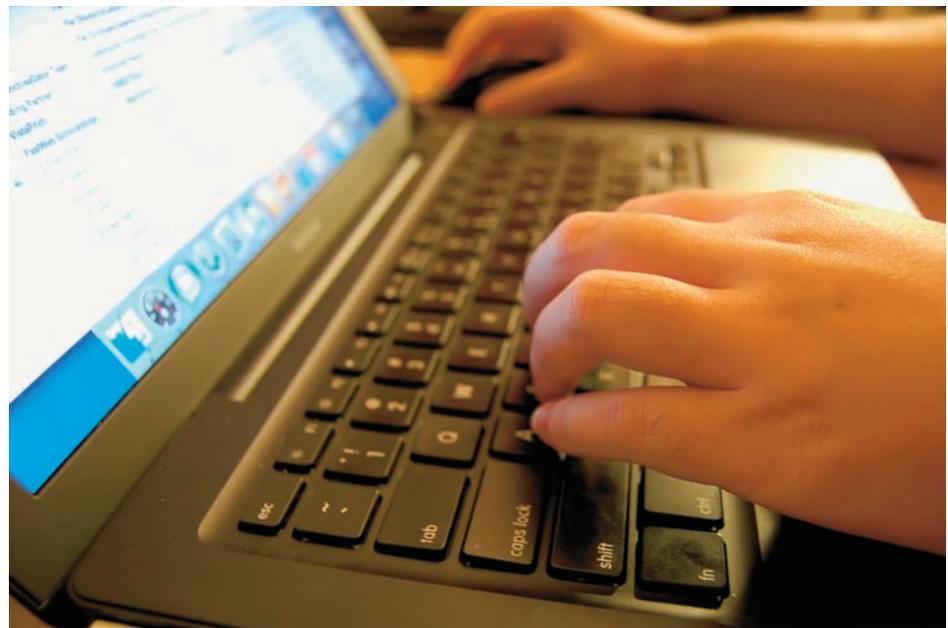
If the response rate had been much higher, then the data would have been more reliable. As it was, there was the strong possibility that any policy responses by the association could be an overstatement of the problem. Only time will tell if this was the case.

Census findings that have reshaped Medical Services

Over time findings from surveys and censuses have been instrumental in challenging preconceptions of various medical services and interests. Below are several examples.

Scottish GPs and Holistic Treatment

A 2001 census of Scottish 3,713 GPs revealed that pressures of overwork, low morale, dwindling resources and so forth, were major contributors to the increased focus on a single disease diagnosis, rather than exploration of a holistic approach that is endorsed by public policy. Of particular concern was the finding that nearly 90 per cent of the GPs showed strong support for the holistic approach and its improved



The 2008 Census only takes 15 minutes to complete and guarantees FULL confidentiality

treatment options for patients. Nevertheless, only 21 per cent of GPs were currently able to offer this form of treatment, with the rest finding that stress and time constraints accounted for their high prescription rates and referral to specialists.

The implications of these findings on public policy makers is striking, particularly as research shows co-morbidity of physical and mental conditions to be widespread.

Census Results Can Reveal Unexpected, but Important Information

A 2007 census of all US medical schools and 15 large teaching hospitals revealed that 60 per cent of departmental heads had a financial relationship with a drug company as either a consultant, member of a scientific advisory board, a paid speaker, an officer, a founder, or a member of the board of directors.

The ethical issues of the above have far-reaching consequences.

Structure of the 2008 Census

1. Formats: The census will be made available in two formats, by an online link, and by mailed hardcopy. Online questionnaires are easier to complete and are far less expensive for the College. If you can complete an electronic version of the questionnaire it would be greatly appreciated.

2. Confidentiality: All participants can be assured of 100 per cent confidentiality.

3. Your Views: This year we propose to include space for members to make comments on any matter of importance to them. We urge members to take advantage of the confidentiality of the census to make their views known to us.

There will be further details of the 2008 census of the Fellows in the next edition.

References

For copies of references used in this article, please contact Mirella.delorenzo@surgeons.com, +61 3 9249 1108



E-Journalism



John Hall,
Editor-in-Chief

How should the ANZ Journal of Surgery adapt to e-journalism?

There is a lot more to e-journalism than developing new ways of transferring information: it has to be accompanied by a viable business model

The ANZ Journal of Surgery started to 'go electronic' in 1998; and now, after almost ten years, we can start to see the opportunities that this offers. So far, the main components of e-journalism have been the electronic handling of manuscripts and the availability of copies of articles on the Journal website. More recently, technology has made it possible to transfer sounds and images (podcasts), but we have yet to adapt to these useful advances. The future is far more complex – instead of articles about surgical technique we may be offering guidance through the on-line simulation of new procedures.

It is going to take time for surgical journals to adopt the opportunities provided by new technology. First, journals are still grappling with a new found ability to make additional information available, layer information, and cross-link articles.¹ Second, we are conservative creatures and the default position is to resist change – except, that is, for our junior surgeons and Trainees who are part of the 'Nintendo generation'. Third, it comes at a cost because electronic platforms are expensive to build and maintain.

Does the paper-based journal have a future? The answer is undoubtedly 'yes' in the foreseeable future. The reading of novels and magazines remains as popular as ever: bookshops abound whilst attempts to produce 'electronic books' have so far failed to gain acceptance. However, in the very long term it is hard to see paper-based journals surviving as the primary method of transferring information about technical and professional information. The same applies to textbooks – they are expensive, unwieldy to produce, and the information that they contain is often out-of-date by the time that they are published.

What are the implications of these changes for the content of the ANZ Journal of Surgery? At the present time the Journal has two main components – 'original articles' (analytical reports that count towards the Journal's citation rates and its credibility as a peer-reviewed journal) and various forms of 'commentaries' (non-prime source material that offers observations, explanations, clarifications and interpretations). The latter includes Editorials, Perspectives, Updates, Critical Evaluations, Images for Surgeons, and Letters. These are

"Is it possible to develop e-journalism and still maintain a viable paper-based journal? De-bulking the original articles in the paper-based journal would reduce the size of each issue without diminishing its attractiveness for the vast majority of our readers."

the parts of the Journal that our Fellows and Trainees enjoy reading most. In contrast, the main means of distributing our original articles to the world of surgery is online – searches for relevant articles are via electronic databases, primarily PubMed. Some journals are publishing short versions of their original articles on paper and linking them to the full versions, which may also contain supplementary material, on-line. This is an approach that we could adopt within the next couple of years.

Is it possible to develop e-journalism and still maintain a viable paper-based journal? De-bulking the original articles in the paper-based journal would reduce the size of each issue without diminishing its attractiveness for the vast majority of our readers. On the other hand, the Journal's website needs to do more than just provide a static archived version of the paper-based issues of the Journal. There needs to be more layering of information with better cross-linkage between articles. For instance, there is the potential for the editors for each specialty group to develop their own

area. We could also present information in a more coherent way for surgical trainees and medical students.

How could it be funded? Initially, it would be possible to divert some resources from the paper to the electronic versions of the Journal. But this would have to be quite limited otherwise it could unravel the hard work that has gone into improving the Journal over the past year. Other than that, the two main sources of income for the Journal are subscriptions and advertising. Subscrip-

tions can only be increased by maximizing our commercial arrangements and improving the quality of both forms of the Journal. Advertising, on the other hand, is flowing away from paper-based journals. Online advertising in Australia increased by more than fifty per cent in 2007, and it is expected to keep growing at the same rate in 2008.² Part of this growth is a trend for advertisers to spread their online budgets to smaller, more specialised websites (narrowcasting). We cannot ignore this trend.

The challenge is to be pro-active over the next several years and develop a viable business model right from the start. The alternative is to slide into it without a cost-efficient plan – and then spend the next decade or so having recurring debates about the value and costs of an electronic journal.

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National Institute of Clinical Studies

Stop the Clot

Integrating Venous Thromboembolism (VTE) prevention guideline recommendations into routine hospital care

VTE CONTINUES TO be a major cause of preventable morbidity and mortality among hospitalised patients, who have a 100-times greater risk of developing VTE than those in the community. Eighty per cent of VTE cases are attributable to surgical and medical hospital admissions.

The evidence base surrounding VTE prevention is clear, yet simple prophylactic

measures that are known to dramatically reduce the risk of VTE remain underused in many Australian hospitals.

Since late 2005, the NHMRC's National Institute of Clinical Studies (NICS) has run a national VTE Prevention Program, working with 40 hospitals across Australia to improve the use of VTE prophylaxis in hospital settings.

The NICS publication, *Stop the Clot: Integrating VTE prevention guideline recommendations into routine hospital care*, provides practical step-by-step guidance for health professionals to ensure that best practice is being followed in this important clinical area.

This month we publish an abbreviated version of Steps 7 and 8 of the guide.

Step 7

Develop a plan

The implementation team must develop a plan that directly addresses the barriers to best practice that have been identified locally (see Step 6). Use the findings of your initial audit to inform decisions about which areas to focus on.

It is critical to involve frontline nurses, physicians, surgeons and pharmacists in the development of the plan and to consider its impact on workflow. A plan that adds an extra burden of work for frontline personnel is much harder to implement, so aim to simplify the system as much as possible and to integrate the plan into existing work processes.

Choose interventions that match the barriers you identified in Step 6. While there is limited evidence on the effectiveness of strategies that are tailored to overcome identified barriers to change, a summary of available evidence to guide the matching of specific interventions to identified barriers is provided below.

The literature on what interventions have been successful in improving VTE prophylaxis has been systematically reviewed in a report commissioned by NICS from the Australian Safety and Efficacy Register of New Interventions – Surgical (ASERNIP-S)¹. The main finding was that passive dissemination strategies are ineffective; rather, a number of active

strategies used together are more likely to result in improvements. Active strategies might incorporate paper or electronic reminders for clinicians to assess patients for VTE risk on admission and to assist in the selection of appropriate prophylaxis by risk category.

To effect change in the use of VTE prophylactic measures requires clinical leadership, improved clinician knowledge of risk assessment and prescribing and a supportive reminder system which operates independently of individual clinicians or managers.

Key elements in any intervention to improve VTE prevention

Key element	Suggested strategy
Demonstrate importance/relevance of VTE prophylaxis in your hospital.	Conduct local audits and provide unit-specific feedback to clinicians and heads of units.
Improve clinician knowledge of VTE risk assessment and appropriate prophylaxis by risk category.	Provide risk assessment summaries and tools and include in hospital medical officer education and orientation sessions and at Grand Rounds.
Remind clinicians to assess patients for VTE risk.	Include stickers or reminders in medication charts, care plans, clinical assessments or clinical pathways. Integrate reminders into electronic patient management systems. Use a risk assessment form to assess and document risk ² .
Assist clinicians to prescribe prophylaxis appropriately.	Include risk assessment and management summaries, forms or guidelines in medical record.
Assess effectiveness of interventions and continue to review and refine your interventions.	Conduct regular small scale audits and surveys. Use the results to identify and overcome issues that are preventing best practice.



Planning involves more than simply deciding how you are going to tackle a problem. A fully developed plan will provide details of tasks, resources and timelines. It should include a formal justification document which sets out clear-cut aims expressed as numerical targets for the chosen performance indicators. For example, one of your performance indicators might be to improve the percentage of high risk patients on appropriate prophylaxis by 30 per cent in five clinical units or wards within 12 months. This level of information provides those responsible for executing the plan, as well as those overseeing it, with the capacity to monitor progress in practical and measurable terms. Further examples of project plans and performance indicators are available on www.nhmrc.gov.au/nics.

Helpful tips...

- Plan for sustainability from the beginning; avoid making your change reliant on individuals and embed the changes into routine systems of care.
- Don't get bogged down in the detail. The plan will change over time.
- Use the plan to communicate what you are doing. Include your key performance indicators in the plan from the beginning.
- Design your plan with a view to making it easy for people to do the right thing and hard for them to make errors or omissions.
- Accept that there is no shame in saying that some things are too hard to change.
- Focus on what you might be able to achieve as a first step.
- Make sure your plan goes to the hospital executive for sign-off and support.

Step 8

Implement the plan

When implementing the plan, allow yourself a degree of flexibility. It is best to anticipate that your plan will require refinement along the way. It is wise to pilot test the interventions you are planning to introduce on a small scale first to find out what the practical challenges really are. It is crucial to recognise that change takes time. Be realistic and assign enough time when planning the intervention to allow for learning and adapting the changes as you test them out.

One aspect of implementation that can be overlooked is the need to put strategies in place for measuring the effectiveness of your actions. It's vital to document the implementation issues that arise to facilitate evaluation. A commonly used approach to testing and adapting changes

in order to achieve the desired improvements is the Plan-Do-Study-Act (PDSA) model:

- **Plan** what you are going to do, e.g. include documentation of risk assessment in nursing care plans. Decide who is going to do what, how and when, e.g. educate nursing staff in one pilot ward about new nursing care plans and explain when and how staff are expected to fill them in.
- **Do** it, e.g. introduce new nursing care plans for one week in one pilot ward.
- **Study** it, e.g. get feedback from users about the new forms, monitor how often and how appropriately they are filled in.
- **Act** on the feedback and measurement to amend, implement more widely or abandon the concept being tested.

The PDSA model is underpinned by three improvement questions³.

- What are we trying to accomplish?
- What change could be made that might lead to an improvement?
- How will we know that a change is actually an improvement?

The answers to these questions are used to plan the PDSA cycles, as illustrated in the following example.

What are we trying to accomplish?

- To increase the percentage of patients who are assessed for VTE risk on admission to hospital.

What change could be made that might lead to an improvement?

- Include a risk assessment form² in the patient admission pack in two trial units.
- Conduct in-service training sessions about the trial and the risk assessment and management process with medical and nursing staff from the trial units.
- Disseminate copies of the hospital policy on VTE prophylaxis and associated risk assessment form to staff in the trial units.

How will we know that a change is actually an improvement?

- Measure the percentage of admitted patients with completed risk assessments in the two trial units.
- Measure the percentage of at-risk patients on appropriate VTE prophylaxis in the two trial units before and after the trial (use a 20 patient sample size each time).

Helpful tips ...

- Undertake small scale trials to test and refine ideas for changes and be persistent.
- PDSA cycles apply to even the smallest steps in a change process.
- Continue to consult with and seek feed-

back from frontline staff on any new changes you are testing.

- Communicate and provide feedback on improvements to clinical groups, and make sure you receive feedback from them.

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Next month *Surgical News* will publish Step 9: Monitor progress and Step 10: Sustain improvements.

A full text version of the Stop the Clot guide and associated electronic resources is available at www.nhmrc.gov.au/nics.





CASC 2008

Vincent Cousins, Convenor &
Michael Leung, Scientific Convenor

Conjoint Annual Scientific Congress

Easy registration is now available through the new online registration program www.surgeons.org/casc2008

Beautiful Hong Kong and the spectacularly situated Hong Kong Exhibition and Convention Centre are the venue for our 2008 Combined Annual Scientific Congress (CASC) in May. The Centre is readily accessible from the surrounding hotels on Hong Kong Island and by Star Ferry from the mainland.

This is the first Congress held beyond Australia or New Zealand for 25 years – the last meeting in 1983 was also in Hong Kong.

Easy registration is now available through the new online registration program. If you wish to avail yourself of the Earlybird discount you will need to register before Saturday 1 March. Log on to www.surgeons.org/casc2008.

Also available from the website are the full details on the Scientific program, the Associates program and the post-congress tours to Beijing, Guangzhou, Xi'an and Shanghai. Remember that a visa is required to visit mainland China, although an Australian or New Zealand passport with a minimum of six months validity is accepted to visit Hong Kong.

Mainland China Visas.

Everyone going into China requires a Visa. This can be supplied on application to the Chinese Consulate/Embassy nearest to you in Australia or in New Zealand. Visas can also be obtained in Hong Kong. Please state that

you wish to apply for an individual tourist visa. This applies to whether you are going on a tour on your own or to one of the post-CASC Conferences in Guangzhou.

If you join one of the tours advertised in the CASC Provisional Program, HRG, the tourist agent, will ask you for a photocopy of the front page for your passport. They will apply for a group tourist visa at no extra cost to you. Such a visa will only permit you to travel in and out of China as a group. You would not be allowed to deviate from the prescribed itinerary.

Those attending the post-CASC Conferences should check with the organisers regarding the venue and the time of the meetings

The Conjoint Meeting brings together for the first time:

- Royal Australasian College of Surgeons;
- The College of Surgeons of Hong Kong;
- Australian and New Zealand Burn Association;
- Australasian and New Zealand Society of Craniomaxillofacial Surgeons.

A total of 25 sections and special interest groups will be meeting under the auspices of the Conjoint Annual Scientific Congress with sessions of special interest for Trainees, Fellows and Associates.

Plenary program

The Plenary program is an important aspect of every Annual Scientific Congress and in Hong Kong we have the opportunity to discuss with our colleagues from Hong Kong a range of topics at the forefront of debate amongst Fellows of both Colleges. Surgical leaders from both Colleges will contribute to the programs:

Tuesday 12 May:

More with less: improving bed utilisation without compromising standards. Where is the pressure coming from to change established patterns of practice, what is 'fast track' surgery and do short-stay wards and day surgery centres always work?

Wednesday 13 May:

Minimally invasive surgery: the future for all surgeons? Is it always cost-effective and how can our skills be upgraded?

Thursday 14 May:

How is the surgeon credentialled for new technology and who is responsible? Is it even necessary and does credentialling achieve its aims?

Friday 15 May:

Identifying and aiding the underperforming surgical colleague: do the Colleges want to know about underperformance or should some-one else be responsible? If it is a College's



“Everyone going into China requires a Visa. This can be supplied on application to the Chinese Consulate/Embassy nearest to you in Australia or in New Zealand.”



responsibility, how should it be investigated and what options are available to help?

Named Lectures

The duration of each Plenary has been reduced to one hour and in the remaining 30 minutes a prestigious Named Lecture will be presented.

Wednesday - Professor John Wong will deliver the Hamilton Russell Memorial Lecture

Thursday - Sir Gordon Wu, Hong Kong's world famous civil engineer will deliver the RACS President's Lecture

Friday - Professor Russell Stitz will deliver The Hong Kong College's GB Ong Lecture

Several other Named Lectures will be delivered during the scientific sessions including the Rupert Downes and the Weary Dunlop Memorial Lectures.

Perforator Flap Workshop

Trainees in plastic and reconstructive surgery should note the excellent one-day Perforator Flap Dissection course arranged

by the convener of the Plastic surgery program, James Leung. The workshop is on Monday 12 May in the Skills Laboratory, Anatomy Department, University of Hong Kong. The cost of the workshop and materials is being generously subsidised by Johnson and Johnson Medical. The cost to delegates is HK\$4,200 (~A\$600, ~NZ\$700) and you can book for the workshop on the Registration Form under 'Workshops'.

Tailoring

And do not forget that Hong Kong is recommended for custom-made clothing including shirts and suits. We expect there will be a booth at the Congress from one of the leading bespoke tailors so you can be measured and fitted between sessions.

We look forward to welcoming you to Hong Kong!



Cancer – how are you travelling?



The National Breast Cancer Centre has developed a consumer resource about the psychosocial impact of cancer. Titled, Cancer – how are you travelling? the booklet has been written for people diagnosed with any kind of cancer, as well as their family and friends.

The booklet de-stigmatises the emotional, social and practical impact of a cancer diagnosis and helps readers to be aware of the effect cancer may have on their lives, their relationships and their overall wellbeing. It may be most useful for people recently diagnosed with cancer, however, there are some issues discussed that may be relevant at other times throughout the cancer journey.

The booklet covers:

- The psychosocial challenges faced by people with cancer
- The way a person's cancer diagnosis may affect the people around them
- Times when people may be likely to experience higher levels of anxiety

- Reasons why some people may find the cancer journey more difficult than others
- The role of different health professionals throughout the cancer journey
- Types of support and treatment available
- How to ask for help.

The resource is based on the world-first Clinical practice guidelines for the psychosocial care of adults with cancer developed by the National Breast Cancer Centre and the National Cancer Control Initiative.

Cancer – how are you travelling? can be ordered free of charge online at www.nbcc.org.au/resources or by calling 1800 624 973.

The National Breast Cancer Centre is funded by the Australian Government and works with consumers, health professionals, cancer organisations, researchers and governments to improve health outcomes in breast and ovarian cancer.



*Robert Thomas, Professor/
Director, Surgical Oncology,
Peter MacCallum Cancer Centre*

Academic Surgical Oncology

The Peter MacCallum Cancer Centre is eager for Trainees who may be interested in pursuing a MD or PhD project

The Peter MacCallum Cancer Centre (Peter Mac) was established under an act of Parliament and has a greater than 50-year history of providing cancer care to Victorians. Originally the only radiotherapy provider in the State, this discipline formed the basis of the Institute's activity and development. It was in the discipline of Radiation Oncology that the national and international reputation of Peter Mac was developed. From the earliest days research activities were associated with the provision of clinical care. A Department of Medical oncology was established in the mid-1980s originally under the leadership of Professor Jim Bishop.

Surgery has had a long, but limited history at Peter Mac. The late Sir Benjamin Rank was committed to the Peter MacCallum Institute and worked closely with his Radiation Oncology colleagues in the multi-disciplinary management of skin cancer. Minor surgeries such as central venous line insertion, lymph node biopsy, and breast biopsy were also performed during the 1980-90 era. This occurred under the auspices of Professor Dick Bennett and Professor Michael Henderson but with many other surgeons providing dedicated service to Peter Mac.

During the latter half of the 1990s the reputation of the Peter MacCallum Cancer Institute became enormously enhanced internationally with the recruitment in 1995 of powerful world figures to head up the Radiation Oncology Division (Professor Lester Peters) and the Research Division (Professor Joe Sambrook). There was a strong commitment to translational research even before the term became fashionable.

However, with the loss of the sole provider status of Radiation Oncology, the proliferation of private and public Medical Oncology facilities and the recognition that to achieve full cancer centre status a formal and extensive Surgical Oncology program was essential, the

decision was made in 1999 by the board to create an integrated comprehensive surgical program at Peter Mac. The implementation of this decision has been an interesting ride which I will briefly describe.

A full-time professorial position in Surgical Oncology was created and filled in Nov 1999.

The development of surgical oncology as a new program was difficult for many reasons. Even at the end of the 1990s the hospital was not only physically isolated but could not really have been called an acute care hospital in the full sense of the word. The HMO program was minimal, there was no High Dependency Unit or ICU, and there was certainly no ability to manage a crisis in an inpatient area without calling in outside help. This level of care could not support a major surgical program. Despite the fact that the hospital suffered all these deficiencies in terms of acute clinical care it did have a huge community reputation as being a caring, supportive hospital with high quality medical and nursing professionals who provided excellent care, particularly for the advanced cancer patient. It was with this firm internal and external base of support that the surgical program was pursued. With the support of St Vincent's Hospital, the HMO program was strengthened considerably with effective cover being obtained night and day. A Director of Anaesthesia, Dr David Skewes, was recruited and he commenced the herculean task of creating a full-time, 24 hour cover, Anaesthetic Department. The ICU program was put in place (after a battle) again with the support initially of St Vincent's Hospital who rotated consultants to cover the ICU. The physical state of the operating theatres was upgraded, although still deficient, being the old St Andrew's operating theatres built in the 1970s. Recognising the clinical risk of introducing a new surgical program in this type of setting, a very complete surgical audit program was instituted and

has been maintained to the present day.

The thrust of the activity was to provide a academic surgical oncological focus to the cancer care program at Peter Mac and to concentrate the surgical activities in areas which where appropriate and effective. The key was to have collaborative links with the major hospitals to ensure surgical patients were appropriately triaged between hospitals depending in their particular needs. It was always recognised that some surgery would be inappropriately performed at Peter Mac because of lack of specialised support.

The strategy has been very successful with elective oncological surgery being carried out at a rate which is at or above the Group 2 hospitals and in some cases running at a higher rate than the Group 1 hospitals. Surgeons came on board, in particular in areas such as GI, Colorectal, Urological Surgery, Thoracic Surgery and Head & Neck Surgery. At all times good relationships were maintained with the surrounding institutions that had previously provided all the surgical access for Peter MacCallum and had continued to provide access, and the surgeons themselves came on board happily and contributed mightily to the program. The fact that this exercise started at a time when elective access for surgery at public hospitals became more difficult undoubtedly contributed to the success.

The final chapter in this story is about to be written as Peter Mac embarks on a process which will lead to the creation of a new multi-faceted CCC at Parkville, in a move which will enhance the provision of services for all Victorians and provide the basis for a resurgent cancer research program at Parkville.

This paper is not to discuss in detail the Peter Mac surgical program but to point out some aspects which I think have been critical to the development of what is a successful, harmonious and interactive surgical group at Peter MacCallum. There will be a plea at



“Perhaps nowhere are surgeons and other practitioners more confronted with their impotence in dealing with complex and difficult patients, than in the oncology area.”

the end of this paper directed towards our younger surgeons and surgical Trainees about their involvement with research.

1. I believe there has been great value in having a full-time component to the surgical staff. Peter Mac has two full-time surgeons, another surgeon who was for many years at least half-time, a junior surgeon who was close to full-time. This group provided a core for the activities of the Division of Surgical Oncology and acted to support the VMOs in their always limited ability to deal with the surgical issues which arise in the course of their practice. It has enabled programs such as the audit program, the development of KPIs, the nurturing of the younger generation, together with a high involvement of surgeons in hospital politics and the shaping of the direction of the hospital. Even the slightly old fashioned Dept of Surgery with a discrete functional area, where the surgeons could work and discuss issues and research projects with each other and the juniors - has been a huge factor in the program development

2. It was fortuitous that at the same time Surgical Oncology came of age within Australia. In the past twenty years or so the Society of Surgical Oncology and the Surgical Oncology generation within the USA has been flourishing. There has been consideration that this may have had a financial element to it as designation as an oncology surgeon may have improved re-imburement from insurance companies. However, to put a more elegant light on this development, there was an increasing recognition that Surgical Oncology is something over and above classical surgery. The development of Surgical Oncology by the RACS gave the College a voice in cancer affairs across Australia; it commenced a process to allow the education of surgeons in the principles of oncology, the principles of multi-disciplinary care and the interaction with the other disciplines in the management

of the cancer patients. It has exposed surgeons and trainees to the issues of communication to cancer patients, supportive care for cancer patients and the critical issues of psychosocial support for patients and their families when suffering from and having to deal with cancer. There is also a newer understanding of what might be called (surgical) palliative care. Oncology surgeons are involved in palliative care and deal with the patient with advanced cancer trying to assess whether or not surgical intervention is possible and reasonable. Doing something to improve the symptomatology in an individual who can't swallow from obstructive cancer or is bleeding from a bladder cancer is not a minimalist exercise for surgeons at Peter MacCallum, but part of the daily activity. As an aside, I believe one of the great advantages of this program for the HMOs (and now the multiple accredited surgical trainees working at Peter MacCallum) is their contact with this group of patients and their education and experience in dealing with the complex issues raised by these patients.

3. In all major institutions oncology programs are academic programs. Perhaps nowhere are surgeons and other practitioners more confronted with their impotence in dealing with complex and difficult patients, than in the oncology area. We are irresistibly drawn to the idea of understanding the work we do. Resource helps. Having dedicated resource for research is a key feature of high level Peter MacCallum positions and extends to the surgeons. It enables work to go on while competitive grants are sought and gained. It enables the surgeon to move from his macro-technical discipline to the delights of gene expression, stem cell understanding, micrometastasis, mucosal transformation, to name just a few issues which have to be worked through in the laboratory setting. The surgical program at Peter MacCallum has shown how critically important is interaction

between the surgeon at the coal face and the scientist in the lab working with the surgeons on these programs. Both feed off each other and neither can do without each other. Clinical trial programs, translational research, that is from the lab to the clinic, and translational research in the reverse order, that is from the clinic to the lab, understanding public health issues, epidemiological issues, prevention issues, screening issues are all part of the surgical oncology program and as surgeons widen their area of interests and expertise, the world is their oyster to investigate as they wish.

So this short presentation really prefaces a plea. Unless we expose appropriate young surgical Trainees to the benefits of research, unless we have them look to the wider picture and realise that there are matters which concern surgeons outside the operating theatre, unless we imbue them with the thrill of being an expert, even a world expert, in a particular area of activity, then we are not alerting them to what is available. I absolutely believe it is essential for the College to continue to nurture appropriate academic development of its Trainees and its surgeons. We need to have a good way of tapping into that bunch of clever young Trainees who are willing to spend two to three years (it passes quickly) really doing something effective in terms of setting themselves up for life with some academic knowledge. So the Surgical Oncology Division at Peter Mac is desperate for the right sort of Trainees. We have projects galore, we have money to spend, we have tried and true success and we are keen to contact any Trainees across Australia who may be interested in pursuing an MD or PhD project. We can guarantee them a good time and a successful time. And of course we are not alone. I am sure many departments across the country would echo these sentiments and the College council is dedicated to the process. It is just a matter of getting the message across.



Fellows in the News



The Da Vinci Robot

This type of technology enhances the surgeon's visual field making surgery safer for all involved

After working with Professor Tony Costello in 2004 on the \$3 million Da Vinci Robot at the Epworth Hospital in Melbourne, Urology surgeon Dr Hodo Haxhimolla has retained a keen interest in new technology. During a visit to the US in May last year for a Urology conference, he examined new equipment that could offer surgeons a three-dimensional view during laparoscopic procedures at a fraction of the cost of the cutting-edge Da Vinci Robot.

He spoke to the Australian distributors seeking access to the machine, called the Viking Visual System, for a one-month trial. The request was met and Dr Haxhimolla and fellow surgeons at the Canberra Hospital are believed to be the first in Australia to use it.

The Viking Visual System provides a three-dimensional image transmitted from the surgeon's telescope to a high-definition monitor located within a helmet worn by the surgeon. Dr Haxhimolla said there was a camera for each eye so that the surgeon can see as if they were conducting an open procedure.

"One of the real advantages of this system is that it allows for better depth perception within the abdominal cavity. Normally in laparoscopic procedures we see in two dimensions so this system improves perceptions enabling surgeons to discern the structures better," he said.

"It does not have the same accuracy as the Da Vinci Robot but it is much more affordable. The robot costs close to \$3 million whereas the Viking Visual System is closer to \$200,000."

Dr Haxhimolla said he had used the system for complex urological procedures, particularly reconstructive work while general surgeons at both the Canberra Hospital and the National Capital Private Hospital had used the technology for a range of procedures including bariatric surgery.

"The real bonus of this is that it greatly enhances our ability to accurately and efficiently perform dissection and suturing in



Dr Haxhimolla with the new technology

long and complex laparoscopic procedures. It is not a system that would be of such use for smaller procedures like removing a gall bladder, but for reconstructive surgery like radical prostates, for example, it is a very helpful addition to our surgical equipment," he said

"It was a successful trial. I liked the system and the only limitation we found was that if the telescope came too close to tissues, the auto-focus is limited and results in blurring of vision."

Dr Haxhimolla said the helmet was light and that it did not feel awkward.

"A lot of surgeons work with headlamps already to get a reasonable view of the abdominal cavity so it does not feel much different to that. The high-definition unit is light and more comfortable than those designed in the past and I expect with further development will get even better."

Dr Haxhimolla said he would write an

evaluation on the equipment for internal hospital use. He said he enjoyed working with new medical technology and said there was no doubt much of it was adding to patient safety.

"This is an exciting field, particularly for those of us in Urology because we deal with many complex cases, more and more of which are done via laparoscopic procedures and some of these technologies definitely enhance our ability to navigate through different structures. I think this technology that enhances the surgeon's visual field makes surgery safer. When using the Da Vinci Robot you almost feel you are inside the body. While the Viking Visual System is not as good, it does expand the field of perception and when using it, when you find a small bleeder, you step back because you feel so close," he said.

"Clearly if your perceptions are better, the safety margins must be better."



New to
Council



I.M.A Newfellow

The Appeals Committee

Many appeals heard are regarding non-selection into training or dismissal from training

I have told you previously about the “Holy Trinity of Ians” – Ian Civil (Censor in Chief), Ian Gough (Vice President) and Ian Dickinson (Chair Professional Development and Standards Board). This month I want to tell you about one member of the triumvirate of Johns.

They are John Quinn, Executive Director of Surgical Affairs (Australia), John Simpson, Executive Director of Surgical Affairs (NZ) and John Collins, Dean of Education. My mind raced when I thought of how one could interpret the title “Executive Director of Surgical Affairs” but as Mrs Newfellow reads this column I had better stop speculating.

I had a chat to John Quinn last Council meeting. He always looks dapper in his bow tie. He is a vascular surgeon from Brisbane who was previously the Elected Vascular Representative on Council but had to resign when he became a College employee. This rule is in Section three (e) (vi) of the Articles of Association which states that a Councillor may not be in paid employment of the College (I bet Mr. Nit Picker did not know that section reference).

The position of Executive Director requires (according to the job description)

- Good knowledge and understanding of the medico-political and social environment in which the College operates;
- Excellent verbal and written communication skills;
- High level analytic skills;
- Ability to review issues and research appropriate responses;
- Ability to work cooperatively and in committee structures;
- Ability to interact effectively with professional and lay colleagues.

Now John has all of those qualities, but what does he really do, I ask. Apparently he does administrative activities that require some surgical knowledge in contrast to administration that can be done by a non-surgeon. He was telling me that one of his major time commitments is preparing material for the Appeals Committee. Good Corporate Governance requires that there be a review mechanism for decisions that may affect Fellows or Trainees. In fact, the Australian Competition and Consumer Commission required that we have such an appeal process. He asked if I would like to attend an Appeal – as a Council-

lor I am allowed to attend any Committee of the College as an observer.

So that is how a few weeks later I was in the Council Room as an Appeal was heard. The committee was three non Fellows and two Fellows (outvoted immediately, I thought). However the Chair, Ms Fiona McLeod SC, ran a very tight ship and rapidly identified the issues and eliminated the voluminous amount of irrelevant material that the Trainee had presented. Apparently the applicant often uses a “blunderbuss” approach rather than identifying the real issue. Many appeals are regarding non-selection into training or dismissal from training. What was encouraging was that the Appeal Committee found by a unanimous decision that there had been errors of process by the original committee and ordered that the matter at hand be heard again by a new committee that had none of the original members on it. I was also impressed by the contributions of the two Fellows – they both had a good grasp of the issues and were absolutely impartial. Regrettably, I must admit that they both did a good job – they were my old nemeses, Mr. Nit Picker and Mr. Pot Stirrer.



Royal Australasian College of Surgeons

Specialist Re-Entry Program

Are you interested in re-entering the Workforce after a period of absence from Clinical Practice due to illness, retirement or sabbatical?

Who is eligible?

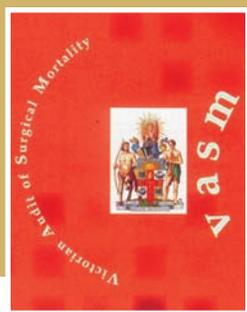
The program aims to assist those Fellows of the Royal Australasian College of Surgeons who have an Australian Medical Board registration and who want to resume clinical practice in Australia after having taken a break. Such specialists may include those who have left the workforce for family or health reasons or have a desire to return to clinical practice after working in a non clinical role.

For more information about the specialist re-entry program please contact Sabina Stuart, Project Officer Rural Services on +61 3 9276 7407, email rural@surgeons.org

Supported by the Commonwealth Department of Health and Ageing.



VASM



Colin Russell,
Clinical Director, VASM

Victorian Audit of Surgical Mortality

Following several years of planning, the Victorian Audit of Surgical Mortality (VASM) has now commenced in Victoria

VASM is funded by the Victorian Department of Human Services (DHS). The Victorian Audit of Surgical Mortality is part of a national audit (Australian and New Zealand Audit of Surgical Mortality [ANZASM]). It is managed by the Research, Audit and Academic Surgery (RAAS) Division of the College and is supported and funded by State Governments. The audit process is designed to highlight system and process errors. It is intended as an educational rather than a punitive exercise. Participation in a peer reviewed surgical audit is an annual requirement of the College's Continuing Professional Development (CPD) Program. Participation in VASM provides credits towards satisfying the criteria for re-certification under this program.

Such an audit has been running successfully in Western Australia since 2001. The West Australian Audit of Surgical Mortality (WAASM) database has identified system issues associated with mortality and informed Surgeons of processes to address these issues.

The South Australian Audit of Perioperative Mortality (SAAPM) has been auditing surgically related deaths in South Australia for more than two years. SAAPM is in the process of analysing data for their second Annual Report.

Tasmania was the second Australian state to introduce a voluntary audit of surgical mortality, known as the Tasmanian Audit of Surgical Mortality (TASM). Whilst Tasmania's population is relatively small, the data collected by the audit will be of significant value in improving surgical outcomes.

Through the efforts of Dr Jon Cohen, 14 Queensland hospitals have signed on to the Queensland Audit of Surgical Mortality (QASM). They are delivering notifications of deaths that have occurred in patients admitted to hospital for a surgical procedure or under the care of a surgeon. These hospitals are the largest public hospitals in the state. There are plans to extend this network to include other

hospitals in the near future.

The Clinical Excellence Centre in New South Wales (NSW) is undertaking the Collaborative Hospitals Audit of Surgical Mortality (CHASM) in NSW, which is also a member of the ANZASM, following the same audit criteria, data collection process and assessment protocols.

As part of the nationwide rollout of the audit, participating hospitals will notify VASM of all deaths that occurred in patients who underwent a surgical procedure and/or were admitted under the care of a surgeon. The surgeons responsible for the care of the reported patients will be contacted directly by VASM to request their (voluntary) participation in the audit process. Surgeons who agree to participate will complete the structured audit form and submit it to VASM for peer review by members of the College who have volunteered for the task. The review process is described in a separate communication to health services and surgeons.

Peer review of reported deaths is performed by surgeons in the appropriate subspecialty who have volunteered to be first or second line assessors. These assessors will be chosen at random from a different hospital to that in which the death occurred.

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

The Audit Process

1. Notification of death

The VASM office receives notification of a death from a variety of sources, such as the medical records department of a hospital, the surgeon involved, the Coroner's office or relevant state health record data sources.

2. Surgical Case Form

The surgical case form is posted to the surgeon responsible for the patient's inpatient care. If

the surgeon agrees to participate, he/she will complete the surgical case form and return it to the VASM office.

3. First Line Assessment

All deaths are peer reviewed; this is called 'first line assessment.' A first line assessor will be chosen from the list of regional surgeons who have agreed to act in this role. The surgeon will be of the same specialty, but working at a different hospital to the surgeon responsible. The first line assessor will review the surgical case form and compile a report.

First line assessment will result in one of two recommendations:

Recommendation 1: The surgical case form information is complete and indicates that there were no perceived problems. After providing this feedback to the treating surgeon the case is closed.

Recommendation 2: There is deemed to be insufficient information on the surgical case proforma alone or there are perceived problems with surgical care that warrant further investigation and a patient case note review (second line assessment).

4. Second Line Assessment

A second line assessor will be chosen from the list of regional surgeons who have agreed to act in this role, again from the same specialty but a different hospital. The second line assessor will compile a report based on the surgical case form, the patient's medical records and the first line assessment feedback. The report will again be fed back to the treating surgeon. If the treating surgeon disagrees with the report a further review can be requested.

5. Victorian Surgical Consultative Council (VSCC) Assessment

A referral to VSCC will be made of all de-identified reports from VASM cases that have been referred for second line assessment, reviewed by first and second line assessors and classified as requiring further review by a cross-section of surgeons.

“As part of the nationwide rollout of the audit, participating hospitals will notify VASM of all deaths that occurred in patients who underwent a surgical procedure and/or were admitted under the care of a surgeon”

It is possible that the audit process might occasionally identify surgeons perceived to be responsible for persistent adverse outcomes. The College has a moral and ethical responsibility to review the basis of such perceptions and decide if such a surgeon could be considered to be a possible ‘Outlier’. This potential but sensitive area is currently under review by RAAS Division of the College. It is important to reiterate that the aim of the project is to

educate and to improve patient safety and to avoid a ‘naming and shaming’, punitive approach.

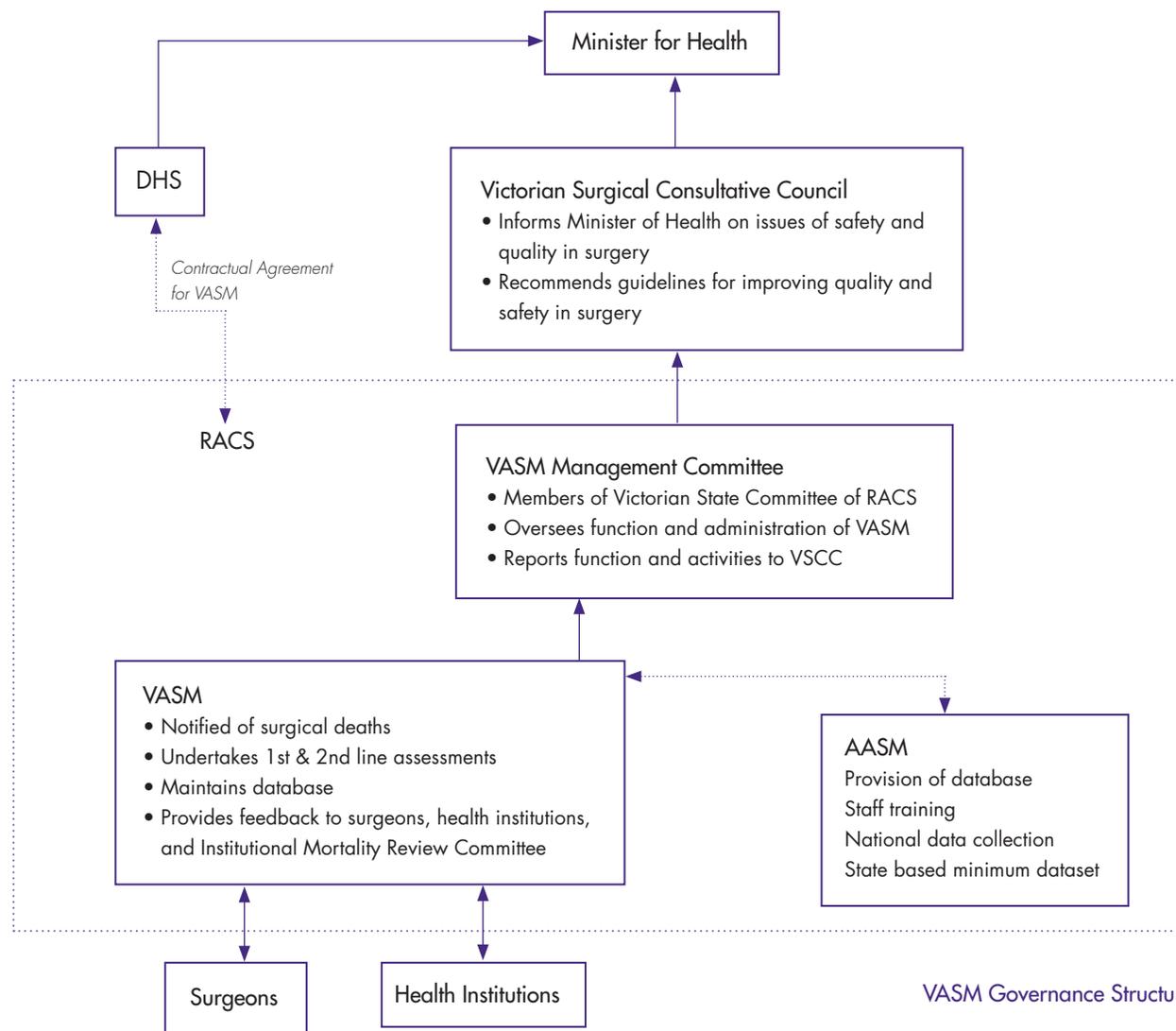
The VSCC was established by the Minister for Health in 2001 to review causes of avoidable mortality and morbidity associated with surgery and to provide feedback to the medical profession on any systemic issues identified. VSCC has reviewed issues associated with Coroners cases, “Sentinel Events” reported to the Victorian Department of Human Services and cases voluntarily reported directly to VSCC by surgeons. The commonality of goals has encouraged a close working relationship between VASM and VSCC. This has led to the appointment of the Chairman of VSCC to the management committee of VASM and the Clinical Director of VASM being co-opted onto the VSCC.

The VSCC has indicated it will cease reviewing reports of surgical mortality sent directly to it after 1 January 2008 and urges Fellows to direct such reports to VASM for review. This will minimise any duplication of reporting.

VASM will inform the VSCC of trends in surgical mortality and assist with the development of processes to enable the surgical community and healthcare providers to address any system issues. Along with the VSCC, VASM aims to support further improvements in patient care in Victoria. VASM is also intended as a collegial method of encouraging surgeons to participate in mortality audits.

All Victorian surgeons will now have received an invitation to participate in VASM, and an ‘Agreement of Consultant Participation’ form. If you have not already done so, please return your form to the VASM project team indicating your agreement to participate and act as a first and/or second line assessor. Please use the reply paid envelope provided.

For further information on the audit, the VSCC’s Project Officer can be contacted on +61 3 9096 1382 or via email at: vscc@dhs.vic.gov.au. The VASM office can be reached on +61 3 9249 1128 or via email vasm@surgeons.org.



VASM Governance Structure



Melinda Van Oosterum,
Advocate, Rural Surgical
Training Program

The Windy City

I was grateful for the opportunity to work in Whyalla, the depth and range of surgical work was amazing

I started the six-month term back in August. I brought my hockey stick and my tennis racquet, as well as the youthful enthusiasm of a junior registrar, eager to 'become' part of the community.

I didn't get to play tennis or hockey, or much of any sport for that matter. But I did become part of the community. I'm not sure when it actually happened, but I do know when it became obvious to me.

I was about two months into the term, on-call for the weekend. It had been a pretty busy weekend, with lots of calls from the usual cuts and injuries caused by Friday and Saturday revels getting out of hand. Mid Sunday afternoon was the first chance I had to get a breather, and I decided to walk down to the shopping centre to buy a paper. I had just arrived when I received another phone call. The emergency registered nurse told me that she had a 12 year old en-route to the hospital in a critical condition, with unknown injuries. It takes me seven minutes to drive to the hospital on a normal

day. I ran home from the shops and raced to work in just over three minutes.

Whyalla means 'windy city' in the local aboriginal dialect. On this particular day, it had been really windy, and a tree had been uprooted in one of the church grounds. This young girl, our patient, had been struck and pinned down by the tree. It had taken the ambos around 12 minutes to free her. Unfortunately, she never recovered from the injuries she sustained.

"There was a lot of fantastic work on this rotation, with an extremely broad range."

Becoming part of the community brings all sorts of challenges. This young girl was the next door neighbour of one of the emergency nurses, the social worker's son went to the same church with his kids and their families had witnessed the whole thing. This was not just a patient, but a person who was part of the

community, and somehow this accident had managed to reach deep into the hearts of all of those people involved, myself included.

There was a lot of fantastic work on this rotation, with an extremely broad range. I managed to do everything from shoulder relocations in the Emergency Department to ovarian cystectomy, hone methods in colonoscopy and endoscopy, perform laparoscopic procedures as well as quite a good number of open appendicectomy and cholecystectomy procedures, and my first unassisted inguinal hernia repair. The depth, breadth and range of rural surgery is astounding, and the community is truly lucky to have the skills of the two surgeons that are currently in Whyalla. I owe a lot of my surgical education to them, and I don't mean just the operative side of things either.

But what I really got out of this rotation was not the work, although that happened as we went along. I learnt that the thing that makes you part of the community is not what you do for them, but what they do for you.

AUSTRALIAN & NEW ZEALAND POST FELLOWSHIP TRAINING PROGRAM in Colon & Rectal Surgery 2009

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

Information and Enquiries:

www.cssanz.org
Professor Michael Solomon: msolomon@med.usyd.edu.au

Closing Date:

Friday 16th May 2008

Applications:

Applications are to be made by letter, including Curriculum Vitae and the names and addresses of three referees.

Please send to:

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





**AUSTRALIAN & NEW ZEALAND
HEAD AND NECK SOCIETY**
10TH ANNUAL SCIENTIFIC MEETING



TRANSLATION & COMMUNICATION



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Professor Gregory Wolf

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Meeting Announcement



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College Conferences and Events Management

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Under the Auspices of the Royal Australasian College of Surgeons

INTERNATIONAL CONFERENCE ON SURGICAL EDUCATION AND TRAINING



5 MARCH 2008

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
MELBOURNE, VICTORIA, AUSTRALIA

Convener: John P Collins, Dean of Education, RACS

- Selection of Trainees - Reaching an international consensus
 - Workplace-based assessment - Use of new tools and their feasibility
 - Managing the underperforming trainee
 - Simulation - What is its role?

Join the panel of International and Local Experts to discuss these important and difficult questions and reach a consensus, a summary of which will be published in the Australian and New Zealand Journal of Surgery.

Further information: kymberley.walta@surgeons.org

Information for the 13th Ottawa International Conference on Clinical Competence can be found at www.ozzawa13.com
Hosted by Monash University and The University of Melbourne

Workplace Bullying



Andrew Lewis, Senior Industrial Relations Adviser, AMA Victoria

Workplace bullying and harassment

A hospital issue with an ever increasing profile

On 7 October, the Sunday Herald Sun reported on one of AMA's recent major wins under the headline "Bullied doctors paid \$290,000 compensation". The article explains that the settlement was to a large extent based on underpayment of wages but made clear that allegations of bullying underwrote the dispute.

Allegations were made in the Australian Industrial Relations Commission that doctors were forced to work high risk unsafe hours for an unlawfully low salary under threat of not being re-employed. These allegations reflect not just what the article described as "an embarrassment for the Health Service" but if proven would have exposed the employing hospital to civil penalties and expose the perpetrators to dismissal for their breach of hospital Code of Conduct.

AMA Victoria can report an increasing number of Doctor-in-Training (DiT) members seeking advice and/or representation because they no longer wish to tolerate inappropriate work cultures as exist in some hospital units or sub-specialities. It is not acceptable for some areas to choose bullying and harassment as a way of ensuring an existing culture prevails where, for example, overtime payment is refused and DiT advocacy for change is deemed unacceptable. The legal reality is that hospitals must pay for all work performed and the management reality is that encouraging DiT consultation and local level problem solving is best practice.

In addition to this type of bullying, there



appears to be some prevalence of verbal abuse in the workplace. DiTs may be able to rationalise their toleration of such behaviours on the grounds that in high stress, time critical, life and death scenarios "blowing off steam" or belittling someone for perceived incompetence in front of colleagues is understandable; at least to some extent. The same rationalisations may apply when a DiT is on the receiving end of destructive innuendo or inappropriate jokes. However, for DiTs to rationalise and tolerate bullying is wrong headed and only nurtures a negative culture.

If you exhibit or are on the receiving end of any of the above or similar behaviours the priority should be to change the behaviours. It is worth noting that apart from bullying reflecting unprofessional conduct, the circumstances within which bullying behaviours manifest are

not capable of mitigating culpability or acting as a useful defence.

In the environment described a DiT can feel powerless and be concerned about "bucking the system". However, in light of AMA Victoria's recent win and emerging legal precedent, Victorian public hospitals regard these issues as a main focus of risk management and will actively support DiT claimants. This year several DiTs in separate, unrelated, cases alleged bullying and were successfully represented by AMA Victoria.

In each case AMA and the DiT concerned operated within structured hospital policy frameworks that encourage visibility of issues, resolution by mediation wherever possible and independent investigation where required. The positive outcomes from these processes can assist the wellbeing of DiTs generally and give hospitals the tools to manage change and improve culture. This is because potential costs of dispute and litigation are avoided and the benefits of workplace communication, trust and productivity are enhanced.

Stamping out bullying and harassment is a core focus for hospitals wanting employer of choice status to ensure they recruit and retain the best doctors. Any DiT Member believing they may be bullied can ring AMA Victoria's Workplace Relations and Advocacy Unit for confidential advice and support.

Reprinted the AMAs' vicdoc, December 2007 issue, with kind permission.

LOANS FOR TRAVELLING FELLOWS 2007

The Royal Australasian College of Surgeons provides a number of interest free loans to Fellows who plan to undertake approved studies outside Australia and New Zealand.

To be eligible to apply for a loan, an applicant must:

- Be a financial member of the College.
 - Demonstrate financial need.
 - Be assessed as undertaking appropriate research and/or training.
 - Not have an application pending, nor have received, a RACS Scholarship or Fellowship co-incidental with this loan.
 - Not receive more than one loan every five years.
- Applications can be submitted at anytime with assessment

being undertaken upon receipt.

Loans will not exceed A\$20,000 each and will be subject to the availability of funding. These loans are interest free for a period of up to two years.

For further information on applying for a loan, please contact:
Megan Sproule
Tel: +61 3 9249 1220
Email: megan.sproule@surgeons.org



Law Report



Michael Gorton,
College Solicitor

Caring and sharing – privacy of genetic information

Changes to the Privacy Act (Cwlth) made in 2006 have made it easier for medical practitioners to disclose genetic information of patients to their relatives who might be affected by genetic conditions or genetic weaknesses.

The Privacy Act 1998 has for some time imposed general privacy obligations and confidentiality obligations on those who collect or hold personal health information. These statutory obligations have been in addition to the ordinary common law duties of doctors to maintain patient confidentiality. In many respects, the Privacy Act has simply reflected existing obligations on doctors to appropriately collect, use and prevent disclosure of personal health information.

The Privacy Act has always had an exception to permit disclosure if a Doctor reasonably believes that the use or disclosure is necessary “to lessen or prevent a serious and imminent threat to an individual’s life or safety, or a serious threat to public health or public safety”.

Several legal cases have permitted doctors to disclose personal health information “in the public interest”.

A New Zealand case in 1958 acknowledged that in some circumstances disclosure of confidential information may be necessary in the public interest, with a possibility of harm to the patient or to others arose. Similar issues arose in circumstances surrounding the Victorian ‘Queen Street killings’ in 1987, where a counsellor/psychologist of the gunman may have been aware of a psychiatric disorder. The Coroner in that case has suggested formal mechanisms were needed for referral of such information where harm to the individual or others was possible. In a 1976 USA case, the Court considered whether there was a duty or obligation on a doctor to reveal information, where there was the threat of harm to others. In the US case, when the doctor became of a threat via patients to kill the patient’s girlfriend, the doctor issued no warning regarding the intention, and

the Court determined that the public interest required disclosure, which was not outweighed by the importance of preserving the confidentiality of the doctor/patient relationship. A UK case in 1989 involved disclosure by a doctor, without the patient’s consent, of information regarding the psychological state of the patient. The UK Court agreed that, although the doctor owed a duty of confidence to the patient, the doctor had an overriding duty to the public to reveal the information to the Authorities. (See “Surgery Ethics and the Law - Dooley, Bearnside, Gorton, 2000 pp 164-165).

The amendments to the National Privacy Principles in 2006 have extended exceptions to permit disclosure in relation to genetic information.

Genetic information can now be disclosed if:

- the doctor reasonably believed that the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety (whether or not the threat is imminent) of an individual who is a genetic relative of the patient, and
- the recipient of the genetic information is a genetic relative of the patient, and
- the use of disclosure is conducted in accordance with guidelines issued by the Privacy Commissioner.

A “genetic relative” is an individual who is related to the patient by blood including, but not limited to, a sibling, parent, or a descendant of the patient.

These amendments do not make it mandatory for doctors to disclose genetic information to relatives who may be at risk or affected by genetic condition or disorder. The new provisions are merely permissive.

In addition, the amendment does not change the existing common law duty or obligation of patient confidentiality. At common law, to disclose patient information there would still need to be a “public interest” in disclosing the information, because the relatives were at

“The changes to the Privacy Act go some way to providing additional protection to doctors who must seriously consider whether private genetic information of the patient should be disclosed to relatives who may be at risk.”

risk. It is not clear, as yet, what degree of “risk” required, and a minimal or merely potential risk may not be sufficient to warrant disclosure in the public interest. Doctors would need to consider the likelihood of the genetic disorder or condition affecting the relative, as well as the degree of harm involved in the genetic condition or disorder, whatever the likelihood. The legislation requires that there must be a “serious risk” before disclosure is permitted.

Nonetheless, the changes to the Privacy Act go some way to providing additional protection to doctors who must seriously consider whether private genetic information of the patient should be disclosed to relatives who may be at risk.

Of course, in the first instance, the consent of the patient can always be obtained to the disclosure, and then disclosure made freely. However, where a patient does not provide consent, these changes offer some additional protection to doctors concerned about relatives who ought to be made aware of the possible risk to them.

References

- 1 “Disclosure of Genetic Information to at risk relatives: Recent amendments to the Privacy Act”, 1998, Otlowski, MJA October 2007 Vol 187 No. 7.
- 2 “Medical Records and Confidentiality”, Michael Gorton (“Surgery Ethics and the Law”, Dooley Bearnside Gorton, 2000)



Trauma



Rob Atkinson, Chair, Road Trauma Advisory Subcommittee

You can help stop the road carnage

The Colleges' Road Safety Watch Program - opening a forum for Fellows and their families to identify problems within their communities

We've seen the dramatic fall in road deaths due to seatbelt legislation and the introduction of RBT, but still too many needlessly die or are seriously injured on our roads.

Road trauma has become an epidemic. It is the most likely cause of death for those aged four to 44 years and it has been suggested that over the next decade, road trauma will rank ahead of cancer in terms of life-years lost. The Chair of the National Transport Commission said recently at a National Transport Summit that as a community we have embraced the fight to find a cancer cure by donning pink for a day. We've supported the research into SIDS by acting the clown, red noses strapped to our faces, yet we, as a community don't embrace the fight to find a solution to reducing the carnage on our roads. We need to share the responsibility and not just leave it to the

Government and road authorities to do so.

But how can we do this? The College Road Trauma Advisory Subcommittee and its regional trauma committees have thought that we can begin to do something within our organisation by opening a forum for Fellows and their families to identify problems within their own regions or communities. These ideas would be looked at by the Road Trauma committee and action facilitated within the government bureaucracy for appropriate action. This might begin to empower the College community at least to manage circumstances surrounding road trauma and by developing a culture of responsibility and empowerment, it may lead to improved road conditions and behaviour that could translate into less road trauma. Perhaps you might think about taking this idea to the

wider community and a good starting point could be college staff, practice staff, hospital staff, families and patients. In 2002, this idea was trialled with some success in the South Australian community of Millicent.

Do you have a road safety concern? Write an email to road.safety@surgeons.org including the following:

1. Clearly define the problem. Perhaps attach a photo illustrating the problem;
2. Present one or more plausible solutions;
3. Identify the Accountable Body/Authority responsible;
4. Estimate a sensible time-line for resolution.

The Road Trauma Committee will publish regularly on the College's website, www.surgeons.org some of the problems and appropriate actions.

Handover

MJ Fasset, TJ Hannan, IK Robertson,
SJ Bollipo & RG Fasset

A national survey of medical morning handover report in Australian hospitals

Clinical handover is the transfer of information and responsibility for patient care from one doctor, or medical team, to another within the broader context of care. In 2005, 53 Australian hospitals, classified as accredited for basic physician training, responded to a questionnaire survey to identify use, structure and format of a type of clinical handover; the medical morning handover report (MMHR). The aim of MMHR is to help to ensure adequate transfer of information and responsibility between after-hours and day personnel in hospitals.

Results: The survey showed that those hospitals with a higher level of Royal Australasian College of Physicians (RACP) accreditation were more likely to use MMHR

but that overall only 58 per cent of hospitals routinely carried out MMHR (n=31). Handovers in those hospitals took an average of 15-30 minutes, focused on complete handover of cases, was chaired by a consultant, included no formal teaching and was used to discuss ward problems occurring overnight.

The authors note that this low rate of MMHR use is not in keeping with recently published Australian Medical Association guidelines or with the RACP accreditation requirements that a consultant-led handover should be conducted. They conclude that greater commitment is needed to encourage MMHR use, potentially linking to other accreditation processes to ensure compliance.

Take Home Message

This survey shows that the uptake of clinical handover procedures is still alarmingly low in many Australian hospitals, pointing to the need for systems and programs to encourage clinical handover practices that assist doctors across metropolitan and rural hospitals.

The AMA guide to clinical handover, Safe Handover: Safe Patients, provides more information and is available at: www.ama.com.au

Reprinted from the Australian Patient Safety Bulletin Newsletter, Newsletter of the NHMRC Centre of Research Excellence on Patient Safety October 2007, Issue 7.



QASM Update



Jon Cohen,
Clinical Director of QASM

Queensland Audit of Surgical Mortality

About half of the Fellows from Queensland have agreed to participate in the audit

The Queensland Audit of Surgical Mortality (QASM) is functioning strongly again. The start-up was suspended temporarily while Queensland Health and the College clarified some legislative issues.

Through the efforts of Dr Jon Cohen, 14 hospitals have signed on; they are delivering notifications of deaths that have occurred with patients admitted to hospital for a surgical procedure or under the care of a surgeon. These hospitals are the largest public hospitals in the

state. There are plans to extend this network to include other hospitals in the near future.

Approximately half of the Fellows from Queensland have agreed to participate so far, and the majority have agreed to be assessors. Because of the volume of work involved, more are needed.

As of late January 2008, 206 notifications of death have been received, but it is too early yet to release any findings from the audit. Individual feedback is being continually sup-

plied to surgeons; case note reviews will be distributed twice a year; and an annual report will be sent to all Queensland surgeons.

The year was spent establishing the project and 2008 promises to be busy. We look forward to presenting our first annual report.



THE UNIVERSITY
OF ADELAIDE
AUSTRALIA

16th Seminars in Operative Surgery

ROYAL ADELAIDE HOSPITAL, SOUTH AUSTRALIA

An international meeting focussing on the Oesophagus, with keynote speakers:

- Luigi Bonavina, Professor of Surgery, Institute of General & Oncological Surgery, University of Milan, Italy
- Bernard Launois, President, French Academy of Surgery, Paris, France
- Robert Luketich, Professor & Chief, Division of Thoracic and Fore-gut Surgery, Presbyterian University Hospital, Pittsburgh, Philadelphia, USA
- Jan van Lanschot, Professor & Chairman, Department of Surgery, University of Rotterdam, Netherlands
- John Windsor, Professor of Surgery, University of Auckland, Auckland, New Zealand

This educational activity has been approved in the Royal Australian College of Surgeons' CPD Program. Fellows who participate can claim one point per hour (maximum 15 points) in Category 4: Maintenance of Clinical Knowledge and Skills towards 2008 CPD totals.

And an opportunity to learn in detail the state-of-the art in Oesophageal Surgery and Oesophageal Disease featuring two stand-alone one-day seminars:

- Thursday, 6 March 2008 – Seminar: Oesophageal Structure & Function in Health & Disease
- Friday, 7 March 2008 – Seminars in Operative Surgery of the Oesophagus

Registration deadline Friday, 15 February 2008. Please book early to avoid disappointment (Accommodation in Adelaide will be scarce during this time due to the Festival of Arts)

Find information, brochures, program and registration form online at <http://www.health.adelaide.edu.au/surgery>

Seminar enquiries to Professor Glyn G Jamieson
Registration and general enquiries to Irene Burlein

Tel 08 8222 5516
Fax 08 8222 5596
Email irene.burlein@adelaide.edu.au

REGISTRATION FEE

- AUD\$250 (incl. lunch) Thursday, 6 March 2008
- AUD\$300 (incl lunch & dinner) Friday, 7 March 2008
- AUD\$400 (incl lunches & dinner) Thursday 6 & Friday 7 March 2008





THE 16TH SEMINARS IN OPERATIVE SURGERY

Eleanor Harrald Building, Royal Adelaide Hospital
Oesophageal Structure & Function in Health & Disease -
A One-day Course, Thursday 6 March 2008



THE UNIVERSITY
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AUSTRALIA

1. 08:30 -09:00

Registration in the Eleanor Harrald Building, Level 1, Royal Adelaide Hospital

2. 09:00 – 09:30

The normal function of the upper oesophageal sphincter and its relationship to high cervical dysphagia and to Zenker's diverticulum

Ian Cook

3. 09:30 – 09:50

Normal peristalsis, abnormal peristalsis and other motor function abnormalities in the body of the oesophagus

Geoffrey Hebbard

4. 09:50 – 10:10

Nerve gut interactions in the oesophagus – the current state of knowledge and some thoughts on future directions

Ashley Blackshaw

5. 10:10 – 10:30

Deconstructing and constructing the anatomy of the gastro oesophageal region

John Windsor

10:30 – 10:50 *Morning Tea*

6. 10:50 – 11:15

The mechanics of Impaired Gastroesophageal Competence

John Dent

7. 11:15 – 11:40

Standard and high resolution manometry and their use in differentiating diaphragmatic from lower sphincter function with particular reference to dysphagia after fundoplication

Jennifer Myers

8. 11:40 – 12:15

Gastric emptying and its derangements with particular reference to gastro oesophageal reflux disease

Michael Horowitz

12:15 – 13:00 *Lunch*

9. 13:00 – 13:35

Functional disorders of the oesophagus and stomach

Gerald Holtmann

10. 13:35 – 14:10

The cardia: the beginning of the end (of the oesophagus) or the end of the beginning (of intestinal metaplasia)?

Sarah Thompson

11. 14:10 – 14:35

Methylation and its role in intestinal metaplasia and adenocarcinoma of the oesophagus

Eric Smith

12. 14:35 – 15:10

A short course in immunohistochemical techniques used for the diagnosis of lymph node micrometastases in oesophageal cancer

Andrew Ruszkiewicz

15:10 – 15:30 *Afternoon Tea*

13. 15:30 – 16:05

Stem cells and their relationship to oesophageal cancer

Wayne Phillips

14. 16:05 – 16:40

Molecular genetics and oesophageal cancer – Quantitative pathology using molecular markers and the application of micro array technology in predicting cancer dissemination

Jan van Lanschot

Fax: +61 8 8222 5896 Tel: +61 8 8222 5516
Email: irene.burlein@adelaide.edu.au <http://www.health.adelaide.edu.au/surgery>





THE 16TH SEMINARS IN OPERATIVE SURGERY

Eleanor Harrald Building, Royal Adelaide Hospital

Operative Surgery of the Oesophagus -
A One-day Course, Friday 7 March 2008



THE UNIVERSITY
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AUSTRALIA

- 08:00 – 08:30** Registration in the Eleanor Harrald Building, Level 1, Royal Adelaide Hospital
- 08:30 – 09:00** **THE JOHN LUDBROOK LECTURE** *Chairman, Glyn Jamieson*
The Contributions of French Surgeons to the Surgery of the Oesophagus *Bernard Launois*
- 09:00 – 10:45** **ANTI-REFLUX SURGERY: THEME AND VARIATIONS** *Chairman, Guy Maddern*
- Total Fundoplication: Short gastrics? Pledgets? Bougie? *Sarah Thompson*
Anterior or posterior narrowing of hiatus?
- Anterior Fundoplication: One way *John Windsor*
Another way *Les Nathanson*
And yet another way *Glyn Jamieson*
- Posterior Fundoplication *David Gotley*
- Revisional Surgery: Laparoscopic *Mark Smithers*
Open *Glyn Jamieson*
- Endoscopic Surgery *David Watson*
A new sphincter augmentation device for antireflux surgery *Luigi Bonavina*
Anti-reflux Surgery in the Obese: Strategies to help the Surgeon *Philip Game*
Roux-en-Y gastric bypass as an anti-reflux operation *James Luketich*
Mesh repair of hiatus hernia *Garret Smith*
- 10:45 – 11:00 *Morning Tea*
- 11:00 – 12:45** **SURGERY FOR MOTILITY DISORDERS, BENIGN TUMOURS** *Chairman, Peter Devitt*
- Myotomy and anti-reflux procedure for achalasia *Simon Woods*
The European randomized achalasia trial: endoscopic versus operative therapy *Jan van Lanschott*
Revisional surgery in achalasia *David Watson*
Zenker's diverticulum: endoscopic treatment *Luigi Bonavina*
Zenker's diverticulum: open treatment *Peter Lamb*
Epiphrenic diverticulum: open and laparoscopic approaches *Les Nathanson*
Removal of benign tumours of the oesophagus, laparoscopic and thoracoscopic approaches *Luigi Bonavina*
- 12:45 – 13:45 *Lunch*
- 13:45 – 15:45** **CANCER OF THE OESOPHAGUS** *Chairman, Justin Bessell*
- How we undertake a synchronous abdominal and thoracic approach for oesophagectomy with incidental lymphadenectomy *Andrew Lord*
How and why I undertake a node dissection in the abdomen and the thorax *Jan van Lanschott*
How I construct an anti-reflux anastomosis *Glyn Jamieson*
How I undertake a laparoscopic and thoracoscopic oesophagectomy *James Luketich*
How I undertake a vagal sparing and/or eversion extraction oesophagectomy *Peter Devitt*
- TRAUMA
How I treat Boerhaave's Syndrome *Jan van Lanschot*
- 15:45 – 16:00** Afternoon Tea
- 16:00 – 17:30** Horror movies: a catalogue of mistakes, complications and acts of God *Chaired from his 'glasshouse' by Glyn Jamieson*
- 19:00 *Seminar Dinner*

Fax: +61 8 8222 5896 Tel: +61 8 8222 5516
Email: irene.burlein@adelaide.edu.au <http://www.health.adelaide.edu.au/surgery>



Fellows in the News



Di Morrison & Peter Hewitt visit a remote Masai community in Tanzania; the people here have to walk long distances to fetch water.

Peter Hewitt Care for Africa Foundation

The aim is to improve the lives of less fortunate African people and to cultivate an ethos of philanthropic endeavour in young Australians

Tasmanian Surgeon Dr Peter Hewitt, who was born in Pretoria, South Africa and first started working as a consultant in Cape Town, always intended in his later career to give back what he could to the continent of his birth. Like many surgeons, he had visions of a dynamic, philanthropic retirement phase. But since he diagnosed his own advanced prostate cancer in 2004, he has been forced to accelerate the process.

Thus in a profound testament to his courage and determination, the Upper GI/Hepatobiliary surgeon has established a charity, called the “Peter Hewitt Care For Africa Foundation”, to do just that.

“I was looking at an academic career and then a fulfilling retirement but when something like this happens, you have to take a radical left turn. It makes you realise there are more important things in life than your own personal plans. So we developed the Foundation and I am loving it, particularly seeing the enthusiasm of young people who want to help,” he said.

Along with Launceston nursing colleague Di Morrison, Dr Hewitt established the aid organisation not just to provide much-needed assistance

to struggling African communities, but to promote the spirit of philanthropy in Australia.

According to the Foundation, the central mission is not only to provide aid to those less fortunate but to cultivate an ethos of philanthropic endeavour in young Australians through participation in projects that advance the well-being of orphans and other groups in need in Africa.

“What we are aiming to do is try and enrich the lives of local young people at the same time as we try to improve the lives of Africans. We’re trying to get them away from their iPods and video games and their consumer lifestyles, so that they can see what life is like for children in poorer communities,” Dr Hewitt said

“A number of schools have now become involved and we have so far sent two container loads, one with an ambulance in it, and a third container is almost ready to go. It has been amazing to see the enthusiasm of the young people. I often think that they just don’t get a chance to participate in projects like this but when the opportunity is offered they love it.”

Dr Hewitt’s first African trip was initiated

after hearing the stories told by the daughter of a doctor based in the Northern Tanzanian town of Tarime. At the time she was spending her junior doctor’s year at the Launceston General Hospital. When she explained the conditions in which her father worked, hospital staff began fundraising to send a container-load of medical equipment to the impoverished community, and later, Di Morrison and Dr Hewitt visited Tarime which he describes as “one of the poorest places on the planet”.

“The amazing thing though, is that everyone there is happy. They have absolutely nothing but they don’t have all the hang-ups that we in the First World have.”

“While I was in Tarime I did some work in the hospital doing gynaecological and general cases and it was an extraordinary experience. They had no oxygen, no monitoring, no cautery, no running water, no sterilisation equipment and the anaesthetist was the gardener who gave Ketamine. Subsequently we installed an autoclave and the labour ward has been refurbished with separate cubicles for patients and a resuscitation unit,” he said.



But Dr Hewitt said that while the project began with medical aid as a focus, it was now being designed around a general needs basis.

“Although the first couple of containers have carried medical equipment - like a generator, beds, linen and equipment for a hospital, there are also urgent needs in terms of education which we aim to address,” he said.

“Only 4.8 per cent of Tanzanian children can afford to go to secondary school and yet they are all so incredibly keen to learn.

“At the same time most teachers have had no formal training, so we want to try and develop teach-the-teacher courses in which we raise money to send Australian teachers to help. We are also in the process of collecting reference books and computers, because in Tanzania if you can speak English and have computer skills your chances in life improve dramatically.

“And some of the schools have no safe water. This is also a problem in many of the communities where people get their water from shallow wells that are infected with typhoid. So one project we have is to pipe water from a mountain spring to a Masai village, but we have to dig deep trenches for the pipes otherwise the elephants tear them apart.”

Dr Hewitt said the local reaction to the Care for Africa Foundation had been “fantastic”. A fundraiser held recently in Launceston, the Love Africa Spring Ball, was expected to attract 300 people but instead 450 turned out to aid the organisation.

“So many people want to get involved and so many want to go and help, like nurses, medical students, builders and teachers, but we need to have the infrastructure in place first. They need identified projects to work on or it becomes too chaotic and the conditions in Africa are just so different from Australia,” he said.

“But the enthusiasm has been incredible to see and I never thought it would take off like this within less than a year.”

Dr Hewitt said that as part of the mission to engage with local young people, the “Care For Africa Foundation” was hoping this year to send 12 disadvantaged children on a visit to the region.

“We would like to send over kids who might otherwise never have the chance to travel but who would benefit from a world view. We also want to focus on schools in Africa, maybe 10 or 15, and then partner them with local schools here so that they can start fundraising projects to help with things like libraries and sports facilities because none of the schools in the African communities we are working with have anything like that,” he said.

“As part of the mission to engage with local young people, the “Care For Africa Foundation” was hoping this year to send 12 disadvantaged children on a visit to the region.”



Just before his last trip to Africa, Dr Hewitt had to have radiotherapy for a metastasis in the brain, but as soon as the treatment was finished he climbed on the plane. He didn't want to stay and dwell on his problems when there was an opportunity to help others. He said fighting the disease was a complex experience as a surgeon.

“One, you know too much and two, you have the dichotomy of being a doctor and a patient at the same time,” he said.

“One minute I can be sitting having chemotherapy next to a person I'll be operating on later in the week the next minute my oncologist will come with a pile of X-rays wanting my opinion on some of his other patients. It's a Dr Jekyll-Mr Hyde experience but eventually you realise you can be a hybrid, and there is some comfort in that I suppose.”

Dr Hewitt said that if surgeons wished to support the Foundation there was much to be done. He said while most Fellows would be vastly over-qualified for the work in Tanzania given the limited facilities, there were a lot of people suffering birth defects and chronic disabilities in some communities.

However, he said rather than treating them

Top: In the middle of nowhere, Trans Mara, Southern Kenya: Peter Hewitt looks on as a colourful church procession approaches.

Above middle: The Tanzanian school curriculum focuses on didactic teaching of traditional subjects like chemistry and physics while some subjects like English are poorly taught. Children would benefit far more by learning computer skills or some type of trade.

Above: Peter Hewitt and scrub nurse Tatu operating in the Tarime Goodwill Foundation Hospital; sometimes the lights fail and the surgery has to be completed by torch-light.

directly, donations to help them get to local hospitals could be of greater practical assistance. To become involved or make a donation please visit www.careforafrica.org.au





*Anthony Scott,
Professorial Fellow,
University of Melbourne*

Improving your working life – MABEL

MABEL (Medicine in Australia: Balancing Employment and Life) is a new national longitudinal survey of doctors funded by the NHMRC. Policies about the medical workforce and how to alleviate shortages of doctors need to be based on evidence about doctors own views, preferences and work and family circumstances. Otherwise such policies are unlikely to work and be insensitive to the realities of medical practice in Australia.

MABEL is the first survey to provide such rigorous evidence in Australia. It will be used to: i) improve doctors' morale and work satisfaction, thus leading to improved patient care; ii) improve the population's access to medical

services; iii) develop policies to help doctors manage their workload; and iv) improve the evidence base of medical workforce policy.

MABEL focuses on examining a number of issues influencing the work-life balance of all types of doctor in Australia, and includes doctors in training to doctors close to retirement. The longitudinal nature of the survey is very important as it will enable changes in doctors' views, preferences and circumstances to be examined and followed up over time. The survey gives doctors the opportunity to provide important information about what it is like working in medicine and how this interacts with their family and personal life.

Invitation letters for the first wave will be posted to a stratified random sample doctors in May 2008, and piloting is taking place at the moment. Doctors can also register to take part in MABEL at www.mabel.org.au.

The survey is being led by Professor Anthony Scott at the Melbourne Institute of Applied Economic and Social Research at the University of Melbourne, in collaboration with the Faculty of Medicine, Nursing and Health Sciences at Monash University. The survey is supported by a Policy Reference Group comprising professional organisations and state and commonwealth governments to ensure the survey is relevant and its results implemented.

CLINICAL DIRECTOR – INTERNATIONAL MEDICAL GRADUATES ASSESSMENTS DIVISION OF EDUCATION AND TRAINING ADMINISTRATION

0.4 EFT Position (days negotiable)

Melbourne CBD

Salary Package

A part-time (0.4) position exists in the IMG Assessments Department at the Royal Australasian College of Surgeons for a Clinical Director who has previous experience in medical education and administration, and is a Fellow of the Royal Australasian College of Surgeons.

Reporting to the Director, Education and Training Administration and working closely with the Senior Manager, IMG Assessments, the Clinical Director has a key role in the preliminary assessment of International Medical Graduates who want to practice surgery in Australia for comparability with a surgeon who has trained in Australia or New Zealand.

This role involves collaboration with the Specialist Societies, the Australian Medical Council (AMC), the Department of Health and Ageing, Medical Boards, and other state health jurisdictions. The successful applicant will also be responsible, with the Senior Manager, for reviewing the assessment process and developing support mechanisms for IMG supervisors.

Qualifications & Experience

- Experience in a medical administration role
- Experience in quality improvements processes
- Demonstrated experience in assessment of medical practitioners
- Demonstrated experience in quality improvement and/or evaluation
- Demonstrated experience in liaising and negotiating with a wide range of professional stakeholders including government jurisdictions at all levels, both internally and externally to the organisation

Skills

Demonstrated ability in the following areas:

- Development of assessment tools to evaluate medical expertise
- Data management and database management
- Ability to undertake reviews of processes
- Utilisation of software packages: Microsoft, statistical analysis and Adobe
- Substantial ability to analyse and streamline processes through a quality improvement approach
- Well developed interpersonal and communication skills
- Well developed negotiation skills

Enquiries can be directed to Mr. Glenn Petrusch, Director, Education and Training Administration,
Royal Australasian College of Surgeons on +61 3 9276 7461 or via email glenn.petrusch@surgeons.org



2009

ROWAN NICKS SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the 2009 Rowan Nicks Scholarships and the 2009 Rowan Nicks Pacific Islands Scholarships. These are the most prestigious of the College's International Awards and are directed at surgeons who are destined to be leaders in their home countries.

The 2009 Rowan Nicks Scholarships are offered to surgeons from Asia, Africa or the Middle East. It is intended to provide an opportunity for the surgeon to develop skills to manage a department and become competent in the teaching of others in their home country. It is emphasised that the scholarships objectives are leadership and teaching and it should not be used solely to develop surgical skill. The scholarship is usually awarded for a period of between three and twelve months.

The 2009 Rowan Nicks Pacific Islands Scholarships are reserved for surgeons from Pacific Island countries. It is aimed at promoting the future development of surgery in the Pacific Islands by providing a period of selective surgical training with the specific purpose of fostering the scholar's potential to provide surgical leadership in his/her home country. The scholarship is usually awarded for a period of between three to six months.

These scholarships cover the scholar's travel expenses between their home country and Australia or New Zealand. A living allowance will be provided equivalent to AUD\$36,000 for up to twelve months or appropriate pro-rata for a scholarship in Australia and NZ\$36,000 for up to twelve months or appropriate pro-rata for a scholarship in New Zealand. The scholarship is tenable in a major hospital (or hospitals) in Australia or New Zealand, and appointees will attend the Annual Scientific Congress of the College if they are in Australia or New Zealand at the relevant time.

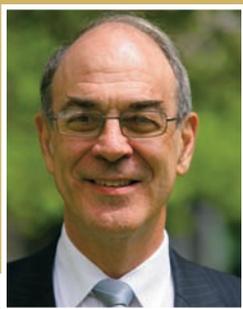
Applicants should be under 45 years of age, fluent in English (an English proficiency test will be requested) and be a citizen of the country from which the application is made. Applicants must undertake to return to their country on completion of the scholarship programme.



Closing date for these Scholarships is **5pm Monday 14 April 2008**
A copy of the application form for either Scholarship is available at www.surgeons.org.
For additional information please contact:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street
Melbourne VIC 3000 Australia
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211
Fax: + 61 3 9276 7431

Professional Standards



Ian Dickinson, Chair,
Professional Development
& Standards Board

How to 'Find a Surgeon'

The College website has more than two thousand searches a month from people looking for a specialist in their area

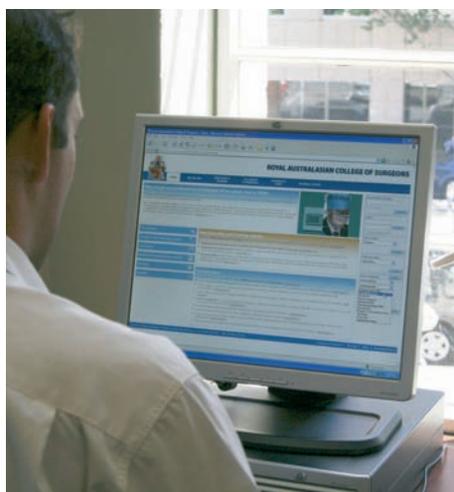
What is the Find a Surgeon Directory?

The College offers a Find a Surgeon Directory on the College website at www.surgeons.org, accessed via the home page. The purpose of the directory is to provide a service to members of the public and to promote the practices of Fellows.

From January 2008, the directory has been updated to only include active Fellows of the College who have met the requirements of CPD Program (or an approved equivalent CPD Program) and have opted to be on the list. Council approved this change to ensure the community that their surgeon has met the College's minimum standards for recertification.

The directory, which is searchable by name, location or specialty or any combination of these, is very popular with members of the public looking for a specialist in their area. There are typically more than 2,000 searches a month conducted through Find a Surgeon and overall it provides consistently good promotion for the surgical practices of Fellows.

In addition, the directory has recently been enhanced to become searchable by keyword. This removes the requirement for people using the directory to understand how the main surgical specialties are defined, for example a search on the word "bowel" will bring up a list of General surgeons who have nominated Colorectal surgery as an area of practice. There are over 100 keywords built into the system to help people find a specialist to match their area of interest.



Are you listed?

The College has been promoting the Find a Surgeon Directory over the past two years and has encouraged Fellows to have their name and contact details featured on the directory. If you have previously registered your details you will remain on the list, provided you have met the requirements of the College's CPD Program (or approved equivalent program). Over 1300 Fellows are currently listed.

How to list yourself on Find a Surgeon – You must opt in

The Find a Surgeon Directory is an opt in listing. Privacy legislation requires that Fellows must consent to their name, specialty areas and

contact details being featured on a publicly available area of the website.

If you are an active Fellow and have met the requirements of the College's CPD Program for 2004 – 2006 (or an approved equivalent CPD Program), take the following steps to add your name.

Login to the College website. After you login, you will see your name in the login box, and under that the text "Update personal information".

- Click on Update personal information to view your personal details
- Select the Web Options button from the horizontal row of choices across the top of the page.
- Click the Web Options link on the next page
- Tick the box for Include in Find a Surgeon.
- Press Update to make the change.

The website re-indexes every night so you'll be able to find your listing the next day.

If you would like help with your user name and password or with adding your name, please contact the Jeremy Lim, Web Co-ordinator, on +61 3 9276 7449 or email at college.webadmin@surgeons.org.

If you wish to confirm your current CPD Program status, please contact the Maria Lynch, Recertification Officer, on +61 3 9249 1282 or email at cpd.college@surgeons.org.

Monday, 12 May, 2008, 2.00-3.00 pm
Convention Centre, Hong Kong

A Multifaith Meeting

Contributions from practitioners of various faith traditions including fellow surgical colleagues on

Surgery and Spirituality All delegates and friends welcome

2008 – WORKSHOPS IN LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING

Course Director
Dr. Paul Dumbrell
M.B.,B.S., F.R.C.S. (Ed.), F.R.A.C.S.

COURSE OBJECTIVES

- Demonstrate the surgical technique of laparoscopic adjustable gastric banding (LAGB).
- Advise and discuss patient selection for the procedure.
- Discuss the post operative management of LAGB patients.
- Discuss identification and management of common complications specific to LAGB surgery. How to prevent them, and how to manage them.
- Advise how to set up a multi-disciplinary obesity surgery practice.
- Post course mentoring

The workshops are designed for surgeons with advanced laparoscopic skills or experienced Specialist Surgical Trainees.

SYDNEY

Thursday, 16th & Friday 17th
October 2008

VENUE

The Hills Private Hospital,
Baulkham Hills, Sydney

MELBOURNE

Thursday 27th & Friday 28th
March 2008

VENUE

Warringal Private Hospital,
Heidelberg, Melbourne

CPD points applicable

CONTACT INFORMATION

Programme Co-ordinator – Robyn Drinkwater

MELBOURNE

5 Burgundy Street
Heidelberg Victoria 3084
Telephone: 03 9450 6800/Facsimile: 03 9457 3295
Email: robyn.drinkwater@laparoscopicenterprises.com

WORKSHOPS SPONSORED BY:

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Transfusion



*Clifford Hughes, CEO,
Clinical Excellence
Commission*

Heading Towards Excellence in Transfusion

Dateline – Joyramkura, Bangladesh 1977. Mohammed was 21. He presented to our little bush hospital of 25 beds with a total pyloric obstruction, gross weight loss and an enormously distended stomach with succussion splash and needed urgent help to survive. His haemoglobin was only six. Despite extensive blood typing of his family and village friends, there was no match available. We were in a quandary! Without surgery he would clearly die.

After discussions with the local Bengali anaesthetist who refused to proceed, we embarked upon a gastrojejunostomy under open anaesthesia administered by the Matron. To my surprise, Mohammed survived both the anaesthetic and the surgery.

Being a cardiothoracic surgical Trainee at the time and having done all my general surgical training in large hospitals, I had come to believe blood was essential for surgery. Mohammed had challenged my beliefs and I began to investigate the traditional attitudes to blood. Not surprisingly in my consultant practice we developed much more stringent guidelines regarding the use of this precious transplanted material and found that patients did well and that our blood usage had plummeted.

That one case was the beginning of a lifetime interest in using blood wisely yet safely. So when NSW Health asked the Clinical Excellence Commission (CEC) to look into issues around blood transfusion, I personally was delighted to lead the team.

Blood is a precious resource. Only one in 30 Australians donate blood, yet the demand for blood continues to increase significantly as our population ages. The fact is, blood is a living tissue transplant and the safety considerations of this are significant yet seriously underestimated.

There is now growing evidence of both immunomodulation – depression of the immune system after transplantation and negative clinical consequences of storage related problems. There are numerous studies which



“Blood is a precious resource. Only one in 30 Australians donate blood, yet the demand for blood continues to increase significantly as our population ages.”

identify blood transfusion as an independent predictor of increased morbidity and mortality, admission to ICU, ICU length of stay (LOS) and hospital LOS. A recent study on red cell transfusions and nosocomial infections in critically ill patients concluded that infection rate was higher in those patients transfused compared to those who weren't. The evidence for the efficacy of blood transfusions is vague yet we continue to use transfusion as a default therapeutic decision.

There is no argument that when used appropriately, at the right time for the right patient, blood transfusions are a life saving procedure. It is essential to develop appropriate evidence-

based transfusion practices which incorporate a whole-of-patient approach, including pre-op, intra-op and post-op management.

The CEC was established in 2004 and, amongst other things relating to improving the quality and safety of care for patients, has embarked on an ambitious program across NSW to achieve excellence in transfusion medicine. The program is called Blood Watch and is funded by the CEC. Each Area Health Service has a Blood Watch CNC and Clinical Lead who are working closely with clinical teams.

The National Health & Medical Research Council / Australasian Society of Blood Transfusion (NH&MRC/ASBT) Guidelines state that the use of red cells is likely to be inappropriate when Hb is greater than 100g/L unless there are specific clinical indications. If there are no clinical indications then the reasons to transfuse should be documented. Interestingly, the Blood Watch red cell audit shows that only 27 per cent of patients had a documented clinical indication for transfusion.

The Blood Watch teams have conducted a comprehensive red cell audit within their major facilities and the results indicate that there is still work to be done in improving transfusion medicine.

- The combined audits included 323 transfusion episodes. Of these, 12.7 per cent of patients were anaemic and had surgery with haemoglobins under 105g/L. The underlying cause of probable iron deficiency anaemia was not investigated or treated pre-operatively.
- Four per cent of patients received red blood cell transfusion with Hb over 100g/L which is outside of the NH&MRC/ASBT Guidelines.
- Ninety five per cent of patients had post-operative red cell transfusion with Hb's above 70g/L and of those, 83 per cent received a transfusion without evidence in the medical record of clinical indication for transfusion.



“Interestingly, the Blood Watch red cell audit shows that only 27 per cent of patients had a documented clinical indication for transfusion.”

In addition to the audits of clinical practice, CEC has undertaken the development of a database which links Health Information Exchange (HIE), pathology and blood bank data which, for the first time, is allowing comparison of red cell usage and dosage by DRG and by hospital. This data is able to show the ratio of transfusions which are occurring above the state average. Preliminary analysis shows that some hospitals, on a case mix adjusted relative use index, are transfusing up to 43 per cent above the state average (see Figure 1 graph from database). This database has been provided to Area Health Service Transfusion Committees as part of their review and improvement of performance.

Internationally there is a shift towards a new standard of care in transfusion medicine called patient blood management. The key strategies that support this new paradigm include:

- Optimising the patient’s own red cell mass pre-operatively;
- Minimising peri-operative blood loss, and;
- Tolerating lower haemoglobins in patients and consider other treatments before discharge.

It is the three pillars of blood management which provide us with a blueprint for the way forward towards excellence in transfusion.

Visit www.cec.health.nsw.gov.au

New Zealand Association of General Surgeons

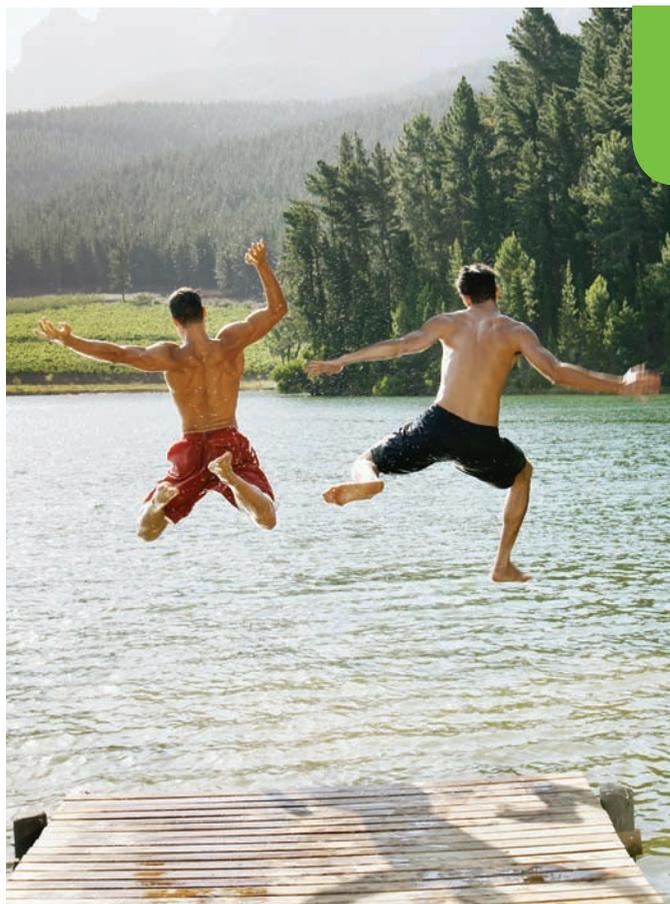
Annual Meeting

Copthorne Hotel & Resort – Bay of Islands
Paihia, New Zealand
Friday 4th to Sunday 6th April 2008

Online Information: www.mianz.co.nz
(conference calendar)

Convener: Peter Milsom

Conference Managers:
Medical Industry Association of New Zealand
Phone: +64 9 917 3645
Email: admin@mianz.co.nz
Website: www.mianz.co.nz



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www.doctorshealthfund.com.au



PROFESSIONAL DEVELOPMENT ACTIVITIES 2008

In 2008 the College is offering exciting learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities will earn you CPD points and assist you to maintain your knowledge and skill base in training, mentoring and interviewing as well as strengthening your communication, business, leadership and management abilities.

Mastering Professional Interactions

Thursday 6 March,
Royal Australian College of Surgeons,
Melbourne

Doctor to Doctor communication is a significant source of litigation and safety risk, so it is worth reflecting on where litigation risk lies and examining strategies to reduce exposure.

This all day workshop concentrates on understanding the perspectives of clinicians, Doctor-Doctor interactions focusing on risk awareness and patient handover communication. It will provide you with the techniques and skills training to improve communication with colleagues and formulate an effective response that does not increase risk to patients or Doctors.

Cost: \$715 (RACS members)
\$895 (RACS Non Members)

CPD: one point per hour

Beating Burnout

Tuesday 11 March, Australian Institute of Management, Brisbane

Are you at risk of burning out?

This evening workshop helps you to identify and address the risk factors of 'burnout' before they affect your career and personal life. Proven time and stress management strategies are explored as well as simple techniques to manage the effects of burnout

You will leave the workshop with practical simple steps that can be applied immediately to restore balance to your life.

Cost: \$242 (RACS members)
\$302.50 (RACS Non Members)

CPD: one point per hour

Surgical Teachers Course

6-8 March, Wrest Point Conference Centre, Sandy Bay, Hobart

Spend two and a half days unwinding in scenic Tasmania while learning how to be a better mentor, teacher and leader to trainees at the Hobart Surgical Teachers Course.

Experienced Faculty members from the Surgeons as Educators Committee will lead energising and challenging sessions under four modules: Feedback and Assessment, Teaching Skills, Change and Leadership and Adult Learning. Course commences 6pm Thursday 6 March to 1pm Saturday 8 March. Meals and accommodation for non-local participants included.

Can't make it to Hobart?

Register for Perth, from 3-5 July, or Sydney, from 23-25 October.

Cost: \$242 (RACS members)
\$302.50 (RACS Non Members)

CPD: 60 points

Specialists as Teachers (Rural)

9 February, Bendigo VIC

8 March, Bunbury WA

5 April, Coffs Harbour NSW

Further dates to be confirmed shortly

In conjunction with the roll-out of the new Surgical Education & Training (SET) program, the College is pleased to announce the launch of a new free course that offers support and advice for rural supervisors and trainers working within SET.

Skills learned include the use of in-training assessment tools commonly used by the specialties, managing underperforming trainees and developing performance management plans around the start of rotation, mid-rotation and end of rotation meetings. There will also be an opportunity to gain insight into College policies, legal issues and the expectations placed on rural educators.

In addition to providing an understanding of SET and its requirements, this is also an important opportunity for rural surgeons to sit down with their colleagues and discuss what it means to be a part of the new program and what avenues for support there are within it.

We look forward to seeing you there!

Cost: Free

CPD: one point per hour

2008 PROFESSIONAL DEVELOPMENT CALENDAR

Further Information Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org select the Fellowship and Standards menu and then click on Professional Development. Easy online registration is available.

QUEENSLAND

- 11 March: **Beating Burnout**, Brisbane
- April 12: **Neurotrauma Workshop for Rural Surgeons**, Brisbane
- 6 June: **Winding Down from Surgical Practice**, Gold Coast
- 9 August: **Mastering Difficult Clinical Interactions**, Brisbane
- 3-5 October: **Surgeons as Managers (SaM)**, Cairns

NEW SOUTH WALES

- 5 April: **Specialists as Teachers**, Coffs Harbour
- 15 April: **Interviewer Training**, Sydney (by invitation only from Specialty Training Boards)
- 29 July: **Mastering Intercultural Communication****, Sydney
- 8 September: **Mastering Professional Interactions****, Sydney

- 10 October: **Winding Down from Surgical Practice**, Sydney

NEW SOUTH WALES (cont'd)

- 23-25 October: **Surgical Teachers Course (STC)**, Sydney

VICTORIA

- 19 February: **Mastering Intercultural Communication****, Melbourne
- 6 March: **Mastering Professional Interactions****, Melbourne
- 15 March, 15 November: **Communication Skills for Cancer Clinicians**, Melbourne
- 29/30 Mar: (**Orthopaedics**); 13/14 June; 22/23 Aug: **From the Flight Deck**, Melbourne;
- 3 June: **Practice Management for Practice Managers**, Melbourne
- 19 July: **Expert Witness**, Melbourne

- 21 June: **Writing Reports for Court**, Melbourne

VICTORIA (cont'd)

- 28 June: **Neurotrauma Workshop for Rural Surgeons**, Melbourne
- 8 November: **Risk Management Foundation**, Melbourne

SOUTH AUSTRALIA

- 26 July: **Mastering Difficult Clinical Interactions**, Adelaide
- 19 September: **Practice Management for Practice Managers** Adelaide

WESTERN AUSTRALIA

- 8 March: **Specialists as Teachers Course**, Bunbury
- 27 May: **Beating Burnout**, Perth
- 29 April: **Interviewer Training**, Perth (by invitation only from Specialty Training Boards)

- 3-5 July: **Surgical Teachers Course (STC)**, Perth

NEW ZEALAND

- 2 April: **Interviewer Training**, Auckland (by invitation only from Specialty Training Boards)
- 4 April: **SAT SET Course**, Bay of Islands (General)
- 4-6 July: **Surgeons as Managers (SaM)**, Queenstown

TASMANIA

- 6-8 March: **Surgical Teachers Course (STC)**, Hobart

**New Workshops for 2008

Please Note:

Additional SAT SET Courses will be offered in each region; visit the College website for more information for all workshops.

Simulated Surgical Skills Program

ASERNIP-S



*Guy Maddern, Chair,
Research, Audit &
External Affairs*

The Australian Safety and Efficacy Register of New Interventional Procedures – Surgical ASERNIP-S has recently commenced work on the Simulated Surgical Skills Program (SSSP). This program, funded by the Commonwealth of Australia as represented by the Department of Health and Ageing, is charged with the development, implementation and assessment of a new laparoscopic surgery skills training curriculum. This new curriculum will incorporate the use of laparoscopic simulators alongside traditional training techniques to provide a new mode of surgical skills training.

The SSSP has five core aims, these include:

1. To produce a report examining international laparoscopic surgical simulation training and its implications to Australia;
2. To develop a training and assessment program suited to the Australian education and healthcare systems;
3. To implement this curriculum;
4. To assess this curriculum;

5. To develop a 'train the trainer' program to assess the best way to teach the use of the chosen surgical simulators.

This program will build on current international developments in laparoscopic surgical training to produce a new and innovative curriculum for the provision of surgical education.

We are pleased to have input from New Zealand with their representation on the Projects Scientific Advisory Board.

The initial testing stages of the SSSP curriculum will be done in New South Wales, Victoria, Queensland, South Australia and Western Australia, (with further provision for the development of a 'mobile training unit' for use in rural and remote areas). The curriculum will then be assessed on its ability to improve the standard of surgical trainee skills and other variables. Finally, it is planned that after further amendments this curriculum will be made available as a standard for laparoscopic surgical education in Australia.

Kate Sloan has recently been appointed as the Senior Project Manager for the SSSP. This program will operate out of the newly established SSSP office, located in Stepney, South Australia and is scheduled to run until mid September 2010.

This exciting program allows Australia to demonstrate the abilities of our researchers and surgeons to develop comprehensive, innovative and effective surgical curriculum, placing Australia at the forefront of medical education in this area.

Any further information can be obtained from:

*Professor Guy Maddern
Surgical Coordinator
Simulated Surgical Skills Project
Royal Australasian College of Surgeons
guy.maddern@adelaide.edu.au
or Kate Sloan
Senior Project Manager, SSSP
kate.sloan@surgeons.org*



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2008 CONFERENCES

SOUTH AMERICA
Rio de Janeiro
4-10 June

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Post tour: Cuzco & Machu Picchu

SOUTHERN AFRICA
Capetown
29 Sept-6 Oct

Pre tour: Kruger National Park

Post tour: Victoria Falls (Zambia) & Chobe National Park

Contact Dr Margot Cunich
Phone toll free: 1800 633 131
Email: margot@cunich.com.au

www.uncon-conv.com



The John Mitchell Crouch Fellowship

It is an honour to receive the Fellowship, given the difficulty of attracting financial support for long-term studies

The most recent recipient of the Colleges' prestigious John Mitchell Crouch Fellowship, Professor Jonathan Golledge, has used the research funding provided to extend knowledge of the progression of small abdominal aortic aneurysms (AAA). Conducted through the James Cook Vascular Biology Unit established by Professor Golledge in 2002, the research is investigating lifestyle and genetic factors in the development of such aneurysms, the progress of the vascular disease and possible new treatment options.

Professor Golledge said that while millions of dollars of research funding has been being spent investigating treatments for coronary heart disease, relatively little funding has been allocated to understanding the pathogenesis of, and developing new treatments for, aortic aneurysm.

He said the James Cook Vascular Biology Unit was now in the process of setting up a registry of patients with small aortic aneurysms from around Australia to follow the natural history of the disease, clinical and genetic determinants and the biomarkers predicting aneurysm behaviour.

"We have limited knowledge of the natural history of small aortic aneurysms. However, based on two randomised trials we know that over a ten-year follow-up, approximately 70 per cent of 40-49mm aortic aneurysms will expand to a size requiring surgical treatment," Professor Golledge said.

"Yet our understanding of smaller aneurysms is extremely limited and we do not currently understand clearly the role of co-morbidities or environmental and genetic factors in determining the progress of aortic weakening."

Professor Golledge said that even though more such aneurysms were now being detected through improved imaging techniques, surgical repair still presented difficulties with open surgery having a five per cent mortality rate and stent grafting a one

per cent mortality rate along with concerns relating to durability. He said that if the pathological pathways of the condition were better understood, better treatments could be devised.

"The UK Small Aneurysm Trial showed that of a group of patients with abdominal aortic aneurysms measuring between 40 to 54 mm, 70 per cent eventually came to require treatment. We want to find a treatment, which if instigated at an earlier stage, will reduce the

"I would like to see the development of a range of new treatments for small aortic aneurysms which will save lives and hopefully reduce the need for surgical intervention."

requirement for surgery," he said.

Professor Golledge said such a treatment could come out of a better understanding of the role of inflammation and the consequent loss of structural integrity in the abdominal wall. Recent figures indicate that abdominal aortic aneurysms are the 15th most common cause of death in the US. In 2004, the condition was responsible for 470 deaths and 2169 hospital admissions in NSW.

According to Professor Golledge, the aging of the population, lifestyle issues such as obesity and better detection will increase the need for better treatment options.

"Currently there is no agreed medical therapy which has been shown convincingly to slow progression of aortic aneurysms in patients," he said.

"At present there are also no recognised blood tests useful in defining the presence of abdominal aortic aneurysms with detection requiring abdominal imaging which is not always practical."

Because of these limitations, the James Cook Vascular Biology Unit has established a three-pronged research project. The first involves the patient registry which Professor Golledge said now involved 800 patients but which he hoped to increase to 1500.

The second is the establishment of a mice model of human aortic aneurysm in order to assess the role of different pathways and blocking these on aneurysm development.

The third project is investigating patients with a known aortic diameter to assess the serum bio-markers and genetic sites associated with the presence of the condition.

"It would be pleasing if during the course of my career a range of non-surgical treatment options could be demonstrated to be valuable for AAA. That might come in the form of lifestyle issues of diet and exercise or it might be drug therapy," Professor Golledge said.

"One of the problems with medical research is that you can do an enormous amount of work in a particular area but developments flowing from that work can take a very long time. I would like to see the development of a range of new treatments for small aortic aneurysms which will save lives and hopefully reduce the need for surgical intervention. That is the end point I am aiming at and hopefully I will still be working to see it."

The John Mitchell Crouch Fellowship is awarded to an individual who, in the opinion of the College Council, is making an outstanding contribution to the advancement of surgery or to fundamental scientific research.

Professor Golledge, who is the Director of Vascular Surgery at Townsville Hospital, received the funding in 2007.

He said he was honoured to have received the Fellowship, particularly given the difficulty of attracting financial support for long-term studies as that now underway at the James Cook Vascular Biology Unit.

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Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2009

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

Information and Enquires:

www.cssanz.org

Professor Michael Solomon: msolomon@med.usyd.edu.au

Closing Date:

Friday 16th May 2008

Applications:

Applications are to be made by letter, including Curriculum Vitae and the names and addresses of three referees.

Please send to:

Professor Michael Solomon

Chairman

Training Board in Colon & Rectal Surgery

Level 2, 4 Cato Street, Hawthorn VIC 3122

AUSTRALIA

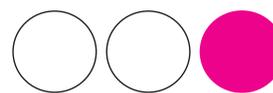
Email secretariat@cssanz.org

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Book Review



Felix Behan

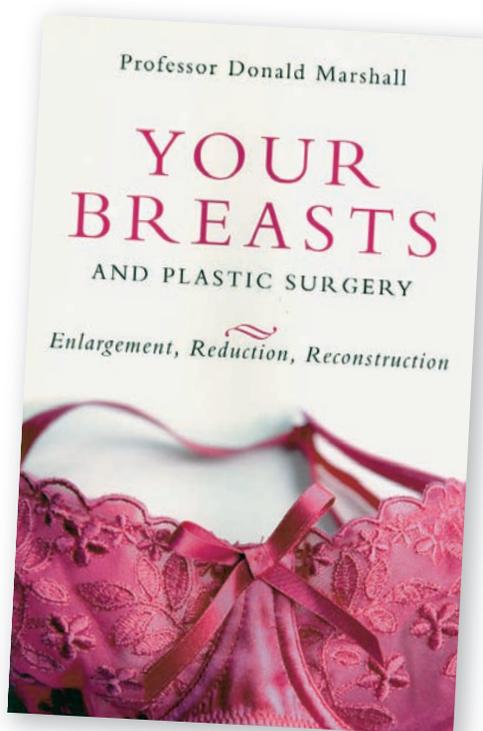
Your Breasts and Plastic Surgery

Don Marshall's book discusses how to develop the patient's confidence and optimise aesthetic results, minimising the possibility of forensic development

I am writing a commentary on Professor Don Marshall's book, titled *Your Breasts and Plastic Surgery* for two reasons. Firstly it is an excellent text for patient awareness and education, and secondly it distils 40 years of clinical experience from one of our most competent plastic and reconstructive surgeons, only recently retired from surgical practice. In fact, this could be a commentary to commemorate this event. Don Marshall has been a mentor in teaching, education and development and furthering the practice of aesthetic surgery and particularly aesthetic surgery of the breast. He was Benny Rank's partner in clinical practice in Royal Parade, and no doubt has carried on not only his principles of surgical excellence but has also subscribed to the underlying service to patients (noblesse oblige, as Don wrote on the frontispiece of the copy I have).

Melbourne has long been recognised world wide as a centre of plastic surgical excellence, and the 5th International Congress of Plastic and Reconstructive Surgery was held in Melbourne in 1971 under the Presidency of Benny Rank. It is coincidental that when preparing this review we are anticipating, in February 2008, another major event when Melbourne will host the 19th Congress of the International Society of Aesthetic Plastic Surgery, bringing together world figures under the presidency of Bryan Mendelson.

Don comments that plastic surgery of the breast is discretionary and the patient should exercise such discretion with considerable care. He also observes that even though we can have defined elective and emergency surgical procedures, breast reconstruction provides evidence of a third category, which he calls discretionary. This demonstrates the balance to be struck between the patient's awareness, informed consent, surgical technique and personal style. To minimise complications (both surgical and personal), repeat consultations



“Peppered throughout the text are little vignettes drawn from his clinical experiences which acknowledge the surgical techniques used to achieve the overall result from the patient's perspective.”

instil patient confidence. The impression to be fostered is of consideration for the patient's overall well-being and specific goals.

There is little value in showing the patient glamorous portrayals of superb results detailed in over-exaggerated glossy advertising media, when such results are not always achievable. They create false expectations, resulting in inevitable disappointment with adverse surgical and emotional outcomes which may give our specialty a degraded reputation.

Don's book discusses how to develop the patient's confidence and optimise aes-

thetic results, minimising the possibility of forensic developments. Such information should be available to any patient considering such procedures.

The word “aesthete” was originally coined by Oscar Wilde in the late 19th century in his Oxford set. It is defined as an appreciation of things beautiful in accordance with the principles of good taste. With the emergence of plastic and reconstructive surgery from the early 20th century (WWI) with contributions from our late New Zealand colleagues Gillies and later McIndoe, one of the basic tenets of reconstructive surgical teaching, reiterated by Don during his time at PANCH to his protégées (as I recall) is, “If you don't do good aesthetic surgery, you don't do good plastic surgery”. A key principle of reconstruction is achieving an excellent aesthetic result (making things beautiful or as close to normal as possible). Those who neglect such principles in reconstructive practice achieve results which are sub-optimal, and with the drawback of scar tissue, it is never possible to return to absolute normality.

The initial chapters of the text describe the historical and clinical background of augmentation mammoplasty. Even more importantly, peppered throughout the text are little vignettes drawn from his clinical experiences which acknowledge the surgical techniques used to achieve the overall result from the patient's perspective.

I note the discussion of capsular contraction and the incident where a patient was embraced from behind around the chest by a footballer and cracking occurred with rupture of the prosthetic capsule. This started the regrettable clinical practice of manual compression of hard prosthetic capsules, with dire consequences of silicone leak and its inferred general metabolic sequelae. We can all recall the eventual backlash in the early 1990s with an initial ban on the use of silicone prostheses as a result.



On a more personal note, I recall my own experiences in the management of capsular contraction, and I often observed in my own practice of aesthetic surgery that one side would be harder than the other due to such capsular contracture. I came to the conclusion that this would be the side opposite the patient's partner. Thus lying on the bed, the body pressure effect would release any early contractures on one side. Thus I advised my patients to change sides with their partner to achieve balance. It achieved its purpose.

The chapter on breast reduction/uplift discusses the intrinsic hazards in all breast reduction procedures with potential excessive scar hypertrophy and nipple necrosis, which we have all encountered in times past. The use of the free nipple graft is detailed for the patient's consideration, alerting the patient to the possible complications and problems with scarring – Don continues throughout the text to focus on the patient's interests.

Increasing rates of breast cancer (the National Breast Cancer Centre quotes an increase in diagnosed cases from 5,318 in 1983 to 13,261 in 2006) may reflect issues relating to diagnosis as well as an aging population. In this context, Don covers all the reconstructive options including his unique breast sharing technique, via simple diagrammatic means which a patient can readily appreciate when considering these procedures. I note that some private insurers in America are now determining the type of the reconstruction that is to be employed. It has been quoted that whatever the surgical technique used, there is a fixed financial amount for all such procedures. In some cases a clinician may spend six hours or more performing a "gold standard" microsurgical breast reconstruction, when a standard lat dorsi and implant procedure can be completed in 90 minutes for the same price. Where economics exert such pressure, cost restraints in time may be the

determinant in the discussion. Comparison of various breast reconstruction techniques must be the clinician's prerogative. All clinicians are well aware of these financial constraints. All administrators are familiar with considerations of budget deadlines and cost containment which compete with the patient's needs.

For the future Don touches on some important aspects, which I consider noteworthy. I note that it is never possible to achieve a result as good as the original. Scars are present and will remain, though fading with time, as a reminder of the surgery. In some cases the resulting scars may be worse than the initial problems.

He goes on to quote recent developments in microsurgery at St Vincent's. Under Jeremy Wilson with tissue engineering using microvascular support into a chamber, mast cells of various progenitive types have been encouraged to develop into fat globules and become pyramidalised and develop ultimately into potential breast tissue, hopefully an exciting indicator for the future. However, where tension from the chamber disappears, this regeneration fails. Thus tension may play an important role in such surgery, as we have found also in the use of the keystone flap in reconstructive applications. Perhaps these facts may call into question the surgical tenet that that tension in surgery is a contraindication.

Don clearly and carefully describes plastic surgery of the breast. His texts should be available in any such consultative environment, and I find it a credit to his experience that these ideas have been put together from such a perspective.

In finalising this commentary I historically hark back to a book titled the *Symposium on aesthetic surgery of the breast*, edited by Owsley and Peterson in 1978. This was donated to the College library by the late John Hueston (who also contributed one of its chapters). In another chapter Robert Goldwyn, who was always worth quoting and had great editorial

“Don covers all the reconstructive options including his unique breast sharing technique, via simple diagrammatic means which a patient can readily appreciate when considering these procedures.”

experience from the *Plastic Reconstructive Surgery Journal*, deals with the aesthetic concepts of reconstruction after radical mastectomy. He eloquently states that “breast reconstruction involves hard decisions for the patient and the surgeon ... of prime importance is how far the patient wishes to go with her reconstruction”.

He notes that considerations for the patient include scars, discomfort, time, money, cost and emotional drain. A basic consideration is to avoid inflicting a significant deformity elsewhere, and the exchange may not be worthwhile. He observes “beauty involves a totality and lies not only in the eye of the beholder but also in the mind of the bearer”. Don's text reflects the same principles. One can appreciate the value of his grey hairs, or as someone said recently “a touch of snow on the gables”.

In conclusion I would like to quote Dante's description of Virgil (the Roman poet of 70-19BC) from *The Divine Comedy*, referring to him as “my master and my author, thou art he from whom alone I took the style whose beauty has done me honour”. I think similar tribute could be paid to Don Marshall, for his style, teaching and reconstructive talents, to the enduring benefit of both his patients and his protégés.

Your Breasts and Plastic Surgery is available through Michelle Anderson Publishing.

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Website: michelleandersonpublishing.com





Singing surgeon

The old proverb that suggests that if you want something done you should ask a busy person could well have been written with surgeons in mind

Despite the long professional hours, the involvement in external professional bodies, the on-going professional development, the College's Fellowship is sprinkled with athletes, musicians, sailors, aviators and artists.

Associate Professor Martin Richardson is one such, an orthopaedic surgeon who combines his practice at the Royal Melbourne Hospital and teaching duties at the University of Melbourne with a love of skiing and now a burgeoning singing career. This comes after deciding some years ago to give his athletics career as a race walker away – even though he almost won selection for the LA Olympics – to concentrate on medicine.

A light baritone with a love of Gilbert and Sullivan, Associate Professor Richardson has now gone back to an even earlier love and has started singing lessons with teacher Francesco Fabris. The surgeon, who plays opera music in theatre as he works, is now also a member of a theatre troupe of a different kind, having joined the Savoy Opera Company which is based in the eastern suburbs of Melbourne.

"My involvement with the company began after I performed in the Gilbert and Sullivan musical *Trial by Jury* at University House as part of their Christmas in July celebration. It was great fun and the Savoy Opera Company asked if I would stay on and sing in *Ruddigore* and *The Mikado*," Associate Professor Richardson said.

Since then, he has even participated in the hit musical *Priscilla, Queen of the Desert* after a walk-on role was offered as part of a fund-raising auction for the Epworth Hospital. And he loved it.

"Obviously it was more a cameo appearance than anything else," he laughed.

"But it was an amazing experience to be backstage to see how such a huge production is handled from behind the curtains, the brilliant wigs and costumes, the speed and organisation involved.

"When you really want to do something you find the time. On the evenings of rehearsal



Martin Richardson, second from left along with fellow cast members of *Priscilla, Queen of the Desert*

I make sure I finish just before 8pm, then I'll head back to do ward rounds later in the night. Music, particularly opera, has now become central to my working life and leisure time, I listen to opera as I am opening and closing and that helps keep me fresh as we all sing along as best we can," he said.

"And I find it adds to my professional life because you need to be fresh to deal with the occasional crisis, but when all is going well it helps time pass to have a pleasant environment. We are much like pilots in that regard."

Associate Professor Richardson said the other great bonus of taking up singing was sharing the experience with his family. He said his intellectually disabled son had a great love of music and particular musical strengths and that both he and his daughter were members of the Young Australian Broadway Chorus.

"That means that now we all troop off for singing lessons and support each other in our performances and that is providing a great antidote to how family-unfriendly surgery can be," he said.

"I also think it is crucial for surgeons to have outside interests and the best of all worlds is to have interests that are physical, like my skiing to help maintain fitness, and cultural interests to explore different aspects of life. But I am not alone. One of my colleagues plays in a heavy metal band. It doesn't have to be high-brow to be an effective remedy to stress – participating in *Priscilla* proves that point."

With the Savoy Opera Company's next production scheduled to be *The Mikado*, he is now concentrating on his lessons.

"If Francesco can turn me into a tenor that'd be great but I'm happy enough as a light baritone."

And who knows where such an interest could take him. During the long history of the Savoy Opera Company, which began life in 1943, a number of performers have gone on to receive international recognition. One member, Marie Collier, became a star at the Covent Garden Opera Company and Gregory Dempsey became a leading tenor with a variety of English opera companies.



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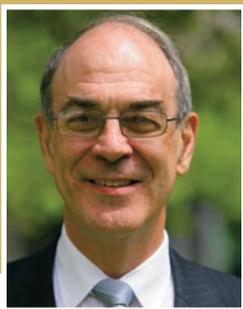
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Professional Standards



Ian Dickinson, Chair,
Professional Development
& Standards Board

CPD program update

The 2007 Continuing Professional Development returns are due 31 March 2008

Continuing Professional Development Program

All active Fellows of the College (engaged in medicine, surgery and medico legal services) are required to participate in the Continuing Professional Development (CPD) Program. The program aims to advance the individual surgeon's surgical knowledge and skills for the benefit of patients and provide surgeons with tangible evidence of participation in and compliance with the program by the award of a certificate.

Ninety-four per cent of Fellows with a requirement participated in the CPD Program for 2006 and of those Fellows 99 per cent complied with the annual requirements.

We continue to encourage all surgeons to participate in the CPD Program and particularly encourage those Fellows who have outstanding returns to make contact with the Professional Standards Department. It is important that surgeons show their ongoing commitment to professional advancement by recording the fact that they are participating in a recognised CPD Program.

Increasingly, medical registration boards, hospitals or other organisations are requiring

evidence of participation in approved CPD Programs and recognise the standards set by the College.

2007 CPD recertification data forms

Fellows should by now have received a Recertification Data Form for 2007. This data form is to record details of your continuing professional development activities during 2007, and should be returned to the College by 31 March, 2008. Please contact Maria Lynch, Department of Professional Standards, on +61 3 9249 1282 or email cpd.college@surgeons.org if you require assistance completing your data form.

Verification

Each year 2.5 per cent of Fellows are randomly selected to verify the information contained in their annual recertification data form/online diary. If you have been selected for 2007, you will have been notified accordingly.

CPD Online

Data collection for the 2008 CPD Program is available online via the College website (www.surgeons.org). Fellows are able to access a personal CPD Online Diary using usernames and

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
CONTINUING PROFESSIONAL DEVELOPMENT PROGRAM
RECERTIFICATION DATA FORM - YEAR ENDING 31 DECEMBER 2007

Name: _____

PLEASE MARK YOUR ANSWERS BY FILLING IN THE RESPONSES AS SHOWN:
Use black or blue ballpoint pens only. Do not use a red or hot tip pen.
Indicate your answers by filling in or writing in the box provided.
Please print CLEARLY.
Focus on correct outcomes.
Please return by 31 March 2008.

Example: 0 2 5

Have you fully retired from all forms of medicine, surgery, medico legal services and other specialist non-procedural and non-clinical work?
If you answered Yes, please specify date fully retired: _____ Yes No

Date fully retired: _____ YEAR

If you fully retired on or before 30 June 2007 do not complete any other questions.
If you fully retired after 30 June 2007 or answered No, complete both Section One and Section Two of this form.
Please consult the CPD Information Manual 2007-2009 if you are unclear about your requirements.

SECTION ONE:
TYPE OF SURGICAL PRACTICE

Please fill in the box that best describes your type of surgical practice during 2007. (One box only)

- Operative practice in public or private hospitals or day-surgery units
Instructions: You must provide information in categories 1, 2, 3, 4, 5, 6 and 7 in Section 2 of this form.
- Operative procedures in rooms only
Instructions: You must provide information in categories 1, 4, 5, 6 and 7 in Section 2 of this form.
- Clinical Consulting (non-operative)
Instructions: You must provide information in categories 4, 5, 6, 7 and 8 in Section 2 of this form.
- Medico legal practice - personal injury (non-operative)
Instructions: You must provide information in categories 4, 5, 6, 7 and 8 in Section 2 of this form.
- Medico legal practice - medical negligence (non-operative)
Instructions: You must provide information in categories 4, 5, 6 and 7 in Section 2 of this form.
- Other non-procedural and non-clinical work, e.g. research, academic, administrative
Instructions: You must provide information in categories 4, 5, 6 and 7 in Section 2 of this form.
- Letter work
Instructions: You must provide information in categories 4, 5, 6 and 7 in Section 2 of this form.
- Surgical Assisting
Instructions: You must provide information in categories 4, 5, 6 and 7 in Section 2 of this form.

passwords to maintain CPD records in a real-time format. Fellows using the CPD Online Diary for 2008 will not be required to complete the hard copy recertification data form issued at the conclusion of 2008, however Fellows are encouraged to continue keeping evidence of CPD activities for verification purposes. CPD Online training and telephone assistance is available through the Department of Professional Standards on +61 3 9249 1282.

Ansell Healthcare

The winners of the five 32" LCD Television for the 2007 RACS Virtual Congress promotion are:

- Dr. Shane Anderson from the Gold Coast Hospital (QLD)
- Dr. Adele Burgess from the Alfred Hospital (VIC)
- Dr. Andrew Botting from Christchurch Public Hospital (NZ)
- Dr. Lindsay Allen from Mater Hospital Townsville (QLD)
- Dr. John Frye from Christchurch Hospital (NZ)

Ansell Healthcare would like to congratulate the winners and thank everyone who participated.





Fellows in the News



Plastic surgeon operates on puppy

Dr Richard Lewandowski was eager to take on the challenge of operating on Lippy the Staffordshire Bull Terrier

In July 2007, the Plastic Surgical Society of Queensland received an unusual email. Local veterinary surgeon Kim Smith was seeking input from the Society to help treat a Staffordshire bull terrier puppy.

Lippy, the patient in question, had been born with a cleft lip, a deformity that usually spells the death sentence for dogs because of the difficulty in eating and drinking and which in turn means that few veterinarians have the surgical skills needed to treat the condition. But his owner, a veterinary nurse who helped deliver him by caesarean section, was determined to save him.

Local plastic surgeon Dr Richard Lewandowski willingly took on the challenge. As a surgical educator, Dr Lewandowski visited the veterinary hospital, checked the patient and drew local vets diagrams of what needed to be done.

"I give advice to other health professionals and I teach medical students, so sharing information with vets was no different to me. If someone asks for a hand you do what you can," Dr Lewandowski said.

Instead of just advising on the procedure however, Dr Lewandowski worked alongside the vets to repair the deformity.

"They have a very professional set-up at the animal hospital and I was pleasantly surprised at the quality of anaesthesia provided and the equipment available. It was an interesting challenge because while the suture material and the basic principles are the same, it was far from a routine procedure and took quite a considerable time longer than such an operation on a human face," he said.

"For instance, dogs noses are not attached in the same way, their muscles are different and they have a different quality of the mucosa and skin. That meant that we had to take our time because things were not where you normally find them and it wasn't a case of working by memory.

"Many surgeons, like myself, happily provide our skills when we are in a position to help and that goes for Lippy too."



1 Lippy before the operation 2. During the operation 3. Stitched up after the operation 4. Lippy three weeks after the operation

"But the procedure was a success and Lippy is by all accounts now doing very well."

A cleft lip occurs when the tissues of the upper jaw and nose fail to join. Though operating on a puppy was unusual for him, Dr Lewandowski has a long history in providing his help where it is needed.

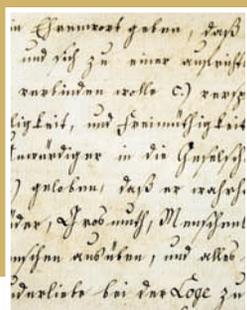
While working out of the Mater Children's Hospital and with his own private practice, he has also provided plastic and reconstructive surgery in developing countries for many years and help established a craniofacial surgical training unit in Hanoi and Ho Chi Minh

City, Vietnam. Dr Lewandowski also heads the Queensland branch of the global plastic surgery charity, Operation Smile. Last year he travelled to Morocco to provide plastic surgery to those in need as part of a global campaign run by the organisation.

"I took on this work voluntarily because it brings with it a great sense of satisfaction not only in terms of treating patients in need but also as a way of passing on skills to local surgeons. Many surgeons, like myself, happily provide our skills when we are in a position to help and that goes for Lippy too," he said.



Letters to the Editor



DEAR EDITOR

I recently raised a serious issue in our public hospital with regard to decisions with serious clinical consequences, made by out-of-touch career administrators. The most recent decision, which spilled over onto the front page of the Hobart Mercury and ultimately was featured on A Current Affair, was the withdrawal of snacks from Emergency Theatres. What has become known as “The Salada Crackers Affair” is a symptom of dysfunctional administration, and a classic one: I, a senior surgeon, raised the issue of withdrawal of food for staff from Emergency Theatres as a safety issue – there was no effective consultation with staff before their decision. After two months of intrahospital agitation eventually spilling over into the media, would you not think that a sensible CEO or his senior surgical administrator would have contacted me and tried to resolve the issue? Not one letter, phone call or email was received by me for two months, and then was a dismissive couple of paragraphs failing to note any of my points and refusing to budge, and dated a fortnight before I received it. This illustrates the current

closed door approach of Royal Hobart Hospital Administration. The senior staff are apparently not worth listening to or responding to – not worth a cracker.

This issue was not about Surgeon’s earnings, respect, or privilege. It was about patient safety, and the increasing detachment of administration from their staff and the coal-face of patient care. It is recognized across Australia that Hospital Administration has been relegated to career administrators whose main skill lies in economic micromanagement. But Public Hospitals are just that – Hospitals owned by the Public and which should be aware of the needs of the community which depend on them. This can only occur if Administration is held accountable to a Board of Management, which must include Nurses and Doctors actually providing the care, and who can advocate for safety, quality and volume of service over and above the balance sheet of the hospital. There is now a Federal Government initiative to reinstitute Hospital Boards, upon which funding will depend. I understand our College supports this proposal.

Our College has identified burnout as a

major issue for Australian surgeons, leading to inability to retain surgeons in the public hospitals. One reason for burnout apart from the punishing workload is a strong sense of lack of responsiveness of Administration to their clinical staff. I challenged the CEO at the Royal Hobart Hospital to spend one 36 hour period with a surgeon and experience what it is like to spend 14 hours seeing patients and operating, THEN starting on call emergency surgery, not having rested, eaten or seen one’s family, and then start the next day’s routine work without a break. Predictably, there has been no response. Most surgeons do not work in the public system because of the income they earn there, but despite the income, which barely covers College fees and insurance. Our actual income is from our private work, itself punishing. Most surgeons work in public because we have a sense of responsibility to the community in which we live. I for one hope that Hospital Boards are reinstated and come to act as a mechanism of review, to filter out destructive and unsafe decisions by distant administrators.

Stephen Wilkinson
AM MBBS MD FRACS

Notice to Retired Fellows of the College

The College maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College.

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve.

We will acknowledge your donation and place your name on the gown, if you approve.

If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.

Alternatively, you could mail the gown to Jennifer C/o the Conferences & Events Department, Royal Australasian College of Surgeons, College of Surgeons’ Gardens, 240 Spring Street, Melbourne 3000.

The College would like to thank anonymous for the donation of a gown.



Working with trauma

Motor vehicle accidents are the primary cause of trauma in Queensland

Three years ago, Professor Michael Schuetz, Princess Alexandra Hospital trauma surgeon, was appointed to help develop trauma services in Queensland.

Just prior to his move to Brisbane, he received a phone call from a Swiss colleague, Dr Martin Wullschleger, who expressed interest in assisting with the project. After completion of his training in General and Trauma Surgery and four years consultancy in a Trauma Centre in the Swiss Alps, Dr Wullschleger was searching for challenges to extend his experience in trauma care, particularly polytraumas.

"Switzerland is a small country of only seven million people and many hospitals which means that we don't have a particularly high trauma case load per clinic," he said.

"I come from the Alpine region where most trauma is caused by mountain accidents, especially sports injuries in winter such as ski and snowboard accidents and summer activities like climbing, paragliding and motorbike tours. Another difference is that most injured people reach the hospitals within 30 minutes of retrieval.

"Here in South-Eastern Queensland, trauma is primarily caused by motor vehicle accidents and one of the major challenges it to overcome the long distances in transporting patients to the hospitals, which frequently takes more than five hours to get a patient from the accident scene to the appropriate hospital."

Dr Wullschleger's move halfway round the globe with his wife and four boys has also made an enormous difference to one local truck-driver.

In May this year, Colin Robertson almost severed his legs when the 20-tonne furniture removal truck he was driving smashed into a power pole. Trapped in the vehicle for more than an hour, Mr Robertson arrived at the Princess Alexandra Hospital in Brisbane by helicopter 40 minutes after paramedics finally freed him from the wreckage.

Professor Schuetz and Dr Wullschleger



Colin Robertson with Dr Wullschleger

were rostered on that Saturday when Mr Robertson was brought in. They initially assessed him together with emergency physicians and found that he was in a critical condition with a blood loss of about two to three litres.

"First we had to do everything to save his life and then consider whether we could save his legs. If we were not able to control the blood loss from the limbs then we would have had no choice but to amputate. However after successful haemodynamic stabilisation by emergency physicians and anaesthetists, as well as local bleeding control, we found that his neurovascular structures were intact," Dr Wullschleger said.

"We decided therefore to try to save his legs by orthopaedic damage control including external fixation."

Dr Wullschleger said that after major efforts from the ICU physicians and nurses to stabilise his general condition, Mr Robertson underwent more than 40 hours of surgery, with the longest single operation taking about 16 hours.

"This long and challenging operation

included bony reconstruction and fixation as well as free and local muscle flaps and skin grafts to fill and cover the wounds, performed collaboratively with the team of trauma and plastic surgeons," he said.

Dr Wullschleger said it took two weeks to determine whether the interventions were successful with sufficient blood circulation for the entire legs and no early signs of infection.

"It was a great feeling to see how the recovery process was improving. It took Mr Robertson nearly four weeks before he believed his legs were safe," he said.

Now Mr Robertson is at home, walking on crutches and undergoing intensive physiotherapy and rehabilitation.

"He will walk again without any supporting devices and probably even run again but that is likely to take more than a year," Dr Wullschleger said.

"It was a serious possibility we would have to amputate, or shorten his legs at the very least, so the work of the team and the patient's own efforts to recover have brought about a very satisfying result."

Dr Wullschleger has now been in Australia for two years and is still going through the Colleges' process of registration and recognition of his European qualifications. In the meantime he continues his clinical work as Trauma Fellow at PAH and is conducting research at the Queensland University of Technology with his main project and PhD study examining the role of minimally-invasive plate osteosynthesis in a sheep model.

"I am really enjoying the opportunity to combine my clinical work with shared research," he said.

His family is enjoying life here too.

"Beautiful beaches, always sunshine with the outdoor lifestyle and many Australian friends are only some of the reasons for us to live here in Brisbane for perhaps a big longer."

Pictures courtesy of Gold Coast Communications



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NSW Regional Committee

Complicated biliary surgery

Lessons from the Professional Standards Committee
of the New South Wales Medical Board

A de-identified decision by the Professional Standards Committee of the NSW Medical Board was sent to the NSW Regional Committee of the College to bring issues arising from an inquiry to the attention of other practitioners to raise awareness and serve as a learning tool. The Medical Board requested that it be advised of the action taken in complying with its order.

The details of the case cannot be published under statutory orders prohibiting publication and to preserve confidentiality, therefore the lessons are generic. The case concerns a complaint by the Health Care Complaints Commission (HCCC) to the Professional Standards Committee of the NSW Medical Board alleging that a surgeon was guilty of unsatisfactory professional conduct. The case was not proven but has provided insight and warnings for all surgeons involved in laparoscopic surgery.

Unsatisfactory professional conduct is defined in the Medical Practice Act 1992 as any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. This case involved a semi-urgent laparoscopic cholecystectomy occurring in the evening on a weekend in a public hospital. Post-operatively the patient deteriorated and on day four was transferred to a larger public hospital where the patient died five hours later.

The complaint by the HCCC alleged that there was:

- (i) Delayed recognition of intra-abdominal complications;
- (ii) Delayed investigation by scans;
- (iii) Delay in seeking advice from colleagues;
- (iv) Failure to appropriately interpret scans strongly indicative of need for re-operation;

- (v) Failure to operate early to address intra-abdominal pathology after obtaining results of the CT scan;
- (vi) Failure to make or ensure making of adequate medical records in accordance with Medical Practice Regulations.

Clinical situation according to the surgeon

A 61-year-old female (85g) was referred to the surgeon's rooms with significant abdominal pain and immediate admission to a public hospital was arranged. Semi-urgent laparoscopic cholecystectomy was carried out two days later. The operation was difficult and lasted three hours. There was a mucocoele with multiple stones but without pus in a very thick walled gall bladder which was stuck to the liver. The cystic duct was identified but could not be cannulated. There was a small amount of mucous spillage and a thorough washout of the gall bladder bed was carried out. A drain was used and intra-venous antibiotics were continued.

The operation report by the unaccredited registrar indicated that the cystic duct was not identified. The surgeon had not checked the accuracy of the operation report. This was criticised by the HCCC as a failure to maintain adequate quality of medical records.

On the first post-operative day there was 100ml of fluid containing a little bile in the drainage bag. The patient was tachycardic which was thought to be due to dehydration due to blood loss and fluid loss. She was reviewed by a physician.

On the third post-operative day the patient remained unwell with a persistent tachycardia. A CT scan was arranged to exclude abdominal pathology. The working diagnosis was pulmonary collapse and infection. There was no ongoing bleeding and no rise in bilirubin. The surgeon discussed the CT findings with a radiologist. Fluid in the right upper quadrant was noted above and below the liver. They

excluded abscess, bleeding and duodenal injury. The patient was in ICU and was noted to have a soft abdomen, was afebrile and haemodynamically stable with a normal bilirubin. Because of the fluid seen in the scan, gentamicin was added to the treatment. The possibility of pulmonary embolism had not been excluded.

The case was discussed with a senior colleague who offered to review the patient. The surgeon did not think that this was necessary. It was agreed that return to theatre was not indicated that night but aspiration of the fluid seen on the CT scan was advised. This could not be done that night in that hospital.

On the morning of the fourth post-operative day the patient deteriorated markedly and urgent referral to a larger hospital was arranged.

HCCC peer review - 1

The peer's opinion was that there was delayed recognition of intra-abdominal complications and was critical of the care after the CT scan revealed the fluid collection. The patient was unwell for more than two days and a bile leak or infection should have been considered. The clinical picture was not clear and included pain, tachycardia, fever, a rise in white cell count, a drop in haemoglobin and a tender abdomen. Chest pathology was present. The peer was critical that an anaesthetic consultation regarding a possible return to theatre was not done and there was no consultation with a senior colleague. The surgeon was faced with a finely balanced and difficult decision regarding return to theatre and the peer was moderately critical of the decision not to re-operate.

HCCC peer review - 2

The peer considered that the deterioration was due to post-operative intra-abdominal infection. The timing of the CT scan was appropriate but it showed substantial fluid in the abdomen and pelvis and indicated a need for laparotomy or laparoscopy. There had been marginal urine output, tachycardia, pain, aci-



dosis, a rise and return to normal of white cell count and a fall in haemoglobin. The peer was critical of the failure to recognise the significance of the CT scan and the failure to act.

The surgeon's peer review – 1

The peer recognised that the patient was unwell from the first post-operative day until death. The care and investigations were appropriate. The CT scan revealed a collection above and under the liver. The peer noted the low albumin, bilateral pleural effusions and a possible respiratory cause of the symptoms. There was a confusing clinical picture which had included tachycardia, hypotension, a decrease in renal function and possible dehydration. The abdomen was not tender and the drain had stopped draining bile. The medical consultation had excluded cardiac disease but not pulmonary embolism or basal atelectasis. Treatment with anticoagulants without a VQ scan was not criticised. The cause of death was probably aspiration and the peer was critical that a post-mortem examination was not done.

The surgeon's peer review – 2

The peer noted that the possible complications included bleeding, bile leak and damage to the bowel. It was prudent to use a drain and give antibiotics especially if a cholangiogram had not been performed. The initial drainage was clear and of small amount and tendered against intra-abdominal complications. The patient became unwell after the drain was removed. The timing of the CT scan was appropriate and the surgeon was entitled to rely on the opinion of the radiologist. As the bilirubin did not rise a major bile leak was unlikely and there was no evidence of intra-

“Unsatisfactory professional conduct is defined in the Medical Practice Act 1992 as any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.”

abdominal sepsis. The surgeon had considered intra-abdominal complications and reviewed the patient regularly. The post-operative pain was intermittent and its significance was unclear. The post-operative investigations of blood tests, chest X-ray and CT scan were appropriate as were the consultations with the physician, radiologist and another surgeon.

The surgeon's peer review – 3

The peer considered that the decision to return to theatre was not clear cut and it was reasonable to wait. The expert opinions differed after the CT scan had been performed. There was an evolving clinical picture over three days of an unwell patient without localising signs. The ICU notes confirmed significant atelectasis and possible fluid overload. There were potentially reassuring features including minimal drainage; a fall in haemoglobin was restored and maintained; the white cell count rose and returned to normal; bilirubin remained normal; the early hypotension did not continue and the patient remained afebrile with a soft abdomen and no peritonism. The post-operative pain was not considered significant. The CT scan revealed an abnormal collection of fluid but the experts disagreed over its significance. The main complication was atelectasis and it could explain the fever, pain and abdominal symptoms. The peer

considered that it was critical that the issue of significant pulmonary pathology be weighed up against the benefits of return to theatre.

Lessons

- (1) The definition of unsatisfactory professional conduct varies with the level of training and experience of the doctor.
- (2) A poor outcome of surgery can lead to complaints to the HCCC, investigations and inquiries by the Medical Board's Professional Standards Committee resulting in a complete and stressful scrutiny of the conduct of the surgeon.
- (3) Delay in diagnosis and delay in treatment can be difficult to explain and could be unsatisfactory professional conduct.
- (4) Delay in seeking assistance and advice in complicated cases will be criticised and could be unsatisfactory professional conduct. This would be proportionate to the gravity of the issue.
- (5) The Medical Practice Regulations allow delegation of record keeping but require the doctor to ensure that the record is an accurate statement of facts or clinical judgment. Inaccurate or incomplete records are a contravention of the Regulations and constitute unsatisfactory professional conduct.

PACIFIC
REGIONAL MEETING

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Pacific Regional International College of Surgeons Meeting (in collaboration with North Australian Surgeons)

For the first time, the International College of Surgeons (Chicago, USA) will be holding a quality Australasian regional forum, in collaboration with the North Australian Surgeons. The focus is to bring together renown international and regional experts in the fields of minimally invasive surgery of relevance to general surgical specialities. The cutting edge state of the art knowledge, skills and technologies will be discussed with emphasis on day-to-day practice. Both international and national speakers will be participating.





Congratulations on your achievements



Sir Louis Barnett

Sir Louis Barnett Medal

Professor Adrianus Marie van Rij FRACS

Professor Andre van Rij has made very significant contributions to education, training and advancement in surgery. He has held the Ralph Barnett Chair of Surgery since 1985, is the Past President of the NZ Association of General Surgeons and served as Chairman of the NZ Society of Vascular Surgery from 1995 to 2001.

He has held a number of important offices within the Royal Australasian College of Surgeons, but perhaps his greatest contribution has been as NZ Censor where he has contributed to the strategic planning and leadership of the College.

Andre has also served as a member of the Court of Examiners and as a member and then Chairman of the NZ subcommittee of the Board of General Surgery. Audit has been a long-term major interest and he has been a member of the Surgical Audit Task Force since 2001. He has played an important role in the development of the widely used and respected Otago Audit system and the New Zealand Vascular Audit. More recently, he has developed an interest in the management of outliers identified by audit.

Andre has been one of the RACS Fellows who has made a major contribution both to the College and to surgery in Australia and New Zealand, while being the head of an academic department of surgery and playing a major clinical role in both General Surgery and Vascular Surgery.

Andre's competence in the areas of education and training and his contributions to the advancement of surgery are beyond question.

Colin McRae Medal, 2007

Mr William Joseph Sugrue FRACS

Mr William (Bill) Sugrue was educated at St Kevin's College, Oamaru and Otago University Medical School. He spent two years at North Middlesex training in thoracic surgery, obtained the FRACS in 1977 and was appointed as a consultant general surgeon to Whangarei Hospital in 1979. Bill has served the hospital and the people of Northland well for almost 30 years working in both the public and private sectors.

Bill is widely respected by his peers as a highly competent surgeon who works across the spectrum of general surgery and thoracic surgery. In 2006, he was awarded the Denys Summer medal by the NZ Association of General Surgeons for his enthusiasm and expertise in surgical teaching.

In 1995, he was made a member of the Court of Examiners in general surgery and in 2006 was elected to the College NZ National Board. Bill has played an important part in medical administration serving both as clinical director of surgery and as medical director of the Whangarei Area Hospital.

Bill has had a long-term interest in surgical aid to developing countries and has served in Vietnam, Pakistan and Afghanistan. More recently, he has taught colonoscopy in Vietnam.

Bill has had considerable involvement in community activities. He has served as Chief

Medical Officer of the St John's ambulance and has also had a major involvement with Rotary and has received the Paul Harris award in 1992 for his services to humanity.

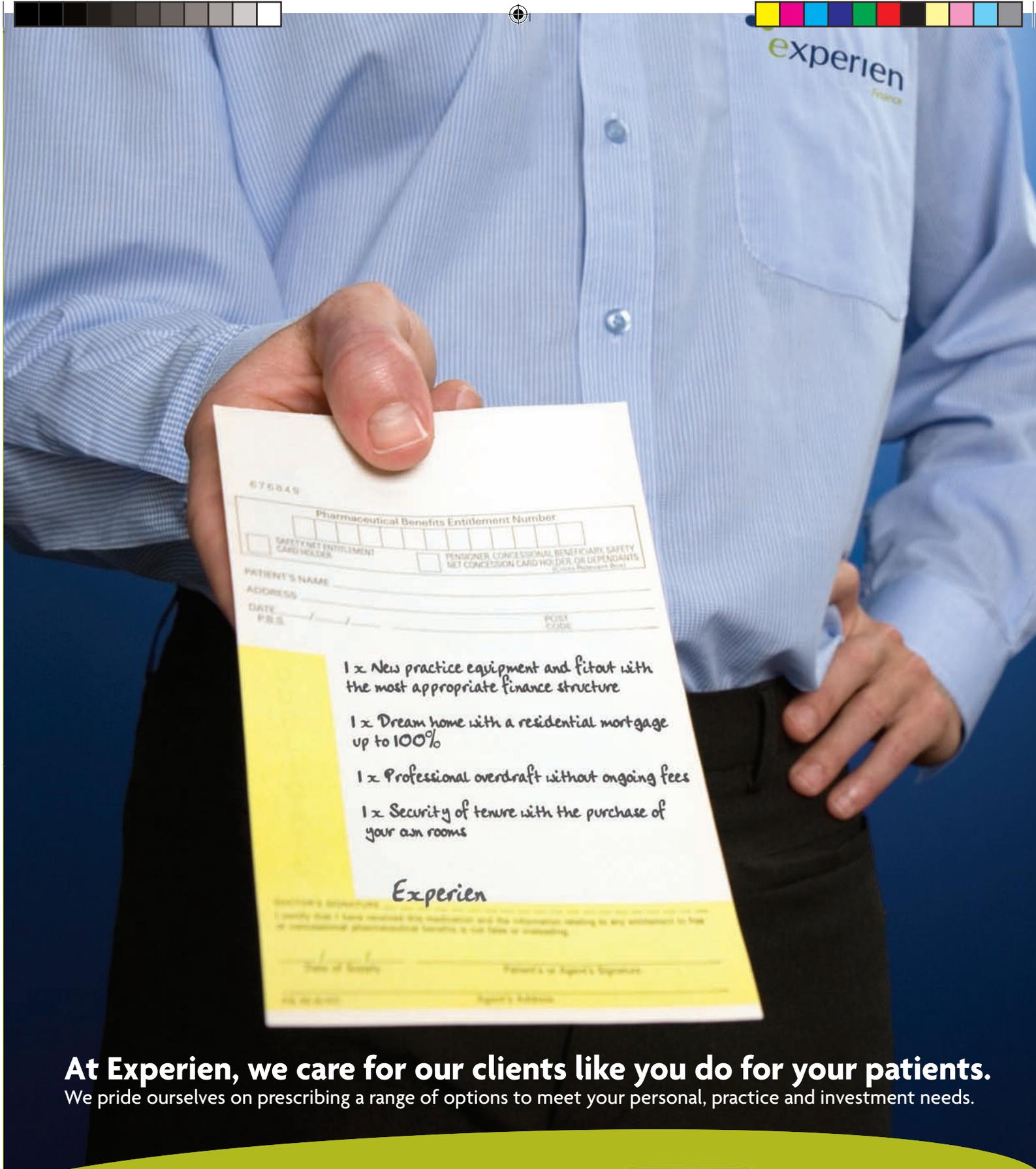
RACS Surgical Research Award, 2007 Professor Glyn Jamieson FRACS

Glyn Jamieson is a South Australian general surgeon who graduated from the University of Adelaide. He travelled overseas to work in Norwich, the University of Edinburgh, the University of Rochester and Duke University. In 1982, he was appointed the Dorothy Mortlock Professor of Surgery at the University of Adelaide.

His research interests and enthusiasm have been substantial over the past 30 years, heading up one of the most prominent University Surgical Departments in Australia and nurturing and encouraging prospective academic surgeons who have taken up practice not only in Australia but also overseas. He has served the College not only as a Councillor but also as Chairman of the Board of Surgical Research.

His personal area of research interest has been primarily the oesophagus and in this area, he has received NHMRC support over the past 20 years. He has achieved an enviable publication record with over 250 peer-reviewed papers in the world's foremost surgical journals. This, combined with his excellent surgical textbooks aimed at not only the specialist but also the generalist, many in their second edition, has positioned him as one of Australia's foremost academic surgeons.

While his research credentials are a model for any academic surgeon, one of the most enduring and significant contributions has been his fostering of young surgeons. With his encouragement, guidance and experience, he has been able to stimulate and train many general surgeons in public and private practice around Australia.



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