

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Vol:10 No:1 January/February 2009



The John Mitchell Crouch Fellowship, page 22:
This is the College's most prestigious scholarship, consisting of a generous \$75,000 grant.

Road Trauma, page 14:
The carnage of road trauma in the past was described as an epidemic.

Club Feet, page 20:
Early treatment of club feet prevents a lifetime of disability.

Artistic Fellows, page 33:
Art is a wonderful antidote to the stress of surgery.

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

PROFESSIONAL DEVELOPMENT WORKSHOPS

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

Advanced Diploma In Business Management – NEW!

May 2009 – October 2010

Need to upgrade your skills by obtaining a recognised business qualification? This 18 month course can hone your management skills and help you to become a better leader in the public sector or your private practice. University of New England (UNE) Partnerships is proud to offer this exciting, learning opportunity tailored to the needs of surgeons who have three years (minimum) relevant workplace experience. It combines distance learning modules with online interaction and three face-to-face workshops. It provides practical workplace focused training to effectively manage the strategic direction of a business through leadership, comprehensive business operations and financial management.

Polishing Presentation Skills

26 February 2009, Sydney
14 August 2009, Melbourne

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

Beating Burnout

4 March 2009, Adelaide
1 September 2009, Sydney

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

From the Flight Deck: Improving Team Performance

6-7 March 2009, Melbourne
8-9 August 2009, Melbourne (Ortho)
2-3 October 2009, New Zealand

This 2 day workshop, facilitated by an experienced doctor and pilot, explores similarities between the aviation industry and surgery by comparing error analysis models. The program combines rigorous analysis of actual airline accidents and medical incident case studies. You will learn more about human error and how to improve individual and team performance. Don't miss out on the unique opportunity to experience a full-motion training flight simulator. You'll be blown away, have fun and walk out of workshop with invaluable knowledge after this intensive course.

Further Information

Please contact the Professional Development Department on +61 3 9249 1106, by email pdactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development. Easy online registration is available for most workshops.

PROFESSIONAL DEVELOPMENT WORKSHOP

DATES: FEB – JUNE 2009

NSW

7 February Supervisors and Trainers (SAT SET) (Facilitator training), Sydney
26 February Polishing Presentation Skills, Sydney
1 April Interviewer Training, Sydney (videoconference)
28 April Supervisors and Trainers (SAT SET), Sydney
4 June Mastering Difficult Clinical Interactions, Sydney
19-21 June Leadership in a Climate of Change, Sydney

QLD

8-12 March Supervisors and Trainers (SAT SET) (Urology), Gold Coast
19-21 March Surgical Teachers Course, Brisbane
25 March Interviewer Training, Brisbane (videoconference)
2-4 May Younger Fellows Forum, Brisbane (pre ASC)
5 May Supervisors and Trainers (SAT SET), Brisbane (ASC)
5 May Writing Reports for Court, Brisbane (pre ASC)

SA

4 March Beating Burnout, Adelaide
16 June Supervisors and Trainers (SAT SET), Adelaide

NT

27 June Supervisors and Trainers (SAT SET), Darwin

WA

3 February Supervisors and Trainers (SAT SET), Perth
29 May Risk Management: Mastering Consent, Perth

VIC

6-7 March From the Flight Deck, Melbourne
14 March Communication Skills for Cancer Clinicians, Melbourne
TBA March Working Together: Surgeons and Administrators, Melbourne
2 April Mastering Intercultural Interactions, Melbourne
29 April Interviewer Training, Melbourne (videoconference)
26 May Supervisors and Trainers (SAT SET), Melbourne
27 June Making Meetings More Effective, Melbourne

TAS

5 March Supervisors and Trainers (SAT SET), Launceston

NZ

21 February Supervisors and Trainers (SAT SET), Auckland
26 May Supervisors and Trainers (SAT SET), Christchurch
26 June Practice Made Perfect: Successful Principles for Practice Management, Auckland

Welcome to 2009

I do hope the New Year sees you refreshed, fit and healthy



Ian Gough,
President

In a world where New Year resolutions seem to be re-worked vigorously it may be that 2009 could see real gains made across the health system in Australia and New Zealand in issues of patient safety.

The Garling Report (released late in 2008) is now being digested and its enormity recognised. Commentary from surgeons and also from editorials in the *Medical Journal of Australia*¹ highlight that the challenges in implementing this report will be substantial. We await the response of the Government with interest as to how this will be achieved.

Implementing issues for safety and peer review in surgical practice is something that the College takes very seriously and has progressed actively over the last decade.

A Platform for Safety

The College has now developed a comprehensive series of activities that can aid all surgeons in maintaining their standards and ensure patient safety is actively reviewed. Importantly, they can link with activities undertaken in each hospital and region. In 2009, the College will be considering the obligation to make these a mandatory component of our activities and Continuing Professional Development.

Mortality Reviews

The Mortality Audit process has been built on the successful Scottish Mortality Audit that was introduced into Western Australia almost ten years ago. The College has facilitated its introduction into most regions of Australia through Regional Mortality Committees.

In New South Wales it is co-ordinated through the Clinical Excellence Commission.



The College looks forward to a busy year ahead

There appears to be some movement in New Zealand to ensure a similar process can be achieved. The annual reports that have now been produced from Western Australia, South Australia, Tasmania, Queensland and Victoria demonstrate the importance of system-wide issues such as infrastructure, access to consultant level care, use of deep vein thrombosis prophylaxis (DVT) and fluid management. Active engagement of surgeons in this voluntary model has been extremely important to the success of these endeavours.

Morbidity Reviews

Morbidity or complication audits are progressively being introduced in all specialties. Leaders have included the orthopaedic surgeons with the Australian Orthopaedic Association (AOA) Joint Registry, breast surgeons with the

Breast Audit, cardiothoracic surgeons with intensive follow-up of cardiac patients and the vascular surgeons who are producing a bi-national approach to add to the success of the Melbourne Vascular Audit.

Importantly, the College is now implementing an electronic log-book under the oversight of Professor Julian Smith. This also has an integrated audit capacity that captures all the fields that are required for the College minimal data set. Consequently, all surgeons will be able to maintain a minimum data set on every patient they treat. This will be incredibly powerful when combined with active peer review and audit.

The College continues to push all hospitals and accrediting bodies like the Australian Council on Health Care Standards (ACHS) to resource and if necessary mandate local peer review and audit. →

Without doubt the active involvement of clinicians in discussions of all deaths and rigorous involvement in morbidity and safety issues is the only way to progressively improve the standards of surgical care. This is key to our platform of surgical safety.

System wide changes

The issue of safety continues to focus on how we can make our systems, our infrastructure, intrinsically safer. The College has been a strong supporter of the Correct Patient, Correct Side, Correct Site Surgery strategy,² which has been implemented across the entire hospital sector. Our best clinicians have recognised the strengths of this approach and incorporated them into their practice in the public hospital system, the private hospital system and their own rooms. There is no doubt this approach saves lives and decreases morbidity.

The College endorsed a World Health Organisation (WHO) initiative 12 months ago. This saw the development of a 19-item surgical safety checklist designed to improve team communication and consistency of care. It has been implemented in eight hospitals around the world, including Auckland Hospital, New Zealand.

The 19 elements are grouped under headings of Sign-in, Time-out and Sign-out. The *New England Journal* has now published the results³ that demonstrate the implementation of the checklist was associated with substantial reductions in rates of death and complications in patients aged greater than 16 years of age undergoing non-cardiac surgery. Post-operative complication rates, including death rates, fell by 36 per cent.

There is strength in these approaches that



will make all of our patients safer. Combined with appropriate DVT prophylaxis, hand-hygiene initiatives and correct fluid balance attention these initiatives are under the direct control of the surgical teams that we lead.

While the politicians struggle with the broader dilemmas of our complex health system, its interactions and its funding, all surgeons can act now on this platform for surgical safety. Surgeons can continue to make real differences to the safety of the care of our patients.

Challenges and the College

There will be many challenges in 2009. The threats of the Government proposed changes in registration and accreditation, the financial crisis which will impact health funding and

the ongoing technological developments of surgery will continue to be with us all. Again it will be a busy year for the College and I look forward to meeting with you in 2009 as these issues are addressed.

References

1. Van der Weyden, M.B., *In the wake of the Garling inquiry into New South Wales public hospitals: a change of cultures* (Editorial). *Med J Aust*, 2009. **190**(2): p. 51 - 51.
2. Atkinson, R., *Correct Patient, Correct Side and Correct Site Surgery*. *Surgical News*, 2008(May): p. 12.
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National registration system

The College is actively involved in registration and accreditation processes



Ian Dickinson,
Vice President

At a meeting on 26 March, 2008, the Council of Australian Governments signed an Intergovernmental Agreement (IGA) on the health workforce aimed at creating a single national registration and accreditation system for nine health professions, including medical practitioners.

Throughout the second half of last year the College was actively involved in the consultation process arising from the IGA, responding to a series of consultation papers on the proposed reforms. As a national system requires enabling legislation, an enabling bill passed the Queensland Parliament in November. A second bill, which will provide for the detail of any new arrangements, will have to pass the Queensland Parliament, and adoption bills will then need to pass all state and territory parliaments and also the Federal Parliament.

While the College welcomes a National Registration system, which among other things will enable medical practitioners to move around Australian states and territories more easily, we have serious reservations about some aspects of the proposed arrangements. These concerns have been raised clearly and forcefully in our submissions to the team charged with implementing the IGA.

Specifically, we see an obvious conflict of interest in the proposal to delegate responsibility for both registration and accreditation to one body. Whilst national registration has a number of important benefits, these need to be kept separate from consideration of the standards of education and qualification required to achieve these, and their maintenance throughout a health professional's career. It is most important that issues relating to standards are

developed and monitored by an accreditation body that is independent of the registration board and free of political influence.

The consultation paper on proposed arrangements for accreditation stated that: "Membership of the accreditation panels should not over-represent the interests of the profession." This begs an obvious, but unanswered, question: How do you define "over-represent"?

The College made the point that for the new systems to work, and for professional and public confidence in them, it is imperative that the chair and the majority of members of key committees be drawn from the relevant health profession.

"The College was dismayed to find no role for the specialist medical colleges in the proposed arrangements... this is a serious omission."

At the same time there needs to be broader representation of the community and of educational and government groups.

The College was dismayed to find no role for the specialist medical colleges in the proposed arrangements. Given the fact that the colleges have ensured world class medical care for generations of Australians, this is a serious omission.

Coupled with the proposal to merge the registration and accreditation functions, this omission leaves open the possibility that the IGA is seeking to increase the number of health professionals by simply lowering educational standards. The College believes that the Australian public expects and deserves a better way of relieving pressure on our health systems.

The College President and I have raised this issue personally with senior officials responsible for the implementation of the National Registration and Accreditation Scheme and we understand that the specialist medical colleges will figure in subsequent consultation papers and/or the draft legislation. While this assurance is encouraging, the College's proven commitment to standards of excellence obliges us to keep a

vigilant eye on developments in 2009.

Our response to the consultation paper on information sharing and privacy emphasised the need to strike an appropriate balance between enabling the flow of information to regulatory bodies and protecting the confidentiality of that information. With regard to public national registers of practitioners banned from practising, the College opposed proposals which we viewed as unnecessarily harsh. We also vigorously opposed any proposal that would unnecessarily increase the burden of red tape on medical practitioners.

The College's submission in response to proposals regarding complaints handling emphasised considerations of natural justice and procedural fairness. We expressed concern about the proposed make up of committees responsible for assessing complaints, which is effectively at the Minister's discretion. We argued for an accused medical practitioner's right to legal representation and called for a mechanism whereby practitioners are in no way disadvantaged by malicious or frivolous complaints.

In addition to raising these fundamental concerns, the College's submissions made constructive suggestions which will, we hope, be reflected in the next stage of the consultation process. This will take the form of an exposure draft of the legislation in 2009, with the new arrangements to take effect from 1 July 2010. The College will continue to be closely involved in this process.

Fellows can examine the proposed arrangements, and the College's formal responses to them, by accessing the Health Workforce Australia website at www.nhwt.gov.au and clicking on the National Registration and Accreditation tab.

CPD program update



Michael Grigg,
Chair, Professional Standards

I have “inherited” responsibility for Continuing Professional Development (CPD). My wife is also a surgeon. I am asked on a regular (daily) basis: “Why should I participate in CPD? What value is it?”

Well, from a practical point of view, an increasing number of healthcare providers (hospitals, medical registration boards, etc) are requiring evidence of compliance with CPD for accreditation purposes. But, I can hear the retort (from close proximity), evidence of CPD is hardly a measure of competence. Perhaps not, but there is increasing evidence that participation in CPD activities does in fact correlate with competence. Besides, who amongst us would rather re-sit the second part exam on a regular basis than participate in CPD to demonstrate ongoing competence?

CPD costs your College quite a lot of money. Why are we doing it?

“It is our responsibility to ensure that healthcare is provided by competent individuals.”

This is not a quote from the College. It is a typical opening sentence of correspondence received by the College on a regular basis from government derived committees and organisations (in this case from the New Zealand Medical Council). Your College is attempting to forestall outside interference with the surgeon-patient relationship by providing tangible evidence of participation in and compliance with professional development, i.e., professionalism. Fortunately, the vast majority of Fellows agree. Ninety-three per cent are CPD compliant.

We need all surgeons to participate in the CPD Program. If you are having difficulty with an outstanding return, make contact with



Participation in CPD is an accepted indicator of competence

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.

If you belong to the small minority refusing to participate in CPD, I would urge you to address the following questions: 1) Am I letting my surgical colleagues down? And, 2) Am I as competent as I think I am?

Clearly the CPD process is not perfect, but it is being regularly reviewed and updated. Please contact me with any ideas or concepts – even negative thoughts will be appreciated (this sentiment does not extend to my wife!).

2008 CPD recertification data forms

Recertification data for 2008 is now being collected. Details of your continuing professional development activities during 2008 should be returned to the College by 31 March, 2009.

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 or CPD online diary

Verification

Each year two-and-a-half 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 2008, you will have been notified accordingly.

(Last year, I was one of the two-and-a-half per cent – I extend my sympathy to this year’s two-and-a-half per cent of Fellows but verification is crucially important to maintain credibility).

CPD online

Data collection for the 2009 CPD Program is available online via the College website www.surgeons.org. You will be able to access a personal CPD Online diary using usernames and passwords to maintain CPD records in a real time format.

The CPD Online diary has been upgraded and was relaunched in January 2009. Both the functionality and the design of the system have been greatly improved and the system now includes the ability to record a recurring meeting/activity. The CPD Online diary is now a more user friendly system and the time required maintaining the online diary will be significantly reduced.

If you use the CPD Online Diary for 2009 you will not be required to complete the hard copy recertification data form issued at the conclusion of 2009, however, continue keeping evidence of CPD activities in case you are one of the “unlucky” two-and-a-half per cent randomly selected Fellows for verification.

CPD Online training and telephone assistance is available through the Department of Professional Standards on +61 3 9249 1282. See page two for information about PD activities.

International Medical Graduates

The question of Article 21 Fellowships has been rigorously discussed at the College

I.M.A Newfellow

Is it 19 or 21? That is the question. This is often the question raised in the IMG assessment panels. Now, for the ignorant, the term “IMG” stands for International Medical Graduate, which is the newspeak for Foreign Trained Doctor or Overseas Trained Surgeon. Article 21 is a term that is spoken of often and refers to the article in the Articles of Association, which are the rules that govern the way the College runs. Under Article 21 a doctor may become a Fellow without examination. The question of Article 21 Fellowships has been vigorously discussed over recent years by the specialty societies and the College. Some societies feel that this article should rarely, if ever, be used.

“It is really a simple matter”, says Mr Bigot (he sits next to Mr Pedant Nit-Picker but does not seem to be a friend). “These foreigners need to do the same examination as all our Trainees.” Now that seems logical to me. If you are claiming to be a surgeon surely you need to show that you are academically “up to it” by passing the same exam as everyone else – except for my mate from London, of course, who wants to move here. He has been a consultant for 20 years in a top London hospital so clearly he does not need to pass the exam. I looked up his credentials and to my surprise found that he was not an Fellow of the Royal College of Surgeons (FRCS) England as I had assumed but had a lesser surgical qualification. So where does he sit relative to our senior registrar (SR), also from London. He has an FRCS England and an FRCS Edinburgh, a Doctor of Medicine (MD) and as he has passed his exams recently also has a Certificate of Completion of Train-



ing from the Intercollegiate Specialty Board in the UK.

That all sounds very impressive so perhaps our SR should get an Article 21 Fellowship and my consultant friend take the exam. I mentioned this to Mr Nit Picker who sits on the IMG assessment panel and he pointed out that my friend had over 100 publications, several book chapters and was a sought after international speaker. Should that count at all? Mr Nit Picker also pointed out that all IMG surgeons who are assessed as being suitable for the Article 21 pathway must have a period of at least 12 months oversight and three monthly reports by two senior Fellows of the Royal Australasian College of Surgeons (FRACS) assessors. In his experience only about 10-20 per cent of IMGs interviewed will qualify for Article 21.

I also recalled another young surgeon that had been with us. He had an Master of Surgery (MS) from an Indian university but the IMG panel had determined that he was not eligible for an Article 21 Fellowship. He was a very nice, competent young man but had to take the examination (and passed). Was that fair when all the consultants in our department supported him?

Mr Nit Picker proceeded to give me a tutorial on what determines the awarding of an Article 21 fellowship. The surgeon must show three things

1. That he/she has completed a training programme comparable to the College training programme.
2. That he/she has taken an exit examination comparable to the College exit examination.
3. That his/her recency of practice is appropriate in the specialty.

Now on those rules our SR would probably get an Article 21 Fellowship and my London consultant friend would not. But there is a life line. The exit examination may be waived if “the scope of surgical practice in the specialty is of a sufficiently high standard as to waive the need to sit the fellowship examination”. So he is probably saved by his prodigious output of papers and book chapters.

What about our young Indian surgeon? On these rules he did indeed need to take the examination as the Master of Surgery assessment was not to the same rigour as the College examination.

Now Mr Nit Picker has a touch of devilry in him and turned his attention to me and evaluated my credentials (somewhat irregular as they are) and past training and declared that I would have to take the exam if I was presenting now as an IMG! The rules and application of the rules all seems very fair and logical – except for me, of course.

Brisbane beckoning – The 2009 ASC

The 78th Annual Scientific Congress will meet the high standards set by previous years

Mark Smithers,
Congress Convener
& **Andrew Stevenson,**
Congress Scientific Convener

Planning for the forthcoming 78th Annual Scientific Congress (ASC) is proceeding smoothly and all indications are that this will be another outstanding meeting which we know is being held in Australia's most liveable city. The Brisbane conveners look forward to welcoming you in May.

Conference website

The central source for all information pertaining to the conference is the Congress website. This is accessed from <http://asc.surgeons.org> or from the College home page; there you can view or download the Provisional Program, register online, submit abstracts and keep up to date with developments.

The scientific aspects of the conference are the primary reason for surgeons and Trainees attending the meeting. The outstanding faculty of national and international speakers will ensure the science is up-to-date and relevant to your daily surgical practice.

There is more to the profession than operating. We live in a time of unprecedented pressure on surgeons, Trainees and our College from all levels of government and from society – pressures to which we must respond with a unified voice if we are to maintain control of our destinies.

The ASC is the opportunity for the most pressing of these issues to be discussed at the plenary sessions (see below), at the College AGM (5:30pm, 8 May), over meal breaks and at section dinners. College Councillors attend

the meeting and are readily available to discuss issues important to you.

The titles for the three plenary sessions are:

- **Re-validation: the future for all ANZ surgeons**
- **Surgery to the needy at home and abroad – what can I do?**
- **Major challenges in surgical training – selection, training and underperformance**

The ASC is the only opportunity afforded by the College for all Fellows and Trainees to come together in a collegiate atmosphere and celebrate the profession to which we belong. Under the overarching title of “surgical conference” there is the Convocation, the College Annual General Meeting (AGM) and the section dinners and the Congress dinner.

Convocation & Welcome Reception Tuesday 5 May

The Convocation is our opportunity to honour young surgeons joining the profession and to honour senior colleagues who have given so much to surgery and to the College. The resounding and prolonged applause that greeted the new members of our College at the Conjoint ceremony in Hong Kong was the topic of much favourable discussion by our sister Colleges.

The Convocation commences with “The Syme”. The Syme Oration is our College's premier Oration and memorialises George Adlington Syme, a Founder and our first President, an outstanding surgeon and leader who died in office in 1929, aged 70.

This year we are delighted that Mr Noel Pearson has accepted the invitation to deliver the Oration. Mr Pearson is a highly regarded Aboriginal leader who has been at the forefront of policy issues for two decades. Educated in Brisbane and Sydney, since 2004 he has been Director of the Cape York Institute for Policy and Leadership.

Members of the profession to be honoured at the Convocation will be Professor Michael Gleeson (London, Honorary Fellowship) and James Semmens (Perth), David Storey (Sydney),

Andrew Sutherland (Adelaide), David Scott (Melbourne), Robert Aitken (Perth), Michael Besser (Sydney) and Patrick Bridger (Sydney). Professor Stephen O'Leary will be presented with the 2009 John Mitchell Crouch Research Fellowship. Professor O'Leary will also deliver the Third John Mitchell Crouch Research Lecture at midday on Wednesday.

Congress dinner Friday 8 May

From a nadir at the beginning of the decade, the Congress dinner has become an extremely popular event and now tickets sell out for this outstanding evening. Remember the Three Waiters in Melbourne, the young stars of the Australian Opera in Sydney, the Air Force theme and museum in Christchurch and the sheer opulence of the setting in Hong Kong last year? Wait till you see Brisbane!

Note: Additional Tuesday Workshop

There will be a workshop on “Writing Court Reports” from 9am to 2pm on the Tuesday program. Facilitated by Leo Cussen Institute barristers and members of the College Medico-legal Section, this workshop provides unique one-on-one training in the preparation of medical reports for use in legal cases. Participants receive individualised feedback on their medico-legal reports and gain an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective. Please register online when you register for the conference. (For further information, see page 47)

Early bird registration

Note that “Early bird registration” will close on Monday 16 March. Online registration has never been easier at asc.surgeons.org

Brisbane beckons – see you there!

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

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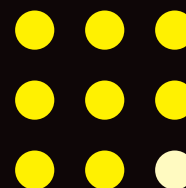
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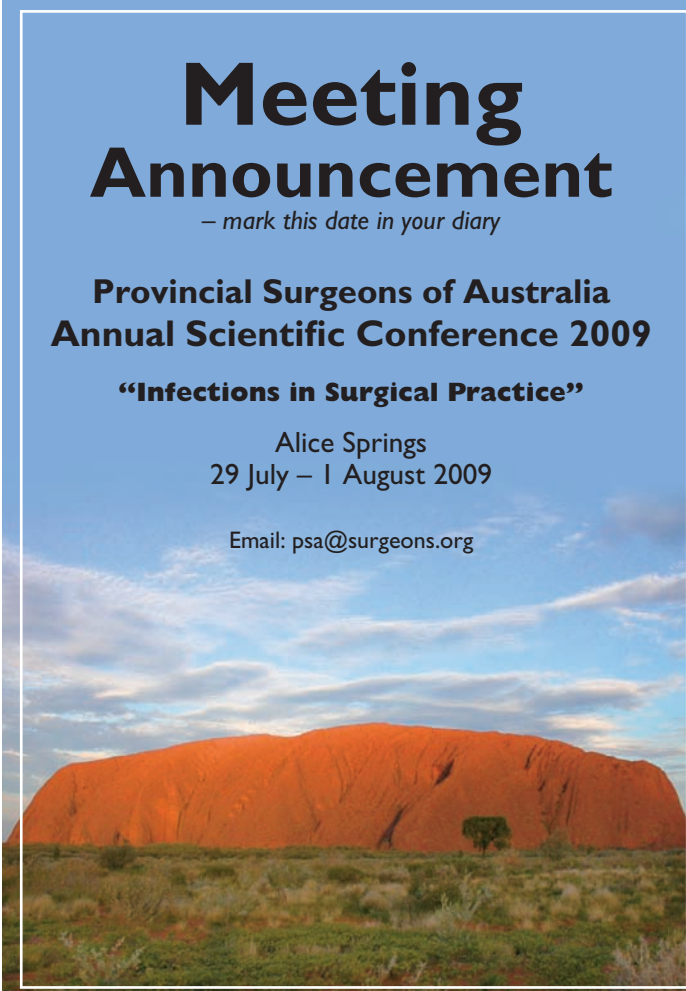
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New reviews from ASERNIP-S

Wrist ganglia and sleep apnoea are some of the topics of recent reviews



Julian Smith,
Chair, Research, Audit & Academic Surgery

The Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) has recently published one new systematic review and five new rapid reviews. A rapid review is a review in which the methodology has been limited in one or more areas in order to answer specific clinical questions and shorten the timeline for its completion.

Systematic literature reviews

- Treatments for varicose veins ASERNIP-S Report no. 69 (This full systematic review was conducted after the rapid review of the same topic in order to compare the main outcomes and conclusions)

Rapid reviews

- Clinical treatments for wrist ganglia ASERNIP-S Report no. 63
- Diagnostic arthroscopy for conditions of the knee ASERNIP-S Report no. 64
- Male non-therapeutic circumcision ASERNIP-S Report no. 65
- Treatments for varicose veins ASERNIP-S Report no. 66
- Upper airway surgery for the treatment of adult obstructive sleep apnoea ASERNIP-S Report no. 67

You can access the above reviews on the publications page of the ASERNIP-S website at www.surgeons.org/asernip-s. The findings of reports no. 63, 64 and 67 are briefly described below. The findings of reports no. 65 and 69 will be published in subsequent editions of *Surgical News* in 2009.

Clinical treatments for wrist ganglia

The safety and effectiveness of clinical treatment options for wrist ganglia compared to simple reassurance was assessed. Clinical treatments for wrist ganglia included both surgical excision and non-surgical techniques such as aspiration and puncture, while simple reassurance included educating patients about the nature of wrist ganglia and informing them that the masses are not cancerous and may resolve spontaneously.

There was some evidence that surgical excision may be no better than aspiration or reassurance in preventing recurrence of wrist ganglia. However, several trials indicated that surgical excision is significantly more effective in preventing ganglia recurrence compared to aspiration, at least in the short term (<6 months). Patients treated with surgical excision were significantly more satisfied compared to those who received aspiration or reassurance, despite the fact that resolution of symptoms was lowest in these patients. Surgical excision was associated with longer time off work and higher complication rates, and may cause more severe complications compared to aspiration.

Based on the available evidence, wrist ganglia should only be treated if symptomatic. Surgical excision should be used as a last resort in view of the relatively high complication rates and the possibility that it does not confer enough benefit to warrant the higher risk. Due to the apparent patient value placed on intervention, aspiration may be the preferred clinical treatment due to its lower complication rates and lower cost relative to excision.

Diagnostic arthroscopy for conditions of the knee

This rapid review aimed to assess the accuracy and safety of arthroscopy for the diagnosis of knee conditions in comparison with magnetic resonance imaging (MRI) and ultrasound. Diagnostic performance outcomes examined included specificity, sensitivity, likelihood ratios and predictive values.

For meniscal lesions and anterior cruciate ligament (ACL) tears, MRI is an effective diagnostic tool when compared to diagnostic arthroscopy

In particular, MRI has a high specificity and negative predictive value, suggesting that screening MRI studies can effectively rule out the presence of meniscal lesions and ACL tears and reduce the number of unnecessary diagnostic arthroscopies performed. MRI is useful in situations where the results of a clinical examination are uncertain, and it is the most appropriate diagnostic screening tool to use before therapeutic arthroscopy. Arthroscopy should be reserved for patients with a lesion that is treatable by arthroscopic methods.

Safety outcomes were not reported in any of the included systematic reviews or in the primary studies included in these reviews; thus, it was not possible to assess the safety of arthroscopy for diagnosing knee conditions in comparison with other diagnostic procedures.

Upper airway surgery for treatment of adult obstructive sleep apnoea

ASERNIP-S reviewed the available evidence to compare the safety and effectiveness of upper airway surgical procedures for obstructive sleep apnoea (OSA) in adults, with conservative therapy and no treatment/placebo. Surgical treatments included uvulopalatopharyngoplasty (UPPP), laser assisted uvulopalatoplasty (LAUP), temperature-controlled radiofrequency tissue ablation (TCRFTA) and palatal implants, while conservative therapy included treatment with devices, namely continuous positive airway pressure (CPAP) and oral appliances.

From the limited high-level evidence available, upper airway surgery for OSA does not provide significant benefit over conservative treatment or treatment with devices. Following failed conservative treatment with devices, selected patient groups with specific anatomical features, body mass index and OSA severity may benefit from certain upper airway surgical techniques. However, at present, there is insufficient high-level evidence on the effectiveness of any surgical procedure, regardless of patient characteristics.

With regard to safety, UPPP had more adverse effects than the less invasive TCRFTA and palatal implant procedures, while LAUP had similar adverse effects to UPPP at similar rates of occurrence.

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Conference diary dates

Please see the College website for links to further information www.surgeons.org, go to the Fellows page, click on Resources for Surgeons then Conferences

Surgery

Australia/NZ

- Annual Scientific Congress
6 - 9 May 2009 / Brisbane QLD AUSTRALIA

Overseas

- 17th Asian Congress of Surgery
20 - 22 March 2009 / Taipei TAIWAN
- International Surgical Congress of the Association of Surgeons of Great Britain and Ireland
13 - 15 May 2009 / Glasgow SCOTLAND UK

Cardiothoracic Surgery

Australia/NZ

- Annual Scientific Meeting of the Thoracic Society of Australia & New Zealand
4 - 8 April 2009 / Darwin NT AUSTRALIA

General Surgery

Australia/NZ

- Clinical Oncological Society of Australia (COSA) Annual Scientific Meeting
12 - 14 February 2009 / Sydney NSW AUSTRALIA
- Trauma 2009
5 - 7 March 2009 / Auckland NEW ZEALAND
- IFSO-APC OSSANZ Conference
First Biennial Scientific Meeting of the International Federation of the Surgery of Obesity (Asia Pacific Chapter) in conjunction with the 22nd Annual Scientific Meeting of the Obesity Surgery Society of Australia & New Zealand
25 - 27 March 2009 / Cairns QLD AUSTRALIA
- New Zealand Association of General Surgeons Annual Meeting 2009
27 - 29 March 2009/ Invercargill NEW ZEALAND

Overseas

- Annual Meeting of the Society of Surgical Oncology (SSO)
5 - 8 March 2009 / Phoenix AZ USA
- Medical Disaster Response 2009
5 April 2009 / Las Vegas NV USA
- Trauma, Critical Care and Acute Care Surgery 2009
6 - 8 April 2009 / Las Vegas NV USA
- American Society of Breast Surgeons Annual Meeting
22 - 26 April 2009 / San Diego CA USA
- American College of Colon and Rectal Surgeons Annual Meeting
2 - 7 May 2009 / Hollywood FL USA

- 16th World Congress on Disaster and Emergency Medicine
12 - 15 May 2009 / Victoria BC CANADA
- Eurotrauma 2009
13 - 17 May 2009 / Antalya TURKEY
- American Transplant Congress
30 May - 3 June 2009 / Boston MA USA
- AOA 122nd Annual Meeting
10 - 13 June 2009 / Bonita Springs FL USA
- 17th International Congress of the European Association for Endoscopic Surgery (EAES)
17 - 20 June 2009 / Prague CZECH REPUBLIC
- 26th Annual Meeting of the American Society for Metabolic and Bariatric Surgery
21 - 26 June 2009 / Grapevine TX USA
- Insight (International Society for Gastrointestinal Hereditary Tumours) 3rd Biennial Conference
24 - 27 June 2009 / Dusseldorf GERMANY

Neurosurgery

Australia/NZ

- Spine Society of Australia Conference
17 - 19 April 2009 / Brisbane QLD AUSTRALIA
- NSA Annual Scientific Meeting
17 - 20 September 2009 / Alice Springs NT AUSTRALIA

Overseas

- 9th Annual Canadian Spine Society Meeting
18 - 21 March 2009 / British Columbia CANADA
- American Association of Neurological Surgeons Annual Meeting
2 - 7 May 2009 / San Diego CA USA
- Annual Meeting of the International Society for the Study of the Lumbar Spine
4 - 8 May 2009 / Miami FL USA

Orthopaedic Surgery

Australia/NZ

- Spine Society of Australia Conference
17 - 19 April 2009 / Brisbane QLD AUSTRALIA
- 2nd Joint Meeting of the International Bone & Mineral Society and the Australian and New Zealand Bone & Mineral Society
21 - 25 March 2009 / Sydney NSW AUSTRALIA
- Australian Orthopaedic Association Annual Scientific Meeting
11 - 16 October 2009 / Cairns QLD AUSTRALIA
- New Zealand Orthopaedic Association Annual Scientific Meeting
18 - 22 October 2009 / Wellington NEW ZEALAND

Overseas

- International 27th Course for Percutaneous Endoscopic Spinal Surgery and Complementary Minimal Invasive Techniques
29 - 30 January 2009 / Zurich SWITZERLAND
- American Academy of Orthopaedic Surgeons Annual Meeting
25 February - March 1 2009 / Las Vegas NV USA
- Hands across the Nile
17 - 21 March 2009 / Cairo EGYPT
- 9th Annual Canadian Spine Society Meeting
18 - 21 March 2009 / British Columbia CANADA
- 9th Annual AAOS / OTA Orthopaedic Trauma Update
2 - 5 April 2009 / Orlando FL USA
- 'Knee Arthroplasty: From Early Intervention to Revision'
30 April - 2 May 2009 / London ENGLAND
- Annual Meeting of the International Society for the Study of the Lumbar Spine
4 - 8 May 2009 / Miami FL USA
- American Orthopaedic Association Annual Meeting
10 - 13 June 2009 / Bonita Springs FL USA

Otolaryngology Head and Neck Surgery

Australia/NZ

- Australian Society of Otolaryngology, Head and Neck Surgery
59th National Scientific Meeting
23 - 27 May 2009 / Gold Coast QLD AUSTRALIA
- Australian and New Zealand Head and Neck Society
11th Annual Scientific Meeting
6 - 8 August 2009 / Fremantle WA AUSTRALIA

Overseas

- American Head and Neck Society (AHNS) Annual Meeting
30 - 31 May 2009 / Phoenix AZ USA

Paediatric Surgery

Overseas

- American Pediatric Surgical Association 40th Annual Meeting
28 - 31 May 2009 / Las Croabas PUERTO RICO
- British Association of Paediatric Surgeons (BAPS) Annual Conference with European Congress of Paediatric Surgery
17 - 20 June 2009 / Graz AUSTRIA
- ANZAPS 2009 Annual Scientific Meeting
12 - 15 July 2009 / Nadi FIJI

Plastic and Reconstructive Surgery

Australia/NZ

- AAFPS Meeting
"Foundations of the Face"
7 - 8 February 2009 / Sydney NSW AUSTRALIA

Overseas

- Hands across the Nile
17 - 21 March 2009 / Cairo EGYPT

- American Burn Association 41st Annual Meeting
24 - 27 March 2009 / San Antonio TX USA
- International Meeting on Aesthetic and Reconstructive Facial Surgery
13 - 17 May 2009 / Mykonos GREECE
- EURAPS 20th Annual Meeting
28 - 30 May 2009 / Barcelona SPAIN
- Canadian Society of Plastic Surgeons Annual Meeting
16 - 20 June 2009 / Kelowna BC CANADA

Urology

Australia/NZ

- USANZ Annual Scientific Meeting
8 - 12 March 2009 / Gold Coast QLD AUSTRALIA
- Renal Society of Australasia National Conference
26 - 28 March 2009 / Rotorua NEW ZEALAND

Overseas

- 40th Annual Duke Urologic Assembly
6 - 10 March 2009 / Las Vegas NV USA
- 24th Annual EAU Congress
17 - 21 March 2009 / Stockholm SWEDEN
- The American Urological Association Annual Meeting
25 - 30 April 2009 / Chicago IL USA
- British Association of Urological Surgeons Annual Meeting
22 - 25 June 2009 / Glasgow SCOTLAND

Vascular Surgery

Australia/NZ

- Australia and New Zealand Society for Vascular Surgery -
Vascular 2009
1 - 4 October 2009 / Sydney NSW AUSTRALIA

Overseas

- Vascular Annual Meeting
11 - 14 June 2009 / Denver Colorado USA

Medical

Australia/NZ

- 7th International "Spark of Life" Conference
30 April - 2 May 2009 / Hobart TAS AUSTRALIA
- ANZCA ASM
2 - 6 May 2009 / Cairns QLD AUSTRALIA
- Physicians Week 2009 (RACP)
17 - 21 May 2009 / Sydney NSW AUSTRALIA

Overseas

- AMA (NSW) Clinical Conference
29 March - 5 April 2009 / Cairo EGYPT

Blood, Belts, Booze and Bikes

Alan Gregory's history of the response of the College to the epidemic of road trauma

Danny Cass,
Chair, Trauma Committee

Trauma kills more one-to-44-year-olds than any other cause and the College has been a leading voice in the field of trauma dating back to 1970, when it successfully advocated for the introduction of car seat belts in Victoria. The work of the College Trauma Committee is highly esteemed world-wide and the Committee is regarded as a world-leader in the pursuit of the prevention and management of road trauma.

Preventative measures such as seat belts, .05 drink driving laws, bicycle helmets and public communications campaigns have seen road deaths in Australasia fall dramatically (road deaths in Victoria have fallen from 1034 in 1970 to 304 in 2008). The College made a remarkable contribution to reducing the road toll and deserves its place in history.

Dr Alan Gregory was commissioned to write a history of the response of the College to the epidemic of road trauma. Dr Gregory is an esteemed Melbourne historian who has written medical and academic histories, including *The Ever Open Door: A history of the Royal Melbourne Hospital* and *Strong Like Its Pillars*, the 2005 centenary history of Melbourne High School.

Dr Gregory was given unlimited access to records and memorabilia held at the College by Gordon Trinca. He has pieced together, through this material and by interviewing many of the key players, an intriguing and stimulating aural history tracing the achievements of the surgeons who were involved in the early fight against road trauma. *Blood, Belts, Booze and Bikes* is the story of how a group of surgeons lent their support to



Peter Danne, Brendan Dooley, Gordon Trinca, Danny Cass and Daryl Wall in front of Sir Edward Hughes' portrait

sway public opinion and behaviour and influence legislators. Tough challenges were faced by the early pioneers as they worked, against the odds and even the scepticism of some of their surgical colleagues, through a mine-field of horrific injuries, statistics and bureaucracy. The College Road Trauma Committee became an integral and important part of the mix that influenced a community sea-change, which brought about legislation such as compulsory wearing of seat belts and bicycle helmets and drink driving limits.

The carnage of road trauma during the 1960s and 1970s was of such proportion that it was described as an epidemic. Fatality and injury rates per head of population exceeded the USA and were double that of the UK. The number of fatally injured road users between 1960 and 1970 was only 388 lives less than the total number killed in World War Two. Traffic accident injuries were increasing and the mortality rate exceeded

that of any other disease. The Road Trauma Committee of the College was established in 1970 to address this epidemic of road trauma.

The book was launched at the College on 20 November, 2008, during College Trauma Week, by Ian Trezise, MP. As a member of the Victorian Parliamentary Road Safety Committee, Mr Trezise is only too aware of the challenges of road trauma, its devastating effect on the community and the break-throughs made in the 1970s regarding road safety. He noted "the absolute lead role the College and Parliamentary Road Safety Committee had in promoting what were probably the first real silver bullets in saving thousands of lives on our roads – seat belts and drink driving".

He said "It was not until the College of Surgeons took the lead role in educating and lobbying for change, did the State Government legislate in 1970, against, unbelievably, a strong tide of anti seat belts, including from



Dr Alan Gregory



Gordon Trinca, Lady Hughes and Mrs Lander



Ian Trezise, Alan Gregory and Ian Johnston

“The carnage of road trauma during the 1960s and 1970s was of such proportion that it was described as an epidemic.”

the then Premier Henry Bolte ... who was of course reflecting an attitude held by many at the time.”

The audience included those involved in the early days of the College Road Trauma Committee – Gordon Trinca, Brendan Dooley, Stephen Deane, Mrs Lander (Chick Lander’s widow) and Lady Hughes, whose late husband Sir Edward Hughes was instrumental in forging the way forward. How appropriate it was that the launch took place in the Hughes Room to honour Sir Edward’s commitment and his foresight four decades earlier.

There was media interest in the event with Channel Nine news attending the launch. Danny Cass spoke at length with Derryn Hinch on Radio 3AW about the book, the past achievements of the Trauma Committee and the challenges that lie ahead.

Nearly all Chairs (past, present and future) of the Trauma Committee were present: Gordon Trinca, Peter Danne, Danny Cass and Daryl Wall (chairmen elect). Unfortunately, Glen Merry, chairman 1993-2000, had to cancel his trip from Brisbane due to devastating storms at home.

The book, funded by the Global Traffic Safety Trust, is readily available from the College. To obtain a copy, please contact Lyn Journeaux, Executive Officer, Trauma Committee by calling +61 3 9276 7448 or emailing lyn.journeaux@surgeons.org

Definitive Surgical Trauma Care Course (DSTC)

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

The DSTC course is an invigorating and exciting opportunity to focus on surgical decision-making and operative technique in critically ill trauma patients. You will have hands on practical experience with experienced instructors (both national and international).

The DSTC course has been widely acclaimed and is recommended by the Royal Australasian College of Surgeons for all surgeons and Trainees.

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.

Please register early to ensure a place!

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

2008 COURSES

Auckland
2 & 3 March 2009

Brisbane
9 & 10 March 2009

Sydney Military Module
21 July 2009

Sydney
22 & 23 July 2009

Adelaide
3 & 4 September 2009

Conflict in the workplace

Well-handled conflict offers the opportunity for education, healing, creativity and growth

The Victorian Equal Opportunity & Human Rights Commission

Over the year, *Surgical News* will profile information about conflict in the workplace. The article below derives from the Victorian Equal Opportunity & Human Rights Commission Contact Officer manual.

The philosophy underlying complaint resolution

Australian and New Zealand workplaces are diverse places. They bring together men and women who have different experiences, values, opinions and ideas about how to do things. What one person finds offensive, another will consider perfectly normal. So it's not surprising that individuals or groups will sometimes find themselves in conflict or that some people will have genuine concerns, enquiries or complaints.

Many approaches are made to officers responsible for complaints by people who just want to describe a concern they have about whether something they have experienced at work is reasonable.

Complaints relate to all aspects of employment, including:

- allocation of tasks
- bullying or harassment
- inclusion or exclusion from work discussions or work-related social events
- jokes or other informal discussions in the workplace (if they mock people with a protected attribute)
- leave (holiday, sick, parental, carers, bereavement or compassionate leave)
- management style
- occupational health and safety
- performance appraisal
- personality clashes



Conflict can be a healthy sign in a workplace.

- rostering
- sexual language or behaviour in the workplace
- skills training or career development
- stress
- the work environment or resources
- working relationships or authority issues.

It is important to understand if there is a breach of your organisation's policies or the law, and what their options are for action, including referring them to others in the workplace or externally.

Complaints are not bad

Complaints do not have to result in conflict. But even if they do, this is not automatically a bad thing.

A problem identified can become a problem solved - not just solved for the complainant but for other current and future staff.

Conflict can be a healthy sign. It is a sign of change. Whether it's an individual giving up smoking or an organisation introducing a new anti-discrimination policy, people face conflict of some sort whenever the new way battles the old way.

Conflict only becomes unhealthy when the issues are ignored or denied, festering and creating victims. It is important to acknowledge conflict and adopt a constructive process to lead to positive change.

Well-handled conflict offers the opportunity for education, healing, creativity and growth. Whatever method of conflict resolution is used by a complainant, it needs to be informed by respect, empathy and the belief that people can change their behaviour and take responsibility for their decisions.

Complainants and respondents will often wrongly assume that the outcome from any complaint will be formal discipline. Most workplace problems can be solved through self-management or informal options such as conciliation, education or training.

Recommended elements of a complaint procedure

Every organisation needs to design a complaint resolution procedure that meets its own situation and needs. The Victorian Equal Opportunity and Human Rights Commission suggests a complaint procedure include the following:

1. Outline what kinds of problems and complaints the procedure applies to
2. Be easily understood by all staff (simple language)
3. Be accessible for all staff (eg on intranet, orientation kit, operations manual)
4. Offer at least four different options to the person making the complaint:
 - a. self-management
 - b. informal (non-disciplinary) solution with help of third party (eg mediation or training)
 - c. formal internal complaint
 - d. external complaint (eg to VEOHRC or WorkSafe Victoria)
5. Provide examples of available possible outcomes (eg apology, agreement that bad behaviour not reoccur, institute training)

for individual or team, reinstate sick leave, changed working arrangements, discipline, etc) including provision for follow-up and monitoring

6. Set out exactly what steps will be taken in the event of a formal internal complaint:
 - a. who the formal complaint goes to (*investigation officer or senior manager etc*)
 - b. a prompt and impartial investigation based on interviews and evidence
 - c. a written statement outlining the complaint is provided to the respondent and they are given the right to respond to it
 - d. witnesses may be interviewed and other evidence considered
 - e. production of a report that includes:
 - i. a finding on balance of probabilities that there either was or was not a breach of policy (based only on the evidence for this complaint - the track record of respondent is **not** relevant to the finding)

“A problem identified can become a problem solved - not just solved for the complainant but for other current and future staff.”

- ii. a recommendation (eg discipline) that is reasonable and commensurate with finding and prior history (track record of respondent **is** relevant to the recommendation)
- f. Set normal time limits for completing each step
7. Apply natural justice principles including:
 - a. confidentiality
 - b. timeliness
 - c. impartiality
 - d. the right to a support person for both complainant and respondent
 - e. right of reply
8. State what documentation will be kept under what circumstances, where and how it

- will be stored and who will have access to it
9. Include an impartial internal appeal system for either the complainant or respondent to challenge either the finding or the recommendation (or both) and have it reviewed
 10. State that a person making a complaint will not be treated less favourably or detrimentally because they made a complaint (victimisation)
 11. Make provision for ongoing review of the procedure's effectiveness.

The next edition of Surgical News will explore the four options for complaints resolution, self management, informal internal process, formal internal process and external resolution options.

2010 ROWAN NICKS SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the **2010 Rowan Nicks Scholarships** and the **2010 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 **2010 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 **2010 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 Australasia. 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 program.

Closing date for these Scholarships is 5 pm Monday 20 April 2009

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.scholarships2surgeons.org
Phone: + 61 3 9276 7482
Fax: + 61 3 9276 7431



Victorian regional news

Paddy Dewan,
Victorian Fellow

Surgery is the scientific application of art and the artistic application of science. Thus, it is not surprising that there are many surgeons who express their artistic talents through media other than the surgical manipulation of tissues, often as a release from the rough and tumble of a surgical life. Many well-known College Fellows are artists, musicians and writers, such as Douglas Stephens and Jeff Rosenfeld. One of my ways of expression and release has been through poetry.

Henry Lawson and A. B. (Banjo) Paterson were the poets who inspired me as a young man growing up in country Victoria, with Rudyard Kipling's *If*, Oscar Wilde's *The Ballad of Reading Goal* and Wordsworth's *Phantom of Delight* and *Daffodils* having added to my enjoyment of the art form. I

particularly enjoy poems that use words to take you on an imaginative journey, as in Ted Hughes *The Thought-Fox*, in which he takes you from watching a fox in a forest to sitting in front of a typewriter in just a few words.

Cancer no Cure is one of the poems that make up the collection *Walking through a Real Fantasy*, the writing of which represents a way that one can cope with what might otherwise be an overwhelming experience. The scene for the lines was a dilapidated outback settlement where an old lady with a fungating breast cancer and her hemiparesed husband were visited by a nurse. The old lady's pack of dogs attacked the nurse, while the old lady tried to drive them off with her walking stick. The fear felt by the nurse and the dread in the woman's eyes as she wondered if the dogs would have to be put down have left a lasting impression, which is hopefully reflected in the words of the poem.

I hope others will be inspired to pursue their hobby and to share their achievements with College Fellows.

Cancer – No Cure

Eight dogs tore at clothes and flesh,
And created a state of terror.
Using her good arm, the cancerous old woman
Waved a stick to chase them away.

She was their keeper, the nurse their victim.
From the way she moved
You could see the old woman
Not only knew she was soon to lose life,
But she would lose her family first.

She turned as her hemiparesed husband
came to help.
He limped to the present and beyond
imagination.
He was lucky, he walked away with
'paining' pills,
And he'll be dead soon.

She took her tablets and went back to
the past.

*Paddy Dewan (Walking Through a Real
Fantasy, 2008 published by Papyrus
Publishing)*



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 contact the Project Officer of Rural Services on **+61 3 9249 1284, or email rural@surgeons.org**

Supported by the Commonwealth Department of Health and Ageing.

Ansell Healthcare

The winners of the ten Nintendo Wii console packages for the RACS Virtual Congress 2008 Competition are:

- Dr. Chris Lehane from St Vincents Hospital (NSW)
- Dr. Tim Pollitt from John Hunter Hospital (NSW)
- Dr. Tony Pang from Royal North Shore Hospital (NSW)
- Dr. Jason Chuen from Box Hill Hospital (VIC)
- Dr. Jimmy Lam from St Vincent's Hospital (VIC)
- Dr. Z Chow from The Royal Melbourne Hospital (VIC)
- Dr. Simon Quinn from Princess Alexandra Hospital (QLD)
- Dr. David Choy from Sir Charles Gairdner Hospital (WA)
- Dr. Walter Flapper from Women's and Children's Hospital (SA)
- Dr. Alvin Cham from Waikato Hospital (NZ)

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

Ansell



Need **current** information on how to introduce a new surgical procedure into a hospital or health service?

The Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) and the Royal Australasian College of Surgeons have recently **updated** the booklet entitled 'General Guidelines for Assessing, Approving & Introducing New Surgical Procedures into a Hospital or Health Service'. The purpose of this document is to provide general guidance to hospitals and health services on the assessment of new surgical procedures and the factors that should be considered prior to their introduction.



For your **FREE COPY**, please contact the ASERNIP-S office at PO Box 553, Stepney SA 5069 Australia, telephone: 61 8 8363 7513, fax: 61 8 8362 2077, email: asernips@surgeons.org or download copies from the College website at <http://www.surgeons.org/guidelines>.

FREE COPIES WILL ALSO BE AVAILABLE FROM ALL REGIONAL OFFICES OF THE COLLEGE.



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25th – 27th March 2009

Hilton Hotel Cairns, Queensland, Australia

www.ossanzconference.com.au

We are delighted to present the First Biennial Scientific Meeting of the International Federation of the Surgery of Obesity (Asia Pacific Chapter) in conjunction with the 22nd Annual Scientific Meeting of the Obesity Surgery Society of Australia & New Zealand (OSSANZ)

The program will include topics catering for surgeons and allied health professionals across the Asia Pacific with the new developments in Metabolic and Obesity surgery presented by invited international and local keynote speakers.

A superb venue in the heart of the vibrant city of Cairns coupled with an program delving into global issues affecting Obesity and Obesity surgery makes this OSSANZ – IFSO (APC) one not to be missed.

For more information please visit the website at www.ossanzconference.com.au

Or contact the Conference office at:
Think Business Events

Ph: +61 2 8251 0045

Fax: +61 2 8251 0097

Email: ossanz@thinkbusinessevents.com.au



From Timor to Ethiopia

Early treatment of club feet prevents a lifetime of disability, the long term objective is to eradicate it

The work done this year will be crucial to the success of the College's efforts to help both treat children born with club feet in East Timor and ultimately eradicate the effects of the condition, according to orthopaedic surgeon Dr David McNicol.

Mr McNicol said the enthusiasm and commitment shown by local midwives and health workers at an information workshop held in Dili in November indicated there was now a ground-swell of support to tackle the congenital abnormality. The workshop was designed to educate the health workers on early detection of the condition and to explain the Ponseti method of treatment, now considered the gold standard, particularly in developing nations.

He said it was now crucial to train the "treaters" and to concentrate on developing Dili and Baucau as initial treatment centres with others to follow later.

"The workshop was attended by over 100 participants and was designed as a community awareness campaign with the distribution of brochures and posters to all participants to inform the wider community that an action can be taken to deal with this condition," he said.

"Early treatment prevents a lifetime of disability meaning that identification at birth is extremely important yet there remains a common misunderstanding that only older children can be treated. Traditionally, there has been no treatment offered to babies and children in Timor Leste, and many present in adolescence or adulthood with severe and debilitating foot deformities.

"Phase One of the project obviously



David McNicol plastering a young boy in Timor Leste

required an education component, then, with Phase Two putting into place the training of the people who can treat the condition."

The Ponseti method of treatment involves early intervention with serial plasters and commonly a tenotomy of the Tendo Achilles. Plaster treatment is maintained for five to six weeks before the child goes into a splint of boots and a bar. This is worn continuously for twelve weeks followed by night time use for three to four years.

The end result is a flat, flexible foot that will sustain the individual through their lives. Because of the limited surgery involved, it is considered the best method of treatment particularly in developing nations that have limited medical services.

The condition affects up to five babies of every 1000 births in East Timor and seems

more common there because of generational genetic traits.

The November workshop was led by Ponseti practitioners in Timor Leste including Ms Irene Fraga, a physiotherapist at the Baucau Hospital who completed the Ponseti course in Sydney in 2008 and Helen Burgan, an expert in the technique who worked with Ponseti in the US and who is now a physiotherapist at the Adelaide Women and Children's Hospital.

A combined effort by the Timor Leste Ministry of Health, ASSERT (a local NGO that works with the disabled), the College and Orthopaedic Outreach, the information workshop was opened by the Director General of Health Mr Agapito da Silva Soares.

Mr McNicol said the challenge for 2009 was to train as many treaters as possible – including nurses and physiotherapists



A young child being treated for club feet in Madagascar

“The end result is a flat, flexible foot that will sustain the individual through their lives.”



Untreated clubfoot in Timor Leste



An operation in progress in Madagascar

to undertake the plaster component of the treatment and with general surgeons trained to perform the tenotomies of the Tendo Achilles.

“Timor Leste has very limited orthopaedic services but there is a bright young man, Dr Alito, soon to take up medical training in Indonesia who would be invaluable.

In the meantime we have to assist if we want to avoid another generation of babies being born with this condition and waiting years for treatment.

“We are hoping to hold another more hands-on workshop in Dili or even a ‘traveling-road-show’ to some of the larger decentralised centres such as Maliana and Oecussi.

“There are currently four orthopaedic team visits to Timor Leste each year, so a team in-country every twelve weeks. Currently, visits are to Baucau and Maliana but all have to pass through Dili so that doing some work or training there with ASSERT and the Institute of Health Sciences is eminently feasible,” he said.

“This is the year that could make all the difference. The fact that this project has the support of the Ministry of Health creates a sense of local ownership which means this

project has the potential for great success. This is not just about treating the condition, the long-term objective is to eliminate it in the country by treating the very young before their lives are affected by it, by giving the local health professionals the skills to do it themselves.”

Fellow Orthopaedic surgeon Mr Graham Forward, who established Australian Doctors for Africa in 2005, is also helping to treat the condition in Madagascar and Ethiopia.

In Western Australia, the same treatment is known as the Gilmour Method in honour of the pioneering work done by Mr Bill Gilmour, a former President of the Australian Orthopaedic Association from Perth.

Mr Forward makes four trips each year between the two regions to teach treatment methods and undertake complex surgery. Fellow surgeons Mick Tiller, Rob Genat and Will Bryceson also regularly give their time and expertise to the small aid organisation.

In Madagascar the surgeons work in the town of Tulear where they not only do the heel-cord surgery to treat young babies with the condition but also conduct fusion and boney corrective surgery to help adolescents and adults.

“We get a pretty good result with these surgeries, they are a good salvage operation for the people who missed out on early treatment,” Mr Forward said.

In Ethiopia, Australian Doctors for Africa offers assistance to the doctors working out of the Black Lion Hospital in Addis Ababa.

“This is the only tertiary referral hospital for the 80 million people of Ethiopia. There we work with a very highly qualified orthopaedic surgeon, Dr Waubalem, who has established a Ponseti clinic within the hospital,” Mr Forward said.

“We help train the doctors, assist in the provision of plaster, provide collaboration and support and surgical expertise for the more complex adult corrective procedures.”

Mr Forward set up Australian Doctors for Africa in the wake of the 2005 Tsunami. The organisation not only provides surgical expertise but regularly sends containers of medical equipment to each of the specific areas including beds, wheel chairs and crutches. More than sixty Australian doctors provide their time and skills including gastro-enterologists, urologists, anaesthetists and general practitioners. A fledgling outreach aid programme has also been established in Somalia.

Premier Surgical Science Award

The John Mitchell Crouch Fellowship has had an enormous influence on the College by creating a milieu where scientific research is highly regarded

One of the College's most generous and significant benefactors, Mrs Elisabeth Unsworth, died late last year at the age of 85. For more than 30 years, Mrs Unsworth funded the College's most prestigious Fellowship, the John Mitchell Crouch Fellowship, in memory of her son John, a promising young neurosurgeon who died of a brain tumour.

In a decision that even now is still considered "visionary", Mrs Unsworth chose to establish a Fellowship to be given to younger surgeons making an outstanding contribution to the advancement of surgery or anaesthesia or to fundamental scientific research in the field.

Since its inception, those outstanding candidates have used the financial support – now up to \$75,000 – to advance medical knowledge in such fields as transplant immunology, microsurgery, colorectal cancer surgery, gene therapy and post-operative healing.

Yet, while other Government funding sources may provide larger financial rewards, the John Mitchell Crouch Fellowship is still considered Australasia's premier surgical science award because of the peer recognition it carries. Over the years, many recipients of the Fellowship have been able to attract other more extensive funding based on the clear understanding that receiving the John Mitchell Crouch Fellowship represents a ringing endorsement by fellow surgeons and scientists.

By designing the terms of the Fellowship as she did, Mrs Unsworth also promoted the



John Mitchell Crouch

cause and future of surgical science at a time when surgery and science were only loosely linked.

The first recipient, Professor Robert Burton, received the Fellowship in 1979 when he was working at the Transplantation Unit of the Massachusetts General Hospital, Harvard University, Boston. Speaking recently of that decision, he said receiving the John Mitchell Crouch Fellowship was not only a great honour but a watershed in the history of the College.

"This was more than just an endowment to the College, because (Mrs Unsworth's) remit was to support younger surgeons when such funding could make a significant difference to their work – rather than in recognition of good work already done," he said.

"But more symbolically, selecting me represented a profound catalyst for change within the College because I was unashamedly a fundamental scientist."

Commenting on the death of Mrs Unsworth, Professor Bruce Gray, who received the Fellowship in 1981 to support his research

into adjuvant therapy in bowel cancer, described it as a significant rung in the ladder of research support. Professor Gray said he had occasionally spent time with Mrs Unsworth and her husband Ken, a noted sculptor, at their farm outside Sydney.

"They were delightful people, generous of their time, generous of their spirit and generous of their money. Funding a Fellowship as she did went outside the normal memorial ideas of the time and has proven to be far more beneficial than a bricks-and-mortar edifice with her son's name on it," he said.

"It looked to the future rather than the past, it gave surgeon scientists support when they needed it and the peer-support aspect was something to aspire to then as it is now. There is no doubt that the research that has been done through her generosity not only has value in itself but has led to further knowledge made by other researchers and other institutions."

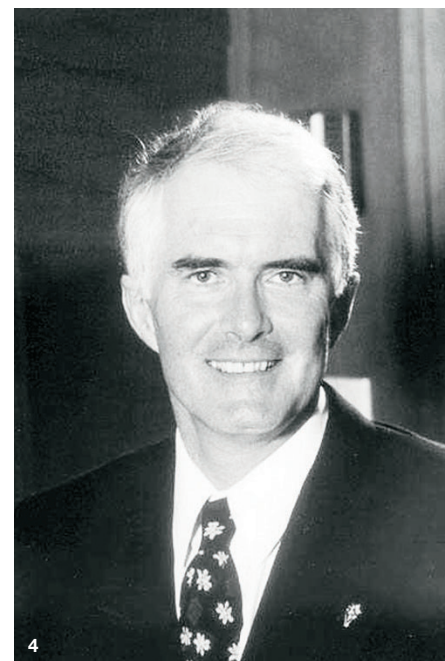
According to an obituary published in the Sydney Morning Herald in January, Mrs Unsworth's life was one of courage, kindness and adventure.

The 2002 recipient of the Fellowship, Professor Spencer Beasley, the Clinical Director of the Department of Paediatric Surgery, Christchurch Hospital and Christchurch Women's Hospital, used the funding to further research into the genetic causes of congenital malformations of the foregut.

Professor Beasley said he had been in correspondence with Mrs Unsworth in line with a tradition in which most recipients sent her a report of their work. He said that the fact that the Fellowship was focused on those who were establishing or developing research projects was important.

"Often at the start of these projects, it is difficult to attract funding simply because it is at the start so the John Mitchell Crouch Fellowship plays a significant role in getting many complex research plans off the drawing board and into the laboratory. It is also clear that the generosity of Elisabeth Unsworth has had an enormous influence on the College by creating a milieu where scientific research is highly regarded.

“It looked to the future rather than the past, it gave surgeon scientists support when they needed it and the peer-support aspect was something to aspire to then as it is now.”



“Much of the research she enabled and sponsored has borne fruit and advanced knowledge or had practical benefits for many, many patients.”

The most recent recipient is the Director of Orthopaedics at St Vincent’s Hospital in Melbourne, Professor Peter Choong who was awarded the Fellowship last year to assist in his work in isolating and controlling genetic triggers believed to affect the growth of particular osteosarcomas.

Also working out of the Peter MacCallum Cancer Centre in Melbourne, Professor Choong said he was honoured to have received the Fellowship.

“In terms of Australian surgery, this is the premier prize and I was delighted to have been chosen to receive it. However, what this award reflects I think is the track record of the research unit not just one person and I see it as a huge accolade for our team, our department and our hospital,” he said.

“It also allows us to take the research up another notch not just through this fund-

ing but because of the other doors it opens, thereby making complex scientific research feasible. I think the concept behind the John Mitchell Crouch Fellowship is visionary and I would say that anyone who receives it feels it as a “Grand Prix”.

Now after more than 30 years, the list of names of the recipients of the Fellowship reads like a “who’s who” of Australasian surgical science.

It includes Professor Wayne Morrison, the Hugh Devine Professor and Head, Department of Surgery, University of Melbourne and St Vincent’s Hospital, Melbourne (1992); Professor James Toouli, Professor of Surgery, Gastrointestinal Surgical Unit, Department of Surgery, Flinders Medical Centre (1994); and Associate Professor Michael Agrez, University of Newcastle (2000).

In 1981, Mrs Elisabeth Unsworth was inducted into the College’s Court of Honour, one of its highest acknowledgements. She died peacefully at home and is survived by husband Ken.

1. Peter Choong, the 2008 recipient
2. Bruce Gray, the 1981 recipient
3. Spencer Beasley, the 2002 recipient
4. Robert Burton, the first recipient in 1979

Elisabeth Unsworth, 1922-2008

A family tragedy led this French pianist to become a benefactor of surgical research

Harriet Veitch

A personal tragedy changed Elisabeth Unsworth's life, but her reaction to it changed many other lives for the better. When her son John, a promising young neurosurgeon, died of a brain tumour, Unsworth set up the John Mitchell Crouch Fellowship for surgeons and surgical research.

The fellowship is now considered the most prestigious awarded by the Royal Australasian College of Surgeons and is worth \$75,000 a year. Since its foundation in 1977, its recipients have used the money to advance knowledge in transplant immunology, microsurgery and colorectal cancer surgery and to improve healing in post-operative patients.

Elisabeth Unsworth, who has died aged 85, was born in Paris, the daughter of Albert and Ruth Volodarsky, but grew up mostly in Egypt and Africa as the family followed her father in his work as an agricultural expert.

Unsworth had a natural talent for music that showed up early in her life and her parents encouraged her study. Her early musical education was at a French school in Alexandria. She also took private piano lessons. She matriculated from an English college in Cairo and for advanced musical education went to Wanda Landowska, a noted Polish harpsichordist and pianist then living in Paris.

By 1951 Unsworth was working as a pianist, giving recitals, and as an air hostess with Sabena Airlines, and later in Manchester as Sabena's director of flight reservations. She had married and had a son, John Mitchell Crouch. In 1953, after her husband's accidental death, mother and son moved to Australia.



Surgical fellowship founder Elisabeth Unsworth

Soon after arriving here, she was offered a position as a recital pianist with the ABC but turned it down because it would have meant moving to Hobart. She chose instead to teach French at a girls' school in Hamilton in western Victoria. This allowed her to speak and teach the language she loved, and support her academically promising son.

While she was teaching in Hamilton, Ken Unsworth was teaching art at nearby Dimboola High School. He remembers his adopted father telling him there was "a beautiful French woman" in the local repertory company. But it was not until 1955, when he was visiting the owners of a music shop in Hamilton, that he saw Elisabeth giving a music lesson and was introduced. They were married a year later in Melbourne.

In 1961 the Unsworths moved to Sydney after Ken was offered a place at the National Art School. To support him while he studied, Elisabeth taught at St Catherine's School in Waverley, and stayed until her retirement.

Unsworth worked tirelessly for her son's and husband's education, and after her son matriculated from Melbourne's Wesley College, he went on to study medicine. He

worked in several big hospitals, notably the Hospital for Sick Children in Toronto and Toronto East General, in Canada, taking neurosurgery as his speciality.

In 1973 John Unsworth returned to Sydney to live, a decision that surprised Elisabeth and Ken as he had been offered a senior position in Canada and was in a relationship. About 18 months later he was diagnosed with a brain tumour. He had several operations and Unsworth nursed him in every spare minute she had until he died in 1977, aged 36.

Unsworth decided to perpetuate her son's memory in the most practical way possible, by establishing the fellowship. She chose to award it to young researchers making an outstanding contribution to the advancement of surgery or anaesthesia or to fundamental scientific research in their field. In more recent years the focus has been solely on surgical advancements and research.

She often made extra funds available to recipients and was so keen to meet her fellows that one year she flew from Paris to Melbourne for a day, to go to a meeting at which that year's recipient would be present. In 1981, Unsworth was inducted into the College of Surgeons' Court of Honour, one of its highest acknowledgments.

After her son's death, Unsworth put all her energy into her husband, encouraging and supporting his passion for art. They travelled Australia and the world for his exhibitions.

They also sometimes shared their art. In 1975 they staged *Five Secular Settings For Sculpture As Ritual & Burial* with her singing *Are You Lonesome Tonight?* and reciting an American poem, *God Wrests*, while he arranged himself within pieces of his sculpture. The performance was recorded by the ABC.

Unsworth was a child prodigy who cheerfully turned her back on the ruthless pursuit of a career in music to dedicate her life and energy to her son and her husband.

Elisabeth Unsworth is survived by Ken. She died peacefully at home with him at her side and their cat, Ninochka, next to her.

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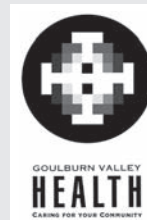
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Stimulating young surgeons

The AAS, founded in 1967, is dedicated to serving the needs of young academic surgeons in all disciplines

Scott LeMaire,
Secretary, Association for Academic Surgery

Our Mission

The mission of the Association for Academic Surgery (AAS) comprises three major objectives: First, the AAS stimulates young surgeons and surgical scientists to pursue a career in academic surgery and supports them in establishing themselves as investigators and educators. Second, the AAS provides a forum for trainees and junior faculty members to present papers on clinical, laboratory or educational research topics. Third, the AAS offers programs to facilitate the development of young surgeons and surgical scientists as investigators and educators. The activities of the AAS focus on expanding our ability to achieve each of these three aspects of our mission.

Stimulating young surgeons and surgical scientists to pursue careers in academic surgery and supporting them in establishing themselves as investigators and educators

Success in this part of our mission begins with recruiting new members so that they can participate in AAS activities and witness firsthand the opportunities afforded by a career in academic surgery.

Recruiting new members, therefore, is a high-priority activity. Several recent initiatives have specifically focused on increasing trainees' interest in joining the AAS and pursuing a career in academic surgery; these initiatives include developing a network of Institutional Representatives who serve as local liaisons at nearly 90 medical schools throughout the United States, the extending of opportunities



The current AAS Executive Council, including the President, Dr Herb Chen (first row, fifth from left) and President-Elect Dr Kevin Staveley-O'Carroll (first row, fourth from left) at the Strategic Retreat held in June 2008

for membership to trainees, and the production of a video that extols the many benefits of choosing this exciting career. We also strive to maintain the participation of senior members, who can provide invaluable mentorship to the younger members.

Despite being an international society, the AAS has traditionally focused on the needs of young American academic surgeons. Recognising the need to expand our efforts in supporting academic surgeons throughout the world, we have recently established several global initiatives, including active recruitment of international members to serve on the Membership Committee, the development of international exchange programs with the Younger Fellows Committee of the RACS and the Taiwan Surgical Association, and the creation of the ad hoc Global Affairs Committee.

Expanding the opportunities for collaboration between the AAS and academic surgeons in Australia, New Zealand, Taiwan and other countries is a major focus of the current AAS agenda.

Finally, the AAS sponsors numerous research awards, each of which aims to provide critical early career support to students,

residents and junior faculty members who are in the process of developing their research programs.

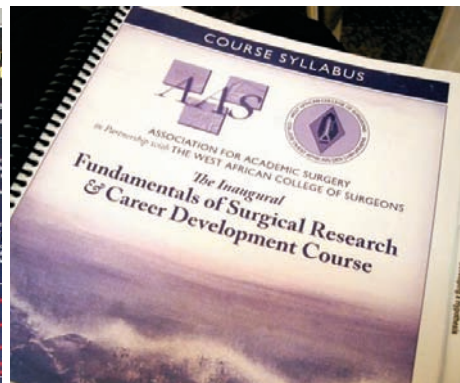
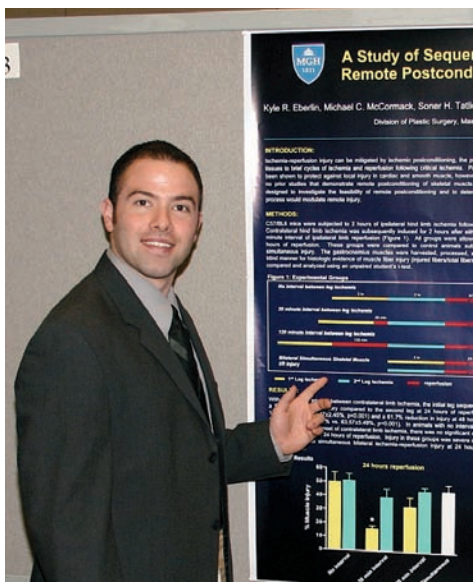
Providing a forum for trainees and junior faculty members to present papers on clinical, laboratory or educational research topics

Through its annual meeting, the AAS has consistently provided a supportive, inclusive environment in which young investigators can present their work and receive constructive feedback. Recent collaborative efforts between the AAS and the Society of University Surgeons have resulted in our annual Academic Surgical Congress, a highly successful, synergistic joint meeting.

The 3rd Academic Surgical Congress meeting, held in February 2008, was an enormous success, as evidenced by the attendance of more than 1000 participants and the presentation of more than 660 scientific abstracts. Importantly, the meeting features sessions covering a broad range of surgical disciplines, including gastrointestinal tract surgery, endocrine surgery, trauma and critical care, vascular surgery, pediatric surgery, surgical oncology, transplantation and cardiothoracic surgery.

Offering programs to facilitate the development of young surgeons and surgical scientists as investigators and educators

In addition to the specialised programs that are presented at the annual Academic Surgical Congress, in October of each year the AAS presents two courses. The Fundamentals of Surgical Research Course covers several critical aspects of conducting surgical research, including experimental design, effective abstract preparation and research presentation skills. The Career Development Course teaches senior residents and junior faculty members how to build an academic program. Topics covered in the Career Development Course include important issues of which to be aware in considering your first appointment, how to balance research and clinical responsibilities, how to obtain academic promotion and how to write effective research grant proposals. Through the efforts of Past President Dr. Fiemu Nwariaku, members of the AAS ad hoc Global Affairs Committee and the West African College of Surgeons, a combined version of these courses has been taught to surgeons in West Africa. The inaugural course was given in Sierra Leone in February 2008 and a second West African course will be given in Nigeria in 2009. Stimulated in part by the success of the course given in Sierra Leone, the AAS and the College Section of Academic Surgery will present the Developing a Career in Academic Surgery Course on May 5, 2009, in Brisbane (see page 28). We hope that this course and other joint initiatives will strengthen the relationship between the AAS and the College and will lead to additional opportunities for international collaboration among the members of both societies.



Top: AAS member Dr Eric Kimchi (left) receives the 2007 Joel Roslyn Faculty Research Award from then President Dr Fiemu Nwariaku. Left: Dr Kyle Eberlin, a resident in plastic surgery, presents his research at the Academic Surgical Congress. Above: The AAS has developed several courses to help young surgeons develop academic careers



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Opportunities in academic surgery

A supportive relationship is resulting in more opportunities for Fellows and Trainees

Richard Hanney,
Past Chair, Younger Fellows Committee

There are several opportunities for both Fellows and senior Trainees that the College has been developing with the Association for Academic Surgery over the last two years. These fit broadly into three categories:

- a Leadership Exchange through the Younger Fellows Committee (YFC)
- potential appointment to International Clinical Fellowship positions at prominent US institutions in the immediate post-Fellowship period
- an inaugural course, “Developing a Career in Academic Surgery”, to be held in Brisbane on Tuesday May 5, immediately preceding the Annual Scientific Congress (ASC).

Brief background

Herb Chen, then AAS President-Elect, was the American College of Surgeons guest of the ANZ Chapter at the Christchurch ASC in 2007 and sought to formally develop further relationships with the College. These enquiries were directed initially to the YFC, but David Hillis, CEO of the College was keen to see further links established with the section of Academic Surgery – a natural fit within our College.

Leadership exchange

The YFC nominated Richard Hanney, their immediate past Chair, to accept an invitation to the three day AAS Academic Surgical Congress held in Los Angeles in February last year. At that meeting the AAS announced they would fund such a guest from the College for each of the next three years. The YFC responded by inviting an AAS representative to attend the three day Younger

Fellows Forum preceding our own ASC – formally establishing the Leadership Exchange between the AAS and the College. Scott LeMaire, the AAS Secretary, was able to accept this privilege in Hong Kong.

In addition to further developing the complementary interests of the College and the AAS, the individual opportunities here for networking and professional growth are considerable and rewarding. The YFC is grateful to Johnson and Johnson for providing a three year sponsorship of this important initiative.

Any Younger Fellow (i.e., within 10 years of FRACS being awarded) interested in participating in this exchange should contact Richard Page, the YFC Chair, by emailing glenda.webb@surgeons.org.

International Clinical Fellowship positions

Access to post-Fellowship clinical training and experience in the UK and Europe has become more difficult with European Union regulations. The AAS, with its membership distributed across many of the leading institutions in the USA and elsewhere internationally, would like to assist in the placement of younger College Fellows in international clinical fellowships. This goes even beyond what is currently provided through the two annual Tyco Traveling Fellowships coordinated by the YFC.

Although exploring this initiative was originally suggested by Phil Truskett, the GSA President, the AAS members arise from a number of the nine core College specialties.

Interested Fellows or senior Trainees should contact either Richard Page or Richard Hanney in the first instance – either through the YFC Secretary on +61 3 9249 1212 or by email glenda.webb@surgeons.org.

Those interested in following this up further themselves should carefully consider the next area in which the partnership between the College and the AAS has been progressing.

Developing a career in academic surgery

As Scott LeMaire has already described, the AAS has held highly regarded courses for 20 years on Fundamentals of Surgical Research

“The individual opportunities here for networking and professional growth are considerable and rewarding.”

and, over the last four years, on Career Development in Academic Surgery.

“Developing a Career in Academic Surgery” is a course which has been tailored specifically to the academic environment in Australia and New Zealand and draws on the best of the AAS Fall courses. This will be held in the Brisbane Convention and Exhibition Centre on Tuesday May 5, immediately preceding the opening of the ASC, and opened by the College President.

The formidable faculty will comprise six visiting AAS Associate Professors, able to contribute through further generous sponsorship from Johnson and Johnson, in combination with senior College academics. This exciting initiative, combining enthusiasm and experience with proven curricula, is being run by the Section of Academic Surgery and coordinated by Professor John Windsor.

The course is for those who are considering or have commenced a career in academic surgery as well as those who want to include research and/or education as part of their career in surgery. A limited number of places will be available. Any Fellow or Trainee looking to hear first-hand from the AAS representatives should also consider attending to take advantage of this opportunity.

More details and the draft program for this course will be provided in the March *Surgical News* or can be obtained through dcas@surgeons.org. Registration itself will be on the ASC registration form with the pre-Congress workshops.

The AAS has shown foresight and generosity in promoting these three initiatives, which provide outstanding opportunities for Younger Fellows and Trainees in the College. Making the most of them, as always, will be up to individuals.

INTERNATIONAL TRAVEL GRANT FOR ASIA PACIFIC SURGEONS 2009

Fellows are invited to nominate overseas surgeons from Burma, Cambodia, Laos, Vietnam and Indonesia who are not Fellows of the Royal Australasian College of Surgeons for the RACS International Travel Grant to attend the Annual Scientific Congress (ASC). The Travel Grant is provided to enable grantees to attend the ASC and for hospital visits in the host city. Up to three Grants will be awarded to outstanding surgeons from ASEAN (Association of South-East Asian Nations) and Oceania regions. Citizens of Burma, Cambodia, Laos, Vietnam and Indonesia are strongly encouraged to apply.

The Travel Grant will consist of registration for ASC in Brisbane, 6th to 9th May 2009 plus up to \$2,000 towards economy travel costs and accommodation.

ELIGIBILITY

- The Travel Grant is available to overseas practising surgeons between the ages of 30–45 who are not Fellows of the Royal Australasian College of Surgeons.
- Surgeons practising in all fields of surgery are eligible however favourable consideration will be given to surgeons whose specialty is represented in the ASC surgical program.
- Precedence will be given to surgeons from ASEAN and Oceania regions who have been formally invited to participate in the RACS International Forum.
- Preference will be given to surgeons who are not likely to be able to fund their own attendance.
- The successful surgeons will be required to supply a report at the conclusion of the Congress on their experiences.

APPLICATIONS MUST INCLUDE:

- a letter of application, including the reasons for applying and anticipated benefit
- a brief curriculum vitae
- two written supporting professional references
- incomplete applications will not be considered

APPLICATIONS CLOSE ON 28 FEBRUARY 2009

Applications may be mailed to:
International Scholarships Officer
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street Melbourne
Victoria 3000 Australia

OR BY FAX OR EMAIL TO:

International Scholarships Officer
Telephone: + 61 3 9249 1211
Fax: + 61 3 9249 1236
Email: international.scholarships@surgeons.org
Website: www.surgeons.org



We need your wisdom and experience:

“Seminar in medical and surgical emergencies” - Rwanda July 2009.

Can you give one to two weeks of your time to teach your specialty in Rwanda during the second week of July 2009?

Specialists without Borders has been invited to provide specialists to teach a seminar in medical and surgical emergencies in July 2009. This commitment would involve two to three lectures within your specialty. The seminar will be held in conjunction with the annual medical conference in Rwanda, and is fully supported by the national University of Rwanda/medical school. Specialists without Borders are also fully supported by the Flinders University and medical school in South Australia. Our aim is to provide high quality medical education in developing countries. We ask you to participate in this with us and the Rwandans.

We have listed the categories below for which we are seeking specialists. If you do not fit into one of these categories, but feel a strong inclination to contribute, we will commit to accommodate you within the program. The specialties already included in the program are attached above. These which will give you an idea of the subjects within each specialty that the Rwandans would like to see taught. However, there is flexibility. The preliminary programme for doctors and nurses is attached.

The commitment required is a week (second week in July) in Kigali. A five-star hotel has been booked for the seminar other cheaper accommodation is also available. If you could stay longer than one week we could use you for clinical teaching in one of the peripheral hospitals or the medical school.

Alternatively, there is the attraction of sitting with the wonderful silverback mountain gorillas or the abundant wildlife next door in Tanzania and Kenya. The possibility of diving on Lamu Island off the Kenyan coast and Zanzibar also exists

Please indicate as soon as possible whether you can assist with teaching in this project.

Dr Paul Anderson

MB, ChB, FRACS, FRCS, PhD, MA, Dip Tch
Consultant Surgeon
Flinders University/Medical Centre
Director
Specialists without Borders
Hospitals of HOPE Africa

REPLY TO pganderson@msn.com.au
or christine.wilson@flinders.edu.au

Specialties Teachers Required

Surgery

- General
- Orthopaedic
- Vascular
- Maxillofacial
- Dental
- Neuro and Cardiac

Medicine

- Physicians
- Pediatricians
- Anaesthetists
- Oncologists
- Radiologists

Aortic arch replacement surgery

A new technique for aortic arch replacement reduces the possibility of brain damage caused by lack of blood flow to the brain

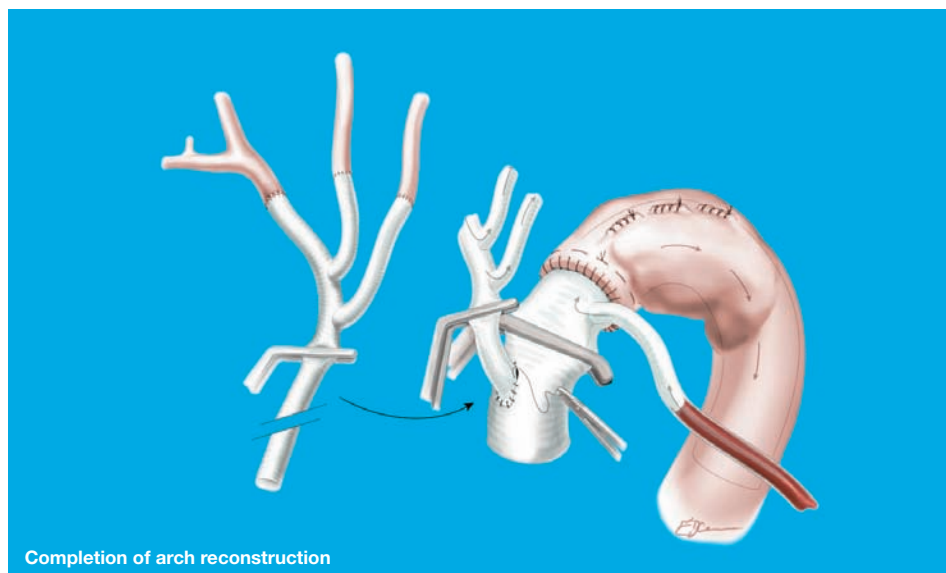
The Cardiothoracic Unit at Melbourne's Austin Hospital is leading the world in the use of a new technique for aortic arch replacement surgery that allows for constant blood circulation to the brain. The new procedure involves the use of a three-branched graft to re-route the three arteries of the aorta destined to supply the brain, with only one artery disconnected at a time allowing the others to provide constant blood flow until all three are finally supplying blood from a bypass machine.

It replaces the standard technique in which machines cool the patient's body to below 18C to give surgeons a short time to operate while the heart is disconnected and blood is not pumped around the brain.

So far, the Austin's Cardiothoracic Unit has undertaken twenty such procedures with one operation conducted late last year broadcast from theatre to surgeons attending the Annual Scientific Meeting of the Society for Cardiothoracic Surgery in Queensland.

The surgical team, headed by the Director of Cardiac Surgery, Associate Professor George Matalanis, replaced the arch of the patient's aorta before placing the aortic valve in the artificial aorta. The three outlets supplying blood to the patient's brain were then plugged directly into the artificial aorta.

Associate Professor Matalanis said the new procedure reduced the possibility of brain damage caused by lack of blood flow to the brain, allowed for a significantly speedier recovery while also giving surgeons far more time in which to work. He has now been asked to present his work at meetings in the US and Europe with publication of data expected later this year.



Completion of arch reconstruction

"In the past, it would routinely take the patient up to three days to regain full awareness after such surgery. Using this procedure, we can extubate within two hours following surgery with patients alert later that day," Professor Matalanis said.

"This is of great significance because recent experiments have shown that the arresting of blood flow to the brain even for 20 minutes has an effect on both fine skills and higher mental function and leads to the "trance state" common in such patients. That means that the trance state is not benign but is rather a diffuse brain injury. To find a way to avoid that is exciting."

Associate Professor Matalanis said the pre-made grafts with branches for the arteries allowed surgeons to replace the arch of the aorta like "plugging in a tube".

However, he said it took some initial courage to operate outside the standard approach of profoundly reducing the patient's temperature.

"Cold was always the great protection so that it did take a bit of courage in our convictions to go without that but we don't cool at all now. The advantages are enormous. The comfort of constant blood flow means that we can take our time to be exact whereas in the past when the clock was ticking, compromises sometimes had to be made," he said.

"Now we can concentrate on those things that matter while at the same time a significant

proportion of patients have not required one drop of blood from the blood bank. Often in the past, the old technique also affected blood clotting mechanisms which often also required the patient to revisit theatre to control bleeding.

"Then when you consider that even just ten years ago many people died from aortic arch surgery this is a profound advance. I'm very proud to be part of this team at the Austin that has perfected the technique and to now be at the stage where we can showcase our work both nationally and internationally."

Associate Professor Matalanis said he was now keen to establish a specialised aortic unit at the Austin Hospital as a centre of excellence for the procedure given they are now doing about one such procedure a week.

"You can't expect all cardiothoracic surgeons to become expert on such procedures as they are not common cases. We believe that having a dedicated unit staffed by a dedicated team to treat time critical patients as well as those patients referred with chronic aortic conditions ultimately is in the best interests of patients," he said.

"We have not received funding for this yet but I am still exploring all avenues."

In March, Associate Professor Matalanis will be presenting his work to the International Symposium on Aortic Surgery in Houston, US, with other presentations to be given in Belgium and Italy later in 2009.

Foundation for Surgery Scholarship

Thanks to the scholarship, Dr Chen was able to defer his cardiothoracic training to focus on pure research

Research now being conducted by Cardiothoracic Trainee Dr Yi Chen into the release of a protein produced by the body during the inflammation process could result in improved treatments for patients suffering post-operative infection, particularly following cardiopulmonary bypass surgery.

The 2008 recipient of the Foundation for Surgery Scholarship, Dr Chen is investigating the pattern of Activin A release as part of his Master of Surgery Degree at the Monash Medical Centre. Dr Chen said Activin A had only been isolated within the past twenty years and that while it was originally understood to be primarily a reproductive hormone, new research suggests it may have a wider role.

“Recent studies have shown that Activin A is released very early by people who have septicaemia as part of the body’s defence mechanism. However, we also believe the body has another naturally-produced protein which binds and inhibits the action of Activin A,” he said.

“Understanding how and when it is released could allow us, then, to target this protein and reduce inflammation.”

Dr Chen said the research had potential significance in relation to cardiopulmonary bypass surgery but that no research had yet focussed on the pattern of Activin A release or its potential role in such surgery.

“Cardiac surgery performed today is still largely done on cardiopulmonary bypass with the help of the heart-lung machine. The blood is diverted to the machine to be oxygenated and then pumped back into the patient’s circulation while the surgeon works on the heart,” he said.

“It has been known for a long time that the heart-lung machine can elicit a strong inflam-



Yi Chen has always been interested in research

matory response in the patient due to the blood coming into contact with a large foreign surface in the heart-lung machine. This inflammatory response can result in significant derangement of the patient’s clotting mechanism, ventilation, as well as blood pressure regulation.

“In severe cases, this can lead to significantly prolonged intensive care unit stay or even death so there is great interest in understanding exactly how the inflammatory response works and how it can be controlled.”

Dr Chen deferred his cardiothoracic training to focus on pure research. He is working under the supervision of Professor Julian Smith and Associate Professor David Phillips, both of whom work out of the Monash Medical centre. Since then, he has also received the Eric Bishop scholarship to allow him to

continue his work.

“I have always been interested in research so I thought I would take the opportunity presented now, earlier in my career, while I have the time. Some people may see pure research as dry but it feels exciting to be part of the process of discovery and to have received such great support from the College,” he said.

“A significant proportion of the biology of Activin A has not been entirely worked out yet but what we do know so far is suggesting that its role could be very significant. My research is aimed at understanding one piece of a bigger puzzle.”

The Foundation for Surgery Scholarship is open to all Fellows and Trainees enrolled in, or intending to enrol in a higher degree. It incorporates a \$55,000 stipend plus \$5000 in departmental maintenance.

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Keynote Speakers:

Professor Andrew Rice
(FPM ASM Visitor) Professor of Pain Research, Imperial College London, UK
A/Professor Steven Passik
(FPM Queensland Visitor) Associate Professor of Psychology in Psychiatry, Cornell University Medical College, USA
Professor Rollin Gallagher
Clinical Professor of Psychiatry and of Anaesthesiology and Critical Care, Penn Pain Medicine Centre, University of Pennsylvania School of Medicine, USA, President-Elect, American Academy of Pain Medicine

FPM Annual Dinner:

Grand Ballroom, Hilton Cairns, Cairns
Registration
Registration brochures will be mailed early in 2009 and will be available for download from: www.fpm.anzca.edu.au or contact the Faculty Office: painmed@anzca.edu.au
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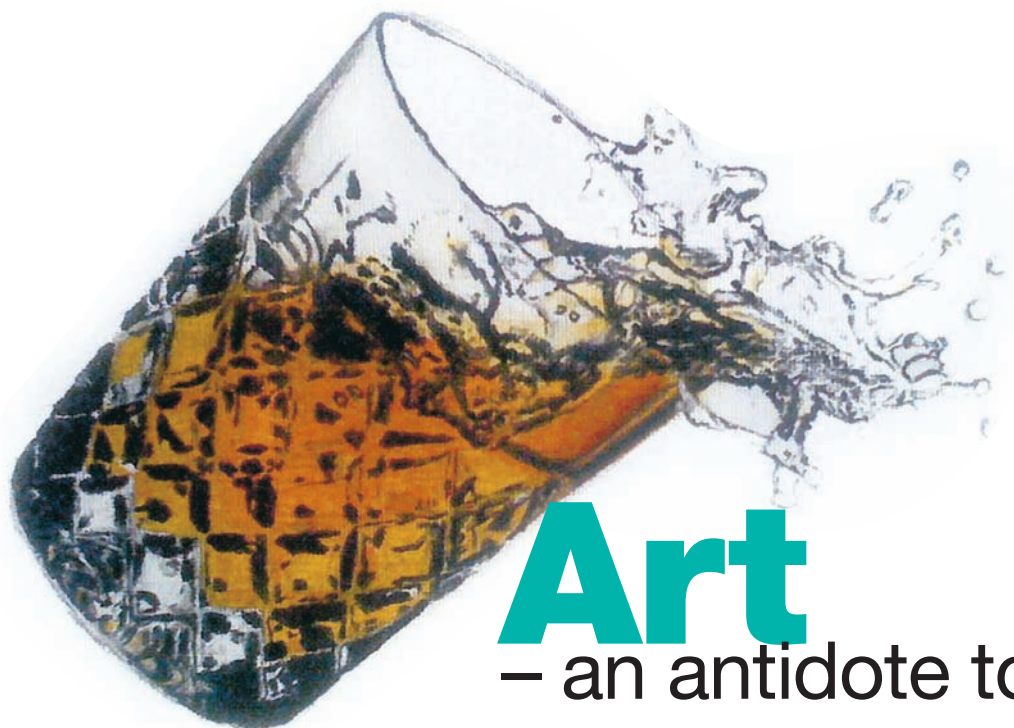
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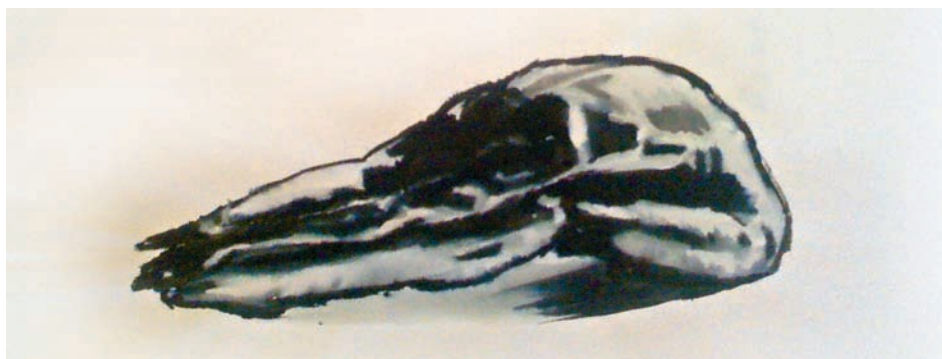
Photo courtesy: Gavin Hansford & Tourism Victoria



Art

– an antidote to stress

Conrad Brandt believes an artistic sensibility is helpful as a surgeon



Over the years Mr Brandt has painted in watercolours and oils

Quite a few years ago now, after Mr Conrad Brandt had won his secondary school art prize and was contemplating his future, his mother gave him some advice. She said: “Son, you can always do art as a hobby, but you can’t do that with medicine.”

So Mr Brandt temporarily set aside his paint brushes and concentrated on his studies.

Now, a general surgeon with an interest in surgical oncology and working out of the Geelong Hospital and St John’s and Geelong Private Hospitals, he has finally picked them up again. Married with two children, Mr Brandt has almost finished renovating the family home which has, at last, a dedicated space for his painting.

“Over the years I’ve had a go at drawing, painting with both water colours and oils and I’ve some done some anatomical clay sculpture as well. Through university I was pretty keen on photography and had my own dark room,” he says.

“They held an annual competition called ‘A Day in the Life of Monash’ and I won that, which was fun, while also doing magazine

covers, T-shirts and invitations for MUMUS, which is the Monash university medical undergraduate society. Since then I’ve always tried to find some time but it gets hard when you become busy.”

Mr Brandt says that while he wished he had more time for his hobby – he plans to indulge it more upon retirement – he believes an artistic sensibility is helpful as a surgeon.

“I do quite a bit of onco-plastic work so having an eye for aesthetics and proportions does help, and I think most patients would appreciate that too,” he laughs.

“Taking time out away from work, whether it’s painting the family or the pets or the things that appeal to me like the wind in the trees, is also a wonderful antidote to the stress of surgery. Even when I find my time limited I get great satisfaction looking at art.

“I went through an anatomical art stage at one point so Leonardo da Vinci was my hero

then, but generally I am drawn to the French impressionist painters like Monet.”

In 2005, Mr Brandt spent a year with his family in Edinburgh during which he began painting a picture of the elegant Georgian townhouses in his local neighbourhood of Stockbridge. Though it is an unfinished work, now that he has his art room it has been put back up on the drawing board.

“It feels wonderful to have a specific art room tucked away at the top of the house, particularly after all our travels. This is where we’ll stay now so I can have all my art supplies around me just waiting for the free time,” he said.

“My five-year-old daughter loves it too so she stands beside me painting away.”

Mr Brandt laughs when asked what advice he will give her when she is at the deciding point. “I think my mother’s advice was right for the time but I think I’d be more inclined to suggest that my daughter does whatever makes her heart happy.”



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Information about deceased Fellows

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

- Peter Blaxland NSW
- James Francis Carter NZ
- John Victor Leonard Colman NSW
- Phillip Richard Douglas NSW
- William Elliot Gillies VIC
- Denis Graham Kermode WA
- Bernard Vance Kyle NZ
- Graham Vaughan La Vere NSW
- Ian Lumsden McVey VIC
- Kenneth John Welfare, VIC
Hon Financial Advisor 2005-2008

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website: www.surgeons.org, go to the Fellows page and click on In Memoriam.

Informing the college

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

ACT	Eve.edwards@surgeons.org
NSW	Beverley.lindley@surgeons.org
NZ	Justine.peterson@surgeons.org
QLD	David.watson@surgeons.org
SA	Daniela.giordano@surgeons.org
TAS	Dianne.cornish@surgeons.org
VIC	Denice.spence@surgeons.org
WA	Penny.anderson@surgeons.org
NT	college.nt@surgeons.org



LETTERS TO THE EDITOR

Frank Stansfield

As another grateful graduate from Frank's "Kensington College" (Vol:9 No:7) may I add a couple of items.

When I started with Frank in 1953 his classes were held in the front room of his home at 26 Gordon Place, Kensington and if memory serves me right, extended to two sessions before we had to move to the local church hall as space demanded.

He was also a "Last Liner", so that classes were suspended when he was away travelling on the last train on any line that was about to be closed down.

He was a great friend and support to many of us.

*Bob Dykes
Invercargill, NZ
He was also a "Last Liner"*

Sir Benjamin Brodie

Brian Courtice of Brisbane, a retired yet hardly

retiring scholarly surgeon has one of the original three volume texts of Benjamin Brodie's publication on orthopaedics. Volume three contains the story of the Brodie's abscess. This was all revealed to me in Brian's early Christmas mail informing me of my error (using David rather than Benjamin) in the November/December 2008 edition of *Surgical News*, for which I thank him. As Francis Bacon said: "Silence is the virtue of fools."

Kind Regards,

*Felix Behan,
Victoria, Australia*

Mr or Dr?

Is it time for surgeons to become doctors? Surgeons in Australia and New Zealand generally have followed the British tradition of using the appellation "Mr" rather than "Dr".

As we all know this originates historically from a time when British surgeons did not have a university medical degree, rather serving

an apprenticeship and receiving a diploma. They were unable to claim the title Dr.

Later, in the Anglo-Australian surgical profession it became a kind of "badge of honour" to retain Mr to distinguish surgeons from physicians.

This quaint tradition is foreign and often bemusing to the rest of the surgical world where surgeons are universally referred to as Dr.

Patients find it particularly confusing and often ask "Should I call you Mr or Dr?"

When I contact a patient I will refer to myself as Dr Williams to avoid confusion.

There are now increasing numbers of female surgeons who, in my experience generally prefer Dr rather than Miss, Mrs or Ms, the latter titles being even less edifying.

I therefore assert that the appellation Mr for Australasian surgeons is archaic, confusing and not applicable to our female colleagues. We should abandon it.

(Dr) Randal Williams,

Day surgery sedation and analgesia

A review of day surgery patients' complaints has revealed a number of concerning issues

Liz Fitzgerald,
Clinical Risk Manager

We are seeing an increase in claims that involve elective day surgery procedures during which medication is administered in order to induce sedation and/or provide anaesthesia. Fortunately adverse events as a direct result of sedation are uncommon but analysis of those claims has alerted us to a number of issues that are cause for concern.

Case study

A 26 year old woman underwent a major liposuction procedure during which she received intravenous sedation. The patient was unhappy about the complications she experienced, the management of those complications and the ultimate outcome.

The patient initiated a claim against the doctor and also reported the doctor to the Medical Board. During a review of the claim it became apparent that the management of the patient while sedated, even though not directly related to the outcome, is likely to be highly criticised by the Medical Board.

The patient's medical record did not provide any information on the sedation administered apart from a two line notation:

I.V Midazolam 10mg titrated

I.V Fentanyl 200mcg titrated

There was no record of the time the titrated dosages were given, no record of any vital signs being monitored during the three and a half hour procedure and no reference to oxygen therapy. It was asserted by the practitioner that some monitoring took place, but in terms of defending any allegations related to the care of this patient, the doctor could not produce any evidence.

In a similar matter also recently before the Medical Board of South Australia, the Board expressed its concern over the standard of monitoring and supervision of patients who are sedated for day surgery procedures. It referred the doctor to the Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical Surgical Procedures recently updated and published (the Guidelines).

The Guidelines

The Guidelines are intended to apply wherever procedural sedation and/or analgesia for diagnostic and interventional medical and surgical procedures are administered. The aim is to ensure patient safety and comfort. The following highlights the pertinent sections of the Guidelines that, when not considered, may expose a doctor to criticism.

Staffing

Individual doctors and practices need to build their own practice guidelines based on the Guidelines while allowing for variations in patient profiles, procedures and practitioner skills.

At a minimum, three staff members must be available for patients having conscious sedation, :

1. A medical practitioner proceduralist with training in sedation and airway and resuscitation skills
2. A practitioner with training in monitoring sedation
3. An assistant to assist 1 and 2.

Individual practitioners have a responsibility to gain the skills and undergo training in airway management and resuscitation. Any practitioner who administers sedative or analgesic drugs that impact on the patient's conscious state must be prepared to manage the following:

- Depression of protective airway reflexes and loss of airway patency
- Respiratory depression
- Cardio-vascular depression
- Adverse reactions, including anaphylaxis.

Monitoring

It is recommended that all patients undergoing procedural sedation be monitored continu-

ously with pulse oximetry with appropriate alarm settings.

Regular monitoring of pulse rate, blood pressure and oxygenation must be made throughout the procedure as well as the patient's response to verbal commands.

Oxygenation

The Guidelines clearly state that during all procedures carried out under sedation or analgesia oxygen supplementation must be provided. In addition, pulse oximetry must be used to ensure an adequate degree of oxygenation.

Documentation

The clinical record must, at least, include:

- The names, dosages and timing of the administration of the medication
- The vital signs (BP, pulse, respiratory rate and oximetry) and times taken
- The names of staff performing sedation.

Being aware of and managing the risks associated with different levels of sedation is paramount for medical practitioners involved in interventional medical or surgical procedures. These updated Guidelines provide a prompt to review current practice and consider implementing changes required to reduce the risks of adverse events.

Risk Management Tips

- Consider how your practice works within the Guidelines
- Documentation of drugs given
- Monitor and record vital signs regularly
- Ensure that all staff are adequately trained

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Congratulations

New Zealand New Year Honours 2009

Companion of the New Zealand Order of Merit (CNZM)

Mr Ronald John Goodey

- for services to otolaryngology

Officer of the New Zealand Order of Merit (ONZM)

Professor Graham Lancelot Hill

- for services to medicine

Australia Day Honours 2009

Member in the General Division (AM)

Clinical Associate Professor

Brian Charles McCaughan

- for service to medicine in the field of cardiothoracic surgery

Medal in the General Division (OAM)

Mr Geoffrey Lewis Klug

- for service to medicine, particularly in the field of paediatric neurosurgery

Member in the Military Division (AM)

Group Captain Alexander Ralph Cato RFD

- for exceptional service to the Royal Australian Air Force Specialist Reserve as the Director of Air Force Health Reserves - Personnel and Senior General Surgeon

Associate Professor Ian

Bruce McPhee

- for service to medicine in the field of Orthopaedic surgery

Dr Malcolm Lees Stening

- for service to medicine as a gynaecological surgeon

THE KING FAISAL PRIZE



The King Faisal Prize for 2010 is available for research that has been conducted into non-arthroplasty management of degenerative joint disease.

The prize consists of a certificate, a gold medal and US\$200,000. Applications deadline is 1 May 2009.

For further information please contact James McAdam +61 3 9249 1278 or email james.mcadam@surgeons.org

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Letter from an Australian abroad

A look at Hong Kong from both inside and outside the surgery department



OP XI

Felix Behan,
Victorian Fellow

Following the College Hong Kong meeting in May 2008, I was invited by Professor Andrew Burd (Professor of Plastic and Reconstructive Surgery at Prince of Wales Hospital, Chinese University of Hong Kong in Shatin NT province) to come as a surgical visitor in mid-November to lecture and operate in his department on the use and wide-ranging applications of the keystone island flap. As it turned out, the Hong Kong Head & Neck Society and the Australian Head & Neck Society were holding a conjoint meeting at the same time.

On Saturday morning the Marco Polo Hotel was bustling with people ready for a comprehensive program on Head and Neck disease. June Corry, our Australian President from the Peter MacCallum Cancer Institute, gave a summary of demographics as they affect practice in Australia. Danny Rischin discussed chemotherapy with complementary presentations from our oriental colleagues, yet the Australian input created wide interest, placing a nice balance on the meeting.

My late entry presentation focused on treatment of parotid carcinoma, particularly in the elderly, reiterating the notion of the “Australian disease” as defined by the late Arnold Levine of the Marsden; mitotic skin disease of the face almost invariably ends up in the parotid after a certain length of time in this age group. Coordinated management of oncological excision and keystone reconstruction – an amelioration concept for the treatment of the elderly – was demonstrated, illustrating that there are now two options for reconstruction in this group.

On Sunday my fond hopes for a leisurely



A two-year-old patient in the burns unit with an amputated left hand resting on mine who said to me ‘Thank you, doctor, for coming to look after me.’ I melted – a gentle gesture from one so young

program of tourist activity were overturned. Andrew Burd and I went by fast train out to Shatin province to present papers for two-and-a-half hours to six trainees in plastic & reconstructive surgery. This was followed by a clinical outpatients session where we saw a range of patients with skin cancers of the inner canthus, burn contractures of the hands and even a recurrent angiosarcoma of the parotid involving the infra temporal fossa all as a pre-operative consultation in preparation for the following day’s surgery. We finished by three o’clock and I was invited to a belated lunch and given the options of Chinese, Japanese, Indian or Thai. We ended up at a major plaza centre where we enjoyed wonderful teppanyaki food.

On Monday I was taken to the Department of Surgery. The quality of the facilities in the university hospital would put us to shame with wood panelling and polished stainless steel fittings for a large number of staff. But there was one drawback – it so happens that in the Department of Surgery, 50 staff members have to share 25 computer cubicles. On reviewing these modern facilities, which have the air of a corporate office

setting, some of our departments in Australia look sadly in need of refurbishment. Nonetheless, in Australia such amenities have to be balanced against the financial burden of research needs and such finance is always limited reflecting government policy and budget restraints.

With China’s recent burgeoning affluence and with its financial reserves approaching two trillion yuan, we in the West are in a reverse situation – bracing ourselves for further tightening in the present climate. In the recent obituary for Peter Karmel, economist and scholar, (*The Age*, Saturday 9 January 2009), it was stated: “He warned against creeping mediocrity in Australian universities, arguing that it was vital for Australia to support elite researches and academics in the same way we support elite sportspeople.”

In preparation for the afternoon theatre session I spent some time in the department, where I incidentally saw on one desk, the *ANZ Journal of Surgery*. One of the departmental heads has an Australian Fellowship. I perused the October 2008 edition, really enjoying Doug Tracey’s summary “Inside

the ropes a surgeons life”, which I may have otherwise missed.

I supervised a series of operations that afternoon, demonstrating the Keystone technique in relation to a burns contracture of the forearm. Subsequently, Andrew did an antero-lateral thigh (ALT) microvascular free flap for a herniating shoulder prosthesis. I supervised a young trainee, Josephine Wong, through a keystone flap for closure of the ALT thigh defect.

“The quality of the facilities in the university hospital would put us to shame with wood panelling and polished stainless steel fittings.”

On Tuesday morning there were four presentations to the students with international visitors, plastic surgical trainees and staff, all this recorded on in-house video. For lunch we went to visit the Golden City Plaza. This shopping centre houses the usual trade outlets as well as the best of the couturier and high fashion labels in a multi-storey complex. One of my young Chinese associates said the plaza had the highest number of commuter personnel of any shopping centre in the world, where mainland China funnels into Hong Kong. The number of persons per square kilometre has been estimated to be 125,000 at peak periods (morning, noon and night). Our singular experience of similar numbers in Melbourne occurs in that Saturday afternoon in late September, where we might approach six figures but only for a few hours.

Then it was on to the Chinese University Anatomy Department for cadaver demonstrations. In my surgical career to date, my research has been at an observational level. My conclusions reflect the Osler precept that observation is the basis of scientific advancement, something also repeated by Darwin in his theory of evolution. I was penning these words coincidentally near the 200th anniversary of Darwin’s birthday. This is the first time in many years that I have resorted to using cadavers as a teaching aid. It was forcibly brought

home to me that closing cadaver tissue with keystone flaps is certainly different from the clinical experience.

I needed to use a suture I had not used on cadavers, it’s known by different names around the world and employs the “block and tackle principle”. In Melbourne in my early surgical training it was called the Hughes suture (after the famous E. S. R. Hughes) while in other cities it is often referred to as a “figure of eight” or “far-near” or “near-far” type suture.

When the suture line is criss-crossed, it becomes self-locking, good for muscle bellies. Even David Gault has published in the *British Journal of Surgery* a self locking mattress suture.

On the Wednesday night before my departure I finally had the opportunity to relax. I was invited by Andrew for parting drinks at the Intercontinental Hotel, overlooking Hong Kong harbour. This was the closest image to Fairyland I have ever experienced. As well as the lights and the passing marine parade, the Hong Kong ferries were almost loaded to the gunnels. I noted the absolute realism, evident in the Shanghai Banking building and its external lumiere lighting system. Architecturally, the building was delineated with fluorescent strips angled in a disguised arrowhead formation and pointing towards their competition in the financial world – this time a major US banking establishment – a potent illustration of feng shui principles (balancing the forces of the natural world). It is interesting to note that that same night on television before my flight departure we heard the latest developments in the global financial crisis, with the Dow Jones reaching a new all-time low. In conclusion, therefore, we must not forget what Horace said: “Those who go overseas find a change of climate not a change of soul.”

.....
1 The department facilities **2** Dr Anne Lee (a world authority on naso pharyngeal carcinoma), Dr June Corry, myself and Dr Danny Rischin **3** Dr Pauline Wong and Dr David Wong with the *ANZ Journal of Surgery*



Combating the scourge of burns

Interplast and the Australian & New Zealand Burns Association (ANZBA) working together in Bangladesh

In 1983, Interplast was established to provide access to plastic and reconstructive surgery for patients in developing countries. Twenty-five years later, Interplast has expanded its services to meet the increasing needs of the resource poor countries where Interplast volunteers work. As the demand for surgical services and training becomes more specialised, Interplast has begun working closely with other Australian organisations to provide the expertise to help establish sustainable solutions. One such project is a partnership with the ANZBA to address the significant impact of burns injuries.

The presentation of patients with severe burn injuries has become an increasing concern on Interplast programs. Currently, approximately 20 per cent of operations performed by Interplast volunteers are for the release of debilitating burns scar contractures. The majority of burn injuries in developing countries occur in the home, over half are caused by cooking over open flames. It is estimated 3.8 million women fall victim to a severe burn from fire each year – the same as the total number of those who are diagnosed with HIV/AIDS every year. Electrocutions, hot cooking liquids and acids in cases of domestic violence are also common causes.

In the year 2000, 238,000 people died as a result of burns – 95 per cent of those were in low and middle income countries. The incidence of burn injury in a developing country like Bangladesh for example is more than double that of a developed country such as Australia and is the second biggest cause of disability in Bangladeshi children. One child dies and a further nine children are disabled from severe burns a day. Not only are the phys-



ANZBA EMSB Faculty who travelled to Bangladesh in 2008, Tony Sparron, June James, David Milliss, Siobhan Connolly, John Harvey, Rebecca Schrale, Kelly Waddell, Peter Maitz, Alison Mustafa, Chandini Perera and Chris Parker (not pictured Peter Haertsh)

ical and emotional burdens on the victims enormous, they also bear a large economic burden which is compounded in communities already disadvantaged by poverty. The treatment of severe burn injury is long, painful and expensive, on average four times higher than the cost of treating other injuries. This presents a significant challenge in countries where health care issues far outweigh the resources available to combat them.

Interplast has worked with the Plastic Surgery Unit and Burns Unit at the Dhaka Medical College Hospital in Bangladesh since 2004. During this time, Interplast volunteers have been overwhelmed by the number of patients in Bangladesh suffering severe burns. Most arrive at hospital many hours, even days, after sustaining their injuries having received no basic first aid or treatment. The absence of appropriate basic management compounds their condition, making subsequent medical treatment more difficult and less likely to be effective. As a result, patients unnecessarily die or sustain debilitating injuries.

With the first 24 hours following burn injury the most crucial, sadly 60 per cent of

burn injury victims in Bangladesh seek health care from unqualified service providers such as medicine shopkeepers and traditional healers. Traditional remedies for burns range from using egg or salt on the wound to slathering the burn injury with mud found at the bottom of ponds as these are believed to have a cooling effect. Such practices greatly increase the risk of infection and lead to further complications due to the delay in seeking correct treatment.

As a first step in trying to address these issues, Interplast and ANZBA have partnered with the Centre for Injury Prevention and Research, Bangladesh (CIPRB) to provide training in the Emergency Management of Severe Burns (EMSB) in Bangladesh.

The renowned EMSB training course is designed for all workers in the health-care industry likely to come in contact with burns victims. EMSB teaches how to recognise, assess, stabilise and transfer the severely burned patient. The long-term objective of this project is to reduce the incidence of mortality and severe disability resulting from burns injury in Bangladesh by introducing



Burns patients at Dhaka Medical College Hospital in Bangladesh

EMS training nationally, thereby reaching village health care providers.

However, the initial focus is to train sufficient numbers of skilled Bangladeshi instructors to enable Bangladesh to establish its own course faculty. This will enable the future delivery of the EMS training courses with minimal support from Australian faculty. With funding support from AusAID, the course was adapted for the Bangladeshi environment and the first courses were delivered in Dhaka during December 2008 by the ANZBA Faculty lead by Prof Peter Maitz. Two courses were delivered with twenty-four senior Bang-

ladeshi surgeons receiving training in the emergency treatment of severe burns patients. Twelve medical professionals from the first course were also selected to participate in a one day instructor training course, which provided in-depth training in the principals of adult learning. The new Bangladeshi Faculty then delivered the second EMS course with the support of the Australian faculty.

“Alongside the educational benefits it was inspiring to witness the development of a new camaraderie within the Bangladeshi senior medical fraternity,” observed Professor Peter Maitz.

Preparations are now underway for a

second round of EMS courses in Dhaka in April 2009. The aim is to increase the Bangladeshi Faculty and establish sustainability so Bangladeshi medical practitioners can train their own counterparts without reliance on assistance from Australia and New Zealand. It is hoped eventually Bangladeshi’s population of 150 million people will have access to the appropriate early intervention so the incidence of mortality and severe morbidity resulting from burns injuries is reduced.

ANZBA courses are being offered to rural surgeons and trainees in 2009. Contact the PD Department on +61 3 9249 1106.

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The Cowlshaw Symposium

Recognising and sampling the College's remarkable collection of historic medical books

Keith Mutimer,
Honorary Treasurer

The 7th biennial Cowlshaw Symposium, convened by Professor Alan Thurston, was held in Melbourne on Saturday 1 November, 2008. This is one of the College's most prestigious events, held every two years to promote research and further knowledge of the Cowlshaw Collection.

The Cowlshaw Collection is the College's key collection of historic medical books, amassed by Sydney physician Leslie Cowlshaw from 1906 to 1943. It is one of the finest collections of historic medical books in Australia, comparable to the rare medical books collection of the University of Melbourne. It is not a surgical collection; its aim is to demonstrate the development of medicine through the ages, out of witchcraft and mumbo-

jumbo into a sophisticated science. The College acquired it at the beginning of 1944, following Cowlshaw's death.

Speakers are invited to research one or more items in the Cowlshaw Collection and to present a paper based on their findings. An important feature of the Symposium is the Kenneth Fitzpatrick Russell Memorial Lecture, dedicated to the man who helped secure the Cowlshaw Collection for the College, catalogued it and maintained it for more than 40 years.

Professor Kenneth (Red) Russell was the foremost medical historian in Australia. He was Reader to the Gordon Craig Library and a member of the Library Committee from 1945 to 1987 and edited the *Australian and New Zealand Journal of Surgery* from 1949 to 1967. This lecture perpetuates his memory.

The range of papers presented at this Symposium covered many interesting topics, from ophthalmology to polar exploration. About 40 Fellows and guests attended. Among the special guests were Virginia West and Penelope Tideman, granddaughters of Leslie Cowlshaw, and Mary Russell, daughter of Kenneth Russell. Mrs Fogo Russell was unfortunately unable to attend. The Symposium was opened by the President, Dr Ian Gough.

The Kenneth Fitzpatrick Russell Memorial

Lecture was presented by Mr Marius Fahrer, whose subject was "The Life and Times of Ambroise Paré".

Other speakers and their topics were:

- Geoff Down *The Monsters of Ambroise Paré*
- Prof. Em. Donald Simpson *From Lanfranc to Sunderland*
- Hon. Prof. Sam Mellick *The Signal Achievements of James Lind, James Cook and Owen Stanley*
- Geoffrey Serpell *Sympathetic Ophthalmia and Glaucoma before Ophthalmoscopy*
- Philip Sharp *Fridtjof Nansen: the Man who penetrated unknown Regions*
- Wyn Beasley *John Brown's Book*
- Prof. Alan Thurston *The Art of preserving Health*.

Texts examined ranged from the *Cirurgia parva magistri Lanfranci mediolanensis* (Venice, 1499) to Wm Mackenzie, *A practical Treatise on Diseases of the Eye* (London, 1840).

Light refreshments, luncheon and evening drinks were provided. All those who attended were in agreement that the day was very absorbing, successful and enjoyable.



1. Alan Thurston 2. Sam Mellick 3. Philip Sharp 4. Rowan Nicks & Cas McInnes 5. Pierre Chapuis, Philip Sharp, Wyn Beasley and Donald Simpson 6. Wyn Beasley 7. John Royle 8. Scotty Macleish & Michael Troy 9. Geoff Serpell 10. Ian Gough, College President presents the Russell Medal to Marius Fahrer

Doctors for the Environment

The College plays host to the annual meeting of this green-minded group of professionals

Bill Castleden,
DEA Founder

Doctors for the Environment Australia (DEA) is a national organisation of medical practitioners concerned to educate the profession, the public and politicians about the serious health effects of environmental degradation and climate change. It has members in every state and territory from all branches of the profession including a significant number of surgeon-members. DEA provides the sole “medical voice” that focuses exclusively on the environment and health. All the other professional bodies, such as the College, the AMA and the other medical colleges may also be involved with environment and health but they also have a myriad number of other concerns with which they have to engage.

DEA has produced a series of posters and brochures for doctors to place in their consulting rooms together with abundant policy documentation and educational material, all of which is available via the website www.dea.org.au

The document *Climate Change Health Check 2020*, available from the website, summarises the health effects of climate change in an easily-digestible format.

DEA has an active Management Committee and a prestigious Scientific Advisory Committee. The day-to-day activities of DEA are carried out by email and teleconference and are in the hands of the Management Committee and the Secretary, Emeritus Professor David Shearman, who is based in Adelaide. The Management Committee has annual face-to-face committee meeting which rotates from state to state, as does the AGM of the organisation. In 2008 it



1 From left to right: Dr Gilles Rohan, ACT; Dr Irene Kirzenow, WA; Dr John Stokes, Treasurer, WA; Dr David King, Queensland; Mr Bill Castleden, WA; Emeritus Professor David Shearman, Secretary, SA; Professor David Kidd, Incoming Chair, NSW; Dr Nick Towle, Tasmania; Dr Grant Blashki, Victoria; and Dr Graeme Horton, NSW. Absent were A-Prof Colin Butler, ACT, and Dr David Strong, Tasmania. 2 Mr Bill Castleden, the outgoing Chair of DEA; Professor Michael Kidd, Professor of General Practice from Sydney; and Dr Grant Blashki, an academic in General Practice and the Victorian State representative on the DEA Management Committee

was Victoria's turn to host these meetings.

In acknowledging the contribution of DEA's outgoing Chair and founder-member, retired Vascular Surgeon Bill Castleden from WA, the College provided the Hailes Room and its teleconference facilities for last year's face-to-face meeting for the Management Committee of Doctors for the Environment on October 2nd.

Bill Castleden's “Winding Down from Surgical Practice” has involved a decade of increasing commitment to the environment and health, firstly by convening with ex-President John Hanrahan a group of WA medicos known as “Doctors for the Preservation of Old

Growth Forests”, and latterly with his involvement with “Doctors for the Environment”. The first group became an integral cog in a huge wheel of community involvement that eventually saved all the remaining old growth forest in WA. DEA is still a work-in-progress with an assured future under its incoming Chair, Professor David Kidd, Professor of General Practice from Sydney and recently President of the RACGP.

The DEA thanks the College for its hospitality. The DEA also welcomes more surgeon-members. Fellows who are interested in the environment and health are encouraged to visit www.dea.org.au and to join via the website.

2009 Brisbane Annual Scientific Congress

TUESDAY 5 MAY

WRITING COURT REPORTS (9:00am to 2:30pm)

Facilitated by 'Leo Cussen Institute' barristers and members of RACS Medico-legal Section, this workshop provides unique one-on-one training in the preparation of medical reports for use in legal cases. Participants receive individualised feedback on their medico-legal reports and gain an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective.

9:00am	Session 1: "The role of the medico-legal surgeon"
10:30am	Morning tea
10:50am	Session 2: Working with legal counsel
12:20pm	Lunch
1:00pm	Session 3: Individual report assessment

Register for this Workshop Masterclass when you register online for the 2009 Brisbane Annual Scientific Congress: asc.surgeons.org

Further details may be obtained from Merylyn Smith at the College (merylyn.smith@surgeons.org).



Register online at <http://asc.surgeons.org>
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