Surgical news

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THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Sailing surgeon

The Tattersall's Cup was won by orthopaedic surgeon Andrew Saies & his team.

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The College of Surgeons of Australia and New Zealand

ROWAN NICKS INTERNATIONAL & PACIFIC ISLANDS SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the 2011 ROWAN NICKS INTERNATIONAL SCHOLARSHIP and the 2011 ROWAN NICKS PACIFIC ISLANDS SCHOLARSHIP.

These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to be leaders in their home countries.

The 2011 Rowan Nicks International Scholarship is offered to qualified surgeons from Bhutan, Cambodia, Indonesia (with preference to applicants from outside the major capital cities of Jakarta and Surabaya), Laos, Mongolia, Myanmar, Nepal and Vietnam. 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 objectives of the scholarship are leadership and teaching and it should not be used solely to develop surgical skill.

The 2011 Rowan Nicks Pacific Islands Scholarship is reserved for qualified 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.

These scholarships are usually awarded for a period of between three and twelve months and 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 (successful candidates may be required to pass an English proficiency test at the appropriate level before being officially awarded a Scholarship) 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 5PM MONDAY 19 APRIL, 2010
A copy of the application form for either Scholarship is available at our website:
www.surgeons.org

For additional information please contact:
Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons Gardens
250 - 290 Spring Street
East Melbourne VIC 3002
E: international.scholarships@surgeons.org
T: + 61 3 9249 1211
F: + 61 3 9276 7431

The Crisis in Emergency Surgery

Welcome to 2010 and another challenging year

Ian Gough
President

This article is a companion to the one in Surgical News in December, 2009

Patients in need of emergency or acute surgical care present with trauma or acute illness. Acute surgical illness e.g. abdominal pain, is the predominant workload in general surgery but in orthopaedics it is trauma. Other specialties will have a different workload distribution.

In considering how we should manage our patients' needs we should look at:

1. access to facilities
2. the facilities themselves, and
3. the available workforce including numbers and expertise.

In the United States of America (USA) there is a newly developed specialty of acute care surgery. It arises from the specialty of general surgery and involves a two year training experience of short term clinical attachments to a variety of relevant specialties such as vascular surgery, thoracic surgery, orthopaedics and neurosurgery and others. Some of the attachments are for only one month. There is certification available via the American Association for the Surgery of Trauma that accredits the training institution and certifies the completion of training. It is new and its efficacy is yet to be established. Most of the surgeons are expected to continue to be involved in elective general surgery.

Another development in the USA is the evolution of acute care surgery as a scope of practice. Some surgeons, usually in community practice settings, have given up elective surgery and made themselves available to hospitals to cover emergencies only. Sometimes they provide a comprehensive service with enough surgeons to cover a roster 24/7, and sometimes they supplement other surgeons continuing a more traditional service. At present general surgery and orthopaedics are involved. The workload and lifestyle for the

"Sometimes they provide a comprehensive service with enough surgeons to cover a roster 24/7"

supplementary version is apparently attractive to some female surgeons. Whether these practice profiles are sustainable in the USA or applicable to Australia and New Zealand is questionable.

It is known that severely injured patients do best if they have access to definitive surgical care within one hour. The receiving facility and the medical and surgical care must be appropriate i.e. expert care; otherwise the preventable mortality is likely to be around 20 per cent rather than an acceptable statistic of around two per cent.

Patients who are injured in Australia and New Zealand are sometimes very remote from a care facility. There are (appropriately) only a few level one and two trauma centres. What happens then? Initial retrieval and resuscitation is vital and the role of Early Management of Severe Trauma (EMST) in training General Practitioners and other medical practitioners is very important. Any hospital should have the capacity to communicate effectively with someone with expertise. This is the era of telecommunications so expert advice on management and transfer should be readily available. Appropriate and timely transfer should be possible for almost everyone.

The College sponsored an Emergency Surgery Workshop that was held in Sydney in November 2009. It was well attended by surgeons, anaesthetists, nurses, administrators and other interested professionals. The meeting analysed the problems and proposed principles that would lead to solutions. Although some of the workload is managed in the private sector the majority will continue to fall to the public sector where resourcing and systems must be improved. There is a predictable emergency surgery workload that should be measured, managed and adequately resourced. Separation of streams of care of acute and elective patients was confirmed as important so that the needs of both groups may be met in a balanced way.

Emergency surgery, including trauma surgery, should remain as a scope of practice/core competency within each of the existing major specialties of surgery. A corollary is the need for continuing professional development pro-

> *"Organisation of rosters into acute surgical teams that are consultant-led and have access to beds and operating theatres allows more timely definitive treatment in the daytime or early evening and improves supervision of Trainees and patient outcomes."*

grams for maintenance of competence and confidence in emergency surgery particularly where surgeons sub-specialise. In Australia the available surgical workforce and the population size and distribution is unlikely to support the development of surgeons who treat only emergencies.

Hospitals should be organised in efficient networks, such as the hub and spoke model, to allow communication, consultation, referral and transfer of patients to the appropriate facility. Each hospital has a clearly designated role with appropriate staffing and resourcing.

Organisation of rosters into acute surgical teams that are consultant-led and have access to beds and operating theatres allows more timely definitive treatment in the daytime or early evening and improves supervision of trainees and patient outcomes. This has already been shown to be effective at several hospitals in several states.

The adoption of these principles should lead to improved care of both emergency and elective surgery patients.

Congratulations

New Zealand New Year Honours

Officer of the New Zealand Order of Merit (ONZM)

- Prof James Geoffrey Horne, for services to medicine

Member of the New Zealand Order of Merit (MNZM)

- Mr David William Sabiston, for services to ophthalmology and the community
- Dr Daniel Charles Sundersingh Devadhar, for services to medicine and the community

Australia Day Honours

Member in the General Division (AM)

- Prof Robert Alexander Gardiner, for service to medicine and to medical research in the field of urology.
- Prof Robert McLaren Jones, for service to medicine as a surgeon, researcher and author, particularly in the area of liver transplantation laparoscopic surgery, as a mentor and through support for organ donation programs.
- Prof David Ferguson Scott, for service to medicine as a pioneer in the field of transplant surgery and through executive roles in professional organisations.
- Dr Andrew Darcy Sutherland, for service to medicine as an orthopaedic surgeon, an innovator in the field of surgical education and assessment, and as a mentor of young doctors.

Medal in the General Division (OAM)

- Dr Geoffrey Stephen Cohn, for service to ophthalmology, and to overseas aid programs fostering improved eye-health services.
- Assoc Prof Denis Warwick King, for service to medicine, particularly in the field of colorectal surgery, to medical education and to professional organisations.
- Dr John Douglas McKee, for service to the community of Bega, to medicine, and to Rotary.

Welcome to

There is much to look forward to in 2010, and the College is busy with numerous issues

Ian Dickinson
Vice President

As Vice President, and Chair of the Governance and Advocacy Committee, I am pleased to report on a number of issues which we have been driving and which directly affect the College and its members. Some have been considerable successes, some seem likely to be successful and some continue to resist further gains.

These are some of the matters we will be focussing on in the year ahead:

Constitution

As you may be aware, the new constitution is to be voted on. While it has already generated some publicity, there will be further discussion of its benefits over the next few months. Further information can be obtained from the College website. The proposed constitution will be the subject of a plebiscite of all Fellows before this year's Annual General Meeting.

Workshop on Emergency Surgery

This was held in November 2009 in Sydney with over 70 invited participants from a number of branches of surgery, emergency medicine, hospital administration, and health departments.

The workshop was tightly focussed and was able to reach a remarkable consensus on the day. A consensus statement has now been finalised and will be available on the College website after a final review by the College Executive.

The President has made some further comments on the workshop in this issue of *Surgical News,* and all feel strongly that considerable improvements can be made to the delivery of Emergency Surgery with goodwill, concerted effort, and not too much in the way of new money. Improved systems in hospitals are the key.

Training in the Private Sector

Our advocacy plans for 2010 include recommendations regarding training in the private sector which, with more than 60 per cent of surgery being performed there, is an issue that must be addressed. So far there has been relatively little interest from the jurisdictions in terms of the provision of infrastructure. Changes in the cultural expectations of surgeons, Trainees and patients all come into the mix. It is expected that workshops regarding this issue will be held at a number of fora during the year, including the Surgical Leaders Forum. It is anticipated that a workshop will also be held as part of the Surgical Education and Training (SET) program review, and a standalone workshop will be convened in July.

Road Trauma

The issue of road trauma is one where the College has been very effective, but where surgeons daily see the need to do more.

In the week leading up to Christmas Day the College issued two media releases, one in Australia the other in New Zealand, urging road users to take personal responsibility for their actions over the holiday period. This is because there is only so much that governments and police can do to protect people from their own foolishness.

As it turned out, some jurisdictions fared better than others, with the road toll being particularly bad in Queensland and New South Wales.

Between 1960 and 1970 the number of Australians fatally injured in road accidents was only 388 less than the total number of Australian servicemen killed in World War Two. Fatality and injury rates per head of population exceeded those of the United States and were double those of the United Kingdom. Numbers of traffic accident injuries were increasing and the mortality rate exceeded that of any other disease.

In New Zealand, road deaths in the early seventies peaked well above 800 per year. (The figure in 2009 was 384.)

The road toll so appalled Australian and New Zealand surgeons that in 1970 the College established its Road Trauma Committee to address

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

Letters to the Editor should be sent to:
letters.editor@surgeons.org

Or The Editor, Surgical News
Royal Australasian College of Surgeons
College of Surgeons Gardens
250-290 Spring Street
East Melbourne, Victoria 3002
T: +61 3 9249 1200 F: +61 9249 1219
W: + www.surgeons.org

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Surgical News Editor: David Hillis

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Failing to wear a seatbelt in Australia contributes to about 300 road deaths per year. If they all wore seat belts, it is estimated about half would survive.

this epidemic. The achievements of this committee effectively constitute the history of road safety in Australasia since 1970. Initiatives developed, or at least supported by the College, are:

- The introduction of seat belt laws – indeed Victoria was the first jurisdiction in the world to make the wearing of seat belts compulsory;
- The development of measures to counter drink-driving;
- The promotion of the concept of optimum care for all road crash victims;
- The introduction of compulsory helmets for cyclists;
- Early Management of Severe Trauma (EMST) courses, designed for doctors involved in the early management of serious injury in the city and country; and
- Continuous advocacy for prevention and better care.

This year, as the Road Trauma Committee marks its fortieth anniversary, the College will continue to fight the epidemic of road trauma – still one of the greatest killers of Australians under the age of 44.

Two important innovations that the College, through its Trauma Committee, is actively promoting are:

- A Bi-National Trauma Registry to help identify developing trends and to measure the effectiveness of trauma prevention and patient care; and
- The Australasian Trauma Verification Program to track the progress of complex patients from retrieval through hospital care and on to rehab, enabling both the measurement and the improvement of patient care and outcomes.

It is anticipated that, as part of this year's Trauma Week, a workshop will be held around the theme of sharing the road, examining ways in which motorists, cyclists and pedestrians can share limited road space more safely.

But of course, the best trauma prevention involves people understanding risk and modifying their behaviour on the roads accordingly. Issues raised in the media over the Christmas period included the relaxation of policing in relation to speed, and the continuing problem of drink driving. The road toll can only fall further if there is greater compliance with existing preventative measures – we wear our seat belts or helmets, we observe speed limits, we don't drink and drive, we don't drive if drowsy. That's why ongoing community education and policing are so crucial – they prevent complacency and have a proven role in achieving improved outcomes.

The College will continue to advocate for better outcomes. The evidence is that there is much more that can be achieved.

When should surgeons retire from active surgery?

Surgeons have a onerous responsibility for human life

I.M.A Newfellow

"I well remember the last operation that I saw Mr. Ancient perform. With trembling hand and failing eyesight he found the common bile duct, isolated it and promptly divided it."

Rather than this made up quote, I was hoping to start this article with a quote from the biography of a senior prominent surgeon in which the author, also rather old, spoke in admiring tones, of the aged surgeon and his even more aged assistant doing the last hernia together, hands shaking, eyesight not so good and a large part of luck and experience guiding them. The biographer seemed to regard their actions as something to be admired, revered and even praised. Age did not weary them but they pressed on regardless. However I can not find where I have put the book, or indeed remember if I ever had the book or if the book exists. Perhaps that is a mental shakiness.

My attention was alerted to the topic of retirement after the last Council meeting at the Friday lunch when Dr. David Newman spoke on "Age related deterioration in mental and physical skills of pilots and surgeons". Often at the Friday lunch, the last day of the Council meeting week, a special guest talks to the Councillors and staff about a topic of interest. Dr Newman is an aviation medicine specialist who served as an aviation medicine specialist in the Royal Australian Air Force. He has a PhD in Physiology from the University of Newcastle, a Diploma in Aviation Medicine from Farnborough in the United Kingdom, and is a graduate of the United States Air force School of Aerospace Medicine. He is also an experienced pilot, with flying time in a variety of military and civil aircraft, including such high performance aircraft as the F/A-18 and the Harrier. Now if anyone should know about pilots and their age related deterioration, he should know. (I was going to be cheeky and ask him when he felt he should retire but as he looked about 30 I thought I should be silent).

Surgeons are often compared to airline pilots. The less gracious would say it is because they are both overpaid Prima Donnas. However both have an onerous responsibility for human life and in both professions things can go badly wrong very quickly. David pointed out that the pilots have hundreds of lives at risk at any one time, not the single life that the surgeon has.

Some commercial airlines apparently still require pilots to retire at 55 years of age but most allow active flying to age 60. In September 2007 the US Senate raised the compulsory retirement age of commercial pilots to 65 years. This change is expected to spill out world wide.

Pilots are assessed yearly on their health and flying abilities. The latter is done via a flight simulator. There are also recency tests for various types of aircraft. All this is to ensure that the men and women with the gold braid on their shoulders are physically and mentally fit to fly us around the country, have trained in the plane they are flying, have recently done a reasonable number of flights in that plane and have kept up with continuing education. If they fail aspects of this assessment process they may be required to do remedial courses or may be told to stop flying. Does this sound a bit like surgery?

My old friend, Mr. Nit Picker, it seems, has a bee in his bonnet about retirement. He Chairs the Senior Surgeons Group which has been looking at the question of the retirement age. When should surgeons retire from active surgery? Should it be when they think that they should do so? Should it be when their anaesthetist takes them aside? Should it be a mandated age; if so, should it be mandated by the College or by government legislation? Should surgeons have surgical simulator testing, neuro-psychological testing and compulsory medical examinations? If they should undergo assessment, at what age and by whom should they be performed?

After Dr. Newman's talk there was a vigorous discussion about these points amongst some of those present. Mr. Nit Picker expressed his view that all surgeons turning 65 should undergo all of the above on a compulsory basis. To my surprise Mr. Pot Stirrer, who as you all know loves stirring, was unusually quiet. I later learned that he had recently turned 65.

A year in review and the year ahead

It has been another busy year in 2009 for the Younger Fellows (YF) Committee as well as the Younger Fellows within the College

Richard Page
Chair, Younger Fellows Committee

Two thousand and nine saw continued growth of the Leadership Exchange Fellowship with the US Academic Association of Surgery (AAS). Due to its success, a Younger Fellow representative will attend at the Annual Academic Surgical Congress in San Antonio, February 2010. This visit will be reciprocated by attendance at the Younger Fellows Forum in May 2010 by Dr. Julie Ann Sosa, an endocrine surgeon from Yale University. The exchange is proudly supported by an educational grant from Johnson and Johnson Medical.

In July 2009 the Royal College of Surgeons of Thailand generously invited four Younger Fellows to be guests at its Annual Scientific Congress. The kind hospitality and academic exchange was enjoyed by Stephen Jancewicz, Sanjay Sharma, Elamurugan Arumugam and Richard Martin. Nominations for the next Thai Annual Scientific Congress from 24-27 July 2010 in Pattaya will soon be open.

In partnership with Covidien, the YF Committee also provided opportunities for two Younger Fellows to travel overseas on a travelling fellowship grant. In 2009 the successful applicants were Mark Porter, an orthopaedic surgeon who went to Geneva for a skills course in foot surgery and Frank Wang, a general surgeon, who completed a hepatopancreatobiliary and liver transplant fellowship in Taiwan. This year Ashraf Chehata, an orthopaedic surgeon and Daniel Novakovic, an otolaryngology Fellow, will be using the grant to further their experience.

'Preparation for Practice' workshops were also very popular in 2009 for YF who are setting up a practice. Successful workshops were convened in Brisbane and Sydney and our plan for the New Year is to offer workshops on a regular, rotating basis in other major centres. A workshop is scheduled mid year in Melbourne and more information will be available soon.

The annual YF Forum was held in May on Sunshine Coast just prior to the 2009 ASC. The Forum has become an increasingly popular event and delegate selection is competitive. The excellent discussions and lively debates were led by a range of interesting presenters including College President Ian Gough and a number of senior council members. The Forum promulgated a number of recommendations for College Council. Some of these recommendations, such as the Communications Working Party formed to look at information technology and communication throughout the College, have already been adopted and enacted. There has also been uptake of new technology and media by the College to improve and enhance our public profile and surgical advocacy. The College President is to be congratulated on his performance skills in the You Tube presentation 'Why Become a Surgeon?' These are examples of the direct influence that YFs enjoy.

The final task of the team challenge at the Younger Fellows forum in 2009 was to create a sand sculpture that depicts 'Surgeons and what they do'.

Prior to the 2009 ASC, YF were able to participate in the inaugural course 'Developing a Career in Academic Surgery'. This was an initiative of the YF Committee convened by the Academic Surgery Section. This course proceeded under the expert guidance of Richard Hanney, a recent YF Committee Chair, and John Windsor. Another course is planned prior to the Perth ASC in May 2010.

Another initiative born out of the Forum is a new and exciting leadership and mentoring workshop which is planned for November 2010; watch this space for more information. The aim is to provide a base platform framework for leadership development throughout your surgical career with some input from luminaries in the health care sector. In addition, we will explore mentoring frameworks, their role in career development over a lifetime and how we can improve these frameworks in the College setting.

Finally, I would like to congratulate Steve Leibman (left), a New South Wales general surgeon who is taking up the reins as YF Committee Chair. He will be ably supported by the new deputy chairs, Jason Chuen, a vascular surgeon from Melbourne and Richard Martin, a Western Australian general surgeon as well as Ally Chen, our enthusiastic secretariat. I will remain on the committee for 12 months and be very happy in the knowledge that Younger Fellows are in safe hands. My best for 2010 to all Younger Fellows!

For more information about the YF Committee and any of these activities, please contact the Professional Development Dept on PDactivities@surgeons.org or +61 3 9249 1106.

College Conferences and Events Management

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

GSA ANNUAL SCIENTIFIC MEETING AND TRAINEES' DAY

Emergency Surgery: The Cutting Edge

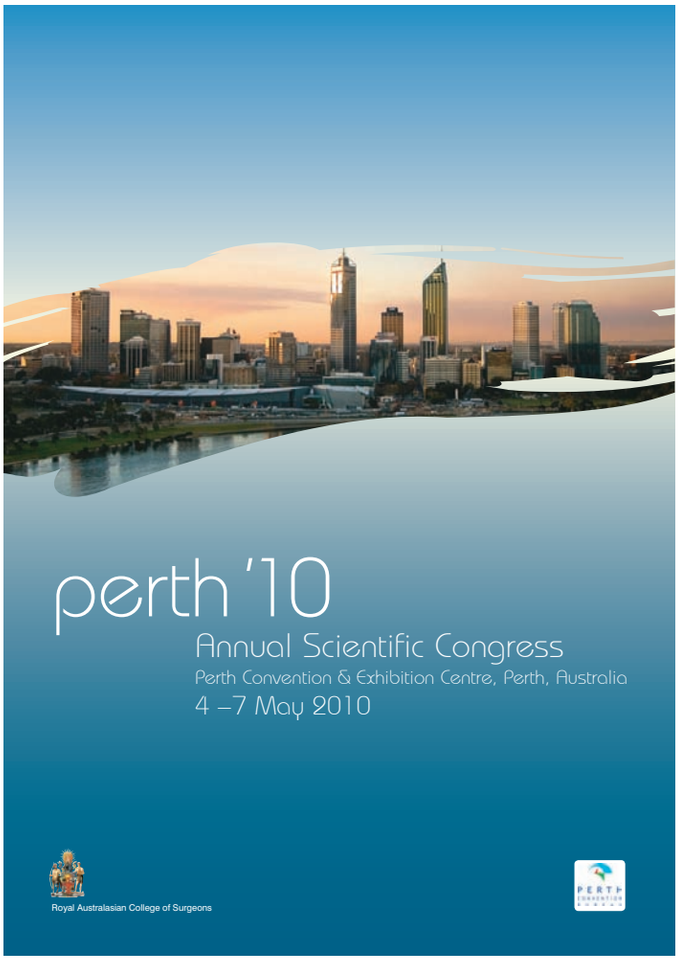
17-19 September 2010

Hyatt Regency Sanctuary Cove, Gold Coast, QLD

Invited Speakers:
Associate Professor Daryl Wall
Professor Michael Cox
Dr Michael Von Papen
Dr Ian Martin

Contact:
Abbey Williams
T:+61 3 9249 1260
E: gsa.asm@surgeons.org

General Surgeons Australia



46TH ANNUAL SCIENTIFIC CONFERENCE

1-4 SEPTEMBER 2010
CABLE BEACH, BROOME
WESTERN AUSTRALIA

PROVINCIAL SURGEONS
OF AUSTRALIA

"WORK – LIFE BALANCE"

Conference Convener **Mr Andrew Thompson**

Further information and sponsorship opportunities contact:
Royal Australasian College of Surgeons
E: psa@surgeons.org
T: +61 3 9249 1260
F: +61 3 9276 7431

The College has a new Dean of Education

Professor Bruce Barraclough is looking forward to improving the safety of Australia's health system

While Australian and New Zealand surgeons are recognised as being among the most technically skilled and highly trained in the world, more opportunities should be offered to surgeons and Trainees to develop, refine and enhance competence and performance in the less technical aspects of surgical care and professionalism, according to the Colleges' newly-appointed Dean of Education.

Professor Bruce Barraclough took up the position late last year and said he intended to focus his tenure on the promotion of this broader set of competencies as a means of improving surgical care and of reducing the number of surgically-related adverse events.

The immediate Past President of the International Society for Quality in Health Care and a former Chair of the New South Wales (NSW) Clinical Excellence Commission, Professor Barraclough said that the literature indicated that 51 per cent of adverse events in Australia involved surgical care and that 70 per cent of all adverse events were caused by a failure in communication.

"I think of my role not so much as the person designing courses or rounding people up to take them, but more like a good chemistry teacher who engages the class by selecting the right catalyst to create the "fizz" when the right agents and reagents are put together."

He said that while College Fellows excelled in such core competencies as technical skills, clinical judgement and patient management, more education and training opportunities were needed in other areas such as professionalism, communication, health advocacy, collaboration, management and leadership, and scholarship and teaching.

"These are generic skills and behaviours required by all doctors and it is possible that there could be collaboration with other colleges and all surgical specialties to provide the necessary courses and resources for training and for continuing professional development.

"In the past these areas have been addressed in a more informal manner but I believe they need to be taught explicitly, and be examined," he said.

"We have very good surgical care in Australia and New Zealand, but if we are going to do even better we need to reduce the inadvertent harm done to patients, the major cause of which, has as its basis, communication failure.

Professor Barraclough said the communication failures that most commonly featured as the cause of adverse events were not merely related to dialogue between surgeons, theatre and nursing staff but also related, for example, to poor systems for checking such issues as patient identity, correct site and side, indecipherable hand-writing, assuming that what had been asked to be done, had been done and difficulties caused by constant interruptions.

"Professor Enrico Coiera at the University of NSW has published a study which showed that approximately 40 per cent of clinical activities within an emergency department are interrupted," he said. "If the average person can hold up to seven things in their mind in their immediate 'to-do' list, obviously things can get scrambled by interruptions whether in the operating room or emergency department.

"While this is not a matter under the direct aegis of the College, we can start and possibly lead discussions about the need to redesign the system in which we work and also provide appropriate educational opportunities to improve leadership and team work and increase awareness of the problems of the system.

"If ten per cent of hospital admissions are currently associated with adverse events, increasing those skills that could prevent them also means that a great deal of extra work, care, costs and time could be avoided."

Professor Barraclough said the surgical skills centres, now located around Australia and New Zealand, could be put to broader use in the teaching and assessment of such professional competencies and that the relevant education and training modules may be able to be delivered and assessed electronically.

"One of the most advanced skills centres in the world, the national simulation centre in Israel has had a throughput of some 60,000 people who have undertaken courses in communication and leadership, and in particular, courses they call 'nightmare training' which allow medical professionals to practice how to deal with issues they fear most such as an extremely difficult procedure, or having to tell parents that their child has died," he said. "Skills centres are a hugely valuable tool and should be used more broadly."

Professor Barraclough said his other main focus in his role as Dean of Education would be to review the training given to the teachers of surgery while also looking at the possibility of changing the assessment processes for trainees.

He said the Colleges' newly-established Academy of Surgical Educators, an initiative of the College Council and President, was soon to hold its first Board meeting and had been set up to define, promote and drive the aspirations required to promote and enhance lifelong learning and to provide the resources and capacity to expand the breadth of surgical education and training in Australia and New Zealand.

"While a great deal of effort and attention is given to Trainees, in some specialties we are still seeing a 30 per cent failure rate," he said. "When you consider the expertise that goes into the selection of candidates and education given them, that failure rate raises the question as to whether it is a problem to be addressed by the students or the educators.

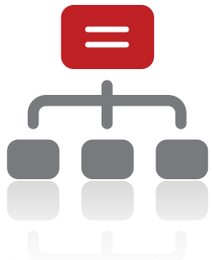
"Professor Enrico Coiera at the University of NSW has published a study which showed that approximately 40 per cent of clinical activities within an emergency department are interrupted,"

"There is now a growing body of opinion that suggests that rather than having a final exam that looms as a major hurdle, surgical assessment may be better delivered with a focus on workplace assessment via on-going repeated formative and summative assessments so that the final exam is just the last check that they have arrived.

"Adult learners need to be encouraged to review and reflect on their skills, attitudes and professional behaviours. We also know that people only really learn what is to be tested."

Professor Barraclough, who has a background in surgical oncology and was President of the College from 1998-2001, said he was looking forward to driving change to improve both the safety of Australia's health system, but also the working lives of surgeons and Trainees.

"I think of my role not so much as the person designing courses or rounding people up to take them, but more like a good chemistry teacher who engages the class by selecting the right catalyst to create the "fizz" when the right agents and reagents are put together."



International Medical Graduates Interviews Schedule for 2010

> The purpose of the interviews for International Medical Graduates (IMGs) is to explore specific aspects of the surgical practice, for example, professional communication skills, ability to evaluate the surgical practice and professional ethics. The IMG Interviews are scheduled to occur once every two months accordingly to the table below.

> All required participants of the interview panels will be notified of the interviews schedule timetables with a minimum of four weeks prior to the interviews.

> Please note that this schedule is also available in the College's website. www.surgeons.org

> The IMG Department would like to thank all participants of the interview panels in advance for making yourselves available in attending the interviews.

> If you have any questions, please do not hesitate in contacting Fabricio Silveira, Acting Manager, IMG Assessments T: +61 3 9 E: fabricio.silveira@surgeons.org

IMG Interviews Schedule for 2010

MONTH	DAY
February	11 – Thursday
April	16 – Friday
June	10 – Thursday
August	13 – Friday
October	7 – Thursday
December	3 – Friday

Professional Development Activities 2010

The College is offering a range of exciting activities to provide you with new skills

Rob Atkinson
Chair, Professional Development

If a surgeon went to sleep today and woke up a year later, he or she would practice less effectively due to the rate of change in our profession; it is estimated that the amount of biomedical knowledge available doubles every 20 years.

This means that our attitudes, knowledge and skills can become rapidly outdated without professional development. This holds true for a surgeon's non-clinical roles such as communicator, collaborator, professional, manager and leader, health advocate, scholar and teacher as well as the clinical roles of medical and technical expert.

One way to maximise learning from professional development is to set aside time for reflection or 'reflectology'. A reflectologist believes that it is essential to build reflection into learning in order for personal and professional growth to take place. Ideas that result from participation in learning which do not lead to actions have little chance of enhancing our competence and performance thus changing our practice.

The College is offering a range of exciting activities in 2010 to provide you with new skills and knowledge to reflect on. For instance there are two new medico legal workshops. The American Medical Association (AMA) Impairment Guidelines Level 4/5: Difficult Cases provides a case-based discussion forum for surgeons involved in the management of unusual, difficult or medico legal cases.

The second workshop Occupational Medicine: Getting Patients Back to Work involves factory site visits so that Fellows have a better understanding of the factors affecting the successful transition back to work after an injury.

Surgeons and Administrators: Working Together to Bridge the Divide is another learning opportunity that will provide food for thought. It explores strategies for improving the working relationship between surgeons and medical administrators by discussing risk management and patient care priorities. This workshop is a 'must' for all surgeons.

Sustaining Your Business, Leadership in a Climate of Change and Providing Strategic Direction are a series of three workshops which can be 'stand alone' or combine with distance learning modules to form an Advanced Diploma of Business. Each workshop has been tailored to meet the needs of surgeons and introduces practical strategies to effectively manage the strategic direction of a business through leadership, comprehensive business operations and financial management.

'Making Meeting More Effective' is a workshop which will challenge anyone who sits on a committee or a board. It explores the ten principles for effective meetings and examines the role and responsibilities of the chair and committee members.

For those involved in selection for Surgical Education and Training (SET), the new SET Selection Interviewer Training workshop will give you plenty to think about. It is modelled on the successful Supervisors and Trainers for SET (SAT SET) course and focuses on the steps associated with successful interviewing summarised by the letters in 'FORCE': Familiarise, Observe, Record, Classify and Evaluate.

I strongly encourage you to participate in these and the other professional development activities during the year. Fellows at all stages of their career need to embrace every opportunity for learning to ensure that Fellows of the Royal Australasian College of Surgeons (FRACS) always stands for excellence in surgical care.

2010 professional development workshops

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

Occupational Medicine: Getting Patients Back to Work

24 March 2010, Wollongong

This half day workshop focuses on improving the return-to-work process through a better understanding of the practical aspects of workplaces. The College is privileged to be able to visit the NSW Coal Mine Training Facility; a state of the art facility used to train coal miners and emergency workers. You will don safety gear and using the virtual reality centre go into what is essentially a real life under-ground coalmine set up just below ground in order to see first hand the roadways, support structure, machinery and the huge advances in mine safety. Numbers are limited so get in early and make sure you do not miss out!

Practice Made Perfect: Successful Principles in Practice Management

3 March 2010, Sydney
23 June 2010, Adelaide
8 September 2010, Melbourne

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

Sustaining Your Business

26 - 28 March 2010, Sydney

Effective business and financial planning is more important than ever for both private clinical practices and the broader health service delivery environment. This two and a half day workshop provides the foundation for the development and implementation of business plans to sustain business growth and performance. It explores financial management; from the preparation and analysis of responsible budgetary plans, decision making, management and reporting to the development of estimates and capital investment proposals. *This workshop is one of three entry points for the Advanced Diploma of Management*

Surgical Teachers Course

25 - 27 March 2010, Melbourne
12 - 14 August 2010, Newcastle
21 - 23 October 2010, Adelaide

The Surgical Teachers Course builds upon the concepts and skills introduced in the Supervisors and Trainers (SAT SET) course. An educational framework provides an effective guide to planning teaching episodes; from needs assessment and goal setting to the instructional methodology. The comprehensive curriculum is delivered over two and a half days and aims to enhance the educational skills of those with a keen interest in the teaching and assessment of surgical trainees. Participants are also encouraged attend a Supervisors and Trainers Course (SAT SET), a forerunner to the Surgical Teachers 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.

professional development workshops

DATES: FEBRUARY – JUNE 2010

ACT
29 June, Canberra
Supervisors and Trainers (SAT SET).

NSW
13 February, Sydney
Supervisors and Trainers (SAT SET).
3 March, Sydney
Practice Made Perfect.
24 March, Sydney
Getting Patients Back to Work.

SA
3 June, Adelaide
Supervisors and Trainers (SAT SET).
23 June. Adelaide
Practice Made Perfect,

VIC
13 March, Melbourne
Communication Skills for Cancer Clinicians.
20 April, Melbourne
Supervisors and Trainers (SAT SET).
27 May, Melbourne
Risk Management: Drafting a Consent.
26 June, Melbourne
Making Meetings More Effective.

WA
23 February, Perth (Urology)
Supervisors and Trainers (SAT SET).
3 May, Perth (ASC)
Polishing Presentation Skills.
3 May, Perth (ASC)
Understanding Your Patients: Become Culturally Competent.
3 May, Perth (ASC)
Selection Interviewer Training.

NZ
5 March, Bay of Islands
24 May, Wellington
Supervisors and Trainers (SAT SET).

Heading west for the congress

Michael Levitt
Congress Convener

David Oliver
Scientific Convener

While Fellows, Trainees and their families enjoyed the Christmas-New Year break (and perhaps beyond), members of the Perth Executive and Scientific committees have been adding the concluding touches to their programs for the 79th Annual Scientific Congress (ASC). The closing date for research papers and posters has now passed and all successful authors will be notified before Early Bird registration closes.

Early Bird registration

Electronic registration for the Perth ASC is easy via the Congress website – asc.surgeons.org. There you can also register to receive periodic updates by email regarding the scientific program. Remember, Early Bird registration closes on Monday 15 March.

Research papers and posters

Irrespective of whether a research abstract is accepted onto the spoken program or accepted as an electronic poster, the abstract is published in the Congress supplement to the Australian and New Zealand Journal of Surgery. The poster is also available for viewing on the Virtual Congress (sponsored by Ansell) for several years following the conference. All abstracts and all presentations from the Brisbane 2009 ASC for which the author gave approval are still available for viewing and the use of new technology means that more of each ASC is presented with both slides and the audio track. The Virtual Congress can be accessed via the Congress website.

Burn Surgery program

The Australian and New Zealand Burn Association first convened a burn management program at the Hong Kong ASC. The Association has appointed a convener for a Burn surgery program at each subsequent Congress with the Perth program being convened by Fiona Wood and Suzanne Rea. Generous sponsorship from Smith & Nephew has allowed the conveners to invite Professor Steven E Wolf, the renowned burn surgeon and editor-in-chief of the *Journal Burns*, to attend the meeting. There will be a prize, sponsored by Smith & Nephew, for the best research paper from a Trainee.

In addition to the scientific program and research papers, there is a Masterclass on Friday titled 'Care of the critically ill burn patient'. Registration for Trainees to attend Masterclasses is at no cost but registration is still required to ensure appropriate numbers are catered for.

General Surgery program

The General Surgery program is convened by Jeremy Tan and the program will feature sessions on acute care, trauma and critical care. The content will provide updates for both the practising surgeon and for Trainees on current management of these patients who are often the most challenging in our hospitals.

The two international invited speakers will be Professor Fred Moore (left) and Professor Karim Haouet (right).

Professor Moore is a renowned expert in trauma and critical care. He is Chief, Division of Acute Care Surgery and Critical Care, The Methodist Hospital, Houston and Professor of Surgery at Cornell University. His major research interests are in the fields of trauma (he is Associate Editor of the *Journal of Trauma*), gastro-intestinal tract dysfunction, haemorrhagic shock and multi-organ failure, areas in which he has published widely.

Professor Karim Haouet (the Bard Visitor) is Head of the Emergency Unit at Charles Nicolle Hospital, Tunis, Tunisia and Professor of Surgery at the Tunis University of Medicine. Professor Haouet has a broad interest in minimally invasive and laparoscopic surgery including hernia surgery, colorectal surgery and surgery for hydatid disease. He also has senior roles in medical education and laparoscopic surgery training.

In addition, there will be a video "How I do it" session, a Masterclass on ventral hernia repair, and prizes for the best Trainee research paper relating to hernia management and the best trainee paper overall.

Hepatopancreatobiliary (HPB) Surgery program

Andrew Mitchell is convening the program in Hepatobiliary surgery and he notes the program will have a multidisciplinary flavour. The section is delighted to have three international contributors: Professor Jacques Pirenne from Antwerp, a transplant and HPB surgeon, Professor Nipun Merchant, the American College of Surgeons Visitor and a pancreas surgeon from Nashville, and Mr Mikael Johanssen a and pancreas surgeon from Gotenberg, Sweden. Colonel David Smith from San Antonio, a trauma surgeon who will contrib-

ute to the Friday session devoted to the management of penetrating liver injuries.

Many sessions will benefit from contributions from our oncologist, gastroenterologist and interventional radiologist colleagues. Combined sessions will be held with several sections including General Surgery, Trauma Surgery and Transplantation.

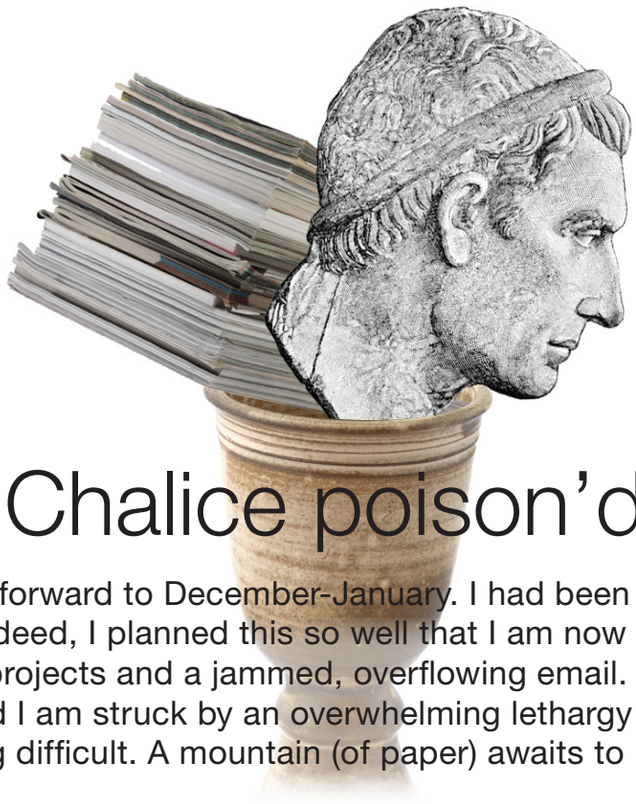
Highlights of the program will be:

- multidisciplinary approaches to the management of liver metastasis
- hepatoma
- cystic disease of the pancreas
- evidence-based pancreatitis management
- the dilated bile duct.

Major sessions will discuss the approach to the difficult gall bladder and the Friday morning session on liver bleeding followed by the Keynote lecture from Colonel Smith.

Delegates are asked to note that the Provisional Program lists the wrong evening for the Plastic and Reconstructive Surgery dinner. It is on Wednesday 5 May; the venue is unchanged.

79th Annual Scientific Congress
Monday 3 May to Friday 7 May
Perth Convention Exhibition Centre



Chalice poison'd

I have been looking forward to December-January. I had been planning this to be my "catch-up time". Indeed, I planned this so well that I am now confronted by piles of accumulated paper, projects and a jammed, overflowing email. Now the time has come to "catch up" and I am struck by an overwhelming lethargy and getting started is proving difficult. A mountain (of paper) awaits to be climbed!

Professor U.R Kidding

And to confound matters further, the hospital Chief Executive Officer (CEO) has decided to use this "down-time" to provide me with "essential reading" designed to improve my skills in management and leadership! I thought that was the criteria when they appointed me to this Director role. Obviously not enough because there is no end to those "fantastically informed articles" that everyone views as a "must read". I end up with multiple copies because they know I am a technical Luddite so they give me a hard copy and then I get it again in one of those endless electronic "infomercials". I really do think Bill Gates has a lot to answer for.

But a couple of things did catch my attention. One was the difference between performance and potential. Potential is the level at which one could perform and performance is the actual level achieved. I thought about this quite a lot in terms of the Heads of Units I became a little uncomfortable that I may not have been providing an environment fully conducive to them realising their full potential. Worse, this necessarily meant that my potential exceeded my actual performance! Worse still, it is not something I can discuss with my better half at the moment!

Another thing was the analysis of the medical profession and their views of leadership. It appears from studies in the United Kingdom (the National Health Service really does need some leadership!!) that the medical profession believe that their leadership should be bolder, more profiled and have distinct plans "to get us out of this mess". However they are super-critical and unforgiving of the people that are contributing and trying to provide the leadership. Sounds like our Medical Staff Group when the sponsorship ran out for the refreshments...

Still problems with Medical Staff Groups and even surgeons are not new!! Even Julius Caesar had his problems when he famously said of Cassius **"Let me have men about me that are fat, Sleek-headed men and such as sleep a-nights. Yond Cassius has a lean and hungry look,He thinks too much; such men are dangerous."** (Julius Caesar Act 1, scene 2, 190 – 195)

Now I know that our New Year resolutions gave us greater respect to the lean and hungry look. The first meeting of the Surgical Division in any year is a great laugh with the fitness campaigns, exercise programs and the injury lists. I can never quite get there myself. However, there are always more than one or two Cassiuss (or is that Cassii) in medical staff groups. Need to remember to keep them involved and "happy". They are a difficult group and forever watchful. Maybe they have that "chip on their shoulder"? As Cassius said **"The fault, dear Brutus, is not in our stars, But in ourselves, that we are underlings."** (Julius Caesar Act 1, scene 2, 135 – 141)

And so the plotting will continue. How many times do you fear that you will hear those words of **"Liberty, Freedom, Tyranny is dead"?** (Julius Caesar Act 3, scene 1, 86)
I will need to practice that section on humility. No one likes a pompous... Maybe I should return the favour and send this passage to the CEO? After all, the average "life expectancy" of a hospital CEO is less than three years. But maybe not.

Back to the reflections on leadership. You take that fantastic modern analogy of "herding cats" and you understand that your New Year resolutions should have included reading a lot more of these management gems. I wonder if they would have included Julius Caesar or other classics from Shakespeare. The problem with Machiavelli's *The Prince* is that everyone expects you to be like that when you have to deal with the Executive of the Hospital, and I need to be honest – the Executive of the Hospital are very practised at it...

Do surgeons need more management training? Alas, yes. Gone are the days when we can rule all we survey unimpeded. Cassii abound in every aspect of our environment. We need to know what we are doing to ourselves; all those time honoured and traditional political manoeuvres and develop an appreciation for those important games that we must definitely play. **Et tu, Brute?** (Julius Caesar Act 3, scene 1, 85)

Mind you, the biggest problem is that December and January have almost gone. The paper mountain has grown, as if it has gained the means of self-replication. The demands become more strident, meetings re-appear and budgets have disappeared – interesting that they are inversely related. Tomorrow another briefing on waiting lists for the Minister. Perhaps he would appreciate Shakespeare or would it be Machiavelli?

To be continued.....

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The National Breast Cancer Audit

In 2010, the audit will be directed by the Breast Surgeons Society of Australia and New Zealand

James Kollias
Chair, Breast Section & Clinical Director of National Breast Cancer Audit

The National Breast Cancer Audit (NBCA) is an initiative of the Breast Section of the College, being managed out of the Research, Audit and Academic Surgery Division of the College through Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). It began in 1998 as a pilot project and is now supported by over 270 breast surgeons from Australia and New Zealand. The surgeons submit data pertaining to episodes of breast cancer through a secure online facility or paper-based format. Between 7000-9000 episodes of breast cancer are recorded each year which account for approximately 65 per cent of all breast cancer episodes in Australia and New Zealand. The aim of the audit is to allow surgeons to assess their individual practice in the management of breast cancer according to several key performance indicators (KPI) which have thresholds above which the surgeons should perform. Recent innovations include the ability for surgeons to download their practice data on an excel spreadsheet to permit statistical analysis and research as well as the implementation of a Minimum Data Set (MDS) which permits for rapid, accurate and timely data submission. Early estimations show that just over half of participants are choosing the MDS option.

The audit is currently assessing surgeons against four KPIs:

1. Percentage of patients with invasive cancer treated with breast conserving surgery who were referred for or prescribed radiotherapy (should be ≥85 per cent).

2. The percentage of patients referred for or prescribed hormonal treatment for oestrogen positive tumours (should be ≥85 per cent)

3. The percentage of patients undergoing axillary surgery for invasive cancer (should be ≥90 per cent)

4. The percentage of DCIS patients who

underwent breast conserving surgery undergoing no axillary surgery (should be ≥90 per cent)

Two new KPIs are due to be implemented during 2010. The first of these is the percentage of patients with high risk of recurrence after mastectomy who are referred to a radiation oncologist. Cases to be included in the calculation for this KPI are invasive tumours which are greater than or equal to 50mm, or that have greater than or equal to four positive nodes. A threshold of 85 per cent has been set. This KPI has been ratified by the NBCA Steering Committee and will be implemented soon.

Another KPI in development is the percentage of patients with moderate or high risk of recurrence being referred to a medical oncologist for consideration of chemotherapy.

The NBCA has an established governance structure, principally involving breast surgeons but includes input from supporting professional groups such as medical oncology, radiation oncology, medical epidemiology, breast nurses, consumers (Breast Cancer Network Australia) and the National Breast and Ovarian Cancer Centre (NBOCC). In 2010, the NBCA will be directed by the Breast Surgeons Society of Australia and New Zealand (BreastSurgANZ). Participation in the audit will be a requirement for full membership of the Society which will provide core funding for audit activities.

For the present time, the day to day management of the NBCA will continue to be administered by ASERNIP-S. The new structure will mean more autonomy for the audit, in terms of its relationships with both the College and funding sources. The Society will receive funding through subscriptions and sponsorships and will allocate a proportion of these funds to the running of the audit. Funding organisations will be sponsoring the Society, rather than directly sponsoring the audit. This will ensure that the integrity of the audit remains high.

A Society audit will also provide added benefits and opportunities for input from the surgeons involved with BreastSurgANZ. The audit is recognised as a quality assurance activity by the College to the application of CPD points. Additionally, the audit has been declared a Commonwealth Quality Assurance Activity, which protects the confidentiality of the audit. The activities of the Breast Surgeons' Society will be promoted to consumers, Divisions of General Practice and general practitioners as a quality assurance program that may assist them in appropriate referrals to high-quality breast surgeons practising in Australia and New Zealand.

Developing and implementing a clinical audit on the scale of the National Breast Cancer Audit continues to be a difficult challenge. Significant input and commitment has been undertaken by a number of stakeholders: the Breast Section Executive, members of the Breast Cancer Audit Steering Committee, the National Breast and Ovarian Cancer Centre (NBOCC) and Breast Cancer Network Australia. The National Breast Cancer Foundation has shown considerable support in financing the audit through the NBOCC up to mid 2009. The audit has been dutifully managed by its committed staff members, Ms Claire Marsh, Ms Louise Kennedy, Dr Primali De Silva, Ms Michelle Ogilvy, Ms Catherine Yap and Ms Maggi Boult.

The Breast Section is thankful for the contributions made by those mentioned.

Most importantly, the College Breast Section Executive and the National Breast Cancer Audit Team are grateful to the dedicated breast surgeons who continue to contribute data to the audit.

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

Post Fellowship Training in HPB Surgery

Applications are invited from eligible Post Fellowship Trainees for training in HPB Surgery.

ANZHPBA's Post Fellowship Training Program is for Hepatic-Pancreatic and Biliary surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in HPB surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit.

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For further information please contact the Executive Officer at anzhpba@gmail.com

Applicants should submit a CV, an outline of career plans and nominate three references, to Leanne Rogers, Executive Officer ANZHPBA, P.O. Box 374, Belair S.A. 5052, or email anzhpba@gmail.com.

Applicants will need to be able to attend interviews which will be held on Monday May 3rd, during the ASC in Perth.

APPLICATIONS CLOSE 5PM, FRIDAY MARCH 26TH 2010.

ANZGOSA
Australia & New Zealand Gastric & Oesophageal Surgery Association

Post Fellowship Training in Upper GI Surgery

Applications are invited from eligible Post Fellowship Trainees for training in Upper GI Surgery.

ANZGOSA's Post Fellowship Training Program is for Upper GI surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in Upper GI surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit.

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For further information please contact the Executive Officer at anzgosa@gmail.com

Applicants should submit a CV, an outline of career plans and nominate three references, to Leanne Rogers, Executive Officer ANZGOSA, P.O. Box 374, Belair S.A. 5052, or email anzgosa@gmail.com.

Applicants will need to be able to attend interviews which will be held on Monday May 3rd, during the ASC in Perth.

APPLICATIONS CLOSE 5PM, FRIDAY MARCH 26TH 2010.

The 2009 Graham Coupland

"The Ups and Downs During the Establishment of the Sydney Cochlear Implant Centre"

The following is a copy of the speech delivered by Professor William Gibson, in 2009

I am very pleased to have been chosen to give this year's Graham Coupland Oration. It is a great honour which I appreciated as a humble ear, nose and throat (ENT) surgeon. I have tried to discover a little about Professor Graham Coupland. He obviously had earned great respect from his colleagues despite a sadly short career. I discovered that his daughter Jenny became Miss Australia in the very year that he passed on. It must have been a tumultuous time for the family.

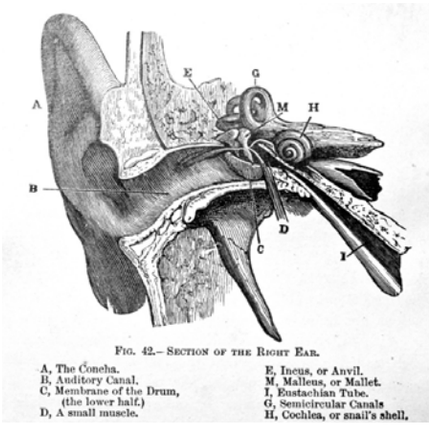


FIG. 42.— SECTION OF THE RIGHT EAR.

A, The Concha.
B, Auditory Canal.
C, Membrane of the Drum, (the lower half.)
D, A small muscle.
E, Incus, or Anvil.
M, Malleus, or Mallet.
I, Eustachian Tube.
G, Semicircular Canals
H, Cochlea, or snail's shell.

The early history of the managment of congenital deafness

The story begins in the 18th century. Prior to this time it was commonly supposed that congenitally deaf children were not only mute and unable to speak, but also stupid. Congenitally deaf people were treated as imbeciles and as a source of ridicule. It was a French priest called Le Abbé de l'Epeé who devised sign language enabling deaf children to communicate and he demonstrated that deaf children had the same level of intelligence as their hearing peers. The Abbé broke the chains away from the deaf giving them self esteem and allowing them to enjoy a new sense of freedom.

Attempts were still made to teach the children to speak. Lipreading alone is not sufficient as only 30 per cent of words can be lipread so acoustic devices were developed to aid hearing loss. Although hearing aids have improved dramatically over the years, but even today they only amplify residual hearing. Hearing aids still provide insufficient amplification for profoundly deaf children. Typically, even with powerful hearing aids, the higher frequencies can not be heard. The deaf child hears the vowel sounds but not the consonants. For example if someone says, "she goes shopping', the child hears 'he go hoppin' and speaks with these sounds. An auditory oral approach was popularised in the 1950s and 1960s. Children were forced to sit on their hands to prevent them signing and to use lip-read and tactile clues, to learn to speak. It was a disaster. With few exceptions, when there was a parent who was prepared to spend countless hours working with their child, most children developed poor speech which could not be understood. The deaf disliked these attempts to make them speak like hearing people and preferred their own identity as Deaf people (spelt with a capital D to indicate they communicated using sign).

In the 1970's and 1980's, it became politically correct to allow deaf children to use sign. As it was realised that most deaf children who only signed had very poor reading and writing skills, a method called 'Total communication' was developed. The children had to use signed English in which every word is signed in grammatical context. This is very slow and cumbersome. The deaf children were also expected to learn some speech using hearing aids. When they left school they usually threw away their hearing aids and enjoyed using fluent sign languages such as Auslan. Together, they formed a strong and proud Deaf community.

The early history of the cochlear implant

The first two cochlear implants were performed in France by Djurno and Eyries in 1954. Their publication caused a flurry of excitement. In the 1960's, a number of groups, especially in the USA, developed cochlear implants but they all encountered problems and it was concluded that cochlear implants should be put on hold until further animal studies had shown it was a safe procedure. Basic scientists condemned cochlear implants as unscientific as they concluded that a few electrodes could never replace the function of the inner ear, and the best any cochlear implant would offer was information of pitch and rhythm, and as such they were no better than vibrotactile aids.

Others stated that an intracochlear electrode would destroy the spiral ganglion so that the recipient would lose not only the ability to hear electrically but would also lose all remaining natural hearing.

In the mid 1970's Bill House and Jack Urban were the first to break rank. They produced a single electrode device which was commercialised by 3M. In Australia, Graeme Clark persisted with the idea of an intracochlear multi electrode device. In 1978, he and his team in Melbourne inserted a device with 22 intracochlear electrodes. The recipient was Rod Saunders who died in 2008. The University of Melbourne speech processor was unwieldy and Rod visited the University department many times so that studies could be undertaken. Most people thought Graeme was foolish to persist in following this idea as the 3M single channel device was being widely accepted as having reached pinnacle of possible performance. The idea that a cochlear implant could provide enough information to make it possible to follow speech without lip reading was ridiculous. The leading ENT surgeons in Melbourne felt deeply disappointed in their new inaugural professor and they visited the Vice Chancellor to request that Graeme could be removed from his position.

In 1982, Paul Trainor who had developed the pace maker company Nucleus decided to commercialise Graeme Clark's cochlear implant. He did not expect to make any profit but hoped to help deaf people. Paul Trainor literally heard Graeme Clark's prayers.

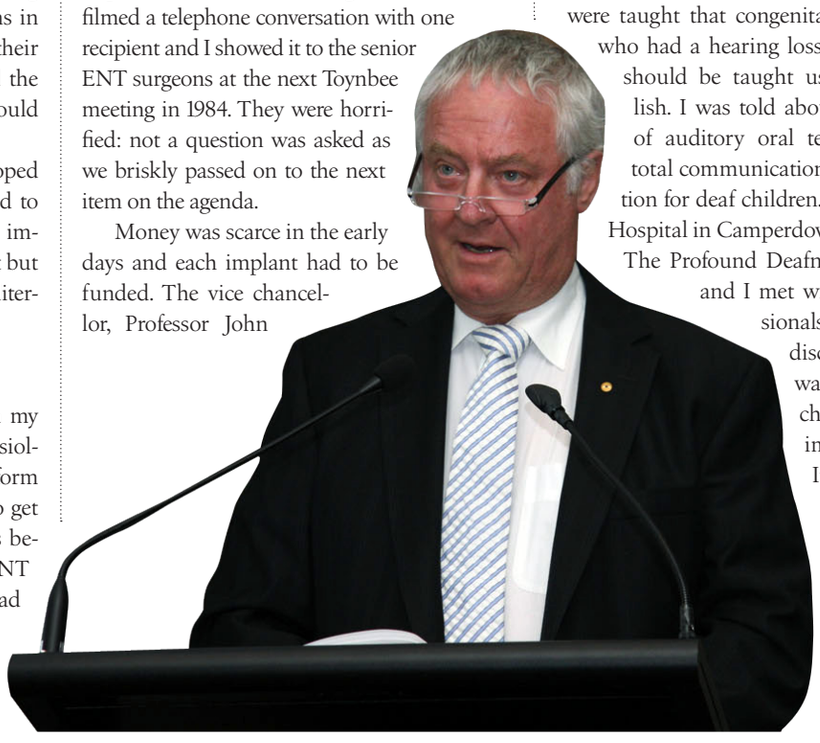
My personal involvement

In 1983, I emmigrated to Australia with my family. I had an interest in electrophysiology. I was approached by Nucleus to perform some cochlear implants and I was keen to get involved. However, as Graeme Clark was being criticised by the elder statesmen of ENT who considered his research was futile, I had to seek permission from my department in Sydney before I dared to go ahead. Dr Barrie Scrivener was my greatest supporter and helped me to get the project started. The first two Nucleus implants were performed in Sydney on August 15 1984. Almost simultaneously, the ENT department in Hannover began their program so there were then three centres in the world offering the new Nucleus cochlear implant.

There was a group of leading ENT surgeons called The Toynbee Club who met each year alternatively at the Melbourne Club and The Australian Club in Sydney for a black tie dinner. In 1983 I was asked to give the dinner speech on my intentions as the new professor in Sydney. I had several projects but when I mentioned I was about to commence using Graeme Clark's cochlear implant which was now commercially available, I had no idea the storm of criticism this produced. Barrie Scrivener saved the day for me.

The results of my first two implants were outstanding and both recipients were able to use the cochlear implant to hear speech without using lip reading. I believe this was the first demonstration world wide that a cochlear implant could deliver enough information. I filmed a telephone conversation with one recipient and I showed it to the senior ENT surgeons at the next Toynbee meeting in 1984. They were horrified: not a question was asked as we briskly passed on to the next item on the agenda.

Money was scarce in the early days and each implant had to be funded. The vice chancellor, Professor John Ward helped me to establish The EAR Foundation at the University of Sydney.



> *"Money was scarce in the early days and each implant had to be funded. The vice chancellor, Professor John Ward helped me to establish The EAR Foundation at the University of Sydney."*

I was desperately keen to perform the surgery on congenitally deaf children. Not surprisingly, the Deaf community was opposed as they were actively promoting a culture of sign. But I soon discovered that the professional establishment was also opposed. The teachers of the deaf were teaching signed English in total communication programs. The audiologists were taught that congenitally deaf children who had a hearing loss of over 90dBHL should be taught using signed English. I was told about all the failures of auditory oral teaching and that total communication was the best option for deaf children. At the Children's Hospital in Camperdown we established The Profound Deafness Study Group and I met with all the professionals each month to discuss the correct way of beginning a children's cochlear implant program. It was soon obvious that the main task of the group was to dissuade me from any hasty action.

To be continued in the next edition.

Treating and teaching in the Pacific Islands

The most important aspect is not just treating patients in need but transferring knowledge

A four person team of Paediatric surgical specialists from Auckland's Starship Children's Hospital visited the Solomon Islands under the College's AusAID funded Pacific Islands Project. In the days leading up to November 2009 the team's imminent arrival was broadcast on radio, so patients from the remote islands could make their way to Honiara for assessment and treatment.

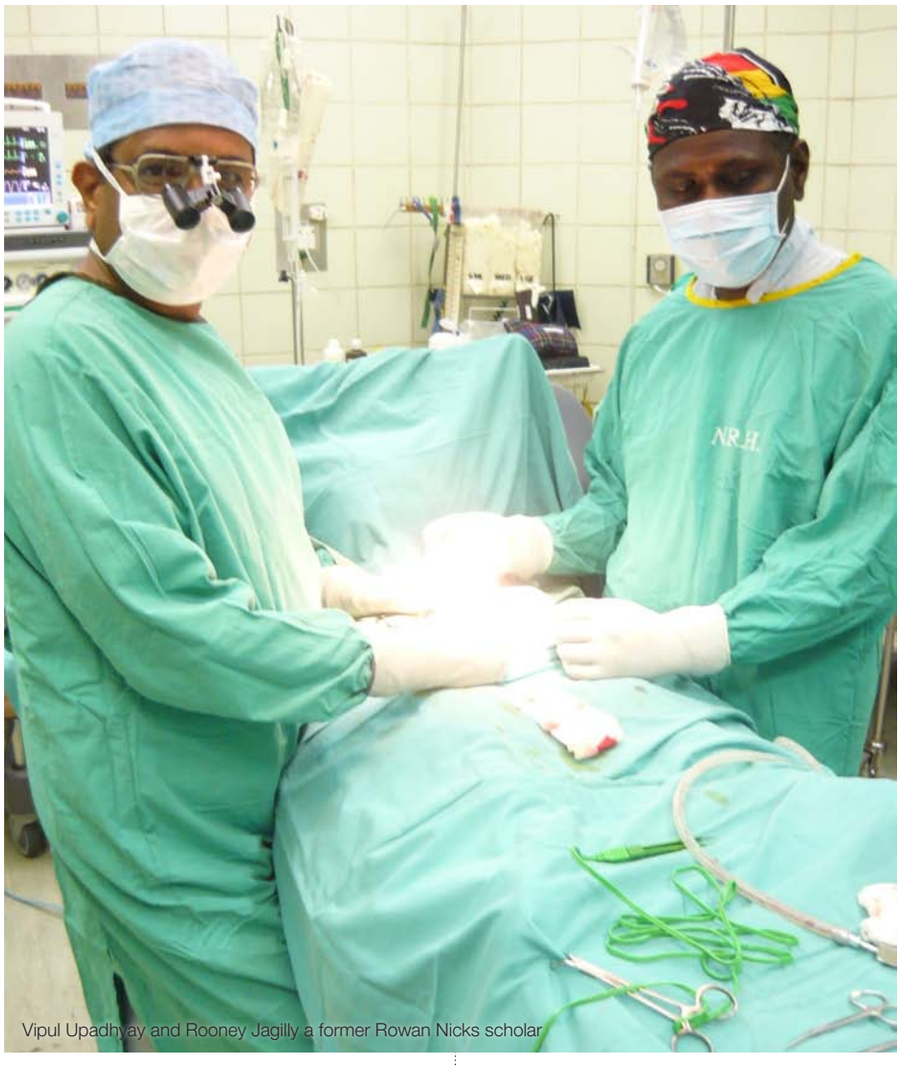
While the staff of the National Referral Hospital in Honiara had already created a list of young patients to be treated by the team, other families, hearing of the visit, travelled for days to Honiara from distant islands in the hope that their children too could be seen by the visiting specialists. According to paediatric surgeon and team leader Mr Vipul Upadhyay all the children brought to the hospital were admitted and treated in turn.

"We found it fascinating that such a call went out and that people went to such great lengths to bring their children into the hospital for treatment. During the seven days of our visit in November we saw everyone who came to see us which meant we examined 40 – 50 children combining outpatients and inpatients and we operated on 13, treating children from as young as few weeks up to 15 years," he said.

Other members of the paediatric surgical team from New Zealand were Ian Chapman, anaesthetist, Ngaire Murray, theatre charge nurse, and Shonagh Dunning, post-operative charge nurse and assistant to Dr Chapman.

The objectives of the visit included conducting outpatients clinics, conducting surgery, transferring paediatric surgical skills to local general surgeons, providing training in paediatric anaesthesia and theatre nursing and post-operative recovery. Mr Upadhyay said that the majority of procedures carried out by the team involved treating urological and gastrointestinal disorders and conducting graft surgery. The local staff had specified what they wished to learn and the procedures they wished to observe.

"The visit was of great benefit because having people around who you normally work with as part of your team (at home) meant we could start work immediately without needing to spend time getting to know each other," he said.



Vipul Upadhyay and Rooney Jagilly a former Rowan Nicks scholar

"From the day we arrived, we began with a ward round and a clinic, recruiting patients suitable for theatre and from Monday to Thursday we operated almost all day leaving Friday free for formal lectures to local staff and a debrief meeting with the hospital management and the AusAID post.

"We also made a point of combining interactive teaching with every surgery conducted over that week."

Mr Upadhyay said that while the National Referral Hospital in Honiara had only limited facilities and equipment suitable for paediatric surgery, the Pacific Island Project Office had provided monitoring equipment and supplies. The team also brought some necessary consumables to support their work.

"Some of the cases allocated for our visit were difficult for the local staff to treat and indeed were challenging for us too. Some surgeries involved new techniques and procedures like free graft transfers and micro surgery with sutures as small as 7/0 which require the use of magnification devices," he said.

The team: Shonagh Dunning, Ian Chapman, Vipul Upadhyay and Ngaire Murray

"Some of these procedures were unfamiliar to some of the local nurses but the surgeons of course were very knowledgeable with the concept of these techniques."

Mr Upadhyay said that while all the surgeries were successful, the highlight of his visit was the great enthusiasm shown by local staff members to learn new techniques and gain new skills.

"The local staff members were extremely eager to learn and grasp everything we said and suggested. They are fantastic people and we built very good relationships and rapport. The local staff were not just passive observers - they told us what they wanted to know, to see, and we did our best to meet those aspirations," he said.

"There was learning and teaching at all times during the stay. The formal lectures and teaching happened on Friday morning but even from our first day we made it a priority to provide a lot of interactive and hands on teaching.

"I helped local surgeon Rooney Jagilly, a previous Rowan Nicks Scholar, undertake a procedure at one point and performed one-on-one teaching during the week. There was also a great deal of interactive teaching and learning between the nurses. Our anaesthetist also taught the local registrars on airway management and caudal anaesthesia and many other areas of interest for them."

The Pacific Islands Project (PIP) is coordinated through the College to provide specialist surgical and medical services to 11 Pacific island nations with the specific aim of improving patient health through the delivery of tertiary health services. Funded through AusAid, the project sends specialty teams to the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

Mr Upadhyay said that while no member of this New Zealand team had been to the Solomon Islands before, such was the success of the visit and the enthusiasm of local staff, plans were now in train for the team to return later this year.

"The most important aspect of an aid program such as the Pacific Islands Project to me is not just treating patients in need but transferring knowledge," he said.

"I have worked in areas in India that are in a comparable situation to the Solomon Islands so I appreciate the need in these countries. I like to contribute something towards helping the children who cannot come to New Zealand for example, to a world –class tertiary health centre.

"I also think that if you transfer some surgical skills to the local surgeons at every opportunity presented, they will then be in a position to treat so many more patients so that for example, the children of such countries as the Solomon Islands will gradually be able to access all the contemporary treatment they may need."

Congratulations on your achievements

Honouring distinguished contributors to medical science

Professor David Storey
Louis Barnett Medal

David Storey is the recipient of the Sir Louis Barnett Medal. It is a singular honour of the College bestowed on persons who have made outstanding contributions to education, training and the advancement of surgery.

The medal was struck in 1990 honouring Sir Louis, who was responsible for the original proposals for creating a New Zealand or Australian Association of Surgeons and for keeping New Zealand in the College despite the communication and political difficulties of the 1930s.

David Wickham Storey grew up in Sydney, and was educated at Sydney Grammar School.

He entered the University of Sydney and having completed a Bachelor of Medical Science, graduated Bachelor of Medicine and Bachelor of Surgery with Honours in 1972. He received the Harry J Clayton Memorial Prize for Medicine.

During medical school, David met and married Kate. When they entered intern year, according to the regulations of the time, they were not allowed to serve at the same hospital and David commenced his lifelong career at Royal Prince Alfred Hospital. Kate moved to Royal North Shore Hospital where she has remained on the staff.

Having performed his surgical training years in Sydney, he received the FRACS in 1979, did further training in the United Kingdom, and was appointed to Royal Prince Alfred Hospital in 1981.

David Storey was a pioneer in endoscopic and upper gastrointestinal surgery and has continuing clinical interests in the nutrition service and in upper GI surgery. He became Director of the parental nutrition service in 1999 and Head of Department of the department of hepato-biliary upper gastrointestinal surgery in 2004.

He served on the NSW State Committee of the College (1994-2000) and was Chair from 1998-2000. David was President of the Royal Prince Alfred Medical Officers Association in 2002-2004, among many other leadership roles. He is Chair of the upper GI – HPB working group of the NSW Cancer Institute.

Professor Storey was the leading advocate for the establishment of the Eastern Collaborative Health, Training and Education Centre (ECHTEC). He has contributed in many academic roles, in education for undergraduates and graduates and as an examiner for the Fellowship examination. He has a deep interest in clinical teaching, the advanced teaching of anatomy, along with interests in history and ethics; he has published and presented widely.

Among others, David has appeared on the television show "RPA" and is famous for giving sensitive medical advice in his judicious style.

David travels frequently both professionally and for leisure and often with his wife as her companion to conferences in her chosen field of Neurology. When time allows he escapes from the city to his bush property at Wollombi.

David Storey, a great contributor, is a truly worthy recipient of the Sir Louis Barnett Medal.

Citation kindly provided by Ian Dickinson

Associate Professor Patrick Bridger
ESR Hughes Medal

Patrick Bridger graduated with Honours from Sydney University in 1960. He gained the FRACS in 1965 and FRCS in 1966. His surgical training was at St. Vincent's Hospital, Sydney and his otolaryngological training was at Guy's Hospital and at the Royal Free Hospital London, where he was a senior registrar.

For 18 months he was a Fellow at Johns Hopkins Hospital, Baltimore. His research on nasal airflow and carcinioma insitu involving the laryngeal mucus gland gained international recognition. In 1970, he received the Ben Shuster Award from the American Academy of Facial Plastic and Reconstructive Surgery.

Patrick provided 36 years of service as visiting Otolaryngologist to Prince of Wales and Bankstown Hospitals. His main interest was the Head and Neck Oncology Unit where he worked with Drs. Smee, Baldwin, and Kwok.

In 1994 Dr. Bridger and Dr.Robert Smee organised the Second World War World Congress on Laryngeal Cancer in Sydney. Almost 900 delegates from 43 countries attended and the Proceedings were published in a book titled "Laryngeal Cancer". The conference and book remain outstanding milestones in the progress of cancer treatment.

Patrick published extensively on laryngeal, ear and nasopharyngeal cancer and sinus melanoma. He was a pioneer in craniofacial resection for paranasal sinus cancer and his article in the US Journal "Head and Neck" 2000 showed unparalleled survival. He developed operations for septal perforations and hereditary nasal telangiectasia.

Professor Bridger has contributed to 54 Australian and 24 international publications and has been a keynote or invited

> *"Professor Bridger has contributed to 54 Australian and 24 international publications and has been a keynote or invited speaker at dozens of international meetings."*

speaker at dozens of international meetings. In 1992, he was RACS Visiting Professor at the Malaysian College of Surgeons meeting in Kuala Lumpur. In 1996, at the forth International Head and Neck Conference in Toronto, Canada he was sponsored by the New York Head and Neck Society to give the keynote address on laryngeal cancer. In 1997, he was visiting Professor at the Memorial Hospital New York. At the fifth International Head and Neck Congress he hosted a "Lunch with the Professor" presentation infratemporal fossa tumours; in 2001, he was examiner at the University of Kebangsaan Malaysia.

Patrick Bridger has been referee for professorial appointments to universities in Singapore, Toronto, Madrid, New York, Malaysia and New Zealand. He is on the editorial board of American Journal "Current Opinion in Otolaryngology and Head and Neck Surgery." For 17 years he was a faculty member at the Vanderbilt University Head and Neck Meeting in Colorado.

Patrick has demonstrated commitment to postgraduate education, conducting many workshops. Three registrars won the Jean Littlejohn award for research under his stewardship and he trained fellows from Indonesia, Papua New Guinea, Malaysia and the USA.

In 2002, Patrick was appointed Conjoint Associate Professor at Prince of Wales Hospital and University of NSW. He has been a senior examiner for the College, President of the Australian Society of Otolaryngology Head and Neck Surgery and inaugural President of the Australian and New Zealand Head and Neck Society.

Dedication to the profession was recognised when in 1995 the University of NSW awarded him M.D.honoris causa.

Professor Bridger is now retired however his son Andrew, also an Otolaryngologist, keeps him informed.

Citation kindly provided by William Coman

The sailing surgeon

Orthopaedic surgeon Andrew Saies and his team won the Tattersall's Cup this year

The media might make a splash about the mega-yachts that take Line Honours as they sail majestically up the Derwent to win the annual Rolex Sydney to Hobart Yacht Race but to yachties it's all about the Tattersall's Cup. That is the victory of their waking dreams, a handicap-based prize that rewards the skill, tactics and teamwork of those in smaller keel boats over the glamour, money and sponsorship of the 60-foot maxis.

This year, the Tattersall's Cup was won by a yacht owned and skippered by orthopaedic surgeon Mr Andrew Saies, his boat, Two True, becoming only the fourth South Australian entry to win the coveted prize in the 65-year history of what is now considered one of the world's greatest ocean races. And the five-day race reads like an boys-own adventure with weather conditions unknown right up to race day, with winds failing leaving yachts to inch their way toward Tasmania only to be then hammered by heavy seas for 12 hours, with daring tactics making a crucial difference and a protest at the end.

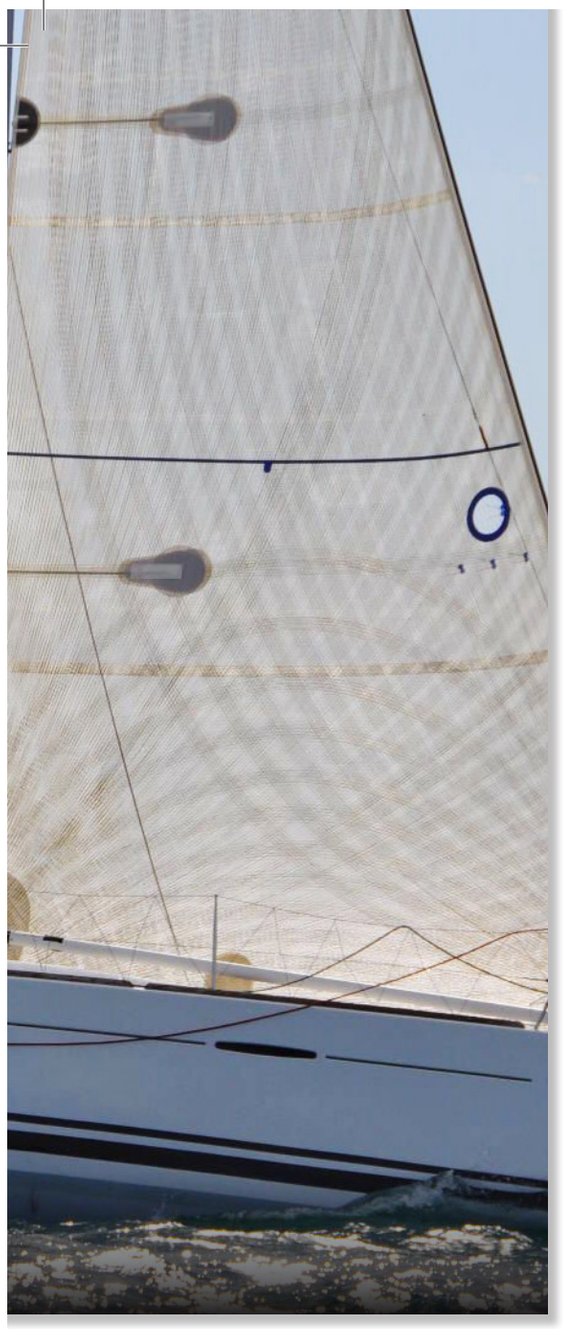
"This race was unusual even to begin with because there was no reliable weather forecast for the duration of the event even right up to Boxing Day where-as in some years you know which boats will get an obvious advantage from particular winds and conditions," Mr Saies said.

"At the start we set ourselves the goal to win our division for boats of a similar size to my Beneteau First 40 but given that we had won our previous ten starts on that boat since I bought it in 2009, we thought if the conditions were right we could win the Cup. Yet to do that we could not just sail off with the flotilla from Sydney Harbour and hope for good luck we had to think strategically."

Mr Saies, who on land is the Managing Director and senior surgeon of Sportsmed South Australia, a private Adelaide orthopaedic hospital, said this involved analysing prevailing currents off the coast of Australia and taking a gamble.

"We knew that about 110 nautical miles off-shore there were strong currents pushing toward Tasmania which, if we could find them, could give us a 25 per cent boost to our usual sailing speed but if we were wrong we would not only lose time getting out there but maybe not even make it to Hobart with the rest of the boats so the stakes were very high.

"We knew how far out was too far out, and how far in was too far in but still the current had to be there and there is never any certainty to this. But we took the chance and thankfully the currents were running and only one or two other boats were out there with us. And while that did give us an advantage, we experienced two or three episodes of very, very light winds where the boats were drifting, even at times going backwards and you have to work extremely



> *"My children are young adults now which frees up weekends for training and competing and I've begun to hand over more of the management of the hospital these days so that I can concentrate more on my two great interests, surgery and sailing."*

hard, use all your skills, to move forward every possible inch.

"Then we met strong winds, a 30 knot southerly off the coast of Tasmania which was unpleasant but not dangerous yet as we made our way down the Derwent, when we knew we were in the lead, then we heard there was a protest relating to the start of the race."

According to Mr Saies, the protest related to a collision between Two True and fellow competitor She's The Culprit in the opening hours of the event as a number of boats converged on one turning mark before making their way out to sea.

It meant that after five exhausting days at sea, Mr Saies and his nine-member crew had to wait an "excruciating" 30 hours to find out if the cup he had dreamt of winning for decades was finally his to hold.

"It was only when we were sailing up the Derwent that we found out a protest was being made but we believed even at the time of the incident that we had taken the right action to avoid a collision and that we had also taken appropriate steps to defend our position," he said.

"The protest committee, as to be expected in such a prestigious event, has very formal procedures to deal with such protests and acts much like a court in that statements are tendered and witnesses questioned which meant it took three hours of hearing to resolve but with the final result coming nearly 30 hours after we finished our race. It was unbelievably stressful for us after all that effort.

"It felt to me like waiting for your Fellowship exam results where you pace outside the Great Hall to hear your number read out. For highly competitive yachties you might only ever get one chance to win the Tattersall's Cup so the waiting was excruciating but then it felt absolutely fantastic when the protest was dismissed and we were awarded the trophy that every Aussie yachty dreams of."

Now Mr Saies has his name etched on the cup that remains in Sydney, a replica to keep, a new Rolex watch, a medallion and is soon, with his crew, to be feted in a civic reception hosted by the Lord Mayor of Adelaide. A member of the Cruising Yacht Club of South Australia, his victory attracted delighted enthusiasm in his home state with staff and patients congratulating him upon his return to work.

Having taken up sailing with his father in his teenage years and competing in his first Sydney to Hobart at age 23 before having to put his nautical ambitions on hold to concentrate on his surgical training, Mr Saies said he thought the time was right, in his 50s, to relive the dream.

"My children are young adults now which frees up weekends for training and competing and I've begun to hand over more of the management of the hospital these days so that I can concentrate more on my two great interests, surgery and sailing," he said.

Mr Saies gave great credit to his crew for the victory that some believe could spark a surge of interest in ocean racing in South Australia.

"Apart from a paid boat manager who also acts as tactician, all the crew are amateurs in that they do it for the love of sailing not a wage and one of the most important elements of winning a race such as this is getting the right group together, people who are good sailors, good at sea for considerable lengths of time and people who are compatible. That takes time but when you get the right team anything is possible and this team are fabulous guys and one fabulous girl."

And the only thing missing from all the glory?

"There was so much stress and drama at the end of the race that I didn't even get to have a beer at the Customs Arms Hotel, the traditional drinking place of yachties, on Constitution Dock," he laughed. That may be the goal for next year."

Continuing Professional Development (CPD)

The CPD online diary has improved significantly for 2010

Michael Grigg
Chair, Professional Standards

Despite the fact that not everyone actually enjoys CPD, well over 90 per cent of Fellows participated in the College CPD program last year with 99 per cent meeting the annual program requirements. This is both noteworthy and praiseworthy. As a professional group we can be proud of this achievement as it provides tangible evidence of our interest in progressing surgical knowledge and skill to the benefit of our patients. From a personal point of view, I am proud to belong to a professional group that demonstrates such a level of commitment. From the College perspective, the level of involvement empowers negotiations undertaken on our behalf.

CPD – more important than ever

It is clear that the vast majority of Fellows have evolved CPD into their professional behaviour but a small minority have not. This small group of surgeons need to carefully consider their behaviour in view of the impending National Registration and Accreditation Scheme for Health Professionals to be introduced on 1 July 2010. It has already been indicated that a compulsory component of registration will be participation in an approved CPD scheme. In New Zealand, Fellows of the College are already required to provide evidence of CPD participation in order to maintain vocational registration with the New Zealand Medical Council. In Australia, attempts by non-compliers to achieve retrospective CPD accreditation when registration as a medical practitioner is not renewed will be difficult if not impossible. This is not intended as a threat but is intended as a warning.

CPD 2010 – 2012

Fellows who are in active practice will have recently received a copy of the CPD program Information Manual for 2010 – 2012. There have been some small but important changes to the Program from the previous CPD triennium. The main changes relate to participation in the Australian and New Zealand Audits of Surgical Mortality and to the annual verification process.

Australian and New Zealand Audit of Surgical Mortality (ANZASM) is currently available in all regions with the exception of New Zealand, the Northern Territory and the Australian Capital Territory. It is expected that ANZASM will be fully bi-national by the conclusion of the 2010 – 2012 CPD Program. The audit has been a significant initiative of the College to increase patient safety by reviewing all deaths that occur during surgical care.

The 2010 – 2012 CPD Program includes a requirement for Fellows to participate in the ANZASM if you are in operative based practice, have a surgical death and an audit of surgical mortality is available in your region.

Verification is crucially important to maintain the credibility and transparency of the College CPD Program and since 2001, 2.5 per cent of Fellows have been randomly selected each year to verify the information contained in their recertification data form/online diary.

From 2010, the number of Fellows randomly selected to verify their CPD information will increase from 2.5 per cent to 3.5 per cent, however verification will focus on only a component of the CPD Program rather than a full 'audit' of an annual return. This change will reduce the burden on those surgeons selected for verification whilst increasing the size of the verification sample.

2009 CPD recertification data forms

Recertification data for 2009 is now being collected and you will have received the 2009 CPD Recertification Data Form in early January.

This form must be returned to the Department of Professional Standards by 31 March 2010. Please contact Camy Podbury, Department of Professional Standards, on +61 3 9249 1282 or email cpd.college@surgeons.org if you require assistance completing your data form.

CPD Online

Data collection for the 2010 CPD Program is available online via the College website www.surgeons.org. Fellows can access a personal CPD Online Diary using a username and password to maintain CPD records in a real time format.

The CPD Online diary has been upgraded for 2010. Both the functionality and the design of the system have been improved. The CPD Online diary is now a more user friendly system and the time required for maintaining the online diary has been significantly reduced.

If you are not already using the online CPD diary, I urge you to try it. I am confident you will find the system much improved – and clearly you will not need to complete the hard copy recertification data form retrospectively. Remember though that you must still retain evidence of your CPD activities in case you are one of the 3.5 per cent of Fellows who are randomly selected for verification.

Fellows using CPD Online for 2009 are requested to finalise their 2009 CPD Online data by 31 March 2010, to enable the issue of the 2009 annual CPD Statement of Participation.

CPD Online training and telephone assistance is available through the Department of Professional Standards on +61 3 9249 1282.

For information about Professinal Development workshops see page 13

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Medico Legal Newsletter

The next meeting will be held on Thursday 6 May at the ASC

The Medico Legal Executive held their fourth and final meeting for 2009 on Thursday 6 November. The Executive has been busily planning a new series of workshops to be offered to Fellows in 2010 based on 'difficult cases' and the (AMA) Australian Medical association 4/5 guidelines. The workshops have been approved by the Professional Development and Standards Board (PDSB) and will be held in Brisbane, Melbourne and Sydney. The evening sessions will include local speakers and facilitators with expertise in interpretation of AMA guides within their jurisdiction. The College will also hold a Writing Reports for Court workshop in Sydney in 2010.

Ted Schutz provided the Executive with a detailed report on the pilot Occupational Medicine site visit held at the Ford Factory in Broadmeadows in October 2009 (see detailed report on this page). The visit was highly successful and generated a substantial degree of interest among surgeons and other medical professionals. In consideration of the interest generated by this visit, another two to three visits will be offered to Fellows next year. Fellows with an interest in Medico Legal matters can also look forward to an innovative and engaging Medico Legal program at the 2010 Annual Scientific Congress (ASC).

While the majority of Section members reside within Australia, there are a number of New Zealand (NZ) members and the Executive has been discussing how to better address the needs of these Fellows. In the next edition of the Medico Legal Newsletter, Michael Sexton (NZ Representative, Medico Legal Committee) will provide a report on what he sees as the issues facing NZ surgeons in the medico legal field and how best we can meet their continuing professional development (CPD). Any comments from Fellows on this topic would be most welcome.

AOA/RACS Joint Medico Legal Meeting. 13–15th November 2009

The joint Medico Legal meeting of Australian Orthopoedic Association and the College took place at the College and the RACV Club from 13th-15th November 2009. The meeting was well attended with 75 participants attending across the three day meeting.

The meeting brought together a variety of speakers including Dr John Coleman (Gastroenterologist), Mr Andrew Keogh (Barrister), Assoc. Prof. Peter Lowthian (Rheumatologist), Judge Frank Saccardo (County Court of Victoria) and Dr Clayton Thomas (Rehabilitation and Pain Management Physician). This multidisciplinary approach ensured a robust and informative meeting which was enjoyed by all. Planning is already underway for the next meeting in 2010 and members will be notified in due course.

Our thanks to the organising committee: Brendan Dooley, Rod Simm, Neil Berry, Tony Buzzard, Drew Dixon, John Hart, Ted Schutz and Kevin Wickham (conference secretariat).

The Colleges' Occupational Medicine For Surgeons – Industry Visit Program.

Ford Assembly Plant

Last October saw the launch of the occupational medicine factory visit program 'Getting Patients Back to Work' in Melbourne. Seventeen Fellows visited the Ford Australia Assembly Plant in Broadmeadows and travelled by 'train' through the plant to view car assembly from the start through to the completion of vehicles as they rolled off the line. 'On foot' we got a closer look at the tasks required to complete the assembly when car bodies descend from overhead conveyor systems onto completed front end, engine and the transmission and rear suspension sections. By following the assembly process, participants were able to observe how a range of injuries could occur and discuss return to work for the workers in each section.

Further visits to factories in Victoria such as an abattoir, steel rolling mill, transport and logistics hub are also being considered. John Upjohn is also investigating a visit to the Metropolitan Fire Brigade training facility.

NSW Coal Mine Training Facility

We are also planning industry site visits in other states such as to the NSW Coal Mine Training Facility near Wollongong, 10 am – 1 pm on Wednesday, 24 March. This state of the art training facility is used to train coal miners and emergency workers from a range of organisations. You will don safety gear and go into what is essentially a real life underground coalmine set up just below ground in order to see first hand the roadways, support structure, machinery and the huge advances in mine safety. The training facility includes a fantastic virtual reality centre. You will be amazed when, although you are standing with your colleagues in the middle of a large dome, you feel alone and in the middle of the 'action' related to the activity being projected. It will be as though you are in the mine. You can also ask the operator to place you anywhere in the mine; on any walkway or

machine...even at the cutting edge.

The College is privileged to have this opportunity to visit the training facility. The visit will take around two and half to three hours and you can have lunch in a restaurant at the top of the Bulli pass or return to your practice. Numbers are limited so get in early and make sure you do not miss out!

Watch this space for more information about upcoming work site visits!

Annual Scientific Congress 2010 - Medico Legal Section

The 2010 Medico Legal program for the ASC is taking shape. Convenor Max Baumwol has brought together a variety of speakers that will ensure this year's program is engaging and informative. Speakers include Capt. Steve Wright, Hon. Chief Justice Martin, Prof Mark Sheridan and Prof Peter Cosman who will give the James Pryor Memorial Lecture.

The Annual General Meeting of the Medico Legal Section will be held on Thursday 6 May at 5:30pm. The conference dinner (held jointly with the Faculty of Pain Medicine) is being held on Friday 7th May at Acqua Viva, overlooking the Swan River.

Call for Members – Medico Legal Executive Committee

The Medico Legal Committee will lose three of its members at the May 2010 meeting with Neil Berry, Malcolm Stuart and Kim Edwards due to retire from the Executive. The College sincerely thanks them for their efforts in driving forward the Medico Legal Section and its activities over the past ten years.

If there are any Fellows or Members of the Medico Legal Section who would like to nominate for a position of the Committee, please email your nomination to the Chair of the Committee Neil Berry nberry@iinet.net.au

Please note all nominations require the support of two Section members. If more nominations are received than positions available, nominees will be put to the Medico Legal committee for vote.

Medicine in Australia: Balancing Employment and Life (MABEL)

This is based on a presentation at the College's' Victorian Annual General Scientific and Fellowship meeting, 23 October, Lorne 2009

Terence Cheng, Research Fellow
Anthony Scott, Professorial Fellow
Melbourne Institute of Applied Economics & Social Research

About MABEL

The MABEL Survey has been funded by the National Health and Medical Research Council (NHMRC) for five years until 2011, and has been endorsed by key medical colleges and organisations, including the College. The strength of MABEL is the longitudinal design, range of questions and strong potential to influence medical workforce policy. MABEL has a Policy Reference Group (PRG) whose members comprise of key stakeholders in the medical workforce policy area. The PRG has been involved from the inception of the survey and meets twice a year.

In 2008, 10,498 doctors responded to Wave 1 of the MABEL survey and Wave 2 (2009) is currently being conducted. The Wave 1 survey was sent to 19,579 specialists and 4,214 specialists registrars, of which 4,311 (22 per cent) and 864 (20.5 per cent) responded. A number of these doctors and other doctors had changed their doctor type and filled out a different version of the survey, which provided 4,596 specialists and 1,072 specialist registrars for analysis. 27.6 per cent of specialists and 38.1 per cent of registrars chose to complete the online version of the survey. The analysis below is based on data from 569 qualified surgeons and 114 surgical registrars, along with 3,675 specialists from other specialties. All data are weighted to provide national estimates.

Characteristics of Surgeons

The descriptive statistics in Table 1 compares surgeons with surgical trainees and specialists from other specialties. Female surgeons constitute 11 per cent of all surgeons compared with 36 per cent for surgical Trainees and 30.6 per cent for other specialists. Surgeons worked an average of 49 hours per week, which is approximately five hours more than their colleagues in other specialties. Overall, surgical Trainees work significantly longer hours, are more likely to do on-call and experienced a higher number of call outs per week compared with qualified specialists. More surgeons provided services in other geographic areas compared with other specialists.

Hours worked & earnings per hour by gender and specialty

As shown in Figure 1 below, on average, female surgeons (47.9 hours) and surgical registrars (65.7 hours) worked roughly similar number of hours per week compared with their male counterparts (49.3 hours and 64.2 hours respectively). The number of hours worked by female and male specialists from other specialties differs considerably. Correspondingly, a lower proportion of female non-surgeon specialists worked more than 50 hours compared with their male colleagues as shown in Figure 2. The hourly earnings of female surgeons are significantly lower relative to the earnings of male surgeons (Figure 3).

Table 1: Characteristics of surgeons, surgical trainees, and other specialists

	Surgeons	Surgical Trainees	Other Specialists
Average age in years	53	33	50
Average hours worked	49.2	64.6	44.3
% Female	10.9%	36.0%	30.6%
% doing on-call	79%	96%	77%
Average number of times called out	1.6	4.6	1.2
Education debt	$2,119	$11,669	$3,051
% who travel to provide services in other geographic areas	43%	–	36%

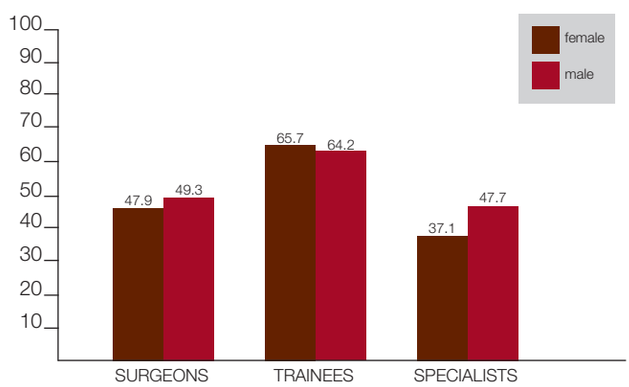


Figure 1: Average hours worked by gender and doctor type

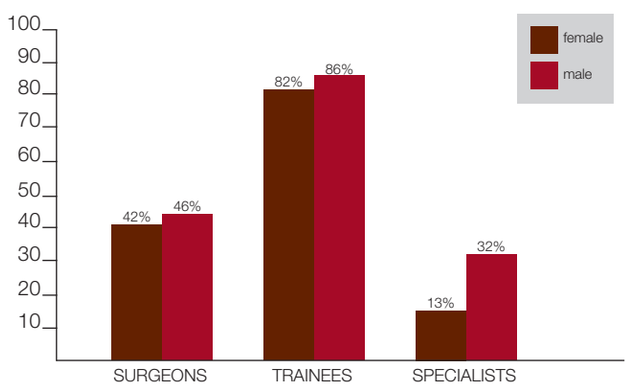


Figure 2: Percent working more than 50 hours per week

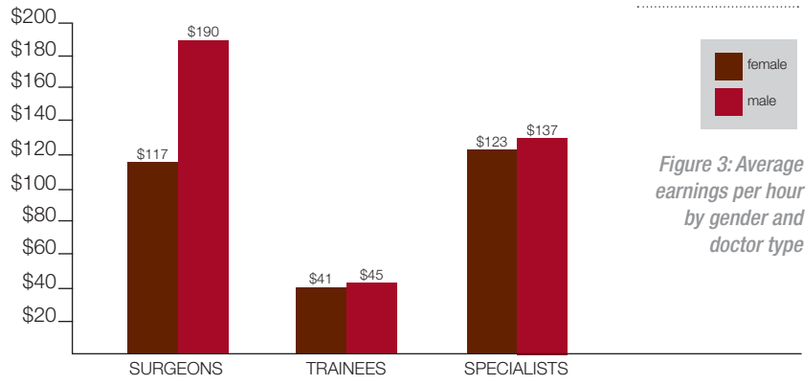


Figure 3: Average earnings per hour by gender and doctor type

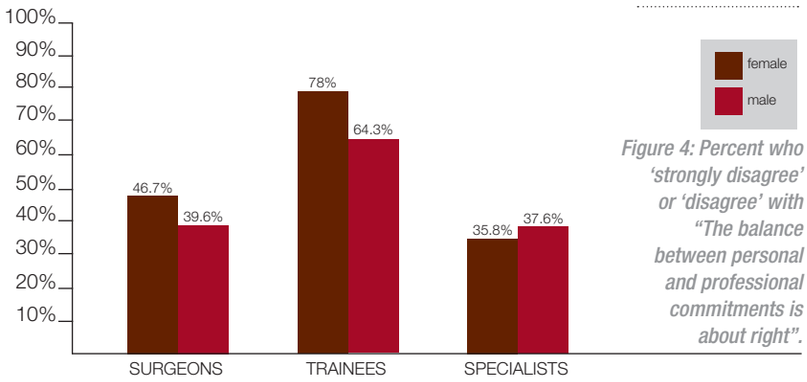


Figure 4: Percent who 'strongly disagree' or 'disagree' with "The balance between personal and professional commitments is about right".

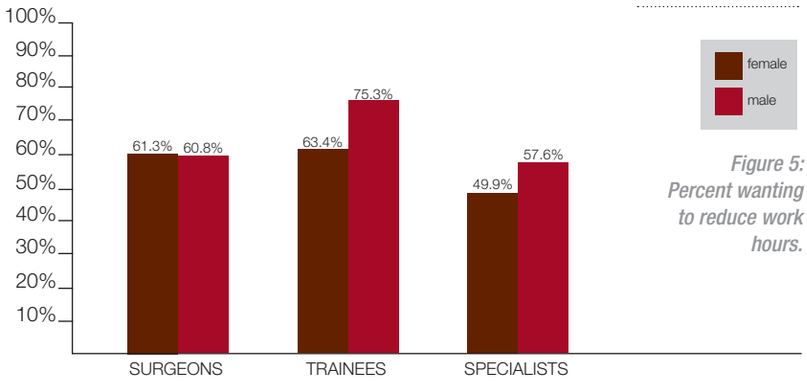


Figure 5: Percent wanting to reduce work hours.

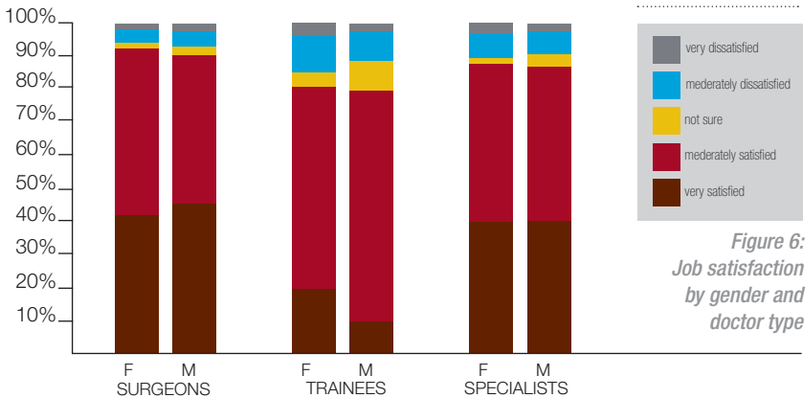


Figure 6: Job satisfaction by gender and doctor type

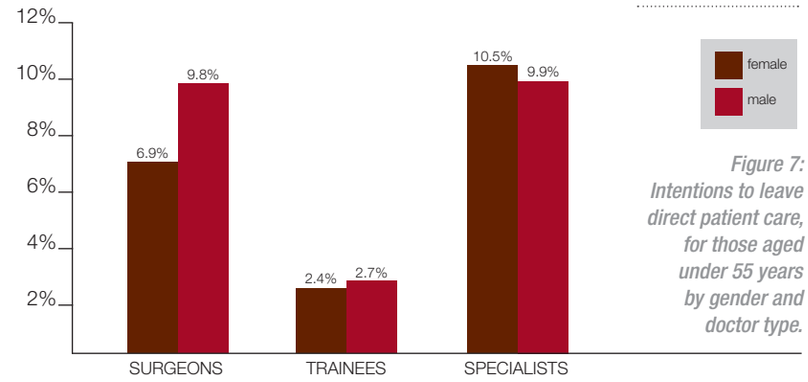


Figure 7: Intentions to leave direct patient care, for those aged under 55 years by gender and doctor type.

> *"The strength of MABEL is the longitudinal design, range of questions and strong potential to influence medical workforce policy."*

Perceptions on work-life balance and job satisfaction

As shown in Figure 4, compared with qualified specialists, a higher proportion of Trainees disagreed that the balance between their personal and professional commitments was about right. Female surgeons and Trainees are also more likely than their male colleagues to share this sentiment. Sixty per cent of surgeons reported that they would like to reduce their hours of work, with few differences between male and female surgeons (Figure 5). Job satisfaction on the other hand is high among surgeons, with more than 90 per cent reporting that they felt very satisfied or moderately satisfied with their jobs (Figure 6). This was higher than other specialists.

Intentions to leave direct patient care

When asked about the likelihood that they will leave direct patient care within the next five years, roughly 10 per cent of male surgeons and seven per cent of female surgeons reported that they were likely to do so (Figure 7). This is slightly lower than other specialists. These figures are for those aged under 55 years, and so we exclude those close to retirement.

Conclusion

The baseline data presented above will provide a solid foundation for examining changes over time in our key outcomes and attitudes to work. The results suggest that although surgeons work longer hours and are more likely to perceive that their work-life balance is 'not right', they are more likely to be satisfied with their jobs and slightly less likely to want to quit compared to other specialists. Further results are available for download from our website www.mabel.org.au. Thank you to those who took the time and effort to participate in the MABEL survey.

ASERNIP-S Review

An independent review of ASERNIP-S compliments its productivity and suggests structural changes

Julian Smith
Chair, Board of Research, Audit & Academic Surgery

In 2009, Council commissioned a review of ASERNIP-S (the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical) activities. This review was independently conducted by Professor Heddy Zola, PhD, FRCPA (Hon), a previous Director of the Child Health Research Institute (CHRI) within the Women's and Children's Hospital in Adelaide. The report was presented, and accepted, at the College Council meeting in October 2009.

ASERNIP-S is part of the Research Audit and Academic Surgery Division of the College. In the past, larger and longer term grants have enabled considerable growth. More recently some of these have been shorter term and thus less reliable funding streams. Such inconsistent funding is an ongoing issue for all research institutions. College Council wished to determine whether any improvements could be made to the ASERNIP-S structure that would better suit the current environment.

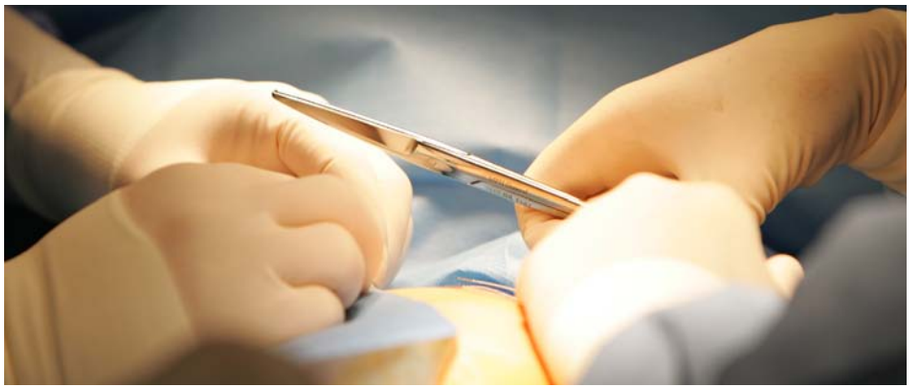
The key areas for review were:

1. To assess the outputs, importance and successes of the ASERNIP-S program internationally by looking at publications, contract/grant successes and novelty areas of endeavour.

2. Impact on the Australian Healthcare community, especially relating to Health Technology Assessment processes such as systematic reviews and horizon scanning.

3. Appropriateness of the current or other structures ie. free standing structure, under university structure or continue as a College subsidiary.

In terms of its outputs, Professor Zola analysed ASERNIP-S publications using standard bibliometric techniques, for quantity, quality and availability of literature published in peer-reviewed journals and elsewhere. The publications were found to achieve a high impact nationally and internationally. As a consequence this provides a high visibility among surgeons and others who in turn cite ASERNIP-S publications. The available data in terms of the Australian healthcare community suggests that ASERNIP-S is valued within hospitals. Additionally, its website is used extensively, and access frequency data compares well with other similar organisations. Professor Zola surmised that, as a result of the high quality of the AERNIP-S products and impact, government agencies recognise ASERNIP-S as being an appropriate organisation to commission work in the area of evidence-based medicine.



An important aspect of the review related to the structure of ASERNIP-S, including mechanisms of financial management. Professor Zola did not recommend that ASERNIP-S become a free-standing structure such as an institute. He said that institutes often tend to struggle financially, remaining small and focussed. Additionally State and Commonwealth governments may be less inclined to put work through institutes such as this.

As an alternative to becoming an independent institute, ASERNIP-S could benefit financially by becoming associated with a University. Becoming a wholly University-controlled unit would have many benefits but would risk ASERNIP-S becoming vulnerable to changes in University senior leaders, policy and support. A better option would be to become a separate but affiliated body within the University. This would allow ASERNIP-S access to some of the potential advantages of University association, but without University control. ASERNIP-S would gain through infrastructure support associated with grants, and the University would gain by counting ASERNIP-S's research in its activity returns.

Professor Zola also suggested considering that ASERNIP-S operates as a more independent entity within the College, similar to that of the structure adopted by the Royal College of Pathologists of Australia for its Quality Assurance Program (QAP). The College of Pathologists QAP is a separate Company, with College representation on the Board. Their activities are all run by Fellows of the College, so there is a real degree of 'ownership'. However, it operates as an independent entity and retains surpluses for re-investment in its work while making a 'donation' to the College. There are significant differences to ASERNIP-S in that the QAP is a fee-for-service program, however, there are parallels which are worth exploring.

Overall, Professor Zola concluded that it is beneficial for the College to have an independent research unit such as ASERNIP-S within its sphere. ASERNIP-S plays an important role in translating research evidence and making it relevant to surgeons, healthcare providers and consumers. The suggestions for improving the structure of ASERNIP-S shall be considered by Council over the next few months.

For further information please contact Professor Julian Smith or Dr Wendy Babidge at ASERNIP-S by phone +61 8 8363 7513 or email asernips@surgeons.org

The Francis and Phyllis Thornell-Shore Memorial Scholarship

Understanding the novel risk factors in the development of arterial disease

With the incidence of diabetes now reaching almost epidemic proportions in Australia, a research project investigating the mechanisms involved and the severity of arterial disease in insulin resistant states undertaken by vascular surgery Trainee Dr Michael Wu attracted considerable financial support over the three years of its duration.

Since he began work upon this PhD thesis, Dr Wu has been granted the RACS Foundation Research Scholarship, the National Health and Medical Research Council Medical Post-Graduate Training Scholarship and the College's Francis and Phyllis-Thornell Shore Memorial Scholarship for 2009.

Dr Wu, who this month returned to his vascular surgery training at Geelong Hospital, said one of the central aims of the research project was to understand the novel risk factors of oxidative stress, endothelial dysfunction and arterial stiffness in the development of arterial disease and how they are affected as individuals move across the continuum from normal blood sugar control through insulin resistance and finally to type two diabetes."

Working out of the Monash University Southern Clinical School, Dr Wu recruited three groups of people for his study: subjects with normal blood glucose levels; subjects with pre-diabetes and patients with a documented history of type two diabetes.

"What we wanted to understand is how diabetes and pre-diabetes affects blood vessels and when that effect starts to occur. After recruiting more than 120 patients and conducting both non-invasive ultrasound-based tests, analysing blood and urine specimens and performing gluteal skin biopsies under local anaesthetic, we have found that the control of blood glucose may be more important in terms of vascular disease than insulin resistance, even in the pre-diabetic stage," he said.

"This in turn means that interventions to lower blood glucose towards normal levels can delay vascular changes and make an enormous difference in limiting the effects of cardiovascular disease associated with diabetes."

Michael Wu monitoring a patient

"There are so many mediators out there which connect vascular disease and diabetes. We also investigated the role of a novel protein, activin A, which was associated with blood pressure and cardiovascular risk in our study groups. By understanding how activin A is involved in diabetes and pre-diabetes, we hope to develop a new target for monitoring or treating vascular disease."

Dr Wu said that while he had not yet finalised his PhD thesis, interim results were presented at the High Blood Pressure Research Council of Australia Annual Scientific Meeting in 2008 and was later awarded joint winner in the Endocrinology section of the Southern Health Research Week in 2009.

Explaining the different roles of glucose and insulin, the paper was titled "Hyperglycaemia rather than Hyperinsulinaemia is implicated in Arterial Stiffness and Endothelial Dysfunction in Type 2 Diabetes Mellitus". Other interim results were also presented at the Australian and New Zealand Society for Vascular Surgery (ANZSVS) Meeting in 2009.

Dr Wu worked on his PhD thesis under the supervision of Professor James Cameron from Monash University and Dr Sophia Zoungas, Research Fellow at the George Institute for International Health.

He said he undertook the research project not only to learn basic science research skills in the laboratory but so that he had a better understanding of the patients he was and would be treating over the course of his career in vascular surgery.

"Obviously vascular surgeons see a lot of patients with diabetes and pre-diabetes so I felt that the more I understood about this disease the better. I also wanted to experience basic science research and I found it particularly interesting designing and performing experiments that could shed light on the problem under investigation," he said.

"Also the aspect of this project that I found particularly appealing was the combination of clinical and basic science; taking what we learn from the laboratory and applying this to patient care and vice versa."

He said he was extremely grateful to the College for all the financial support made available to him over the past three years and said papers on his findings for medical journals were now being finalised.

The Francis and Phyllis Thornell- Shore Memorial Scholarship

was established in recognition of Mr Francis Thornell-Shore who left the bulk of his estate for the establishment of a trust to promote medical research and has an annual value of $60,000.

History of Medicine Cruise in the Eastern

Most major surgical advances are the result of armed conflicts

Below: Route of the 2009 cruise

Peter Burke is a general surgeon in Victoria's Latrobe Valley. Inspired by Professor Ken Russell's undergraduate lectures at the University of Melbourne, he developed an interest in the history of medicine which has led to involvement in the College archives and collections over the years since 1979. Currently editor in Surgical History for the Australia & New Zealand Journal of Surgery, Peter holds the Diploma in the History of Medicine of the Worshipful Society of Apothecaries of London and was invited to participate as a lecturer on this History of Medicine Cruise

Peter Burke
Victorian Fellow

After leaving Rome, the first visit was to the site of Olympia and its museum: the scene had been set with lectures prior to this, including, "The History of Medicine in the Mediterranean and Black Sea" and "Health, Sport and Medicine in Ancient Greece". The ruins of Olympia are expansive, and it was interesting to note that this was not a "regular" village, but a holy place: only priests were allowed to live in the city, even the privileged classes were restricted within the complex.

The next port in Greece led to the site of Epidaurus, thought to be the birth place of Aesclepius, God of healing: now a World Heritage site, Epidaurus was known throughout the Hellenistic world for its medical facilities and healing treatments and was dedicated to Aesclepius. Today most of the structures have been reduced to their foundations with one exception, the remarkable theatre. seating 14,000 spectators; it is one of the best preserved in Greece.

In the Epidaurus Museum, bronze medical and surgical instruments from the 4th c. BC attracted a lot of interest and comment from the touring group, the instruments, although basic, could easily be recognised to include scalpels, curettes and fistula probes.

The cruise then progressed towards Turkey, and traversed the Dardanelles, and it was then that the two surgical lecturers, Peter Burke and Mick Crumplin, gave papers on "Gallipoli- An Australian Perspective" and "The Dardanelles – Military and Medicine", respectively.

The 38 mile long Dardanelles Strait, linking the Aegean Sea to the Sea of Marmara, has often been the focus of dispute, and these historical features were well amplified: Peter, in particular, concentrated his presentation for his English audience, on the events surrounding the Gallipoli Campaign, probably one of the smallest battle grounds in modern history; its furthest point inland from the sea being one kilometre and approximately two kilometres along the sea front.

All medical and surgical aspects were covered, and details were provided regarding the First Australian Casualty Clearing Station, which included seven doctors; this unit landing at Anzac Cove on April 25, 1915, and remaining on a twenty metre stretch of beach for the eight months of the Gallipoli Campaign: problems not only included evacuation of wounded and triaging of injured men, but also the non-battle casualties, where it was noted that 80 per cent of men at Gallipoli suffered with dysentery: the unit itself suffered 15 per cent casualties, being constantly exposed to gunfire.

The cruise proceeded to Istanbul, the largest city in Turkey, and it was extraordinary in these troubled times of Islamic extremist activities, to enter a country where over 98 per cent of the population is Muslim. However, Turkey is a secular state and Islam is not the official state religion. From a medical point of view the travelling group's interest was to cross the Bosphorus Bridge into Asia to visit the old Barrack Hospital at Scutari, which is now the Selimiye Barracks of the Turkish First Army Group. Security, on entering the base, was indeed high but access was granted to part of the former hospital, where Florence Nightingale attended to the wounded British from the Crimean War. Thousands of troops were nursed in appalling conditions along the many kilometres of corridor, having been transported by sea from Sevastopol, via the harbour at Balaklava, in harrowing conditions, to Scutari, a distance of some 300 miles.

Although Florence Nightingale remains one of the great icons of the Victorian age, her ignorance of hygiene seems almost willful in hindsight. It is now considered that the death rates at her hospital were double those of smaller regimental hospitals, and ten times more soldiers died from illness than from their wounds.

The cruise continued on to Russia and visited Sochi, and it was a revelation to see the Mediterranean- type features of this, one of Russia's best known resorts on the Black Sea: not only was the weather conducive to healing but also the "Matsesta", which means "fiery water", obtained from the hot sulphur springs and utilised in various

Mediterranean and the Black Sea

Below: Scene from "The Panarama" Defence of Sevastopol

forms of hydrotherapy at the sanatorium.

The cruise then docked at Batumi, in Georgia, and Peter presented a major lecture on "Wine as Medicine" detailing the history of wine as a medicinal agent through the millennia, particularly concentrating on its antiseptic value as a wound dressing and, more recently, with its anti-oxidant benefits. The topic was choosen at this point in the journey as the oldest pips of cultivated vines, so far discovered and carbon-dated, were found in Soviet Georgia and belonged to the period 7000-5000 BC.

The next major port visited was Sevastopol in the Ukraine and here the group was driven to the top of Sapun Hill to the site where Lord Raglan observed the battle, including the infamous Charge of the Light Brigade. It was from here that Mick Crumplin, former chair of the Court of Examiners at the Royal College of Surgeons of England, came into his own. Many College Fellows would recall his contributions to the Surgical History Section at the last Perth Annual Scientific Congress. An expert on military history, his scholarly dissertations on the battles of Sevastopol and Inkerman were most enlightening: the afternoon in Sevastopol included a visit to "The Panorama" Defence of Sevastopol 1854-1855. The building, in the shape of a rotunda, houses the "Panorama" a mammoth work of battlefield art and an historical-artistic monument to the heroism of those who defended the city during the Eastern (Crimean) War between the Russian Empire and the Allied Coalition of Great Britain, France, Turkey and Sardinia: it is extraordinary to think that only forty years earlier the French and English had been engaged in mortal combat at Waterloo!

It has been truly said that most major surgical advances are the result of armed conflicts; the management of casualties, at least, improved dramatically over the sixty years between the Crimean War and the activities on the Gallipoli Peninsula.

The concept of an Islamic secular state such as Turkey, also provided amazing insights, and the city of Istanbul, with many tourist attractions and a population approaching 16 million people, along with 18 universities, was a revelation. It must never be forgotten that the founder of modern Turkey, Mustapha Kemal Ataturk, rose through the ranks of military school, to be appointed commander of the Gallipoli Campaign and subsequently, through extraordinary personal reforms, founded modern Turkey, being elected President, first in 1927, and with his skill in negotiating treaties, retaining most of the Turkish land mass following defeat in World War 1.

Not a day of the cruise did not present an opportunity to discuss many and varied topics relating to medical history, with fascinating insights from the almost fifty member group of medical/paramedical persons who participated in this memorable cruise.

If the reader has any comment or query please email Peter at surgeon444@bigpond.com.

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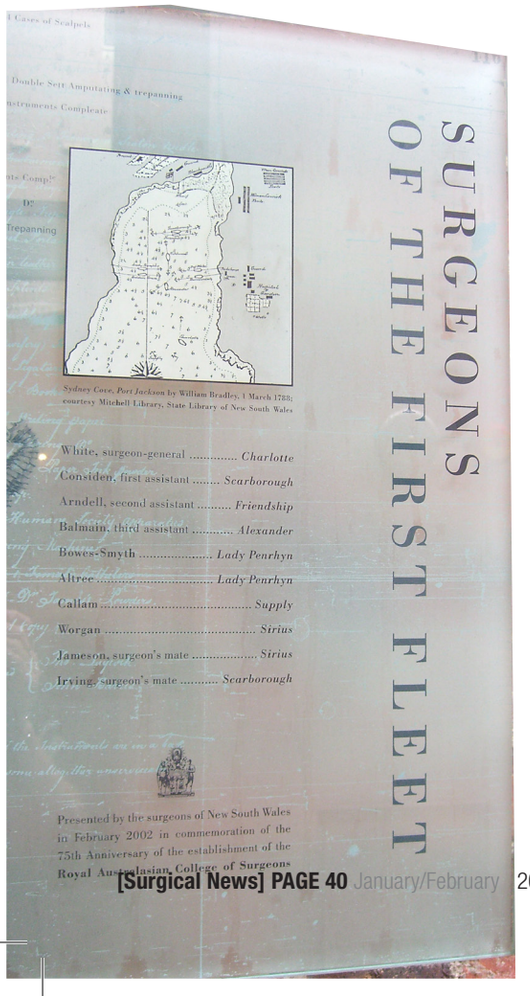
Surgeons of the First Fleet

A commemorative plaque was dedicated to the surgeons of the First Fleet in 2002

Felix Belian
Victorian Fellow

I was in Sydney recently for the College and Hospital Administrators meeting, when my cousin Jan suggested to my wife that we visit the button shop at Circular Quay (why on earth a button shop at the Rocks? – but even Margaret my assistant in this preparation expressed interest). I subsequently realised that we as surgeons have used buttons in the past, particular in hand surgery for flexor tendon repairs before the Kleinert invasion of dynamic reconstruction.



Following this haberdashery diversion, I noticed in a neighbouring shop a word which brought me to a standstill. The letters MOHS enshrined in a large frame occupied a prominent position in a cosmetic store that catered for everything from artificial nails to makeovers. My curiosity (a feline characteristic) impelled me to inquire how MOHS surgery would be involved here, as historically anything is possible in Sydney. As you may know, MOHS surgery uses serial excision and histological examination to achieve tumour clearance of the integument. Originally this was also referred to as chemosurgery, as a mixture of chemical compounds was used to create eschar with necrosis followed by histological examination. Here it simply was an acronym for Mary O'Halloran's Store (MOHS).

Nurses Walk

Meandering along, our progress led us to the Nurses Walk and the wall plaque presented by the Sydney Cove Redevelopment Authority was an interesting snippet. Quoting from that nurses' plaque the first nurses were drawn from the convicts and received no pay. Lucy Osborn was the first Lady Superintendent of Nursing at the hospital from 1868-1884. When Sir Henry Parkes (Colonial Treasurer of NSW) appealed to Florence Nightingale for trained staff for the Sydney Infirmary in Macquarie Street, she was selected and appointed Lady Superintendent (Micky Pohl my colleague said Bruce Connolly would love these vignettes). The title of superintendent was used for males and females and came from the First Fleet, where the Surgeon Superintendent had significant powers in organising people, looking after their welfare and preventing disease. Some say they had more power than the Captain. She was accompanied by five other trained nurses from the Nightingale School of Nursing of St Thomas's in London and successfully established nursing as a profession in Australia (see Lucy Osborn plaque).

My next discovery in the Surgeons Court was a commemorative plaque dedicated to the surgeons of the First Fleet. This was presented by the surgeons of NSW in February 2002 to commemorate the 75th anniversary of the opening of the College in March 1935.

I read from this plaque in February 1778, less than a month after the founding of the colony of NSW on 26 January, Captain Arthur Phillip authorised the building of the first hospital on this site. The original hospital was initiated by the principal surgeon, John White, and was completed by twelve convict carpenters. The initial building could accommodate at least 60 patients. In 1790 the Second Fleet arrived with a pre-fabricated Moveable Hospital which increased the hospital capacity to 488 patients, although 100 tents were also erected around the periphery to accommodate more patients. It arrived with the Second Fleet and was designed by Samuel Wyatt.

It was almost 100 feet by 20 plus feet wide with a copper roof with wooden panelling breaking down to 602 pieces individually with copper fittings and screw pins. It was delivered to a ship on the Thames for £690 (now modern hospitals cost $1-2 billion, as we all know) for transport to the colonies.

Later a hospital store and dispensary were added and the hospital grounds covered two acres. In 1816 the hospital was moved to the present Macquarie Street site and the land taken over by a group of individuals who established dwellings and businesses there. The Rocks area rapidly became a bustling commercial area with a number of pubs, one even called Fortune of War, profiting by the proximity to Sydney Cove and the maritime trade.

As the plaque commemorates the opening of the 75th anniversary of the College in Melbourne, by Sir Darcy Power's and his commentaries on this occasion are worth recalling. Surgery came to Australia possibly from the English, Scottish and Irish medical schools, the graduates usually being the sons of wealthy men graduating particularly from Edinburgh University. This well-equipped medical school providing teachers with a world-wide reputation. Sir Darcy described the English and Irish medical schools as well regulated institutions also. The British Registration Act of 1858 made

Surgeons Court at the Rocks

A wall mural on a Victorian building off Circular Quay

it possible to distinguish between registered practitioners and medical quacks.

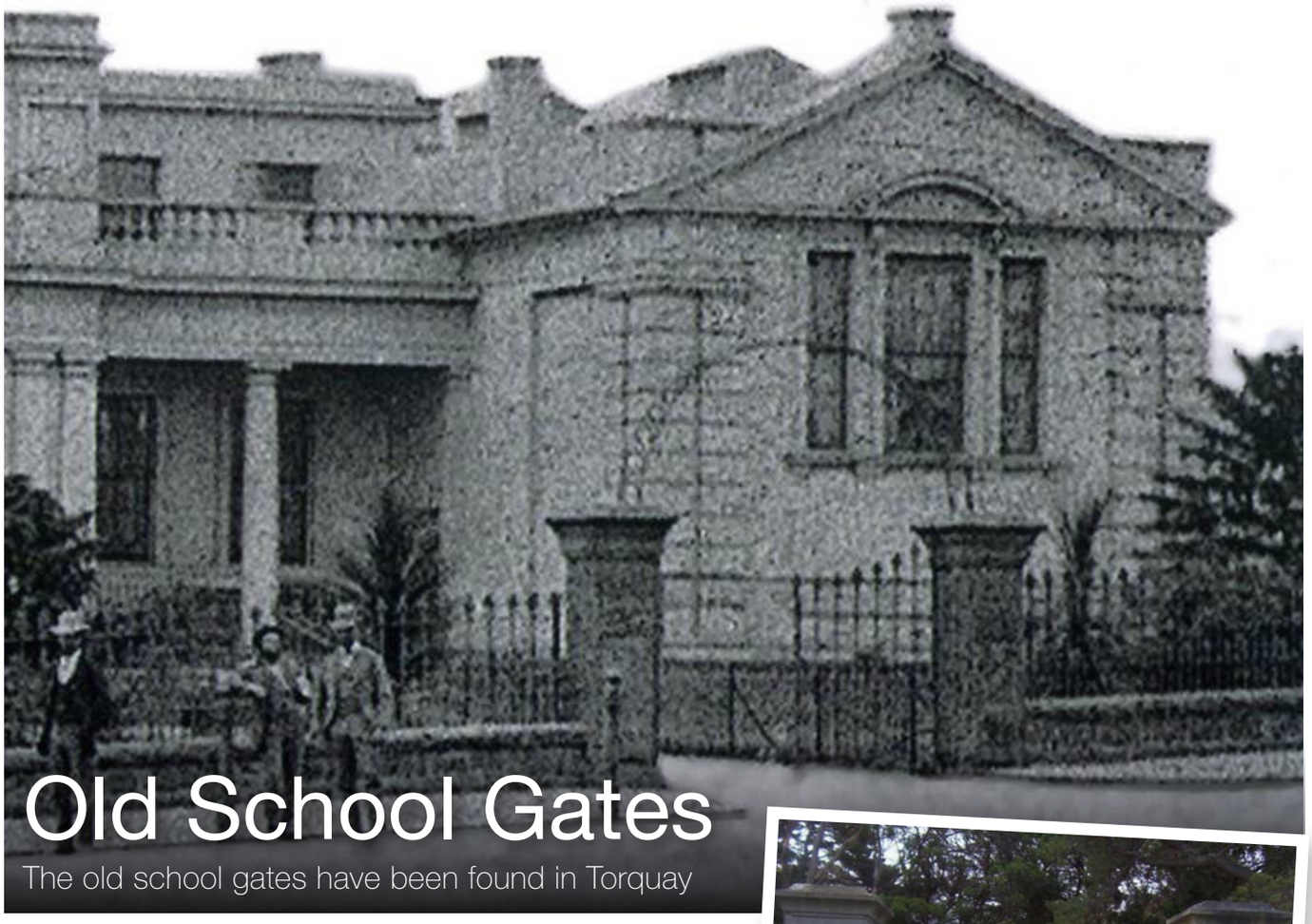
The earliest doctors here were army surgeons attached to the regiments. Midwifery was universally practised by all, with every practitioner an expert obstetrician.

It is also interesting to note that no law existed to prevent any person, medically educated or otherwise, from using a medical title to enable him to practise any branch of the healing art. Sir Darcy goes on to quote that that working side by side with doctors were hordes of quacks "as impudent as they were ignorant". The druggist or farrier might perform the duties of a physician and the butcher or the barber those of a surgeon. It had taken 300 years in England to establish medical governing bodies and councils of medical practice, but this was achieved in Australia in a single generation.

A Medical Act was passed in 1864 to exert some control over the fraudsters, who used many subterfuges to attempt to get on the Medical Register. Just as today forgeries are commonly purveyed on the Internet, forged diplomas and licences from non-existent universities were in evidence. Even an M.D. from the Paris University, which had the highest standards in Europe, was commonly forged - the documents were usually "lost in transit" and the applicants had forgotten all their French diction.

The medical school of the University of Melbourne opened in 1866. However Sir Darcy states that the Royal Melbourne Hospital retarded rather than accelerated the progress of surgery in Melbourne. It was incorporated in 1865, retaining some of the characteristics of older European hospitals, but here is the punch; it was supported by subscribers, who paid a guinea and were entitled to vote on the election of staff. There was therefore no security of tenure and abuse crept in. It happened from time to time that the best choice was not always made and sometimes surgery in the hospital was not of the highest order, with clinical teaching suffering. When medical education was undertaken no provisions were made for a Professor of Surgery to have charge of the beds status in the hospital. Gordon Clunie reversed this in the 1990's typical in the Edinburgh fashion where the surgeons were in control of beds and teaching.

On departing the Surgeons Court I came upon a commissioned mural painting of the rocks areas, which says a lot for the art of drawing in a perspective manner by an expert in his craft, like we as surgeons think we are.



Old School Gates

The old school gates have been found in Torquay

Keith Mutimer
Honary Treasurer

When the Old Model School was built in 1854, it was set in grounds and surrounded by an iron picket fence, as was the custom in those days. This fence was made in England and brought to the Colony by sailing ship. The grounds were accessed through three sets of gates. The main gates faced Albert Street, and were used by school and education system administration staff, and by important visitors. The back gates were on Victoria Parade, and this entrance would have been used by the girl pupils, while the boys' entrance was on Spring Street. The teachers would also have used these entrances, according to the social hierarchies of the time.

Several old photographs of the School clearly show the iron fence and the main gates. However, there seems to be no photographic record of the Spring Street gates, although they are marked on old maps and plans.

When the School was demolished in 1933 to make way for the College, the fence and gates were also removed. This was the fate of many of the iron fences of Melbourne during this period, including those around the Carlton Gardens and the University of Melbourne. They were not, as is sometimes believed, melted down to make Spitfires during World War II - they simply became victims of fashion.

The demolition contract was let to J. Taylor & Sons Pty Ltd, who thought so highly of this job that they produced a catalogue of the bits they had salvaged. Of the fence, the iron pickets were taken away for scrap, but the capstones, into which the pickets were fitted, were turned on edge and recycled as edging stones. They still surround the College gardens today.

The gates on the other hand were taken away completely. It was known that they had been taken south, to a park in one of the towns along the surf coast. The search for them was undertaken by Donald Murphy. As a resident of Geelong he had an excellent opportunity to look for these relics of the Old School.

After a little hunting Donald tracked the gates down in Torquay, where they stand as ceremonial entrances to Taylor Park, a large public open space of about 14Ha in the middle of the town, managed by the Great Ocean Road Coast Committee. The park was created in the mid-1930s as a civic gesture by the sons of J.W. Taylor, who wanted it also to be a memorial. The old School gates were set up on the seaside entrances, and a plaque was placed on one of the pillars. They are now showing the signs of age and weather. The gates themselves are permanently closed, and people walk around them. The great iron bows which once carried oil lamps above the gates have disappeared, and the rods of the old Albert Street gates have lost their finials. The old Victoria Parade gates are also missing some decorative pieces. There is no interpretative signage explaining the origin of the gates. But even though they are now in a poor state (like Taylor park itself), it is good to know that these important witnesses of the past have survived, and one day may be returned to their former glory.

Written by Geoff Down, College Curator

In Memoriam

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:

Edward Allcock, **New South Wales**
Peter Anderson, **Western Australia**
Patrick Boulter, **United Kingdom**
David Conroy, **Victoria**
Henry Eastcott, **United Kingdom**
William Etheridge, **Victoria**
Irwin Faris, **New Zealand**
Peter Grant, **Queensland**
Ka Woo Leung, **Hong Kong**
Francis Smyth, **Queensland**

We would like to notify readers that it is not the practice of Surgical News to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website www.surgeons.org 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
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Homestay Accommodation for Visiting Scholars

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

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

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

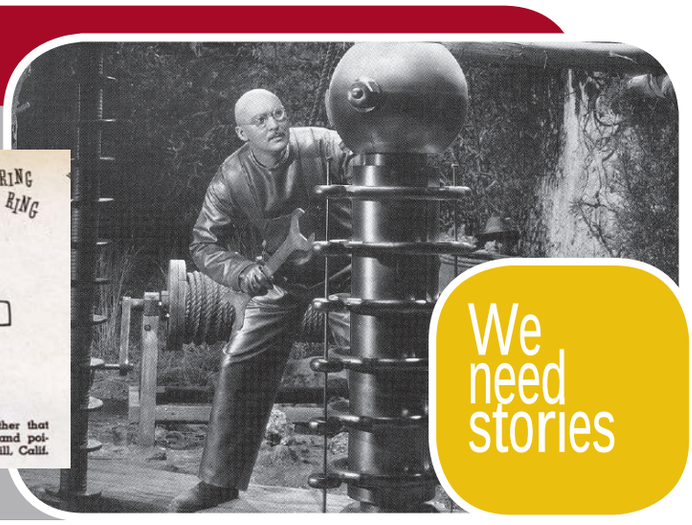
International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring St, Melbourne Victoria 3000, Australia
T: + 61 3 9249 1211
F: + 61 3 9249 1236
E: international.scholarships@surgeons.org

Inventors stories wanted!

If you or someone you know has invented the self retaining abdominal retractor or something like that we would like to hear from you. It can be a successful or not so successful invention in surgery. We are interested in the ideas.

T: +61 3 9276 7430
E: surgical.news@surgeons.org

CUPBOARD ALARM to warn Mother that the children are near the drugs and poisons. Ernest W. Taylor, Morgan Hill, Calif.



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