Surgical news

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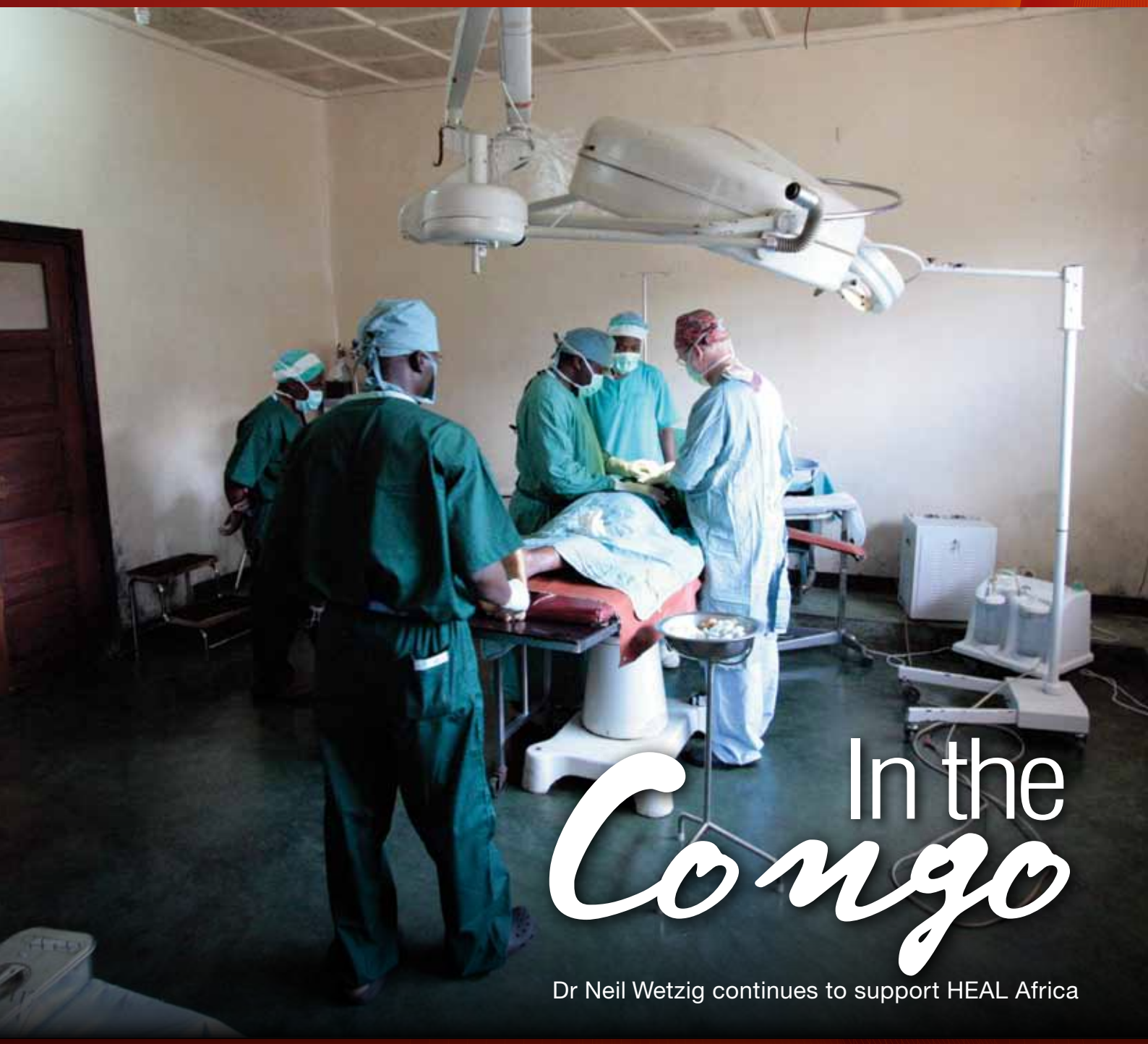
THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



In the Congo

Dr Neil Wetzig continues to support HEAL Africa

The College of Surgeons of
Australia and New Zealand

ON THE COVER: Brisbane General Surgeon, Dr Neil Wetzig continues to be fulfilled by his latest trip to the Democratic Republic of Congo

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A time for community

As disaster surrounds us, it is a good time to look at our role as surgeons

Working together: College President Ian Civil with John Kolbe, President of the RACP and Raymond Leung President of the Hong Kong Academy of Medicine.

Ian Civil
President

This is being written as the floodwaters around Brisbane are starting to recede and the devastation and need for months if not years of re-building is becoming even more apparent.

At the same time as the Queensland disaster is unfolding, flash floods are occurring in Victoria, bush fires have been raging in Western Australia and New Zealand is still coming to terms with two recent natural disasters.

The earthquake that affected Christchurch in September last year destroyed much infrastructure although fortunately few lives were lost. However, the mine-blast at Pike River in New Zealand has overwhelmed the local community with loss of loved ones and a way of life.

Is there something about the New Year that provides us the opportunity to reflect not only on the achievements of the year just gone, the enthusiasm for the days to come, but also our grip on life where nature in her ferocity can literally wrench all away from us?

This is the time of year where cyclones, tsunamis, floods, droughts and bush-fires always seem to be focusing our mind. We may look back to the Cyclone Tracy events in Darwin or the Indian Ocean Tsunami of 2004 for events of enormous magnitude occurring at this time of the year and the annual cycle of natural disasters lingers with us all.

To all the people who now have to re-build their lives, we extend not only our sympathy, but also our support in whatever way we can.

"Is there something about the New Year that provides us the opportunity to reflect …on our grip on life where nature in her ferocity can literally wrench all away from us?"

Although from a smaller perspective, these events also make us reflect on our commitments and skills as surgeons. All of us have had training in trauma and emergency care. Many of us are still involved with the active assessment and treatment of the critically injured. It is these skills in which the College has provided training and ongoing education for many years.

Based on the ATLS® program of the American College of Surgeons, our EMST course is an essential component of our training and also recognised by many other professional bodies. Keeping our skills current and our ability to be "trauma ready" is something the College fully supports.

Importantly, we are also an ongoing conduit to government of information about who is "trauma ready" and prepared to help. None of these natural disasters are predictable and the urgent services are provided at the National or State Government level where infrastructure can be mobilised promptly.

The College continues to liaise with the offices of the Chief Medical Officers and also the military to ensure that surgical skills have been identified, trained, skills maintained and are available no matter where or when the disaster.

Our response to disasters is something that reflects fully on our commitment as surgeons and professionals. Over the past few months I have had cause to reflect a lot on what the public would view as our critical requirements as professionals.

The Honourable Geoff Davies AO who has now retired from our Council as the Expert Community Advisor has challenged all of us with his view that we have much to do to achieve these requirements. Over the next twelve months, I hope to explore these issues more fully.

The paper that he presented at the Annual Scientific Meeting of the Australian Orthopaedic Association in October, 2010, will be printed in a future edition of the ANZ Journal of Surgery. In that presentation he challenged us that although individual surgeons do outstanding work to support various communities and their needs, that as a collective, surgeons may not be perceived as responding to these issues.

How do we ensure that communities of need are identified, their service requirements understood and the health needs of all of our patients are at the fore-front of our requirements? He has left Council with a stinging message that we must do more to truly deliver for the community if we wish to retain the privileges of professionals.

I welcome you all to the New Year and extend my best wishes. In 2011 we are challenged not only by the magnitude of nature's devastation, but also the requirements of our role as surgeons, as professionals, and in support of the community in which we live and work.

The College and the year ahead

With more state elections and one in New Zealand, the College continues to advocate for Fellows while also working on promoting the FRACS brand.

Keith Mutimer
Vice President

I hope that all Fellows managed to find time to enjoy the festive season and that your year is off to a good start.

Advocacy matters

Your College will continue to advocate on your behalf on matters important to health public policy, particularly as those matters pertain to our profession. And 2011 promises to be an interesting year. The Coalition's win in the Victorian election, and a likely Coalition win in New South Wales this March, throws into doubt at least some aspects of the Commonwealth Government's national health reform package. With Western Australia still to sign up to the arrangements, the onus remains on federal Labor to convince Australians that its proposed changes will produce better patient outcomes across the nation's health systems.

The College will continue to be as supportive as possible. There is no doubt that change is needed and where a proposed change seems likely to improve patient outcomes we will support it. Where, however, change is simply an exercise in politics we will identify it as such. We have, for example, dismissed as pure politics the fanciful claim that blame shifting will end if the proportion of health funding between the federal and state governments is switched from 40-60 to 60-40. We are adamant that only a single funder model can end the 'blame game'.

The College will continue to pose questions to the major parties in the lead up to elections, ensuring they are aware of surgeons' concerns and our proposed solutions to some of the problems besetting our public hospitals. The responses of the parties to our correspondence make for interesting reading and are publicly available on the relevant regional page of the College website.

It is likely that the next New Zealand general election will be held in the latter half of this year, and the NZ National Board will be developing an "election manifesto" and engaging with the major parties during the campaign on matters of concern to Fellows.

The Governance and Advocacy Committee is currently developing a position paper in support of the separation of elective and emergency surgery. Based on the fact that surgical workload, be it elective or emergency, is entirely predictable, the paper's main argument is that the streaming of patients into distinct surgical streams, and the appropriate allocation of resources to each stream, ensures more timely emergency care and more efficient elective throughput.

Models developed at several Australian hospitals have yielded compelling results, with much more efficient theatre use, shorter wait times in EDs and shorter hospital stays. Much of this is attributable to the fact that a higher proportion of emergency procedures are performed during daylight hours, when consultant-led surgical teams are fresher and more focused. Significantly, surgeons who were at first uncertain about the new arrangements have quickly become converts, relishing the enhanced work/life balance that comes with a predictable day's work.

It will be stressed, however, that the success of the new arrangements is more than ever dependent on the principle of the surgical team and a commitment to robust and comprehensive handover.

The paper will outline the principles that should govern any separation of the surgical streams, noting that the logistics of any such separation will be determined by local considerations. The model adopted at major metropolitan hospitals will necessarily differ markedly from those at smaller regional facilities.

Any model, however, must ensure that surgeons and trainees have regular exposure to both elective and emergency cases. With balanced rosters and appropriate exposure to emergency work, surgeons are better placed to manage the complications that sometimes ▶

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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"The College will continue to pose questions to the major parties in the lead up to elections, ensuring they are aware of surgeons' concerns and our proposed solutions to some of the problems besetting our public hospitals."

arise in the course of performing elective procedures. Fellows with views on this issue are encouraged to email these to the Director of Relationships & Advocacy at james.mcadam@surgeons.org

FRACS as a trademark

Fellows may not be aware that the College has for several years protected the term 'FRACS' via a trademark. This ensures that the FRACS post-nominals are reserved for use by the College and Fellows of the College.

It is important that Fellows are aware of what that means for them and the use of their FRACS post-nominals. Fellows are obviously permitted – and indeed encouraged – to identify their Fellowship of the College by the use of their post-nominals.

However, using the FRACS as part of a business or website name is more problematic. Here the post-nominals are being used as a marketing tool in a commercial enterprise and the College would prefer that this did not occur without its knowledge or permission. The College may grant permission to use the FRACS in this fashion, but only with adequate acknowledgement of the College itself.

To assist Fellows in appropriately identifying themselves as a FRACS, the College is in the process of developing a new logo for use by the Fellowship. This will allow Fellows to use a stylised FRACS on letterhead, with compliments slips, decals on practice windows or doors and other printed or electronic material if they wish.

This new logo is to be considered by Council later this month and will, I hope, be available to Fellows in the next couple of months.

Past President's reflections

The Governance and Advocacy Committee, in conjunction with the Heritage and Archives Committee, recently invited immediate past President, Professor Ian Gough, to summarise his achievements and to highlight memorable events that occurred during his Presidency and his broader time on Council.

This summary was recorded as a DVD and is now available through the College website. Both committees believed that concept of recording the experiences of a President in his time on Council would form a valuable adjunct to the College tradition of portraiture.

Professor Gough provides a fascinating vista of the change that occurred at the College over his nine years on Council and his insight into matters such as the challenges posed by the ACCC, the introduction of SET and the general politics of healthcare, provides compelling viewing for those Fellows with an interest in the College's history.

The DVD chapters can be found on the Heritage and Archives page of the College website.

Congratulations on your achievements

At the final council week of 2010, Professor Richard Clayton Bennett was awarded the International Medal.

Professor David Watters
Chair, International Committee

The International Medal is awarded for consistent and outstanding contributions over a considerable time to the International work of this College. Professor Bennett became a Fellow of this College in 1960. He was a graduate of the University of Adelaide.

In acquiring his Fellowship, he won the Gordon Taylor prize during the Part I examination in 1957. Later, he was a member of the Court of Examiners from 1972 to 1982 and a member of Council from 1975 to 1987, including honorary treasurer from 1979 to 1987.

He was the founder of the College Foundation and coordinated its activities from 1979 to 1989. As a surgeon in practice, he was based at St Vincent's Hospital, Melbourne from 1966 to 1990, where he was appointed by the University of Melbourne as the Hugh Devine Professor of Surgery.

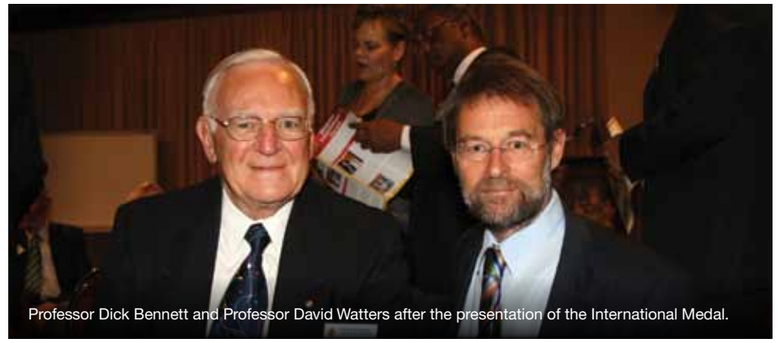
Since 1991, he has held the title of Emeritus Professor of Surgery, at the University of Melbourne.

Here, we recognise his contributions internationally – particularly in Malaysia and Hong Kong. He convened the 1978 Annual Scientific Congress in Kuala Lumpur and again in Hong Kong in 1983.

In 1984 and 1988, he contributed to the second and third Joint International Meetings of the College of Surgeons and College of General Practitioners of Malaysia.

In 1988, he was the College Travelling Fellow to the College of Surgeons of Malaysia, a position he helped establish and which has continued annually. During the 1980s, he was an external referee for senior academic appointments at the University of Malaysia and also an external examiner.

His contributions as an examiner and senior academic in the major teaching centres were balanced by his involvement in regional East Malaysia. Dr Ranjit Mathew Oommen wrote:


Professor Dick Bennett and Professor David Watters after the presentation of the International Medal.

"Professor Bennett came to Sabah in 1988 as a College Travelling Fellow and saw the potential and the need to get involved ... with the development of surgery in Sabah, which then seemed isolated from the rest of the world... he was instrumental in helping us to plan and implement a large scale, State-wide, early detection of cancer campaign."

Dr Oommen also reported that he found sources of funding and established a palliative home care program in Kota Kinabalu, the first of its kind in East Malaysia. Today there is a 16 bed palliative care unit supporting a home care program.

In Hong Kong Professor Bennett was external examiner twice and an invited speaker at the Hong Kong Surgical Forum in 1986 and 1990. He represented the College on the Asian Surgical Association from 1990 to 2000. He also lectured in the Philippines and Indonesia.

Professor Bennett also played an important role in supporting the development of surgery in the Pacific. In 1994, he was instrumental in conjunction with then immediate past-President, David Theile, in ensuring the College took on the management of the Pacific Islands Project.

What he began has evolved through three phases and continues today. His input helped shape the College's involvement in the management of International Projects. A similar project in PNG still runs today and has significantly contributed to surgical training in Papua New Guinea over the past 15 years.

In 1989, he formed the Surgeons International Foundation largely using his private funds. Surgeons International provides education and training opportunities for overseas surgeons and other surgical team members to make short term visits to Australia or New Zealand.

To date, 32 individuals have been awarded scholarships since 1991. The recipients have come from Malaysia, Vietnam, Nigeria, the Pacific, Indonesia, China and Papua New Guinea. Today these individuals are surgical leaders in their home countries. The funding and administration of the scholarships awarded by Surgeons International is now managed by the International Committee of the College.

Professor Richard Clayton Bennett has been a great surgeon, teacher and researcher within his own country and made notable contributions to this College for which he has been previously recognised by the Sir Hugh Devine medal and membership of the Court of Honour.

With this medal, we recognise his international contributions that span over a 30 year period. He personally made significant contributions to surgery in Malaysia, the Pacific, and Papua New Guinea. Senior Surgeons today speak highly of him. However, his legacy, Surgeons International, will ensure his influence will continue for many generations to come.

L-R: The rooms in PNG where Dr Scobie attended patients; Dr Scobie in theatre; with some of his grateful patients

Passing on the healing in PNG

After many years of helping restore sight to people in Papua New Guinea, Dr Michael Scobie is reluctantly passing on the gauntlet.

After restoring the vision of thousands of cataract-blinded people in some of the most remote areas of Papua New Guinea during the past 15 years, retired NSW ophthalmologist Dr Michael Scobie has decided to permanently put aside the microscope and scalpel, and cease his overseas aid trips.

He said that while the decision to fully retire was difficult, he felt it the right time to step away from the lead surgeon role of the organisation he set up, in the steps of fellow ophthalmologist, Dr Frances Booth, to assist the vision-impaired people of PNG.

The Chair of the RACS International Committee Professor David Watters has commended Dr Michael Scobie for his enormous contribution to the people of Papua New Guinea.

Dr Scobie, who spent most of his professional life in Gosford, NSW, said that while he would feel a sense of loss at the conclusion of his work there, he was heartened by the arrival of a local, fully qualified ophthalmologist in Wewak and hoped that perhaps another younger ophthalmologist might take over the work of his Australian-based program.

"It has been both fascinating and challenging working in PNG, and seeing the delight on the faces of people who can see after years of blindness never loses its magic, but most surgeons know when the time is right to stop operating," he said.

"The arrival of Dr David Pahau to Wewak was also a consideration because that part of the country has never had an ophthalmologist before, so even though he is limited in the amount of work he can do by the lack of equipment and disposables, at least he is there and is doing very well.

"Even though I will not be travelling to PNG anymore, the group we established to help in this work will continue to raise funds to buy those disposables to help Dr Pahau treat as many people as possible."

Dr Scobie began visiting PNG in 1996 after travelling there with Dr Booth, having decided he wished to use his skills to assist the people of a developing nation who had little or no eye-care services available.

To do so, he set up his own volunteer organisation called "Central Coast Eye Care" to help fund both annual team visits and buy crucial disposables, with financial and in-kind support provided through private donors, the Gosford Private Hospital, health care organisations and AusAID funding provided through the RACS Tertiary Health Services Project in PNG.

Since then he has taken a team to PNG on 15 occasions and estimates that he and colleagues have restored sight to more than 2,000 people in such remote towns as Maprick, Aitape, Vanimo, Mingende, Popondetta, Kiunga and Kavieng among others.

Some towns have only been accessible by boat or plane, some by the local four-wheel-drive ambulance; "proper" medical facilities are few and far between and at times Dr Scobie has had to operate in a converted school room, or a health clinic turned into a temporary theatre.

"I had worked with Aboriginal communities in North Queensland in the late 1980s and felt I wanted to go further afield and work in a third-world country," Dr Scobie said.

"I set up the Central Coast Eye Care service to operate like an independent mini-Hollows organisation and while it is small in the scheme of things, particularly when presented with the overwhelming need there, the work conducted has been richly rewarding.

"The journeys to some of the communities we have visited have been quite difficult, but that is what makes going there so important, as the people can't travel out easily and often have never had access to eye care at all."

A working team

Dr Scobie said visiting teams were mostly comprised of two ophthalmologists, an anaesthetist and a theatre nurse and conducted mostly cataract surgery with occasional eye trauma and other urgent procedures also done.

He said that throughout his 15-year involvement in PNG, great assistance had been provided by Callan Services for the Disabled, a Catholic organisation based in Wewak that provided team members with accommodation and transport while also conducting much of the patient pre-screening, and "toksave"-information about our service, essential for a visit to be successful.

"Although some problems, both clinical and refractive, are dealt with in the clinic, the vast majority of our work has been cataract surgery, which is well suited to short visits, needing little or no follow up, and providing almost immediate benefit, not just to the patient but to their extended family," he said.

"If older people are no longer independent as a result of poor vision, they must rely on children and grandchildren to lead them around and help them with the requirements of daily living.

"So to restore the sight of older people is to free up the entire family and in a country where everyone is needed to contribute to basic subsistence survival this is of major importance. How old the patients are, in fact, is often guesswork, as most don't know their age; interestingly, when I first went to Wewak, patients simply said they were born before, or after, The War, when Wewak was occupied by the Japanese. It obviously left an indelible impression!"

Help still needed

Dr Scobie said that while there were eight active ophthalmologists now working in PNG, most with constant problems of access and shortage of medical supplies and equipment, the need for cataract surgery remained enormous.

In his last visit, for example, to Popondetta, a short flight north of Port Moresby over the Owen Stanley Ranges, more than 174 people were treated over a two week period even though prior word of the team visit had not filtered out into the community.

"The first week was rather slow in comparative terms because pre-screening and "toksave" had been somewhat limited," he said.

"But the second week proved much busier, as by then it seemed that the word had spread that not only were we there, but that we had also sent home some very happy post-op patients.

"That meant that those who may have been fearful of coming, knowing little about eye operations, were reassured by reports of our results and started appearing at the clinic from near and far. Of all the cases conducted, 94 patients had been blind in both eyes before surgery.

"And that of course is in just one town, in one small province, a tiny fraction of the people blinded by cataracts overall. The local ophthalmologists need all the help they can get and more, to enable them to continue their work

"So it is an uphill battle to keep up with the surgical numbers, particularly now that more people are becoming aware of what surgery can achieve and are presenting for it."

Dr Scobie said while memories of some of the more extreme journeys and remote locations would long stay in mind, it would remain the patients that he recalled most vividly. "On one visit, we operated on a husband and wife who had both been blind for some years on the same day. The look on their faces when their patches were removed and they saw each other again was priceless," he said.

"Then there was a woman who had been blind for about eight years who had a six-year-old child that she had never seen, and a 10-year-old that she hadn't seen since babyhood and for her to suddenly be able to see her children again was very moving.

"We also operated on a blind woman who had had leprosy resulting in both legs being amputated, and when you see such suffering and stoicism it's impossible not to be affected by it."

Dr Scobie said he was very grateful to all the team members who had gone to PNG with him over the years, and acknowledged the great work still being done in PNG by Dr Booth and her team.

"It took a great deal of soul searching to draw a line under this work and I'm sure I'll feel hollow when June arrives and there is no journey in the offing," he said.

"But I have been honoured by the support our little organisation has received and my only disappointment is that I have not found anyone to take over the team in my place.

"However, we will still go on supporting Dr Pahau to help him help the people of PNG."

Ongoing funding for this service is currently being provided through AuAID's Avoidable Blindness Initiative, managed through the RACS International Projects department as part of the Vision 2020 Australia International Consortium.

– With Karen Murphy

Dr Scobie with some of his grateful patients

Poison'd Chalice

How many friends do you have?

"A friend is one that knows you as you are, understands where you have been, accepts what you have become, and still, gently allows you to grow."

Professor U.R. Kidding

I thought asking me about friends was a strange question. We were scrubbing for the last case in the afternoon list. My SET registrar was going to do the final procedure as the principal surgeon with me as the assistant. My mind was pre-occupied with the urgent hospital executive meeting that had been arranged for tomorrow morning. Amazing what election cycles and politicians create. Positive news stories, budget control and happy patients. What else would they want?

Friends; what was the saying, "Keep your friends close, and your enemies closer". Some say it was Sun-tzu who said it first, but certainly Machiavelli and The Godfather always contribute to the discussion.

I shook my head slightly and responded, "Quite a few actually".

There was a pause as communication between Baby Boomer and Generation Y went through a few unspoken loops. She looked at me with something resembling pity. "No," she said, "I was referring to Facebook and friends on your social media page."

My registrar knew that I was a Shakespeare tragic. Facebook apparently quotes Shakespeare in its definition of friends, "A friend is one that knows you as you are, understands where you have been, accepts what you have become, and still, gently allows you to grow."

I don't do social media and prided myself on never even checking on my profile in Google – well rarely anyway. I knew of others who worked assiduously to make themselves internet friendly. Not for me. I reflected that people were saying it was starting to get out of control. Over the mask there was that stare that I occasionally get at family dinners. My daughter had been encouraging me to connect to her Facebook site and communicate more.

"What's wrong with email?" I had replied somewhat proudly as I have become quite adept at email and was anxious to re-enforce my status as one who had "surfed" the internet communication wave successfully. "Put it this way Dad" she replied, "I only get emails from Nigerian Viagra salesmen, the bank and from you.

I decided to push the point with my registrar. I understand that the Medical Students Associations and Medical Associations had just launched a Social Media and the Medical Profession guide. Seems that a lot of people were starting to regret their postings and comments. Problem with the internet, it can last forever. That photo at the medical students' ball – possibly not the most dignified image when applying for your first consultant job. Not that people would ever discriminate against you for your youthful excesses?

Shakespeare, Julius Caesar, Act 4 Scene 3, "A friend should bear a friend's infirmities, but Brutus makes mine greater than they are" was the other quote that Facebook could emphasise a lot more. It should make you wonder about which groups of friends you want to be with and understand what they do. Does that group have your values or could it be accused of being racist, sexist or extremist?

As we walked into the operating theatre, my registrar stated that there was some real trouble brewing as some of the more junior medical staff had accepted patients as friends in their social media and there had been some chat about hospital and clinical problems between other groups. Apparently people were starting to get lawyers involved.

Oh great, I muttered under my breath as she twittered on. Something else to highlight at tomorrow morning's meeting. I can just hear what the talk-back shows would make of this one...

To be continued

Building the strength of East Timor

After many visits to the East Timor to help develop medical care there, Dr Noel Bayley and Mr Andrew Cochrane saw the need to take a further step.

Although Victorian physician/cardiologist Dr Noel Bayley has made more than 20 visits to assist the people of East Timor since Independence, it was not until late last year that his aid work came to public attention.

A news story in the national media which described the plight of one of his East Timorese patients – a young woman unable to win the political or financial support to bring her to Australia for life-saving heart surgery – captured the public imagination and triggered an influx of donations.

Surprised and moved by the response, Dr Bayley gratefully accepted the money and used it first to bring 19-year-old Flavia Guterres to Melbourne for surgery in October and later, Ursula de Carvalho Soares, 17, in December.

Both young women were suffering the effects of childhood rheumatic fever, leading to mitral stenosis. Both were successfully treated with the deployment of mitral balloons at the Monash Medical Centre in Melbourne by cardiologist Professor Richard Harper and his team and both are now back home and doing well.

"These young women suffer dreadfully from the effects of childhood rheumatic fever which often begins as a skin infection, which then triggers an immune response which in turn leads to scarring of the heart valve," Dr Bayley said.

"It means they are teenagers with the hearts of 80-year-olds, but the great tragedy is that many such young women die in labour because their hearts cannot take the strain which is a truly horrible scenario, particularly in a country that values child-bearing and family so highly.

"Yet they can be treated effectively if they can access that treatment which is why the public response to these two young women was so touching and so valuable.

"After the story appeared in the media, I had old-age pensioners visiting my office to leave $50 and other people writing cheques for thousands to cover the girls' airfares or whatever might be needed."

Indeed, so much money flowed in upon that wave of compassion – $13,000 in the first week alone – that he was compelled to set up a charity to manage the funds.

Dr Andrew Cochrane, Marcel de Jesus and John Benger from ROMAC

Dr Bayley, who is the Director of Intensive Care at the Warrnambool Base Hospital with a private practice at the St John of God Hospital, called the new charity East Timor Hearts and placed it under the auspices of the St John of God aid organisation which has extensive ties in East Timor.

With the specific support and commitment of Melbourne cardiac surgeon Mr Andrew Cochrane and the Monash Medical Centre, the money will be used to bring at least three such patients to Australia for treatment each year.

College involvement

Dr Bayley has worked closely with Fellows of the College throughout the years of his aid work, accompanying various RACS cardiac teams to the Pacific, and has known Mr Cochrane, who also visits East Timor regularly, for many years.

He said the support of surgeons in his efforts to bring such patients to Australia for treatment had been crucial.

"This is not all about money," he said.

"There are many charities in Australia that have dedicated funds to cover the expenses of bringing the seriously ill to Australia for treatment, but the every-day strains on our hospital system still mean that accessing treatment here is not easily achieved.

"Yet there is no capacity to do open-heart surgery in Dili so the need is enormous.

"Therefore having the support of surgeons like Andrew Cochrane and Phillip Antippa and paediatric cardiologist Lance Fong along with fellow cardiologist Professor Richard Harper has been of enormous importance."

An adult cardiac surgeon with a particularly interest in congenital heart abnormalities, Mr Cochrane has not only conducted aid visits across the Pacific region for many years, but has been visiting East Timor each year since 2003.

Now he too is in the process of attempting to further help the young people of East Timor by organising an open-heart surgical team visit to Dili.

With the support of the College and the Sydney Adventist Hospital's Operation Open Heart program, he has put the proposal to the health authorities in East Timor and is now awaiting an invitation.

Operation success: Flavia Guterres, Professor Richard Harper and Dr Noel Bayley talk about the Flavia's recovery.
Below: Ursula de Carvalho Soares and Marcel de Jesus are feeling better after their life-saving operation.

"When we visit East Timor we may see 100 patients in need, but of those patients we can only assist about 15 per cent with the equipment and resources available to us in Dili."

"When we visit East Timor we may see 100 patients in need, but of those patients we can only assist about 15 per cent with the equipment and resources available to us in Dili," Mr Cochrane said.

"Many cardiac patients don't go to the Dili National Hospital because of the unfortunate lack of clinics and experienced staff. They therefore end up at Dr Dan Murphy's Bairo Pite Clinic.

"Dr Murphy has up to 300 people on his books, such is the need there."

"We can't do open-heart surgery there because there is no heart-lung machine, yet very few Australian units take cardiac patients and it is a gruelling experience to have to turn away people who you could help if you had the support and equipment.

"But if we could organise an open-heart team visit – if we can manage the logistics, cover the cost of transporting equipment, ensure appropriate post-operative intensive care - we could save the lives of more than 20 people per visit without the extra financial burden of bringing them here or the emotional burden on the patients of moving them away from their familiar environment.

"However, while we wait for all that to take place, the team at the Monash Medical Centre has committed to treating those patients that Dr Bayley can bring here as well as those funded through ROMAC, the children's medical aid program run by Rotary."

Nineteen-year-old Marcel de Jesus is one of those patients brought out by ROMAC, represented by John Benger.

Yet despite the efforts of Australian medical professionals to assist the people of East Timor the difficulties and tragedies remain.

In January, a nine-year-old East Timorese girl died from the effects of a defective mitral heart valve, having been unable to receive the necessary treatment in time.

Dr Bayley saw the child in November last year and said while her case was greatly distressing it was not so much about lack of care as the lack of first-world medical equipment and life-long follow-up treatment.

"This young girl had a severe congenital abnormality which involved a severely leaky mitral valve," he said.

"The damage was so extensive that she would have either needed to have a mechanical valve put in place which would require life-long medication or have a tissue valve inserted which only lasts for about six to eight years.

"Sadly, in East Timor there was no reasonable way to technically offer a long-term solution in such a case.

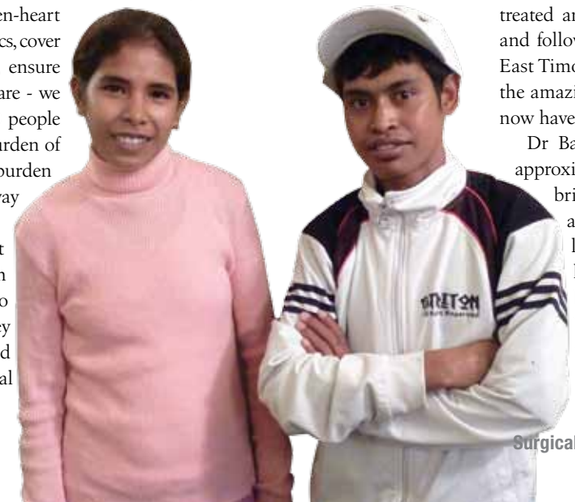
"In contrast, the two young women brought to Australia last year had conditions that could be treated and which wouldn't need sophisticated follow-up treatment which is simply not available there.

"Now they can be expected to live well into middle age and be strong enough for child birth which is so important there.

"Some of these young people who we have treated and who we hope to treat this year and following years have the potential to be East Timor's best and brightest and thanks to the amazing generosity of Australian donors, now have a second chance to live their lives."

Dr Bayley said he now hoped to raise approximately $100,000 per year to bring such patients to Australia and particularly wished to thank logistics company PDL Toll who have agreed to transport patients between Darwin and Dili as well as Virgin Blue who have also agreed to transport patients across Australia to their treating hospitals.

With Karen Murphy



LEFT: One of the Adelaide Convention Centre lecture theatres to host many of our excellent presentations.

What's in store at the 2011 ASC

An outstanding Annual Scientific Congress is ready for all Fellows, Trainees and Associates. In keeping with the milestone of 80 years of charting surgical progress, the conveners have struck an excellent balance between scientific content, Fellowship activities and plenary sessions addressing some of the major issues confronting surgery and surgeons.

Mr Tom Wilson FRACS
and Mr Suren Krishnan FRACS

The Convocation is the formal gathering of the College before other surgical colleges, surgeons and their families. It celebrates everything the College represents in a formal setting. New Fellows will be introduced by the Censor-in-Chief and welcomed into the College by the President.

A number of senior Fellows will be recognised with College awards for their major contributions to the advancement of surgery – the erstwhile College Dean of Education, John Collins (the Sir Louis Barnett medal), Professor Swee Tan (Surgical Research award), Ian Carlisle (International medal) and Leo Pinczewski (Excellence in Surgery); the immediate Past President Ian Gough will be inducted into the Court of Honour.

The Adelaide conveners are proud to be convening this milestone scientific meeting, which will reflect 80 years of the advancement of surgery, of the science that underpins surgery and the way in which we care for our patients. Innovation will remain the order of the day and the Annual Scientific Congress allows us to remain at the forefront of this advancement, not just in our own area, but to be aware of changes across a broader perspective. The ASC allows one to slip into the audience and see what is happening in other fields of surgical endeavour – Unity Through Diversity indeed.

Scientific Program – Colorectal surgery

The convener of the Adelaide Colorectal program, Andrew Hunter, promises an outstanding scientific meeting. He notes that for the first time, we are able to invite three international visitors guaranteeing a meeting of the highest standard.

The principal visitor is Professor Ronan O'Connell, Professor of Surgery at University College, Dublin. His interests include inflammatory bowel disease, pelvic floor physiology and surgical publishing. He has visited us previously and his extraordinary expertise ensures a successful program.

Professor Frank Frizelle is Professor of Colorectal Surgery at Christchurch Hospital, New Zealand. A past Chair of the Colorectal Surgery Section, he has published widely on Crohn's and diverticular disease and he has particular interests in treatment options for advanced rectal cancer and surgery for locally recurrent carcinoma.

Professor Robin Phillips is a consultant surgeon to St Marks Hospital, London and known to many Australian surgeons. His research interests include colorectal cancer, FAP, anal fistula and anorectal disorders. He provides experience, wisdom and enthusiasm to the meeting. Furthermore, Clifford Ko is the Surgical Oncology visitor and he is a Colorectal Surgeon at UCLA and Director of NSQIP (National Surgical Quality Improvement Program) for the American College of Surgeons. He has accepted an invitation to speak on 'Quality of care following colectomy'.

The meeting covers a wide spectrum of interests including the latest recommendations for colorectal cancer screening and surveillance, evolving strategies for the management of rectal cancer and expert advice on issues related to inflammatory bowel disease and pelvic floor disorders.

There are two sessions dedicated to scientific research and, in a new initiative, a separate session provides an opportunity for the best posters to be presented. Three separate prizes are to be awarded to the best research papers. Trainees will also be attracted to two Master classes on 'Colorectal catastrophes' and 'Laparoscopic colorectal frustrations'.

Perhaps the session with most widespread interest is a combined Mini-Symposium to address the issues of sub-specialty training and the acquisition of advanced surgical skills.

Another highlight will be 'Consultants Corner' to be moderated by Robin Phillips quizzing a panel of experts on the management of difficult colorectal problems and cases.

The Colorectal dinner is booked at the magnificent River Café.

The colorectal program covers important topical issues addressed by international and local experts. It will appeal to the general surgeon, the specialist colorectal surgeon and the trainee.

Scientific program – General surgery

The General Surgery convener Trevor Collinson notes that it is a mere 20 years since laparoscopic surgery took the world by storm. These developments in general surgery quickly spread to and changed every other field of surgical endeavour. In the heady early years of one of the great revolutions in Surgery, a veritable free-for-all developed. Surgical inventiveness and enthusiasm overtook meetings; industry could hardly believe what was happening to their businesses. The rapidity of innovation led to egregious failures – of teaching, credentialing and outcome monitoring. New models were developed as reason began to replace the euphoria.

True pioneers emerged, three of whom are our visitors this year and internationally recognised as distinguished leaders in the field of minimally invasive surgery. From the UK, we welcome Michael Bailey, from the US, Lee Swanstrom and from Canada, Mehran Anvari – all primarily laparoscopic surgeons, but each with his own unique focus. This 20 year milestone presents an opportunity to reflect on the past two decades and to imagine what the next two may hold.

"Please note that the Early Bird registration, which represents a substantial discount on the registration fee, closes on 15 March."

The meeting will cover core topics of general surgery, but also new developments in technology and education. News from home if you live in the General Surgical world!

Scientific program – Neurosurgery

The convener of the neurosurgery program, Stephen Santoreneos, has scheduled a three day program from Tuesday, 3 May.

He intends the program to be an update on open and endoscopic skull base surgery including neuro-otology and craniofacial surgery. There will be a multidisciplinary approach to the meeting with contributions from our ENT and craniofacial colleagues in combined sessions.

Stephen is pleased to welcome as our invited guests Professor Takeshi Kawase from Japan whose contribution to the field of open skull base surgery is well recognised and Professor Peter Wormald from Adelaide, a world leader in endoscopic approaches to the skull base. Professor David David will be the invited guest for the Craniofacial surgery program. We look forward to a lively debate on open compared with endoscopic techniques, but also to technical instruction on this complex area of neurosurgery by our expert colleagues. An intention of the program is to develop a consensus on a more formal approach to teaching our young neurosurgeons and encouraging subspecialty interest in this field and finally look to the exciting developments of the future. The craniofacial program (convened by Peter Anderson) will provide a critical appraisal of current and emerging procedures for simple and complex craniosynostosis, but will also include a basic science session in this emerging and exciting area of molecular genetics.

We encourage all our colleagues, but particularly our young and in-training neurosurgeons to participate in and contribute to this program. The Neurosurgery Trainee Research prize will be awarded to the best presentation in the research paper session.

Leaders meet on alcohol and injury

The College Trauma Committee met with community leaders late last year to discuss the rising issue of alcohol related trauma, and what may be done to prevent it.

Associate Professor Daryl Wall
Chair, Trauma Committee

TOP: L to R: Professor Rob Moodie, Dr John Crozier, Associate Professor Robert Atkinson, Professor Danny Cass, Associate Professor Daryl Wall.
BELOW: L to R: Mr Mahiban Thomas, Mr David Read, Mr Graeme Campbell and Dr Ollapallil Jacob.

On 18 November 2010, 60 committed community leaders attended the Alcohol and Injury Workshop of the College Trauma Committee. Speakers included experts from a broad range of professional bodies such as the Nossal Institute for Global Health, Bureau of Crime Statistics and Research, National Drug Research Institute, Alcohol Education & Rehabilitation Foundation and the Victorian Ambulance Service.

Also engaged were a host of professionals including the NSW Commissioner of Police, epidemiologists, psychologists, coordinators of youth prevention programs, members of DrinkWise, addiction medicine researchers, surgeons, nurses, paramedics and government representatives.

Dr John Crozier, vascular surgeon and Deputy Chair of the Trauma Committee, is to be congratulated as the convenor of the workshop. Dr Crozier did a magnificent job of coordinating outstanding speakers and ensuring participation from such a broad range of stakeholders.

He brought a wealth of experience and passion as a lobbyist against alcohol abuse and as a participant in the NSW Summit on Alcohol 2003. I am very grateful for his leadership and energy and his success in raising awareness in the community of this important issue.

The dimension of the challenge was assessed at the workshop. Presentations included analysis of data from around Australia and New Zealand showing the impact on surgical workload and emergency departments of injury associated with alcohol consumption.

Others showed the effect of alcohol sales restrictions on the incidents of injury managed at the Alice Springs Hospital, and the effect of reducing hours of trade of licenced premises and the effect of increased taxation on alcohol consumption.

Policing initiatives such as, Operation Unite, a trans-Tasman initiative to crack down on alcohol-fuelled violence including the horrific injury of 'glassing', were examined.

> *"Dr John Crozier, vascular surgeon and Deputy Chair of the Trauma Committee, did a magnificent job of coordinating outstanding speakers and ensuring participation from such a broad range of stakeholders."*

The Royal Australasian College of Surgeons joined the push by police to change society's binge-drinking attitude and reduce the plague of alcohol-related violence – an initiative called Operation Unite that was held on the weekend of 18/19 December, 2010.

The College position on 'Trauma – Alcohol and other drugs' (located on the College website) was distributed and discussed at the meeting.

The College paper includes strategies to reduce the problem of alcohol abuse and/or misuse throughout the community. These include:

- Regulating the physical availability of alcohol such as restricting the hours and days of sale of alcohol, the density of outlets, availability by alcohol strength, and mandatory and enforced server liability programs;
- Effective alcohol taxation and pricing policies;
- Readily accessible early treatment and intervention programs particularly in the primary health setting and the workplace to reduce hazardous alcohol consumption;
- Proactive policing of licensed venues;
- The installation of suitable breath alcohol testing devices (hand-held, coin-in-slot machines) in hotels, restaurants and clubs;
- Restriction of alcohol advertising particularly restricting advertising to young people, with effective enforcement of the Alcohol Beverages Advertising Code (ABAC) Scheme.

Workshop attendees were enthusiastic and dedicated to the cause of curbing alcohol fuelled violence. They expressed a united determination to take forward the tragic matter of alcohol and injury and a willingness to be the agents for change.

The workshop has established national partnerships with politicians, press, police and publicans who have already generated new research, new strategies and more effective initiatives.

I feel honoured to have been involved in such an important workshop and am impressed with the work and commitment being done by so many. I wish to thank all Fellows who attended the workshop.

We felt particularly honoured to have had in attendance one Fellow who attended an 'alcohol summit' organised by the College some 20 years ago. He reported that only eight people attended that meeting 20 years ago despite the international speakers who were invited to present the latest US research on the effects of blood alcohol readings at 0.05.

The College workshop received extensive media coverage, including the *Daily Telegraph*, on all of the Sydney prime time news programs, the *7PM Project* on Channel 10 nationally, on Sky News nationally (and in NZ) and on many radio networks.

It was also satisfying and interesting to observe the 'coming of age' of College Trauma Week as I noted reference to College Trauma Week on ABC national news radio. We welcome the raised awareness and recognition of the work done by the College Trauma Committee in the area of trauma prevention and care of injured patient.

Critical literature evaluation and research workshop

Need an introduction to clinical research methods and clinical epidemiology?

Professor Phil Truskett,
Chair of the Skills Education Committee (SEC)

This hands-on course is designed to make the language and methodology of literature and research relevant to surgeons in the day-to-day activities of their practice. It is also designed to provide the tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials and associated medial research.

The course runs for two days for 32 participants with a faculty of four to five instructors. It is a combination of lectures and small group teaching.

The CLEAR workshop is available to Fellows and Trainees.

Also available is the Statistics for Surgeons workshop, which aims to increase conceptual understanding and develop practical skills in medical statistics as commonly required in surgical clinical research. This computer-based workshop is available in Sydney and Melbourne only.

Topics covered include:

- Evidence-based practice
- Critical appraisal
- Randomised controlled trials
- Diagnostic tests
- Statistical significance
- Searching the literature
- Systematic reviews
- Decision analysis

To register onto the waiting list for either course, please visit: www.surgeons.org > education & trainees > skills training
For information contact Clare Dilworth, Clare.Dilworth@surgeons.org

New guide for Fellowship services

With this month's *Surgical News* you will find a copy of a new College publication Guide to College Services and Programs.

Mr Graeme Campbell
Chair, Fellowship Services Committee

This new publication highlights how you can get the most benefit from your Fellowship. Please take the time to look at this guide.

An obvious starting point for getting the most benefit from your Fellowship is access to the latest information. *Surgical News* is one great example, but there is more.

The College library and the *ANZ Journal* of Surgery are also important sources of information and a benefit of Fellowship. Did you know the College provides an extensive online library accessible via member login at the College website? The library can also provide a literature search service, which is further described in the guide.

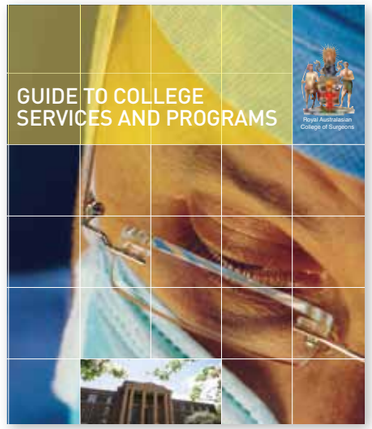
In the same section of the guide is a description of the 'Find a Surgeon" directory. You may wish to be listed in the "Find a Surgeon" directory (it's free) to boost your clinical practice.

Need a scholarship, fellowship, grant or loan? The guide provides information in this field that we hope you will access.

Would you like to save some money on your car hire, home loan or health insurance? The guide might help you save money with Member Advantage, an organisation with which the College partners.

Other sections within the guide include Being Heard as Surgeons, Making a Difference in the Community, Professional Development and Providing Standards Leadership.

Finally as the guide says, "the College thrives on the active participation of Fellows



in a host of committees, working parties and advisory capacities". If you are looking to get involved in education or in our wide range of committees then the guide will be a great starting point.

I hope you will take the time to consider the different facilities that Fellowship of the College provides you.

International Development

The College helps to equip PNG

After an outreach visit to PNG, two Fellows recognised the need for better clinical equipment.

Professor David Watters
Chair, International Committee

During specialist outreach visits to Papua New Guinea through the College's International Development Program, Dr Chris Perry from Brisbane and Associate Professor Vincent Cousins from Melbourne recognised the need for better clinical equipment for the ENT surgeons and registrars practising there.

In November 2010, the College in conjunction with the Australian Society of Head and Neck Surgery (ASOHNS) purchased 10 customised Voroscopes at the request of Professor Dubey, the Senior ENT Surgeon in Port Moresby, to be used by his registrars in training and all the ENT Surgeons across PNG.

The Voroscope is a mobile light source and lens system, which greatly enhances the ability to examine all patients with conditions of the ear, nose and throat. It provides binocular vision giving three dimensional view combined with reliable illumination powered by a rechargeable battery worn on the belt.

It replaces the old fashioned light reflecting head mirror, which used only one eye and generally poor lighting. The scope has been developed over the past 30 years by Mr John Vorrath, an ENT Surgeon from Geelong and they are manufactured there. They are used by almost all surgeons in the Specialty in Australia and New Zealand.

The mobile nature of the scopes allows better examination of patients in the ward and intensive care unit. In the operating theatre, they are used as a light source, with or without magnification, particularly in procedures on the nose and throat. Teaching of registrars and medical students is also facilitated with their use.

Professor Dubey is very pleased with the equipment, which he believes will be of great help to the ENT surgeons and trainees.

"The Voroscope is very useful to examine and diagnose ENT pathologies in patients during the Consultations Clinic and Outpatients… and is particularly vital during visits to provincial hospitals and rural areas in PNG where ENT facilities are non-existent", he said.

He expressed his gratitude to the College and ASOHNS for the provision of this equipment, which will significantly enhance the care of ENT patients in PNG.

Continuing good work

A seminar conducted by Specialists Without Borders in September 2010 is the continuance of medical education in war-stricken Rwanda

Dr Paul Anderson

Specialists Without Borders (SWB) continued its medical education initiatives into Africa by conducting a seminar in surgery over three days in Kigali, Rwanda. This was followed by teaching at the medical school in Butare. Twelve Australasian surgeons undertook the journey as lecturers as well as two surgical registrars, and for the first time, five medical students, who were partly sponsored by Allergan.

The Rwandan Surgical Society requested the seminar as a way to continue the postgraduate medical education and build on the successful seminar conducted in 2009. The 2010 seminar registered 130 Rwandan doctors.

Despite positive feedback from 2009, SWB were looking to improve on the type of teaching delivered. The SWB Executive decided to move to Structured Clinical Instruction Modules (SCIMs).

Each of the consultants who presented on topics was requested to create a SCIM, which would reinforce material presented in morning lecture sessions. It is hoped that these modules will then be part of an evolving curriculum for SWB teaching in developing countries.

Feedback

The seminar was considered to be a great success. Initially there were concerns from the Rwandan doctors as to how SCIMs would work in seminars such as this. However, after day one, there was a unanimous approval from the local doctors for this method of teaching.

Interestingly, the SWB consultants/lecturers also found the small SCIM groups challengingly interactive and therefore more rewarding than just the delivery of lecture material.

Developing education

SWB is therefore looking at evolving the Structured Clinical Instruction Module as a preferred teaching module in developing countries. In Africa this is to be undertaken with the school of medicine/national University of Rwanda.

Future developments

A follow-up seminar has been requested in Rwanda in 2011. Requests have also been initiated from Cambodia/Honduras and Burma. With the growth of SWB, it is felt that with a growing consultant database, three or four postgraduate surgical seminars per year would be possible.

Teaching database

Register with Specialists Without Borders and become part of our growing international database of specialist teachers that we can use in future teaching seminars: www.specialistswithoutborders.org

Membership/Sponsorship

If you would like to contribut /donate to Specialists without Borders, there are several ways to do this. You can sponsor a conference in a developing country, sponsor medical students, doctors/nurses or allied health personnel in developing countries. Online facilities for donations allow specification for each of these groups.

Gratefully acknowledged

Specialists Without Borders National Executive gratefully acknowledge those surgeons and registrars on the trip:

Dr David Birks – Melbourne
Dr Kate Drummond – Melbourne
Dr Katherine Edyvane – Perth
Professor Grantley Gill – Adelaide
Dr John Gan – Tweed Heads
Professor Jegan Krishnan – Adelaide
Professor Suren Krishnan – Adelaide
Dr Candice Silverman – Perth
Dr Mary Theophilus – Perth
Dr Frank Stenning – Sydney
Dr Paul Anderson – Adelaide
Dr Gordon Morrison – Adelaide Registrars
Dr Dora von Conrady – Perth
Dr Arman Kahokehr – New Zealand

Healing in the Congo

Brisbane General Surgeon, Dr Neil Wetzig continues to be fulfilled by his latest trip to the Democratic Republic of Congo to support HEAL Africa, educating local doctors and conducting more complex operations

Dr Neil Wetzig

I had the pleasure recently to lead a volunteer medical team which travelled to the Democratic Republic of Congo (DRC) to support the HEAL Africa Hospital. The main aim of the team is to assist in training the Congolese doctors, but they also deal with the treatment of more complex surgical cases for which the Congolese doctors request assistance.

HEAL Africa is a Congolese not-for-profit organisation, which is making significant advances for the people of eastern Congo by addressing the root causes of disease and poverty. HEAL is an acronym for Health, Education, Action and Leadership. The mission of HEAL Africa is "to provide holistic care for the people of the DRC (around 66 million): training health professionals, strengthening social activists and providing physical, spiritual and social healing" (http://www.healafrica.org). HEAL Africa's aim is to train Congolese doctors to provide quality medical care in the most underserved areas of Congo.

This was my sixth trip to Goma since 2003 and all but three of the team members have been at least once before. Other team members included: Brisbane Doctors Judith Goh and Hannah Krause (Uro-Gynaecologists); Dr Anthony Fisher (Anaesthetist, Townsville Hospital); Dr Murray Thorn (Radiologist), a Radiographer, Dentist and IT support professionals.

The hospital is located in Goma, the provincial capital of North Kivu province in eastern Congo on the border of Rwanda. Only six qualified African surgeons work in eastern Congo servicing approximately 30 million people. The hospital is mainly a surgical facility with 160 beds. It is an integral part of HEAL Africa and is now recognised by the Congolese Government as one of three tertiary referral hospitals in the DRC.

This area of DRC endured great suffering after the Rwandan genocide of 1994 and subsequent conflicts. Medical resources are limited and armed conflict was commonplace until recently. Sexual violence against women has been used as a weapon of war. Women, both old and young, are often left with fistulas, after either prolonged labour or as a result of sexual violence.

Because the Congolese doctors gain considerable knowledge from the internet, the volunteer team has concentrated on improving the IT support for the hospital as well as installing a computer based phone system.

As 2010 is the 'International Year of the Nurse', it was particularly pleasing to include a small group of nurses, who this year concentrated on both theory and practical training for the HEAL Africa hospital nurses. They covered areas such a critical care nursing, (including recovery nursing), midwifery, dressings and infection control.

Laparoscopic surgery does not exist in this environment. Consequently there is an abundance of open surgery. Clinical decision making is essential as there are limited options for investigation. This year such cases included: management of a low rectal cancer and other colonic disease, cases of urethral strictures, a case of gross splenomegaly, a difficult colonic fistula, cases of meningo-myelocoele in infants, cleft lip and surgery for 17 large goitres.

North eastern Congo has one of the highest incidences of very large goitres occurring in Africa due to iodine deficiency and dietary factors. Estimates indicate that up to 65 per cent of the population will develop a goitre in their lifetime. As a breast/endocrine surgeon, I found the surgery and teaching of goitre management in this area particularly fulfilling.

Although the team has been travelling yearly to this area, the improved security in the past year has led to a greater sense of safety. This meant that other programs could be conducted, such as a general surgical outreach program with Anthony Fisher and me for one week in Butembo, a large town several hundred kilometres north of Goma. There are no medical specialists currently working regularly in Butembo.

Building on care

A gynaecology outreach program was also conducted for the second year to Idjwe Island situated on Lake Kivu between Rwanda and DRC. Overall 49 general surgical cases and 46 gynaecology cases were performed.

The repeated visits have allowed the team to develop relationship and trust with the Congolese staff and this has assisted in their training. Teaching on this trip occurred through formal lectures. However, over the past years the team has found that a more effective form of education has been small group tutorials and teaching ward rounds.

A pleasing feature this year was that a doctor who was identified by the team in 2006 as having significant surgical potential, has now returned to work at HEAL Africa after formal surgical training in Uganda. I was able to continue the mentoring relationship with the Congolese surgeon and assist with surgical decision making and technical issues. This surgeon is now more effectively and safely performing surgery on large goitres and continues this work even when the team is not in Goma.

Another highlight this year was to see a young woman who underwent a colonic replacement for a long and tight oesophageal stricture. This major surgery was performed by last year's team in less than ideal conditions and yet the young woman has gained weight, has no significant side effects and is now employed at the hospital.

Her life would not be the same if the team had not visited HEAL Africa. The work done by the volunteer team aims to achieve significant sustainable changes and help the Congolese to develop and improve their medical care.

COLLEGE RELEASE

First national report on surgical mortality

After its inception in Western Australia more than seven years ago, the Audit of Surgical Mortality is now undertaken in each state and territory to provide powerful data for continuing and improving surgical excellence

Guy Maddern
Chair, ANZASM Steering Committee

It gives me great pleasure to announce the release of the first National Report from the work of the Australian and New Zealand Audit of Surgical Mortality (ANZASM). This report is based on the activities and outcomes during 2009.

This first national report contains data from regions that were operational during 2009 and aims to provide a snapshot of the causes behind mortality associated with surgical patients. Now that all the regions are contributing, it will result in a very large and powerful dataset. One of the important challenges remaining is incorporating all private hospitals into the audit system. This has not been embraced by all regions and certainly leaves an important segment of the care of surgical patients unrecorded. I am hoping that recruitment of the private sector will improve over time.

Since the inception of the Audit of Surgical Mortality in Western Australia more than seven years ago, there has been great support and enthusiasm for a National Audit of Surgical Mortality. As a result, the audit is now undertaken in every state and territory in Australia. Each region continues to have its own autonomy, being led by a clinical director who interacts with surgeons, hospitals and their Department of Health to ensure that the regional reports produced are relevant to all of their needs and requirements.

The audit has been able to maintain a constant dataset across Australia, making it possible to provide national figures. It is anticipated that there will be comparisons of trends over time, as more information becomes available. The primary objective of the audit is peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors and trends associated with surgical mortality. It is intended as an educational rather than a punitive process.

The College can be rightly proud of this important initiative in collaboration with the jurisdictions. Aggregated information will be available to surgeons in order to ensure that lessons are learnt and that the highest quality care is provided into the future. Therefore ANZASM should be embraced by all surgeons and actively supported by health departments in Australia.

A limited number of printed copies of this report will be available by requesting a copy from your local regional audit office. Alternatively an online version can be downloaded from the College's website.

Thank you for your ongoing support of this important and valuable initiative.

Important lessons through audit case studies

The Victorian Audit of Surgical Mortality highlight some important lessons from three case studies from the latest audit. These provide continuing education for all Fellows.

A/Prof Colin Russell
VASM Clinical Director

The Audits of Surgical Mortality (ASMs) review deaths that occur while under the care of a surgeon. A primary aim of the audit is education through feedback from the audit process to surgeons.

At regular intervals, cases are extracted that emphasise specific issues arising from clinical care. These are abstracted and published in a 'Case Note Review Booklet'. All such cases have gone through the full audit process with case note review and are deemed closed.

In its most recent Case Note Review Booklet, the Victorian Audit of Surgical Mortality (VASM) identified some facets of care that are worth sharing. The following are summaries of some of these cases. The full description of these and other cases can be viewed at http://www.surgeons.org/vasm

Case study
a case involving input from a number of clinical teams

Leadership in the patient care process: while the benefits of multidisciplinary input to patient care are well proven, one senior clinician should be actively coordinating and supervising all phases of that care. In this case, coordination and supervision from the treating surgeon was felt to be lacking. Dieticians were allowed to increase enteric nutrition in a patient with small bowel obstruction. The unresolved small bowel obstruction and sepsis was not recognised despite strong evidence on CT scan. The assessor felt the outcome for this patient may have been different with better coordinated clinical management.

Comment: When there is input from a variety of disciplines, overall accountability for care should be established and confirmed at the outset, and processes developed for team discussion at regular intervals.

Case study
consultant not informed of patient's refusal to have a colostomy prior to administration of anaesthesia

Informed consent has a dual purpose. Firstly, it informs the patient of probable diagnosis, the treatment options and their consequences. Secondly, the patient can be given more information on issues they don't understand. In this case the full consequence of refusing a stoma may not have been appreciated. From a surgical perspective, the process of gaining consent provides valuable insight into the patient's wishes and expectations. The latter may need to be realigned with known outcomes to avoid inappropriate expectations.

For such a major case with high potential for an adverse outcome, the treating surgeon should be responsible for the consent process. Having to adopt a suboptimal treatment plan would have been an unpleasant experience for any surgeon. We must accept that in this instance the patient had the absolute right to expect their wishes to be observed. However, if the consequences had been fully outlined would the same decision have been made? The communication breach between registrar and surgeon must surely have been a learning process for both.

Comment: Should the operation have been delayed to allow for further discussion with the patient? This, however, would indeed have been a difficult option considering the circumstances. The lesson here for consultants, registrars and others is the importance of timely discussion of consent with patients and ensuring all implications are considered prior to surgery.

Case study
a patient referred to a rehabilitation unit after joint replacement developed a strangulated femoral hernia

This case exemplifies the need to establish a proper diagnosis for persistent symptoms. An orthopaedic patient in a rehabilitation unit developed an acute but correctable surgical problem, which was not recognised. This occurred as the treating doctors did not consider the possible causes of the persistent symptoms of vomiting or examining the patient with those in mind.

After the cause was eventually identified and then confirmed by appropriate investigation, there seems to have been a delay in obtaining surgical input at a senior level. Requests for cross speciality review all too often seem to go through junior medical staff and filter upwards (or not). This is inefficient and unreliable. Surely it would be better if such requests were made directly between appropriate senior medical staff?

Comment: This case highlights the problems with specialised and fragmented care, where clinical problems outside the comfort zone of one speciality are not considered and inappropriate diagnoses are entertained for too long. This case also demonstrates the problems of failure to recognise early clinical deterioration in a patient.

Overall recommendations

- **Complex cases require clear demonstrable leadership in patient management. Regular team meetings involving all disciplines should inform all involved of the treatment plan.**
- **Patient consent is both an essential and valuable process that should not be left to chance.**
- **When clinical deterioration occurs with no defined cause, it should be remembered that the cause may be related to something outside of the treating surgeons' specialty knowledge.**

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.

The 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.

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

Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), 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 2 May, during the ASC in Adelaide.

Applications close 5pm, Friday 25 March 2011

Providing better support for examiners

The Court of Examiners is about to introduce an examiners' training course as a means of providing greater support to new examiners, and to improve the reliability of the Fellowship examination.

Spencer Beasley,
Chair, Court of Examiners

The Court of Examiners recognises that for such a high stakes examination, being an examiner carries with it a number of responsibilities and obligations, and increasingly requires specialised skills. It is expected that the new course will help equip examiners with the knowledge and expertise they need to perform at the level now demanded of them.

Recently three senior members of the Court travelled to Edinburgh to gain information about the UK Intercollegiate examinations, their examiners' training course and other aspects of their assessment processes. The generosity of the UK Colleges in sharing their knowledge has facilitated the development of a RACS course, although our course is one tailored very much to our local needs

The course will focus on a variety of topics, including:

1. Examination preparation (blueprinting content against the competencies being tested, standard setting, and maximising the reliability and validity of the exam);
2. Conduct of the examination itself; and
3. Monitoring and providing feedback on examiner performance.

Instruction of examiners commences with a distant learning component (based on an examiners' manual) followed by a pre-course assessment and a one day course. New examiners then have one Fellowship examination at which they are primarily observers, but during which they will have other tasks, such as assessment of the taxonomy of vivas, review the performance of current examiners, and direct involvement in one viva.

The first recipients of the course will be the nine specialty senior examiners and their deputies. This will be held immediately before the May examinations. There will be two further courses held during 2011, for which priority will be given to new examiners. In due course, all examiners will be expected to complete the course.

The examiners' training course initiative represents another step in the ongoing refinement and improvement of the SET assessment processes.

The Royal College of Surgeons of Edinburgh - Surgeons' Hall

"The backbone of this program stems from the draft publication by beyondblue of the first comprehensive literature review concerning the mental health of doctors."

Doctors and mental health

Doctor's health was the topic of discussion at the latest Victorian General Scientific Meeting, with Fellows teaming up with beyondblue to look at some of the key issues.

Michael Dobson
immediate past Chair of Victorian Regional Committee

I have been the VSC representative on the Victorian Doctors' Health Program (VDHP) for the past two years. During which time I have become more aware of the various roles played by VDHP. Additionally, with the advent of national registration, the excellent model of the VDHP is being adopted in other states of Australia.

The Victorian Annual General Scientific Meeting held in Lorne in September, 2009, had as its major theme "Lifestyle and Surgery". Dr Kym Jenkins (Medical Director, VDHP) created a lot of interest among the delegates in the work of VDHP and the extent of its role in supporting the profession, in particular medical students and doctors in training.

There were 30 referrals for medical students, 41 for doctors in training, 17 for specialists and 25 for general practitioners. This year's figures have not been published, but the trend of referrals is upward.

There has been a change in referral pattern with younger doctors and students self-referring before significant consequences arise. The program, of course, receives referrals from the Medical Board, however, these referrals are now not the majority of its work.

Building on this there has been a major initiative launched at the end of August, 2010, in Victoria – the beyondblue Doctors' Mental Health Program (bbDMHP).

The backbone of this program stems from the draft publication by beyondblue of the first comprehensive systematic world literature review concerning the mental health of doctors.

Ten topics were selected for this literature review.

- Prevalence of anxiety and depression
- Prevalence of substance misuse and self-medication
- Suicide rates
- Risk factors for anxiety and depression
- Help seeking rates for anxiety and depression
- Barriers to help seeking
- Interventions for anxiety and depression
- Attitudes of medical colleagues
- Impact on patient care
- Impact on work and family life

The findings do not suggest higher rates of depression or anxiety in doctors compared to other professionals. Self-prescription was common in medical practitioners. The suicide rate in medical practitioners was higher than the normal population with a 25 per cent higher risk in males. Barriers to help-seeking include concerns about stigma, adverse effect on career development, confidentiality and embarrassment.

'beyondblue' is an Australian organisation dealing with anxiety and depression and it has an Expert Reference Group comprising psychiatrists, Deans of Health Faculties, Medical Directors etc. drawn from a wide range of practitioners throughout Australia.

One consultant psychiatrist from this group summarised thus: "I rather think that the main issues with doctor's health are:

- Break down the stigma of mental illness (a major challenge)
- Encourage doctors to avoid treating themselves without any form of professional supervision.
- Emphasise that psychological therapies do work and cannot always be done as 'self-help'
- Challenge the notion that saying 'no' to work is not unprofessional
- Challenge doctors to exhibit the same level of treatment adherence that they would want from their own patients."

A requirement of national registration is that of mandatory reporting. Prudent counselling of a colleague or friend whose performance is being adversely affected by substance abuse, psychological difficulties or the stresses of professional or personal life may avoid this necessity.

The Victorian State Committee has 'Doctors' Health' on their agenda for 2011. If you would like to contribute or participate in this 'project', you can email your information to college.vic@surgeons.org or call the VRO on 9249 1254 for further contact details.

The following resource is readily accessible on the web. The Mental Health of Doctors-A systematic literature review – www.beyondblue.org.au

Researching to help many

After his work from the Eric Bishop Scholarship in 2009/10, Dr Johnny Wong is continuing his important research into spinal cysts with the Sir Roy McCaughey Surgical Research Fellowship for 2011

While surgeons have known since the 19th century of the existence of a spinal cyst that can form following spinal cord injury, it wasn't until the late 1980s that they had the chance to begin a close study of it.

Called syringomyelia, the cyst occurs in approximately 28 per cent of patients following spinal cord injury, often putting further pressure on the damaged cord which, in turn, can create further neurological deficits in patients who may already be partially paralysed.

However, there is limited understanding of the mechanisms of syrinx formation and enlargement.

Now the recipient of two College scholarships, Dr Johnny Wong, is conducting research to find the answers.

"No-one knows how they form, but we do know that a quarter of patients with spinal cord injuries go on to develop syringomyelia," Dr Wong said.

"They represent a second spinal cord injury in a way, creating further problems such as pain, weakness and numbness. For people who may already be in a wheelchair who may then lose the use of their arms, the development of a syrinx is a very big deal.

"The current thinking is that the original spinal cord injury and scarring resulting from blood around the spinal cord create the environment, which in turn, promotes the cysts to develop.

"Current treatment involves dividing the scar tissue and freeing up the spinal cord or draining the cyst and inserting a shunt. However, this is very difficult surgery and often unsuccessful with the cyst recurring and worsening symptoms over time.

"If we could find the trigger to the initial cyst formation, we hope to find a way to prevent it and if we can identify the factors that influence the flow of fluid going in and out, we may be able to interrupt it."

Dr Wong's particular research involves creating the cyst in rat and sheep models and then using dye and ultra-sound technology to follow the flow of the fluid.

Dr Johnny Wong at work researching

His work has attracted keen interest, with the College awarding him the Eric Bishop Scholarship for 2009/10 and the Sir Roy McCaughey Surgical Research Fellowship for 2011. He has also received a scholarship from the Neurosurgical Society of Australasia (NSA).

Already, Dr Wong has made a presentation outlining his work and initial findings to the NSA and was also invited to present his work to the Syringomyelia International Symposium held in Berlin in December.

"Until now, no-one has ever seen fluid going out of the cyst, but we thought that if fluid was only going in, the cysts would rapidly enlarge and eventually rupture," he said.

"We have found that fluid does flow out of the syrinx and it does so in a diffusion pattern into the spinal cord.

"Recently, we have been investigating the role of water channel proteins in syringomyelia on the basis that if we can change their function at the molecular level we could shrink the cyst either by blocking off the flow into the cyst or promoting the outflow."

Dr Wong is a SET 4 neurosurgical Trainee with the College and undertaking his research as part of a PhD under the supervision of Professor Marcus Stoodley, Professor of Neurosurgery at the Australian School of Advanced Medicine at Macquarie University in Sydney.

"When you operate on a patient you can benefit the individual, but if you make a major advance in research you can help many people."

Given the nature of his research, he has divided his time between the university and the Institute of Medical and Veterinary Sciences in Adelaide where the sheep experiments are performed.

Dr Wong said that even though a year-long research component is mandatory in neurosurgery training, he had chosen a longer-term project because it had the potential to vastly improve the lives of patients already suffering this severe injury.

"I have always been interested in research not only because I enjoy the intellectual pursuit, but also that when you operate on a patient you can benefit the individual, but if you make a major advance in research you can help many people," he said.

The Eric Bishop Scholarship has been made possible due to a generous donation from the late Eric Bishop and is available to Fellows or Trainees wishing to take time away from clinical practice to concentrate on research. The Sir Roy McCaughey Surgical Research Fellowship is available to Fellows or Trainees wishing to conduct PhD research in NSW.

Both scholarships carry a stipend of $60,000.

With Karen Murphy

NZ mortality review

Mid last year, New Zealand's first national Perioperative Mortality Review Committee was established. Recent amendments to the New Zealand Public Health and Disability Act 2000 now place this committee within the newly established Health Quality and Safety Commission.

The Committee has been working towards its inaugural report, the first truly national snapshot of perioperative mortality in New Zealand.

"It was very clear from the first meeting that all of the committee members are committed to ensuring the development of a very effective system that will significantly add to the overall quality and safety of New Zealand healthcare", says Professor Iain Martin, Inaugural Chair of the Perioperative Mortality Review Committee and Dean of the Faculty of Medical and Health Sciences at the University of Auckland.

The Committee is responsible for reviewing deaths following any invasive procedure and deaths that have occurred following anaesthesia (local, regional, or general).

Specifically, perioperative mortality deaths include:

1. a death that occurred after an operative procedure
   a. within 30 days
   b. after 30 days, but before discharge from hospital to home or a rehabilitation facility.
2. a death that occurred whilst under the care of a surgeon in hospital even though an operation was not undertaken.

Gastroscopies, colonoscopies, and cardiac or vascular angiographic procedures (diagnostic or therapeutic) are included in this definition.

Once these data have been collected and analysed, the Committee will be able to make national recommendations on how perioperative mortality rates can be understood and reduced, taking a whole of system approach. Developing strategic plans and methodologies to reduce mortality and morbidity in this area is a key role of this Committee.

The Committee's first report will look at the approximately 2,900 deaths in 2009, with a focus on the 400 or so deaths that were associated with elective surgery. The reports will be available publicly and will contain collated, non-identifiable data on the deaths. Each year's report will contain an overview of all perioperative deaths with a detailed analysis of a particular category of deaths.

"The Committee is committed to working with health providers to help improve the quality and safety of perioperative services within New Zealand", says Dr Cathy Ferguson, member of the Committee and Otolaryngologist at Capital and Coast District Health Board.

Collection of these data is made possible by the unique legislation that protects both the information itself and those who provide information. Only an individual signed up as an "agent" of the Committee may view the personal data that the Committee collects. The Chair, or delegated authority, may request personal information, examples of which include patient records, clinical advice and related information or information that became known solely as the result of a declared or protected quality assurance activity. It is an offence of any agent of a mortality review committee to disclose personal information, carrying a fine of $10,000 for failing to comply.

Disclosure of personal information can be authorised by the Minister for the purposes of investigation, prosecution of a serious offence, or a Royal Commission or commission of inquiry. A ministerial authority, however, does not require the disclosure or create a duty to disclose the information.

"Health providers should be comfortable with the extent of the protection of information and those who provide it", says Dr Leona Wilson, Deputy Chair of the Committee and Anaesthetist at Capital and Coast District Health Board.

-Deon York

The Committee comprises a range of experts in the area of perioperative mortality review:

> Professor Iain Martin (Chair)
Dean, Faculty of Medical and Health Sciences, University of Auckland

> Dr Leona Wilson (Deputy-Chair)
Anaesthetist, CCDHB

> Dr Catherine (Cathy) Ferguson
Otolaryngologist, CCDHB

> Dr Philip (Phil) Hider
Clinical Epidemiologist, University of Otago

>Associate Professor Jonathan Koea
Hepatobiliary and General Surgeon, ADHB

> Dr Digby Ngan Kee
Obstetrician and Gynaecologist, MDHB

> Ms Rosaleen Robertson
Chief Clinical, Safety and Quality Officer, Southern Cross Hospitals Ltd

> Mrs Teena Robinson
Nurse Practitioner, Adult Perioperative Care, Southern Cross QE Hospitals

> Dr Tony Williams
Intensive Care Medicine Specialist, CMDHB

The inaugural report of the Committee is due for release in July of this year.

More information
www.pomrc.health.govt.nz
www.hqsc.govt.nz
Ministry of Health Contact: Deon York, 04 496 2000 or deon_york@moh.govt.nz

Developing a Career in Academic Surgery (DCAS)

Monday 2 May 2011, 7.00am – 4.00pm

Adelaide Convention Centre, North Terrace, Adelaide

This inspirational course contains elements of interest for medical students through to any surgeon who has ever considered involvement with publication or presentation of any academic work. Come along and find solutions to questions you have always wondered about in regard to surgical research.

In addition to highly regarded faculty from Australia and New Zealand, faculty in the 2011 DCAS course represent The University of Edinburgh, Baylor College of Medicine, The Johns Hopkins Hospital, The University of Wisconsin, Vanderbilt University, University of Texas, University of Michigan and the North Western University in Chicago.

Topics addressed include:

- Where do good ideas and research questions come from?
- Why every surgeon can and should be an academic surgeon
- How do I get started as an academic surgeon?
- Writing a successful abstract and paper
- Delivering an effective research presentation
- Finding the money for research
- Choosing a Journal for submission
- Writing a successful grant application
- Analysing your data
- Success in surgical research - basic science and outcomes
- Designing and running successful Randomised Controlled Trials (Clinical/ Translational)
- Career pathway development
- Challenges to successful research
- Development of Academic Surgery in Australia and New Zealand - a historical perspective
- How do you fit it in: work-life balance
- The future of academic surgery

Interactive Workshops

- *Challenges in any current research project. Bring your problems with you for brainstorming and discover how the experts would approach them.*
- *Approaches to research from rural/remote locations as well as from developing nations.*

Keynote Speaker: Professor Guy Maddern FRACS
"Lessons learned in my own academic career so far"

RACS Faculty include: Zsolt Balogh, Bruce Barraclough, Peter Choong, Richard Douglas, John Fletcher, John Graham, Richard Hanney, John Harris, Andrew Hill, Julie Howle, Glyn Jamieson, Benjamin Loveday, Frank Miller, Susan Neuhaus, Matthew Oliver, Richard Page, Arthur Richardson, Tarik Sammour, Jonathan Serpell, Stan Sidhu, Mark Smithers, Noel Tait, David Watson, David Watters and John Windsor.

AAS and International Faculty include: Herbert Chen, Justin Dimick, Lillian Kao, Scott LeMaire, Fiemu Nwariaku, Rowan Parks, Timothy Pawlik, Carla Pugh and Carmen Solorzano.

The Association for Academic Surgery (AAS) in partnership with the Royal Australasian College of Surgeons (RACS), Section of Academic Surgery

Johnson & Johnson MEDICAL COMPANIES

Proudly sponsored by Johnson & Johnson Medical Companies

2010 Comments

"This course greatly exceeded my expectations"
SET trainee

"Fantastic set of presentations and invited speakers"

Further information

Conferences & Events Management
Royal Australasian College of Surgeons
T: +61 3 9249 1273
F: +61 3 9276 7431
E: dcas@surgeons.org

Registration: Cost $176.00 inc. GST. Register on the ASC registration form or online at **http://asc.surgeons.org**

There are 15 complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org

NOTE: New RACS Fellows presenting for graduation in 2011 will be required to marshal at 3.30pm for the Convocation Ceremony.

The information is correct at the time of printing however the Organising Committee reserve the right to change the program without notice.

CPD Points will be available for attendance at the Course with point allocation to be advised at a later date.

Developing a career as an academic surgeon

The 2011 DCAS course is an enjoyable and informative day that aims to help every surgeon and trainee to find ways to improve academic aspects of their own career pathway

Attendants at the 2010 DCAS course.

Dr Richard Hanney

The Academic Section of the RACS and the Association for Academic Surgeons (AAS) will be running the third annual course, "Developing a Career as an Academic Surgeon (DCAS)" on the day before the RACS Annual Scientific Congress (ASC) in May in Adelaide. The President of the AAS has described an academic surgeon as "any surgeon that plays some active role in educating others or in conducting research of any type". On this basis and in partnership with the RACS Academic Section, the DCAS course aims to inspire every surgeon and help them find ways to improve academic aspects of their own career pathway.

Challenged by "Why every surgeon can and should be an academic surgeon", the 72 registrants in 2010 ranged from medical students to Department Heads and included all levels of surgeon and trainee in between. "Research in Private Practice" demonstrated the commitment of organisers to recognise one direction in which surgical research and training is currently progressing in Australia and New Zealand. The 2011 course will also again include an interactive workshop where experts from amongst the 37 faculty will sit down with participants to help work through any seemingly insurmountable challenge in any current research project. Participants in 2009 rated this session alone as being worth the time and $176 registration fee of the course. Bring your questions and problems with you!

Topics to be addressed in the 2011 course will include "Where do good ideas and research questions come from?", "Designing and running successful Randomised Controlled Trials", "Writing a successful abstract", "Writing your paper", "Presenting your work" and "Approach to submitting and revising your manuscript – choosing your journal". Speakers selected as outstanding role models from the US, UK, Australia and New Zealand will address issues that all surgeons and trainees grapple with in their career progression.

New for 2011, a separate interactive workshop will address the issues of academic surgery in rural and remote Australasia as well as in the developing world. Partnered with the International Forum and supported by GSA, this session will also consider how to return to academic surgical practice after time overseas.

How to get started as an academic surgeon, why trainees should consider time in full-time research as well as how to write successful grant applications, analysing data, setting up and running an academic program and pathways to promotion will all be considered for those more likely to take up full-time academic positions.

The 2011 DCAS course will be an enjoyable and informative day relevant to every surgeon and every trainee on the Monday before the ASC. Spend the weekend in the beautiful winegrowing regions surrounding Adelaide and provide yourself a professional challenge at the same time. Spearheaded by Andrew Hill, from Auckland, and Richard Hanney, from Sydney, and supported by a non-aligned educational grant from Johnson and Johnson: Medical Companies. this course makes every effort to provide an outstanding educational experience.

Defining competence through standards

Setting out degrees of competency will help in assessing Trainees and providing feedback. Your feedback on the standards set out here is welcomed.

Bruce Barraclough,
Dean of Education

An important component of competency based training is to be able to differentiate between Trainees who are competent, and those who are not.

However, a clear definition of what it means to be competent, or not-competent, and how can we determine the difference is not so easy to find. It is also difficult to find clear definitions of a standard, or levels of performance that could potentially separate competent from not competent.

The College and specialty training boards have developed detailed statements of the knowledge, skills and attitudes, which Trainees are required to meet across each of the nine competencies at the end of training. The College, through the Surgical Competence and Performance Working Party has also published behavioural markers for Fellows. However, the decision of competent versus not competent still remains dependent on the professional judgement of the person, or people making the assessment.

This is not an issue that is unique to the College. Much has been written in medical education literature over the past two decades about competency based training (CBT).

One approach that has been used in some of the surgical specialties (in both Australasia and overseas) to define technical competence has been to make a detailed analysis of the skills required to successfully perform a specific procedure. The four main difficulties with this approach are that:

- not all surgeons perform the same procedure in exactly the same way;
- this analysis tends to become increasingly focused on smaller and smaller components;
- each procedure is defined separately, therefore;
- the process is quite time consuming and labour intensive.

A second approach, favoured by this College, is to develop global frameworks of 'standards', which define increasing levels of difficulty and complexity of knowledge, skills and attitudes associated with a competence, and the level of performance at which 'competence' is achieved.

These standards frameworks are based on extensive research of international literature and best practice, as well as consultation with the different groups within the College involved in education, training and professional development. Currently this approach is being used to identify standards:

- in medical and technical expertise that could be expected of medical graduates and PGY1 and 2 (i.e. prior to commencement in SET);
- in medical and technical expertise that could be expected of Trainees at different stages of their progression though SET; and
- in the seven non-technical or professional competencies.

The first of these is being overseen by the Skills Education Committee and the second is the responsibility of the specialty training boards. The initial definition of all the professional (non-technical) competencies is being done within the College and then promulgated through a range of different forums for consultation.

This paper, presenting the first of the professional standards is published to initiate discussion through the Fellowship and wider surgical community.

Judgement – Clinical Decision Making

Judgement-Clinical Decision Making is a competence that is central to both diagnosis and performance of all procedures.

In his latest book, The Checklist Manifesto, Atul Gawande (2009) makes a distinction between errors of ignorance (mistakes we make because we don't know enough) and errors of ineptitude (mistakes we made because we don't make proper use of what we know). For surgeons, the latter kind of error, that of poor judgement, can have extreme consequences.

For the purposes of defining an acceptable standard of performance in the competence of Judgement – Clinical Decision Making for surgical Trainees, the following five components (knowledge, skills and attitudes) have been identified:

A. Perform a complete and appropriate assessment of a patient.
B. Recognise the symptoms of and accurately diagnose problems.
C. Organise diagnostic testing, imaging and consultation as appropriate.
D. Manage patients.
E. Monitor and evaluate own decision making processes.

The behavioural indicators in each of the five standards following correspond with each of the five components (A-E).

RACS – Five Stage Framework showing the Development of Judgement – Clinical Decision Making

Characteristic behaviours

Stage 1
Base level

A. Identifies patterns in a list of evidence about a patient
B. Rigid adherence to taught rules or plans
–Knows basic algorithms or decision trees - applies them rigidly
C. No discretionary judgement
D. Little situational perception or anticipation of potential issues

Stage 2
Novice

A. Takes a history, perform an examination, and arrive at a well-reasoned diagnosis
B. Explains relationships and rules applied among patterns
–Hypothesises explanations for patterns, tests generalised explanations and eliminates alternatives
C. Choices and decision of most appropriate tests, etc based on knowledge that can be gained only after some prior experience of the condition(s)
D. May miss some critical details
E. Can synthesise and justify decisions

Stage 3
Advanced Beginner

A. Conduct an effective, efficient and focused examination of patients with common conditions
B. Recognise the most common disorders and differentiate those amenable to surgical treatment
C. Conscious deliberate planning and choices, focusing on key attributes
–Critically evaluate the advantages and disadvantages of different investigative modalities
–Can appraise and interpret radiographic investigations against patient's needs
D. Effectively manage complications of common conditions generating or applying solutions from standardised and routine procedures to other situations
E. Recognises own errors

Stage 4
Competent

A. Conduct an effective, efficient and focused examination of patients with complex conditions
B. Identifies what is most important in a situation
–Sees situations holistically rather than in terms of single components
–Deals with deviations according to the situation
–Capable of conjecture and hypothesis testing to deal with exceptions to the general rule
C. Selects medically appropriate investigative tools and monitoring techniques in a cost-effective, and useful manner
–Consults and calls for assistance appropriately
D. Manages all patients (including the critically ill) in ways that demonstrate sensitivity to their physical, social, cultural, and psychological needs
–Manages complexity and uncertainty, anticipating and planning for potential problems
E. Recognises own errors and adapts to patient needs or changed circumstances

Stage 5
Proficient

A. Seeks second opinion when appropriate
B. Intuition, insight and creative approaches are used to solve problems
–No longer consciously relies on rules, guidelines or maxims; operates from a deep understanding of the total situation and potential complexities
C. Plans ahead to ensure availability of all necessary resources
D. Initiates balanced discussion of pros and cons with care team
E. Analytical approaches are only used in novel situations or when a problem occurs

The base-level is indicative of a person who has studied the area, but has had little or no experience in applying their knowledge.

The novice, advanced beginner, and competent levels indicate that the person has both studied and had some experience in the area – the difference being in their ability to move more effectively through the process and to adapt their thinking to both changes and errors.

At the levels of proficiency, the person becomes so efficient in their judgement-clinical decision making that to a naïve person they may appear to be jumping to conclusions. What is not observable is the wealth of experience and previous similar clinical situations that are being drawn on.

It is important to recognise that in each clinical environment where they lack experience, a Trainee's performance can be expected to drop down one or two levels. However, over the period of training, even though they may have less knowledge in a certain clinical area, their skill and approach to clinical decision making ought to remain at least in the middle of the range (Advanced beginner – Competent).

If this standards framework is an accurate representation of the knowledge and skills of 'Judgement – Clinical Decision Making' then it will be a useful tool to enable a Trainee, a supervisor, or trainer to identify fairly quickly the level at which the Trainee is functioning and to use that as a basis for both feedback and assessment.

An important component of competency based training is to be able to differentiate between trainees who are competent, and those who are not. To guide those decisions a clear set of articulated and shared standards are necessary.

Your feedback on this, the first of the standards frameworks on the professional – nontechnical competencies, will be much appreciated. Please provide your feedback to the Dean of Education bruce.barraclough@surgeons.org

1> VP Keith Mutimer presents Russell Lecture Medal to Philip Sharp. 2> Donald Simpson. 3> Felix Behan. 4> Jenny Royle and John Royle. 5> Virginia West & David West

PHOTOS COURTESY OF JOHN ALOYSIUS HENDERSON.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Cowlishaw Symposium

The eighth biennial Cowlishaw Symposium was held on Saturday 6 November, 2010, in the Hughes Room at the College's Melbourne office.

Mike Hollands
Treasurer

The Symposium began with the 10th Kenneth Fitzpatrick Russell Memorial Lecture, delivered by Philip Sharp, whose topic was Herman Boerhaave: the "Dutch Hippocrates".

The Symposium was opened by Keith Mutimer, Vice-President of the College, who also chaired the first session and presented Philip Sharp with the Kenneth Fitzpatrick Russell Medal.

In the first session Elizabeth Milford, the College Archivist, gave a presentation on some letters from Sir William Osler to Leslie Cowlishaw, which are held in the College Archives. Ms Milford prepared a display of these items for the Symposium, which was much appreciated.

Following Ms Milford, Geoffrey Down, the College Curator, gave two presentations, the first a brief footnote to a paper given at the 2008 Symposium on The Monsters of Ambroise Paré, the second and more substantial presentation being on the ramifications of the trepanation of Pope Clement VI carried out in 1343.

After the tea break, the second session began with Emeritus Professor Donald Simpson discussing the exploits of Bartolommeo Eustachi, the papal anatomist, in Renaissance Rome.

The last paper before lunch was given by Hon. Professor Sam Mellick, whose subject was Sir Kenelm Digby, the 17th century diplomat, scientist, entrepreneur, poet, philosopher, privateer, duellist and general eccentric.

After lunch Felix Behan gave an enthusiastic presentation on the restoration of one of the Cowlishaw books, Anatomia deudsch, the first German edition of Vesalius (1551), currently being undertaken by Nick Doslov of Renaissance Bookbinding.

Associate Professor John Royle and his daughter Jenny Royle MD then presented a paper on Edward Jenner and the eradication of smallpox. This was the first time a father-daughter duo had presented a paper at the Symposium. Jenny Royle is an immunologist at the Royal Children's Hospital in Melbourne.

The final session belonged to New Zealand, with Wyn Beasley and Alan Thurston presenting papers respectively on weasels, keys and Thersites, and congenital abnormalities of the upper limb. The Symposium closed at 5pm, after which a cocktail reception was held in the Council Room.

The day was a great success, some participants even expressing the opinion that this was the best Symposium so far. Honoured guests included Mary Russell, daughter of Professor Ken Russell, and Virginia and David West, grandchildren of Leslie Cowlishaw. Dr David West is a general practitioner in New South Wales and this was the first time he had seen his grandfather's collection of medical books.

The College's thanks go to the presenters, who spend many hours researching and preparing their papers, to the convener Alan Thurston, who again provided a good and diverse range of speakers, to Vice-President Keith Mutimer, and to the College support staff, especially Megan Sproule and Geoffrey Down.

TURNING IT OUTWARDS

DESPAIR & DELIGHT AN EXHIBITION OF DOCTORS' ARTWORKS

The Turning it Outwards exhibition aims to challenge doctors to respond creatively to conflicting and difficult emotions in their day-to-day work, through media such as painting, sculpture and photography. The exhibition hopes to lift the veil on the medical profession, and to provide a window into the private and intimate emotional landscape of doctors.

It is not always possible for doctors to express themselves amongst peers or patients, and this inability or unwillingness can (and does) contribute to burnout, suicide, marital breakdown and mental health issues. Without an effective outlet, emotions bottle up, percolate and may ultimately explode. Some doctors have found that laying bare their humanity through a creative outlet can bring perspective to such issues and enrich their lives.

If you would like to apply to be part of this collaborative exhibition, please send a detailed submission of your proposed artwork(s) in any medium, together with your CV and some images of your previous work, to:
Dr Jeremy Rosenbaum, jeremy@rosenbaum.net
OR Jeremy Kibel, info@blockprojects.com.au
by 30 April 2011. For further information, please call Jeremy Rosenbaum on 0412 313 411.

The restoration of the 1551 Vesalius Textbook – "De Humani Corporis Fabrica"

From a presentation at the Cowlishaw Symposium at the Royal Australasian College of Surgeons meeting in November, 2010

Felix Behan,
Victorian Fellow

I have used Helen Keller's quote "Yesterday's heresy is tomorrow's orthodoxy" as an introduction to this story of Vesalius, because his contemporaries scorned him for daring to question Galen of Pergamon, Turkey (127 – 199 AD) and his edicts on anatomy.

Galen's presence was so prestigious in Rome that even the Emperor Marcus Aurelius appointed him as surgical practitioner for the Roman legions.

Recently I saw again the film the Gladiator with Maximus in charge of the Roman forces under Marcus Aurelius and in this historic/fictional account, Galen was featured attending to the mutilating injuries in the Germanic campaign.

This story of the Vesalius textbook restoration takes me into the back streets of Fitzroy in Melbourne, where I met Nick Doslov, an antique book restorer at Renaissance Bookbinders. He was doing some leatherwork on the leather casing of my set of antique silver goblets (for drinking malt on the moors in times past, no doubt) when he showed me, with reverent homage, this 1551 Vesalius textbook he was restoring for the Royal Australasian College of Surgeons under the curatorial supervision of Geoff Down.

The book was in a state of severe deterioration including borer damage to the leatherwork and water stains to the end-plate pages. The silk ribbon page markers had been eaten back to the binding reflecting its 450+ years.

This textbook has been part of the College heirlooms since the Cowlishaw collection was purchased in 1943 – it had been offered unsuccessfully for sale in Sydney to the Royal Australasian College of Physicians.

Luckily the RACS purchased this under Sir Alan Newton (for something in the order of £2,500). What is its value today? When I was in Paris recently at Alain Brieux, the antiquarian book retailer on the Left Bank, I was shown an original Tagliacozzi in his sale catalogue for €50,000. Relatively, this puts the value of the Vesalius textbook in the six figure range.

What important anatomical and surgical minds would have leafed through these pages (gloved, one hopes!) over the years. Over nine months, I went to Nick's studio on a fortnightly basis to record the details of his craft, and the value of the restoration alone may have approached $4,000 to $5,000.

The work included removing glue detachments (Ex Libris) of previous owners, pencil marks using a rubber eraser, fumigation to eliminate any remaining spores, restoring damaged pages and recolouring them with weak Bushells Tea to add authenticity to match the original.

Nick Doslov from Renaissance Bookbinders with the antique text; the borer-damaged book before restoration.

I warned Nick about the dangers of tuberculoses organisms that might be lying dormant and I repeated the World War I stories about tetanus spores re-emerging following surgical re-exploration of old war wounds.

This led me to review the history of Vesalius. He was born on New Year's Eve in 1514 and died as a shipwrecked sailor in Zakynthos in 1564. His text *De Humani Corporis Fabrica* was one of the most influential textbook of anatomy ever written. Perhaps we should also thus say he was a founder of modern surgery.

It may be similar to my colleague Bob Marshall's 2004 textbook *Living Anatomy: Structured as the mirror of function,* which reflected his comprehensive surgical career based on the love of anatomy. It is a landmark publication of the 21st century and will be seen as the same light as Vesalius in time I suspect.

Vesalius was born in Brussels (Bruges) and his father was an apothecary to Emperor Maximilian and Charles V. He studied Galen under Jacques DuBois in Paris in 1533, doing the anatomical dissections himself without an attendant, as was the habit of the time and supported his findings with meticulous drawings.

His updated version of "Institutiones Anatomicae" led to criticism from his detractors. Yet any new emerging principle always creates controversy, and it brings to my mind the Brendan Behan quote about such types: "Critics remind me of eunuchs in a harem – they know how to do it, they see how to do it, but ..."

Vesalius was forced to leave Paris in 1536 following the outbreak of hostilities between the Holy Roman Empire and France. Vesalius went on to Venice, the origin of this publication, before going to Padua where he held the chair in surgery.

In 1539, a Paduan judge made available the body of an executed criminal for dissection purposes, which broke the long standing tradition prohibiting human anatomical dissection, established since the time of the Roman era and adopted subsequently by the Church.

This became the first accurate anatomical dissection drawing by a commissioned artist with copper etchings by Calcar, a pupil of Titian.

In 1541, he found Galen's anatomical findings were based on animal studies thought to be Barbary apes. Actually, they were Macaque monkeys indigenous to Gibraltar, an outpost of the Roman Empire.

In 1541, he published a correction of Galen's *Opera Omnia* with some corrections which included: the heart was the mechanical unit for circulation and not the liver as declared by Galen's canon; the sternum consisted of three major portions (Galen said there were seven); and the jawbone was a single unit and not double as Galen stated. The trunk, abdomen and limbs were re-evaluated.

He also named various bones of the skull including the sphenoid and stated that the brain and nervous system was the centre of the mind, discounting another faulty Aristotelian claim who said it was the heart.

He then proposed the striking hypothesis that anatomical dissection might be used to test physiological findings to establish functional principles – the beginnings of evidence-based medicine.

In 1543, his public dissection in Basel in Switzerland became known as the Basel skeleton, still preserved to this day – the world's oldest anatomical preparation.

In the seven volumes of the 1544 publication, Calcar did the copper engravings. It was a major success, like *Gray's Anatomy*, with Vesalius only 30 years of age at the time (Gray was 31 when he produced his 1858 publication with the help of Van Dyke Carter, the illustrator).

He went into the court of Charles V, Holy Roman Emperor and King of Italy with an extensive Empire. Over 11 years there, he was the subject of scorn while travelling with the court to various battlefields, once more bringing to light the inseparable link between surgical development and the traumas of war.

The other courtiers mocked this barber surgeon as lacking 'prestige and status'. Some physicians still think this way, like the Navy, the senior service. We are trying our utmost to erode this entrenched perspective.

College curator Geoff Down with the restored book. Inset: Vesalius himself.

He was even sent on pilgrimage to the Holy Land as punishment following an Inquisitional type inquiry by the court of Charles V. Why? He conducted a post mortem on someone whose heart was, unknowingly, still beating with the person presumably brain dead.

Vesalius died at 50 years of age on the Ionian seas, shipwrecked near Zakynthos. He was about to be given a pauper's grave there (where usually the bodies were fed to the dogs) but a benefactor stepped in, at the 11th hour, to pay for the funeral.

This story of anatomical dissections reminded me of my own experiences in London in the 1970s when I was engaged in research at the Royal College of Surgeons as a Bernard Sunley Research Fellow into the vascularity of flaps.

The homeless who died under Waterloo Bridge were taken across to Charing Cross Hospital in the Strand for final post mortem assessments. The mortician at Charing Cross allowed me access to the cadaver before they were buried in a pauper's grave (as what almost happened to Vesalius himself).

I harvested flaps from the forehead and chest wall and scalps from the bodies of these unfortunate individuals to come upon my concept of the Angiotome. The procedure of draping the post mortem scalps over a bowl after hair removal helped identify superficial temporal and occipital vessels. This technique was used in preparation in the first published microsurgical scalp replacement at the Alfred with Graham Miller, John Anstee and John Snell in 1974.

This clinical application must reflect our indebtedness to such deceased individuals. We still rely today on the generosity of those who are willing to bequeath their remains for the purposes of medical research and education, an altruistic principle as medical science has benefited from this in our ongoing educational development.

Professional Development Activities 2011

The College continues to provide a range of courses to help you through your working life.

A/Professor Marianne Vonau
Chair, Professional Development Committee

The challenge for all Fellows is to keep up-to-date so that FRACS after our name stands for excellence throughout our working life.

This requires us to regularly take part in educational activities as part of life-long learning in order to maintain and further develop our competence and performance. The College is offering a range of exciting activities in 2011 to provide you with new skills and knowledge.

We are keen to provide ongoing support to supervisors and trainers so have developed a new three hour workshop called Keeping Trainees on Track. This workshop aims to complement our other surgical teachers courses; the Supervisors and Trainers for SET (SAT SET) Course and the Surgical Teachers Course.

Just like SAT SET, Keeping Trainees on Track will be facilitated by Fellows interested in surgical education. It focuses on techniques to encourage trainees to be independent adult learners and the performance management of inexperienced and underperforming trainees through goal setting and effective feedback.

Another new course that can help to improve your communication skills is the Process Communication Model (PCM). The theory proposes that each person has motivational needs and a preferred communication style.

Before the Introductory PCM course each participant completes a diagnostic questionnaire which forms the basis of an individualised report about their preferred communication channel.

The course explores how you can recognise each communication style and use it to motivate the people around you and communicate more effectively with team members.

The course also introduces tools to help identify stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

There are also workshops to support Fellows interested in leadership and management such as Leadership in a Climate of Change, Providing Strategic Direction and Sustaining Your Business.

"The course explores how you can recognise each communication style and use it to motivate the people around you and communicate more effectively with team members."

The content of these workshops has been given a surgical perspective by Prof Cliff Hughes FRACS and explores practical strategies to effectively manage the strategic direction of a business through leadership, comprehensive business operations and financial management.

These workshops can be 'stand alone' or combine with distance learning modules toward an Advanced Diploma of Business through the University of New England.

All of the College professional development activities are tailored to the specific needs of surgeons. RACS Fellows are usually directly involved in developing the content of workshops and as either facilitators or convenors.

In addition, other Fellows on College Boards/Committees have input as the workshops move through the development, approval and reporting process. Their involvement helps to ensure that our workshops support the maintenance of your skills and knowledge in today's dynamic world.

The College's professional development activities focus on the non-technical aspects of competence as identified in the College's definition of surgical roles and competence. These generic roles include communication, collaboration, management and leadership, health advocacy, scholar and teacher and professionalism – in addition to the clinical roles of a surgeon in relation to medical expertise, technical expertise and clinical decision making.

Many of these activities are also suitable for other medical professionals.

I look forward to seeing you at some of these invaluable workshops.

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

Professional Development WORKSHOPS

The professional development activities that the College is offering in 2011 are tailored to the specific needs of surgeons. By providing these workshops, the College supports the maintenance of your skills and knowledge in today's dynamic world.

>Communication Skills for Cancer Clinicians

12 March 2011, Melbourne

In partnership with The Cancer Council Victoria, this four-hour workshop focuses on teaching you evidence-based, step-by-step communication skills that break down the challenge of delivering bad news to patients and their families. A clinical psychologist will demonstrate the communication strategies and a role play exercise with an experienced actor enables you to practice your new skills.

>Providing Strategic Direction

18 - 20 March 2011, Sydney

Want a solid understanding of the strategic planning process? Over 2½ days you can gain the skills and knowledge to produce and implement an organisational strategy. Focus will be on how to establish a strategic direction through an effective planning process. You will also learn more about conducting an organisational/market analysis, sustaining a competitive advantage and developing strategic measurement systems.

>Supervisors and Trainers for SET (SAT SET)

23 March 2011, Perth. 5 April 2011, Melbourne

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. Participants will learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. The workshop offers an opportunity to explore strategies to improve the management of trainees, especially those that are underperforming, with focus on how to prepare, conduct and review a mid-term meeting. It is also an excellent opportunity to gain insight into the College's policies and processes; including legal requirements and the appeals process.

>Surgical Teachers Course

31 March – 2 April 2011, Sea World Gold Coast

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.

>Occupational Medicine; Getting patients back to work

Friday 8 April 2011, Melbourne

Doctors are increasingly expected to participate in the process of helping patients return to work. Understanding a patient's working environment, job restrictions and work role alternatives can improve communication between stakeholders and assist doctors to provide better advice to patients. The next Occupational Medicine course will visit two industries after; the Mushroom Exchange, Australia's largest mushroom growing and packing complex plus the QANTAS aircraft maintenance facility. Participants may choose to attend one or both sites.

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.

2011 DATES:
FEB – JUNE

NSW

>18-20 March, Sydney
Providing Strategic Direction

>26 March, Sydney ***NEW***
Keeping Trainees on Track (KToT), (Facilitator)

>11 June, Sydney
Keeping Trainees on Track (KToT)

>28 June, Sydney
Supervisors and Trainers for SET (SAT SET)

QLD

>31 March – 2 April, Gold Coast
Surgical Teachers Course

>27-29 May, Brisbane
Sustaining Your Business

SA

>29 April – 1 May, Adelaide
Younger Fellows Forum

>2 May, Adelaide (pre ASC)
Keeping Trainees on Track (KToT) ***NEW***

>2 May, Elizabeth (pre ASC)
Occupational Medicine

>2 May, Adelaide (pre ASC)
Polishing Presentation Skills

>2 May, Adelaide (pre ASC)
Practice Made Perfect

>2 May, Adelaide (pre ASC)
Supervisors and Trainers (SAT SET)

VIC

>12 March, Melbourne
Communication Skills for Cancer Clinicians

>5 April, Melbourne
Supervisors and Trainers for SET (SAT SET)

>8 April, Melbourne
Occupational Medicine

>25 June, Melbourne
Making Meetings More Effective

WA

>23 March, Perth
Supervisors and Trainers (SAT SET)

>11 June, Perth ***NEW***
Keeping Trainees on Track (KToT)

Early Management of Severe Trauma in Samoa

Disaster can be a painful time though also a time to recognise opportunities. An Early Management of Severe Trauma Course (EMST) was conducted in Samoa in September 2010

Professor Phil Truskett
Chair, EMST committee

In September 2009, a devastating tsunami in the Pacific struck several island nations. The most severely affected area was along the southern coast of Upolu, the main island of Samoa, where over 100 people lost their lives and many others suffered trauma and injury.

This region was remote from Samoa's main hospital in Apia; consequently medical and other resources were not readily available. Many of the islands' 40 or so registered medical practitioners were pressed into service that day to help with the recovery and treatment of victims, often with minimal resources at their disposal.

The tsunami experience galvanised the need for an Early Management of Severe Trauma (EMST) course to be provided for the local medical community who had shown interest in EMST after a number of Samoan doctors had attended the course in Fiji.

As the EMST course is designed to teach lifesaving skills with minimal resources, particularly in the first few hours after trauma, it was seen to be highly beneficial in providing medical practitioners with additional trauma management skills. With this in mind, a request was made to the Pacific Development Unit (PDU) in New Zealand to see if an EMST course could be run in Apia.

Funding became available as a consequence of the relief effort and particularly by a charitable donation from BUPA Healthcare, providing the means to make the course a reality.

Several volunteers that had put their names forward to instruct on the course headed out a few days early. This provided the opportunity for faculty to see the proposed venue and to set up and plan the course to ensure it ran smoothly and also to head off around the island where faculty were able to see some of the worst hit areas for themselves.

In Samoa, there was high media interest in the course with articles and pictures appearing in the local press. The course was arranged to take place around the anniversary of the tsunami itself and was held at the Oceania University of Medicine (OUM) which had kindly cut lectures for three day to allow us to utilise the lecture room, lab and various other areas for the course.

Nearly all of the 16 participants had been involved in the aftermath of the tsunami and their stories were fascinating. They ranged in speciality from General and Orthopaedic surgery through to Gynaecology and Paediatrics and out to Private General Practitioners.

We ran the course in its standard two and a half day format with a combination of inter-active lectures and practical skill stations with some slight modifications to the program to take into account the local environment and available resources.

For example, Samoa doesn't have a blood bank or a fully equipped Intensive Care Unit. Their splints tend to be bamboo sticks rather than full traction splints and things like FAST scanning and embolisation are just not available.

The most relevant final day scenarios for the local environment were selected; the hypothermia case was modified for example! Medical student volunteers acted as patient models for the cases and the faculty applied the moulage make up themselves – it was worryingly good in some cases!

The participants genuinely enjoyed the course and they all seemed to get a tremendous amount out of it. The course and faculty dinners were well attended and we were privileged to hear some of the harmonious singing for which the Samoans are renowned. The course catering was some of the most impressive I have seen as was the amount that the participants managed to get through.

In a single course, a good proportion of the Samoan medical fraternity has now participated in the EMST experience. The course was a valuable and enriching experience for all involved, broadening the horizons of faculty and participants alike and providing new skills and insights into trauma management.

With Mark Sanders, EMST Course Director

> *"The tsunami experience galvanised the need for an (EMST) course to be provided for the local medical community."*

Getting patients back to work

The Medico Legal Section is continuing with industry visits on return to work practises after a successful 2009 program.

A/Professor Marianne Vonau
Chair, Professional Development Committee
Written by Edward (Ted) Schutz Convener

Below: Attendees at BlueScope Steel in Pt Kembla

> *"Through the workshops, you can gain industry knowledge and learn what will make the most difference in assisting your patients and their employers in the return-to-work process."*

Industry visits are a part of the CPD program convened by the Medico Legal Section. Each workshop held to date has been an amazing adventure. They provide a unique opportunity for participants to gain valuable insights into industry as well as CPD points through this hands-on course.

As surgeons, we treat and advise patients from our specialised knowledge base. Through the workshops, you can gain industry knowledge and learn what will make the most difference in assisting your patients and their employers in the return-to-work process.

The next site visits are to Mushroom Exchange, Qantas, Melbourne in March, 2011 and to GM Holden in Adelaide, as a pre-ASC workshop on Monday, 2 May, 2011. At both workshops participants will see factories, workers and management in action and be able to consider their skills and needs from a new perspective.

Earlier articles have been half day visits to the Ford motor company in Broadmeadows, Victoria and the Coal Mine Training Facility in NSW. Feedback indicated that a whole day format would be preferable for future workshops. Consequently, the next workshop was a full day.

On 12 November 2010, in Victoria we visited In2Store, which is the largest undercover warehouse distribution centre in Australia; and Sutton Tools, a fourth generation precision engineering company exporting worldwide.

At In2Store, we were able to observe the complete process from goods arriving through warehousing, picking and packing to dispatch. We saw first-hand the range of activities performed, much of which was machine related, but with some manual handling. We saw how the warehouse accommodates workers in returning to work. This store has a relatively young workforce with a strong desire to return to work.

At Sutton Tools, we heard and saw that production has changed from manual handling to precision engineering, where workers now mostly control machinery. However, some manual handling areas remain. We also noted multi-skilling. In this factory there is a very low turnover of staff and a very high rate of return to work, whether the reason for being off work was work-related or not. This factory has a relatively older workforce: the workers want to return to work as soon as possible and the older workers do not wish to retire.

In November 2010, we toured the BlueScope Steel blast furnace and hot rolling steel mill site at Pt Kembla NSW, which is the largest single-industry site in Australia which was simply incredible and an amazing experience. We were treated to an in-depth look at the steel production process. Being heavy industry, most processes are machine and computer-controlled. During our visit some maintenance was also being performed, so we were able to observe crane assisted manual handling.

Each site visit includes in-depth presentations concerning the industry and, of particular interest to surgeons, return-to-work in action. Case presentations are included where possible. The discussion focuses on shortened treatment times and proactive communication through written reports and certificates detailing recovery and return-to-work advice. The industry knowledge gained improves our ability to proactively manage cases back to work, which is a great assistance to workers and management.

The Occupational Medicine Course and all CPD programs convened by the Medico Legal Section are open to all surgeons. Other 2011 programs include Writing Medico-legal Reports and AMA5 Difficult Cases courses.

For more information email MedicoLegalSection@surgeons.org or call +61 3 9249 1106 or visit www.surgeons.org and follow the links to Fellows/Professional Development/activities.

Chris O'Brien Travelling Scholarship

The American Head Neck Society and the Australian and New Zealand Head Neck Society have created a joint award to honour Professor Chris O'Brien in order to foster ongoing education and research between the three countries. This scholarship will be awarded every two years and alternate between Australia, New Zealand and North America. In 2008, Carsten Palme was nominated and chosen as the inaugural "Chris O'Brien Travelling Scholar" and undertook his trip in January 2010.

Dr Carsten E. Palme FRACS

I was presented with the "Chris O'Brien Travelling Scholar" award at the annual meeting of the American Head Neck Society in Phoenix in 2009. My itinerary included three major head and neck cancer centres in both the US and Canada for a period of three weeks. These included Memorial Sloan Kettering, New York, the Wharton Head Neck Cancer Centre, Toronto and MD Anderson, Houston.

I arrived in a very chilly New York City in January 2010. After overcoming jetlag I attended the Head Neck Cancer Service at MSKCC, where I was warmly welcomed by Dr Ashok Shaha and his faculty.

Over the course of my visit, I saw some interesting pathology and attended operating rooms and outpatient clinics. I presented grand rounds on transoral laser surgery and skin cancer.

As a bonus I had the great pleasure of attending a clinic by Dr Michael Tuttle, who is a world renowned thyroid endocrinologist.

As a result, I gained great insights into Dr Tuttle's thinking and approach to the management of these most difficult and challenging cases. I would highly recommend a visit with Dr Tuttle to anyone planning a career in thyroid surgery.

During my stay I had the great luck to catch an ice hockey match between the New York Rangers and the Boston Bruins at Madison Square Gardens.

I then left New York for Toronto, which I consider my second home having spent a significant time there during my fellowship in 2002 and 2003.

It was a wonderful opportunity to catch up with colleagues, nurses and chat with the Fellows.

I led a teaching session and presented grands rounds to the Faculty of the Department of Otolaryngology, University of Toronto on

my experience with transoral laser surgery of early vocal cord cancer.

I also spent time with my mentor and friend Dr Ralph Gilbert. An influential person in my career in head and neck surgery, Dr Gilbert is a great teacher, outstanding clinician, researcher and innovator.

I naturally caught up with Dr Patrick Gullane, who is one of the 'greats' in head and neck surgery. Dr Gullane has passed a wealth of knowledge and vast experience to an entire generation of young head neck surgeons like me all over the world.

He has recently had the great honour of being awarded the Order of Canada.

After Toronto, I flew to Houston, Texas, my last stop. I had heard a lot about MD Anderson. I was slightly anxious given the great reputation of this institution.

I was pleased that it was warmer in Houston. I was greeted by great Texan hospitality when I was picked up from the airport by Shirley's Towncars, generously organised by Dr Randal Weber.

I have never seen a larger and more concentrated medical precinct. MD Anderson is made up of many high rise buildings all connected by enormous above ground walkways.

Dr Weber explained that the budget for MD Anderson per annum alone exceeds US $3 billion. Many other hospitals are located within the vicinity.

I attended the outpatient department operating suite and presented grand rounds on metastatic cutaneous scc of the head neck and laser surgery for early vocal cord cancer..

This trip was one of the most intense and amazing experiences in my professional life as a head and neck surgeon.

It was a great privilege and honour to spend time with the world leaders in head neck oncology.

Presenting our own data and some of the work that I have been involved with to some of the most recognised and well respected clinicians was at first slightly daunting and overwhelming. But having survived this experience it has made me more determined to continue our work, participate in research and to share our knowledge.

It is easy to be disappointed by the lack of resources and infrastructure in our health system when you travel abroad, but I feel that the most significant resource we have are our clinicians themselves and their dedication.

The challenge remains to how we are to improve our approach. The first step is to embrace this association with North America and fully support the "Chris O'Brien Travelling Scholar" Award.

I would like to give thanks to both the Australian and New Zealand Head and Neck Society and the American Head and Neck Society for bestowing this great honour on me.

A great thank you goes to all the members of the head and neck faculty at Memorial Sloan Kettering, University of Toronto and MD Anderson. I would also like to acknowledge all the people that have trained me and influenced me in my career. This foremost includes all my colleagues at Westmead Hospital, and significantly, Professor Patrick Gullane and his faculty.

Most importantly, I would like to thank Professor Chris O'Brien, who gave me the opportunity to embark on a career in head and neck. Without his integral involvement, support and belief in me I would have never had the great opportunities and experiences that I had and continue to enjoy today.

ANZ Chapter of the ACS

Chapter celebrated 25 years in 2010

Dr John Buckingham
President, ANZ Chapter of ACS

The Australian and New Zealand Chapter of the American College of Surgeons was established 25 years ago by Fellows including Tom Reeve, Doug Tracy, Murray Philes, Ken Cox and John Ham. Membership is open to all Fellows of the ACS residing in Australia or New Zealand. Tom obtained fellowship due to his training in the US, but all RACS Fellows in practice for three years can apply for fellowship of the ACS. The major benefit of the ACS Fellowship is that it opens up many educational opportunities offered by the ACS both in the US itself and via the world wide web.

One of the major benefits is the Clinical Congress held every October. The Congress Registration Fee for Fellows of the ACS is negligible. The cities it rotates through include Chicago, San Francisco and this year, Washington. Apart from the obvious benefits of visits to these interesting cities, the Congress has many panel discussions and educational courses on current topics of surgical interest as well as state of the art lectures. The trade displays are amazing to behold.

There are 36 international chapters of the ACS. The ANZ Chapter celebrated its 25th birthday in 2010. It was the first international chapter to establish a Travelling Scholarship. Twenty five years ago this was initiated and a young American surgeon under the age of 45 has attended our Annual Scientific meeting and visited several other centres in Australia and New Zealand every year since. This is a highly sought-after fellowship and many awardees have gone on to hold important roles in American Surgery (J. Am. Coll. Surg 2010; 211:279-284).

This year the ANZ Chapter has made the Travelling Fellowship reciprocal. Baxter has supported this, as has the RACS and it is called the Hugh Johnston ANZ Chapter Travelling Fellowship. The first award recipient is Dr Peter Anderson, a cranio-facial surgeon based in Adelaide. He will go to the 2011 Annual Clinical Congress and then visit two other American medical institutions.

The ANZ Chapter's next initiative will be to encourage RACS Trainees to become resident members of the ACS and our Chapter. This will open up for them a vast array of educational material available on the ACS website. We will also be offering a scholarship to send a selected trainee to the ACS Annual Clinical Congress.

Our chapter has an annual luncheon held on the first day of the RACS Annual Scientific Meeting. Our travellers give a short talk and we have been honoured by the presence of every President of the ACS for the past 11 years. They usually give a short presentation on current surgical issues in the US.

The International Relations Committee of the ACS also offers Guest Scholarships that include attending the Clinical Congress. This has been awarded to a number of Australian or New Zealand surgeons over the years including Andrew Barbour, Wendy Brown, Reginald Lord, Julian Smith, Grant Christey and Jonathan Barnes Koea.

We would like to encourage all RACS Fellows to consider joining the ACS as Fellows and encourage Trainees to join the Resident and Associate Society of the ACS (RAS-ACS). Details can be obtained from the following website – http://www.facs.org/ras-acs/index.html

ACADEMY OF SURGICAL EDUCATORS

Your chance to get involved

Building the Academy of Surgical Educators means asking for the involvement of both Fellows and Trainees

A/Professor Vincent Cousins
Chair, Board of the Academy of Surgical Educators

The Academy of Surgical Educators (ASE) was established by the College in 2009 in recognition of the increasing complexity of delivering a comprehensive surgical training program and the need to further embrace modern educational theory and practice, including the use of new technology.

Fellows of the College are responsible for the design, delivery and assessment of all surgical training across nine surgical specialties and the Academy will enable the College to better support and further develop those activities at the highest level.

The College's President and Dean of Education at the time stated that the Academy "will promote high quality patient care by providing expert educational leadership, guidance and advice and through the advancement and application of educational scholarship."[1]

The Academy is administered by the Dean of Education, Prof. Bruce Barraclough, with the assistance of a part-time Research Officer and secretarial support. It is governed by a board made up of senior internal and external office bearers and individuals who have an active interest in surgical education. The board reports to Council via the Board of Professional Development and Standards.

An Advisory Committee supports the board and is chaired by the Dean. It is made up of representatives of the 13 Surgical Societies and Associations, other senior surgeons with active surgical academic and educational roles and a trainee representative.

The Academy will work in collaboration with all other educational groups in the College and external educational institutions to foster and promote the pursuit of excellence in surgical education and to sustain a strong culture of professional development. It is

charged with assessing current practice and in providing support and innovation to improve content and delivery of educational programs for Trainees and Fellows.

The Academy staff have already done a lot of work related to the alignment of all specialty SET programs with the College competencies. The Dean is in the process of meeting with all nine Surgical Boards, seeking to understand where advice and support from the Academy may be helpful in the delivery of education and training activities. He has also begun to develop cooperative partnerships with universities and other bodies to provide further training and qualification in education and non-surgical disciplines such as leadership and management for Trainees and Fellows.

Membership

Membership of the Academy will be open to Fellows, Trainees and others who contribute to the surgical education and surgical training programs and who have an interest in increasing their personal capacity and capability to deliver surgical education.

Non surgeons such as members of University medical education departments who are actively involved in College programs may also be eligible for membership.

Faculty Membership of the Academy will be those Fellows and others who are essential to the delivery of the educational mission of the College. The Academy of Surgical Educators aims to maximise educational leadership, innovation and research, and the academic standing of the College.

Faculty Members will have active roles in these areas. They will act as key links between the College, universities and other educational institutions to expand the educational opportunities for Trainees and Fellows.

It is anticipated that some Members will become Faculty Members either through commitment to surgical education over time, or by self-improvement in their ability to deliver teaching through the achievement of a recognised tertiary educational qualification or appointment.

Membership will be gained by application to the Membership Subcommittee of the ASE Board. Application will be a relatively straightforward process in paper or electronic form. Details of the policies relating to the Academy, criteria for membership and application are available on the College website.

Tenure of membership will be for three years initially with the option of continuing following review at three year intervals.

I encourage all Fellows who are actively involved in surgical teaching and training to become part of the Academy and apply for membership. The educational opportunities and academic support will be valuable to you personally and invaluable in your training the next generation of surgeons. Interested Trainees should also consider applying for membership.

For more information, email Rachel.Lennon@surgeons.org or call +61 3 9249 1237

Reference

1. An academy of surgical educators; sustaining education – enhancing innovation and scholarship. Collins, J. and Gough, I. *ANZ J Surg* 80(2010) 13-17

Preventing heel pressure ulcers

Recognition of the need to improve a patient's theatre and hospital visit was behind a new product to relieve pressure ulcers.

Dr David Huber
NSW Fellow

I am a vascular surgeon at Wollongong Hospital and have heel and ankle pressure ulcers referred to me for treatment. Many develop in supine surgical patients. I felt that they were preventable and decided to develop a device to decrease their incidence.

Approximately 25 per cent of pressure ulcers begin in the operating theatre1 and cost the Australian health system $89m and $US900m in the US, not to mention the suffering endured by patient and family.

Craig Andrews from Design Momentum was approached to develop an operating theatre device. The brief was to elevate the heel (offload), protect the lateral malleolus and flex the knee slightly while allowing the use of calf compressors.

Hyperextension of the knee (seen when the heel is off-loaded without knee support) causes popliteal vein compression (PVC) in 19 per cent of people.2 We studied supine anaesthetised patients and found significant PVC in 64 per cent.3

I believe that off-loading the heels without flexing the knee, places patients at increased risk of DVT. Theatre acquired Venous Thrombo-Embolism cost the Australian health system $56m4 and the US system $US6b.44

We tried a pillow behind the knee, but MRIs showed that the weight of the leg was enough to close the popliteal vein. The knee needs to be flexed without placing pressure in the popliteal fossa. PVC also decreases the effectiveness of calf compressors.5

After approximately 16 prototypes, we have a device that offloads the heel, protects the lateral malleolus, protects the skin over the Achilles tendon and flexes the knee. It consists of a polypropylene body (orthosis) supporting the calf.

There is a foam component, which engages the distal end supporting the ankle. Interface pressure studies shows that the material which generates the lowest pressure is open cell foam.

It disperses pressure better than Viscose Elastic Gel (VEG), reduces moisture, prevents rising skin temperature and decreases shearing, all of which increase the risk of pressure ulcers. That created a new problem – how best to attach the disposable component.

The obvious solution is double sided tape, but this is expensive, adds work for the nurses and leaves a residue. The solution was to create a tongue in the foam that engages a hole in the orthosis. It must be disposable to satisfy infection control guidelines.6

We have developed a VEG form of the distal component to decrease the ongoing cost of disposables. It can be used for short cases or where the risk of developing a pressure ulcer is considered low. Foam should be used if there is a risk of infection and for long cases.

We have performed interface pressures tests comparing pressure on the heel, lateral malleolus, Achilles tendon and the calf, and showed that the new device is a significant improvement compared with two different gel blocks, gel pads, and operating theatre mattresses.7

In October, 2009, the consensus document of the European and National Pressure Ulcer Advisory Panels (peak bodies in Europe and North America) was published.8 The section dedicated to the operating theatre recommends:

- offloading the heels,
- distributing the weight of the leg along the calf
- flexing the knee slightly.

As yet, there are no Australian protocols.

We have begun marketing through Arjo Huntleigh. Our device is called "GuardaHeel", the foam "GuardaCover Foam" and gel "GuardaCover Gel". We hope to enter the US this year.

References

1. Bliss, M. and Simini, B., 1999, "When are the seeds of postoperative pressure sores sown?" *BMJ*, editorial comment, 2 October 1999, Vol.319, p.863.
2. Leon, M., Labropoulos, N., Hajj, H., Kalodiki, E., Fisher, C., Chan, P., Belcaro, G. and Nicolaides, A.N., 1992, "Popliteal vein entrapment in the normal population", *Eur J of Vascular Surg*, 6(6), 623-627.
3. Huber, D.E., and Huber, J.P., 2009, "Popliteal Vein Compression Under General Anaesthesia", *Eur J of Vascular & Endovascular Surg*, 37: 464-469
4. *Access Economics*, 2008, The burden of venous thromboembolism in Australia.
5. Levine, A., Huber, J.P. and Huber, D.E., 2009, "Changes in popliteal flow velocity with knee flexion - the efficacy of calf compressors", accepted for publication in *Phlebology*.
6. National Health and Medical Research Council (NHMRC), 2010, *Australian Guidelines for the Prevention and Control of Infection in Healthcare, Australian Government*.
7. Malkoun, M., Huber, J.P. and Huber, D.E., 2010, "A Comparative Assessment of Surgical Theatre Heel Pressure Ulcer Prophylactics", submitted for publication.
8. European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel (EPUAP and NPUAP), 2009.

Therapeutic use of self and the relief of suffering

This is the first half of an article that originally appeared in the July issue 2010 of Cancer Forum, and has been reproduced with permission from the Cancer Council Australia and Prof Kearsley.

The next half will follow in the March issue of Surgical News.

Professor John H. Kearsley

Suffering is a universal human experience, which may be engendered by the onset of illness, especially if illness is perceived to be life threatening. This paper examines the essence of suffering and the common sources of suffering in the setting of illness and the health system. It is proposed that many health care professionals, despite mastering the diagnosis and treatment of physiologic dysfunction, may be at a loss when it comes to helping to relieve patient suffering. At an existential level, suffering arises from the meaning ascribed by patients to events of illness, and is commonly expressed as a personal narrative. In order to help alleviate suffering and to promote healing, clinicians are encouraged to recognise themselves as therapeutic tools in understanding the nature of suffering, listening proactively to the narratives that patients need to tell so that narratives with new meanings can be created.

Nature of suffering

Suffering is a universal experience whose boundaries extend beyond the horizon of our understanding and its depth may be unfathomable to our enquiry. According to Cassell, suffering "arises from perceptions of impending destruction of an individual's personhood and continues until the threat of disintegration has passed or the integrity of the person is restored".[1] Life threatening illness represents an assault on the whole person, the physical, psychological and spiritual. Furthermore, suffering is experienced by whole persons, not bodies. Coulehan suggests that suffering "is the experience of distress or disharmony caused by the loss, or threatened loss, of what we most cherish".[2] The experience of suffering is idiosyncratic, mysterious and may vary in terms of intensity and duration. Reed characterises the intensity of suffering as a continuum extending from distress, through misery, anguish to agony.[3] Perhaps the major themes of suffering are expressed most succinctly by Manon in Puccini's eponymous opera, when she tearfully declares herself to be "sola, perduta, abandonata",[4] – alone, lost, adandoned. The four great themes of suffering, variably expressed in their intensity, are isolation, hopelessness, helplessness and loss. Concomitant with all suffering is some element of fear because according to Reed, "the patient's world view and sometimes his or her very existence are threatened by the disease or circumstances".[3] According to Gillies and Neimeyer, [5] it is a common observation that "illness threatens the integrity of personhood, isolating the patient and engendering suffering". Furthermore, suffering alienates the sufferer from self and society, and may engender a "crisis of meaning". [6] As restated by Neimeyer, "profound loss perturbs these taken-for-granted constructions about life, sometimes traumatically shaking the very foundation of one's assumptive world".[5] For many of our patients, drained of meaning and abandoned in the foreign world of sickness, "this is never how it was meant to be".

The experience of suffering is often idiosyncratic; intensely personal, the expression of suffering to clinicians includes patients describing themselves as being shattered, broken and disconnected. For many, their world simply falls apart and they fall to pieces. They become like "broken pottery". [7] Suffering is therefore associated with a disintegration of self, a disintegration of values, belief systems, traditions and even daily routines. There is also disintegration of hope. Kearney considers suffering as "the experience of an individual who has become disconnected and alienated from the deepest and most fundamental aspects of him or herself". [8] Kissane refers to this constellation of feelings and perceptions as the "demoralisation syndrome", in which hopelessness is the core construct, and involves negative cognitive attitudes such as pessimism, stoicism and fatalism, despair, loss of purpose, sense of failure and meaninglessness. [9] Disintegration of interpersonal and community connectedness is common. Others refer to the condition as "spiritual pain".[10]

Sources of suffering in the context of illness

Of the many sources of suffering, the distressing effect of physical pain and other somatic symptoms cannot be over-emphasised. However, suffering may exist in the absence of significant physical symptoms,[11] and suffering may even continue despite careful attention to physical distress. The suffering which may result from survivorship after cure of cancer has been recently highlighted,[12] as has been reported the finding that a significant percentage of patients with advanced cancer do not consider themselves to be suffering.[13] Undiagnosed depressive and anxiety disorders, unrecognised family dysfunction, fatigue, communication breakdown and emotional distress have been found to be additional important sources of suffering in palliative care patients.[14] Wilson's recently reported study of suffering in patients with advanced cancer found that there was a dominant physical component in those with significant suffering (especially pain, malaise, functional loss, weakness and inability to eat).[13] The major non-physical sources were grouped around the dimensions of social-relational concerns (especially dependence, isolation, concerns for others), psychological morbidity (especially anxiety, depression, hopelessness, loss of pleasure) and existential worries (especially loss of dignity, loss of resilience, loss of control, spiritual crisis).[13]

Problem of suffering for clinicians

Despite the universal expectation that healthcare professionals have a central (core) role in relieving suffering, it is acknowledged that healthcare professionals are poorly trained and unprepared to diagnose, assess and manage patient suffering, even though pain management, psychological issues and psychiatric diagnoses are often covered.[15] Since suffering frequently has an existential component, related to a shattering of meaning, purpose and hope, physicians cannot rely solely on theory, knowledge and skills that address physiologic dysfunction. Rather, as Coulehan, suggests "we must learn to engage the patient at an existential level".[2]

Therapeutic use of self: a wholly communion

The starting point in attempting to engage with the suffering of our patients stems from our readiness to develop a deep awareness of illness, its meaning and symbolism to our patients and to recognise both mute and expressive phases of the suffering which may result from illness.[16] That is, we need to be awake or alive to the other person, and to develop a readiness to connect with the 'person' of the patient.[17] As Sassall says, the good doctor "must come close enough to recognise the patient fully".[18]

To be physically present during another's personal illness and distress is important. Our training places little emphasis on the importance of 'being there' and 'listening' in times of turmoil. Silences can often penetrate those places where words cannot go. In one of her earlier essays, Saunders suggests that it is sometimes simply enough for our patients to perceive that we are with them in their struggles and that we are on their side. Accordingly, "we are not there to take away, or explain or even understand it".[10] It is important for our patients to know that we are witness to their suffering and that they are not abandoned.[19] However, even when we dare to remain physically present, it is sometimes more comfortable to remain detached or to withdraw to the confines of the traditional medical history and unknowingly, conceal and imprison the distress of our patients within it.[2]

The theologian Henri Nouwen uses the term 'self emptying' to describe the process of being there, fully present in order to "pay attention to others in such a way that they begin to recognise their own value".[17] However, as health professionals we tend to be in a state of preoccupation with emphasis on diagnosing, investigating and curing the physical aspects of disease; "curers of disease" rather than "healers of the sick".[20] Nouwen continues: "Every time we pay attention we become emptier and the more empty we are the more healing space we have to offer".[17]

Dobkin and Stewart emphasise the importance that physicians develop 'mindfulness' as an initial step in fostering healing in their patients,[21,22] and many commentators stress the need for physicians to better understand their own beliefs, feelings, attitudes and response patterns.[23] Mindfulness is characterised by learned mental habits, such as attentive observation of self, patient and context - critical curiosity, a fresh mind and presence ('being there').[23,24] Mindfulness enhances the physician's ability to bring awareness to the treatment of another human being. It is not what is done, but how it is done that matters most. It is not how much time is spent with a patient, but rather what transpires within that time.[24] It has been recommended that mindfulness be introduced early in medical education, recognising the need to broaden training such that curing and caring are equally valued.[23] Mental preparation in order to fully exercise compassion is a prominent teaching in Buddhism,[24,25] as well as other followings.[17]

We therefore connect by emptying ourselves and listening actively. It has been said that the most valuable thing we can give each other is our attention (our emptiness), taking the time, being genuinely interested and not being distracted by professional title, by what I think I have to offer or what I want to be the outcomes. My essential self is sufficient.[24]

The recent interest in teaching communication skills to healthcare professionals is both encouraging and overdue.[26,27] However, the communication techniques which are taught do not necessarily guarantee connection and better communication. The teaching of communication skills alone without true underlying communion, will predictably be seen by patients as gratuitous and superficial at best, and demeaning at worst. For many patients, communication techniques will only be of benefit when they are used in the context of a deep awareness that has already been established. Saunders suggests that patients "need someone who will come to this meeting not bearing any kind of technique, be it therapeutic, pastoral or evangelistic, but just as another person".[10] As observed by Sackett, widely regarded as a father figure of evidence-based medicine, "the most powerful therapeutic tool you'll ever have is your own personality".[27]

The importance of connecting with patients and becoming aware of the therapeutic use of ourselves is usually not taught formally in medical schools.[28] Instead, many aspiring young doctors might see that to be 'professional' also means becoming detached.[2,25] Providing a listening ear may risk opening up our own vulnerabilities. There has been an unwritten caveat that getting too close to patients can be dangerous, both personally and professionally, because so much perceived pain, negativity, fear and loneliness can prove to be overwhelming and may lead to emotional exhaustion and compromise good sound clinical decision-making and on the job learning. As Shlim describes it: "The only way they (doctors) feel they can care more for patients is by not caring too much".[25] Remen has contrasted the important clinical roles that doctors have in fixing, helping and serving patients.[29] In discussing the clinical role of service, Remen suggests that "we can only serve that to which we are profoundly connected, that which we are willing to touch".[29]

References

1. Cassell E. The native of suffering and the goals of medicine. *N Engl J Med.* 1982; 306: 639-645.
2. Coulehan J. Compassionate Solidarity. *Perspect Biol Med.* 2009;52:585-603.
3. Reed FC. Suffering and Illness. FA Davis Company, Philadelphia; 2003.
4. MacMurray JM. *The Book of 101 Opera Librettos.* Black Dog & Leventhal, New York; 1996.
5. Gillies J and Neimeyer RA. Loss, grief and the search for significance: towards a model of meaning reconstruction in bereavement. *J Construct Psych.* 2006;19:31-65.
6. Barrett DA. Suffering and the process of transformation. *Journal of Pastoral Care.* 1999;53:461-472.
7. The Holy Bible. Psalm 31. New Testament Version. International Bible Society. East Brunswick, New Jersey; 1978.
8. Kearney M. *Mortally Wounded: stories of soul pain, death and healing.* Marino Books Dublin; 1996.
9. Kissane DW, Clarke DM and Street AF. Demoralisation syndrome – A relevant psychiatric diagnosis for palliative care. *J Palliat Care.* 2001;17:12-21.
10. Saunders C and Clark D. Cecily Saunders. *Selected Writings:1958-2004.* Oxford University Press;2006.
11. Chapman CR and Gavrin I. Suffering and its relation to pain. *J Palliat Care.* 1993;9:5-13.
12. Braude HD, MacDonald N and Chasen M. Healing and survivorship: What makes a difference? *Curr Oncol.* 2008;15:185-187.
13. Wilson KG, Chochinov HM, McPherson CJ, LeMay K, Allard P, Chary S, et al. Suffering with advanced cancer. *J Clin Oncol.* 2007;25:1691-1697.
14. Cherry NK, Coyle N and Foley KM. Suffering in the advanced cancer patient: a definition and taxonomy. *J of Palliat Care.* 1994;10:57-70.
15. Egnew TR and Scheady DC. Medical trainee perceptions of medical school education about suffering: A Pilot Study. *J Palliat Medicine.* 1994;12:929-935.
16. Reich WT. *Speaking of Suffering: A moral account of compassion.* Soundings. 1989;72:83-108.
17. Nouwen HJM, McNeill DP and Morrison DA. *Compassion*. Darton, Longman & Todd, London,1982; 1st Edition:4.
18. Berger J and Mohr J. *A Fortunate Man.* Pantheon, New York; 1967.
19. Back AL, Young JP, McCown E, Engelberg RA, Vig EK, Reinke LF, et al. Abandonment at the end of life from patient, caregiver, nurse and physician perspectives. *Archives of Internal Medicine* 2009;169:474-479.
20. Egnew TR. The meaning of healing: Transcending suffering. *Annals of Family Medicine.* 2007;3: 255-262.
21. Dobkin PL. Fostering healing through mindfulness in the context of medical practice. *Curr Oncol* 2009;16:4-6.
22. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ* 1995;152:1423-1433.
23. Novack DH, Epstein RM and Paulsen RH. Towards creating physician-healers: fostering medical students' self-awareness, personal growth, and well-being. *Academic Medicine.* 1999;74:516-520.
24. Halifax J. *Being with Dying.* Shambhala Publications Inc, Boston; 2008.
25. Rinpoche CN and Shlim DR. *Medicine and compassion.* Wisdom Publications, Boston 2006;4.
26. Maguire P and Pitcheathly C. Key communication skills and how to acquire them. *BMJ.* 2002;325:697-700.
27. Smith R. Thoughts for new medical students at a new medical school. *BMJ.* 2003;327:143-1433.
28. Maddocks I. Teaching the therapeutic value of personality. *Med J Aust.* 1990;152:2-3.
29. Remen RN. In The Service Of Life. *Noetic Sciences Review.* Spring 1996;1-2.

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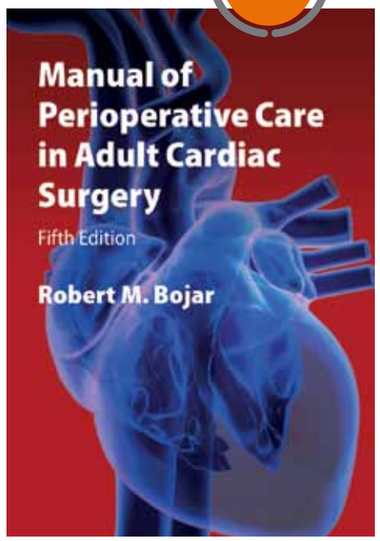

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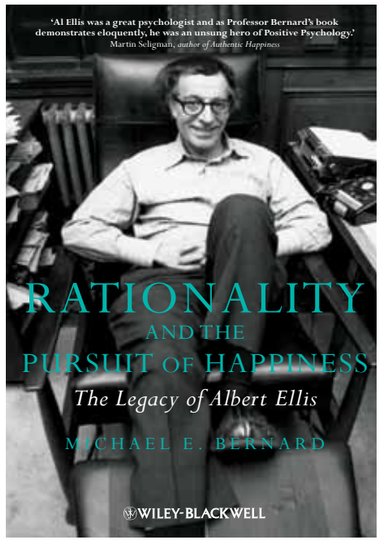

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In Memoriam

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

>Vilen Kertsman, VIC General surgeon

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>Brian Gilbert Storey, NSW Urology surgeon

>Alastair Robson, NSW Orthopaedic surgeon

>Jeffrey George Watson, QLD Urology surgeon

>Simon Bernard, VIC Plastic surgeon

>Gordon Baron-Hay, WA Paediatric surgeon

>James Sturrock Peters, VIC Urology surgeon

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.

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Grafting in the 1950s
Experimentation was the name of the game in the 1950s

Letters to the Editor ...

Nylon shirt to the rescue

Dear Sir,

The following anecdote may add a little more to the interesting account of early aortic surgery by Professor Jepson (Surgical News Vol 11, No 9, 2010, page 46) contrasting with the research oriented approach developing in academic departments.

In 1965, I was a Senior House Officer at the Eastern Suburbs Hospital, a newly opened small suburban hospital in Bondi Junction, Sydney, and desperate to pursue a career in surgery. Hence, I was delighted at the wide range of experience provided by the three general surgeons just joining the staff.

Alan Sharp, also a visiting surgeon to Sydney Hospital, was one of these. Having just returned to Sydney from training in vascular surgery in the UK, he was keen to advance as a special interest alongside his general surgical practice.

A male patient was admitted with a painful abdominal aneurysm, and Alan Sharpe decided to attempt resection at Eastern Suburbs. Preparations included mobilising the pathology department for blood, and his wife with her sewing machine and a Marks and Spencer nylon shirt.

The operation was a long and tedious process, since it was still standard practice to dissect the aneurysm from the vena cava. While this was proceeding, his wife tailored (in the anaesthetic room) a trouser graft from the shirt, to match the measurements sent out to her.

The graft was inserted, total operating time about 10 hours from memory, with an initial satisfactory result; I do not know the long term outcome.

This tour de force – for that time – greatly stimulated my desire to pursue a career in surgery, although at that time any ideas of academe did not cross my horizon. How times have changed!

Leslie Hughes
MB.BS (Sydney) 1955. FRACS 1959.FRCS Eng) 1959. Emeritus Professor of Surgery, University of Wales College of Medicine.Cardiff, UK

Good faith and reporting

Dear Editor,

I refer to Mr Gorton's response to my letter (Surgical News, Vol 11, No 9, 2010, page 44) in relation to statutory protection and fear that he has rather missed the point of my letter, which was not to assert that Fellows need to be unduly concerned about being found liable in defamation for undertaking reporting, mandatory or voluntary.

The point I was trying to make was that nothing can prevent an aggrieved individual about whom a notification has been made from commencing civil proceedings. It is not until that happens that issues relating to whether the notifier has formed a 'reasonable belief' in relation to the matter complained of or whether the notification has been made in good faith, can be adjudicated upon.

With that in mind, I simply reiterate what I said in the final paragraph of my original letter, which was that any Fellow when making a notification, mandatory or voluntary, makes it in good faith having formed a reasonable belief of the alleged misconduct.

RWL Turner LLB FRCS FRACS FAOrthA
Chairman

Dear Editor

As always, Felix Behan's contribution 'Fellows in the Vines' (Surgical News, Vol 11, No 9, 2010, Page 40) was informative, interesting and entertaining. Mr Behan's articles are always looked forward to and in fact I now find *Surgical News* of much more interest than the scientific journal of the College.

I realise that a man of Mr Behan's wide reading and interest has many subjects upon which to write, but if there was another subject to be interested in, I remember Wayne Morrison, some years ago speaking about a finger joint prosthesis which was developed by a Melbourne surgeon in the 1880s. I feel that this could form the basis of another interesting story.

Well done & keep up the excellent work.

Yours sincerely,
Philip Slattery
MBBS (Hons) FRACS

thank-you

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