Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **JAN/FEB 2012**

New
post op
12 page Summer Lifestyle section:

–Travel & Fly Fishing
–The Author Surgeon
–Delights of Sydney
–The Ironman Surgeon

The College of Surgeons of Australia and New Zealand

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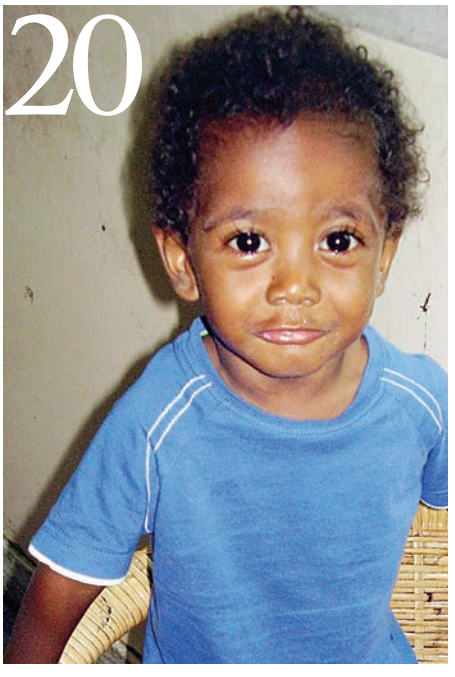

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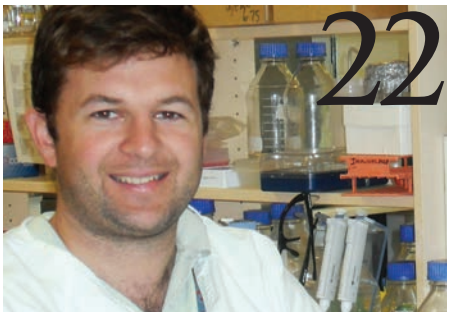

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WELCOME
to our new-look *Surgical News* that includes *post op*, a special lifestyle section to appear every three months

President's Perspective

So why this reflection? We live in turbulent times…

The beginning of a new year always brings some time of reflection. Over the course of the past year I have commented a few times on the disasters that have been evident in Australia, New Zealand and other parts of the world. We watched the anguish of much of Brisbane being flooded and many lives being dislocated. During the year Christchurch moved and has continued to move on numerous occasions.

Much progress has been made in Queensland in rectifying the flood damage. In Christchurch, however, the stabilisation and rebuilding is an ongoing and substantive task likely to take many years. During the course of the year we have used these examples to remind surgeons to consider their personal and organisational disaster preparedness.

This year has started with more disasters, of a different sort, but disasters no less. While on a week's summer holiday in the Bay of Plenty I was able to see the wreck of the foreign-flagged container ship Rena which ran aground on a well charted reef in October.

At that time significant amounts of oil spilled onto the beautiful beaches and earlier this month the ship broke in two, half sank and disgorged the contents of numerous containers over the same beaches.

And then it is with some horror mixed with amazement that I view the evening news with scenes of the Costa Concordia cruise ship that ran aground off the west coast of Italy. Another well charted area and a sophisticated modern vessel.

We have all experienced either directly or by close friends the joy of the modern cruise liner that has an almost indestructible aura. Such liners appear almost impregnable with many of these vessels larger than aircraft carriers in the navies of the world. And yet they are still obviously fragile with disaster so close.

So why this reflection?

We live in turbulent times and despite our best endeavours, the fury of nature and the external world confront and attempt to overwhelm us. We plan thoroughly and diligently for the future.

Have we plotted a safe course? Do we know where those reefs and rocks are? Are we going too close to shore? All important questions. Not just for the maritime industry, but also for us as individuals and within the organisations and institutions where we have responsibility.

The College previously undertook a substantial review of its strategic plan in 2008. We update it yearly and then with a detailed business plan distribute this to all Fellows and Trainees. It was initially felt that the overall strategic direction would be consistent until 2015.

However, much has changed. To follow my earlier analogies, there has been much tempest in the regulatory, educational and professional world of surgery. The health sector in which we are key professionals continues to be de-stabilised and stressed by substantial change.

It is time that the Council of the College again confirm our strategic directions, identify where the hidden rocks and reefs are, be active in our responses and plot a safe course.

Within our current strategic plan, we identified the four key pillars of ongoing College activity. These are:

1. Guarantee continuing provision of high quality training.
2. Provide service to the Fellowship.
3. Promote health and well-being for the community.
4. Drive surgical excellence.

But are these enough to address some of the key areas of 'tempest' highlighted by the Council Executive? These include:

1. Highlighting the importance of professionalism for the surgical profession as much as the individual surgeon.
2. Training in a competency based world and maximising the opportunity of the simulation environment.
3. More effective advocacy and using the critical mass of the College more deliberately.
4. Helping the Trainee (and Fellow) in trouble.
5. Getting the balance right between the ambitions of specialties, societies, Fellows and the College.
6. Increasing importance of continuing professional development and its validation.

The College needs to review, adapt and change. Our world is not a constant and it is an imperative we understand the key issues that are confronting our Fellows as well as other stakeholders. What do you regard as the key things that we should be addressing over the next five years?

The College is presently reviewing both governance and educational relationships. In addition there will also be a much broader strategic planning process undertaken in March and leading to consideration at the June Council meeting. If there are specific areas where you feel the College needs to reconsider its course I would welcome your feedback.

I close with that familiar Darwinian saying.

"It is not the strongest of the species that survives, not the most intelligent that survives. It is the one most adaptable to change."

How should the College do this? I look forward to your comments.

Mr Ian Civil
President

Action-packed 2012

The new year has already brought some issues to consider

I hope this first issue of Surgical News for 2012 finds Fellows well rested and ready for another busy year. You will note that the magazine has a new appearance and is designed to be more "user-friendly". Four times a year it will include a new lifestyle section, Post-Op, which will focus on the non-surgical aspects of our lives – the ways in which Fellows unwind when the day's work is done.

The year got off to a particularly busy start for one of our specialties, with the Plastic Surgeons' societies on both sides of the Tasman fielding scores of media inquiries regarding breast implants supplied by the French manufacturer Poly Implant Prosthese (PIP).

The President of the Australian Society of Plastic Surgeons (ASPS), Associate Professor Rod Cooter, said the TGA has asked all medical colleges and societies to provide data that would assist in determining rupture rates of PIP breast implants compared with the rupture rate of other breast implants.

He said ASPS was closely monitoring the situation and working with its international counterpart plastic surgical societies. He emphasised that the situation underscored the need for an international breast device registry for all patients having implants for cosmetic or reconstructive surgery.

ASPS is currently developing a new Breast Device Registry in collaboration with Monash University which will be opt-out. It is being piloted now and will be launched in October this year at the International Breast Cancer Conference in Sydney. Surgeons are encouraged to contact ASPS if they want more information on the registry. In the meantime surgeons can encourage patients to register with the current Breast Implant Registry which ASPS runs.

ASPS has asked that surgeons contact them about any aspects of PIP implants, especially alerting the society to their experiences and any rupture rates. While ASPS has canvassed its own membership, it is conscious of the fact that many General Surgeons also do implants.

The College continues to monitor the progress of proposed legislation before the Australian Parliament which would means-test the private health insurance rebate. The rebate currently reimburses 30 per cent of the cost of the premium for people who purchase private hospital cover.

No-one can say with certainty what the effect of means-testing the Private Health Insurance Rebate would be, with estimates varying enormously. Treasury estimates that 25,000 consumers would drop their private health cover in the first year of means-testing.

But this forecast was rejected in a report last year by market research company ANOP and consultant Deloitte. Based on market research and a Newspoll of 2000 Australian households, it found that over five years an estimated 1.6 million consumers would withdraw from private hospital cover and a further 4.3 million would downgrade their cover. It estimates the policy change would increase private

"The situation underscored the need for an international breast device registry for all patients having implants"

health insurance premiums by 10 per cent more than otherwise by 2016.

Irrespective of the number of privately insured patients who drop their cover, there would inevitably be some additional pressure on Australia's already over-stretched public hospitals, with adverse repercussions on the quality of patient care.

The College has identified an additional concern. Many surgeons practising in rural locations do some of their clinical work in local private hospitals. If a decline in the number of privately insured patients threatens the viability of these private hospitals, this would be a significant disincentive for surgeons to move to, or stay in, rural practice – which would have a detrimental effect on country patients, irrespective of their insurance status.

These facts have been brought to the attention of those independent MPs who hold the balance of power in the House of Representatives and will, therefore, determine the fate of the proposed legislation. Significantly, some of these MPs represent rural electorates.

Rural surgeons and their patients have been high on the agenda of the Governance and Advocacy Committee recently.

Late last year we wrote to the Northern Territory's Health Minister, warning that the situation at Alice Springs Hospital was unsustainable. You will recall that the Director of Surgery there, Dr Jacob Ollapallil, wrote of this situation in the last issue of Surgical News. A small team of General Surgeons is having to cope with a growing number of trauma cases and a quite staggering burden of disease. Working conditions are such that it is proving very difficult to attract and retain the services of surgeons.

I am pleased to report that the Minister responded very positively to our suggestion that a small working party of surgeons with experience of the rural setting make a site visit to Alice Springs Hospital to assess the situation and develop a sustainable solution to this problem. It is anticipated this visit will occur early this year.

I wish you all the best for the year ahead.

Keith Mutimer
Vice President

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

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 further information please 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 early June 2012 in Melbourne. Applications close 5pm, Friday March 23rd 2012.

AMA says 'Don't Rush'

An advertising campaign from the AMA has featured the critical message of 'Don't Rush'. Associate Professor and Fellow Brian Owler has taken part in the campaign after seeing the aftermath of road accidents too many times.

"It was a consequence of good people making bad decisions on the road. I wanted people to make the right decisions, and as the ad says, "choose wisely".

Professor Owler rejects notions that being part of Public Health campaigns means promoting the 'nanny' state. Rather, he says: "These campaigns remind us of our own mortality and vulnerability ... They indicate that we as a society care about each other and in particular our children."

Sydney Morning Herald, 13 Jan.

Attack on Medicare

The MJA has released an article damning the Medicare system, claiming that up to $3 billion is being wasted every year. Former Professional Services Review head Tony Webber called for tougher rules to close loopholes that take the responsibility away from owners of corporate owned clinics. Recommendations were made to the government in October to close the current loophole, yet a response is yet to be seen. ***The Australian, 17 Jan.***

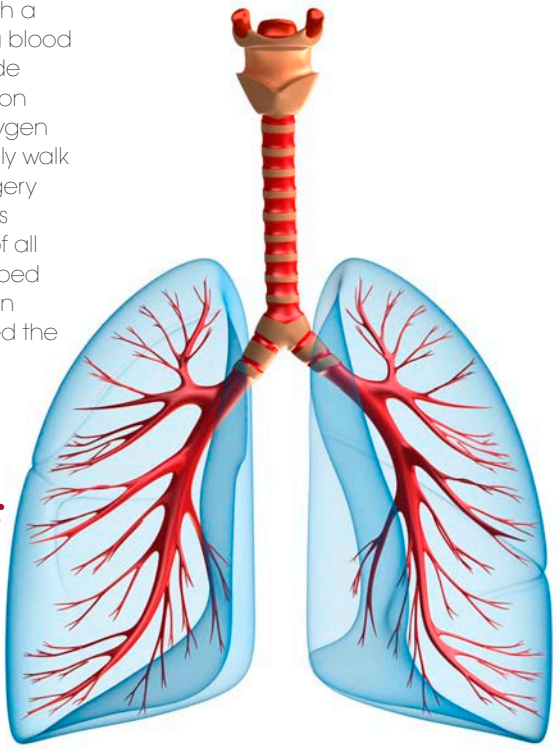
Rare surgery

Cardiothoracic Fellow Mark Edwards performed surgery recently on a patient with a rare and life-threatening blood clotting disorder. Adelaide teenager Ayrton Anderson was being starved of oxygen that meant he could only walk a few paces. In the surgery the teenager's body was cooled down, drained of all his blood, his heart stopped and brain was shut down while Mr Edwards cleared the pulmonary arteries.

"I can take a deep breath and my lungs feel a lot clearer,"

the recovering teenager said.

Weekend West, 14 Jan.



Breast registry gains strength

The latest scandal regarding the French-made PIP implants has drawn further support for the national registry from the Australian Society of Plastic Surgeons. The society is seeking support from the government and a meeting with the Federal Minister for Health, Tanya Plibersek. "Such a registry is not only in the best interest of patients in terms of safety and quality assurance, it would also enable rapid comparison of international data should a circumstance occur again," the society's president Rod Cooter said.

Sun Herald, 15 Jan.

Surgical Research Society of Australasia

48th Annual Meeting

The SRS held a very successful annual scientific meeting in Adelaide in November 2011. A record number of abstracts were submitted this year of which 37 were chosen for oral presentation with the remainder as posters.

The quality of the research and presentations was excellent and the meeting drew its largest attendance for a number of years with more than 70 registrants. Some had taken the opportunity to attend a very worthwhile Section of Academic Surgery meeting the preceding day.

The SRS is grateful to its invited guests Prof Wayne Morrison, who gave the Jepson Lecture, and Dr Justin Dimick, the Association of Academic Surgeons visitor.

A number of prizes were awarded. Best Poster was awarded to Dr Nigel Johnson. The three Travel Awards were received by Kiryu Yap, Andrew Wood and David Westwood.

The inaugural DCAS Award, which will enable the winner to attend the Developing a Career in Academic Surgery workshop at the ASC in Kuala Lumpur this year was awarded to Matthew Roberts, and the Young Investigator Award, which will enable the winner to attend and present his research in a plenary session at the 2012 Academic Surgical Congress in Las Vegas, was presented to Connor O'Meara.

The Section of Academic Surgery and Surgical Research Society will hold consecutive day meetings again in Adelaide in 2012. Please note 8 and 9 November, 2012, in your diary for these most informative meetings.

John McCall
President, Surgical Research Society

Poison'd Chalice

Professor U.R. Kidding

"The heavens themselves, the planets and this centre. Observe degree, priority, and place"

It was hot. I was distracted. My real focus was the quality of the red in the glass carefully balanced in my right hand. Once again, I reminded myself of my own 'law of nature' – the combination of ultra-violet radiation and C2H5OH, especially the red variety, is detrimental to wakefulness let alone clear thought (Amazing how effective red wine can be at making things clearer in the dark hours though!).

Yes, I was taking advantage of the 'compulsory shut down of theatres' that once upon a time comprised a small break between Christmas and New Year. Now, in desperation to not exceed funding allocations, the break inches each year ever closer to Easter! I suspect that if it was up to the Department of Health, partial shutdowns would extend to most weeks of the normal working year.

Maybe we should have a new calendar... drop the Gregorian version and consider one more fitting to the Department of Health's economists' views of hospitals... what would they do? The surgical version might end up with less than 12 weeks if they had their way.

However, I am still distracted. I was trying to extend my command of the English language through advanced crosswords (Actually I suspect that I am trying to reassure myself that my neurons remain plentiful and connected).

I was staring at the clue 'form of portmanteau'. Never heard of it, I thought... some wise guy made it up. Starts with a 'B'. I stared into the distance. We were at the beach. Blue sky. Sounds of waves crashing to the foreshore.

My 'better half', far more learned than me, walked past. "Portmanteau... easy. Do you want the luggage version or the blending of two words version? You (my dear) suffer from Bardolatry. Excessive worship of Shakespeare – you know – 'the Bard'. Maybe that is the 'B'."

I was incensed. Someone had produced another label for me. I do agree I have a strong appreciation of Shakespeare. It relates to many frustrating years as a teenager caught within the grasp of an English Literature teacher who saw no greater virtue than being able to quote Shakespearean text.

This was too much for me in my holiday mode. I reached again for the bottle.

I do like Shakespeare. Not only the man, but a bit of the time as well. One just needs to reflect on the words from The History of Troilus and Cressida. *'The heavens themselves, the planets and this centre. Observe degree, priority, and place'.*

A bit of priority and place. Now, that would be nice. I must admit when I accepted the role of Surgical Director at my esteemed hospital, I thought there would be at least some recognition of priority and place. Well, to be honest, I had hoped for a lot.

But I have learnt that like governments, management can confuse present aspirations with future realities. What they don't confuse, that is both government and management, is the difference between "needs" and "wants". Previously I hadn't given the differentiation any thought, but now in my "elevated position" beset with ever increasing budgetary constraints, I am acutely aware of the difference.

Who could argue against the proposition that Surgery is the most important area of medicine. Surgeons do things. We do not just talk and talk and talk. We sort things out, get things done. Patients get better. Their health actually improves... People said they appreciated this. They needed this. They wanted it.

But doing things is also expensive and, as ever, elective surgery remains the "soft underbelly" of the health service – it is the first to suffer when physicians forget to discharge patients, obstetricians insist on delivering another baby and psychiatrists complain of increasing madness in the world.

Politicians are forced to pay lip service to the Waiting List figures by journalists intent on having their by-line published of course, but explanation and side-stepping rather than action is the result

It seemed much easier when I first took this job. But now, increasingly unable to satisfy "wants", it is more difficult. Makes me reflect on those great words from Venus and Adonis (Shakespeare of course!) ... 'The path is smooth that leadeth on to danger.' Well in my case the danger was the budget papers. Smoke and mirrors at the best, flagrant cuts to services dressed up in bows and ribbons.

I enjoy this beach view – changing, but not changing – full of the activities of the inactive. Soon it would be time to return to the realities of a surgeon's life, but for now I "want" just a little peace and I "need" another glass of that soporific red.

My 4-hour rule

Surgical News arrived recently with its selection of articles to divert the 10 year retiree including the usual CD. The first segment on the CD outlined the problems associated with the 4-hour rule for patient waiting times in the emergency department as introduced in Western Australia. I was aware that such a rule had been introduced in the United Kingdom, but not in WA.

My memory returned to 1965, when I was appointed Casualty Surgeon to The Alfred Hospital, Melbourne. I arrived to find the 1880s Casualty Department had been replaced by a generous ground floor area in a new building with excellent ambulance access, 18 examination cubicles and a dedicated X ray facility with a miraculous film processing unit producing dry films in five minutes.

Much thought had gone into the planning, but possibly not by anybody with any emergency experience. This was reinforced when I was informed the ledger at the reception desk was to be the only source of patient information.

Within two days my premonitions were fulfilled when, during my 5pm round, I found a patient who had been in a screened cubicle since 11am without being seen! All my training and experience as a Squadron Commander in the Armoured Corp with its emphasis on control, intelligence evaluation, timing, feedback and flexibility of response was finally to be put to good use.

Defying officialdom (by not telling them), I reclaimed a discarded ED ledger and ruled it up to record all the information I thought would be needed to monitor a patient's progress through the department: time of arrival in the cubicle area, cubicle number, examination time, initials of the examining doctor, tests ordered with results. Amusingly, the cubicle numbers were fixed on the back wall of the cubicle so that when the screens were drawn the occupants ceased to have a numbered position – a problem that was promptly addressed.

With a functioning ledger the staff could track a patient's progress, but there were still significant delays. The ledger made it possible to isolate the cause, which was in the X-ray area. I found the radiographers would take the views requested, but leave the patient on the table until the films were processed and found satisfactory or repeated if not. This could reduce through-put to as few as four patients per hour. The hold up was rectified by recommending the purchase of a 90 second rapid processing unit. While the processing of the films was rapid, the time taken to approve the purchase was anything but. This required three months and the removal of a wall.

At that time there was no data on what was a 'reasonable' stay in the ED. As Director, I decided to replace the 'as long as it takes' rule with a 4-hour rule; four hours seemed reasonable for diagnosis and admission, transfer or discharge. I announced my decision to the staff, stipulating in addition that relatives must be kept informed of the patient's progress. Nowadays this would be a performance indicator.

As the medical staff were first year interns, I wrote a manual incorporating the most expeditious ways to speed patients along their pathway, mindful that the majority of the patients were non-surgical. Insured patients were transferred out of The Alfred as often as possible.

What was the result? Forty years later I am hardly surprised to hear the same problems I encountered being repeated, the biggest problem being the inadequate number of admission beds. The poor admitting officer was beset from all directions, working from a position of weakness, competing with registrars, senior staff and consultants, all trying to access the same limited number of beds.

Several systems were tried, but I was astounded at the number of subterfuges undertaken to evade the main purpose of the 4-hour rule of decision making. The other fascinating response was from my own staff who interpreted my decision dictum as literal; the patients must be discharged in four hours – patients were 'hidden away' in areas rarely visited.

Eventually I became aware of this manoeuvre. I had to point out the medico-legal implications of such activity and reinforced the idea of a decision being made by four hours and not that the patient had to be physically gone in this time.

Of course I did not think of reclassifying the 'over four-hour' group in a totally new patient category to satisfy the bean counters – a very creative approach in my view!

Eventually, responsibility for the Department passed into other hands; the manual and the four-hour rule quietly died. Based on my experience I would have said that a 4-hour rule should never be implemented as a statutory requirement.

Ken Stuchbery

Agree on name change


Regional news

Change is inevitable, change is constant

Is it time for a name change to prevent confusion?

The recent New Zealand ASM was held in Queenstown.

Scott Stevenson
Chair, New Zealand National Board

As the seasons come and go, we are reminded our world is constantly changing. In New Zealand, early winter brings celebrations of Matariki – the Maori New Year. In late May a small group of stars becomes visible in the north-eastern pre-dawn sky. Matariki is celebrated at the first new moon after the appearance of the Pleiades (The Seven Sisters). Like all New Year celebrations, it is a time to reflect on the past and prepare for the future. This mid-year celebration is one of the many ways New Zealand differs from Australia and as we move into spring, I suggest we should accept changing our College's name to more accurately describe its bi-national nature.

In June 2005, Murray Fitchie, then Chair of the NZ National Board, wrote an article in *Surgical News*, presenting the case for replacing the term "Australasian" with "Australia and New Zealand". After Fellowship surveys and a Council vote in support of a name change, a postal ballot took place in 2007. While more than two thirds of Fellows supported a change, this majority did not reach the 75 per cent support required under the constitution in place at that time. The new constitution requires a two thirds majority for votes on changes in the Articles of Association.

Like all organisations, the body that represents surgeons in Australia and New Zealand has undergone many changes. Until the 1820s, surgeons were comfortable gathering in the Surgical Section of the Australasian Medical Congress of the British Medical Association. I don't think this body had an acronym.

As support grew for an independent body to represent surgeons, a series of meetings in 1926-1928 debated the issues, including an appropriate title. It seems opinion alternated between "Australasian College of Surgeons" and "College of Surgeons of Australasia." "CSA" was settled on initially, perhaps because the alternative would have led to Fellowship being abbreviated to FACS (which was already used by the American College, since its inception in 1913). Even at that time, it seems the College founders recognised the same risk of confusion that we face today, as the journal first published in 1929 had the title *Journal of the College of Surgeons of Australasia who Includes New Zealand*.

Adding Royal to the title in the 1930s required another name change and allowed Fellowship to become FRACS (avoiding conflict with the American award). However, continuing to use

I have taken a few days off work so I have more time to indulge in my pastime, i.e. to browse through journals and magazines scattered all over the house much to the annoyance of my wife.

The other day I came across the article by Dr. Scott Stevenson, Chair of New Zealand National Board[1] and the beautiful photograph of Queenstown reminded me of my time working in Westport[2] and prompted me to write this letter.

Many years have passed since then (three to four) and I fully agree with Dr Scott Stevenson that change is constant and inevitable. Like him I feel a change in the name of our College may be of common benefit for fellows in New Zealand and Australia, given the fact that FRACS is the recognised post graduate surgical qualification in both countries.

Questions may arise if any name change will diminish the image of the College in Asian countries. To the best of my knowledge most Asian countries have their own college of surgeons and postgraduate surgical qualifications specific to the country concerned. If the RACS maintains its current links to Asian and regional countries through various exchange programs, any name change will have little impact on the image of the College.

There is no doubt in my mind that a strong independent College of Surgeons is essential for maintenance and implementation of high standards of surgery in both countries.

Nevertheless any change in the name of our College can only go ahead if majority of fellows in Australia and New Zealand approve in favour for a change and also come up with an alternative name acceptable to majority of fellows. In that case, one name I can think of is: Royal College of Surgeons of Australian and New Zealand, with post graduate qualification abbreviated as FRCS (ANZ) and speciality designated e.g., Gen Surgery

Dr Ratnakar Bhattacharyya
Chatswood. NSW
bhattacharyya@optusnet.com.au

References
1. Stevenson Scott. Change is inevitable, change is constant. 2011 Surgical News. R.A.C.S, 12. 14-15
2. Bhattacharyya R. Solo Surgeon. 1983 Ann R.C.S. Eng; 65, 57-58

In Memoriam

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

Aubrey Bowring, NSW
Paediatric surgeon

Aubrey Jansz, Vic
General surgeon

Kwok Wing Lee,
General surgeon

Leslie Le Quesne,
Honorary Fellow

John Venerys, WA
Orthopaedic surgeon

Allan Campbell, SA
General surgeon

Allan Morgan, NZ
General surgeon

David Cousins, Vic
General surgeon

David Chamberlain, Vic
Orthopaedic surgeon

Douglas Stephens, Vic
Urological surgeon

Peter Cromack, WA
Orthopaedic surgeon

Daniel Devadhar, NZ
General 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.

Informing the College

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

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

National Registration Report Card

The forming of the Australian Health Practitioner Regulation Agency will mean a more efficient system in the long run

Late last year the Australian Health Practitioner Regulation Agency (AHPRA) issued the first annual report for the 12 months ending June 2011. The report contains much information about national registration, and the first "snapshot" of the 10 health professions registered under the national scheme.

For the first time we can confirm that there are more than 530,000 health practitioners registered over the 10 professions, with over 88,000 medical practitioners registered.

Under national registration, the eight separate state and territory systems have become one national scheme. Over 65 different pieces of legislation across Australia have now become one nationally consistent law. The scheme required the transfer of 85 health practitioner registration boards into the 10 national professional boards, and 38 regulatory organisations across Australia became one national agency (AHPRA).

Of benefits to help professionals is the ability to now have Australia wide registration, with only one fee payable for practice in all of Australia. Registration and practice standards are now as consistent as possible, across Australia, and across the 10 professions.

The obvious logistical effort required to create the new national scheme within a relatively short period of time, was reflected in the poor performance of AHPRA in the early part of the year, with technology and communication issues causing some considerable disruption and angst. Those issues appear now resolved, with recent renewal arrangements for over 400,000 health professionals in late 2011 having being completed satisfactorily and easily.

The AHPRA annual report also discloses that at 30 June, 2011, there were 8,139 complaints or notifications received during the year, of which there were 3,879 notifications that remained opened at 30 June, 2011. Of these, 4,122 notifications were received in the 12 months to 30 June, 2011, against medical practitioners, of which 1,763 notifications were remained opened at year end.

Accordingly, complaints against all of the 10 professions represented 1.5 per cent of registered health practitioners. Of all the notifications received, 50 per cent related to medical practitioners, and therefore complaints were received in respect of approximately 4.6 per cent of medical practitioners in Australia. By contrast, nationally only 0.3 per cent of nurses were subject to notification, 1.8 per cent of chiropractors were subject to notification, but 5.8 per cent of dental practitioners were subject to notification.

Table 1: Categories of AHPRA professions

Profession	Grand Total
Chiropractor	4,350
Dental practitioner	18,319
Medical practitioner	88,293
Midwife	1,789
Nurse	290,072
Nurse and Midwife	40,324
Optometrist	4,442
Osteopath	1,595
Pharmacist	25,944
Physiotherapist	22,384
Podiatrist	3,461
Psychologist	29,142

The principal reason for complaints during the 12 month period included professional conduct, treatment issues, medication issues, communication and information issues and issues relating to reports/certificates.

The largest number of notifications came directly from the community (patients, self reporting, relatives or the public), constituting approximately 36 per cent of complaints. About 26 per cent of complaints came from other health complaints bodies, such as health services commissioners.

Of all the complaints received, a relatively small number actually proceeds to a disciplinary panel hearing or tribunal hearing, most complaints either having been dismissed, resolved or dealt with in other ways.

The year to 30 June, 2011, was also the first year in which the national mandatory notification requirements applied across Australia. The AHPRA annual report discloses that it received 428 mandatory notifications, of which 58 per cent related to nurses and 33 per cent related to doctors. This represented a rate per 10,000 practitioners of 7.5 in the case of nurses, and 16.3 in the case of doctors, Of all mandatory notifications received, 7 per cent related to sexual misconduct, 4 per cent related to drug or alcohol use, 30 per cent related to practice with impairment, 60 per cent related to alleged significant departure from accepted professional standards of practice.

This was also the first year in which students were required to be registered, so that a complete tabulation of workforce across the 10 health professions could be more accurately gauged. Over 98,000 students across the 10 professions were registered in the year, with over 16,000 medical students registered.

The national registration scheme also contains a specialist register. The annual report discloses that there were over 23,000 doctors with general registration, 45,000 doctors with general and specialist registration, and 5,300 doctors with specialist registration alone.

Despite its shaky beginnings, the national registration scheme is evolving into a more efficient system or dealing with registration and complaint issues for all health professions. For the first time we now have accurate data across the country in relation to our health professions workforce. In 2012 four new categories of health professionals will join the national scheme – medical radiation practitioners, occupational therapists, Aboriginal and Torres Strait Islander health practitioners and Chinese medicine practitioners.

(Michael Gorton AM is a member of the Agency Management Committee of AHPRA)

Michael Gorton,
College Solicitor

Salamat datang ke Malaysia -

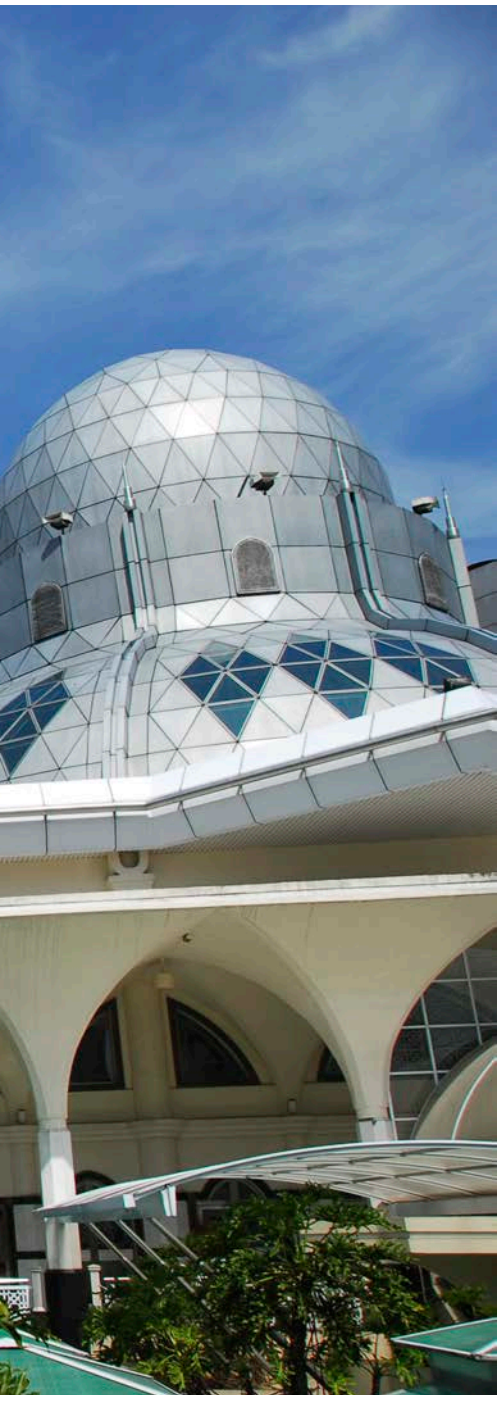
Welcome to Malaysia

The 81st Annual Scientific Congress will be held this May in Kuala Lumpur with the theme of Communication, Collaboration, Professionalism and Teamwork

By now, all Fellows and Trainees should have received a copy of the Provisional Program for the 81st Annual Scientific Congress in Kuala Lumpur. If you have not received a copy, the program can be accessed on the Congress website (asc.surgeons.org) or email Katie Fagan in the ASC secretariat to request a mailed copy (katie.fagan@surgeons.org). To register for the meeting, go online to the website and click on the link.

The meeting begins on Sunday, 6 May, and the College has arranged discounted airfares with Malaysian Airlines (MAS). When booking online with MAS enter the coupon code RACSKL to access the cheapest fare at the time. The discount applies to economy, business and first class. Details regarding travel from KL airport to the conference hotels and the accommodation options are in the Provisional Program.

On Sunday, there are four workshop sessions in addition to the 'GSA Trainees Day' and the 'Developing a Career in Academic Surgery' course. These are followed by the Convocation and Syme oration at 4.30pm and the President's Welcome at 5.45pm. The Convocation will take place in the spectacular setting of the Great Plenary Hall at the world renowned KL Convention Centre. Fellows who have received their Fellowship in the past five



years, and who have not previously convocated, may apply to convocate. They will receive complimentary registration for the meeting. All eligible Fellows will be contacted by email or you can contact Katie Fagan in the secretariat to register your interest (email details above).

The scientific programs will run over four days, Monday to Thursday (7-10 May). In all, 28 section programs are being convened. In addition to more than 40 international and national faculty members, many conveners have invited distinguished Malaysian surgeons to participate in the meeting. Thirty-five Masterclasses will be held, and there is sure to be at least one that is relevant to your practice. Continuing the trend of recent years, the members of the invited faculty are participating on many of these sessions.

Culinary evening and section dinners

Delegates will note that all the section dinners will be held on Tuesday evening (8 May). This will free up Monday evening for a very casual, but unique dining experience – the Culinary and Cultural evening. Full details regarding this evening are on page 15 of the Provisional Program. The Congress dinner on Wednesday night will highlight the many threads to the exciting spectacle of Malaysian dance.

Surgical education program

The Surgical education program is convened by Mary Langcake. The program will combine a broad range of topics within the scope of the Congress themes of "Communication, Collaboration, Professionalism and Teamwork". We are proud to have as our keynote speaker Professor Rhona Flin, from the University of Aberdeen, Scotland. Professor Flin is Professor of Applied Psychology and has published widely on non-technical skills in safety-critical occupations, organisational safety structure and safety leadership. In these times of increasing need for greater accountability and vigilance in patient safety, we are sure that Professor Flin's presentations will be both stimulating and thought-provoking.

In addition, there will be an interactive workshop on the Wednesday afternoon discussing Professional Skills in Surgery and how to both teach and learn them. Other topics to be addressed include bad behaviour in surgeons, making multidisciplinary teams work, international collaborations and how to facilitate them. Also, in recognition of the fact that patients and trainees now use electronic communication to both gather information and disperse it, there will be a session on social media in medicine – how to surf the net and not drown.

Breast surgery

The 2012 ASC Breast Surgery Program in Kuala Lumpur is shaping up to be an exciting and diverse meeting. It is convened by Kylie Snook and Patsy Soon. The Breast Surgery Program includes visitors from around the globe. Professor Armando Giuliano from California will update us on the impact of the ACOSOG Z0011 trial, a randomised study of axillary dissection versus no further surgery in women who have a positive sentinel node; Mr Douglas Macmillan (Nottingham Breast Institute) will demonstrate cutting-edge oncoplastic and reconstruction techniques and Dr Eisuke Fukuma from Japan will introduce us to endoscopic breast surgery.

Two Masterclasses are offered – 'Prosthetic Breast Reconstruction: All you need to know" and 'Risk-reducing surgery' with contributions from our highly experienced panellists. The program includes scientific sessions comprising state-of-the-art breast surgery to evolving concepts in sentinel lymph node biopsy as well as surgical collaboration in advanced chest wall disease and the medico-legal minefield of multidisciplinary clinics. The debate session on issues of interest for breast surgeons promises to be entertaining as well as thought-provoking. To 'top it all off', our section dinner will be combined with the Endocrine surgeons at the Petroleum Club in the world-famous Petronas Twin Towers. Patsy Soon and Kylie Snook look forward to seeing you in Malaysia.

Colorectal surgery

The three day Colorectal Surgery Program is packed with international and local speakers. The convener, Chris Byrne, has invited four renowned international speakers including Professor Anders Mellgren, who trained in Sweden and now heads research at the Department of Colorectal Surgery at the University of Minnesota. He has a strong research interest in faecal incontinence and the treatment of pelvic floor disorders.

Mr Ian Lindsey is an Australian-trained Fellow who is a consultant surgeon at Oxford's John Radcliffe Hospital where he leads the pelvic floor unit and has an interest in minimally invasive colorectal surgery, laparoscopic ventral rectopexy, TEMS and laparoscopic colorectal training. Dr Arun Rojanasakul from Chulalonkorn University, Bangkok has an interest in anorectal conditions and anatomy. He has popularised the LIFT operation as a sphincter preserving technique for anal fistula surgery. Dr Parvez Sheik is the former President of the Association of Colon & Rectal Surgeons of India and has a substantial experience in difficult perianal fistula and haemorrhoid surgery.

The conference includes combined sessions on the management of diverticulitis, modern treatment of rectal cancer, management of large bowel obstruction, pelvic floor disorders and difficult abdominal closures. The Mark Killingback prize for best research paper by a trainee or recent Fellow remains fiercely contested. Three breakfast Masterclasses are being conducted; pelvic floor disorders, anal fistula surgery and haemorrhoid surgery – each has two international speakers. The section dinner is being held on the Tuesday night at the highly regarded, French themed 'Frangipani restaurant'.

The Executive and the Scientific conveners look forward to welcoming you to Kuala Lumpur for an outstanding Congress. For further information on the 2012 Annual Scientific Congress, go to asc.surgeons.org

*By **Philip Truskett** (Congress Convener) and **Raffi Qasabian** (Congress Scientific Convener)*

Royal Australasian College of Surgeons

Dean of Education

Applications are invited for the position of **Dean of Education**. The position is nominally 0.6 – 0.8 EFT to encourage both a significant commitment to the role and also the flexibility to maintain some external responsibilities. Although predominantly located at the College headquarters in Melbourne consideration will be given to applicants who need to be based in other cities of Australia or New Zealand.

The College is associated with a number of Surgical Societies and Associations and is the Australian Medical Council accredited provider of Surgical Education and Training to over 7,000 Fellows and Trainees. The appointee will be in the key leadership role to develop and promote a strong and collaborative educational ethos throughout and beyond the College.

The appointee will be a Fellow of a Medical College, ideally possessing a postgraduate qualification in education or research. They will be experienced in managing within a complex environment requiring substantial consultation. An understanding of adult learning and a demonstrated record in the development, implementation and evaluation of innovative education programs are essential. Importantly they will have demonstrated leadership within complex professional environments.

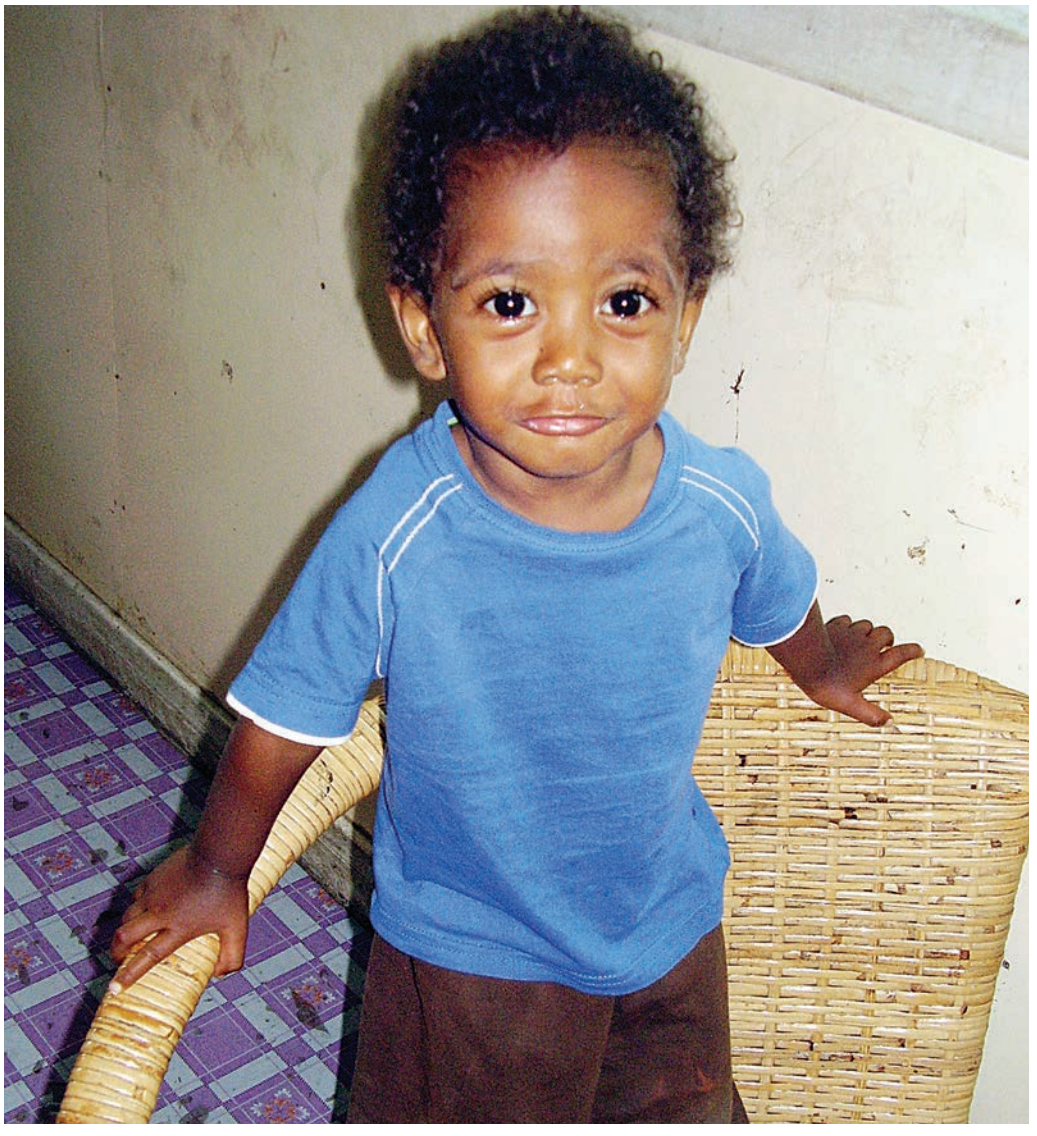
The appointment is available as an initial three year contract, renewable by mutual agreement. Salary package is negotiable depending on qualifications and experience.

The position description and statement are available on the College's web-site at www.surgeons.org Further information is available from Dr David Hillis, Chief Executive Officer by telephoning + 61 3 9249 1205 or email david.hillis@surgeons.org

Applications in writing to the Chief Executive Officer, Royal Australasian College of Surgeons, 250 - 290 Spring Street, EAST MELBOURNE VIC 3002 by March 23, 2012

Journey of responsibility

A story in the Canberra Times in late November featured the work of Fellow David Croaker and Rotary Oceanic Medical Aid for Children



Tavaleana Bird from the Solomon Islands was less than 48-hours-old when he endured the first of a number of surgeries initially designed to keep him alive long enough to receive the specialist surgery required to repair a long-gap oesophageal atresia.

The first procedure, a gastrostomy conducted by a local surgeon, was the start of an 18-month journey that brought the baby to Canberra for that surgery in 2010 through the fund-raising efforts of Rotary Oceanic Medical Aid for Children (ROMAC) and the ACT Government.

At one stage as Tava was almost starving to death and at risk of drowning in his own saliva, his devoted mother was required to suck on a trap catching the spit every five or ten minutes for the first three months of his life.

Yet now the toddler is eating, drinking and speaking his first words thanks to the skills of Australian National University medical school Associate Professor of Paediatric Surgery David Croaker.

Professor Croaker said that when he first saw Tava, the baby weighed less than his birth-weight necessitating a three-month delay before surgery to boost his nutrition and ability to survive the required procedures.

"Tava was born in March, arrived in Canberra in June, 2010, and weighed only a couple of kilograms upon arrival," he said.

"He was like a survivor from a World War II concentration camp because the tube in his tummy was leaking somewhat and at that stage he looked like having only one or two more weeks to live.

"Before we could do anything though, we had to deal with nutrition, not only for his immediate survival, but because malnutrition is a great predictor of surgical complications."

Once he had gained weight, Professor Croaker then conducted a Foker procedure, which uses tension-induced growth to save the existing oesophagus by attaching sutures to the unconnected ends that are stretched slightly and tethered into place to stimulate it to grow on its own.

Unfortunately for Tava, however, this did not work well.

"The sutures pulled out and we could not join the ends, which was disappointing so two months later we mobilised the stomach and moved it up so that the two ends of the oesophagus met," Professor Croaker said.

"At the same time we had to deal with scarring caused by acid reflux with a number of oesophageal dilatations, and finally injected steroids around the join to limit the structuring, given that in certain severe cases you can lose the oesophagus entirely because it shrinks away to nothing from excessive scarring making it impossible to swallow."

Survival unlikely

While the condition of oesophageal atresia presents in one in every 3,500 live births, around 95 per cent of such babies survive in Australia, yet the lack of a specialist paediatric surgical service in the Solomon Islands along with limited paediatric intensive care facilities meant that without his visit to Australia, Tava would have been unlikely to survive.

However, in November last year a smiling Tava and his father returned to Canberra for his final face-to-face check-up with Professor Croaker, although the Canberra surgeon will continue to monitor his progress from afar through collaboration with local Solomon Islands surgeons.

"Now his oesophagus looks beautiful and the fact that he is eating and not just able to swallow liquids is a great result," he said.

"However, we know that children who are born with oesophageal atresia have almost universal gastro-oesophageal reflux, and in the long term probably an increased risk of going on to develop oesophageal cancer so we sent him home with letters for his doctors to monitor his progress possibly for the rest of his life.

Associate Professor David Croaker (second from left) with his registrar and Tava's happy parents Lily (far left) and Tapera (far right).

"Before we could do anything, though, we had to deal with nutrition, not only for his immediate survival, but because malnutrition is a great predictor of surgical complications"

"I think the late follow up is an important part of doing cases like this one with Tava. It is wonderful and rewarding to do these great operations and save lives, but we still have a responsibility to follow the patient's progress and complications. As well as that, I think that there are probably unrecognised late sequelae of these conditions. I don't think we know all the late consequences of these conditions yet.

"Unfortunately we can all become a little too specialised, in that paediatric surgeons may not be talking to the adult specialists if the worst does happen later."

Professor Croaker has a long and distinguished history of international aid work having provided his skills to the Tansen United Mission Hospital in Nepal for 25 years while he has also worked in Gaza since 2006 and undertaken a specialist visit to Mongolia.

He has also been invited to Africa this year and has discussed a visit to the Solomon Islands to allow him to treat patients and train surgeons upon invitation.

He said he had now treated around 30 babies with oesophageal atresia.

Yet he said he was not filled with confidence when he first saw the starving and suffering little Tava.

"I think the only proper attitude is one of terror to be honest," he said.

"I think you need to keep in mind that things can go wrong trying to treat such a weak infant, but you work toward the best possible outcome.

"You know they are going back to a poor, medically isolated country with a surgically complicated condition and it was not clear to me that all would be well even though he was fine and doing OK when he was discharged.

"You can't do a big operation like this and walk away; you have to accept that such patients are your responsibility for however long they need your care, but having said that, it was a great joy to see him in November and he should lead a pretty normal life now."

With Karen Murphy

Reducing the scarring with research

Dr Alexander Cameron's studies are in the pursuit of better outcomes for scarring victims

The current recipient of the WG Norman Trauma Fellowship, Plastic Surgery Trainee Dr Alexander Cameron, has spent the past year researching the role of the oddly-named actin remodelling protein known as Flightless in the formation of hypertrophic scarring.

Discovered only a decade ago, the protein was named Flightless after its gene was mapped in the Drosophilia, with scientists later finding that if one copy was knocked out, the insect had defective flight muscles.

Now also known as Flii, the protein has been found to be one of the players in what Dr Cameron described as "the tightly orchestrated interplay" of agents which lead to excessive scarring.

Comparing human skin samples and using animal models, Dr Cameron has found that Flii is increased after injury and remains elevated in scar tissue and that decreasing Flii results in improved scarring.

"Hypertrophic scarring results from an aberration of the normal wound healing process in which the inflammatory stage of wound healing is upregulated and prolonged resulting in over production of collagenous extracellular matrix by fibroblasts," he said.

"This carries a large burden of disease and requires years of ongoing therapy and revision surgery because such patients suffer severe disfigurement while contracture can cause severe disability.

"Until now, TGF-, a pro-scarring cytokine, has been the most widely-studied agent affecting wound healing. Our research has shown that, among other functions, Flii is an upstream regulator of TGF- which means that if we can find a way to interrupt Flii's action we could potentially improve wound healing and reduce scarring.

"Already we have developed an antibody to block the action of Flii which has just been trialled in preclinical animal models including pigs, while safety studies for human trials are imminent.

"Although wound healing is a very complex process and it is difficult to target one agent among many to make a major difference, we think that an anti-Flii treatment, in the form of an injection, cream or as part of a dermal matric, could be one of a range of treatments developed in the next decade."

Dr Cameron has been conducting his work as a member of Professor Allison Cowins' Wound Healing Team at the Women's and Children's Health Institute in Adelaide as part of his PhD being undertaken under the supervision of Professor Cowin and Associate Professor Peter Anderson.

profile

EDUCATION

2010: PhD of Surgery (previously Masters of Surgery). Adelaide University

"The role of Flightless (Flii) in hypertrophic scarring and

2006: Bachelor of Medicine, Bachelor of Surgery (MBBS)

St. Vincent's Hospital Clinical School, Melbourne University

2004: Bachelor of Medical Science (B. Med Sci). Melbourne University

"The immunoquantification of caveolin-1 in atherosclerotic human vessels"

"I feel very lucky to be involved in this project because a lot of research can be years and years away from practical results whereas the results of this work are tangible"

He described the research as greatly rewarding and said that if the work was successful, the anti-Flii treatment could theoretically be applied to a range of scarring-related pathologies.

Along with the WG Norman Trauma Fellowship given to Dr Cameron in both 2011 and 2012, he has also received the RACS Plastic Surgery Research Award for 2012, first prize in the Adelaide University Health Faculty Research Conference and the 2011 Don Robinson prize for best research by a Plastic Surgery Trainee in South Australia.

"I feel very lucky to be involved in this project because a lot of research can be years and years away from practical results whereas the results of this work are tangible," Dr Cameron said.

"I am also the only clinician in the wound healing team and it is a great privilege to work with a team of highly skilled and motivated scientists. It is also a privilege to be supported financially by the College to undertake the research on a full time basis. I originally tried to combine the project with full time clinical work, but it was not feasible.

"I think surgeons benefit from a dialogue with scientists because at times the two professions can be working on a solution to the same problem, but in parallel, unaware of each other's progress. I think it is vital for new developments that we work to break down the cultural barriers that divide us."

This year, Dr Cameron will be visiting the US to collaborate with Professor Geoffrey Gurtner, a world leader in the field of scarring and a Plastic Surgeon at Stanford University and will also attend the International Burns Symposium to be held in Edinburgh.

He said he was looking forward to working with surgeon scientists in this major international facility and hoped to bring back skills to bridge the divide between the two.

"Professor Gurtner has been working on an animal model of scarring based on wound tension, so we are going to collaborate on the role that Flightless may play in regulating the response to mechanical tension at the cellular level," Dr Cameron said.

"Hopefully in the future there will be more cross pollination between surgery and science because it is difficult for scientists working on a solution to a clinical problem to have the same experience and perspective as surgeons, who in this case are treating wounds and hypertrophic scars on a daily basis. Likewise, it is difficult for surgeons to keep abreast of progress in basic science or have the time to devote to animal and lab work."

Dr Cameron is in the process of writing up his research to submit to the Journal of Clinical Investigation and aims to present his work while in the US.

The WG Norman Research Fellowship arose from a bequest from the late WG Norman of Adelaide. The South Australian award was established to fund advances in surgery on injuries occasioned by any form of accident or trauma to young persons. Subsequently, the fellowship was broadened to encompass any research with a trauma focus.

With Karen Murphy

Book available on PANCH

When PANCH doors closed in 1998 in Preston, a northern suburb of Melbourne, a great community hospital died. At this time Ken Brearley wrote a book entitled Images of PANCH, The Life of a Hospital. It is a hard covered volume of 200 pages with 300 photographs of many staff members including surgeons. About 1000 copies were sold at the time, but some are left and if you would like a copy – free of charge – contact Ken Brearley's rooms at 15 Collins Street, Melbourne on +61 3 9654 5188 or email him at k.brearley@usa.net

Your thoughts on the content and style of Surgical News are always welcome.

Contact us at: surgical.news@surgeons.org

Improving Island life

The latest ENT visit to the Solomon Islands helps local
Trainee general surgeon Dr Larry Lagatiana improve skills

The ability to provide one-on-one training to local ENT trainee Dr Larry Lagatiana, currently studying at the University of PNG, was the highlight of a 10-day visit to the Solomon Islands made late last year by a team led by Victorian ENT surgeon Mr Brian Costello.

Mr Costello said that Dr Lagatiana, a general surgeon, had chosen to specialise in the field given the urgent need for such surgical care in a country without an ENT surgeon and where such a significant proportion of the population suffer chronic upper respiratory infections often caused by polluted water.

He said that during the 10-day visit, Dr Lagatiana had conducted a number of procedures as primary surgeon and stayed on for three days to treat more patients following the team's departure.

"The opportunity to provide this type of training was the most valuable aspect of the trip because it meant that not only were we able to provide surgical care to people in need at the time, but we were also able to assist in the provision of surgical care into the future," Mr Costello said.

"Dr Lagatiana conducted tonsillectomies, myringotomies to relieve the pressure of fluid build-up in the eardrum and also treated nasal polyps.

"We also taught him the technique to treat severe cholesteatomas of the ear and mastoid, which can be urgent cases because, if left untreated, they have the potential to erode bone and cause an abscess in the brain.

"He will be returning to the Solomon Islands in 2013 as a permanent staff member which will be of huge importance to the people of the country.

"My colleague on the trip, Dr Alistair Walpole, also had the opportunity to educate doctors who are currently studying anaesthesia in Fiji and we both felt this to be the most pleasing and significant aspect of the visit."

Mr Costello's trip to the Solomon Islands took place in October last year with the team comprising Mr Alistair Walpole, anaesthetist, Ms Tania Wieg, nurse, and Mr Simon Davis, audiologist.

Working out of the National Referral Hospital in Honiara, the team conducted three extensive outpatient clinics, carried out 105 consultations and performed 21 operations.

Audiologist Simon Davis conducted hearing tests on more than 70 people and screened others for possible treatment.

Mr Costello said that as with all such visits, choosing those patients to receive surgical care was the most difficult aspect.

Difficult choices

"We really had no option, but to concentrate on those cases that could receive appropriate levels of post-operative care," he said.

"This always makes for very difficult choices because such conditions as advanced malignancies would require high dependency care which is simply not available.

"There are so many people with so many illnesses in places like the Solomon Islands that a team visit such as this can only treat the tip of the iceberg and you then have to choose whether it is best to spend one day on one patient or treat as many patients as possible.

"Still that decision-making never gets easier."

In his report on the trip to the College, Mr Costello suggested that Dr Lagatiana's training could be further stimulated through assistance to visit Australia.

He also said that even when the country had its own ENT surgeon, such team visits would still be required.

"He is going to be so good

for the Solomon Islands, but I think his training would be enhanced if he was either able to attend a conference or even spend a month in an Australian hospital environment because I think that would be of tremendous advantage to him," he said.

"Then on his return I think team visits will still have value not just in helping him treat all the patients that need surgical care, but to continue his education."

Mr Costello, who has also provided such surgical services to the people of East Timor, praised the nursing staff in Honiara.

"The quality of the nursing staff is very high, particularly in outpatient clinical settings and the nurses are able to clean out ears and manage wounds to a high standard although they often have to deal with equipment and supply shortages," he said.

"They were also able to give us insight into how the different parts of the Solomon Islands community operated so that the screenings and clinics ran smoothly."

While there, the team was visited by the Australian High Commissioner to the Solomon Islands, Mr Matt Anderson, who thanked them for their assistance.

Following the trip, he was quoted in the local newspaper as saying: "Not only do the (team members) make a difference to the people they treat and operate on, they also boost the skills of the local surgeons, doctors and nurses at the hospital which leaves a lasting legacy".

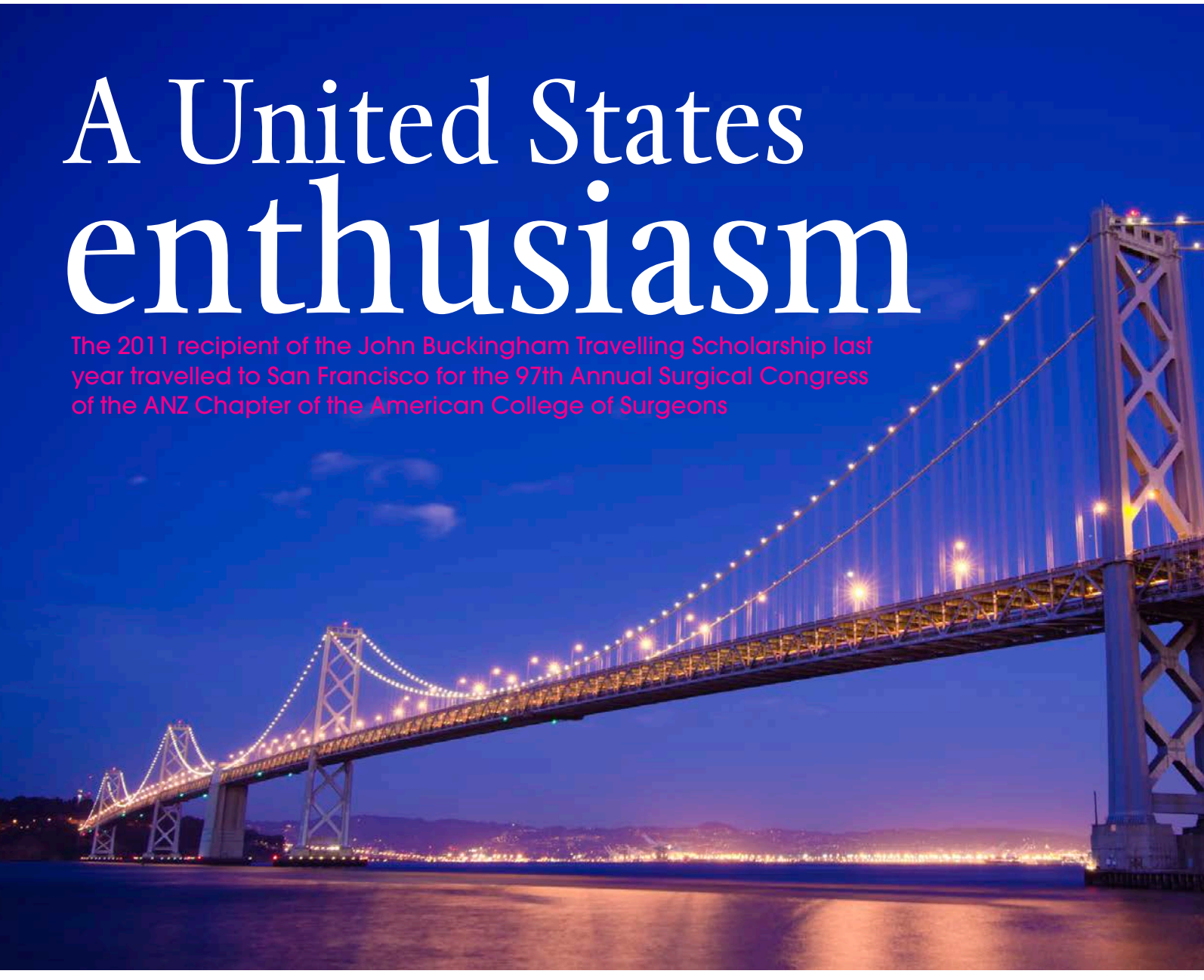
Mr Costello said that the team had taken more than a dozen large bags of equipment with them on the journey including drills and audiology equipment, but that the excess baggage allowance was waived by Qantas and Virgin Airlines and reduced by Solomon Airlines, which was very much appreciated.

The visit was co-ordinated through the College's Pacific Islands Project with funding provided by AusAid.

With Karen Murphy

A United States enthusiasm

The 2011 recipient of the John Buckingham Travelling Scholarship last year travelled to San Francisco for the 97th Annual Surgical Congress of the ANZ Chapter of the American College of Surgeons



Every October, our counterparts from the American College of Surgeons congregate to engage in a small "chin-wag" and "spinning a few yarns", while downing a few "cold-ones" and even nibbling on a barbequed "shrimp" or two. While such rhetoric may sound rather culturally cringe-worthy, it isn't that far from the truth. Surgeons from not only North America, but from all over the world recently converged upon San Francisco where the 97th American College of Surgeons Annual Surgical Congress was held.

As the grateful recipient of the John Buckingham Travelling Scholarship, I was in the privileged position to be able to attend the meeting. What I witnessed was on a scale like no other. The only place I had previously seen over 10,000 people gather was at the Sydney Cricket Ground and if you include industry representatives, this number swelled toward 15,000! I was clearly in for a unique experience.

A smorgasbord of educational opportunity was on offer and proved rather bamboozling at times. Hmm, shall I attend the "peri-anal potpourri" convened by those chaps at the Cleveland Clinic or "meet the experts" in bariatric band-sleeve-switching over a more than generous lunch (hold the mayo!).

That Strasberg character sounds familiar; perhaps I'll get the opportunity to test his knowledge of bile duct injuries! Hang on, Quan Duh is luring me to the symposium on "mega-goitres" which sounds worthwhile, but it clashes with the "how to close the open abdomen" session staffed by those dealing with "routine" penetrating trauma in the Deep South.

That must be quality judging by the 1,000 or so surgeons taking seats in what resembles an aircraft hangar with giant football field sized monitors. Have I cleared customs yet?

There was no doubting the educational benefit of this meeting, not only for the surgeon-in-training, but for the new fellow and "grey hair" surgeon (a US trainee's term, not mine I swear!) alike. Cutting edge discussions held by expert panels and even more in the audience ensured lively, entertaining and informative discourse.

Americans not shy

Our North American counterparts are certainly not shy of a word and they lived up to expectations with spirited and articulate rhetoric being had at the conclusion of almost every session. This was employed in good humour and obviously in the knowledge that progress is not something that occurs without an appropriate amount of effort, persistence and mutual respect.

This is an interesting point and juxtaposed with the most passive slave of all surgeons; no, not your registrar, but the robot! Once the domain of the economically endowed, ambitious prostate surgeon, the robot has metastasised beyond the retropubic space of Retzius and has infiltrated almost every organ, natural orifice and surgical discipline.

During the meeting I witnessed robot assisted pancreatoduodenectcomies (with a seemingly nonchalant vascular resection!), total thyroidectomies ("did you see the nerve?") and total mesorectal rectal surgery. I must admit that I am not convinced as yet, but this surgical evolution definitely smacks of déjà vu (at least that's what I'm led to believe).

A wise old surgeon was once heard to lament: "A cholecystectomy through the umbilicus! You must be crazy!" I can only liken this experience to what my own mentors must have witnessed 20 years ago.

The US has been quick to not only adopt such technology, but like the Koreans and Europeans are already publishing large series providing evidence that robotic surgery is not just safe, but is leading to improved outcomes for patients; and just when I got my head around this laparoscopic suturing caper. I'll have to wait for that Medicare sponsored robot; but hang on, training in the private sector is now becoming a reality; speaking of which...

The modern trainee experience did not go without getting its fair share of the limelight; particularly so given the recent introduction of the capped, 80 hour work week (is that all?!) in the US training environment.

Before we all sit back, and proclaim "back in my day", it has become clear that a dilution in the modern training experience is greater than the sum of its parts; i.e.: more than just about hours in the operating theatre. ▶

"A smorgasbord of educational opportunity was on offer and proved rather bamboozling at times"

Trainees are fast being robbed (for lack of a better word) of technical, hands-on training opportunities by improvements in technology (e.g. interventional radiology) and more conservative, watchful waiting than ever before.

While correlated with improved outcomes for the modern patient, the ages of total colectomy for non-localised torrential lower GI bleeding, oversewing bleeding ulcers in the wee hours of the night and even open splenectomy for trauma are fast becoming rare, if not extinct altogether.

Add to this the fact that trainees in the era of laparoscopic surgery are now expected to be able to "tie shoe laces from two feet with chopsticks" means that they are at times left at sea and unable to cope with generic and basic skills such as exploratory laparotomy for trauma.

How does one know what the traumatised pancreas feels like if you are only ever manipulating a normal organ with a laparoscopic instrument from 40cm away? It is no longer fair to compare our current training experience with those brought up in the open era, so we should stop trying to do so.

Further discussions with fellow US trainees revealed the same thoughts, feelings and fears regarding the training experience. A deep seated desire to pursue formal research was also obvious among this ambitious young group and scientific presentations were delivered in a convincing manner and with great scientific rigour.

Held in regard

It was also pleasing to hear the positive regard in which our own Fellows are held. Many of the large US centres regularly host RACS Fellows during visits or formal fellowship terms and hold their own against the US's best without issue.

I was lucky enough to briefly discuss such matters with the newly sworn in President of the American College of Surgeons Dr Patricia J. Numann MD FACS. She was quick to impress upon me the importance of cross collegial ties and sited the increased focus that her own College has had upon the travelling fellowship concept in recent years.

Beyond the boundaries of the gargantuan Mascone Convention Centre lies San Francisco in all its glory (yes, there is more to it than the Golden Gate Bridge and Alcatraz).

Clearly Obama was impressed with the destination and he visited briefly before being chased out of the city centre by a politically charged demonstration. He had apparently "occupied" the financial district for far too long.

It was exciting to see freedom of speech at work within a democratic jurisdiction. In keeping with such themes, college politics were in full swing and, as with all meetings among active and ambitious groups of like-minded individuals, there was never a dull moment.

It was interesting contrasting some of the ACS's challenges with those of our own RACS. The difficulties of developing a unified voice for such a large and diverse body of practising surgeons is not something I could ever hope to understand. The ability to be successful in doing so is a testimony to the determination of those driving the College from the top.

While the late Associate Professor John Buckingham left an impression for his personal and clinical capabilities, I was not privileged enough to get the chance to seek a greater understanding of his motivation.

Now that I have had the opportunity to attend the American College of Surgeons Congress, I feel that I am at least a little closer to feeling what exactly motivated the man to where he stood as a surgeon, colleague, mentor, family man and friend.

I thank the Royal Australasian College of Surgeons, the ANZ Chapter of the American College of Surgeons and RACSTA for the opportunity to attend the ACS ASC and highly recommend attending the 98th congress in Chicago this year if you have the opportunity.

summer *Lifestyle*

post op

12 page lifestyle section

Trekking far from *Surgery*

New Zealand's Dr Catherine Ferguson takes Italy's walking Tour of Gran Paradiso

post op appears every three months in Surgical News

Trekking through Italy

Councillor Dr Catherine Ferguson talks to post op about her recent trekking tour in Italy and the pleasures of the open road

Otolaryngology surgeon Dr Catherine Ferguson was the first woman elected as Chair of the New Zealand National Board of the College in 2006 and is now a College Councillor. With her private practice based in Thorndon, Wellington, Dr Ferguson is deeply appreciative of the beauty of her own country, yet still distant shores continue to beckon.

When did you take the trip and how long was it for?
We took the trip in the second half of August last year. The whole holiday was five weeks, but the trek took up a fortnight at the beginning while we were still fit and fresh!

Where did the journey take you and was it an independent trip or a guided tour?
It was a guided journey and was called a Tour of Gran Paradiso – which was literally a circular route within the Gran Paradiso National Park going around Gran Paradiso Mountain, Italy's highest. It is in north-west Italy, not far from the French border and the French Alps.

Why did you choose Italy and why that particular region?
We went to Italy with friends who are keen wine lovers like ourselves and wanted to visit the wine-growing area called Piedmont which is just a little further south. We have done some shorter walks in New Zealand with this couple and have also done some other walking in Italy, and so we decided to do this together at the beginning, before the more indulgent part of the holiday.

What was the highlight of the journey and why?
It's very hard to pick a single highlight but I'd have to list the jaw-dropping scenery, the wonderful alpine flowers and the abundant animals (chamois, ibex and cute marmots). However, the satisfaction of achieving what was for me quite a challenging trek, with high altitudes and some tricky mountain descents was also extremely gratifying.

Have you taken a hiking holiday before and if so where?
We always try to incorporate a walking holiday when we go away, but they are usually a little less challenging and with more luxurious accommodation each night. We have walked in Italy and Sicily and in France – the Jura and in Alsace. These have been self-guided walks. In addition we have done most of the great walks of New Zealand – all guided.

L to R: Rob Delamore, Dr Ferguson's husband Mike During, and Dr Cathy Ferguson enjoying the peaks of their hiking in Italy.

What do you enjoy about trekking over the comforts of more orthodox travel?
If possible we like to combine the exercise of trekking/walking with the comforts of more orthodox travel at the end of each day, but we like to be outdoors and feel that although we may only be covering a tiny dot on the map, we are really getting to experience the local area. We also find that we get to appreciate and interact with the local people a lot more in the small villages and hamlets that we pass through.

Where would you say is the most beautiful place to trek and why?
New Zealand of course. The remote bush, the mountains, lakes and rivers are like nowhere else on earth.

Do you think it is getting harder or easier for surgeons to take the time they need away from the consulting suite and theatre to relax and recharge?
I would say that it has probably become easier in that there is now more acceptance of the need to take a holiday while there are more colleagues to cover you while you are away. However, with so many meetings, conferences and courses, it is easy to find that you spend a lot of time away from clinical duties and therefore it can be hard to find the time to fit in a holiday.

How long have you been a College Councillor and why did you choose to give your time to support the profession in this way?
I was first elected to Council in 2010, having been involved with the College through the New Zealand National Board for about 10 years prior to that. I enjoy the people I have met in this role including surgeons from other craft groups as well as the extremely talented and dedicated College staff. I like to be involved in the decision-making process rather than sitting on the sidelines and I feel there is a great opportunity to learn a whole new set of skills as well as to contribute.

Why did you opt to become an Otolaryngologist, Head and Neck Surgeon?
That was a long time ago! I think I chose it because of the appeal of so many subspecialty possibilities at a time when this was less developed than other specialties.

Do you have plans for another trekking journey?
Yes, but they are still in the early stages. We are thinking perhaps of the French Alps or the Pyrenees or perhaps Scotland.

A surgeon's guide to Sydney

Karen Murphy catches up with Councillor Phil Truskett on the best Sydney has to offer

It is apparent when talking to senior General and Upper GI surgeon Dr Phil Truskett that he sees his life and work in the broadest of terms. While his dedication to the profession is evidenced by the fact that he has been a College Councillor for the past four years and is the current chair of the College's Skills Education Committee he is also a keen traveller, wine collector and jazz lover.

With an increasing number of surgeons now travelling the globe to keep abreast of developments in one of the most rapidly changing of all professions, Dr Truskett has often been asked to host guests to his beloved home town of Sydney.

Below he lists his tips for enjoying the pleasures of one of the world's great cities, but first to his professional interests.

Dr Truskett said the key challenge confronting the training of future surgeons was to design and develop education packages to address the changing exposure trainees now have to clinical practice.

He said high patient turn-over in public hospitals, mostly a result of the increased number of surgical procedures that can now be conducted in day surgery, and the consequent change of surgeons' consulting routines were combining to reduce the hours trainees spend learning on the hospital ward.

"This patient and clinical access is very different than it was years ago and presents us with a great challenge in terms of training," he said.

"Many more procedures are now conducted in day or short stay surgery. In the past trainees would have the chance to spend time with patients before surgery to understand their illness and after surgery to monitor post-operative recovery.

"At the same time, many surgeons' practices have now become far more fragmented, with many visiting the wards to see patients late at night or first thing in the morning, which makes it much harder to achieve the Grand Rounds of the past.

"This is not just a matter of technical skills either

in that trainees in the past, by accompanying the senior consultant at the bedside, would have the chance to learn from an expert how to deliver distressing or difficult news, for example. The opportunity for this has certainly reduced.

"All of these issues need to be addressed by designing and developing appropriate educational and training packages that can be measured and tested to make sure the skills transfer that used to happen as a matter of course can be provided in a controlled simulated environment."

Describing himself as a devoted amateur wine collector, Dr Truskett lists the treasures in his cellar as being a 1976 La Chapelle Hermitage and a few bottles of 1982 Grange, one of the best years for one of the best wines ever made in Australia.

His preferred varietal, however, is pinot noir and he lists his current favourites as coming from the Central Otago region of New Zealand such as Chard Farm and Felton Road.

Having worked most of his life in Sydney, Dr Truskett knows now to make the most of a trip to the glamorous city on the harbour, from the obvious delights to the hidden gems.

GET OUT ON THE WATER: Whether it's an evening harbour cruise or tootling around on the ferries, Sydney sparkles on the water. Her famous iconic ferries have operated on Sydney Harbour and its related waterways for more than 135 years and now carry over 14 million travellers each year. Check out the departure wharfs, destinations and timetables at www.sydneyferries.info but for a more free-wheeling way to explore the hidden bays and inlets you can also hire a water taxi.

THE ROCKS: The Rocks, nestled at the foot of the Sydney Harbour Bridge, is one of the oldest areas of Sydney and is often described as an outdoor museum. Almost destroyed decades ago in the development craze of the 1960s, it didn't just survive, but has prospered, recently undergoing an amazing transformation. Dr Truskett lists his favourite haunts at the Rocks as being the Altitude Bar at the Shangri La Hotel (176 Cumberland Street); one of the oldest pubs in Sydney, the Hero of Waterloo Hotel (81 Lower Fort Street); as well as the Orient Hotel (89 George Street) and the Basement Nightclub (29 Reiby Place) for the music. He said: "The Altitude Bar has panoramic views of the harbour and you don't have to book or eat, you can just go up there for a drink. The Hero of Waterloo is a great old pub and the mother of a friend of mine lay in front of the bulldozers with Jack Mundey to save it. The Basement is a wonderful live music venue, a musician's venue, the kind of place that Mick Jagger would go to if he was in town."

CONNECT WITH NATURE: Known as the "Zoo with a View", Taronga Park Zoo boasts spectacular views overlooking the Harbour, the Harbour Bridge and the Sydney Opera House. Located on Bradley's Head Road, Mosman, it is home to over 2600 Australian and exotic animals representing around 340 species, and includes a Giraffe House, platypus and nocturnal houses, waterfowl ponds and a rainforest aviary. A cable car, known as the Sky Safari, runs through the treetops offering not only an easy way to reach the top of the hill, but views of the city and water. "A visit to the Zoo can be a fantastic day out, particularly taking the Sky Safari over the top of the animals while I'd also praise the Royal Botanic Gardens for its beauty and calm in a busy city," Dr Truskett said.

HAVE A BITE TO EAT: From a converted butcher's shop now serving fabulous fresh fish in an informal setting to some of the world's finest of fine-dining restaurants, Sydney continues to serve up culinary class. Dr Truskett lists his favourites as Mohr Fish (202 Devonshire Street, Surry Hills), Rockpool (107 George Street, the Rocks), Golden Century Seafood Restaurant (303 – 300 Sussex Street) and Doyle's Restaurant (11 Marine Parade, Watsons Bay). He said: "Mohr Fish is friendly and cheerful with fabulous fish. You can't book, but if you can't get a seat you wait at a nearby pub and they come and get you when a table is available. The Golden Century in Chinatown does great steamed fish and scallops and is open almost 24 hours so it's a great place to visit after a show. Doyle's is always good and it's fun getting to Watson's Bay and an interesting place to wander around."

TASTE SOME WINE: As a "dedicated amateur" wine collector, Dr Truskett recommended the Ultimo Wine Centre as a Sydney treasure. Located at Shop c21/99 Jones Street, the Ultimo Wine Centre is considered to be one of the leading retail wine stores in the country. With an enormous range of both imported and aged wines, the Centre holds free tastings most Saturdays. He said: "The Ultimo Wine Centre can be a bit hard to find, but the effort is worth it. It has one of the best selections of wine in Australia and the staff is incredibly knowledgeable."

TAKE A DRIVE OUT OF TOWN: For spectacular views of a different kind, take a two-hour drive out of Sydney to visit the breath-taking look-out of Echo Point at Katoomba and gaze upon the grandeur of the Three Sisters rock formation in the Blue Mountains. To fully grasp the scale of the location take a trip on the Scenic Railway, the steepest railway incline in the world which takes you down past Orphan Rock, through a tunnel and the beautiful fern-damp cliff face. If you want even more excitement take the Scenic Cableway, the steepest aerial cable car in Australia. Dr Truskett said: "I think it would be a great pity to come to Sydney and not see Echo Point. It is a unique experience and it's incredibly awe-inspiring with some visitors I've taken there likening it in grandeur to the Grand Canyon in America."

THE CREME DE LA CREME: If you know some months in advance that you are coming to Sydney, try and try and try to get a reservation at Tetsuya's. Located at 529 Kent Street in Sydney, Tetsuya's is a refurbished heritage-listed site offering serenity amid the bustle of the city. Considered by some as the high temple of gastronomy, the food is based on the Japanese philosophy of using natural seasonal flavours enhanced by classical French technique using the freshest possible ingredients. Dr Truskett said: "It might take a while to get in, but the wait is absolutely worth it. It is a fabulous experience and in all my travels I have never had better food anywhere."

On the Fly

Professor Ian Gough finds time in his busy schedule to enjoy the art of fly fishing.

Professor Ian Gough, immediate past President of the College and Professor of Surgery at the University of Queensland, has become the only surgeon currently practicing in Australia to be elected as a Fellow of the Royal College of Physicians of London.

With the membership stipulations requiring personal distinction and a significant contribution to the practice of medical science or medical literature and working as a consultant in a substantive post for several years, Professor Gough described the achievement as a "rare honour".

He said it followed his nomination last year by Professor Geoffrey Metz who was the President of the RCP at the same time that Professor Gough was President of the RACS.

"While working in surgery in the UK in 1974 I passed the exams for membership of the combined Royal Colleges of Physicians," he said.

"I have always thought that a surgeon should have a broad knowledge of medicine and I try to apply this in my own practice.

"Mine is not an Honorary Fellowship; it is elected and I pay the annual subscriptions and need to remain in good standing while I continue in practice."

With his particular area of expertise being complex endocrine surgery, Professor Gough is Senior Visiting Surgeon and Head of Endocrine Surgery at the Royal Brisbane and Women's Hospitals.

He is a former President of Australian Endocrine Surgeons, a member of the International Association of Endocrine Surgeons, the Asian Association of Endocrine Surgeons and Breast Surgeons International.

In addition to professional commitments, Professor Gough finds the time once or twice a year to make a trip somewhere around the world to enjoy the pleasures of fly fishing.

He said he first took up the challenge around 10 years ago after watching the ABC television series A River Somewhere, which followed the fly-fishing adventures of comedians Tom Gleisner and Rob Sitch who travelled the world with the aim of catching trout in exotic locations.

Since then, he has travelled in search of his elusive quarry to sometimes remote and glorious locations in Scotland, Ireland, Canada, the US, Chile and Argentina although he believes New Zealand to be the best and most beautiful place on earth to fish for trout.

"One of the great attractions of fly fishing, especially for trout, is that one is so far away from everyday concerns and beyond the reach of all telecommunications," he explained.

"Some places require hiking to reach the location, but others are accessible by road while some rivers are suitable for rafting and camping out on a trip that could last three or four days. I often travel with my wife although she is mostly interested in the beautiful locations rather than the fishing."

Professor Gough said fly fishing is defined by the casting of the fly line itself which is followed by a fly, in contrast to casting bait or lures whose weight and momentum carry the line forwards. He said while most people knew about fly fishing for trout, it was also possible to fly fish in salt water for almost any species.

Flies consist of a hook with feathers or fur and other artificial materials tied on to resemble fish food such as smaller fish or insect nymphs, and are either fished deep under the water or floated on the surface to resemble a hatched insect.

"In fresh water fishing for trout there are a variety of methods for getting the flies near the fish," Professor Gough said.

"In rivers we mostly use floating lines with weighted nymphs near the bottom and it is important to have the line and the flies moving at the same speed as the current – otherwise the fish will not take the fly.

"When an insect hatch occurs at twilight in summer the trout come to the surface to feed. This is known as the 'evening rise' and provides one of the great pleasures of fly fishing in a remote place.

"Another particular feature of fly fishing is to cast to a fish that has been seen by scanning the water using polarised sunglasses.

"Sight-fishing, that is casting to an individual fish, gets the adrenaline flowing and attracting it to take the fly is extremely satisfying."

Professor Gough said the vast majority of members of the fly fishing community was deeply aware of, and committed to, the environmental health of river systems and lakes and the fish stocks located within them.

He said some areas were so delicately balanced that many fly fishers wished to see lowered kill limits.

"Most rivers we fish in New Zealand were only stocked once in the late 19th century so the fish are truly wild," he said.

"When there have been big floods or there has been overfishing of the system, the fish population comes under pressure so it is quite fragile.

"We only practice catch and release in these special places and would like to see lowered bag limits."

Professor Gough said that salt water fishing is mostly subsurface with sinking lines and larger flies and hooks requiring the use of heavier rods. The fishing takes place on reefs, sand flats or in deep water for large predators such as tuna.

He described such fishing as hard work and only primarily done for sport, rather than in pursuit of the evening meal, though the difficulty added to the satisfaction of success.

"The finest fish I have caught was a trophy bone fish at Ningaloo Reef in Western Australia," he said.

"This is an elusive fish and requires dedication to successfully hunt and catch because they are hard to locate and sight and very strong and fast.

"There are much easier ways of catching fish than with a fly – it's actually the hardest way of all – but the locations, the friends (I have a fishing companion who is very experienced and enthusiastic) and the satisfaction make it most worthwhile.

"It has been said that it is an activity that combines mind, body and spirit and that is its great attraction and although it may be done individually it is enhanced by good company and as my regular fishing companion says: 'all fly fishermen are good company'." ●

–Karen Murphy

The best of times

A lifetime of travel has led to a tale of words from Ken Clezy. Karen Murphy chats with the retired surgeon.

The life of general surgeon and committed Christian Ken Clezy, AM OBE, is a tale not only of courage, adventure and professional ability, but also one of tragedy, loss and sacrifice from an era of the travelling general surgeon now rapidly passing into history.

His long career took him from his home in rural South Australia to medical school in Adelaide and to the UK as a ship's doctor. He gained a position at St Andrew's Hospital, Billericay, where he worked under the leadership of senior surgeon and pioneer of vascular surgery Peter Martin before becoming a Fellow of the Royal College of Surgeons of England in 1958.

In 1961 Mr Clezy took his wife Gwen and young family to New Guinea where he was surgeon at the government hospital in Rabaul. Eventually he became the first professor of surgery at the University of PNG in Port Moresby.

He performed brain and spinal tumour surgery there for many years, but had other interests too. He mistakenly thought he'd discovered a new operation for complicated gall stone disease; he became the country's phaeochomocytoma surgeon and was a pioneer of non-operative management of the ruptured spleen in adults.

His particular expertise, however, was in the reconstructive surgery of leprosy deformities, which he performed across PNG, in Indonesia and the South Pacific after spending 1964 working alongside the pioneer in the field, Dr Paul Brand, at a dedicated leprosy hospital in India.

In 1988, the Clezys left PNG for Burnie, Tasmania, for 10 years before the urge to once again take up fulltime mission work took them to Jibla, a city in the south west of Yemen.

Ken Clezy is the only general surgeon elected an honorary member of the Neurosurgical Society of Australasia (NSA) and has also received the RACS International Medal, which is bestowed only upon those who have made a lasting and significant contribution to surgery in the developing world.

Personal tragedies

Outside the surgical arena, however, his sorrows have been deep. In Yemen, he lost three colleagues, shot by a Muslim extremist shortly before the Second Gulf War and probably missed death himself only because he'd gone home for breakfast.

He lost a beloved daughter to the slow ravages of anorexia and was away from home in PNG when his wife was attacked and raped by a gang of local men, which led to a criminal trial that Mr Clezy described as a great testament to his wife's courage and resilience.

Following his 2005 retirement from Jibla and return to Adelaide, Mr Clezy turned his attention to writing his memoirs.

That book, called *Now in Remission*, was published last year and is currently one of the most globally successful publications of Wakefield Press.

Written with a touch of mischief, great compassion and professional detail, it is not just a personal memoir, but a history of surgery and a cultural history of PNG as it moved toward Independence.

He writes about his internship when junior doctors were left both unsupervised and exhausted, which would now be considered both barbarous and illegal and how the fear of the Senior Consultant's wrath could outweigh the impact of a patient's sudden death.

While performing neurosurgical procedures gave him great professional satisfaction, treating the victims of leprosy was the most personally rewarding. It was, he writes, his time working with Dr Brand that sparked his enthusiasm.

"Before Brand, leprosy was a disease apart in every sense and was left to the leprosy doctors," Mr Clezy writes.

"Brand took up the challenge and after prolonged experimentation, arrived at a modification of a previously described, but rarely performed, tendon transfer that produced excellent results.

"Before he studied nerve damage, some experts believed loss of digits and the appearance of non-healing ulcers, particularly common on the feet, were due to local destruction of tissue by the leprosy bacillus. Others saw this destruction as evidence of depressed immunity to germs that ordinarily were harmless.

"Brand proved that the real cause of loss of tissue was repeated unrecognised trauma to numb parts.

"It is scarcely possible to exaggerate the importance of the discovery that trauma to anaesthetic parts is the cause of loss of tissue in leprosy and that its prevention requires unflagging, lifelong effort, almost amounting to an obsession.

"Diabetics and their physicians face a somewhat similar problem with anaesthetic feet and despite wide publication of Brand's work, the same fundamental discovery had to be made all over again in that disease."

Amazing thinker

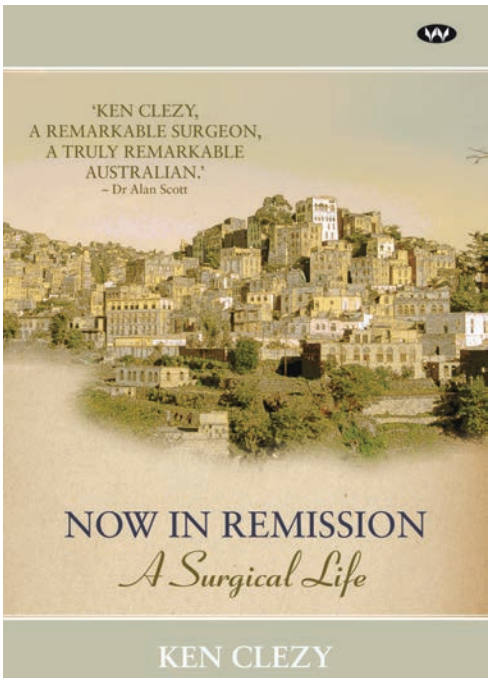
Speaking to *post op*, Mr Clezy said that of all the great surgeons and surgical pioneers that he has known, it was Dr Brand who stood at the pinnacle of professional endeavour and personal commitment.

"Brand was an amazing thinker and revolutionised our understanding of leprosy," he said.

"In India, more so than in PNG, the claw hand had a terrible stigma attached to it which meant that people with it could be kicked out of their families, their jobs, even pushed off a bus onto the street so that if we could make it look more normal such patients could hope for a more normal life.

"Paul Brand taught many of us how to examine people with leprosy, how to prevent or correct the damage and despite his fame he did not change."

Mr Clezy said his favourite place among all his peregrinations was Jibla, Yemen, during a period that, perhaps surprisingly, was not forever tainted by the violence he witnessed there, including an incident in which a randomly fired bullet narrowly missed his wife.



Now in Remission can be found in most good bookstores, but if you cannot find it, contact the publishers at www.wakefieldpress.com.au

"I had only seen two gunshot wounds before I went there, but there is a very strong gun culture in Yemen where people settle feuds with them or sometimes just shoot into the air without thought of where the bullets might end up," he said.

"Even though the loss of our colleagues was shocking, most of those present that day seemed to cope better than colleagues who had recently left us.

"Surgeons are trained through their experiences to deal with most things and after losing our daughter, life seemed to set the two of us up to handle anything."

Among the many accolades and honours he has received throughout his long career, Mr Clezy said receiving the RACS International Medal and his election as an honorary member of the NSA were the most significant.

"A lot of people get OBEs, not always deservedly, but there aren't many of the International Medals bestowed, which makes it very special to me while the honorary membership of the NSA meant peer acceptance of the neurosurgery I performed, mainly in PNG."

Mr Clezy said that among the many reasons he wrote *Now in Remission*, one was to record an era now disappearing in an environment of increasing surgical sub-specialisation.

"I think the days of the roaming general surgeon are coming to an end and in some parts of the world that shift will leave major gaps in the provision of surgical services," he said.

"I think surgeons of my generation lived and worked in the best of times and I remain very grateful for the wonderful opportunities given to me to offer treatment in a variety of regions to a wide variety of patients."

This article on Michael Besser AM MBBS 1971 FRACS FRCSC FACS Clinical Associate Professor Discipline of Surgery first appeared in the November issue of the University of Sydney's alumni publication Radius. An edited version is reproduced here.

Michael Besser; Pollie Pedal Cyclist, Ironman, Neurosurgeon

When Professor Michael Besser retired in 2008 after more than 30 years at the pointy end of neurosurgery at Royal Prince Alfred Hospital, it gave him the time to pursue other interests. He greatly enjoyed tutoring medical students this year in the whole body dissection classes in Anderson Stuart's new dissection rooms. He has completed a number of units in the Master of Medical Humanities, and is full of praise for the course that encourages a different perspective on medicine and care.

Retirement has also given him time to pursue a life-long passion for training and fitness. Instead of pounding the pavement at 4am or late in the evening after work, he can now indulge himself several times a week with four or five hour cycling sessions or long leisurely runs. He has had time to prepare for and participate in a number of triathlons and other competitions on the burgeoning calendar of events open to "veteran" athletes. Three years into retirement and aged 65, with the 1,000 kilometre Surfers to Sydney Pollie Pedal and several shorter triathlons under his belt, (when he spoke to *Radius*) he was making plans for the Busselton Ironman last December.

For those unfamiliar with the Ironman events, to say they are a physical and mental challenge is putting it mildly. They start with a nearly four kilometre swim followed by 180 kilometres on a bike. A quick change to running shoes and then 42 kilometres run on the blistering roads – in this case, around Busselton in south west of Western Australia. At the front of the field, the world's best athletes finish an Ironman in around eight hours. Others, including opposition leader Tony Abbott in his first attempt at such an event last year in NSW, take 12 or more hours. Either way, it is a long day.

"I retired at 62, but had been thinking about it since I was 60. I think all surgeons should. You need high-end coordination to be at the top of your game and it is inevitable that your skills will decline. I wanted to leave on a high rather than be remembered for my last mistake. I was still taking on difficult cases, but I found that the emotional side of interacting with patients was getting harder. When you are young, things bounce off you. When you are older you are more aware of your mortality and that of others. And I wanted to leave while I had the capability to pursue my other interests".

He didn't have a history as a triathlete, but had been a reasonable swimmer at school and grew up cycling with the Lidcome-Auburn Cycle Club. Throughout his working life, he has managed to maintain a level of fitness, but with a surgeon's working hours and four children, it was not easy.

He credits his wife Anne, for getting him into the competition and overcoming his initial reservation over the merits of triathlons. "In the mid 1990s my wife was a triathlete and represented Australia at the World Championships and she was my age. She was having fun, I was doing support and I eventually got sick of being the 'bike bitch'."

Retired neurosurgeons are unlikely to be disorganised in their training, nor ever do things by halves, so it is no surprise to hear Michael Besser describe his exercise program: concentrate on one discipline per day, either cycling four or five hours, swimming two to three kilometres or running 10 to 15 kilometres, with an occasional two-session day. He has a triathlete coach based in Melbourne who sets a new program every six weeks. He emails her the data from his bike computer and they follow up on the telephone.

He trains mostly alone or with Anne. The concern is staying injury free. "Triathlon is good for the older age group because you are cross training and resting different parts of your body on alternate days."

What he enjoys greatly about triathlons, and competitions and training more generally, is that it provides a new focus and challenge, plus a life outside medicine. "I enjoy the social aspect – the people and the personalities – but also setting and achieving goals."

Mentoring and Leadership

The right mentoring is important to development

A brainstorming session on this subject was recently held at the RACS Melbourne office. Presentations from Fellows as well as industry, sport and military representatives formed the first half of the morning. Subsequent discussion revolved around the potential role for more formalised mentoring and leadership programs. These are some concepts and thoughts that evolved from the discussion.

Firstly we all have a different personal understanding of what mentoring is. The industry representatives explained that in their environment mentoring and coaching mean different things. Coaching, in this setting, is in the context of a 'boss and worker' relationship; the objective is to attain better outcomes for/in the workplace. Coaching is performed by all supervisors, coaching is for everyone and coaching is a management tool. Mentoring is for the leadership stream. Potential leaders are recognised early and accelerated through the ranks. Successful leaders within the business environment have recognised weaknesses in leadership style which are addressed through a mentor-mentee relationship. This organised relationship has a specific objective; the mentor and mentee have no influence on each other's careers, and their roles are clearly delineated.

Two NRL players (legends and part of the 'Club ambassador' program) presented next. The NRL have problems similar to our own... when the back pages of the newspaper end up on the front page. For them, drug-fuelled behaviour caught on cell phone cameras is a recipe for disaster. A comprehensive effort has been made to influence young adult players (essentially 18-30 year old men) to gain insight into their situations and actions; achieving wisdom and maturity without the detrimental experience of front page exposure. Hand-picked 'go to' players are identified, monitored and if they hold enough 'mana', are asked to be involved in the personal development of club players. Only respected players, who want to be involved, become a club ambassador.

An Australian colonel also gave pointers on spotting 'leaders of the future'. He provided a wonderful two word summary for observing a wide range of qualities; the 'say-do' gap. The 'say-do' gap focuses on what people say they will do versus what they actually do. We know our mentors often change with time. So in the army potential leaders are scrutinised carefully for one year at a specific location; "you can't hide for a year". The parallels with annual hospital rotations and the fellowship years are hard to miss.

Through all the talks, some themes were common:

1. There is a two by two square: those who want/do not want to be leaders by those who can/cannot be leaders.

2. Every leader is also a follower in another situation.
3. Poor leadership and poor 'followership' can both be disastrous.
4. Mentoring requires trust, confidentiality and respect.
5. The aim of mentoring is obtaining wisdom and maturity prematurely.

Other mentoring programs that I am aware of in medicine include:

1. The Rural Australia Medical Undergraduate Scholarship[1] (RAMUS) program, which aims to increase the number of students from rural Australia returning to practice in rural Australia.
2. The Queensland Health Bonded Medical Scholarships (QHBMS) Email Mentoring System[2], which provides scholarship recipients with the opportunity to access vocational training advice and guidance from experienced medical officers to support and strengthen their career opportunities. The mentor and mentee might never talk, see or meet each other, as communication may be only via e-mail.
3. Paediatric physician trainees choose a mentor for their training program, which is role specific[3].

When we think of our mentors, we usually think of surgeons who we seek advice from during in our training program. In most other groups that have mentoring relationships, this surgical mentor would be called a 'coach'. As we do not have a formal mentoring program (organised confidential relationships with an aim of achieving wisdom and maturity) coaching in surgery continues to be synonymous with, and encompassed within, mentoring. Whether we need both coaching and mentoring in surgery is another question.

Gowan Creamer
Younger Fellows Committee

References
1. http://ramus.ruralhealth.org.au/
2. http://www.health.qld.gov.au/orh/scholarships/qhbms/ementor.asp
3. http://www.racp.edu.au/index.cfm?objectid=AD761666-ADB0-396E-E67BD844708972E7

Courses to gain new skills

There is a large range of professional development activities for you to choose from in 2012. Engaging in professional development means more than simply receiving information to improve your performance or practice.

They provide valuable opportunities to expand your knowledge and gain new skills as well as exchange ideas and share experiences with your peers about issues that are challenging health professionals.

For example 'professionalism' has become a 'hot' topic due to changes in society, health service delivery and technology. The new Non-Technical Skills for Surgeons (NOTSS) workshop focuses on some core components of professionalism; situational awareness, communication, decision making and leadership/teamwork.

You can get a better understanding of how these non-technical skills underpin safer operative performance and learn to identify behavioural markers that contribute to superior or substandard performance. You also practise using a rating scale which can be used for self-reflection and the assessment of others.

Effective communication is important for good patient outcomes; inside and outside of theatre. The Process Communication Model (PCM) course aims to improve your communication skills by exploring different motivational needs and their associated communication styles.

Before the course, participants complete a diagnostic questionnaire which forms the basis of an individualised report about their preferred communication channel.

Some of the other workshops provide practical strategies to effectively manage a business through leadership, strategic planning and financial management. 'Leadership in a Climate of Change', 'Strategy and Risk Management for Surgeons', 'Finance for Surgeons' and 'How Well Do You Know Your Practice? A Game Plan for Success' explore different aspects of managing a team and a practice.

The College is also offering professional development via its new eLearning activities. More than 2,000 people have attended the Supervisors and Trainers for SET (SAT SET) face-to-face workshop and this workshop is now available online for those who have not yet attended or for those who would like to refresh their skills. More eLearning activities will be launched in 2012 so watch this space for more information.

The College's professional development activities have been tailored to the needs of surgeons, but many of the activities are also suitable for other medical professionals so please tell your colleagues about these learning opportunities. I look forward to seeing you at some of these workshops.

Marianne Vonau
Chair, Professional Development

Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit www.surgeons.org - select Fellows then click on Professional Development.

in 2012

Workshops & Activities

Life long learning through professional development can improve our capabilities and help us to realise our full potential as surgeons as well as individuals.

Non-Technical Skills for Surgeons (NOTSS) *NEW*

27 April Melbourne,
6 May Kuala Lumpur (ASC)

This new workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve your performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into elements or behavioural markers that can be used to identify a superior or substandard performance. Through a series of interactive exercises you will better understand how these markers can be used to reflect on your own performance and that of the surgeons and Trainees you work with.

Keeping Trainees on Track (KToT)

28 February, Brisbane; 17 March, Melbourne; 2 April, Sydney; 21 April, Launceston; 6 May, Kuala Lumpur (ASC)

This 3 hour workshop focuses on how to support trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Introduction to the Process Communication Model (PCM)

8-10 March, Wellington NZ;
26-28 April, Brisbane

Patient care is a team effort and a functioning team is based on effective communication. PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. PCM can also help to detect stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

How Well Do You Know Your Practice; Successful principles in practice management *NEW*

9 March, Perth

A willingness to critically review and understand what goes on in your practice is the cornerstone of an organisational culture where business and clinical principles are effectively aligned. Knowing and monitoring your "Game Plan" is the first step to effective management. This new whole day workshop focuses on how gathering data and information, in a systemised manner, through analysis and a willingness to challenge the status quo, can lead to effective decision making and improved customer service. Practice managers and Fellows are welcome to attend.

DATES

NSW

30 March, Sydney
Occupational Medicine

2 April, Sydney
Keeping Trainees on Track

NZ

8 – 10 March, Wellington
Intro to the Process Communication Model

QLD

28 February, Brisbane
Keeping Trainees on Track

21 March, Brisbane
Polishing Presentation Skills

26 – 28 April, Brisbane
Into to the Process Communication Model

29 May, Brisbane
SAT SET Course

SA

27 February, Adelaide
SAT SET Course

30 March, Adelaide
Non-Technical Skills for Surgeons

TAS

21 April, Launceston
Keeping Trainees on Track

VIC

27 March, Melbourne
Keeping Trainees on Track

27 April, Melbourne
Occupational Medicine

27 April, Melbourne
Non-Technical Skills for Surgeons

30 April, Melbourne
SAT SET Course

WA

9 March, Perth
How Well Do You Know Your Practice?

Healthcare reform in the US

The US should no longer delay reforming an unequal system

Most Americans believe they have a good healthcare system. A vehement critic of the President, the commentator Rush Limbaugh, wrote that "Barack Obama ... has taken the greatest healthcare system on the face of the earth and is nationalising it, slowly killing it." However, complacency regarding the state of the US healthcare system is not justifiable.

While it is true that America provides probably the best healthcare available anywhere, that only applies for some patients. Overall the quality is quite variable. The OECD's most recent comparative data in 2009 showed that while the per capita spending on healthcare in the US is the highest in the world by a big margin (more than $7,000 per person per annum) the average life expectancy of Americans is below the mid range of comparable western countries by about three years. Other reviews of outcomes by the WHO and the Commonwealth Fund show many shortcomings on multiple measures of healthcare. The US performs comparatively poorly on infant mortality and is far inferior to other western countries on reported timely access to care and continuity of care. Comparable countries spend approximately half of the American spend (as a percentage of GDP), yet achieve better value for money – this includes Australia and New Zealand.

Possible bankruptcy

The US spends more than 17 per cent of GDP on healthcare, of which about 45 per cent is from the government. The quantum and percentage is continuously rising and health is the only sector of the US economy to have grown in the past three years since the since the start of the GFC. Many think that, without reform, the US Medicare system is heading towards bankruptcy.

Reform of the healthcare system was the major topic of discussion at many sessions at the recent American College of Surgeons Annual Clinical Congress, including meetings of the Board of Governors and Board of Regents and the opening keynote lecture. The lecture asked the question whether the health system was too big to fail. It is certainly too expensive and failure in the near future does seem a possibility.

"While it is true that America provides probably the best healthcare available anywhere, that only applies for some patients"

There is a lot of waste throughout the system that essentially functions as a free market. While drugs and devices have to meet safety criteria before approval there is little attention given to cost-effectiveness. A new drug or device is likely to be very expensive and widely adopted without much regulatory oversight. This freedom from review seems to be expected in America and the idea of limited or strategic rationing seems too difficult for many to contemplate.

Another area that requires reform is legal liability, but this also seems too hard. Of course, there are many powerful vested interests at play, but the very high cost of indemnity and payments to plaintiffs drives over-servicing to a degree that is far beyond reasonable clinical need. Industries have been organised to exploit this, the most recent and obvious being PET scanning. PET scanning is expensive and limited in its role, yet most patients with cancer have had one done before referral to a surgeon. The cost of the PET scan often exceeds the total cost of the surgical treatment.

The Commonwealth Fund is an independent foundation that conducts research into healthcare. They have estimated that if the administration of health insurance companies was made as efficient as in the best performing comparable countries, it would save about $116 billion per year.

In 2010 the Patient Protection and Affordable care Act was legislated. It aims to:

1. Improve access to care, particularly for the 50 million Americans without cover
2. Reform insurance
3. Reform payments
4. Re-design health delivery systems including measurement of performance.

All of these seem reasonable and pressing, yet support is divided among both the people and the politicians. Legal challenges are gradually working their way through the courts and delaying implementation.

The three main elements of an effective healthcare system are quality, affordability and access. The current system in the US is failing on affordability and access and quality is compromised for many patients as a consequence. At some time it may have been possible to claim that the US had an excellent health system, but no longer. Major system review is urgently needed.

Ian Gough,
Queensland Fellow

Preparation for Business

Hard work deserves good business sense

The word 'Business' has considerably more than four letters, but mention it in polite medical company, and there is an uncomfortable mood that descends immediately. A polite cough, a couple of mis-started sentences, some delicate fidgeting and adjustment of body position... almost as if someone has pointed out the elephant in the room, that has long since died and only now is the smell becoming apparent. Awkward.

Why is the concept of business and medicine so discomforting? Why do discussions about money raise certain compunctions within many surgeons, deep feelings of guilt and embarrassment at the thought of charging for our services? Can we not openly admit the desire, or the right, to be well paid for the many years of hard work and training?

Certainly the ruthless pursuit of money is a false idol. The American system of unbridled capitalism has bred a generation of people who cannot understand how they can possibly be so unhappy, when they have made so much money. Equally, the communist system breeds discontent if hard work, training and excellence are not recognised and rewarded in turn.

The reality of surgical training is that most is done in the public system, an arena where there is no knowledge required of MBS item numbers and descriptors. There is no need for a trainee to consider anything other than the lofty ideals to which the ivory towers in which they are taught aspire and where there is a certain disdain for the emolument of the private sector.

Most enter medicine with a desire to help their fellow man, and many would work even if the pay was negligible or non-existent. Full time public positions are not always readily available, however, and many surgeons work well past the usual age of retirement creating something of a tight market for teaching hospital FTE.

By the time FRACS is awarded, few trainees have any real understanding of the machinery involved in private practice and the many potential pitfalls that await the unwary and the unwitting. Awareness of private sector medicine as a business is essential if the venture is to be a successful and long lasting one.

The Younger Fellows Committee has been charged with redressing this knowledge gap, and in each state and territory the younger fellow representative is working with the regional committee to provide a Preparation for Practice seminar, which will cover the essentials for starting out in the private sector.

These seminars will be run at cost, and provide a significant discount to some 'outside' courses that are being offered, some costing thousands of dollars, and often without the input of surgeons currently in practice. These courses will be run on an 'as needs' and 'as interested' rotational basis in Australia and New Zealand

Business is not a four letter word, but it is regarded as somewhat dirty none the less.

Richard Martin,
Younger Fellows Committee

A 'How well do you know you Practice' workshop is being held in Perth on 9 March. There will be a Preparation for Practice Workshop in Melbourne, over the weekend of August 25 and 26, 2012. For more information contact +61 3 9249 1106 or pdactivities@surgeons.org

Individual Specialist Professional Development Grants

New Rural Health Continuing Professional Development grants are available

The Rural Health Continuing Education (RHCE) program is pleased to announce individual Continuing Professional Development (CPD) grants of up to $10,000. The grants are available to aid rural and remote specialists to access education and professional learning opportunities.

Eligible applicants include Fellows of the Royal Australasian College of Surgeons and overseas trained specialists with specialist recognition or working as a specialist in an Area of Need Positions

The objectives of the RHCE program, funded by the Australian Government through the Department of Health and Ageing, are to provide education opportunities that support CPD for individual specialists as well as groups of specialists in rural and remote locations in Australia, with a focus on activities that encourage multidisciplinary team-based learning.

The application guidelines and application forms for RHCE Stream One Program grants can be downloaded from the website: http://www.ruralspecialist.org.au/default.aspx

Forward your applications by 24 February, 2012 to:
Merrilyn Smith
Manager, Professional Development
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 - 290 Spring Street, East Melbourne. VIC 3002
E: merrilyn.smith@surgeons.org P: +61 3 9276 7441

Please note:
- > The CPD event must take place in Australia
- > The CPD event is a maximum of five days and a maximum budget of $10,000
- > An application must be submitted as a typed MS Word file; a signed paper copy is also submitted.
- > Applications must be verified by Colleges as being eligible to the program.
- > Attendance at annual scientific meetings is classified as a much lower priority than other 'hands on' workshops.

THE UNIVERSITY OF WESTERN AUSTRALIA ctec

PANORAMA OF EMERGENCY SURGERY
3RD ANNUAL STATE CONFERENCE
BUNBURY
SAT 17 – SUN 18 MARCH 2012

Convenor | Mr Val Lishman, AM
Venue | Lecture Theatre B6, Edith Cowan University Roberstson Drive, Bunbury WA
Course content | This two day interactive conference covers topics relevant to the "single-handed" doctor working remotely and includes a series of emergency surgery lectures by local specialist consultants.
Fee | $110 (inc GST) includes light meals, refreshments
Further information and registration | (08) 6488 8044
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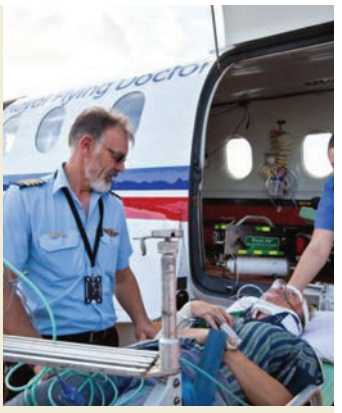

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Government of Western Australia Department of Health

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THE UNIVERSITY OF ADELAIDE AUSTRALIA

SUB CRUCE LUMEN

The University of Adelaide, Discipline of Surgery
presents

19th Seminars in Operative Surgery
SPECIALIST SURGERY FOR GENERAL SURGEONS
Friday 9th March 2012
Royal Adelaide Hospital, Adelaide, Australia
Meeting Convenor: Professor Glyn Jamieson

Registration and conference details can be found at:
www.health.adelaide.edu.au/surgery/sos or by contacting
Ms Kai Holt 08 8222 5516 kai.holt@adelaide.edu.au

There are many operations undertaken by specialist surgeons which are well within the remit of a well trained General Surgeon, and this applies particularly to surgeons who work in remote, rural or peripheral city practices. This seminar is designed to demonstrate such operations as skin flaps for skin lesions, varicose vein surgery and treatment of leg ulcers, carpal tunnel decompression, right hemicolectomy, modern techniques in bowel anastomosis, breast surgery and other operations to keep general surgeons up to date with the best way to undertake such techniques.

This educational activity has been approved in the College's CPD Program. Fellows who participate can claim one point per hour (maximum 7 points) in Category 4: Maintenance of Clinical Knowledge and Skills towards 2012 CPD totals.

Planning for the future

Workforce development, curriculum reform and engagement with stakeholders were the focus of activities by the Indigenous Health Committee (IHC) during the latter part of 2011

In September the College was proud to sponsor the annual scientific conference of TeORA, the Maori Medical Doctors' Association, held in Auckland. Maori committee member A/Prof. Jonathan Koea, and Fellow, Dr Maxine Ronald, presented on pathways to surgical training to an audience of 150 indigenous medical practitioners and students from both New Zealand and Australia.

Workforce development

The presentation generated considerable interest in surgery as a career and dialogue is continuing with TeORA how best the College can support the development of the Maori medical specialist workforce.

The Committee also continued its engagement with the Australian Indigenous Doctors' Association (AIDA). In October the Committee sponsored the participation of Dr Nino Scuderi in AIDA's annual symposium in Broome. Dr Scuderi is an Aboriginal doctor and a co-opted member of the IHC. His presence at the symposium allowed for follow-up with the students and doctors enrolled in the College's program to promote surgery as a career.

In October, the Committee was invited to participate in the National Forum for Indigenous Medical Academic Leadership, convened by the Medical Deans Australia and New Zealand (MDANZ) and AIDA. The forum, in part, reviewed programs supporting the recruitment and retention of Aboriginal and Torres Strait Islander students in medical education, training and research.

The experience and insights gained are of great interest to the medical colleges as we embark on the implementation of our own National Aboriginal and Torres Strait Islander Medical Specialist Framework, endorsed by the Committee of Presidents of Medical Colleges (CPMC) in 2010. Recently the CPMC appointed Dr Netra Khadka, a medical educator formerly with the Batchelor Institute of Education, to work with the medical colleges and AIDA to implement the Framework. Dr Khadka will be based at RACS and will support the CPMC's Australian Indigenous Health Subcommittee in this exciting initiative.

Curriculum development

In November, the College presented at the Leaders in Indigenous Medical Education (LIME) Connection conference in Auckland, on the two Indigenous health projects being developed with funds made available through the Rural Health Continuing Education (RHCE) Program.

Both projects aim to support the professional development of specialists caring for Aboriginal and Torres Strait Islander patients and communities in rural and remote Australia. Metropolitan based specialists will also be encouraged to access the resources being developed.

The Australian Indigenous Health and Cultural Safety Online Portal project is a collaboration between the medical specialist colleges to create a portal to link, promote and share resources and activities in Indigenous cultural learning, cultural safety training and Indigenous health, for ease of access and use by Fellows, Trainees, IMGs and staff from all medical colleges.

Named nichelearning.info, the portal is expected to be launched by mid-2012. The project steering committee includes representation from all medical colleges, AIDA and the National Aboriginal Community Controlled Health Organisation (NACCHO) and has worked hard to ensure the design and content of the portal adequately reflects the needs of stakeholders. The partnership that has developed is a great reflection of the long-term and shared commitment to Aboriginal and Torres Strait Islander Health.

The RACS Australian Indigenous eLearning Modules project has developed three online learning modules with face-to-face workshops to raise awareness of the cultural issues impacting Aboriginal and Torres Strait Islander health and access to appropriate health care services. It aims to promote a multi-disciplinary approach to patient care and incorporates the attainment of several of the key competencies of the College. The modules will explore the surgeon's relationship with the patient and his or her context within the surgical team and multi-disciplinary practice. The Committee is very grateful to the staff of the Awabakal Aboriginal Health Centre for their involvement and contribution in the development of the modules.

The future

The Committee looks forward to another busy year as we continue to assist the College and its Fellowship achieve the goals we have set for improving the health of our Aboriginal, Torres Strait Islander and Maori communities.

Finally, but not least, it is with pleasure that I welcome Dr Wil Harrison, Dr Nirmal Patel, Dr Maxine Ronald, Dr Pieta Taylor and Dr Paul Snelling as new members of the committee. I thank all current members for their commitment, hard work and dedication. It is the Fellows' contribution which has made some of our achievements as a College possible and I truly thank them for their time.

Kelvin Kong
Chair, Indigenous Health Committee

CONGRATULATIONS on your achievements

Citation read by Kathleen Hickey, Director EDA
Citation for the Award of the RACS Medal to Mrs Lorraine Jennings

I have the honour to present Lorraine Jennings, who has served the College as a member of staff for over 30 years.

Joining the College on 4 July 1981, her initial position was as secretariat to the Trauma Committee. This was at a time when the work of Gordon Trinca to improve road safety was a major activity of the College and had significant public and political profile. In her words, it was rewarding work and exciting times.

In 1996, she transferred to Education with responsibility for the OSCE Examination. In 2000 Basic Surgical Training was introduced and she became Administrator for the program. Outlasting BST, she currently administers the SET Clinical and OPBS examinations.

Lorraine views each examination as a singular event and gives consistent and equal attention to each sitting. With her calm demeanour, she is a stalwart to the trainees who rely on her for information and 'motherly' advice. Examinations under her direction run seamlessly.

Lorraine provides a conduit between 'the good old days' and the College as it is today. She has adapted to changing times and the challenges of evolving work practices and new technology with good humour, tenacity and a willingness to learn and contribute. Her extensive corporate knowledge of the organisation is invaluable and as unofficial historian, she has verified facts and events and provided background information in the absence of official sources. It is no wonder that she is fondly known as "the Queen".

Not only a 'mother figure', Lorraine has proudly raised Andrew, Jacki and Cameron and is grandmother to Chelsea, Nathan, Sam, Scarlett and Lucas.

Her approach in dealing with Fellows and Trainees is exemplary and she has earned the respect and trust of those within her sphere. Lorraine is a much loved and valued member of staff and personifies service and dedication to the College.

The RACS medal is awarded for distinguished service to the College; I have great pleasure in presenting Lorraine Jennings for this award.

Awarded by Mr Ian Civil, RACS President, Friday 28 October 2011

Improving the validity of the Fellowship examination

Ongoing development of the Fellowship examination has seen the process of assessment continue to improve

In the context of the RACS specialty training programs, the validity of the assessment processes is a measure of how well they determine whether a candidate has acquired the skills to become a competent surgeon. These relate to the nine surgical competencies as defined by the curriculum of each specialty:

- Medical expertise
- Judgment and decision making
- Technical expertise
- Communication
- Professionalism
- Health Advocacy
- Collaboration and teaching
- Management and leadership
- Scholar and teacher

The final exit examination (the Fellowship examination) involves a criterion referenced assessment. It tests whether a candidate has achieved a set standard.

The standard is predetermined by the specialty courts at the time of their exam preparation workshops and the candidate's responses are matched against this standard. Marking descriptors are used to assist the examiners determine whether the candidate's performance matches the designated standard.

The exit exam is acknowledged as primarily assessing two areas of surgical competence well: the clinical application of knowledge and professional judgment.

The remaining competencies in the curriculum are either not assessed at all or assessed to a lesser degree in the exam. These competencies should have been already more extensively (and more appropriately) assessed during SET training and are more appropriately assessed in the workplace setting.

The exit exam and workplace based assessments should be seen as being complementary to each other. The marking system used in the Fellowship examination reflects the criteria referenced basis in that candidates are classified as having achieved a pass, fail or are borderline.

The validity of the exit exam can be measured in a variety of ways. Content validity refers to the knowledge required according to the particular competency being assessed.

The knowledge is specialty-specific and clearly defined in the syllabus. The competencies assessed generally relate to the application of knowledge and clinical judgment – although some questions may be designed to test other areas as well.

The content and the competencies being tested can be compiled in a matrix to ensure that the examination has the appropriate emphasis and breadth. This exercise is termed "blueprinting" and is an important part of exam preparation and forms part of the Key Performance Indicators (KPI's) required of each specialty court.

Construct validity relates to the nature of the questions. A candidate may be assessed on a range of topics that range from basic knowledge (as in a recall of facts) to constructing a management plan using judgment and experience.

The development of the specialty-specific surgical science exams, where factual knowledge relevant to each specialty is assessed earlier in the training program, allows the final exam to concentrate on higher order questions.

To facilitate this, the specialty courts also use blueprinting of the examination according to Bloom's (1956) taxonomy (classification of questions in ascending order of complexity of cognitive function from knowledge, comprehension, application, analysis synthesis through to evaluation). This helps examiners to concentrate on testing higher level clinical judgement.

Simply ensuring questions are of a higher order of taxonomy does not guarantee that a proficiency is assessed accurately. Questions and examiners perform differently in their accuracy of assessment.

Data is now being collected as part of the trial of an expanded Close Marking System that will help examiners better identify discriminating questions. The validity of the examination is improved by increasing the number of marking points.

Historically, examiners working in pairs mutually decide at the end of an assessment session whether the candidate has achieved the required standard. In the close marking system this was signified by a number (pass 9, fail 8 and doubtful 8.5). Additional marks could be added by the examining pair that sometimes would influence the final decision on a doubtful candidate.

The new expanded close marking system correlates marks for each question from each examiner for each of the seven sections of the exam. In this way, analysis should allow for inter-examiner reliability to be improved.

Criterion validity is the measure of the overall success of the process in identifying those who are truly competent surgeons. However, the final exit exam can only test a few areas of competency, and must be seen as being complementary to other assessments that occur during SET training.

In short, the validity of the process is improved with proper planning (blueprinting), a move to higher order questions (Bloom's taxonomy) and an analysis of the "performance" of the questions used, and of examiners. If the criteria used to define the competent surgeon are appropriate, we will achieve our goal.

Spencer Beasley
Chair, Court of Examiners

With Mr Andrew Brooks, Deputy Chair (AUS) Court of Examiners

Travelling on College Business

Some points to remember when claiming expense reimbursements

I appreciate that busy Fellows may not always have the time to acquaint themselves with the intricacies of College policies.

Therefore I would like to take this opportunity to draw your attention to two particular clauses in the Expense Reimbursement Policy which are not always understood by Fellows and others who travel on College business.

Claims Based on Redemption of Awards Based Points

Any goods and/or services purchased by way of customer loyalty programs and/or similar award based membership schemes using award based points will not be deemed as a claimable transaction for expense reimbursement purposes. It is determined that redemption of award based points for goods and services are of a private nature and are not to be used when undertaking College related business activities.

Non Allowable Expenses

All non-allowable expenses are deemed private in nature and not reimbursable by the College and include, but are not limited to, expenses relating to:

- Fines and penalties
- Scams, frauds and illegitimate schemes
- Customer loyalty programmes/ award based membership
- Interest on overdue amounts and late payment of penalties
- Tipping above 10 per cent of the GST inclusive value for Australia and above 20 per cent for overseas
- Child and pet minding expenses
- Personal subscriptions and membership
- Private travel, including travel incurred for an accompanying family member
- Equipment for private use

The College appreciates the commitment made by all Fellows and I trust that this information is of assistance.

Adventures in Abyssinia

Before becoming a College anatomist, Raymond Jack Last took up a noted post as surgeon to the exiled Abyssinian Emperor, Haile Selassie.

In May 1936, the second Italo-Abyssinian War was over. Italy had annexed Abyssinia (Ethiopia) and the Abyssinian Emperor, Haile Selassie was in exile. The war had been a rout. Italy's military capacity was infinitely superior to the Abyssinians and strategies like the illegal use of mustard gas (banned by the Geneva Protocol of 1925) heightened this advantage.

European support for Abyssinia was lukewarm. Despite Haile Selassie's impressive speech to the League of Nations, the League's sanctions against Italy were ineffective. And the scandalous Hoare-Laval Plan devised by the French Prime Minister and English Foreign Secretary implied tacit support for the Italians.

For Italy, the victory over the Abyssinians vindicated their infamous defeat at Adowa (Adwa) in the first Italo-Abyssinian war (1896). It also confirmed their imperialist ambitions in East Africa and in June 1936, Abyssinia was merged with Italian Somaliland and Eritrea to become Africa Orientale Italiana.

The Rome-Berlin Axis (Pact of Steel) of May 1939 formalised fascist Italy's alignment with her German counterpart and after the outbreak of WWII in September, Abyssinia's fortunes began to change. Abyssinian resistance to Italian rule as evidenced by the Gojam revolt (1938) had never waned and after the outbreak of war, concern for their East Africa territories provided the impetus for the British to oust the Italians from the region.

To this end, the deposed Emperor Haile Selassie, disguised as a 'Mr

RJ Last c1940

"Last had been working as a surgeon in London and as he was unable to join the British Army Medical Corps, he was returning to Australia to enlist there"

Strong' then a 'Mr Smith' returned to Abyssinia via Sudan and worked with the British, Indian and South African forces to reclaim Abyssinia. This was achieved in early 1942 when the last of the Italians surrendered to the British near Gondar.

In December 1940, Raymond Jack Last and his wife, Margret were en route to Australia on the MV *Napier Star.* Last had been working as a surgeon in London and as he was unable to join the British Army Medical Corps, he was returning to Australia to enlist there. The Last's plans were scuppered when the Napier Star was sunk in the Irish Sea. They both survived the sinking and when they were recovering in England, the British Red Cross advertised for a surgeon to go to Abyssinia. The surgeon was to accompany the British force sent to Abyssinia and also to minister to Haile Selassie and his family. RJ Last was the successful applicant and his Abyssinian diaries are in the College Archive.

Last took a circuitous route to East Africa – travelling by sea and air to Khartoum and then, taking a river boat down the Nile to Cairo to source supplies for his unit. As this extract shows, his visit to the Temple of Karnak at Luxor left him spellbound.

Monday 21st April 1941

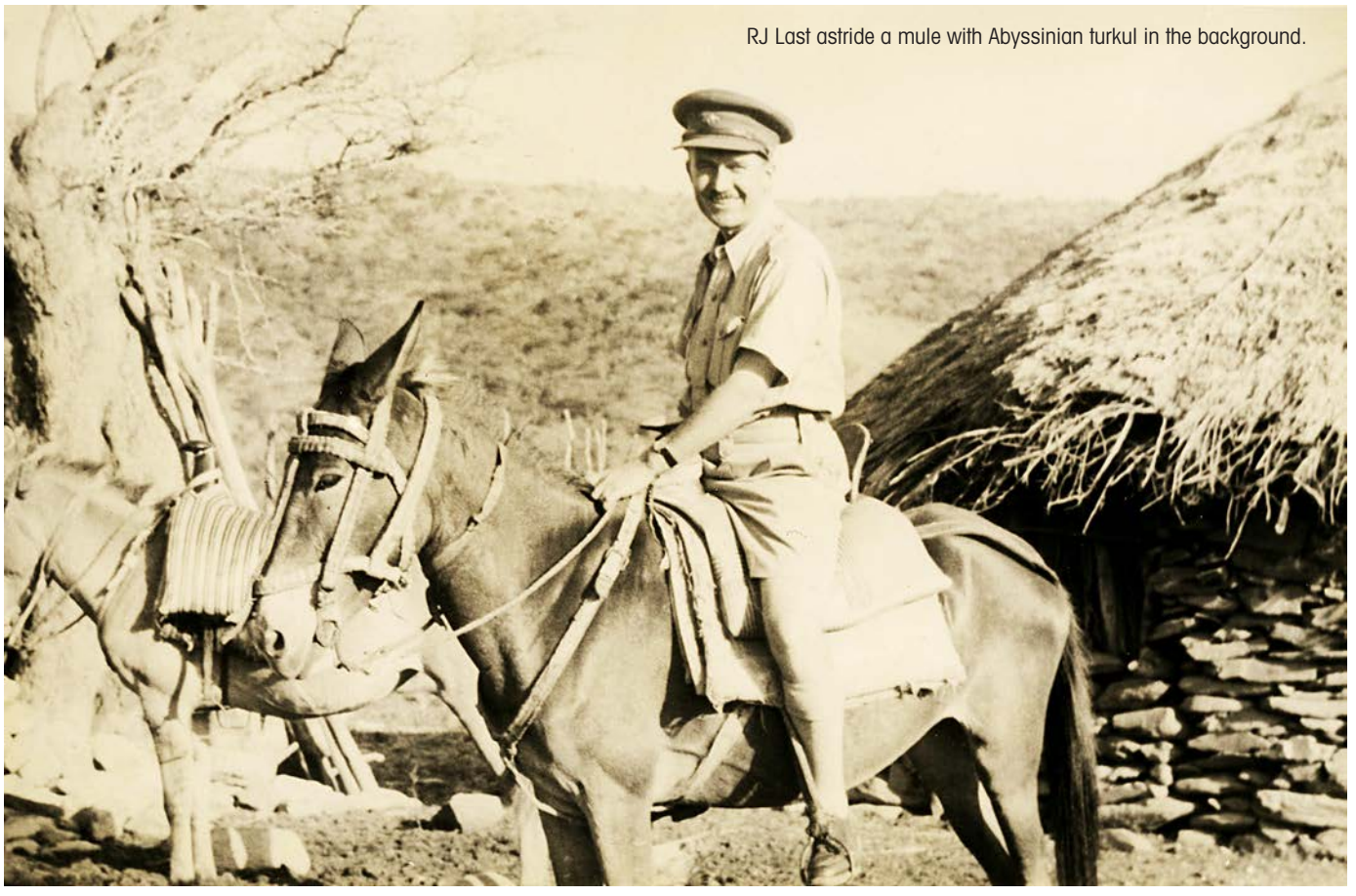
Why does Egypt do this to me? I am not ordinarily imaginative, but something in Egypt gets right under my skin. I feel as if I am one of their old priests. I touch this figure, the granite polished as smooth as silk, the breasts warm as though it is alive. Seckmet, Seckmet. The stone is being replaced, my beautiful, my hideous, my unbelievable black Seckmet is again merging into the engulfing gloom.

Arriving in Eritrea, Last left Asmara for Adowa and went over the dramatic heights of Amba Alagi, captured from the Duke of Aosta in May 1941. Ironically Last's travelling companion was the Duke of Aosta's mistress, Signora Tait.

Monday 9 June 1941

Still hundreds of smashed Italian lorries here. I took some pleasure in pointing them out to Signora Tait. It was here that her husband [probably Captain Aldo Tait] (and the Duke of Aosta) were captured. Crowds of Abyssinians around these lorries, smashing them up with sledgehammers or even setting fire to them.

Last was in Adowa until September 1941 and worked under difficult conditions at the hospital. Medical supplies were limited and the only available drugs were those left by the Italians; water pumps did not work and autoclaving could take up to four hours. Patient numbers were also large – venereal disease, malaria, fevers and tuberculosis were common and the surgical work was hindered by the lack of staff or inadequate supplies.



RJ Last astride a mule with Abyssinian turkul in the background.

Sunday 27th and Monday 28th July 1941

Did a blood transfusion this afternoon on an old chap with a chronic suppurating fracture of femur. Everything went wrong without proper assistance… Eight patients were admitted from the 'battle' at Gondar – six with Syphilis, one Gonorrhea and one TB, and not a wound on any of them.

...Interrupted at 11.30pm by three bomb casualties – man threw an Italian hand grenade & killed a child & peppered two women and a man...

Regional visits to obtain further supplies or treat malaria or outbreaks of trench fever in remote villages were made in whatever was available – lorries, military ambulances or other purloined vehicles.

Reunited with his wife and the Imperial contingent in Addis Ababa, RJ Last had audiences with the Emperor and it was decided that he would go to Dessie for a few months and then his unit would work at the Menelik Hospital (later renamed the Haile Selassie Hospital) in Addis Ababa. Last found the Emperor an astute man:

Saturday 6 September 1941

Behind a desk set obliquely was standing the Negus [Negus Negusti – King of Kings] in his khaki uniform…His most striking feature is his eyes – large and brown, they have unfathomable depths. His hands, thin and delicate like all the Amharas…We sat and chatted through the interpreter. Lush said the Menelik Hospital in Addis would soon be vacant and we could have it. [Last] The Emperor replied, "What does Mr Last think of that?" I replied I thought it would be suitable…

Haile Selassie was also an absolute monarch with some unusual quirks – when Last operated on the Crown Prince for an appendectomy, he was disturbed to find the Emperor at his shoulder checking every detail of the procedure.

Dessie was about 190 kilometres from Addis Ababa and was accessed via the treacherous mountain road over the Amba Alagi. The hospital at was very different to that at Adowa and Dessie was a less chaotic town than Addis Ababa. On arrival Last noted that the hospital was staffed by 10 Italian doctors, 16 nuns and 16 Italian dressers and stated after his eight course lunch that 'the Italians are doing themselves very well'.

Christmas was in Dessie – 'a majestic countryside and beautiful climate' but by February 1942, Last was back in Addis Ababa and his unit was installed at the hospital. His diary entries then cease until December when the diary ends with descriptive passages about a tour of Northern Abyssinia.

Sunday 13th December 1942

…far below us Lake Tana in the distance – we are 10,000 ft up here. Now a series of long curving descents to Gondor with its fine empty Italian buildings and old Portuguese castles – quite the most picturesque town I have yet seen in Abyssinia.

Ray Last and his wife spent over three years in Abyssinia but perplexed by Haile Selassie's decision not keep the hospital in Addis Ababa open, they left Abyssinia in late 1944. Last then began his better known role as an anatomist at the Royal College of Surgeons.

Written by Elizabeth Milford, College Archivist

2012 Training in Professional Skills

New dates for Training in Professional Skills (TIPS) have been set for 2012

The Training in Professional Skills (TIPS) course is a new program delivered by RACS that offers Trainees and International Medical Graduates (IMGs) the opportunity to:

- understand the importance of professional skills in surgical practice
- recognise what constitutes professional skills
- develop skills relating to professional competencies by practicing in a safe environment.

Seven of the nine defined surgical competencies are related to professional skills. As is the case for technical skills, competence in professional skills requires deliberate and repeated practice for expertise to develop – TIPS provides the setting and structure for that practice.

Learn techniques for working with patients and colleagues that can be applied to clinical practice.

The TIPS course is recommended for all SET2+ Trainees and IMGs. Places are available on the following courses:

- 30-31 March 2012, Melbourne
- 29-30 May 2012, Brisbane
- 23-24 August 2012, Sydney
- 9-10 November, Auckland

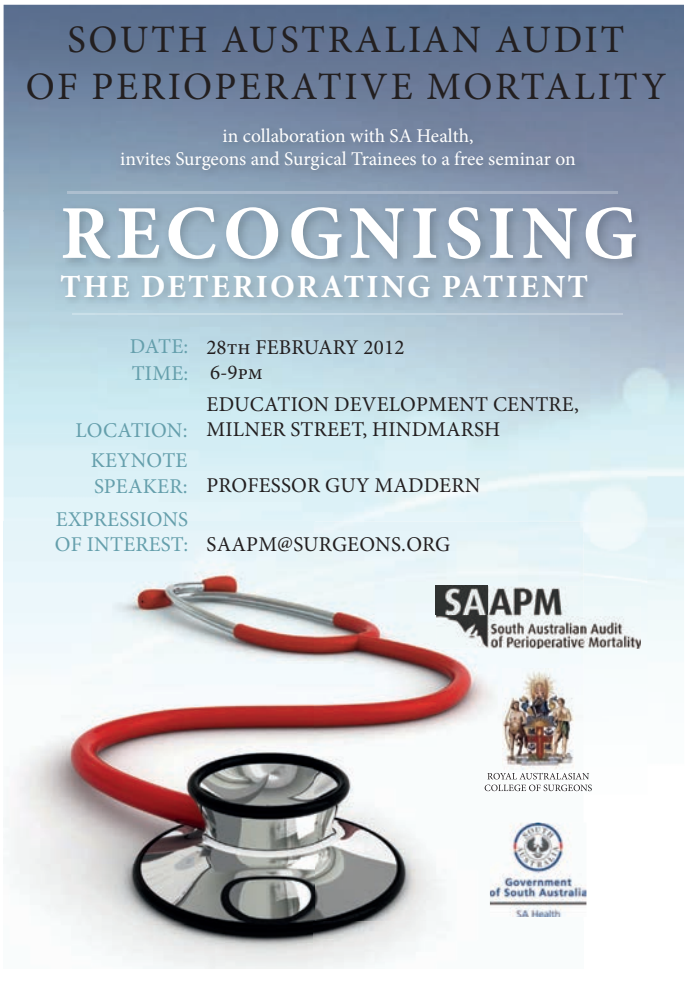
It is anticipated that a nominal fee of $330* will apply to doctors allocated to courses from May onwards. Registration on the waiting list is free and can be completed either via the online TIPS registration form (www.surgeons.org) or by calling Jess Murphy on +61 (0)3 9276 7419. Confirmation will then be sent to eligible applicants.

** Fee to be confirmed via www.surgeons.org in February.*

Fellows are encouraged to attend the NOTSS course, see page 31 for more information.

Medical Study Tours 2012

Study Tour	Tour date
Medicine in Cuba	7 – 19 March
Paediatrics in Cuba	14 – 26 March
Norwegian Cruise	20 May – 2 June
Medical History - Turkey & Greece	24 June – 8 July
Medical History in Egypt	12 – 25 October
Medicine in China	27 Oct – 11 Nov
Medicine in Ecuador and the Galapagos Islands	16 – 29 November



The 'How To' Guide to the Generic Surgical Sciences Examination

The top 10 tips from someone who has been there and worked through it

The Generic Surgical Sciences Examination is a hurdle that all surgical trainees need to jump before reaching SET 3. Having sat the exam last year, here are some tips and tricks for getting through it. I am by no means overly studious, but still managed to pass – so if I can get through the exam, I'm sure you can as well.

1.Start early

If you haven't yet started studying for the February sitting, I would suggest that you have left your run a little late! My colleagues recommend four to six months of solid preparation. This means a few hours after work most nights and studying some of the day on your weekends off. In addition, try to obtain one to two weeks of study leave prior to the exam to cram as much in as possible.

Communicate with the other members of your surgical team so everyone knows you have an exam coming up. Check with your local workforce unit, but generally you are entitled to one week of exam leave (on the week of the actual exam) and two weeks of study leave per six month rotation. Use it.

2. Don't miss the cut-off

There have been a few disappointed surgical Trainees who missed out on sitting the examination because they failed to read the website with the cut-off dates. Watch the examination section and send your form in early to avoid any last minute issues, such as not being able to find a fax machine that works. Please be organised with the application – sitting the exam should be the stressful part, not applying to sit the exam!

Introducing RACSTA for 2012

RACSTA (RACS Trainees Association) was formed to give Trainees a voice at council level within the College. Our training program is about creating safe and competent surgeons and sometimes the best people to offer feedback to the College are the trainees themselves. If you have any issues or concerns about your training, RACSTA is here to help. The executive board for 2012 is:

Carolyn Vasey: Board Chair (VIC, General)
carolynvasey@hotmail.com

Greg O'Grady: Immediate Past Chair (NSW, General)
ogradyg@mac.com

Sally Ng: Education Portfolio (VIC, Plastics)
sallykng@yahoo.com.au

Benjamin Loveday: Training Portfolio (NZ, General)
benjaminloveday@gmail.com

Grant Fraser-Kirk: Support and Advocacy Portfolio (QLD, Plastics)
grantfraserkirk@me.com

Amy Nall: Communications Portfolio (VIC, Orthopaedics)
c20005514@hotmail.com

General Queries
racsta@surgeons.org

If you have any questions, please email any of the above members and we will be in touch.

"Communicate with the other members of your surgical team so everyone knows you have an exam coming up"

3. Find a study group

The best advice I received about this exam was to find a study group. Your study group will keep you motivated and answer any difficult questions you may have. They are also great for clarifying past questions, picking up discrepancies in the practice questions (there are a few!) and for sharing material.

The members of your study group will also become your close friends on the program and are fantastic for talking about non-study matters too. If you are on a country rotation you can chat over email, Skype or MSN to share information. Meet once a week, grab a meal or a bottle of wine and go through a topic. It really helps.

4. Use the college website

The college website has the syllabus and recommended reading material published online. Follow the guidelines because you don't want to waste your time studying overly detailed neuroanatomy if this topic is not examined.

There are also some talks from the examiners, explanation of the marking process and practice questions. Familiarise yourself with the website early on so you can go back and refer to it later.

5. Know the practice questions inside out.

The practice questions are a fantastic study resource. There are a few repeats on the actual exam, and it is a relief to answer at least one or two questions confidently on the day.

They also show you where your weaknesses are. Most senior registrars will have a copy of the 'bank' questions somewhere – just ask.

6. Make a timetable and stick to it

The syllabus is a reasonable reflection of the examination material. I would recommend making a timetable of what you expect to cover and when, taking into account your on-call and other commitments. Most topics can easily be covered in one to two weeks.

7. Keep your hobbies

I still followed non-medical pursuits, but reduced the amount of time I spent on them. In the few weeks leading up to the exam there is the potential to become very focused (which others may view as being cranky, tired and argumentative – I prefer focused). Take 15-30 minutes a day to do something that you enjoy. You will come back refreshed and ready to tackle the next topic.

8. Pay back your colleagues for the time off

If you were lucky enough to have supportive fellow registrars, someone has been doing your work while you have been away. Make sure you say thank you and pay back your time off and on-call, and remember to help them out when they are sitting their fellowship exam. What goes around comes around.

9. Reward yourself at the end

Find somewhere nice to go out at the end of the exam with your colleagues and families; have a few drinks and relax. It's a fantastic feeling when you don't have to study so use your meals and entertainment card and splurge!

10. Thank your partner/friends/family when it's all over

They haven't seen you for a while so try to remember what they have been dealing with as well!

So they are my top 10 tips for sitting the Surgical Sciences Examination. All trainees must pass the examination within two years of active training or four attempts and I would recommend sitting as early as possible. Your responsibilities as a registrar become greater as you become more experienced so try to get through early. Good luck!

Who's auditing the auditors?

The Victorian Audit of Surgical Mortality (VASM) recently underwent an external audit.

As part of its contractual agreement with the Victorian Department of Health, the Victorian Audit of Surgical Mortality (VASM) recently underwent an external audit conducted by Aspex Consulting. The purpose of this evaluation was to determine the extent to which VASM was meeting its objectives in relation to its contractual obligations, data processes (procedures, collection, maintenance, security and reporting) and communication of recommendations to stakeholders and governance. Overall, the evaluation found that VASM is achieving its goals, and identified a number of opportunities for the future.

The evaluation process

The evaluation was conducted in three stages, spanning a period of six months:

Stage 1:
A preliminary review of VASM documentation, datasets and data analysis.

Stage 2:
A survey of 216 stakeholders (predominantly surgeons, but also health management, nurses and medical staff) to ascertain the impact of VASM.

Stage 3:
In-depth consultation with 43 stakeholders, including representatives of the Australian and New Zealand Audit of Surgical Mortality (ANZASM), two other jurisdictional audits of surgical mortality in Australia, public and private health sector representatives and surgeons.

Key findings

- VASM has secure processes to manage information and provide reporting to a range of stakeholders. Indeed, recent audit activities have focused on streamlining operational processes, suggesting that the program has reached a certain degree of maturity.
- Indicative estimates of inter-assessor reliability demonstrate agreement in relation to clinical management issues identified.
- Both surgeon and hospital participation in the audit is strong.
- Surgeons are generally satisfied with the quality and timeliness of feedback regarding individual cases, although there was consensus for more detail in case reports, particularly in regards to recommendations on improving surgical practice.
- Hospitals expressed a desire to receive some form of individualised hospital report on an annual basis to inform their own internal quality improvement initiatives.

"The purpose of this evaluation was to determine the extent to which VASM was meeting its objectives"

- The Case Note Review booklets and Annual Reports are the most favourably viewed VASM publications, while the website is the least recognised source of information about the audit.
- Stakeholders are satisfied with the governance mechanisms in place; operational procedures sufficiently protect the privacy and confidentiality of information.
- The collaboration between VASM and the Victorian Surgical Consultative Council (VSCC) is seen as becoming increasingly important into the future.

Opportunities for the future

As a result of the evaluation, Aspex Consulting has recommended a number of ways in which VASM could enhance its processes in the future.

Opportunity 1:
Maintain surgical trust and commitment in the audit

- Increase recruitment and participation by promoting early awareness via medical education providers and re-engaging disaffected participants, as well as reinforcing the mandated requirement to participate as part of the Continuing Professional Development Program.
- Distinguish VASM from other established surgical registries and contribute the audit findings to other quality assurance mechanisms to validate emerging systemic issues.
- Communicate the benefits of qualified privilege arrangements to the surgical community.

Opportunity 2:
Streamline the current audit processes

- Clarify governance for the release of public information to ensure that audit data are appropriately represented in the broader context of quality assurance initiatives in Victoria.
- Simplify the regional-specific processes for surgeons and hospitals within the state. Mechanisms may include reinvestigating requirements for patient de-identification, facilitating hospital processes for obtaining medical records, and exploring criteria for case reporting to determine whether expected deaths require review.
- Strengthen the first-line assessment process to maximise constructive feedback. Feedback should focus on new or emerging issues that have the potential to impact patient management, rather than reiterating known issues. To achieve this, the possible value of assessor training and monitoring of inter-assessor agreement has been raised.
- Highlight outcomes of concern and target additional questions to such issues, to monitor the impact of any interventions aimed at system-wide improvement.
- Enhance audit forms by improving the cognitive flow of questions and identifying questions that should be added, reviewed or removed.
- Examine the ongoing diagnostic sensitivity and coverage of the audit and its findings by validating VASM data with other sources such as coronial case reports, scientific literature, Victorian Admitted Episodes Data Set and the National Death Index.
- Extend analysis to focus on selected areas of morbidity. However, the final evaluation report acknowledged that such a move would require detailed design changes and a considerable investment of time.

Opportunity 3:
Promote integration of information

- Currently, feedback to originating hospitals on the outcome of a particular audit is at the discretion of the surgeon. It was recommended that VASM develop summary reports for participating hospitals that outline themes identified from the review of cases.

Opportunity 4:
Target the messages identified through the audit to relevant stakeholders

- Collaborate with the VSCC to provide seminars and workshops that discuss key issues of concern identified through VASM data. The first of those is scheduled to be held on 23 February.
- Develop a plain language summary of the annual report for those who may not have specialised knowledge of surgical procedures.
- Increase peer-reviewed publications and professional presentations of VASM data to demonstrate how the audit findings promote positive change of practice.
- Enhance the use of the VASM website by making it a more appealing and accessible source of information about the audit's activities and outcomes.

Final thoughts

VASM has already begun to implement some of the recommendations from the external audit. For example, revised surgical case and assessment forms are currently pending approval from the ANZASM Steering Committee. Additionally, a collaborative workshop with the VSCC and the Victorian Managed Insurance Authority has been scheduled for early 2012, which will be offered to surgeons, interns, hospital medical officers, emergency physicians, senior nursing staff, and quality and safety officers. The workshop will focus on managing deteriorating patients, as this is an issue that has emerged through VASM data and is also a national priority area of the Australian Commission on Safety and Quality in Health Care. In taking such steps, VASM will ensure that it remains a credible, independent and transparent entity that is positively regarded in the surgical community.

Colin Russell,
Clinical Director, VASM

Rural Fellows can participate in the Rural Procedural Audit, contact kylie.harper@surgeons.org

With thanks to Melbourne City Council and the Van der Toorren Gallery

Reflections on what makes a complete surgeon

Looking back at Bob Marshall, a man whose drawings are still legendary

Opus XXI

Felix Behan
Victorian Fellow

Recently I just happened to meet June Allen, a fellow Parkville resident, who rented the flat above John Hueston's rooms at 89 Royal Parade for more than 30 years. She knew Bob Marshall, the subject of this tale when he worked at the Royal Melbourne before she went on to become Director of Nursing at the Alfred Group of Hospitals. It was she who suggested I go down to look at an exhibition at the Block Arcade in which Bob featured.

The Van der Toorren gallery, one of the oldest tenants at Melbourne's famous Block Arcade, was holding an exhibition spanning 50 years of business personalities working in Collins Street. Bob worked for 56 years at 24 Collins Street and received his platinum card from the Lord Mayor.

From my own experience I first met Bob Marshall as the college anatomy lecturer for the Primary course in 1967. Bob was the ultimate surgeon with a strong focus on education. He was approachable, likeable and entertaining. His style was in sharp contrast to the famous quote about the Harvard man: "You can tell a Harvard man, but you can't tell him much".

On a sweltering Friday afternoon when bushfires were raging in Tasmania this man was dressed in Saville Row style of the finest quality tailoring and presented, off the cuff as it seemed, notes and drawings and tuition about the anatomy of the back, which still is indelibly impressed on my mind. Bob's impromptu drawings of the base of the skull are still legendary.

This exposure to his anatomical talents culminated for me when he brought to my rooms on that Friday afternoon in August, 2004 (I still remember distinctly), a personal copy of his text, *Living Anatomy – structure as a mirror of function*.

This is a synopsis of his lifelong academic studies and a tribute to his scholarly approach to teaching. His letter to me accompanying a complimentary copy of the book included his personal observation, where he said, "Part 1 encapsulates everything I believe to be miraculous in anatomy".

The frontispiece of the text is the Michelangelo sketch of Raphael – (more correctly a "cartoon" i.e. a preliminary sketch for a major artwork, rather than the more modern humorous connotation). He goes on to say in the Preface that there was an irresistible compulsion to share educationally with others his personal views, communicating his passion and enthusiasm for the subject.

His next statement should be in neon lights: "anatomy has always seemed to me the most elegant of disciplines". He reflects on Paganini's virtuosity, a master showman of his day who once took one of the four strings off the violin and played with three, to produce the same melody.

His writing reflects the interest of a practising surgeon in macroscopic anatomy with clinical application. He

offers some insight into how the body works, spilling over into the disciplines of histology, embryology and comparative anatomy.

This text should be obligatory reading for any student preparing for a career in surgery, because the clinical applications are so widespread. In the Preface he mentions that his passion was kindled by Sidney Sunderland and the books of Frederic Wood Jones, and acknowledges his colleague Bob Zacharin and his brothers Vernon and Don, also including Ian Taylor's monumental work on the vascularity patterns of the integument.

When discussing Darwin's Origin of Species, he mentions the Frenchman le Chevalier de Lamarck who had the opposite view that both structure and behaviour are acquired characteristics and this fits in well the sentiment of the Protestant work ethic. While Wood Jones opposed Darwin's theories, he was very much of the Lamarck philosophy, whose pedestal still stands in the forecourt of the French Museum of Natural History.

Bob's skill as an artist is reflected in the 200 diagrams, all unsigned. And on that memorial day last year, I saw one of his exercise books with the same stylised illustration, they being the signature of the man. He illustrates homo erectus, the flight of the albatross, the elephant's forelimb, the penguin flipper and the racing cheetah.

They all have a hint of Michelangelo. I particularly enjoyed the Ben Hogan golf image, the American master who won nine majors.

One illustration shows his golf swing at the point of impact, around pronated forearms, the arms in the quadruped position with no carrying angle, the elbows bent forwards and the wrists sideways, the head behind the ball and the hips rotating in a barrel, the essence of a good golf swing – what science! In my university golf team days I had a set of Ben Hogan's clubs and a copy of his book, and he was my master, hence my vintage.

Talented artist

In Living Anatomy every illustration confirms Bob's talent as an artist. I find the simplicity of his black-and-white drawings reminiscent of the work of Matisse, stimulated by the present exhibition at the Queensland Gallery of Modern Art (GOMA) in Brisbane.

This interesting association between anatomy and art has continued through history, and my first awareness of this important link was from Sir William Dargie. He had painted portraits of my parents now at the University Queensland Art Museum after his return from London, where he had completed a portrait of the Queen in wattle tones.

A print of this formerly hung in the RACS foyer, now in Geoff Down's offices. He described anatomy as the basis of sound portraiture. If you can draw anatomically, the resultant image and realisation of appearance is the blend that produces the intrinsic likeness. Drawing is an essential ingredient to good portraiture, as Dargie would elaborate on many occasions.

As Miriam Cosic said in a recent review in the Australian, Matisse was the "wild beast" who instigated Fauvism around its origins in an exhibition at the Salon d'Automne in Paris in 1905 in which the works of these wild beasts were displayed in strident colours.

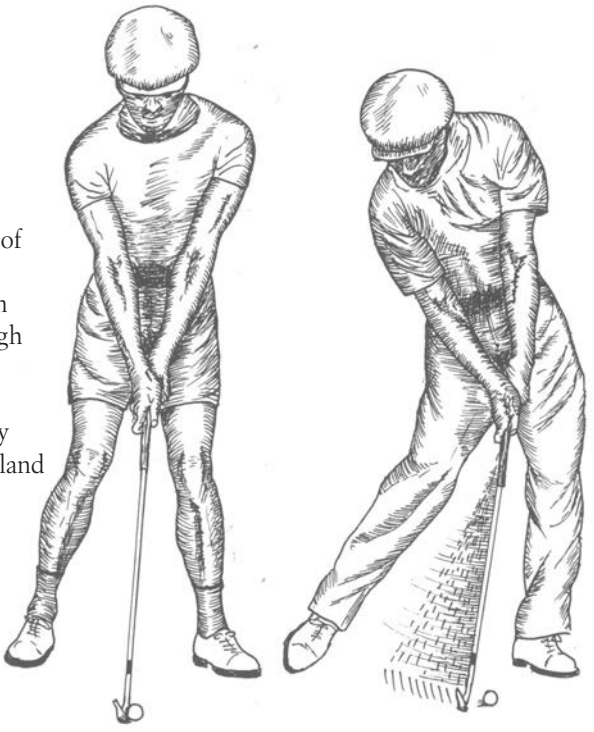
The more I read, the more I see obvious similarities between these two personalities. Both Bob and Matisse kept rigid working hours right to the end. Both stayed married to their wives forever. Bob was married to Phyllis for over 60 years, and even celebrated this anniversary event a week or two before he passed on.

Both maintained their expertise, Bob operating almost every day until he retired from surgery and Matisse kept on drawing in the same regular manner right to the end. I have an interesting snippet which Bob told me was the reason for giving away his surgical career. He said to me one day: "Felix, what clever guy pays $15,000 indemnity insurance to earn $12,000 doing herniae?"

Bon vivant

Finally Bob was a bon vivant and a bel esprit, a clarinettist, a jazz fan, mountaineer and a hi-fi enthusiast – even an epicurean. On a number of occasions I socialised at table with him. Two particular occasions spring to mind.

One hot Friday afternoon we were dining then at La Chaumiere in North Melbourne – the building exterior



was the closest thing to architectural decadence, but inside the white linen cloths and table decor reflected the Champs Elysees.

During our meal Bob made the statement, "I have one criterion with which to judge a good French restaurant. It is the quality of the soupe à l' onion", which he had on this occasion in the middle of summer at 37°C.

On another occasion when we were enjoying elegance at the Hyatt with wines from Bordeaux and Burgundy, Bob ordered moules a la mariniere with the restaurant supplying a disposal dish. However, Bob had another solution. In his typical organised and dexterous fashion, he stacked the shells, locking them one into the other, forming a concertina, producing stability and thus helping the waitress with discrete removal.

Now every time I partake of either dish I recall Bob's personality, with such hand-eye coordination personified.

Thus I will say vale and valete to a great mind with these recollections on what could be construed as the ingredients of a compleat surgeon as Walton might say. Virginia Woolf goes so far to state: "Arrange whatever pieces come your way" or "as there are many facets on the diamond" a quote from my late father, Norman Behan.

Dad donated his art collection to the University of Queensland under the suggestion from the late Sir Zelman Cowan. As a gesture to Bob Marshall (and the Marshall trio) I will donate a Henry Burn painting of the Grampians to the College art collection in recognition to their contribution to my surgical development.

Welcome to the Surgeons'

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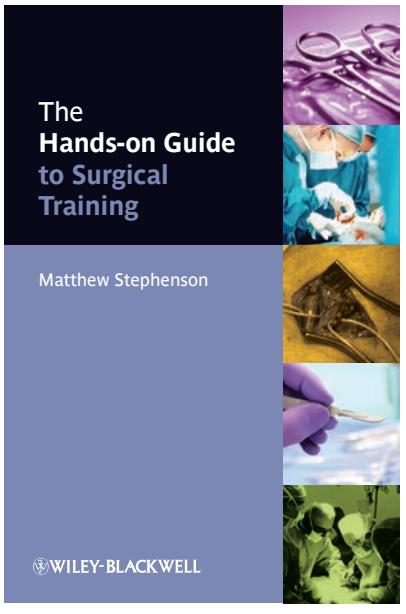

The Hands-on Guide to Surgical Training

Matthew Stephenson
9780470672617 | Pbk | 326 pages | January 2012

~~AU$39.95~~ | AU$29.96
Member Price

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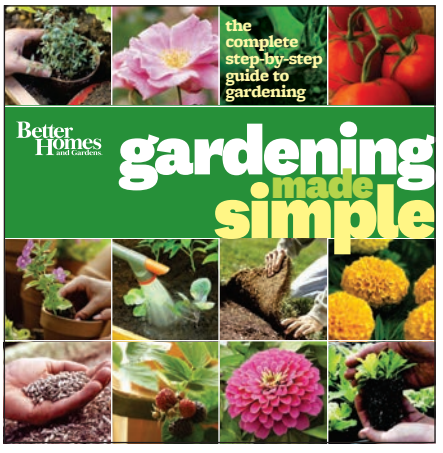

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Holly Hughes, Julie Duchaine
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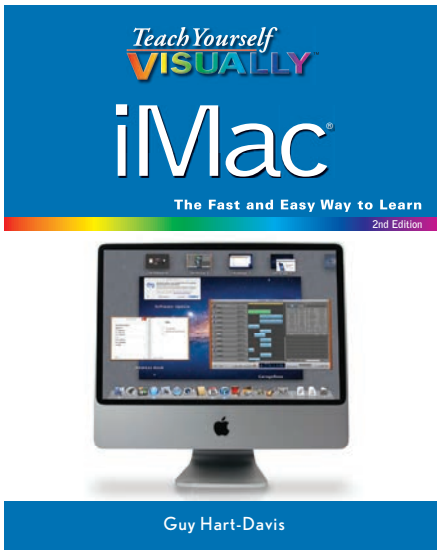

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Guy Hart-Davis

9781118147627 | Pbk | 384 pages | October 2011

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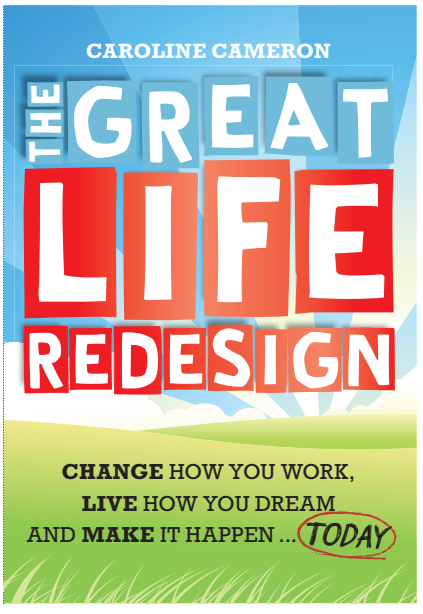

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Developing a Career in Academic Surgery

Kuala Lumpur Convention Centre, Malaysia
Sunday 6 May 2012

Provisional Program

7:00am Registration and Breakfast
7:15am Welcome . . . . . *Ian Civil (RACS President)*
Introduction . . . . . *Melina Kibbe (Chicago, USA) and Andrew Hill (Auckland)*

SESSION 1: STARTING AND PLANNING YOUR RESEARCH CAREER
Moderators: Scott LeMaire (Houston, USA) and Arthur Richardson (Sydney)

7:30am Why every surgeon can and should be an academic surgeon . . . . . *Mark Smithers (Brisbane)*
7:50am Research pathways: Outcomes, Translational, Educational, Basic science – which one is right for you? . . . . . *Allan Tsung (Pittsburgh, USA)*
8:10am Where do good ideas and research questions come from? . . . . . *Russell Gruen (Melbourne)*
8:30am Critical ethical issues in medical and surgical research . . . . . *Timothy Pawlik (Baltimore, USA)*
8:50am Understanding statistics for clinical research and trials . . . . . *Lillian Kao (Houston, USA)*
9:10am Panel discussion and questions from the floor . . . . . *Moderators and speakers*
9:30am MORNING TEA

SESSION 2: PRESENTING YOUR WORK TO PROGRESS YOUR CAREER
Moderators: Timothy Pawlik (Baltimore, USA) and Raffi Qasabian (Sydney)

9:50am Writing an abstract, choosing your journal . . . . . *Malcolm Brock (Baltimore, USA)*
10:10am Submitting and revising your manuscript . . . . . *Melina Kibbe (Chicago, USA)*
10:30am Delivering an effective research presentation . . . . . *Greg Kennedy (Madison, USA)*
10:50am Networking and building academic collaborations . . . . . *Daniel Anaya (Houston, USA)*
11:05am Building a research group/program (who is right for the roles and how to manage them) . . . . . *Leigh Delbridge (Sydney)*
11:20am Panel discussion and questions from the floor . . . . . *Moderators and speakers*
11:50am **KEYNOTE LECTURE: Training, academic surgery and private practice** . . . . . ***Michael Solomon (Sydney)***
12:20pm LUNCH – faculty at tables with registrants as small group discussions

CONCURRENT SESSIONS:

SESSION 3: EARLY ACADEMIC CAREERS
Moderators: Melina Kibbe (Chicago, USA) and Julie Howle (Sydney)

1:00pm Building a career pathway: opportunities, obstacles and getting past them - *Daniel Anaya (Houston, USA), Erica Jacobson (Sydney)*
1:20pm Timing research projects – how much time is right, and when to fit it in? - *John Windsor (Auckland)*
1:40pm How do I get started as an academic surgeon- *Michael Vallely (Sydney)*
2:00pm Why a trainee should consider doing fulltime surgical research - *Zoe Wainer (Melbourne)*
2:20pm Panel discussion

SESSION 4: CAREER PATHWAY DEVELOPMENT
Moderators: Greg Kennedy (Madison, USA) and Russell Stitz (Brisbane)

1:00pm How do Post-graduate degrees lead to promotion? Choosing a pg degree, nil v Masters v Doctorate *Guy Maddern (Adelaide)*
1:20pm Why should surgeons be into genomics? – the essentials *Andrew Biankin (Sydney)*
1:40pm Writing a successful Ethics application *Jane Young (Sydney)*
2:00pm Building and presenting an academic CV/ promotion as an educator - *Andrew Hill (Auckland)*
2:20pm Panel discussion

SESSION 5: WORKSHOPPING CURRENT RESEARCH PROJECTS
Moderators: Diane Simeone (Michigan, USA) and Marc Gladman (Sydney)

1:00pm Study design workshop to brainstorm current issues – attendees to bring current research and study challenges for discussion - *Allan Tsung (Pittsburgh, USA), Timothy Pawlik (Baltimore, USA), Cas McInnes (Melbourne), Jonathan Serpell (Melbourne)*

SESSION 6: GRANT WRITING WORKSHOP
Moderators: Malcolm Brock (Baltimore, USA) and Robert Thomas (Melbourne)

1:00pm
Scott LeMaire (Houston, USA), Sue Stott (Auckland), Wayne Morrison (Melbourne)

2:40pm AFTERNOON TEA

SESSION 7: PLANNING A SUSTAINABLE CAREER
Moderators: Lillian Kao (Houston, USA) and Andrew Hill (Auckland)

3:00pm Doing an overseas Fellowship – how to choose wisely . . . . . *Warren Hargreaves (Sydney)*
3:15pm Putting it all together and remaining sane – observations from outside the club . . . . . *Richard Hanney (Sydney)*
3:30pm Questions from the floor to all faculty
3:45pm The future of academic surgery, and closing remarks . . . . . *John Windsor (Auckland)*
4:30pm CONVOCATION AND SYME ORATION followed by ASC Welcome Reception

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