



THE ROYAL AUSTRALASIAN  
COLLEGE OF SURGEONS

# SURGICAL NEWS

Vol:9 No:6 July 2008

## July Highlights:

### PAGE 14 MEDICO LEGAL SECTION

"There have been a number of changes in personal injury and the law over the past two years."

### PAGE 19 DISASTER PREPAREDNESS

A register has been established at the College, for surgeons willing to respond at times of disaster.

### PAGE 22 INTERNATIONAL DEVELOPMENT

"East Timor has a higher birth rate of children with club feet because of a genetic/racial predisposition with four to five children of 1000 live births born with the condition compared to one in 1000 in Australia."

Former College President turns photographer, page 26



The College of Surgeons of Australia and New Zealand



# 2008 Professional Development Calendar

## QLD

- 26 July, 23 Aug - Northern Australia Surgeons Network (NASN) Videoconferences
- 9 Aug - Mastering Difficult Clinical Interactions, Brisbane
- 3-5 Oct - Surgeons as Managers (SaM), Cairns

## VIC

- 22-23 Aug - From the Flight Deck: Improving Team Performance
- 8 Nov - Risk Management Foundation: Informed Consent, Melbourne
- 15 Nov - Communication Skills for Cancer Clinicians, Melbourne

## NSW

- 29 July - Mastering Intercultural Communication\*\*, Sydney
- 8 Sept - Mastering Professional Interactions\*\*, Sydney
- 10 Oct - Winding Down from Surgical Practice, Sydney
- 23-25 Oct - Surgical Teachers Course (STC), Sydney

## SA

- 26 July - Mastering Difficult Clinical Interactions, Adelaide
- 19 Sept - Practice Management for Practice Managers Adelaide

## WA

- July 26, Aug 23 - Northern Australia Surgeons Network (NASN) Videoconferences
- 3-5 July - Surgical Teachers Course (STC), Perth
- 30 July - SAT SET, Perth

## NT

- July 26, Aug 23 - Northern Australia Surgeons Network (NASN) Videoconferences

## NZ

- August 16 - SAT SET, Palmerston North
- August 23 - SAT SET, Dunedin

## Mastering Intercultural Communication, 29th July (Sydney, NSW)

*Do you deal with colleagues and patients from a range of cultural backgrounds?*

*Would you like to be a more effective communicator with people from a different culture?*

If you answered yes to these questions, then the Mastering Intercultural Communication workshop is for you.

During the three-hour evening workshop, you will discover how to recognise and utilise the eight most common communication styles and you will learn to develop strategies for dealing with people from other cultures. This is essential training for anyone practising in multicultural Australia or New Zealand.

## SAT SET, July 30 (Perth WA), August 16 (Palmerston North NZ), August 23 (Dunedin NZ)

The SAT SET course enables supervisors and trainers to effectively fulfil the responsibilities of their important roles, under the new Surgical Education and Training (SET) program. Participants will learn to use the more common of the workplace assessment tools that have been developed as part of SET; focussing on the Mini-Clinical Examination exercise (Mini CEX) and Direct Observation of Procedural Skills (DOPS). Participants will also explore strategies to improve their management of trainees; especially those that are under-performing and there will be an opportunity to develop understanding of College training policies, supervisor and trainer responsibilities, the appeals process and legal support provided by the College.

## Mastering Difficult Clinical Interactions, 9th August (Brisbane, QLD)

The master class looks at the causes of difficult clinical interactions and helps surgeons develop skills to deal with communication breakdown

and conflict in their relationships with patients. The workshop utilises presentation, group discussion and role play to give surgeons a unique opportunity to practice their skills in a non-threatening environment.

## From the Flight Deck – Improving Team Performance, 22-23 August (Melbourne)

From the operating theatre to the skies, join your colleagues for an exciting and inspiring weekend that will challenge you as no other PD activity has before! Learn more about risk management and team dynamics. 'From the Flight Deck' is a challenging, fun and valuable learning opportunity for any surgeon who wants to know more about minimising their risk and developing positive team dynamics.

## Mastering Professional Interactions, September 8 (Sydney)

Want to develop more effective communication skills so that you can better interact with medical colleagues? This full day course focuses on how to deal with the potential areas of conflict which can occur when health professionals communicate with each other in stressful or sensitive situations.

\*\*New Workshops for 2008

**Please Note:** Additional Supervisor and Trainer Courses (SAT SET) will be offered in each region; visit the PD section of the College website for more information.

## Further Information

Contact the Professional Development Department on +61 3 9249 1106, by email [PDactivities@surgeons.org](mailto:PDactivities@surgeons.org) or visit the website at [www.surgeons.org](http://www.surgeons.org) select the Fellowship and Standards menu and then click on Professional Development. Easy online registration is available for all workshops.



*Ian Gough,  
President*

# Health and Hospital Reform

The College supports a single funder model of health care to improve responsibility and accountability

## **National Health and Hospital's Reform Commission (NHHRC)**

The Rudd Government established the Reform Commission earlier this year. The Commission has produced its first document "Beyond the Blame Game" and is into a substantial consultation process. Two members of the Commission, Dr Mukesh Haikerwal and the Hon Rob Knowles presented to the Executive Committee in May. They highlighted the importance of achieving reform for the current Australian Health Care Agreement (AHCA) which focuses on funding for the State based public hospitals. The Commission also intends to extend the process looking at the total health sector. Taking the opportunity to reform the health system and do this in the context of a new federalism means that this commission has the opportunity to achieve real change. Some of the key points made in the College submission follow.

### **The College supports a single funder model of health care to improve responsibility and accountability**

As the initial report highlights, one of the key ambitions is to ensure the service design and governance principles for Australia's health system minimise the confusion of accountability and responsibility between funding bodies. This can only be efficiently achieved through one funding body. The College used, as an example of current inefficient health delivery, the challenges confronting oncology patients who often need to attend multiple venues and providers to access diagnostics, treatment and ongoing follow up.

### **Health outcome goals need to be accepted by the individual, community and government**

Preventive medicine is often promoted as the saviour of the health system and is frequently

funded out of decreasing hospital budgets. The College emphasised the importance of having outcome goals that measure real change within the health system. This should include measures like an absolute decrease in road mortality or acute brain injury or smoking rates by 10 percent each year.

A combination of legislative changes, public health initiatives and individual action could achieve this. We need to move away from measuring only screening participation rates or other process measures to meaningfully measure the goals of reduced morbidity and mortality and improved health. The initiatives that are required need to be funded in addition to the hospital funding – not as a substitute.

### **Audit and peer review should be mandatory and be fully funded in all hospitals**

Standards in our clinical practice are underpinned by good quality audit and peer review. As surgeons we are committed to this but need funding and infrastructure through the local hospitals to support these activities. The roll-out of the mortality audits are a good example of the coordination and success that the College can achieve. However, audit dealing with surgical morbidity needs to be strongly focused on the hospital where the systems cause the majority of the adverse events. Peer review and valid risk adjustment must take place in the hospital and be adequately supported and resourced by employers.

### **Ethical systems ensure that appropriate care is provided**

This is a debate that needs to happen! Ethical issues are often highlighted in hospitals about whether a particular treatment should be undertaken. This is particularly applicable to the elderly and terminally ill. More needs to be done to support care in the nursing home

or alternative accommodation for the elderly so that support and dignity can be maintained towards the end of life

Although politicians are reluctant to admit that health care must be rationed, we know that clinical prioritisation (and administrative prioritisation, regrettably) exists in an environment of limited resource capacity. It has been estimated that 50 per cent of the health expenditure in Australia is on patients in their last year of life. If all patients were required to provide a hospital with a personal advance health care directive before being allowed admission for elective treatment, some treatments of doubtful value might be avoided. This would be both ethical and cost-efficient for the individual patient and others.

### **Funding for research and technology assessment is critical for the future health and financial performance of our health system**

The introduction of new technology is increasingly with us as advances accelerate from the design to clinical application stages. It is critical that we know how they will advantage patient care and also be responsibly afforded by the health system. The introduction of laparoscopic techniques was a learning curve for all of us, particularly on issues of training in new techniques and understanding the process of the introduction of new procedures into the health sector.

The work that is undertaken by the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASER-NIP-S) and the Australian Orthopaedic Australia (AOA) Joint Registry is critical. Such valuable organisations must be maintained and expanded so evaluation can fully occur before and during the introduction of new techniques. In its submission the College also advocated for ongoing research into the health delivery systems themselves. ➔

## President's Perspective

“The role of the College and Specialist Societies in providing training and ongoing professional support needs not only acknowledgement but ongoing support.”

### **Standards are not a “Given”, they are based on high quality training, assessment and ongoing professional development**

The Colleges are critical to the ongoing training of high quality medical specialists. One of the concerns we have is that because our standards are at a consistently high level, this almost becomes assumed. We and the community must never become complacent. The role of the College and Specialist Societies in providing training and ongoing professional support needs not only acknowledgement but ongoing support.

### **Training requires infrastructure, ongoing service provision and support in both the public and private sectors**

The College continues to highlight the support that our Surgical Supervisors need in Hospitals to be able to undertake the responsibilities of this role. As training is progressively taken up in the private sector this will become even more significant to ensure support to our trainees and audit of our clinical outcomes.

### **Acute service access needs dedicated and committed resources, preferably separate to elective surgical work**

The College has highlighted the importance of access to acute services on many occasions.

Emergency surgical services need to be recognised at a far higher level within hospital structures and be resourced to ensure timely access to operating theatres. This will involve different ways of approaching on call rosters, scopes of practice of surgeons and continuing professional development, and availability of hospital facilities.

### **Faculty of Surgical Educators**

I see this as one of the more important issues to address over the next 12 months. To maintain a high quality training program, the College must provide support and developmental opportunities to the surgeons undertaking these roles. This includes being an instructor, supervisor or undertaking educational committee work. The College is establishing a senior level committee for overseeing this process that will report to Council through both the Education Board and the Board of Professional Development and Standards. There is a high commitment at Council to improve the conditions for our faculty in the work environment, ensure they are properly supported and also have the fullest opportunity to

obtain additional skills to undertake these roles. I look forward to discussing this with Fellows in the various meetings I will attend over the next 12 months in Australia and New Zealand.

### **Post Fellowship Training**

In discussions with the Presidents of the Specialist Societies and College Council at the Conjoint Annual Scientific Congress (CASC), initiatives are now underway for groups to develop these concepts more fully. As an example, in the area of spinal surgery, both the Orthopaedic and Neurosurgical groups will progress the curricula and assessment processes that would be required. There will be more communication about this in forthcoming *Surgical News*.



President Ian Gough with past President Andrew Sutherland at the unveiling of Andrew Sutherland's portrait painted by Robert Hannaford



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Ian Dickinson,  
Vice President

## Advocates for change

It is important for the College to campaign for change, to make the health system safer

College advocacy in Queensland over the last year has shown how important it is for the College to engage with Government to make the health system as safe and as effective as possible for patients and the health professionals working in it.

The Government has taken trauma deaths seriously by allocating \$28 million to improve trauma care throughout the state and this money will save patients lives.

The \$28 million will be used over the next four years to establish a state-wide trauma system under the Queensland Trauma Plan the main feature of which is to prevent unnecessary deaths as a result of traumatic injury

All the research tells us the golden rules of treating trauma patients are that we get the patient to the right hospital, with the right facilities, in the shortest amount of time possible, preferably within an hour of the injury.

In Queensland the resources have been focused on supporting four main trauma centres, instituting multidisciplinary teams in trauma departments and having the resources in the system to get the patient into the operating room as soon as possible.

The money will also enable us to research where people are being injured and why and what we can do to prevent the injury. We know that with the proper trauma systems in place we can reduce the number of traumatic injuries.

Progress towards the Queensland Trauma Plan was articulated through the Queensland Trauma Committee by Chair Daryl Wall. Cliff Pollard, the former Chair and also a member of the Queensland Emergency Medical Services Executive Committee had previously actively promoted the plan and also played a significant role.

Michael Schuetz, Professor of Trauma at the Princess Alexandra Hospital, was able to achieve the support of the acting Director General of Health and succeeded in secur-

ing the final agreement. The Government has also agreed under the trauma plan to develop legislation for the prevention of trauma which would include the ability to confiscate vehicles of recidivists lawless drivers, hoons, drunks, drugged or unlicensed drivers.

Daryl Wall, stated that it was the College's ability to advocate strongly for such high profile initiatives that was crucial to obtaining money from Government. Dr Wall said that teamwork and collaboration across the entire spectrum of healthcare in relation to trauma was necessary to the success of the development and acceptance of the plan.

The College and Government have also been able to work together well in establishing audits of surgical mortalities across the states of Australia and there is the expectation that this will also follow in New Zealand. Information from these audits is already changing surgical practice and saving patient lives. In Queensland, the Queensland Government agreed to fund the Queensland Audit of Surgical Mortality (QASM) for \$1.1 million last year.

The former State Chair, Dr Chris Perry said in the first six months of the Queensland Audit of Surgical Mortality more than 50 per cent of Queensland's surgeons had agreed to participate in the audit and this is a very encouraging start.

Results from audits underway in other states show that after a few years 97 per cent of surgeons are participating and 73 per cent had changed their practice in some way as a result. The early progress in Queensland is better than expected and is a very positive outcome.

That surgeons are participating in such numbers shows that they want to retain the confidence of the public by being involved with a patient safety program and that surgeons do regard patient safety as paramount. ➔

## Census 2008

### Update

The first round of feedback for this year's census questionnaire has been undertaken with Specialty Society Presidents and Regional Chairs. This represents one of several stages in which consultation is undertaken to ensure that the final questionnaire is both relevant and effective in addressing Fellows' issues.

### Applications of the Data

Data from the census will allow the College to more effectively advocate on behalf of Fellows as the final report will provide facts and figures that will clearly illustrate current issues that require action.

With the addition this year of an open comments area, the final report will also highlight any issues previously unknown to the College.

### Fellow Invitation

If you would like to suggest issues/questions to include in the 2008 census questionnaire, feel free to email the Senior Researcher and Workforce Planning Officer at [Mirella.DeLorenzo@surgeons.org](mailto:Mirella.DeLorenzo@surgeons.org)

*NOTE: For Fellows wishing to have their suggestion/s treated with full confidentiality, please make a note of this in your email.*

## Relationships Report

“The Government has taken trauma deaths seriously by allocating \$28 million to improve trauma care throughout the state and this money will save patients lives.”

What the audit found, and these are only preliminary results, was that deaths from surgery all involved major surgical procedures with known significant risks. Not surprisingly there were no deaths in patients having routine surgery regarded as being relatively simple and straightforward.

Some of the main points to come out of the data show that the average patient who died

- Was aged about 79
- Had a incapacitating systematic disease that was a constant threat to life
- Had three serious morbidities at the same time, for example cardiovascular disease, diabetes and respiratory disease.
- Was at considerable risk of death before surgery.
- Had had emergency surgery.

Australia is one of the few places in the world to attempt a nationwide audit of surgical death.

What the latest international research tells us is that when there is an adverse event it is rarely as a result of one person, it is usually a team failure and this audit will demonstrate that.

The principal aim of the audit is to improve the quality of healthcare in by providing education to surgeons through feedback which will also benefit patients, hospitals, the health service and the public in general.

The national audit is based on the model where all deaths in hospitals under a surgeon's care – whether an operation has taken place or not, are reviewed.

Thesetwoinitiatives: the Queensland Trauma

Plan and the Queensland Audit of Surgical Mortality are examples of excellent leadership by members of the College advocating for surgery and patients.



Past Presidents, Andrew Sutherland, Russell Stitz & Kingsley Faulker with David, their tour guide in Beijing, after the CASC.

## Definitive Surgical Trauma Care Course (DSTC)

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) is pleased to announce the courses for 2008.

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

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

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



### Please register early to ensure a place!

To obtain a registration form, please contact Sonia Gagliardi on 02 9828 3928 or email: [sonia.gagliardi@sswhs.nsw.gov.au](mailto:sonia.gagliardi@sswhs.nsw.gov.au)

#### 2008 COURSES:

Sydney: 23 & 24 July 2008,  
Military Module 22 July 2008

Auckland: 28-30 July 2008

Brisbane: TBC

Melbourne: 17-19 November 2008



*I.M.A Newfellow*

## Not cricket

Surgeons in New Zealand face different problems to their Australian counterparts – but losing at rugby is not one of them

Last month I told you about my one fan letter. Now I must tell you of my brickbat letter. The writer said that I did not say much about New Zealand (NZ) except snide remarks about cricket. That is a fair accusation and this month I intend to correct this deficiency without any snide remarks about NZ cricket.

It is interesting to reflect that the current NZ population of 4.3 million is not yet approaching the population that Australia had at the time of the foundation of the College in 1927. The census of 1921 revealed an Australian population of 5.4 million and that of 1933 showed an increase to 6.6 million. The view of some Councillors is that NZ has sufficient size to have a surgical college in its own right. However this view is debatable when one looks purely at numbers.

One NZ Councillor described NZ as a large state of Australia (I am sure that he was referring to its population rather than any political or social desire to be a part of Australia – if not, I am sure he would be lynched by his compatriots). In some respects it does not function as such within the College.

Each state in Australia has its own Regional Board and Chair – so does NZ, except it is called the National Board. However, New Zealand has its own Censor and its own Executive Director of Surgical Affairs, which is not the case in any of the Australian regions. The position of Censor-in-Chief is mentioned in the Memorandum and Articles of Association, but oddly enough there is no job description. The NZ Censor does not even rate a mention. Our ever-vigilant CEO has, however, produced a job description in the Policies Section of the College webpage. It is three pages long. Essentially it says that the two censors are in charge of education at all levels. The NZ Censor has this function in NZ. As an odd quirk the current Censor-in-Chief, Ian Civil, is a New Zealander.

There is also a NZ Executive Director of Surgical Affairs (EDSA), John Simpson, who is currently retiring from the role.



*“I promised that I would not make any snide remarks about NZ cricket. I did not however make any such promise about NZ rugby union.”*

Those who know John know him as a quiet, gentle man. He is a general surgeon from Wellington with an interest in Breast Surgery. Like his equivalent in Australia, his function is to be involved in administrative matters that require a Fellow's knowledge. He was telling me a few meetings ago that he rarely has to get involved in an appeal from a Trainee, unlike John Quinn, the Australian EDSA who spends a lot of his time on such matters. What a bolshie bunch we Australians are – unlike the well-behaved New Zealanders!

The pattern of surgical practice in NZ is different to Australia. Whilst 60 per cent of the

surgery done in Australia is done in the private sector, only about half of that amount is done in NZ. The numbers of surgeons in NZ is slightly less – one FRACS per 6,800 of population compared to one for 6,000 in Australia.

One perennial problem that faces NZ is the constant drain of medical graduates to overseas positions. Some data suggests that as many as one third of recent NZ medical graduates were not registered in NZ, though this may decrease somewhat as time elapses. Mr. Nit Picker, who seems to know a lot about the workforce, said that in his specialty (where rotation amongst training units and states is compulsory) the Trainee often settles in the city of the last rotation, perhaps due to a partner, a good job or a natural transition from a senior trainee to consultant. He felt that if NZ had its own training programs in all specialties the retention rate of surgeons would be better. Perhaps he is right. (I can hardly believe that I am acknowledging his wisdom!)

At the beginning I promised that I would not make any snide remarks about NZ cricket. I did not however make any such promise about NZ rugby union. I have searched for a way to take a gentle dig about NZ Rugby, but how can I when I see that the Bledisloe Cup has been won 35 times by the All Blacks and 12 times by the Wallabies. It is odd, however, that the contest has been rather erratic – gaps of several years, sometimes one game, sometimes two and even three. It has only been played on an annual basis since 1984. Lord Bledisloe donated the Cup in 1932 when he was the Governor General of NZ. He was also the President of the Lydney (Gloucestershire) Rugby Union Club from 1888 to 1958. Now there is a goal for one of our College Presidents to aim at – 70 years of Presidency.

Having found nothing in rugby to allow me to take a dig at our friends across the Tasman, I should start searching in the annals of Trans-Tasman netball.





Michael Gorton,  
College Solicitor

## Refusal to treat – Discrimination

Doctors refusing treatment to patients need to consider the range of legal ramifications

There are a range of legal and professional obligations involved in a decision by a doctor not to treat a particular patient. Given the need to rationalise medical services, there has been much discussion as to whether doctors and hospitals should be required to treat smokers, morbidly obese people or persistent drug users. Additionally, doctors have faced a dilemma in being required to treat patients when their HIV status may be unknown, and the patient refuses to either disclose or have tests conducted to determine their status.

In all of these cases there is a professional (but not necessarily legal) obligation to ensure that the patient receives appropriate treatment, in all of the circumstances. That does not necessarily mean that the doctor must treat the particular patient, but the doctor must ensure that the patient is referred to either a public hospital or other medical service, where treatment will be available.

There may also be legal obligations involved, where the refusal to treat may breach discrimination law. A recent Federal Court decision (*Wood v Calvary Healthcare ACT Limited* (2006) FCA 1433) considered whether a decision by a hospital not to treat a patient who had a history of drug use and morphine dependency could amount to discrimination.

In this case the patient admitted that she had a history of intravenous drug use. She sought access to the “Calvary at Home” (CAH) scheme which enabled a patient to be treated by the hospital without having to be admitted as an inpatient. The patient then qualified for treatment at home.

In the court proceedings it was admitted by all parties that drug addiction could constitute a disability (and on the same basis, addiction to tobacco and being morbidly obese would similarly be regarded as a disability). The patient was denied access to the CAH scheme,

but there was some doubt as to whether access to the scheme was then available, due to nursing staff unavailability. In other words, it was suggested that she was denied access because the scheme was not then operating, rather than being denied access solely or principally because of her disability.

The hospital had also said that it was not appropriate for the patient to be treated at home under the CAH scheme, due to her history of intravenous drug use and the occupational health and safety risks presented to nurses. However, ultimately the Court accepted that the scheme was not operating at that time due to staffing issues, and that the patient was in reality treated the same as people without the disability, as no patient then seeking access to the scheme would have been able to participate.

The case raises a number of issues:

As noted, drug addiction, smoking addiction, morbid obesity, etc will be regarded as disabilities, and a refusal to treat exposes doctors and hospitals to potential discrimination claims.

The case did not consider whether the occupational health and safety risks that arose should have been an exception to a discrimination claim. Most discrimination laws in Australia and New Zealand contain an exemption where the decision not to treat or not to provide a service is because of health and safety risks either to the patient or to others. For example, the refusal to treat a patient where their HIV status is unclear, could be justified on the basis that it presented an unreasonable risk to the doctor or nursing staff who treated the patient, given that special precautions and special measures may need to be taken to treat the patient safely.

It does not matter that a decision or conduct is done for one or more reasons, if one of the reasons is because of the disability of a person. If one of the reasons for refusal to treat is because of the disability of the patient, then discrimination law can still apply.

Even if a decision does not breach discrimination law, doctors still have a professional obligation to ensure that the particular patient is referred to alternative treatment.

Other issues also arise when considering whether or not to treat a patient.

For example, is it possible to refuse to anaesthetise a Jehovah’s witness where there is a significant risk of blood loss? Is it possible for a Roman Catholic Specialist to refuse to terminate a pregnancy?

### Do patients have any “legal rights” or legal recourse to be treated for non emergency procedures?

A legal right is one that can be enforced at law.

The law confers rights on a person once they have been accepted for medical treatment. That is, once a patient-doctor relationship has been established.

If no relationship has been established (i.e. the doctor has not accepted the person as a patient) the potential patient has little scope for claiming a legal right to treatment.

A doctor was found to have a duty to provide medical care in an emergency situation, when reasonably able to do so according to s.36(l) of the Medical Practice Act 1992 (NSW). This is the only Australian authority to impose such a “duty to treat” where there is no pre-existing doctor patient relationship. This statutory duty is only enforceable in NSW as there is no similar statutory duty in the other states of Australia.

The Courts are reluctant to impose a common law duty to treat in emergency situations but the position is not entirely clear. (See previous article on doctors duties in emergency situations titled “Doctors to the Rescue”). Of course, if the refusal to treat is based on discriminatory reasons, there may be a claim under equal opportunity and anti-discrimination law.



“In the court proceedings it was admitted by all parties that drug addiction could constitute a disability (and on the same basis, addiction to tobacco and being morbidly obese would similarly be regarded as a disability).”

### Employment contract

A doctor's employment contract may specify an obligation to treat all patients admitted. Breach of this contractual obligation could subject the doctor to disciplinary action from their employer.

### Ethics

Ethical issues may influence a doctor's decision not to treat, but cannot override legal obligations.

Codes of Ethics and the like do not provide potential patients with legally enforceable rights. For example the Australian Medical Association (AMA) Code of Ethics 2003 would not be enforced by a court of law as such codes are viewed as normative guides and aspirational in nature.

The AMA Code of Ethics 2003 reflects legal requirements. In particular the section titled "Patient Care" paragraph 1.1 (j) guides doctors to refrain from denying treatment to patients based on discrimination. Later on, paragraph 1.1 (q) recognises that doctors may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency.

### Conclusion

There is only one directly applicable Australian case where the courts have imposed a duty to treat in an emergency and it only applies to doctors in NSW. Although the position is still unclear and not formally tested, it is unlikely that a court would acknowledge an enforceable right to health services for a person who has not previously been accepted for treatment.

Publicly funded institutions may be required by statute and funding requirements to provide urgent or emergency treatment. It is unlikely that such a duty would be extended to non emergency procedures.

A doctor's decision to refuse treatment should not be based on discrimination.

There may be some scope for an employer to take action against the doctor for breach of obligations under the employment contract. In order for doctor's to protect themselves from being personally liable they should follow the policy of their employer in refusing to treat patients.

So, for the doctor refusing to anaesthetise a Jehovah's witness where there is a significant risk of blood loss, or the doctor refusing to terminate a pregnancy, it is advisable that the following process be followed:

- 1) if applicable, check and comply with the employer's policy, procedure or protocol for refusing to treat;
- 2) fully inform the potential patient of the reason/s for refusing treatment;
- 3) ensure the potential patient has continued care with another appropriate health care provider; and
- 4) seek advice as to possible discrimination issues.

Remember, a doctor can refuse to treat a potential patient for non-emergency procedures as long as the refusal is based on reasonable medical grounds.

*Michael Gorton,  
Partner, Russell Kennedy*

### Mastering Intercultural Communications

If you are interested in learning about cross-cultural communications see the mastering intercultural comm, page 2

## Congratulations



## The 2008 Queen's Birthday Honours

### Member (AM) in the General Division

Associate Professor Robert Neville ATKINSON RFD – SA  
Professor Russell William STITZ RFD – QLD

### Medal (OAM) in the General Division

Associate Professor David Allan MORGAN – QLD  
Professor Robert J S THOMAS – VIC

*There are no New Zealand Queen's Birthday Honours for June 2008*



Chris Perry, Outgoing  
Chair, Queensland  
Regional Committee

## Queensland Audit of Surgical Mortality (QASM)

**A**s outgoing Chair of both the Queensland State Committee and the QASM Steering Committee I would like to advise on how pleasing it is to have QASM commence and how myself and all surgeons should look forward to its findings over the coming years. There are many misleading stories about surgical deaths and it will be fruitful to have the facts as QASM develops.

QASM is operated from the Queensland College Regional Office in Spring Hill. Dr Jon Cohen is its Clinical Director and Ms Therese Rey-Conde is its Project Manager. QASM commenced operations in July 2007.

In the period until late August 2007 QASM signed 14 of the largest Public Hospitals in Queensland to consent to participate in the Audit. From early September 2007 QASM started receiving some notifications of death from Hospitals. A legal issue arose with Queensland Health and the audit process (which had begun to gain momentum) stopped. In late October 2007 this issue was overcome and the audit process recommenced. QASM is included in Queensland Health's "In Hospital Deaths Policy". Surgeons in Queensland should note that QASM processes are separate from the Health Quality and Complaints Commissions (HQCC). It is important that QASM material is maintained confidentially under "Qualified Privilege" law

Surgeons Participating in QASM		
General	157	55%
Vascular	30	97%
Urology	26	39%
Neurosurgery	30	94%
Orthopaedic	91	46%
OHN	22	29%
Paediatrics	7	44%
Plastics	22	42%
Cardiothoracic	25	89%
<b>Total</b>	<b>417</b>	<b>53%</b>

and cannot be disclosed to anyone (not even to the HQCC or its Investigators).

Fifty three per cent of all surgeons in Queensland have signed up to participate in QASM, and whilst this varies within specialties, we would like to encourage everyone to become involved so we can have 100 per cent participation.

QASM as at 13 June 2008 had received from participating hospitals 512 Notifications of Death, of which 291 have been completed.

Within the next month QASM will distribute its first two reports which are:

1. "Lessons from the Audit" - a booklet containing a number of reviews of cases developed by Dr Jon Cohen.
2. "First results from QASM" - a booklet that contains the initial results of the first six months of the Audit.

Surgical Case Forms are being returned, on average, within about four weeks and we're hoping to reduce this time. The return of Second-Line Assessments is where the major block is. While conceding that these are time-consuming and require a review of medical records, it is important that these are returned as soon as possible.

There has been discussion about remuneration for Second-Line Assessments which can take up to a couple of hours to complete. Either remuneration or an increase in CPD points (currently one point per hour) is being discussed by the QASM Management Committee. Dr Cohen will let you know what transpires.

As part of informing surgeons on the audit process and outcomes a presentation about QASM was given to the Australian Orthopaedic Association QLD meeting in Noosa in June 2008 and a further presentation will be given at the QLD Annual State Meeting at Novotel Twin Waters on 11 - 13 July. An Annual Report will be published at the end of 2008.

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Meeting Announcement  
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for the General Surgeon"**  
26-28th September 2008  
Hyatt Regency Coolom, Queensland, Australia

**Program includes:**

- ♦ Exam 'demystifying' session for Trainees
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- ♦ Acute Care for the General Surgeon

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**College Conferences and Events Management**  
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**Meeting Announcement**



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*Adrian Anthony, Chair,  
SA Regional Subcommittee,  
Board in General Surgery*

## Electronic Logbook

The College is developing a web-based logbook system to promote communication between Trainee, supervisor and training board

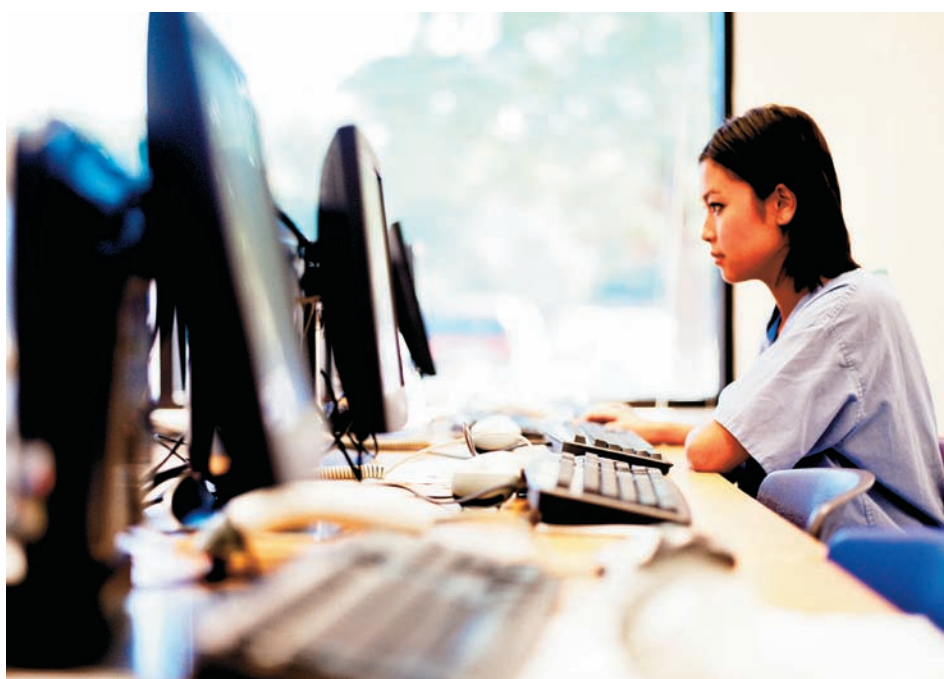
There are a variety of methods for capturing logbook data, such as paper, spreadsheets and database tools. The College has been developing an electronic version which aims to streamline this process for all SET Trainees. It is anticipated that this system will become a full practice audit tool for Fellows.

The web-based system has been developed to improve the validity and consistency of the operative and non-operative experiences recorded in a logbook. To achieve this, defined lists have been developed for a number of data fields. The Trainee or Fellow can select appropriate responses from these lists, which have been collated using existing Australian data standards such as the International Classification of Diseases (ICD-10).

The Logbooks are available through a number of browsers for both Microsoft and Mac suites. The College is currently upgrading its IT infrastructure, which will enable the Logbooks to be highly accessible and allow it to link with existing College systems. In this web-based system, users will also be able to utilise web enabled mobile and handheld devices to access the logbook, and to upload logbook data from a number of existing programs, minimising duplication of data entry.

A minimum dataset as published in the Surgical Audit and Peer Review Guide (2007) have been incorporated into the Logbooks. It is recognised that within each specialty additional data may need to be recorded. This can be achieved by adding specific datasets tailored to meet the requirements of the specialty group.

The system would promote communication between the trainee, supervisor and training board through various reporting functions, which are standard features of the Logbook. These reports will assist trainees, supervisors, specialty boards (regional and national) and the College with the collection and verifica-



tion of logbook data. Furthermore, logbook data may be used by the training boards for longitudinal assessments of training provided by accredited posts.

It is expected that progress will be made towards the establishment of an audit process for Fellows. This would see all Fellows recording their operative experiences without the need for supervisor verification.

### Current progress

The Logbooks have been released as part of an initial test phase. General Surgery Trainees and a supervisor across three major metropolitan public hospitals in South Australia have been involved. The system was well received by this test group, who indicated that it had improved their data collection and communication with their supervisors and would improve their collation of the data. This testing resulted in a review of the Logbooks to incorporate minor system changes.

It is expected that once this review is completed, further Trainees from other specialty areas will be approached to extend the testing phase.

At the recent Conjoint Annual Scientific Congress in Hong Kong, an update on the Logbook system was presented, discussing results from the initial test phase and future directions.

There has also been a recent review of the Surgical Audit and Peer Review Guide (2008) which resulted in the inclusion of updated information pertaining to the web-based Logbooks.

The coming weeks will see the extension of the test phase to include Trainees and supervisors from other specialty groups within South Australia. Subsequently, a multi-region test phase will be established. This can only be achieved through the continued consultation and involvement of all specialty areas within the College, which remains an important focus for this project.



## Laparoscopic Surgery



*Ian Shaw,  
FLS Representative to the  
Board of General Surgery*

# The Fundamentals of Laparoscopic Surgery (FLS) program

In 2005 the College entered into discussions with the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), the American College of Surgeons (ACS) and the Queensland Skills Development Centre (QSDC) to introduce the FLS program into Australia and NZ, thereby establishing the first testing centres outside of the USA.

Developed by SAGES in association with the ACS the FLS program has been validated as a means to train and assess the physiology, fundamental knowledge and technical

skills of basic laparoscopic surgery. FLS is a comprehensive, CD-ROM-based education module that includes a hands-on skills training component and assessment tool. The FLS Laparoscopic Trainer Box allows participants to practice their technical skills and improve dexterity and psychomotor skills.

FLS has received widespread interest and support from Fellows interested in assisting with the roll-out of FLS nationally.

The FLS Committee is in the process of finalising dates for One Day Courses. Courses

will consist of short lectures followed by supervised instruction of hands-on skills. A multiple-choice question cognitive exam can be taken on the day. The Trainee then has several weeks to practise on a trainer box before returning to the skills centre for further testing of manual skills.

The cost of the course is currently being met through a generous grant from Applied Medical.

Trainees will be contacted via their regional RACS office. More information can be found at [www.sdc.qld.edu.au](http://www.sdc.qld.edu.au) and [www.flsprogram.org](http://www.flsprogram.org).



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The successful candidate will ideally possess FRACS or an equivalent international qualification, together with considerable general surgical training and experience. The position is suitable for an International Medical Graduate under oversight or supervision.

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## WE WANT TO PROMOTE AND SHARE YOUR GOOD WORK

### Calling all Fellows and Trainees:

We would appreciate your donation of permitted photos or video clips that promote the great work that you have done in Australia or overseas. What we are looking for are before and after operations, surgeons with patients in their local environment, before and after surgery units (equipment purchases and the positive impact) as well as any art work that our budding surgeons as artists may have completed. These will be used to increase the profile of our Fellows and the improvement in life to their patients.

**For further information please contact  
Andrea Edye +61 3 9249 1205 or  
[foundation@surgeons.org](mailto:foundation@surgeons.org)**



Neil Berry, Chair,  
Medico Legal Section

## Medico Legal Section

Certain patient records may be classified as “protected communications.”  
How is this determined, and how does it affect the medical community?

### Your medical records - protected communications

If you practice in an area where you provide psychiatric treatment or counselling to patients who allege they have been the victim of a sexual offence, from time to time you may receive a subpoena or an order requiring you to produce your patient records to the court. You need to be aware that aspects of your records may be protected from disclosure by public interest immunity.

Since 27 June 1999, Division 9 of the Evidence Act 1929 (South Australia) has severely restricted the circumstances in which records created in a therapeutic context, of counselling and psychiatric/psychological treatment of victims or alleged victims of sexual offences can be used in court. These records are classified as “protected communications”.

A protected communication is one made:-

- in relation to a victim or alleged victim of a sexual offence; and either
  - to enable a counsellor or therapist to assess the nature and severity of the trauma suffered by the victim or alleged victim or consequent psychiatric, psychological or emotional harm;
- OR
- for the purposes, or in the course, of psychiatric or psychological therapy provided to the victim or alleged victim.

For a communication to be protected, it is not necessary to know at the time of the consultation that your patient is the victim or alleged victim of a sexual offence.

The following communications are not protected:

- a communication made for the purposes of, or in the course of, a physical examination of the victim or alleged victim of a sexual offence by a registered medical practitioner or registered nurse; or
- a communication made for the purpose of legal proceedings arising from the

commission of the alleged offence or for the purpose of commencing such proceedings (i.e. medico-legal assessments); or

- a communication which evidences a criminal fraud, an attempt to pervert the administration of justice, perjury or another offence.

This protection is not applicable to any communications that occurred prior to 27 June 1999. Furthermore, protection is not provided to communications which occurred prior to the date of the alleged offence.

The protection of these communications cannot be waived by the counsellor or therapist, the victim (or guardian), or a party to the communication. These provisions of the Evidence Act override the provisions of the Privacy Act which permit a patient to authorise the release of their health records.

Protected communications are not admissible in committal proceedings in the Magistrates Court, cannot be admitted in any other legal proceedings without permission of the court and are not liable to discovery or other pre-trial disclosure.

In determining whether to grant access to a protected communication, the court is required to balance the public interest in preserving the confidentiality of protected communications against the public interest in preventing a miscarriage of justice that might occur if relevant evidence is suppressed.

We realise it may not be easy to determine whether or not your records contain protected communications. As such, if you receive an order or subpoena for the production of your records to a court and you think there may be protected communications within your records, we recommend the following:-

1. If you are uncertain, contact MIGA for advice
2. If you are certain that your records contain protected communications:
  - Ideally extract from your records all

### Chair's Comment

This year's medico legal program at the Hong Kong CASC was a resounding success and I'm sure the meeting has generated numerous friendships between Australian and Chinese Colleagues. I'd like to thank all involved in organising the program, particularly the scientific convenors Peter Wilde (Australia) and James Chiu (Hong Kong).

Sadly, we also farewelled three members from the Executive. Tony Buzzard, Ross Blair and Michael Fearnside have over the years given much time, effort and vision to the section and our thanks go to them for this service. At the meeting I was elected interim Chair on the grounds that there was not a quorum of the Executive and this decision will be tabled for ratification at the next meeting of the Committee.

There have been a number of changes in personal injury and the law over the past two years and I expect that this will influence some change in direction in the section. The Committee will also be reviewing options and opportunities for medico legal professional development activities. My vision is for the section to be a resource base for surgeons encountering the interface between medicine and the law. I would welcome input from members on how best to formulate the way ahead for the section.

Neil Berry, Chair  
Medico Legal Section



“For a communication to be protected, it is not necessary to know at the time of the consultation that your patient is the victim or alleged victim of a sexual offence.”



protected communications and place them in a separate envelope from the balance of your records;

- Produce your records to the court under cover of a letter in the following terms:

“I have received an order/subpoena for the production of my records concerning [patient’s name].

My records contain confidential material created in the course of assessing (patient’s name) and/or counselling, psychiatric or in providing psychological therapy (delete where appropriate) to him/her since (date of first consultation) which may be “protected communications” pursuant to the Evidence Act. I have (where applicable) separated that mate-

rial from the balance of my patient records.

My records are enclosed under cover of this letter. Please return these records when the court has no further use for them.”

If you are not able to separate out the material it is sufficient for you to identify that your records may contain protected communications and amend the wording of the above letter accordingly.

3. Notify your patient that you have received the order/subpoena for the production of your records.

If at any stage you have any concerns regarding the production of your records to the court, please contact a solicitor at MIGA for advice.

*Geoff Black, Partner, Wallmans Lawyers*

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## AOA Medico-Legal Society Clinical Meeting

Date: November 28, 29, and 30, 2008  
Venue: TBC, Sydney

All College Fellows are most cordially invited to the AOA Medico-Legal Clinical Meeting being held on November 28, 29 30 in Sydney.

The guest speaker will be Professor Mohammed Ranavaya, Contributing Editor of the AMA Guides, who will be presenting the program on ‘Understanding the 6th Edition Guides and contrasting the new Guides with AMA 5 and AMA 4’. Professor Ranavaya is a distinguished impairment assessor and has lectured on many occasions in Australia. The areas covered will be the Upper and Lower Limbs, Spine and Pain Assessment and he will relate the experience with AMA 6 during 2008 in North America.

The program will conclude with a debate on the proponents of AMA 5 and 6. For further details, please contact the Conference Secretariat, Kevin Wickham: [kevin@wickhams.com.au](mailto:kevin@wickhams.com.au)

*Drew Dixon  
Chair, AOA Medico-legal Society*

## New York City



Alan de Costa

# A bite of the big apple

A tour of an inspiring colorectal clinic is combined with cultural highlights on this Cairns surgeon's trip to New York

Those amongst us general surgeons who presume to manage patients with rectal cancer, must be constantly reminded of the high standards required. Having completed the remarkable Lap4CR course in Brisbane in February this year, I arranged a visit to the Colo-Rectal Service of Dr Douglas Wong at The Memorial Sloan-Kettering Medical Center (MSK) in New York.

A brisk 45 minute walk in the morning Spring chill took me across town from my hotel near Madison Square eastward to York Avenue close to the river. There is little to identify MSK from the outside as the great medical institution that it is; certainly no vast concourse and ambulance bay, and no impressive signs in lights. It is a series of tall buildings surrounded by many others, in a city of very tall buildings. Banks of elevators provide the essential transport, presumably where the idea of vertical integration was born. I eventually found Dr Wong's offices and was organized in no time with an ID badge and white coat, by his efficient and charming secretary.

The clinic, my destination for the day, was in an adjacent building, so down to the ground, into a hospital bus, and another series of corridors and elevators, where I was courteously received by Dr Wong. Douglas Wong is no stranger to Australian Surgery. He has been a distinguished visitor and contributor to colorectal surgery here over many years, and was even familiar with North Queensland. In his spare time he manages the Presidency of the American Society of Colon and Rectal Surgeons. There are four other surgeons in this unit, each with a different emphasis. When I first met him I enquired tentatively about laparoscopy. He allowed himself the faintest of smiles, saying "I only do the hard stuff". And of that, I was soon left in no doubt, as we reviewed patients with pelvic exenterations, sacrectomies and the complex calculus of chemoradiation.



*"In a single April week, Central Park shed its wintry garb of brown and grey and burst into Spring's festive colours."*

Were there any lessons to learn? Despite the brevity of my visit, and the gulf between the American system of private medicine and our mix of public and private, there were some things that I thought were of interest to surgeons in Australia.

The first thing that struck me was the operation of these clinics. They were substantially run by Physician Assistants (PAs) and Nurse Practitioners (NPs). The only permanent medical presence appeared to be the senior consultant. Each patient was worked up and presented by the PA, who had all the information and imaging to hand, and was then interviewed in one of the consultation rooms. Most of these rooms had flexible and rigid endoscopy equipment and were expertly (and may I say proudly) run by NPs. One room

had the endo-anal ultrasound equipment, and this was a focus of teaching and research in which the only resident there was involved. This resident also worked up and presented a case to the consultant, for discussion and management.

There were no pagers going off, or calls to theatre or Emergency. Senior medical time obviously comes at a premium, but without much hurrying the team got through about 20 complex patients in just under six hours. There was also a considerable research effort in evidence with data gatherers and specimen collectors constantly present.

In between patients Dr Wong commented on the great challenge facing patients with rectal cancer and their doctors. Despite the advances made in the local control of the





disease with good surgery and adjuvant treatment, there has been little or no improvement in overall survival. This is an important focus of the research effort at MSK.

Where does post-graduate teaching take place? Residents are certainly not used as labour as they are in Australia, as could be inferred from the running of the clinics. I watched Dr Wong meticulously assist his chief resident doing an abdomino-perineal resection for rectal cancer, allowing the trainee carriage of the case, though I understood DW wielded a very focused sucker.

A Trainee doing major surgery on a private patient in a private hospital, albeit under supervision would be a rare sight in Australia. As the operation evolved, I was also able to reflect that the male pelvis produces remarkably similar challenges, in Ireland, in the National Health Service in England, in Sydney, Brisbane and indeed in Cairns, and that my own surgical training to date had not been a Totally Meaningless Exercise. In passing, I was also intrigued to note that a consultant anaesthetist was not present through the major part of the operation. In person at least!

I sense that in metropolitan and regional centers in Australia, colorectal cancer is managed in a pretty standard fashion. In Cairns our access to adjuvant therapy is sometimes constrained, but our patients nonetheless receive it when indicated, though they have to travel for radiotherapy. When patients experience the real tragedy of abdominal or pelvic recurrence,

their management is far less reassuring. While there are individual surgeons in our cities with formidable abilities, to my knowledge there is no centre of excellence to which these desperate patients can be readily referred, particularly in the public system. I would be happy to be corrected on this. This is the strength of places like MSK. Great resources, personal and institutional, are focused on the individual. Exchanges like:

“Doctor, who will take out my uterus?”

“I can, but if you like we can get in your gynaecologist.”

“Who will remove the bladder, and make the second bag?”

“I can, but we can get a urologist to help us.”

“How long will all this take?”

“Eight hours.”

“Will you be there throughout?”

“Yes.”

“Where will I have my radiation?”

“Here.”

“And my chemo?”

“We will start things off here, and manage things afterward in a clinic”.

All this of course is immensely reassuring to these patients and their families, but I am not sure there is a ready Australian equivalent. Our Gynaecological Oncology colleagues have made some inroads, but for general and colorectal surgeons there is still a way to go.

In a single April week, Central Park shed its wintry garb of brown and grey and burst into Spring's festive colours. The great mag-

nolias on the avenues suddenly in bloom, softened the severity of the serried ranks of apartment blocks, and made us pedestrians simply stop and stare.

And what about culture, you may ask. A whole day in the Met (grave injustice), visits to the Getty, Frick, MoMA, and for the first time to the Neue, where I renewed my acquaintance with Klimt's Adele Bloch-Bauer, who adorns my waiting room wall, incandescent in the North Queensland light. We had first met in Vienna's Belvedere from where, in a twist of history and justice, she had been removed to New York. Concerts every night (booked over the net from Cairns). Saw St Martin-in-the-Fields band, memorably led by Sir Neville himself in wonderful recitals of Mozart and Haydn in the Lincoln Center, and Kathleen Battle in concert at the Carnegie where she received a standing ovation before she had sung a note. A new kind of American Royalty. Our final night's concert again at the Carnegie was all Brahms violin, with no less a performer than Anne-Sophie Mutter. After several encores and standing ovations, she played the Lullaby, and sent us off contented into the night.

For all this, I was pleased to return to Cairns. A city small, and still imperfectly formed, where progress is sometimes plodding, but where I can still run my dog at dusk on a deserted beach where the rainforest meets the sea.

A bite of the big apple. Twill suffice.





*Philip Truskett,  
Outgoing Chair  
NSW Regional Committee*

## Acute Care Surgery Services

The College takes on an advocacy role to promote this arguably undervalued area of surgery

It is pleasing to see how discussion relating to Acute Care Surgery Services has progressed over the past few years. Although I have taken a personal interest in this issue, I think it is important to state that the stimulus to this debate has been College based recognition of the problem, subsequent discussion and promotion and the development of potential solutions. The College is substantially responsible for the platform and forum to promote this both amongst the surgical fraternity and the various Departments of Health. It is an excellent example of how the College can be an effective advocate for both the surgical workforce and the community and there is still a lot that can be done.

### Acute Care Models

There are now at least three centres that have adopted acute care surgical models in metropolitan Sydney. A model has also been established in the Hunter. Other states are now also initiating models to suit their needs.

For those that are interested in this development, I would like to outline the philosophy behind the initiative. It is important to state at the outset that there is not "one size fits all" to this initiative, but there are common threads.

The essential feature is to provide a timely on-site surgical service for acute care surgery with certainty of duty period for the consultant surgeons involved. This is often coupled with a level of control of an emergency surgery operating theatre by the acute care surgeon (ACS). The way that this roster is constructed is dependent very much on personnel, work load and the facility. The aim is to ensure that emergency surgery is done during the working day and that surgery after hours is only performed for limb or life threat. It must be accepted that patients who have not had definitive care provided by the end of the duty period of the ACS are handed on to the incoming surgeon. This style of practice

requires that the rostered ACS is onsite during the working day without extraneous activities. This ensures a consultant lead service to the acutely ill surgical patient. Not only is this efficient for patient care, it is an excellent teaching tool.

### Further Needs

The College has published a position paper on Emergency Surgery. This paper is available on the College website and outlines many of the relevant issues. It is clear that Emergency Surgery is undervalued on all levels. Although the service is clearly important to the community it is often left to serendipity and allowed to fit in as required. It does not seem to enjoy the workplace priority that it should and is very much the poor cousin to elective surgery. It is also poorly remunerated and is considered disruptive to lifestyle. Despite this, many surgeons do enjoy the challenge of acute care.

The other challenge that faces acute care surgery is the issues that flow on from subspecialisation. Subspecialisation is good for some elective surgery, but provides unique challenges to acute care surgery rostering. Should all surgeons in their specialty be capable of provide acute care across the breadth of the subspecialties in their discipline? Should there be a specialty developed for Acute Care Surgery? This is clearly a debate to be had within College and the Specialty Societies. With the ageing workforce and safe hours considerations, a rational approach to these issues will need to be developed.

### The Garland Inquiry

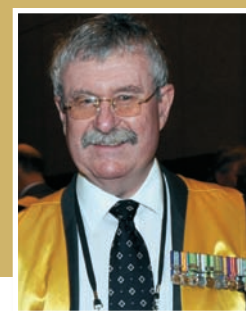
As a result of the avoidable death of a young head-injured patient at a Sydney Hospital, Justice Garling has been requested to assess the standard of acute care provision in NSW Hospitals. This inquiry has all the powers of a Royal Commission and has a relatively tight time line with a report expected by the end of July.

Its terms of reference are to report on:

1. Any systemic or institutional issues in the delivery of Acute Care Services in NSW Public Hospitals raised in submissions you receive that you consider appropriate for you to inquire into and recommend any changes which should be made to address them;
2. Identify existing models of patient care used in the delivery of Acute Care Services in NSW Public Hospitals with particular regard to case management including supervision of junior clinical staff, clinical note-taking and recordkeeping and communication between health professionals involved in the care of a patient;
3. Recommend any changes which should be made to the existing models of patient care identified under paragraph one to improve the quality and safety of patient care in NSW Public Hospitals;
4. Identify any systemic impediments to the implementation of changes recommended under paragraph three;
5. Recommend any changes which NSW Health should make to overcome any impediments identified under paragraph four; and
6. Recommend any changes which NSW Health should make to ensure that its workforce policies and practices support improved models of patient care.

These terms of reference are tightly focused on acute care provision and have the potential to have a significant impact on how acute care may be delivered in the future. It is timely that the College has been considering these issues and has been in a position to provide a considered submission to Justice Garling.

This is an example of how the College can provide a strong advocacy role for the provision of surgical services to our community. This must be considered core business of the College.



*Rob Atkinson, Chair,  
Disaster Preparedness  
Working party*

# Disaster preparedness – how would your hospital fare?

**T**he Disaster Preparedness Working Party continues to develop ways to establish best-practice preparedness for a disaster – whether it be at home, abroad or within the hospital. The following list of initiatives are the result of many minds at work and I would like to thank my committed and active colleagues who form the Disaster Preparedness Working Party at the College for their work and support.

## Surgeons willing to respond at times of a disaster

A register has been established at the College of surgeons willing to respond at times of a disaster. Data is collected on Early Management of Severe Trauma (EMST), Definitive Surgical Trauma Care (DSTC) & the Major Incident Medical Management and Support (MIMMS) courses, major trauma experience, involvement in developing countries, language, Defence Force membership and immunization. If you wish to be added to this list, please download the form (website below) and return it to Lyn Journeaux at the College Trauma office fax: +61 3 9276 7432 – or call +61 3 9276 7448 and a form can be forwarded to you.

[http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/FellowshipServices/Trauma/Disasterpreparedness/Disaster\\_ready\\_form.pdf](http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/FellowshipServices/Trauma/Disasterpreparedness/Disaster_ready_form.pdf)

## Personal Equipment List

You may have read last year's article in Surgical News regarding the 'survive for five' principle – five being five days, not five hours! This may have been a bit too close for comfort for some Victorians who experienced the mini hurricane in Melbourne and areas of Victoria early in April. Some areas were without power for over five days. How would you fare if this were your house, family or workplace? The personal equipment list (especially the wind up torch!) may have come into its own then. The list, pre-



pared to assist Fellows who are heading overseas to assist at times of a disaster, is also a handy list for all sorts of evacuations – including family camping trips. The Personal Equipment List can be found on the web:

[http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/FellowshipServices/Trauma/Disasterpreparedness/Personal\\_kit\\_for\\_deployment\\_R.Atkinson\\_et\\_al\\_28.11.06.pdf](http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/FellowshipServices/Trauma/Disasterpreparedness/Personal_kit_for_deployment_R.Atkinson_et_al_28.11.06.pdf)

## Surgical Mass-Casualty Clinical Operations Plan

Work is in progress on the development of a Policy to include a Surgical Mass-Casualty Clinical Operations Plan, Mass-Casualty Resource Calculator and Mass-Casualty Flow Diagram for Severely Injured Patients.

## Aide Provocateur:

A small business-size card acting as an "Aide Provocateur" will be issued in November. This is intended to stimulate thought and discussion about whether your hospital has a

properly formulated disaster plan. The aide provocateur can be carried in your pocket, ready to hand over to your colleagues when you suspect that more can be done to create or maintain your hospital's disaster plan.

## Aide Memoire:

One of the continuing endeavours of the working party has been the development of a simple generic hospital response plan. This includes such basic questions as "does your hospital have a Disaster Plan?" The simple hospital response template (printed on the next page) contains a number of questions that will help in the development of a Hospital Disaster Plan. Please feel free to use this list as an aide memoire, by displaying it in the hospital Operating Theatres. This should provoke discussion and raise awareness of the benefits of having a robust, current and visible Disaster Plan in place in your hospital. Both the aide memoire and the aide provocateur can be laminated and used as effective tools to keep you and your hospital well prepared for any disaster that may arise.





The Royal Australasian College of Surgeons  
**Trauma Committee**

# Is your hospital prepared for a disaster?

Does your hospital have a Disaster Plan?

Who contacts and organises the surgeons?

What is the surge capacity of the Emergency Department?

What is the surge capacity of the Radiology Department?

What is the surge capacity of the Intensive Care Unit?

Is there a senior surgeon designated to be in Emergency Department for surgical Triage to the Operating room?\*

☐☐☐☐☐☐☐



☐

Is there a senior surgeon designated to be included in a site team, for surgical emergencies (eg amputation/extractions) and for triage?\*

☐

Does the hospital have an updated list of which surgeons are Early Management of Severe Trauma (EMST), Definitive Surgical Trauma Care (DSTC) and Major Incident Medical Management Support (MIMMS) current?

☐

How are the elective surgical lists managed?

☐

What is the surge capacity of the operating theatres?

☐

What is the ability of the hospital to expand the bed situation?

☐

What is the patient flow pattern? (i.e. is it one directional?)

☐

How many drills or practices occur in one year?

☐

Is there a log of lessons learned and problems solved?

☐

Is there a rendezvous point in the hospital, which is known to all surgeons, - for allocation of tasks?

☐

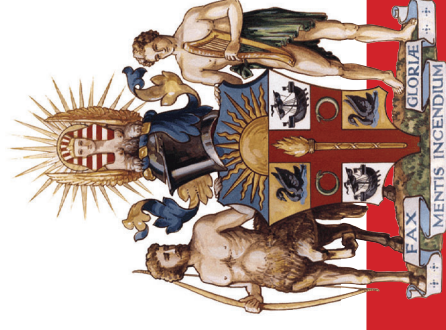
Is there a general place to meet in the hospital for disaster response?

☐

Is there a list of participating specialists with home telephone numbers?

☐

Is there a reliable message carrier appointed who knows hospital layout?



\* *Are you up to date in EMST, DSTC and MIMMS?*



## The Club Foot Program

An Australian orthopaedic outreach team is helping East Timor's surgeons on the road to self-sufficiency

The establishment of a treatment program for club feet that has been proven particularly suitable for developing countries is one of the new initiatives now being implemented by Australian surgeons undertaking orthopaedic outreach to East Timor.

Co-ordinated by the College and headed by Canberra orthopaedic surgeon Mr David McNicol, the outreach program is now in the process of rolling out Ponsetti courses for local medical, physio and nursing staff so they can become self-sufficient in the management of the condition.

The Ponsetti technique involves serial plasters, usually percutaneous division of the heel cord, putting the limb in plaster again and the subsequent use of splints. This technique is not only the gold standard treatment in developed first world nations but is highly suitable for poorer countries because it is cheap and can be done without the need for specialist surgeons.

Mr McNicol said East Timor has a higher birth rate of children with club feet because of a genetic/racial predisposition with four to five children of 1000 live births born with the condition compared to one in 1000 in Australia.

He said the Club Foot Program was a pleasing aspect of the gradual capacity building efforts of the outreach programme to help East Timor become self sufficient in its health service provision and therefore less reliant on visiting international teams.

"We have already brought the physiotherapist from Baucau to Australia to undertake the training course in the technique and we will be using her as the focal point to train the local doctors, nurses and physiotherapists. Within the next few months we are also going to help fund a public information campaign to inform parents and medical staff that the treatment is available and affordable," Mr McNicol said.

"We have identified a charitable organisation in Dili, called ASSERT, that will make the splints and have sent them some to use as prototypes and they have already begun to make them within the last couple of weeks.

"Establishing this program is very rewarding because not only is it the gold standard treatment, they can do it themselves. And of course the best aspect is that it works so well, so that after the treatment the foot is nice and flat and flexible and all the treatment requires is some minor surgery, some plaster-of-Paris and a splint. It results in normal walking and therefore a life-time of dividends for the patients."

Mr McNicol said the financial support for the Club Foot Program was currently being provided through the Orthopaedic Outreach Fund but that requests had now been put to AusAid for assistance as well as to the government of East Timor to enhance the sense of local ownership for the project.

A former president of the Australian Orthopaedic Association and now the chair of the Orthopaedic Outreach Fund Management Committee, Mr McNicol has visited the country six times and will go again in November.

He said that while the outreach program had been initially based in Dili, senior health officials had recently asked the team to undertake more regional work.

Consequently they are now based in Baucau, East Timor's second-largest city as well as visiting Maliana for the first time in August 2008.

The current team comprises Mr McNicol, fellow surgeon Dr Phil Aubin, anaesthetist Dr Rashmi Patel, scrub nurse Mr Michael Aiashi and Mr McNicol's wife, orthopaedic nurse Janine McNicol. Together, they conduct patient consultations during the first two days, seeing between 60 to 100 patients, and then conduct up to 20 surgical procedures in a week.

"Establishing this program is very rewarding because not only is it the gold standard treatment, they can do it themselves."

Mr McNicol said that having two orthopaedic surgeons meant that the team could now take on bigger surgeries some of which are to treat patients who have been in pain and distress for years.

"Last visit we nail-plated a femur, reconstructed a man's dislocated elbow and undertook the first procedure to treat a girl with a knee contracture which had fused her calf to her thigh. We are still even seeing the aftermath of injuries from the time of occupation in terms of bullet wounds and crushed feet while the contractures relate to infections left untreated in bones or joints and the deformities of cerebral palsy."

But while it is clear that Mr McNicol finds surgically treating such patients highly rewarding, his enthusiasm is particularly focused on helping the East Timorese care for themselves.

He said a local East Timorese general surgeon, Dr Alito Soares, had recently expressed interest in becoming an orthopaedic surgeon and had worked alongside the team during the last visit to allow them to assess his capabilities. Now, Outreach and the College have asked that he be considered as a Trainee within the Indonesian orthopaedic training program.

"It is pleasing to see the Indonesian medical community supporting the East Timorese and we have a strong relationship with our Indonesian orthopaedic counterparts. We have put his name forward and hopefully he could be East Timor's first home-grown orthopaedic surgeon," Mr McNicol said.





David McNicol operating on a baby with club feet



David McNicol & Phil Aubin trying to get home from Baucau to Dili



Gueterres (right) with his wife recovering from a successful foot reconstruction



The ward staff at Baucau Hospital



David McNicol & Phil Aubin operating on a hip



David McNicol & Phil Aubin with a patient recovering from a hip operation

Mr McNicol also said that while training and support was a priority, particularly in terms of assisting a Cuban orthopaedic surgeon currently working out of Baucau with text books and email advice, practical support was also important.

He said Australian hospitals had contributed equipment and that the orthopaedic equipment industry had been generous supporters. And he said that while facilities were poorer in Baucau than in Dili, gradually the situation was improving.

"We have been to Baucau for the last three visits which means that we are now developing strong relationships with the local staff and patients," he said.

"While the hospital in Bacau is past its use-by date they are in the process of building a new hospital which is desperately needed because Baucau Hospital covers the entire

eastern half of the country.

"When I first went there, they had no orthopaedic equipment but slowly, with assistance, we are gradually equipping the place with the basics. Recently the Princess Alexandra Hospital in Brisbane donated an image intensifier and we are now in the process of organising the local radiographer to visit the Brisbane hospital for two weeks training. In May we also took a flash steriliser so gradually we are building not only the equipment base but the expertise required to use it."

Mr McNicol described his outreach work as pleasing both personally and professionally.

"Professionally you see such amazing orthopaedic problems that you just don't see here. It takes you out of the square, you have to improvise and you have to be able to think on your feet, without all the equipment we are used to here, and at the same time you

can change lives and relieve pain and distress," he said.

"The fact that we, as a team, know each other well and have travelled together often, means that we all know what to expect, what equipment is needed, we know each other's skills and strengths, and I wouldn't go without my wife Jannine. She used to surgically assist for me before our second surgeon Phil Aubin came on board.

"Everyone in the team has a great respect for each other's professional abilities and over the course of our visits to East Timor we have become very good friends. Trainee registrars have also come with us and they are knocked out by the experience. They of course will be the next generation of outreach surgeons."

Based in Canberra, Mr McNicol is a member of the College's International Committee.





*Keith Mutimer,  
Honorary Treasurer*

## College Honorary Financial Adviser – Doug Oldfield retires!

At the February meeting of Council this year I had the honour to farewell the “Senior” Honorary Advisor to the College, Mr Doug Oldfield.

The Resources Committee of the College has been generously supported by Honorary Financial Advisors since the 1980s. In recent years the “team” of advisors has grown and now provides expertise and oversight into Finance, Audit, Insurance, IT, Property and general governance issues.

Although we have “lost” our senior advisor, the Resources division is still ably supported by Mr Anthony Lewis – Financial Advisor and Audit committee Chair, Mr Brian Randall – Chair Investment committee, Mr Ken Welfare – Investment Advisor, Mr Michael Randall – Investment Advisor and Mr Robert Milne – Property Advisor.

Doug joined the College in an advisory capacity in 1984 at the request of then Treasurer, Professor Richard (Dick) Bennett when Mr Mervyn Smith was President. Doug and Dick had many years providing support to Wesley College, Melbourne, in a number of roles. During this period of service to our College Doug has worked for thirteen Presidents and I am the ninth Honorary Treasurer that Doug has supported.

He has attended more than seventy Council meetings and seventy Resources (Finance) Committee Meetings as well as numerous other Finance meetings in support of his role to the College. Remarkably Doug, quite often with his wife Jean, has attended most of the College ASC meetings since 1984. Doug’s consistent attendance would have ensured his CPD requirements if he needed College recertification and is a challenge to the record of many Fellows attending.

As well as providing his valuable time to the College Doug has many other interests. He was actively involved with Wesley College as President of the Wesley College Coun-



Doug Oldfield, right, enjoys a drink with Brian Randall at the President’s drinks last year in the College courtyard

cil and the Old Wesley Collegians as well as serving on many other committees, including the Board of Management of the Army & Air force Canteen service, Victorian State Council of the Girl Guides Association and President of the Athenaeum Club, Melbourne.

No doubt Doug and Dick’s involvement at Wesley provided many insights into progressing aspects of the College and its financial administrative structure.

Doug progressed as an accountant through chartered accounting and became a partner of Ernst and Young, current College Auditors, when he retired from that role in 1990. During his professional career Doug was the State Chair of the Institute of Chartered Accountants in 1974 and admitted our (then younger) Director of Resources, Mr Ian T Burke, as an associate member of the Institute. Little did anyone realise that their paths would cross again over twenty years later.

Over the years with the many changes of

Council membership and College staff, Doug has developed probably the most extensive corporate knowledge of the College with the exception perhaps of a previous College Secretary, the late Mr Ray Chapman.

In recognition of Doug’s commitment to the College he was made a member of the Court of Honour in 1997 which is one of the highest honours of this College. This award exists to honour distinguished College members and others who provide support and advice to the College as well as past Presidents.

Doug has now eased back into a quieter retired life to enjoy more time with his supportive wife Jean and their four children and nine grandchildren. He has left the College a much better place through his enormous contribution over these three decades and the Fellowship owes him an enormous debt of gratitude. Doug Oldfield, many thanks for a job well done from all the College Fellows.

# Royal Australasian College of Surgeons

Victorian Annual General Scientific & Fellowship Meeting

October 24-26, 2008

Century Inn, Traralgon VIC

## Program Includes:

Partner Program

Professional Development

Workshops

CPD Credit Points

Networking

Social Activities:

- coal mine tour
- golf clinic
- parachuting
- air flights
- GJ Royal lecture
- Formal Dinner

## Special Early Bird Registration:

For registration & further details contact the Victorian Regional manager,  
Denice Spence +61 3 9249 1254 or  
[denice.spence@surgeons.org](mailto:denice.spence@surgeons.org)

The Victorian regional committee wish to thank the sponsors for their generous support of this meeting:

- Experien Medical Finance
- AVANT
- MDA National
- Johnson & Johnson

Now accepting abstract submissions

Closing Fri 25 July 2008, 5 pm.

Contact the College for application forms on  
[college.vsc@surgeons.org](mailto:college.vsc@surgeons.org) or download from the web  
on [www.surgeons.org](http://www.surgeons.org)



## The Sir Edward Hughes Memorial Clinical Research Prize in Surgery 2008

**Cabrini Hospital, Saturday 18th October 2008**

**Cabrini Monash University Department**

**of Surgery & Cabrini Institute -**

**Education and Research**

*Open to surgical trainees in all sub-specialties,*

*including registrars & residents, &*

*first year surgical fellows post FRACS.*

**\$6000.00 prize**

**Abstracts requested by**

**Friday 29th August 2008.**

**For further information:**

**[www.med.monash.edu.au/surgery/cabrini/](http://www.med.monash.edu.au/surgery/cabrini/)**



## FELLOWSHIP IN BARIATRIC SURGERY

The Australian Institute of Weight Control (AIWC) is pleased to announce its inaugural Fellowship Program in Bariatric Surgery. This is an outstanding opportunity for fellowship training in Bariatric surgery in Australia as part of a multi-disciplinary centre for the treatment of obesity.

AIWC has evolved from the combination of four leading weight loss clinics across Australia, located in Perth, Adelaide Gold Coast and Sydney. AIWC has performed over 7000 bariatric procedures and fulfils the "Centre of Excellence" criteria. It provides a long term multi-disciplinary support program called "Circle of Care", ongoing audit and quality assurance programs, and prospective data collection. AIWC has an active research program including clinical trials, and basic science research. AIWC has developed "the fundamentals in Bariatric" course.

AIWC supervisors of training include:

- Professor Jeff Hamdorf St John of God Hospital, Perth
- Dr. Sue Taylor, St. John of God Hospital, Perth
- Professor James Tooili, Flinders Private Hospital, Adelaide
- Dr. Lillian Kow, Flinders Medical Centre, Adelaide
- Dr Laurant Layani, John Flynn Hospital, Gold Coast
- Dr Roy Brancatisano Baulkham Hills Hospital, Sydney

There will be 4 Bariatric fellowship positions available commencing in January 2009, for a period of 12 months. There will be opportunity to extend the position to 24 months and to spend at least 6 months at another location within the network.

The fellows will have a substantial clinical workload with more than 1500 bariatric operations performed per annum across all sites, and will be involved in all aspect of the obese patient's management as part of the multi-disciplinary team. The successful applicant will be required to participate in clinical research and collaborative studies as part of their clinical training. The applicant will also have the opportunity to gain further experience in advanced laparoscopic gastro-intestinal surgery and will be offered substantial professional development.

Requirements

- FRACS and completed advanced training in general surgery with an interest in upper GI laparoscopic surgery
- Registration with the Medical Board of your State.
- Medical Indemnity cover

Further information regarding the fellowship and application requirements may be obtained from [www.circleofcare.com.au](http://www.circleofcare.com.au) or from Kathy Noble 1300 WEIGHTLOSS or email [kathynoble@circleofcare.com.au](mailto:kathynoble@circleofcare.com.au)

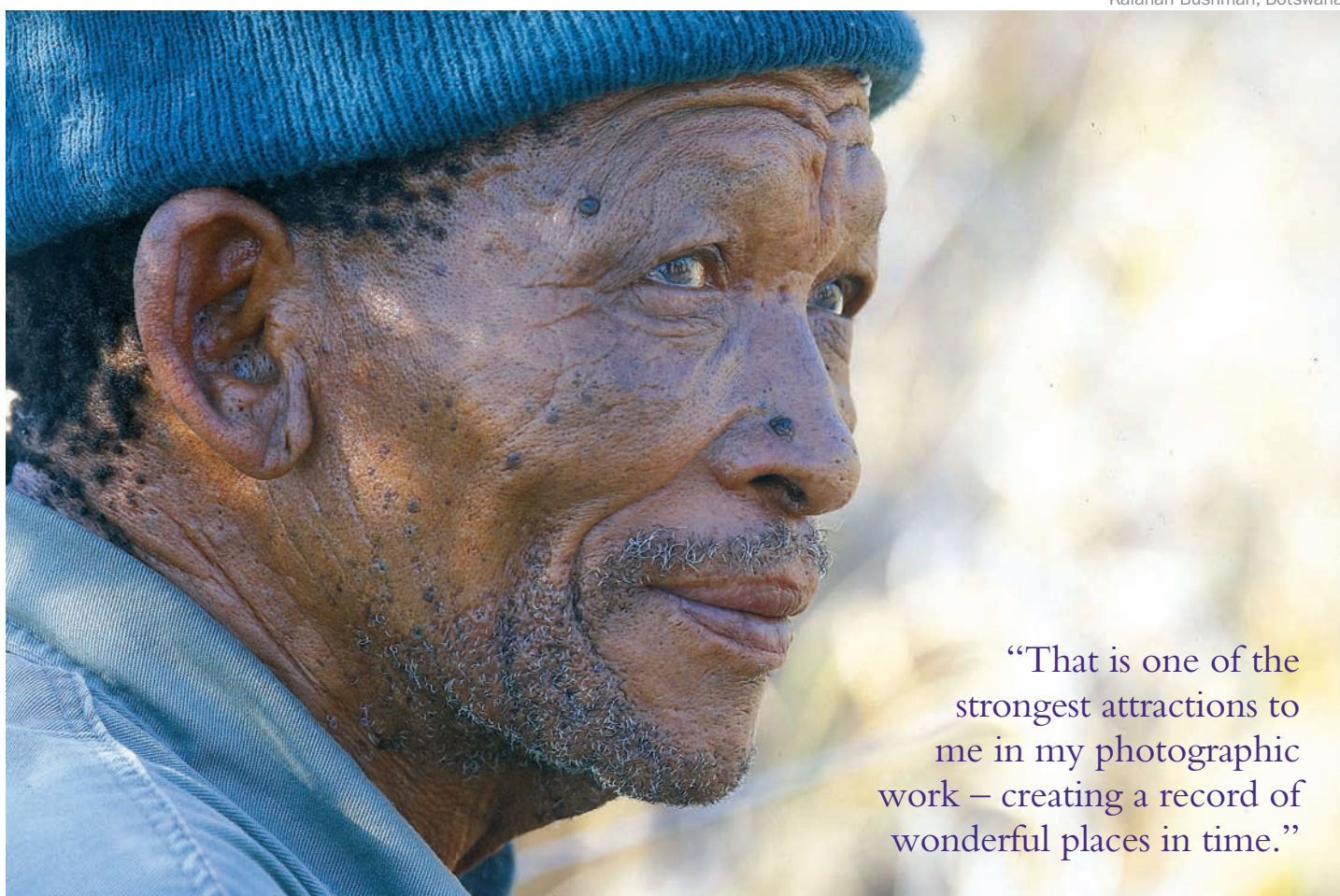




## Creating visual records

After 40 years in surgery, John Hanrahan's skills turn to capturing the beauty of nature on film

Kalahari Bushman, Botswana



“That is one of the strongest attractions to me in my photographic work – creating a record of wonderful places in time.”

When former College president John Hanrahan pulled down the shutters of his practice in 2002, he took the opportunity to spend more time opening the shutters of his trusted camera. After more than 40 years as a plastic and reconstructive surgeon with interests in micro-surgery, breast and facial reconstruction, he was intimately familiar with the minutiae of the human form. Not surprising, then, that his artistic interests, both before and after his retirement, tended more towards landscape and wildlife photography.

As well, this art form allowed him to combine his aesthetic sensibilities with his interest in

geology, the technical aspects of photography and most of all his love of the environment.

Based in Perth, Mr Hanrahan produced a book of photographs of Western Australia's beautiful Shark Bay in 2000, has held exhibitions of his work at a Perth gallery and has photographed stunning Lake Eyre. Recently he has taken on two commissions to photograph the historic station homesteads sprinkled across the state before they disappear.

“I have always been drawn to remote places and wilderness areas and I find great beauty in the natural world. I hope by taking these photographs that people looking at them stop and think about

what they are actually seeing because some of these beautiful places may be lost,” he said.

“That is one of the strongest attractions to me in my photographic work – creating a record of wonderful places in time. Many of the station homesteads are lovely old buildings but some of them will soon disappear because the stations themselves are no longer economically viable, so I was asked to record them for two shires so that they would not be lost to history.”

Mr Hanrahan said that while he had been an “occasional photographer” during his professional life he was now devoting more time to it, particularly during his overseas and domestic



travels. Last year he visited Botswana creating a photographic record of the visit and recently travelled the Silk Road by train through Russia into China.

And his interests are expanding, returning to the human form.

“Recently I have started taking more portrait shots, or as I call them people pictures. Photography allows you to look at the world with a more intense focus in that you are seeing the landscape and animals in connection to each other, the relationship that each has with the other, the landscape, life and light,” he said.

“Yet travelling the Silk Road by train was a wonderful experience particularly in terms of seeing such different people, the way they dressed, the shape of faces, their place in the world. I found that very interesting and looking through the lens forces you to think about them more keenly.

“At the same time my wife was getting bored with my images of patterns on sand and bark and had been urging me for some time to do more portraiture so I chose, wisely, to listen to that advice.”

Mr Hanrahan, who was president of the College from 1991 to 1993, said he had found retirement a great joy and did not miss his busy practice, saying he enjoyed it up until his last case. He said while he always had an artistic streak, he began to relish the extra time to pursue his interests after getting over the first six months of post-retirement guilt.

“My personal opinion is that any plastic and reconstructive surgeon who is not an artist at heart should pack up and do something else. I think it is crucial to have an eye for aesthetics, for proportions, for an appreciation of beauty,” he said.

Now he spends his time not only taking photographs and travelling but also sailing his boat up the West Australian coast with friends. He has also instigated a private project, again with friends, to clean up Abrolhos Islands, the site of the Batavia wreck.

“It is a national reserve, a couple of hundred kilometres from Perth, which over time has become a rubbish dump. Most of the rubbish is flotsam and jetsam and fishing detritus but I just decided to do something about it because of my concern for the natural environment,” Mr Hanrahan said.

“That is one of the strongest attractions to me in my photographic work – creating a record of wonderful places in time.”



Fishing boat, Chile



Black browed albatrosses nesting, South Georgia



Pelican & Seagull, Rottnest Island, Perth



## Successful Scholar



*Pictured: Noojan Kazemi*

# RACS Foundation Scholarship

There is a new imaging technique that detects increased blood activity in the part of the brain that causes seizures

The College Foundation has funded research through its scholarship program that has the potential to revolutionise the understanding and surgical treatment of Temporal Lobe Epilepsy (TLE). Dr Noojan Kazemi, a neurosurgical Trainee, received the RACS Foundation Scholarship in 2007 which allowed him to conduct research on the analysis of seizure spread patterns in subtypes of TLE using a new imaging technique that detects increased blood activity in the part of the brain that causes seizures.

The research team was able to capture images of the brain during a seizure which in turn allowed it to compare the increased blood activity against images of normal brain activity.

The research could in future allow surgeons to target only that discrete area of the brain in the surgical treatment of intractable epilepsy and also has the potential to be used in the treatment of other neurological disorders such as Parkinson's disease. Already, the new technique is being trialled by the well-known Mayo clinic in the United States in patients with epilepsy and movement disorders.

"Intractable epilepsy is a common condition in the population with approximately 1 per cent of the population affected. Of these patients a significant proportion cannot be controlled with single or multiple medications. The purpose of our study was to describe the role of cerebral perfusion patterns in localizing the onset focus of seizures in patients with Temporal Lobe Epilepsy," Dr Kazemi said.

"We examined the role of cerebral perfusion by using Single Photon Emission Computed Tomography (SPECT) nuclear medicine imaging to detect the seizure-creating zone and seizure spread patterns in patients with TLE and the assessment of seizure outcome following image-guided surgery."

Dr Kazemi said the research had been done as part of a Doctor of Medicine Degree under the supervision of Associate Professor Terence O'Brien and was based at the University of Mel-



bourne and Royal Melbourne Hospital with some further analysis and validation undertaken at the Mayo Clinic.

"As part of this research, which built on the work previously done by A/ Professor O'Brien, we developed a novel way of using voxel-wise statistical analysis of SPECT imaging to better identify this seizure focus in TLE patients. We have called our technique STATISCOM (Statistical Ictal SPECT co-registered to MRI) and we were able to confirm the utility of our method in over 100 patients by demonstrating its superiority in determining the seizure onset focus compared to traditional methods involving SPECT, MRI and PET scan imaging," he said.

"Importantly, we were also able to demonstrate that resection of the cerebral region identified by this technique was associated with better outcomes after surgery compared to other regions resected."

Dr Kazemi said the technique could become a potentially useful addition to the pre-operative investigations performed for patients with intractable epilepsy.

"Using this technique we were able to identify group patterns of perfusion in subtypes

of intractable epilepsy, which also allows us to predict where in this part of the brain surgery may be maximally effective. In developing this method of group analysis, the potential for application to other neurological disorders was also realised including conditions such as Parkinson's Disease, Essential Tremor and other movement disorders," he said.

Dr Kazemi said he was grateful to the College for the scholarship funding, particularly for the support it provided during his time working here and in the United States. He said it had been an extremely rewarding experience to be involved in break-through research and said that work continued in validating and deriving results from the technique.

"Surgery is still an under-utilised treatment method for epilepsy," Dr Kazemi said.

"However, we believe this and other imaging techniques have the potential to improve post-operative outcomes and further the efficacy of either surgical resection or deep brain stimulation in a variety of neurological conditions. We have presented our work at both American and Australian Epilepsy Society meetings and plan to present further results at international Neurosurgical meetings."



Pictured: Chris O'Brien

## The urgent need for extensive cancer centres

Funding for, and the development of, comprehensive, multidisciplinary cancer centres is critical and urgent if Australia is not to fall behind international developments in treatment and research, according to the former director of the Sydney Cancer Centre, Professor Chris O'Brien.

Professor O'Brien, who resigned from his position when diagnosed with an aggressive brain cancer in 2006, said the centuries-old teaching hospital model was inadequate for tackling the disease and was failing Australian patients, particularly those with rare forms of cancer.

He said that the Australian public should no longer passively accept the current mortality rate of 40,000 deaths per year which he believed would cause outrage if caused by an infectious disease or work-related accidents.

Professor O'Brien originally put his views before an audience at the Sydney Opera House brought together for a fund-raising event at which Prime Minister Kevin Rudd confirmed federal funding of \$50 million to go toward the redevelopment of the Sydney Cancer Centre.

Speaking to *Surgical News*, Professor O'Brien said Australia was now almost 40 years behind the US in cancer care and research.

"In 1971 the Nixon Administration established the National Cancer Institute which embraced the cancer centre model. Now they have 60 such centres, 40 of which are designated as comprehensive centres in that they combine world-leading research, innovation, clinical care, outreach and educational components," he said.

"During that same period of time Australia has continued to rely on a quite ancient English teaching hospital model that simply cannot provide the dedicated focus needed to tackle the immense challenge posed by the cancer burden.

"What is needed is the ability to co-locate a critical mass of clinical excellence



Chris O'Brien with Prime Minister Kevin Rudd

and research expertise in order to develop the unity of purpose necessary to create the break-throughs and innovations needed that will offer real improvements in patient outcomes."

He said plans to move the Peter MacCallum Cancer Centre from East Melbourne to Parkville to integrate its services with those provided by the Royal Melbourne and the Royal Children's Hospitals as well as linking it into the research program of the Walter and Eliza Hall Institute were timely and important. The new federal funding will allow a similar integration of services in Sydney.

"While the Australian survival rate at early diagnosis is as good as the rate in the US, that is because we have very good clinicians and excellent nursing care," he said.

"However, we still lack an environment that encourages world class research and an environment that can attract and retain the best and brightest of our own clinicians and researchers and the best and brightest from overseas."

Professor O'Brien said the new funding

for the Sydney Cancer Centre would pay for the construction of two buildings located near, and associated with, the Prince Alfred Hospital. One building will house the clinical care facilities with the other housing research facilities.

He said the clinical care facility would also have a Wellness Centre where complementary and alternative therapies will be offered to patients as they undergo mainstream cancer treatment.

"We would like to scientifically test, trial and research these alternative therapies to see what works and what doesn't. While they have been comprehensively embraced by the Australian public, not a great deal of scientific rigour has been focussed on various treatments and it is time that was done," he said.

Professor O'Brien also said that recent research suggesting that positive thinking was useless in dealing with cancer should be questioned and further studied.

"There was an important gap in that study in that the authors didn't look at quality of life issues. Having a positive attitude can have an enormous impact on the patients, the family and the carers and I think it would be very upsetting if people took this research to mean such an attitude with all its positive effects on a patient's quality of life had no value," he said.

Professor O'Brien recently underwent his fourth operation to remove a focus of recurrent brain tumour and is about to go back onto chemotherapy. He said that while it was pleasing to be 18 months from his initial diagnosis, the prognosis was still guarded though he felt very well.

He has recently finished writing a book, titled "Never Say Die", a memoir both of his professional life and his personal cancer experience, and has asked the Prime Minister to launch it in October. Speaking at the fund-raiser in Sydney in May, Mr Rudd said his government had allocated \$214 million for cancer programs





Sam Mellick

## Changing our religious profile

A reflection on the disappearance of  
two long-standing traditions

For many years the College GSM (now the Annual Scientific Congress ASC) included a Church Service at its commencement and this service was regularly attended by the Council and a varying number of Fellows and accompanying persons. Paralleling the decline in regular church attendances in the community, our services have attracted diminishing numbers.

In 2003 at the Brisbane ASC, an ecumenical service was conducted, not in a church but in the Convention Centre itself. At the recent Hong Kong Meeting, a small number of interested people attended a well structured Multi Faith Service on Monday afternoon, May 12, conducted by representatives of Christian, Buddhist, Hindu, Jewish and Muslim Faiths. No Council member attended and I have just learned that the College Council has resolved that no Religious service should be part of its ASC and none will be included in the next ASC in Brisbane in May 2009.

### And another thing...

Since 1961, by courtesy of our sister college in London, we have on appropriate occasions used their College Grace as our own. This year in Hong Kong (for the first time to my knowledge) Council declined the use of this Grace at the College Banquet and Specialty dinners.

It is true that with poetic licence, William Shakespeare's King Henry V advanced



From left to right: Mr Michael Bruce, Rabbi Martin Van Der Bergh, Reverend Matthew Vernon, Professor NG Patil & Mr Gordon Low



Iman Muhammad Arshad



Professor Chan Li

his wooing of Kathryn, daughter of the King of France, by telling her that "nice customs courts'y to great Kings", and thereby succeeded in overturning the custom of "no kissing before marriage". I fully support our

Council properly deciding policy for us, but on this occasion I believe there might well be many Fellows, who like me, deplore these two decisions which deprive us of long standing and honourable traditions.

### Notice to Retired Fellows of the College

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

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

We will acknowledge your donation and place your name on the gown, if you approve. If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.

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



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Royal Australasian College of Surgeons

## NEW ZEALAND ANNUAL SCIENTIFIC MEETING

Convention Centre, Palmerston North, New Zealand  
Wednesday 27 - Friday 29 August 2008



#### Invited Speakers Include:

James Church, Colorectal Surgeon, Cleveland Clinic, USA  
Professor Bruce Mann, Surgical Oncologist, and Breast Surgeon, Sydney, Australia  
Professor John Windsor, Upper GI and HPB, Auckland, NZ

#### Call for Abstracts:

Abstracts must be submitted online via the conference website.  
Please refer to submission information on the website

Abstract Submission Deadline  
Early Bird Registration by  
Online Registration by

16 June  
25 July  
20 August

If you require any further information please contact:  
Medical Industry Association of New Zealand, PO Box 8378, Symonds Street, Auckland





## THE GARNETT PASSE AND RODNEY WILLIAMS MEMORIAL FOUNDATION AWARDS FOR 2009

### PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2009.

Project Grants are for a period of up to three years and must be conducted in an Australian or New Zealand university, teaching hospital or research institute. Individuals with a previous history of support from the Foundation are particularly encouraged to apply. Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2009, is ineligible.

The annual level of support will be up to AUD100,000 and, within this cap, grants must include the salary of the applicant and/or research assistant(s), on-costs, maintenance, equipment and all other costs. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 29 August 2008

### GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2009.

Grants-In-Aid are for a period of up to two years and must be conducted in an Australian or New Zealand university, teaching hospital or research institute. Otolaryngologists or Trainees in the Specialty who are in possession of the First Part of the FRACS are eligible to apply. Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2009, is ineligible.

The annual level of support will be up to AUD50,000 and grants are restricted to equipment and maintenance. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 29 August 2008

Further details concerning the above awards together with the current application forms can be obtained from:-

The Secretary  
The Garnett Passe and Rodney Williams Memorial  
Foundation  
PO Box 577  
EAST MELBOURNE VIC 8002

Telephone: +61 3 9419 0280  
Facsimile: +61 3 9419 0282  
Email: [gprwmf@bigpond.net.au](mailto:gprwmf@bigpond.net.au)

### PRELIMINARY NOTICE – SURGICAL RESEARCH SOCIETY ANNUAL MEETING

## The Surgical Research Society 45th Annual Scientific Meeting will be held in Adelaide on Friday 21st November 2008

The meeting will be titled "The Best New Surgical Research in Australasia"

This meeting is open to all who are involved in or who are interested in research, including surgeons, surgical or medical trainees, researchers or scientists.

### CALL FOR ABSTRACTS:

Abstracts must be submitted no later than Wednesday 1st October 2008.

### CONVENOR:

Professor Guy Maddern

### FOR FURTHER INFORMATION CONTACT:

Julia Cooper  
Administrative Officer  
Tel: +61 8 8363 7513  
Fax: +61 8 8362 2077  
Email: [julia.cooper@surgeons.org](mailto:julia.cooper@surgeons.org)





Keith Mutimer,  
Honorary Treasurer

## Ode to an Urn

A silver samovar in the College's Melbourne Council Room harbours a fascinating history

Standing on the bookcase on the north side of the Council Room in Melbourne is a large silver samovar. It was presented to the College by Sir Henry Newland.

The samovar stands 41cm high, and is 39cm wide across the handles. It is made of Sheffield plate, and dates from the late 18th century. It is supported on a square base with four cast lion's feet attached by elaborate mounts at the corners. The main vessel or tank is circular, and set on a short columnar stand. These elements are heavily fluted. There are two elaborately decorated cast handles attached to the sides of the tank. A long spout with a cast tap extends from the bottom of the tank. The handle of the tap is ivory, and unfortunately the nut which once held the handle in place has disappeared. The lid is plainer, with a fluted and scalloped edge, and is capped with a finial. Inside the tank is a cylindrical immersion container for hot coals, a primitive type of heating element.

There is a crest, probably that of the original owner, engraved on the shoulder of the tank above the tap.

A samovar is a Russian tea urn. The word *самовар* means "self-brewer", and the true Russian type incorporates a water tank with a tap, an immersion container for hot stones, pinecones or charcoal, and a stand on the top, on which is placed the teapot. A samovar of this type could bring a gallon (4½ litres) of water to the boil in about 20 minutes.

The College's samovar is not a tea urn, as



it does not include the stand or the teapot. It is in reality a hot water urn. Undoubtedly it was intended to provide hot water for tea, and the absence of a matching teapot indicates a cultural difference between the English and the Russians, in the way in which they went about brewing tea. It is a showpiece, intended for use and display in the reception rooms of

the house. It is far too elaborate to be meant purely as a functional object in the kitchen. In the 18th century the serving of tea was an important act of hospitality and a statement of social status, for in those days tea was still a rare and exotic import from the Orient.

The handles, tap and other decorative features of the samovar are made of solid cast silver, but the body of the vessel, and the base and the lid, are made of Sheffield plate. This technique was invented, as its name suggests, in the English Midlands, by a cutler named Thomas Boulsover, who in 1742 perfected a way of fusing sterling silver onto copper sheet. This made production of silver objects not only much cheaper, but also much easier due to the malleability of the copper base beneath the silver coating. Silver goods now came within reach of the rising middle classes. Sheffield plate was superseded in the 1840s, when electroplating became a commercially viable technique. Whereas Sheffield plate was produced by skilled craftsmen, electrolysis laid a coating of silver onto copper almost automatically, requiring less labour and lower skill levels. Very soon the world was flooded with cheap objects made of electroplated nickel silver (EPNS).

The plating on the samovar is now wearing thin due to years of diligent polishing, and the copper is showing through in several areas. However, replating is not desirable, as it can never be done to the original standard, and in doing so the originality of the piece is compromised. Even though its little tarnish may have to be accepted, this fine antique will continue to grace the Council Room with its elegant form for many more years yet.

Written by Geoff Down,  
College Curator



## Member Benefits



# RACS Member Advantage

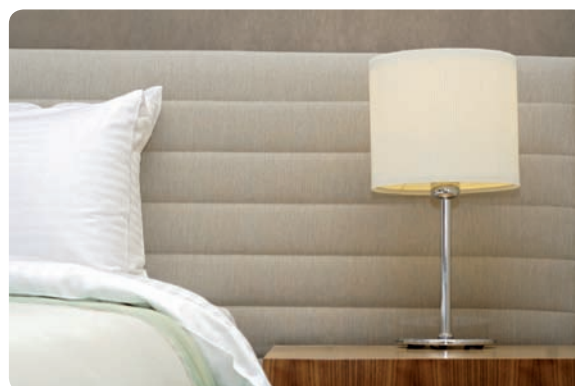
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**Call** Member Advantage to discuss options on 1300 853 352 or visit your webpage via [www.member-advantage.com/racs](http://www.member-advantage.com/racs) for more information.



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\* Discounts applicable to new and current HCF health policies only.

^ HCF will waive the excess for all same day procedures; or for hospital treatments which are the result of an accident and given within 12 months of the accident.

## Thank You

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## Congratulations on your achievements

### **Professor Chris O'Brien – Award for Excellence to Surgery**

Professor O'Brien has been the outstanding Head and Neck Surgeon in Australia and New Zealand in the last decade and has a national and international profile that is arguably unequalled. Choosing early retirement due to serious illness, his brilliant career and lasting contribution to surgery in general and head and neck oncology in particular is suitably recognised by this college's award for excellence in surgery.

Professor Chris O'Brien's international career began with his appointment as Fellow and Honorary Clinical Assistant in the Head and Neck Unit at the Marsden Hospital, London, England in July 1984. He pursued further training as Clinical Fellow in Head and Neck Oncology in the Department of Surgery, University of Alabama at Birmingham, Alabama, U.S.A. July 1985.

Upon returning to Australia he was appointed Attending Surgeon and then became Chairman of the Department of Head and Neck Surgery, Royal Prince Alfred Hospital. He was also Consultant Surgeon to the Sydney Melanoma Unit from 1988 to 2000. His contribution to the specialty has been internationally recognized by his invited membership of the UICC TNM Expert Advisory Panel on Head & Neck Cancer and membership of the Council, American Head & Neck Society in 2005.

He is also a member of the Executive Council of the International Federation of Head and Neck Oncologic Societies, and a member of the Council of the International Academy of Oral Oncology 2005.

He received a Presidential Citation from the President of the American Head and Neck Society, presented at the fifth International Head and Neck Cancer Conference, San Francisco, August 2000, for outstanding contribution to head and neck oncology espe-

cially in the fields of melanoma and salivary gland surgery.

Chris has attained the highest level of surgical achievement by world standards in the field of Head and Neck surgery.

Professor Chris O'Brien's lasting legacy will be as founder of the Sydney Head and Neck Cancer Institute (SHNCI) and Australian and New Zealand Head and Neck Society (ANZHNS). He was founder of Australia's first multidisciplinary organisation for surgeons, radiation oncologists, medical oncologists and allied health professionals aiming to advance knowledge in head and neck oncology.

Professor O'Brien's key initiatives were the development of a comprehensive Head and Neck Database at the Royal Prince Alfred Hospital and the establishment of a basic sciences research program and an international fellowship programme.

He collaborated with scientists from the Departments of Anatomical Pathology, Infectious Diseases and Endocrinology, at RPAH and Sydney University to develop a basic research program; conducting research into the molecular genetics of cancer, in the field of viral oncology and the role of human papillomavirus (HPV) in mucosal squamous cell carcinoma.

Chris O'Brien has published over a hundred peer reviewed articles and has been on the editorial boards of the ANZ Journal of Surgery as well as the prestigious international journal on head and neck cancer - Head & Neck. He has contributed to 18 book chapters and developed 10 videos for surgical training in head and neck procedures. He has made over a hundred oral presentations at national and international meetings, mostly as an invited speaker.

In summary Professor Chris O'Brien has distinguished himself as an internationally renowned surgeon of eminence, an educator and researcher with the highest of surgical

and ethical standards and well worthy of the Royal Australasian College of Surgeons Award for Excellence in Surgery and deserving of his place in the history of the College.

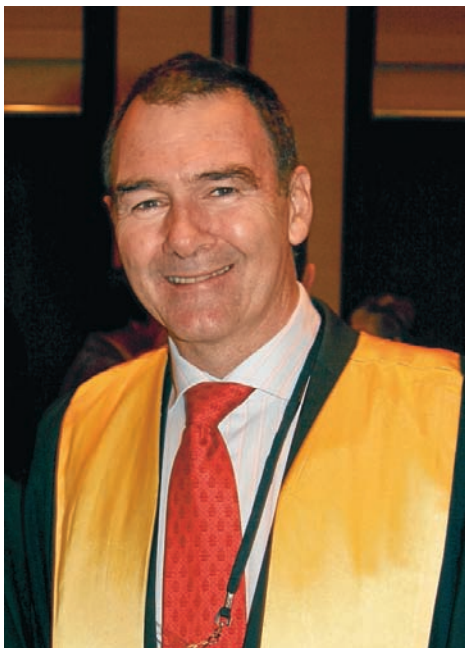
### **Professor Russell Stitz – Court of Honour**

Professor Stitz' admission to the Court of Honour is in recognition of his outstanding contributions to our College and his skills as surgical leader and statesman.

Russell Stitz was born in Queensland and educated at Ipswich Grammar School and the University of Queensland. His surgical training was at the Royal Brisbane Hospital, the Guildford District Hospitals in Surrey and St Mark's Hospital in London. He was admitted to Fellowship of this College in 1972 and the Royal College of Surgeons of England in 1974 and awarded Honorary Fellowships of the Royal College of Surgeons of Edinburgh and the College of Surgeons of Hong Kong in 2006.

He has practiced as a general surgeon specialising in colorectal surgery earning an enviable reputation as surgical leader and teacher. His extensive list of guest professorships and invited lectures attests to his national and international standing. He has been a consistent contributor to diverse organisations including the Presidencies of the Colorectal Surgical Society of Australia and the AMA Queensland Branch. He is a Colonel in the Royal Australian Army Medical Corp and has held a number of important defence posts including Commanding Officer 2nd Field Hospital and Director of Medical Services Defence Centre, Brisbane.

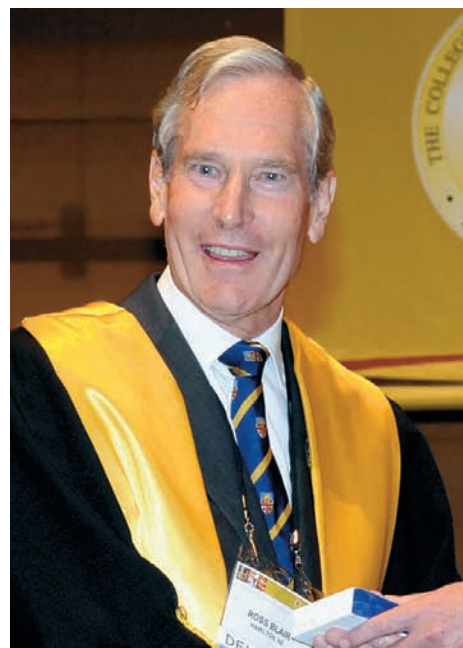
Russell Stitz was elected to the Council of this College in 1999 and has served on a number of important committees including the Professional Development and Standards Board. He demonstrated a strong commitment to effective and documented life long



Professor Chris O'Brien



Professor Russell Stitz



Mr Ross Blair

learning and under his leadership this Board became one of the principal committees of the College.

He was elected College President in 2005. He stated that his goal was not only to strengthen the role of the College in education, training and standards but also to recognise the changing nature of the College and the need to represent the Fellowship more broadly. He was successful in both of these areas.

It had become clear that the pre-fellowship education and training programs of the College not only faced a number of educational issues but were also a barrier to appropriate relationships with governments. Under Russell's leadership the College introduced radical changes resulting in its programs becoming more relevant to specialty training, more contemporary in their educational principles and able to graduate surgeons in a more timely fashion. This required the engagement of the specialist societies and a comprehensive communication strategy for Fellows and health jurisdictions. Due to his drive and enthusiasm the new Surgical Education and Training program was developed and implemented in record time.

He also introduced processes for effective and regular communication with the specialty societies and associations and the College's regional committees' recognising that the College must be aware of and respond to the views and needs of its Fellows wherever and however they practice.

By electing Russell Stitz to the Court of

Honour, Council honours his service to the College and looks forward to his ongoing advice and wise counsel.

#### **Mr Ross Blair – RACS Medal**

The RACS Medal has been awarded to Mr Blair in recognition of his singular contribution to the College. Ross Blair has been a distinguished Fellow of the College and a surgical leader in the Waikato region of New Zealand for over 30 years. He has served the College well over this period in a number of different ways.

Ross was educated at Auckland Grammar School and Otago University Medical School. He graduated MB ChB in 1965 and then did his surgical training in the Auckland Hospitals, obtaining the FRACS in 1970. After a year working in the cardiothoracic surgical unit at Green Lane Hospital, he went to the Essex County Hospital in Colchester where he spent two years obtaining additional surgical experience.

Ross was appointed as consultant thoracic and vascular surgeon, to Waikato Hospital in 1974 and remained in that position until 2003. During this period he served as Director of Vascular Surgery and Head of Surgery. He has had considerable involvement with the NZ Army Medical Corps from 1977 to 2000 culminating in his appointment as Director of Army Medical Services. In his time with the Army he reached the rank of Colonel and served in Tonga, Solomon Islands, the Gulf War and East Timor.

His increasing involvement with the College began in 1988 with his appointment to the Court of Examiners in General Surgery and his election to the New Zealand Committee, which he chaired from 1992-94. In 1998 was elected to College Council. One of his most notable achievements was chairing an inter-College committee to bring about a change in the New Zealand law relating to medical manslaughter. As the result of the efforts of that committee the threshold for a manslaughter charge to be laid is now much higher than it was previously.

As a councillor, Ross became Deputy Chairman of the Court of Examiners in 1999 and then Chairman from 2003 to 2005. He has also been Chair of the College's Fellowship Services Committee and Ethics Committee. As a vascular surgeon he has been the Senior Examiner in vascular surgery and Chairman of the Division of Vascular Surgery.

Ross has also held office as President of the NZ Association of General Surgeons, filled a number of roles within the NZ Medical Association and the Association of Salaried Medical Specialists and served on numerous committees at Waikato Hospital. Finally he had the considerable honour of being appointed as Honorary Surgeon to HM Queen Elizabeth II.

Ross has had a very distinguished career covering general surgery, vascular surgery and thoracic surgery in a clinical context and numerous RACS activities as described above. He is a worthy recipient of the RACS Medal for his service to the College in many different ways.



## In Memoriam



# Information about deceased Fellows

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

**Mr Max Ellison Minchin** WA  
**Dr Chi-Lai Charles Yau** HONG KONG  
**Mr Neville Coleman Davis** QLD  
**Mr Thomas Emanuel Antonie** VIC

We would like to notify readers that it is not the practice of Surgical News to publish obituaries. Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website <http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/Inmemoriam/default.htm>

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

## Tyco Healthcare Travelling Fellowship Grant

The Younger Fellows Committee in partnership with Tyco Healthcare, is pleased to offer two Travelling Scholarships to assist Younger Fellows who are travelling overseas in 2009 to further post Fellowship studies and diversify their surgical experiences.

The inaugural Tyco Healthcare Travelling Fellowship Grants were awarded in December 2006.

The applicant must be a Younger Fellow of the College (within ten years of gaining Fellowship) at the time of submitting their application, who is planning to travel overseas within the next 12 months to further post Fellowship studies prior to returning to Australasia to practice.

The Tyco Healthcare Travelling Fellowship Grants are each valued at AUD\$7,500.

For further information, please contact the Younger Fellows Secretariat, Glenda Webb, on +61 3 9249 1122 or email [glenda.webb@surgeons.org](mailto:glenda.webb@surgeons.org)

*Applications close 5.00pm  
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