Surgical news

Vol: 11
No:6
July
2010

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

A surgeon at war

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The College of Surgeons of Australia and New Zealand

2010 professional development workshops

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

Beating Burnout
6 August 2010, Gold Coast

Tired? Stressed? Overworked? Sometimes the demands of clinical life appear to be ever increasing and unavoidable. This afternoon workshop explores key burnout risk factors and provides practical strategies for achieving a better work/life balance given the competing demands surgeons face. You will have an opportunity to discuss important stress management issues with your peers and be introduced to proven techniques to prevent burnout.

Making Meetings More Effective
7 August 2010, Sydney

Tired of meetings that never seem achieve what you want them to? This whole day workshop helps you to understand the characteristics of effective meetings. You will develop a greater awareness of the roles and responsibilities of committee members and explore the strategies for making your meetings more productive.

AMA Impairment Guidelines Level 4/5: Difficult Cases (NEW)
19 August 2010, Sydney

The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This evening workshop provides surgeons with a forum to review their difficult cases, the problems they encountered and the steps applied to resolve the issues.

Practice Made Perfect
8 September 2010, Melbourne

This whole day workshop is a great opportunity to improve your business outcomes and develop your practice staff, giving them the tools for building strong practice processes. Learn about the six P's of sound business and practice management; purpose, planning, promotion/marketing, people, performance and problem solving.

Occupational Medicine: Factory Visit Program
Friday 12 November Melbourne / Friday 19 November Sydney 2010

There have been two industry site visits as part of the Occupational Medicine program; the Ford Assembly Plant, Victoria and the Coalmine Training Facility, NSW. Fellows have been amazed at what they have seen and learnt. Due to the enthusiastic response surgeons now have the opportunity to see other industrial sites. The program is evolving and the feedback has been used to tailor the visits to surgeons' needs. The future visits will include case studies relating to return-to-work. Please note these dates in your diary. Each visit will take about three hours with an opportunity for discussion. Combining two visits in a whole day program is to improve efficiencies and to make it worthwhile for those from further afield. Participation in the program attracts 5 CPD points per hour. The broader program has included relevant topics in medico legal, surgical conferences; the next being the forthcoming AOA/RACS conference 13 – 15 October, Gold Coast

Further Information: Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development.

professional development workshops

DATES: JULY – OCTOBER 2010

NSW
7 August Sydney
Making Meetings More Effective
12-14 August, Newcastle
Surgical Teachers Course (STC)
19 August, Sydney
AMA Impairment Guidelines Level 4/5: Difficult Cases, Sydney
11 August, Newcastle
Supervisors and Trainers for SET (SAT SET)
3 September, Sydney
Supervisors and Trainers for SET (SAT SET),

NT
19 August, Darwin
Polishing Presentation Skills,

QLD
6 August, Gold Coast
Beating Burnout,
8 August, Gold Coast
Supervisors and Trainers for SET (SAT SET),
17 September, Sanctuary Cove

SA
14 October, Adelaide
Practice Made Perfect
21-23 October, Adelaide
Surgical Teachers Course (STC)

TAS
6 August, Hobart
Supervisors and Trainers for SET (SAT SET)

VIC
16 July, Melbourne
Surgeons and Medical Administrators
30-31 July, Melbourne
From the Flight Deck
8 September, Melbourne
Practice Made Perfect
25-26 September, Melbourne
Preparation for Practice

NZ
23 July, Wellington
Mastering Difficult Clinical Interactions

WA
20 October, Perth
Supervisors and Trainers for SET (SAT SET)

Health workforce self sufficiency, an international ethical issue

We have a responsibility to ensure the countries from which foreign trained doctors come from are not irredeemably disadvantaged by the migration

Ian Civil
President

I had always thought that the health sectors of Australia and New Zealand relied too heavily on overseas countries for their health professionals, in particular nurses and medical practitioners. Over the past month this has been confirmed by the significant public profile and discussion which followed the World Health Organisation's endorsement of a code of practice governing the international recruitment of health professionals.

The WHO Global Code of Practice on the International Recruitment of Health Personnel followed six years of consultation and negotiations and reflects the pressing need to avoid the recruitment of health personnel from poor countries where there is already an acute shortage of medical staff.

Although the code is voluntary, the College is now urging the governments of Australia and New Zealand to implement measures that will ensure both countries honour its spirit. This is because our two countries have the highest proportion of foreign born doctors among Organisation for Economic Co-operation and Development (OECD) nations. A study conducted by Jean-Christophe Dumont and Pascal Zurn in 2008 found that the percentage of foreign born doctors in Australia was 43 per cent and in New Zealand was 52 per cent [1]. To be more specific about utilising health professionals who are trained in other countries, 36 per cent of active medical practitioners in New Zealand were foreign trained in 2005.

However, the coming and goings of health professionals is a complex issue. New Zealand also has the third highest and second highest expatriation rates for doctors and nurses (28.5 per cent and 23 per cent respectively). So the number of New Zealand born doctors living in other OECD countries represents half the number of foreign-born doctors in New Zealand. The number of New Zealand-born nurses living in other OECD countries is matched by the number of foreign-born nurses in New Zealand (about 7500). It is also interesting that the major direction of the emigration from New Zealand is to Australia or United Kingdom. However, the number of Australian born doctors and nurses in New Zealand is much smaller.

As the study noted[1] there is no specific immigration policy for health professionals, although the permanent and temporary routes make it relatively easy for doctors and nurses who can get their qualification recognised to immigrate to New Zealand. So it appears somewhat amazing that immigration policy for the health workforce which accounts for about 70 per cent of the cost of delivering public health services and about 5.5 per cent of the workforce overall has only recently started to be recognised in its importance.

> *"Although the code is voluntary, the College is now urging the governments of Australia and New Zealand to implement measures that will ensure both countries honour its spirit."*

The Code of Practice speaks to establishing and promoting voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel. Both Australia and New Zealand have a particular responsibility to ensure that we do not leave poor nations bereft of the ▶

2010 Joint SA, WA & NT Annual Scientific Meeting 19 – 21 August 2010 Darwin Convention Centre, NT

Registration now open

2010 marks a unique ASM.

Western Australia, South Australia & Northern Territory will hold a joint Meeting in the newly built Darwin Convention Centre, opened in June 2008 at the Darwin Waterfront Precinct.

PROGRAM OF EVENTS

Thursday 19 August 2010
Evening Welcome Function, Darwin Convention Centre

Friday 20 August 2010
Scientific Meeting, Afternoon NT Activities
Evening ASM Dinner at PeeWee's at the Point

Saturday 21 August 2010
Scientific Meeting / AGM, Afternoon NT Activities

THEMES

Pitfalls of Dealing with Indigenous Health, Trauma Response
Disenfranchised Surgeon – Where have all the Surgical Units Gone?
Distance Education – How are we going to train our Rural Surgeons?

Please ensure to book flights early to avoid disappointment!

We are holding accommodation at the following Hotels
Medina Grand Darwin Waterfront – 08 8982 9999
Vibe Hotel Darwin Waterfront – 08 8982 9998
Crowne Plaza Darwin – 08 8982 0000

51–54 Palmer Place, North Adelaide SA 5006 Australia
Postal: PO Box 44, North Adelaide SA 5006
T:+61 8 8239 1000 **F:**+61 8 8267 3069 **E:** college.sa@surgeons.org **W:** www.surgeons.org

medical expertise their people so desperately need. The Code of Practice also speaks to the obligations that are particularly owed to developing countries to ensure that international endeavours improve health systems and increase capacity and capability. This is highlighted in the area of health personnel development.

The Code of Practice strikes a balance between the rights of health personnel to move between countries and the right of source countries to benefit from their investment in the education and training of those personnel. So while we have the right to welcome these workers, and they have the right to live and work in our countries, we have an ethical responsibility to ensure the countries from which they come are not irredeemably disadvantaged by the migration. The College has had extensive outreach programs for many years and these have had particular emphasis on building capacity and involve the training of surgeons from developing countries.

The College is now in active dialogue with Health departments and Ministers of Health to recognise these issues of international importance, to designate a national authority responsible for the exchange of information on health personnel migration and the fuller implementation of the code.

1. Zurn P, Dumont J. Health Workforce and International Migration: Can New Zealand Compete? OECD Health Working Papers. Paris, France, 2008.

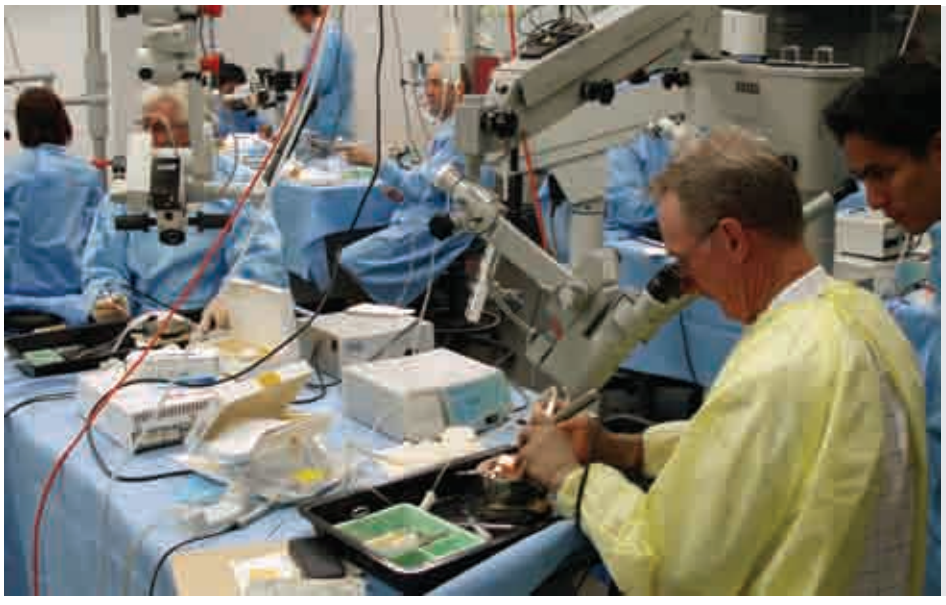
Skills & Education Centre

The lab is set up to offer a huge range of learning, practice and research opportunities

Keith Mutimer
Vice President

Anyone visiting the Melbourne office first thing in the morning will notice a hubbub of activity in reception. This isn't just the College's 120-strong local staff eagerly signing in for another day at the office, but includes some of the approximately 27,000 Fellows, Trainees, affiliates, College staff, medical professionals and other guests who attend the Victorian Skills and Education Centre each year.

One of the key functions of the College is to deliver ongoing high quality education and training for surgeons and other medical professionals at all stages of their career. To help facilitate this, the Skills and Education Centre provides a well-equipped and flexible skills training laboratory as well as a number of meeting rooms able to accommodate groups of people from two to 220 and both presents and hosts a wide range of events every year. These include advanced classes for Fellows, skills courses for surgical Trainees, workshops for specialists and Trainees from other medical Colleges, up-skilling for general practitioners, training for nurses, and workshops for other health professionals.



For those of you who have not yet visited the facility's Skills Laboratory, I recommend that you take the opportunity next time you are in the area. With eight stations serviced with water, suction, compressed air and smoke evacuators, operating microscopes, power instruments and a good range of both basic and specialised instruments, the lab is set up to offer a huge range of learning, practice and research opportunities using human cadaveric material, animal tissue, simulators, and other models.

Headed by clinical director Mr Donald Murphy, the lab benefits from experienced staff who use both ingenuity and skill to prepare a range of models from a variety of animal and synthetic materials. Request a visit to the prep room and you will find anything from anal pustules made from toothpaste and latex gloves implanted into chicken portions, skin for suturing made from wetsuits, partially de-seeded rock melons for laparoscopic removal of nodules, latex and tennis ball constructions for the removal of kidney ▶

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

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

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

ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd.
ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

stones, to chicken thighs supplied with pumping blood for practising microsuturing under magnification ... but maybe I shouldn't give away too many of their secrets.

This impressive range of models is used not only to provide a safe and realistic opportunity to learn and become skilled in already well-established surgical practices, but also to facilitate the research and evaluation of new techniques – another of the College's aims. The Skills Laboratory regularly opens its doors to surgeons and companies wishing to trial new techniques and works with them where requested to develop new training models. A couple of the more recent examples include sessions to investigate the placement of new-generation cochlear implants, and to develop an innovative model for training in new ultrasound-guided anaesthetic delivery systems for chronic pain relief. Skills Laboratory staff also work closely with companies to provide opportunities for practitioners to receive demonstrations and to experiment with new equipment and devices as they are released to the market.

Smoke evacuators

One of this year's improvements to the Skills Laboratory facility has been the purchase of surgical smoke evacuation systems for each station. These units remove smoke generated during surgical procedures where electrosurgery is used for dissection and haemostasis. The obvious benefits of this development are that the unpleasant smell of burning tissue will be reduced and visibility improved by removing smoke from the area. However, we also hope that the smoke evacuators will significantly reduce potential health risks for course participants and encourage awareness of the issue. Research into the long-term effects of surgical smoke has compared a single inhalation of surgical smoke to three puffs from a filtered cigarette, and equated the smoke from one gram of tissue to that from six cigarettes.

The Skills and Education Centre is also currently host to the Melbourne arm of the Simulated Surgical Skills Program (SSSP). Running until August 2010, the Commonwealth-funded trial is investigating both the use of surgical simulators as effective laparoscopic skills training methods, and the effect of fatigue on skill levels. Volunteers are randomly assigned to either a Fundamentals of Laparoscopic Surgery (FLS) low-fidelity simulator of a high-fidelity virtual-reality simulator (LapSim). Once a standard of proficiency has been achieved on their assigned simulator, volunteers are required to take a fatigue test as soon as possible after a minimum 10-hour hospital shift. Everyone benefits from this program as volunteers have the opportunity to enhance their laparoscopic surgical skills in a safe environment while the College gathers invaluable data which may be used to help address important curriculum and workforce issues.

There is no doubt that the Skills and Education Centre offers excellent facilities and access to cutting-edge equipment and effective models, but I believe that its major strength is, of course, the people involved. Participants regularly comment in their workshop evaluations on the practical, friendly and down-to-earth approach from presenters and staff and this is where we need you.

"There is no doubt that the Skills and Education Centre offers excellent facilities and access to cutting-edge equipment and effective models, but I believe that its major strength is, of course, the people involved."

I urge Fellows to contact either Donald Murphy or the Skills and Education Centre manager David Lawrence if they are willing to present at an existing workshop. We are particularly interested to hear from anyone with ideas for a new workshop. At the moment some specialties are represented far more than others and Don and David are keen to ensure that the College meets the changing training needs of Fellows and Trainees in every specialty. Details of courses and workshops are regularly disseminated and available through the usual College channels.

Please take the time to have a look and call David on +61 3 9276 7455 or david.lawrence@surgeons.org to discuss your involvement in any way or to arrange a visit.

Covering the costs to run the College

As I recall the Battle of Waterloo at which Napoleon met …

I.M.A Newfellow

I found that I have a sister a few weeks ago that I did not know that I had. Now I do have a sister in the usual sense of the word – a female sibling with whom I grew up, someone to fight with, argue with and ultimately love.

But this sister is different. I have been vaguely aware of her existence for many years, but never really met her. Before you jump to the wrong conclusion may I say that I am not referring to one of my parents' illicit liaisons. She lives overseas and is older than me, but has similar ideas and problems. In fact all the Fellows of the College have this older sister. She is the Royal College of Surgeons (RCS) of Edinburgh.

I had the pleasure of visiting the marvellous old city of Edinburgh and stumbled across the College in Nicolson Street, Edinburgh. I was actually looking for a hotel called 10 Hill Place, which surprisingly has as its address 10 Hill Place (those Scots are so precise – Mr Nitpicker would love them). I will say more about the hotel later.

I noticed a sign to a surgical museum and wandered in after paying my five pounds admission to find that I was in the museum of the RCS Edinburgh. It was a marvellous museum with all sorts of specimens and displays. One series of displays that intrigued me were paintings of wounded soldiers from the Napoleonic wars. As I recall the Battle of Waterloo at which Napoleon met his, well, Waterloo was 1815 so these paintings are pretty old. The poor soldiers all look suitably miserable with nasty wounds of their limbs. In a cabinet next to the painting were the bones of the amputated limb usually with a musket ball embedded – no wonder the soldiers looked miserable. I guess this was the earliest attempt at a PowerPoint presentation. I explained about the collection of casts of World War II facial injuries in our museum and the Librarian, Ms Marianne Smith, who kindly showed me around displayed polite interest.

Our sister College also has similar characteristics to our own College. They have to deal with governments, they run courses, they hold examinations, they have an elected Council and numerous sub-committees, they have "difficult" sub-specialty societies, they have a heritage listed building (about 100 years older than ours) and lots of paintings of the Councillors. Many Fellows may be aware that one of the traditions of the College is to commission a painting of the President when he or she demits office. I assume that the cost is covered by the College. Now I noticed that the thrifty

View of Edinburgh

Scots have a much better method than us. About 300 years ago they commissioned paintings of many prominent Councillors, but the Councillors had to pay for their own portraits. Now I think we could do that and also charge a fee for wall space when the painting is hung. As we surgeons are a somewhat "not quite so humble" bunch and I think that we would be overwhelmed with potential portraits and make a lot of money.

Now back to 10 Hill Place. This is a hotel owned by the College and run as a normal hotel, but Fellows of the Edinburgh College get a special rate. This idea appeals to me. At the next Council meeting I shall propose a motion that the College put an offer in for the Windsor Hotel on Spring Street. Then we could all stay there at reduced rates for the football and cricket. What do you think of that?

Report Card on Surgical Education

Of deep concern to most of the specialties was the level of experience of new Trainees

Brett McClelland
Education Portfolio Chair, RACSTA

After two exciting years, the College recently held a two-day workshop to review the implementation and success of the new Surgical Education and Training (SET) Program. The attendees represented all of the surgical specialties, executive members and representatives from the jurisdictions. The Trainee body was also represented and invited to make a submission through the Royal Australasian College of Surgeons Trainees Association (RACSTA).

There was enthusiastic debate with equal lashings of criticism and praise. Some common threads were identified across most of the specialties, and there was a seldom-appreciated insight into the jurisdictional perspectives on workforce allocation and clinical services. Smaller groups tackled reviewing the selection process, progression through the program and examinations.

A common thread through the workshop was the essential requirement for a robust, comprehensive and thorough assessment process to evaluate a Trainee's performance in each term. A core strength of the SET Program was the transition from a 'time-based' system to a 'competency-based' program. In order for this to work, we need to be confident that we have valid tools in place to assess the nine recognised College core competencies, and that these are reproducible across all training areas.

The new SET Program has certainly seen an increase in the number of Trainees receiving 'red flags', being placed on probation for inadequate performance, or indeed, being removed from their training programs entirely. This situation certainly prompts one to ask if indeed we have a change in the Trainees, or a change in the system.

The Trainee body raised the important issue of flexible training. In the recent RACSTA survey, only 0.3 per cent of respondents were currently working part time, however, when asked about interest in flexible training 33.8 per cent expressed an interest in less than full-time training. This is clearly an area where the College will need to focus some attention in order to facilitate easier access to part-time training, job sharing and deferment for academic or other reasons.

One of the areas to which Trainee's are often oblivious is the extra demand in terms of teaching time, paperwork, and supervision that are placed on our trainers. The new SET Program has certainly seen an increase in the number of forms, assessments and reviews of the Trainees that need to be completed by supervisors. There are also increasing numbers of Trainees, amplifying the burden on those passionate about education and training. The College is mindful of trainer fatigue and is endeavouring to limit this burden on the Fellowship.

Of deep concern to most of the specialties was the level of experience of new Trainees. Spirited debate revolved around the appropriate first year of application to the SET Program. Allowing junior doctors in their second postgraduate year (PGY) to apply has meant that Trainees can be selected with very little if any experience in their specialty, and certainly no Registrar experience. Having said that, the hard data shows that only 17 per cent of newly selected SET 1 Trainees were accepted from the PGY 2 cohort. Indeed the median Trainee was selected from PGY 4.

In any case, many of the specialties now feel they are increasingly needing to provide basic surgical skills to less experienced Trainees, rather than focusing solely on specialty specific skills. However, one can ask who has been teaching the Trainees these skills in the past, for it must surely be a surgeon in some specialty, and is he or she glad to no longer be burdened with the education of the entire Trainee population?

Overall, the workshop was a productive event, with several promising proposals tabled for review by the Board of Surgical Education and Training. As Trainees from the old Basic Surgical Training/Specialist Surgical Training system are still progressing through to Fellowship, we have not seen the 'finished product' of the SET program. The questions of adequate graduating surgical experience can not yet be answered, but with a system in place for regular review of the SET Program by all involved parties, any fine tuning required will be promptly recognised and managed accordingly.

Queen's Birthday Honours 2010

AUSTRALIA

Member (AM) in the General Division
Dr Herbert Edward Clifford AM
Associate Professor Robert Anthony MacMahon AM

Medal (OAM) in the General Division
Dr Sadanand Nagesharao Anavekar OAM
Dr Frederick Hugh Bartholomeusz RFD OAM
Dr John Royston Crellin OAM
Mr John Dixon Hughes OAM

NEW ZEALAND

Officer of the NZ Order of Merit (ONZM):
Dr Leona Fay Wilson ONZM
(former ANZCA Council representative)
Member of the NZ Order of Merit (MNZM):
Mr John Cameron Cullen MNZM

congratulations

GSA ANNUAL SCIENTIFIC MEETING AND TRAINEES' DAY

Emergency Surgery: The Cutting Edge

17-19 September 2010

Hyatt Regency Sanctuary Cove, Gold Coast, QLD

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General Surgeons Australia

Head & Neck 2010

Register online: www.anzhns.org

Australian and New Zealand Head and Neck Cancer Society
12th Annual Scientific Meeting
2-4 September 2010
Novotel Sydney
Manly Pacific
Manly, NSW

MERCK SERONO

College Conferences and Events Management

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

ANNUAL SCIENTIFIC CONGRESS
ADELAIDE CONVENTION CENTRE, ADELAIDE, AUSTRALIA
2 – 6 MAY 2011

Royal Australasian College of Surgeons

UNITY THROUGH DIVERSITY 80 years of the ASC

46TH ANNUAL SCIENTIFIC CONFERENCE

PROVINCIAL SURGEONS OF AUSTRALIA

1-4 SEPTEMBER 2010
CABLE BEACH, BROOME
WESTERN AUSTRALIA

"WORK – LIFE BALANCE"

Conference Convener **Mr Andrew Thompson**

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NOVARTIS ONCOLOGY

Recognition of Prior Learning

RPL is available to Trainees once they commence the Surgical Education and Training Program

Simon Williams
Chair, Board of Surgical Education & Training

While the Surgical Education and Training (SET) program is open to applications from doctors who are in their second post graduate year (PGY2) of medical practice, a growing number of applicants are from later post graduate years. Those who are then successful in getting onto SET, will commence the program with prior experience that may replicate elements of the training program.

The College has therefore implemented a Recognition of Prior Learning (RPL) Policy available to all Trainees once they commence the SET program. This policy enables Trainees to make an application to the relevant board or committee seeking exemption from SET courses or rotations where they can demonstrate that they have undertaken equivalent activities.

While the relevant Specialty Training Board manages Trainees, that board is not solely responsible for the delivery of all training. Within the College governance structure there are committees that are responsible for the delivery of skills courses. Consequently Trainees seeking exemption from the Early Management of Severe Trauma (EMST), Australian and New Zealand Surgical Skills Education and Training (ASSET), Care of the Critically Ill Surgical Patient (CCrISP) or Critical Literature Evaluation and Research (CLEAR) courses are required to apply for RPL directly to those committees. Should the committee consider the course previously undertaken by a Trainee to be equivalent, it will advise the Trainee accordingly, as well as the governing Specialty Training Board.

Specialty Training Boards do have responsibility for assessing applications for exemption from surgical rotations. When applying for RPL for rotations, applicants are required to demonstrate how that experience, which must have been undertaken in the previous five years, has contributed to the acquisition of College competencies. In assessing the application, Boards will request a retrospective assessment report from the supervising clinicians.

Should an application be granted this would lead to a shortening of the published minimum duration of the training program (subject to the satisfactory completion of all other requirements of the program). The period of exemption is at the discretion of the Board, and may not equate to the period assessed for RPL.

There is, however, one area of the College SET program that cannot be exempted due to RPL and that is College examinations. College examinations are aligned specifically to the curriculum of the training program undertaken. For this reason it is not possible to recognise examinations from other training programs (such as those of the British Colleges) as they are not aligned to our programs.

Should Trainees require further information regarding recognition of prior learning please refer to the policy on the College website under Surgical Education and Training, or contact the Surgical Training Department at the College SETenquiries@surgeons.org

Privacy laws

Family history and genetic information and the potential for conflict

Michael Gorton
College Solicitor

Since the introduction of privacy laws there has been the potential for conflict between the requirements of the privacy legislation and the usual practice of doctors taking family histories, which involve the collection of health and social information of other family members and third parties. Sound medical practice may require obtaining information about the medical, social and family history of others. In addition, expansion of access to genetic information means doctors acquire information of potential health consequences for other family members.

In particular, there is contemporary concern regarding the disclosure of genetic information of family members and third parties. Breaches of genetic privacy raise the possibility of discrimination and denial of insurance or increased insurance premiums.

These issues have been addressed by the Federal Privacy Commissioner and the National Health and Medical Research Council (NHMRC) in guidelines.

Collection:

The guidelines, in general terms, exempt doctors from complying with the requirement to obtain the consent of third parties, before collecting information regarding them and their medical, social and family history.

The guidelines permit a doctor to collect health information from a patient about a third party, without the third parties consent, if:-

- the collection of the social, family or medical history is necessary for the treatment of the patient; and
- the information is relevant to the family, social or medical history of the patient.

Where information is collected regarding third parties (including family members) under this exemption, doctors are still required to otherwise observe the privacy protections required under privacy legislation. That is, the information should still only be used for the purpose for which it was collected (treatment of the patient). It should not otherwise be unlawfully disclosed and the information should be stored in a secure and confidential manner.

The question arises as to whether a third party can, using access rights under privacy legislation, require a copy of the information from the doctor - even though the third party is not the patient of the doctor. The doctor will still be holding medical, social and other information in relation to the third party, and, theoretically, is therefore accessible by the third party by request. However, the doctor could refuse to disclose the information held and refuse access to the third party, where to do so would infringe the confidentiality of the existing patient, or otherwise have negative or adverse consequences.

Disclosure:

The guidelines also provide for disclosure of genetic information to genetic relatives without the consent of the patient in certain circumstances. These:

- allow use or disclosure of a patient's genetic information, without the patient's consent, in circumstances when there is reasonable belief that disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of his or her genetic relatives;
- apply to private sector organisations that have obtained genetic information in the course of providing health services to individuals (these include private medical practices, pathology services, private hospitals) and their employees;
- apply only to genetic information concerning a living person that was collected by an organisation on or after 21 December 2001;
- does not apply to situations concerning genetic information that presents a serious threat to an unborn child

Disclosure without consent has the potential to cause distress. Appropriately, managing the patient in such situations is considered an integral part of duty of care and good practice.

The Guidelines establish when, by whom and in what manner, use or disclosure of genetic information may take place without patient consent, and provides for disclosure when there is:

- a serious threat to life, health or safety of a genetic relative;
- the use or disclosure is necessary to lessen or prevent that threat.

As disclosure without consent represents a significant departure from normal practice and is only permissible in certain circumstances, medical practitioners may wish to consult their medical defence organisation before authorising disclosure.

For further information: Privacy Commission – www.privacy.gov.au

ASERNIP-S review

Enhanced recovery after surgery – what is the evidence?

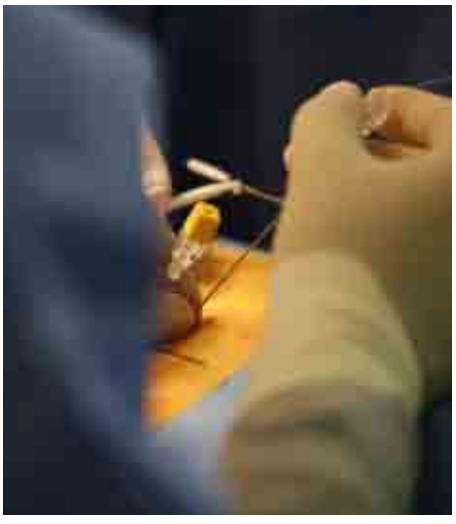
Guy Maddern
ASERNIP-S Surgical Director

Recent evidence-based studies investigating the effects of conventional surgical care show that many traditional approaches, such as preoperative bowel clearance, the use of nasogastric tubes, drains placed in cavities, enforced bed rest, and the use of graduated diets are unnecessary or even harmful. Enhanced recovery after surgery (ERAS), also called fast-track surgery, multimodal or optimised surgery originated with Henrik Kehlet in Denmark in the 1990s, and is now being taken up worldwide. Various strategies are involved to facilitate better conditions for surgery and recovery in an effort to achieve faster discharge from hospital and more rapid resumption of normal activities after both major and minor surgical procedures, without an increase in complications or readmissions. The main purpose of this multimodal approach is to reduce psychological and physiological stresses associated with surgical illness.

Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) undertook a rapid systematic review to assess the safety and efficacy of ERAS programs on patient outcomes. This included a comprehensive literature search to identify randomised controlled trials (RCTs). Semi-structured telephone interviews were also conducted with specialists participating in this field, identified through publically-available data sources. This was undertaken to add expertise and local context to the review.

Eleven RCTs were retrieved which reported a total of 573 patients across a range of interventions. Each study had relatively low patient numbers. The most common specialties were colorectal (four studies) and orthopaedic (two studies). Baseline patient demographics such as age and disease severity were relatively broad throughout. All studies were conducted in single centres and were published between 2003 and 2008. One systematic review and one consensus guideline were also retrieved.

In terms of the RCTs, common elements



of the ERAS programs included allowing feeding up to two hours before surgery, early nutrition after surgery, early mobilisation, and clear discharge criteria. Other elements utilised by some of the trials included formal patient information or counselling, no bowel preparation, avoidance of opioids, prevention of hypothermia, high oxygen concentrations, prophylactic antibiotics, epidural anaesthesia, no nasogastric tubes and no drains.

For certain outcomes (length of hospital stay, mobilisation and time out of bed and gut function), a significant improvement was reported in the optimised patient group in all but one study. For pain and pain relief, most studies reported no significant differences between the two groups, although some studies reported improvement in the optimised group at certain times after surgery. Readmission rates varied between studies. Only one study reported a significant difference which was in favour of optimisation. Quality of life and patient satisfaction measures were rarely reported.

What were the results?

Safety and adverse events were reported by all 11 studies. Two studies reported improvements in the optimised group. In all other studies outcomes were similar between both groups, or no statistical analysis was performed.

There was considerable heterogeneity between the studies across many issues including indications, types of surgery (laparoscopic or open procedures), discharge criteria, and outcome measures. The actual elements used in the ERAS programs differed between surgical units, but shared many common features. However, overall it seems that optimising conditions before, during and after surgery can reduce the length of hospital stay for patients with no increase in readmission rates. Importantly, there appeared to be little difference between ERAS and conventionally-treated patients suggesting that optimised protocols are safe. The results of the literature review in general matched the opinions of the local experts.

There is currently no consensus on a defined protocol for fast-track surgery for different indications. Many surgical centres have adopted, or are in the process of adopting, some elements of optimised surgery. Further research would be beneficial to define the essential elements of an optimised protocol; to establish the indications and patient populations that will most greatly benefit from optimised surgery; to define the actual improvements of optimised over conventional surgery; to determine whether there are long-term implications for patients; to determine whether there is any shift in the burden of health care beyond the hospital setting; and to determine the cost-effectiveness of implementing an optimised program (which should consider staff training costs).

The complete review was commissioned by the Victorian Department of Human Services and is available in through the ASERNIP-S website: www.surgeons.org/asernip-s

For further information please contact Professor Guy Maddern or Dr Alun Cameron at ASERNIP-S (+61 8) 8363 7513 or asernips@surgeons.org

This topic was the subject of a poster presentation at the Health Technology Assessment International (HTAi) annual meeting in Dublin (June 6-9, 2010). Reproduced with permission of the Victorian Minister for Health.

Poison'd Chalice

"the fool thinks himself to be wise, but the wise man knows himself to be a fool" – William Shakespeare (Measure for Measure)

Professor U.R. Kidding

I was now well into a discussion with the senior Trainee on the unit... Last year it had been the junior consultant on the Orthopaedic unit... The story was starting to have a familiar ring and the discussion was not going well.

There was no doubt they "knew their stuff". Sometimes described as quirky, but lacking tact in team based activities... They had progressed through their medical training and then specialist surgical training as if they had been on tram tracks - one way and straight ahead. It was when they were needed to respect other people in the clinical team, go that extra bit for the more challenging patients and their families that the wheels became wobbly, not that they noticed.

It is becoming more apparent to me that righteous conviction of one's brilliance and infallibility is the province of the breath-takingly arrogant. It is something of a shame that it is also the hallmark of the below par performer.

My tactic in the discussion had been to hold up a "mirror" for the Trainee to reflect on his actions and behaviour. But all he could see was the reflection of a "great surgeon to be". Though the complaints about him were many and varied, his innate denial was up to the challenge. I was a bit stunned. Most people acknowledge that they have "stepped over the mark", "need to apologise" or "not get so stressed". I have discovered that this takes a key ingredient called insight. There needs to be acknowledgement of an issue to address.

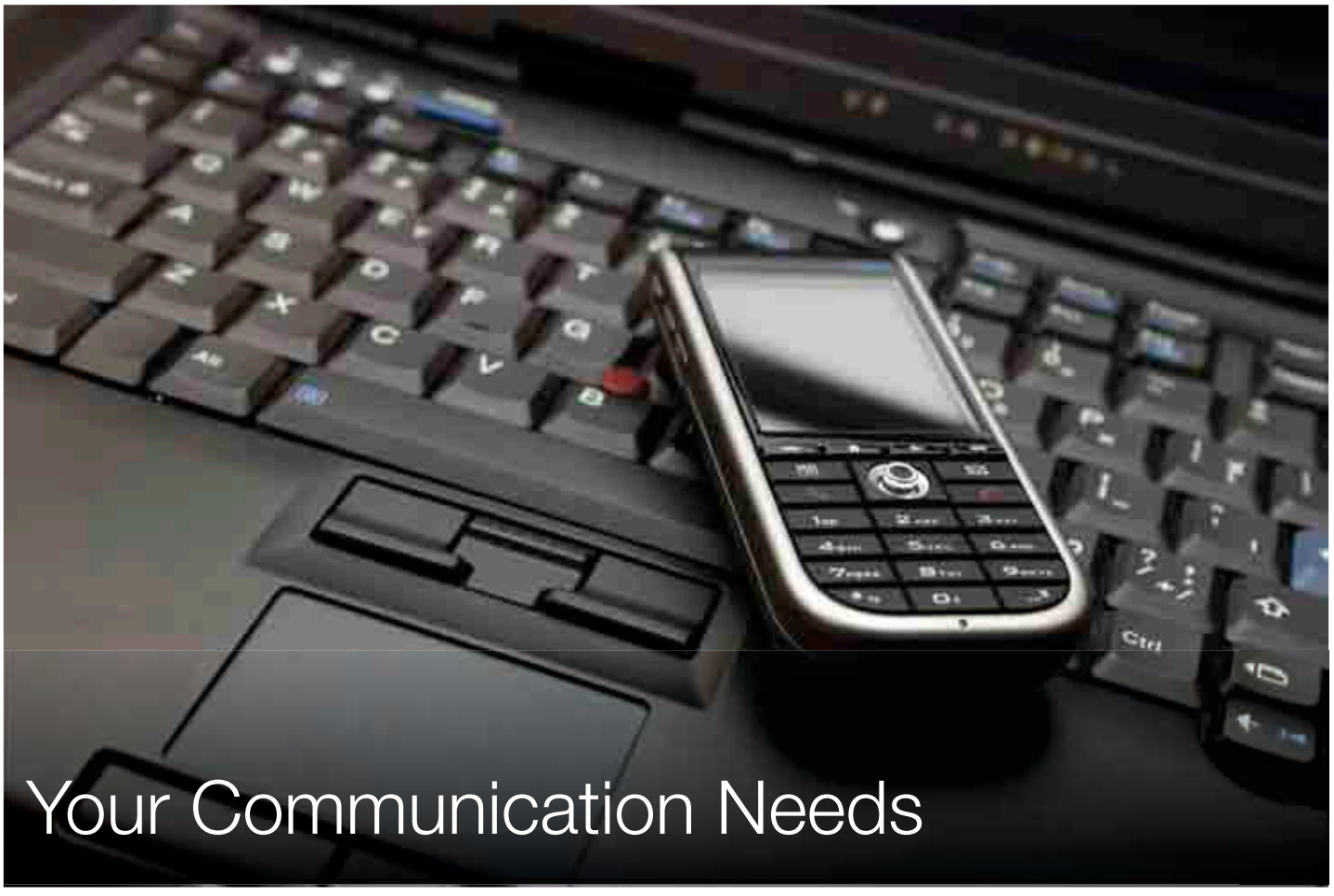
I tried a different tack – "why would so many people be complaining about his behaviour and actions?" There was a hesitation. ("Ah" I thought, "a breakthrough".) But no - I should have anticipated his answer – "jealousy!"

Without introspection and an ability to see the inner nature of things our innate narcissism appears to overwhelm us, our hubris becomes unchecked and the confidence required to undertake our key clinical roles become a liability. We assume that we can be "all-wisdom". As surgeons, and Trainees, we are at great risk. We all have complications, we all do patients harm. It takes a special kind of courage to be able to get up the next day and take the risk again, but it takes even greater courage to face the truth about ourselves, that we are fallible. The courage to reflect on our failures and inadequacies may lead to self-improvement, but it also risks inertia and withdrawal. The strength to balance rationalisation with realisation is hard to achieve and must be learned.

I felt that I was failing. I was about to resort to outright admonishment and to create rigid parameters of behaviour when I remembered the Annual Scientific Congress in Perth and listening to Linda de Cossart talk about her academic activities in developing the wise doctor. Now what would she have done? Context and reflection would be so important. Should I ask this Trainee to write up the team based clinical care of this patient and their key role in that, impediments to other team members performing at their best? Perhaps we should both commit to meeting regularly to discuss the importance of working within clinical teams. Hopefully I can trigger this most important attribute of insight.

It was a struggle. Firstly with my inner demons of identifying the right techniques to ensure the Trainee advanced in his understanding of this important area. They did not teach me about this in the "School for Surgical Directors", and secondly to highlight to the Trainee the absolute importance of getting this area right. So often these areas are thought of as peripheral, but they can leave professional careers as well as personal relationships in tatters and patients traumatised.

We both agreed to meet next week. Hopefully I will be able to catch up on techniques for advancing this area and the Trainee will have carefully thought through the issues of supportive team work and developing clinical teams. It might be a start...



Your Communication Needs

More than 1000 responses help determine future for appropriate communications

Graeme Campbell
Chair, Fellowship Services Committee
Chair, Communications Working Party

Thank you to everyone who took the time to respond to the Your Communication Needs survey which was run under the auspices of the College's Communications Working Party (CWP). The survey ran from March 12 - April 12. It was available online and print copies were sent out with March *Surgical News*. There were 1,071 responses and 80 per cent of these were completed online. Of the respondents, 76 per cent were Fellows, 20 per cent Trainees and four per cent International Medical Graduates.

Email, print or SMS?

The survey asked whether people preferred to receive various communications from the College as email, print or SMS. There was a strong preference for email communications over print for general notices, Council Highlights, Regional newsletters, confirmation of College records and events notification, however, most respondents preferred to receive billing information in hard copy. The preference for *Surgical News* format was 55 per cent electronic and 45 per cent print. There was limited interest in SMS

Web based networking?

Fellows and Trainees indicated strong interest in professional networking, special interest group discussions and mentoring via a secure College based facility. A secure College product was strongly preferred to any of the commercial products such as Facebook and LinkedIn. Most respondents were not interested in social networking.

College email account?

Fifty one per cent of respondents were interesting in having a College email account.

E-learning?

The survey responses showed very strong interest in a range of online learning activities. This question offered the opportunity to comment and over 100 free text comments were received. These comments will be very helpful in the development of the College's e-learning program.

Smart phone applications?

There was significant interest in accessing smart phone applications for specific aspects of the website such as the Online Library (MIMS, Medline, key journals), for Logbooks/ audit and online learning activities such as MCQs. Trainees were especially interested in the convenience and portability of being able to access information and training requirements via their phones. This question also offered a comments box facility and over 80 free text comments were received.

Preferred technical design level?

Most respondents considered their skill in using educational technologies to be at an intermediate level. As the College's website, and e-learning resources are redesigned to provide more contemporary features, they will be developed for the intermediate skill level user, rather than basic or advanced users.

Next steps

As requested by Council, the CWP will be making recommendations for appropriate communication technologies to the October meeting of Professional Development and Standards Board and Council.

Please contact CWP Secretariat Anne Casey by phone +61 3 9249 1272 or email to anne.casey@surgeons.org for information. Comments or suggestions are welcome.

Happy 3rd Birthday

The SAT SET course has reached over 1200 Fellows in both Australia and New Zealand

Bruce Waxman, Chair &
Jeff Hamdorf, SAT SET Committee

It was time to blow out the candles in April when the Supervisors and Trainers for the Surgical Education and Training (SAT SET) course celebrated its 3rd birthday

What's happened in three years?

This course was developed to assist surgeons, in Australia and New Zealand, either supervisors or trainers, with the transition to the new (SET) framework and aims to enable them to effectively fulfil the responsibilities of their very important roles.

The focus of the course is on the effective use of the new workplace assessment tools unique to SET, such as the Mini Clinical Examination (Mini CEX) and Direct Observation of Procedural Skills (DOPS) and as importantly it offers an opportunity for Supervisors and Trainers to explore strategies to improve the performance management of Trainees, especially those that are underperforming. What's more, the course is also an excellent opportunity to gain an insight into the College's policies and processes; including legal requirements and the appeals process.

The SAT SET course has been popular and attendance has rapidly increased since its launch in 2007. In its first year 230 Fellows attended, 320 participated in 2008 and a huge 450 in 2009. Today the SAT SET course has reached over 1200 Fellows in both Australia and New Zealand.

At the Workshop to review SET held in Melbourne in April 2010, the importance of surgeons having some form of recognised training, who assess SET Trainees was emphasised. The need for all surgeons working with SET Trainees to complete a SAT SET course will increase as SET evolves.

Has SAT SET achieved behavioural change with surgeons?

Recently a survey of SAT SET participants was undertaken on behalf of the College with the aim of assessing whether participation at the SAT SET course translated into behavioural change in surgical trainers and supervisors.

Out of the 943 surgeons who had completed a SAT SET course at that time, 332 completed the survey representing a response rate of 35 per cent. Most respondents thought the course was well designed, easy to follow and met its objectives. As a result of completing the course, a clear majority felt more comfortable with the use of the new in-training assessment tools and were confident that they had a more structured approach to analyse their Trainees' performance. More importantly, most indicated their roles as supervisors had been improved by attending the SAT SET course.

In addition, informal feedback to Trainees was said to have increased although structured feedback rates remain low. In regards to fears of an increased workload, most respondents said that this had not occurred and just under half of the respondents considered that objective assessment of Trainees had improved without fear of legal implications.

Conclusions were that the SAT SET course has been well received and has better informed surgeons about their roles and resulted in an appreciable positive behavioural change in their practices as supervisors and trainers.

The success of SAT SET has been a team effort combining College staff and Fellows, who took the challenge and made the commitment. We give special thanks to Fellows on our committee; Robert Rae, Jeff Hamdorf, Fiona Lee, Marianne Vonau, Mellick Chehade, Sharon English, Jenepher Martin and Bruce Waxman.
For more information contact pdactivities@surgeons.org

Foundation for Surgery Research Scholarship

The Scholarship has helped Dr Arul Bala sharpen his research and analytical skills

The 2009 recipient of the Foundation for Surgery Research Scholarship, Dr Arul Bala, has used the attached funding to further scientific understanding of the workings of a region in the brain known as the zona incerta. Working under the supervision of Professor Chris Lind, a world leader in deep brain stimulation, Dr Bala designed and conducted studies to investigate the effects of electrical stimulation to the area located in the brain stem.

Until recently, patients with disorders such as Parkinson's Disease have been treated with deep brain stimulation to the subthalamic nucleus located in the mid brain and brain stem. However, work by surgeons and researchers in Bristol in the UK suggested such therapy could be more successful if electrodes were placed further back in the zona incerta.

The work now being done by Dr Bala and his supervisors at the Sir Charles Gairdner Hospital in Perth makes it only the second such centre in the world investigating the role of this region of the brain.

He said the research not only indicated an improvement in the tremors experienced by patients with Parkinson's Disease, but also that the zona incerta was linked to the system controlling horizontal saccadic eye movement.

"The most rewarding aspect of this research is not only successfully treating patients, but having the opportunity to conduct purely physiological research into an area of the brain that is little understood. After the electrodes are put in place we can then use different levels of electrical charge to see what impact it has on patients," Dr Bala said.

"We have undertaken such tests to see the effects on balance, posture, gait and brain metabolism via PET scans to not only make sure there are no side effects to using the new target, but to better understand the role played by this region of the brain.

"The patients don't feel any difference with such low voltage stimulation yet it gives us a wonderful opportunity to further finesse deep brain stimulation therapy and broaden our knowledge of the working of the brain. To find that the zona incerta controls horizontal eye movement was one such discovery."

Dr Bala is undertaking his research as part of a Masters of Medical Science Degree, which he hopes to have finished in March next year. He has worked under the supervision of Professor Lind and fellow neurosurgeon Professor Neville Knuckey and neurologist Professor Mastaglia.

In the process now of writing up to eight papers for publication on the varied findings of the research, Dr Bala said the team was still collecting more data on the effects of targeting the new brain region.

"We are conducting this research out of the Australian Neuromuscular Institute which is attached to the Sir Charles Gairdner Hospital and affiliated with the University of Western Australia," he said.

"We have a movement clinic within the Institute through which we are recruiting patients for this therapy and finding out all we can about the severity of their tremors, the effects on their gait, their quality of life and depression. We are then conducting the deep brain stimulation therapy and then doing follow up analysis over two years to compare if the new target provides better outcomes which are durable."

"The real value in such research is having the time to sit and think about the science behind your work, which you just don't have the opportunity to do in clinical practice."

Dr Bala said the work being done out of the Institute looking at the basic physiology of the brain region now being explored was the only research of its kind currently being conducted in the world.

"Not only are we working with a new target here, we are using a new technique in which patients can now be under general anaesthetic rather than having to remain awake through the procedure via the use of MRI to accurately place the electrodes," he said.

"It is very exciting medicine because we have been able to reduce the tremors of patient's with Parkinson's Disease by up to 90 per cent."

Mr Bala has recently passed his neurosurgery exam and is now back in a clinical role within the hospital. He thanked the College for the support offered through the scholarship which carries a $55,000 stipend and $5000 in departmental maintenance.

"The real value in such research is having the time to sit and think about the science behind your work, which you just don't have the opportunity to do in clinical practice," he said.

"It allows you to sharpen your research skills, your analytical skills in reading papers and collecting data, understanding how to conduct randomised and blinded studies as well as providing a better grasp of statistical analysis.

"We have already had one paper accepted for publication in the journal Neurosurgery and expect others to follow." - *High Frequency Pallidal Stimulation for Camptocormia in Parkinson's Disease (Thani N, Bala A, Lind C.)*

With Karen Murphy

Surgical research opportunities at The University of Auckland

Research Topics in Surgery

The Department of Surgery at The University of Auckland in partnership with New Zealand's largest private surgical facility, MercyAscot, offers a range of excellent opportunities for fulltime research in 2011 and beyond. Research can be towards a Masters, MD or PhD degree.

Available projects include:

- Mapping and modelling the human stomach in health and disease
  Prof. Andrew Pullan and Prof. John A. Windsor
- Modelling human gait
  A/Prof. Susan Stott and Dr. Katja Oberhofer
- Profiling mitochondrial function in major surgery
  Prof. John A. Windsor and Dr. Anthony Phillips
- Perioperative care in colorectal surgery
  A/Prof. Andrew Hill
- Immunohistochemical analysis of the inflammatory response in normal and diseased sinonasal mucosa
  Dr. Richard Douglas and Prof. John Fraser
- Circulatory and renal regulation during surgery
  Dr. Mattias Soop
- Mesenteric lymph targeted therapy in acute pancreatitis
  Prof. John A. Windsor and Dr. Anthony Phillips
- Role of probiotics in liver transplantation
  A/Prof. Lindsay Plank and Prof. John McCall
- Immunophenotype of hepatic antigen presenting cells
  Dr. Adam Bartlett, Dr. Anthony Phillips and A/Prof. Rod Dunbar
- Managing bowel obstruction in the oncology patient
  A/Prof. Ian Bissett
- Health and wellbeing in junior doctors
  A/Prof. Andrew Hill
- The roles of the X-protein and HCV core protein in carcinogenesis induced by the Hepatitis B and C viruses
  A/Prof. Geoff Krissansen and A/Prof. Jonathan Koea
- The role of exercise in surgery
  Dr. Mattias Soop
- Clinical training in virtual worlds
  Dr. Scott Diener and Prof. John A. Windsor

The Department will be offering three Lecturer in Surgery positions in 2011 and a number of Scholarship positions in partnership with MercyAscot.

To discuss these world-class opportunities at New Zealand's leading university, please contact:

Scott Aitken
s.aitken@auckland.ac.nz
+64 9 923 6929
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MercyAscot

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Attendees

Another home run for academic surgery

Every surgeon can and should be an academic surgeon

Richard Hanney
Convenor, Developing a Career in Academic Surgery

The day preceding the Perth Annual Scientific Congress (ASC) in May saw a wonderfully successful follow-up to last year's inaugural Developing a Career in Academic Surgery (DCAS) course, once more jointly convened by the Section of Academic Surgery of the College and the Association for Academic Surgery (AAS). The day was full of constructive networking and collaboration.

This year the 71 participants ranged from medical students to full professors of surgery. An expert faculty of eight mid-career academic surgeons from the AAS combined with 19 Australasian surgeons and Trainees to provide an outstanding faculty skilled in getting their message across to a willing audience. The College's Conferences and Events Department ensured that everything ran smoothly in an excellent venue. As with last year, the course was sponsored with a educational grant from Johnson and Johnson medical, who have since provided a long term commitment to this important initiative. This ensures the continuing development of this rewarding academic interface between the AAS and the College.

The course was opened by the immediate past President of the College, Ian Gough, who gave an entertaining and insightful speech that helped set the tone for the day. John Windsor, who has overseen the successful development of the DCAS course and has recently been elected Chair of the Section of Academic Surgery, emphasised research and education as the two pillars of academic surgery and how both are required for surgery to advance.

The first session, "Starting and planning your research career", began with Guy Maddern from Adelaide with a provocative talk, suggesting that "every surgeon can and should be an academic surgeon". John McCall, from Dunedin, followed this with a lucid talk on where good research questions come from. Malcolm Brock, from Johns Hopkins University and a former Rhodes scholar, outlined different fields of research available to aspiring clinical academics. Andrea Hayes-Jordan, from the MD Anderson Cancer Centre in Texas, and Jane Young combined to outline a practical approach to ethics in modern research and practice. Dan Albo, from Baylor College of Medicine in Houston, closed the morning session describing how to integrate clinical and research interests utilising his own exciting and rewarding academic program as an illustration.

Julie Ann Sosa, from Yale, gave a carefully crafted introduction to Design, Power and Statistics before two repeat performers from last year spoke. Melina Kibbe, from Northwestern University in Chicago, and Kevin Staveley-O'Carroll, from the University of Pennsylvania, gave their highly ranked talks from last year's course on how to write and how to present, respectively, and they were again outstanding.

Fiona Wood, the 2006 Australian of the Year, gave an inspiring keynote address on "The highs and lows of a successful research career". She has had to learn from the inevitable lows, but has taken those lessons and moved on to a very successful research career. She has an infectious and boundless enthusiasm, which has helped her establish collaborations and to raise the funds necessary for her research program.

The early afternoon parallel session was a successful addition to the program this year and was a response to feedback from 2009. Comments from participants indicated that these smaller and more interactive sessions were very popular and allowed participants to bring their own issues to the table. One of the sessions on the relationship between research and the private sector was particularly well attended.

Mark Smithers and Dan Albo chaired the final session of the day and this focussed on establishing a sustainable career. Cuong Duong from the Peter MacCallum Cancer Centre in Melbourne illustrated, to those considering emulating his experience, challenges and possibilities in organising post-Fellowship work in the USA, in his case through New York's Memorial Sloan-Kettering Cancer Center. Andrew Hill, from Auckland, delivered a well received presentation on work-life balance. Andrew will be assuming the oversight of the DCAS course from John Windsor, who closed the day with a very positive vision for the future of academic surgery.

The DCAS course provides support, inspiration and leadership for academic surgeons, while also encouraging all surgeons to develop their academic skills. The evaluations from this year's course provided an overall mean score of 4.7 out of five, and the individual scores were uniformly high. The organisers are very encouraged by the

John Windsor and Scott LeMaire

College's foresight and encouragement in developing this extremely well received course. It was exciting to have the participation of 20 prevocational doctors attending this year's course. The complimentary participation of medical students was possible in the self-funded course budget. Ross Roberts-Thomson, President of the Australian Medical Students Association, was full of praise for this initiative to involve medical students.

The stage is now set for the 2011 course which will be held in Adelaide on May 2, 2011. The AAS looks forward to providing another talented cohort of academic surgeons to match the outstanding Australasian faculty. There will be further changes to the course structure and content, based on feedback, and this will ensure that the course is fresh and beneficial to those who attend each year. The organisers look forward to welcoming all those interested in taking part in the future of surgery down under.

Above: John Harris, Melinda Kibbe and John Fletcher

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

LAPAROSCOPY COURSE:

Principles & Practice of Appendicectomy & Cholecystectomy

A Foundation Course

Auckland, 22 September 2010

ADVANCED CLINICAL SKILLS CENTRE

Convened by: Mr Garth Poole
Laparoscopic & General Surgeon Auckland

This is a practical hands on course to gain experience in the techniques of laparoscopic surgery. Participants will receive a solid grounding in the basic laparoscopic procedures and have the opportunity to develop their manual skills.

The day will combine lectures with manual skills training on simulators.

Participants will have the knowledge to perform Diagnostic Laparoscopy and Laparoscopic Appendicectomy following the course.

Registration
Registration fee, $1530.00, GST inclusive. Registration closes on 20 August 2010. A course manual and full catering are provided. Please register online at: www.acsc.auckland.ac.nz

Accommodation
Within walking distance or short taxi ride

Alpers Lodge**
Tel: 09-523 3367

Domain Lodge****
Tel: 09-308 0161

Langham Hotel*****
Tel: 0800 616 261

For further information contact:
Administrator ACSC
Phone: +64 9 923 9304

PRELIMINARY NOTICE

SURGICAL RESEARCH SOCIETY

47th ANNUAL SCIENTIFIC MEETING

will be held in Adelaide on Friday 19th Nov 2010

This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers and scientists.

JEPSON LECTURER: Professor Michael Solomon
"Attaining Quality in Surgical Outcomes Research"

GUEST SPEAKER: Professor Herb Chen, past President, Association for Academic Surgery
"Targeting Notch in Neuroendocrine Cancers: Bench to Bedside"

CALL FOR ABSTRACTS: The call for abstracts will be open on Monday 2nd August 2010 and must be submitted no later than Wednesday 29th September 2010. Abstract forms will be available from the email address below from mid July.

CONVENOR: Professor Guy Maddern
PRESIDENT: Professor John McCall

FOR FURTHER INFORMATION CONTACT:
Sue Pleass, Scholarship Co-ordinator
T: +61 8 6363 7513 **F:** +61 8 82162 2077
E: scholarships@surgeons.org

The 2010 Younger Fellows Forum

The Forum provides a chance for your voice to be heard and speak directly to councillors

Richard Martin
Deputy Chair, Younger Fellows Committee

It's hard to believe that after a year of planning and organisation, the Younger Fellows Forum has come and gone so quickly. The Swan Valley was a beautiful and picturesque location, and the calibre of the speakers would be the envy of many major scientific meetings. Many thanks to all who helped make it a weekend to remember.

Just what is the Younger Fellows Forum all about?

The College has been very progressive in recognising that Fellows within 10 years of Fellowship are uniquely qualified as both critics and praises of their College experiences. With the memories of training and examination still fresh in their minds, being integrated with the experiences of becoming a new consultant, the challenges of supervising Trainees, setting up private practice, dealing with Medicare etc, Younger Fellows have a valuable viewpoint not only on what has worked well, and what could have been done better during training, but also on what the needs of a junior consultant are and how the College can help to meet these needs in the future.

The Forum is thus a melting pot of ideas, where surgeons from a diverse surgical and geographical background are brought together with the ultimate aim of 'stirring the pot' to produce a harmonious blend of recommendations which can be presented to Council for the benefit of all surgeons and Trainees. Co-ordinating a group of surgeons in this way has been described as much akin to 'herding cats', thus the weekend is organised firstly to herd the cats into the pot, where they are then melted down and become much easier to deal with thereafter.

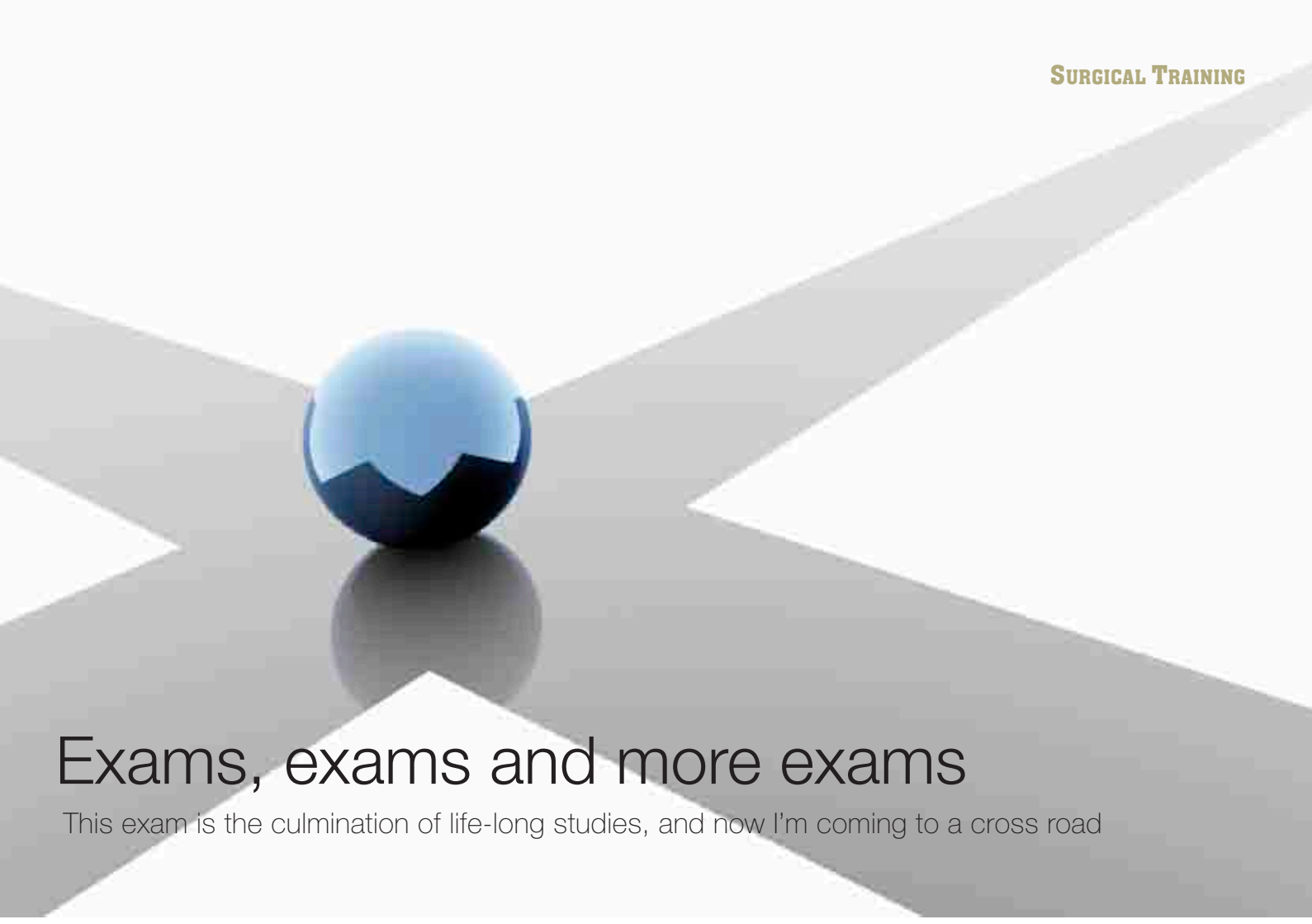
Melting cats aside, the weekend is also a chance to relax, reflect, enjoy some time out, learn, experience a sense of Fellowship and to promote cross-fertilisation of ideas. Perhaps more importantly, it is also a chance to have your voice heard and one of the many highlights of the Forum is the chance to speak directly with the President and two councillors in residence, who are present for the whole weekend. Participants thus have an incredible opportunity to actively engage with our surgical leaders and to discuss with them burning issues first hand.

This year the theme was 'Surgeons and Technology' where we took a '360 degree' look at all aspects of technology from the formative idea stage to production of devices, assessment and on to the widespread adoption and auditing of new technology and process. We also looked at how technology impacts on training, patient safety as well as leadership and mentoring issues culminating with our Association of Academic Surgeons (AAS) visitor, giving us some insights into the workings of the American health care system and the challenges ahead for our colleagues overseas.

"The weekend is also a chance to relax, reflect, enjoy some time out, learn, experience a sense of Fellowship and to promote cross-fertilisation of ideas."

A great weekend was enjoyed by all and I hope at least some of our recommendations will be acted on. Once again I'd like to thank all those involved in the Forum, in particular our outstanding group of speakers, and I advocate to all Younger Fellows to self nominate for next year's Forum. Have your say, be part of your College, and enjoy the delights of South Australia.

For more information about the 2011 Younger Fellows Forum, please contact PDactivities@surgeons.org or call +61 3 9249 1106.



Exams, exams and more exams

This exam is the culmination of life-long studies, and now I'm coming to a cross road

Dr Ina Training

The last few weeks have been a bit of a blur for me. The final year Trainees are sitting their exams and as usual our rostering arrangements have been pretty tight, what with all the extra leave these guys are taking. I can't really blame them and know that soon enough I will be in the same boat, tapping into my extensive hordes of accumulated leave to cram for the exam that will (hopefully) mean the end of my life as a registrar. But at the moment, I'm not yet ready to sit.

Yep, my friends were raucously getting sauced at the local watering hole after the end of last week's written exams, leaving me stuck in the hospital doing the evening ward round, dealing with a string of post-op complications and patients trying their hardest to die. They still have the viva to go, and I wish them success. But for the next four weeks I'll do my best to "hold the fort" while they get to the other side of that exam, albeit cussing and complaining quietly under my breath. I can't really call it unfair. It's a tough period for everyone. And I'll be dumping back on them soon enough.

That exam; the exit exam, Fellowship exam, finals, call it what you will. I am now staring down the barrel of the lead up to what is potentially one of the most pivotal barrier exams in my life. And I can't get motivated.

My study notes are spread out before me; little summaries of diseases, anatomy, operative management. My eyes glaze over, my head rolls forward and my eyelids droop. I read the same sentence three times and it still doesn't make any sense. Shake my head, pour another cup of coffee. Check what my siblings are doing on facebook. I miss my family. And my friends. And... well, you know, intimacy and stuff. But we aren't really allowed to talk about those sorts of things, given that we are (or will be once we have the Fellowship exams and been accepted by our college peers) surgeons, and of course none of those things matter so much when you're saving lives.

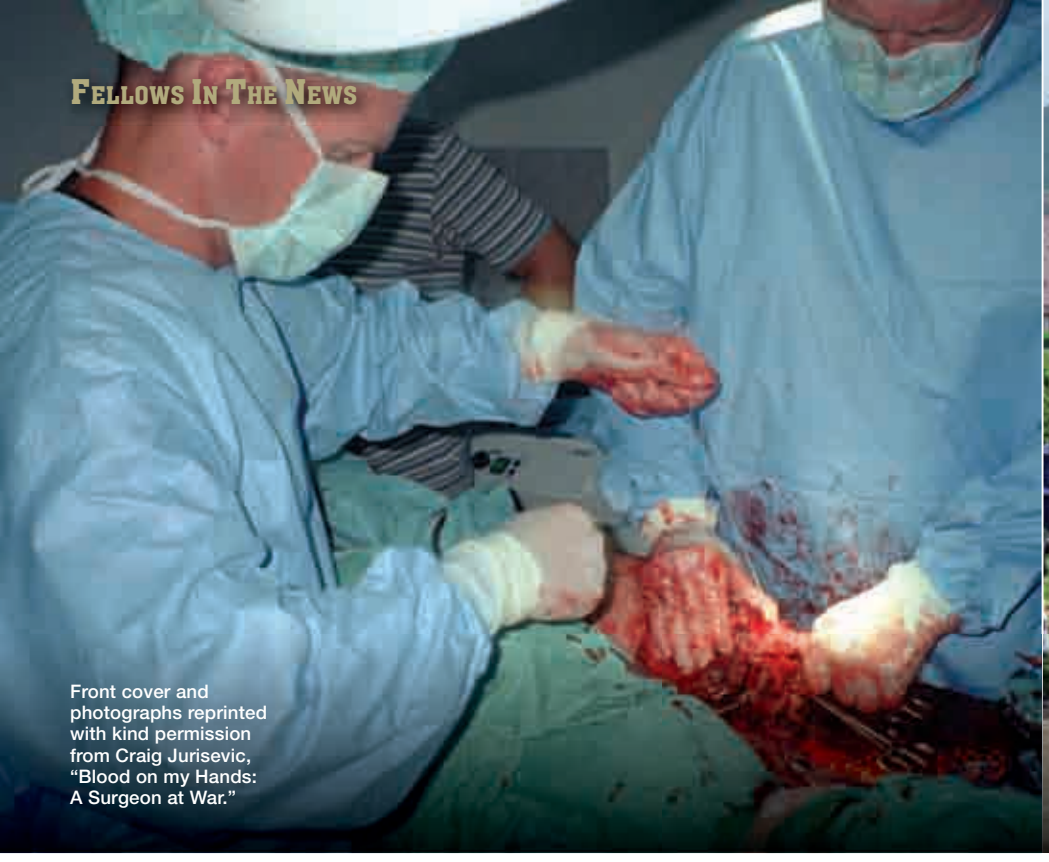
And once my friends have passed their exam (and they will, after all, they're an intelligent bunch and I have studied with them), I will be alone. Figuratively speaking, of course. Surrounded by a sea of lovely faces that are helpful and supportive, but I still have to do this alone. Hence my problem, as I really cannot drum up enough motivation to turn a page let alone sit this exam.

Working through choices

This is not a new story. I'm not sure how many people I have spoken to who have found it difficult to knuckle down and "crack on" with it at some stage. Nor is it new for me, but I have found that motivation only really becomes an issue for me personally when there are competing interests at stake or the outcome is nebulous, at best. Enough so that it makes you question where you are coming from, where you are going to, and how the heck are you going to get there?

This exam is the culmination of life-long studies, and now I'm coming to a cross road. Do I continue to work as I have been, or do I try to take time away from the profession to build a family? If I took time off will my operating skills vanish? Should I undertake further training? Would it be better to work another year as a senior registrar? Do I move or stick with the city that I know? And how will all of these things work in practise? Is there a job out there that would be suitable to someone such as myself? It is so much harder to motivate oneself for this exam with all of these unanswered questions hanging over your head. Particularly when the training program I initially embarked on and had such high hopes for has had withdrawal of government funding and no longer exists. (Yes, I ticked the rural Trainee box.)

Most of them have plans for post-Fellowship training positions. Most of my supervisors and mentors have exceptional levels of achievement in specialised areas. At this point of my life I'd rather dance naked at the next Annual Scientific Congress than have to do more study, more hours, more on-call, or more lackey work for somebody else. As I keep saying, I'm not yet ready for this exam, and I'm worried that I never will be.



Front cover and photographs reprinted with kind permission from Craig Jurisevic, "Blood on my Hands: A Surgeon at War."

Blood on my Hands: A Surgeon at War

The suffering of the children remained with Adelaide surgeon constantly

It isn't often that a Fellow of the College writes a book about surgery that captures the public imagination to such a degree that it leaps almost immediately onto the best seller lists, but such is the rare achievement of Mr Craig Jurisevic.

A cardiothoracic and trauma surgeon based in Adelaide and a Major in the Armed Forces, Mr Jurisevic wrote the book last year as a personal memoir to help deal with the haunting memories of his time serving with the International Medical Corps in the brutal Kosovo War in 1999.

So gripping was his account that it was immediately chosen for publication and within weeks of its launch has now become one of the top selling books in Australia. Titled "Blood On My Hands: A surgeon at War", the book is soon to be released in the US, UK and Canada.

Mr Jurisevic said he wrote the work in only eight weeks after the idea was suggested to him by soldiers serving in Afghanistan who he had met while on assignment there in 2008.

"The reaction to the book has been a bit of a shock actually because I wrote it mainly for myself," he said.

"I didn't realise it at the time, but for the years following the war I think I was suffering a form of post traumatic stress disorder. This was due to a whole host of factors, but most significantly as a direct result of the barbarity with which the Serb forces treated civilians.

"The suffering of the children remained with me constantly. The fear on their faces as they tried to escape the conflict, fleeing across the border with only their mothers and grandparents; the younger men, their fathers, brothers, uncles captured or killed by Serb paramilitaries and regular forces. It is always the children that make war unbearable."

Mr Jurisevic had already spent time in conflict zones including Borneo and the Gaza Strip early in his medical training and had almost completed his cardiothoracic training when news of Milosevic's campaign of ethnic cleansing began to filter back to Australia.

He immediately volunteered in April 1999 to go and work as a trauma surgeon, a decision that saw him battling corruption in Albania, taking on the UN bureaucracy, giving weapons training to young Kosovans hiding in the mountains and undertaking gruelling surgery in a mountain cave.

Assigned to Kukes Hospital, Albania, upon his arrival, Mr Jurisevic was surgical co-ordinator for all three refugee camps in the area. There he realised that all was not as it should be as hospital beds remained empty when there was clearly such pressing need.

Corrupt management

"That was extremely confronting given that the hospital had brand new equipment and adequate staff. It soon became clear that the hospital was being run by an official, who was also a member of the local mafia, who was permitting refugees to die if they didn't have the money to pay, while at the same refusing us permission to operate in the refugee camps," he said.

"I took this up all the way to Kofi Anan, but the UN did little or nothing and it wasn't until we exposed the situation to NATO that we were allowed back into the theatres to do what we were there to do."

But that fight also made Mr Jurisevic a mafia target in a lawless land and he was taken in by the Kosovo Liberation Army (KLA) both for protection and so that he could use his trauma skills to help those closer to the frontline. High in the rugged Mount Pastrik range, under attack from Serbian sniper and artillery fire, he set up a primitive operating space in a cave patching wounds, staunching bleeding and amputating limbs.

At night he lead retrieval teams behind the lines to rescue injured civilians from nearby villages while also taking the wounded, if shelling permitted, back down the mountain to a Norwegian medical base for definitive treatment.

Often Mr Jurisevic and the KLA soldiers shared the cave with the dead as it was too dangerous to go outside to bury them.

"When I was up at the front line I treated 322 injured of which 72 died," he said.

"We talk (as trauma surgeons) of the "golden-hour" when dealing with casualties. On the

ABOVE: Refugees crossing into Albania at the Morina border crossing. With little more than plastic sheeting to shield them from the elements many have travelled like this for over a week. Most refugees were from farming communities. They would carry as much of their livestock as could fit on their tractor-trailers when fleeing the attacking Serb troops.

ABOVE: Dusk retrieval. The heavy loss of life with patrols necessitated night movement. By this stage of the war I was underweight and exhausted. Craig is pictured on the right at the front.

battlefield in most modern conflicts the golden hour is a luxury: you have more like a golden 20 minutes to save many of the worst injured from certain death.

"I was working out of a cave; I had only basic general surgical equipment and no anaesthetist. I sedated the patients with Ketamine with one of the soldiers helping to maintain the air way and had some saline, but no blood.

"All I could do was to debride the wounds and stem the bleeding even if that meant amputation and, if the shelling was not too heavy, accompany the retrieval team down the mountain at night to the Norwegian camp.

"It was hellish and I did fear for my life, but only occasionally. In that environment when the shelling is constant and the danger ever present, your fears oddly begin to dissipate, aided also by exhaustion and sleep deprivation.

"But I'd also say that surgical training helps a lot because we're trained to focus on the problem at hand, what needs to done right there and then and it is possible to remove distractions; even the distraction of ceaseless nearby shelling."

Taught weapons skills

Soon after having been taken in by the KLA, Mr Jurisevic realised how ill- prepared and inexperienced were the young volunteers, many of whom had returned to defend Kosovo from their new homes around the world. As a lifelong recreational shooter in the bush outside Adelaide, Mr Jurisevic used what little time he had between operating to teach them basic weapons skills.

At another time, he acceded to the heartbreaking request of a fatally-wounded woman to end her suffering with the Beretta pistol given him for his safety by the local KLA commander.

"There were so many traumatic aspects to the experience in Kosovo, but at the time such decisions and such actions were not difficult. I was quite prepared to put aside the ethical issues that confront us in times of peace to help the people who needed help," he said.

"In terms of providing basic weapons training, I saw it as an obligation to help the young volunteers not just for their own self-defence, but also so that they had less chance of injuring themselves or their comrades.

"I never went to Kosovo to fight and only joined with the KLA as a way to get to the frontlines where I was most needed."

Mr Jurisevic's last military posting was to Afghanistan where he treated those injured by artillery fire, improvised explosive devices and mines. He said he would go again if called, but would rather defer such an assignment until his children are older.

"I think you can run out of luck," he said. "I think you would be foolish to believe that you

> *"In that environment when the shelling is constant and the danger ever present, your fears oddly begin to dissipate, aided also by exhaustion and sleep deprivation."*

can keep going into dangerous environments without eventually suffering harm.

"But still I think the role of the military surgeon is a crucial one. War, in most instances, is futile and there are many better ways to sort out conflict, but as humans we don't seem to have reached that point of understanding yet.

"And invariably it is the innocent civilians who suffer the most and they deserve whatever medical care that can be given. Equally, the men and women of the Australian Armed Forces who are sent into conflict zones deserve world class treatment for they are there on our behalf."

Mr Jurisevic works out of the Royal Adelaide Hospital as Supervisor of Thoracic Surgical Training and is a Senior Lecturer in Surgery at the University of Adelaide.

"Blood on my Hands: A Surgeon at War" is published by Wild Dingo Press and is available in most book shops.

With Karen Murphy

Clocks do tick

The Australian Medical Council and the Medical Council of New Zealand continue to review our training programs

Ian Civil
President

The regulatory world in which the educational programs of the College exist is complex and demanding. It has been interesting to watch the development of this over the past 20 years.

For most surgeons this has "passed us by" as just one of those irritating yet demanding requirements of training the surgeons of the future. Then all of a sudden an apparently arbitrary hurdle or deadline impacts on a colleague and it seems dramatically "unfair" and demonstrates an organisation that is neither flexible nor Trainee focused.

These deadline crises continue to happen year after year as a very small number of applicants to training, Trainees progressing between stages of the various programs or Fellows in practice believe that ignoring requirements and then creating a ground-swell of outrage will "win the day" in the ongoing battle of the individual versus the system. Whatever or whoever the system may be.

It is worthwhile outlining the key changes that have occurred over the past 20 years. A report in 1994 called A Cutting Edge[1] created substantial angst in its day as it painted a picture different from the perception of the College. The Fellows of the College contribute enormously to the education of the next generation of surgeons through training, course instruction and various examinations and assessments. The angst of this report was that it stated this was all self-serving in that it allowed the College to control the number of Trainees in the educational programs and consequently place constraints on the total number of qualified surgeons in Australia and New Zealand.

Outrage in the College was extreme as the constraints are from the lack of funding for hospital training posts primarily, but the report firmly established the dogma that training provided through the College structures serves multiple goals.

Later in the 1990s a report was generated from the Medical Training Review Panel[2] where issues of selection, assessment and progression of Trainees in all College educational programs was carefully reviewed. One of the highlighted recommendations was that creation of good quality policy and procedure around selection and progression through the program had been achieved centrally, but was being compromised by differing implementation and interpretation across all the regions of Australia and New Zealand. It was from this that the College started moving into a national selection process and far more regular application of policies and procedures. The Colleges had been accused of "playing favourites" depending on issues like political patronage. This was deemed to be unacceptable.

Continual reviews

The Australian Medical Council and the Medical Council of New Zealand continue to review our training programs. The College was one of the first to be accredited and we have continued to be accredited through the 2000s. One of the key developments from this was the creation of memoranda of understanding and

> *"The clock ticks at the same speed for everyone and local time variations are not acceptable."*

then service agreements between the College and 13 specialty societies for the delivery of the nine educational programs of the College. Much of the basis of this is a comprehensive array of policies and procedures across all the educational activities of the College. These are all publicly available on the College web-site and are communicated broadly to all Trainees and supervisors. With these policies come very clear expectations around requirements including application timelines.[3]

Most people would be aware that the College was reviewed by the Australian Competition and Consumer Commission. This was because of concerns that the College and the Australian Orthopaedic Association had not been complying with their own regulations and had been behaving anti-competitively.[4] The College went through an authorisation process that was very expensive and spent an additional five years updating all its policies and procedures relating to our educational activities. These are now highly developed and have recently been accredited to ISO standards.

Whilst all of these regulatory concerns have been developing there has also been an increased expectation on the breadth of expertise of all medical practitioners, including surgeons. Most surgeons would have heard of Canadian Medical Education Directions for Specialists (CanMEDS) and then the College adaptation of this competency framework.[5] There is now a greater expectation on many parameters of our behaviour, particularly professionalism where issues of understanding the regulatory world and working with its constraints are far more obvious. [6]

Surgical training

It is interesting watching the development of surgical training across the world. In some parts it is undertaken by universities, in other parts it is oversighted by statutory bodies that are given a presence by legislation. The College structures in Australia and New Zealand do not have that and this is both a strength and a weakness. Governments have not legislated our position in regard to education and training. We need to justify and prove it repeatedly. The College and specialty societies need to demonstrate they have better educational content and better processes than universities. We need to apply all of our processes firmly and without favour. Fairness is judged by applying all the regulations in a known and appropriate manner.

As would be apparent from this discussion, surgical education now functions in a legal environment. Rules must be explicit, publicised and adhered to. There can be no "elastic band" applied to timelines. Having said that, all processes must be able to be appealed. Rationale for any appeal must be presented and simple disorganisation is not a reason that will win an appeal. While at times this might appear unfair to the appellant, it might be even more unfair to a larger numbers of potential appellants who made choices based on the known rules and were unable to meet the deadlines. The College cannot be perceived as playing favourites, even when there is considerable sympathy and support for the individual. The clock ticks at the same speed for everyone and local time variations are not acceptable.

1. Baume P. A Cutting Edge: Australia's Surgical Workforce. Canberra, 1994.

2. Trainee Selection in Australian Medical Colleges. Canberra: Medical Training Review Panel, Commonwealth Department of Health and Family Services, 1998:1 - 166.

3. Accreditation of Specialist Medical Education and Training and Professional Development Programs. Standards and Procedures. Canberra

Australian Medical Council, 2003.

4. Royal Australasian College of Surgeons authorisation A90765: Australian Competition and Consumer Commission, 2003.

5. Frank JR. The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care. Ottawa: The Royal College of Physicians and Surgeons of Canada, 2005.

6. Ginsburg S, Kachan N, Lingard L. Before the white coat: perceptions of professional lapses in the pre-clerkship. Med Educ 2005;39 (1):12-9.

Update from Queensland

It's been a busy year in negotiations with all levels of Government for the Queensland arm of the College

Queensland College Building

Maurice Stevens
Chair, Queensland Regional Committee

Hopefully as this article arrives with you we expect to have received the Development Application (DA) Approval for the College's new building in Queensland (QLD). Many hours of meetings and reports to satisfy the requirements of the Brisbane City Council has gone into the past 12 months. The College thanks its Project Manager Mr Michael Milne and its lead Architect and Town Planner Mr Steve Matovick for their work and long negotiations with the Brisbane City Council which are now into their ninth month. The detailed planning will then occur and it is anticipated that demolition of the current building and construction of the new building will commence in the early part of 2011.

On a State level, negotiations have continued on numerous fronts and the College has been well represented through:

- Regular meetings with the Minister for Health
- Membership of the Queensland Committee of Medical Specialist Colleges
- Ministerial Taskforce on Specialist Training in Regional Areas
- Surgeons Advisors Committee
- Surgery Strategy Workshops
- Clinical Services Capability Framework
- Specialist Outpatients Strategic Services
- Ministerial Taskforce on Specialist Training in Regional Areas
- Physicians Assistants Advisory Committee
- Clinical Senate
- Queensland Audit of Surgical Mortality (QASM)
- Liaison with Medical Workforce Unit of QHealth
- Liaison with Hospital Access Unit of QHealth
- Area of need discussions with Medical Board and Medical Workforce Unit of QHealth.

Outcomes displayed

The outcomes of the relationship with QHealth will best be displayed at the QLD Annual Scientific Meeting 2010, which this year will be combined between the College and QHealth on 6-8 August 2010 at Sheraton Mirage Gold Coast being convened by Professor Russel Stitz and Dr Maurice Stevens.

The biggest disappointment has been the continuing lockout of the College from making formal contributions to the new QLD Children's Hospital development. Despite raising this matter a number of times with Government, the unwillingness of the project head Dr Peter Steer to formally engage with the College's representatives has been very disappointing. However, there are encouraging signs in all the areas listed above. Particular mention should also be made of the advances in QASM with a soon to be implemented online version of the surgical case form and who will also support the Northern Territory Audit of Surgical Mortality after successful negotiations were organised by the Australian and New Zealand Audit of Surgical Mortality.

On a national front the Committee was required to support the negotiations federally of the new National Registration and Accreditation and also the recent developments with the National Health and Hospitals Network. The Committee has been fortunate that during such a busy reform agenda to have had both Professor Ian Gough and Dr Ian Dickinson's advice and guidance in their roles of College President and Vice President.

The Committee would particularly like to express its sincere appreciation for the 17 year contribution that Professor Gough has made to the Queensland Committee.

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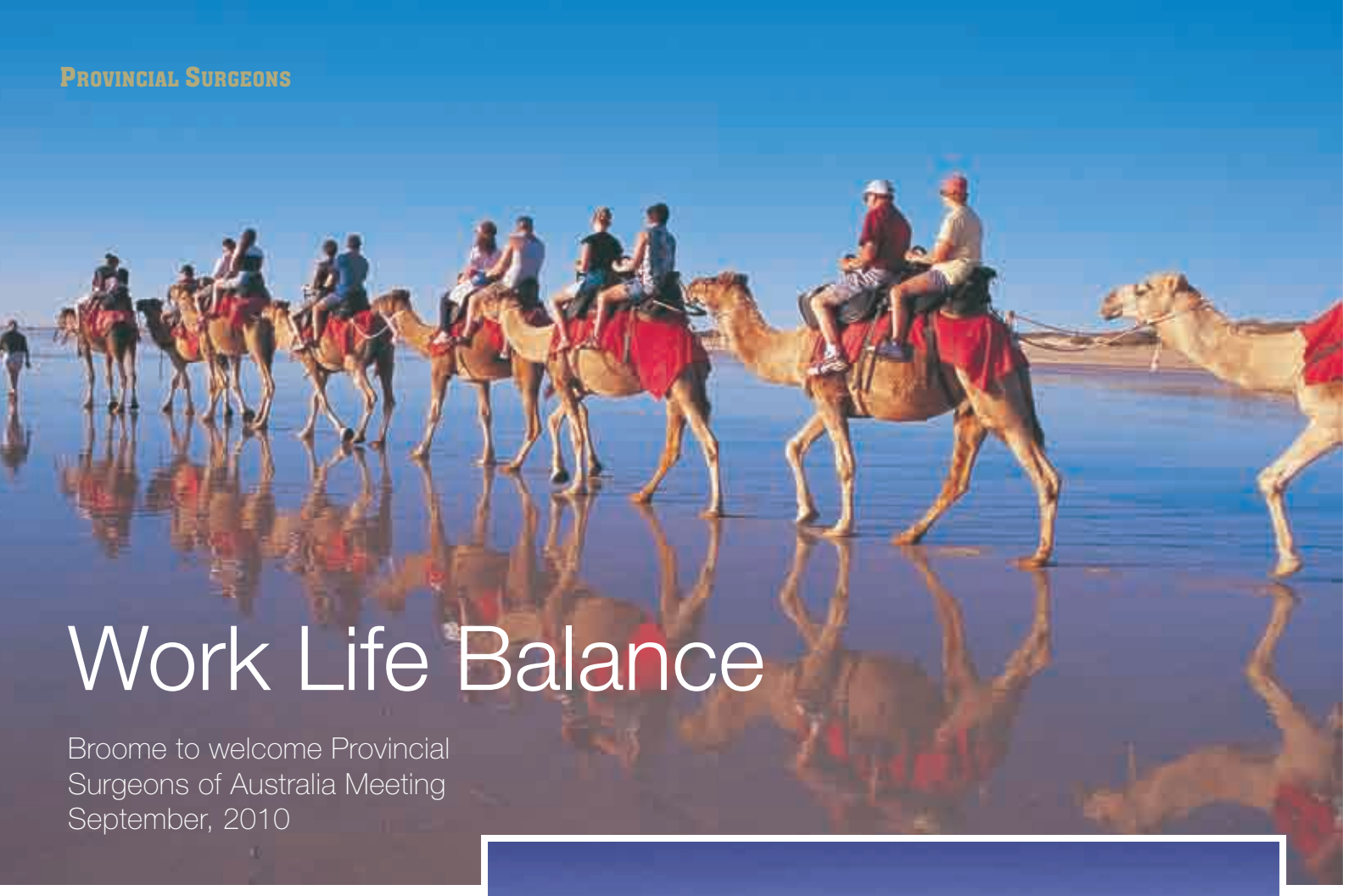

Work Life Balance

Broome to welcome Provincial Surgeons of Australia Meeting September, 2010

Andrew Thompson
PSA Convenor

This years Provincial Surgeons of Australia (PSA) meeting will be held at the Cable Beach Club in Broome, Western Australia, from September 1 to 4. The PSA meeting has been held annually since 1965 and is attended by surgeons across Australia, New Zealand and Papua New Guinea. It is always held in a rural town and run by the local surgeons. It takes delegates to places where they might otherwise not visit. This year gives delegates and associates the opportunity to go visit Broome.

The meeting always has a solid scientific program of interest to rural surgeons, general surgeons and sub specialists. This year's invited speakers are Mr Michael Levitt delivering an update in colorectal surgery, Professor Christobel Saunders with a breast and melanoma interest, and Associate Professor Matt Zimmerman a gastroenterologist covering recent advances in investigations and treatment of gastrointestinal conditions.

As always there will be interesting and eclectic research papers. The PSA is a forum for surgeons and Trainees to present papers that reflect the diversity of surgical practice and interests in rural regions.

An overarching theme of the meeting is "Work Life Balance" and this is the topic of the preconference workshop. This workshop is open to delegates and associates. There will be some self analysis including the use of unique interactive technologies to profile the group. We will examine the practicalities of maintaining a balanced life including techniques to avoid overwork and burnout.

Broome is a port town that was established to service the pearling industry after the 1861 discovery of the Pinctada maxima pearl in the Kimberley waters. With divers and workers arriving from all over the world, Broome became a melting pot of Caucasian, Asian and Australian indigenous people and cultures. Broome remains a unique multicultural town and continues to produce the largest, most lustrous pearls in the world. The Cable Beach Club was established by Lord McAlpine in 1988 and is the premier resort in Broome.

In keeping with the "Work Life Balance" theme, attendees are invited to take time to relax on either side of the conference. There are post conference tours available for people to see more of the Kimberley.

The associates program includes a tour of Willie Creek Pearl farm, a cruise to Eco Beach on Roebuck Bay and visiting the historic Courthouse Markets. The conference dinner will be at Sun Pictures, the oldest open air cinema in the world.

As convenor of the 2010 PSA, I would welcome seeing you in Broome.

For further information contact Abbey Williams +61 3 9249 1260 or abbey.williams@surgeons.org

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Nitin receiving the the Order of Timor Leste from Jose Ramos-Horta

Healing the blind in East Timor

East Timor will soon be ready to meet the eye-care needs of the population

Tasmanian ophthalmologist Dr Nitin Verma stood amidst men of global renown recently when he was honoured with the Order of Timor Leste for his work in establishing and co-ordinating the East Timor Eye Program. Presented at a ceremony on the evening before the country celebrated its eighth Independence Day on May 20, Dr Verma received the honour from President and Nobel Peace Prize winner Dr Jose Ramos-Horta.

Beside him on the podium at the Presidential Palace also receiving the Order was Mr Lech Walesa, the former Polish president and fellow Nobel Peace Prize recipient.

Mr Verma was chosen to receive the honour this year to mark the ten-year anniversary of the establishment of the Eye Program. Originally established to provide vital services to the nation, but which has recently changed focus to help East Timor become self-sufficient in eye care by 2015 and to work towards eradicating preventable blindness by 2025.

Each year since its inception, the program has sent teams to East Timor to prescribe and distribute spectacles, perform consultations and conduct surgeries over a one to two-week visit, five to six times a year. The predominant procedure performed by the teams is cataract surgery.

So far, the program has conducted more than 30,000 patient consultations, performed more than 4,000 surgical procedures and dispensed over 28,000 spectacles.

Dr Verma, who has already visited East Timor three times this year alone, said he was delighted to have been honoured with the Order of Timor Leste.

A team effort

"This was a pleasure to receive because they don't give out too many of these awards, but still it is less a personal honour than a tribute to the entire team involved. "We have ophthalmologists, optometrists, nurses, volunteers and co-ordinating staff and they have all been pivotal in making the program as successful as it has been," he said.

"Now thanks to all their efforts we are in the process of handing it over to the East Timor health authorities which is the most rewarding aspect."

Dr Verma said there were now five ophthalmologists working in East Timor from a variety of countries including China, Cuba, Australia and India. The most important one for the program long term, is Dr Marcellino Correia, the first and only East Timorese Ophthalmologist who was

PHOTOGRAPHY COURTESY OF ELLEN WHINNETT

The East Timor Eye Program has helped many people.

trained as part of the East Timor Eye Program. This means that the country was well-placed to meet the eye-care needs of the population.

He said receiving the honour allowed him to reflect on the changes made in East Timor in the ten years since he first visited to treat those who had become virtually blind from cataracts.

"It has been an extraordinary experience to help the people of East Timor not only in terms of providing medical care, but also in the rebuilding of services required after Independence. When we began going there in 2000 there were very few undamaged buildings, very little in the way of infrastructure, organisation and skills," he said.

"Yet the health sector in particular has moved forward dramatically in recent years not only with the new hospital in Dili, but also with the construction and commissioning of district hospitals across the country.

"There is a great joy in seeing this development as well as being able to provide services when and where they were needed. It is very rare to get a chance to do something like the Eye Care Program, to set up a service from scratch and to have the chance to determine how best to design, run and manage it and then to attract the funding and the personnel to do it."

Difficulty of access

Mr Verma said that while East Timor would now become more autonomous in its provision of eye care services, the program would still continue to send teams to conduct more complex surgery. He said the remaining challenge for the delivery of eye care services was overcoming the difficulties of access to the more remote regions of East Timor.

"Now thanks to all their efforts we are in the process of handing it over to the East Timor health authorities which is the most rewarding aspect."

"Even though the construction of regional hospitals has made an enormous difference, there is still a need to penetrate deeper into the sub-districts and villages of East Timor," he said.

"That presents problems with logistics and putting in place a system to let people know of the service and then to win their acceptance of it."

Not content to sit back and watch as the program devolves to the East Timorese, Dr Verma and his colleagues have established a scholarship worth up to $15,000 per year to allow a young ophthalmologist to work there. This is the Hobart Eye Surgeons Royal Australian and New Zealand College of Ophthalmologists Eye Foundation scholarship.

"The plan is to give this funding to allow a young surgeon to learn the skills they will need in India and then work in East Timor for a few months," he said.

"We need to be encouraging younger surgeons to take on such work because they don't get the same opportunity as my generation did because the training regime and requirements now are quite different."

Dr Verma paid tribute to all the surgeons, optometrists and nurses who had volunteered their time to the program and also thanked the College for its support.

In particular he also thanked Provision Eye care and Optometry Giving Sight, Foresight, St John's Ambulance and the Eye Surgery Foundation for their support as well as that offered by companies such as Alcon, Zeiss, Ellex, Bausch and Lomb and Micromed.

Speaking at the award ceremony before the diplomatic corps and the Governor General of New Zealand, Dr Ramos-Horta thanked Dr Verma for his commitment to the people of East Timor.

Having almost lost his life in an assassination attempt in 2008, Dr Ramos-Horta used the occasion to reflect on the difficulties faced and overcome by the people of the fledgling nation as it worked to establish a strong and stable democracy.

"The restoration of Independence gives us responsibility. This anniversary makes us reflect on the crises that we have faced and which must serve as a lesson so that we don't repeat them in the future, no matter how divergent our opinions may be," he said.

With Karen Murphy

Surgical Leaders Forum – May 2010

Solving the problems facing surgery on both sides of the Tasman

Keith Mutimer
Vice President

The most recent Surgical Leaders' Forum was held in Perth on Monday, 3 May, in the week of the Annual Scientific Congress.

Presentations and discussions centred on three broad areas: Audit outcome data and health quality improvement, College interaction with State Health Departments, and Surgical Education and Training.

The first theme was the subject of a presentation by Mr Kim Snowball, Acting Director-General of the Western Australian Department of Health. Mr Snowball provided an overview of those programs aimed at measuring and analysing healthcare outcomes in Western Australia, with a view to achieving ongoing improvements in patient care. These programs include:

- WAASM – the Western Australian Audit of Surgical Mortality (operated in partnership with the College, and Australia's first audit of surgical mortality);
- WARM – the Western Australian Review of Mortality;
- The Coronial Liaison Service;
- SQuIRe – Safety and Quality Investment for Reform; and
- VLAD – Variable Life-Adjusted Display.

Mr Snowball concluded with observations on Activity Based Funding and on the introduction of the Four Hour Rule in Western Australia, which aims to see a steadily increasing proportion of patients admitted, transferred or discharged within four hours of presentation at the Emergency Department.

Surgical Culture

The second area of discussion featured presentations by three Regional Chairs. The retiring Queensland Chair, Dr Richard Lewandowski, has had a long association with the Queensland Health Department and his presentation reflected this. While surgeons work hard to be heard by hospital management and senior state bureaucrats, and some significant achievements have been made, more needs to be done. Recommendations to government have highlighted the need to restore a surgical culture, and there has been significant input into the Retention and Return of Surgeons Project. Dr Lewandowski suggested that surgeons could benefit from management training, enabling them to speak "bureaucratic jargon" and draft health related policies.

Dr Jessica Yin, the Western Australian Chair, presented an altogether different view of the Four Hour Rule from that of Mr Snowball, citing the concerns of many doctors from around Western Australia who had responded to a survey on the subject. Generally, these concerns centred on the perception that the Four Hour Rule was placing timeliness of care above quality of care. Subsequent discussion of the issue was informed and constructive.

Retiring Victorian Chair, Mr Michael Dobson informed delegates that the Victorian Health Minister regularly attended meetings of the College's Victorian Executive and seemed genuinely attentive to the concerns and ideas of surgeons.

Training and Education

The rest of the morning's proceedings were devoted to issues of training and education. Mr Hugh Martin, who chairs the College's Post Fellowship Education and Training Committee, updated delegates on the Committee's work, while Professor Spencer Beasley chaired a session on Progress in Surgical Education and Training (SET).

This session included presentations entitled: Opportunities of SET: Aspirations and Impediments; Changes to the Early Surgical Sciences Examination; The Importance and Nature of Formative Assessment, and The New SET Surgical Supervisor.

Once again, the Surgical Leaders' Forum proved itself to be a valuable opportunity for councillors, and for the chairs and CEOs of specialty societies, to discuss issues of importance to Australian and New Zealand surgeons.

Despite inevitable differences of opinion, discussion is always positive in tone as delegates seek to identify and solve the problems facing surgery on both sides of the Tasman.

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MEDFIN FINANCE

HICAPS

MLC

more give, less take

nab

*Source: East & Partners' Business Banking Sentiment Index (BBSI) – April 2010. 789 respondents from businesses with annual turnover $1m to $100m.
^ Source: APRA Monthly Banking Statistics. October 2008 – October 2009. Based on actual dollar value of new and existing lending. Percentages have been rounded to the nearest number. Immaterial results for other banks have been excluded.

Brian Millar with the Millers Visceral Retainer Sweetlip in the operating theatre

The yellow ribbon sweetlip

The Miller's Visceral Retainer

It had struck me for a number of years, during the course of numerous laparotomies that there was a better way

Brian Miller
Queensland Fellow

My background as a consultant in General Surgery in Brisbane has been at the Princess Alexandra Hospital (PAH) in the University of Queensland (UQ) since 1988. I started at PAH as a senior lecturer, and joined the fledgling Colorectal Unit under the chairmanship of Dr Jon Cohen in 1991. Over the last 20 years the unit has grown, and now with the acquisition of our best registrars, three of whom have returned as consultants, the unit has become laparoscopically oriented for elective colorectal work.

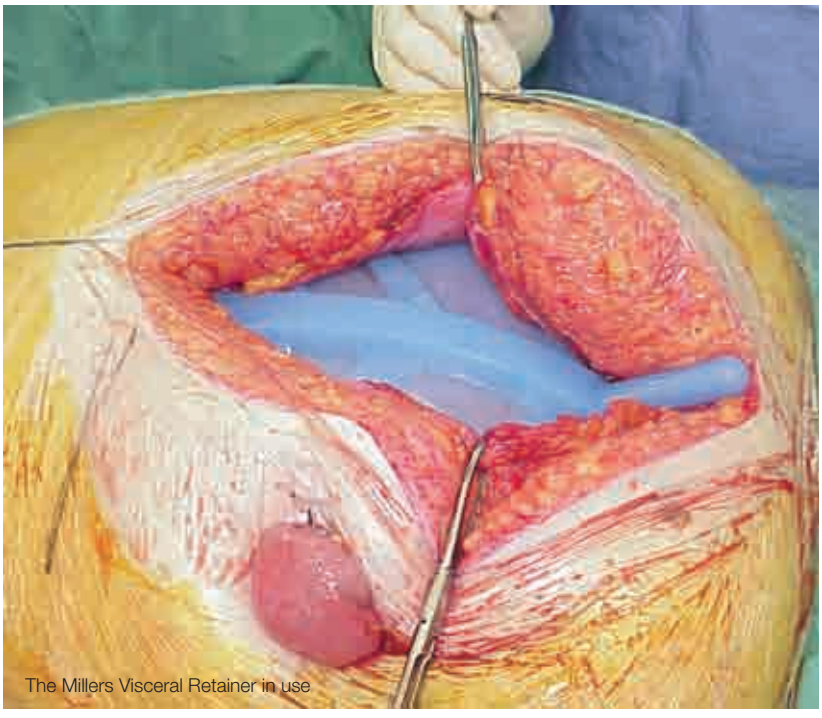
My particular responsibilities are to administer and teach the surgical terms for the third year graduate UQ students at PAH, and to supervise the twice weekly training sessions for our general surgical registrars. Another major clinical interest has been with annual charitable outreach general surgical visits to West Timor and Flores since 2005. I was also fortunate enough to have been involved in the inception of the Early Management of Severe Trauma (EMST) program in 1989, and I continue to instruct each year. My little red book "General Surgical Lists and Reminders", which is a revision tool for registrars, is now in its sixth edition and has recently become available on e-Books at www.ebooks.com/ebooks/book_display.asp?IID=534350

It had struck me for a number of years, during the course of numerous laparotomies, that the accepted way of controlling protruding bowel during abdominal closure by progressively withdrawing damp abdominal packs was inefficient and unnecessarily traumatic to the viscera. And this was particularly the case during difficult circumstances late at night with tired staff, perhaps typified by the conclusion of an arduous open operation for a complex bowel obstruction.

I had seen older surgeons use a variety of ad hoc devices to mitigate the problem including malleable metal retractors and even sterilized portions of car tyres. It was this situation that led to my idea for a smooth, shapely device to control the intra-abdominal viscera in a less abrasive and less risky manner while suturing the linea alba. Also considering that the device would only be in situ during each operation for a few minutes, to make it re-usable would be an advantage.

I then made some enquiries of local engineers in the immediate vicinity of the PAH in South Brisbane and soon met a versatile mechanical engineer who was prepared to manufacture the original steel mould for my idea, based on a wooden model that I had constructed. The steel mould contains multiple heating elements to cure the silicone uniformly for ten minutes at 130degC.

The Miller's Visceral Retainer (MVR) was first manufactured in 1998 as an autoclavable radio-opaque silicone device by Mr Fred Howie at Howie Engineering in Stones Corner, Brisbane. The barium that was originally mixed



The Millers Visceral Retainer in use

into the silicone was kindly donated by the PAH Radiology Department. The MVR went through several early prototypes where more longitudinal turgidity was given to the spine of the device by altering the steel mould.

The MVR has been produced for sale in its present form by Howie Engineering under my supervision for the last ten years. Its particular features are the firm spine and soft wings to keep protruding bowel gently under control, the incorporated handle for ease of removal, and its capacity for re-sterilisation by autoclaving or by the Sterrad method.

The device was on display at the Abdominal Compartment Syndrome conference at the Sheraton Hotel in Noosa in 2004, and the Australian trade mark "M.V.R. (tm)" was secured in 2005. The MVR has been marketed by the Elite Medical Co. Ltd. in Bulimba, Brisbane since 2008.

The latest version of the MVR is the 'MVR sweetlip' which is moulded using a mixture of blue, yellow and white silicone for a distinctive look. This device is latex-free and has become quite popular with general surgeons throughout Queensland, and to an extent elsewhere in Australia and New Zealand. Very little actual advertising has been done, but for past ten years I have given each of my registrars at the end of their six month term on the Colorectal Unit at the Princess Alexandra Hospital an MVR, to encourage some 'word of mouth' promotion.

I see the device as being valuable during closure of the abdomen after laparotomy

1) to reduce inadvertent injury to bowel

2) to reduce needle-stick injury to staff by allowing a proper grasp of the linea alba with toothed forceps.

Whilst the need for a visceral retainer has decreased with the advent of laparoscopic general surgery, it is now considered an essential piece of equipment for the open case as advocated by the College of Surgeons in their Supervisors and Trainers for the Surgical Education Training (SATSET) program video.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

COURT OF EXAMINERS

For the Fellowship Examination

Applications from eligible Fellows willing to serve on the Court should be forwarded to the College Examinations Department no later than Wednesday 1 December 2010 for appointment in 2011.

Fellows are asked to note the following vacancies on the Court, in the specialty of:

- ✔ Cardiothoraciv Surgery
- ✔ General Surgery
- ✔ Neurosurgery
- ✔ Orthopaedic Surgery
- ✔ Otolaryngology Head & Neck Surgery
- ✔ Paediatric Surgery
- ✔ Plastic & Reconstructive Surgery
- ✔ Urology
- ✔ Vascular Surgery

Should you wish to apply to be a member of the Court of Examiners, please forward your application form with your curriculum vitae to:
examinations@surgeons.org
or post to Examinations Department. Royal Australasian College of Surgeons
250 - 290 Spring Street
EAST MELBOURNE VIC 3002

- → Application forms are available for downloading via the College website www.surgeons.org
- → The policy in respect to Appointments to the Court of Examiners and Conduct of the Fellowship Examination can be found on the College website.
- → For inquiries, please email examinations@surgeons.org

New To Council

When should surgeons retire from active surgery?

Surgeons have a onerous responsibility for human life

I.M.A Newfellow

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

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

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

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

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

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

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

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

[Surgical News] PAGE 7 January/February 2010

When to retire?

Dear Editor

Re: Recent article by Mr Newfellow– when to retire from surgery (Vol: 11, No:1 January/February 2010 page 7

I have done this some years ago and my guiding principle was when you stop having fun or, to be less flippant, when operating stops being enjoyable. When an operation becomes hard work it is time to go.

The last advice of my mentor when he retired was 'go when people say, why did he go? Don't wait till they say, why didn't he go?'

A.N Oldfellow
John Walker
New South Wales Fellow

Professional Development

Dear Editor

Re: Professional Development Workshops

The visit that you arranged to the Coal Mine facility at Woonona was very interesting and I would be interested in any further industrial visits. My first choice would be the Port Kembla Steel Works as my interest is primarily noise induced hearing loss.

I believe that the Newcastle coal mines are setting up a new facility.

Yours Sincerely
John Walker
New South Wales Fellow

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

Or The Editor, Surgical News
Royal Australasian College of Surgeons
College of Surgeons Gardens
250-290 Spring Street
East Melbourne, Victoria 3002

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:

Douglas Trevor Beetham, Ohope, NZ
Andrew Brian Fagan, SA
William James Cook, WA
Oswald Joseph Davies, NSW
Norman Garrick Graham, UK
Geoffrey Carl Hipwell, NSW
George Condor Hitchcock, Auckland, NZ
William Gerald Lucas, NSW
James Warwick Macky, Auckland, NZ
Pearl Anna Macleod, UK
Johannes Albertus Myburgh, South Africa
John Cuthbert Parr, Dunedin, NZ
Timothy Savage Taupo, NZ
Frank Don Webb, WA

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

Informing the College

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

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

Wave 3 of MABEL Survey 'goes live' in June 2010

The third wave of the MABEL (Medicine in Australia: Balancing Employment and Life) survey will 'go live' in June. MABEL is a major national, longitudinal survey of doctors that aims to make a difference. Funded by the NHMRC and conducted by the University of Melbourne and Monash University, the first and second waves of MABEL were conducted in 2008 and 2009.

MABEL has been endorsed by the 38 major medical specialist colleges, societies and training providers. The research team continues to meet regularly with the MABEL Policy Reference Group, which is providing advice about medical workforce issues that are informing the collection and analysis of data to ensure MABEL is not just an academic exercise, but rather makes a real difference to doctors' working lives.

In Wave 1 (2008) of the MABEL survey 10,498 doctors participated. Publications and newsletters outlining preliminary results from Wave 1 are available for download from the MABEL website, as is a listing of journal submissions, conferences and presentations relating to MABEL; this list will grow exponentially in the coming years as further waves of MABEL data become available. Wave 2 (2009) data are currently being processed and cleaned to be ready for analysis by the spring.

The MABEL research team would like to thank all those doctors who participated in Waves 1 and 2 of MABEL in 2008 and 2009, and wishes to encourage them, and newly admitted doctors who will be contacted for the first time in 2010, to participate in this important national survey.

For further information about MABEL please go to: www.mabel.org.au or email enquiries@mabel.org.au or call: 03 8344 2600.

Congratulations on your achievements

RUSSELL STITZ
- Sir Hugh Devine Medal
Citation by Ian Gough

Russell Stitz with Tom Reeve

Professor Russell Stitz is an exceptional surgeon. He is a Queenslander, originally from Ipswich where he grew up and was educated. He attended the University of Queensland Medical School, graduating in 1966. He worked at the Royal Brisbane Hospital, training in general surgery and achieved the Fellowship of the Royal Australasian College of Surgeons (FRACS) in 1972. His training continued in the United Kingdom achieving the Fellowship of the Royal College of Surgeons (FRCS) England in 1974.

He developed an interest in colorectal surgery and worked at the specialist St. Mark's Hospital for two years. After returning to Brisbane he pursued an outstandingly successful career at multiple levels.

Russell is a surgical leader of the highest order. He continuously strives for excellence in his own activities and has the ability to inspire others with similar vision. At the Royal Brisbane Hospital, where he worked for most of his consultant career, he had many leadership roles including Head of the Colorectal Surgical Unit and Chair of the Medical Staff Association and more recently as Professor of Clinical Surgery and Head of the Discipline of Surgery at the University of Queensland. His private practice at the Wesley Hospital was extremely busy, managed expertly by his life partner Anne.

He has been a civilian military surgeon, with roles including Colonel in the Medical Reserve and Honorary Surgeon to the Governor-General. For this service he was awarded the Reserve Force Decoration.

The groups that Russell becomes involved with benefit from his energy and collegiality and usually appoint him as their leader. He has been President of the Colorectal Surgical Society of Australia and New Zealand, and President of the Queensland Branch of the Australian Medical Association.

His service to the College has been outstanding. He has been a member or Chair of many boards and committees. He was Chair of the Queensland State Committee. He was a Councillor for nine years and was Chair of the Professional Development and Standards Board for three years and President of the College for two years.

He is known as an excellent speaker and has delivered many named lectureships and was twice a Foundation Lecturer to the College's Annual Scientific Congress

He is the immediate past Chair of the Committee of Presidents of Medical Colleges and in that role advocated effectively for high standards of patient care, being particularly involved in advising on the principles that should apply to the National Registration and Accreditation Scheme for Health Practitioners.

"He continuously strives for excellence in his own activities and has the ability to inspire others with similar vision."

Throughout this very busy life Russell has been a family man with his wife Anne and three children and now grandchildren.

He is an honorary Fellow of the Colleges of Surgeons of Edinburgh, Hong Kong and Thailand. He is a member of our Court of Honour and a member of the Order of Australia.

The Sir Hugh Devine medal is awarded for meritorious service to Surgery and is the highest honour the College may award a Fellow. There have been only nine previous awards since its inception in 1972. The honour is thoroughly appropriate for Russell Stitz.

DAVID STOREY - Louis Barnett Medal

Citation kindly provided by Ian Dickinson

> *"He has a deep interest in clinical teaching, the advanced teaching of anatomy, along with interests in history and ethics; he has published and presented widely."*

Professor David Storey is the recipient of the Sir Louis Barnett Medal. It is a singular honour of the College bestowed on persons who have made outstanding contributions to education, training and the advancement of surgery. The medal was struck in 1990 honouring Sir Louis, who was responsible for the original proposals for creating a New Zealand or Australian Association of Surgeons and for keeping New Zealand in the College despite the communication and political difficulties of the 1930s.

David Wickham Storey grew up in Sydney, and was educated at Sydney Grammar School. He entered the University of Sydney and having completed a Bachelor of Medical Science, graduated Bachelor of Medicine and Bachelor of Surgery with Honours in 1972. He received the Harry J Clayton Memorial Prize for Medicine.

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

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

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

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

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

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

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

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

ACCOMMODATION FOR VISITING SCHOLARS

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

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

If you would like to be contacted by the College if the need for accommodation in your area arises, please register your details by contacting the International Scholarships Secretariat on the details below. We are currently seeking accommodation in Melbourne, Geelong, Liverpool (NSW), Brisbane and Townsville for visits in the latter half of 2010 and 2011.

International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250-290 Spring Street
East Melbourne, Victoria 3002
T: + 61 3 9249 1211
F: + 61 3 9276 7431
E: international.scholarships@surgeons.org

Surgeons as patients

Sixty-three-year-old Randal Williams tells us about his experience of having a hip replacement

Randal Williams
South Australian Fellow

Recently I entered hospital for a total hip replacement, due to the late onset of osteoarthritis after a childhood illness. Everyday activities had been becoming increasingly difficult due to pain and restricted right hip movements and I was becoming heartily sick of being asked about my increasing limp, which one of my colleagues accurately, but somewhat unkindly described as an "antalgic gait ".

Alarming snapping and clicking noises emanated from the hip joint. I was having trouble walking around hospitals to do my ward rounds; I needed a sock applicator to get socks on and had long discarded lace-up shoes in favour of slip-ons; the tricks of necessity. Getting dressed and undressed (sometimes several times a day for operating theatre work) became a slow and painful chore.

I was on maximum doses of diclofenac and slow release paracetamol to get me through the day. When pain started to intrude on sleep I knew the time had come. I consulted a respected orthopaedic surgeon experienced in hip replacement who confirmed the clinical and radiological signs of severe osteoarthritis in my right hip joint with bony outgrowth and acetabular impingement. (My other joints are fine and I liked to joke "the rest of me is perfect".)

The surgeon speculated that I might have had a slipped upper femoral epiphysis as a teenager. My history is that I had an episode of severe right hip pain as a 14-year-old and underwent surgery for what was described at the time as septic arthritis. Either way it was time for a joint replacement.

I have the "workaholic" traits common to many surgeons and was reluctant to take too much time off. However, six to eight weeks was strongly advised so I dutifully "cleared the books".

I had the usual preoperative blood tests, electrocardiogram and pre-anaesthetic assessment. Noting that my haemoglobin reading was 176 gm/dl, I decided against storing autologous blood, figuring that in my case some blood- letting might be therapeutic!

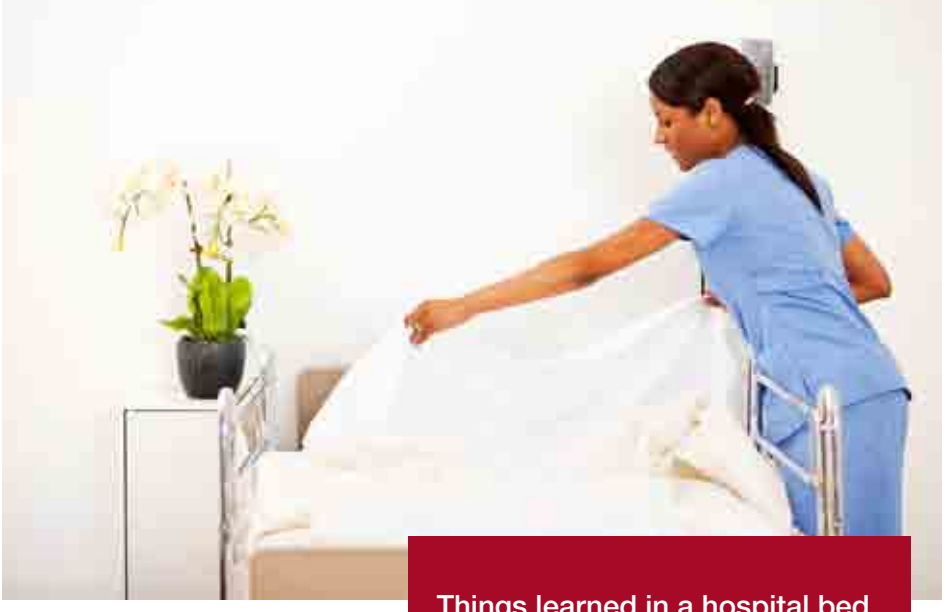
The day of surgery arrived and to my surprise I was not apprehensive: having confidence in the team was the key. I have worked and operated in the hospital for 20 years and know all members of the surgical team; this was very comforting. Everything went like clockwork.

The "spinal" was in (not unpleasant) and the last thing I remember was the anaesthetist injecting intravenous (IV) midazolam. The operation, as I was later to learn, went very smoothly with an un-cemented prosthesis used, a masterpiece of titanium alloy, cobalt-chrome and polyethylene. Total operating time was just over one hour.

I awoke as I was being transferred from the operating table back to a bed with a Charnley abduction pillow attached to my legs to prevent hip adduction/internal rotation that might risk dislocation. I was returned to the ward after a satisfactory X-Ray of the new prosthesis and lay comfortably in bed, somewhat euphoric, as I guess all patients are when they realise they have come through a major surgical procedure.

In addition to local anaesthetic, intrathecal morphine had been administered and this kept me very comfortable for 12 hours, long after the spinal anaesthesia had worn off. I blessed this innovation.

Late in the evening of surgery, a deep- seated ache in the hip area set in and I was then able to use a fentanyl patient controlled analgesia (PCA) system to control the pain, aided by IV paracetamol. The latter was surprisingly effective and I could feel an improvement in pain and joint mobility as soon as it was administered. While using the PCA I was required to wear nasal "specs" for supplemental oxygen; this is surely the most user-unfriendly device ever invented. The cannulae irritate the nares and frequently slip out. I surreptitiously removed them whenever I could. The indwelling urinary catheter was a godsend.



"I was returned to the ward after a satisfactory X-Ray of the new prosthesis and lay comfortably in bed, somewhat euphoric, as I guess all patients are when they realise they have come through a major surgical procedure."

Easily the worst part was being turned regularly on to my side (with the Charnley pillow in place) for pressure area care. The nurses were extremely diligent in this difficult activity. The area of the surgical wound became hot, red and itchy. This was post-operative inflammatory change and bruising, not infection (much to my relief), and an ice pack did wonders.

I was anorexic and a bit distended abdominally for two to three days, probably due to the inhibiting effects of the surgery and spinal anaesthetic on my GI tract. Eventually the passage of copious flatus solved this problem and at one stage I heard applause from a neighbouring room. Only in hospitals!

The day after the operation a physiotherapist and nurse got me to stand up holding a frame and to take a few small steps. This progressed rapidly to walking to the bathroom, then to sit in a chair and have a shower, a welcome, but painful and exhausting exercise the first time.

The turning point for me was going off the PCA and on to oral diclofenac. This was as effective as it had been preoperatively and my confidence and mobility increased rapidly. I was now free of all tubes.

By day five I was showering, dressing myself and walking the corridors with a frame, progressing to a walking stick.

I decided not to go to the rehabilitation facility which was offered and went home on day six, with oral analgesia and daily low molecular weight heparin (LWMH) injections. When you get home there are certain practicalities to attend to. The golden rules are not to flex your hip beyond 90 degrees, bend down or cross your legs. A toilet-raiser is needed, as well as a pick-up stick device and a higher than normal chair with arms to push yourself up (I used a garden chair with a cushion). I found it easiest to wear loose clothing and slip-on shoes.

I continued to make excellent progress at home, progressing to pain-free unaided walking in three weeks and a return to work in a limited fashion after four weeks. I did manage to catch up on some journal reading during this time, but here is only so much of this and daytime television that one can stand!

The main difficulty was sleeping on my back with a pillow between my legs to prevent crossing my legs. This had to be continued for six weeks, along with restricted hip flexion and bending, and no driving.

I consider myself lucky to have been able to have this operation at a time when it almost has been perfected, and complication rates minimised. I am impressed with the surgical skills and the range and quality of prosthetic hip joints;

Total hip replacement has been described by one of my orthopaedic colleagues as "the most successful operation ever devised". I won't argue with this somewhat extravagant claim. It certainly has changed my life and allowed me to continue walking and working, free of pain. If I need a revision hip replacement in 10-15 years I will not hesitate to ahead with it.

I am grateful to my surgical and postoperative teams, the designers and manufacturers of the prosthetic hip joints and of course to the late Sir John Charnley who pioneered the procedure in the UK in the 1960's and refined it over the following two decades.

Things learned in a hospital bed

- Everything you need is either out of sight or just out of reach
- Arrival of visitors inevitably coincides with mealtimes, nursing observations (or a visit from the surgeon) and is a cue for both your mobile phone and the landline to ring simultaneously.
- The number of nursing visits to your room in a given period is inversely proportional to your need for assistance.
- Oral oxycodone results in a dry mouth and halitosis. No one will tell you this, but the clue is that they stand well back when you are talking.

Advice to colleagues facing hip replacement surgery.

Don't delay the decision unduly; if you are having difficulty with daily activities or losing sleep, you already have left it too long.

- Find an orthopaedic surgeon who does a lot of hip replacements and revisions and has a good reputation in the field. Ask theatre nursing staff and anaesthetists -they always know.
- Let the surgeon use his/her usual team and normal routines. Become a patient, not a doctor and let the nurses and ancillary practitioners do their jobs. Nurses can be apprehensive about looking after surgeons. Make a point of telling them to treat you like any other patient.
- If possible have the procedure under spinal anaesthesia with IV sedation. Ask for intrathecal morphine.
- Afterwards, don't eat until you have passed flatus and feel hungry.
- Have a urinary indwelling catheter for 48 hours.
- Request an oral nonsteroidal anti-inflamatory drug as soon as you are eating, unless otherwise contraindicated. You may get urinary frequency and mild dysuria as a side effect.
- Continue LMWH DVT prophylaxis at home for three weeks.
- If you are still dependent at the time of discharge from hospital, or do not have help at home, consider going to a rehabilitation facility for one to two weeks.

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The Enigmatic Dr Brown

What do Dr Brown's casebooks reveal about his practice in the early 20th century?

Letter from Sarah Parish of Lorne to Dr Brown

Maud Fitzgimmons circa 1913

Mike Hollands
Honorary Treasurer

In June 1966, B K Rank reported to the Executive Committee of Council 'that the College has been presented with three volumes of operating notes of W H Brown who practised surgery in Colac from 1891 onwards.' The three bound casebooks date from 1899-1920 and contain some loose papers – including letters, pathology reports and photographs. Although they provide evidence of the diverse skills of the country surgeon in the early twentieth century, the books tell us little about their creator.

William H Brown was a member of the Royal College of Surgeons of England (MRCS). In the 19th century this was a Conjoint Diploma paired with a Licentiate from the Royal College of Physicians (LRCP). Many surgeons stated practice with a MRCS and then completed a Bachelor of Medicine and Surgery a year or two later. Dr Brown never took this next step nor did he obtain Fellowship of the English College.

When Dr Brown came to Colac in the early 1890s, it was a large and prosperous town central to the Shire of Colac which had been established in 1864. Serviced by a railway that linked it with Geelong, Melbourne and the Otway Ranges, its first hospital was established in 1879.

By the early 20th century the two main medical groups in the town, which included Dr Brown's practice had established their own private hospitals – Dr Brown's was called Derinook. These private concerns were probably bigger than the main Colac hospital which only had one or two beds. Patients who could not walk were ferried to hospital either by Ashford litter, horse and cart or the mail truck – after it had delivered the mail.

Prolific and varied

Dr Brown's practice was a mixture of surgery, gynaecology and 'physick' and it appears to have flourished until 1920 when his name disappears into oblivion. After this time, his son, Dr Arthur Edward Brown – later infamously known as 'Commy Brown' for his advocacy in the 1930s for a Nationalised Health Scheme – is dominant in the Colac Health scene.

What do Dr Brown's casebooks reveal about his practice in the early twentieth century? Cases of appendicitis such as that of

> *"Patients who could not walk were ferried to hospital either by Ashford litter, horse and cart or the mail truck – after it had delivered the mail."*

William Bell in February, 1905, were rife. In Bell's entry, Brown writes '... the peritoneum stitched and cut gut sutures to draw out the muscles. External fascia sewn with silk then horsehair for the skin. [sic]'. After 1908, catgut and silk were the most commonly used sutures, but Brown prefers the nineteenth century method of 'mixing and matching' his sutures. In January, 1914, he operated on Lenny Calvert's inguinal hernia and uses '... three silver sutures to join conjoint tendon to steep surface'.

Colac was a cattle and potato area so the scourge of hydatids is barely evident in Dr Brown's casebooks. However, he dealt with a plethora of female ailments – ovarian cysts, breast and fallopian tube removal - as well as ulcers, gallstones and operations for tumours. Significantly, he also performed a rhinoplasty on Maud Fitzsimmons in July, 1912. Rhinoplastys were not particularly common in rural practice and this operation was clearly outside the scope of Brown's expertise. Mrs Fitzsimmons returned to the hospital in June, 1913, and Brown records that 'The last operation was quite unsuccessful as regards its object viz to bring the nose forwards and prevent its lower end falling in again.'

A spectral character

Dr Brown also appears to have been active in professional medical circles. In the British Medical Journal of March, 1910, he gently refutes (he had performed the same operation seven years earlier) Mayo Robson's claims about performing a Gastro-enterostomy in acute dilation of the stomach. A spectral character, Dr Brown lives through his casebooks – a small, but poignant glimpse of an early rural surgeon.

With Elizabeth Milford, College Archivist

THE GARNETT PASSE AND RODNEY WILLIAMS MEMORIAL FOUNDATION

AWARDS FOR 2011

PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2011.

Project Grants are for a period of up to three years and must be conducted in an Australian or New Zealand institution. Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2011, 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, equipment, maintenance and all other costs. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 27 August 2010

GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2011.

Grants-In-Aid are for a period of up to two years and must be conducted in an Australian or New Zealand institution. Otolaryngologists or Trainees in the Specialty are eligible to apply. Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2011, is ineligible.

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

Closing Date: 27 August 2010

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

The Secretary
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PO Box 577
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Surgical Mortality

The Northern Territory and Queensland are to collaborate on a new audit of surgical mortality for the Territory

Julian Smith
Chair, Research, Audit & Academic Surgery

The Queensland Audit of Surgical Mortality (QASM), in June 2010, begins a collaborative project with the Northern Territory Audit of Surgical Mortality (NTASM). This project is funded by the Northern Territory (NT) Department of Health and Families. It will allow QASM to assist with and share experience gained in establishing a College-supported surgical mortality audit.

All state-based audits conduct external, independent, peer review of surgical mortality and are funded by the individual State Health Departments (Western Australia, Victoria, South Australia and Tasmania) and have protection under federal quality assurance legislation. New South Wales is a member of the Australian and New Zealand Audit of Surgical Mortality Steering Committee, but operates outside of the College under the management of the NSW Clinical Excellence Commission (CEC). The Australian Capital Territory will begin data collection in July 2010.

Northern Territory surgeons and the NT Department of Health and Families will provide members to a NTASM-Steering Committee. QASM surgeons will also participate on the committee with the Queensland Regional Chair and the QASM Clinical Director taking part. Professor Guy Maddern, the Chair of the ANZASM Steering Committee, is keen for surgical specialty groups in the College to provide representatives.

Queensland surgeons may be asked to assess Northern Territory cases at both first-line and second-line assessment levels. Likewise, NT surgeons may be asked to assess Queensland cases. The QASM office, based in Brisbane, will administer NTASM with the vital help of key staff in NT hospitals.

Most major surgical work in the NT occurs in two major hospitals: the Royal Darwin Hospital, and Alice Springs Hospital. Both public hospitals will be participating in NTASM.

QASM welcomes and supports this evolving project with NTASM, and would like to thank Northern Territory surgeons for this opportunity for important collaborative work.

Brisbane surgeon wins international award

Webcast real-time surgery recognised for benefits in training

Colorectal surgeon Professor Andrew Renaut recently won a prestigious international award for his groundbreaking use of technology to webcast live and archived surgery to trainees and surgeons across the globe.

The Brisbane-based surgeon was honoured for his work in setting up an internet-based multi-media company called Videosurgery to stream a live-feed of the surgery conducted in a self-funded, specially-equipped theatre at the Brisbane Private Hospital.

Professor Renaut, with the assistance of production technicians located in an adjoining room, offers members a view of the surgery being conducted from a combination of wall-mounted and endoscopic cameras.

Since establishing his media company in 2006, Professor Renaut now has more than 2000 members and has set up the Australian Institute of Medical Education to manage the membership list and verify medical registrations.

Each time Professor Renaut plans to webcast surgery, all members are notified of the type and time of the procedure to be done while the software used allows viewers to put questions to him via his production assistants as he operates. Videosurgery is the only system currently operating in the world offering a live stream of real-time surgery.

Professor Renaut said he designed the system particularly to assist trainees, but also said that the more surgeons from a range of specialties willing to become involved in webcasting, the more it could be used for the purposes of continuing professional development.

"I have long had a passion for both education and technology and for some time felt that the Internet was being greatly underused in our profession," he said.

"There are, for example, many operating rooms located across Australia that have been kitted out with audiovisual equipment which is very seldom used, yet it would not be expensive or difficult to link that equipment to this technology.

"If we embrace this as a profession, not only will trainees have a chance to watch a variety of specialists go about their work, but it will also allow Fellows to watch new procedures being conducted anywhere in Australia either live or via the archive at a time that suits them."

Great training tool

Professor Renaut said his company was dedicated to offering webcasts of surgery across all specialties and urged Fellows to consider participating.

"I understand that people are cautious of new technology and that some people might see filming as an imposition," he said.

"However, we are now in a position to offer a great training tool to our junior colleagues and to each other in the spirit of free surgical education that has long been a defining aspect of our profession.

"While nothing is as good as actually being there, standing beside the surgeon, this comes pretty close because it is live and because the archives are not edited.

"Anyone can make an edited video of surgery and take out the difficult or unexpected moments, but as specialists we should know how to deal with those moments and that is where live webcasting as an educational tool comes into its own."

Professor Renaut has so far webcast 100 procedures including bowel resections, gallbladder and hernia operations. The number of members tuning in at any one time is variable depending on the time and type of surgery being conducted, but the system allows for up to 2000 simultaneous viewers.

"We have neurosurgery and orthopaedic trainees and surgeons as members so they don't necessarily want to see gallbladder surgery," he said.

"But if we had Fellows webcasting around Australia and around the clock then more people will be able to watch what they wish to watch."

Professor Renaut said all patients were asked for their written consent before entering theatre and were draped and anaesthetised before filming began to preserve anonymity. He said surgeons wishing to participate really only needed to provide a running commentary to explain what they were doing - much as they do now with registrars and trainees.

Webcast conferences

He said he had also used the software and Internet platform for the high-definition webcasting of medical conferences around the world.

"I have set up a system to record and webcast power-point presentations plus the actual presenters which can then be kept so surgeons can refer back to them at any time."

The award presented to Professor Renaut was made to him in April at the Wisconsin headquarters of Sonic Foundry, a global leader in webcasting using its patented Mediasite platform and content management system.

The judges praised Professor Renaut's program for "giving surgical trainees unprecedented access to live surgery and allowing them to appreciate unexpected events that may occur so they can learn from professionals how to cope with them in real time".

He said that while he was honoured to receive the accolade, his focus remained on helping trainees learn what they needed to learn in an environment of a time-poor surgical workforce and a public hospital system under increasing pressure.

He also said he believed the live webcasting could be of use to allied health professionals who have limited access to theatre.

"Theatre nurses could use this to learn about instrumentation and theatre set-up while physiotherapists could also be interested to see what is actually done in theatre so they have a better idea of what may be needed in post-operative therapy," he said.

"If we get this right and if we finally get world-class broadband in Australia I also believe this could end up being an important export industry to China and India."

Professor Renaut works out of the Brisbane Private Hospital and the Northwest Private hospital and has an academic appointment at Shandong University in China.

With Karen Murphy

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