SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:5 June 2009

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This years Annual Scientific Meeting was a triumph for the College.

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There is a new tradition for the Indigenous Health Committee.

Successful Scholar, page 20

"I've been impressed at how supportive the College is to people who want to do research."

Fellows in the News, page 44

"It was a typical day when the call came through alerting the hospital to a fatal boat blast."

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

Rowan Nicks Fellowships

AUSTRALIA & NEW ZEALAND/ UNITED KINGDOM & REPUBLIC OF IRELAND

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of the United Kingdom and the Republic of Ireland, and Australia, to apply for the **Rowan Nicks Fellowships**. Rowan Nicks Scholarships and Fellowships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country.

The **Rowan Nicks Australia and New Zealand Fellowship** is offered to a surgeon from Australia to take up the Fellowship in New Zealand. The **Rowan Nicks United Kingdom and the Republic of Ireland Fellowship** is offered to a surgeon from the UK or Republic of Ireland to undertake the Fellowship in Australia or New Zealand. The Fellowships are intended to provide an opportunity for surgeons to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The aim is to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base.

Applications for the 2010 Fellowships close on 31 October 2009.

For further information and application details, please refer to the College website: www.surgeons.org or contact Sunita Varlamos, Secretariat, Rowan Nicks Committee:

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The 2009 Annual Scientific Congress

Convincing answers are provided to the many important questions we face

Ian Gough
President

Congratulations to all involved with the highly successful 2009 Annual Scientific Congress (ASC). The College has deliberately structured a program that is relevant to all Fellows and Trainees of the College in key issues including professionalism, communication, research and advocacy. These are highlighted next to the technical advances in many of our specialties. As emphasised by Hollands and Miles[1] in a recent article of the *ANZ Journal of Surgery* the commitment to lifelong learning and the active participation in a CPD program is driving the progressive development of the ASC. Educational formats are now varied and although the didactic lecture still has a role, there are more workshops, interactive case presentations and small group discussions. These are important to ensure that convincing answers are provided to the many important questions we face.

The quality of the faculty is critical and the RACS visitor program combined with support from our industrial partners is able to provide outstanding international leaders from across the world to discuss issues of revalidation, international humanitarian aid, educational advances, as well as the progress of our individual specialties.

Although there were many outstanding presentations the presentation by one of our Trainees, Dr Rowan Gillies was particularly notable. Dr Gillies is a Past International President of Medecins Sans Frontieres (Doctors Without Borders). He gave an inspiring talk on his work in many refugee camps around the world, but a talk that was tinged with both the horror and despair that this critical work confronts. A large and appreciative audience was clearly moved by this wonderful lecture.

Kelvin Kong, Ian Gough & Rowan Gillies at the ASC

Strengths of our advocacy – being the unifying force for surgery

Readers of *Surgical News* would be aware of the vigorous advocacy the College has been undertaking around issues of National Registration and Accreditation. This representation by senior Fellows and the detail of our many submissions has been most substantial. It is rewarding to say that success has been achieved. The College will remain vigilant to ensure that the communiqué released during the week of the ASC is fully detailed within the upcoming legislation. However, key issues now agreed by the Ministerial Council include

- Professional accreditation functions will be independent and use existing accrediting bodies such as the Australian Medical Council
- Specialty registers for the medical profession will exist. Importantly specialist registers will not cover "area of need" practices
- Continuing professional development will be a requirement for annual renewal of registration
- National boards will have at least half but not more than two thirds of the members being practitioners and at least two must be appointed as community members
- State and Territory Boards will also exist to oversee registration and complaints processes in their area as delegated by the National Boards.

At the same time careful observation will need to be continued as the ministerial council also stated that there will be a requirement that practitioners and employers (such as hospitals) report registrants who place the public at harm and that criminal history and identity checks will also apply to all health professionals registering for the first time in Australia.

The College regards these outcomes as major achievements and I thank all Fellows who have contributed to our advocacy at local, regional and national levels. ➔

Strengthening Continuing Professional Development

The vast majority of surgeons successfully fulfil their responsibilities to professional development through the College or associated groups. However we need to remain aware of the issue that we may not be assessing our day to day clinical performance to the level required. The College needs to address this by a number of methods. Already in active discussion is the requirement to make involvement with surgical mortality audits compulsory in the regions where it is provided. Funded by the various State Governments in Australia (Except Australian Capital Territory and Northern Territory), and with strong leadership by the College, the mortality audits have progressed and matured to the level where compulsory involvement should now be addressed.

Compulsory involvement with mortality audits has already been the focus of lively debate at the Surgical Leaders Forum in February. Based on that discussion a motion proposing that mortality audits are compulsory in areas where they are available will be presented to June Council.

Challenges of re-validation

By maintaining a strong focus on compulsory professional development with demonstrated audit involvement and local peer review, it is hoped that the re-validation struggles that appear to have occurred in United Kingdom and United States of America would be avoided in Australia and New Zealand. Presentations at the ASC warned of the challenges and the heavy bureaucratic involvement that could confront us. However, to ensure we have a system that works will require the College and Specialty Societies to be pro-active in ensuring that we can assure the communities that not only do we stay up to date across all the competencies of being a surgeon but that our technical expertise is assessed, monitored and reviewed.

Reference:

1. Hollands M, Miles C. The annual scientific conference: what does the future hold? *ANZ J Surg* 2009;79(3):205-7.

Dean of Education

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

The College is associated with a number of Surgical Societies and Associations and is the Australian Medical Council accredited provider of Surgical Education and Training to over 7,000 Fellows and Trainees. Importantly the College is now developing an Academy of Surgical Educators who are the key faculty delivering our courses and training programs. The appointee will be in the key leadership role to develop and promote a strong and collaborative educational ethos throughout and beyond the College.

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

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

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

Applications in writing to the Chief Executive Officer, Royal Australasian College of Surgeons, 250 - 290 Spring Street, EAST MELBOURNE VIC 3002 by June 30 2009

A long-term health reform plan

The National Health and Hospitals Reform Commission charts a new course

Ian Dickinson
Vice President

When the interim report of the National Health and Hospitals Reform Commission was released in February the focus in the press was on options for the Commonwealth to take over the entire health system. Beyond the headlines there are significant changes proposed that are of great interest to the College and surgeons. These are being digested by the Department of Health and Ageing and other agencies towards policy implementation. The College is active in engaging with the Government on this agenda from a surgical perspective.

The mandate of the Reform Commission was to provide a long term health reform plan that would tackle some key challenges including –

- The rapidly increasing burden of chronic disease
- The ageing of the population
- Rising health costs
- The inefficiencies of the "blame game"

The report is a readable 386-page doorstopper and there are many elements that will be of interest to surgeons.

Preventive health

The report sustains a theme developed by the then Labor Opposition through its 2007 election campaign by focussing on prevention of illness under the banner "Taking Responsibility". Proposed reform directions on prevention include the targeting of disadvantaged groups, the establishment of a health promotion and prevention agency, the development of 10-year health promotion and prevention goals and the review of regulatory barriers to health promotion by employers and health insurers. While the report notes the necessity to take a "broad view" of what contributes to health, citing community connectedness, urban planning and a sustainable environment there is little evidence of a greater "whole of government" approach to illness prevention.

One notable exception is in car design where higher standards of safety through Australian Design Standards managed by the Department of Transport might prevent much injury and death.

Hospitals

The report states that expenditure on hospitals is forecast to be the fastest growing cost element over the next 25 years. The Reform Commission proposes several quite significant changes in respect of hospitals. Firstly low urgency presentations (21 per cent of emergency presentation categorised as semi-urgent or non-urgent) are argued to be better served by primary health care services encouraged and fostered by the Commonwealth. Secondly the Commonwealth is proposing a stronger role for safety, quality, clinical governance and leadership in Australian hospitals. This would be achieved by reporting against national clinical indicators, financial incentives, national access targets, collection of episode data and "sustained national leadership" through something like the Australian Commission on Safety and Quality in Health Care.

Of interest to all surgeons is the proposal to fund hospitals to provide a minimum level of bed availability and activity for emergency departments. This, and proposals to better separate emergency and planned surgery are aimed at dealing with the resource competition between the two spheres. State medical administrators however will ask "where is the money?"

Indigenous health

The government has shown leadership with its strategic objective to close the life expectancy gap between Indigenous Australians and the rest of the community within a generation.

The Reform Commission gives this significant attention within a section called "Facing Inequity" (Rural Health is within the same section). The report notes that most Aboriginal and Torres Strait Islanders live in a major city or regional centre but that they are more predominant in remote areas. →

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To illustrate how taxpayer money disproportionately favours the advantaged over the (largely) Indigenous disadvantaged, the report records how Medicare funded primary health care costs Australia $80.00 per person in remote Western Australia and $900 per person in metro Sydney.

One of the key challenges for the College in the field of indigenous health flows from the under-representation of Indigenous people in the medical workforce. Increasing the Indigenous workforce is seen as very important to the 'closing the gap' agenda. The report promotes significant investment in aboriginal-controlled community health services, increases in investment in aboriginal health and the training of the Indigenous health workforce. There are clear implications for the College in potential curricula, strategic relationships and projects.

Rural health

The report notes that Australians' health outcomes worsen with remoteness and that building a quality health workforce in remote and rural areas is a ....

"complex challenge and requires sophisticated strategies of recruitment and support"

This section should be read together with a section titled "Working for us: a sustainable health workforce for the future".

From a surgical perspective there is little encouragement for rural surgeons. Whereas at the state level there is some support for "promoting surgical generalism" to deal (where appropriate) with the tyranny of distance, the Commission proposes very little.

The focus is on taking the person to care, networks of primary health care services (as if they don't currently exist!), Telehealth and on-call telephone and internet consultations get a mention as under-utilised. This is hardly a compelling recipe. The Commission does propose increasing funding to "national average medical benefits and primary health care service" levels but is vague on how this would be done or where the medical workforce would come from. The Commission is more commanding on the subject of new health professional educational undergraduate and postgraduate facilities being built in rural areas. The report argues these facilities are more likely to facilitate the retention of its graduates for the medical workforce in the rural domain.

"…students who train in rural areas are more likely to practice in rural Australia" (COAG Nov. 2008)

Driving quality performance

In addition to a specific chapter on this subject throughout the Commission report there is a focus on quality. Clinical indicators, continuous improvement, outcome measures, quality improvement and research – all get a lot of attention. Some of this focus can be seen as the natural evolution of public administration sometimes termed "new managerialism". New managerialism is briefly a movement away from the measurement of inputs (how much money was spent), or outputs (how many procedures were done) towards a measurement of results. The other explanation is that of vertical fiscal imbalance. The Commonwealth raises the bulk of taxes and the States spend it. Setting standards and finding robust, universal and meaningful measures of success and then holding a State or Commonwealth authority accountable is firmly on the agenda in the Reform Commission paper.

Clinical Training Agency

The proposal for the creation of a National Clinical Education and Training Agency did not receive support from the College. The UK experience suggests that failure to properly recognise the existing, interconnected, specialist training fabric can have serious unintended consequences for educational outcomes. Indeed the outcomes in the United Kingdom have been extremely counter-productive.

The Commission's report is the beginning of a reorientation of Commonwealth priorities. The Commonwealth seeks and needs trusted opinion in this field and the College has an important role to play. The Commission's plan presents significant opportunities for the College in the fields of Indigenous Health, emergency, and workforce which we will pursue with vigour. The College has an important role to play in advocating continued high standards and improved service delivery.

Budget 2009

The College was quick to respond to the recent Federal Budget, issuing a media release within 45 minutes of its being brought down. We expressed our concern at the government's announcement that the existing 30 per cent rebate paid to those with private health insurance will be progressively reduced for singles earning more than $75,000 per annum and couples earning more than $150,000 per annum.

Notwithstanding the increase in the Medicare levy surcharge, and some optimistic Treasury modelling, the decision to reduce the rebate paid to many Australians with private health cover will drive at least some of these people back into the public system. Moreover, the upward pressure this will place on insurance premiums could drive poorer and more vulnerable Australians back into the public system.

With our public hospitals at breaking point, it is unsustainable for the federal government to try to retrieve money from them at the federal level while withholding the funds that states and territories need to invest at the "coalface" of the public health system. Far from delivering on the Rudd Government's stated determination to "end the blame game", it is likely that this decision will only exacerbate the blame game played between the levels of government. This development does not bode well for our public hospitals, particularly in light of the fact that the Interim Report of the National Health and Hospitals Reform Commission was ominously silent on the need for extra spending.

"One of the key challenges for the College in the field of Indigenous health flows from the under-representation of Indigenous people in the medical workforce."

The Surgical Leaders Forum

The joy of the forum is to see all the talk over cups of coffee after the session

I.M.A Newfellow

It had all the intrigue of an Agatha Christie story, all the excitement of an action movie, the boredom of the Federal Budget speech, the beauty of a romance and the humour of a comedy. It was placid, it was fiery, it was boring, it was interesting. I could go on and say that it was the best of times and it was the worst of times but I think that script has been written before.

I am speaking of course about the Surgical Leaders Forum at the recent ASC in Brisbane. You probably have not heard of this meeting. Now, you must understand that a fairly select group is invited to this ASC Forum – College Councillors, Chairs of Regional Committees, Presidents of Surgical Societies and the Chairs of the Surgical Education and Training (SET) Boards of Training. There are about 50 in total. The idea is to meet every three to four months so that issues can be discussed and thrashed out.

The Forums which usually occur just prior to a Council meeting in February, June and October are very good at progressing issues that are of unquestioned value to the Fellowship overall, but will trip up the yet-to-be-thought-through issues. Mr Nit Picker loves them as things can be discussed at length from many angles. Mr Pot Stirrer is also known to give things a not too subtle dig.

Well, in Brisbane discussed at length, not too subtle dig and thrashed out were all correct. All was placid until we came to the topic of the proposed "Academy of Surgical Educators". The idea of the Academy still stays confused to many people. For some it is a professional development effort to make available courses to provide ongoing opportunities to improve our educational skills in areas like being a supervisor, examiner or establishing curricula. However it is blurred with its own selection process and possibly elitism to create a group that is involved with such matters as course design, Trainee selection techniques and curriculum design. Now it seems that Mr. Pot Stirrer has a special interest here as his speciality does not like this confusion and because of that is yet to be convinced it is a good idea. Then the meeting became fiery (or at least luke-warm). As Mr Pot Stirrer saw it there already were departments within the College that should do the functions proposed.

"Mr. Pot Stirrer has a special interest here as his speciality does not like this confusion and because of that is yet to be convinced it is a good idea."

Mr. Pot Stirrer was also concerned that the new Academy would take over the functions of important committees such as the Education Board, the Board of Professional Development and Standards and the Board of Surgical Education and Training. Fortunately the Censor in Chief indicated that he did not see it as a threat to the autonomy of the Education Board and peace again reigned.

If that was not enough Mr. Nit Picker was there and was up to his old tricks, namely picking nits. Nobody had noticed that the business plan had some rather rubbery figures that needed closer and more critical examination. Well Mr. Nit Picker did notice and asked about the finances. As usual the Chief Executive Officer had his head around it all and was able to explain that the cost would not be great as there were to be some internal re-alignments that would assist greatly in the costs. As he said the College has already provided the Supervisors and Trainers Surgical Education and Training (SATSET) course to over 500 Fellows and that was already within our cost structure. Mr Nit Picker still was not too sure.

There was a new person in the meeting whom I had not seen before, Mr Willhe Protest. He made the point and made the point and made the point that the idea of a selection process for persons to enter the Academy implied elitism and that the surgical supervisors at the "coal face" were the real educators. This seemed to get some support but people were actually glad to hear from someone else apart from Mr Nit Picker.

The joy of the Surgical Leaders Forum is to see all the talk around cups of coffee after the session. You may have been left with the view that the Academy had been thrashed. I had been left with the overall feeling that it was not going to be an easy path forward. However I then saw some of the key players discussing in a rational and reasoned manner the main issues. Hopefully Mr Nit Picker and Mr Pot Stirrer will be happier next time. Certainly Mr Willhe Protest will be consulted – that is for sure!

It seems to me that if one of the main purposes of the College is to further surgical education, whether it be of Trainees or consultant surgeons, then we need all the help that we can get. However surgeons and particularly Australian and New Zealand are an egalitarian bunch. There should not be a self-defined elite that dictates educational matters to the elected representatives – sounds like a UK model to me!! Obviously Mr Nit Picker wants to be Treasurer next – he will make sure it is financially sound.

So in my own self-reflection I wandered to another small gathering – would that be a gaggle?? I am sure that I heard Mr. Nit Picker say that he agreed with the proposal provided that the $10 discrepancy in the budget he had detected was corrected; Mr. Pot Stirrer agreed with the proposal but also said something outrageous about an element of truth and Mr. Willhe Protest said it again and again and again. Oh well, that is the College for you – a strange mixture of personalities that somehow basically seems to work. The amazing thing is that they often get it right.

Horizon Scanning Network

Keeping stakeholders informed of new and emerging health technologies

Guy Maddern
Chair, Professional Development
& Standards Board

It seems as if manufacturers are bringing out new health technologies every day that purport to offer a significant improvement over current alternatives, and it is almost impossible to keep up with these advances. Importantly, it is also frequently difficult to understand whether these novel technologies truly are as safe, effective and cost-effective as the manufacturers claim. These are issues of importance not only to surgeons and other practitioners, but also to decision makers in state and federal health departments, who wish to be kept informed of developments and how this may, in the future, affect their health systems.

In 2003 the Australia and New Zealand Horizon Scanning Network (ANZHSN) was set up as an initiative of the Medical Services Advisory Committee (MSAC), the Australian Government Department of Health and Ageing (DoHA) and all Australian Health Ministers' Advisory Council (AHMAC) jurisdictions. The aim of the program is to provide advance notice of significant new and emerging technologies to health departments in Australia and New Zealand, and to exchange information and evaluate the potential impact of emerging technologies on their respective health systems.

Central to the operation of the ANZHSN is the Health Policy Advisory Committee on Technology (HealthPACT). HealthPACT comprises representatives from state and territory government health departments, DoHA and the New Zealand Ministry of Health, and MSAC. The Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) acts as one of two assessors for the process, specifically through our New & Emerging Techniques - Surgical (NET-S) horizon scanning team.

What is horizon scanning?

The methodologies are somewhat different to that used in traditional health technology assessment. It is not the intention of horizon scanning documents to be full and comprehensive systematic reviews (such as those produced by ASERNIP-S and MSAC); however, they provide rapid 'state of play' advice from the currently available evidence. The purpose of horizon scanning is to provide evidence to stakeholders regarding the potential impact of new technologies before they are introduced into the health system.

HealthPACT publish documents in one of two formats:

- horizon scanning prioritising summaries (short concise assessments of 10-15 pages)
- horizon scanning reports (more comprehensive assessments of 50-90 pages with more detailed analysis of available evidence).

Due to its very nature, the information on new technologies is often limited. Hence the program evaluators utilise a variety of sources to identify new technologies of potential interest, such as:

- access to horizon scanning/early warning systems in other countries
- reviews of industry literature (manufacturing and pharmaceutical)
- reviews of major and specialist medical and scientific journals
- interest group profiles
- experts and expert groups, including professional colleges - formal and informal networks
- conference papers
- news databases and other media sources, including financial reports/manufacturer announcements
- regulatory/licensing agencies e.g. Therapeutic Goods Administration, Food and Drug Administration.
- reviews on health futures and technology forecasting (time span >10 years).

Recent examples of horizon scanning assessments produced by ASERNIP-S for the ANZHSN include:

- prioritising summaries
  - percutaneous aortic valve replacement
  - transoral robotic surgery for head and neck cancers.
- horizon scanning reports
  - embolic protection devices for carotid artery stenting
  - continuous flow ventricular assist devices for bridge to transplantation.

These assessments are freely accessible through the ANZHSN website. Importantly, HealthPACT is a collaborative agency for EuroScan – the International Information Network on New and Emerging Health Technologies. This ensures that all horizon scanning information is shared in a wide forum.

More information on the work of HealthPACT and ANZHSN can be found at http://www.horizonscanning.gov.au/

Horizon scanning summaries and reports are also available on the NET-S page
http://www.surgeons.org/asernip-s

EuroScan is at
http://www.euroscan.bham.ac.uk/

Alternatively, for further information please contact Professor Guy Maddern or Dr Alun Cameron at ASERNIP-S by phone +61 8 8363 7513 or email asernips@surgeons.org

A new tradition

Collaborating with Indigenous health providers to improve the health of Indigenous people in Australasia

Indigenous Health Committee

Indigenous Health Committee (IHC) members embarked on a new tradition by holding their inaugural face-to-face meeting at Inala Indigenous Health Service (IIHS) on Tuesday 5 May 2009. The IHC made the decision to hold all future face-to-face meetings at a local Indigenous health service the day before the College's Annual Scientific Conference commences. By meeting at a local Indigenous community health service, Committee members receive a rare insight into the operational problems that face indigenous health providers as well as the solutions developed for the provision of health care to indigenous communities. Meeting Indigenous health providers will also raise the profile and awareness of the College's commitment to Indigenous health.

The Inala Indigenous Health Service (IIHS) was established in 1994, funded directly by Queensland Health. The health centre is based in Inala in South Brisbane – an area with a high population of Aboriginal and Torres Strait Islanders. The New Zealand members of the Committee were pleased to see at least two Maori Australians (Mozzies) wearing All Black jerseys in the waiting room of the primary health provider.

Over the years, the IIHS has developed a reputation as a leading and effective Indigenous health service centre increasing attendance from 5.7 per cent in 1995-96 to 24 per cent in 2005-06.

The Committee was greeted by Associate Professor Noel Hayman, Clinical Director of IIHS who navigated a tour of the premises. The IIHS was a visual delight and welcoming with the display of Indigenous art and artefacts placing an appreciation of culture central to health and well being. Most importantly, we were introduced to Elders of the surrounding Indigenous communities, who were not necessarily there for treatment, but had volunteered their time to oversee and support the IIHS.

We met the multi-disciplinary team of allied health professionals (general practitioners, physiotherapists, podiatrists and dieticians), and saw many specific interventions to increase access by indigenous patients to healthcare including Indigenous specific patient information pamphlets and brochures on better health management and promotional posters.

The IIHS vision is to remove Indigenous access barriers to mainstream health services. To achieve this five key strategies are used:

1. Employ Aboriginal and Torres Strait Islander staff,
2. Provide culturally appropriate health information and material,
3. Provide cultural awareness talk to staff members,
4. Engage and communicate with the Aboriginal and Torres Strait Islander community on a regular basis
5. Promote intersectorial collaboration

The Committee was treated to presentations from community Elders and staff members who emphasised the importance of Aboriginal and Torres Strait Islander doctors, the visiting services from endocrine, paediatric and psychiatry specialists, as well as the various projects through the government-funded Healthy For Life initiative and Medical Specialist Outreach Program. The Committee was advised that the notable absence of a visiting surgical service was currently being addressed.

Culturally appropriate service provision for detection, treatment, management and monitoring at IIHS has impressive results. Health checks of 15 to 50 year olds have increased from 25 per cent to 60 per cent. Most impressive is that 90 per cent of the IIHS's regular patients are of Aboriginal or Torres Strait Islander descent. Following the presentations and a hearty lunch, the IHC completed its Committee work in the IIHS conference room.

The benefits of holding the IHC's face to face meeting at this outstanding Indigenous health service emphasises the success of Indigenous-operated health services in defining community needs and reducing health disparity. On behalf of the College, the IHC will continue to meet and collaborate with Indigenous health providers to improve the health of indigenous peoples in Australasia.

Professional misconduct

Reporting Medical Practitioner misconduct in Australia and New Zealand

Michael Gorton
College Solicitor

It is important for any practitioner to be aware of when they may report another practitioner for misconduct and even more importantly to be aware of when they must report a practitioner's misconduct. A national scheme for mandatory reporting of professionals who may place the public at risk of harm is under discussion by Australian health ministers. However, at the moment each jurisdiction has its own different legislation and requirements. When faced with the possibility that a fellow practitioner may have been behaving improperly it is always a good idea to first seek advice as to the appropriate course of action.

New Zealand

Section 34 of *the Health Practitioners Competence Assurance Act 2003 (NZ)* governs when a practitioner can report another practitioner's misconduct. It states that when one practitioner "has reason to believe that another practitioner may pose a risk of harm to the public by practicing below the required standard of competence" the first practitioner may give written notice of this with reasons to the registrar of the relevant Authority.

In section 5 the required standard of competence is unhelpfully defined as the "standard of competence reasonably to be expected of a health practitioner practising within that health practitioner's scope of practice". Under the definition in section 5 and section 11 the scope of practice is determined by the relevant regulatory body. The requirement of "has reason to believe" is quite low. This does not even require that a person does believe or suspect that the practitioner may pose a risk of public harm but only that they have reason to believe this is the case.

In any case any person giving notice that a practitioner may pose a risk of public harm is protected from litigation by section 34(d) of the Act unless they have acted in bad faith. Therefore it is generally open to a practitioner to report another practitioner if they have reason to believe they may pose a risk to the public.

New South Wales

In New South Wales reporting of medical practitioner is dealt with under the *Medical Practice Act 1992 (NSW)*. Under section 41 of the Act anyone may make a complaint. Section 39 lays out the grounds for a complaint, the most important of which are (b) unsatisfactory professional conduct or professional misconduct and (c) lack of competence.

Examples of unprofessional conduct are given in section 36. The list includes, amongst other things, conduct significantly below a reasonable standard; contravention of various Acts; accepting benefits for referrals etc; overservicing (unnecessary medical treatment); and failing to render urgent attention. It is important to note that this list is not an exclusive definition and other conduct may amount to unprofessional conduct as well. Professional misconduct is defined in section 37 and is any one or more acts of unprofessional conduct that is sufficiently serious to justify suspension from practise or deregistration.

Section 71A(2) of the Act now also requires medical practitioners "who believe, or ought reasonably to believe" that any other medical practitioner has committed "reportable misconduct" to report the conduct in the same way a complaint under section 39 would be made. "Reportable misconduct" is defined in section 71A (1) as practising medicine while intoxicated by drugs or alcohol, practicing in a manner which is a "flagrant departure from accepted standards of professional practice or competence and risks harm to some other person", or engaging in sexual misconduct. While the first and last examples of reportable misconduct are fairly clear, the meaning of "flagrant departure from accepted standards" is less obvious.

Flagrant departure from accepted standards is a high threshold. A flagrant departure would have to be more than just a difference of opinion. To satisfy the threshold the conduct would have to be an obvious or glaring departure from standard practice. Therefore practitioners will only be compelled to report their colleagues in these serious situations.

However, the Act makes it clear that failing to report any such conduct will amount to unprofessional conduct or professional misconduct by the practitioner who should have reported. Section 47 of the Act protects any person who makes a complaint or report in good faith from any liability for the complaint/report. In a situation where it is unclear if there is reportable misconduct or not, it may be safer for a practitioner to report the conduct than to ignore it.

Victoria

Victorian legislation provides for when notifications about health practitioners can occur. In Victoria, complaints about a health practitioner are governed by the *Health Professions Registration Act 2005 (Vic)*. Section 42 sets out when a notification can occur and includes circumstances of alcohol and drug dependency, unprofessional conduct and professional misconduct.

Unprofessional conduct is defined in section 3 of the Act, and includes failure to practise at a reasonable standard; providing services that are not reasonably required; and breaches of the Act. It is important to note that this is not an exclusive definition and other conduct may amount to unprofessional conduct. Section 3 also defines professional misconduct as a substantial or consistent failure to reach a reasonable standard of competence and diligence; conduct that is substantially short of the standard of professional conduct of members of the profession; or conduct that would establish that the practitioner is not a fit and proper person to practise in that profession.

Under section 36 of the Act a treating practitioner must report if the practitioner being treated has seriously impaired ability to practise or may seriously impair the practitioner's ability to practise – and the public may be put at risk. The Victorian legislation contains provisions protecting those practitioners who notify a responsible board under section 42. Section 37 protects the notifier from civil or criminal liability for any notice or report made in good faith.

Queensland

The *Health Practitioners (Professional Standards) Act 1999* (Qld) provides for when a complaint may be made. Section 47 of the Act states that any person may make a complaint, and section 48 specifies that a complaint may be made for any reason that would merit disciplinary action. One of the grounds for disciplinary action under section 124 is for unsatisfactory professional conduct, which includes failure to reach a reasonable standard; incompetence; misconduct in a professional respect; and providing unnecessary services. It is important to remember that this is not an exclusive definition and other conduct may amount to unsatisfactory professional conduct.

A recent amendment to the *Medical Practitioners Registration Act 2001* (Qld) will require practitioners to report misconduct in certain cases. Section 166 will require a practitioner to give notice of "reportable misconduct" when they become aware or reasonably suspect that it has occurred. The section defines reportable misconduct as conduct causing, or likely to cause harm to a person receiving services from the practitioner or sexual misconduct. Harm here does not mean only physical harm but includes any significant detrimental effect of a physical or psychological nature.

The requirement that the practitioner be aware or reasonably suspect the conduct has occurred is less onerous than the NSW provisions. Failure to make a report of reportable misconduct is a basis for disciplinary action and therefore if a practitioner is in doubt as to whether they should report or not, in general it may be safer to do so.

Western Australia

Complaints about medical practitioners in WA are dealt with in the *Medical Practitioners Act 2008 (Qld)*. There is no requirement in the Act that a practitioner must make a report about fellow practitioners. However, under section 83 any person may make a complaint which relates to impairment, competency or disciplinary matters.

Disciplinary matters are set out in section 76 of the Act and include failing to maintain the required professional standard, unnecessary treatment, sexual misconduct, and acting carelessly or improperly. Competency matters are defined in section 77 as having insufficient knowledge and skill to practise medicine or a speciality.

"...it is always a good idea to first seek advice as to the appropriate course of action."

Section 150 provides protection against torts (such as defamation) for anything done in good faith under the Act. Therefore any practitioner who chooses to make a complaint under section 75 would be protected from most civil actions, so long as the complaint was not made for an ulterior purpose.

South Australia

In SA complaints and reports about medical practitioners are covered by the *Medical Practice Act 2004 (SA)*. Under section 51 complaints may be placed before the Board by a "person who is aggrieved" for any conduct which would be grounds for disciplinary action. A person who is aggrieved is not defined in the Act, although it usually means someone who has had their legal rights infringed.

Section 49(1) of the *Medical Practice Act 2004 (SA)* imposes an obligation on a treating practitioner to report to the Board a practitioner being treated who is "medically unfit to provide medical treatment". Section 77 also requires a practitioner to notify the Board if he/she believes that he/she is or may be medically unfit to provide medical treatment.

If a practitioner finds themselves in a position where they are considering the need to make a complaint, then under section 46, disciplinary action may be sought for unprofessional conduct. This is defined in section 3 as improper or unethical conduct, incompetence or negligence, a contravention of the Act or a Code of Conduct endorsed under the Act, or committing an offence punishable by imprisonment for a year or more.

Tasmania

There are no mandatory reporting requirements for practitioners in Tasmania. Complaints about medical practitioners in Tasmania are covered by the *Medical Practitioners Act 1996 (Tas)*. Under section 44 any person may make a complaint about a practitioner for the reasons set out in section 45, which includes professional misconduct. Professional misconduct includes contravention, of the Act and some other Acts; incompetence, deceptive or misleading conduct; bringing the profession into disrepute; or trying to stop a person from making a complaint. Under section 44 any practitioner who makes such a complaint in good faith is protected. Therefore a practitioner in Tasmania can make a complaint without fear of litigation, so long as it was not made for some ulterior motive.

However, section 72 of the *Pharmacists Registration Act 2001 (Tas)* may require a practitioner to report in relation to a pharmacist in certain circumstances.

Australian Capital Territory

There are no mandatory reporting requirements for practitioners in the ACT. Under section 78 of the *Health Professional Act 2004 (ACT)* any person may make a report about a health practitioner who has contravened the "required standard of practice" in the ACT. The required standard of practice is defined in section 18 as the level of "professional judgment, knowledge, skill and conduct at a level that maintains public protection and safety". This may be prescribed in regulations for each speciality. Section 78 also protects anyone who makes a report from civil or criminal liability, unless they know it to be false or misleading.

Northern Territory

There are no mandatory reporting requirements for practitioners in the NT. Aggrieved persons may make complaints in the NT under section 55 of the *Health Practitioners Act 2004 (NT)*. Since an aggrieved person is generally one whose legal rights have been infringed it is less likely that a practitioner would be able to make a complaint under the Act. Section 56 of the Act sets out matters about which complaints may be made. This list includes lacking the capacity to practice competently and engaging in professional misconduct. Professional misconduct includes contravening the Act or any other health Act; negligence or incompetence; and behaving in a fraudulent or dishonest manner. It is important to note that this is not an exclusive definition and other conduct may amount to unprofessional conduct.

Under section 118, anyone who makes a complaint in good faith is protected from civil or criminal liability. Therefore a practitioner in the NT can make a complaint without fear of litigation so long as it was not made for some ulterior motive.

Women in surgery

Women represent a key untapped pool of surgical potential that the Committee hopes to reveal

Kate Drummond
Chair, Women in Surgery

The Women in Surgery Breakfast session was a popular and productive event at the ASC. Approximately 30 delegates attended a lively discussion on the challenges of attracting and holding women in the surgical profession. Women in Surgery Chair Kate Drummond made sure that participants worked for their breakfast with the room divided into groups discussing critical issues of workforce participation and retention, workplace design and work/life balance for men and women in surgery.

Having been active since 1994 guests examined the ongoing relevance of the Committee. At just eight per cent of the surgical workforce, and at a time of intense workforce supply challenges, women represent a key untapped pool of surgical potential that the Committee hopes to reveal.


Kevin Staveley-O'Carroll, David Watson, Melina Kibbe, Kim Kirkwood & Susan Neuhaus

Inspirational course takes off

The aim of the course was to provide insight and demystify academic practice

The Section of the Academic Surgeons (SAS) recently convened the inaugural "Developing a Career in Academic Surgery (DCAS)" course on the day before the Annual Scientific Congress in Brisbane. It was an inspirational and highly successful course, made possible because of the generous and stellar contributions of 16 faculty members.

There were seven visiting faculty from the Association of Academic Surgeons (AAS), the largest organisation of academic surgeons in the world and based in the United States, and nine faculty members from around Australia and New Zealand. While Scott LeMaire (AAS) and John Windsor (SAS) were responsible for the course, the credit for the superb organisation goes to Richard Hanney, who was ably supported by Caroline Handley and Andrew Hill. The course was underwritten by a non-aligned educational grant by Johnson and Johnson, and they have committed to ensuring that this course continues into the future.

The course hit the target. It attracted 56 registrants, the majority of whom are engaged in surgical research or those contemplating it. The purpose of the course was to provide an insight into, and demystify, academic practice by promoting its positive aspects, making it more accessible to participants. The audit of the course indicated that these aims were more than met, with the overall rating for the course at 4.88 out of five. There is a search out for the dissenter! All registrants left with all of the talk captured as PDF files on a flash drive, to ensure the continuing benefits of the course.

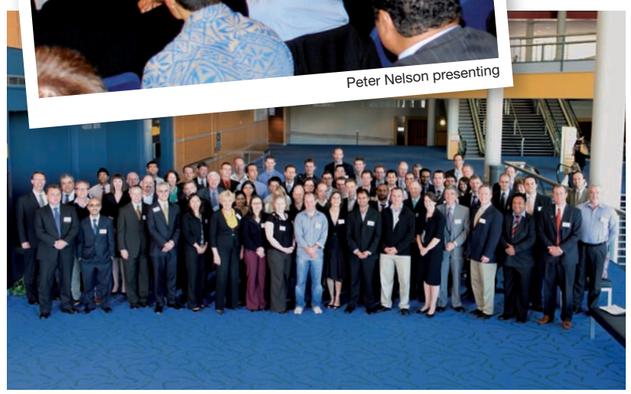
The content of the course was varied and was drawn from two separate two-day courses run by the AAS. One is for those who are engaging in surgical research and the other for those seeking to establish a career in academic surgery. There were many highlights of the course: Professor Ian Gough, President of College, opened the meeting with an affirmation of the importance of academic surgery and Scott LeMaire from Houston spoke with passion about what it means to be an academic surgeon and the inspiration he drew from his mentor and surgical hero Denton Cooley.

Other highlights included a pragmatic talk on academic writing by Melina Kibbe of Chicago. It is quite clear that she uses a lot of red ink with her research fellows. Lillian Kao from Texas spoke on "Design, Power and Statistics" and it made sense. It was the sort of talk that every research fellow needs to hear at the outset. She emphasised that statisticians need to be engaged early in the research process and should not be asked to do a post-mortem on the analysed data. Collaboration with basic scientists is critical for many research programs, and Kim Kirkwood from San Fransisco, reassured us that it sounds like they are speaking French, that we will feel like idiots for some of every laboratory meeting and that this feeling does not subside with the passage of time. The most highly rated talk was by Kevin Staveley-O'Carroll (AAS President from Pennsylvania) who 'walked the talk' on effective research presentations.

There were excellent talks on developing a research program (Peter Nelson, Florida), running clinical trials (John Fletcher), clinical and translational research (Mark Smithers), medical education research (John Collins), being an effective teacher (Jeff Hamdorf) and writing successful research grants (David Watson).

Mike Solomon spoke about surgical outcomes research and the highly successful masters program that is being offered from the University of Sydney. Ian Civil spoke about academic surgery and the College, highlighting that one of the fundamental reasons for the formation of the College in 1924 was to support research. Max Schmidt from Indiana spoke from his heart about finding the balance between work and life, and inspired all with the example he sets as father and husband. Many could not understand how he could be so productive as an academic surgeon and not take any work home with him. He admitted that he occasionally worked late in the office.


Peter Nelson presenting



Top: DCAS attendees
Above: John Fletcher, Lillian Kao, Peter Nelson, Melina Kibbe & Christopher Christophi

Ben Loveday, a Trainee from Auckland, ended the day on just the right note with an inspired talk on academic surgery from a surgical Trainee's perspective, with an overview of the reasons for doing research, what is required to be successful in research and what would encourage more surgical trainees to do research.

The inaugural course has sealed a wonderfully collegial relationship between the SAS and the AAS and this will make a significant contribution to our Trainees and younger Fellows in the years to come. One of the additional benefits of having the involvement of our American colleagues in this course was that they were put to work during the Annual Scientific Congress, in their respective specialities and there were many reports of their outstanding contribution. John Cameron, the visiting President of the American College of Surgeons was amazed to encounter so many younger academic surgeons at our Congress and was delighted to see their level of engagement. This completed the loop very nicely, as the opportunity for this pilot project had originally come from the ANZ chapter of the ASC in Christchurch just two years ago.

HOMESTAY ACCOMMODATION FOR VISITING SCHOLARS

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

Due to the short term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. The International Scholarships Department and Project China are seeking expressions of interest from those willing and able to provide homestay accommodation for our visiting scholars. If you have a spare room, and are interested in learning about another culture and language, 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 nominal stipend.

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

International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street, Melbourne, Victoria,
Australia, 3000
Telephone: + 61 3 9249 1211
Fax: + 61 3 9249 1236
Email: international.scholarships@surgeons.org

Definitive Surgical Trauma Care Course (DSTC)

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) is pleased to announce the courses for 2009.

The DSTC course is an invigorating and exciting opportunity to focus on surgical decision-making and operative technique in critically ill trauma patients. You will have hands on practical experience with experienced instructors (both national and international). The DSTC course has been widely acclaimed and is recommended by the Royal Australasian College of Surgeons for all surgeons and Trainees.

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.
Please register early to ensure a place!

To obtain a registration form, please contact Sonia Gagliardi on 02 9828 3928 or email: sonia.gagliardi@sswahs.nsw.gov.au

2009 COURSES

Sydney
Military Module
21 July 2009

Sydney
22 & 23 July 2009

Adelaide
3 & 4 September 2009

Better communication in NSW

Our goal as surgeons is to provide the best possible care for our patients

Joseph Lizzio
Honorary Secretary
NSW Regional Committee

Communication & NSW Public Hospitals

"Clear, reliable and accurate communication between health professionals is essential to patient safety and the efficient operation of New South Wales (NSW) public hospitals." This statement is from the final report of the Special Commission of Inquiry into the Acute Care Services in NSW Public Hospitals by Peter Garling SC which was released in NSW on 27 November 2008 following a long period of disquiet over the state of the NSW hospital system. The Commission visited 61 public hospitals; heard evidence from 628 people, including patients, community members, doctors, nurses and allied health professionals; received over 1200 written submissions; conferred with 27 peak bodies such as the College and received extensive briefings from NSW Health and the staff of the eight area health services.

Poor communication & distrust – how bad is it in NSW?

The Inquiry received a large amount of evidence about the divide between clinicians and management. The breakdown of good working relations between clinicians and management was seen to be very detrimental to patients. The Inquiry heard that the amalgamation of area health services in NSW to form eight huge areas and the new management structure has not allowed the same input by clinicians as the previous structure and has diminished the interaction between management and clinicians. Clinicians feel disempowered and unable to contribute to hospital or area health management. They say that decisions are made by senior managers or the chief executive with little feedback to those involved as to how their views were considered. Clinicians are feeling disengaged from the whole feeling of belonging and feeling proud of their hospital.

Clinicians expressed disquiet about a lack of consultation by managers who are making decisions affecting patient care. They told the Inquiry that they are not invited to attend meetings at which decisions are made that bear directly on clinical work. The inquiry found the lack of communication between management and clinical staff to be quite demoralising. The Inquiry found that there is considerable distrust by clinicians of managers. The witnesses gave evidence that the worsening disconnection between administration and clinicians has occurred over the last five to six years.

Examples of better communication & clinician consultation

The Inquiry also found examples where hospitals had involved clinicians in the running of the hospital more successfully than others. The fewer problems with regard to clinician-management engagement were due to good communication and management. The clinicians felt that they were listened to by management. The example involved a governance committee which included clinicians from each division of medicine and surgery and management staff. The Inquiry found that this was simply a communication structure creating a sense of involvement which is very important to the public health system.

The Inquiry heard that a major medical indemnity organisation has identified poor communication as a major risk to patient safety in NSW public hospitals, and one of the most important factors contributing to adverse health outcomes. The Inquiry found that the open exchange of timely and appropriate information regarding adverse events is vital to drive and support improvements in the safety and quality of health care. It also found that reconnecting clinicians with management requires communications to involve clinicians to redesign clinical practices where necessary, and to monitor safety and quality of care of units and wards. It found that unless clinicians are involved in the design of models of care, the prospects of successfully introducing any model of care locally or on a state-wide basis is negligible. NSW Health acknowledged that it encounters difficulties when models of care are mandated that have not been developed with substantial involvement of clinicians.

Role of the College

The NSW Regional Committee has visited hospitals in NSW and reported that the breakdown of communications between clinicians and management is widespread and particularly affects surgeons. These findings and the report on surgical services have been noted by the Director General of Health. While the Committee can advocate better communication at a state and area level, it is for individual surgeons to strive to improve communication with their local hospital management.

The College Regional Committee in NSW has been a communication link between the state Medical Board and all surgeons and Trainees in NSW and has drawn attention to issues arising from cases that have been referred to the Professional Standards Committee of the Board. These are de-indentified clinical cases involving allegations of unsatisfactory professional conduct by surgeons and the scenarios are used as a learning tool to raise awareness. NSW Health is also communicating with all Fellows and Trainees in NSW via the NSW office of the College regarding recent cases of operations being carried out on the wrong side or the wrong patient despite "Time-Out" having been observed. The communication via the College is aimed at having a greater impact on all Fellows and Trainees than simply an e-mail bulletin from the department of health.

The Commission of Inquiry found that the supervision of Trainees also required a stronger engagement between hospital management and individual senior clinicians to ensure that every junior doctor was truly supervised at all times. As an example, the Inquiry noted that the low rates of hand hygiene among health professionals are particularly confronting when considered against the requirements of their professional bodies and statutory regulations. The NSW Minister for Health has put doctors on notice of the disciplinary consequences of non-compliance with hand hygiene.

Every Fellow working in a NSW public hospital would agree totally with the findings of Garling SC regarding the poor state of communication and the divide that exists between clinicians and public health care management. Our goal as surgeons is to provide the best possible care for our patients and this requires Fellows and Trainees to communicate with management of the public hospital system. Communication skills are part of the non-technical modules of Surgical Education and Training (SET) requirements.

What you can do with unwanted fat

Trainee Michelle Locke, is investigating the potential uses of mesenchymal stem cells

Plastic surgery Trainee Michelle Locke readily admits that visiting plastic surgeons rooms and asking liposuction patients for their unwanted fat was an amusing experience – though necessary for her research.

While some patients thought she was part of a candid-camera style prank, all agreed to the strange request once she explained that she needed the adipose tissue to further her stem cell research. Now her work investigating the potential uses of mesenchymal stem cells, undertaken as an MD project through the University of Auckland's School of Biological Sciences, stands amid some of the most fascinating research into such stem cells.

So far this work has won her the Plastic and Reconstructive Research Award (2007 and 2008), the Foundation for Surgery Research Scholarship (2007), the Foundation for Surgery New Zealand Research Fellowship (2008) as well as a grant through the Stevenson Charitable Trust in Auckland.

Dr Locke said that mesenchymal stem cells, one of the three types of adult stem cells, were those that grew bone, fat and muscle and that her two-year research project investigated how to isolate and identify the stem cells from adipose tissue, how to grow them and their potential uses in the regrowing of tissue as part of reconstruction surgery.

"After liposuction, litres of fat get thrown away so I went around collecting some of it for this project and there's no doubt that it was an amusing experience to ask people for their unwanted fat," she said.

"Not surprisingly, most people were very happy to give it away.

"Then I took it back to the laboratory, washed it, digested it with collagenase and then spun it to get a cell pellet after which we looked at how to identity the different cell types within the stromal vascular fraction and isolate these particular stem cells.

"Then we looked at the expression of different genes within the cells – that is those genes that build bone, cartilage or fat – and then we looked to see whether virus cells or carrier molecules could be used to switch on various cell functions."

Dr Locke said that adipose-derived stem cells had only been discovered in 2001 so that much work was now being done to understand how they work and how they could be made to work particularly in terms of regrowing tissue.

"We think they could be very useful in Plastic Surgery to help reconstruct defects in patients who have lost tissue, for example following cancer surgery. They may also be used as gene transfer vectors, such as a treatment for muscular dystrophy, while there is also evidence to suggest they can home in on and repair areas of tissue damage which could have a huge impact on patients who have suffered heart damage after a heart attack, for example. ."

Dr Locke conducted her research under the supervision of Professor John Windsor from Auckland Hospital and immunologist Associate Professor Rod Dunbar and has now completed her thesis.

She presented a paper on her findings at last year's ASC in Hong Kong and is now writing up some further findings of her research for publication.

Now completing her final year of plastics training at the Waikato Hospital in Hamilton, New Zealand, Dr Locke thanked those at the College who had supported her desire to undertake pure research even though it required interrupting her training.

"We think they could be very useful in Plastic Surgery to help reconstruct defects in patients who have lost tissue."

"The College has been fantastic. The people involved cross-credited one year of my research to go toward my training which was great and the financial support I have received has made all the difference," she said.

"I've been very impressed at how helpful and supportive the College is to people who want to do research and I think that sends out a strong, positive message about the value of research and learning to our profession. I'm also grateful for the support of my supervisors and I think it's wonderful that New Zealand is now in a position, with the facilities and the skills, to advance this work, to make a global contribution in this area of complex scientific research."

The Brisbane Annual Scientific Congress

PHOTOGRAPHS COURTESY OF RHH NOVEN

There were many interesting media releases circulated at this years congress, one of them was David McNicol's

Orthopaedic surgeon Mr David McNicol urged surgeons attending the College's 78th Annual Scientific Congress (ASC) last month to oppose Federal Government plans to change the process of medical education.

Delivering the 2009 Hamilton Russell Memorial Lecture, Mr McNicol said that the proposal to set up an accreditation system answerable to politicians represented an "immediate and very real threat" to the standards of healthcare in Australia.

Mr McNicol was referring to the Council of Australian Governments' proposed reforms to the registration of health professions and the accreditation of medical education and training courses. He said that while the College supports the national registration of health professions – which would facilitate the movement of doctors between states and territories – it strongly opposed proposed changes to arrangements whereby medical education and training courses are accredited.

The proposed reforms could see such courses accredited by a body answerable to politicians rather than the current arrangement whereby accreditation is done by a body free of political influence and genuinely committed to medical excellence.

Describing the reforms as "tricky and underhand", Mr McNicol said they could lead to short-term political solutions over the long-term needs of the national health care system such as lowering standards to ease workforce pressures.

He urged surgeons to see the proposed reforms as a "call to arms" and to involve the public in the debate to ensure they were not implemented.

"The community must be shown by us that these issues are theirs and that they must take ownership of them in partnership with us," he said.

"The wider community does not know what is at stake and has not been brought into this debate effectively. It is time for us to fight for patient rights."

The Hamilton Russell Memorial Lecture is named for the pioneering orthopaedic surgeon who served as the College's Censor-in-Chief until his death in 1933 and was one of the highlights of the ASC held from May 6 at the Brisbane Convention and Exhibition Centre.

More than 1,500 delegates from across Australia and New Zealand attended the three day conference.

Despite the gloom on the political front, however, Dr Peter Malycha told the Congress that new data showed that Australian and New Zealand patients continued to receive world-class treatment for one of the most common cancers affecting the community. He said that the National Breast Cancer Audit (NBCA), one of Australia's largest-ever studies into the type and quality of surgical care being offered for any disease, showed that treatment offered to Australasian patients is among the best in the world.

The audit now has data on more than 80,000 episodes of breast cancer conducted by approximately 300 surgeons since 1998 with those statistics being used to determine what treatments are being offered where and to set minimum surgical standards to ensure quality care.

Dr Malycha, the Chair of the Steering Committee of the NBCA and former Clinical Director of the NBCA, said the study indicated that the rates of mastectomy, partial mastectomy, radiotherapy and hormone treatment were proportionally in tune with best-practice treatment offered anywhere in the world.

"The NBCA is one of the largest surgical audit projects ever undertaken and the information it is giving us, as to treatment choices and results, is incredibly important," Dr Malycha told the Congress.

"We can now say Australia and New Zealand are leaders in the management of breast cancer."

Professor Christobel Saunders, however, told delegates that despite the hard-fought public campaign to have breast cancer drug Herceptin listed on the Public Benefits Scheme, a new audit found that only a small percentage of women with breast cancer have tumours likely to respond to the drug.

She said that the main reason was that most tumours were simply not of the kind that respond to the drug (HER2 positive) while other reasons for exclusion included the presence of other disease, age, metastases, small disease volume and patient choice.

"The small number of women eligible for the drug was a surprise to us and I think there was an expectation of there being a greater percentage of patients who could benefit from the drug before it was listed," she said.

Professor Saunders, who is a Professor of Surgery at the University of Western Australia, said that one of the most positive findings of the audit was the lack of disabling side effects caused by Herceptin.

Mr Jacob Ollapallil, the Director of Surgery at the Alice Springs Hospital, used his presentation to the Congress to call on the government to boost education campaigns to stem the rising tide of injuries now occurring in the Northern Territory. He said while the number of motor vehicle accidents had declined in all other states in Australia, it continued to rise in the NT due to factors such as speed and driver fatigue but that the most striking aspect of the increased number of trauma cases related to dog attacks in the town camps of Alice Springs.

"Dogs are much valued by indigenous people and are used for hunting, company and warmth while they are also used to keep the spirits away, yet they do cause skin disease, diarrhoea, parasitic diseases and injuries," Mr Ollapallil told the Congress.

"One house should not have more than two dogs but some houses in the town camps have up to ten and we believe that an education campaign is urgently needed to teach people about responsible dog ownership, how to care for them, feed them appropriately and the need for sterilisation."

Dr Leong Tiong, a surgical Trainee with an interest in surgical oncology, also told the Congress that current national guidelines which recommend regular surveillance colonoscopies every three to five years after curative surgery may need to change with an initial colonoscopy performed within one to two years to detect early disease relapse.

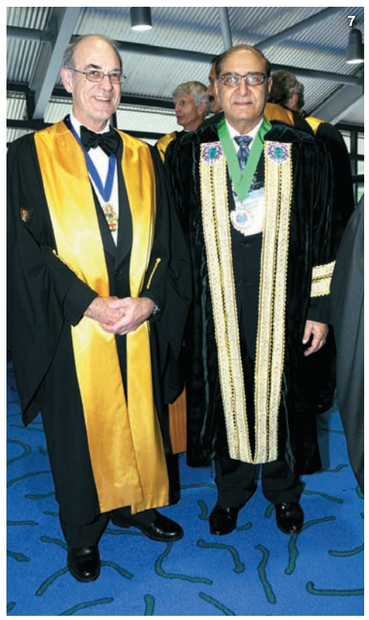
He based his conclusions on the findings of a retrospective audit of patients in South Australia which showed that a significant proportion had their second cancer detected between 13-18 months after curative treatment of their index tumours.

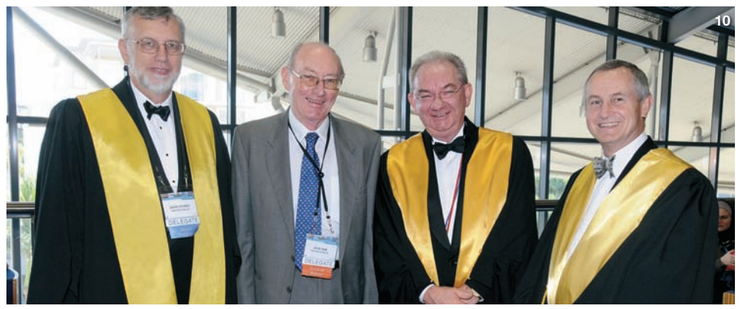
With its continuing commitment to aid programmes, the College's ASC was also told of the successful work being done by Australian surgeons in training local surgeons in Vietnam in the treatment of encephalocoeles, a disorder which involves the protrusion of the brain through a congenital defect in the skull. Mr Alan Breidahl, a plastic and reconstructive surgeon, said that a five-year programme in Ho Chi Minh City, initiated and overseen by Operation Smile Australia, has now enabled the training of a local team in the surgical treatment of the disorder.

ASC 2009 BRISBANE

1. Andrew & Aida Stevenson with John Masterton
2. Steve Smith & Brian Draganic
3. Lydia & Clifton Washaya
4. Gwen & Brian Morgan with Roxanne Wu
5. Ian Civil & Mary Langcake
6. Ian Gough introducing the President's Lecture
7. Taking time out to catch up on reading
8. Keith Mutimer & Spencer Beasley
9. Richard Barnett & Keith Mutimer
10. Stephen White & Andrew Stevenson

11. Kyra Thompson, Jessica Weekes & Verity Sutton
12. Navin, Anika, Shehama & Lalitha Niles
13. David Walsh, Susan Neuhas, Paul Dolan & Joanna Morgan
14. Mohammed Ashrafi & Rhona delos Santos Ashrafi
15. Jacob Ollapallil & David Scott
16. Methods of communication
17. Mary Self & Hung Nguyen
18. Marianne Vonau & Danny Cass
19. Matthew Peters & Ravi Huilgol
20. Senarath Werapittya & Deepal Attanayake reading through the programme





1. Adrian Nowitzke & John Laidlaw
2. Wyn & Alice Beasley with Sam Mellick
3. Peter Callan, Garry Buckland & Gaye Phillips
4. Ian Gough, Rowan Gillies & Rowan Nicks
5. Frank Keane, Doris Cameron & Spencer Beasley
6. The panel for the plenary session - Surgery to the needy at home & abroad
7. Ian Dickinson & Zafarullah Chaudhry
8. Scotty McLeish, Lyndal & David Scott with Kingsley & Kathleen Faulkner with Dorothy & Durham Smith
9. Virginia & Jean-Claude Theis with Andrew & Sibby Sutherland
10. David Storey, John Ham, Phil Truskett & Mike Hollands

11. Pauline & Rob Atkinson, Russell Stitz, John & Wendy Graham
12. Jitoko Cama, Iferemi Waqainabete, Saio Piukala & Rowan NIcks
13. Babatunde Salman & his family
14. Maria Lynch & Saeed Tourani at the College Professional Development booth
15. John Orr's congress dinner speech
16. Ian Gough with the Johnson and Johnson team
17. Bill Lindsay & Tim Porter
18. Allan Panting, Dennis Atkinson & Eddy McCaig
19. Julian Smith, Rob Atkinson & Graeme Campbell

Photographs courtesy of John Aloysius Henderson
The photographs are available on DVD, please contact John Aloysius Henderson +64 418 158 881









1.Sally Adair & Mark Moore
2. John North, Nirmala & Raja Sabapathy
3. Vic Mar
4. Zamzuri Zakaria, Iferemi Waqainabete, Rowan Nicks with Angela & John Materson
5. Mr Smithers from Applied Medical & Mark Smithers
6. Ruth Blackham
7. Rosalee Elliott-Teddy, Eugene Lim & Peter Teddy
8. David Watters, Loa Daera Kevau & Ikau Kevau
9. Chris Wallace, Warwick Stening & Marianne Vonau
10. Kendall Francis, Michael Troy & John Henderson

The Surgeons' Bookclub

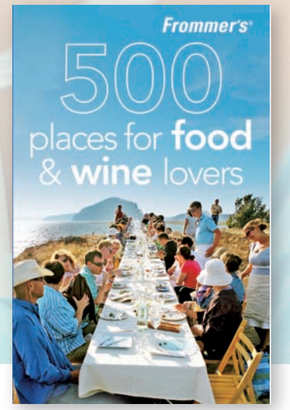
Welcome to The Surgeon's Book Club

Highlighted in this months issue are recent and new titles from across the spectrum of books available from John Wiley & Son.

Book of the Month
New **20%** Discount

iPhone 3G Portable Genius
Paul McFedries and David Pabian 9780470423486
July 2008 | PBK ~~AUD$34.95~~ / AU**$27.96**

You don't have to be a genius to use an iPhone 3G. But if you want to get the very most out of yours, put this savvy *Portable Genius* guide to work and start ramping up the pace. Want to e-mail attachments twice as fast? Talk and browse at the same time? Quickly locate the nearest coffee shop? Sync your iPhone 3G with multiple computers? You'll find cool and useful Genius tips, full-color screenshots, and pages of easy-to-access shortcuts and tools that will save you loads of time and let you enjoy your new iPhone 3G to the max.



WILEY-BLACKWELL

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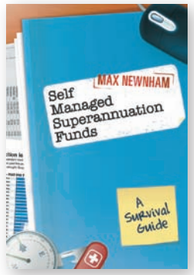
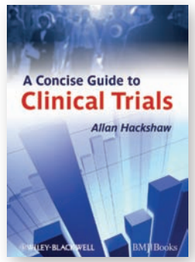


Leisure Reading

Self Managed Superannuation Funds: A Survival Guide
Max Newnham 9781742169262
June 2009 | Paperback ~~AUD$34.95~~ / AU**$29.71**

This complete guide to self managed superannuation funds (SMSFS) gives readers the tools that they need to establish and get the most out of their funds. The book will cover everything from establishing an SMSF, to managing one, paying out benefits and winding it up. Written in an accessible style, this book contains practical tips and tools combined with the most up-to-date information to help readers manage their retirement nest egg — hands on!



A Concise Guide to Clinical Trials
Allan Hackshaw 9781405167741
April 2009 | PBK ~~AUD$82.95~~ / AU**$70.51**

A Concise Guide to Clinical Trials provides a comprehensive yet easy-to-read overview of the design, conduct and analysis of trials. It requires no prior knowledge on the subject as the important concepts are introduced throughout. There are chapters that distinguish between the different types of trials, and an introduction to systematic reviews, health-related quality of life and health economic evaluation. The book also covers the ethical and legal requirements in setting up a clinical trial due to an increase in governance responsibilities and regulations. This practical guidebook is ideal for busy clinicians and other health professionals who do not have enough time to attend courses or search through extensive textbooks. It will help anyone involved in undertaking clinical research, or those reading about trials.

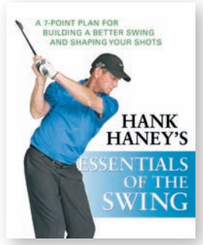
Leisure Reading

Frommer's 500 Places for Food & Wine Lovers
Holly Hughes 9780470287750
April 2009 | PBK ~~AUD$32.95~~ / NZD**$37.99**

Covering global food festivals, farmer's markets, cooking schools, street food, wineries, wine trails, and restaurant wine lists-as well as the world's best restaurants in several price ranges and categories throughout the world, this book is your guide to the culinary world. Includes:

- Open-air markets, farms, culinary festivals, and street food
- Cookbook and kitchenware shops
- Gourmet and specialty food stores
- Food vacations, including inns/resorts, cruises, and cooking schools
- Vineyards, breweries, and distilleries
- Must-visit restaurants, coffee bars, and dessert places

The book includes contact and Web site information, plus details on accommodations and services to help with trip-planning. Photographs bring the places and experiences to life, while geographical and topical indexes make it easy to find information quickly.



Hank Haney's Essentials of the Swing: A 7-Point Plan for Building a Better Swing and Shaping Your Shots
Hank Haney 9780470407486
March 2009 | HBK
~~AUD$42.95~~ / AU**$36.51**

Hank Haney is one of the most well-respected and sought-after golf instructors in the world today. He is famous for rebuilding the swing of the world's #1 player, who has gone on to win six more Majors and counting. Haney has also worked with hundreds of top pros, including Masters and British Open champion Mark O'Meara, who attributes the durability of his swing to Haney and says that "Hank knows more about ball flight and what controls it than anyone in the game."

Point by point, chapters cover every aspect of the swing, from grip to contact to ball flight, with 160 illustrations to help players understand the concepts and check their form. A master work from a master instructor, *Essentials of the Swing* will be essential reading for any golfer who is looking to reach the height of his or her game.

Memorabilia of Sir Thomas Dunhill

Dunhill is remembered for his pioneering work on the treatment of exophthalmic goitre on which his reputation was built on

Keith Mutimer
Honorary Treasurer

Ross & Coral Peel, Ivo Vellar & Donald Murphy with the photograph of Sir Thomas Dunhill

Above: Sir Thomas Dunhill's CMG
Left: Sir Thomas Dunhill's Fothergillian medal

Sir Thomas Dunhill, a Fellow of the College and one of Australia's most illustrious surgical expatriates, died on 22 December 1957. In his Will he bequeathed a number of personal effects to the College, which have become prized pieces in the College's heritage collections. These include the portrait by Sir James Gunn now hanging in the Hailes Room, the silver porringer presented to him by Queen Mary, his war medals and the insignia of the Royal Victorian Order and the Most Distinguished Order of St Michael and St George.

Thomas Peel Dunhill was born on 3 December 1876, at Tragowel, a pastoral run to the south-east of Kerang, near the Murray River in northern Victoria. His father, the station manager, died of typhoid fever in 1878, and his mother, Mary Elizabeth Peel, returned to her family home at Inverleigh, west of Geelong. She subsequently remarried, and the family moved to Daylesford, where Tom attended school. He then studied pharmacy at the University of Melbourne, and was registered in June 1898. But instead of going into practice, he turned to medicine, graduating in 1903 with three first-class Honours, and exhibitions in medicine, and in obstetrics and gynæcology. He joined the resident staff of the (Royal) Melbourne Hospital, where he began his lifelong study of the thyroid gland.

In 1905 Dunhill joined the staff of St Vincent's Hospital in Melbourne. Here he did his pioneering work on the treatment of exophthalmic goitre on which his reputation was built. He obtained his MD from Melbourne in 1906. His success in dealing with thyroid disorders was spectacular. By 1910 he had carried out over three hundred operations with a mortality rate of one per cent, at a time when the expected mortality from thyroidectomy was around thirty per cent. His paper on goitre, presented to the Royal Society of Medicine in London in 1912, caused a sensation.

With the outbreak of War in 1914, he enlisted in the AIF, and was posted to the 1st AGH, seeing service principally in France. He was mentioned in despatches three times, promoted to the rank of Colonel, and appointed CVO and CMG. At the end of the War, he returned to Australia and to St Vincent's.

However, during his time in Britain and Europe, Dunhill had come to the attention of George Gask, who in 1920 invited him to join the professorial surgical unit at St Bartholomew's Hospital. From then on his career flourished, and honours were heaped on him. King George V appointed him surgeon to the royal household in 1928, an honorary surgeon to His Majesty in 1930, and elevated him to KCVO in 1933. King George VI continued with his services, appointing him Serjeant-Surgeon in 1939, and elevating him to GCVO in the spring of 1949. On the death of the King he resigned his office, but Queen Elizabeth retained him as an extra surgeon. His association with the royal household lasted over twenty-five years.

He became a Fellow of this College (not Honorary, as is sometimes stated) in March 1930.

Recently some further memorabilia of Sir Thomas were presented to the College by the Peel family, his relatives on his mother's side. Several of the Peel family, some of whom still live around Inverleigh, came to the College and were shown the items already in the collections. This visit was arranged by Donald Murphy FRACS, the Medical Director of the College.

The Peel family presented to the College a framed black-&-white photograph of Sir Thomas in full court dress, taken probably at the time of the Queen's coronation. It shows him wearing the medals and insignia which the College now has. Another much older photograph, a copy of an original in the State Library of Victoria, shows a young Tom with his mother.

Also presented was Sir Thomas' Fothergillian Gold Medal. This award, instituted in 1787 by John Coakley Lettsom, is presented every three years by the Royal Medical Society of London. In 1941 it was awarded to Sir Thomas Dunhill. The Medal is normally made of solid gold, but due to the somewhat difficult circumstances of 1941, Sir Thomas had to make do with one cast in bronze. Other recipients have included Edward Jenner, Sir Victor Horsley, Sir Frederick Treves, Sir Arthur Keith and Russell (later Lord) Brock.

The College is most grateful to the Peel family for presenting these further pieces of memorabilia of one of the College's most distinguished Fellows, and also to Don Murphy for his efforts in arranging the donation.

ROTARY TRAVEL FELLOWSHIPS

FOR PACIFIC SURGEONS ATTENDING INTERNATIONAL SURGICAL WEEK IN ADELAIDE 6 – 10 SEPTEMBER 2009

Rotary Australia World Community Service has endorsed a Fund to help surgeons from the S.W. Pacific Rim to attend International Surgical Week in Adelaide in 2009.

All applicants from the region who are planning to attend ISW 2009 are encouraged to apply for a Fellowship. Successful applicants may receive up to AUS$4000 to help with fares, registration and other costs. Budget accommodation or Home Hosting by local Rotarians may also be available.

In the allocation of Fellowships preference will be given to surgeons working in isolation, surgeons who have already been involved in Rotary projects in their region or surgeons who can obtain support from a Rotary Club in their area.

Registrants intending to apply for a Rotary Travel Fellowship should indicate their intention on the ISW 2009 Registration Form and include a short statement supporting their suitability to receive assistance in this way.

Further information can be obtained from Dr. C.R.T.Hughes, Medical Director SAPMEA email : isw2009@sapmea.asn.au

Information about International Surgical Week 2009 (ISW 2009) can be found on the Congress website – www.sapmea.asn.au/conventions/isw2009/index.html

Burnside Rotary Club (the Club sponsoring RAWCS project 44/2008-09) plans to fund Travelling Fellowship valued at Aus$4000 and hopes that other clubs or individuals will support the project to enable at least 3 Rotary Travelling Fellows to attend ISW2009.

Supplementary information for potential donors:

Burnside Rotary Club (the Club sponsoring RAWCS project 44/2008-09) plans to fund Travelling Fellowship valued at Aus$4000 and hopes that other clubs or individuals will support the project to enable at least 3 Rotary Travelling Fellows to attend ISW2009.

Donations to the Rotary Travel Fellowship Fund are invited not only from Rotary Clubs but also from individuals (Rotarians or non-Rotarians, medical professionals or otherwise) and from Companies. Donations from individuals or companies will attract Tax Deductibility if cheques are made out to

"RAWCS, Rotary Overseas Aid Fund, Project 44/2008-9 " and forwarded C/o Dr CRT Hughes, SAPMEA 200 Greenhill Rd., Eastwood SA 5063.

Companies supporting Rotary Travel Fellowships financially will also receive acknowledgement on the ISW 2009 website and recognition with other sponsors in the Congress Handbook

MONASH University
Medicine, Nursing and Health Sciences

Postgraduate Course in Clinical Anatomy

The Monash University Departments of Anatomy & Developmental Biology and Surgery (MMC) are pleased to announce the Postgraduate Course in Clinical Anatomy for 2009. The Course will provide postgraduate training in anatomy for graduates wishing to advance their knowledge in anatomy. Though designed for trainees preparing for specialist college examinations, the course is open to graduates from any other health science discipline. In view of previous popularity, registrants are advised to enrol early.

The Course will be taught by anatomists from Monash University along with relevant specialist surgeons. It will involve the use of the Museum and Dissection Room facilities at the Clayton campus. The Course will consist of 16 sessions on Monday evenings from 6.30-9.30pm and will cover the gross anatomy and surgical anatomy of the entire body. Participants in the Course will have access to the Anatomy & Pathology Museums. Examiners for the College of Surgeons will give optional formative assessments if requested. The course does not involve cadaveric dissection, but will include examination of wet specimens.

Attendees will receive a CD of relevant software and a comprehensive syllabus. Each participant will receive a copy of the College approved anatomy text 'General Anatomy - Principles & Applications' (McGraw Hill 2008). Participants completing the course in 2009 will receive a Certificate of Attendance.

Further details of course are provided below:

Registration is due by Friday June 26
Dates: Monday 6 July to Monday 26 October, 2008 (including one week break)
Venue: Department of Anatomy and Developmental Biology, Building 13C, Monash University, Clayton campus.
Cost: $1,500 including GST.

If you have any questions please contact:
mira.petruzalek@med.monash.edu.au;
ph 03 9594 5500.
Further Information
Professor Julian Smith
Department of Surgery, Monash Medical Centre, Clayton, Vic 3168
julian.smith@med.monash.edu.au
ph 03 9594 5500
or
Dr Gerry Ahern
Department of Anatomy and Developmental Biology, Monash University, Clayton, Vic 3800;
gerard.ahern@med.monash.edu.au
ph 03 9905 5794

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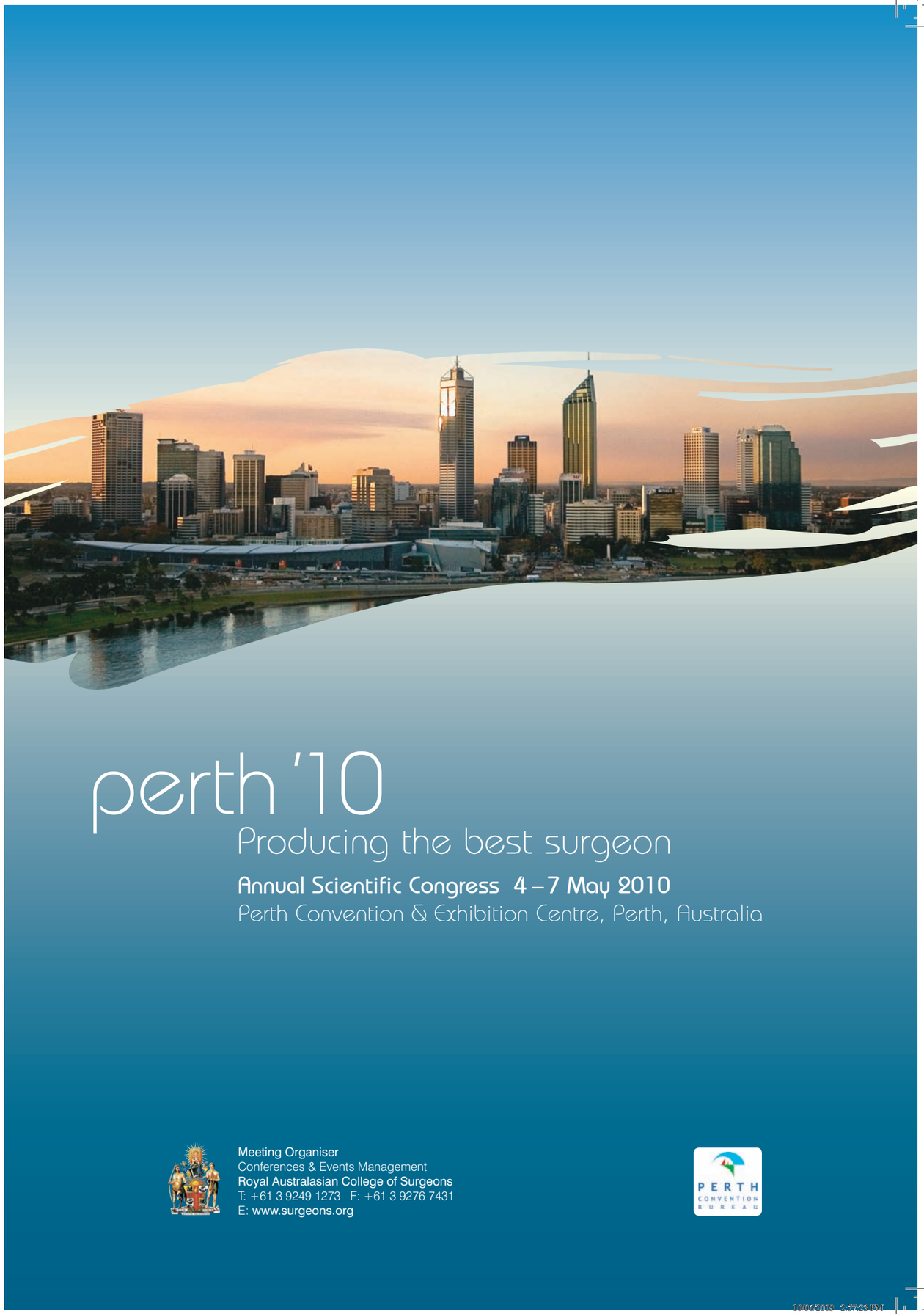


Sir Albert Coates and his life

Peace – an Anzac Day reflection

I enjoyed Felix Behan's essay on Sir Albert Coates and his times. I was pleased to see that Felix identified the tank as the brainchild of Winston Churchill – but his dating of Churchill's inspiration to 1916 calls for correction.

At the outbreak of war in August 1914 Churchill was First Lord of the Admiralty and, having a background of soldiering himself, was unhappy with the way trench warfare soon developed, with its heavy toll in lives and its limited potential for the exploiting of gains. This prompted him to two proposals: one was, of course, the Dardanelles campaign – a brilliant idea which failed for lack of in-theatre command competence.

The other dates, in the formal sense, from 5 January 1915, when Churchill wrote to Asquith the prime minister: 'It would be quite easy in a short time to fit up a number of steam tractors with small armoured shelters, in which men and machine guns could be placed,... Forty or fifty of these engines, prepared secretly and brought into positions at nightfall, could advance quite certainly into the enemy's trenches, smashing away all the obstructions.'

Asquith sent Churchill's letter on to Kitchener, who arranged a certain amount of design work, but failed to show the sense of urgency that Churchill felt necessary. He decided therefore to make the subject of 'land-ships' a naval initiative, which he could handle within his own portfolio. To mislead those who might accidentally see the designs, the structures were called 'water-carriers for Russia'; but lest this might be abbreviated to 'WC's for Russia' the name was changed, first to 'water-tanks', then 'tanks.'

On 20 February 1915, an Admiralty conference convened [in Churchill's bedroom: he was suffering from influenza at the time] at which a Land Ships Committee was set up, with Captain E Tennyson D'Eyncourt, director of naval construction at the Admiralty, as its chairman. Churchill gave the committee £70,000 from Admiralty funds to get the project going without delay.

Three months later Churchill, now the scapegoat for Gallipoli, was dumped from the Admiralty; another six months and he was commanding a regiment in France; and on 7 May 1916, a year after losing office, he returned to London as a back-bench MP, quite devoid of influence on the conduct of the war and, *pace* Felix Behan, utterly without an entourage.

The Army pursued the development of the tank, somewhat sluggishly, and introduced it in dribs and drabs, which might have negated its influence altogether; but at Cambrai in November 1917 the tank's potential was, for the first time, demonstrated. Montgomery, in his *History of warfare*, has written: 'Without any preliminary bombardment, over 300 tanks went forward in massed formation. That day they made a hole in the Hindenburg Line four miles wide, and for a loss of 1500 men took 10,000 German prisoners and 200 guns.'

Regards
Wyn Beasley, Retired surgeon
New Zealand Fellow

Corpus Medicorum

I would like to thank you for your article regarding myself in the latest *Surgical News* April 09 pg36.

I was touched and humbled – I found it a great privilege to share some of my most personal thoughts about my two greatest passions.

I must say I had a very entertaining couple of hours on the phone with the journalist, and find it refreshing to see that my sentiments were captured far better that I could have ever thought to express them.

I feel guilty not crediting the photo – taken in 2002 by Plastic Surgeon Murray Stapleton FRACS

Thanks and Kind Regards
Phillip Antippa, Cardiothoracic surgeon
Victorian Fellow

Ear, nose and throat surgery (ENT) in Papua New Guinea (PNG)

I was delighted to read two articles on PNG in the recent Surgical News (April 2009) – one on "Pioneering Surgery in PNG" by Frank Smythe, with whom I had the privilege to work several years at the Port Moresby General Hospital and the other on "PNG Surgeons learn surgery success" under the International Development section.

I would, however, like to correct some factual errors in the article about ENT surgeons in PNG. The first ENT surgeon at the Port Moresby General Hospital (and for the whole of PNG) was not Dr Avdesh (not Ardesh) Gupta as stated in the article, but Dr Patit Ghosh. I was at the time Head of Surgery at the University of PNG and persuaded the Ministry of Health in PNG to create a permanent position for an ENT surgeon and then requested the Director of the All India Institute of Medical Sciences (AIIMS), New Delhi for an ENT surgeon. (Do you need to say this?)

Prior to this, Australian ENT surgeons used to visit PNG for short periods funded by the Australian Development Assistance Bureau. Professor Ghosh was seconded from the AIIMS to Port Morseby towards the end of 1981. Dr (Professor) Patit Ghosh left PNG in December 1985 and Dr Gupta joined the hospital later in 1986. Mr Christopher Perry visited PNG in 1990 while I was there as Professor of Surgery.

Yours sincerely
Sankar Sinha, General surgeon
Tasmanian Fellow

Dear Professor Sinha

It is good to hear from you, you great supporter of ENT and Dr Gupta in the early days of our program. Thank you Professor for correcting my historical inaccuracy. I was under the impression that Professor Ghosh left in about 1982, not 1985. In the third paragraph I did state that Dr Gupta "... was the first to work there since 1982". I do stand corrected and thank you for making this historically important fact more plainly stated. I did tell the editorial staff of the *Surgical News* about Prof Ghosh but his name wasn't included by them in the article.

It also gives us the opportunity to correct the typographical error misspelling Dr Avdesh Gupta's name. It also gives me the opportunity to correct the impression that I was the first Australian ENT surgeon to go to PNG to start the training of local doctors into well trained and qualified ENT surgeons. It was in fact Hugh Millar from Melbourne, who initially set up the connection between the PNG training scheme and the Australian ENT society at that time and the College. Once again that fact was transmitted to the authors of the article but then missed by me when I proof-read the article.

The fact that Hugh Millar was at that stage the President of the ENT society and was then a recent senior examiner for the College, gave the PNG program the credibility and the "grunt" it needed to receive from day one, to get the wholehearted support of the Australian specialty. This was integral to the program's eventual success.

Yours Faithfully
Chris Perry, Otolaryngologist
Queensland Fellow

International Medical Graduates (IMGs)

The issue of IMGs and their practising ability is a contradictory one. Many IMGs are allowed to take up consultant roles in "Areas of Need" and are duly allowed to do this even though they may not have passed the Australian Fellowship exams. Yet surely if they are allowed to undertake this practice they have been "ratified" by the college and should not need to sit the exams after a period of adequate supervision. The corollary should be that unless the exams have been passed, these positions should not be offered. Furthermore, the enormous discrepancy with respect to individual states as to who is granted an article 21 Fellowship is astounding. In many areas IMGs working as consultants are also allowed rights of private practice. It is time that the College recognised the regional variations and developed a nationally applicable policy on what role IMGs have in the surgical workforce. At the moment too many people can easily point to clear discrepancies in the system

Regards
Pankaj Rao, Surgical Trainee
New South Wales

Dear Dr. Rao

The issue of IMGs in Area of Need (AoN) positions is one that the College has devoted considerable attention to. The Board of Surgical Education and Training has governance of International Medical Graduates in Australia and has developed policies and procedures relevant to this area. The Specialist Assessment of IMGs in Australia and the Clinical Assessment of IMGs in Australia policies detail the College's standards.

A specialist assessment determines comparability to the full range of practice in one of the nine specialties in which the College trains, whereas an AoN assessment is restricted to the scope of practice for the AoN position. Area of Need posts are declared by the relevant state or territory jurisdiction rather than the College. The Colleges role is to ensure that an IMG seeking appointment to an AoN post has the skills, competencies and attributes required to fulfil the duties (i.e. the scope of practice) of the post. Therefore, where the College finds an IMG appropriate for the position it does not mean that the IMG is endorsed to undertake the *entire* scope of practice for the specialty relevant to the position.

The standards applied by the College for AoN positions are that an "IMG will be deemed to have comparability for an AoN position if:

- There is evidence of recency of specialist surgical practice in the relevant specialty, comparable to that of an Australian or New Zealand trained surgeon within the defined scope of practice relevant to the AoN position; and
- There is evidence of completion of a specialist training program comparable to the College programs including the competencies, skills and attributes relevant to those required for the AoN position".

With regard to Article 21 assessments (i.e. where the IMG is not required to present for the Fellowship Examination) there is no basis for your claim of regional variation. IMGs are not assessed on a regional basis. Assessment is coordinated by the IMG Assessment Department, with the document assessment undertaken by the IMG Clinical Director (Mr. Andrew Roberts FRACS) and the Board Chair (or nominee) of the specialty that the IMG is seeking assessment in. If the document assessment supports an interview these are undertaken at the Melbourne Head Office of the College and the assessment panels are comprised of representatives of the specialty training boards, senior Fellows of the Board of SET and jurisdictional representatives. This is to ensure procedural fairness and transparency. IMGs recommended for Article 21 are required to undertake a period of oversight with clinical assessors appointed by the specialty training board. Clinical oversight reports are approved by the Specialty Board Chair (or nominee) and this ensures that the appropriate standards are applied consistently and fairly to all IMGs, irrespective of location.

Kind Regards
Ivan Thompson, Deputy Chair, Board of SET

TRAUMA COMMITTEE REGISTRARS' PAPERS' COMPETITION

9 September 2009

The College Trauma Committee is hosting the third 'Registrars' Paper Competition' in Adelaide on Wednesday 9 September 2009 as part of the Trauma Committee program at the International Surgical Week (ISW) meeting. Trainees/Registrars are invited to submit abstracts of trauma research projects – deadline for abstracts 22 July 2009. A select group, of around 6 registrars, will be asked to present their paper at the ISW meeting on 9 September. Candidates will need to cover their own travel expenses.

Registration for ISW is not necessary if trainees are only attending the ISW for this event. The winner will receive a certificate and may have the opportunity to present their paper at the Annual Meeting of the American College of Surgeons Committee on Trauma – in Las Vegas in March 2010.

Last year's winner, Alexios Adamides, Surgical Trainee – Neurosurgery, presented his paper at the US Residents' Trauma Paper Competition. He won that competition too – well done Alex!

Further information –
www.surgeons.org/trauma – or contact Lyn Journeaux, Executive Officer, Trauma Committee – Tel: 03 9276 7448; fax: 03 9276 7432 or email: lyn.journeaux@surgeons.org

A passion for surgery

There is no greater sense of satisfaction to be had than having conducted a good operation and seeing a good outcome for the patient

There are some childhood obsessions that do not pass with the passing of time. Take Mohamed Khadra for example. From the time he was a toddler all he dreamt of, all his play, was based upon being a surgeon. He'd dress up in either a white smock or a diminutive business suit, hook his teddy bear up to the cords attached to the stereo and concentrate for hours to save his patient's life.

His parents, visitors, "anyone who would sit still long enough" would be subject to his surgical ministrations. For his sixth birthday, his father bought him a glass syringe and needles that he filled with various liquids, coloured by liquid food dye, which he injected into the long-suffering bear.

Decades later it is clear that this passionate interest has never waned with Professor Khadra's career encompassing not only his work as a urology surgeon but also as a surgical educator and as the author of two books detailing life from both perspectives of the health system – as a surgeon and as a patient.

Born in Ghana to Lebanese parents, Professor Khadra came to Australia at the age of ten, did his surgical training at Sydney's Prince Alfred Hospital and is now Professor of Surgery at Sydney University.

"I started writing my first book called 'Making the Cut' on my first day as an intern and it is a collection of stories based on patients facing illness and death. This latest book is about the patient, a sort of realistic novel which looks at the journey of the patient through the health system," he said.

"Day after day we surgeons sit across the desk from a patient, we look at biopsy reports and various tests and know that what we are about to say is going to change the patient's life forever, yet most people are totally unprepared.

"Many people in the west, it seems to me, have created lives based on the idea that they are going to live forever and often when you tell them bad news the first thing they ask is how much time they might need off work. I think that is very sad so I thought a book that puts illness into a bigger perspective, even to include a spiritual component, may be of help to some people."

Exploring the experience of the patient is not just an academic exercise, however, given that ten years ago Professor Khadra was diagnosed with thyroid cancer.

"I know what it feels like to be given shocking news. One morning I woke up with a lump in my neck and that in turn meant that I had to confront my own mortality and I was not ready to do it. I can remember being worried about work, about my patients, about paying for the house we had just bought," he said.

"It is a reasonable reaction but in many ways it is not a helpful reaction."

When asked if this experienced change him as a surgeon, Professor Khadra said it had but not the way that most people would expect.

"For many years I was less compassionate actually because I didn't want to revisit my own pain and anxiety, I didn't want to feel what the patients were feeling because it was too raw," he said.

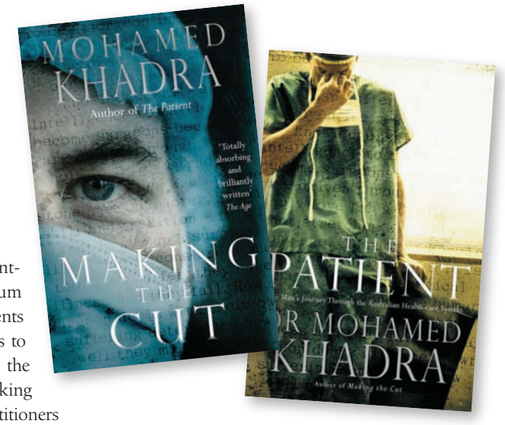
"There is a reason we surgeons put on our gowns and it is not just about sterilisation. We need to remain detached, to be separate, even to the point of thinking about the patient on the table as a machine that needs fixing rather than a human being so that our technical expertise is to the fore rather than an emotional investment.

"That to me is part of the fascinating aspect of surgery – that we need to have a heart of steel, a clear and focussed mind, technical expertise but still be able to relate to patients at the bedside or over the desk.

"Many people in the west, it seems to me, have created lives based on the idea that they are going to live forever ..."

"People want us to be compassionate, technically perfect, scientific researchers and health policy advocates and many of us are but sometimes I think we underestimate what we do on a day to day basis."

After Professor Khadra regained his health, he moved to Wagga Wagga to take up the position of inaugural director of Australia's first rural medicine school where he established the Longitudinal Patient-Centred Curriculum whereby medical students are attached to patients to follow them through the system rather than working alongside medical practitioners – an education model designed to overcome the problems associated with the limited number of medical specialists located in rural areas.



Later, he became Pro Vice Chancellor at the University of Canberra followed by tenure as Chair of Surgery at the Australian National University.

Later however, frustrated at Australia's limited help to educate people in disadvantaged countries while taking their best and brightest, he set up an on-line university called the Institute of Technology Australia which offered degrees in such areas as business and IT. But throughout those years he simply missed surgery.

"While I found working in education an interesting experience it was also frustrating in terms of having to deal with bureaucracy, with marketing, with the money men.

"There is no question that surgery is my great love and there is no greater sense of satisfaction to be had than having conducted a good operation and seeing a good outcome for the patient," he said.

His teddy would be so proud.

The Patient: One Man's Journey Through the Australian Health Care System is published by Random House.

The 2009 Trainees' Forum

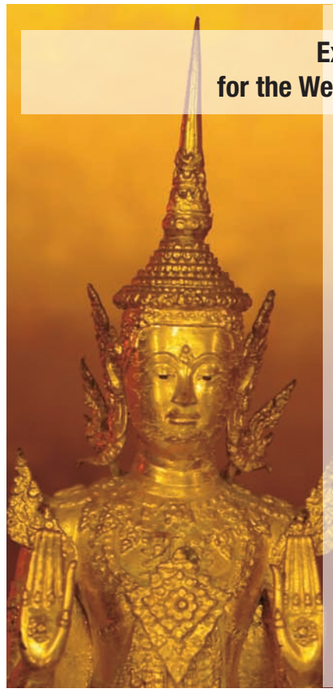
Matthew Peters
Chair, RACSTA
Section Convener, ASC Trainees' Programme

The inaugural Trainees' forum took place at the ASC, providing Trainees of all stages with helpful advice and guidance for both their training period and early post-fellowship life. The forum was divided into two sessions. The first dealt with matters of relevance to those still in training. Professor Spencer Beasley, Chair of the Board of Surgical Education and Training (SET), provided an overview of the SET programme and what the future may hold. Associate Professor Julie Mundy, Chair of the Generic and Specialty Specific Examinations Board, discussed the generic and specialty-specific SET1 examinations, providing a thorough overview of the requirements of the examinations. Dr Mark Edwards, Chair of the Court of Examiners, then lead a discussion about the Fellowship examinations and the Court of Examiners. For those in attendance the session was both useful and reassuring.

The second session, commencing at 1030, explored 'post fellowship planning.' Dr Chris Que Hee from the Younger Fellows Committee introduced the session and led presentations by the College and industry representatives of relevance to the newly graduated fellow, including Glenn Petrusch, Director of Education and Training Administration from the College, Colonel Crozier from the Australian Defence Force, Professor William Coman representing In Vivo (medical defence), Lyn Edgerton from Ramsay Health Care, and Robyn Peters from Direct Control (practice management software).

Continuing this theme of 'post fellowship planning', three younger Fellows of the College then presented their experiences of life after training. Dr Ravi Huilgol (Vascular surgery – Sydney) provided advice and guidance relating to establishing oneself in a metropolitan center. Dr Sam Baker (General Surgery – Townsville) then described his experience in a regional setting, with Dr Andrew Barbour (General Surgery – Brisbane) finishing the session with a presentation discussing his fellowship years in both the U.S.A. and the U.K. and the planning required if one is considering such opportunities. The salient points and words of wisdom from all three younger fellows were well received.

Thanks must be extended to all of the presenters for their time and effort, and to Diana Kirke and Grant Fraser-Kirk, co-conveners of the Trainees' programme. Organised without precedent, your support in the development of this forum is much appreciated.



Expressions of interest are invited from Fellows for the Weary Dunlop Boon Pong Travelling Fellowship – Thailand

This is the first invitation of a new, annual College Travelling Fellowship to Thailand funded from the Weary Dunlop Boon Pong Scholarship Fund.

It has been established to complement the Weary Dunlop Boon Pong Scholarship Fund activity that brings up to six Thai surgeons to Australia each year for four months of surgical experience.

The Weary Dunlop Boon Pong Travelling Fellowship is open to expressions of interest from Fellows who have supervised / mentored a Weary Dunlop Boon Pong Scholar in Australia and who volunteer to travel to Thailand for a period of two weeks to follow up their protégé and to help with the implementation of the skills gained in Australia in the protégé's clinical environment. This would ideally occur six to 18 months after the completion of the Australian experience of the Weary Dunlop Boon Pong scholar. Fellows interested in this Travelling Fellowship will need to include with their expression of interest a request to visit, from their Thai scholar.

The Weary Dunlop Boon Pong fund subsidises the cost of the Fellow's travel to and from Thailand by providing an economy class air-fare to Bangkok and one night's accommodation. The Royal College of Surgeons of Thailand and local Thai health institutions may, on occasion, contribute to costs of local (in country) travel and accommodation. Costs not met by RACS or Thai organisations will be met by the Fellow.

Up to three Weary Dunlop Boon Pong Travelling Fellowships may be awarded in the one year.

The Travelling Fellows are expected to act as ambassadors for the College during the Fellowship and will provide a report of their activities to the RACS International Committee and to the Royal College of Surgeons of Thailand within two weeks of their return.

Eligible fellows are encouraged to indicate their interest in this Travelling Fellowship to enhance our College's outreach activities

Bruce Barraclough AO
Australian Convener,
Weary Dunlop / Boon Pong Scholarship program.

For more information please contact International Scholarships Officer, Sunita Varlamos on +61 3 9249 1211 or sunita.varlamos@surgeons.org

The Younger Fellows and Trainees Dinner

Grant Fraser-Kirk
Chair, RACSTA Qld

Gianni's Events Portside was the venue for the 2009 Younger Fellows and Trainees Dinner. Guests were treated to an indulgent three course experience prepared by one of Brisbane's leading chefs. The slow braised wagyu beef cheeks will remain on many palates for years to come!

Guests were then serenaded by a trio of international singing waiters. The classically trained tenors took the audience on a journey through France, Italy, Spain, and finally Australia. The performance culminated in 200 guests, including several senior fellows, waving their napkins above their heads!

Dinner was followed by some spirited dancing to the live band. Guests then proceeded to Brisbane's newest "place to be seen" where they mingled with celebrities including a prominent retired Qld and Australian Rugby League Legend. Overall the night was immensely enjoyable and remains the dinner to attend at the ASC. Perth will host the dinner in 2010 and early bird registration will be essential to avoid disappointment.

It would not be possible to put together a night like this without the support of our generous sponsors. We would like to thank Johnson & Johnson, Covidien, and Ramsay for their support (and we hope they had a good time!)


Grant Fraser-Kirk at the ASC

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Surgeons take up epic rescue mission

The team at the Royal Perth Hospital successfully managed to treat all 23 burnt asylum seekers sent to them

It was a typical busy Thursday morning for plastic surgeon and burns specialist Mr Mark Duncan-Smith from the Royal Perth Hospital (RPH) when the call came through alerting the hospital to the fatal boat blast off the Western Australian coast in mid April. As the senior clinician on call at the time, Mr Duncan-Smith was told that five men had been killed in an explosion upon a boat carrying 47 asylum seekers off Ashmore Reef and asked to fly up to Broome to conduct an initial triage and manage the immediate care of the survivors.

Many of the injured men had been blasted into the sea, then rescued by helicopter, evacuated to a nearby ship, then flown to Truscott airfield in far north Western Australia and onto Broome. The accident occurred on April 16 after a boat of asylum seekers was intercepted by Australian authorities.

Mr Duncan-Smith conducted one operation in Broome on a patient who required immediate surgery to reduce swelling and maintain his airways. Then, after only a few hours sleep returned to the Royal Perth Hospital where 23 of the wounded were transferred on an Air Force Hercules back to Perth while other patients were transferred to Darwin and on to Brisbane.

They began arriving at 3am on Friday (with the last on the 23 patients landing in Perth at lunch time) where they were met by the internationally regarded RPH burns team headed by Professor Fiona Wood. By then, the hospital had initiated its external disaster plan, Code Brown, which meant staff were available and theatres readied to treat the injured in the shortest possible time.

As part of the RPH burns unit protocol, all patients are aggressively cleaned as soon as possible to limit infections so all wounded were again triaged to determine the airway, depth of burns, the surface area and circumferential limb burns were assessed for the need of surgical release escarotomy.

"It was amazing," said Mr Duncan-Smith who also treated some of the injured following the Bali Bombing.

"By the time we arrived volunteer nurses with burns experience had arrived from other hospitals, the medical administration had cleared the way for theatre use, the Intensive Care Unit was ready, the anaesthetic team and the emergency department were all there and ready to go. Four theatres had been made available so by early Saturday morning we had three burns surgeons and one plastic surgeon in each one, operating for twelve hours on both days while other theatres were working as usual treating weekend trauma cases.

"During those two days we conducted operations on all the injured men, including debriding and grafting, including harvesting skin off the back and abdomen, some of which took up to five hours."

Mr Duncan-Smith said that of the 23 injured, one-third had burns to less than 20 per cent of the body, one-third had burns of 20 – 40 per cent and one-third up to 60 per cent of surface area. He said that while being thrown into the water probably helped to absorb heat and limit the extent of the injury, it also meant the men were exposed to bacteria which added to the need for urgent surgery.

He also noted that a majority of the wounded asylum seekers, all of whom were from Afghanistan, showed a tendency to bleed which was most likely due to vitamin deficiency.

"The majority of the men had burns from the mid-thigh to the ankle and from their hands to mid-arm and burns to the face which is the pattern of injury you would expect in such an accident. It would indicate that while their clothes protected other areas they didn't catch alight because the men were thrown into the water," he said.

"So there is an upside and a downside because while such a large body of water is able to dissipate heat, the men were then exposed to bacteria which resulted in some complications later, including lung damage due to inhalation of the sea water.

"Some of the patients will have serious scars but most of them can be covered while all of their faces have come up well.

"The vast majority of patients were healed with only one operation which is a wonderful outcome and shows how well the disaster plan worked, how important was the contribution of all hospital staff from ICU to the anaesthetics department and the nursing team.

"Four men had further surgery because some of the skin grafts didn't take because of the onset of fungal septicaemia and had to be done again but now, a month later, we only have one very seriously ill patient who suffered deep burns from the feet to the groin and wrists to upper arm and abdomen."

Mr Duncan-Smith said the huge media and public interest in the accident had been handled well by the hospital's public relations department but that the hospital was conscious of the sensitivities surrounding asylum seekers.

"I was asked at one stage on radio whether there had been any backlash about the idea of caring for people trying to reach Australia to claim asylum and I must say that we did not experience anything like that," he said.

"They were people first, injured people who needed our help but at the same time RPH was conscious that it had to maintain its services to the people of Western Australia. This was one of the reasons that we worked so hard for so long on the weekend. It seemed both medically and socially the reasonable thing to do."

Head of the RPH's burns unit Professor Fiona Wood said the success of the surgery and medical care provided was indicated by the fact that by four weeks, only three men remained in hospital.

"I see this as a great success for the patients and for RPH and the disaster response systems in WA. It's about having the right environment in terms of being able to keep the patients isolated and together, it's about having stringent infection control, aggressive initial cleaning, it's about getting the patients into surgery as quickly as possible and that, of course, relates to man power which relates to planning," she said.

Professor Wood, however, said the emergency allowed the hospital to understand where some improvements could be made to disaster management and to initiate changes that could even further improve the immediate care of the injured.

"I think the time of transfer remains crucial and while I think that is getting better all the time, in a perfect world it could be faster," she said.

"There might also be some work we could do on communication systems so that everyone within the hospital knows what's going on from microbiology to emergency but I say that only on the basis that improvements can always be made, as the effort of everyone was extraordinary."

Fiona Wood, Mark Duncan-Smith & Suzanne Rea, a full-time consultant at the RPH

The treated and discharged asylum seekers are now in a low-security detention centre in Perth and receiving continued rehabilitation treatment where needed, focusing on scar outcome physical and psychological function.

NOTICE TO RETIRED FELLOWS OF THE COLLEGE

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

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve. We will acknowledge your donation and place your name on the gown, if you approve.

If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.

Alternatively, you could mail the gown to
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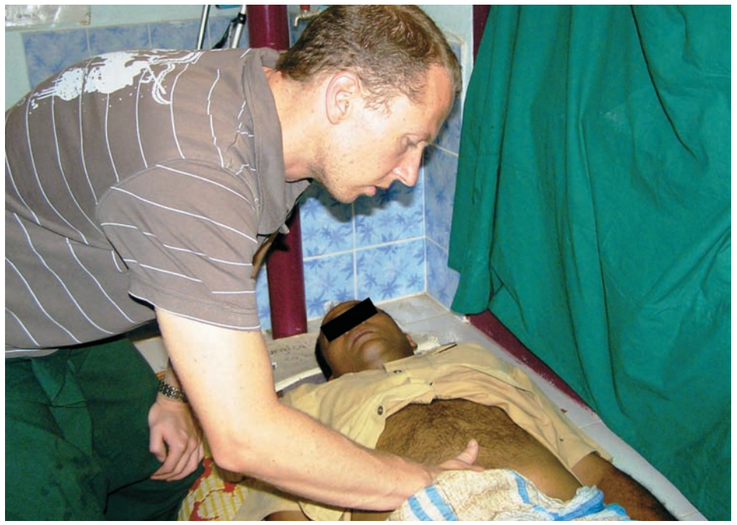
Teaching trauma in Mae Sot

Common trauma presentations included road, farming, falls and conflict injuries

Nick Russell



Assessing a patient with multiple rib fractures from a fall

The health and human rights of the Karen people in Eastern Burma has been described as a chronic emergency. These people are faced with forced displacement, civil war, malaria, landmine injuries, widespread malnutrition and political instability.

The Mae Tao Clinic (MTC) was established in 1988 by Dr Cynthia Maung to provide basic medical services for illegal Karen immigrants fleeing to Thailand. This medical clinic, situated on the border in Mae Sot, has grown over the years and with the generous support of many doctors and aid organisations now provides a wide range of medical, surgical, paediatric and reproductive health services. There is also a strong focus on education, both in community health and in running education programs for the trainee medics, many of whom return to their local villages inside Burma after six months of training.

Having been immersed in the life of MTC as a medical student on a six week elective, I decided to return as a practising doctor to share some of my newly acquired skills in an attempt to contribute in some small way. In particular this included teaching some of the concepts I learned through my recent participation in the internationally recognised course Early Management of Severe Trauma (EMST).

During my nine day visit I was able to provide clinical teaching to staff and trainee medics, many of whom I knew from my visit three years ago and who were keen to learn as much about the Australian approach to surgical management as possible. Common trauma presentations include road, farming, falls and conflict injuries. Many presentations are serious injuries and treated by medics with inadequate training and resources. Often trauma presentations are delayed by many days or even weeks due to the time it takes for patients to travel from remote and isolated villages.

I was able to help develop a surgical training curriculum for the students, and ran a series of lectures (translated) to a group of 30 medics on the basic EMST principles of trauma management, tailored specifically to the Mae Tao Clinic environment, and the more basic environment that many medics will return to. The students valued learning an approach that is used internationally and can be applied in a range of environments.

Some of the challenges that the medics will face in applying the EMST principles are that the medical facilities in many Karen villages do not have oxygen available, and often don't have intubation or airway equipment. Transporting patients to more advanced health care facilities may require a five day trek through jungle, making life supportive measures difficult or even impossible. Therefore it was appropriate that I focused the course material on simple and treatable life-threatening injuries such as hypovolaemia, tension pneumothorax and massive haemothorax, rather than injuries that require intensive treatment such as severe traumatic brain injuries.

I worked in conjunction with Dr David Downham, a retired Urologist from Canada who spends six months of each year volunteering in the clinic, and Dr Larry Mueller, a Vascular Surgeon from California who has done yearly operating trips for many years and helped establish the operating theatre. These two experienced surgeons helped me understand some of the practicalities of working in and developing a surgical service in third world conditions.

My ongoing contact with Mae Tao Clinic has been an eye-opening cultural experience as well as a valuable learning opportunity in teaching trauma management and establishing a surgical facility in a challenging environment. My privileged training in Australia has enabled me to be of benefit to these people, and I encourage my colleagues to take similar opportunities when they arise, not only to benefit communities in need but also for personal and professional development.

Well done on your achievements

Professor William Coman was awarded the ESR Hughes Medal at the recent ASC

Suren Krishnan
South Australian Fellow

William Coman

Professor William Coman is the inaugural Garnett Passe & Rodney Williams Memorial Foundation Professor of Otolaryngology, Head and Neck surgery at the University of Queensland, a fellow truly deserving of the award of the ESR Hughes Medal.

Professor Coman has been the outstanding Otolaryngologist, Head and Neck Surgeon of his time and his contribution to the specialty of Head and Neck Surgery, to our College, to his state of Queensland and to the people of Australia is not easy to quantify. Perhaps the best testimony to this great Australian surgeon's impact on practice, teaching and research is the legion of surgeons who have had the privilege of training with him and who have been inspired by his teaching.

He has served this College as a Councillor, an examiner and chief examiner. Professor Coman was Chairman, Board in Otolaryngology Head and Neck Surgery for six years, President of the Australian Society of Otolaryngology Head and Neck Surgery (1995- 1997) and hosted the first International Federation of Otorhinolaryngological Societies meeting held in Australia.

He has an international presence, altogether enjoying membership or fellowship of 11 other Associations and Societies, including the Cartesian Society of which he was sometime President. He is one of only 13 surgeons to receive Honorary Fellowship of the Section of Otolaryngology, Royal Society of Medicine.

Professor Coman's career has spanned some 45 years beginning with contributions to ear surgery, working in the prestigious centres of Europe including the Royal Infirmary, Edinburgh, Saint Bartholomew's Hospital, London and in Cologne and Tubingen. He has impressive experience in rhinology and was highly regarded as a surgeon and teacher in the art of rhinoplasty surgery.

His most significant contributions have been in Head and Neck oncology. In 1978, with senior colleague, Dr Gerry McCafferty he established and now chairs a multi-disciplinary Head and Neck Cancer Clinic at the Princess Alexandra Hospital, one of the first multidisciplinary clinics in Australia. This approach ensured excellent and comprehensive care for patients with head and neck cancer.

Professor Coman has been an enthusiastic teacher and research worker. He has been Lecturer or Clinical Lecturer in Otolaryngology for medical students, clinicians and nurses since 1974 and has held the position of Professor of Otolaryngology, Head and Neck Surgery, within the Department of Surgery at the University of Queensland, since 1990. Since 1983 he has been invited as guest lecturer at 73 national and international meetings, conferences or courses, including being the Invited Guest of the Royal Society of Medicine, London in 2006; in 2003 he was the First International Guest Professor for the Society of University Otolaryngologists – Head and Neck Surgeons in Washington DC and he has delivered the prestigious Sir William Wilde lecture for the Irish Otolaryngology Society in 2002.

William Coman has published some 50 peer reviewed articles, contributed numerous book chapters and sits on five Editorial boards. Professor Coman has been a prolific researcher in fields as diverse as quality of life outcomes and surgical technique to the challenges of molecular biology of head and neck cancer and the cellular response to viral diseases including the role of the Human Papilloma Virus.

He has also been involved in Indigenous health projects, establishing a registrar training program in Papua New Guinea. In 2005, he was awarded membership to the Order of Australia for services to Medicine.

Professor William Coman has been an outstanding surgeon, teacher, researcher and mentor. He has been unstinting in his service to the College, a great ambassador for Australian Otolaryngology, Head and Neck Surgery and a most worthy recipient of the ESR Hughes Award.

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