Surgical news

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2010

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The 79th Annual Scientific Congress.

Promoting learning and fellowship at the ASC (page 22)

The College of Surgeons of Australia and New Zealand

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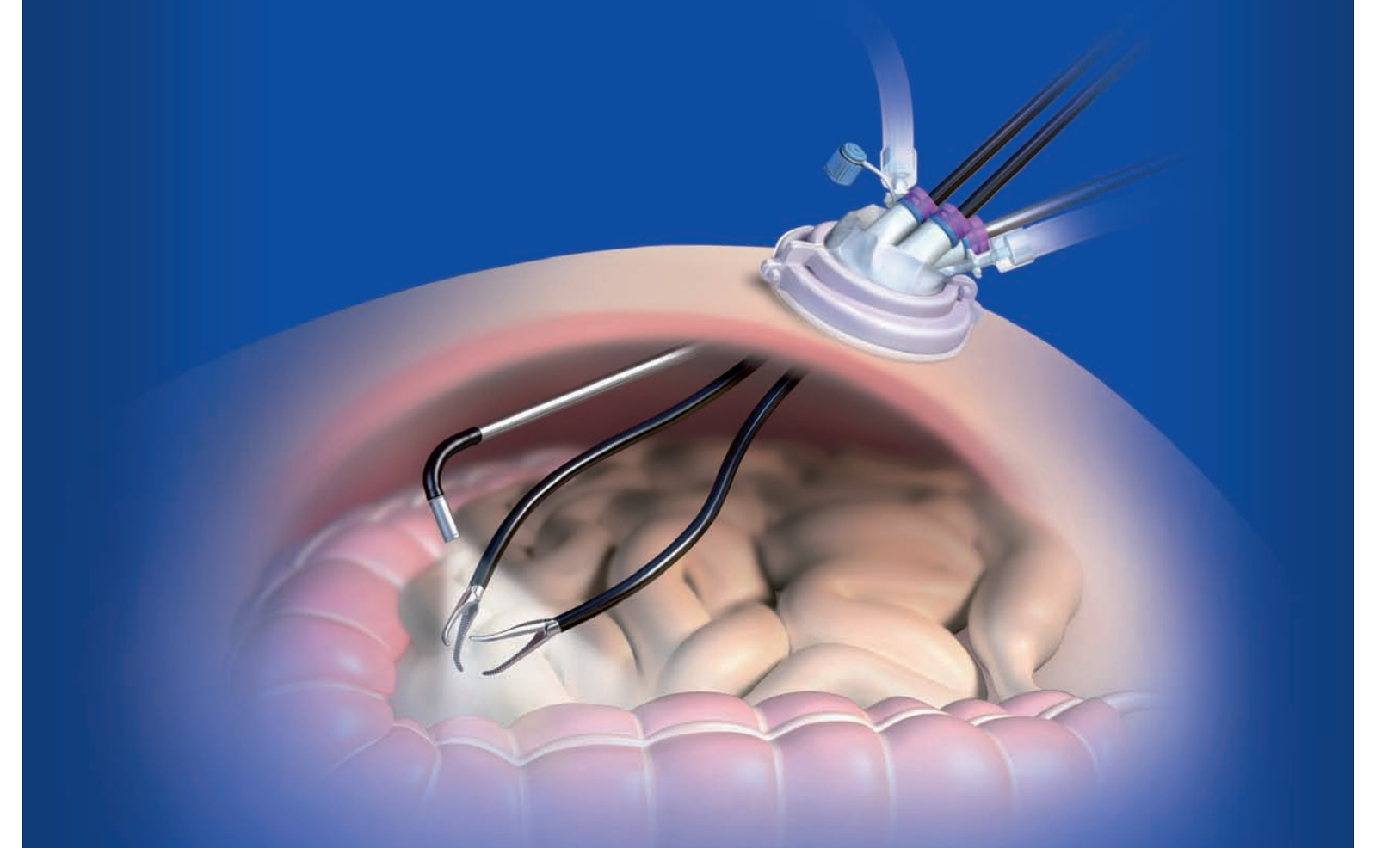

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Professionalism and surgery

Professionalism underpins the standing of surgeons in society; this is not an inherent right, but an obligation on us all

Ian Civil
President

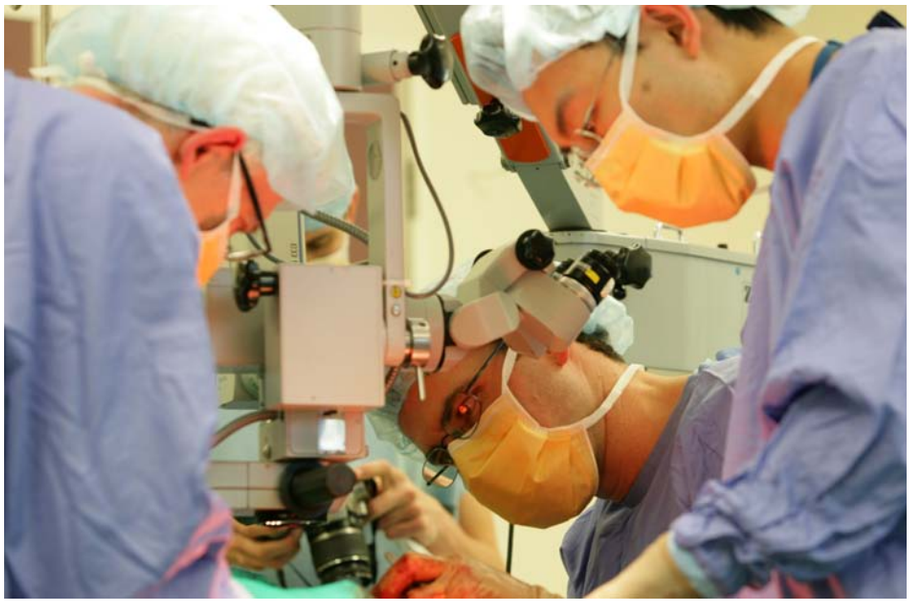
Having just attended the Annual Scientific Congress in Perth, the content provided ample opportunity for a Presidential perspective. The Plenary sessions in particular were again outstanding in terms of the significance of the issues and the diversity and depth of views being articulated. In Perth the topics were

1→ Are Surgeons losing the fight to control surgery?
2→ The Fellowship of the Royal Australasian College of Surgeons in 2020
3→ Professionalism in surgery – behavioural issues
4→ The future of sub-specialisation in surgery

All of these topics relate to the breadth of surgery across the nine surgical specialties and the discussions and debates were great to be part of. They showed the vitality of our specialty as we tackle the issues that affect surgery and our ability to deliver surgical services to the community.

The issue I would like to explore in this perspective is professionalism. To many it is a vague and somewhat nebulous term. Traditionally professionalism was defined as relating to a body of practitioners who shared specific knowledge and/or skills, and were able to self-regulate. More recently, however, the emphasis has moved towards describing professionalism in terms of behaviours and actions. Thus, typical characteristics now associated with a professional include altruism, respect for others, ethical standards, advocacy and compassion.

Professionalism speaks not only to the high degree of knowledge that is required to function in the role and the autonomy of our practice, but increasingly to the requirements of self regulation and our obligations to the community and society at large. Professionalism underpins the standing of surgeons in society and importantly this is not an inherent right, but an obligation and responsibility on us all.



The plenary session on behavioural issues was enlightening, not because it described things that were new, but rather because it made more apparent the different interpretations that can be placed on professionalism. Discussion highlighted the concrete expectations highly familiar to surgeons such as duty, accountability and trustworthiness as well as the less familiar self-awareness, empathy, and integrity. If we expect surgeons to possess all these professional attributes there must be an expectation that they can be taught and assessed.

There is considerable debate about how to teach professionalism[1]. It would seem that while courses and formal education on aspects such as ethics are appropriate, more than in any other area of surgical education, role modelling is central. Effective role modelling will likely result in appropriate professional behaviours and actions and the converse is true. See one, do one, teach one, may no longer be appropriate for technical skills, but 'see one' in relation to professional behaviour, may well be effective in ensuring appropriate ongoing professional behaviour in the observer.

> *"Thus, typical characteristics now associated with a professional include altruism, respect for others, ethical standards, advocacy and compassion."*

Assessment of professionalism is even more controversial, but it seems unlikely that assessment in a formal examination environment is particularly relevant[1]. The Surgical Education and Training (SET) program and Fellowship examinations provide limited opportunity to assess professionalism. On the other hand, in-training assessment, particularly that involving 360 degree or multi-source feedback, allows the assessment of professional behaviour in real life situations and is likely to be much more reliable. As assessment drives learning, effective assessment of professionalism is ▶

necessary if we expect to produce surgeons who behave professionally. Ongoing reviews of our assessment matrix must effectively balance the ability of the various assessment tools to evaluate competence in all areas of surgical practice and professionalism must be part of that.

The College has been in the forefront of addressing the professional issues relating to our practice. The College has had a Code of Conduct for many years. It was expanded with more explicit guidelines on Interactions with the Medical Technology Industry and given depth by the College booklet on Bullying and Harassment. These have all been broadly distributed over the past 12 months, but are also available on the College web-site (www.surgeons.org).

We are expecting to revise the Code of Conduct in the near future as there have now been a number of external bodies such as the Medical Board of Australia and New Zealand Medical Board who have produced their own documents with much clearer expectations of standards.

Since these have been promulgated there has been an increasing expectation not only amongst Fellows and Trainees, but also the community, of professional behaviour. The College produced its policy about breaches of the Code of Conduct and is now implementing it – repeatedly. The policy is deliberately structured around an educational model in that if an issue is brought to the attention of the College, then the Executive Directors of Surgical Affairs are particularly involved with highlighting how important the Code of Conduct is and the expectation of full compliance. This is accompanied by the requirement to sign a Statutory Declaration about adhering to the standards of our profession into the future. It is not a statement about what had happened, but a commitment to the future and understanding what is expected. It is the College's absolute expectation that Fellows and Trainees adhere to this and if they are not able to fulfil the requirements of the Statutory Declaration a repeat offence may lead to removal of their Fellowship.

All of us need to be reminded on occasions that what may seem "OK" on the spur of the moment is well beyond the acceptable on moments of reflection. Issues addressed in the last few months include surgical standards, interactions with patients, interactions with the medical industry and interactions with colleagues who include Fellows, Trainees or other health professionals. It may not be surprising that our Trainees Association is now being approached about progressing concerns with regards to bullying and harassment.

Professionalism is far more than a constellation of behaviours. It also covers communication, collaboration, management and advocacy[2]. However, our behaviours are perhaps the most immediate and tangible evidence of the importance that we place on professionalism. The College believes most strongly that it is critical for surgeons to fully understand the current societal expectations of professionalism. Without a professional approach, surgeons will find that society will withdraw the rights traditionally associated with professionals and relegate us to the ranks of skilled labourers. The future of surgery will slip from our hands.

I look forward to discussing these issues with you further, as I meet with you in a number of forums over the next 12 months

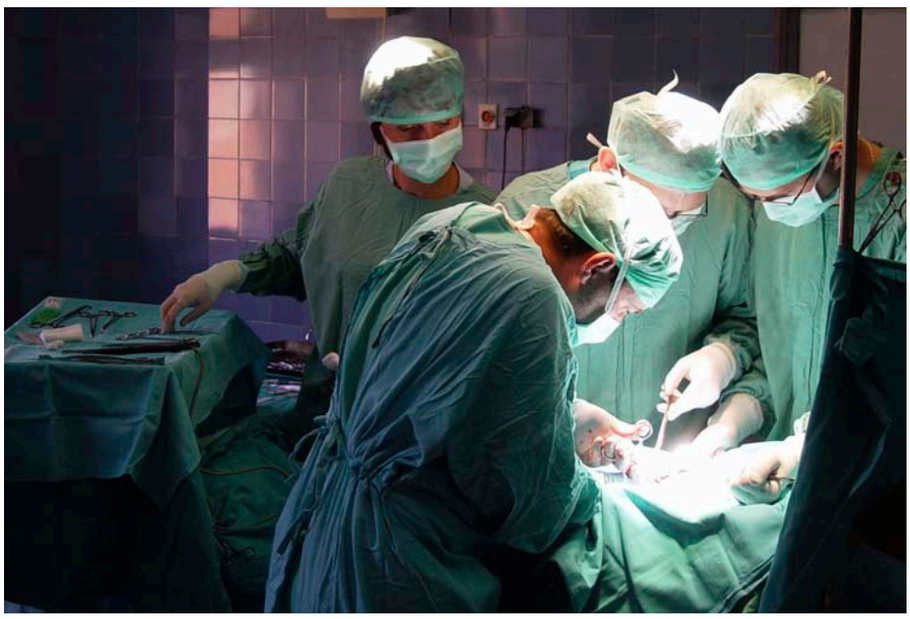
1. Wearn A, Wilson H, Hawken SJ, Child S, Mitchell CJ. In search of professionalism: Implications for medical education. NZ Med J. 2010:123-1314;4116
2. Gruen RL, Campbell EG, Blumenthal D. Public roles of US physicians: community participation, political involvement, and collective advocacy. JAMA 2006;296(20):2467-75.

The 2009 Census Findings… enclosed

Keith Mutimer
Vice President

As you are aware the College census of the Australian and New Zealand surgical workforce was conducted in 2009. An excellent response rate of just over 80 per cent was achieved, providing a robust data set and a valuable tool for advocacy. Under the strong leadership of my predecessor as Vice President, Dr Ian Dickinson, the data was refined to provide illustrative findings in an easy to read format. I would like to take this opportunity to thank you for taking the time to participate in this important project and I am pleased to release the findings in this edition of *Surgical News*.

The Surgical Workforce 2009 report covers Fellowship, Working Patterns and Aging and Retirement Plans. Your responses regarding the issues of work-life balance and workplace stressors will be explored through *Surgical News* articles. For example, you may recall that a census related article, "Threat of Litigation – An Unavoidable Stress?" was published in the last edition of *Surgical News*.



Key Findings

Workforce

Key findings in the Surgical Workforce 2009 report included an overall increase in the number of surgeons per population across Australia and New Zealand. In Australia the ratio has changed from 1:6000 in 2005 to 1:5000 in 2009. In New Zealand the ratio changed from 1:7000 in 2005 to 1:6000 in 2009.

These ratios are attributable to increased numbers of active surgeons in both Australia (up 16.7 per cent) and New Zealand (up 15.0 per cent) between 2005 and 2009. Of note is the increased number of women in the surgical workforce (up 61.5 per cent in Australia and 42.9 per cent in New Zealand). On a yearly average, one female entered surgical practice for every 3.6 males between 2005 and 2009.

On a more sobering note, nearly a quarter of Fellows intend to retire from public on-call within the next five years.

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

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

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

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message

about National Registration and Accreditation processes

The new registration processes start on 1 July 2010 and it is important that all Fellows understand the changes ahead.

IT IS VERY important that you ensure that you are currently registered with the medical board in the state or territory in which you practise. This will ensure that you transition smoothly into the national scheme and are registered with the Medical Board of Australia. It is also important that you check that your contact details and mailing address with the current state or territory Board are correct.

IN EARLY MAY, every medical practitioner will receive a letter from the Medical Board of Australia. This letter will list your registration details as currently recorded by the medical board in the state or territory in which you are registered and your proposed registration type under the National Law that will apply after 1 July 2010. The letter from the Medical Board of Australia will also give information about your obligations under the national law.

IT IS ESSENTIAL that you take the time to check the accuracy of the information in the letter and promptly provide feedback to the Australian Health Practitioner Regulation Agency (AHPRA), the Agency that is supporting the Board, if something is not correct.

DOCTORS WHO ARE registered in multiple jurisdictions may receive more than one letter, although data cleansing and de-duplication work is being undertaken to reduce the likelihood of this occurring.

ALL DOCTORS WHO are registered on 30 June 2010 will be automatically registered in the national scheme until the end date of their current registration. Annual registration renewal for doctors with general registration with the Medical Board of Australia will be 30 September, regardless of the state or territory in which you practise. If you are due to renew your registration between now and 30 June 2010, your registration will be valid until the end date. The next time you renew in 2011 will be with the Medical Board of Australia and will be for a period that brings you in line with the 30 September registration renewal date for all medical practitioners.

DIFFERENT RENEWAL TIMELINES apply to International Medical Graduates with conditional or limited registration and interns.

FURTHER INFORMATION
is available on the Medical Board of Australia website which is accessible via www.ahpra.gov.au or directly at www.medicalboard.gov.au

Working Patterns

The overwhelming need for more surgeons in public practice is obvious. A substantial percentage of Fellows perceive a need for further colleagues (half or full time plus) in the public sector. This was the view of 50.2 per cent of Australian respondents and 54.9 per cent of New Zealand respondents. Among the specialties, 48.1 per cent of paediatric surgeons perceive the need for one or more full time surgeons. A third or more surgeons in most of the surgical specialties perceive the need for one or more full time surgeons.

Surgeons continue to do more work in the private sector than the public sector. Surgeons are spending more time consulting and undertaking procedural work in the private rather than public sector. More than half of the Fellows who responded to the census are involved in teaching and a significant amount of pro bono work is being undertaken.

Committed to the public sector

Despite public and government perceptions, we are demonstrably committed to the public sector. Nearly two thirds of surgeons are undertaking on-call work in public hospitals in their principal specialty. Of note, almost a third of surgeons found the level of on-call work in the public sector to be heavy or extremely heavy. In particular, 57.8 per cent of paediatric surgeons, 47.0 per cent of cardiothoracic surgeons and 45.0 per cent of vascular surgeons found the level of on-call public sector work heavy or extremely heavy. In the regions, 62.5 per cent of Northern Territory and 36.6 per cent of South Australian based surgeons found the level of on-call public sector work heavy or extremely heavy.

More than half of Fellows found the level of on-call work in the private sector to be light or extremely light. The exception was cardiothoracic surgeons, a quarter of whom reported the level of on-call work in the private sector to be heavy or extremely heavy.

Almost half of Fellows are undertaking an on-call workload of one in five or more, on both daily and weekly rosters. The majority of Fellows viewed one in four or less for both daily and/or weekly roster as the frequency that maximises patient safety.

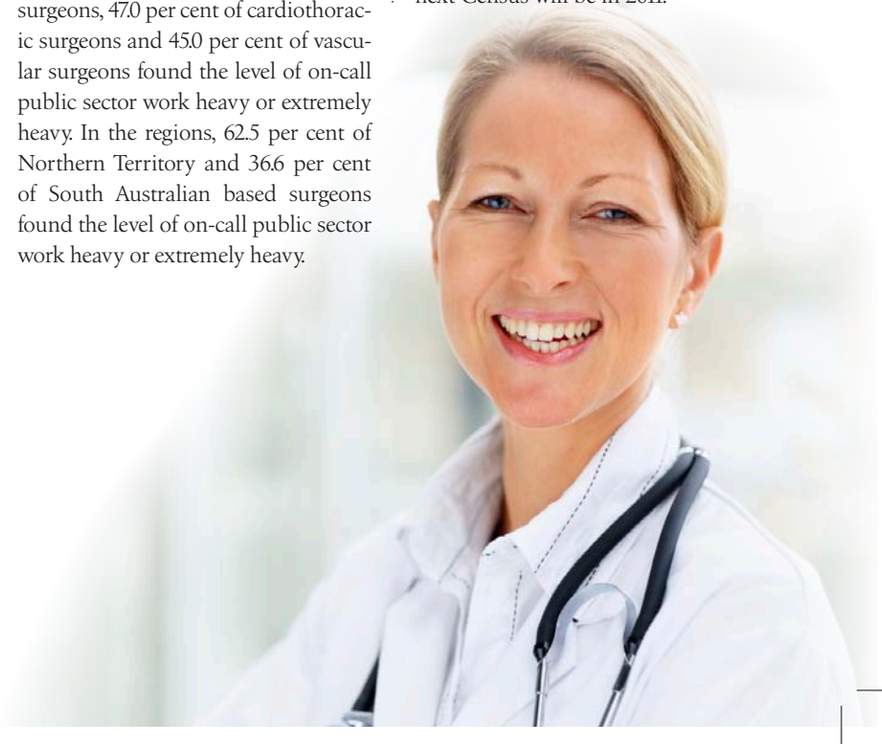
Infrastructure

A substantial percentage of Fellows perceive the infrastructure for surgical services to be adequate. Of note, more than a third of Fellows perceived junior medical staff cover to be dangerously inadequate or barely adequate.

Where to next?

With your help, the College now has a clearer awareness of current gaps in the surgical workforce and areas of current and future need. The findings are now being scrutinised with a view to developing plans that can be taken to Australian and New Zealand governments.

Supported by extensive and reliable data arising from the census, the College's ongoing advocacy efforts will be significantly facilitated. Thank you once again for your participation. The next Census will be in 2011.



Policies and more policies

See how your practice measures up to the College's policies

I.M.A Newfellow

I bet you did not know that the College has a policy on documents. It is actually not a policy, but three policies. One is on "Storage and Handling", one is on "Records Management" and the third on "Vital and Confidential Records". Now by this stage, 90 per cent of my readers have gone onto the next page, but I promise that it will get more interesting.

My interest (if you can call it that) in documents, arose recently when I was at the home of a retired surgeon. He wanted to show me his restored classic car in the garage. However, the thing that caught my eye was not the gleaming red metal, but the pile of case notes in a corner, names clearly visible and stored without any real security. His aged labrador was certainly not "security". The wind whistled into the garage and fluttered the pages, tempting them to go "AWOL".

Now maybe you don't mind the neighbourhood knowing that you had a fractured tibia, but what about your HIV status or your genital herpes? I would prefer that my prostatic status and haemorrhoidectomy remain "secret men's business". Mrs Newfellow also would like both of these bits of information to be secret, even to her.

That seminal document on "Storage and Handling of Documents" does not give us anything exciting; it only tells us what sort of filing cabinets to use, but does make the obvious case that documents should be stored in a "secure area". It does not mention home garages.

The equally fascinating policy document on "Record Management" tells us about eight separate pieces of legislation that affects those persons charged with the management of documents. However, the real killer is that masterpiece of policy documents, "Vital and Confidential Records". Vital records are defined as those that "enable the College to continue operating during or following an emergency or disaster without a break in business continuity". If you look at your own practice, what would happen if you suddenly lost all your accounts or the records of the last year of patients or those currently under treatment. All those are very vital. It is, however, surprising how often computer records like this are not backed up. An IT friend says that there are only two types of computer users – those that have had a hard disc failure and those who are going to have one.

Now the bit that really interested me is the confidential bit. However, the masterpiece of a policy document does not really define confidential. Our Chief Executive Officer, Dr. Hillis, is a policy fiend so I should let him know this lack of a robust definition. To me "confidential" means that which you would not like your best friend or your worst enemy to have access to. That really covers virtually all medical history and treatment.

So one Saturday when you have nothing to do (and I mean absolutely nothing) download these policies and see how your practice measures up. As for me, on that "absolutely nothing to do Saturday", I might explore the nethermost regions of my garage and see if anything lurks there that that should not be lurking.

Bike ride in the scenic Boonah Valley

The inaugural Foundation for Surgery bike ride organised by Michael McAuliffe was a huge success with 66 cyclists raising $8,500

Michael McAuliffe
Board Member, Foundation for Surgery

The beautiful Boonah Valley situated in the scenic rim near Ipswich, Queensland was the location for the first Foundation for Surgery bike ride. Sixty-six keen cyclists, who were arranged in teams of four or five, set off at 7.30am to enjoy the scenery and the riding. The degree of enjoyment that the riders had was somewhat tempered by whether they were going up or down one of the many hills on the course.

There was a wide range of riding ability involved on the day. The leading team scorched around the 96km course in around two hours and 40 minutes averaging 35kms an hour, whereas the final finishers took around six hours and completed the course at a very leisurely rate. There were riders from various parts of south-east Queensland, but would certainly welcome teams from further afield and interstate if they were able next year.

The ride raised approximately $8,500 and these funds will be distributed by the foundation to one of its many projects. The event was a great success and this was in no small part due to the wide variety of volunteers and sponsors.

I would firstly like to thank my wife and the staff at my practice who put in a tremendous amount of ground work and organisation on the day. A number of surgical Trainees also contributed significant time to the event as did volunteers from the National Australia Bank and St Andrews Hospital Ipswich. The event received excellent support from our sponsors which included: Avanti Bikes, Peak Fuel, Medartis, Lima Orthopaedics, Mater Hospitals and Springfield Land Corporation.

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The winning team from left to right Graeme Smith, Andy Patten, Andrew Grady, Chris Millen (Captain)

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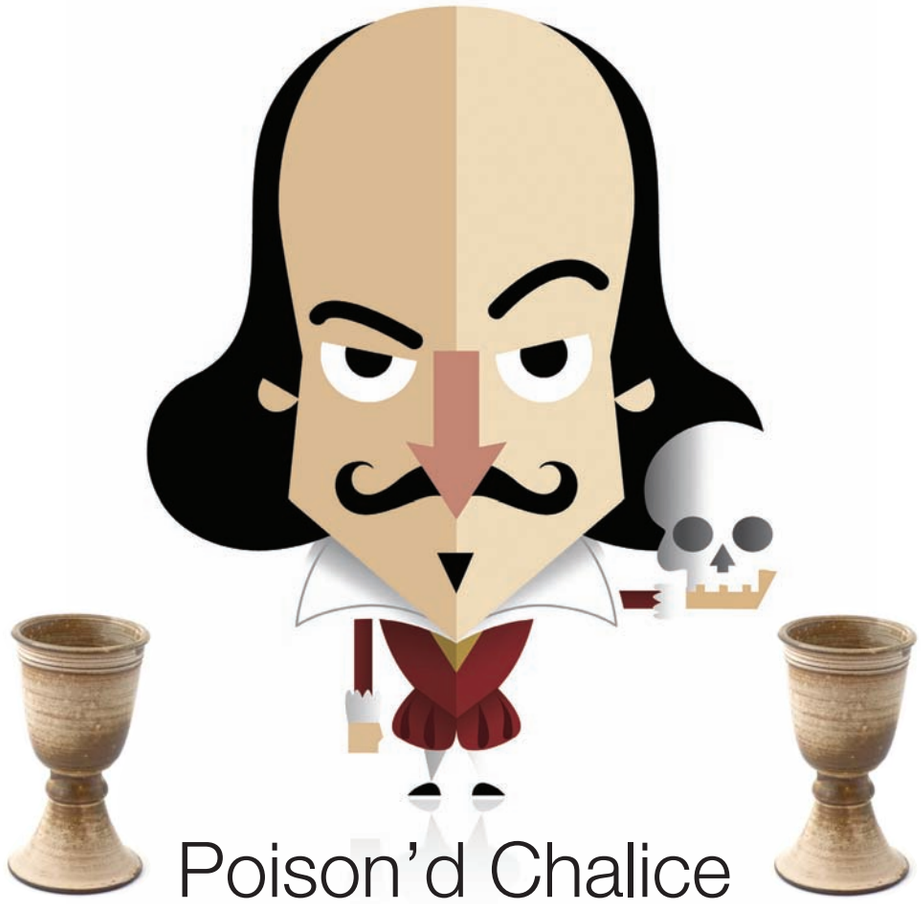

Poison'd Chalice

Being Head of a Surgical Service is not what it is all cracked up to be

Professor U.R.Kidding

People think being in charge is all about networking with the politicians and making oneself indispensable to the formal hospital management structure. Glass of white in one hand, policies and strategies in the other, profound words listened to intently by all gathered around.

However, it has its moments of more intense reflection. The words of Shakespeare were again echoing from As You Like It (Act 2, scene 7) where Jaques states, "All the world's a stage, and all the men and women merely players; They have their exits and entrances, and one man in his time plays many parts, His acts being seven ages."

You see I had known this senior surgeon well. I had respected him immensely. Not only was he technically really good, but he had nurtured a large group of Trainees and expected excellence. He was someone who everyone looked up to, had looked up to. There were now the whispers in the tea room, the concerned heads nodding in the corridors. Of more significance, he was more regularly an absentee from our Peer Review Audit or Morbidity/Mortality meetings. Some of the braver registrars had presented anonymous cases, but it was all quite clear who the Consultant had been. He was resisting being part of the National Mortality Audit process. Apparently, he was too busy for that. Importantly our ongoing surgical service audit of post operative blood loss and transfusions had him as an outlier.

How does a "junior" approach a "senior" even when the alarm bells are ringing? Even when the junior has all the authority of this wonderful position called "Head of Surgical Services". In this case with sadness.

Macbeth came to mind. "Life's but a walking shadow, a poor player that struts and frets his hour upon the stage and then is heard no more." I am certain that when my time as a well respected surgeon was up, that someone would tell me and that I could exit, gracefully before being thought of as "full of sound and fury, signifying nothing." Too morbid, but that is what these circumstances can do.

I marshalled my thoughts, I assembled my strategies. I would use the compulsory nature of the surgical mortality audits as the entrance strategy, his lack of attendance at the morbidity and mortality issues as a real concern and the outlier for transfusion rates as a trigger for thorough review of all his operative cases. Grasp the nettle, I said to myself. That is the job.

I rang his rooms and asked to be put through. He was cheerful on the phone although puzzled about the call. Remarkable coincidence he stated, I was just about to give you a ring and make an appointment to see you. He explained that he had a pact with his closest colleagues. They were his anaesthetist and a nurse who had scrubbed / assisted him in private for decades. The pact was they would tell each other when they needed to move forward and embrace a non-clinical and particularly a non-operative stage of life. He was concerned he was "not quite there" anymore and he had always resolved he would call his time. However, he really wanted to be involved in teaching medical students and anatomy to surgical Trainees – they really do not know much of it these days. That is why he wanted to see me.

I almost cried with relief. My strategies were rapidly re-shuffled and we made a time to talk so he could contribute in different, but very meaningful ways.

Strange this job as surgical leader, the opportunities to learn are endless. One thing that I have learned is that insight is possibly the most important of all attributes possessed by a surgeon. Alas it is not universally apparent – its sharp edge blunted by repeated rationalisations. But more of this another time...

For now, I am just happy that dignity, respect and achievement have been preserved.

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Selection into Surgical Education and Training

The College has put considerable effort into improving referee reports, to make them a better tool for discriminating between applicants

Simon Williams
Chair, Board of Surgical Education & Training

The College has commenced selection into the Surgical Education and Training (SET) program with successful applicants scheduled to commence formal training in 2011. Registration opened in January, with applications received in April from 859 doctors. In total 1132 applications are being processed by the College's nine Specialty Boards into the 13 programs (there are separate selection processes in Australia and New Zealand for the specialties of General Surgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery and Plastic and Reconstructive Surgery).

A key feature of the SET program is that young doctors interested in pursuing a career in surgery can apply to surgical training at any stage from Post Graduate Year Two. The implication of this is that many applicants have had very little surgical experience at the time they apply to a specific specialty. This is a situation quite different from previous years when Australian and New Zealand educated applicants had already completed a minimum of two years of the College's Basic Surgical Training program as a pre-requisite for specialty training, and often already had several years experience in the specialty to which they were applying.

One of the problems created by this early selection of Trainees on to the SET program relates to how best they can be selected. Their short period of surgical exposure at the time of application for selection means that any Fellow asked to complete the referee reports – one of three selection tools used – may have had little opportunity to observe or to judge their technical skills, and not much more opportunity to assess their other attributes (non-technical skills).

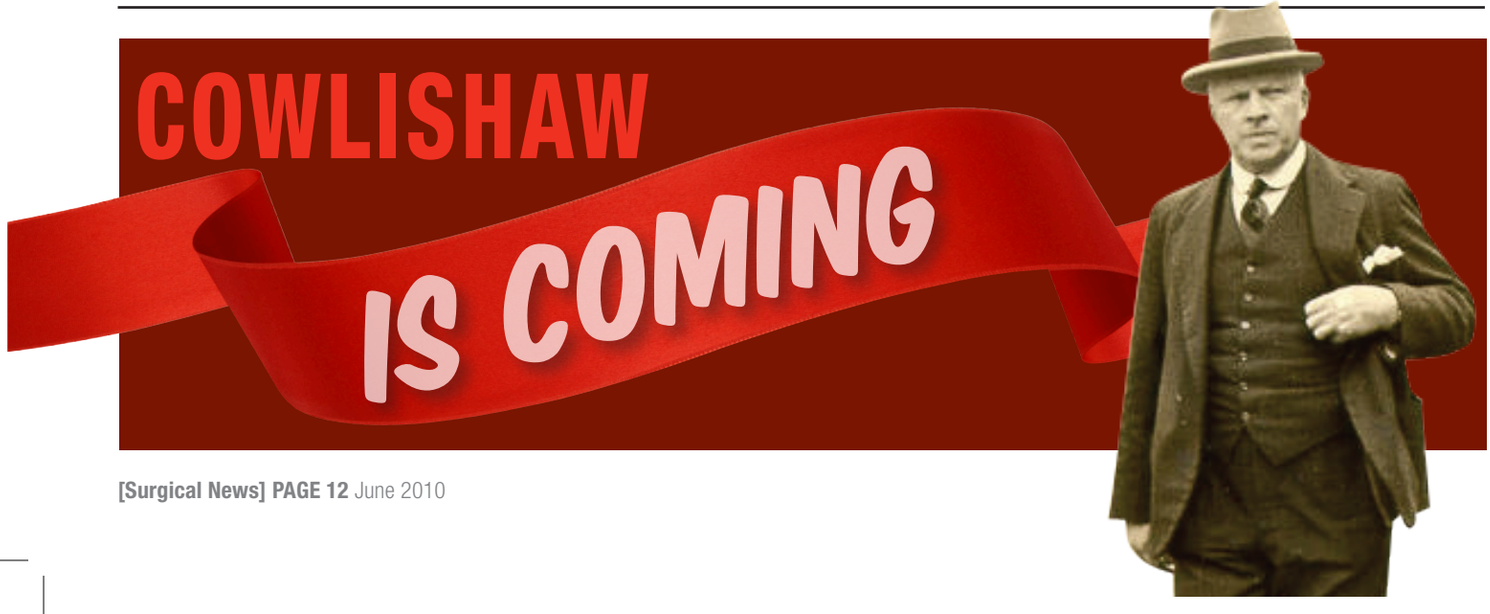
This unsatisfactory situation is compounded by the fact that historically, referee reports have lacked standardisation and consistency, and have often been filled in poorly. Their value has been suspect. Until recently, each specialty has had its own form. The parameters assessed have varied between training programs, have been difficult to mark consistently, and have not always been aligned to the desirable attributes or competencies that the College has identified as being indicators of a doctor suitable for specialist training.

For these reasons, the College has put considerable effort into improving the referee reports, to make them a better tool for discriminating between applicants, and to more closely align their content with the attributes that reflect trainees most able to acquire the desired surgical competencies.

From 2010, at least 11 of the 13 training programs will be using the one form. This form has been developed and refined over several years with input from all specialty boards and a number of external experts, including Professor Fiona Patterson of City University, London, who facilitated a selection workshop in April 2009 (*Surgical News*, Volume 10, Number 4, page 20). The new form is better aligned with those attributes that are believed to be required for success in the training program, and ultimately for safe surgical practice. It can be completed online, is easy to mark, and it will obviate the need for Fellows to fill out a different form for each specialty – no doubt this will be welcome news for many.

In addition, the forms include questions which will help discriminate applicants who all score within the same band. This will improve further its usefulness as a selection tool. Ultimately though, it is the care and attention that is taken by us as Fellows when we complete these forms that will have the greatest influence on our ability to select those who will become the best surgeons.

A new selection Interviewer Training Workshop is now on offer. Call +61 3 9249 1106 for more information.



2010 professional development workshops

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

Supervisors & Trainers for Surgical Education & Training (SAT SET) Course

29 June, Canberra / 21 July, Brisbane / 7 August, Hobart

This course has attracted very positive feedback from the one thousand Fellows who have attended. It clarifies the roles and responsibilities within the Surgical Education and Training (SET) program and teaches you how to use workplace assessment tools, specifically the Mini-Clinical Evaluation Exercise (Mini-CEX) and the Directly Observed Procedural Skills (DOPS). You also explore strategies for management of trainees, especially in areas of underperformance.

Surgeons and Administrators: Working Together to Bridge the Divide

16 July 2010, Melbourne

This full day workshop focuses on a better understanding of the surgeon-medical administrator working relationship and development of more cooperative health service management. This workshop is offered in collaboration with the Royal Australian College of Medical Administrators. The objective are to have a greater greater understanding of the roles, responsibilities and priorities of surgeons and medical administrators. Plus develop strategies for improving surgeon and medical administrator relationships

Building Towards Retirement

30 July 2010, Sydney

Work is an important part of life so when you stop full time surgery or are approaching retirement, you need to take time to plan for the next stage. This whole day program covers key issues including maintaining health and well being, career options after surgery, superannuation and legal advice, community involvement, building relationships and networks. It provides an opportunity for Fellows and their partners to share experiences and plans for winding down from a full-time operating career.

Surgical Teachers Course

12-14 August 2010, Newcastle / 21-23 October 2010, Adelaide

The Surgical Teachers Course builds upon the concepts and skills introduced in the Supervisors and Trainers for SET (SAT SET) course. An educational framework provides an effective guide to planning teaching episodes; from needs assessment and goal setting to the instructional methodology. The comprehensive curriculum is delivered over two and a half days and aims to enhance the educational skills of those with a keen interest in the teaching and assessment of surgical trainees. Participants are also encouraged to attend a SAT SET course, a forerunner to the Surgical Teachers Course.

Practice Made Perfect

8 September 2010, Melbourne

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

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

professional development workshops

DATES: JUNE – SEPTEMBER 2010

ACT
29 June, Canberra
Supervisors and Trainers (SAT SET).

NSW
7 August Sydney
Making Meetings More Effective
12-14 August, Newcastle
Surgical Teachers Course (STC)
19 August, Sydney
AMA Impairment Guidelines Level 4/5: Difficult Cases, Sydney

NT
20 August, Darwin
Polishing Presentation Skills,

QLD
21 July, Brisbane
Supervisors and Trainers for SET (SAT SET)
17 September, Sanctuary Cove
Supervisors and Trainers for SET (SAT SET)
22 September, Brisbane
Beating Burnout

SA
23 June, Adelaide
Practice Made Perfect

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

VIC
18-20 June, Melbourne
Leadership in a Climate of Change
16 July, Melbourne
Surgeons and Medical Administrators
26 June, Melbourne
Making Meetings More Effective
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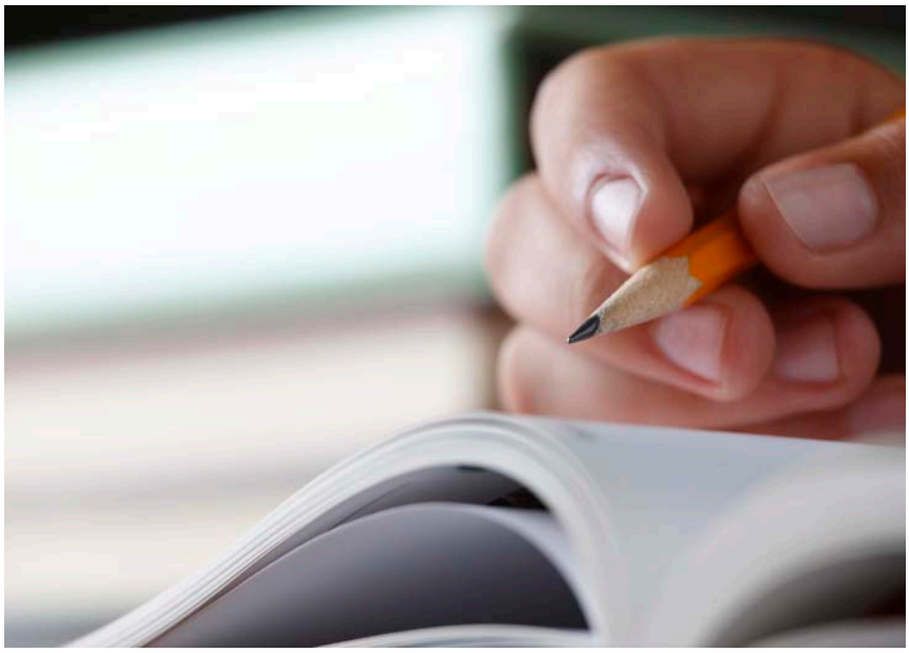
8 September, Melbourne
Practice Made Perfect

NZ
23 July, Wellington
Mastering Difficult Clinical Interactions

Has SET changed how we examine?

The intention is to improve the quality and validity of the Fellowship examination

Spencer Beasley
Chair Court of Examiners
& Mark Edwards
Censor-in-Chief



Many Fellows may be interested about the effect the new Surgical Education and Training (SET) program has had on the final Fellowship examination, and on the basic science examinations. In short, the Fellowship examination (previously known as the "Part 2 examination") has remained largely unchanged. Some Fellows may not be aware it has not always been in its current format. Over the history of the College, it has progressively expanded from four components to the seven components with which our Younger Fellows are so familiar. There are some minor differences between specialties, but for most, it consists of two written papers and five vivas.

What did change with the SET program was the assessment of the basic sciences. Formerly, this was done through the Basic Surgical Training (BST) examination (previously known as the "Part 1 examination"), comprising 360 multiple choice questions (MCQs) and a clinical examination. This had to be completed before selection on to one of nine specialty training programs as a Speciality Surgical Trainee (previously known as an advanced surgical Trainee). One of the consequences of introduction of the SET program was the discontinuation of the generic BST scheme.

In its place, applicants for surgical training are now selected directly into one of the nine specialties. There is a new Surgical Science Examination (SSE) - or series of examinations - which involves, at least theoretically, a generic component limited to material truly generic to all specialties, and an expanded specialty-specific component, the curriculum for which each specialty has responsibility. There has been a requirement for the SSE to be completed within two years of entering the SET program.

Despite best intentions, it would be fair to say that the transition to the SET program has not been entirely without difficulty. One of the problems has been that the curriculum for the generic basic science component has not been reduced to the degree anticipated, but rather has remained essentially unchanged from what it was in the old BST days. For example, the MCQs are essentially the same as they were in the old BST days. This has put a huge burden on the Trainees to learn material that is not necessarily relevant to their choice of specialty. And this is at a time when most specialty training boards might prefer their energies were spent more productively in other areas.

Some specialty training boards have been more proactive than others in developing a relevant specialty-specific curriculum. This involves an enormous amount of work by the specialty boards, or their agents, but needs to occur across all specialties with some urgency. There is educational sense in acquiring, and confirming acquisition of, relevant basic science knowledge early on in training. This then can be applied to the clinical situation. Indeed, the main purpose of the Fellowship examination is to test the clinical application of this knowledge.

Given this, the appropriateness of including basic science (as distinct from its clinical application) in the Fellowship has been questioned. This will be one of a number of issues to be addressed soon. Already a number of specialty boards have removed the "Anatomy" and "Pathology" vivas from the Fellowship examination, and brought their assessment forward to an earlier stage of SET training. In essence, for these specialties, they have become their specialty-specific component of their SSE. Other areas that will be considered include: better methods to train examiners and assess their performance; introduction of a structured form for candidate feedback; and review of the organisation and financial structure of the examination.

The intention is to improve the quality and validity of the Fellowship examination. The Board of Surgical Education and Training, the Court of Examiners and the SSE and Clinical Examination committee are all working closely to refine the processes of formative and summative assessment of SET Trainees to make it increasingly relevant and valid.

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Sir Roy McCaughey Surgical Research Scholarship

The scholarship has allowed Dr Watson to concentrate on his work, which will hopefully save lives

Alasdair in the research operating theatre, where they perform pig heart transplant experiments

The Victor Chang Cardiac Research Institute

The innovative use of existing drugs to improve the preservation of hearts for use in transplantation could broaden the pool of Australian and New Zealand donors by extending the time a heart can still be viable after removal. Research using rat and pig models is now being conducted into the use of the drugs by Dr Alasdair Watson, the current recipient of the College's prestigious Sir Roy McCaughey Surgical Research Scholarship.

Dr Watson has spent the past two years investigating the cardio-protective efficacy of erythropoietin, a hormone that stimulates the production of blood cells, and glyceryl trinitrate which dilates blood vessels, in a bid to extend the time a heart can remain viable after removal.

The drugs, used in combination with a commercial preservation solution known as Celsior and an experimental compound zoniporide, designed to protect cells from the effects of a lack of oxygen, had never before been used for organ preservation.

"When a heart is transplanted, it is obviously subjected to a variable period of time outside the body during which it is deprived of oxygen and metabolic substrates, which cause cellular injury in a time-dependent manner," Dr Watson said.

"The currently accepted maximum 'safe' period of ischaemia is approximately six hours, however risk of mortality after the transplant increases after four hours."

Working out of the Victor Chang Cardiac Research Institute in Sydney, Dr Watson has shown a striking beneficial effect in adding the drugs to Celsior using an ex-vivo rat model.

In this initial study the hearts were removed, arrested and stored in various combinations of the chemical agents and then reperfused at various time intervals.

Dr Watson said that experiments showed that the hearts had negligible recovery of function after six hours of ischaemia using only Celsior, but that the use of any single agent in the preservation solution offered a 50 per cent return of cardiac output after the same time period.

The combination of all three chemicals had even allowed Dr Watson to effectively reperfuse the hearts after ten hours.

"In Australia and New Zealand, because of small populations and large distances, there is a greater time delay between obtaining the heart and transplantation than in Europe for instance so to find a way to allow the heart to retain its function over a longer time period would be of great value," he said.

"Here too, because of the smaller population bases, we often have to use donors that are considered marginal in that they may be older than 50 years, require significant inotropic support, or demonstrate some degree of ventricular dysfunction prior to organ retrieval.

"However, this research, if it can extend the time that a heart remains viable outside the body, could open up a broader pool of donor organs that need to be transported from donor to recipient across greater distances.

"The average time of ischaemia in Australia and New Zealand is four and half hours with a decent proportion closer to six hours which often require a period of mechanical circulatory support after transplantation to allow the organ to recover from the ischaemic insult.

"We are also hoping that this research could allow us to reduce the incidence of primary graft failure by up to 50 per cent, and thus lead to a reduction in the requirement for mechanical cardiac support post-transplantation, which would have significant benefits in terms of resource utilisation."

Dr Watson is now conducting studies on the use of the drugs in a pig model of cardiac transplantation with human trials expected to take place at St Vincent's Hospital in Sydney later this year.

A surgical Trainee, Dr Watson is undertaking his research as part of his PhD under the supervision of Professor Peter Macdonald, a transplant cardiologist at St Vincent's Hospital and Head of the Transplantation Research Laboratory at the Victor Chang Cardiac Research Institute.

> *"The Sir Roy McCaughey Surgical Research Fellowship is available to both Fellows and Trainees wishing to undertake a PhD"*

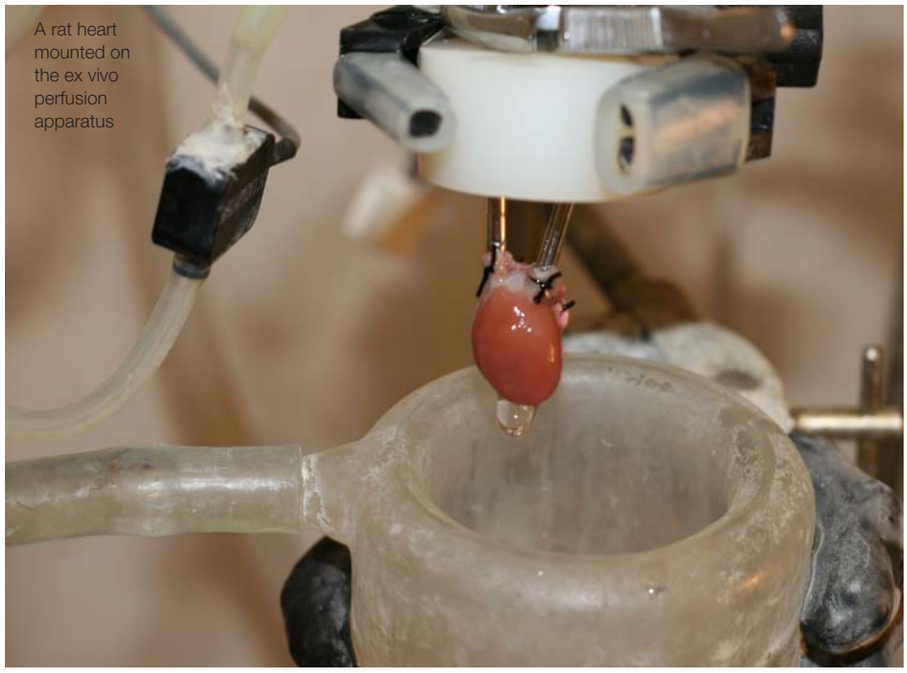
His co-supervisor is Dr Paul Jansz, a cardiothoracic and transplantation surgeon also at St Vincent's Hospital.

The Sir Roy McCaughey Surgical Research Fellowship is available to both Fellows and Trainees wishing to undertake a PhD with the research to be conducted within New South Wales. It carries an annual stipend of $55,000 with $5000 to cover departmental maintenance costs.

Dr Watson, who is planning to begin cardiac surgical training next year, said he was honoured to receive the support of the College over the past two years.

"To have the ability to hone my surgical skills via the pig model while attaining a PhD has been a tremendous opportunity," he said.

"The funding that comes with this scholarship has allowed me to concentrate on this work which is not only fascinating in itself, but which will have direct clinical application and hopefully save lives and save the system money."



A rat heart mounted on the ex vivo perfusion apparatus

Leadership Exchange program

The program gives younger Fellows a chance to meet a group of people who are similar, yet different in many ways

'Mission Impossible' winning team

Julie Ann with a koala

Christine Lai
SA/NT representative, Younger Fellows Committee

I recently attended the Younger Fellows Forum (YFF) in the Swan Valley and had the privilege and pleasure of meeting with Julie Ann Sosa, an Associate Professor of Surgery in the Divisions of Endocrine and Oncologic Surgery at Yale University. Julie Ann was the recipient of the Younger Fellows Leadership Exchange program between the Association of Academic Surgery (AAS) and the College.

At the Forum, Julie Ann was impressed that Fellows from our College Council, including the President and two Councillors, were in attendance and were actively engaging in discussion with Younger Fellows. In the United States (US), young surgeons do not have the opportunity to interact with leaders of the American College of Surgeons in such a forum. There is also no equivalent opportunity for American younger surgeons to socialise and exchange ideas with a group of colleagues outside of their specialty, geographic region and from different work backgrounds and "have fun doing it". In particular, Julie Ann enjoyed the opportunity to participate in the team building activity of "Mission Impossible", where her team won. Julie Ann also met the challenge of presenting a 2000 page summary of President Obama's US health reforms within a 30 minute session.

The Leadership Exchange also included Julie Ann's attendance at our Annual Scientific Congress (ASC) in Perth. Julie Ann delivered three invited presentations and taught at the 'Developing a Career in Academic Surgery' (DCAS) Course. Her highlights in Perth included meeting Australian surgeons at different levels from Younger Fellows to those who have achieved at the highest levels in the profession, including Emeritus Prof Tom Reeve.

Accepting the invitation to the Leadership Exchange also provided Julie Ann with the opportunity to visit the Department of Endocrine Surgery at Royal North Shore Hospital and the Department of Surgery at the Queen Elizabeth Hospital. Medical students at the University of Adelaide and the University of Sydney's clinical schools were inspired by her enthusiasm and knowledge and her highlights included teaching students at Westmead and speaking on "Lessons learned while becoming a surgeon" to a full lecture theatre in Adelaide.

Younger Fellows of the College can nominate to represent the College at the AAS Annual Scientific Meeting (ASM) through the College-AAS Leadership Exchange program. AAS is a group of dynamic younger surgeons who are within 10 years of obtaining their specialist qualifications. It is a chance to meet a group of people who are similar, yet different in many ways. The Leadership Exchange recipient may also use this opportunity to visit centres in the US to broaden their experiences, which the AAS committee members and Julie Ann would be delighted to facilitate.

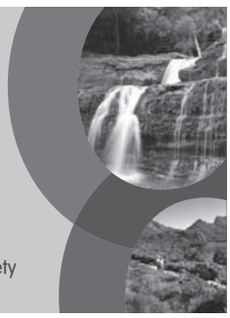
The next AAS ASM will be held at Huntington Beach, LA, California from 1-3 February 2011. Please send your Expression of Interest to Younger Fellows Secretariat at Younger.Fellows@surgeons.org

Hobart 10 – 12 November 2010

OSSANZ Conference 2010

The Changing Shape of Bariatrics

23rd Scientific Meeting of the Obesity Surgery Society of Australia and New Zealand



We are delighted to announce the 23rd Scientific Meeting of the Obesity Surgery Society of Australia and New Zealand will be held in Hobart, Tasmania, 10 – 12 November 2010.

We invite bariatric surgeons, practitioners & allied health professionals to come to the conference to learn and contribute to knowledge and understanding of the changing nature of bariatrics.

The scientific program will include keynote presentations by national and international leaders, oral papers, video presentations, posters, lunch and breakfast educational sessions.

We look forward to welcoming you to the picturesque city of Hobart for OSSANZ Conference 2010.

Call for Papers closes 2 July 2010

Conference Office **Think Business Events**
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Applicants will need to be able to register/ be registered with Medicare Australia for specialist recognition. Work provided for the Regional Hospital will be as a nominated practitioner on a VMP contract. This work attracts fee-for-service.

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RAMSAY HEALTH CARE

Surgical Fellowship - 2 Positions

John Flynn Private Hospital (JFPH) and The Tweed Hospital (TTH)

- **Laparoscopic Bariatric / Upper GI / HPB**
- **Laparoscopic Colo-Rectal**

We are pleased to announce the continuation of Fellowships (2) in Advanced Laparoscopic Surgery at both John Flynn Private Hospital and The Tweed Hospital, for a one year period commencing January 2011. These fellowships offers an outstanding opportunity for training in Advanced Laparoscopic surgery with a substantial clinical workload in operating sessions, post op ward care and weekly multi-disciplinary meetings.

The holders of the fellowships will also be encouraged to participate in clinical research programs and will be offered the opportunity to initiate clinical/collaborative research study. Medical student teaching at TTH will be a significant responsibility for one of the positions.

Applicants should hold a FRACS; be eligible for registration with the Medical Boards of Queensland and NSW; have recently completed advanced training in general surgery, and be seeking further experience in Advanced Laparoscopic Surgery in gastro-intestinal, colo-rectal and bariatric surgery. Fellows will work under the supervision of three specialist surgeons and assist with private surgical operations.

The successful applicant for each position will be required to hold combined appointments both at JFPH (0.5) and The Tweed Hospital (0.5). These appointments are mutually dependent.

You will require personal medical indemnity cover, but employer indemnity will be offered by Ramsay Health Care. Ramsay Health will pay a base retainer to the Fellow. Income will be supplemented from private surgical assisting, which can be retained in total by the applicant. In addition, a study grant to attend one international and one local conference during the year applies.

Remuneration and conditions for The Tweed Hospital are in accordance with the relevant NSW Award.

Enquiries:
For the Bariatric / Upper GI position, Dr Laurent Layani (07) 5598 0500
Suite 8B Fred McKay House John Flynn Private Hospital, Tugun Qld 4224
or email: drlayani@lapsurg.com.au.
For the Col-Rectal position, Dr Stephen White (07) 5598 0955,
Suite 5G Medical Centre, John Flynn Private Hospital, Tugun Qld 4224.

Application requirements may be obtained from:
Greg Jenke, Chief Executive Officer,
(07) 5598 9008
John Flynn Private Hospital
Applications close: Tuesday 20 July 2010

JOHN FLYNN PRIVATE HOSPITAL

Giving the gift of sight

Cataract blindness is a major problem in countries like PNG where teams see some kids who are almost blind

Donated glasses ready for distribution
Right: The donated Anaesthetic Machine

As a medical student, anaesthetist Dr Fergus Davidson took time out from his training in Australia and went to work in a bush hospital in Tanzania.

Now the Director of Anaesthetics at Canterbury Hospital and Staff Specialist Anaesthetist at Concord Hospital in Sydney, that experience remains as a central reference point of his working life, inspiring him to take leave each year to work in Papua New Guinea (PNG).

"Working in Tanzania taught me the great value of spending time in such places, where your work even over a short period of time can have such an enormous impact," he said.

"I enjoy working within the framework of fundamental needs and even though I have been to PNG on six visits, it still thrills me to work within hospitals that survive with so little.

"PNG is only a short flight from Sydney, yet it remains a world away from our world in that their needs are so basic and it can still be a bit confronting to walk into one of their hospitals and see rubber gloves hanging on the line and plastic syringes being washed."

Dr Davidson travels to the Pacific island nation as part of the PNG Eye Care Program headed by Sydney Ophthalmologist Dr Frances Booth.

The program is co-ordinated through the College, and supported locally by Callan Services for Disabled Persons, a charitable mission established by the Christian Brothers in 1991.

Recently, following a visit to Alotau Hospital in PNG's far south east, Dr Davidson organised the donation and the delivery of a new anaesthetic machine to replace one that had been broken down for more than six months.

With the hospital performing up to 2000 surgeries a year, the loss of the machine slowed patient treatment and required the manual inflation of lungs.

Given by Canterbury Hospital, the machine had been determined to be superflous to the Hospital's need, but still perfectly workable, and in accordance with World Health Organisation standards for donations of medical equipment.

"The central reason behind organising this donation was that on the original visit to Alotau, I realised the machine they were using was exactly the same as the machines no longer required at Canterbury Hospital," Dr Davidson said.

"That is crucial when you are providing equipment, to actually find out if the donation is appropriate because the local biomedical engineers need to know how to support it, fix it and the staff need to know how to use it.

"It may not be at the dizzy standard that we require in Australia, but it is perfectly workable and efficient and will allow the anaesthetist to work hands-free, and automatically monitors the patient.

"There is a constant tension in these matters between reconciling our standards while trying to provide practical help and when I return to Australia sometimes I'm forced to laugh at the things we find absolutely necessary when you see how other people manage."

Speaking just days before his next trip, this time to Wabag Hospital in the PNG Highlands, Dr Davidson said the team expected to conduct more than 100 cataract surgeries over the two week visit.

All will be suffering severe blindness, yet though the majority of patients will be older, some will present as virtually blind even as children.

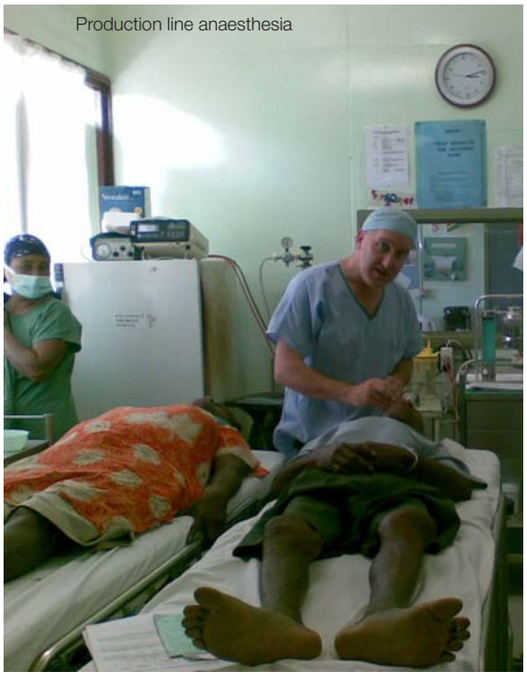
The patients have their lenses replaced in surgery and then provided with donated glasses to further correct their vision.

"Cataract blindness is a major problem in countries like PNG and while children in Australia can have them, they are usually treated very early whereas we see there some kids who are almost blind," Dr Davidson said.

"They are believed to be caused by a combination of diet, genetics and sunlight, but we don't really know. Yet we can treat them. Each procedure takes about 45 minutes and we use the old-fashioned method of scissors, knives and stitches rather than the vacuum method now used in Australia."

On this trip, Dr Davidson will be accompanied by Ophthalmologist Dr Frances Booth, theatre nurse Louise Rogers and will work alongside local Ophthalmologist Dr David Pahau who divides his time between

Coke bottle as ventolin spacer, Ingenious



Production line anaesthesia

"The patients have their lenses replaced in surgery and then provided with donated glasses to further correct their vision."

government services in Wewak and working with Callan Services.

The team will also be taking an Australian trainee Dr Ethan Nguyen who is hoping to join the ophthalmology training program.

Under the Eye Care Program, the team stays in convent or student accommodation while there, take all their own disposables and drugs provided as donations by pharmaceutical companies, with all packs sterilised through the generosity of Canterbury and Concord Hospitals in Sydney.

"These visits have become the highlight of my year, even though on day three of each one I think 'never again', but it is the local people who work so hard to make this work – the people who co-ordinate the visit, who screen the patients and who manage them while we are there and after we have gone – who deserve the credit, but get very little recognition", Dr Davidson said.

"It is also very exciting and a major advance to have David Pahau working outside Port Moresby."

Dr Davidson said one of the highlights of his work in PNG was treating a young girl named Barbara who was only nine when she presented as almost completely blind.

"We treated Barbara on one of the earlier visits and a year later when we returned we met her again," he said.

"She was in school then, reading picture books, and it was wonderful to see. She was severely blind when we operated on her and really wouldn't have had a chance to live the life she deserved to live."

With Karen Murphy

Logistics for the donations of the anaesthetic machine and spare parts were provided by TNT Australia, TNT Papua New Guinea and Burwood Pack and Send, while the cost of freight was funded by AusAID and the College.

From encouraging Indigenous surgeons to chewing gum as

The creation of a new specialist Society of Breast Surgeons, proposals to expand the range of skills needed by city surgeons who may wish to work in the bush and the analysis of a survey on Trainee fatigue were among the highlights of this year's Annual Scientific Congress (ASC) held last month in Perth.

Presentations were also made on innovative surgical developments in the management of patients undergoing menopause and cancer therapy, pain relief for post-operative colon surgery, radical surgical techniques for the treatment of obesity and developments in battlefield surgery.

The new Breast Surgeons' Society of Australia and New Zealand (BreastSurg ANZ) was launched by Dr James Kollias at the ASC to both guide the delivery of education and training in breast surgery as well to promote surgical collaboration and research.

The first Annual General Meeting of BreastSurgANZ was convened during the Congress with more than 200 surgeons endorsing those aims, particularly the Society's commitment to the National Breast Cancer Audit.

"The incorporation of this new Society is a fundamental development in the subspecialty of breast surgery in Australia and New Zealand," Dr Kollias said.

"With several hundred members, the Society hopes to become a strong voice for surgeons on issues affecting the treatment of breast disease and we look forward to fostering closer working relationships between breast surgeons and the National Breast and Ovarian Cancer Centre, Breast Screen Australia, Breast Screen Aotearoa and Breast Cancer Network Australia."

Also at the ASC, a proposal to offer training courses to up-skill city-based general surgeons as a way to overcome the critical shortage of rural general surgeons was raised by surgical trainee Dr Ruth Blackham.

Dr Blackham from Perth said such a course could be modelled on a recent emergency surgery course conducted in Bunbury by the University of Western Australia earlier this year which aimed to familiarise surgeons with the type of operations they may be required to perform in rural settings as well as the medico-legal implications associated with working outside a subspecialty.

She told the Congress that such a course aimed at enabling city surgeons to become "rurally competent" would at the very least allow for a far greater pool of locum surgeons to provide relief to their country counterparts.

"Such a model could be an important part of a system which provides ongoing support for the permanent rural surgical workforce and which also exposes city-based surgeons to the challenges and charms of working in the bush," Dr Blackham said.

"Such courses are not in themselves the solution to the rural surgical workforce crisis, but they could well be part of the solution."

Trainees' working hours

Yet while rural surgeons may be under increasing professional pressure caused by the workforce shortage, a paper presented by Dr Greg O'Grady, an Auckland based surgical Trainee and Chair of the College's Trainees' Association, indicated Trainee working hours were now considered "about right" by most respondents to an on-line survey.

The survey indicated that on average, Trainees in Australia and New Zealand spent 61 hours per week at work with 74 per cent also being on-call after hours. This compares with Trainees from the United States (US) who regularly work 80-hour weeks.

The survey showed that while most Trainees believed their working hours were appropriate in terms of skills training and the development of technical competence, time for study and research was lacking while fatigue was thought to routinely compromise Trainees' study and learning after work.

pain relief, the May Congress covered a wide range of topics

"While practical training needs and patient care needs are met by most Trainees' rosters, there is little doubt that they would benefit from more study time and reduced fatigue," Dr O'Grady told the Congress.

"Further analysis of the data produced by this survey will enable us to identify which roster structures are perceived as most supportive or disruptive of training and learning."

The ASC was also told that a specialised clinic established in Perth to help manage the combined health issues of cancer and menopause had been so successful in its dedicated approach to such patients that health authorities in other Australian states, the United Kingdom and the United States were now in the process of replicating the model.

Established by Professor Christobel Saunders, Professor of Surgical Oncology at the University of Western Australia, the clinic is staffed by gynaecologists and specialist nurses and is supported by multidisciplinary input from breast surgeons, an endocrinologist, oncologists, a psychiatrist, clinical psychologists, a physiotherapist, genetic counsellors, a dietician and researchers.

Professor Saunders said the clinic, known as the Menopausal Symptoms After Cancer (MSAC) service, aimed to reduce the severity of menopausal symptoms which can affect some women's quality of life to such a degree they are tempted to stop taking their cancer medication.

"There has long been a gap in dealing with these (combined) health issues in that oncologists know about cancer, but not menopause and GPs and gynaecologists know about menopause, but not how treatments may interact with cancer therapy," Professor Saunders said.

"At this clinic, each woman receives a personalised care plan to reduce those symptoms, while it also provides us with an amazing venue for further research."

Fellow Perth-based surgeon Mr Jon Armstrong told delegates that sleeve gastrectomy, long considered one of the more drastic surgical treatments for morbid obesity, is safe and effective.

The surgery involves the removal of a large portion of the stomach to create a tubular structure which is not reversible.

Mr Armstrong, a bariatric surgeon, presented the findings of a study of 301 patients who had the procedure between 2006 and 2009. The study showed that the percentage of excess weight loss was 47.2 per cent at one year, 69.7 per cent at two years and 66 per cent at three years. Of those patients, there were only five post-operative complications and no deaths.

"These initial findings indicate that laparoscopic sleeve gastrectomy can be performed safely and with excellent short to medium term weight loss," Mr Armstrong said.

Something to chew on

An intriguing paper presented by Dr Stephen Smith, a general surgeon at Newcastle's John Hunter Hospital, analysed the effects of gum chewing in reducing patients' pain following colorectal resectional surgery.

Dr Smith told delegates that gum chewing is a form of sham feeding which can potentially stimulate the gastrointestinal tract via cephalovagal pathways.

He said that while research looked into whether gum chewing could reduce the duration and severity of ileus, it was found to have most impact on post-operative pain on days two to five.

"Gum chewing does not appear to decrease the duration of ileus following this surgical procedure, but we can conclude that it is a safe intervention that may result in reduction of post-operative pain," Dr Smith said.

Issues relating to the health and wellbeing of Indigenous Australians as well as developing pathways to encourage more indigenous people both in Australia and New Zealand to become surgeons were also raised at the Congress.

Professor Russell Gruen, Director of the National Trauma Research Institute, said that in some remote areas, the mortality rate for Indigenous Australians in motor vehicle accidents – including single vehicle rollovers and pedestrian deaths – could be 17 times higher than the national average.

He called on Government, health and law enforcement agencies to improve road safety and access to trauma care if Australia was to have any hope of reducing that death toll.

"It is urgent that we create the health infrastructure and the regulatory framework within these regions that the rest of Australia takes for granted and which have reduced our national road toll so dramatically in past decades," Professor Gruen said.

As part of efforts by the College to promote surgery as a career in Indigenous communities, this year the College will be a sponsor of the Australian Indigenous Doctors' Association (AIDA) annual symposium.

Dr Nino Scuderi, a Resident Medical Officer with Northern Sydney Central Coast Area Health and Mr Cody Morris, an intern at the Lyell McEwin Hospital in Adelaide were guests at this year's ASC.

Dr Peter Sharwood, a Brisbane-based orthopaedic surgeon who also holds the rank of colonel in the Australian Army, addressed the Congress on the changing nature of war injuries given the type of weapons now in use in conflict zones and protection offered by body armour.

Dr Sharwood said that improvised explosive devices and small arms projectiles now produced the majority of injuries with extremity injuries and burns accounting for at least half of the wounds seen.

He said developments in surgery and the speed with which soldiers can now be treated had impacted on the historical use of limb sacrifice as a life saving procedure in battle casualties.

"With modern surgical techniques of limb salvage, damage control surgery and the advent of Level 1 trauma care at the battle front, the trend is now to attempt to save limbs which in previous conflicts would have been sacrificed," Dr Sharwood told delegates.

"In fact, the situation is now emerging, with the advent of highly sophisticated prostheses, where patients with limbs that have been 'saved' are now requesting amputation."

Congress Banquet

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Rob Pearce and Ian Civil at the Weary Dunlop lecture

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

1. Ian Gough & Ian Civil with platinum sponsor J&J
2. Cas McInnes
3. Tammi Waters & Neil Mclean
4. David Oliver
5. Ian Dickinson & Alan Skirving
6. Anne Deane, Erwin Thal & Stephen Deane
7. Liviu & Mihaela with Maris and Mihai Popa
8. Damien Bolton & Ian Gough
9. William Fitzgerald & Brendan Dooley

Perth Annual Scientific Congress 2010

Erwin Thal receiving his Honorary Fellowship from Ian Gough

Andrew & Sibby Sutherland with John Graham

10. Grant Christey, Zsolt Balogh, Cody Morris, Russell Gruen, Michael Schuetz & Cino Bendinelli
11. Margaret & Ian Dickinson with William Fitzgerald
12. Denise & Ian Civil
13. Trevor Collinson, Campbell & Vivian Miles with Tom Wilson
14. Allan & Sunny Panting with Jean Claude & Virginia Theis
15. Ian Civil receiving the President's Medal from Ian Gough
16. Gary Yee and his family after the convocation
17. Rob Atkinson

David Scott & Hind Al Mahajrafi at the Foundation for Surgery Booth

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David Watters, Arnold Wainer, Peter Kaminel, Victor Golpak & Dahlia Moss

7

3

Julian Smith & Patricia Davidson

8

9

1. David Watters, John Masterton & Michael Hollands
2. Complex patient ambulance transport vehicle
3. John & Pam Henderson
4. Dusadee & Nopadol Wora-Urai
5. Mansoor Mirkazemi, Adnan Safdar & Arash Shahidi
6. Bruce Waxman
7. Association for Academic Surgery Workshop
8. Sam Baker & Mathew Peters
9. Registration desk

Perth Annual Scientific Congress 2010

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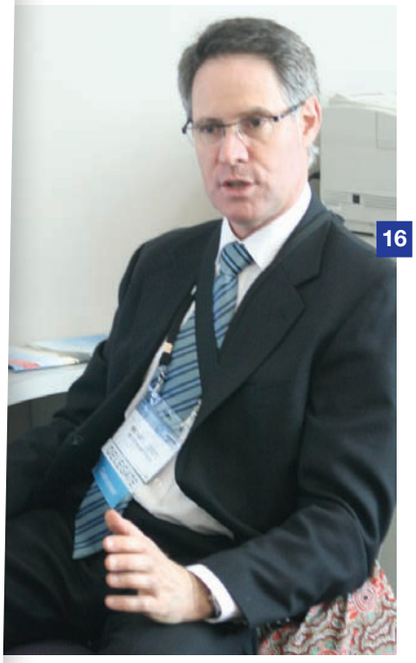
Jorg Imberger delivering the Syme oration



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10. Inside the surgical simulation van
11. Meetings at the ASC

12. Senan & Saad Al-Mahaidi
13. Women in Surgery Breakfast
14. Jayne Whibley, Heidi Walker, Mark Omundsen & Magda Biggar
15. Standing : Kiki Moate, Saia Piukala, Deacon Teapa, Thome Joel, Ikau Kevau, Eddie McCaig & Sonal Nagra
Seated: Jitoko Cama, Daliah Moss & Ifereimi Waqanaibete
16. Michael Levitt
17. Tom Reeve, LaMar McGinnis & Sam Mellick

Surgical History/Military/Trauma/Surgical Education Dinner

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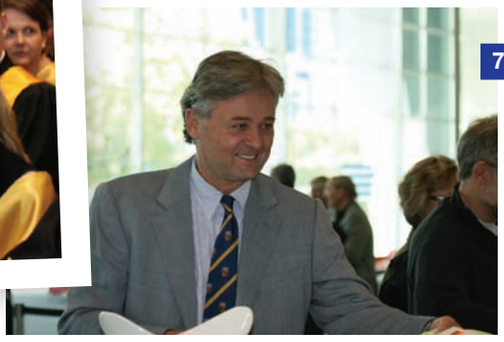
Waiting for the convocation



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Gillian Wright & Sarah Stephens

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1. Chung-Kwong Yeung, William Fitzgerald Anthony Sparnon, Kyaw Myint Naing, Spencer Beasley & Vince Cousins

2. Mark Moore & Teddy Prasetyono
3. Sam Mellick, Wyn Beasley & David Scott
4. Malcolm Brack & Kelvin Kong
5. Wayne Perron, Peter Callan & Jesse Kenton-Smith
6. Kok Chai Tan, Daliah Moss, KW Chang & SK Lum
7. Keith Mutimer
8. Christos Apostolou with Jeremy, Nicole, Isaac & Ethan Hsu
9. Ikau Kevau and David Watters

5. Wayne Perron, Peter

Annual Scientific Congress

Adelaide Convention Centre, Adelaide, Australia

2 – 6 May 2011

UNITY THROUGH DIVERSITY 80 years of the ASC

Royal Australasian
College of Surgeons

Rained out Camerons Cnr bitumen at last

Can we eat all of these?

Life after retirement

As retirement came closer, Damian Connelly stopped his private practice completely to increase his public hospital work

The key to a happy retirement, according to Victorian ear, nose and throat (ENT) surgeon Mr Damian Connelly is not just about financial planning, but also relates to consciously living your professional life fully so there are no regrets, no gaps, when the time comes to put down the scalpel.

Having retired last year – but having planned for that day for more than 20 years – Mr Connelly now looks out upon a golf course from his living room window and said he was very happy with the freedom of his new life.

He said, however, that he believed his current contentment was based in large part upon the decisions made along the way to fulfil his dreams and ambitions, both within and without surgery.

For example, as a third-year medical student, Mr Connelly chose a Royal Australian Air Force (RAAF) cadetship to finance getting married in fifth year. Then, as a medical officer on flying bases, he was encouraged to learn to fly as a co-pilot on training flights, first with the helicopter and VIP squadrons at Fairbairn, then on various propeller and jet aircraft at East Sale.

While still in the Air Force he passed the Part One Fellowship exam, then graduated as a general surgeon before embarking on ENT training and relocating from Melbourne to Geelong where he established a very busy private practice.

For some years, Mr Connelly did all the Head and Neck surgery in Geelong and in 1992 set up the first multidisciplinary Head and Neck unit – including plastic and reconstruction, facio-maxillary and general surgery – to be located outside a capital city.

With such a gruelling workload and heavy on-call roster, Mr Connelly took up surfing as an antidote to the stress, an activity only made possible through the support of his wife Lynn.

"My wife and I met at high school and she has been my lifelong best friend. In those early days in Geelong she would sit in the car at the beach with our two-year-old daughter and if the pager went off she'd blink the car lights and my two teenage sons and I'd take the next wave in," he said.

"She is an ENT theatre nurse and throughout my career she ran the practice, looked after the instruments and did the bulk of the financial planning so that we could retire when I reached 60 or 65 years and we achieved that.

"I probably wouldn't have a bean without her but she brought her Methodist frugalism to the task and set out about 20 years ago to find out how much capital we would need to generate the income we wanted."

According to Mr Connelly, the numbers they were told then, after being adjusted for inflation, remained about the same so that when he attended a College Preparation for Retirement course he was not shocked to hear that roughly $1 million of capital is needed for every $50,000 of income if you're going to maintain that capital.

Over the years, the two saved and invested with this figure in mind, having, luckily, more successes than failures for the financial freedom to walk away from work at the time of their choosing.

As the walking away day came closer, however, Mr Connelly found he had one more professional ambition he wished to satisfy and to the surprise of many, stopped his private practice completely in 2005 to increase his public hospital work.

"That was quite a controversial thing to do, but I loved it," he said.

"I had always wanted to concentrate solely on Head and Neck surgery, but when I began my career there were no full-time appointments in the field.

"I also took on the role of Chair of the Medi-

Damian Connelly at Central Park, New York, in Spring

> *"But I had the experience of walking away from that without regrets when the time was right, which proved to be a big help in knowing that about myself."*

cal Staff Group to be the interface between clinicians and the hospital executive, which I had also always wanted to do, but never had the time for when in private practice."

Having done, then, all that he set out to do, Mr Connelly found that he stopped thinking about work from the first day away and stopped dreaming of it within months. And surprisingly, he said his experience as a pilot helped.

"I flew little jet trainers, helicopters and learnt aerobatics, all of which was high-adrenalin, dangerous stuff," he said.

"But I had the experience of walking away from that without regrets when the time was right, which proved to be a big help in knowing that about myself.

"A mentor once told me to go when you think you're still getting better and I never forgot it," Mr Connelly said.

"Wonderful reputations have been lost if you don't go then and I didn't want that to happen to me."

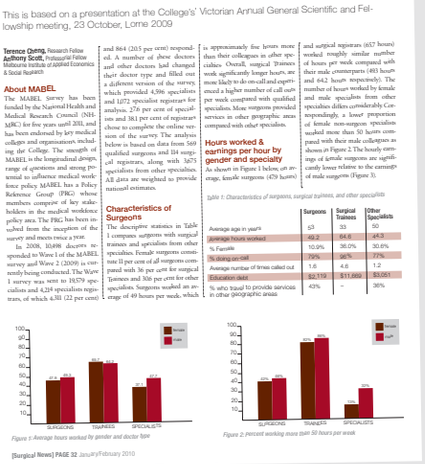
Lynn and I have always travelled a lot and we still do, especially with our son's family including our three grand kids in Toronto, where he is a research cardiologist. We have a great social golf group and with two houses with gardens to maintain, "I don't know how I ever had time to work." *With Karen Murphy*

Building Towards Retirement workshop see page 13 for information.

Employment & Life Balance

Medicine in Australia:
Balancing Employment and Life (MABEL)

This is based on a presentation at the College's' Victorian Annual General Scientific and Fellowship meeting, 23 October, Lorne 2009



MABEL Study

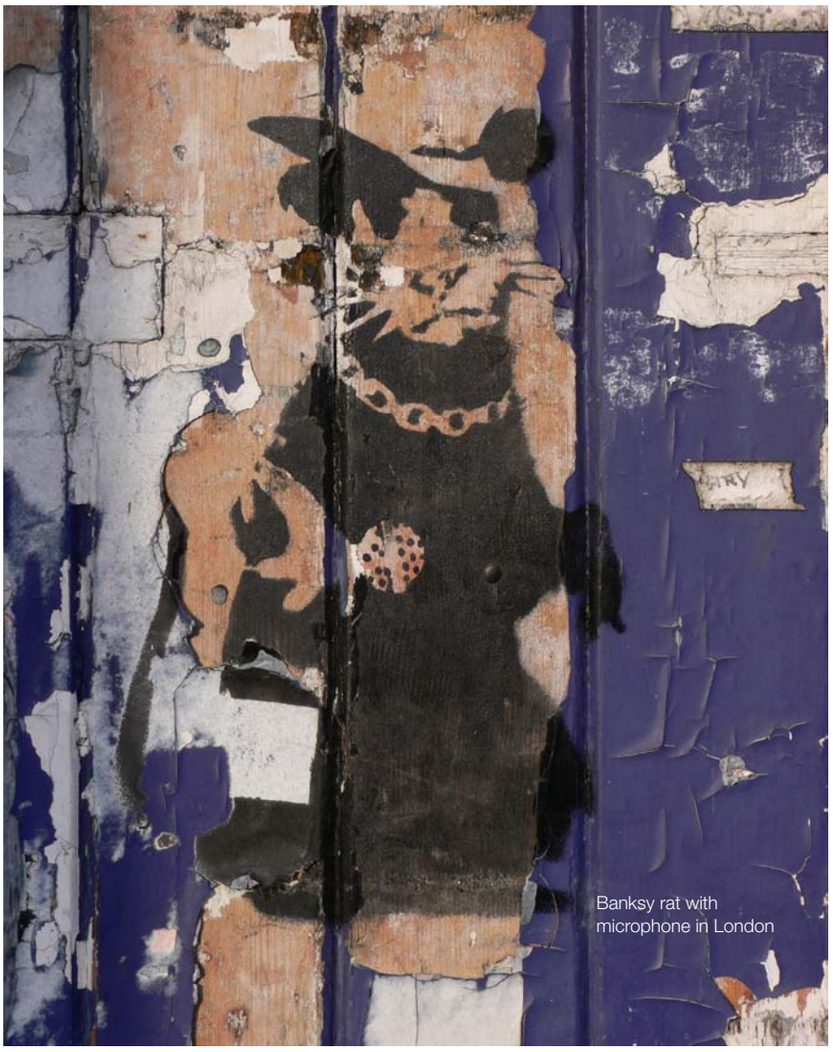
Dear Editor

I may have got this completely wrong but it appears (*Surgical News* Vol: 11, No 1, Page 32) from the bar graphs that male and female surgeons are working the same horrendous hours, that males are paid more and they are the ones most likely to leave direct patient care if they are aged under 55. I guess some people would find getting paid more for the same work tiresome.

Regards
Jessica Yin
Urological Surgeon
Western Australia

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

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



Banksy rat with microphone in London

Surgeons of the first fleet

Dear Editor

In the latest article I wrote for the *Surgical News* (Volume 11, Number 1, page 40) – I was given the pen name Belian which gave me a slight chuckle. Incidentally on the meeting on Hand Surgery in Paris, March this year, one of my co-presenters was an attractive Parisian female dermatologist stunningly dressed, who had a name spelt almost the same. Should I do a Samuel Clemens (who used the pen name Mark Twain which came from the two metre water mark on the Mississippi Paddle steamer) and adopt this option?

Every reporter likes a scoop, but the editorial red pen deleted my little dissertation on graffiti when I discussed the particularly impressive mural art of a large painted scene on a rendered terrace wall in shades of grey in the environs of the Surgeons Court. I mentioned the value of such mural art, perspectively detailed, as I thought the likes of Leonardo could only do. I went on to note that some graffiti artists, fully aware of the imposition on society in terms of cost, are successful artists as well. I discussed the French stencil artist Blek Le Rat with his remarkable illustrations, which fetch prices in the thousands, featured in High Street when exhibited. Lo and behold, this week Banksy, who featured in the press in Melbourne. The illustration of the parachuting rat on the back of the Nicholas building was "defaced" by the council cleaning team. I went on to ask whether art on a gallery wall is any different to the illustrations in a public space. It is a cultural statement and a reflection on society. As Jan Buk in the Age wrote earlier this year, "hypocrisy too comes in shades of grey".

The final reason I put this letter together is that I simply wanted to quote the Frenchman Rochefoucauld, who describes hypocrisy as the homage paid by vice to virtue.

Kind Regards
Felix Behan
Plastics & Reconstructive surgeon, Victoria

PS. I did not acknowledge the contribution made by Richard Barnett to the establishment of the Surgeons Court and his family with the historic link in my original article

Congratulations

Dear Editor

Congratulations to Ian Civil on his taking office as President of the College. I hope that his editorials will soon reflect the fact that the College is an organisation that represents two countries. His first editorial follows previous Presidents in reflecting an Australian only vision of the Colleges activities. As a New Zealander I hope he will see that it is important to mention NZ interests in his writings.

Kind Regards
Geoffrey Horne
Orthopaedic Surgeon
Wellington New Zealand

What is acceptable behaviour?

Queries on acceptable behaviour are common these days

Allan Panting
Executive Director of Surgical Affairs
New Zealand

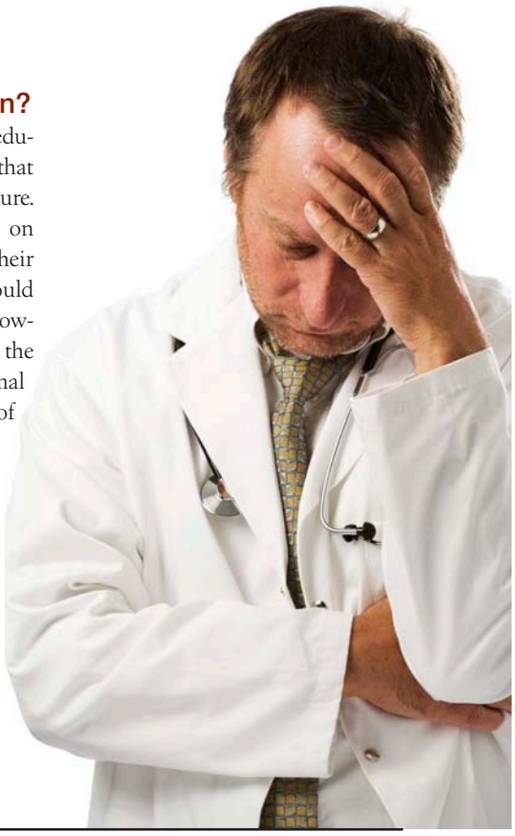
The role of the Executive Director Surgical Affairs gets us involved in discussions with many Fellows and Trainees across Australia and New Zealand. More and more we are being asked for confirmation about what is acceptable behaviour and what is not.

These discussions are often interesting and thought provoking. Often we may be tempted to say, would your parents be proud of you, if you described this? Would your mother have allowed you to behave this way when you were growing up?

What are the barometers of acceptable behaviour and how does one define acceptable or professional behaviour? Certainly in our ongoing roles we are confronting more issues than we ever anticipated. Now that the College is taking a more overt stand on issues like Code of Conduct, Involvement with the Medical Technology Industry and Bullying and Harassment, issues are being directed to us requesting some "action". Armed with our new policy about Breaches of the Code of Conduct there is more definite action for the processing and warning about concerns.

How would you handle these concerns in this modern day of telephones with cameras and so on?

A group of Trainees are gathered together at an educational session. They are discussing procedures that would be broadly described as aesthetic in nature. However, they are referring to images that are on their phones that have been recorded during their work over the past months. The discussion could be considered as respectful and educational, however, when asked about the patient's consent to the taking of the photographs or their use in informal educational settings, the facial expressions were of disbelief rather than embarrassment.



Please send us an email to john.quinn@surgeons.org or allan.panting@surgeons.org For those who need some coaching on the subject, the College Solicitor published an article on this in *Surgical News* last year.

Solving the world's addiction problems

Fresh Start Recovery Program grew out of a need to help drug users who haven't had success with other drug treatment programs

After Perth gynaecologist Dr George O'Neil had successfully established his medical device manufacturing company, called Go Medical Industries in the 1980s, he began to dream up very big ideas of how to use the profits.

In the mid-1990s he called together the board of the company and listed his plans which included solving child malnutrition in third world countries, reducing cancer pain and beating drug and alcohol addictions. The members of the board, though impressed with the vision, suggested he choose one.

In response, he selected to tackle addictions and after wide travel and deep research investigating the various therapies then in use around the world, he set up the Fresh Start Recovery Program, the only clinic in Australia providing a service using the drug Naltrexone for opiate addiction without cost barriers.

The drug is delivered via dissolvable 1800mg implants placed in the patient's lower abdomen which release 3mg of the opiate blocker per day.

So much success has he had with the treatment, that Dr O'Neil was a guest speaker at the College's recent Annual Scientific Congress in Perth.

"Naltrexone was invented in 1964 as a blocker to the receptors for opiates, but when it was first used in the United States and United Kingdom it was available only as a one-day treatment which made the addicts sick," he said.

"This meant that they often didn't want to take it so the problem was clearly about developing a better delivery system.

"When we began using the drug here, there were only five bottles of it in Australia so we had to establish an import system and then we had to design this delivery system."

Since then, Dr O'Neil has treated more than 7000 patients and has a staff of 120 including surgeons, counsellors and research chemists with the entire privately-funded Program – which treats everyone who attends regardless of their capacity to pay – costing an estimated $6 million per year.

He said that given that up to 10 per cent of patients attending the clinic now come from outside Western Australia (WA), surgeons may need to be aware of the devices.

"Most of the implants cause no adverse reaction, but in one or two per cent of patients they can cause inflammation," he said.

"However, if surgeons remove them the patient is at greater risk of harm not only because the addict may wish to go back to using, but also because their tolerance for the drugs they use will be diminished so they need to be managed after such surgery.

"Anaesthetists may also be concerned about their impact on pain control, but that is best addressed by the use of epidurals and increasing the dosage of opiates via a PCA device."

Dr O'Neil said that since treating his first patient in 1997, research now indicated that the use of Naltrexone was so successful in treating addictions, that 50 per cent of the drug and alcohol addicts given this treatment never returned to their former habits, with others, usually those who began using addictive substances in their teens, requiring longer therapy.

It is now being used at the clinic to even help control gambling addictions.

However, despite such success, the treatment remains controversial sitting outside, as it does, the twin and opposing paradigms of abstinence versus methadone treatments.

Dr O'Neil said research now indicated that opiate street addicts face a 2.5 per cent risk of death when using, which fell to zero if they were physically removed from the drugs and temptation, but which rose to five per cent upon their return to their former environment because their tolerance had been reduced.

Methadone, he said, reduced that risk from 2.5 per cent to 0.6 per cent, but offered addicts only a three per cent chance of being opiate free within three years.

The use of the Naltrexone implants, however, offered such patients a 90 per cent chance of being addiction-free within the same time span.

"There is a terrible conflict in this area of medicine between those promoting abstinence and those dedicated to reducing the risk of death through swapping one addictive substance for another," he said.

"However, Naltrexone is the only substance that has been proven to beat opiate addictions with a 100 per cent success rate provided enough is delivered over the right time frame.

"With the enormous advances made in neuroscience in past years it has become abundantly clear that addiction is a physiological brain disorder that can be successfully treated through drug therapy and people should be excited by the fact that we are now in a position to treat it."

Dr O'Neil said there were two types of addicts - no matter the drug of choice.

The first were people who became addicted to a substance or behaviour later in their physiological development and simply found it too hard to give up. Such patients, he said, were most effectively and efficiently treated with Naltrexone.

The second group was those who had begun taking substances in their teens who had impaired brain and social development.

"When a person drinks alcohol, takes drugs or even surrounds themselves with constant stimulus such as that of computer games the brain releases a lot of opiates which can wear out the receptors meaning that more of the drug or stimulus is required to feel the same sense of pleasure," he said.

"That is just the science of addiction. Added to this, however, are those children who began using a substance be-

Left: George O'Neil with a Go Medical Springfusor, which he uses at his clinic to treat benzodiazepine-addicted patients with flumazenil, a 'benzo blocker'

Right: Former patient Bernard and his wife Margaret. Bernard has beaten a 27-year heroin addiction using naltrexone implants
Below: George with two former patients who are outside the clinic babysitting their friend's son while she is treated with naltrexone implants

tween the ages of 12 – 22, often because of a lack of security, love and nurturing.

"As soon as people feel they are not loved, particularly at that age and stage, they sit in a metaphorical dark corner and need opiates from outside to provide a sense of comfort and security.

"That lack of security can cause very severe damage to the pre-frontal cortex which means that those kids don't develop their normal executive function. They have impaired memory and decision-making capacity and feel as if they stand apart from family and community, making outside stimulus both necessary and attractive.

"These patients can take more than one Naltrexone treatment and years of counselling to repair that damage, but the good news is that it can be done and is being done."

Now Dr O'Neil, a Fellow of the College of Addiction Medicine, is campaigning for government funding and political support to help make Naltrexone more widely available, particularly within the suffering Indigenous population of WA.

He said the Rudd Government had so far refused to support the Program while it awaits further research results as part of the registration and PBS-listing process, yet that while they waited, people were dying. The registration and PBS listing process will take a further two-and-a-half years or more.

"Up to 80 per cent of the prison population in WA is comprised of Indigenous people most of whom suffer some addiction. By refusing to support a treatment that has been proven to be successful, you are in fact allowing the destruction of a whole community" he said.

"We can now prove that Naltrexone implants control 100 per cent of heroin and illegal opiates addictions, 80 per cent of alcohol addictions and 70 per cent of amphetamine addictions and we as a community, as a nation, owe it to the people affected to give them the help they need."

The O'Neil Long Acting Naltrexone Implant is made up of 10 pellets which dissolve slowly to release 3mg per day of naltrexone.

Dr O'Neil urged interested surgeons to visit the Fresh Start website to examine the work and in this election year to lobby both political parties for financial support to make the treatment available to those in need.

He said that with more patients attending the clinic, the costs of treatment were becoming increasingly difficult to meet and said he would be delighted to not just receive financial support, but also to make contact with any surgeon wishing to learn the management method with Naltrexone implants and provide the treatment.

"My estimate is that on any given day in Australia, 50,000 people are attending a methadone clinic and 50,000 others are trying to score heroin," he said.

"We, as surgeons, can do something about this if we can push for government support and if young surgeons join us to allow us to expand our reach."

"The drug is delivered via dissolvable 1800mg implants placed in the patient's lower abdomen which release 3mg of the opiate blocker per day."

Dr O'Neil said any surgeon wishing to discuss the Program with him was welcome to call him at home on (08) 9388 1991 or visit the website at www.freshstart.org.au

With Karen Murphy

Congratulations To The Trainee Prize Winners

SECTION	*PROUDLY SPONSORED BY*	*NAME*	*TITLE OF PRESENTATION*
Vascular	Covidien	Dr Rana Dhillon	Predictors of creatinine rise post endovascular abdominal aortic aneurysm repair based on a retrospective analysis of 102 patients
Burn	Smith & Nephew	Dr James Anderson	Distant changes in nerve density following localised burn in rat and human model
Breast	Covidien	Dr Katharine Kirkpatrick	The Impact of Axillary Staging by Ultrasound in the Mammographic Screening Population
HPB	Covidien	Dr Mandira Chakraborty	Peripheral mitochondrial funtion during early experimental mild acute pancreatitis
Plastic - reconstructive	Covidien	Dr Michael Wagels	Pedicle Autonomy in Muscle Flaps
Plastic - aesthetic	Covidien	Dr George Pratt	Body contouring in public hospitals: a review of 45 cases of abdominoplasty in 1 year
Upper GI	Covidien	Dr Jodi Hirst	Minimally Invasive Oesophagectomy: Health Related-Quality of Life Outcomes
Surgical oncology	AstraZeneca	Dr Akshat Saxena	Progression and Survival Results following Radical Hepatic Metastasectomy of Advanced Neuroendocrine Tumor Supports an Aggressive Surgical Approach: A 17-Year Experience from an Australian Hepatobiliary Unit
Bard	Bard	Dr David Links	Initial experience with Endoloop technique to reduce post-operative seroma after totally extraperitoneal (TEP) repair of direct inguinal hernias (DIH)
General	Covidien	Dr Arman Kahokehr	Recovery after Open and Laparoscopic Right Hemicolectomy: A Comparison
Trauma	Covidien	Dr Anojan Navaratnam	Traumatic Pneumomediastinum – An Australian Trauma Centre Experience
Paediatric	RACS	Dr Sarah Giutronich	Aortopexy for tracheomalacia: highly effective in selected infants
Surgical History	Johnson & Johnson Medical	Dr Owen Sou Yang	Looking Through The Operative Microscope, Its Past, Present and Future

ROWAN NICKS FELLOWSHIP AUSTRALIA AND NEW ZEALAND

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of New Zealand to apply for the 2011 Rowan Nicks Australia and New Zealand Fellowship. 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 2011 Rowan Nicks ANZ Fellowship is offered to a surgeon from New Zealand to take up the Scholarship in Australia . The Fellowship is intended to provide an opportunity for the surgeon 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. The Fellowship will be awarded for a period of between six and twelve months.

Applicants must be under 45 years of age and have completed a Fellowship of the Royal Australasian College of Surgeons at the time of application. Applicants must undertake to return to their home country on completion of the Fellowship program.

The Scholarship is valued at up to $75,000 AUD pro rata in addition to airfares, depending on the circumstances prevailing for the candidate and provided sufficient funds are available.

APPLICATIONS MUST INCLUDE THE FOLLOWING:

1. A covering letter that outlines the aspirations and intended program*
2. Curriculum Vitae
3. Copy of basic medical degree and Fellowship
4. The names and details of two referees who will be contacted separately

*A Sponsor in Australia is desirable (from the candidate's point of view) but is not essential and will not detract from the application.

The Rowan Nicks Committee will determine the successful applicant in November 2010. The application form and instructions are available for download via the College website: www.surgeons.org.

FORWARD APPLICATIONS BY 28 JUNE 2010 TO:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons Gardens
250 - 290 Spring Street, East Melbourne VIC 3002
E: international.scholarships@surgeons.org
T: +00 11 61 3 9249 1211
F: +00 11 61 3 9276 7431

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Professor Valerie Lund CBE
Professor Jay Rubinstein

FOR FURTHER INFORMATION, CONTACT HELEN DAVIS:
P +61 3 9419 0280
F +61 3 9419 0282
E gprwmf@bigpond.net.au
W www.gprwmf.org.au/frontiers

The Garnett Passe and Rodney Williams Memorial Foundation

NOTICE TO RETIRED FELLOWS

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 donations and place your name on the gown if you approve.

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

Alternatively you could mail the gown to Katie Fagan c/o Conferences and Events Department. Royal Australasian College of Surgeons. 250-290 Spring St, EAST MELBOURNE, VIC 3002

Homestay Accommodation for Visiting Scholars

Through the RACS International Scholarships Program and Project China, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to 12 months. Due to the short term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. If you have a spare room or suitable accommodation and are interested in helping, send us your details. We are seeking people who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a reasonable rental and eternal appreciation.

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

Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring St, Melbourne Victoria 3000, Australia
T: + 61 3 9249 1211 F: + 61 3 9249 1236
E: international.scholarships@surgeons.org

Promoting Surgery as a Career in Indigenous Communities

The program aspires to be responsive to individual needs and provide forums for group interaction

The Indigenous Health Committee (IHC) has launched a program to promote surgery as a career in Australian Indigenous communities. Increasing the numbers of Aboriginal, Torres Strait Islander (ATSI) and Maori people in the medical workforce is a key policy initiative to help deliver better health outcomes and better futures for Indigenous people in Australia and New Zealand.

As far as we can ascertain, Australia has one Aboriginal surgeon and New Zealand has five surgeons of Maori descent. The College recognises it needs to enrol and train more Indigenous doctors in its Surgical Education and Training program to close the gap in surgical work force under-representation, and has made promoting surgery as a career in Indigenous communities a priority in its Strategic Plan for 2010-2015.

The College is a strong advocate for the inclusion of Indigenous health curricula in training and professional development programmes for the mainstream health workforce. This will enable non-Indigenous health workers to deliver health care services to Indigenous communities in an acceptable manner that observes social and cultural sensitivities.

The IHC program to promote surgery as a career has begun and has immediately had some success. The program aims to foster interest in a surgical career among Indigenous medical students and graduates and to provide prospective Indigenous trainees with opportunities to enhance their educational and professional development by working with surgeons, undertaking surgical-related research, attending surgical workshops and forums and engaging with appropriate mentors. Under this initiative two Aboriginal doctors attended the recent Annual Scientific Congress in Perth as guests of the College. They are among 18 ATSI medical students and graduates from across Australia who have expressed an interest in surgery as a career.

The program aspires to be responsive to individual needs and provide forums for group interaction and networking. As part of this program the Committee will, later in the year, host a surgical career expo at the annual symposium of Australian Indigenous Doctors' Association, where students and graduates can meet with surgeons and surgical trainees.

The sustainability of this program rests on the steady flow of Indigenous students into medical schools and their graduation as doctors. There are currently around 140 Indigenous doctors in Australia, far short of the 928 estimated by the Australian Medical Association in 2004 as what should be the Indigenous contribution to the medical workforce to reflect the Indigenous to the non-Indigenous population ratio. Measures to address the causes of low high school completion rates, low enrolments in university education and low retention rates in tertiary education are important if improvements to educational outcomes for Indigenous people and their participation in the medical (and other) workforce are to be realised.

Out reach program

It is fitting that the second face-to-face meeting of the IHC in 2010 took place at the Centre for Aboriginal and Dental Health (CAMDH) at the University of Western Australia (UWA). Its director, Professor Helen Milroy, is Australia's first Indigenous medical graduate and an inspiration to many. UWA has one of the higher Indigenous medical student enrolments in the country and its success with student recruitment and student retention can be attributed to the outreach and support programs offered by CAMDH. Members of the Committee met

> *"The College is a strong advocate for the inclusion of Indigenous health curricula in training and professional development programmes for the mainstream health workforce."*

Below: Kelvin Kong and Cody Morris talking to students about life as a surgeon

Kelvin Kong, Nino Scuderi and Jonathan Koea

Kelvin Kong, Cody Morris and Nino Scuderi

with staff and students to understand the barriers that prevent young Indigenous people achieving better educational outcomes and to hear about the strategies used by UWA to try and overcome them.

CAMDH's high school outreach programs nurture Indigenous high school students from Year eight through to pre-medicine. They run science camps, health career and university orientation camps to foster interest in science subjects, encourage students to complete Year 12 and consider university education as an option. CAMDH's outreach program extends to families to encourage community support for students while they study, reinforcing the benefits education will have for young Indigenous people and to the Indigenous community in the longer term. CAMDH's outreach programs are having an effect. Forty per cent of Indigenous students entering health courses at UWA were participants in CAMDH's outreach programs.

CAMDH runs an intensive pre-medicine program and works with the Faculty of Medicine and Dentistry to identify prospective students and offers a range of facilities, practical and social support for students once they are enrolled. The Centre's base at Shenton House provides students with space to work and socialise in a culturally familiar, safe and supportive environment. Works of traditional and contemporary Indigenous art hang throughout the Centre creating a visually stimulating, warm and welcoming environment. The success of CAMDH's programs would not be possible without the dedication and commitment to students shown by its staff. Their work is inspirational and a model for what is possible in educational institutions engaged with Indigenous students.

The College's commitment to improving the health and health care of Aboriginal and Torres Strait Islander and Maori people is outlined in its Indigenous Health Position Paper and is the framework through which it will develop productive and culturally appropriate responses to improve Indigenous health outcomes in both Australia and New Zealand.

The Committee recently welcomed the Australian Indigenous Doctors' Association, represented by Dr Nino Scuderi and Te Ohu Rata o Aotearoa (TEOARA), the Mori Medical Practitioners Association of Aotearoa/New Zealand, represented by Dr James Te Whare, to its ranks. Their engagement is an important step to help inform and progress the College's Indigenous health strategy and give effect to Indigenous workforce objectives for the surgical profession in Australia and New Zealand.

They join a dedicated group of Fellows whose expertise and contribution to the work of the Committee is acknowledged. Current members are Pat Alley (general surgeon, New Zealand), David Gawler (vascular, Northern Territory), Russell Gruen (general surgeon/trauma, Victoria), Jonathan Koea (general surgeon, New Zealand), Ollapalli Jacob (general surgeon, Northern Territory) and Chris Perry (ear, nose and throat surgeon, Queensland).

Fellows interested in becoming involved with activities to promote surgery as a career to Indigenous communities or who are interested in philanthropic donation to Indigenous health projects can contact the Indigenous Health Committee at indigenoushealth@surgeons.org

The power of one - Operation Open Heart

Helping fellow human beings far less fortunate than oneself has a powerful effect on the spirit

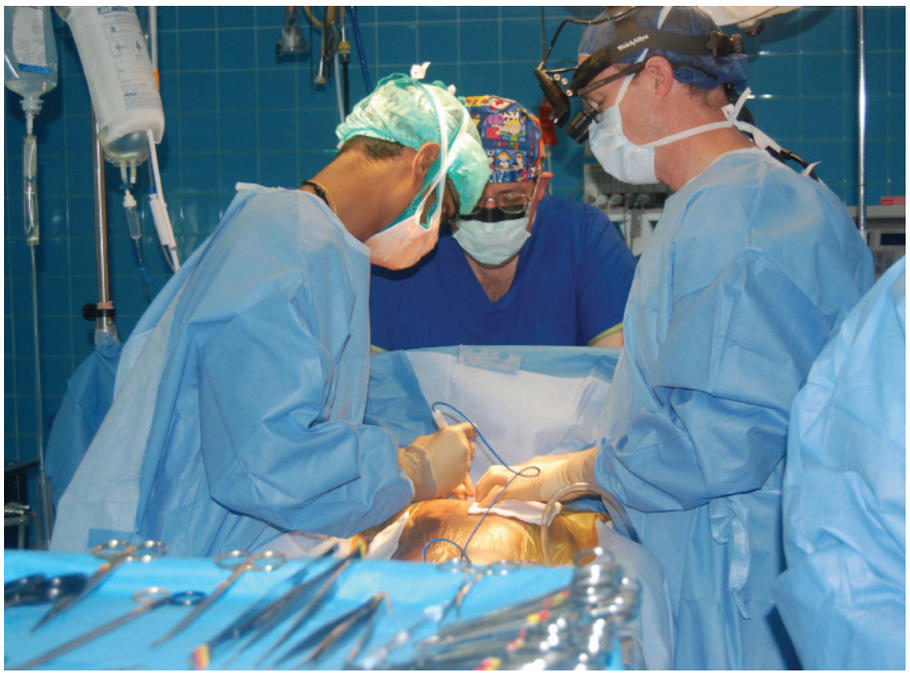
Robert Costa
Honorary Secretary
NSW Regional Committee

"Onto bypass please". These words are uttered daily by cardiac surgeons in operating theatres throughout the developed world. They signal the beginning of a "bypass run", or more specifically, the heart lung machine taking over a patient's circulation while the patient's heart is stopped to allow the surgical team to repair or replace a malfunctioning heart valve, correct a congenital heart defect or bypass occluded coronary arteries.

We are so accustomed to such procedures being readily available they are now no longer newsworthy in Australia. In developed countries, governments and health authorities are held accountable if these advanced surgical facilities are not accessible to all. The awe of yesteryear at the thought of cardiac surgery has long since disappeared.

The complexity of a cardiac surgical operation, however, does not escape the mind of an outreach team operating in a developing country far from the security of an Australian or New Zealand hospital. The team faces not only the clinical challenge of the case in hand, but the challenges of operating in a third world nation. The infrastructure they are working within and their own preparedness will be questioned. Will the power supply be uninterrupted? Have we all the necessary instruments? Do we have adequate surgical supplies? Will the newcomers be able to cope with the conditions? Is it safe to be here? These and many more thoughts fly through the mind of team leaders and members of an Operation Open Heart team operating in a developing country far from the security of familiar surroundings.

Operation Open Heart is part of the Healthcare Outreach Program of The Sydney Adventist Hospital The hospital has a long history of providing healthcare to disadvantaged communities. In May 2010, a team of volunteers undertook the hospital's one hundredth outreach trip with a visit to the Fiji Islands. The hospital's Health Care Outreach has provided assistance to 11 countries around the world.



Dr Sonal Nagra being assisted by Mr Jon Ryan

Operation Open Heart is the name of the hospital's volunteer based program whose aim is to provide cardiac surgery to patients in developing countries who would otherwise have no hope of accessing such services. Its inception was the idea of an intensive care nurse who was moved by the lack of life saving cardiac surgery in Pacific Island countries. Such was his dismay that he took it upon himself to provide such services. In 1986 largely, through a single individual's efforts, the first group of volunteers travelled to Tonga in the South Pacific. The program has over the ensuing years expanded to involve other Pacific Island nations and many countries further afield.

In the 24 year history of the cardiac program, many Cardiothoracic Fellows of the College and Trainees have donated, and continue to donate, their time. In recent years, a further arm of the hospital's outreach program has developed, and is termed the Reconstructive Program, involving Orthopaedic and Plastic Surgical Fellows of The College. The Fellows from all specialties who have become involved in International Outreach firmly believe they are making a contribution to the College International Development Program and helping to achieve social justice for all people. The hospital's outreach program has helped 2850 patients with the involvement of over 1500 volunteers.

The original heart team volunteers were all directly associated with The Sydney Adventist Hospital. However, teams are now largely composed of individuals who simply identify with the ideals of the program's charter and wish to contribute their services. Volunteers come from multiple faith traditions, multicultural backgrounds and any number of Australian and New Zealand Hospitals.

Each team is composed totally of volunteers who donate their skills and time, and make a substantial financial contribution to enable the program to continue. Over time, the aims of the program have broadened to not only provide immediate surgical services, but to train and educate the local medical, nursing and paramedical staff. Education and instilling the will to learn, to improve and hopefully to achieve self-sufficiency is now a primary aim of the program.

TOP LEFT: Team photo with some of the volunteers with the Australian High Commissioner to Fiji Mr James Batley (Mr Batley is the man with glasses, standing and wearing a pink coloured shirt).
TOP RIGHT: A Fijian ICU nurses with a post-op patient having undergone triple valve surgery.
BOTTOM LEFT: Ward Rounds with the local medical staff

It is with great pride that the paediatric cardiac surgeons, who have made a commitment to Papua New Guinea (PNG), have at Port Moresby trained two local surgeons to be able to perform closed cardiac cases such as the ligation of a patent ductus arteriosus independently and without supervision. These same PNG surgeons, anaesthetists and ancillary staff are now training to perform more complex procedures requiring the use of cardiopulmonary bypass.

Through the influence of the visits of the Operation Open Heart team and the financial assistance of Rotary Australia, The Ministry of Health in Fiji has installed a donated cardiac catheterisation laboratory in the Colonial War Memorial Hospital in Suva. As a consequence the hospital administration has established a cardiac working party with the aim of examining the feasibility of establishing a cardiac surgical unit. In other countries self-sufficiency has been achieved and a mentoring role only is required. The members of teams aim to teach with a combination of didactic lectures and bedside teaching at all opportunities as well as demonstrating surgical techniques.

Through the auspices of the AusAID funded Pacific Island Project of The College, the Open Heart Program receives some financial assistance. However, the main sources of funding originates from the Sydney Adventist Hospital itself, volunteer contributions, generous assistance from the medical supply industry, community service organisations and private donations and, where possible, a contribution from the government of the nation visited. Financial assistance remains, and will continue to remain, a significant issue for all international outreach programs. The recent global financial situation has unfortunately negatively influenced all avenues of financial assistance.

OPERATION OPEN HEART TEAMS

Unlike many other surgical specialties, cardiac surgery requires a multidisciplinary approach and as a consequence each team numbers 40 to 50 members. At the completion of the surgery, the patient requires intensive care management and nursing. This requirement is generally not available in developing countries that require such a large number of volunteers. Not only is the appropriately trained staff not available in developing countries, but the necessary equipment is also not available. As a consequence, surgical instrumentation, anaesthetic machines, cardiopulmonary bypass pumps and ancillary equipment, ventilators and monitors all need to be transported. The inventory also includes expensive pharmaceuticals and artificial heart valves. This equates to many tonnes of equipment and a logistical and financial nightmare.

Each Operation Open Heart trip begins many months prior to the actual departure date. The requesting nation is asked its specific requirements and the team and equipment planned accordingly. Local cardiologists have a list of patients they feel would benefit from surgical intervention. These patients are then reviewed and further assessed by the Open Heart team cardiologists and their suitability discussed at a multidisciplinary team meeting. All attempts are made to review the patient data and patient selection largely agreed upon prior to departure; however, this is not always possible. Many patients with complex congenital lesions or advanced acquired conditions, which in Australia or New Zealand would be considered operable, but high risk, are not able to be offered surgery. Patient selection is one of the greatest moral, ethical and emotional challenges faced by senior team members.

Many critics of international outreach would say that transferring patients to a hospital or country where cardiac surgery or other specialised surgery is available would be preferable. For the majority of developing nations such costs would be prohibitive and only a few privileged patients would be able to access tertiary referral. Operation Open Heart hopes to offer the opportunity to those patients and their families in genuine need who would otherwise not be in a financial position to access cardiac surgical services. The loss of the education would further add to the loss of health care outreach.

> *"The members of teams aim to teach with a combination of didactic lectures and bedside teaching at all opportunities as well as demonstrating surgical techniques."*

The effect on the local staff of the presence of a visiting medical team in a hospital needs to be personally experienced to be believed. The expectancy, the excitement and the morale boost it generates are intangible. The camaraderie between team members, the cleaning of walls and floors, the organisation and preparing of wards and equipment are all used as teaching opportunities. Additionally it allows bonds to be forged at a level other than politically.

The majority of individuals find the experience of participating in an outreach trip so uplifting they wish to continue to contribute their efforts. When questioned they often lack the words to describe the reasons. One can only surmise that the experience of helping fellow human beings far less fortunate than oneself has a powerful effect on the human spirit.

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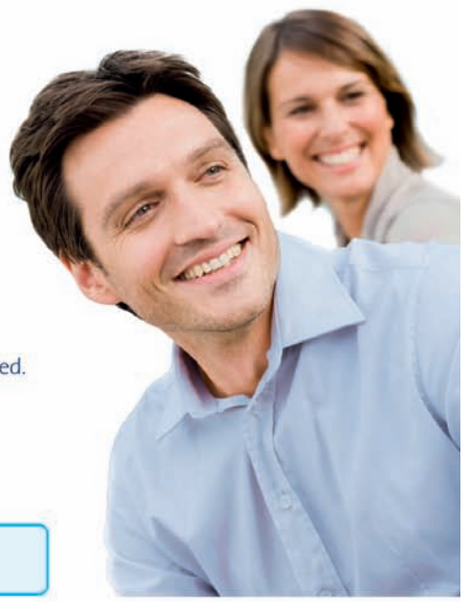

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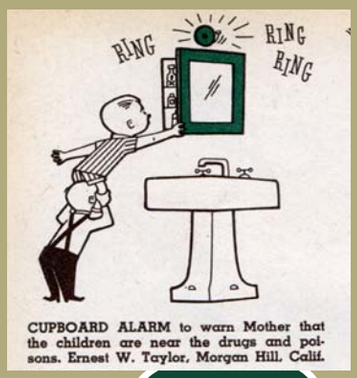

CUPBOARD ALARM to warn Mother that the children are near the drugs and poisons. Ernest W. Taylor, Morgan Hill, Calif.

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In conjunction with many DSTC courses the Definitive Perioperative Nurses Trauma Care Course (DPNTC) is held. It is aimed at registered nurses with experience in perioperative nursing and allows them to develop these skills in a similar setting.
The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.

To obtain a registration form, please contact Sonia Gagliardi on (61 2) 9828 3928 or email: sonia.gagliardi@sswahs.nsw.gov.au

2010 COURSES:
Sydney (Military Module): 27July 2010
Sydney: 28-29 July 2010
Auckland: 2-4 August 2010
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INTERNATIONAL GUEST SCHOLARSHIPS

The American College of Surgeons offers International Guest Scholarships to competent young surgeons from countries other than the United States or Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of US$8,000 each, provide the Scholars with an opportunity to visit clinical, teaching, and research activities in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons Clinical Congress.

The scholarships provide successful applicants with the privilege of participating in the College's annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses plus admission to all lectures, demonstrations, and exhibits, which are an integral part of the Clinical Congress. Assistance will be provided in arranging visits, following the Clinical Congress, to various clinics and universities of their choice.

In order to qualify for consideration by the selection committee, all of the requirements must be fulfilled. Formal American College of Surgeons International Guest Scholar applications appear online on the College's Web site (www.facs.org). Supporting materials and questions should be directed to:

Administrator
International Liaison Section
American College of Surgeons
633 N. Saint Clair St.
Chicago, IL 60611-3211
USA
Fax: 312-202-5021

Right: Heri Miller's Cartoid Artery Clamp
Below:Heri Perforator and brace, 17th centuary

Neurosurgical Instrument Collection

A surgical instrument from the 17th Century is the oldest item in the historical collection held by the College for the Neurosurgical Society of Australasia

Mike Hollands
Honorary Treasurer

In August 2009, the College accepted, on long-term loan, the collection of historical instruments belonging to the Neurosurgical Society of Australasia (NSA).

This collection was built up over many years by Professor Donald Simpson, who catalogued it and acted as its curator. From its beginnings around 1973, the collection has grown into a large and important collection of instruments ranging in time from the 17th to the late 20th century, and in size from brain clips to stereotactic frames, illustrating many aspects of the development of neurosurgery.

The first object to enter the collection was a pocket craniotomy set, donated by Kenneth Jamieson, retiring President of the NSA. It consists of a trephine, a Hey's saw, a double-ended elevator, a metatarsal saw, a curved knife and five scalpels, in a velvet-lined case. Other donations soon followed.

The oldest object in the collection is a 17th-century French brace and perforator made of iron and ivory by Bonnerout of Montpellier.

A number of instruments have important associations with notable neurosurgeons and Fellows of the College, including Hugh Trumble, Sir Hugh Cairns, Sir Leonard Lindon and Sir Douglas Miller.

Sir Leonard Lindon, President of the College 1959-61, donated almost his entire set of neurosurgical instruments in his leather instrument case.

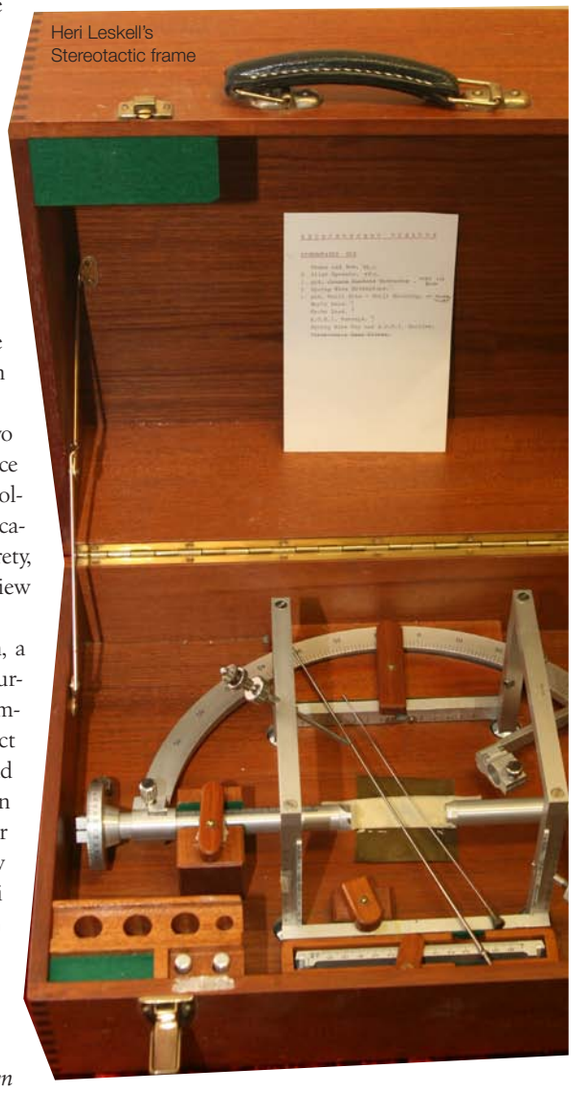
Miller's Carotid Artery Clamp is believed to have been made to a specification devised by Sir Douglas Miller, a founder of the NSA and President of the College 1957-59. It consists of two rods, the longer of which has a T-shaped handle grip, while the shorter has a screw thread and knurled knob, which is turned to open and close the jaws of the clamp. It is nickel plated, and was probably made in Sydney.

The largest instruments in the collection are the stereotactic apparatus, of which there are four. One of these is Leksell's Stereotactic Frame, designed by the Swedish neurosurgeon Lars Leksell to replace the older and more cumbersome Reichert-Wolff frame. These frames were used to target specific locations in the brain with great accuracy. This Leksell's Frame was used by the late Trevor Dinning at Royal Adelaide Hospital in the treatment of Parkinson's Disease.

The collection used to be displayed in two exhibition cases in the Dinning Neuroscience Library at Royal Adelaide Hospital. As the collection increased, however, it outgrew the capacity of the facility to display it in its entirety, so only a small amount could be placed on view at any one time.

To mark the handover of the collection, a small ceremony was held by the Senior Surgeons Group in the Hughes Room on September 8, 2009. Donald Simpson gave a succinct and very interesting talk on the collection and its relation to the history of neurosurgery in Australia. After some 36 years of caring for this collection, Professor Simpson has now retired. Associate Professor Gavin Fabinyi has kindly taken on the rôle of liaison in matters to do with this collection. We hope that this loan will be advantageous to both the NSA and the College, and will continue to provide benefits well into the future.

Written by Geoff Down



Heri Leskell's
Stereotactic frame

Dining in Dupuytren's Restaurant

The restaurant has been the traditional haunt of hospital consultants for years

Felix Behan
Victorian Fellow

On my last evening in Paris while attending and speaking at the International Mega Hand Symposium in March this year, I was taken for a farewell dinner (not by a surgical colleague, but by an artistic friend and his German partner, the French editor for Elle Magazine). The restaurant Vieux de Paris, built in 1594, is situated next to Notre Dame in the Renaissance district in the shadows of the Hôpital Hôtel Dieu, Dupuytren's old alma mater.

This restaurant has been the traditional haunt of the hospital consultants for years and no doubt Dupuytren himself may have dined here in the early 1800's when he was full-time Head of surgery at the hospital - enjoying French food of the highest elegance, a wine cellar overflowing with stock from Bordeaux and Burgundy and a bonhomie between staff and client one commonly sees in the French countryside.

On leaving the restaurant, having finished a second bottle of Pomerol, I noted an effigy of the Cure d'Ars in the foyer, a spiritual figure of Paris, in keeping with the long history with Notre Dame and the hospital. The thought of going into the main hospital at that late hour would probably have distressed security, although I would have liked to have shown my friends the statue of Dupuytren in the hospital forecourt. The last time I saw this figure (photographed for one of my earlier *Surgical News* articles) he was dressed up as an early 19th century Parisian, smoking a cigar and painted all colours of the rainbow – a tradition still observed every six months with the changeover of junior surgical staff.

Why do I say I was dining (or dreaming) in Dupuytren's domain? The clue came to me when Richard, the maitre d', explained that the senior orthopaedic surgeon at the Hôpital Hôtel Dieu comes regularly on Fridays for a "clinical meeting" with his staff. I even recall visiting Tubiana, an associate of the late John Hueston, at his hospital years ago. His female assistant prepared lunch, need I say with a bottle of rose, and did the closures in the afternoon list. The atmosphere of this ongoing French surgical tradition was evident throughout this Mega Hand meeting I had just attended, and I can now appreciate what a surgical and emotional high John Hueston must have experienced on his regular Parisian excursions.

This meeting was held in the shadow of the Eiffel Tower at the UIC centre (and to my great astonishment, next to the Australian Embassy). I was impressed by the range of surgical techniques displayed by the French surgeons, with a strong focus on the use of stem cells for tissue regeneration and reconstruction. Scientific, aesthetic, functional and historical perspectives all featured in their presentations. At this late stage of my career, I have learnt now, not to despise fat anymore (even my own BMI), yet how could this be significant in hand surgery? Following the centrifugation of harvested liposuction fat, three layers of sediment are produced. The important scientific fact here is that multi-potent stem cells from the lowest third of the sediment have higher regenerative capacity than those derived from bone marrow. Thus injection techniques serves to improve the contour, releases scar tissue adhesion, even in irradiated tissue and improves the aesthetic appearance. The Parisian experts were Dr Illous and Dr Fournier, and the American specialist was Dr Sydney Coleman.

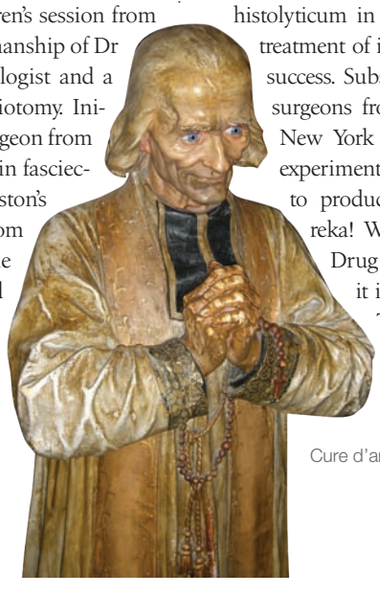
In the afternoon session, Dr Brada Da Silva from Brazil showed how he reconstituted a three centimetre median nerve defect (typically repaired with cable grafting). The technique consisted of surrounding the neural loss with a Silastic tube and filling the vacant space with the fat cell distillate. On later exploration of the nerve, the intact nerve was evident with 50 per cent return of function. I was understandably impressed.

During the meeting, it was certainly pleasant to wander around the base of the Eiffel Tower after the midday meal. The French of course are known for their fascination with food, family and fashion, but not familiarity! In my 36 years of attendance at surgical meetings, I have never experienced delicacies that ranged from jambon d'os (ham on the bone), boeuf bourguignon, tartes des pommes and other sweets. It certainly was in contrast to the plasticised sandwiches (convenience store quality) we have experienced at "Starving Harbour". In contrast in the antipodes, Kiwi hospitality excels.

The menu

Saturday morning was taken up with Dupuytren's disease. I can repeat, he was a noted surgical figure at the Hôpital Hôtel Dieu who occupied the chair of Clinical Surgery until his death in 1835 (Wikipedia). He was a successful surgeon of humble origins, dedicating endowments to the Ecolé Medicine, a benevolent institution for elderly physicians (as Verdi also did for his less fortunate musical associates). He was technically adept and quite resourceful – I have even seen an illustration of his cystoscope. His innovative mind helped him to solve problems individually rather than reverting to multiple opinions from multiple sources. He claims Laennec stole the idea of melanoma from one of his public lectures. He even treated Napoleon's haemorrhoids, documented in the history of the battle of Waterloo (could this have affected the outcome?). On another tack, even John Hueston had a collector's item – a request for military stores signed by Napoleon during the Egyptian campaign. I saw this at the Collector's Night at the University of Melbourne in the mid-70s. Even John failed to arrive that night due to his heavy surgical commitments.

On Saturday the Dupuytren's session from 8:00am was under the chairmanship of Dr J L Lermusioux, a rheumatologist and a world expert on needle fasciotomy. Initially Ms De Greef, a hand surgeon from Belgium, discussed advances in fasciectomy and featured John Hueston's three historic publications: from 1963 on fasciectomy, in the 1970s on knuckle pads, and then the firebreak principle of the 1980s. John used to say "you must publish" as was evident here.



Cure d'ars

In my own experience, Gordon Clunie gave me similar advice, "If you have something new to say, get off your derrieré and put pen to paper. And if you have something that is controversial, new or left field, launch it locally" as I have done in the ANZ Journal of Surgery regarding the Keystone principle. This session encompassed the full range of treatment of Dupuytren's – the needle fasciotomy (popularised by the rheumatologist), the standard fasciectomy (the surgical domain), and finally the use of Collagenase. On reflection, rheumatologists regularly treat painful nodules on the hand with steroid injection. It is easy to speculate that on one such occasion maybe 30 years ago, the chairman could have injected a painful palmar nodule with steroids with the resultant rupture of the contractual band.

Commercial realities

Incidentally, I was interviewed by a marketing firm, a week before my Parisian departure, concerning the use of Collagenase costing approximately $2500. Historically, the original enzyme was isolated by Mendel from Clostridium histolyticum in 1957 in New York for the treatment of indolent ulcers with limited success. Subsequently, two orthopaedic surgeons from the State University of New York (Hurst and Badalamente) experimented by injecting this enzyme to produce a flaccid rat's tail. Eureka! With subsequent Food and Drug Administration approval, it is now a commercial reality. They are now enjoying the royalties with the use of Xiaflex (the modern commercial name for Collagenase) and collecting 0.5 per cent of monies generated for such treatment on the American scene which may go as high as $5000. Pfizer (who markets Viagra) bought the Xiaflex licence for Dupuytren's; and with a five per cent co-prevalence of Peyronie's disease in Dupuytren's, the Urologist may soon be consulted. I obtained all of this information from the financial section of the International Herald Tribunal between Singapore and Paris, while nothing of this was revealed by the marketing firm during my interview which they termed confidential.

Thus at the conclusion of the session it was noted that these three modes of treatment are presently in a state of flux, with the value of each alternative to be subsequently assessed. One can foresee that the case mix will be governed by the co-morbidities – while an 80-year old might do well with Collagenase and/or fasciotomy. If it recurs she still ends up with a finger in her eye when washing her face, she may well come back for surgical management. Surgery will always have a place.

I left the meeting before the closing bell that Saturday afternoon, having attended from 8:00am to 6:00pm each day, with each presenter limited to a maximum of 10 minutes (needless to say, this taxed me). Yet I was overwhelmed by the diversity and academic input from this impressive meeting organised by the French surgeon, Matthieu Beustes.

I would certainly encourage my colleagues, young and old alike, to avail themselves of every opportunity to attend such international meetings and to present their own experiences to the international surgical community. And again, thank you John.

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