Surgical news

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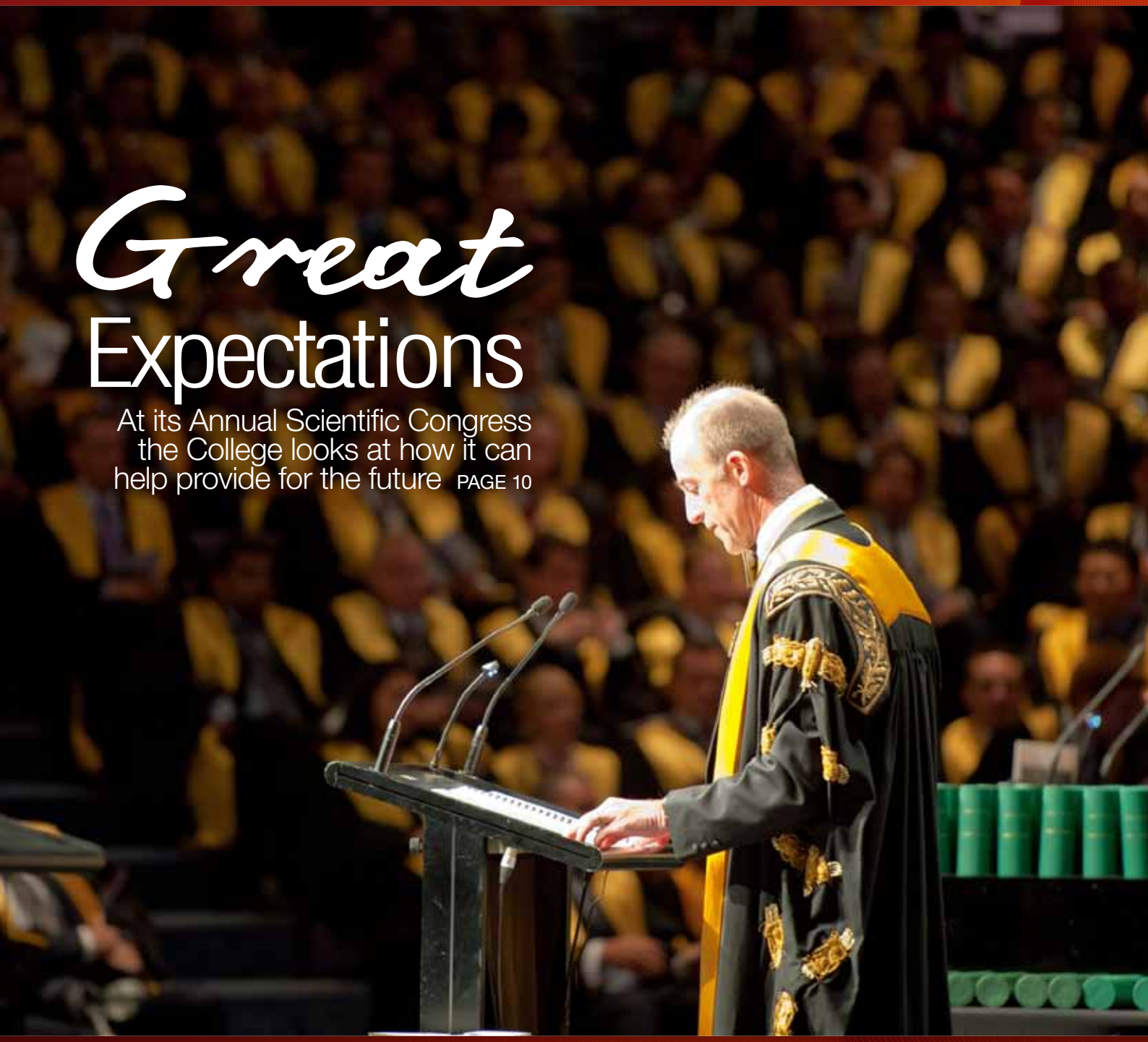
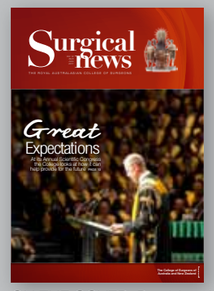
THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



Great Expectations

At its Annual Scientific Congress the College looks at how it can help provide for the future PAGE 10

The College of Surgeons of Australia and New Zealand



ON THE COVER: President Ian Civil presenting at Convocation at this year's Adelaide ASC

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Innovating change

The President Ian Civil congratulating Lord Ara Darzi on delivering the President's Lecture.

Ian Civil
President

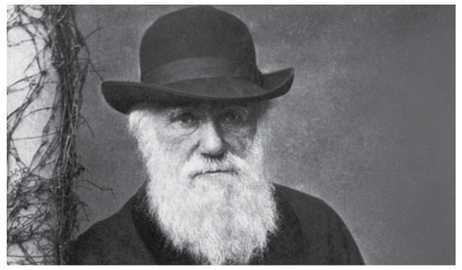
I am writing this shortly after the Annual Scientific Congress that was an outstanding success in Adelaide in early May. As highlighted at the meeting, our thanks go to the Convenors based in Adelaide who brought together an excellent program speaking to the theme of Unity through Diversity.

International visitors were profiled throughout the week and they spoke not only to their areas of scientific expertise, but contributed to plenaries and workshops that emphasised issues important to us all. Our dependence on innovation, the opportunities and threats of commercialisation, the importance of professionalism and demands of an academic career were all issues given the benefit of international expertise and experience.

Lord Darzi was a key international visitor and would fully qualify as one of the most influential and strategic thinkers in the delivery of health care in the world today. Having previously been the Parliamentary Under-Secretary of State (Lords) at the Department of Health in the UK, he oversaw substantial policy review and significant improvement in the way that clinicians were involved in the delivery of health care and quality services across the UK. He has now resigned his parliamentary role and returned to his academic and clinical roles. In June 2010 he was appointed Chairman of the Institute for Global Health Innovation at Imperial College, a body dedicated to improving healthcare around the world and reducing health inequalities in developed and developing countries.

His lecture on innovation was particularly inspiring because as surgeons we have seen incredible changes for the better during our professional careers. Importantly, innovation drives economic growth, ▶

> *"It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change."*



quality of life and, as Lord Darzi stressed, is the only hope of addressing the major challenges that we face. He is most concerned that society's current short-sightedness has created an innovation deficit that will impact on future generations.

Innovation can be through new technology, products or services, the implementation of new processes or the provision of services through new business models. It is not surprising he stressed the importance of the Surgical Safety Checklist with the six safety parameters of objective airway evaluation, proper administration of antibiotics, site confirmation, appropriate preparation for significant expected blood loss, pulse oximetry and sponge counts. The six safety indicators are statistically and substantially improved through the Safety Check list. The College will continue to advocate for its use.

Of particular interest was the work from the World Economic Forum where 21 examples from transformed business cases in the delivery of health have delivered substantially improved outcomes. The delivery of cataract surgery has been transformed in India where 1.6 million outpatients are assessed, 240,000 cataracts are replaced and the lens that is used is now exported to over 120 countries through an innovative program. This care is delivered at about one thirtieth of the cost of the NHS. However other examples where world class quality services are delivered in far more affordable models have also been demonstrated from US, Africa and Europe.

Surgery has been confronted by what Lord Darzi would describe as disruptive innovation. As he outlined, in the past 50 years we have seen the technological development of life saving surgery in the form of coronary artery graft procedures. However, the disruptive technology is now moving this procedure from the operating theatre to an area of less expense, where less expertise is required and with a reduction in morbidity. And this is not an isolated phenomenon as a number of health activities that required specialist care in major acute hospitals have now with innovative solutions been delivered locally in polyclinics, elective centres and even in the home.

The day of the "expert patient" particularly in chronic disease care is with us.

It was a confronting discussion. It was also an inspiring presentation. It certainly is a discussion we must be involved with and support.

His final slide was a picture of Charles Darwin with the famous quote, "It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change."

The plenary sessions of the Congress continue to be outstanding forums for all surgeons to be informed and invigorated. For those of you who were unable to attend they are also available on the College Virtual Congress through our web site www.surgeons.org

At the recent Younger fellows forum in the Barossa Valley

Providing for the future

New Zealand faces some very real problems for the future provision of a well trained, high quality surgical workforce. It is up to us all to respond

Keith Mutimer
Vice President

Our ability to have a well trained, high quality surgical workforce of sufficient size to meet the demands of population growth and population ageing is undoubtedly one of the greatest challenges facing our College in both countries. As Charles Darwin might have said, if this 'species' is to survive, we must review our current processes and be prepared to be flexible in our work practices.

New Zealand has one of the highest percentages of overseas doctors in the OECD (approximately 40 per cent). Unlike Australia, New Zealand governments did not approve additional funds to increase graduate numbers from local medical schools until very recently; and that increase will not enable New Zealand to achieve self-sufficiency in its medical workforce. In addition, Kiwi graduates have a qualification that is very marketable in the international arena and, unlike their zoological namesake, they are great flyers; and many have an interest in expanding their geographic horizons.

Health Workforce New Zealand (HWNZ) has developed a number of initiatives to encourage New Zealand trained doctors to return home. One is a scholarship program that assists specialist trainees with costs associated with post fellowship training overseas. There is a requirement that they have an assured specialist position to return to in a New Zealand public hospital and are willing to be bonded in that position for several years.

District Health Boards had been unwilling to commit to employment in advance, but have recognised flexibility is required if they are to staff their hospitals with well trained specialists. A number of New Zealand surgical trainees and recent graduates have been approved for these scholarships.

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"Unlike Australia, New Zealand governments did not approve additional funds to increase graduate numbers from local medical schools until very recently."

It is recognised internationally that there will be a relatively lesser amount of money available for healthcare so greater efficiencies will be required to produce even the same level of care. Simultaneously with our ageing population, we have a relatively smaller proportion of working age people. Healthcare will be competing within this smaller pool for staff. If we wish to expand and do better, then we need to be innovative about what we are doing.

No one initiative can solve the workforce problems. If a well trained, quality surgical workforce is to survive in sufficient numbers to meet the needs of the population, then Fellows need to acknowledge the problems and consider how change in their practice may help the 'species' survive.

Increasing surgical graduate numbers through access to training opportunities in the private sector will assist but, again, is insufficient on its own. Sections within our workforce are looking seriously at aspects of their work which may be undertaken by other health professionals under their oversight. This would free them up for the specialised roles that only they should provide.

New programs

Two such initiatives in New Zealand are the Physician Assistants' trial in the General Surgery Department at Counties Manukau and HWNZ's Musculoskeletal Workforce Service Review. The latter has been undertaken by orthopaedic surgeons resulting in the "overarching concept that the most appropriate person should examine and assess the patient in the most appropriate way when they are first referred; and that assessment by a surgical specialist should only occur when there is a realistic expectation that the patient will require surgery".

Our workforce difficulties require a careful consideration of our activities and the place for role delegation. In order to maintain or improve our present outcomes we must collaborate with medical colleagues, other health professionals and those in government and management positions. Surgeons must take leadership in these initiatives. We must all be responsive to change if we are to continue to provide the appropriate standard of surgical care for the public of New Zealand and Australia.

On a knife's edge

Is this a dagger which I see before me, the handle toward my hand? Come let me clutch thee

Professor U.R. Kidding

I gently swirled the remnants of the delightful Shiraz and watched the light of the room reflect. I was in my study, where I seem to spend more time than ever before. It was late at night, the house quiet and asleep. By reflex I reached for the bottle and muttered an expletive as it was so obviously empty. "Was this job getting me down," I wondered.

In my role as Surgical Director I had been exposed to a lot of "new thought" educational and human resource "thought bubbles". Reflection, they said, was a powerful tool for educational and personal growth – the initial vital first step towards insight. Mentally I created an equation – reflection + honesty = insight. Is this valid?

Twaddle, I thought... Surgeons are known for decision making, dealing with uncertainty and getting things done. Sound decision making and the action of the knife had been what had captured my attention as a medical student. Shakespeare had a fascination with knives and daggers. Who could forget the words of Macbeth "Is this a dagger which I see before me, the handle toward my hand? Come let me clutch thee." (Act II, i). From the outset of my training I was sure surgery was for me – I have never had cause to question this conviction.

But life and managerial solutions are not so romantic or as "clean cut". The major difference between my career as a surgeon and my career as an administrator is that with the former, I am aiming for a solution, an end-point, a defined destination. Alas with the latter career, solutions are elusive and I am confronted with deriving some benefit from the journey – constant positioning within a sea of "white water".

My last missive highlighted a performance review with one of our trainees. You may remember I had described it as he did not want to be there and nor did I... Well, it got worse. I developed the sense that I was standing on the edge of an abyss and did not quite know how to negotiate back from the edge.

The trainee was certainly not performing. At least he acknowledged that he had not always reviewed patients, not always attended clinics and did not think handovers were worthy of him. I indicated that without substantial improvement, he was likely to have unsatisfactory reports for both his surgical training program and for his hospital service record – he looked uncertain.

He replied – "but I have reports from my psychologist and psychiatrist that say because of my medical condition I need to control the stress of my role and reduce the activities when I am on the edge."

"I often am on the edge." (Was that him or me he was referring to.) The abyss awaited.

"Ohhhhh... Did you discuss your choice of career with your psychologist and psychiatrist? Surgery is not really a stress free zone. Indeed most hospital based practice can be pretty stressful. Perhaps another field that was more predictable would have been appropriate?"

"No" was the response, "this only developed after I got on the program and my lawyers say that the Surgeons owe me a duty of care to ensure I can finish my training program in a protected manner" Now the abyss didn't seem so threatening – I wanted to jump! How did we ever get into this state? Is such conviction as to the merit of one's personal rights compatible with insight, let alone professionalism?

I stated to the somewhat defiant trainee that patient safety was his upmost concern and could not be abrogated – issues like consultation and hand-over were both essential and compulsory. We began to work out a performance plan for him that met the expectations of the training program and himself.

We agreed to meet in a week where he would have documented his expectations for both himself and the training position over the next 12 months. I would get further advice from the Training Board, College and Hospital about supporting his training with the constraints of his medical condition. In the meantime, he would need to determine if we could jointly speak with his psychologist and psychiatrist. I wondered whether he was impaired, lazy, selfish or possibly all three, and whether or not he would ever be in a position to achieve the degree of insight and responsibility that will be required as a surgeon.

That was six days ago. Tomorrow we were meeting again. I did not want the meeting. I am sure he did not want the meeting ...

So now the big decision – bed, and hopefully sleep, or the cellar for another bottle of that 'cheeky' shiraz. Bed or cellar I pondered as an administrator unable to decide. Ah, but I am also a surgeon and capable of making a decision. Instantly I got out of my chair and headed to ...

Leading change through disaster

Recent disasters in New Zealand and Australia have meant that Fellows have had some rapid learning in the field, highlighting the need for training for these situations

The readiness of Australian and New Zealand surgeons to respond to major disasters in our region was the focus of the most recent Surgical Leaders' Forum, held in Adelaide in the lead-up to the College's 80th Annual Scientific Congress.

Following a recent spate of disasters – including bushfires in Victoria, floods and cyclones in Queensland, and a devastating earthquake in Christchurch – the College decided to use the Surgical Leaders' Forum to consider the issue of surgeons' roles in the planning for, and response to, major disasters.

The Surgical Leaders' Forum is held four times annually, enabling the College to interact closely with specialty societies and associations. The forum facilitates consideration and discussion of a wide range of matters, from the specifically surgical to much broader issues such as governance and funding in the public health sector and proposed healthcare reform.

The consensus among presenters was that while surgeons have responded with considerable effectiveness to recent disasters, there needs to be a redoubling of planning and training efforts. There needs to be clinicians' involvement in the planning phase and a clear understanding of who takes leadership roles in the event of a disaster.

Surgeons need to be trained to cope with the challenges of working in the field, with minimal resources and in very difficult conditions. As one presenter said: "Going on a deployment for the first time is not the way to learn".

It was agreed that databases need to be maintained to ensure that surgeons who had indicated their willingness to serve in a disaster scene were in fact qualified and able to do so.

It was also suggested that there be greater coordination of resources between states and territories, and between civilian and military authorities.

College President, Mr Ian Civil, said the forum was an unprecedented opportunity to bring together experts in the field of disaster response, and would ensure surgeons' ongoing and enhanced participation in disaster relief.

Speakers at the most recent forum were:

>Dr Ian Norton
Director Disaster Preparedness and Response, National Critical Care and Trauma Response Centre (Royal Darwin Hospital)
As head of a centre established in response to the Bali bombings, and based at the hospital which frequently serves as the forward receiving hospital after disasters in our region, Dr Norton spoke of the importance of preparing and training those surgeons, physicians and allied health professionals who are among the first at the scene of mass casualty incidents.

>Mr Barry O'Loughlin
Royal Brisbane and Women's Hospital
Mr O'Loughlin recounted the challenges, the successes and the lessons learnt in coping with the floods that swept through Queensland in January.

>Dr Pieter Prinsloo
Director of Surgery, Cairns Base Hospital
Dr Prinsloo gave a detailed account of the precautions taken in anticipation of Cyclone Yasi, including the complete evacuation of Cairns Base and Cairns Private Hospitals.

>Mr Greg Robertson
Director of Surgery, Christchurch Hospital
Mr Robertson told of the magnificent response of Fellows to the earthquake which killed and injured so many in Christchurch on 22 February.

>Mr Michael Weymouth
Plastic and Burns Surgeon, The Alfred Hospital, Melbourne
Mr Weymouth recalled the events of February, 2009, when bushfires ravaged the north eastern fringes of Melbourne, and areas around Bendigo and central Gippsland. He said that excellent triage work done at the scene of the fires had ensured that the most severely injured were the first to arrive at the burns units of Melbourne's major hospitals.

>Dr Annette Holian
Deputy Director of Trauma Service, Royal Darwin Hospital
Dr Holian spoke of the challenges of disaster relief work in communities far removed, geographically and culturally, from mainstream Australia and New Zealand.

>Associate Professor Andrew Pearce
Clinical Director of Training and Standards MedStar Emergency Medical Retrieval Service in South Australia
Professor Pearce emphasised the importance of ascertaining a volunteer's suitability for disaster work. Inappropriate selection and preparation of candidates can result in relief workers becoming a counter-productive presence, requiring rather than providing medical assistance.

>Professor Chris Baggoley
Acting Commonwealth Chief Medical Officer
Professor Baggoley provided delegates to the forum with an overview of the Commonwealth Government's disaster preparedness plans and the way in which separate agencies with distinct functions are supposed to coordinate their efforts in the event of a mass casualty incident.

>Professor Karim Brohi
Professor of Trauma Sciences, Queen Mary School of Medicine and Dentistry, London
Professor Brohi recalled the London bombings of 7 July, 2005, and detailed the response of emergency services confronting mass casualties at four different points of one of the world's most populous cities at peak hour.

Summon, a new search experience for the Online Library

The library now has an easy access search tool

Cathy Ferguson,
Chair, Fellowship Services Committee

As the Online Library has grown, so has the number of different links and publisher platforms. Clicking through these in order to keep up to date with new information can be a disjointed and cumbersome experience.

As one Trainee reported recently, "Devices like the iPad are becoming the preferred means of accessing the library ... it is a pain to click through multiple links. You want to quickly check something during Outpatients or before theatre. If it takes too long you won't bother."

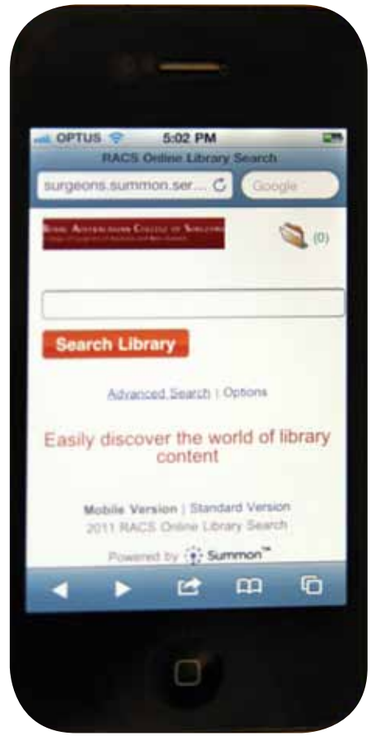
To address this issue, the Library has integrated a new feature called Summon which provides a web search experience to match Google for convenience and speed.

All the Library content is now available through a single search box that will take you from keywords to full text articles in one click.

Your search results will be returned in a relevancy-ranked list with the most relevant results at the top of the list. You can limit the search, for example to journal articles only or ebooks only, or to specific publication dates or alternatively expand your search with the help of subject term prompts. All results will link to the Library's full text content.

Summon provides "Did you mean?" suggestions with alternative guidance for misspellings or low yield queries, along with the capacity to easily export citations to bibliographic management software applications such as EndNote, RefWorks and ProCite.

The Library will continue to also provide Medline on Ovid. The difference between Summon and Medline? Summon searches the Library's full text content, with a fast reliable response. Medline is independent of the Library, and results may or may not have links to full text. Medline can give you more opportunity to combine various keywords for the purpose of complex research. For the past month Library staff have been testing every search on both platforms and Summon compares to Medline very well with the added convenience of instant full text.



Summon is mobile accessible. If you're pressed for time and need credible information fast, Summon will get you there in one click, from your mobile device.

For information, contact the Library on +61 3 9249 1272 or email College.Library @surgeons.org

Royal Australasian College of Surgeons

Fax Mentis
The torch of the mind

Are your details correct?

After recommendations from the College Communications Working Party, the College now distributes a weekly e-newsletter, Fax Mentis, as a way of streamlining communications to Fellows and Trainees.

If you are NOT receiving the e-newsletter, your details may be incorrect.

Please fill out the change of details form that comes with the *Surgical News* and return by instruction, or contact the College on +61 3 9249 1200.

Correction:

In the May 2011 issue of *Surgical News*, errors appeared after final author corrections for the article The Carpal Tunnel Syndrome & the Two Fat Ladies by Felix Behan. Please note that in the first paragraph the word should have been Lorne corniche, rather than cornice. Also the correct term for the subhead should be Carpal Tunnel Syndrome.

Worth Celebrating

This year's ASC looked at what we need to provide for the future

Strategies to deal with the coming 'tsunami' of young doctors about to graduate in Australia and New Zealand, the receipt of desperately needed funding to allow for the ongoing development of a National Trauma Registry and advances in the treatment of burns injuries were among the highlights of the RACS' 80th Annual Scientific Congress.

Held last month in Adelaide, this year's ASC also included presentations on the controversial topic of anatomy education, the need for surgeons to know the prevalent bacteriology in tropical settings if the incidence of morbidity and mortality in burns patients was to be reduced along with a tribute to the remarkable life of pioneering neurosurgeon Hugh Cairns.

With the number of Australian medical graduates set to double over the next few years, with a sharp rise also looming in New Zealand, the development of simulated learning programs and an expansion of private hospital training posts were now becoming vital, ASC delegates were told.

Mr Mark Cormack, the CEO of Health Workforce Australia (HWA) told the Congress that with too few specialists training places available, HWA's National Training Plan now included a targeted program to boost Simulated Learning Environments which will receive initial funding of $94 million and $20 million the year after.

Dr Michael Walsh, CEO of Cabrini Health in Melbourne, said private hospitals should also be funded to expand the number of training posts available.

He said that with the public sector lacking the finances and patient throughput to sustain more training posts, the private sector now carried out the majority of surgical procedures. However, he said that specialist training in private hospitals would only increase markedly if Accredited Private Specialty Training Centres were established with guaranteed funding and systems which fostered accountability and commitment.

Mr Robert Claxton, a General Surgeon at Sydney's Canterbury Hospital, also told delegates that providing smaller city and regional hospitals with the appropriate up-to-date equipment and training would allow surgeons and registrars to do more high-volume procedures that would ease the burden on major city hospitals.

Appropriate resourcing

He said small hospitals could do such work as laparoscopic gall bladder surgery, hernia surgery and other abdominal surgery very successfully if they are adequately resourced.

"Over the past few decades there have been massive and rapid advances in medical techniques and technology, but surgical staff at smaller hospitals cannot keep up with this unless they are appropriate resourced," Mr Claxton told the Congress.

"If smaller facilities are funded appropriately, the major city hospitals would not be as overburdened as they are now and more patients could be treated in an appropriate, safe and cost-effective way – often nearer to their homes."

Professor Mark Stringer, of the University of Otago's Department of Anatomy, told ASC delegates of the great success of a new postgraduate diploma course in surgical anatomy which incorporates both distance learning along with intensive campus-based tuition and whole-body dissections.

Launched in 2009, the course is proving more popular each year, with 81 graduates applying this year for only 24 places available.

"The diploma aims to equip junior surgeons with a sound understanding of regional anatomy relevant to common diagnostic and therapeutic procedures, together with an understanding of common or important anatomical variants," Professor Stringer told the Congress.

"Close collaboration with the RACS was essential when developing and accrediting the qualification and rigorous internal and external review encourages the maintenance of high educational standards."

Another significant success story presented at the Congress was news of an 11th-hour funding injection to allow for the continued development of a National Trauma Registry.

Professor Clifford Pollard, the Director of Trauma Services at the Royal Brisbane and Women's Hospital, said the aim of the registry was to enable the collection of data which would in turn facilitate the identification of best practice and lead to measurable improvements in the care of trauma victims.

However, he said that despite receiving funding from 2003 to allow for the employment of a full-time project officer, no further funding could be found after 2009.

Fortunately, negotiations last year with the National Trauma Research Institute and the National Critical Care and Trauma Response Centre in Darwin resulted in the announcement of a joint $750,000 contribution to continue the development of a National Trauma Registry and supporting trauma quality improvement programmes.

"The future now looks considerably brighter," Professor Pollard told the ASC.

Thermal imaging

Among the hundreds of presentations on developments in surgery given at this year's Congress, a paper was presented on the use of Infra-Red Thermographic Imaging in the Serial Assessment of Burns.

Dr Anna-Marie Loch-Wilkinson, a Plastic Surgery Registrar, told the ASC that while infra-red thermal imaging had been used widely in the fields of construction, military, search and rescue and vulcanology, it could also be used to assess the healing rate of burns injuries.

She said that infra-red thermal imaging cameras could detect and quantify temperature variations of less than 0.04 degrees Celsius.

Presenting the findings of a study conducted at the Burns Unit of Sydney's Westmead Children's Hospital in 2009, Dr Loch-Wilkinson said: "Thermographic imaging showed a decreased temperature in the areas of burnt skin consistent with the phenomenon of evaporative heat loss in de-epithelialised wounds.

"Photographic software was used to calculate the percentage change in surface area of the de-epithelialised portion of skin between initial and follow-up assessments. By plotting this percentage change against time, a rate of re-epithelialisation and therefore time to healing was extrapolated."

Dr Si Jack Chong of Singapore General Hospital's Department of Plastic, Reconstructive and Aesthetic Surgery also told the Congress that with infection now a major cause of morbidity and mortality in burns patients, appropriate antimicrobial therapy must be guided by knowledge of the prevalent bacteriology, particularly in hot and humid climates.

Dr Chong said he had analysed the data on the culture isolates taken from burns patients between 2004 and 2009 including tissue cultures, wound swab cultures, endotracheal cultures, urine cultural, fungal cultures and blood cultures.

"Sixty per cent of all bacteremeic episodes occur within 48 hours of burns excision and there is significant correlation between bacteremia and time from surgery," he told the Congress.

"All culture methods had a good correlation, yielding the same bacteria strand causing bacteremia while we also found that the yield of wound swabs is, in general, lower than tissue cultures.

"Knowledge of local flora and the adoption of strict infection control measures are needed to reduce burns wound infection rates (while) the choice of appropriate culture and the timing of the culture should be carefully considered to ensure good and timely information as this is essential to effective antimicrobial therapy."

The remarkable life of Hugh Cairns was the focus of this year's history presentation.

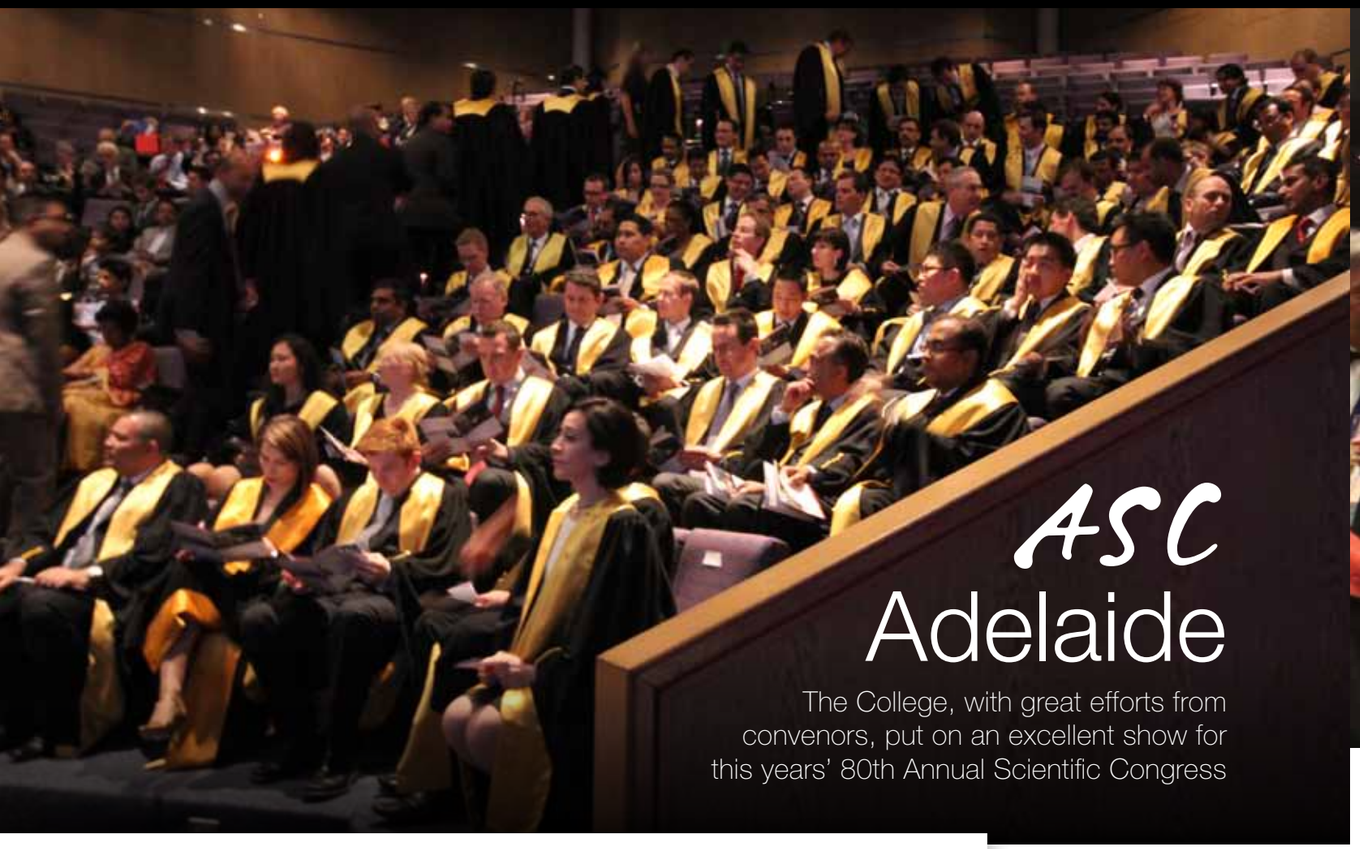
Delivered by Professor Susan Neuhaus, an Adelaide-based General Surgeon, the address described the contribution made by Cairns who, as a soldier, survived the brutality of the Dardanelles campaign of the First World War to go on to become a Rhodes Scholar and later a pioneering neurosurgeon.

Born in Port Pirie in 1896, Hugh Cairns decided to enter the relatively new discipline of neurosurgery after completing his studies at Balliol College, Oxford, travelling to Boston to train under Harvey Cushing.

During the Second World War, he became a pioneer of military neurosurgery, developing mobile field neurosurgical units while he and fellow South Australian Howard Florey introduced the use of penicillin into the management of casualties in North Africa.

Cairns' most famous patient was T.E. Lawrence (Lawrence of Arabia) who sadly died under his care following a motorcycle accident in 1935. According to Professor Neuhaus, this event had a profound affect upon Cairns and led to his developing the first motorcycle helmets.

She told the Congress, that although it took some 32 years before the use of helmets was made compulsory for all riders and pillion passengers in the UK, this was perhaps his most significant legacy.



ASC Adelaide

The College, with great efforts from convenors, put on an excellent show for this years' 80th Annual Scientific Congress

1

1. Swee Tan receives his Excellence in Surgical Research Award from Ian Civil

Launch Night

2

Convocation guests were given an alternative view of the future with the Syme Oration by former Foreign Minister Hon Alexander Downer.

2. Spencer Beasley and Alexander Downer
3. Tim Wilson and Leo Pinczewski
4. Ikau Kevau and Loa Daera Kevau
5. A Hisham, Bruce Barraclough and Roger Kneebone

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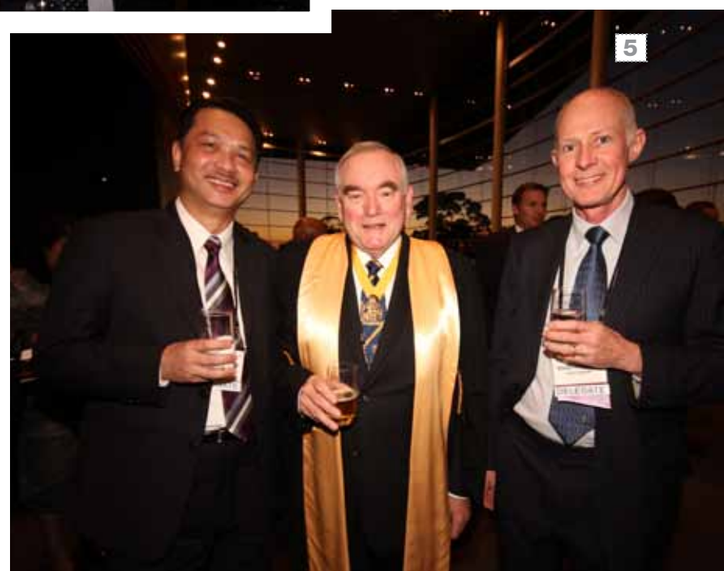

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5

1. Sunny Lee and family
2. Simon Williams and Guy Maddern
3. Richard Walsh, Leona Eddie McCaig and Jitoko Cama
4. Abdul Lathif and family
5. Daryl Wall, Andrew Bullen and Ian Civil

6. Kevin Scarce Council and convenors
7. Suren and Prima Krishnan and Day Way Goh
8. Liz Scarce, Kevin Scarce, Ian Civil and Denise Civil
9. Cathy Ferguson, Julian Smith, Keith Mutimer, Sam Baker and Simon Williams
10. Moira Truskett, Vince Cousins, Phillip Truskett and Michael Grigg


6

Government House

Council and Convenors were treated to a reception at Government House by Governor of SA, Rear Admiral Kevin John Scarce and his wife Liz


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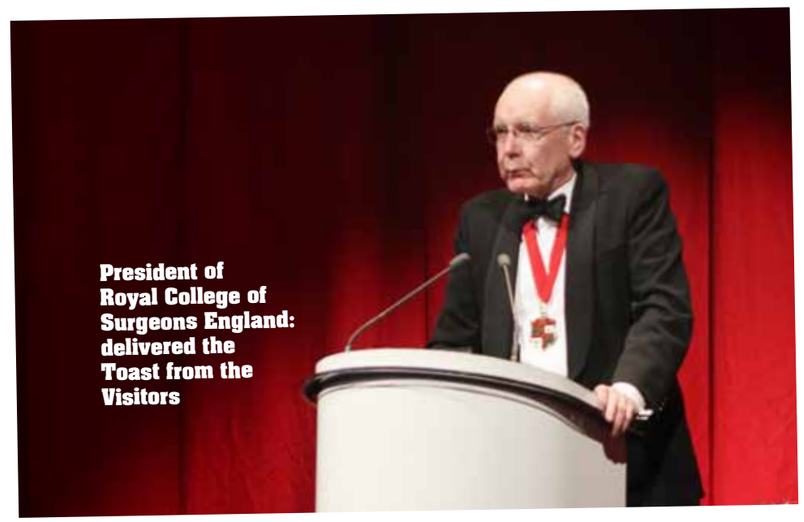
Women in Surgery Breakfast

Melissa Bochner and Kate Drummond

Congress Dinner



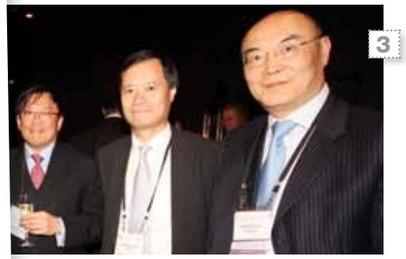
President of Royal College of Surgeons England: delivered the Toast from the Visitors


1

A grand dinner accompanied by handpicked wines was served to more than 400 guests at the Adelaide Convention Centre

1. Pip Rhind, Sally Langley, Swee Tan and Bruce Rind
2. Gary Crosthwaite, Graeme Campbell and Michael Cox
3. James Khong, Stephen Cheng and Hung To Luk
4. Craig Juresevic and Peter Sharwood
5. Campbell and Vivienne Miles
6. Tom Wilson and Michael Griffin


2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Hamilton Russell Memorial Lecture
Greg Baker and Ian Harris

Mark Cormack from Health Workforce Australia

Thur Plen Michael Walsh, Sam Baker, Roger Kneebone, Mark Cormack and Michael Jay

Younger Fellows dinner

David David speaks on the relationship of Government and Surgery

4

Photographs courtesy of John Aloysius Henderson

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1. John Collins and family
2. Brian and Gwen Morgan and John Royle
3. Andrew Bullen, Susan Ziada, Sam Mellick and Daryl Wall
4. Anthony Morris, Glyn Jamieson, Peter Woodruff and Andrew Sutherland for the Patel Case
5. Anne and Stephen Deane
6. Ian Bennett, Sam Baker and Barry O'Loughlin
7. Anne and John Henderson

Research for technology

The W.G. Norman Research Fellowship has helped Dr Leong Tiong to pursue a passion for research

South Australian general surgery trainee Dr Leong Tiong has used the funding attached to the Foundation for Surgery W.G. Norman Research Fellowship to investigate new methods to conduct tissue ablation for treatment of liver cancer.

As part of his Masters of Surgery Degree, Dr Tiong conducted a study to investigate whether Bimodal Electric Tissue Ablation (BETA) which incorporates electrolysis into radiofrequency ablation (RFA) could increase the size of radiofrequency ablations.

Using a pig liver model, Dr Tiong found that ablations produced by BETA were significantly larger compared to the standard RFA and could thus be used to treat larger liver tumours more effectively.

"The purpose of my work was to see if there was a way to increase the size of ablations so that we could treat larger liver tumours," he said.

"A reasonably high percentage of liver cancers cannot be treated surgically because they are too advanced or there are simply too many tumours on the liver and while the use of ablation has opened up new treatment options, we have been limited by the technology.

"The standard RFA technology does not generate enough heat to treat larger tumours. Using this technology, we can only treat liver cancers of approximately 3cm in size. RFA for larger tumours has higher risk of disease recurrence, because of the inability to completely ablate 100 per cent of the tumours.

"BETA technology, however, can increase the size of radio-frequency ablation therefore allowing larger liver tumours to be treated."

Dr Tiong said the new technology could have a significant clinical impact on the treatment of liver cancer patients who are too old or too ill to undergo surgery, while the technology could also be used to treat certain lung and bone cancers.

"RFA is the most popular and most widely used technology world-wide now and a change to BETA would only require modifications to current RFA generators," he said.

"Now we are hoping that once we get all the data finalised and assemble the electronic equipment we could start human trials within a few years."

Dr Tiong is undertaking his Masters of Surgery Degree through the University of Adelaide. His research is being done at the Animal Laboratory at the Queen Elizabeth Hospital in Adelaide and he is working under the supervision of Professor Guy Maddern.

He has already been published in the Journal of Surgical Research with other articles pending and has presented his findings at local conferences.

Dr Tiong received the W.G. Norman Research Fellowship in 2010. The Fellowship has a gross value of $60,000 and is open to Fellows or Trainees resident in South Australia with all research to be conducted there.

"The encouragement and support I have received from the College and the Board of General Surgery has been greatly appreciated," Dr Tiong said.

"I have been interested in academic surgery for some time and so to receive this funding and the research opportunity, particularly the chance to work with Professor Maddern, was great.

"I learnt how to design experiments, how to conduct literature reviews, how to navigate ethics regulations and how to write for scientific publications, all of which have made for a very interesting year."

On the right *note*

Urology Trainee Dr Ben Namdarian performed in a theatre of a different kind last month after winning the plum role of Rory in the world premier of *How to Kill Your Husband*, an opera based on the darkly comic novel by Kathy Lette. Dr Namdarian talks to *Surgical News* about his twin passions of music and medicine.

"At one stage, for this production, I went from a 16-hour shift at the hospital to sitting in a workshop with artists deconstructing relationship issues. It was a dramatic shift of headspace but great fun."

Having taken up singing as a treble at the ripe old age of eight, Dr Ben Namdarian has sung with the National Boys Choir and later the Trinity College Choir during his undergraduate studies at the University of Melbourne. Now a tenor, he has worked with such luminaries as Baz Luhrman in a production of A Midsummer Night's Dream and performed with both the Victorian State Opera and Opera Australia.

Is playing Rory in How to Kill Your Husband the biggest operatic role of your career so far? I began working with the Victorian Opera three years ago and took on understudy roles in 2009 for Andrew Ford's premiere of Rembrandt's Wife and Richard Strauss' Ariadne auf Naxos, both of which were great fun to do but yes, this is my biggest role so far.

What appealed to you about this opera? *How to Kill Your Husband* is about two couples and the difficulties they face in their relationships and it's very clever, very dark and very modern. It is not a typical opera in that the music ranges from Handel recitative to 70s rock musical styles a la Tom Jones and Barry White which makes it great fun to do as a performer and hopefully entertaining for the audience. It also has a tremendously talented cast including Tobias Cole, Dimity Shepherd, Christa Hughes and Jocelyn Hickey and to work with them is an absolute thrill. I was quite surprised to be asked to understudy with the Victorian Opera a few years ago, so to be asked to sing the role of Rory felt like a great privilege given that I have had no other theatre training other than voice training.

How have you organised the time to perform in terms of your training schedule? Both this year where I'm working at the Alfred Hospital, and last year at the Royal Melbourne, I used up all my annual leave to allow the time for rehearsals and performance. My supervisors at both hospitals and the board of the Urology Society have been greatly supportive which has made an enormous difference, particularly my current training supervisor Dr Kate Martin and Professor Nathan Lawrentschuk. At one stage, for this production, I went from a 16-hour shift at the hospital to sitting in a workshop with artists deconstructing relationship issues. It was a dramatic shift of headspace, but great fun.

What can you tell us about the role of Rory? Rory is a vet so I still get to wear scrubs. His relationship is in trouble so he and his wife decide to visit a sex therapist. Unfortunately Rory becomes somewhat distracted by the therapist which doesn't do his relationship much good at all and in one scene I'm wearing little more than a dog collar to give you some idea.

Do you suffer from stage fright? It's always daunting to go on stage, in this instance not only because of the hugely talented people I'm working with on How to Kill Your Husband, but also because of the costume arrangements as I mentioned. My supervisors and professors have said that they may attend a performance and I might have to try and block out that knowledge because I have a feeling they might not see me quite the same way afterward. Another character plays a philandering surgeon so there's no escape.

Do you think taking on such controversial roles could ever have an impact on your professional standing as a surgeon? That might have been an issue in the past, but now I think patients or colleagues who saw me on stage would simply consider that performing is just a different aspect of my character. The College has long been promoting the idea that we as surgeons should not just concentrate on being professionally proficient, but take on broader roles within hospitals, within the field of research and out in the community. I think most people now believe that surgeons with interests outside the operating theatre enhance their professional capabilities.

Are there are any links between music and medicine? Yes I think there are a great many actually. Both medicine and music are very interactive and both are performance-based in a way. As surgeons we interact with patients, fellow surgeons and hospital colleagues just as artists interact with other singers, musicians and writers to bring a production to completion and the audience, of course, during the run. Both roles also require technical proficiencies to a very high level which is why, I think, so many doctors are attracted to music and the arts.

Have you ever dreamed of a life as a professional opera singer? Having had exposure to the world of the performing arts from the time I was young obviously planted the seed of such a dream, but it is very difficult in Australia to make a living as a professional opera singer and I have great admiration for the artists who do that and remain so committed because it is extremely tough. I feel very fortunate, because of the support I have received, that I have not had to choose because I greatly enjoy my interaction with colleagues and patients as much as my singing so having the opportunity to marry both of my great loves is a wonderful experience.

What are you other interests? I'm currently in the process of completing my PhD Thesis looking into the identification of biomarkers in urological malignancies under the supervision of Professor Anthony Costello and Associate Professor Christopher Hovens at the Royal Melbourne Hospital and the University of Melbourne. I'm hoping to record a CD next year while I remain involved with the Melbourne University Soccer Club

With such a busy schedule, how does your home life work? My wife Cressida and I have just had our first baby so things are pretty hectic at the moment. My wife is greatly supportive of both my work as a surgeon and as a singer. When I'm home I try to do as much as I can to help, particularly after participating in How to Kill Your Husband, which is one of the few operas where it is not the women who die. Much of the plot revolves around women driven to distraction by their distracted men so I don't want life to imitate art!

With Karen Murphy

Rural Surgery Futures Project

The Surgery Futures project was a major initiative for the Surgical Services Taskforce and the Department of Health for 2010.

Donald MacLellan
Statewide Director of Surgery

The Surgery Futures project involved the greater Sydney area and it was always recognised that a subsequent project was required to concentrate on issues specific to rural surgery.

The provision of surgical services in non-metropolitan NSW over the next 5 to 10 years is an important next phase of the Surgical Futures project. Major challenges exist in rural surgery that are well recognised and significantly different from those in non-rural surgical practice. Population growth rates and age demographics differ widely across rural NSW. The impact of major population centre growth on surrounding smaller towns, differential development of surgical sub-specialty services and the challenges of maintaining comprehensive rosters with small numbers remain. Providing the comprehensive medical, nursing and allied health workforce to enable the welcomed development of rural cancer services and commissioning of planned major rural base hospital developments are another challenge.

There are concerns about the training of generalist surgeons with skills broad enough to equip them for rural practice. There are also challenges with the recruitment and retention of surgeons, anaesthetists, GPs and other specialist health staff.

Professional isolation, the amount of on-call duties, rural hospital infrastructure and lack of locum cover all affect rural surgery and may tend to discourage younger surgeons and GP proceduralists venturing into the country.

Referral networks are often not well enough established causing some rural surgeons to struggle with inter-hospital transfers.

Social factors including partner employment opportunities and schooling are also issues of importance for rural professionals.

The aim of the Rural Surgery Futures project is to provide a framework for public sector surgery (both planned and acute) in rural NSW for the next five to 10 years.

The project will take into account the Surgical Futures report findings, national and international models of care for rural surgery, projected demand for rural surgery due to demographic changes and disease prevalence.

The project will include referral networks and inter-hospital transfers, anticipated trends in surgical practice and other clinical services, technology, treatment modalities and diagnostic services and private sector developments.

Workforce issues will be considered including the environment that attracts and retains surgeons, anaesthetists, GPs, operating room nurses and surgical unit staff, projected medical, nursing and allied health workforce availability and training and up-skilling requirements for rural clinical staff.

The project will also take into account the best use of existing and planned public sector resources, including optimising the location and scale of both planned and acute surgical activity.

A Steering Committee for the Rural Surgery project has been established and is chaired jointly by Assoc. Prof. Austin Curtin (Lismore) and Dr Tim Smyth (DD-G HSQPI).

The Steering Committee has broad representation of surgeons, anaesthetists, GP proceduralists, nurses and managers.

Outcomes of the project to date include:

> An 'Insights Paper', which has been developed to provide some background to the project and has been distributed electronically.

> A rural survey, which has been launched and is continuing to provide valuable information to the Steering Committee on the issues that concern clinicians and managers working in rural NSW.

> A Rural Surgery Webpage, which has been established to host project information and project links.

> A newsletter, highlighting the aim and goals of the project and outlines the project timeline.

> A schedule of rural hospital consultations for the project. Griffith and Wagga Wagga Hospitals have already hosted Rural Surgery Futures forums. A further 10 forums are to be conducted.

For information please contact Professor Donald MacLellan, Statewide Director of Surgery at donald.maclellan@doh.health.nsw.gov.au or by phone +61 2 93919298.

When one door closes, another opens

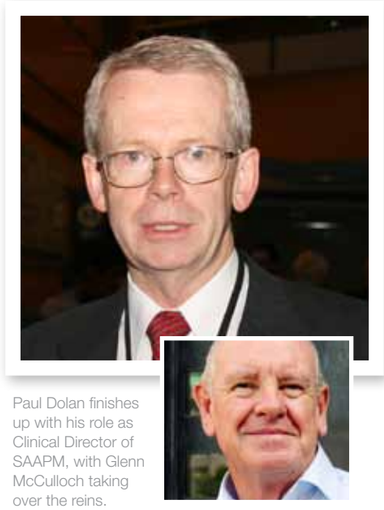
As we say goodbye to Paul Dolan, we welcome Glenn McCulloch into an important role at SAAPM

Guy Maddern
Chair, ANZASM

In 2005, Mr Paul Dolan established the South Australian Audit of Perioperative Mortality (SAAPM) and after six years as Clinical Director he has resigned from this role. Under his leadership SAAPM has grown significantly to have over 50 metropolitan and country hospitals enrolled, and more than 98 per cent of Fellows participating in the audit.

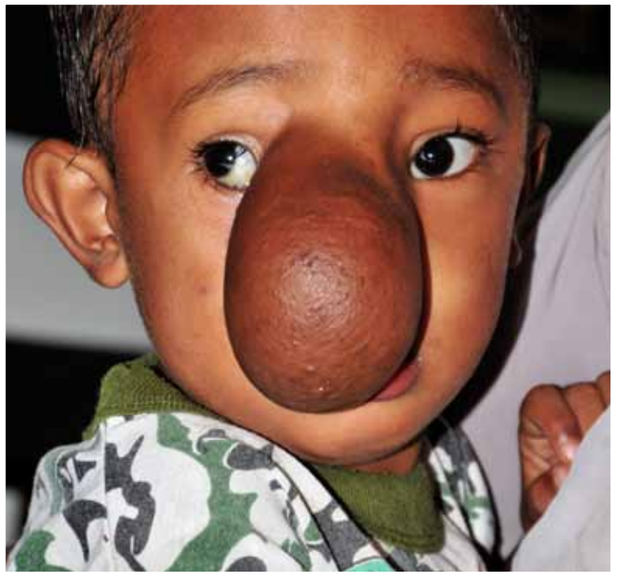
I thank Paul for making SAAPM an extremely successful program within the Australian and New Zealand Audit of Surgical Mortality (ANZASM). This success is due to many reasons, but particularly because of Paul's enthusiasm for investigating and improving surgical processes which will provide the best outcome for patients. Annual Reports and Case Note Review booklets produced by the audit each year have been very well received.

I would also like to take this opportunity to welcome Mr Glenn McCulloch into the role of SAAPM Clinical Director from May 2011. Glenn is a retired Neurosurgeon and ex-Councillor at the College. I am sure that Glenn will bring with him some new ideas for the project. There are opportunities for SAAPM to continue to develop through enrolment of the few remaining private hospitals and the refinement of reports, as well as workshops for the surgical community within South Australia on topics that have been highlighted in the Annual Report.



Paul Dolan finishes up with his role as Clinical Director of SAAPM, with Glenn McCulloch taking over the reins.

Dr Joao Ximenes, Dr Mark Moore, Dr Joao Pedros after completing surgery.



Boy with herniation was an important candidate for Mr Moore.

Collaboration of success

The latest trip to East Timor by Mr Mark Moore has been a great success, following another excellent International Forum at this year's ASC

Days after acting as convenor of the International Forum at this year's Annual Scientific Congress, Plastic and Craniofacial surgeon Mr Mark Moore was back in theatre at the Children's Hospital in Adelaide treating an East Timorese child suffering from a fronto-ethmoidal meningo-encephalococle herniation between his eyes.

The local theatre team, led by Mr Moore with assistance from a neurosurgeon, worked for four hours to remove the herniation, repair the layers between the brain and face and rebuild the small boy's nose.

First assessed for surgery last year during a visit by a College' Overseas Specialist Surgical Association of Australia (OSSAA) team led by Mr Moore, the child now has only a small pattern of scars over the nose, is doing well and should be home within weeks with follow-up to occur during the next team visit.

With theatre staff and time donated by the hospital, visas and passports organised by College staff in Dili and transport and accommodation provided by the Children's First Foundation, the life-changing surgery was a testament to the power of strong networks, according to Mr Moore.

"This was a very nice example of how well international and inter-organisational networks can work if they are properly nurtured and respectfully sustained," Mr Moore said.

"This little boy was first seen by clinic staff in Maliana who assessed his condition and understood where assistance may be found given that he could not be treated in Dili. The College staff in Dili located the child's parents and facilitated the necessary paperwork, the Children First Foundation assisted in getting them to Australia and then we did our bit.

"This is all about building strong networks both from the bottom up, in that patients can be seen and assessed in remote locations, and from the top down where relationships exist between organisations to allow for treatment in sophisticated centres.

"I feel most fortunate, through my work with the College, OSSAA and the Australian Craniofacial Unit to experience both pathways, to work at the intersection of both systems.

"During team visits, we can assess such patients in their remote locations, we can refer them to Dili or to Indonesian clinics and surgeons, bring them to Australia or treat them during an Australian team visit.

"This depth of co-operation can only develop over time."

Mr Moore has headed OSSAA – originally established by Mr John Hargrave to provide assistance to the disadvantaged people of East Timor and Eastern Indonesia – for more than 10 years and in April conducted his 29th clinical visit.

It was, he said, one of the most successful team visits for many years after previous visits being marred by communication breakdowns and consequent confusion, limiting both

the number of patients seen by the team and training opportunities.

Working out of Hospital National Guido Valadares in Dili and over just seven days, the team undertook 30 cleft lip repairs, four cleft palate repairs, four burn or burn contracture procedures, three tumour excisions and a significant nasal reconstruction utilising a costal cartilage graft.

All were done with the enthusiastic co-operation of Dili hospital staff, all provided opportunities for training to both theatre staff and trainee surgeons and all procedures were successful.

The Australian team included Mr Moore, anaesthetist Dr Andrew Beinssen and theatre nurse Sr Vanessa Dittmar while participating local staff included Dr Eric Vreede, RACS team leader in Dili, and fellow surgeons Dr Joao Ximenes, Dr Joao Pedro and Dr Raj Singh.

Significantly, 20 Timorese Nurse Anaesthetists and Instrument Nurses also participated.

"It is often said that following disappointment and failure, if properly managed with the appropriate changes instituted, great success will follow, and that's what this trip felt like," Mr Moore said.

"After the visit in November, where communication breakdowns meant that few people knew we were coming or the type of surgery we could offer, or the training we could provide, extensive discussions were held to see how we could make sure this was not repeated.

"The College staff in Dili were terrific and made sure TV and radio announcements were made while also going out to the regional centres to notify clinic staff of our date of arrival, scout for patients in need and assess those patients for surgery.

"Mr Sarmento and Dr Ximenes went out on motorbike to different centres to assess patients not just for our team visit, but for surgery in Dili or for treatment by other visiting teams later this year.

"All this meant that 126 patients turned up for treatment, with 40 wait-listed for future surgery.

"In addition, improved communication with the nursing staff within the hospital in Dili saw the best level of cooperation and interaction between the visiting team and local nursing staff for many years while the commencement of clinical attachment of Timor Leste Medical Students in the hospital added a further opportunity for teaching and training."

Mr Moore said that the increasing use of mobile phones in East Timor was now making it much easier to keep patients and their families informed of the team's arrival while a special effort had been made to better distribute posters explaining what conditions the team could treat.

More still to treat

Mr Moore said he believed, based on statistical and epidemiological evidence, that there remained a significant cohort of cleft lip and palate patients still untreated in East Timor and has designed a project to try to encourage such patients or their parents to seek treatment.

"We would expect in a population of one million people that there would be between 1,000 and 1,500 cleft patients," he said.

"We now have 750 on our data-base, which suggests there are still many people who either do not know that we can treat them, or who are afraid to seek treatment or cannot travel for surgery.

"I have suggested that with local medical students' help, we conduct a small study in a small village such as Same analysing the outcomes to patients and conducting a quality of life survey over five to ten years post-surgery to show both local people and funding agencies the difference this treatment can make.

"Even recently we treated a 17-year-old girl with a cleft lip and palate who had been hidden away because of shame who had never been to school so she, and other individuals like her, become a burden to an economically struggling society rather than a contributor.

"We should make extensive use of photographs not only as a pictorial measure of outcomes but as a way of advertising our surgical services.

"The before and after pictures are a really graphic way to explain what we can do, to assuage people's fear of the unknown and demonstrate that the patients look beautiful after only a 30 or 40 minute operation."

Mr Moore said he was also extremely pleased with the advances being made by Dr Ximenes, a general surgeon undertaking training in reconstructive surgery who did his first solo cleft lip and palate repair last year.

"Because I go back to 2000 in East Timor, I feel greatly privileged to see the local medical staff flourishing and to see them establish their own systems from Year Zero."

Mr Moore said the main themes of the International Forum of this year's ASC included discussions relating to the transitioning of aid to developing nations to allow for self sufficiency and the problems and advantages confronting surgeons in the Pacific region.

The more controversial subject discussed, however, remains taking trainee surgeons and medical trainees on international aid visits.

"There is a great deal of work going into this now, with the AMA and other medical colleges working on protocols to guide the use of trainees in international work," he said.

"Of course there are ethical issues, as people from developing countries deserve the best care possible, but I believe that if we can come up with clearly defined guidelines, trainee participation could represent benefits for all, because it will be the young doctors of today who will be leading teams in the future."

Communications Innovations – Fax Mentis and the FRACS brand


Royal Australasian College of Surgeons

Fax Mentis

The torch of the mind

Friday 29 April, 2011

In this issue

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- Launch of TGA's new website
- Urgent advice from the TGA regarding Pneumovax 23
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- Injury Prevention and Safety Promotion
- Australian Civilian Corps
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- Attention South Australian Fellows
- SET Selection – Stage 3 Online Referee Reporting
- Save with Member Benefits
- College media and advocacy
- Professional Development
- Upcoming events
- Surgical positions vacant
- In memoriam
- College staff

Contact Us
www.surgeons.org
fax_mentis@surgeons.org

Updated College survey policy

The College has introduced a new and more efficient way of dealing with the increasing number of requests for College members to participate in on-line surveys.

As of February 2011, RACS introduced an updated policy relating to the conduct of surveys within the College. This policy was introduced in order to prevent the administration of a large number of repetitive surveys to College members, and to ensure that Fellows' and Trainees' private information is protected. Read more ...

Roads to rural practice forum series

On 12 May 2011, the Victorian Department of Health are hosting the second forum on Enhancing specialist training opportunities in rural Victoria. The forum will be in Bendigo. The program is available on the Health workforce website.

Launch of TGA's new website - 4 May 2011

On 4 May 2011 the Therapeutic Goods Administration will be launching its new website. The TGA website receives on average 200,000 unique visitors every month, and is an important resource for all those interested in the regulation of therapeutic goods in Australia.

The redevelopment of the website has involved extensive consultation and testing with consumers, health professionals and industry. Read more ...

Urgent advice from the TGA regarding Pneumovax 23

The Therapeutic Goods Administration has released recommendations regarding the Pneumovax 23 vaccine. Reviews have shown an apparent increased rate of reactions following administration of the second dose. Read more ...

UPDATE: Health Insurance Amendment (Compliance) Act

The Health Insurance Amendment (Compliance) Act 2011 took effect from 9 April 2011.

The new legislation amends the Health Insurance Act 1973 and will provide Medicare Australia with the necessary powers to require health professionals to produce documents to substantiate claims made under the Medicare program. Read more ...

A snapshot of registered Health Practitioners

The Australian Health Practitioner Regulation Agency released figures this week of registered Australian Health Practitioners. See the website for details.

The College has introduced some important communications initiatives for Fellows

Keith Mutimer
Vice President

The College has recently added two new innovations to its suite of communications media. The first is a College e-newsletter, Fax Mentis, which is forwarded to you weekly, except those weeks in which Council Highlights appears. This is an important initiative, intended to consolidate and streamline the flow of information to you from the College.

A communications working party, established by the College in late 2009, identified the need for such a newsletter. Fellows had suggested to the working party that a single point of contact with the College was preferable to the flow of emails you were receiving from the various divisions of the College. Accordingly, most material once circulated in broadcast emails to various groups is now forwarded via this newsletter.

It is important therefore that Fellows keep up with the forthcoming events section of the newsletter. Details of upcoming events of interest, including opportunities for Continuing Professional Development, which might once have been sent to you by email, are now to be found here.

The newsletter also enables the College to keep you up to date on the Fellowship – those Fellows new to the College, those who have won awards or honours and, regrettably, those who have died.

You can also be kept apprised of developments at, and new opportunities offered by, the College's Library.

The College's latest media releases, and its advocacy efforts, can also be accessed via the newsletter.

With regard to the name of the newsletter, Fax Mentis, meaning "the torch of the mind" was chosen. This is taken from the College motto "fax mentis incendium gloriae", which is most simply translated as "the torch of the mind is the flame of glory".

It is important that the College has your latest email address – without it we cannot send you Fax Mentis and keep you abreast of developments at the College.

Feedback on the newsletter can be sent to fax.mentis@surgeons.org

The other initiative, launched at the Adelaide ASC, is the new FRACS brand.

FRACS
Fellow of the
Royal Australasian College of Surgeons

FRACS
Fellow of the
Royal Australasian College of Surgeons

While your College has protected the post-nominals FRACS, we have not actively branded or marketed the advantages to patients in ensuring that their surgery, and that of their loved ones, is performed by the best qualified practitioners in Australasia – those holding a FRACS.

With the many challenges now facing the College – cosmetic surgeons, podiatric surgeons, the post-Patel environment and others – it has never been more important to ensure that the public understands the many advantages of having their surgery performed by a FRACS qualified surgeon.

You will recently have received a CD containing several versions of the FRACS logo for your use on stationery, promotional material and the windows and partitions of your consulting rooms. We ask that you read and follow the guidelines to the use of the logo carefully.

If you have not received the CD, or have questions or concerns about the brand, please contact james.mcadam@surgeons.org

I trust Fellows find these initiatives of ongoing value to their work.

Covidien Travelling Fellowship Grant

Dr Daniel Novakovic was the recipient of the Covidien Travelling Fellowship Grant in 2009. He is currently practising as an Otolaryngologist, Head and Neck Surgeon in Sydney and recounts his North American experiences

Daniel Novakovic
2010 Grant recipient

My foray into laryngeal and pharyngeal surgery began with a six month rotation at the University of Toronto, Canada under the guidance of Dr Gullane and Dr Freeman. The Head & Neck Surgical department was impressive with seven full time academic surgeons spanning four hospitals.

My morning trip to work usually involved trudging through deep snow in scrubs, which were standard issue uniform for all hospital staff. Full days of operating theatre or clinic were supplemented by an extensive academic program with teaching rounds every day of the week.

I was exposed to the whole spectrum of complex head and neck procedures from skull base down to innominate artery along with advanced reconstructive techniques. Laryngeal oncological surgery was mainly open and usually after radiotherapy failure. Total and partial laryngectomies were often supplemented by regional or free tissue flaps to improve healing.

An open approach for access, resection and appropriate free flap repair was the rule of thumb for pharyngeal neoplasms and the experience gained was extensive. The Canadian day often ended with compulsory shovelling of snow to clear the pathway outside our house before a warming family hot chocolate.

The second part of my overseas fellowship training involved 12 months at the New York Centre for Voice and Swallowing Disorders at St Luke's Roosevelt Hospital in Manhattan. Employed by the hospital as an attending surgeon I ran a weekly clinic for people with state insurance, often with little or no English. With two physicians' assistants and extremely meagre resources we would see 50 to 60 people in a day.

Other days were spent in the private clinic seeing patients with Dr Blitzer or Dr Strome – mostly Laryngology or Head and Neck oncology. Due to hospital costs and long turnover time there was heavy emphasis on office based procedures. Vocal cord injection laryngoplasty, laryngeal biopsies and trans-nasal oesophagoscopy were performed routinely under local anaesthetic.

We were fortunate enough to have access to five different lasers and used them in the office to treat oral dysplasia and laryngeal lesions. Training with an endoscopic head and neck cancer surgeon, people would often present for consideration of minimal access treatment of their pharyngeal or laryngeal tumours.

My exposure to neurolaryngology was entirely new. We trained in diagnostic EMG and used it in conjunction with Botulinum toxin for a wide range of Head and Neck hyperfunctional disorders, often in the setting of a clinical trial.

I was fortunate to attend a number of meetings including two robotic surgery conferences. The concept of minimal access robotic surgery has recently rapidly gained popularity in the US with many centres adopting the technology for laryngo-pharyngeal oncological surgery as well as trans-axillary thyroid surgery. Seeing a video of an endoscopic transoral total laryngectomy ignited my interest in the field. With the support of the Covidien Travelling Fellowship Grant, I was able to explore this new technology in greater depth.

I visited Montefiore Hospital in New York to observe Dr Richard Smith performing a supraglottic laryngectomy and a tongue base resection. Some weeks later I visited the University of Pennsylvania to undertake formal robotic training under the guidance of Drs Weinstein and O'Malley. This comprehensive program included time in the extremely efficiently run outpatient clinic and time in the operating room observing equipment setup and live surgery.

In addition, there was a scheduled visit to the skills lab where hands-on experience was obtained using a porcine model. I felt the technology to be quite intuitive and was impressed with my efforts as an ENT surgeon in performing a laparoscopic live porcine nephrectomy in 45 minutes! A second skills lab session involved cadaveric training performing oropharyngectomy, tongue base resection and supraglottic laryngectomy exercises.

I returned to Australia with a new skillset and very fond memories of my time in North America. The opportunity to meet many of the world leaders in my specialty was also invaluable and has opened up a new professional network for life. My family also enjoyed the opportunity to live overseas and we also returned with an extra member in the form of an American son. I would like to thank Covidien and the College for their support and helping to make this unique learning experience possible.

Professional Development WORKSHOPS

Professional development is important as it supports your life-long learning. The activities offered by the College are tailored to needs of surgeons. They enable you to acquire new skills and knowledge while providing an opportunity for reflection about how you can apply them in today's dynamic world.

>Supervisors and Trainers for SET (SAT SET)
28 June, Sydney

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. Participants will learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. The workshop offers an opportunity to explore strategies to improve the management of trainees and focuses preparing for, conducting and reviewing a mid-term meeting. It is also an excellent opportunity to gain insight into legal issues.

>Keeping Trainees on Track (KToT) *NEW*
12 July, Melbourne; 13 July, Bendigo; 18 August, Queenstown

'Keeping Trainees on Track' is a new workshop in the 'Supervisors and Trainers for SET' (SAT SET) series. Over 3 hours it explores how to performance manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. Participants are also given the opportunity to learn methods for encouraging self-directed learning by establishing expectations at the start of term meeting.

>AMA Impairment Guidelines Level 4/5: Difficult Cases *NEW*
6 July, Brisbane; 26 August, Perth

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

>Process Communication Model (PCM) *NEW*
22-24 July, Melbourne; 26-28 August, Sydney

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

>From the Flight Deck: Improving Team Performance
29-30 July, Melbourne;

This two-day workshop is facilitated by an experienced doctor and pilot. It examines the lessons learned from the aviation industry and applies them to a medical environment. The program combines rigorous analysis of actual airline accidents and medical incident case studies with group discussions and an opportunity to use a full-motion airline training flight simulator. You will learn more about human error and how to improve individual and team performance.

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.

2011 DATES:
JUNE – OCTOBER

NSW

>28 June, Sydney
Supervisors and Trainers for SET (SAT SET)

>8 August, Sydney
Surgeons and Administrators: Working Together to Bridge the Divide

>26-28 August, Sydney *NEW*
Process Communication Model

>TBC, Sydney
Occupational Medicine

>19 October, Sydney *NEW*
Keeping Trainees on Track (KToT)

>20-22 October, Sydney
Surgical Teachers Course

QLD

>6 July, Brisbane
AMA Impairment Guidelines Level 4/5: Difficult Cases

>5 September, Brisbane *NEW*
Keeping Trainees on Track (KToT)

>1 October, Brisbane
Building Towards Retirement

>19 October, Brisbane
Writing Medico Legal Reports

TAS

>23 September, Hobart *NEW*
Keeping Trainees on Track (KToT)

VIC

>25 June, Melbourne
Making Meetings More Effective

>12 July, Melbourne
Keeping Trainees on Track (KToT)

>22-24 July, Melbourne *NEW*
Process Communication Model

>29-30 July, Melbourne
From the Flight Deck: Improving Team Performance

>13 September, Melb *NEW*
Keeping Trainees on Track (KToT)

WA

>26 August, Perth
AMA Impairment Guidelines Level 4/5: Difficult Cases

>21 October, Perth
Polishing Presentation Skills

NZ

>17 August, Auckland
Keeping Trainees on Track (KToT)

>1-3 September, Auckland
Surgical Teachers Course

A passion for patient outcomes

At the recent ASC in Adelaide Associate Professor Leo Pinczewski was presented with one of the College's most prestigious awards

The College's most prestigious accolade – the Award for Excellence in Surgery – has been bestowed upon Associate Professor Leo Pinczewski, a Sydney-based orthopaedic surgeon and recognised world leader in knee reconstruction surgery.

The award, presented upon only nine occasions in the past two decades and the first to an orthopaedic surgeon, is given to surgeons or surgical units who have demonstrated the highest level of surgical achievement by world standards and who have provided a prolonged and sustained contribution to the art and science of surgery.

Previous recipients include Professor Graeme Clark for the development of the Cochlear Implant and Sydney neurosurgeon Professor Chris O'Brien.

Associate Professor Pinczewski commenced orthopaedic practice in Sydney in 1984, becoming a Visiting Medical Officer at the Mater Private Hospital where he has built a reputation for excellence. He is recognised internationally for his research and development in the field of knee surgery, with the highest level of surgical achievement in the area of anterior cruciate ligament (ACL) reconstruction.

In 2009, he performed his 10,000th ACL reconstruction, a significant milestone in surgical experience by international standards.

His research, which has resulted in more than 40 articles published in international journals of Orthopaedics and Sports Medicine, has enabled the refinement of surgical techniques, while his innovations have resulted in new procedures and equipment to enable the advancement of knee surgery.

According to the Citation provided by College Fellow Dr Justin Roe and delivered at this year's Annual Scientific Congress in Adelaide, Associate Professor Pinczewski has been awarded the Evelyn Hamilton Trust Memorial Prize for best scientific paper at the Australian Orthopaedic Association Scientific Meeting on three occasions and the inaugural AOA research award. He continues to present extensively at international forums and publish his research in peer reviewed journals.

"As Co-founder of the North Sydney Orthopaedic and Sports Medicine Centre, Leo Pinczewski has provided leadership in the field of Orthopaedics and Sports Medicine, supervising and instructing over 75 international Orthopaedic Fellows, Australian Fellows, registrars and PhD students," the Citation reads.

Daughter Rachel, Leo and his wife Liz.

"In 2009, Associate Professor Leo Pinczewski performed his 10,000th ACL reconstruction, a significant milestone in surgical experience by international standards"

"He currently holds a clinical associate professorship with the University of Notre Dame, Australia, and teaches postgraduate medical students. Currently he holds esteemed memberships nationally and internationally in various Orthopaedic and Sports Medicine associations.

"His commitment to his patients is shown through the considerable time that he commits to their care (and) the high quality of his work is reflected in the numbers of patients that seek his advice and expertise on a weekly basis. He will continue to influence the development of surgical techniques with his experience and research into the future and these characteristics and his exceptional surgical expertise have made him well suited to receive the award of Excellence in Surgery."

Speaking to Surgical News after receiving the award, Associate Professor Pinczewski described it as the highlight of his career and completely unexpected.

"The first I heard about this was when I was working at a country clinic and I was asked to call the College," he said.

"The hairs on the back of my neck stood up and I wondered what had gone wrong so to hear of the award was a nice surprise."

Associate Professor Pinczewski said the award meant a great deal to him given the absence of a public hospital or university appointment. Instead, he said, he worked to make the Mater Private Hospital a centre of excellence in the field of orthopaedic surgery.

"Initially we established training posts for medical students, then orthopaedic surgical training and were one of the first hospitals to do that in the private sector," he said.

"Then we developed a world renowned post-Fellowship training program to teach international surgeons.

"This award is significant to me because it reflects peer recognition for the work that my team performs, in particular for our commitment to quality patient care."

Associate Professor Pinczewski did his own training at the Royal North Shore, Mater, Concord Repatriation and Royal Prince Alfred Hospitals and in 1982 he undertook overseas training in rheumatoid surgery in Edinburgh.

Initially trained as a hip surgeon and unable to secure a place in such a specialist unit, he took the opportunity to work with knee specialist Dr Mervin Cross.

He said that receiving the American British and Canadian (ABC) Travelling Fellowship in 1992 had been a watershed in his career.

"This was a six-week travelling Fellowship which allowed me to visit all the top units and meet the people who wrote the text books," he said.

"It was an eye-opening experience in a way to find they were very normal people, very caring and very dedicated, but that along with that they were totally committed to research.

"When I returned, I began my research work, initially simply in order to understand the surgical outcomes for my patients. The introduction of computers at that time made this possible in that you didn't need the resources of a university to compile useful data and it meant that we were in a position to question how outcomes could be improved.

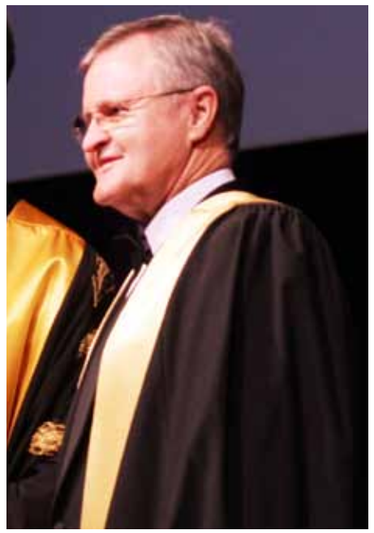
"Out of those questions, came the development of a new operation of soft-tissue grafts for knee reconstructions, such as using the hamstring tendons and conducting the procedure with an arthropscope when most other units were still doing open surgery."

Associate Professor Pinczewski said the challenges still ahead continued to lie in improving patient outcomes.

In particular, he said his team was now working on new techniques to reduce post-operative pain, new methods to reduce blood loss in joint replacement patients and the surgical management of patients on anti-coagulant medication.

"There is always something new to discover or improve and I remain keen to explore and unravel the inconsistencies we still see in patient outcomes; the mysteries of the human body you could say."

With Karen Murphy



Congratulations on your achievements

Members of the Court of Honour are chosen from those who show continuing personal interest in the College. The Court exists both to honour its members and to provide advice to Council.

PROFESSOR IAN GOUGH FRACS
Induction into Membership of the Court of Honour

I have the privilege of presenting Professor Ian Gough for admission into the Court of Honour.Professor Gough undertook his medical training in Brisbane and graduated MBBS with Honours from the University of Queensland in 1970. Ian's house officer years were completed at the Princess Alexandra Hospital, Brisbane before he left for the UK where he completed his early surgical training culminating in the award of the FRCS Edinburgh in 1975. On return to Brisbane, he completed the requirements of our College and obtained his Fellowship in General Surgery in 1976. His career took an academic track with lectureship, associate professorship following in turn and appointment to a full academic professorship being achieved in 1991.

Ian's clinical area of special interest is breast and endocrine surgery and he has numerous achievements in this area. He has been head of the Endocrine Unit at the Royal Brisbane Hospital since 2003. Professor Gough has been Visiting Professor to overseas institutions no less than 30 times, has authored over 100 peer reviewed publications and has delivered nearly 200 presentations. He has also filled many other leadership and service roles within surgery in his hospital, in Queensland, in Australia and on the world scene.

"Ian's clinical area of special interest is breast and endocrine surgery and he has numerous achievements in this area"

Council times

Professor Gough was first elected to the College Council in 2002. However, even at that stage he had provided extensive service to the College. Ian was a member of the Queensland State Committee for 12 years, a member of the Board in General Surgery for nine and Chairman for two; an examiner in General Surgery for 10 years and Senior Examiner for three. After election to College Council he was rapidly elected to important roles within the Education portfolio. He was firstly Deputy Censor-in-Chief then Chairman of the Board of Specialist Surgical Training, followed by Chairman of the Court of Examiners and Censor-in-Chief before being elected Vice President in 2007. Professor Gough then was elected President of the College, serving from 2008-2010.

Despite a life full of scholarly achievement and professional leadership, Ian maintains many active interests outside medicine. His family are particularly important although may not fully qualifying as 'an interest outside medicine'. Ian's wife, Ruth is a psychiatrist and his elder daughter Jenny, a Fellow of this College. However his other interests, in particular fishing and golf, are never far from his thoughts.

Any brief citation such as this will fail to do justice to the achievements of a remarkable man full of service to surgery and to this College. I have no hesitation in presenting Professor Ian Gough for admission into the Court of Honour.

Citation kindly provided by Ian Civil

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 Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to twelve months.

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

If you would like to be contacted by the College if the need for accommodation in your area arises, please register your details by contacting the International Scholarships Secretariat on the details below. We are currently seeking accommodation in Melbourne, Geelong, Sydney and Adelaide for visits in the latter half of 2011 and 2012. We would love to hear from you!

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

Restrictive trade practices

With the commencement of the Competition and Consumer Act 2010 (Cth) ("Act"), which replaced the Trade Practices Act 1974 (Cth), at the start of this year, it is an important time to review Australian competition laws and how they apply to the practice of medicine

> *"The laws preventing restrictive trade practices apply equally to practitioners who conduct their practice through a company as they do to those who practice in their own name"*

Michael Gorton
College Solicitor

The medical profession has often come under the scrutiny of the Australian Competition and Consumer Commission (ACCC) in relation to restrictive trade practices. Anti-competitive arrangements in the medical market have been the subject of numerous ACCC prosecution cases over the past five years, the most recent concluding in October last year. Penalties imposed for such conduct have ranged from being required to give undertakings to having to pay fines of up to $55,000.

The legislative provisions that prohibit restrictive trade practices (found in Part IV of the Act) are numerous and lengthy, however, they all operate to prevent one thing: collusive conduct between suppliers of goods or services to reduce or eliminate competition between them. Whilst the provisions in the Act apply primarily to corporations, equivalent legislative provisions applicable to individuals exist in each state. Consequently, the laws preventing restrictive trade practices apply equally to practitioners who conduct their practice through a company as they do to those who practice in their own name.

The following is a brief summary of three types of conduct that are prohibited by the Act, which have particular bearing on medical practitioners.

Cartel conduct – Division 1, Part IV of the Act

A cartel provision is a provision in any contract, arrangement or understanding to fix prices, allocate market share (either geographically or by classes of consumers) or restrict the operation of any of the parties. The arrangement is made between parties who would otherwise be in competition with each another. Corporations are banned from entering into any arrangement containing a cartel provision or giving effect to such a provision, whether or not they were a party to the arrangement. Cartel conduct is considered a serious offence under competition law. A finding of guilt for cartel conduct attracts criminal prosecution with a maximum sentence of 10 years, plus individual fines of up to $10,000,000.

There were previous allegations of cartel conduct made against CSL and its major competitor, Baxter International, in late 2009. A small, publicly owned hospital in the US commenced a class action against the two companies, alleging they colluded to prevent oversupply of blood plasma products in order to increase prices. Although the action was brought in the US, such conduct here would be considered cartel conduct, and therefore criminal behaviour.

Cartel conduct can also occur on a much smaller scale. Something as simple a group of independent GPs all agreeing to only see a limited number of patients a day, thus allowing each to charge more for each consult, would infringe the prohibition on cartel conduct.

Anti-competitive conduct – Division 2, Part IV of the Act

A corporation is banned from making a contract or agreement, or arriving at an understanding, that has or would be likely to have the effect of substantially lessening competition in the market. The Australian courts have accepted the provision of medical services in a specialised field constitutes a 'market' and as such the Act applies to medical and surgical practices.

October last year saw the conclusion of an ACCC investigation into conduct dating back to the early 1990s by St Vincent's Private Hospital, Sydney, and its Department of Anaesthesia. The ACCC investigated allegations of an anti-competitive arrangement between the private anaesthetists in the department where they had allocated among themselves all permanent anaesthetic work at the hospital. The ACCC concluded that the conduct alleged is likely to have constituted anti-competitive conduct. However, rather than take the matter to trial, the ACCC accepted court enforceable undertakings from the responsible entities. The hospital and the department have now undertaken (among other things) that the hospital, not the department, will allocate the permanent work and that the hospital will conduct trade practices law compliance training.

Secondary boycotts – Sections 45D to 45DD of the Act

Conduct by parties acting in concert to hinder or prevent another party from being able to supply its goods or services is prohibited under section 45D of the Act. Similarly, conduct by parties acting in concert to substantially lessen competition from another party is also prohibited. This conduct is termed 'secondary boycotting'. If two or more of the parties engaged in the secondary boycotting are employed by the same organisation, that organisation is deemed to also be a party to the conduct. Any loss or damage caused by the secondary boycotting will be attributed to the employer organisation and proceedings can be brought against it (rather than the parties). This is likely to occur where the amount of damage caused is beyond the means of the individual parties to compensate.

In the case of Australian Competition and Consumer Commission v Knight [2007] FCA 1011, the respondents, two surgeons from South Australia, had allegedly determined to prevent a junior cardiothoracic surgeon from entering practice without first undertaking further training. The respondents claimed their actions were based on a belief that, as the junior surgeon had not completed his 18 month overseas placement, he was not competent to perform surgery unsupervised. The Court found, however, that as the junior surgeon was legally qualified to supply his services, the respondents' conduct amounted to "entering into an arrangement containing provisions that would have been likely to have the effect of substantially lessening competition in the market". Although determined under South Australian laws, the alleged behaviour of the two respondents would be considered secondary boycotting under section 45DA of the Act.

Conclusion

Despite restrictive trade practices being prohibited in Australia by legislation for some 35 years, it appears that knowledge about the practical application of these laws to the medical profession is regrettably uncommon. The above examples are merely a glimpse of the operation of these laws. It may be beneficial for colleges, practices and hospitals to conduct competition law compliance training for their practitioners. This would help prevent practitioners from facing severe penalties for engaging in seemingly innocuous behaviour, such as agreeing not to compete with one another in certain geographical areas or agreeing to charge the same rate for services. Medical practitioners should therefore avoid any collusive conduct that has the effect of:

1> preventing patients from having reasonably unfettered choice in who to engage for medical services, such as agreeing to refuse to practice in nominated hospitals;
2> standardising their practices' operations, such as agreeing upon set working hours, numbers of patients seen per day or rates for services;
3> dividing work between themselves in a way that is designed to prevent practitioners having to compete for patients, such as by geographical area or by patients' personal attributes;
4> or hindering other legally qualified practitioners from practicing freely; and
5> any other conduct which is likely to substantially reduce competition between practitioners in the medical market.

The court at the latest meeting in Melbourne.

Are we changing the Fellowship examination?

No, but its reliability and validity are being improved

Spencer Beasley
Chair, Court of Examiners

Fellows are well aware of the close scrutiny under which first the ACCC and then the AMC have placed the College and its processes. At times, this had caused the College to change what it does, admittedly (albeit painfully) sometimes for the better. Various jurisdictions have reviewed our assessment processes, including the Fellowship examination, and because of this there has been uneasiness by some of our fellows that, as a result, we may be obliged to make significant changes to our Fellowship examination. Fortunately, that is not the case.

In short, the fellowship examination has been awarded a clear nine, and will remain pretty much in its current form. There is agreement that an exit examination has an important role and should remain. From the candidates' perspective the examination will appear to be no different, except that they will have the added confidence of knowing that its reliability and validity are being improved. They can also gain some comfort in knowing that what they will be questioned on in the future is more appropriate for a true exit examination, particularly in the areas of the clinical application of knowledge and professional judgment.

For the examiners there is little change either. It is business as usual in terms of the format, although some of the tools are being modified to keep up with technology. Snowy and opaque pathology pots that leak if not held upright have gone, and it is now more likely that examiners will be seen sitting (in a relaxed and non-threatening way, of course) on either side of a candidate discussing some images on a computer screen. But the basic format – with some minor specialty differences – remains two written papers and five vivas.

Behind the scenes, however, there are some changes occurring, mostly related to standard setting and improving the reliability and validity of the examination, in all its components. And for this to be achieved, data are required.

Information is collected about the scope of material tested in relation to the syllabus and surgical competencies, the level of cognitive function at which it is being tested (as an exit examination, basic knowledge is assumed, but the application of that knowledge is more critical), and how each examiner marks.

The standard setting process is being consolidated and improved. These initiatives will enhance the reliability of the examination by making it more consistent and by reducing inter- and intra-examiner variability. Also, they will increase the exam's validity in ensuring that it actually tests what it sets out to test. The underlying goal remains: it is to ensure that all surgeons who are successful in this examination are at the same high standard as their predecessors, and safe to practice without supervision.

Introducing the Rural Coach Project

The College aims to help Trainees and Fellows move into rural surgery

Cathy Ferguson
Chair Fellowship Services Committee

The College recently launched a new project, Rural Coach, as a means to give support and assistance to surgical trainees who are considering working in rural Australia in the future. As is widely recognised, many of our country towns and regional areas are in great need of increased levels of specialist surgical care – a problem that looks only to worsen in the coming years. The Rural Coach Project is seeking surgical trainees who are interested in helping to bridge this gap.

According to the 2010 Royal Australasian College of Surgeons' Surgical Workforce Report, 41 per cent of all active Fellows are aged 55 years or over, and 24 per cent of Fellows indicated their intention to retire from public on call rosters within the next five years. The proportion of non-metropolitan general surgeons in Australia intending to retire is higher still, at 27 per cent, and therefore it is possible that a workforce shortfall will develop across country Australia, if it doesn't already exist. Most of us would appreciate the urgent need to increase the throughput of appropriately trained new surgeons to rural areas.

The College has been a vocal advocate of improvements to rural surgical services across the country and in pursuing Australian Federal Government programs beneficial to the rural workforce. Recently, Rural Coach was launched as part of the Commonwealth's new Specialist Training Program (STP), which aims to expand the skills development of medical specialist trainees in settings beyond traditional training hospitals. Rural Coach focuses on some of the challenges facing the rural Australian surgical workforce, by delivering a number of support services to those surgical trainees who are considering rural surgery as a viable career avenue.

Associate Professor Francis Miller, an experienced rural surgeon based in Wangaratta and Clinical Director for the project, states that Rural Coach services may include anything from financial support to attend relevant courses or meetings – for example, the Provincial Surgeons of Australia (PSA) conference – advocacy for and assistance in gaining good training positions, or simply providing trainees with someone knowledgeable and understanding to talk to about their career development and opportunities.

It should be emphasised that Rural Coach will not deliver additional training. Rather, the professional support and career development opportunities delivered to participating trainees are aimed at facilitating a smoother and more rewarding transition into surgical practice within rural Australia. Certain services may prove invaluable, in particular attendance at the Provincial Surgeons of Australia (PSA) meeting. As the most important gathering of rurally based specialists in Australia, any trainee considering rural surgical work cannot afford to miss out on attending. Nor could one argue with the value in the networking opportunities such meetings provide, or the merit in having an additional surgical mentor at the end of a phone call or email. By supporting those trainees who are considering practising in country Australia, Rural Coach hopes to contribute to a new generation of confident and experienced surgeons, and to the sustainability and resilience of the rural surgical workforce.

A/Prof Miller believes that although the prospect of finding and training enough surgeons to ensure a sustainable workforce may seem a tall order, the attraction of the work itself, recognition by society of the importance of surgical care for all citizens, and the goodwill of surgeons ready to assist, will see the process through.

Trainees interested in working in rural Australia, or in learning more about the Rural Coach project, are encouraged to contact the College via the Rural Coach Project Officer – trish.meldrum@surgeons.org

You can't kid a kidder

Where did you get that word "Chapess" R.U. Kidding (Surgical News Vol 12, No 3)? Is this the equivalent of a "Guyess"?

Feminists at least north of the border have long appropriated the term "guy" as being gender neutral. The same should apply to words like chap, mate, bloke, friend, fellow and other similar collective nouns.

You appear to be giving a "nod" in the direction of gender equality, but you are actually, I think, reinforcing a distinct gender specific line.

I do not walk that line myself as you will have noted. I am a "Jay Walker".

Dr John B Walker
MBBS (SYD) DLO (LOND)
FRCSED, FRCSE, FRACS

Response from Professor Kidding

Dear John,
I am very grateful for your excellent letter (I do hope that you do not mind me addressing you so informally). It is a relief, whenever I receive correspondence, to know that at least a few people read my meagre contribution.
Ulysses
(U.R. Kidding)

Surgical Services

Poison'd Chalice

To choose or not to choose – is that really the question?

Professor U.R. Kidding

I have long since realised that Directors of Surgery attend meetings – lots of meetings! In common with all the surgeons I know, the idea of a 'talk-fest' is about as palatable as a colonic washout.

Of course there may be benefits of clarity of thought and peace of mind to be derived from having a spotless descending colonic mucosa but I am pleased to declare that I have no personal knowledge.

When the invitation to attend a Department of Health forum for Surgical Directors from around the state arrived, I began to formulate the development of a "last minute emergency" requiring my attendance – lame maybe, but understandably legitimate.

Alas, my plans unravelled when I was contacted by my CEO with warnings that the Department was a wake up to me and they had been mentioning my name as a virtual appointment... Sharpishly I had hung up the phone, mumbled and decided that perhaps I had better attend.

The forum was on the changes to the requirements for selection processes and credentialing for surgeon appointments. The Department was really going to be looking closely at it. Apparently ACHS was still worried about Dr Patel and the detailed selection and review requirements were now mandatory.

Glad someone is worried about it, because if you looked at issues like AHPRA, the Medical Board of Australia and Senate Enquiries you could believe that standards were always going to be the second and poorer cousin to "just give me someone who can cut".

There seems to be the prevailing view driven by the bureaucrats that any surgeon is better than no surgeon. Of course the bureaucrats are driven by their political masters who don't want their constituents deprived of easy access to surgical care. Whatever happened to Hippocrates' "primum non nocere"? But then again politicians are not required to take or even know the Hippocratic Oath.

Sitting next to me was a colleague from a more regional if not remote area of the state. He was equally bemused by all of this, but for entirely different reasons. His predicament was the total lack of locally trained medical practitioners of any type and the endless bureaucracy of area of need, visas, and assessment processes. He didn't sound very happy about it...

I must admit I always preferred the selection process where the conclusion of "He (she) is a jolly good chap (chapess)" was enough of an answer. Was the nepotism system really that bad? Are our current selection procedures really going to improve the quality of surgeons in the future? Best of all, if a trainee was not working out, if a surgical career was clearly not for them, you could get rid of them.

Now we are embroiled in a legal system much more interested in the rights of the individual than the future welfare of the unsuspecting society that will be subject to their detected ineptitudes. Where is the balance between standards of care, individual rights and access to care? Maybe we shouldn't be seeking a balance at all?

But dutifully I tried not to let my mind wander and watched the PowerPoint slides on the correct policies and procedures to make it all work and reliably select the best candidate. As the Bard reflected in The Merchant of Venice, 'All that glisters is not gold'. Then they discussed the Appeals process that is needed to try and prevent any court action. Oh great, will really love having to talk to the lawyers about our decisions.

So we got beyond the correct medical degree, the approved specialist qualifications, the currency of practice, the mandatory CPD and insurance status. Job done, I thought. But no, how do we make sure that the scope of practice is clearly understood and defined. Not only that, but how is it checked on an ongoing basis with annual reviews and confirmation that the scope of practice matches the training and currency of practice of the individual, but also the infrastructure and support teams in the hospitals? Isn't the ordeal of achieving a FRACS enough? Clearly not in this brave new world.

One occasionally hears of the adventurous doing Whipples or oesophagectomies or complicated fracture repairs in places where triage and transfer would have been a better decision. But isn't this the role of adverse event meetings, morbidity and mortality meetings and audit. Isn't this what peer review is meant to be about?

It occurred to me that the process overall is perceived not to be working. As I drifted further into my own dream world, I had the uneasy realisation that peer review – the constructive questioning by peers of one's management of a patient – has either been lost or never been properly achieved.

Is it possible to discuss how things might have been done better or are surgeons now so competitive, so ego protective that such analysis and accountability is no longer possible? If so, our independence as a profession is going to be threatened – the manifestation of which is the very forum that I find myself embroiled in. I resolved to discuss this at the next Heads of Unit meeting.

Perhaps my colleague from the buds had it easier. He could hardly keep his hospital staffed and they rarely stayed more than two years...

Surgical News PAGE 7 April 2011

In Memoriam

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

>Max Clifford Moore,
SA Ophthalmologist

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

Informing the College

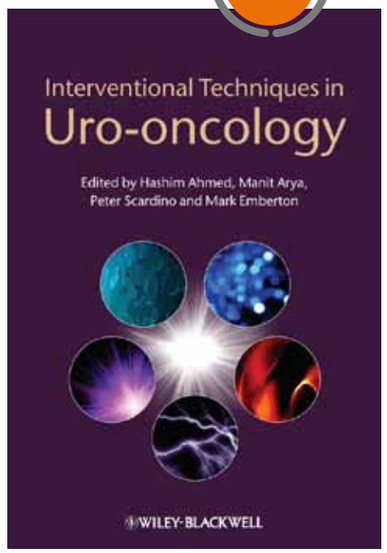
If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office. They are

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

Welcome to the Surgeons' BOOKCLUB

Highlighted in this month's issue are recent and new titles from across the spectrum of books available from John Wiley & Sons.

BOOK OF THE MONTH 25% Discount



Interventional Techniques in Uro-oncology

Manit Arya, Hashim Uddin Ahmed, Peter Scardino, Mark Emberton (Editors)
9781405192729 | Hbk | 208 pages | April 2011
~~AU$200.00~~ **/ AU$150.00**

Minimally invasive surgical techniques are moving into the mainstream of urological practice. Even less invasive techniques, some of which can involve no use of the knife whatsoever, are rapidly being developed and implemented for treating urological cancer. Interventional Techniques in Uro-oncology is the first text to cover these techniques in total and provides a comprehensive review of the state-of-the-art minimally invasive interventions.

This well-illustrated reference provides the basic science behind each technique before explaining when and how best to perform them. It examines their use in different clinical settings, the advantages and disadvantages of each technique in the management of specific tumor types, and their suitability for different patients. Future techniques are discussed including the potential of nanotechnology in the delivery of urologic healthcare. Each chapter is easy to navigate with key points and references.

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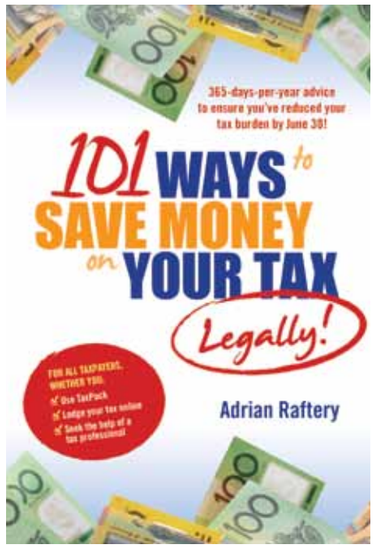

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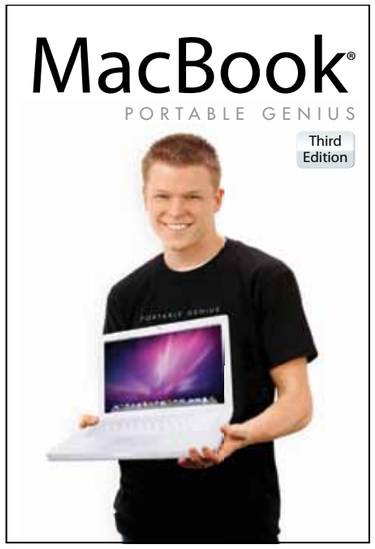

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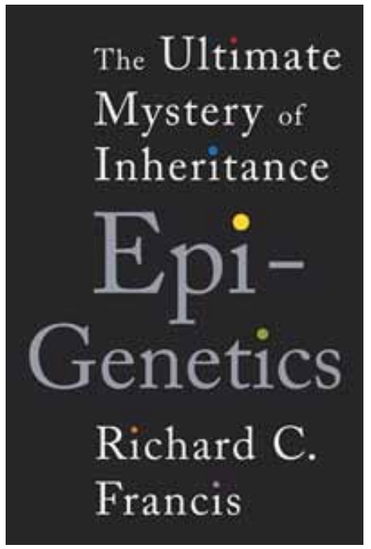

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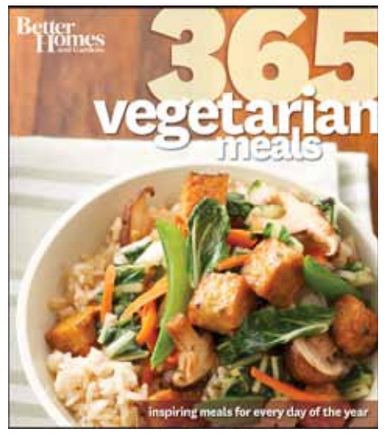

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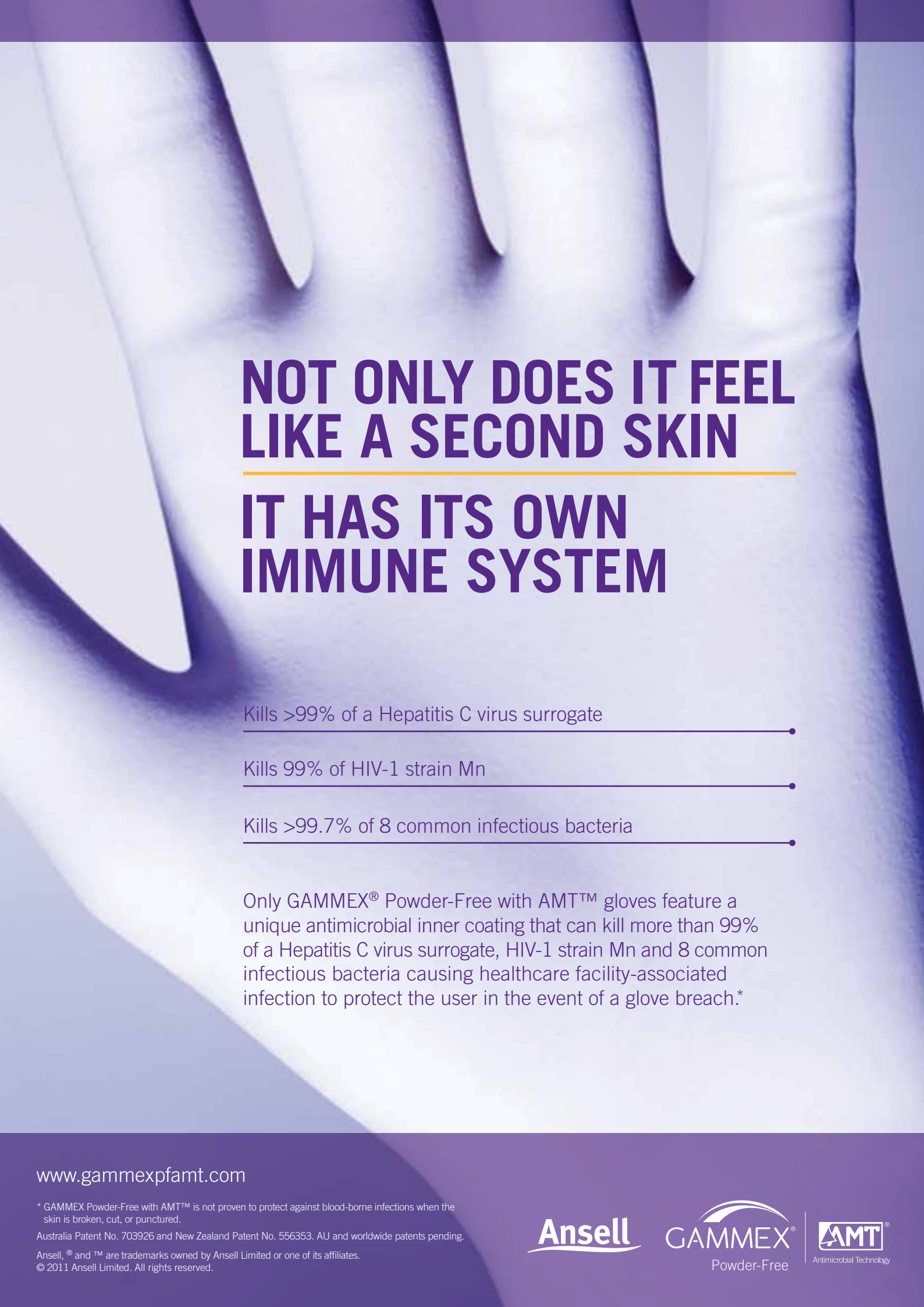

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