SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 15 NO 5 / JUNE 2014

Bright lights of Congress

Singapore 2014 ASC dazzles

The College of Surgeons of Australia and New Zealand

2014

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Keeping Trainees on Track (KTOT)

24 June, Adelaide; 29 July, Brisbane; 16 August, Perth

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Writing Medico Legal Reports

24 July, Brisbane

This 3 hour evening workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This ability is one of the most important roles of an expert adviser. This activity is proudly supported by mlcoa.

Non-Technical Skills for Surgeons (NOTSS)

5 August, Sydney; 23 September, Auckland; 24 October, Launceston

This workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues. This activity is proudly supported by Avant.

Clinical Decision Making

6 August, Sydney

This three hour workshop is designed to enhance a participant's understanding of their decision making process and that of their trainees and colleagues. The workshop will provide a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes.

Management of Acute Neurotrauma

7 August, Perth (the day before the WA, SA & NT ASM)

You can gain skills to deal with cases of acute neurotrauma in a rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, you can learn these skills using equipment typically available in smaller hospitals, including the Hudson Brace. This activity is proudly supported by RHCE.

Strategy and Risk Management for Surgeons

7 August, Brisbane

This whole day workshop is divided into two parts. Part one gives an overview of basic strategic planning and provides a broad understanding of the link between strategy and financial health or wealth creation. It introduces a set of practical tools to monitor the implementation of strategies to ensure their success. There is also an introduction to a committee's and board's role in risk oversight and monitoring.
Part two of the course focuses on setting strategy; formulating a strategic plan, the strategic planning process, identifying and achieving strategic goals, monitoring performance, and contributing to an analysis of strategic risk. You will have an opportunity to explore risk for an organisation and learn how to monitor and assess risk using practical tools. This activity is proudly supported by Bongiorno National Network.

AMA Impairment Guidelines 5th Edition: Difficult Cases

13 August, Sydney

The American Medical Association (AMA) Impairment Guidelines inform medico-legal practitioners as to the level of impairment suffered by patients and assist with their decision as to the suitability of 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 3 hour evening seminar compliments the accredited AMA Guideline training courses. The program uses presentations, case studies and panel discussions to provide surgeons involved in the management of medico-legal cases with a forum to reflect upon their difficult cases, the problems they encountered, and the steps they applied to satisfactorily resolve the issues faced. Please note: Fellows will still need to attend AMA training to be accredited to use AMA guidelines. This activity is proudly supported by eReports.

Global sponsorship of the Royal Australasian College of Surgeons' Professional Development Program has been proudly provided by Avant Mutual Group, Bongiorno National Network and Applied Medical.

Supervisors and Trainers for SET (SATSET)

16 August, Perth

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can 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. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. *This workshop is also available as an eLearning activity by logging into the RACS website.*

Preparation for Practice

23 to 24 August, Melbourne

This two day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice. This activity is proudly supported by the Bongiorno National Network, mlcoa, Rooms With Style and MDA National.

workshop

July-October

QLD

24 July, Brisbane
Writing Medico Legal Reports,

29 July, Brisbane
Keeping Trainees on Track (KTOT)

7 August, Brisbane
Strategy and Risk Management for Surgeons

25 to 26 October, Brisbane
Preparation for Practice

28 October, Gold Coast
Non-Technical Skills for Surgeons (NOTSS)

29 October, Brisbane
Clinical Decision Making

SA

24 June, Adelaide
Keeping Trainees on Track (KTOT)

1 to 3 August, Adelaide
Process Communication Model Part I

VIC

6 June, Melbourne
National Simulation Health Educator Training Program (NHET-Sim)

23 to 24 August, Melbourne
Preparation for Practice

9 September, Melbourne
Keeping Trainees on Track (KTOT)

29 September, Melbourne
Academy Educator Studio Session

NSW

5 August, Sydney
Non-Technical Skills for Surgeons (NOTSS)

6 August, Sydney
Clinical Decision Making

13 August, Sydney
AMA Impairment Guidelines 5th Edition: Difficult Cases

5 to 7 September, Sydney
Process Communication Model Part II

25 September, Sydney
Polishing Presentation Skills

18 October, Newcastle
Keeping Trainees on Track (KTOT)

18 October, Newcastle
Supervisors and Trainers for SET (SAT SET)

WA

7 August, Perth
Management of Acute Neurotrauma

16 August, Perth
Supervisors and Trainers for SET (SAT SET)

16 August, Perth
Keeping Trainees on Track (KTOT)

NT

24 August, Darwin
Management of Acute Neurotrauma

NZ

21 to 23 August, Auckland
Surgical Teachers (STC)

23 September, Auckland
Non-Technical Skills for Surgeons (NOTSS)

21 October, Wellington
Supervisors and Trainers for SET (SAT SET)

22 October, Wellington
Keeping Trainees on Track (KTOT)

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REGULAR PAGES

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ON THE COVER:
The ASC 2014 Exhibition Hall, p 12

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BUZZ IN SINGAPORE

The 'buzz' of the meeting was palpable … Opportunities were in abundance

Final plenary on Surgeons of the 21st century – professionals, technicians or tradesman with Sir Bruce Keogh and John Harris.

Some key presentations help us to reflect on the time we are in

MICHAEL GRIGG
PRESIDENT

The Annual Scientific Congress in Singapore was an outstanding success. A combined meeting with the College of Anaesthetics saw 4500 enthusiastic delegates attend an incredible array of specialty discussions and have the opportunity of engaging with high-quality plenaries. The 'buzz' of the meeting was palpable – maybe it was the size; maybe because it came together brilliantly despite its complexity; maybe it was the off-shore destination that gave people more 'space' to embrace the professional development and the social networking. Opportunities were in abundance.

The ASC 2014 also saw the return of Orthopaedic Surgery to have a formal and dominant role in the meeting. Many thanks to Martin Richardson, Orthopaedic Surgeon from Melbourne who as the ASC Convenor for the meeting along with Sayed Hassen as the Scientific Convenor saw 30 separate programs being delivered. They were supported by a large team of scientific convenors.

To follow the orthopaedic theme, Richard Lander, previous President of the NZOA was Orthopaedic Convenor, Kanwaljit Soin, prominent Singapore Orthopaedic Surgeon gave the most prestigious College address, the Syme Oration, at the Convocation and Keith Willett, Professor of Orthopaedics at Oxford University delivered the President's lecture. Such was the success of the Orthopaedic program, planning is now underway to see the program develop for the Perth ASC in 2015. The College does indeed embrace the unity of surgery.

There were many themes for the Congress and I wish to highlight a small number. Dr Soin's presentation (which is available through the Virtual Congress) highlighted standards of excellence, stewardship and self-actualisation for surgeons. In presenting a cogent case for the criticality of these areas, Dr Soin highlighted many of the attributes for the successful surgeon including commitment, focus, mental readiness, distraction control and constructive evaluation – those attributes that not only assume technical competence, but also go well beyond it. It was summarised by Mike Hollands in his address to the convocation of aspiring for excellence, but also extending that to wisdom itself. But beyond the individual requirements of excellence and wisdom there was much discussion during the week about the ongoing complexity of the interactions between professionals and particularly between surgical professionals and society.

Self-regulation and stakeholders

There is increasing importance that surgeons understand that our ongoing autonomy depends on much greater responsibility for self-regulation. This is not only an individual requirement, but critically one of the profession itself. At the same time being actively involved in the broader healthcare discussions is vital. Professor Willett's lecture on 'If it's about quality and cost; let us run healthcare' provided ample evidence of the importance for leadership by clinicians. Significant changes have occurred in the NHS because of the work by Professor Willett and others.

Michael Hollands presnting his final Convocation and Welcome Ceremony. Left: New Fellows recite their pledge.

I had the pleasure of being personally involved in the plenary addressing issues of 'Surgeons of the 21st century – professionals, technicians or tradesman'. Sir Bruce Keogh, Medical Director of the NHS, delivered the BJS Lecture and John Harris the ANZJS Lecture. Sir Bruce looked into the future and described a digital age where it would be increasingly difficult to distinguish a surgeon by what he or she did. My thought was that surgeons will continue to be recognisable, but by the quality of their training more than their actual activity. He warned, and I would agree, that over-valuing technical competence would likely result in eventual obsolescence.

There is a reality that there has been a decline in the moral authority for the surgical profession. It was a common theme. We all addressed the issue of what I termed the change in the social contract. Our profession is confronted by three substantial external challenges and three internal challenges. The external ones are the changes that now see accountability valued over autonomy, territorial imperatives and state imposed revalidation. The internal challenges are avoidable medical harm, corporatisation of medicine and a perceived failure of self-regulation.

Challenges ahead

These are the challenges confronting us all individually, but particularly as a profession and this is where we need our College and Specialty Societies to be unified in intent. It is timely that Orthopaedics has returned. It is the strength of us all that can ensure both the perceptions and reality of surgeons are consistent in being an outstanding profession into the years ahead. This will be an ongoing theme and provides focus for what needs to be addressed.

Finally the ASC was significant on a personal level as it is the time when I became the President of our College. I feel a debt of gratitude to my predecessor Mike Hollands. Mike has worked tirelessly for our College in the past two years. It was his aim to achieve a constructive way forward with the Specialty Societies and in this he has been singularly successful. He sought to establish a College presence on the global surgical stage and by virtually constant travelling for the last 12 months has been successful in this also. Mike's focus has been to achieve strength through consensus and engagement. Personally he has sacrificed much in his service to the College. We all owe him, and his wife Jane, gratitude for the successes that have been achieved.

Foundation for Surgery
Passion. Skill. Legacy.

PLEDGE FOR YOUR FOUNDATION

Pledge a Procedure Month is upon us and your help can assist surgeons of the future both here and abroad

DAVID WATTERS
VICE PRESIDENT

In June the philanthropic arm of the College, the Foundation for Surgery, is again conducting its major annual campaign, Pledge a Procedure Month, to raise funds to support a raft of important and worthwhile surgical-related programs.

These programs help address regional health inequities and improve access to emergency and essential surgical care for disadvantaged communities.

Funds are used mainly where there is an opportunity to increase surgical capacity by contributing to surgical training and the provision of quality patient care in neighbouring developing countries, such as Papua New Guinea, Timor Leste, the Pacific Island countries and Myanmar.

For remote and Indigenous communities within Australia and New Zealand, the Foundation helps implement Indigenous surgical programs and encourages Indigenous doctors to consider a career in surgery.

It also expands research across all surgical specialties and sub-specialties by providing assistance to promising young surgeons through the conferment of scholarships and grants to enable new research, advanced study and surgical related travel opportunities.

The Foundation is an integral part of the College and I encourage all Fellows to help maintain and expand our support for these important programs. It is gratifying that through generous and thoughtful donations to the Foundation from Fellows, we have as a profession clearly demonstrated our willingness to support a growing capacity for local surgeons and their health services to deliver improved patient care.

However, the needs remain great, so that our sustained support is vital to ensure the Foundation is able to expand its activities and thrive. In doing so, it will continue to facilitate health programs that measurably improve the lives of people in less fortunate circumstances than ourselves.

As we approach the end of the Australian financial year and prepare to lodge our tax returns, I encourage you to donate the proceeds from just one procedure of your most common major operation making June the 'Pledge a Procedure Month'. Your donation, irrespective of the amount, will make a tangible difference. I am also pleased to assure you that all donations are tax deductible in Australia and New Zealand.

Previous donations to 'Pledge a Procedure Month' have supported programs such as the implementation of an annual trauma and fracture management course in Fiji. These courses, build surgical capacity by training local surgeons in complex orthopaedic surgical procedures and in the advanced management of all levels of trauma. I have recently returned from meetings in Fiji where this particular course was highly praised and much appreciated. The beneficiaries come from many Pacific Island Nations.

Helping our neighbours

The rapid development of emergency medicine in Myanmar, including a Diploma of Emergency Medicine in Yangon, has been an outstanding success. Within two years of representing the College at a meeting to plan for emergency medicine as a specialty, the first 17 diplomates graduated in December 2013, just in time for the S E Asian Games.

The funding from the College Foundation, together with the pro-bono contributions of many specialist volunteers has made this possible. Myanmar is now keen to run further surgically-related courses. The primary trauma care program which preceded and runs parallel to the Emergency Medicine training has been highly successful in training a local faculty of trainers. Patients suffering trauma and emergency conditions in Myanmar are now receiving better quality care in many centres. Myanmar surgeons are teaching the next generation of specialists.

Foundation funding also enabled specialists from South East Asia, the Pacific Island countries and Papua New Guinea to participate in practical training attachments in New Zealand or Australian teaching hospitals. These attachments are crucial in building surgical capacity in developing countries and enable talented health specialists to broaden their understanding and skills in the latest surgical techniques, technologies and treatments.

The attachments also create valuable networking opportunities and sustained engagement over many years. The Foundation enables us to address some of the global inequities in health, and gives Fellows the opportunity to address unmet needs in neighbouring countries.

The Foundation is also active on-shore. Your support helped inspire Aboriginal and Maori medical students to consider a career in surgery by providing five students with bursaries to attend the second Australasian Surgical Students Conference in Auckland and to participate in presentations and workshops in all surgical specialties.

It also assisted the College's Mobile Surgical Simulation Bus to be available for medical students attending the Australian Indigenous Doctors Association Symposium in Canberra and the Australian Medical Students Convention on the Gold Coast, which enabled the students to test their technical performance in a simulated environment.

Scientific research is at the core of our profession, thus the conferment of scholarships and grants is vital for the expansion of surgical research and the provision of advanced study opportunities for Fellows and Trainees. Our donations enabled the Foundation to award more than 30 scholarships and grants last year to surgeons who are now undertaking research across a wide range of surgical specialities and in a variety of centres in Australia, New Zealand or overseas.

Again, I urge you to support **'Pledge a Procedure Month'**. Your support of the Foundation for Surgery is vital in ensuring the continuance and expansion of worthwhile and effective programs such as these. I can assure you that what you pledge will count and really makes a difference. *Surgical News* will continue to provide detailed reports as to the effectiveness of how your funds are used.

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Tri-Society Head & Neck Oncology Meeting 2014

Thursday 14 - Saturday 16 August 2014

Darwin Convention Centre, Darwin, Northern Territory, Australia

To register online or to submit an abstract, go to: **www.anzhncs.org**

Abstract submission deadline: 25 May 2014

Australian and New Zealand Head & Neck Cancer Society

Hong Kong Head & Neck Society

Head & Neck Cancer Society, Singapore

Perth ASC

The College will celebrate the centenary of ANZAC at next year's Annual Scientific Congress in Perth. The Royal College of Surgeons of Edinburgh will also join in the gathering, which is hoping to attract an extra 1000 international surgeons. It is hoped that surgeons will make a special trip to mark the anniversary of Australia and New Zealand's sacrifice during the First World War. There will also be further celebrations in Albany following the congress.

***cei.asia website,* April 22**

Bread clip redesign

The common bread bag clip can cause massive internal complications ending in surgery according to an article published online for the *Australian and New Zealand Journal of Surgery.*

Authors at the Adelaide University paper are calling for the industry to redesign the clips, which when accidently swallowed, can lodge themselves in the wall of intestines.

Guy Maddern, Head of the University's Discipline of Surgery said that the problem is uncommon but recurring.

"Given that most cases occur in elderly patients and we have an ageing population, the food industry needs to cater for this so the clips pose a reduced risk."

***The Australian*, May 16**

3D parts

The possibilities of 3D printing are endless and are having a positive effect on simulation training for our next generation of paediatric surgeons. Trainers at the Royal Children's Hospital in Melbourne are using the printers to create plastic models for less common procedures such as bronchoscopy. Practicing the technique has the potential to drastically increase the surgeon's experience, particularly for rare scenarios.

Paediatric Surgeon and Chair of the Victorian Regional Committee, Robert Stunden said that the technology could revolutionise training.

"Previously, you had to be present at an operation with a rare anatomy to be able to appreciate it."

***The Age*, May 27**

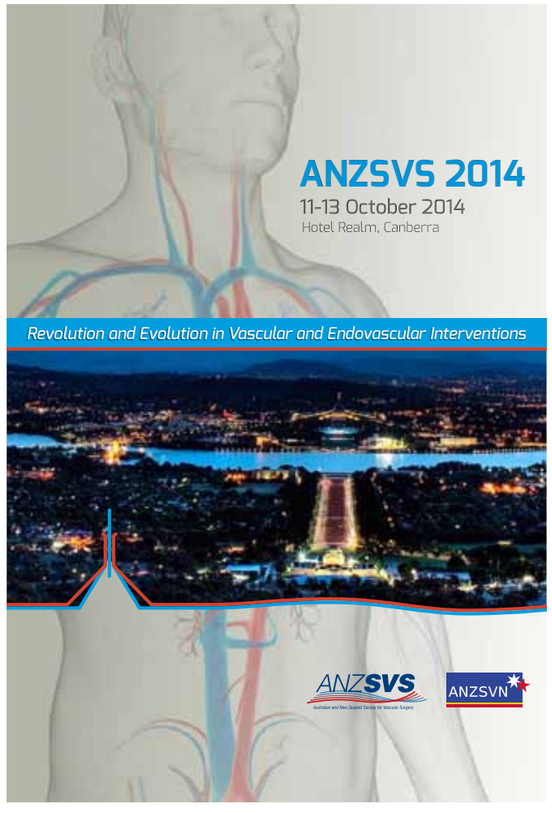
2014 NSA Annual Scientific Meeting

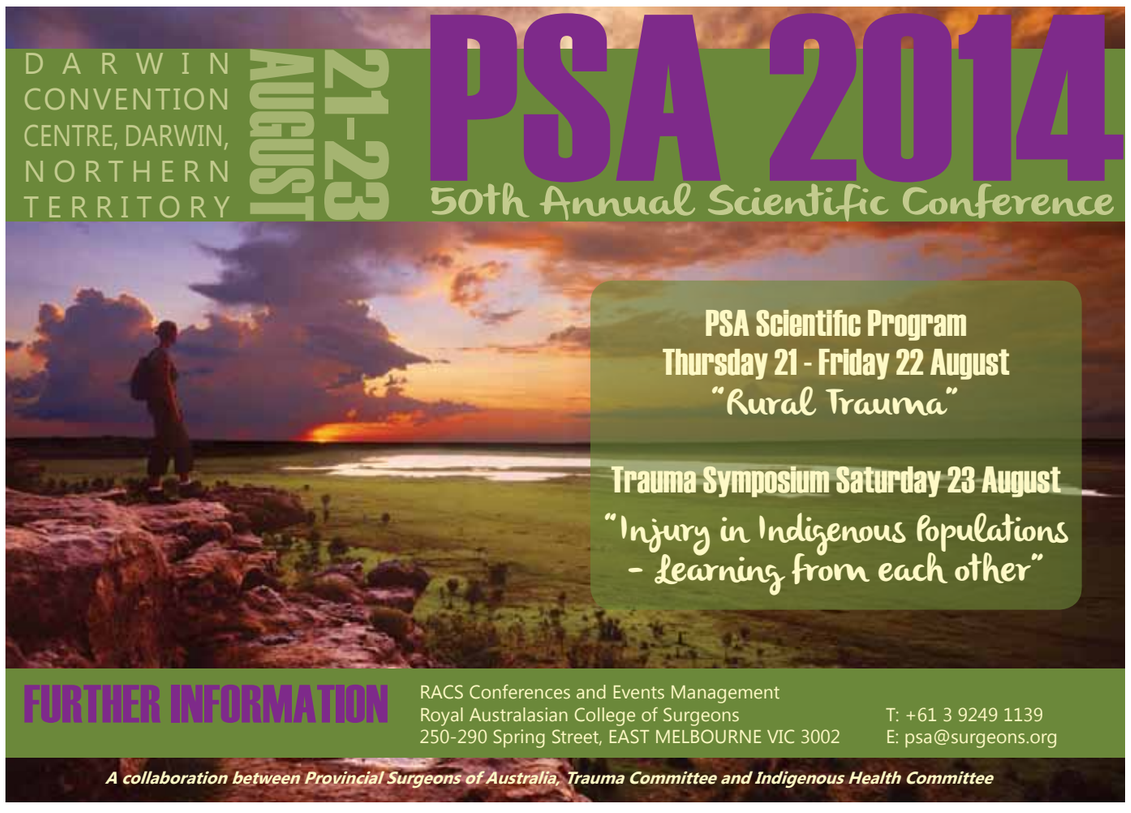
Thursday 2 – Saturday 4 October 2014

Crown Perth Convention Centre
Crown Perth, Perth, Western Australia

To register online or to submit an abstract, go to:
www.nsa.org.au

Abstract submission deadline: 25 May 2014





WORKING TOGETHER

The Royal Australasian College of Surgeons' 83rd Annual Scientific Congress held in Singapore last month was by all measures an extremely successful event

Held in concert with the Australian and New Zealand College of Anaesthetists' Annual Scientific Meeting, the combined event saw more than 4000 delegates descend on the Sands Expo and Convention Centre on the edge of spectacular Marina Bay.

The conjoint event was held under the banner of 'Working together for the benefit of our patients' and this was a consistent theme for the speakers and presenters across the five-day meeting.

Throughout the meeting speakers explored the latest developments in all the surgical specialties and how surgeons and anaesthetists work together to achieve the best possible health outcome for patients.

The major purpose of the Congress is for delegates to avail themselves of the opportunity to engage with the thought-leaders and researchers of the profession.

A host of international guests, speakers and delegates ensured engaging discussion, lively debate and rare networking opportunities.

There were about 80 exhibitors represented on the exhibition floor covering everyone from Ansell to Wiley and featuring ASC Gold sponsor Johnson and Johnson Medical Companies and Bronze sponsor Medtronics.

More than 30 specialties and areas of practice were catered for and Orthopaedic Surgery featured prominently, capped-off by Singaporean Orthopaedic Surgeon Kanwaljit Soin delivering the prestigious Syme Oration.

From the robust interrogations of the plenary session panels to the thought-provoking theorising of the keynote addresses and lectures – notably Keith Willett, Professor of Orthopaedics at Oxford University who delivered the President's lecture on 'If it's about quality and cost; let us run healthcare' – there were amazing presentations of opinion and perspective, prediction and research.

There were also lighter moments such as the 'Comedy Debate' on behalf of the Foundation for Surgery featuring the battle of wits and quips between Kingsley Fawkner and College solicitor Michael Gorton.

There was also the moving and impressive formal convocation ceremony that saw almost 200 be-gowned graduates accept the mantle of Fellow.

From those just starting their careers to those reflecting on many years of service to the community – and everyone in between – there was a plethora of things to learn and things to share. As there will be in 12 months' time when the 84th Annual Scientific Congress will be taking place, 4 – 8 May in Perth, Western Australia.

Welcome Party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01: David Watters & John Royle **02:** Bruce Waxman, Deborah Amott & Marianne Vonau
03: Keith Mutimer & Michael Hollands **04:** Nitin Sharma and Family **05:** Kay, Clive and Amy O'Connor
06: Int visitors John Hedson, Rooney Jagilly, Dudley Maenu'u Ba'erodo, Timmy Tingnee **07:** Mark Edwards & Sean Hamilton

Convocation


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Younger Fellows Dinner


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01: Francis and Helen Dunn, Dato' Dr Palayan Kandasami **02:** Dato'Dr Palayan Kandasami, Professor Shih-Hui Lim, Eddie McCaig & Graeme Campbell **03:** Brigitte and Laurie Malisano, Debra Bailey & Julie Mundy **04:** Guy Maddern, Gordon & Rosie Low **05:** Michael Grigg & David Thiele **06:** New Fellows Sophie and Michael Nightingale and Family **07:** John Batten, Arthur Richardson & Robert Costa **08:** The Trainees and Younger Fellows Dinner was held at the S.E.A Aquarium. **09:** Mike Hollands enjoys the entertainment with Younger Fellows.

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Industry Reception

Lectures


14


15


16


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10: Ethicon: Marcos Serrano & Dane Holt **11:** Philips: Victor Davis, Andrew Kobylinski & Matt Hollier **12:** Covidien: Sam Wegg, Tim Carroll & Sarah Gorman **13:** The Olympus stand **14:** Hamilton Russell Lecture; Carol-Anne Moulton **15:** Michael Wertheimer Lecture: David Watters & Michael Grigg **16:** John Mitchell Crouch Lecture: Andrew Hill **17:** Weary Dunlop Lecture: Mike Hollands with lecturer Peter Sharwood **18:** President's Lecture: Keith Willett **19:** Hamilton Russell Lecture; Carol-Anne Moulton

Plenary


01


02

03


04


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Trainees Workshop


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Simulation Room


08

01: John Harris **02:** Bruce Keogh **03:** Friday Plenary **04:** Mike Hollands presenting Wound Care in Disaster Situations **05:** Thursday Plenary **06:** Trainees attending GSA's Monday workshop. **07:** Wendy Brown presenting at GSA Trainees Day. **08:** The College Simulation Room at work

Gala Dinner


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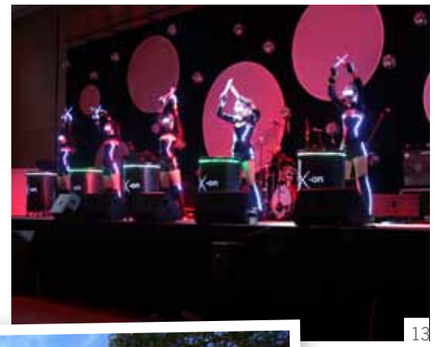
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09: Michael Grigg, Nicole Gao & Carlos Pelligrini **10:** Denise Civil, Jane and Michael Hollands & Ian Civil **11:** Royal College of Surgeons in Ireland President Patrick Broe **12:** Wendy Brown, Cas McInnes and Sheryl Wagstaf. **13:** Singapore Drummers **14:** Andrew & Sibby Sutherland **15:** Gala Dinner drinks on the deck overlooking the Singapore skyline. **16:** New President Michael Grigg and Sherryl Wagstaf **17:** Gala guests welcomed by Singapore Chinese Dragons. **18:** Mike During and Cathy Ferguson

Closing session

01

02

03

Great Comedy Debate

04

01: Question time from the audience **02:** Michael Grigg, Kingsley Faulkner and Michael Gorton presented the Foundation's Great Comedy Debate. **03:** College Foundation for Surgery Chair Kingsley Faulkner **04:** Enjoying the discussion

05

06

07

05: Bruce Waxman & Carmelle Peisah **06:** Women in Surgery Chair Kate Drummond **07:** Former ANZCA President Kate Leslie presented on part-time and flexible training.

Women in Surgery

Sir George Adlington Syme was the first President of the Royal Australasian College of Surgeons and the Syme Oration is the College's most prestigious lecture, delivered at the Convocation ceremony of each year's Annual Scientific Congress.

Dr Kanwaljit Soin, FRACS, is a global ambassador of HelpAge International, a UK based international NGO serving disadvantaged older people worldwide. She is a Board Member of Washington University International Advisory Council for Asia. She is also the Vice President of the Singapore Orthopaedic Association.

STANDARDS of excellence, stewardship and self-actualisation for surgeons

President Michael Hollands, Council members of the Australasian College of Surgeons, Presidents of other Surgical Colleges, old and very importantly, new Fellows of this Australasian College, ladies and gentlemen, a very good afternoon to all of you. Today is indeed a momentous occasion. I am deeply honoured and I feel very privileged to have this opportunity to deliver the George Adlington Syme Oration. The challenge for me is to say something equal to the occasion and something useful to new Fellows.

First, I have a confession to make. I have changed the title of this oration from what has been printed in the program to 'Standards of Excellence, Stewardship and Self-actualisation for Surgeons'. I make a small apology for this, because as a woman, I am entitled to change my mind.

My second confession is that I am not an elite surgeon, but I would like to think that I am a careful, conscientious, compassionate and canny surgeon. The first three adjectives are understandable, but why canny? Because when necessary, I routinely consult and enlist the help of my colleagues in the management of my patients. I feel no loss of ego or prestige in doing this and my patients, hopefully, benefit because two heads are better than one.

To fulfil our role as surgeons we have to:

- Strive to achieve standards of performance excellence;
- Aspire to become trusted stewards of our patients;
- Serve the interests of society at large, and
- In the process become self-actualised surgeons.

ASC
2014

Looking now at standards of performance excellence for surgeons, I would like to quote from an interesting study done by Professors Judy McDonald and Terry Orlick from the University of Ottawa in 2005. The study was a qualitative analysis of interviews with 33 active and highly proficient surgeons representing six surgical subspecialties and looking at seven elements of excellence, which are also displayed by astronauts, world-class athletes and top classical musicians.

1. **Commitment –** all surgeons had a high level of commitment and gave unstintingly of their time and expertise to their patients. For 70 per cent of the surgeons, their commitment was also related to feeling personally responsible for and fearful of diagnostic and procedural errors, which might result in patient harm.
2. **Belief –** All surgeons interviewed projected a strong belief in themselves and their surgical ability. They felt that their confidence increased with experience but they could enhance it by manipulating the environment as much as possible; e.g. picking their own team and by postponing surgery if more preparation time was needed.
3. **Full focus –** this is the single most important skill associated with performance excellence. Focusing refers to the ability to concentrate totally on what we are doing – for the duration of the surgery, on the task at hand, in the moment and in the zone. This is mindfulness at its best.
4. **Mental imagery –** this was reported by 80 per cent of surgeons either before or after surgery. Surgery lends itself well to creating and rehearsing visual and tactile experiences.
5. **Mental Readiness –** 70 per cent of surgeons mentioned that it was essential for them to take some quiet time to prepare themselves mentally before operations. Consulting with the patient and colleagues was also felt to be significant in terms of mental preparation.
6. **Distraction Control –** in recalling distractions that occurred during best performances, all surgeons reported getting back on track quickly especially during surgical crises.
7. **Constructive evaluation –** Self-evaluation was viewed as very important to assess results, but often more useful when assessing complications, and working through on how to avoid them in the future if possible.

From this study, the top surgeons made it clear that surgeons perform at an exceptional level largely because of the quality of their mental skills, and suggested that mental skills might be more important than technical skills in surgical performance. Thus we have to nurture these enduring mental skills within our practice and not just worry about manual skills, which are often easy to master and change with time and technological advancement.

Let us now turn from standards of surgical excellence to the environment in which the surgeon has to operate. In this era of free market capitalism, marketised health care, changing patient expectations and limited resources, how can we ensure that as surgeons we retain our professionalism and remain as trusted stewards of patients and the community at large? It has long been acknowledged that the role of a surgeon requires more of us in

terms of knowledge, skill, integrity and professionalism than most other professions. Reciprocally, it has been a tradition that society accords a surgeon respect, honour and deference in return.

In the context of upholding professional standards and our duty as stewards of patients and our collective duty to society to improve health care systems, I would like to say something on surgical meritocracy. Surgical meritocracy is the idea that a medical system should aim to select surgeons with above-average ability and who are also able to make morally informed medical decisions. That means that surgical meritocracy has two key components – firstly, surgeons should have both superior ability and virtue, and secondly, the selection mechanism should be designed to choose such surgical leaders.

This is akin to the Confucian ideal of government by intelligent honourable men (there were hardly any women in public life at that time) and these men, in return, have a duty to do right for the people who trust and respect them.

There is no doubt that most surgeons have superior ability as the system is designed to exclude those without this quality, but there is no mechanism to ensure that those chosen should also possess superior virtue. Is it possible to have such a selection mechanism? Would such a system enable us to keep our respected and trusted position in society? This is an area worthy of consideration and debate.

Finally where superior virtue is concerned, I would like to say a few words on the self-actualised surgeon, which we should all aspire to become. Growing older is to some extent fortuitous, but growing up is optional and self-actualisation is the pinnacle of growing up.

Self-actualisation is a term used in psychology to describe a state of being where you feel you are fulfilling something worthwhile and achieving your goals and dreams. Self-actualisation is the total fulfilment of one's talents and abilities, the realisation of a person's potential.

Abraham Maslow proposed a hierarchy of needs that motivate human behaviour. At the peak of this hierarchy is self-actualisation. Only two per cent of people are capable of reaching the highest level of motivation and are driven by the desire to accomplish all they are capable of. I would like to think that we surgeons could aspire to be in this rarefied group. Zen Buddhism and Taoism are also both concerned with the development of the full human potential. Psychological perspectives as diverse as Taoism, Zen Buddhism, and the self-actualisation theories of Carl Rogers and Abraham Maslow, indicate universality in human aspirations and experience. So what are the characteristics of self-actualised individuals and how do they relate to us as surgeons?

- **Firstly, self-acceptance and realism –** self-actualised people have realistic perceptions of themselves, others and the world around them. Self-actualisers accept their own human nature with all its flaws. The shortcomings of others and the contradictions and irrationality of human behaviour are accepted with humour and tolerance. This is not always easy when we as surgeons are overworked and harried and patients are difficult and demanding, but with reflection and self-reminders, we can become more tolerant and empathetic.
- **Secondly, problem centring and not self-centring –** self-actualised persons are concerned with solving problems outside of themselves, including helping others and finding solutions to problems in the external world. These people are often motivated by a sense of personal responsibility and ethics. Thus self-actualised surgeons strive for both effectiveness of clinical care and effectiveness of interpersonal care. We do not rationalise our paternalistic stance in our effort to help and protect our patients. We practice moral, compassionate, competent and affordable care with scientific and personal excellence. We display humility in the face of complexity of biology and do not over-estimate what we know and discount what we don't.
- **Thirdly, spontaneity –** surgeons can conform to guidelines and protocols but can also show a creative spark when needed and that is how different and improved techniques in surgery often come about.
- **Fourth, peak experience –** surgeons have moments of deep meaning and intense happiness when saving lives and performing successful complicated surgery, and this drives us to continue to fulfil our potential and augment our personal development.
- **Fifth, continued freshness of appreciation –** surgeons continue to be inspired by even simple routine daily clinical encounters with patients. I always marvel at how I don't get bored with many different patient consultations with the same complaint of backache. Each patient encounter is like listening to a new novella.
- **Lastly, discrimination between means and ends and between good and evil –** self-actualised persons do not twist means and ends in a way that hurts others. Thus as self-actualised surgeons, we refrain from over-diagnosis, over-treatment, unnecessary care, and wastage of resources so that we do not harm in our zeal to help or heal. We accept that technology enhances the practice of medicine and surgery, but technology does not make us better surgeons, so we do not want to end up as technologically superior but morally inferior practitioners.

I have touched on three main aspects of being a complete surgeon – standards of surgical excellence, stewardship and self-actualisation and how these aspects intertwine and enable us to achieve the best in our profession. For a life to be great, it must be meaningful, not only to ourselves, but also, more importantly, to others around us.

We are indeed privileged to be surgeons because surgery is a very meaningful profession – we wake up every day, and often at night, with the knowledge that our job is to improve the human condition – to alleviate pain and suffering, to prevent disease and to heal where possible – it is hard to think of a more worthwhile way to spend our life.

I will end with a quote from Voltaire: ***"With great power there must also come great responsibility"*** and that is our karma as surgeons. For the new Fellows, today you have great power bestowed upon you, and you achieved that through hard work, dedication and sacrifice. Your greater responsibility to your patients and to society will remain with you for the rest of your careers, so please embrace it, enjoy it and excel at it.

ORTHOPAEDIC's at the 2014 Congress

Orthopaedic Surgery sessions were welcomed back to the Annual Scientific Congress in 2014 and look towards more educational opportunities for our Fellows

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02

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01: Congress Convenor Martin Richardson **02:** Richard Lander and Angus Gray chair orthopaedic research papers.
03: Questions from the floor **04:** Allan Panting **05:** Ian Incoll **06:** Richard Lander

THE QUESTION OF BUTTONS

Why are there buttons when there should be none?

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is buttons. Now don't get me wrong, buttons can be very useful and even essential. Shirts without buttons would be a nightmare. I recall some years ago there was a vogue for shirts that were not cut like shirts and had to have Velcro to hold the shirt closed. To me a shirt is a front and a back and two sleeves – short or long. The line should be cut straight up and down or perhaps a little tapered below the chest to emphasise the manly figure (or where the manly figure used to be). It should not be cut curved with dips and wobbles – that is for women's clothes.

But back to a proper shirt – straight and clean cut and (here is the important bit) just enough buttons to get the job done. Why at the cuffs do you need an extra button or two or three? I bought a shirt a few weeks ago and instead of a button on the cuff there was another one positioned such that my wrist would have been about the circumference of my radius to fit inside it. Just what is the point?

This purchase caused me to do a survey of my shirts and I found that most have surplus buttons. Some have an extra button above the cuff on the free edge of the sleeve; they are such tiny buttons that no one could possible do them up. Some had this tiny button and an extra one for the very slim wristed persons – three buttons where one would have sufficed. Then there was the short sleeve shirt with a tiny button on the hem of the sleeve – but there was nothing to fasten, so why I ask.

Have you noticed that only the better quality shirts have an extra button sewn on the hem of the shirt in case you break or lose one. Some even have a little plastic bag with extra buttons, but, alas, those shirts are never a problem with buttons. It's the other ones that look fine, but suddenly a button will come off because it is sewn not onto the material of the shirt but onto the thread itself; so once it starts unravelling it just goes on and on.

I remember the days when fly buttons were also a problem – coming off at the most inopportune time. This was solved by the invention of the zipper (but there is also a new problem of things catching in the zipper, but we will not go there). I have had a great idea – I am going to replace all my shirt buttons with zips! Or more correctly I will ask Mrs Curmudgeon to do it for me. I am sure she will be thrilled with my brilliant idea – functional, practical and a real fashion statement!

IN MEMORIAM

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

Yi Hau Xie
Victorian Fellow

Peter Isbister
NSW Fellow

James Martin
Victorian Fellow

John Drew
NSW Fellow

Richard Cunyhame Opie
NSW Fellow

Edward George Brownstein
Victorian Fellow

Peter Burke
NSW Fellow

Damien Mosquera
New Zealand Fellow

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.

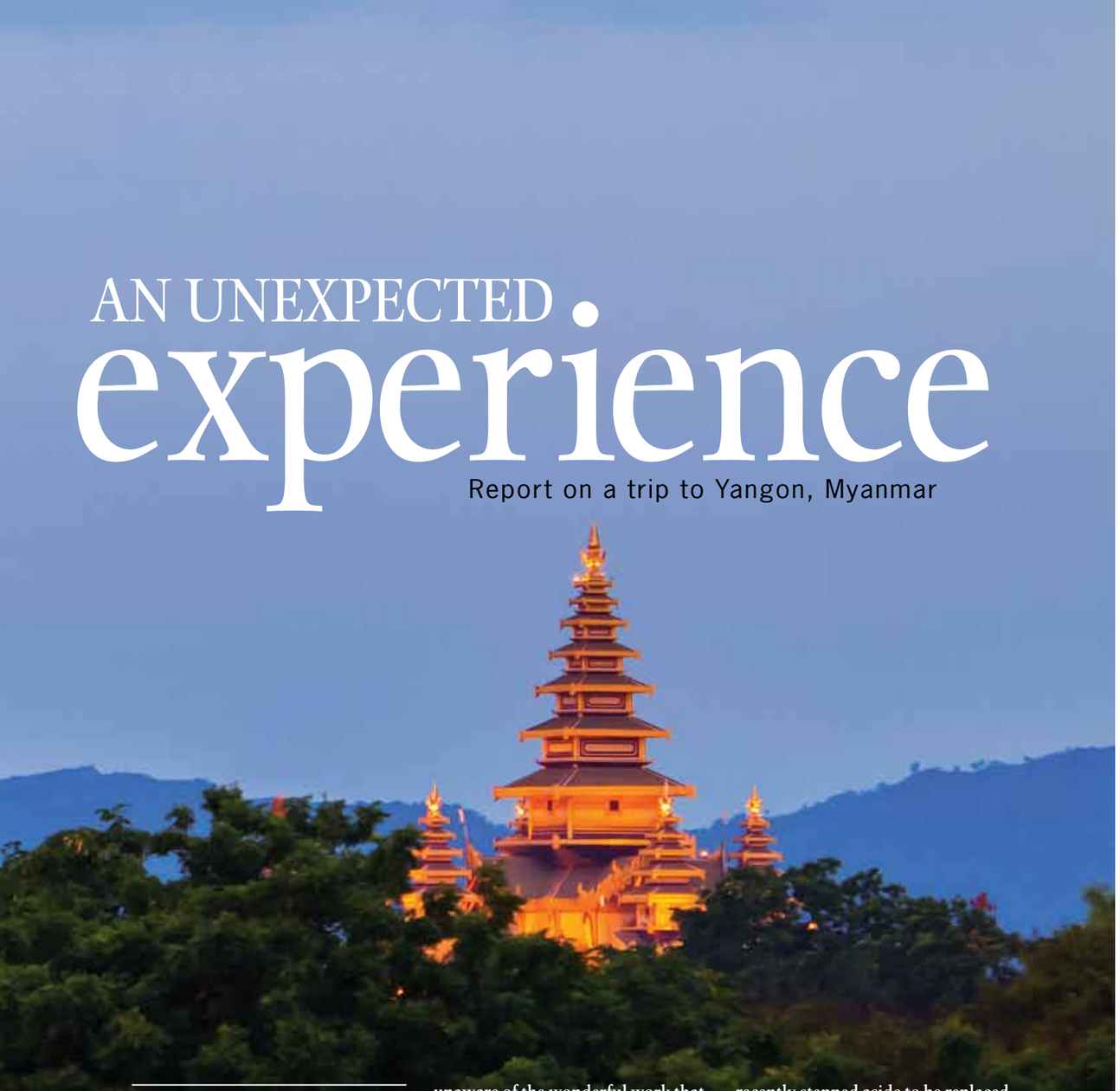
Informing the College

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: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Daniela.Ciccarello@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

AN UNEXPECTED experience

Report on a trip to Yangon, Myanmar



JOHN MASTERTON
CHAIR, ROWAN NICKS COMMITTEE

Late one evening towards the end of January 2014 I received a most unexpected phone call from Sydney. It was from Bruce French, a member of the Rowan Nicks Committee. He, supported by Alan Gale, asked me if I would like to join a group from the Adventist Hospital in Sydney who were going to Yangon leaving mid-February.

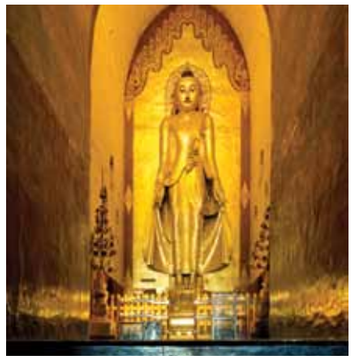
I was completely taken aback. First I had barely heard of the Adventist Hospital affectionately known as the San and secondly I was quite unaware of the wonderful work that had been done by the group over many years in the area of overseas aid in the field of cardiac surgery particularly in Myanmar.

The driving force behind this splendid work was Alan Gale, a cardiac surgeon with prodigious energy particularly in overseas aid. Some 10 years ago Alan started going regularly to Myanmar with a cardiac team from the San to teach and advise. The objective was very much in line with the philosophy of Rowan Nicks – to transfer knowledge and skill.

From early beginnings the team concept grew in scale. Alan has recently stepped aside to be replaced by Bruce French. But this is by no means an individual effort. The team to which I was invited consisted of nearly 45 volunteers all self-funded, which was a matter of some amazement to me.

It consisted of a very dedicated coordinator, Chris Waite, who is an intensive care nurse, three cardiac surgeons, anaesthetists and a very comprehensive group of cardiologists, nurses etc. Many of the participants had been to Yangon many times. I think the record was 16 times by Dr Paul Wajon, cardiac anaesthetist and perfusionist from Sydney.

Alan Gale (left) and Brigadier-General Tin, General Superintendent, Defence Services General Hospital, Yangon, Myanmar and Chief of Cardiac Surgical Services with John Masterton (right).



Rowan Nicks Scholar Win Win Kyaw with John Masterton.

When Bruce French first asked me, I was somewhat hesitant because I wondered where I would fit in. However, with significant encouragement from my colleagues in the Rowan Nicks Committee I accepted the invitation with alacrity. I am so glad I did. I knew that I would meet two former Rowan Nicks scholars in Yangon and a prospective scholar all of whom were cardiac surgeons. This was an added incentive.

The journey to Myanmar via Singapore was made that much more pleasant as I had as a companion a very charming paediatric intensive care nurse, Kiraka Nakazawa, who is based in Melbourne. Not all the team were from the Adventist Hospital. There were representatives from Adelaide, Brisbane and even an American Nurse who was based in Ulan Bator in Mongolia.

Coordinator Chris Waite set off for Myanmar on February 12 in order to get things organised. There was a considerable amount of equipment to be supervised bearing in mind that the team would be deployed in three hospitals. These were the Defence Services General Hospital and the Yangon General Hospital, which were the original hospitals to which Alan Gale had gone 10 years ago.

In recent times the Yangon General Hospital has been visited several times by our immediate past-President Michael Hollands. It is here that Professor Khin Maung Lwin our first Myanmar Rowan Nicks scholar is head of cardiac surgery. The third hospital where the team was to be working is a combined children's and adult hospital where our other scholar Prof. Win Win Kyaw is based. A small group was also to be deployed to Mandalay for a few days. I did not go there.

The whole party were put up in the Traders Hotel which is good as it is centrally located. Alan Gale, Kiraka and I arrived on the same flight from Singapore at close to midnight on Saturday, February 15.

It was characteristic of Myanmar hospitality that we were met at the airport by Win Win Kyaw, Aung Zaw Myo our next scholar who is going to St. Vincent's Hospital in Melbourne with Mr Yii the cardiac surgeon and Sandar Ko, a charming and incredibly helpful lady from the Defence Forces General Hospital. As it transpired, she looked after the needs of us all throughout the week ahead. We finally made it to the hotel about 1am on Sunday morning.

In spite of our late arrival Alan and I, after the usual American style sumptuous breakfast on the Sunday morning, fronted up at a case conference at Win Win's hospital at about 10.30am headed by Bruce French and Win Win who started off with presenting an extremely rare case of an infant with an abdominal aortic aneurysm which was given as a paper at the Annual Scientific Congress in Singapore.

Then a series of fascinating cases were presented and discussed with the aim to decide whether to operate during the week ahead. Other than Bruce French, there was Bruce Bastian, interventional cardiologist from Newcastle and a veteran of many visits, Rob Hislop, Intensivist from Royal Prince Alfred Hospital and a number of other members of the team. The interchange of ideas was very good. I looked on while Alan Gale participated in the discussion. ▶

Alan and I moved off after lunch to meet Prof. Khin Maung Lwin at the General Hospital with Aung Zaw Myo who is in the cardiac unit there. Once more there was a case conference where some very challenging problems were presented. Homayoun Jalali was the team's cardiac surgeon who was assigned to be at the General Hospital throughout the week. One patient who presented was in significant heart failure and was rejected as a candidate for surgery. That took us to the end of the day.

Monday was to be the beginning of the full working week for all the team with theatre sessions in all three hospitals under the team's remit. Alan was my guide. First we visited the Defence Services General Hospital, which is not purely for the military and deals with both adults and children. I was not able to ascertain how the general population gets access to this hospital, which is seemingly well funded and under the overall charge of Brigadier General Tin Maung Aye, a long time friend of Alan Gale.

We first visited the recently refurbished Intensive Care Unit where the staff had set up a display celebrating Alan's 10 years of involvement with the unit. This was quite impressive with acknowledgement of the Australian commitment (Open Heart International). The intensive care unit was spacious, well-equipped and on a par with similar facilities in Australia.

Next we went into the operating suite where two theatres were in full swing. In the first an open heart operation was just being concluded. The facilities in this and the neighbouring theatre were first class. For example the cameras recording the operations were very sophisticated and the heart lung machines were very adequate as observed by someone not himself an expert.

In the second theatre I witnessed the closure of an atrial septal defect being done under the supervision of Graham Nunn, from Sydney. Overall my impression was that the Military Hospital was well run and adequately financed. At the conclusion of our visit Col. Tin gave us a general review of the running of his facility.

The Military Hospital is quite far out of town and from there Alan and I called into the General Hospital briefly before returning to the Traders Hotel and the usual group meal in the evening.

Bruce French (left) with patients and staff and Rowan Nicks Scholar Win Win Kyaw (right).

"The team to which I was invited consisted of nearly 45 volunteers all self-funded, which was a matter of some amazement to me"

Tuesday saw us driving out to the Military Hospital again where Alan was due to give a talk which did not eventuate and there was a publicity photo shoot for the two of us. We then proceeded to the General Hospital where there was much discussion by the team's anaesthetist as to the wisdom of him anaesthetising a small child for a difficult open heart procedure. He felt uneasy about this as his expertise was in the adult field. Consequently, the case was cancelled.

On Wednesday we visited Win Win again. She was in the midst of inserting two prosthetic valves in a patient. Again bearing in mind my very superficial knowledge of these matters, I reckoned she did it very well. Alan thankfully agreed.

During the week I had the privilege of visiting cardiac catheter labs in the General and Military Hospitals. These were new experiences for me with a background of General Surgery and Burn Care. In both instances the facilities had been generously supported by overseas donors. Consequently they were not the very latest, but they seemed very adequate. The Open Heart International operatives seemed comfortable with them too.

The final night in Yangon was wonderful. We had a gala dinner in the Traders Hotel for all the team and our hosts who were generous in their thanks and generosity in presenting us with gifts. I at no time had felt on the outer. This was confirmed by many spontaneous remarks.

For my part I had a thoroughly rewarding time and met many people whom I will remember as friends. The Open Heart International was really a great group of people who deserve to be recognised much more for their contribution to the wellbeing of a people who are so much in need of support.

In conclusion, I have no doubt that this trip has helped me understand even more the vision of Rowan Nicks and the benefit of dialogue with those who need the help of our College.

Neuropsychological Evaluation for Cognitive impairment

DR BB G-LOVED

Last month I introduced you to Mr Burt Enderleng, a surgeon in his 70s with an arthritic hip and impaired mobility, who has recently had cases that have suffered complications. He consulted Dr BB G-loved asking, "Should I still be operating?"

Having assessed his physical capability, I must say I was in doubt that he had the stamina for a difficult procedure. Perhaps a hip replacement would restore his mobility and reduce his dependence on analgesics, but it was also my responsibility to assess his cognitive ability.

I gave him a standardised mini-mental examination (SMMSE). This is a commonly used screening test that involves 12 questions that most doctors can knock off in a couple of minutes. Burt Enderleng managed time, date and place (Q1-3), but did struggle on Q4 spelling WORLD backwards; he mixed up the O and the R, but corrected himself (DLORW to DLROW).

On the three words to remember, he got only two (Q5), and then, perhaps frustrated, was somewhat irritated by having to recognise a wristwatch (Q6), a pencil (Q7) and repeating the phrase "No ifs, ands or buts" (Q8). He could follow instructions and closed his eyes on the second prompting (Q9). His complete written sentence was, "I am not sure this is a valid test!" (Q10). His pentagons did overlap on the second attempt, though without the interlocking four-sided figure.

He could easily fold a paper with both hands and put the paper down on the floor, though this provoked a wince on account of his arthritic hip (Q12). In the end, he scored 26 out of 30 (probably abnormal in a high achiever, though in the normal range of 24+). One problem with the mini-mental is that it is only a screening test, and doctors being intelligent, may suffer considerable cognitive impairment before a mini-mental will detect it (ceiling effect).

I was concerned that he may have some mild cognitive impairment, but that is often only detected by co-workers becoming aware of declining work performance. This was why I hoped he would have the insight to undertake the College Competence and Performance Multisource Feedback Assessment.

I told him that I wanted an independent and more objective opinion and that I would arrange for neuropsychological evaluation (NPE) which involves three to four hours of intensive tests. The incidence of cognitive impairment and dementia rises with age, and to continue in operative practice, a high level performance was required, and thus he must be assessed using techniques that will detect subtle changes in his cognitive, motor, behavioural, linguistic or executive functioning.

Possible conditions causing cognitive impairment range from Alzheimer's disease to other types of dementia (vascular or Lewy body), Frontal lobe syndromes and dementia and Parkinson's disease.

There is a vast choice of neuropsychological tests targeting the different domains of higher function – intellectual functioning (Weschler Adult Intelligence Scales –WAIS), academic achievement (WIAT), language processing (Boston Naming Test), visual-spatial processing (Judgment of Line Orientation), attention/concentration (Vanderbilt Assessment Scale), verbal or visual learning and memory, executive functions (WAIS subsets), motor speed and strength, motivation, speed of processing and personality assessment.

NPE is a specialised area, but the tests provide quantifiable data about reasoning and problem solving ability, language, short and long-term memory, working memory and attention, processing speed, visual spatial organisation, visual motor coordination, planning, synthesising and organising abilities. The results are adjusted for estimated premorbid IQ, culture and age, and are less prone to ceiling effects.

NPE needs to be correlated with imaging, preferably a CT and/or MRI; sometimes a PET scan. These tests will differentiate between dementia and psuedodementia, and between deficiency related to disease (including dementia) as opposed to indifference.

In addition to standard lab tests, one should screen for chronic renal impairment, liver disease, hypercalcaemia, hypomagnesaemia, hypothyroidism, B12 deficiency (<250pmol/l is bad for your nervous system) and Vitamin D deficiency (<70nmol/l). It is also hard to draw conclusions about cognitive impairment in patients who are depressed.

Mr Burt Enderleng seemed to be genuinely concerned. He agreed to undertake performance assessment by peers, and to undergo neuropsychological evaluation. I hope he has the patience for the latter. I have to be vigilant when there is a risk of impairment in a medical practitioner, be it from ageing or from illness. His age places him in a higher risk group and the tools do exist that will answer his original question, "Should I still be operating?"

If he is cognitively impaired and does not retire from clinical practice, I will have to inform the Medical Board. My responsibilities are to protect the public as well as my patient, Mr Burt Enderleng. I hope his only problem is his hip.

ALUMNI HONOURED

Trauma advocate Professor Frank McDermott has a building named at St Kevin's College

Although now retired from his public appointment at the Alfred Hospital (1996) and from private practice (2006), Professor Frank McDermott has maintained his commitment to, and interest in, trauma care and public health that came to define his professional life.

Now aged 82, Professor McDermott is still collaborating on research projects investigating subjects as diverse as a comparison of head injury rates of cyclists in Australia and the Netherlands to an examination of the traumatic injuries suffered by bushranger Ned Kelly during the infamous shoot-out at Glenrowan, Victoria.

Now Adjunct Professor in the Department of Surgery at The Alfred, Monash University and Honorary Professorial Fellow at Austin Health, University of Melbourne, Professor McDermott co-wrote an editorial published last year by the Medical Journal of Australia and is currently writing up his findings on the Ned Kelly investigation for inclusion in a forthcoming book.

Well known for his work as Chair of the Victorian Road Trauma Committee of the College from 1982 to 1997, Professor McDermott was instrumental in promoting legislative changes to reduce road injuries including the introduction of zero blood alcohol limits for learner and probationary drivers and the introduction of mandatory wearing of safety helmets by cyclists.

In the mid-1990s, working alongside Professor Stephen Cordner of the Victorian Institute of Forensic Medicine (VIFM), Professor McDermott established the Consultative Committee on Road Traffic Fatalities which found a Victorian trauma care system in disarray, with one third of deaths found to be preventable or potentially preventable, and systemic deficiencies in all stages of care.

This evidence-based research resulted in the development of the highly-regarded Victorian State Trauma System which designated the Alfred, Royal Melbourne and Children's Hospitals as primary trauma centres with specialist trauma teams and systems in place to manage injured patients from the moment of arrival. The work conducted by the Consultative Committee is now recognised as one of the world's most influential and effective trauma quality improvement initiatives ever undertaken.

Professor McDermott's contribution to public health and road safety has been recognised through a variety of awards including Member of the Order of Australia (1994), Honorary Membership of the American Association of Surgery for Trauma (1999) and the Distinguished Service Medal of the RACS (2002).

"The work conducted by the Consultative Committee is now recognised as one of the world's most influential and effective trauma quality improvement initiatives ever undertaken"

He has twice been awarded the prestigious Hunterian Professorship by the Royal College of Surgeons of England, has had an award named in his honour by the National Trauma Research Institute and last year received the singular honour of having a new biology laboratory named after him by his alma mater, St Kevin's College, Toorak.

Yet despite all the accolades and the obvious pleasure and interest he still takes in research, Professor McDermott retains a practical and professional approach to his achievements.

"Yes I did this work, and yes it brought down the preventable death rates caused by road trauma and was associated with a reduction in total Victorian road deaths by about 50 per cent, but I worked alongside a considerable number of other surgeons and specialists, particularly Professor Cordner," he said.

"I never think of the lives I've saved or anything like that. To me, it was simply a matter of doing the work that needed to be done and promoting the changes that needed to be introduced.

"But that is not to say that I don't appreciate the recognition I've received; we all like a pat on the back occasionally."

Professor McDermott said he had wanted to become a surgeon from an early age after contracting diphtheria as a child.

"When ill, I was transferred late to the Fairfield Infectious Diseases Hospital and I nearly died there, so that early brush with medicine might have sparked my first interest," he said.

"Another reason for that decision, however, was that while I understood all the other trades and occupations that I came in contact with as a boy, there were two that left me mystified.

"One of the jobs was that of the local doctor with his unusual instruments and the other was that of the priest with all that Latin mumbo jumbo, so after some consideration I decided on medicine which I thought might be rather more interesting and helpful."

An active history

Professor McDermott graduated with his Medical Degree from Melbourne University in 1955 and received an internship at St Vincent's Hospital before completing general surgery training in England. He returned to Australia in 1964 and took an appointment as lecturer and senior lecturer in the Department of Surgery Alfred Hospital, Monash University, headed by the late Professor Hugh Dudley.

He said his efforts to improve trauma care and public safety had been inspired by his mentor, the legendary late Professor Sir Edward Hughes.

"Sir Edward was the Chair of the Road Trauma Committee of the RACS when I was working as a general surgeon at the Alfred," he said.

"He had promoted the hospital blood testing of all road trauma casualties and he asked me to analyse the results after I joined the committee.

"After that, we looked at young drivers who were already over-represented in the mortality statistics even without alcohol so it became pretty clear, pretty fast that they should not increase their risk with alcohol as learner and probationary drivers.

"I then moved on to investigating head injuries and helmet wearing in cyclists and the results of that work can be seen everyday around Australia when you see riders wearing their helmets.

"In a large prospectus study we found that helmet wearing reduced the risk of head injury by 45 per cent.

"This work led to world-first legislation mandating the wearing of helmets by all cyclists."

Even after his retirement, Professor McDermott continued to conduct research with his friend and colleague, Professor Stephen Cordner who retired last year after 25 years as Director of the Victorian Institute of Forensic Medicine.

Recently Professor Cordner and others at the VIFM examined bones disinterred from Pentridge Prison and subjected them to an exhaustive historical, forensic and DNA analysis to identify those of Ned Kelly.

"Professor Cordner asked me to contribute a chapter describing the wounds sustained by Ned Kelly during the shoot-out, what the treatment was for such wounds at the time and how they would be managed now," Professor McDermott said.

"Those injuries were all related to low velocity gunshot wounds to his legs, his right elbow and his foot and there was a creasing injury to the lower humerus consistent with damage to the ulna nerve.

"He had a bullet wound below the knee and you could still see the shot gun pellets embedded in the bone and he had a wound to the foot which fractured the joint of the big toe.

"All these injuries fit the picture of a man wearing armour to protect his head, chest and abdomen, but who was nonetheless so injured that his arm was pretty well useless, he couldn't fire his rifle and he could barely walk.

"I asked Associate Professor Max Esser to write up the section relating to modern surgical care because I am not an orthopaedic surgeon, while I looked into the literature to investigate what treatments were current in the 1880s.

"Almost all contemporaneous treatment options were pretty basic and often based on the treatment offered soldiers in the American Civil War.

"Unfortunately for the wounded of that time, the most common operation for such serious limb injuries was amputation."

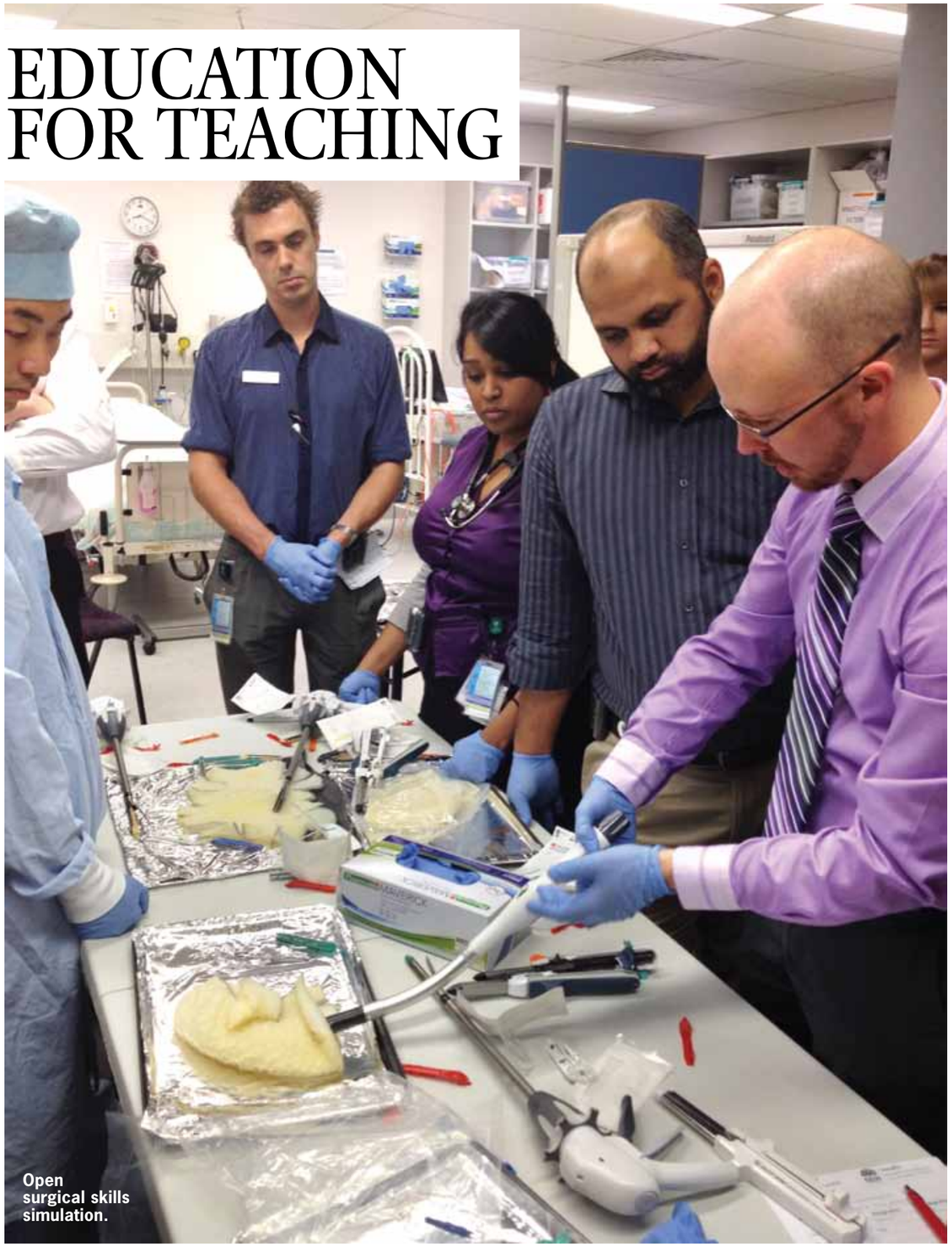
Professor McDermott described his most recently accolade, the naming of the new biology laboratory in the recently constructed science building in his honour, as being a pleasant novelty.

"I still have warm feelings for the school so it was great to be recognised this way," he said.

"I began my secondary schooling at Christian Brothers College in St Kilda which I found to be like a concentration camp in the 1940s, so going to St Kevin's for me was like arriving in Paradise and I still feel a sense of gratitude for that deliverance."

With Karen Murphy

EDUCATION FOR TEACHING



Open surgical skills simulation.

Tony Palasovski attended meetings to build his skills and improve the learning experience for Trainees

NSW Oncoplastic Breast Surgeon Mr Tony Palasovski has used the funds attached to the Ian and Ruth Gough Surgical Education Scholarship to attend meetings and participate in courses designed to enhance his skills as a surgical educator.

During 2013 Mr Palasovski attended the surgical education section of the College Annual Scientific Congress in Auckland, travelled to France to attend the 19th Annual Meeting of the Society in Europe of Simulation Applied to Medicine (SESAM) and participated in a Surgical Teachers Course in held in Perth in October.

Now a VMO at the Wollongong and Shellharbour Public Hospitals, Mr Palasovski also attended a master-class in thyroid and neck ultrasound held in Melbourne under the direction of Endocrine Surgeon Ms Julie Miller in November.

Mr Palasovski, who is in the process of completing a Masters of Surgery focused on ultrasound in surgery, said he had chosen the meetings and courses to assess the current standards in, and the development of, the use of simulation and ultrasound in Australia.

He said his travels had convinced him of the need to train Australasian surgeons in the use of ultrasound at the point of care – either at consultation, the bedside or in theatre – along with the need to further develop simulation technologies for training purposes.

He said that in an era where safe working hour regulations had significantly reduced the volume of cases and exposure to procedures available to Trainees, simulated training packages could be vital in providing Trainees with the necessary hands-on experience.

"This scholarship gave me the chance to develop a valuable insight into the vast possibilities that exist to enhance surgical education and training," Mr Palasovski said.

"These begin with the fundamental educational techniques and mentorship as presented at the Perth and Auckland meetings and extend to the most advanced simulation models as demonstrated in Paris.

"The incorporation of ultrasound into mainstream surgical training could be facilitated through simulation to complement the currently available skills courses and this was highlighted in Paris and during the ultrasound master-class in Melbourne."

Mr Palasovski said that while some first-generation simulation technologies were available in Australia, such as those used to teach laparoscopic procedures, the US and Europe were now using far more sophisticated equipment to train future surgeons.

He said such computerised systems provided bio feedback, analysed movement, downtime and patient welfare all in real time.

"The equipment, technologies and systems presented at the conference in Paris were simply quite amazing and covered most surgical specialties such as paediatrics, endoscopy, emergency medicine and GI surgery," he said.

"They allow Trainees to practice their skills in an environment that replicates reality in astonishing detail, as if they are handling real tissue in real time.

"There were prosthetic breasts with various pathologies in place in different locations to teach Trainees how to examine and what to look for, there were simulated babies in the paediatric section that reacted to care or distress, there were endoscopic simulation systems and equipment that measured every single thing a surgeon did down to the millisecond.

"I also attended a presentation by surgeons from the University of South Carolina that has an entire, fully staffed simulated operating theatre.

"There, Trainees go through the entire operating process from scrubbing in, to operating, to dealing with intraoperative complications, to closing, to outlining post operative care yet not one thing is real about it.

"Obviously, it would be difficult to fund such an amazing training facility here in Australia, but we could take components from it because I think there is an urgent need to move past our first generation technologies if we are to give our Trainees the skills they need in this era."

Mr Palasovski also said there was a growing push toward, and need for, ultrasound training of all Australian surgical Trainees, which he described as a major deficit in current training programs.

"Now that we have hand-held ultrasound machines there is no reason that we shouldn't use them at times when we need more information to make a diagnosis and which could eliminate the need to wait for hours or days for a report," he said.

"The central problem seems to be that it requires dedicated training and therefore the people to teach it, most of whom are already extremely busy.

"Still, I think within the next 10 years it will become a core part of surgical training, but in the meantime we need to establish a task force through the College to investigate the best way to introduce and implement ultrasound training across Australia."

Mr Palasovski said he had developed a keen interest in surgical education and academic surgery since he designed a training course for registrars and medical students at the Wollongong Hospital in 2011.

He said the Travel Scholarship had also allowed him to focus on not only the technical aspects of surgical education, but the optimum methods of transferring knowledge to enhance not only the skills and knowledge of Trainees, but also the Trainee experience.

"I now firmly believe that it is no longer satisfactory simply to teach operative skills to Trainees," he said.

"The education of surgeons begins with simple communication techniques, involves ongoing mentorship and debriefing and incorporates current technologies in simulation, including point of care ultrasound.

"There is a distinction between being a supervisor and mentor, for instance, that needs to be understood and there are communication methods that can be adopted to help Trainees learn and retain what they have learned.

"In particular, I believe we need to introduce new methods of supervision and debriefing of Trainees, where we can go over any mistakes that may have been made in a way that transfers the necessary knowledge without crushing their confidence.

"No-one can go through surgical training without making a mistake, but it should be less traumatic for Trainees so developing our use of simulation technology could provide Trainees with the experience they need to gain both the necessary skills and confidence.

The Ian and Ruth Gough Surgical Education Scholarship was established to encourage surgeons to become expert surgical educators.

Mr Palasovski said he had been honoured to have been selected to receive it and that he had already changed his training methods within the Wollongong hospital.

"It was a great privilege to be able to travel to all these places and learn about so many aspects of modern surgical education and training and the enormous possibilities available to us," he said.

"All the meetings and courses have provided me with fascinating concepts and I have already changed my practice in the way I approach Trainees, explain procedures and debrief them and I hope to develop my approach to, and understanding of, surgical education for years to come."

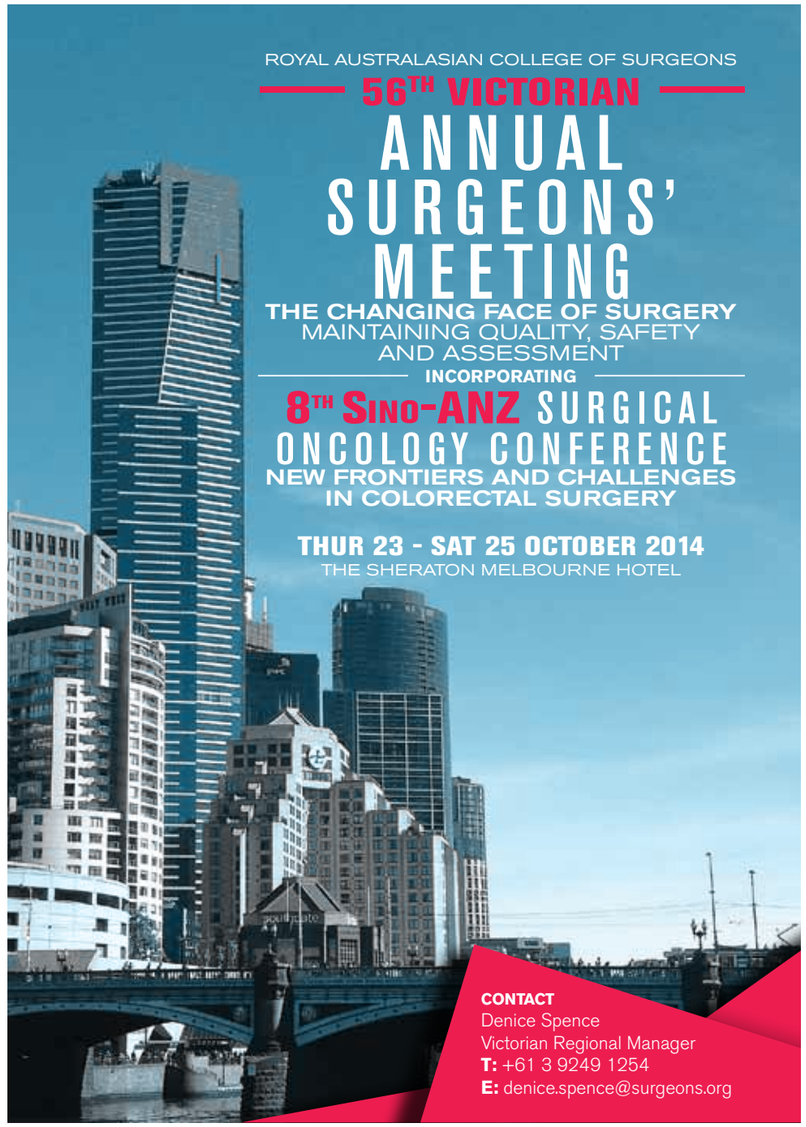
With Karen Murphy

Laparoscopic training at Wollongong Hospital.

The Congress Centre de la Villette, Paris.

Tony Palasovski's Current Projects and Professional Activity

> Master of Surgery, University of Sydney.
> Establishment of modular teaching program for surgical registrars at Wollongong Hospital incorporating current curriculum in General Surgery.
> Establishment of modular surgical skills program for surgical registrars at Wollongong Hospital incorporating open and laparoscopic principles.
> Development of modular teaching program for registrars in General Surgery focusing on the instruction, practice and use of ultrasound in surgery – currently intended for registrars at Wollongong Hospital, but will be extended to Trainees on a national basis.
> Examiner for clinical component of primary exams June 2012 (Newcastle).
> Founding member and past Vice President of Australian Macedonian Medical Society (AMMSOC).
> Member of the Academy of Surgical Educators.



Announcement of Medico Legal Meeting

The AOA/RACS/MedLaw Combined Medico Legal Meeting will be held at the Sydney Masonic Centre, 66 Goulburn St Sydney, on **Friday 21 and Saturday 22 November** 2014.

For details please contact Kevin Wickham, Conference Secretariat, at Kevinwickham@iinet.net.au.

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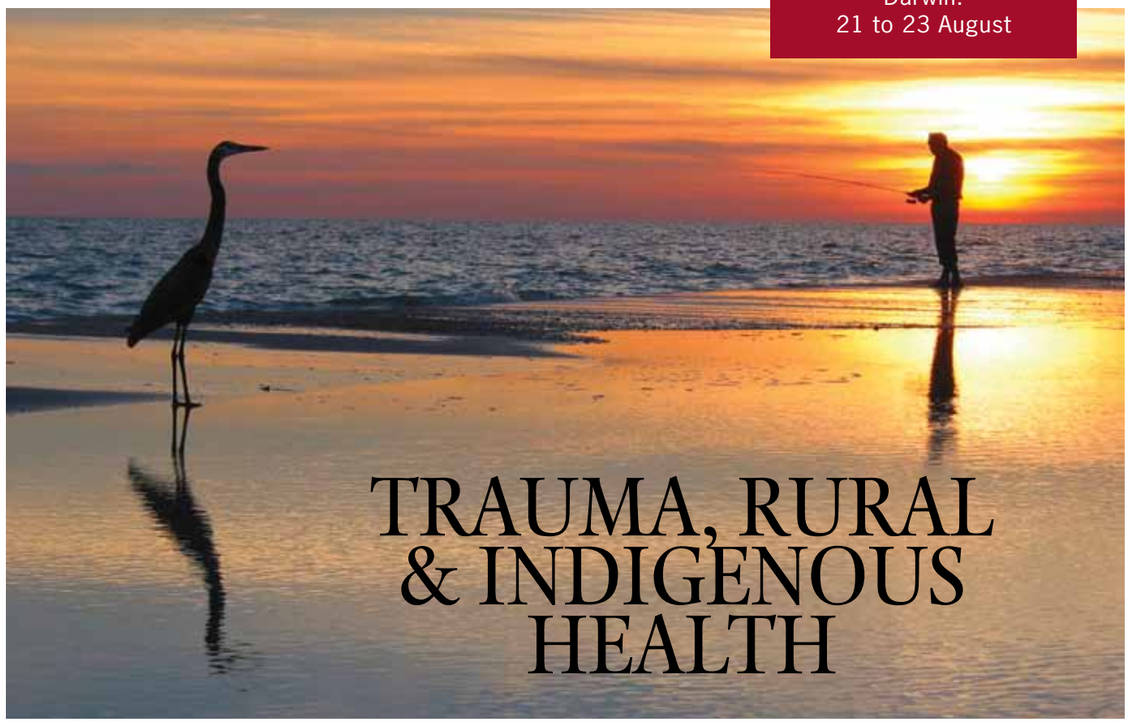
SPECIALISTS ON DRUMMOND

DR MAHIBAN THOMAS AND DR STEPHANIE WEIDLICH, CONVENER, PSA 2014
DR DAVID READ AND ASSOCIATE PROFESSOR KELVIN KONG, CO-CONVENERS, INJURY IN INDIGENOUS POPULATIONS – LEARNING FROM EACH OTHER

TRIPARTITE EVENT
Provincial Surgeons Australia 2014 Trauma Week & Indigenous Health, Darwin:
21 to 23 August



TRAUMA, RURAL & INDIGENOUS HEALTH

This year the Provincial Surgeons Australia (PSA) will celebrate its 50th Annual Scientific Conference at the Darwin Convention Centre, NT from 21 to 23 August 2014. The conference will be a collaborative event of the PSA and the College's Trauma Committee and Indigenous Health Committee, and will feature the annual Trauma Symposium on Saturday 23 August 'Injury in Indigenous Populations – Learning from each other'. This is an exciting opportunity to convene with professionals who care for the injured patient, patients in rural and remote communities and Indigenous populations.

The PSA conference is the educational component of the College Rural Surgery Section (RSS). It is an important event providing opportunity for surgeons working in rural and remote areas of Australia to engage with peers in a scientific environment and be updated with new developments in technology and treatment options for general surgery.

These surgeons are important stakeholders in their communities and hospitals and have significant influence on decisions for hospital upgrades, equipment acquisitions as well as incorporation of new treatment modalities. We are proud to celebrate 50 years of the PSA and recognise the great contribution of the provincial surgeons to this accomplishment.

The Trauma Committee is based on a tradition of research, the application of fact to a defined problem, inter-disciplinary organisation, and an integrated cooperative approach with other organisations and the community to achieve successful outcomes in reducing the tragic effects from injury.

Each year, the College Trauma Committee holds its annual face-to-face meetings where they review and explore issues surrounding three main areas of trauma – Care, Education and Prevention. To capitalise on this 'union' of trauma professionals, a symposium is held annually to explore issues that, if addressed, bear the potential to mitigate the devastating effects of injury within the community.

The College Indigenous Health Committee (IHC) was established to guide the College in its commitment to help improve the health of the Indigenous populations of Australia and New Zealand. The committee is responsible for developing College policies and position papers on Indigenous health, building stakeholder relationships and identifying projects that will contribute to better health outcomes for Aboriginal, Torres Strait Islander and Māori people. The College focuses on both prevention and treatment of surgical conditions and recognises that improvement of Indigenous health in Australia and New Zealand will require collaborative, cross-disciplinary efforts.

The College has a robust history of advocating for injury and disease prevention, with notable success in the area of prevention of serious trauma related injuries. However, the continuing burden of injury in our community and in particular the over-representation of injury in our Indigenous populations, reminds us that greater collaborative action is needed if we are to make a significant impact on injury statistics and outcomes.

We are honoured that this tripartite gathering will bring together experts from Canada, India, New Zealand and Australia to offer international, local and Indigenous community perspectives and approaches to dealing with the challenges of trauma related injury in our rural and remote communities and Indigenous populations.

Responsibility for the tripartite scientific program is being shared by Dr Mahiban Thomas, a General and Maxillofacial Surgeon at Royal Darwin Hospital (RDH), Dr Stephanie Weidlich, General Surgeon at the RDH, Dr David Read General Surgeon and Director of Trauma at the National Critical Care and Trauma Response Centre, RDH and A/Prof. Kelvin Kong, ENT surgeon at the John Hunter Hospital Newcastle.

Among our international speakers are Dr Alex Poole, General Surgeon, Whitehorse Hospital, Yukon Territory, Canada; Prof. Ranijinkanth J, General Surgeon and Prof. Thilak Jepagnanam, Clinical Leader for Trauma, both from the Christian Medical College and Hospital in Vellore India; and Dr Grant Christey, General Surgeon and Director of Trauma Services, Waikato Hospital and Midland Regional Trauma System, New Zealand.

Indigenous perspectives will be provided by Dr Hinemoa Elder FRANZCP, Visiting A/Prof of Indigenous Research, Te Whare Wānaga o Awanuiārangi NZ; Mr John Paterson, CEO, Aboriginal Medical Services Association NT; Dr Stephanie Trust, Kimberley Aboriginal Medical Service and Ms Donna Ah Chee, Central Australian Aboriginal Congress.

National perspectives will be provided by rural and trauma surgeons and by other experts in the field including A/Prof Teresa Senserrick, Transport & Road Safety Research University of NSW; Mr Brad Stewart, AFL NT; Mr Michael Holland, Territory Insurance Office and Mr Simon Manzie, Simon Says TV.

We thank all the sponsors for their support for this tripartite meeting, and in particular to the National Critical Care and Trauma Response Centre in Darwin and the Foundation for Surgery for their generous sponsorship of the Saturday symposium.

We look forward to welcoming you to the 'Top End' to participate in our tripartite event and celebrate the 50th anniversary of the Provincial Surgeons of Australia, Annual Scientific Conference.

The provisional program is now available on the College website: http://www.surgeons.org/media/20788092/psa_2014_provisional_program.pdf
For enquiries, contact Lyn Journeaux at the College Trauma office + 61 3 9276 7448 – email: lyn.journeaux@surgeons.org

Following the conference, an Acute Neurotrauma Management (Rural) workshop will be offered at NTMP – Flinders University Sunday 24 Aug 10am to 4:30pm. Places are strictly limited.
To register, please visit http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/acute-neurotrauma-management-rural/

For inquiries, please phone program coordinator Annette Ostrand +61 3 9276 7473 or email Annette.Ostrand@surgeons.org

PROGRAM

Thursday 21 August – PSA
Friday 22 August – PSA & concurrent meetings of the Trauma Committee and Trauma Sub-Committee
Saturday 23 August - Symposium Injury in Indigenous Populations – Learning from each other
Sunday 24 August - Acute Neurotrauma Management (Rural) – Contact the Professional Development Department to register

Topics will include:
> Rural Trauma
> Abdominal and Pelvic Trauma
> Transport of Burns Patients
> The Physiology of a Disaster
> Disaster Management
> Farm Management
> Head and Neck Trauma
> Anaesthesia in Trauma
> Hand Trauma
> Trauma within Indigenous populations: reflections and lessons from the past
> Cultural Awareness
> Profiles of Indigenous Injury
> Indigenous Trauma (Indigenous perspective)
> Panel and audience discussions: Interventions and prevention strategies in Indigenous communities and how should the College advocate for change in Indigenous injury

WORKING TOGETHER ON REVALIDATION

Conjoint Medical Education Seminar 2014

STEPHEN TOBIN
DEAN OF EDUCATION

The Tripartite alliance of the Royal Australasian College of Surgeons (RACS), Royal Australasian College of Physicians (RACP) and Royal College of Physicians and Surgeons of Canada (RCPSC) hosted its third Conjoint Medical Education Seminar on 14 March 2014 entitled 'Revalidation'. The event attracted a number of pre-eminent local and international speakers including: Sir Peter Rubin, Dr John Adams, Dr Craig Campbell, Dr Linda Snell, Dr Joanna Flynn, Professor Liz Farmer, Dr Jocelyn Lockyer and Dr William Pope.

The day began with a surveying of the scene discussing revalidation from the United Kingdom (UK), Canada, New Zealand (NZ) and Australia. A panel of regulators came together to give an insight of what Revalidation means to them. All of these regulators have been or are practising doctors.

In the UK from the General Medical Council's (GMC) point of view, revalidation is about the doctor demonstrating that he or she is "...up to date and fit to do what they do..." The introduction of revalidation in the UK was considered essential and the Colleges collectively had not had a useful role in that process.

In Canada, the University system continues through the continuum of medical education, so there is considerable involvement of Universities in postgraduate medical education as well. Because of the Continuing Professional Development (CPD) mandated by the RCPSC and the College of Family Physicians of Canada; the 'matrix' of information obtained about a doctor is exchanged with the regulator to a variable degree depending on the province.

In NZ, pilot practice visits in several medical craft groups of New Zealand have been demonstrated at this early stage to be most useful, as well as being very well received.

It was felt that the Medical Board of Australia's (MBA) role was to encourage an open and inclusive conversation about the subject. There is a regulated need for a doctor on the specialist register to meet the CPD requirements of their College whether working full time or not. These processes should show up to date knowledge and demonstrate good professional behaviours and should be able to be verified when required. At present RACS does not report failure to comply with CPD to the MBA. The Board believes that the Colleges could be much more active in this area.

There was then a discussion on how to assess the individual's performance. We heard how the RACS Surgical Competence and Performance Guide (2nd edition) informs CPD. The College CPD system is supported by a points system that now rewards a properly structured peer review practice visit or multisource feedback. There are templates available to suggest how one might go about being involved in such a process.

An online (e-MSF) system will be available in the near future to enable participation in CPD. This approach to practice review was supported by the UK experience as well as the NZ practice visits, particularly those visits piloted by the New Zealand Orthopaedic Association (NZOA).

In the UK, the mandated revalidation approach may demonstrate problems in the doctor's practice. The GMC does not cancel the doctor's license, but "...defers their revalidation..." The remediation and review process is usually carried out in the local health system area to attempt to improve the doctor's practice. The first group of doctors are only now going through this process. The GMC sets guidelines for how this might be done, but expects it be conducted in the doctor's location of practice whether that is in family practice or hospital based. Guidelines in the NHS may be more easily set and results documented because almost all (99%+) doctors in the UK are involved in the NHS.

> *"Revalidation is a process to identify and improve the performance of those who are at the lower end of the bell-shaped curve and to move the whole curve to the right"*

A report of the Victorian data from the Victorian Audit of Surgical Mortality (VASM) analysed several factors which may be contributing to the reduction of overall mortality. In Victoria in the past five years, the surgical mortality associated with having a surgical procedure in Victorian hospitals has fallen from 0.4 to 0.3 per cent across a large patient base. These figures are statistically significant and represent a 25 per cent reduction in surgical mortality in operated patients.

A demonstration of how a NZ cardiology unit reviewed personal performance and systemic issues to improve clinical outcomes was presented. It was clearly demonstrated that it was more than the cardiologist's prowess – teamwork is important – and it was important to also improve the hospital system that the doctor works in.

We heard about the Alberta experience with the Physician Achievement Review and the Physician Learning Program. This is a comprehensive and mandated revalidation program in the province of Alberta (www.par-program.org).

The Demonstrating Professional Performance paper developed by the Tripartite alliance highlighted that whether we call it "revalidation" or call it "active verifiable Continuing Professional Development", the principles behind this approach are reasonable.

Approaches to giving feedback to the doctor about information obtained in a revalidation or CPD program was discussed. The R2-C2 model for change from Calgary is about establishing rapport, discussing the results and obtaining a reaction from the doctor being revalidated. This model looks at the content in the context of the doctor's practice, establishes understanding and leads to a learning plan or coaching for improvement. The process aims to demonstrate improved practice in the future. Currently in Alberta, those in the lowest 10 per cent in physician achievement review are subject to such an approach (as a pilot).

The current MBA approach was discussed and it was noted that excellent CPD might almost be enough to achieve a revalidation approach. If revalidation was introduced by the Board "...what would this add and at what cost, what tools would be used, would this really enhance performance?"

It was also noted that the notification rate to the Medical Board is about 4 per cent per annum of the practising doctors in Australia. From the Board's approach, the next steps will be a working party, some social research work to establish what the community requires, a discussion paper and some piloting of different approaches.

There were multiple issues in the system that had led to the Medical Council of New Zealand's (MCNZ) current approach. MCNZ has now mandated community job rotation experience for doctors in their first two post graduate years.

Revalidation had been thoroughly covered with interactive questions from the audience and a debate on the topic of "Revalidation should replace continuing professional development". By show of hands, the negative team was considered to have won the debate. Would this be the prevailing view of the medical profession?

Finally Sir Peter Rubin commented on the day: he commended the Colleges for their leadership and suggested that the debate should be continued vigorously in Australasia.

For a full listing of the Conjoint Medical Education Seminar – Revalidation presentations refer to: http://www.surgeons.org/for-health-professionals/academy-of-surgical-educators/cmes-2014/

SAFETY THE TOP CONCERN as regulator ponders revalidation

This article originally appeared in the March 2014 issue of The Australian and New Zealand College of Anaethetists' 'Bulletin' magazine.

Patient safety and good medical practice are at the heart of discussions on revalidation, writes Medical Board of Australia Chair, Dr Joanna Flynn

DR JOANNA FLYNN
CHAIR, MEDICAL BOARD OF AUSTRALIA

The Medical Board of Australia has started a conversation with the medical profession and the community about revalidation for medical practitioners in Australia. The International Association of Medical Regulatory Authorities defines revalidation as "the process by which doctors have to regularly show that they are up to date, and fit to practise medicine".

In the UK, New Zealand, Canada and the US, medical regulators are discussing how to ensure that doctors in active practice are competent and professional. In some jurisdictions the focus is on enhancing continuing professional development (CPD) frameworks; in others on additional requirements for performance evaluation and feedback. Programs vary between those that target doctors known to be at higher risk and those that take a population wide approach. The UK introduced revalidation for all practising doctors from late 2012. New Zealand has introduced a recertification program for all doctors with a general scope of practice; that is those who are not specialists, and requires all doctors to undertake a structured audit of their practice as part of their CPD. Some Canadian provinces target doctors who practise in isolation or those who are over the age of 70.

The core purpose in all of these programs is to support patient safety and ensure good medical practice. Medical regulators have public protection as their primary consideration. Their role is to regulate standards of practice in the public interest. There is a solid body of international research, which demonstrates that a significant proportion of practising doctors underperform. This comes as no surprise to any practising doctor, as almost all of us can identify colleagues about whom we would have some concerns.

Revalidation is not a tool to weed out bad apples. Its purpose is not to identify a Shipman or a Patel. Doctors who are practising in ways that are in serious breach of accepted standards are identified in other ways and are dealt with through other processes involving employers, the Australian Health Practitioner Regulation Agency and the Medical Board of Australia and sometimes through courts and tribunals. Rather, revalidation is a process to identify and improve the performance of those who are at the lower end of the bell-shaped curve and to move the whole curve to the right.

So is there a place for revalidation in Australia? Who would need to be involved? What would they have to do? How often? What would it cost? And, most importantly, what value would it add?

What does the medical board have in place now to ensure appropriate standards of medical practice? As well as responding to notifications, the board sets registration standards, publishes codes and guidelines and approves accreditation standards developed by the Australian Medical Council (AMC) for basic and specialist education. The board has set registration standards for CPD and for recency of practice and has published Good Medical Practice, the code of conduct for doctors in Australia.

In the registration standard for CPD, the board has mandated specialist colleges as the appropriate bodies to set CPD requirements for those in their specialty. In turn, within the accreditation of specialist colleges by the AMC, one focus is the college's approach to CPD. Each year, when doctors renew their medical registration they are required to make a number of declarations, including that they are meeting the CPD requirements. This year the board will start to undertake random audits to ensure that practitioners are meeting the registration standards.

The board recognises that in Australia there are many other patient safety and quality assurance mechanisms. Clinical governance and performance appraisal are keys to good health service management and delivery. But not all doctors participate.

The board asks the profession and the community whether these processes are enough, whether the combination of CPD and clinical governance process are sufficient to allow the board to assure the public that all doctors on the register are competent and fit to practise. And if they are not, what needs to happen? Can or should CPD programs be redesigned? Should the board be targeting groups of doctors known to be at higher risk?

The way forward in Australia is not yet clear. The board needs to consult widely, gather evidence about where the gaps are and about what is effective, watch what is being learned from international experience, consider what may be feasible and test some proposals.

The ultimate question is what will provide a sufficient level of assurance that the trust that the community places in the medical profession is soundly based?

Royal Australasian College of Surgeons
2014 WA, SA, & NT **ANNUAL SCIENTIFIC MEETING**

Save the date
8–10 August 2014

The Pullman Resort, Bunker Bay, WA
Theme: The introduction of new technology in Surgical techniques - the do's and don'ts!
Convener: Mr Richard Martin

If you would like to contribute to the content of the meeting, please email your ideas and suggestions to ***college.wa@surgeons.org***

NEW SURGERY FOR Vanuatu

An attachment based in Geelong has widened the scope of surgery in Vanuatu

A former Rowan Nicks Scholar, general surgeon Dr Richard Leona, has become the first surgeon from Vanuatu to conduct Transurethral Resection of the Prostate (TURP) procedures for local patients following a 12-month training attachment under Urology Surgeon Mr Richard Grills at Geelong Hospital.

Between August 2013 and March 2014 the local team in Port Vila, led by Dr Leona, has conducted 29 TURP procedures using one of two Urology Endoscopic 'Towers' and endourological equipment donated by the Hamilton Hospital in Victoria.

According to detailed data sets maintained by Dr Leona, the patients had an average age of 69 years with prostate enlargement of up to 100gms.

Prior to Dr Leona's return from Australia and the arrival of the Endoscopic Urology equipment, such patients were either forced to undergo open surgery, seek treatment outside the country or wait for an Australian Government-funded Pacific Island Program (PIP) team visit.

Many such patients required in-dwelling catheters (IDCs) during their wait for treatment, which often caused personal distress, discomfort and social isolation, making Dr Leona's urology skills a great advance for the country and for his patients.

Dr Leona's data showed that of the patients he has so far treated, 23 of 29 had IDCs prior to surgery with an average IDC in place for three and a half months up to a maximum of eight months.

Almost all of his patients, 28 out of 29, were continent post-surgery with the remaining patient experiencing intermittent continence.

Dr Leona described his ability to now conduct TURP procedures as being of great significance for the people of Vanuatu and the region and said he hoped to be soon training other surgeons in the technique.

"We have never before done TURP procedures here outside PIP visits since the history of surgery started in Vanuatu so this is of huge significance," he said.

"Until recently, we had to conduct open surgery for prostates and that is a big undertaking as there is an associated high morbidity and high mortality risk because prostate patients are mostly older and they've often got co-morbidities such as diabetes, high blood pressure or heart problems.

"Many had to stay in hospital for up to four weeks to recover.

"Now they stay in hospital only for four or five days which both frees up hospital beds for other patients and saves the patient's families a considerable amount of money getting to and staying in Port Vila.

"The patients I have treated are extremely happy that they no longer have IDCs in place for months. They enjoy their lives again and many have left my office with tears of joy on their faces."

In 2012, Dr Leona undertook a Urological Surgery specialist training attachment at Geelong Hospital under the supervision of Mr Richard Grills with funding provided by the Rowan Nicks Scholarship.

Such support did he receive there, that the hospital provided not only his accommodation but also agreed to bring theatre and ward nurses from Vila Central Hospital to Geelong Hospital to learn the intra-operative and post-operative treatment of TURP patients.

Two theatre nurses from Geelong Hospital and two ward nurse have since held training workshops and performed exchanges at Vila Central Hospital.

Also during his visit, administrators of the Hamilton Hospital heard of Dr Leona's developing urology skills and the great need for such surgery in Vanuatu and donated Urology Endoscopic 'Towers' and complete sets of endourological equipment that were to be replaced and upgraded. The total cost of this equipment was around $350,000.

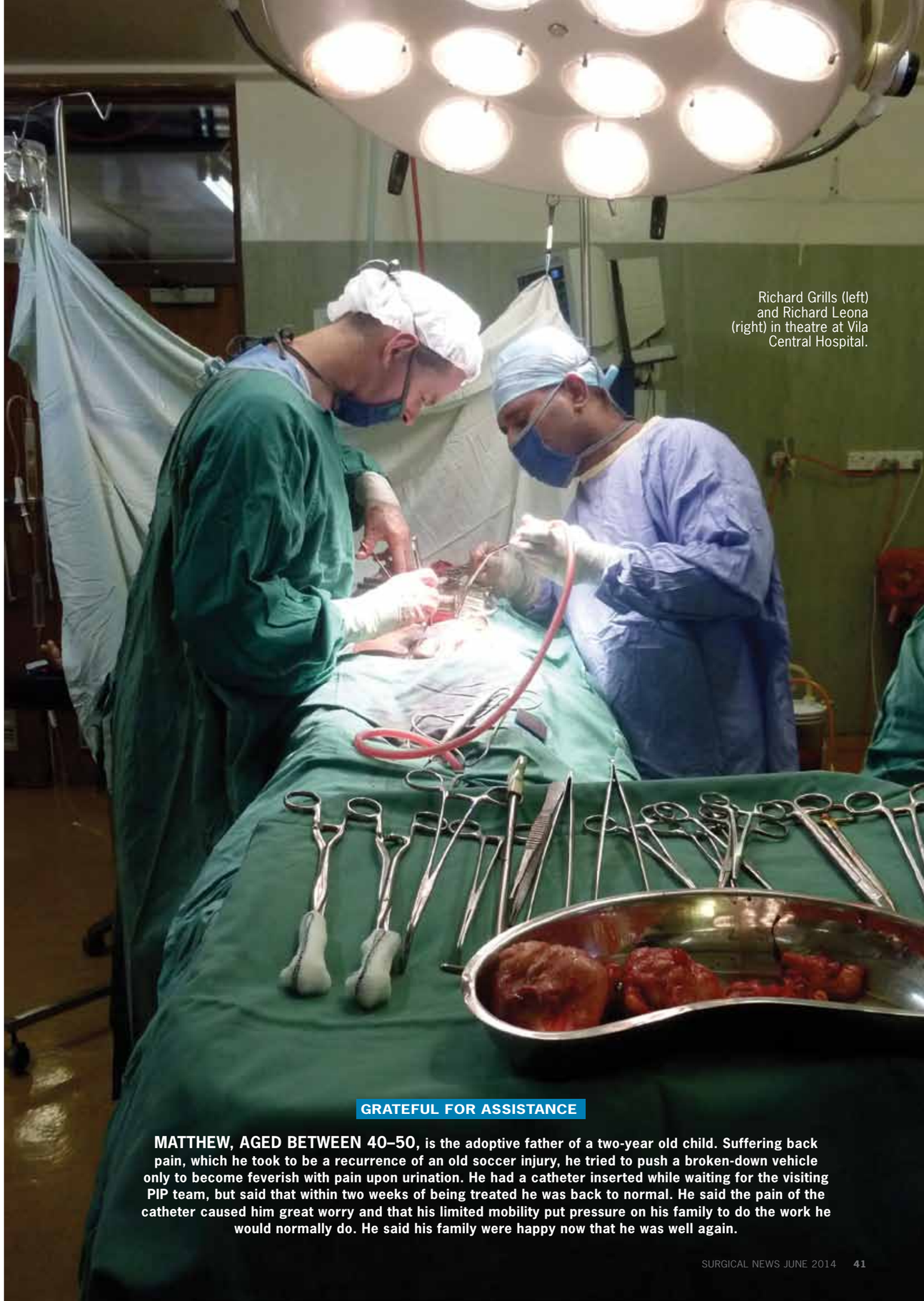
Dr Leona described the training provided to nurses, both in Geelong and by visiting nurses involved in PIP visits, as being a crucial component in the successful delivery of a urology service in Vanuatu.

"The nurses in Vila Central Hospital are now managing post-operative urology patients very well without too much supervision from me," he said.

"While visiting nurses taught them a lot, the training in Geelong has made a key difference because before that, there were a lot of problems with post-op care for patients who had TURP's simply because it was such a new procedure.

"But now they have really improved which is very important for me in my ability to provide the lower tract endoscopic urology service in Vanuatu.

"The nurses are also assisting me in theatre with confidence and there have been no problems so far. I haven't even been called at night for any post-op problems which is great." ▶



Richard Grills (left) and Richard Leona (right) in theatre at Vila Central Hospital.

GRATEFUL FOR ASSISTANCE

MATTHEW, AGED BETWEEN 40–50, is the adoptive father of a two-year old child. Suffering back pain, which he took to be a recurrence of an old soccer injury, he tried to push a broken-down vehicle only to become feverish with pain upon urination. He had a catheter inserted while waiting for the visiting PIP team, but said that within two weeks of being treated he was back to normal. He said the pain of the catheter caused him great worry and that his limited mobility put pressure on his family to do the work he would normally do. He said his family were happy now that he was well again.

Dr Leona using the new equipment.

Dr Leona described his time in Geelong as the best time of his training life overseas and thanked the College for awarding him the Rowan Nicks Scholarship.

He said he was looking forward to the next Urology PIP visit led by Mr Grills during which he hoped to refine his skills in upper tract endoscopic urological services such as percutaneous nephrolithomy (PCNL).

"The Rowan Nicks Scholarship was a golden opportunity for me to achieve the urological and surgical capacity to benefit Vanuatu," Dr Leona said.

"I not only increased my surgical skills during my time in Geelong, I also learnt about different systems and approaches to problems which have helped shape me to be a medical leader in Vanuatu today."

Mr Grills has participated in five PIP visits to Vanuatu with a sixth trip scheduled last month (May 2014).

He said that he had met Dr Leona during one of his early trips and when told of the Rowan Nicks Scholarship, he approached administrators from Geelong Hospital to find out if a urology training attachment could be arranged.

He praised the Geelong Hospital administrators, his fellow urological surgeons and nursing staff for the support offered to Dr Leona during his stay.

"To provide Dr Leona, and later the nursing team, with exposure to the cases that were needed to assist with their training required the support and co-operation of many departments within the hospital and that support was extraordinary," Mr Grills said.

"All the urology consultants had to be involved to allow him to work on particular cases, rosters had to be changed, nursing staff gave of their time to train the visiting team in intra-operative and post-operative care of TURP patients and patient lists were altered to maximise the nurses' exposure to TURP cases during their stay.

"Then, Hamilton Hospital generously donated all the equipment Richard would need upon his return which meant that we were able to provide an extremely valuable package including training Dr Leona, training the nursing staff and providing equipment.

"The Geelong Hospital Administration spent a great deal of time and effort to allow the visiting personnel to work and observe here which was wonderful to witness given that there was nothing in it for them apart from the altruist value.

"Budgets are tight, everyone has a full work load and just because developing world surgery is a passion of mine, didn't mean that everyone else had to get on board – but they did."

Mr Grills said that now that Dr Leona could conduct TURP procedures, more complex cases would be chosen for treatment by the visiting PIP team in May, including patients requiring complex kidney stone surgery and those with urethral strictures

He said that the results of Dr Leona's first year conducting TURP procedures were a testament to his skills, the training provided at Geelong Hospital and the on-going value of the Rowan Nicks Scholarships.

"Dr Leona is a paramount chief in Vanuatu, is very well known across the islands and knows how to get things done which is of great value when building medical systems in developing countries where making lasting change can sometimes be elusive," Mr Grills said.

"When he speaks in Vanuatu, people listen and to have that standing in a health setting is a rare and very valuable commodity.

"The great value of the Rowan Nicks Scholarships rests in selecting the right people and then giving them access to networks and mentors who can help them build their own systems which links in perfectly with the Australian Government-funded Pacific Islands Program.

"We have a group of surgeons, anaesthetists and nurses in Geelong who feel a sense of commitment to Vanuatu and it would be ideal to get a second general surgeon involved in training to help Dr Leona build his country's urological service."

With Karen Murphy

GRATEFUL FOR ASSISTANCE

PETER, AGED OVER 60, travelled for two days and one night from the island of Pentecost to Port Vila to be treated by the visiting PIP team. Seen by Dr Leona before the visit, Peter had blood in his urine and sufficient pain to limit his ability to farm, provide for his family and attend to some of his chiefly duties. While it took him some time to recover from the surgery, mainly due to co-morbidities, he can now work his subsistence farm once more, garden and attend his chiefly meetings, an important responsibility.

FROM THE NATION'S CAPITAL

Progress on training and services

WENDELL NEILSON
CHAIR, ACT REGIONAL COMMITTEE

Hello all surgeons!

My name is Wendell Neilson and I'm a vascular surgeon and current chair of the regional committee for our College in the ACT.

I took office in July of last year as a two-year posting, having been on the committee for three years.

So what has been happening in Canberra and its surrounds?

I am very pleased to inform the surgical community that The Canberra Hospital has been made a primary allocation centre of surgical training as of next year (2015). We feel that the region as a whole will benefit from this decision. We feel that this will help us to nurture a stronger surgical base in the area.

Currently we only receive Trainees on secondment from Sydney, who rotate for six to twelve months. With The Canberra Hospital being a primary allocation centre, and the centre for a training hub through our regional hospitals we can now train registrars from acceptance onto the program through to the completion of their Fellowship.

This will hopefully have flow on effects to the region's hospitals as they will gain support through the allocation of registrars and the responsibility of training. The credit for this change should be given to Dr Frank Pisconeri and Prof Guan Chong.

At the October Council meeting I mentioned how we are hoping to move toward an Acute Surgical Service (as has been successfully implemented in some of the Sydney metro hospitals). I have met with the ACT Minister for Health about this concept, who was very receptive.

As a result we have had the appointment of a Cross Territory and Regional Liaison Officer who will assist in the logistics of setting up the necessary arrangements at the two public hospitals, and the surrounding regional hospitals. These will be exciting times and should result in a more accessible urgent surgical service and a more efficient elective surgical process.

With this new acute surgical service we will also be able to push forward with the ACT Shock and Trauma Service, which currently is being stalled by the duplication of services at the two hospitals.

As with other States and Territories we are looking forward to our Annual Scientific Meeting to be held later in the year, and would encourage all Trainees to submit an abstract for review with the hope to present. This would also be a good opportunity to come and visit our nation's capital.

I would also like to wish all the applicants for the SET program 'Good Luck', and maybe we will see you in the Canberra region as one of our Trainees next year

In the meantime, happy operating.

TECHNOLOGY, SOCIAL MEDIA AND TRAINEES

The medical digerati are on the horizon, we must embrace the new coming

BRIAN LOH

The thrust of the Trainee and younger Fellow session at the Annual Scientific Congress (ASC) in Singapore was the way we as surgeons adapt to the evolving digital landscape and how to avoid the pitfalls of social media platforms.

The stage is now set for the digital disruption of the medicine.

In the three decades since Motorola produced the first mobile phone and the personal computer became a viable reality, we have completely changed the way we listen to music, communicate, surf the web, take pictures, play, read and think. The hybridisation of the burgeoning Internet and the increasing portable power of smartphones were the two most vital components of the social media convergence.

When Mark Zuckerberg started facebook in 2004, could anyone have predicted that there would be over 1 billion users today. More than 1.5 trillion messages are sent per year via facebook. Twitter, with over 280 million registrants connects more than 20 per cent of internet users. There were 300 million tweets a day in 2013.

Silent giant GOOGLE+ is the 2nd largest social network with 359 million users in 2013. We are in a state of near-constant connectivity; whether it is rapidly digesting text, graphics, links, photos or videos, we are constantly scanning an extraordinary body of data. Maybe the next generation of Trainees (Generation Z doctors) will be the first generation of medical digital natives, perfectly adapted to a highly dense, data-rich environment. The medical digerati.

Instant connection

Social networking immediately and intimately connects individuals irrespective of the tyrannies of distance and time; making it so much easier to trip up when success should have been reasonably easy to attain – the epic online fail.

As a result, governing bodies have taken to releasing social media policies to guide us. The American Medical Association policy statement emphasises privacy and professionalism and succinctly sums it up thus: Physicians must recognise that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers and can undermine public trust in the medical profession.

If there are so many pitfalls, why should surgeons bother?

In the mid 20th century, Joseph Schumpeter, the noted Austrian economist popularised the term 'creative destruction' to denote transformation that accompanies radical innovation. In recent times, the world has been 'Schumpetered' by the infiltration of digital devices into our daily lives. But our world, the medical one, has been largely insulated and compartmentalised from this digital revolution. Medicine is remarkably conservative to the point of being characterised as sclerotic, even ossified. We are on the verge of the creative destruction of medicine, we will be 'Schumpetered' in the coming years and we need to engage.

This is about a super convergence, made possible by the maturation of digital technology – the ubiquity of smartphones, bandwidth, constant connectivity and social networking. Add into this, the limitless possibility of cloud computing, genomics and improving imaging capabilities. A new medicine is on the horizon.

The revolutions in 2011 in Tunisia and Egypt were powered by social media and young citizens exploiting the digital world. Why not revolutionise medicine? Those of us who can embrace this creative destruction and emerge as the medical digerati will have a decided advantage. We need to evolve, not just to survive, but to thrive in the world of digital medicine.

GOOD COMMUNICATION – good investment

Complex cases call for compassionate dealings

GUY MADDERN
CHAIR, ANZASM

An elderly geriatric patient with multiple comorbidities was diagnosed with an adhesive small bowel obstruction based on clinical history and radiological findings. The patient also had a past history of multiple abdominal operations.

The patient was initially treated conservatively and started passing flatus after several days. The treatment included oral fluid, a light diet and soon had the nasogastric tube removed. However symptoms recurred and, nearly a week after non-operative management, the treatment was declared unsuccessful.

Total parenteral nutrition (TPN) was started after consultation with anaesthetics and Intensive Care Unit (ICU) physicians. It was not felt that the patient was a potential candidate for post-operative ICU care.

Discussions were held with close relatives pre-operatively regarding end of life issues. The patient was taken to theatre and a laparotomy revealed extensive and dense adhesions throughout the abdominal cavity. Extensive lysis of adhesions was performed from duodenojejunal flexure to the ileocaecal junction. A tight stricture was also encountered in the distal ileum.

A simple side to side anastomosis was performed bypassing the stricture. There were no iatrogenic enterotomies during this extensive procedure. A warm saline washout was performed at the end of the procedure.

The patient's post-operative course was unremarkable and TPN was continued. After nearly a week, the patient spiked a temperature and chest X-ray suggested an acute pneumonia. The following day right iliac fossa and abdominal pain began, but the abdomen was not distended. A Computed Tomography (CT) scan revealed large bilateral pleural effusions, and lower lobe loss of volume suggested a pneumonic process. No free air was present in the intraperitoneal space, but multiple small bowel loops were noted in the pelvis.

Although the issue of anastomotic leak was raised, there did not appear to be any support for this. Medical consultation was sought for the acute pneumonia and again discussions with the family were undertaken regarding future management plans. No further invasive treatment was requested and the Palliative care team was consulted to continue the patient's care. The patient passed away nearly two weeks post-operatively. The patient's family did not want a post-mortem.

Comment

Management of a geriatric patient can be complex. Non-operative management in this patient with multiple comorbidities was initially appropriate. A strictly defined time line should also be established at the commencement of this type of treatment. Forty-eight rather than 72 hours may have been a better point at which to seriously reconsider management.

Throughout the care of this patient there was good communication with close family and clearly they were very satisfied with the care and outcome.

Lesson

The importance of compassionate and honest communication in assisting relatives dealing with the emotional discomfort associated with a seriously ill or pre-terminal loved one is demonstrated in this case. The ability to communicate successfully may not come easily to some of us. Work hard at your communication skills and always make time for explanations. The surgical case form on this patient was well described and type written. The first-line assessor had no problems whatsoever commenting on the case that was sent for assessment. The second-line assessor's comment was: "This sounds like a well-managed and complex case".

We like to hear these comments!

CONGRATULATIONS on your achievements

The Council of the Royal Australasian College of Surgeons admits from time to time distinguished surgeons, scientists and other persons to Honorary Fellowship of the College in recognition of their contributions to Surgery, Surgeons and the College. The purpose of the award is to recognise significant work of eminent individuals in any field of endeavour.

Mr Iain Anderson FRCS FRACS (HON)

Honorary Fellowship

Iain studied medicine at the University of St. Andrews and Manchester University graduating with Honours in 1983. He trained in Surgery in Manchester and Edinburgh gaining Fellowship of the College of Surgeons of England in 1987 and the Intercollegiate Specialty Fellowship in general surgery in 1994.

Iain has maintained a broad based practice in general surgery with interest in colorectal, gastric, hepatobiliary and endocrine surgery. In 1989 he was awarded an MD from the University of Manchester for his thesis entitled: 'The effect of Injury on the Arterial Baroflex in Man'.

His broad surgical training and acute care interest has had a major influence on his surgical career both as a clinician and educator.

Iain is currently the senior surgeon of the Intestinal Failure Unit at the Hope Hospital Salford. This is a nationally funded 19-bed dedicated unit which manages complex problems of intestinal failure, open abdomens with intestinal fistulae and abdominal sepsis. This unit accepts patients from all over the UK and Europe. It also provides an outreach service giving advice and management to what many would consider to be the most complex problems in abdominal surgery.

In 1994 Iain was appointed by the College of Surgeons of England as Tutor in Surgical Critical Care. His remit was to establish a course to teach surgical Trainees to improve their management of the sick surgical patients. The result was the CCrISP Course which was established in 1998. This course in surgical critical care is now taught in the UK, Hong Kong, Malaysia and Australasia. Its value was soon recognised by our College and it was made compulsory for all surgical Trainees.

Iain has been a good friend to our College. He has personally been involved in the introduction of the CCrISP Course in Australasia and has overseen its development; a contribution we greatly value.

Iain's contribution to surgery was recognised by the Royal College of Physicians and Surgeons of Glasgow with the awarding of an Honorary Fellowship in 2006. He was awarded an MBE by his nation in 2014 for "services to clinical surgery and medical education".

Citation kindly provided by Mr Philip Truskett FRACS

In 1992, Council resolved to create awards to recognise Excellence in Surgery in Australia and New Zealand. The awards may be for clinical performance, for research or for education and may be made to an individual, a unit or a group.

EXCELLENCE IN SURGERY AWARD Professor Arthur Richardson FRACS

Arthur was educated at Trinity School, Sydney playing in the first XV. He studied medicine at Sydney University, graduating in 1978. He was one of the initial intake of Trainees at Westmead Hospital where he was strongly influenced by Professor Miles Little.

After obtaining his FRACS in 1985 he travelled to France working with Professor Charles Proye in Lille, a post organised by Professor Tom Reeve. Here Arthur gained extensive experience in oesophageal and endocrine surgery. He then worked with Professor Chapuis and Didier Houssin at University de Paris Sud in endocrine and transplant surgery. His following appointment was in Oxford with Sir Peter Morris as Fellow in Transplant Surgery. Arthur returned to Australia in 1989 and was appointed to the staff at Westmead Hospital. True to his skills he undertook vascular, transplant and general surgery.

He has served as Supervisor of Surgical Training, Examiner in General Surgery, served on the Board of ANZHPBA and was Chairman of the NSW Regional Committee. He is head of Upper Gastrointestinal and Hepato-pancreato-biliary Surgery at Westmead. He currently serves on the NSW Surgical Services Taskforce and chaired its Workforce Planning Committee. He was an early advocate of emergency surgery units.

Arthur is a respected teacher, developing modules for the Master of Surgery Course at Sydney University. He has published over 50 papers in peer reviewed journals.

Arthur was appointed an Associate Professor of Surgery, Sydney Adventist Hospital Clinical School of Sydney University in 2010. Despite all these commitments, he completed a Doctorate of Surgery at Sydney University in 2012 with a thesis entitled, "Aspects of liver resection and the treatment of colorectal liver metastases".

Arthur is a master surgeon, comfortable in a wide variety of operative fields. He is the surgeon colleagues seek advice from and refer their family to. He has managed to combine clinical excellence, teaching, surgical research and substantial leadership roles in his hospital, his College and his community and truly exemplifies surgical excellence.

Citation kindly provided by Mr Robert Costa FRACS

General Surgeon

SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL, QLD

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The SCUPH will be collocated with the new public hospital – Sunshine Coast Public University Hospital, on the Kawana Health Campus which is currently under construction.

Sunshine Coast University Private Hospital

For a confidential discussion, please contact:
Dr Tony Hayek on 0407 175 831
or email CV to Lynne Edgerton, National Recruitment Manager (Medical)
at edgertonly@ramsayhealth.com.au

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WINDING DOWN FROM MEDICAL PRACTICE

As the 'Baby Boomers' look towards retirement, the legal issues involved in winding down from medical practice loom large

MICHAEL GORTON
COLLEGE SOLICITOR

There will be the usual financial planning arrangements, as medical practitioners prepare for retirement, including superannuation, future insurance requirements ("tail cover" for claims arising from previous practice), the transfer of medical records and referral arrangements. Some medical practitioners may be thinking to sell or transfer their practice, hoping for some windfall amount or value. Many may be surprised as to what little they have to offer by way of sale and of value to others, when the point of retirement is reached. For some it may be too late to maximise the value of their practice.

What do you have to sell?

In essence, the value of a medical practice is the goodwill, reputation and client base, which may or may not be difficult to transfer.

A typical medical practitioner may have premises (either owned or leased). The practice will have a patients' roll, establishing goodwill. However, transfer of patients and their medical records does require some formality under privacy legislation. There may be some medical and office equipment. All in all, as a practitioner is ready to retire, it may be too late to extract the real value of the practice.

Accordingly, a better method of extracting value from a practice may be to enter into partnerships or associateships well ahead of the scheduled retirement date. A cost sharing arrangement with a junior colleague who may ultimately pay to take over the practice (and pay a goodwill amount upon entering the practice) may be the best method of extracting value. This permits a transition to retirement over time as the junior practitioner increases productivity and patient involvement, and the senior practitioner can wind down.

What should you consider?

Tax issues need to be considered. Capital gains tax on the sale of assets, including goodwill, may be relevant to practices commenced or created after September 1985. If CGT applies, there will need to be a determination of the cost base, and therefore any tax that may be payable. There may be stamp duty on a sale of business in some States (not Victoria), and certainly stamp duty on the transfer of any property or premises.

Upon retirement the practitioner should arrange "tail cover" insurance, which insures the practitioner into the future for any claims arising in connection with the previous practice. This provides some added safety and security in retirement.

Where a business is closed, there are professional obligations to make appropriate arrangements to transfer patients by way of referral, as well as specific arrangements under health records and privacy legislation for the transfer of medical records. Any medical records retained still need to be maintained securely, and only destroyed in accordance with appropriate legislative requirements. It may also be necessary to maintain medical records for insurance purposes, in the event of a potential future claim.

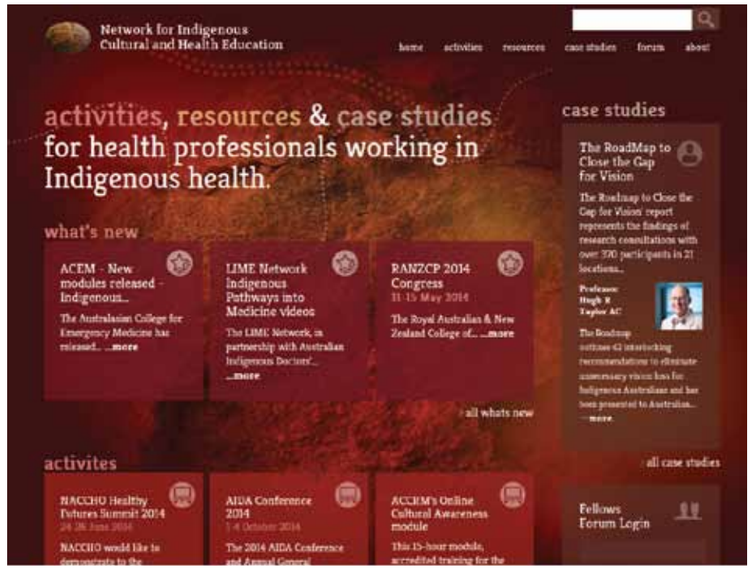
For those approaching or contemplating retirement there are a number of things to consider:

1 Think about it now and plan for retirement well in advance;
2 Review your existing corporate structures, to ensure that they allow for flexibility for future sale or involvement of a partner or associate;
3 Consider what you can sell, and to whom it may be sold;
4 Seek appropriate tax, accounting and legal advice as part of preparation; and
5 Consider your intentions in relation to patients and their records as part of a future plan to retirement.

ONLINE RESOURCES
for Indigenous health specialists

New Indigenous Health Education Resource for Medical Specialists – nicheportal.org

KELVIN KONG
CHAIR, INDIGENOUS HEALTH COMMITTEE



Niche Portal, the Network for Cultural and Health Education Portal, http://nicheportal.org/ provides links to educational and learning resources in Aboriginal and Torres Strait Islander health and cultural competency, for medical specialists caring for Indigenous communities.

Niche Portal is a searchable database that stores records in one of three categories – Activities, Resources or Case Studies. Records on the database provide information and links to

> accredited courses, online learning packages, workshops, conferences and scientific meetings in Aboriginal and Torres Strait Islander culture and health;
> publications, manuals, brochures and information leaflets, podcasts, videos, Interviews with specialists, relevant websites;
> case studies to illustrate disease profiles, the diversity of Aboriginal culture and local issues affecting health care access and service delivery; and
> site specific reports and anecdotal information to foster multi-disciplinary practice networks and provide multi-disciplinary perspectives.

Niche Portal also offers a free discussion forum, the 'Fellows Forum', to encourage the exchange of knowledge, expertise, information, reviews and tips. The forum is only open to Fellows, Trainees and IMGs of the Specialist Medical Colleges.

Niche Portal is a collaborative initiative of the Specialist Medical Colleges led by the Royal Australasian College of Surgeons (RACS) and funded through the Commonwealth Government's Rural Health Continuing Education (RHCE) Program. The majority of the content has been created by partners in the project or been checked for appropriateness against content guidelines developed by the portal's steering committee.

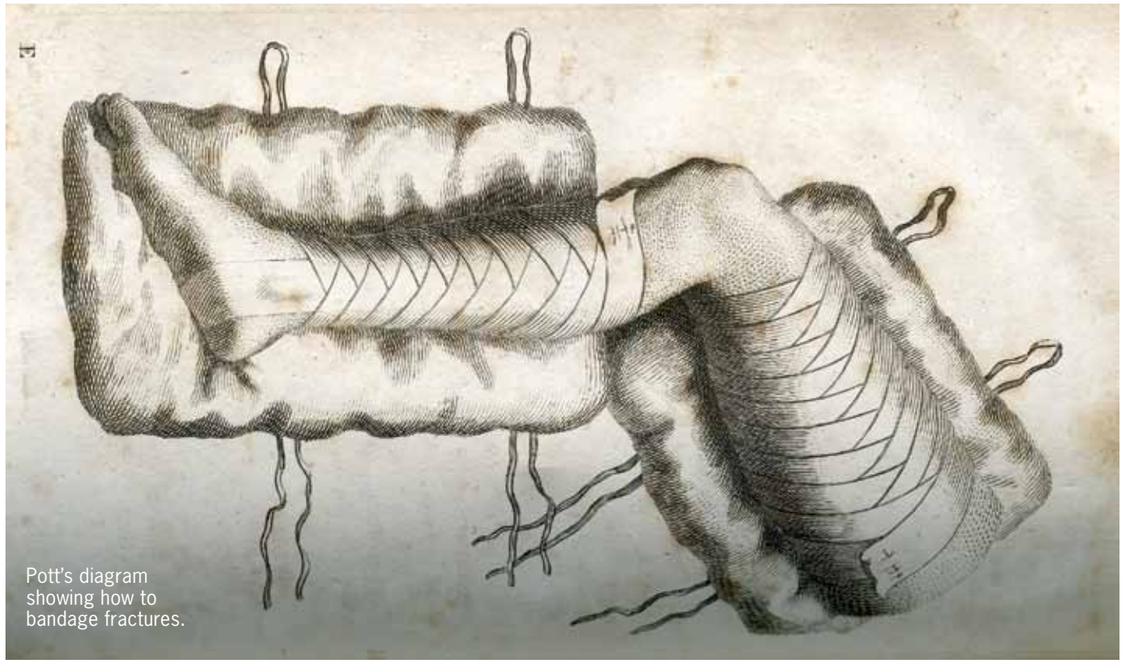
The portal initiative has three main objectives:

> to encourage and support a multi-disciplinary approach to Indigenous health care through sharing and easy access to learning activities, engagement with other professionals, the formation of networks and communities of practice;
> to be an interactive and innovative platform and resource base through which Fellows, Trainees, International Medical Graduates (IMGs) and college staff can access practical information in Aboriginal and Torres Strait Islander health and culture; and
> to support the Committee of Presidents of Medical Colleges (CPMC) and its member colleges in implementation of the CPMC National Aboriginal and Torres Strait Islander Curriculum Framework.

Members of the College are encouraged to visit the Network for Cultural and Health Education Portal at http://nicheportal.org and join the Fellows Forum. We would be happy to receive your suggestions for content or feedback on the portal.
For more information about the Niche Portal and its Fellows Forum, please contact either Melanie Thiedeman on (03) 9276 7407 or Monique Whear on (03)

A GLIMPSE OF 18th CENTURY SURGERY

Some clues on early surgery are revealed through the oldest piece in the archive collection



Pott's diagram showing how to bandage fractures.

ELIZABETH MILFORD
COLLEGE ARCHIVIST

The oldest document in the College archive is a certificate dated 7 December 1786 admitting Thomas Ashwell to the Company of Surgeons of London. A parchment document in good condition, the certificate contains the almost indecipherable signature of the Master and Wardens of the Company; and of the examiners including Percivall Pott and Josiah Warner.

Ashwell's examiners found him to be "a fit and capable Person to Exercise the Art and Science of Surgery". Admission to the Company of Surgeons reflected the increased professionalism of surgery in the late 18th century. By 1786, the Company of Surgeons was an established body having split from the Company of Barber Surgeons in 1745. It was the precursor to the Royal College of Surgeons in London who were granted their charter in 1800 and later became the RCSE.

We know little about Thomas Ashwell. He may have been related to Samuel Ashwell who was an Obstetric Physician and Lecturer at Guy's Hospital in the 1840s and wrote 'A Practical Treatise on Diseases Peculiar to Women' in 1844. However, Thomas Ashwell's examiner, Percivall Pott was "ranked as highest surgeon of this period".

Pott was an interesting character – charismatic and energetic, he was an extremely successful surgeon and by 1769 "enjoyed the largest, most fashionable and most lucrative practice in London". Beginning his career as apprentice to Edward Nourse at St Bartholomew's Hospital, he was also a pupil of William Cheselden, a rapid and exacting surgeon who could perform a lithotomy in four minutes. By the 1740s, Percivall Pott had been admitted to The Company of Barber Surgeons and had secured a post as assistant Surgeon and Lecturer at St Bartholomew's Hospital. He also promoted the establishment of a separate Company of Surgeons.

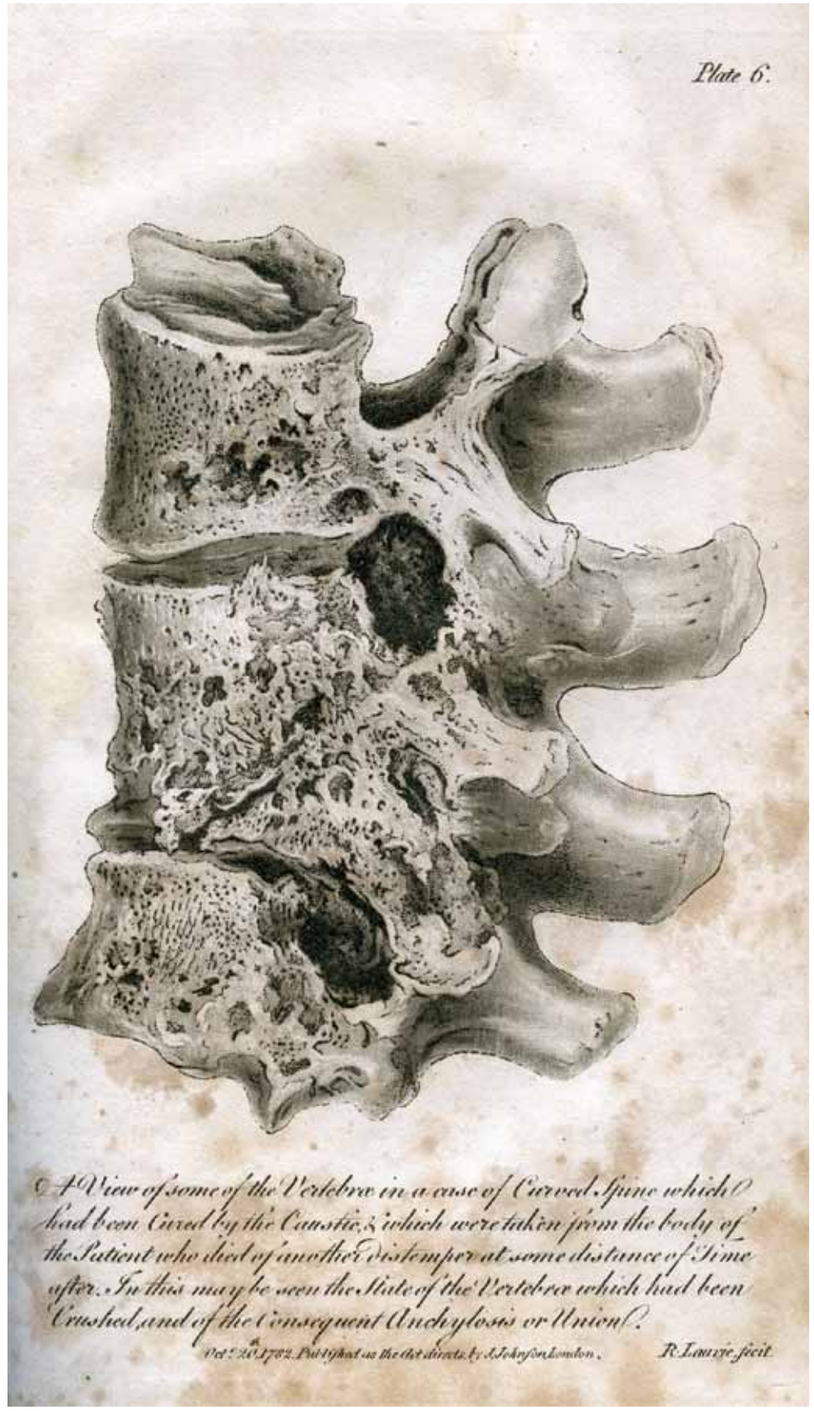
> *"By 1786 the Company of Surgeons was an established body having split from the Company of Barber Surgeons in 1745"*

In 1756 Pott fell from his horse in the Old Kent Road and severely fractured his leg. He insisted on being carried back to his house on a nearby door, resisted amputation and had the leg splinted instead. The procedure was successful and Pott, who spent his convalescence writing, was to document his observations in the *Chirurgical Works of Percival Pott FRS*. Significantly, the College has editions of this work in the Rare and Historic Books Collection. The first volume of the 1808 edition contains 'Remarks on Fractures and Dislocations':

"The true and proper use of splints is, to preserve steadiness in the whole limb, without compressing the fracture at all... in order to be of any real use at all, splints should, in the case of a broken leg, reach above the knee and below the ankle; should be only two in number; and should be so guarded with tow, rag or cotton, that they should press only on the joints, and not on the fracture."

Pott was cautiously innovative – and avoided the use of cautery and escharotics. He was the first to suggest that scrotal cancer in chimney sweeps was caused by their exposure to soot and to describe tuberculosis of the spine, now known as Potts' Disease. As a surgeon, "Nothing much is known about his personal technique, but he is said to have taken particular pleasure in his many successful cranial operations". But perhaps his greatest achievement were his writings which were very influential and, partly due to his Fellowship of the Royal Society (1765), widely circulated.

More than 200 years later, Thomas Ashwell may have slipped under the historical radar, but the certificate admitting him to the Company of Surgeons can still providestill provides developments of his day.



Early theatre return can avoid problems

The recent article by Professor Maddern "Audits of Surgical Mortality" in 'Surgical News' April 2014, highlights not only the hazards of poor postoperative communication, but also the risks of postoperative lower urinary tract bleeding. The current acceptance of the need to "return to theatre" after urological procedures, even using the new technologies, as being a slight on the competence of the urologist involved is unfortunate. Over the years, I found that early return to theatre, often under only LA and sedation, can easily rescue the situation and avoid the otherwise difficult problems of clot retention, recurrent catheter obstruction and blood loss.

Yours sincerely,
Robert D. Wines FRACS
(Retired Urologist)

Ulysses – I moan your passing!

Mr President, Congratulations and may your term in office be illustrious and not too stressful!

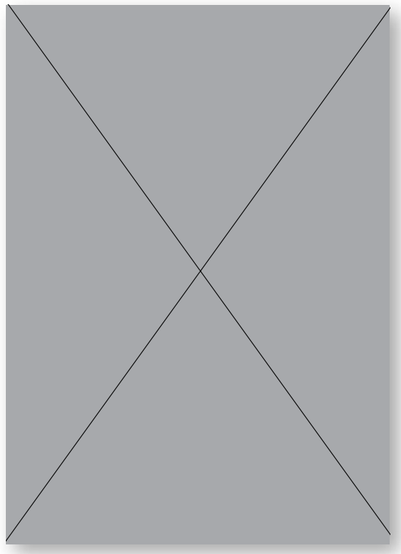
Michael, many thanks for your brilliant contributions to 'Surgical News' over the past five years. May you outlive your deceased nom de plume for many years!

After that introduction, there's not much else to say, and if I keep going, the Bard might say he, "doth protest too much, methinks"!

I was one of the many surgeons who have taken the trouble to write to Professor Kidding expressing understanding and empathy and it's nice to know it was appreciated.

I guess at 83, that I am now an "experienced and old surgeon" having graduated in 1954 and obtaining my FRACS in 1959. I taught and organised courses for the Primary, examined in Pathology and Physiology in Sydney, Melbourne, Perth and Singapore. I was Chairman of the NSW State Committee of the College in the late '70s and am still on staff at the Royal North shore in the Breast Screen Assessment Program – after 60 years! All of which you might reasonably say are the ramblings of an OLD Man!

Best wishes and kindest regards,
Ray Holling FRACS



ANZAC article postscript

In my recent article in *Surgical News*, I recalled some items which had surgical relevance to the ANZAC season. My 1500 word limit was exceeded, but I felt I must add some items as a postscript

Over the years I must say that those patients I welcomed most in my surgical career were those repats who had served their country. No setback was ever menial, no complication ever a problem and their likeable personalities made outpatient consultations and theatre experiences a welcome alternative. Any criticism was not part of their personality. I even learnt how to fish from one of my patients from Peter Mac, who one day told me, "Felix, the only way to catch fish in Fiji in 1944 was to explode a hand grenade on the surface of the lagoon and the fish would float to the surface."

Could this be the origin of our vernacular expression of a 'stunned mullet'. My secretary Margaret reminded me of Henry Lawson's story 'The Loaded Dog' of 1901, where a similar approach (dynamite) was used. I must again admit to being a bit of an opsimath, as Sam Mellick observed.

My final piece about the Shrine is worth recalling to complete this ANZAC portrait. When working at the Western Hospital in the 1990s, I had the privilege of operating on one of the repat individuals involved in its original construction – the builder, designer, stonemason or even the architect (I know not what). We came to know each other well over multiple admissions for multiple skin malignancies. He had the maquette (the 3-D architectural model of the Shrine which was inspired by the ancient Mausoleum at Halicarnassus) stored in his backyard. After the umpteenth admission, he said to me, "Sir (an army inclination), I really appreciate the work you have done and I have a present for you. The maquette of the Shrine is yours."

I always have been a little tardy in accepting any personal gifts from patients, yet I intended to donate it to the College anyway. When I finally got round to planning a visit to arrange for collection, his daughter that day in the ward said they intended to keep it when he died. I lost out because I was slow and the College missed a marvellous piece of architectural history, but in the end the family was happy.

Felix Behan
Victorian Fellow

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