



THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL NEWS

Vol:9 No:2 March 2008

March Highlights:

PAGE 14 INVITATION TO APPLY

The Board of Surgical Research invites Fellows and Trainees to apply for Scholarships, Fellowships and Grants, 2009.

PAGE 32 AUSTRALIAN ARTIST

Robert Hannaford admits to seeing surgeons differently since being diagnosed with cancer in 2006.

PAGE 38 INDIGENOUS HEALTH

The 2007 Trauma Symposium found that a multidisciplinary approach seems the best chance for implementation of a successful health program.

The College launches the new Foundation for Surgery, page 25



The College of Surgeons of Australia and New Zealand

PROFESSIONAL DEVELOPMENT ACTIVITIES 2008

There are exciting learning opportunities on offer designed to support Fellows in many aspects of their professional lives. PD activities will earn you CPD points and assist with the maintenance of knowledge and skills in training and interviewing as well as strengthening your communication, business, leadership and management abilities.

Specialists as Teachers Workshops

Date: 5 April, Coffs Harbour
Cost: Free to registered participants
CPD: 5 in Category 7

These free workshops have been developed as a means of providing important information to rural supervisors and trainers operating under the new Surgical Education and Training (SET) program. The course enables participants to become comfortable with using in-training assessment tools being adopted as part of the SET program by the specialties, managing underperforming trainees and developing performance management plans around the start of rotation, mid-rotation and end of rotation meetings. There will also be an opportunity to gain insight into College policies, legal issues and the expectations placed on rural educators.

Proudly supported by



Neurotrauma Workshop

Date: 12 April, Brisbane & 28 June, Melbourne
Cost: \$100
CPD: 25 in Category 4

These day-long workshops provide an invaluable opportunity to learn a range of neurosurgical techniques essential for the rural surgeon dealing with cases of severe neurotrauma; where the urgency of a case or difficulties in transporting the patient demand immediate action. The practical component of the workshop presents an opportunity to practice these techniques on human cadavers. Participants will learn procedures including a craniectomy, craniotomy, tap-shunt and burr-hole procedure. Most importantly, all of this will be learned using equipment commonly available in rural hospitals, such as the Hudson Brace.

Proudly supported by



Northern Australia Surgeons Network Videoconferences

Dates: April 26, May 24, June 28, July 26, Aug 23
Cost: Free
CPD: 10

The Northern Australia Surgeons Network (NASN) is a network of general surgeons and trainees working across public and private practice in sites such as Cairns, Townsville, Mackay, Mount Isa, Darwin, Alice Springs and Broome. This is a unique collegial experience for rural surgeons to develop educational activities and share collective wisdom. Monthly peer presentations are presented via video-link and include case discussions, literature reviews and focused audits. Fellows and Trainees from public and private sectors are invited to address these challenging and topical issues in an informal, welcoming setting.

Proudly supported by



Beating Burnout *Are you at Risk of Burnout?*

Date: 27 May, Perth
Cost: \$242
CPD: 3

This evening workshop helps you identify and address risk factors of 'burnout' before they affect your career and personal life. Proven time and stress management strategies are explored as well as

simple techniques to manage the effects of burnout. You will leave the workshop with practical simple steps that can be applied immediately to restore balance to your life.

2008 PROFESSIONAL DEVELOPMENT CALENDAR

QUEENSLAND

- 12 April: **Neurotrauma Workshop for Rural Surgeons****, Brisbane
- 26 April, 24 May, 28 June, 26 July, 23 Aug: **Northern Australia Surgeons Network Videoconferences**
- 14 June: **Winding Down from Surgical Practice**, Gold Coast
- 9 Aug: **Mastering Difficult Clinical Interactions**, Brisbane
- 3-5 Oct: **Surgeons as Managers (SaM)**, Cairns

NEW SOUTH WALES

- 5 April: **Specialists as Teachers****, Coffs Harbour
- 15 April: **Interviewer Training**, Sydney (by invitation from Specialty Training Boards)
- 29 July: **Mastering Intercultural Communication****, Sydney

- 8 Sept: **Mastering Professional Interactions****, Sydney
- 10 Oct: **Winding Down from Surgical Practice**, Sydney
- 23-25 Oct: **Surgical Teachers Course (STC)**, Sydney

VICTORIA

- 29/30 Mar (Orthopaedics); 13/14 June; 22/23 Aug: **From the Flight Deck**, Melbourne;
- 3 June: **Practice Management for Practice Managers**, Melbourne
- 19 July: **Expert Witness**, Melbourne
- 21 June: **Writing Reports for Court**, Melbourne
- 28 June: **Neurotrauma Workshop for Rural Surgeons****, Melbourne
- 8 Nov: **Risk Management Foundation: Informed Consent**, Melbourne
- 15 Nov: **Communication Skills for Cancer Clinicians**, Melbourne

SOUTH AUSTRALIA

- 26 July: **Mastering Difficult Clinical Interactions**, Adelaide
- 19 Sept: **Practice Management for Practice Managers** Adelaide

WESTERN AUSTRALIA

- April 26, May 24, June 28, July 26, Aug 23: **Northern Australia Surgeons Network Videoconferences**
- 27 May: **Beating Burnout**, Perth
- 29 April: **Interviewer Training**, Perth (by invitation only from Specialty Training Boards)
- 3-5 July: **Surgical Teachers Course (STC)**, Perth

NORTHERN TERRITORY

- April 12: **Specialists as Teachers****, Darwin
- April 26, May 24, June 28, July 26, Aug 23: **Northern Australia Surgeons Network Videoconferences**

NEW ZEALAND

- 2 April: **Interviewer Training**, Auckland (by invitation only from Specialty Training Boards)
- 4 April: **Supervisors and Trainers Course (SAT SET)**, Bay of Islands (General)
- 4-6 July: **Surgeons as Managers (SaM)**, Queenstown

ASC IN HONG KONG

- 15 May: **Supervisors and Teachers (SAT SET) Course**

**New Workshops for 2008

Please Note: Additional Supervisor and Trainer Courses (SAT SET) will be offered in each region; visit the PD section of the College website for more information.

Further Information Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org select the Fellowship and Standards menu and then click on Professional Development. Easy online registration is available for all workshops.



Andrew Sutherland,
President

The College has a great role in the international surgical community

One only needs to scan the contents of surgical journals to appreciate that Australian and New Zealand surgeons contribute to surgical education and the development of new surgical concepts at a level greater than that suggested by our small populations. Our College and each surgical specialty society have important spheres of influence around the world, and their members regularly contribute to international meetings and publications. The high profile of Australian and New Zealand surgeons could never have been achieved by the College alone. However, the College does have an important part to play. The challenge is how to appropriately represent all surgeons internationally, in all specialties, from two countries and to support the specialty groups in their important work.

The President of your College and those of the specialty societies each have a round of international commitments at significant cost to their members. One of the first things you are asked when elected President is your travel itinerary. The value to the Fellowship of such presidential travel is difficult to quantify but seems necessary in terms of international relationships and good will. It goes without saying that most of us have experienced the warm and friendly reception around the world accorded to surgeons from our two nations. Our reputation makes it easier for young surgeons to make contact with hospitals and leading institutions seeking further experience and training.

The initial stimulus for the founding of our College was the visit in 1924 of two American surgeons, Franklin Martin and Will Mayo, who encouraged local surgeons to form a college as America had done a decade before. However the new College, when formed in 1927, was more aligned to the culture and practice of the UK colleges. Australian and New Zealand surgeons have traditionally gained experience in the UK or North America, and many leading surgeons in our region have had some or all

of their education in Australia or New Zealand and are Fellows of our College. I had all of my orthopaedic training in Canada and the United Kingdom, and my first Fellowship was of the Canadian College. I was awarded the Fellowship of our College in 1975 by examination.

It has been a tradition for Presidents of surgical colleges around the world to be guests at the annual scientific meetings of their equivalent organisations. Certainly the presidents of colleges including those of North America, the United Kingdom, South Africa, the Sub-continent and Asia usually attend our Annual Scientific Congress (ASC) and will do so again this year in Hong Kong. It is interesting that many of our sister colleges no longer have an equivalent meeting to our ASC. The Canadian annual meeting only deals with their training programs and is attended principally by program directors and surgical educators. The UK colleges no longer meet annually but get together at the International Surgical Congress of the Association of Surgeons of Great Britain and Ireland to be held this year at the same time as our ASC. This organisation represents all of the surgical colleges and specialist societies in the UK.

During my twelve months as President I have concentrated my overseas travel in our local region and south-east Asia not only because I believe that this is our economic future but also to mark the fact that our 2008 ASC is combined with the College of Surgeons of Hong Kong. I have been a guest at meetings in Japan, Malaysia, Singapore Thailand and Papua New Guinea. The Vice President, Ian Gough, attended the American College of Surgeons meeting on my behalf. These countries all vary in the nature and development of their medical systems and education programs, but all recognise the value of our College's contributions to surgery. I had the opportunity to present our experiences in the development of the Surgical Education and Training (SET) program and Continuing Pro-

fessional Development programs. The future of surgical education is an important regional topic. Our College has moved over the years from the original concept that the Fellowship examination is the most important role for the College to the reality that a structured educational process is of equal importance.

Training and Educating Surgeons

In surgical education and training our College has particularly strong historical links with the United Kingdom, Canada and the United States. However the training environment, service delivery and relationships with universities, departments of health and other regulatory or funding bodies are different in each of these countries. This has resulted in diverse models and roles for each of our equivalent colleges. Our College is the only non-government body to have such a pivotal role across all aspects of surgical education in partnership with our specialist societies. The College is involved from selection into training to the exit examination and everything in between. It then has an important role in life-long learning and the maintenance of competence. We all have a lot to learn from each other as each country makes advances depending on its expertise, experience and the opportunities presented. The International Conference on Surgical Education and Training being held at the College in the first week of March will see the progression of a number of initiatives, particularly in regard to selection, assessment and the role of simulation.

We have assisted a number of countries to develop specific education programs. We have been instrumental in the introduction of the American College of Surgeons' Advanced Trauma Life Support (ATLS) course, locally known as Early Management of Severe Trauma (EMST), into neighbouring countries such as Thailand, Indonesia, Fiji, and New Guinea. We are currently working with the Malaysian College to assist them in a similar fashion. →

President's Perspective

College Fellows across a number of specialties have also been involved in the Definitive Surgical Trauma Care course of the International Association of Trauma Surgery and Intensive Care. As the medical systems of our neighbours become more sophisticated, the relationship moves very quickly onto an equal footing. An increasing number of centres have world-class standards, and we can look to each other for improvements and innovation, particularly in education. A key role for us to consider may be an exchange of examiners with other colleges that still undertake an exit examination process.

The College has at various times provided extensions of our training programs into south-east Asia. Currently the College accredits posts and examines in General Surgery in Hong Kong. They feel that this gives their programs and examinations overseas recognition and endorsement. However, the changes introduced by our new SET program mean that the concept of an offshore training program must be re-examined to ensure it is essentially the same as that run in Australia or New Zealand. There is now an increased emphasis on the educational validity of the program with regular in-training assessment and mentoring. A high degree of rigour is expected to ensure that Trainees who are struggling can be supported and counselled. Equally those Trainees who are excelling and completing the requirements of the program can be considered for acceleration wherever possible. Maintaining this degree of scrutiny will be a challenge for both local and offshore programs

Continuing Professional Development

Maintenance of professional standards is an issue of international concern. A number of countries are progressing to make continuing professional development a compulsory component of reg-

istration. This is a controversial topic among the Fellows of our College. It is interesting that in the voluntary model that the College currently offers, compliance exceeds 90 percent. Meaningful peer review and audit is moving our program to be more relevant and more stringent for the practicing clinician. All of us are concerned about our clinical standards. The College in partnership with the specialty groups is building the capacity to assess technical skills and is starting to work on material relevant to the non-technical skills. Drawing from overseas experience and in particular work done within the Scottish health system, our ability to communicate, collaborate and work effectively within team environments will also be examined. As pre-Fellowship education learns to deal with the nine College competencies, so should our Continuing Professional Development program. There is more to surgery than just maintenance of technical competence, and this is being recognised internationally.

International Aid Programs

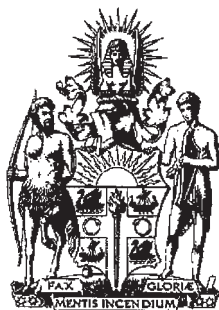
For decades surgeons have contributed to international aid initiatives. The College is now the organising body for a substantial number of AusAID funded programs. More than five million dollars are spent each year in this way. Over the life of the generally four-year programs the College is managing projects worth close to \$25 million. They provide opportunities for our Fellows to donate their time and energy, participating in exciting and beneficial work. Each year the AusAID funded programs involve about 100 surgical teams and more than 700 team members including surgeons, anaesthetists, nurses and allied health professionals. This commitment of money and people just about doubles if one takes in to account programs closely allied with the College such as Interplast and Orthopaedic Outreach. Initially built on a

“Each year the AusAID funded programs involve around 100 surgical teams and over 700 team members.”

model of flying in the expertise, performing a substantial amount of clinical work and then departing, the model is now one of training the local work force for sustainability. The infrastructure available in many of these countries will not support the health system that exists in Australia and New Zealand in the short term. However, by training surgeons in the local environment, the ability to provide ongoing care and attention is improved. The philanthropic support of individuals like Rowan Nicks and Richard Bennett have sponsored many surgeons and other health professionals from developing countries to work in Australia to improve their skills and makes a real contribution to surgical care.

Involvement with the International Arena

Our College must maintain an international profile. This is critically important, as solutions to surgical issues will be best identified by the sharing of information and by international discussion. It also makes it possible for individual surgeons from Australia and New Zealand to make significant contributions to the craft of surgery around the world. This may be the presentation of a high-level research paper at an international meeting or bringing surgical care to those who can least afford it. No doubt future Councils will continue to look at presidential travel and our international projects with this strategic focus in mind.



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Ian Gough,
Vice President

Occupational Hazards of Surgery

It is important for surgeons to recognise why injuries in the operating room occur and how they can be prevented

Last year the issue of burnout, which is largely caused by heavy workloads and excessive red-tape, was reviewed and it received a great deal of interest – as noted by numerous requests for the references used in that article. As a general feature of every workforce, the issue of stress and burnout has become endemic and therefore has a high level of recognition. However, other forms of occupational risks that affect medical workers, particularly surgeons, are less well known, if known at all. In this article, several examples of occupational injury which affect surgeons and surgical Trainees, in particular, are highlighted.

Needle Stick Injuries

The most frequent occupational injuries affecting surgeons and Trainees are needle stick injuries. Such injuries affect all medical workers, but studies suggest they have a higher incidence among Trainees and surgeons, because of the nature of their work.

According to Martin Makary from Johns Hopkins University (2007):

The operating room is the highest risk setting for occupational injuries, since a single operation can involve hundreds or thousands of internal stitches and a high number of sharp hand-offs

In a seminal 2003 study into the prevalence of needle stick injuries, 699 Trainees in 17 US medical centres were surveyed to examine the incidence and consequences of these injuries. The findings showed that 99 per cent had experienced a needle injury with an alarming 56 per cent sustained with patients at high risk of a blood-borne infection.

The findings for residents was little better, with the added feature of low injury reporting. It was discovered that 51 per cent of residents chose not to report their injury due to the extent of red tape required within an unremitting workload. In a disturbing testament to the occupational nature of these injuries, 20

per cent reported that they considered such injuries impossible to avoid.

In a recent edition of *The Journal of the Royal Society for the Promotion of Health* (2007) it was noted that “on average every US surgeon has received around eight needle stick injuries”. In other studies the scenario is common, procedures which require suturing and other high level use of needles result in correspondingly high levels of injury. With the risk of blood-borne contamination, the consequences of being infected shed a sobering light on these injuries, particularly as numerous studies show that low numbers of surgeons and Trainees have themselves tested for infection after a needle injury.

“It was discovered that 51 per cent of residents chose not to report their injury due to the extent of red tape required within an unremitting workload.”

Back Pain

Back pain is experienced, at least intermittently, by most people, and can be caused by a variety of factors. In surgery, perhaps the most common type of back pain occurs to the lower back region as a consequence of working conditions associated with the profession.

An occupational healthcare survey among 406 Plymouth doctors (2000) found a high prevalence of lower back pain which was largely attributable to such factors as height of the operating bed, standing for long periods of time, and the methods required to perform

particular procedures. Of the 62 surgeons who responded to the study, 77 per cent reported the need to reduce symptoms of lower back pain by sitting when operating, while 85 per cent found that their symptoms improved by simply making adjustments to the height of their operating beds. While these are easy to implement, the pace of surgery in operating rooms does not always allow for sufficient time to make adjustments to the operating bed. Of interest, over half of these surgeons (58 per cent) found there was considerable abatement of back pain when they were on vacation.

In this and other studies, lower back pain among surgeons was found to have a higher incidence than is the case for the general population, which underscores the occupational nature of this form of injury. Notable contributory factors to lower back pain are poor posture, incorrect table height, and the awkwardness that can sometimes be involved in surgical movements.

To illustrate the latter, ophthalmologists, who have the highest incidence of lower back pain, would seem to be vulnerable to uncomfortable posture, with eye surgery often requiring long periods of stooping over their patients.

Neck pain is also a significant risk for all surgeons and is related to holding the head and neck in flexed and rotated positions for uncomfortably long periods. It is important, if a surgeon intends to have a long operating career, to pay attention to his or her posture during operations. Consider changing the height of the operating table so the spine is straight, or nearly straight. Keep your neck straight and flex mainly at the top at the atlanto-occipital joint. Avoid lateral flexing and rotation wherever possible: for example, by having your head, hands, the operating field and the screen all in alignment during laparoscopic surgery. →

Relationships Update

“Lower back pain among surgeons was found to have a higher incidence than is the case for the general population.”

Hand Pain

In some cases, injuries are specific to particular procedures and or specialties. A particularly interesting example is a hand injury that is common to Urologists.

An extensive 2006 investigation into the incidence of ischemic hand pain among Urologists performing hand-assisted laparoscopic nephrectomy found that this was in the large an occupational hazard of the procedure.

Electrocautery Toxins

For most people, proximity to hazardous toxins is stringently regulated to avoid any exposure. In the case of some elements of surgery, exposure to toxins, including anaesthetic gases, cannot be avoided.

Electrocautery is commonly used in surgery to dissect tissue and to cauterise blood vessels. While it is highly effective, the process involves a great deal of smoke and vapour emission that contains several substances likely to be toxic to humans.

To date there has been insufficient research to indicate any long lasting problems associated with surgeons' exposure to these toxins.

Issues to Consider

While only a few occupational injuries of the surgical profession have been presented, it is clear that the potential for serious injury can be high. It is important for us to understand how these injuries occur and how they may be avoided.

Trauma Committee

Rob Atkinson,
Chair, Road Trauma Committee

Registrars' Trauma Papers Day

With the establishment of the American College of Surgeons Region 16, of which Australia and New Zealand are a part, an opportunity was created to submit a paper at the American College of Surgeons Committees on Trauma as part of the 2008 Resident Trauma Paper Competition being held in Washington DC on 13 March 2008.

The College Trauma Committee held a competition for registrars as part of College 'Trauma Week'. With the enticement of an airfare to the US and three nights accommodation in Washington DC, plus \$US500 (generously funded by the ACS) and the opportunity to present at an international scientific meeting, the registrars responded quickly.

The competition was announced in September and 30 expressions of interest were

received by the deadline on 19 October. Six registrars (David Dewar, David Wheatley, Louis Shidiak, Emma Johnston, Mark Romero and Jonathan Foo) were short-listed to present their trauma paper at the College in Melbourne on Wednesday 21 November. A group of 25 trauma specialists were part of the audience and Professor Frederick Moore, US visiting Trauma Surgeon and President of the Western Trauma Association, delivered an informative and lively presentation to the registrars about reperfusion injury, trauma care delivery and a future career in trauma.

The panel of four judges chose David Dewar as the winner. His paper 'Predicting post injury multiple organ failure in Australia' will be presented at the American College of Surgeons meeting. "The trauma paper day is



David Dewar

an exciting opportunity to present and review current Australian trauma research," said David. "I enjoyed presenting this year, and am thankful for the chance of presenting my work at the American meeting. Hopefully the paper day will continue to grow in future years."

Congratulations to David – and thank you to all the registrants who expressed interest in this competition. It is expected this will be an annual event. The Trauma Committee is planning to develop this activity and have more information accessible on the Web. Watch this space!



I.M.A Newfellow

Still Showing Good Grace

Prayers have been removed from the Council dinners, but there's no shortage of goodwill

This month I thought that I would tell you about prayer and love in the College. Hold on a moment – please keep reading! All will be revealed in time, but I suspect that I have lost the majority of readers already.

The issue of prayer came up at the last Council meeting. I bet you did not know that the body has a College Grace to be said before the dinners that are held on the Thursday night of Council week. The first two dinners that I attended were very impressive events. One was held in the Melbourne Club and one in the Ballroom of the Windsor Hotel on Spring Street. The Windsor Hotel (originally called the Grand Hotel) was designed by the Melbourne architect, Charles Webb. He also designed the Melbourne Grammar School and other notable buildings in the city.

I had read he also designed the Melbourne Club but have been unable to confirm this. In any event, the Ballrooms of these two buildings are magnificent – do have a look next time you are in Melbourne (although to enter the hallowed walls of the Melbourne Club

you need a Victoria pedigree that is immaculate, must have gone to the right school and barrack for the right football team).

You may well ask why the Council has a dinner each Council week. I wondered that for a time until I observed that the persons who were invited include the honorary advisers and their spouses. I would suggest that this a way for the College to thank them for the many hours of pro bono work they provide. Three dinners a year is cheap wages for about 100 hours of professional advice. Senior staff are also invited – my observation is that good friendships develop and the staff feel that we are all working together.

I am afraid that I have wandered from the point. The College Grace is:

*“God grant grace to the Queen,
Wisdom and prosperity to this Royal College,
And to every one of us a thankful heart for
His good gifts today”*

At the last dinner there was no Grace said. It later transpired that some Councilors felt that in our secular society it was no

longer appropriate. A discussion took place in the Council meeting at which various opinions were expressed. Mr. Gentle Giant spoke with passion and a deep sense of faith about there being more to being a surgeon that just operating – there was also the need to be an advocate, friend mentor and spiritual guide. These were not his exact words, but the sense of what he said is there. It was really quite moving. In contrast, Mr. Nit Picker said that as an atheist he felt that there was no place for religion or religious ceremonies in the proceedings of the College, a secular educational body. What a contrast!

It went to a vote and Grace lost. I later saw Mr. Nit Picker and Gentle Giant in an intense conversation. Being basically a sticky beak, I drew close expecting to hear an argument. But no – they were discussing with concern and empathy the difficulties of a particular Trainee. They differed in views about Grace but were drawn together by a common concern regarding a Trainee. So there you have it – prayer and love in the College (well, a deep mutual respect if you must be precise).

Notice to Retired Fellows of the College

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

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve.

We will acknowledge your donation and place your name on the gown, if you approve.

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

Alternatively, you could mail the gown to Jennifer C/o the Conferences & Events Department, Royal Australasian College of Surgeons, College of Surgeons' Gardens, 240 Spring Street, Melbourne 3000.



National Institute of
Clinical Studies

Stop the Clot

Integrating Venous Thromboembolism (VTE) prevention guideline recommendations into routine hospital care

VTE CONTINUES TO be a major cause of preventable morbidity and mortality among hospitalised patients, who have a 100-times greater risk of developing VTE than those in the community. Eighty per cent of VTE cases are attributable to surgical and medical hospital admissions.

The evidence base surrounding VTE prevention is clear, yet simple prophylactic

measures that are known to dramatically reduce the risk of VTE remain underused in many Australian hospitals.

Since late 2005, the NHMRC's National Institute of Clinical Studies (NICS) has run a national VTE Prevention Program, working with 40 hospitals across Australia to improve the use of VTE prophylaxis in hospital settings.

The NICS publication, *Stop the Clot: Integrating VTE prevention guideline recommendations into routine hospital care*, provides practical step-by-step guidance for health professionals to ensure that best practice is being followed in this important clinical area.

This month we conclude our serialisation of the guide.

Step 9

Monitor progress

There are three key aspects of optimal VTE prophylaxis management: risk stratification, choice of prophylaxis and dosage and duration.

The following evaluation and monitoring questions address these central issues.

- 1. Risk stratification:** Are all patients being classified appropriately into high, moderate and low risk? If not, what patient groups are being inappropriately categorised? Are there mechanisms in place to review patients' risk of VTE during the course of their hospital stay?
- 2. Choice of prophylaxis:** Are patients receiving the right form of pharmacological or mechanical prophylaxis according to their level of risk? Are there patients receiving prophylaxis for which they have a contraindication?
- 3. Dosage and duration:** Are prophylactic measures commenced at the right time? Are patients receiving the optimal dose of pharmacological prophylaxis? Is prophylaxis continued for a sufficient duration in accordance with the evidence? Are mechanisms in place to ensure that prophylaxis continues post-discharge if required?

As important as the above questions are, the responses they elicit will be mostly 'yes'

or 'no'. Continuous variables are required for monitoring and evaluation purposes so questions like the ones above need to be framed in terms of the proportion of patients meeting defined targets.

Good data that is reliable, timely and easily understood is critical. The data you collect needs to relate back to the key performance indicators in your action plan. Most well-planned quality improvement activities produce positive results, though often the improvements are modest. If you can achieve an improvement in practice of around 10 to 20 per cent, you will have done well. Celebrate small gains but aim to meet targets.

You need to be open to the possibility that some of the changes that result from the interventions you introduced will not be effective or may lead to unintended consequences. This is a further reason why evaluation is important, as it allows for unexpected consequences of the intervention to be quantified.

In this process you will learn lessons by monitoring data and critically examining the observed effects of the intervention. Making evaluation findings actionable involves explaining effectively what has been learned, both to the hospital executive and all other interested stakeholders. Generally, an evaluation report will conclude with a formal set of recommendations on what should happen next.

A likely outcome is that certain aspects of the intervention will be embedded into routine practice, while other aspects will require further planning to develop the next cycle of improvement. Quality improvement is a cyclical process.

Helpful tips...

- Report back to your hospital executive on a regular basis.
- Include progress reports and data from your team into relevant regular hospital reports, such as quarterly safety and quality reports.
- Use a standard format every time. The NICS audit report tool includes a number of standard, easy to use graphs.
- Sustainable mechanisms must be put in place to allow for ongoing monitoring. These routines should be set up in a way that is not reliant on the involvement of the implementation team.

Step 10

Sustain improvements

Getting sustained improvements in practice is the biggest challenge. In hospitals this means embedding successful changes into routine systems of care. How this is managed will be determined by local processes. A multitude of issues may arise which the hospital's management will be responsible for resolving. These include:

“Good data that is reliable, timely and easily understood is critical. The data you collect needs to relate back to the key performance indicators in your action plan.”

- altered role descriptions
- additional equipment
- additional costs
- impacts on medical records and other processes.

The executive sponsor and team coordinator are integral to ensuring that these outcomes are foreshadowed well in advance and the implications of the new procedures are communicated effectively to those affected.

Finally, while the engagement of clinical leaders is essential to initiating new ways of working, a system that is unduly reliant on the enthusiasm of particular individuals isn't going to work in the long-term. The clinical leaders themselves as well as the organisation's managers must recognise the need to put in place protocols, routine procedures and reporting structures that free the advocates for change to get on with their usual job and perhaps start thinking about tackling other issues.

Helpful tips...

- You will have new staff at the beginning of each year and rotating junior medical staff throughout the year. Include materials on VTE prevention in all clinical staff orientation presentations, especially junior medical officer orientation sessions.
- Ensure that audit results are fed into regular clinical department meetings.
- Continue to measure and report VTE prophylaxis audit results. Make this a standing agenda item in safety and quality meetings.
- Embed VTE prophylaxis indicators into your hospital's regular performance monitoring systems.
- Advocate for VTE indicators to be included among clinical governance indicators and hospital accreditation standards around appropriateness of care.
- Ask people to tell you what they need to make the change sustainable.

- Acknowledge and reward the effort people have put in and the work they have done – regardless of the outcome.

Resources and further reading

Kakkar AK, Davidson BL, Haas SK. The Investigators Against Thromboembolism (INATE) Core Group. Compliance with recommended prophylaxis for venous thromboembolism: improving the use and rate of uptake of clinical practice guidelines. *J Thromb Haemost* 2004; 2(2): 221-7.

McMullin J, Cook D, Griffith L, et al. Minimizing errors of omission: behavioural reinforcement of heparin to avert venous emboli: the BEHAVE study. *Crit Care Med* 2006; 34(3): 694-9.

A full text version of the Stop the Clot guide and associated electronic resources is available at www.nhmrc.gov.au/nics.

Clinical Surveyors *Required*

Opportunity to provide clinical leadership and expand your professional experience

The Australian Council on Healthcare Standards (ACHS) is currently seeking clinicians to join our team of surveyors.

Surveyors play a collaborative role during onsite accreditation surveys and provide education and information so that the organisation can understand how to progress while ensuring they achieve the standards to the required level. Verification is conducted through onsite visits and includes meeting with employees, management and clinicians as well as documentation review.

The ACHS surveyor workforce consists of approximately 370 experienced, senior health care practitioners with recent and broad experience in health care.

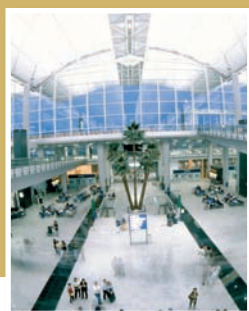
The ACHS has recently introduced a new set of standards for the fourth edition of our Evaluation and Quality Improvement Program (EQUIP 4). The focus of EQUIP 4 has been to further strengthen the standards overall and in relation to clinical care particularly.

An ACHS surveyor is trained to assess the performance of health care organisations against these standards. Many of the surveyors provide their time on a voluntary basis for up to ten days or two surveys per year while still employed in the health care industry. A small honorarium is paid to surveyors who are not employed and have recently left the health industry. Each team has a coordinator that is experienced, undergoes further training and is able to support the team during the survey.

To find further information about the ACHS and becoming a clinical surveyor, please refer to our website:

www.achs.org.au/becomingasurveyor or email Heather McDonald, Executive Manager, Customer Services, ACHS: hmcdonald@achs.org.au

CASC
2008



Vincent Cousins, Convenor
& Michael Leung, Scientific
Convenor

Meeting of minds in Hong Kong

You can book for any of the CASC dinners on the conference website www.surgeons.org/casc2008



The planning for the outstanding 2008 Conjoint Annual Scientific Congress is now on the final path and all indications are that the meeting will be a memorable one. Memorable for being in a great location, memorable for being a fully conjoint meeting with our colleagues and friends who are Fellows of the College of Surgeons of Hong Kong and for combining the Convocations and Congress Banquets of both Colleges. Six hundred abstracts have been received for the research sessions and over 50 new Australian and New Zealand Fellows will convocate and our College will also recognise 14 surgeons with awards – including Russell Stitz and Peter Woodruff, who will become members of the Court of Honour.

May is spring in Hong Kong, the best time of the year to visit according to our co-conveners. The days are warm and mild, the evenings balmy – and that is when the Hong Kong skyline lights up around Victoria Harbour. For the delegates attending section dinners on The Peak the views will be more spectacular – although the night sights from the

venue for the Younger Fellows and Trainees dinner (One Peking Road, Kowloon) are no less breathtaking. The Congress banquet will be in the beautiful Grand Dining Room at the Marriott Hotel, a short distance from the Congress hotels. A spectacular Chinese banquet with selected wines will be on offer. You can book for any of these dinners on the conference website (www.surgeons.org/casc2008). If you wish to add to an existing registration email casc.registration@surgeons.org.

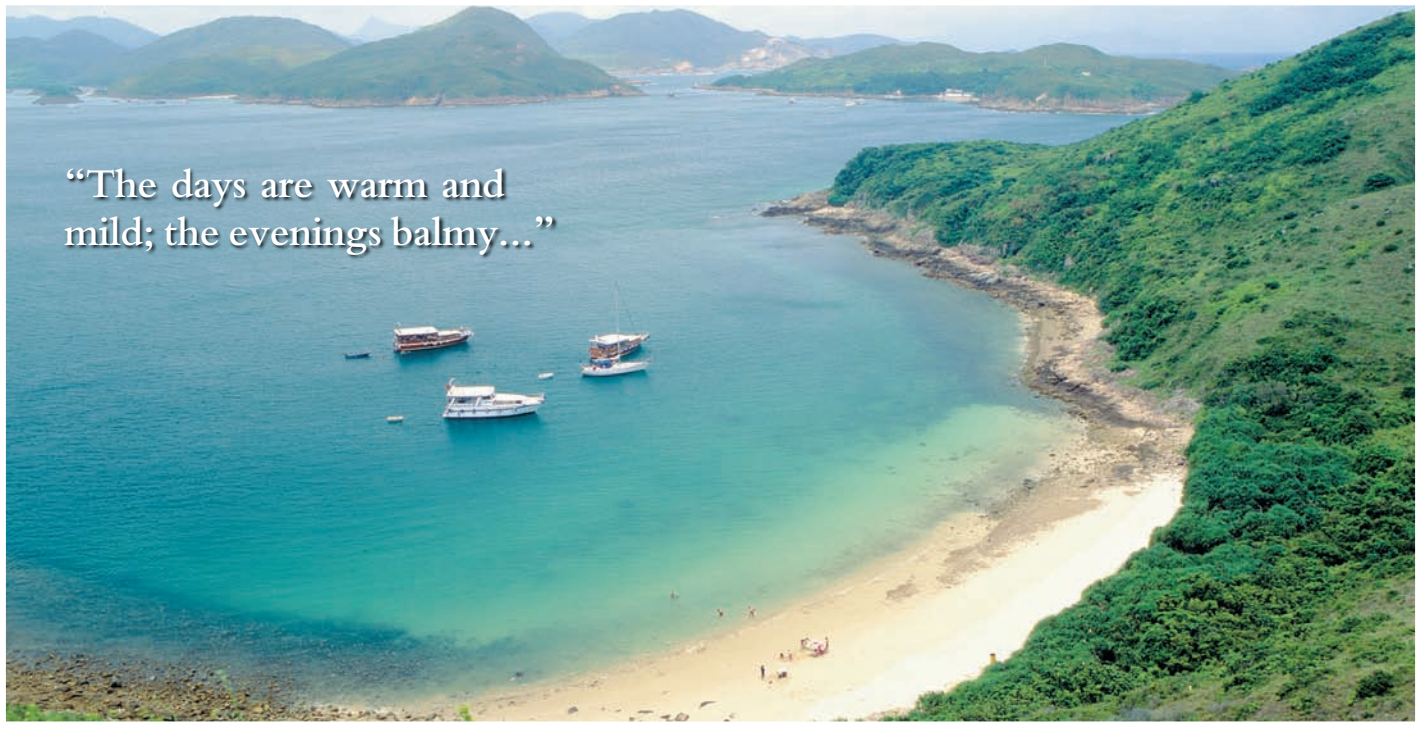
Professor Franklin Sim

Professor Franklin Sim, the Head of the Orthopaedic Surgery Department at the Mayo Clinic, is a surgeon of worldwide renown. Professor Sim will receive an Honorary Fellowship in recognition of his very significant contributions to orthopaedic training on a world scale. His particular area of expertise is in Sarcoma and he will be the lead speaker in a session on Pelvic Sarcoma, which has been convened by Professor Peter Choong (2008 John Mitchell Crouch Fellow) and the section convener, Bruce Mann.

Rural Scientific Program

Rod Mitchell, the convener, has a distinct advantage in that he worked in Hong Kong for several years and has maintained close professional and personal relationships with a number of Hong Kong surgeons and, in particular, with the co-convenor of the Congress, Samuel Kwok.

This year's program reflects a bias towards the spectrum of disease encountered in the region with a particular emphasis on Upper GI, salivary gland, and thyroid surgery. There are further collaborative sessions on damage control in general surgery, demonstrations of advanced endoscopic techniques, an update on optimal management of acute pancreatitis, and burns management. There will be an international session related to delivering surgical services to remote areas, a session on 'evaluating the surgeon and surgical Trainee' combined with the Surgical Education section and a combined session with the Medico-legal section. Our Section's RACS Visitor is Mr Simon Paterson-Brown from Edinburgh. He is involved with rural surgical services in Scotland and he will



“The days are warm and mild; the evenings balmy...”

bring a unique prospective to the conference and in the Masterclass will address difficult gastric emergencies; Simon’s keynote lecture will discuss the highly topical subject ‘Improving patient safety in the operating room’.

The Fellowship aspects have not been forgotten and the General and Rural dinner (Tuesday) on The Peak should be a standout.

The Divisional Group of Rural Surgery will hold its AGM on Wednesday at 5:30pm and all members are welcome to attend.

HPB, Upper GI and Bariatric surgery

The five co-ordinators of the combined Upper GI, HPB and Bariatric Programs for the 2008 ACS have put together an exciting and challenging program and certainly one of the largest in recent years. Several surgeons from the mainland with particular expertise have been invited to speak and working with their colleagues in Hong Kong they have attempted to cover both the most common conditions seen in these specialties, as well as exploring new and challenging procedures.

The HPB program is being co-ordinated by Professors Chris Christophi in Melbourne and Moon-Tong Cheung in Hong Kong. Professor Joseph Lau from Hong Kong will be our RACSA Visitor and in his keynote lecture he will discuss optimal training in HPB surgery.

The Upper GI program has been co-ordinated by Professor Simon Woods (Melbourne) and Dr Enders Ng (Hong Kong). The ‘Johnson & Johnson Medical’ Lecturer will be well known to many Fellows – Professor Mark Smithers from Brisbane. Mark has been instrumental in the design of many Australian trials in oesophageal cancer. His keynote address will evaluate the optimal treatment for oesophageal cancer now and into the future.

Drs Wendy Brown and Enders Ng have convened the Bariatric surgery program. The RACSA Visitor will be Professor Paul O’Brien – a pioneer of bariatric surgery in Australia with experience dating back to the 1980s. Paul will reflect on the evolution of bariatric surgery, and the powerful health effects that accompany weight loss in his keynote address.

Whilst each section will run sessions that are of sub-specialist interest as well, the convenors have worked together to plan sessions where there will be the opportunity for interdisciplinary input. Examples of these include a session addressing the best management for obese patients with reflux as well, medicolegal issues in Upper GI/HPB and Bariatrics and video sessions on new techniques.

The section dinner will be a Chinese Banquet at the Conrad on Tuesday 13 May. Numbers will be strictly limited and members of our section are encouraged to enrol early. We look forward to seeing you in Hong Kong!

Trauma surgery – vital breakfast session

Delegates with an interest in or those involved in the delivery of Trauma services are asked by the convener of the Trauma program, Associate Professor Martin Richardson, to note that there will now be a very important breakfast session on Wednesday at 7am to discuss current issues relating to delivery of trauma services in Australian hospitals.



PROJECT CHINA is one of the longest running outreach programs of this College. The main objective is to facilitate the contact of Fellows of the College with fellow surgeons of China in order to create avenues for the exchange of ideas and expertise for the advancement of surgical science between Australia/ New Zealand and China. We are endowed with excellent academic and research facilities; China, with her huge population, is bountiful in clinical material. A sharing of the resources between the two parties can be the basis of fruitful collaboration.

For more information on Project China please look on the College website www.surgeon.org and look under External Affairs



Road Trauma Committee

Saving Young Drivers

Thirty nine years of persistent lobbying by the College Trauma Committee has brought significant changes in road safety

Restrictions on P-plate drivers

The College's Road Trauma Committee has long advocated for measures to reduce the disproportionate number of young people involved in road crashes. In the early 1980's (then) Chair Frank McDermott and the Committee pushed for zero blood alcohol for all probationary drivers with legislation being introduced in Victoria in 1984.

Then, in 1993, the Committee recommended that probationary drivers should be subjected to night-time curfews and passenger restrictions, particularly in their first year of licensure, but changes regarding this issue have not emerged until very recently.

In June 2006, changes to the P-plate system were announced by the Victorian Government that included restrictions on mobile phone use, limitations on the size of car engines for P-plate holders, and the requirement for 120 hours of training for learner drivers.

While our desired changes were not fully accepted at that time, it was hinted that ongoing public education on the dangers of multiple passengers and night-time driving with inexperienced drivers would continue, and that it would not be unrealistic to expect that our desired legislative changes could be introduced in the medium future.

There was then a national push for change in the following year as a result of some horrific multiple losses of lives at the hands of young and inexperienced drivers in single vehicle accidents.

Since July 2007, the NSW government, in response to community pressure, legislated that drivers in their first year of licensure were subject to peer passenger restrictions between the hours of 11pm and 5am. In Queensland, a similar campaign saw the same restrictions introduced.

Following on, the Victorian Government finally made the courageous decision to introduce passenger restrictions for all first

“The road safety issue is a great lesson in the benefits of not losing sight of the College's main aims of community service.”

year probationary drivers starting from 1 July 2008. The Victorian Government went a step further, however, mandating that restrictions will be for 24 hours of the day.

The Road Trauma Committee congratulates these governments for their wisdom, and hopes other jurisdictions will follow suit.

Advocating for road safety

It is not easy to advocate for legislation to improve road safety. The process usually takes years, because of other political pressures on governments. However, the College has found a reliable formula that works – constructed and tested since the campaign for mandatory seatbelts. The necessary ingredients are effective partnerships, research and data, courage and persistence.

Between 2001 and 2005, research published by the National Institutes of Health showed that the part of the brain that assesses risks and controls impulsive behaviour is not fully developed until about age 25 (23 years in females).

Utilising this research, the media statement 'Courage to Stop the Carnage' was released nationally by the College Trauma Committee on Sunday, 7 November 2006. A number of crashes involving several young drivers and their passengers had occurred. Following the media release, Danny Cass, along with Harold Scruby of the Pedestrian Council of Australia, Bicycle NSW, The George Institute and a parent of one of the boys killed in a recent accident, formed a "Coalition for P-plate reform" in NSW to lobby the NSW Transport Minister's P-Plate Advisory Panel

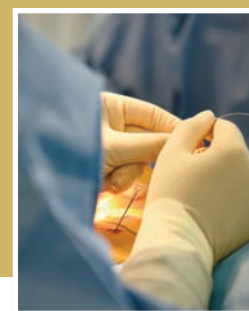
to seriously consider passenger restrictions, night-time curfews and a minimum P-plate age of 18 years (as in Victoria).

In South Australia, letters to the Minister for Road Safety from the Committee preceded an announcement in April 2007 that the Road Safety Advisory Council would recruit for a Youth Road Safety Taskforce. The College Road Trauma Committee was successful in gaining young medical representation on this Taskforce. We hope the Taskforce will help bring South Australia into line with the eastern states. The remaining states and territories and New Zealand will also be targeted.

In October 2005, the Victorian Branch of the College Trauma Committee made a submission to the Victorian Government's Discussion Paper on Young Driver Safety and Graduated Licensing. The submission emphasised that the significant increases in crashes involving young drivers can be related to brain immaturity rather than inexperience.

The fight to improve the graduated licensing system is not restricted to Australia only. In New Zealand, a media release during the College's ASC in Christchurch in 2007 highlighted the need to increase the age of probationary drivers. The New Zealand Trauma Committee is continuing to recommend changes through correspondence with the Government and comments to the media. It is forming partnerships with the New Zealand Police to advocate for improvements in road safety, such as raising the driver age and reducing legal blood alcohol levels.

Thirty nine years of lobbying by the College Trauma Committee has seen significant changes in road safety. The road safety issue is a great lesson in the benefits of not losing sight of the College's main aims of community service, persisting regardless of the number of obstacles experienced and seeming to be unpopular, working with like-minded organisations, and using good research.



Susan Gollop,
General Surgical Trainee

John William Corboy

8 December 1969 - 20 December 2007

It is with great sadness that we say goodbye to our leader John Corboy. John enthusiastically took on the Chair position of RACSTA after being elected at the first meeting of 2007. He was exceptionally generous with his time and an effective representative for all Trainees of the College. On a personal level he was a dedicated man who was a delight to work with. We shall miss his joy for life and his uncompromising generosity.

Damian Amato Co-Chair RACSTA

John began his life in Otorohanga, NZ and grew up as the eldest of five brothers on a dairy farm in Te Awamutu. He was schooled as a boarder at Sacred Heart College in Auckland as was the tradition in his family. After choosing between childhood dreams of priest, pilot or doctor, John completed Medical School at Otago University in 1994 where he initially stayed in Carrington Hall before flatting with friends.

There the traditional ended.

John managed to fit an extraordinary life into the next 13 years while remaining quietly unassuming. He was a modest man of great internal strength, able to continue to give to others while he himself was fighting for his life. Writing an obituary is difficult as John did not let many know of his achievements and it is only on his passing that many of us found out the complex and courageous man he was.

John perhaps showed signs of things to come by organising his elective at NASA, Houston – studying space medicine and becoming a Third Dan in Siedo karate.

Initially spending two years as a HO in Wellington, he chose surgery, as, in his own words, it was his “calling” and worked as a surgical registrar from 1997 to 1999.

In 1998 life turned upside down for John with the diagnosis of leukaemia. Determinately, John had ongoing treatment as he continued to work as a GP, obtaining his Primex and becoming a Fellow of the Royal New Zealand College of GPs. He also gained a Diploma in Aviation Medicine and sat exams



“He was a modest man of great internal strength, able to continue to give to others while he himself was fighting for his life.”

in Appearance Medicine which allowed him to become instrumental in laser tattoo removal in South Auckland, writing what was to become

a national reference on the subject.

John continued to work towards a surgical career, passing his Part I exam after a number of attempts, while unwell, but adamant he was to be treated just like anyone else. He then became an Specialist general surgical Trainee and worked at Auckland Hospital 2006 to mid 2007. Never one to back down from the political, John was elected to be our (the NZ General Surgical Advanced Trainees) representative in 2006 and after one meeting in Australia had impressed everyone so much with his integrity and diligence that they promptly elected him to be the Chair of the RACSTA.

On the 27th of December 2006, John and his wife of two years, Susan, had a baby boy named William. Again beating the odds after all of his chemotherapy.

However, in a devastating blow he developed myelodysplasia and required a bone marrow transplant. With plans to return to work within the year John battled graft vs host disease but sadly in the company of his loved ones he passed away peacefully at home just before Christmas.

John was a kind and genuine doctor who had a great passion for surgery. I had the pleasure and privilege of working with John over the last two years but regret that only in writing this I have come to know him. But that, it would seem, was John – a humble man who achieved so much in so little time. We have lost a great surgeon and leader but are thankful for all he managed to give in the face of such adversity.

Invitation to Apply

Scholarships, Fellowships and Grant Opportunities for 2009

The Board of Surgical Research invites Fellows and Trainees to apply for the following Scholarships Fellowships and Grants for 2009.

Research Scholarships and Fellowships

Please note:

- *The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department for the following research scholarships and fellowships.
- Applications for scholarships and fellowships below must be received by 5.00pm on Friday 30 May 2008.
- Where applications are open to all surgical trainees then applicants to surgical training are also eligible to apply in anticipation of their acceptance into the Surgical Education and Training (SET) Program. They must be accepted into the SET Program by 1 August in the year prior to the commencement of the scholarship in order to take up the award.

Foundation for Surgery Funded Research Scholarships and Fellowships

| AWARD | ELIGIBILITY CRITERIA | GROSS VALUE | TENURE |
|--|--|---|---------------|
| *Surgeon Scientist Scholarship | Open to Fellows and SET Trainees, enrolled in, or intending to enrol in, a PhD. | \$70,000 \$60,000 stipend plus \$10,000 departmental maintenance. | Up to 3 years |
| *Foundation for Surgery John Loewenthal Research Fellowship | Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *Foundation for Surgery New Zealand Research Fellowship | Open to Fellows and surgical Trainees enrolled in, or intending to enrol in, a higher degree. Applicants must be New Zealand residents. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *Foundation for Surgery Scholarships including: • Research Scholarships • Catherine Marie Enright Kelly Scholarship • Reg Worcester Research Fellowship • ANZ Journal of Surgery Scholarship | Open to Fellows and surgical Trainees enrolled in, or intending to enrol in, a higher degree | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *Foundation for Surgery Peter King Scholarship | Open to Fellows and surgical Trainees enrolled in, or intending to enrol in, a higher degree with the topic relevant to the practice of surgery outside of metropolitan areas. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *WG Norman Research Fellowship | Open to Fellows and surgical Trainees, resident in South Australia and enrolled in, or intending to enrol in a higher degree. The research topic should have a trauma focus. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *Foundation for Surgery Scholarship in Surgical Ethics | Open to Fellows, SET Trainees, or members of the public with a special interest in ethical issues of modern surgery. The latter must be sponsored by a Fellow of the College. Applicants must be enrolled in or intending to enrol in a higher degree with a topic relevant to ethical problems confronting surgery. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *Foundation for Surgery Louis Waller Medico Legal Scholarship | Open to Fellows, surgical Trainees or law graduates. Applicants must be undertaking, or intending to undertake, doctoral research on the topic of medico-legal risks and the law in this area. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance | Up to 3 years |

Bequest, Donation and Sponsor Funded Research Scholarships and Fellowships

| AWARD | ELIGIBILITY CRITERIA | VALUE | TENURE |
|--|---|--|---------------|
| *Paul Mackay Bolton Scholarship for Cancer Research | Open to Fellows and surgical Trainees enrolled in, or intending to enrol in, a higher degree. Research topic must focus on the prevention, causes, effects treatment and/or care of cancer. Applicants must be working in Queensland or Tasmania. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance | 12 months |
| *Eric Bishop Scholarship | Open to Fellows and surgical Trainees enrolled in, or intending to enrol in, a higher degree. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *Francis and Phyllis Thornell-Shore Memorial Scholarship | Open to Fellows and surgical Trainees enrolled in, or intending to enrol in, a higher degree. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | 12 months |
| *Sir Roy Mc Caughey Surgical Research Fellowship | Open to Fellows and surgical Trainees enrolled in, or intending to enrol in a PhD. Research must be conducted in NSW. | \$60,000 \$55,000 stipend plus \$5,000 departmental maintenance. | Up to 3 years |



***Raelene Boyle
Scholarship -
Proudly Sponsored
by The Sporting
Chance Cancer
Foundation**

The Raelene Boyle Scholarship, sponsored by the Sporting Chance Cancer Foundation, is offered for the value of **\$60,000** comprising \$55,000 in stipend and \$5,000 in departmental maintenance.

The scholarship is expected to draw interest from Fellows or trainees of the College working within either a university or hospital research unit, involved in cancer research that is expected to make a notable impact. Preference will be given to research projects with a focus on pancreatic cancer. Applications for the Scholarship are open to Fellows and surgical trainees enrolled in, or intending to enrol in, a higher degree. Applicants to surgical training are also eligible to apply for a scholarship in anticipation of their acceptance into the SET Program. They must be accepted into the SET Program by 1 August in the year prior to the commencement of the scholarship in order to take up the award. The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department.

**Rehabilitation Medicine
CONROD – RACS Trauma
Fellowship**



A grant from the Motor Accident Insurance Commission matched by Foundation for Surgery funds has enabled the College to offer annual research funding for research into trauma to the amount of \$50,000.

The 12 month Fellowship is open to Fellows and SET Trainees. Proposed research may be in any of the following areas: epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma. A single Fellowship of up to \$50,000 will normally be awarded but more than one Fellowship may be made to a total of \$50,000 in any one year. The Fellowship may be used for either or both salaries and expenses. It is not a requirement of this Fellowship that the research be conducted in Queensland but it must be shown that the potential benefits flowing from the research will assist the people of Queensland.

**John Mitchell Crouch
Fellowship**



The John Mitchell Crouch Fellowship of \$75,000 is awarded to an individual, who in the opinion of the Council, is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in the field. The grantee must be working actively in his/her field and the award must be used to assist continuation of this work.

The Fellowship commemorates the memory of John Mitchell Crouch, a Fellow of the College who died in 1977 at the age of 36. The Council of the Royal Australasian College of Surgeons invites applications or nominations for the above Fellowship.

Criteria:

- The grantee must be working actively in his/her field.
- The award must be used to assist continuation of this work.
- The grantee must be a Fellow of the Royal Australasian College of Surgeons who is a resident of Australia or New Zealand.
- To be eligible, applicants must have obtained their College Fellowship or comparable overseas qualification within the past 15 years.

Applications:

- Applicants must provide a brief statement about current research work and future plans.
- A detailed curriculum vitae, including a list of publications, must accompany the application. Applicants must provide a list of what they consider to be their five most important publications as well as the most important national or international lectures they have been invited to deliver, numbering no more than five in total.
- Applications must also include impact factors and the impact range for their sub-speciality.

The successful applicant is expected to attend the convocation ceremony at the next Annual Scientific Congress (ASC) of the College for a formal presentation. The Fellowship recipient must also be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.

Please note that there is no formal application form for this Fellowship and a new application must be made for each year of application.

**Fellowship in Surgical
Education**

The College and the Department of Surgery at the University of Toronto are offering a joint Fellowship to fund Fellows and SET Trainees wishing to undertake a Masters in Surgical Education at the Centre for Research in Education at the University of Toronto, Canada. The successful applicant will only pursue educational activities as part of the Masters program – no clinical work will be involved. The Fellowship is available for a period of up to two years subject to satisfactory performance. It is valued at AU\$50,000 stipend per annum with the University of Toronto providing a similar contribution comprising tuition and ancillary expenses.



**Plastic and
Reconstructive Surgical
Research Award**



Applications are invited for the Plastic and Reconstructive Surgical Research Award. This Award is funded by plastic and reconstructive surgeons to promote and support plastic surgical research and to encourage SET Trainees and recent Fellows to undertake postgraduate research studies. It recognises the link between research and clinical advances and demonstrates the Australian Society of Plastic Surgeons (ASPS) and the New Zealand Association of Plastic Surgeons (NZAPS) commitment to academic excellence within their specialty. This Award of \$25,000 is designed to encourage a one year period of supervised research, preferably leading to a research degree. Please refer to the College website for eligibility criteria.

There is no formal application form for this Award. Please submit a letter of application addressing the above criteria.

**Research Scholarship in
Military Surgery**

Applications are sought for a 12 month Research Scholarship in Military Surgery commencing in January 2009. The position available is Research Instructor at the Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA. The successful applicant will examine "Resuscitation Research for the Combat Mission" under the supervision of COL David G. Burris USMC. The position carries an initial stipend of US\$40,000.

To be eligible, applicants must hold Australian or New Zealand citizenship and to have fulfilled all the requirements for entry into SET Level 2, however preference will be given to SET Level 2 – 5 Trainees, Post-Fellowship Trainees, and Fellows.

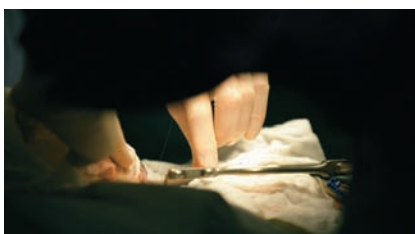
Travel Scholarships, Fellowships And Grants

Bequest And Donation Funded Travel Scholarships, Fellowships And Grants

**Murray and Unity Pheils
Travel Fellowship**

The Murray and Unity Pheils Travel Fellowship was established following a generous donation made by the late Professor Murray Pheils. The Murray and Unity Pheils Travel Fellowship has a value of \$10,000 and is awarded to a Trainee or recent Fellow of the College to assist him/her to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates wishing to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply. Applicants must not have commenced their travels prior to the closing date for applications. The duration of the Fellowship is 12 months.

**Stuart Morson Scholarship
in Neurosurgery**



The Stuart Morson Scholarship in Neurosurgery has been established following a generous donation by Mrs Elisabeth Morson in memory of her late husband. The Scholarship is designed to assist young neurosurgeons within five years of obtaining their Fellowship of the College or neurosurgical Trainees to spend time overseas furthering their neurosurgical studies by undertaking research or further training. The Scholarship is also open to exceptional young surgeons who are registered to practice neurosurgery in Australia or New Zealand but are not Fellows of the College. From time to time, the Scholarship may also be applied to assist overseas surgeons to spend time in Australia or New Zealand to further their training and/or research in neurosurgery. Overseas applicants cannot have commenced travel prior to applying for the scholarship. The value of the Scholarship is \$30,000 and is intended to assist the recipient to meet the costs of undertaking further training and / or research work in neurosurgery. This scholarship is for 6 months.

Hugh Johnston Travel Grants

The Hugh Johnston Travel Grants arose from a bequest of the late Eugenie Johnston. These Grants for \$10,000 are designed to assist needy and deserving Fellows and trainees of the College to gain specialist training overseas. Applicants must not have commenced their travels prior to the closing date for applications.

Margorie Hooper Scholarship

The Margorie Hooper Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is for SET Trainees or Fellows of the College who reside in South Australia. The Scholarship is designed to enable the recipient to undertake postgraduate studies outside the State of South Australia, either elsewhere in Australia or overseas. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the surgical community of South Australia. Preference will be given to the latter. This scholarship is for 12 months. The stipend is \$65,000 and there is provision for accommodation and travel expenses upon application.

Morgan Travelling Scholarship

The Morgan Travelling Scholarship was established to fund a Fellow of the College to travel overseas to gain clinical experience or to conduct research for a period of approximately one year. To be eligible, the surgeon must have gained his/her Fellowship in the past five years. The scholarship is open to a Fellow from any specialty. The scholarship must be the only College funding secured by the Fellow but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The duration of the scholarship is 12 months. The value of the scholarship is \$10,000.

Lumley Exchange Research Fellowship

An exchange Fellowship between the Royal Australasian College of Surgeons and the Royal College of Surgeons of England, endowed by the Henry Lumley Charitable Trust, (incorporating the Edward Lumley Fellowship Fund), this Fellowship is designed to enable a Fellow or SET Trainee to spend a year undertaking research in the UK and is valued at \$60,000 plus a return economy airfare. The Fellowship is available for 12 months.

Ramsay Fellowship - Provincial Surgeons - 2008



The Ramsay Fellowship was established through a bequest following donations made in 1986 and 1993 by Mr James Ramsay, AO, and subsequently through the generosity of Mrs Diana Ramsay, AO. This Fellowship is only available to provincial surgeons in Australia or New Zealand and is designed to enable such surgeons to spend time developing their existing skills or acquiring new skills away from their provincial practice.

The Fellowships can be taken for a period of eight weeks (one Fellowship of \$50,000), a period of four weeks (two Fellowships each of \$25,000), a period of two weeks (four Fellowships each of \$12,500), a period of one week (eight Fellowships each of \$6,250), or a combination of the above.

The Fellowship grant is intended to contribute substantially to:

- Return airfare to city (cities) of choice;
- Daily living allowance (travel, meals, accommodation, ongoing practice costs);
- No additional amounts are payable for travel or accommodation for family, locum costs, insurance, or any other unspecified costs.

The Fellowship does not incorporate payment for or arrangement of a locum. However, assistance in arranging a locum, if required, can be obtained from the Rural Services Department at the College on +61 3 9276 7407.

The Fellow must spend a major part of each week at the appropriate institution and give a guarantee to continue in practice in his local area on completion of the Fellowship. There is no application form. A letter of application including the following should be forwarded to the Scholarship Officer:

- The intended Fellowship duration;
- An outline of the experience or skills you aim to gain through the Fellowship and how this will benefit your current practice / hospital;
- An indication of the locations to be visited in order to achieve your aim;
- Two written supporting references.

There is no official closing date for this Scholarship. Applications will be accepted at any time until all funds have been allocated. NB: This Scholarship is open for travel in 2008.



Important General Information

These advertisements are to be used as an initial guide only. Please consult the College website from 1 March 2008 at <http://www.surgeons.org/scholarships.htm> for detailed information about the scholarships, fellowship and grants offered by the College, relevant application forms and scholarship conditions. Scholarships, fellowships and grants are open to College Trainees and Fellows as per the criteria stipulated for each award. The availability of the scholarships and fellowships advertised above is subject to funding.

Contact Mrs Rosemary Wong, Scholarship Officer, Royal Australasian College of Surgeons PO Box 553, Stepney SA 5069. Tel: +61 8 8363 7513; Fax: +61 8 8363 3371; Email: scholarships@surgeons.org for further information.

A scholarship information booth will also be located in the College Boulevard at the Conjoint Annual Scientific Congress in May. Applications close 5.00pm on Friday 30 May 2008.



Jane Bolton, Canterbury
Charity Hospital

The Canterbury Charity Hospital

This hospital is an amazing example of a community pulling together for the greater good

While his involvement as Chair of the Canterbury Charity Hospital Trust in Christchurch, New Zealand, most certainly contributed to Associate Professor Philip Bagshaw being awarded the highly acclaimed New Zealand magazine North & South's New Zealander of the Year for 2007, Bagshaw refuses to take all the credit for the success of the Charity Hospital. It is not a case of one man's altruistic dream; this is a fine example of a community pulling together to meet some of the health needs amongst its people that are not being met by the New Zealand Public Health System.

"The Charity Hospital is a hospital that has been set up and run by the community, for the community. That goes from the trustees who founded and manage the Trust, right through to the builders who converted the villa into a state-of-the-art operating theatre and day surgery facility, to the ladies who run reception, the gardeners, the people who continue to raise money to fund the hospital, and of course the medical staff who put up their hands to volunteer their time and services, without payment," explains Bagshaw.

The Canterbury Charity Hospital Trust is a registered Charitable Trust formed to provide free, elective day surgery and medical outpatient clinics for some people in the Canterbury community who would otherwise not have access to such services. Operating out of a converted villa in the suburb of Harewood, The Canterbury Charity Hospital serves the wider Canterbury region, stretching from Kekerengu north of Kaikoura to Rangitata in the south, and from the Southern Alps to the east coast, encompassing the Banks Peninsula district.

In order to receive treatment through the Canterbury Charity Hospital Trust, patients must first be assessed by their GP, who will assess the following:

- An established surgical or clinical need.



Phillip Bagsaw, Chair of the Canterbury Charity Hospital

- An established exclusion from treatment in the Public Health System (ie. that the patient has been removed from or been denied access to the Public Health waiting list)
- Written declaration of insufficient personal financial means to access private treatment

If the points listed are confirmed by a GP, the patient may then be referred to the Canterbury Charity Hospital Trust.

So who are the volunteers, why do they give their time and expertise, and where do they come from?

The Charity Hospital performed its first operations in August 2007, and today has more than 17 surgeons lined up to operate from one day a week through to fortnightly, monthly and quarterly.

"Among many of the volunteers there has been a tradition of voluntary work passed down through the family. Many are second and third generation surgeons who have seen their fathers and grandfathers do what they can for their communities. For others, it is a case of being able to meet an unmet need that they encounter on a daily basis, along with a desire to try to join together with their community as was more common in the past" says Bagshaw.

For Dr Terry Richardson, an anaesthetist from Christchurch, why he is offering his services and skills free of charge to the Charity Hospital is a question he says he can't really answer: "One feels they have a social responsibility to do what one can. I work full time for the public hospital and split my time between

Christchurch and Ashburton, which means I get days off during the week from time to time. I have done a couple of clinics at the Charity Hospital and it is my intention to be there about once a fortnight this year," says Dr Richardson.

Dr Richardson praises the work Bagshaw and his Trustees have done in setting up the Charity Hospital, and says it is a wonderful place in which to work. "Everyone is there for a common purpose, from the lady who makes the scones through to the nurses and surgeons who are in theatre. It's a small affair where everyone works together and has morning tea as a team. Here one is not bogged down by protocol and systems, which is certainly not to say that everything isn't done properly. It's more a fact of everyone being there to get on with the job."

As to whether or not the Charity Hospital could be replicated outside of Christchurch, Dr Richardson believes it certainly could: "I certainly see the concept growing from here. One thing that really strikes me is that the Charity Hospital seems to have a mind of its own. I see it as being an ever-evolving place, and that is what it is all about," he says.

Another volunteer, and also the Chair of the Charity Hospital's clinical board, Dr Martin MacFarlane is a Christchurch-based neurosurgeon. He views the Charity Hospital as being a robust, honest and transparent means of treating patients who have been unable to access the public health system. Dr MacFarlane says he will be performing predominantly carpal tunnel decompressions at the Charity Hospital. "This hospital could be repeated anywhere where there is a need, and where

"The Canterbury
Charity Hospital Trust is
a registered Charitable
Trust formed to provide
free, elective day surgery
and medical outpatient
clinics."

people are willing to find the resources to provide."

Not all those volunteering to work at the Charity Hospital come from the Canterbury community. Professor John McCall, a liver transplant expert from Auckland, says that although liver surgery is not applicable to the day surgery allowances the Charity Hospital provides, he is hoping to travel to Christchurch to perform operations for gall bladders, hernias and other lumps and bumps. Similarly, Dr Murray Pfeifer, who is based south of Christchurch in Invercargill, says he has put his hand up to volunteer at the Charity Hospital as a result of being inspired by Philip Bagshaw's tremendous vision and drive. "It will be nice to be able to contribute to that effort and make life better for some New Zealanders – it doesn't matter whether they live in my direct community or further afield, we are all New Zealanders," says Dr Pfeifer. Dr Pfeifer points out that while the operations being performed at the Charity Hospital are not for acute conditions, they can nevertheless deflect in a major way from the sufferers quality of life and prevent them performing to their full potential.

Visit www.charityhospital.org.nz/



Canterbury Charity Hospital

Honours

Congratulations

New Zealand New Year Honours 2008

Officer of the NZ Order of Merit (ONZM)

Mr Harry Lawrence McIntyre Smith
FRACS – *for services to medicine*

Mr Alan Graeme Hall (Member of the Court of Honour) – *for services to people with disabilities and the community*

Doctor of Laws

Mr John Hall-Jones was awarded the honorary degree of Doctor of Laws (Hon. LL.D) by Otago University in December 2007

Commander of the Most Venerable Order of the Hospital of Saint John of Jerusalem

Mr Ian Donald Shepherd Civil FRACS

Order of Australia - Australia Day Honours 2008

Officer (AO) in the General Division

Dr William John Glasson – *for service to medicine through contributions to people in rural and remote areas, to the eye health of Indigenous people and to professional organisations*

Adjunct Professor Michael Lawrence-Brown – *for service to medicine, particularly endovascular surgery, as a clinician, researcher and teacher and through contributions to professional organisations*

Member (AM) in the General Division

Associate Professor Michael Robert Fearnside – *for service to medicine, particularly neurosurgery, as a clinician, researcher and educator, to medical administration and the development of professional standards and to the medico-legal sector*

Dr Jonathan Howell Rush – *for service to medicine, particularly in the field of orthopaedics, as a clinician, researcher and educator and through monitoring and review of the quality of surgical care in Victoria*

Medal (OAM) in the General Division

Dr Robert William Sillar – *for service to medicine, particularly in surgical oncology and melanoma and humanitarian surgical aid overseas*

International Graduates



IMGs: are we getting it right?

The acting Clinical Director of the IMG assessment program is planning change, but will continue to put patient safety first

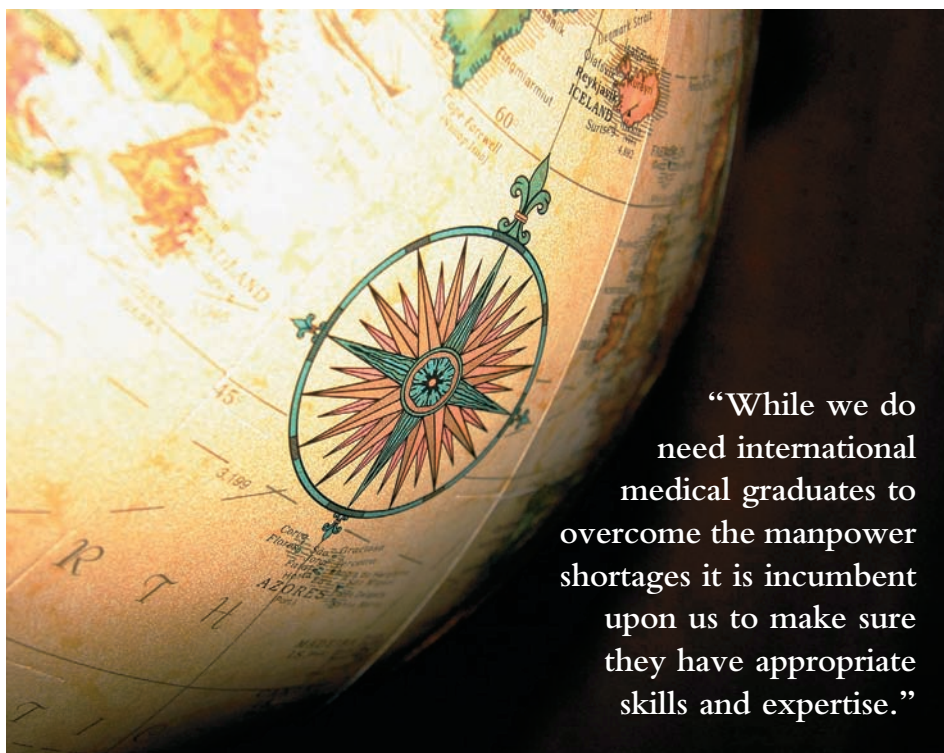
With applications for specialist surgical recognition from overseas-trained graduates almost doubling in the past three years, the College is in the process of appointing a new Clinical Director to help standardise and enhance the system that is used to assess these applications. In 2004, the College received 66 applications for specialist surgical recognition from overseas-trained graduates but that number jumped to 129 in 2007.

The acting Clinical Director of the College's International Medical Graduates (IMG) Assessment Program, Mr Andrew Roberts, said he believed that the program could be improved by the use of a Federally-coordinated approach rather than having both State and Federal rules and regulations and processes as currently applies.

The IMG Assessment Program aims to ensure that overseas-trained graduates seeking specialist surgical registration in Australia have comparable skills and expertise to graduates who are trained here. The process is based on a thorough assessment of a graduate's comparability to Australasian standards, with the College functioning as an advisory body to the Australian Medical Council (AMC).

Mr Roberts said he had taken on the position, upon his retirement from vascular surgical practice, to bring a more pragmatic approach to a process he described as critical to ensuring continued patient safety in Australasia. He said that while improvements could be made in time via a nationally coordinated and funded standardised system, the current program is achieving its aims.

"I think there has been a perception that the assessment process regulating the specialist registration of International Medical Graduates has been cumbersome and complex. Yet it must be remembered the fundamental premise is to make as sure as we possibly can that the doctors performing surgery in Australasia are compe-



"While we do need international medical graduates to overcome the manpower shortages it is incumbent upon us to make sure they have appropriate skills and expertise."

tent, capable and safe," Mr Roberts said.

"Applications for specialist surgical recognition are received from graduates from around the globe, from the UK, America, Canada, India, Asia and Africa, which obviously involves a wide variation of qualifications and capabilities."

Current figures indicate that the majority of applications are now being received from graduates trained in India, with those from the UK and South Africa making up the bulk of the remainder. Under the College program, the specialist assessment of an IMG focuses on education, training, quality and quantity of clinical experience, level of formal assessment including specialist qualifications in surgery and the recency of relevant practice.

Following the assessment process, IMGs applying for specialist recognition are then

deemed to be (a) non-comparable, (b) partially-comparable or (c) substantially-comparable.

Mr Roberts said that 120 applications were processed last year with 54 International medical graduates now being under oversight or supervision. He said that while some applicants may have been disappointed or have found the system too complex, patient safety across Australasia had to remain the paramount guiding principle.

"This program is particularly critical to Australasia now given that we have such a shortage of surgical manpower and an ever-increasing number of Area-of-Need (AoN) locations. Regrettably many younger Australian and New Zealand surgeons wish to remain in major metropolitan centres and are reluctant to practise in rural or remote areas" he said.

“It must be remembered the fundamental premise is to make as sure as we possibly can that the doctors performing surgery in Australasia are competent, capable and safe,”

– Andrew Roberts

“That means that while we do need IMGs to overcome the manpower shortages it is incumbent upon us to make sure they have appropriate skills and expertise. It must always be remembered that Dr Patel in Bundaberg did not come through the College IMG assessment system.”

Mr Roberts also said that recent data has revealed a lower-than-expected pass rate for IMGs sitting the Fellowship exam. This is now the subject of a Government-funded research project that is trying to establish the reasons for the poor exam performance and identify strategies to improve the IMG's exam success rate.

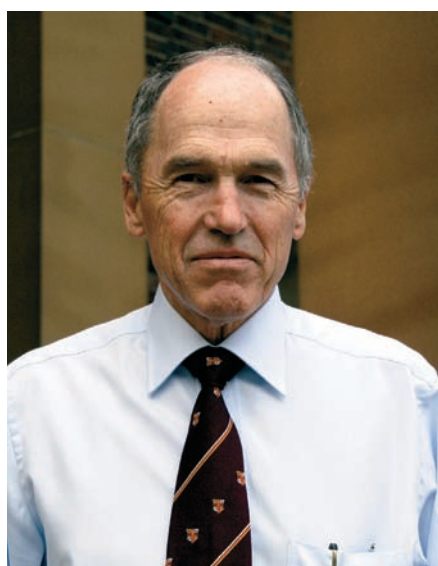
“We don't yet exactly know what the problem is. It could be cultural difficulties, it could be time constraints if they have been sent to a rural or regional hospital which does not have a teaching component or it could be about confidence given that there are particular skills needed to pass such an exam,” he added.

However, again Mr Roberts suggested that such difficulties could be solved through a nationally driven and funded system.

“Under such a system, I would see designated posts in established centres where IMGs can be placed and receive the support and educational assistance they require,” he said.

“While we need to ensure all IMGs are capable and competent to practise their surgical specialty, it can also be traumatic for the person involved to have to come back and sit an exam a second or third time.”

Mr Roberts has spent his surgical career not only as a Director of Vascular Surgery at the Austin Hospital, Melbourne, but also as a member of the Executive of the Board of Vascular Surgery, the ANZ Society for Vascular Surgery and is also a founding member of the executive of the Melbourne Vascular Surgical Audit program.



He has been a member of the Professional Development Board of the College and has given pre-FRACS final exam tutorials, particularly emphasising examination technique for many years.

“Upon my retirement, when the phone began ringing, I gave the initial acting appointment some considerable thought and believed that this area could benefit from pragmatic practical surgical input. This may overcome the perception that the process was an administrator driven bureaucracy,” he said.

“I felt that as a surgeon with experience in teaching and consulting for more than 30 years, with a keen interest in under-graduate and post-graduate education, that I had a certain amount of experience that could be put toward this area for the good of the profession and the promotion of public safety.

“Specialist recognition through FRACS is a cherished degree and one that I will passionately protect and it will be over my dead body that the standards we uphold will be eroded.”



IMG ASSESSMENT PROCESS

→ All relevant documentation, with qualifications checked via the AMC through the International Credentials Service of the Educational Commission for the Foreign Medical Graduates (ECFMG) of the United States, are sent to the College

→ The documents are reviewed by both the Clinical Director of the IMG Assessment Program and a representative of the appropriate Specialty Board

→ If the documents reveal the applicant's skills are non-comparable, the IMG is referred back to the AMC to attain medical registration and apply for a Surgical Education and Training post (SET)

→ If the applicant is deemed, on the basis of the submitted documentation, to have partially-comparable or substantially-comparable skills they proceed to an interview

→ Following the interview, if an applicant is considered to have non-comparable skills they are referred back to the AMC

→ If they are assessed as being partially comparable, a period of 24 months in a supervised surgical position is recommended so they can both practise surgery and prepare for their Fellowship Exam, with extensive supervision and assistance offered to improve their skills and capabilities

→ If the applicant, however, is found to have substantially comparable skills he or she is asked to work under supervision or oversight for between 12 to 24 months with three-monthly progress reports provided to the College. If they receive satisfactory clinical assessment throughout this time they are then invited to become a Fellow.

For further information email toula.panagopoulos@surgeons.org or look on the College website www.surgeons.org under Education & Training



Anne Trimmer,
CEO, MIAA

Keeping Good Company

The MIAA is reviewing its Code of Practice to ensure the integrity of industry links

The Medical Industry Association of Australia (MIAA, shortly to be the Medical Technology Association of Australia) is the national peak body for the medical technology industry. Members include companies involved in the supply and manufacture of medical technologies in the diagnosis, treatment and management of disease and disability.

MIAA has had a Code of Practice since September 2001. A revised Code was introduced in March 2006 to provide more in-depth guidance on interactions with healthcare practitioners. A further review is underway with the third edition to be implemented in the first part of 2008. This will be followed by an extensive education program along with the Fellows of the College, with whom industry works very closely.

The main thrust of the self-regulatory Code is to ensure the integrity of industry behaviour. The Code regulates, amongst other things, the nature of professional interactions with healthcare professionals.

The elements of the Code that Fellows of the College need to be aware of, are focused on:

- Claims and endorsements in advertising material
- Provision of product training and education by industry
- Sponsorship of, and grants for, third party educational conferences
- Hospitality for healthcare professionals
- Consultancy arrangements with healthcare professionals

Claims and endorsements in advertising material

As very few products are marketed directly to consumers, most advertising material is directed to healthcare professionals. A company must be able to substantiate a claim that it makes in an advertisement. It may only

make claims that are consistent with the intended purpose of the product listed with the Therapeutic Goods Administration. A company may not use the name or photograph of a Fellow without consent or in a way that is contrary to the College's Code of Conduct.

Provision of product training and education by industry

One of the characteristics of medical technologies is that further research and development often results through feedback from a Fellow who uses a product. Companies provide considerable training in their products to ensure that Fellows are able to make best use of them. The Code acknowledges the need for this type of training and sets out the guidelines within which it may occur. In general, the training must be conducted in appropriate training facilities and any hospitality provided to a Fellow must be modest in value and subordinate in time and focus. A company may pay for reasonable travel and accommodation costs incurred in attending the training.

Third party educational conferences

One of the most vexed areas is sponsorship of attendance at professional conferences in Australia and overseas. There is benefit to a company in having a Fellow present at a conference on his or her experience with a procedure or product. There is also a broader educative benefit to the healthcare sector in attendance at conferences. However, in order to ensure transparency in the relationship between the Fellow and a company, the Code does not permit direct payment to a Fellow of the costs of travel and attendance.

The Code permits the payment of a grant or sponsorship to the organiser of the conference (usually a professional association or training institution) to enable funding of attendance, provided the conference organiser selects the

recipient. Alternatively a company may make a grant to an educational institution for medical education which may be applied by that institution in meeting the cost of a Fellow or trainee to attend an educational conference.

Hospitality for Fellows

The Code permits companies to provide hospitality to Fellows in limited circumstances – by sponsorship of hospitality at a third party conference and by provision of hospitality as a subsidiary part of product training. The key requirements are that the hospitality is subordinate in time and value to the overall proceedings.

Consultancy arrangements with Fellows

For reasons mentioned earlier, there is a very close and ongoing working relationship between medical technology companies and Fellows. It is not uncommon for a company to retain a Fellow on contract as a consultant to provide advice, research or consulting services, or to serve on an advisory board. The Code permits such an arrangement provided that any compensation is consistent with fair market value for the services provided, selection is based on the qualifications and expertise of the consultant and not on volume or value of business generated, and the arrangements are well-documented.

The Code is voluntary and while binding on members of MIAA is advisory only for non-member medical technology companies. MIAA would like to see all companies working in the industry adhere to its principles. The Code includes a comprehensive complaints process – a complaint may be brought by a range of interested persons, including a Fellow. MIAA will be working with the College over the next few months to assist Fellows to understand further the implications of the Code for the working relationship with industry.



AUSTRALIAN & NEW ZEALAND
HEAD AND NECK SOCIETY
10TH ANNUAL SCIENTIFIC MEETING



TRANSLATION & COMMUNICATION

HEAD & NECK 2008
GRAND HYATT, MELBOURNE
4 - 6 SEPTEMBER



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INVITED SPEAKERS
Professor Paul Harari
A/Professor Cathy Lazarus
Professor Gregory Wolf

Visit www.surgeons.org/headneck2008 for further information



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Meeting Announcement



I.A.A.S.

8th International Congress on Ambulatory Surgery
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First time hosted in the Southern Hemisphere.

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College Conferences and Events Management

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



Meeting Announcement

GSA Annual Scientific Meeting

"Acute Care & Oncology for the General Surgeon"

26-28th September 2008

Hyatt Regency Coolum, Queensland, Australia

Program includes:

- ▲ Exam 'demystifying' session for Trainees
- ▲ Trainees' Day & Trainees' Forum
- ▲ Educational day on "Principals of Surgical Oncology"
- ▲ Ultrasound Workshop
- ▲ Acute Care for the General Surgeon

GSA Organising Committee

Mr Philip Truskett
Professor Bruce Mann
Mr Graeme Campbell
Ms Meron Pitcher
Dr Mary Theophilus

For further information contact:

Kymerley Walta
RACS Conferences and Events Department
Tel: +61 3 9276 7406
Fax: +61 3 9276 7431
Email: kymerley.walta@surgeons.org



Joseph Lizzio, NSW
Regional Committee

Lessons From a Delayed Diagnosis

A surgeon's unsatisfactory professional conduct over managing his waiting list had fatal consequences

The Professional Standards Committee of the New South Wales Medical Board ordered that a de-identified copy of a recent decision be provided to the New South Wales Regional Committee of the College for educational purposes.¹

The Health Care Complaints Commission alleged that a general surgeon was guilty of unsatisfactory professional conduct within the meaning of the Medical Practice Act² in that the surgeon had demonstrated that the knowledge, skill or judgment possessed, or the care exercised, in the practice of medicine was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. The general surgeon was working as a Visiting Medical Officer in an Area of Need and saw a female patient with an anal mass, rectal bleeding and lower abdominal pain. The surgeon advised a flexible sigmoidoscopic examination under anaesthesia and possible excision of the anal mass which he took to be an anal papilla. The patient was placed on a public waiting list for investigation within 90 days. The patient returned to the surgeon for review after seven months as she was still waiting for admission and this had been scheduled in a further four months. The palpable lump had increased in size.

Eleven months after the initial consultation the patient was seen by another surgeon who confirmed that the mass was a squamous cell carcinoma of the anus. Despite chemo-radiation and surgery the patient died of metastases within 10 months of the diagnosis.

The Professional Standards Committee rejected the HCCC's submission the clinical records made at the time of the initial consultation indicated the surgeon did not consider malignancy in the differential diagnosis. The Committee found that the surgeon had considered the possibility of malignancy because a biopsy of the nodule had been advised within 90 days. The surgeon considered that the anal

lump was unlikely to be malignant.

The Committee found that the surgeon had failed to take an active approach in the management of the waiting list and had not pressed for the patient to be advanced on the waiting list. The surgeon indicated the index of suspicion that the anal nodule was malignant was low and changing the priority might have displaced other patients who were more urgent. After the first consultation, the Committee was satisfied that failure to take a more proactive approach to ensure that diagnostic surgery took place promptly and appropriately did not represent that the conduct of the surgeon was below, or significantly below, the standard reasonably expected of a practitioner of an equivalent level of training or experience.

The Committee acknowledged the rarity of anal malignancy and was not satisfied with the HCCC's submission that at the second consultation, the surgeon had inappropriately reassured him/herself that the patient had benign pathology. The Committee accepted that this did not demonstrate the surgeon's knowledge, judgment or care was below, or significantly below, the standard reasonably expected of a surgeon of an equivalent level of training or experience.

However, the Committee found that advising the patient at the second consultation to wait until the scheduled time and failing to advocate to ensure the required surgical investigation was expedited, demonstrated that the knowledge, skill or judgment possessed, or care exercised, by the surgeon was significantly below the standard reasonably expected of a surgeon of an equivalent level of training and experience.

The Committee determined the surgeon had been guilty of unsatisfactory professional conduct within the meaning of the Medical Practice Act. The surgeon was reprimanded and ordered to participate in and complete, at the surgeon's own cost, all components of the Clinical Communication Program for Gene-

“Surgeons must manage their waiting lists and will be held responsible for failing to appreciate the urgency of a particular condition.”

ral Practitioners conducted by the Cognitive Institute. The Program is conducted over six months and is comprised of three phases.

Lessons from the case

- (1) The quality of the medical records is always an issue in complaints and civil claims. It is difficult or impossible to defend a medical practitioner where the medical records are poor.
- (2) Surgeons may be criticised for not including relevant negatives in their medical records and this may lead to an allegation that a serious condition had not been considered and therefore implying a lack of knowledge.
- (3) Surgeons are expected to manage their waiting lists and will be held responsible for failing to appreciate the urgency of a particular condition. Failure to arrange the timely management or referral of life threatening conditions will be considered to be unsatisfactory professional conduct. This is defined as the practice of medicine that is significantly below the standard reasonably expected of a practitioner of an equivalent level of training and experience.
- (4) Patients delayed on waiting lists and returning for review should have their priority reassessed carefully.

References

1 Under the Medical Practice Act 1992, Schedule 2, clause 6, the Chairperson of the Committee directed that the names of the doctors, patient and witnesses are not to be published.

2 Section 36(1)(a) Medical Practice Act 1992.

“We give people hope for the future – you can be part of this by giving to the Foundation for Surgery”

In West Timor, volunteers came across Alfred, who had an undiagnosed disease. Alfred's only form of mobility was along the floor. After two sessions of casting his legs, Alfred was able to walk, and now his life is full of hope.



Your tax deductible gift will also help us advance surgical sciences, improve quality of life and find solutions to the causes of major diseases.

The Royal Australasian College of Surgeons

The Foundation for Surgery

The Foundation for Surgery is the organisation that combines the International Development Program, the College's Scholarship and Fellowship Program, the Cultural Gifts Program and General College Bequests. The Foundation is Chaired by former College President, Professor Bruce Barraclough AO.

The College's International Development Program

Since 1994, The College's International Development Program has worked with the Australian Government's overseas aid program, AusAID to deliver specialist surgical services and training to East Timor, Papua New Guinea and the Pacific Islands.

The over arching aim of these projects is to alleviate human suffering and provide help to those most in need, regardless of race, political beliefs, religion or culture. Over the past 12 years, with the support of the Australian public and AusAID, the Program and its numerous selfless volunteers have successfully treated over 30,000 people.



This boy had an enormous growth on his neck which meant he could hardly turn his neck. The complex operation was successful and the smile on his face was a huge reward.

In the countries where the College's surgical teams are deployed, projects work hand-in-hand with local health authorities to determine the types of medical treatment and supplies urgently needed to help individuals and communities.

According to Dr Glenn Guest who recently led a general surgical team to Larantuka, Flores "...more so than in Australia, every surgery we do here is a life-changing operation. it takes away an impediment to the person having a normal life... These problems keep people from working, falling in love and contributing to their communities."

International Scholarship Program

The College International Scholarships Program provides scholarships for surgeons from developing countries. These scholarships fund training opportunities and facilitate professional contact with Australian medical personnel. The most significant of these are the Rowan Nicks Scholarship and the Surgeons International Award.

The Rowan Nicks Scholarship is an annual scholarship which is offered to young surgeons from selected developing countries who have shown particular promise, and are destined to be leaders in their own countries.

The Surgeons International Award which provides for doctors, nurses or other health professionals from underprivileged backgrounds to undertake short term visits to one or more Australian hospitals to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's country.



Through private donations and AUSAID, the Program has been supporting professional development opportunities for surgeons from the Pacific. These surgeons from Fiji and Papua New Guinea were funded to attend the Definitive Surgical Treatment of Trauma course.



RACS - The College of Surgeons of Australia and New Zealand

The Scholarship & Fellowship Program

The Scholarship and Fellowship Program offers over one million dollars in funding annually to the most academic and able surgical trainees and Fellows. It funds research conducted for the greater good of the entire surgical and medical community and which saves patient lives.



"I was very grateful for the opportunity provided through the Scholarship to devote myself to pure science, particularly given that I have a family," says neurosurgical Trainee Dr Yi Yeun Wang.



"It gives me great comfort to know that my late husband and I will be remembered for research scholarships that will help others."

Types of Awards

The Scholarship Program offers two main types of awards: research and travel. The centrepiece of the Program is its research scholarships and fellowships and these make up the majority of awards offered. One hundred per cent of the money donated to the Scholarship Program goes towards funding scholarships.

Named Memorial Scholarships

For many people, a scholarship or grant provides a meaningful memorial to a lost loved one. The majority of our donor and bequest funded scholarships are named either for the donor or for a family member as directed by the donor. Memorial scholarships offer a unique opportunity for you or your loved one to be remembered for giving back to the community now and for future generations.

The Cultural Gifts Program

The Cultural Gifts Program is a philanthropic program managed by the Australian Government (Department of Environment, Water, Heritage & the Arts). Its principal aim is to encourage a culture of giving by offering taxation incentives to those who donate to approved public institutions. The College of Surgeons Museum and the Art Gallery have both gained endorsement from the Australian Taxation Office as Deductible Gift Recipients, which enables them to participate in this program.



Donations to the College

The College welcomes donations and gifts, of all kinds of art works, rare or historic medical or surgical books for the Colishaw Collections, and surgical instruments for the Museum. The College is looking to expand its art collection, and gifts of art work are especially welcome. To exhibit its collections the College has established in Melbourne the College of Surgeons Museum and the College of Surgeons Art Gallery.



Thank You

Donations to the Foundation for Surgery

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Mr C Chow
Mr K Fung
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Mr K Wong

Thailand

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Total:

\$13,768.12

Sydney Upper Gastrointestinal Surgical Society Presents a symposium on

PANCREATIC PATHOLOGY and BARIATRIC UPDATE

SATURDAY 12th APRIL 2008 / 9.00am - 3.00pm
NOVOTEL, OLYMPIC BOULEVARD, HOMEBUSH BAY

International Faculty:

Mr Colin McKay - West of Scotland Pancreatic Unit, Glasgow Royal Infirmary

Topics

9.00am-10.30am

Aetiology & Diagnosis of Acute Pancreatitis
Acute Pancreatitis: Lessons from the West of Scotland Pancreatic Unit
Post Pancreatitis/Resection Bleeding
Surgical treatment of Chronic Pancreatitis

11.00am-12.30pm

Anatomy of Pancreatic Resection:
Avoiding the Pitfalls
Pancreatic Cystic Lesion
Intraductal Papillary Mucinous Neoplasms of the Pancreas
Chronic Inflammation & Pancreatic Cancer
Biomarkers of Prognosis & Response to therapy in Pancreatic Cancer

1.30pm-3.00pm

Teamwork & Communication in Surgical Practice
The Bariatric Physician
Laparoscopic Adjustable Gastric Banding: Outcomes
Laparoscopic Sleeve Gastrectomy & Gastric Bypass: Outcomes
Biliopancreatic Diversion: Outcomes

Panel Discussions after each session

REGISTRATION FORM

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Suburb:.....
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| | | |
|---------------------|--------|---------|
| Member: | \$ 150 | \$..... |
| Non Members: | \$ 200 | \$..... |
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| Membership Dues | \$ 50 | \$..... |
| Total | | \$..... |

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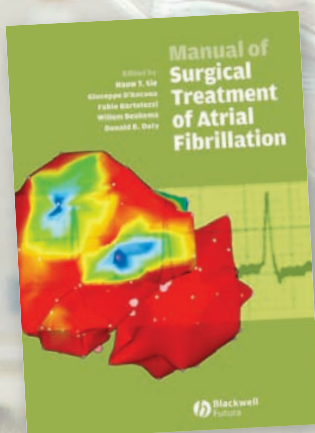
SYDNEY UPPER GASTRO INTESTINAL SURGICAL SOCIETY
Please return registration forms to:
Cherie Berry,
Level 2, Vindin House Royal North Shore Private Hospital,
ST LEONARDS NSW 2065
Ph: 02 9926 6897, Fax: 02 9926 8930

The Surgeon's Book Club



Welcome to The Surgeon's Book Club

Highlighted in this month's issue are recent and new titles from across the surgical spectrum available from John Wiley & Sons (inc Blackwell Publishing books).



Feb 08 9781405140324
HB A\$137.95 A\$110.36

Book of the month 20% discount

Manual of Surgical Treatment of Atrial Fibrillation NEW

Edited by: Hauw Sie (Isala Klinieken), Giuseppe D'Ancona, Fabio Bartolozzi, Willem Beukema (Isala Klinieken) and Donald Doty (University of Utah School of Medicine, UT)

In recent years, a myriad of surgical protocols have been developed to manage atrial fibrillation, increasing the confusion over which are the most effective approaches. This timely book presents a multidisciplinary, international team of authorities who have reviewed the evidence in order to establish which surgical approaches should be used under which circumstances. Divided into five parts, the book not only explores surgical treatment of atrial fibrillation, it also offers a complete understanding of its underlying causes:

- Anatomy, Pathophysiology, and Electrophysiologic Basis of Atrial Fibrillation
- Surgical Approach to Atrial Fibrillation: The Cox-Maze Procedure
- Modifications of the Cox-Maze, Use of Alternative Surgical Patterns, and Energy Sources
- The Invasive Cardiologist Approach
- Perioperative Complications, Reporting Results, and Statistical Analysis

With its clear presentation and analysis of the current findings in surgical treatment of atrial fibrillation, this book points the way towards a scientific approach for the surgical cure of atrial fibrillation and is essential reading for all cardiac surgeons.

Pulmonary Embolism

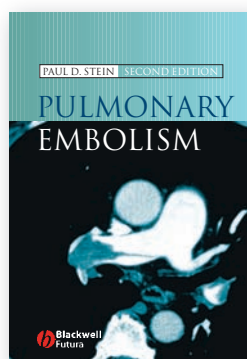
Second edition

Paul Stein (St. Joseph Mercy-Oakland, Pontiac, Michigan)

"...the best book I've seen on this topic"
– William C. Roberts, MD, Editor in Chief of the American Journal of Cardiology, in a review of the first edition

This second edition supplies the latest information on epidemiology, methods of diagnosis, preferred diagnostic pathways, new medications, and new recommendations for prophylaxis and treatment of pulmonary embolism and its immediate cause, deep vein thrombosis.

Pulmonary Embolism, Second Edition, incorporates important data from the recent Prospective Investigation of Pulmonary Embolism Diagnosis II (PIOPED II). Every chapter of the book has been revised and updated, and 56 new chapters appear in this edition. Through the writing ability of its single author, the text remains as easy to read as it is to consult.



Aug 07 9781405138079
HB A\$150.95 A\$128.31

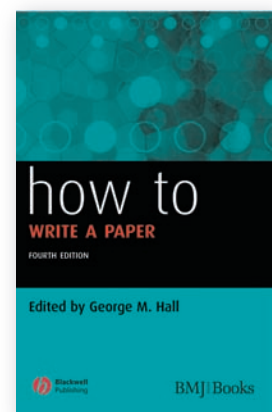
Best Seller

How to Write A Paper

Fourth edition

Edited by: George Hall
(St George's Hospital Medical School, London, UK)

This bestselling guide provides clear instructions on getting published in biomedical journals. Now in its fourth edition, How to Write a Paper has been fully revised and updated to include all aspects on writing each section of a structured paper incorporating the latest information on open access, electronic publication and submission. Written by editors of leading medical journals as well as publishing experts, this guide is relevant and easy to use for any novice writer wanting to publish in journals.



Feb 08 9781405167734
PB A\$49.95 A\$42.45



Aug 06 9780470093160 HB
Oct 06 A\$480.95- A\$408.

Surgery for Congenital Heart Defects

Third edition

Jaroslav F. Stark, Marc R. de Leval,
Victor T. Tsang, Michael Courtney

Over 10 years after the publication of the second edition, Wiley now publishes the third edition of the popular volume *Surgery for Congenital Heart Defects*.

Completely updated and expanded, this new edition describes step-by-step the surgical procedures for congenital heart defects and includes detailed illustrations for each operation.

New in this edition are chapters on exercise testing, MRI, EP studies and catheter ablation of arrhythmias, extracorporeal circulatory support and paediatric lung transplantation. A greatly expanded ultrasound chapter contains numerous colour Doppler's of many conditions.

Surgery for Congenital Heart Defects, Third Edition:

Provides complete coverage of the current issues in paediatric cardiac surgery

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A 20% discount is offered on the Book of the Month.

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Leisure Reading

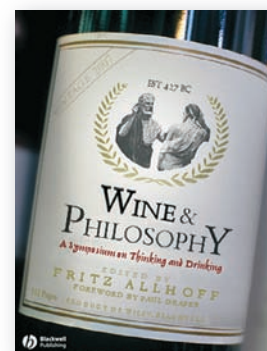
Wine & Philosophy

A Symposium on Thinking and Drinking

Edited by: Fritz Allhoff (Western Michigan University)

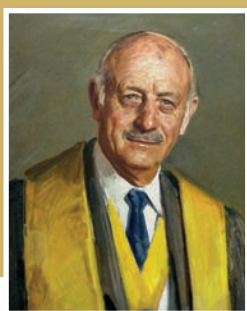
Wine & Philosophy offers a collection of essays which explore a range of philosophical topics related to food; it joins *Food & Philosophy* and *Beer & Philosophy* in the "Epicurean Trilogy." Essays are organized thematically and written by philosophers, wine writers, and winemakers.

Chapters include, "The Art & Culture of Wine"; "Tasting & Talking about Wine"; "Wine & Its Critics"; "The Beauty of Wine"; "The Metaphysics of Wine"; and "The Politics & Economics of Wine". Essays are accessible to a general audience while at the same time covering some serious philosophical ground. A great complimentary text to any guided-tour visit to the Australian wine regions.



Nov 07 9781405154314 PB
A\$35.95 A\$30.56

Australian Artist



Portrait of Sir John Lowenthal

A Different Perspective

Artist Robert Hannaford has painted the portraits of a number of College Presidents

Renowned artist and sculptor Robert Hannaford admits that he sees surgeons somewhat differently – both literally and metaphorically – since being diagnosed with cancer in 2006.

Although familiar with surgeons in their robes and regalia, having painted the portraits of many past College Presidents including Anne Kolbe, Kingsley Fawcner and current President Andrew Sutherland, as a patient he developed a different perspective on the surgical species.

Speaking from a hotel room in Melbourne during a break in painting two commissions for the Melbourne Cricket Club, Hannaford reveals he has painted eight portraits for the College so far.

“They’re a lovely lot and I’ve been fortunate to make some friends,” he says.

“But they are all getting younger. I’ve been doing this for so long now that I painted the portrait of D’Arcy Sutherland when he was president and now his son Andrew.

“Since I was diagnosed with cancer of the tongue, though, I have to say I hold surgeons in even higher regard than I did, particularly my surgeon, Guy Rees in Adelaide.”

Born in 1944 on the family farm at Riverton, South Australia, the town in which he still resides, Hannaford is one of Australia’s leading realist and portrait painters.

A self-taught artist, he first worked as a political cartoonist for the Adelaide Advertiser from 1964–1967 while seeking the guidance of his South Australian mentors, Sir Hans Heysen and Ivor Hele.

Since becoming a full-time artist in 1970, he has painted the portraits of Paul Keating, Dame Joan Sutherland and Sir Donald Bradman and has received such commissions as the enormous task of painting the opening of Parliament for the Centenary of Federation as a companion to the famous Tom Roberts work.

Hannaford has entered the Archibald Prize

each year since 1991 and has been a finalist every year that he has entered. He has won the People’s Choice Award for his Archibald entries in 1991 (a portrait of Hugh Stretton), in 1996 (a self portrait) and in 1998 with a portrait of Rolf Prince.

In 1990 he won the Doug Moran Prize with his portrait titled “Bill”.

However, his output – which also includes landscapes, still lifes, nudes and sculpture – came to a temporary halt with a diagnosis of cancer of the tongue in 2006.

“I painted the portrait of Darcy Sutherland when he was President and now his son Andrew”

“There is a suggestion, given that I don’t smoke, that I may have developed this through the habit of putting the stems of my brushes in my mouth when working,” Hannaford explains.

“My hands get covered with paint which then gets smeared on the paint rag and on the stems of brushes, yet there is likely to be lead and cadmium in that paint so it probably wasn’t a very good habit to get into for 40 years. Solvents can be dangerous too.”

Hannaford was treated for his condition at the Royal Adelaide Hospital, care which he describes as excellent.

“I couldn’t work during that time because it was pretty intense treatment,” he says. “I had chemotherapy and radiotherapy and for six months I had to be fed through a tube in the stomach so I couldn’t get out of bed, let alone work.”

He is now waiting for his two-year test to see if he remains free of the disease but feels well and without pain and specifically wishes to thank the staff at the Royal Adelaide Hospital for his recovery, “The fact that I’m

alive and working now is a testament to their skills and care.”

Hannaford does not work from photographs for his portraits, but arranges six or seven sittings, of up to three hours, spread over a week. He prefers this, he says, because it allows him to get to know the person he is painting, so that the finished product is not just a likeness but an analysis.

“Portraiture is an exploration of character that goes beyond photography,” he explains. “It is an ongoing thing over a long period of time. You get elements of various emotions that can be sensed in the painting.”

Though he has made friends along the way he has no favourites. “I always think my last sitter was my favourite sitter,” he says.

While Hannaford prefers his subjects now to come to him in his rural idyll in the mid-north of South Australia, Hannaford makes exceptions such as that for College past-president Anne Kolbe.

“She wanted a New Zealand background with trees so I travelled to New Zealand for that commission,” he says.

“She didn’t want to be painted in her gown of office but instead have it somewhere in the picture, in her case draped across the back of a chair, and I’m happy to go along with what people want.

“Gowns are great fun to paint. I painted his father 30 years ago at the same age and there was a definite resemblance.

“But it was a strange experience because when I started most of my sitters were considerably older than I was but now I’ve caught up or am even older.”

After his time with the sitter, Hannaford takes the work back to Riverton to complete. There he combines his work on commissions with his landscape paintings and also spends a considerable amount of his time walking through the hills and observing birds and animals and plant life.

“I couldn’t work as it was pretty intense treatment ... the fact that I’m here now is a testament to their skill and care”



Above Left: Robert Hannaford's self potrait with tubes 2007 Top right: Portrait of Kingsley Fawkner Above right: Portrait of Anne Kolbe.

One of his artistic objectives, he admits, is to learn from nature including the nature of humans. “I love both but I enjoy the restraint of portrait painting because it still provides enormous scope for creativity,” he says.

After his recovery from cancer, Hannaford painted the portrait of Dr Lowitja O’Donoghue, –a work commissioned by the Commonwealth of Australia for inclusion in the collection of the National Portrait Gallery.

Last year, he opened a newly-renovated sculpture studio and gallery in the main street of Riverton.

And last year he also married Alison Mitchell, a landscape painter who is currently carrying out a PhD in anthropology to work in with her artistic endeavours.

Hannaford admits that the experience of developing cancer and then fighting it changed him.

“If I survive two years then I have a better than average chance of having a few more and that’s good because I feel good,” he says.

“And I think the experience has both helped me to appreciate being alive a little more and I also think it has improved my painting.

“I’m working more directly now, it is more immediate. Life feels very sweet to me now.”



pictured: Bruce Barraclough

Weary Dunlop Boon Pong Exchange Fellowship grows

A scholarship funded by the College that commemorates the bond forged between Australia and Thailand in the horrendous building of the Burma-Thai railway during World War Two is to be expanded.

Known as the Weary Dunlop Boon Pong Exchange Fellowship, the program brings young Fellows of the Royal College of Surgeons of Thailand (RCST) to Australia for four months to assist and observe under the supervision of a local mentor. So popular has the program become since its inception in 1958, the College last year decided to raise the number of exchange Fellowships available from four to six per annum. More than 60 Thai surgeons have already been funded to visit Australia under the scheme.

The co-ordinator of the Fellowship program, Professor Bruce Barraclough, said it allowed Thai surgeons to not only increase their individual skills but improve the local health care system upon their return.

“These are very well trained surgeons who are Fellows of the RCST, usually in the second or third year of their surgical practice. However, much of the work they do in Thailand is trauma and emergency medicine so they are extremely keen to experience a wider range of elective surgical procedures and get exposure to the Australian health system,” he said.

“At the same time, this exchange program provides wider benefits than simply increasing the skill levels of individual surgeons. For example, there are 60 million people in Thailand with the vast majority travelling on motor cycles, yet the use of helmets was not common nor legally mandated – resulting in a significant number of head injuries.

“One of the surgeons who came to Australia via this exchange program went back and pushed local authorities to introduce such laws so the impact of this program stretches further than the individuals involved.”

Under the exchange Fellowship, applica-

tions and CVs are sent to Professor Barraclough from the Thai program coordinator Professor Thongueb Uttaravichien. Professor Barraclough then approaches Australian Fellows in the relevant specialty with a request to supervise and mentor the Thai surgeons during their stay.

He said he was yet to be refused.

“This is not an insignificant ask – to bring in someone to the team for four months, to help them find accommodation, to make them feel welcome, to teach and supervise. The local surgeons involve them in their public hospital work, take them on ward rounds with other registrars, explain medical science and tests that they may be unfamiliar with and also allow them to assist in their surgery in private hospitals, he explained.

“That willingness to participate says a lot about Australian Fellows, many of whom continue to act as mentors when the Thai surgeons return home. We have surgeons from all specialties seeking this scholarship and over the years we have found them mentors across Australia.

“For their part the Thai surgeons appreciate the exposure to procedures and medical care and science not available in Thailand and the opportunity to develop those mentor relationships with senior local surgeons.”

Under the Exchange Fellowship, the scholars observe and assist elective operations during the day and emergency operations at night and weekends but take no primary responsibility for patients.

The recipients are not registered for the provision of care to individual patients as prime carers, mainly because of language requirements. However, they have access to hospital libraries and participate in surgical meetings and surgical audits. Classroom training is minimal, but the scholars are encouraged to attend appropriate lectures relevant to their interests.

The scholarship consists of a \$10,000 stipend with travel allowances usually provided

from the RCST. The Weary Dunlop Boon Pong Exchange Fellowship is named after Sir Edward “Weary” Dunlop, one of Australia’s greatest wartime heroes and life-long humanitarian and Boon Pong, a local Thai man who helped the prisoners of war forced to build the notorious Burma-Thailand railways by the Japanese.

After the fall of Singapore, Sir Edward Dunlop elected to stay with his unit and was taken prisoner by the Japanese for three years.

One of 13,000 prisoners, he worked on the railway during which 4500 prisoners perished and as commanding officer and surgeon, and champion of his men, earned the nickname “Weary” and the admiration of his fellow POWs.

After the two ends of the railway were joined, Sir Edward and fellow surgeon Albert Coates went on to build an 8000-bed hospital at Nakom Paton at the “Bridge on the River Kwai”, near Bangkok.

Upon his return to Australia, Sir Edward was appointed Honorary Surgeon to Outpatients at the Royal Melbourne Hospital and resumed his career as a surgeon and teacher, winning wide recognition as a leader in cancer treatment and research. His frequent return visits to Java and his desire to heal the wounds of war prompted a medical exchange between Australia and Thailand, including the establishment of the College program named in his honour.

A recent exchange Fellowship recipient, Dr Winai Ungpinitpong, is now back in Thailand having spent a four-month period in Australia from September 2007.

As a colorectal surgeon, he spent his time here at the Royal Prince Alfred Hospital in Sydney. Now back working at the Surin Hospital, a 700-bed facility in the north-eastern region of Thailand near the border with Cambodia, Dr Ungpinitpong said the main problem confronting the health system was a lack of experienced doctors.

“The most important thing that I received through the exchange program was not only the experience in surgery but the chance to make friends and develop relationships with surgeons in Australia which I will never forget.”

“This (program) gave me the chance to gain and share experience with the Fellows of the College in Australia, particularly in my special interest. I have now the inspiration to set up a better system and good team in my hospital,” he said.

“The most important thing that I received through the exchange program was not only the experience in surgery but the chance to make friends and develop relationships with surgeons in Australia which I will never forget.”

Professor Barraclough, the Chair of the Board of the NSW Excellence Commission, Associate Dean at the University of Western

Sydney Medical School and President of the International Society of Quality in Health Care, has a particular interest in the scholarship because his father was one of the prisoners of war.

“Weary Dunlop was one of Australia’s great heroes, however there were many doctors who were forced to work on the Burma-Thai railway and they were all considered heroes,” he said.

“I knew a lot about this history because my father was there and I met friends of his who were also there but this exchange program has meaning in its own right. After this amount of time I would doubt that many

of the Australian mentors or Thai surgeons would know the details of this period in history, but fostering the spirit of international cooperation has its own value.

“Thailand is progressively building up its surgical workforce and while they do not yet have enough surgeons, they are trained to a high standard and doing the very best they can in the circumstances they must work in, with many more patients per surgeon than in Australia.”

Sir Edward “Weary” Dunlop died in Melbourne in 1993, with some of his ashes appropriately lying near the railway at “Hellfire Pass” in Thailand.



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*Anthony Buzzard, Chair
Medico Legal Committee*

Medico Legal Committee

Reform of Expert Evidence in Civil Cases in NSW
has proven to be a more efficient and just solution

Chair's Comment

The article by Drew Dixon in this issue provides an interesting insight into the NSW personal injury jurisdiction. There are also reviews currently being held into the workers compensation jurisdictions in Victoria and Tasmania. With 'Wall to Wall' Labour governments, it would seem to be an appropriate time for 'harmonisation' across all of the personal injury jurisdictions in Australia.

The Hong Kong CASC program continues to progress. The Medico Legal Section has a very full program with a number of associated sectional activities. There is a lot of interest in us from our Chinese colleagues. The Medico Legal committee is grateful for the work of our scientific convener – Peter Wilde.

Our deputy chair, A/Prof Michael Fearnside has been awarded an AM in the Australia Day Honours list for, amongst many other things, his medico-legal work. Heartiest congratulations.

Expert Evidence: The New Uniform Civil Procedure Rules (Amendment No. 12) 2006 NSW Government Gazette No. 175

This paper looks at amendments to the UCPR which took effect from December 8, 2006 in NSW with the aim to provide more effective pre-trial management and to ensure more efficient use of Expert Evidence by professionals in Civil Cases.

The Law Reform Commission in NSW recommended that the "permission rule" (UK) in its complete form not be adopted, however, the amended rules provide greater control of Expert Evidence by the Courts. The Courts are able to confine the number of Experts called as well as direct the evidence that is able to be adduced as Expert Evidence

that is reasonably required (Rule 31.17). The Expert Witness may be;

1. A parties single Expert or
2. A Court appointed Expert or
3. More than one Expert
4. Multiple Experts.

In the latter categories evidence is adduced concurrently at the direction of the Court.

In Rule 31.20, the Court may at any time give directions in relation to the time for service of Reports and direct which evidence may or may not be adduced on specific issues. The number of Expert Witnesses may be limited. The Court may direct Experts to confer in a pre-trial conference and may direct that a single report is given as evidence in chief.

Recommendation 7.1 of the Law Reform Council was that there were provisions for joint Expert Witnesses, although there is a preference in the UK under the Woolf Report (July 1996) and in the Supreme Court of Queensland, for single Experts. (The UCPR 1999 (QLD) (429H)6.)

While the evidence of joint Expert Witnesses is of great weight it has no different status to that of other Medical Witnesses. It is felt that the use of joint Expert Witnesses can reduce partisanship and encourages the experts to present balanced and representative view points. By grouping Experts it reduces Court costs and facilitates quicker and cheaper resolution of the real issues in proceedings.

The Court may order an alternate to the single Expert agreed to by the parties, a Court appointed Expert who is the Court's witness and differs from the parties' single Expert in that the Court directs, the issue(s) to be dealt with. Single and Court-appointed Experts, should not communicate with the person about the issues in dispute prior to the engagement.

The LRC Report stated in Recommendation 9.2 that funding arrangements for each Expert Witness should be known to all parties and to the Court, however, this may represent an unwarranted intrusion and lead to a decrease in the pool of Expert Witnesses available.

Concurrent Evidence provides for a structured professional discussion between peers in the relevant field and enables Experts to make more concessions and state matters more frankly than they might have done under the traditional type of cross-examination. The questions need to be more constructive than those encountered in traditional cross-examination and the concurrent taking of evidence is less adversarial in nature. Concurrent Evidence increases the potential for the Court achieving a just decision and will reduce time and costs.

In Concurrent Evidence, the judge needs to set the agenda and arrange to provide pre-trial directions. He may instruct pre-trial conferencing, so that a single lead document is produced as evidence in chief. He may direct that each Expert Witness gives evidence of the issues concerned in turn and may direct that these opinions be qualified by the other Expert Witnesses. He may direct the sequence of cross-examination and re-examination, either completing the examination of each witness on the available evidence or putting to each Expert Witness in turn, each issue at a time.

The Expert Witnesses may be permitted to ask questions of other Expert Witnesses.

The amended Uniform Civil Procedural Rules which came into practice from January 29, 2007, represent a number of significant changes to the pre-trial management of Civil Cases, particularly in Claims for Damages for Personal Injury or Disability.

All Expert Evidence should now be given concurrently unless there is a single Expert

Previously these articles were distributed as a newsletter to the Medico Legal section, it will now be included in Surgical News four times a year to update the whole Fellowship.

“While the evidence of joint Expert Witnesses is of great weight it has no different status to that of other Medical Witnesses.”

appointed or the Court grants leave for Expert Evidence to be given in an alternate manner.

As a guide there has to be selection of witnesses in the same Specialty, for eg Surgeons, Cardiologists or GP's (“inequality of experts” is avoided) if there is substantial issue as to ongoing disability then more than one expert in any specialty may be required.

These amendments to UCPR provide for a swifter, more just and less costly judicial process in Civil Cases and with good Court management, allow for just settlement of claims in a less adversarial manner.

Drew Dixon

Update: Workcover NSW – Prepayment of Medicolegal Reports

Since I last reported to Fellows on the negotiations going on between WorkCover NSW and a group of legal representatives, AMA and medical representatives, there have been some changes to the WorkCover legislation. This has necessitated putting negotiations on hold until the ramifications are understood. While this is occurring there is agreement that prepayment of reports is acceptable.

In the meantime Mary Hawkins, the Director of Provider and Injury Management Services, would welcome questions on any burning issue and where appropriate the answers will be published in the next edition of the Medico Legal Section Newsletters.

Neil Berry, Editor

From The Flight Deck: Improving Team Performance

The Medico Legal Section of the Australian Orthopaedic Association and the College are conducting a Risk Management Work Shop at the Ansett Flight Simulator in Tullamarine on Saturday and Sunday March 29 and 30,

2008. This meeting is open to those of the College who would like to attend and the instructional course lecturer will be Dr David G Newman, Aviation Medical Specialist and pilot, who will cover areas of risk management as they apply to surgical practice. The workshop will be over two days, finishing mid-Sunday afternoon.

Those wishing to attend should direct their enquiries to Rebecca Clancy (rebecca.clancy@surgeons.org). The program outline will be available in the New Year and all participants will receive a Certificate of Attendance on completion of the workshop.

Drew Dixon

Chair, AOA Medico-Legal Society

Medico Legal Workshops In 2008

The Royal Australasian College of Surgeons is offering two Medico Legal workshops in 2008:

Writing Reports for Court

Date: Saturday 21st June 2008

Venue: Royal Australasian College of Surgeons, Melbourne

Cost: \$633 (incl. GST) for Members of the College

CPD: 7 points Category 7

Presenter: Leo Cussen Institute Medico Legal Executive/RACS Fellows

Expert Witness

Date: Saturday 19th July 2008

Venue: Leo Cussen Institute, Melbourne

Cost: \$875 (incl. GST) for Members of the College

CPD: 7 points Category 7

Presenter: Leo Cussen Institute Medico Legal Executive/RACS Fellows

If you would like any further information about these workshops or to register please contact Rebecca Clancy, Medico Legal Secretariat, on +61 3 9276 7473.

Call for Medico Legal Executive Members

There is an opportunity for Fellows with a keen interest in Medico Legal issues to nominate for membership of the Medico Legal Executive Committee.

The Medico Legal Committee:

- Advises the Council of the College on matters relating to medico legal issues, educational activities and standards of practice through the Professional Development Committee and the Board of Professional Development and Standards.
- Assists in the development of programs of continuing education and standards of practice where they relate to medico legal activities.
- Organises and correlates scientific programs at the Annual Scientific Congress of the College and on such other occasions as may be decided from time to time by arrangement with the Council of the College.

The Executive also oversees the content of the Medico Legal News and may be called up to provide advice on Medico Legal matters when required.

The Medico Legal Committee meets four times per year by teleconference and also hold a face-to-face meeting at the College ASC.

If you are interested in joining the Medico Legal Executive or would like more information, please contact Rebecca Clancy (Medico Legal Secretariat) on +61 3 9276 7473.



Russell Gruen, Trauma
Symposium Convenor

2007 Trauma Symposium

Injury in Indigenous populations – towards a safer future

Womin Jeka mirambeek beek.
Boonerwung Nairm derp Bor-
dupren uther willam.

Welcome in the language of my ancestors, welcome to the traditional country of the Boonerwung and our neighbours the Wurundjeri.

With these words and a gift in the form of a gum leaf, Boonerwung Elder, Carolyn Briggs welcomed 80 delegates to the Trauma Committee's 2007 Symposium on Injury in Indigenous Populations – Towards a Safer Future. The gum leaf, as explained by Ms Briggs, symbolises a safe passage and journey through the Boonerwung people's land. The gift was accepted by College Councillor, Mr John Graham, who has a longstanding interest in Indigenous health.

The symposium on 22 November brought together Indigenous and Non-Indigenous health professionals from Australia, New Zealand, North America and the Pacific Islands to share experiences, concerns and effective strategies to reduce deaths and suffering due to injury in the Aboriginal, Torres Strait Islander, Maori and Pacific Islander populations.

The workshop was an initiative of the College Trauma Committee, in conjunction with the College Indigenous Health Working Party, chaired by Mr Kelvin Kong.

The program included sessions on 'Indigenous Health Programs', 'The Challenge of Injury in Indigenous Patients', 'Providing Care for Injured Indigenous People', 'The Roles of Professional Colleges' and 'Challenges and the Way Forward'.

The workshop commenced with Mr Jonathan Koea, Professor Ian Anderson, Dr Mark Wenitong and Professor Karina Walters. All are dedicated to the ongoing work of improving the health of the Indigenous population of their nations: Australia, New Zealand and North America.

Jonathan Koea, a Hepatobiliary surgeon of Maori and Scottish decent, began the



Carolyn Briggs

workshop by presenting a comprehensive lesson on the events in history that influenced the ever changing health trend amongst the Maori and how social and cultural movements taken by the Maori population in recent decades resulted in improving health status and mortality rates of the Maori people. This was appreciated by many delegates who were moved by the background and current health status of the Maori peoples.

However, like Aboriginal and Torres Strait Islanders, the Maori population continued to experience lower economic growth, and higher incidences of injury and disease.

To gain further understanding of other successful health systems, Professor Karina Walters, member of the Choctaw Nation of Oklahoma and Founding Director of the Indigenous Wellness Research Institute at the University of Washington, spoke on the history of the policies made by previous US governments and the impact on the social, economic and health outcomes for the American Indian population. Later, further interna-

tional focus was provided by Professor Frank Plani who drew comparisons between trauma injuries in Australia and South Africa and Prof Eddie McCaig who presented on the injuries experienced in the Pacific Islands.

In many presentations it was emphasised that understanding patients' connections to land, historical and spiritual life, as well as their living conditions, health beliefs and socio-economic situation, were very important to providing effective health care. The successful Australian Indigenous Health Program – a combined educational initiative of the College and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists aimed at Fellows, Trainees and International Medical Graduates – was highlighted as a way of orientating non-Indigenous health care providers to understanding those connections.

For the College it was obvious that such partnerships are needed with like-minded groups that have similar goals of preventing and treating injury amongst Indigenous populations in Australia and New Zealand, similar to very successful College models for road safety advocacy. Presentations from Associate Professor Noel Hayman and College staff Louisa Tesimale and Monique Whear showed this would bring together the different skills and resources of varying groups with interests in Indigenous health and safety, and be a strong alliance to effect change.

Professor Ian Anderson is a descendant of the Palawa Trouwunna: Plaimairrenner and Trawlwoolway clans in Tasmania and is Professor of Indigenous Health at The University of Melbourne. Ian put into perspective the current health policy challenges and how they relate to the high incidence of trauma injuries. Ian emphasised that to close the health gap between Indigenous and non-Indigenous populations, a coherent policy on Indigenous health and concerns had to be further developed nationally.

Dr Mark Wenitong is of the Gubbi Gubbi ancestry, custodians of the land in and around

“A multi-disciplinary approach seems the best chance for implementation of successful Indigenous health programs.”

the Sunshine Coast in Queensland, and was president of the Australian Indigenous Doctors Association. As a GP, Mark reflected on his experience as a primary health care practitioner by providing a broad outlook on the political and social implications in which injuries were sustained. Speaking about the high incidence of injuries resulting from family and interpersonal violence, Mark highlighted that effective policy was a plausible solution to combat and reduce these incidences of violence.

The many professionals who presented on the experiences of Australia’s Indigenous population echoed a very similar pattern experienced by the Maori and American Indian Indigenous peoples. What was most alarming was the global similarity in the statistics, which showed Indigenous populations presented with a higher number of injuries from motor vehicle accidents, interpersonal violence and self-harm, often resulting from or associated with substance abuse and economic deprivation, in Australia, New Zealand, North America, South Africa and the Pacific Islands.

Presenters at the workshop also included experts in epidemiology and injury prevention, Indigenous committees at other Colleges, policy-makers and health care providers. For example, Mr Jacob Jacob described the high rates of stabbing injuries and multiple-passenger car accidents in Alice Springs, while further emphasis on injuries in the Northern Territory were presented by Dr Steve Skov. Professor Kathleen Clapham, descendent of the Murrawarri people of New South Wales



1. Danny Cass & Louis Peachey 2. Kelvin Kong & John Graham
3. Jonathon Koea, Kelvin Kong, Russell Gruen & John Graham

and Director of the Woolyungah Indigenous Centre at the University of Wollongong, presented on sources of data and provided an overview of the difficulties and issues in understanding the nature of Indigenous injury in Australia as well as the effects of road trauma. Dr Kylie Cripps from the University of Melbourne, discussed evidence around interpersonal violence, and Dr Rowena Ivers, from the George Institute in Sydney, presented an overview of injury prevention.

Associate Professor Helen Milroy, a descendant of the Palyku people of the Pilbara region of Western Australia, presented a startling but helpful reminder to all health care providers to be aware of the mental health issues that coincide with all of the effectors and effects of disadvantage and poor health among Indigenous populations. She also called for sensitivity to the effects mental health issues have on the willingness and capacity for Indigenous individuals to present for, understand and comply with medical treatment of all kinds. Dr Louis Peachey, member of the Girimay Clan of the Djiribal People of North Queensland and founding president of the Australian Indigenous Doctors Association, spoke on the theme of respect for communities as well as individuals, imploring

health care providers to consider the need for health care to be taken to remote communities, rather than uprooting the individual from familiar surroundings to a foreign environment without family support.

So, what were the lessons from the day?

We heard that our focus should be broad – including the clinical and non-clinical, getting back to grass-roots level, reviewing the effectiveness of current educational curricula and policy decisions, embracing our professional roles as experts and the public orientation that this implies, showing cultural respect, and taking healthcare to the population.

A multi-disciplinary approach seems the best chance for implementation of successful Indigenous health programs. We heard effective partnerships with colleagues and other leading health care organisations, particularly Indigenous health care organisations, are possible and can effect systemic changes and influence policy development. Professional Colleges have important roles within their sphere of influence to improve health care delivery, promote healthier lifestyles and communities, and impact on the public’s understanding of and consideration for the well-being of Indigenous people.

2009 ROWAN NICKS SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the 2009 Rowan Nicks Scholarships and the 2009 Rowan Nicks Pacific Islands Scholarships. These are the most prestigious of the College's International Awards and are directed at surgeons who are destined to be leaders in their home countries.

The 2009 Rowan Nicks Scholarships are offered to surgeons from Asia, Africa or the Middle East. It is intended to provide an opportunity for the surgeon to develop skills to manage a department and become competent in the teaching of others in their home country. It is emphasised that the scholarships' objectives are leadership and teaching and it should not be used solely to develop surgical skill. The scholarship is usually awarded for a period of between three and twelve months.

The 2009 Rowan Nicks Pacific Islands Scholarships are reserved for surgeons from Pacific Island countries. It is aimed at promoting the future development of surgery in the Pacific Islands by providing a period of selective surgical training with the specific purpose of fostering the scholar's potential to provide surgical leadership in his/her home country. The scholarship is usually awarded for a period of between three to six months.

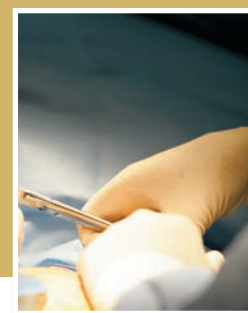
These scholarships cover the scholar's travel expenses between their home country and Australia or New Zealand. A living allowance will be provided equivalent to AUD\$36,000 for up to twelve months or appropriate pro-rata for a scholarship in Australia and NZ\$36,000 for up to twelve months or appropriate pro-rata for a scholarship in New Zealand. The scholarship is tenable in a major hospital (or hospitals) in Australia or New Zealand, and appointees will attend the Annual Scientific Congress of the College if they are in Australia or New Zealand at the relevant time.

Applicants should be under 45 years of age, fluent in English (an English proficiency test will be requested) and be a citizen of the country from which the application is made. Applicants must undertake to return to their country on completion of the scholarship programme.



Closing date for these Scholarships is **5pm Monday 14 April 2008**
A copy of the application form for either Scholarship is available at www.surgeons.org.
For additional information please contact:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street
Melbourne VIC 3000 Australia
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211
Fax: + 61 3 9276 7431



AK Jha, EJ Orav, Z Li & AM Epstein

The hospital quality alliance measures

The possible inverse relationship between mortality rates and performance in the hospital quality alliance measures

Public reporting of hospital quality data is prolific in the United States. In this article the authors advocate that performance indicators provide a means for tracking hospital performance and that reporting these data to the public allows patients to select high-quality providers creating incentives for hospitals to improve care.

The Hospital Quality Alliance (HQA) is a national program in the US that has recently started to release public reports on process-based indicators of care.

The aim of this study was to determine whether performance on ten HQA indicators for three conditions (AMI, CHF and Pneumonia) is related to risk-adjusted, in-hospital mortality rates. Indicators are listed in Table 1. These ten measures were selected on the basis that financial incentives were offered for reporting them so the data collection was the most complete.

For each hospital, the researchers calculated three weighted averages for the HQA performance indicators relevant to three conditions. The HQA average scores for each hospital were then linked to the Medicare Provider Analysis Review (MedPAR) data set, which is an administrative data-set holding discharge data on all fee-for-service Medicare beneficiaries.

All patients aged over 65 discharged with an ICD-9 diagnosis code of AMI, CHF or pneumonia were included and inpatient mortality was the primary outcome variable of interest. Separate risk-adjustment models were built for each of the three conditions, but each included adjustment for co-morbidities, race, age, sex and hospital characteristics.

Results

Complete performance indicator data was obtained from 3,720 hospitals (80 per cent of all acute care US hospitals). After adjustment for patient and hospital characteristics, the odds

Table 1. HQA performance indicators used to calculate summary score

| AMI | CHF | Pneumonia |
|-----------------------------------|--------------------------------------|---|
| Aspirin at arrival | Left ventricular function assessment | Antibiotics provided within 4 hours or less |
| Aspirin at discharge | ACE inhibitor for LVS dysfunction | Pneumococcal vaccination |
| Beta-blocker at arrival | | Oxygenation assessment |
| Beta-blocker at discharge | | |
| ACE inhibitor for LVS dysfunction | | |

of death for patients in hospitals in the highest performing quartile on the indicator summary scores were compared to patients in hospitals in the lowest performing quartile. For each of the three conditions, the odds of death for each of the three clinical conditions were as follows: AMI – OR= 0.91 (95 per cent CI: 0.86- 0.96), CHF – OR= 0.92 (95 per cent CI: 0.88-0.98) and Pneumonia – OR= 0.90

Comment

A critical question to ask is whether the indicators collected actually reflect the quality of in-hospital care. Whether or not a person arrives in hospital on aspirin and beta-blockers or has received pneumococcal vaccination isn't likely in an Australian context – it more likely reflects quality of care in the community.

“A critical question to ask is whether the indicators collected actually reflect the quality of in-hospital care.”

(95 per cent CI: 0.86- 0.95). The authors calculated that approximately 2,200 in-hospital deaths would have been avoided if all hospitals had the mortality rates of those in the highest performing quality quartiles.

The authors note that a limitation of this study is that the main outcome of interest was in-patient mortality, yet many of the measures being assessed, such as beta-blockers at discharge, are unlikely to influence in-hospital mortality. Therefore, the authors believed these results are likely to indicate that hospitals which perform well on the selected indicators may perform well on other unmeasured processes of care.

Take Home Message

This study demonstrated that high performance on ten HQA process-of-care indicators was significantly related to lower in-patient mortality rates in this population. While, on face value it appears an important finding it requires careful consideration. Clearly there is an association, however it should not be inferred that it is causal.

Reprinted from the Australian Patient Safety Bulletin Newsletter, Newsletter of the NHMRC Centre of Research Excellence on Patient Safety October 2007, Issue 7.



Michael Gorton,
Partner, Russell Kennedy
Solicitors

Liability for negligence

Practitioners must ensure that they minimise any legal risks and avoid falling short of the requisite standard of care

The practice of medicine is not perfect. Many patients suffer from disease or conditions for which there may be no, or no adequate, treatment. Nonetheless, patients have come to expect perfect results.

Patients may suffer “adverse medical outcomes”. These, more often, are a natural outcome from the disease or condition which they suffer, the inherent risks and side-effects of a procedure or administration (ie. drug) or some other systemic error which is unrelated to the doctor’s care and attention.

At law, doctors are only responsible for their own want of care, or the failure to apply the proper standard of skill and attention that might be expected in the circumstances.

Examples of obvious negligence are death or injury resulting from:

- administration of the wrong drug or an excess of a normal drug being administered
- administration of a drug in the wrong area of the body
- the wrong limb being operated on
- tourniquet remains too long with vascular complications
- pressure areas or burns or other injuries to an anaesthetised patient

Liability can arise under different causes of action:

Negligence

In addition to a failure by the doctor to exercise proper care and attention, the doctor could also in some circumstances be negligent in failing to obtain informed consent (informing the patient of all material risks relevant to the procedure).

Assault/Trespass

If a doctor treats a patient without proper consent, the doctor is technically committing a trespass or assault on the patient.

Breach of Fiduciary Duty

In rare cases, the Courts have recognised a fiduciary duty arising from the “special relationship” between the patient and the doctor.

Where a doctor fails to act in the best interests of the patient, and fails to disclose any conflict of interest, it is sometimes argued that this fiduciary duty is breached.

Breach of Contract

In common with a negligence claim, it is sometimes argued that the failure by the doctor to exercise due care is also a breach of the contract between the patient and the doctor.

In a negligence claim, the courts will usually assess three elements:

- 1 the duty of the doctor to take reasonable care of the patient
- 2 whether there has been a breach of duty by the doctor; and
- 3 whether the damage that the patient has suffered is a result of the doctor’s failure of care.

The Duty

Doctors are generally asked to exercise the standard of care expected of doctors of good quality and standing, and with the requisite degree of skill and experience in the relevant specialty of the doctor.

A specialist practitioner in a certain field is required to have that skill “of the ordinary skilled person exercising and professing to have that skill”. The law recognises the variability of individual practitioner’s skills and does not demand that doctors always perform at the highest standard of their peers. However, courts are now the final arbiter of negligence. Evidence of medical experts will have an important role in aiding the court to decide if a medical practitioner had been negligent.

Breach of Duty

The standard of care is that which a “reasonable person” would have taken in the circumstances. The courts will determine whether that standard has been met. Whilst the court may have regard to the practices and procedures of other doctors in similar circumstances, the court will determine whether the standard

has been met, having regard to the skills of the doctor, general practices in the profession, the level of knowledge and research available and the other relevant factors.

Negligence can arise for positive conduct, but can also apply where the doctor has failed to undertake any action.

Damage Caused

Patients will be entitled to claim compensation for loss or damage which they suffer as a consequence of the negligence of the doctor.

The patient must show that the loss or damage would not otherwise have arisen if the doctor had not been negligent. This distinguishes between negligence and merely an “adverse outcome”.

Trainees

Training or junior doctors like other professionals are required to exercise the skill “of the ordinary skilled person exercising and professing to have that skill”. This test is satisfactory for patients who choose their physicians. But public hospital patients cannot choose their practitioners. A junior officer is only required to fulfil the skill required of their position. But this junior will be liable, if they negligently perform a duty outside their range of skill or fail to refer a question beyond their capabilities to another practitioner.

The hospital or supervising doctor may be liable if the junior doctor escapes liability by referring a situation to their superior and the negligent treatment is not dealt with soon enough, or if the junior doctor has not been adequately supervised or instructed.

The State of Medical Knowledge

Other factors may affect whether the requisite standard of care has been reached in diagnosis and treatment. A medical practitioner is only expected to have the knowledge of an “ordinary skilled” person in their field. If

“At law, doctors are only responsible for their own want of care, or failure to apply the proper standard of skill and attention that might be expected in the circumstances”

the state of medical knowledge means that a failure of equipment could not be predicted, preventative measures such as were required to prevent injury were not regularly taken at the relevant time, or the dangers of a type of treatment were unknown, there may not be a breach of duty.

The law accepts that, in order for medicine to progress, new techniques must be tested. However, if such techniques are used, there is a very high standard of disclosure required that demands patients be informed of alternative forms of treatment.

Failure to Disclose Risks/ Informed Consent

The law recognises that a doctor has a duty to warn a patient of a material risk which is inherent in any proposed procedure or treatment.

Failure to Diagnose/Follow Up Tests

One of the obvious areas for negligence is failure to diagnose accurately or properly the particular disease or condition of the patient.

A recent case in South Australia has highlighted the responsibility doctors have to ensure

appropriate follow up on tests ordered or reports requested. Doctors should have appropriate systems in place to ensure that, when tests are ordered or reports requested, there is a follow up to ensure that any adverse outcomes are detected within time. Reports and test results can often go astray. Doctors cannot rely on patients contacting them again for follow up, and doctors must therefore have their own systems to ensure that follow up occurs.

Doctors should also emphasise to patients, to a much greater extent, the need for the patient to call back to ascertain the results of tests, and should advise the patient of the implications of failing to follow up or failing to keep an appointment made, in detailed terms.

Vicarious Liability

At law, an employer may be held responsible for the negligence of its employee, acting in the course of his or her employment. Accordingly, hospitals and other health institutions are responsible for and will be liable for the acts or omissions of their staff.

The staff member nonetheless remains liable for their own negligence.

Additionally, doctors will therefore be liable for the actions of their own employees (locums, administrative staff, office staff, etc.). These issues are important in considering whether an insurance policy maintained by the employer will cover particular staff members.

These issues highlight the need for medical practitioners to ensure that they have adequate and appropriate insurance for themselves, their practice, and for their employees (for whom they may be liable).

Risk Management

To minimise legal risks, doctors should ensure that:

- appropriate insurance is maintained
- relevant standards, protocols and guidelines are followed
- detailed and appropriate communication is maintained with patients
- they have good “informed consent” procedures
- detailed notes and records are maintained
- they respond to an adverse incident promptly
- if in doubt, they consult their insurer or legal adviser

AUSTRALIAN & NEW ZEALAND POST FELLOWSHIP TRAINING PROGRAM in Colon & Rectal Surgery 2009

Applications are invited for this two year Program. The program is organised by a Conjoint Committee representing the Section of Colon & Rectal Surgery of the RACS and the Colorectal Surgical Society of Australia and New Zealand.

Information and Enquiries:

www.cssanz.org
Professor Michael Solomon: msolomon@med.usyd.edu.au

Closing Date:

Friday 16th May 2008

Applications:

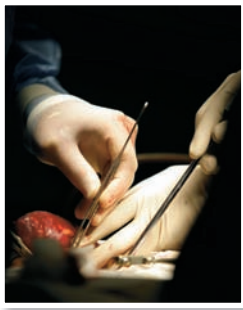
Applications are to be made by letter, including Curriculum Vitae and the names and addresses of three referees.

Please send to:

Professor Michael Solomon
Chair
Training Board in Colon & Rectal Surgery
Level 2, 4 Cato Street,
Hawthorn VIC 3122
AUSTRALIA
Email secretariat@cssanz.org



Younger Fellows



*Richard Page, Chair,
Younger Fellows Committee*

2007 Tyco Healthcare Travelling Fellowship Grant Announcement

The Younger Fellows Committee together with Tyco Healthcare are pleased to announce the recipients of the 2007 Tyco Healthcare Travelling Fellowship Grants. The aim of this Grant scheme is to financially assist Younger Fellows who are travelling overseas to further their post Fellowship studies. In 2007, a number of high quality submissions were received by the Younger Fellows Committee; the Committee would like to thank all those Younger Fellows who took the time to apply for this grant and wish them the best of luck with your endeavours.

Congratulations to the 2007 Tyco Healthcare Travelling Fellowship Grant recipients; Dr Venu Chalasani and Dr Jai Seema Bagia.

Dr Venu Chalasani is participating in the Society of Urologic Oncology Fellowship Program at the London Health Sciences Centre, Ontario, Canada. Dr Chalasani will engage in a broad range of diagnostic and treatment options used in Urologic Oncology, gain experience in the surgical management of all complex tertiary and quaternary uro-oncology referral cases and participate in the development of new, investigational and emerging treatment modalities.

Dr Jai Seema Bagia is pursuing a twelve month Fellowship comprising post specialist training in liver and small bowel transplantation at the Thomas E. Starzl Transplantation Institute, Pittsburgh, USA. This Fellowship will consolidate experiences gained as a Hepatobiliary Fellow in Liverpool, UK; the Paul McMaster Fellowship in hepatobiliary and liver transplant surgery at the Queen Elizabeth Hospital, Birmingham; experience in paediatric liver and small bowel transplant at the Birmingham Children's Hospital. The Starzl Unit has the largest cumulative and current experience in small bowel work.

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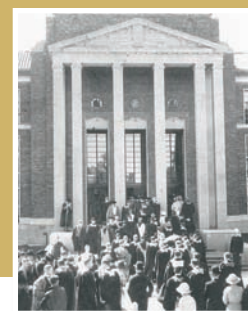
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Keith Mutimer,
Honorary Treasurer

A sigmoidoscopy set

The term sigmoid refers to the shape of the lowest section of the descending colon



Sigmoidoscope. What romantic images does the very name conjure! Who was Sigmoid? An ancient Germanic hero? Is this an instrument through which we can peer into his past? The legions of sigmoidoscopes number greater than the stars in the sky. Where do they all come from? Where do they all belong?

As its name implies, the sigmoidoscope is used for examination of the sigmoid colon. Since the 1970s the older rigid scopes have largely given way to the modern flexible variety, and as a result, the College Museum has a very large number of plated brass and stainless steel examples in its collection, some in better condition than others. The term 'sigmoid' means 's-shaped', like the Greek letter sigma (ς), and refers to the shape of the lowest section of the descending colon.

The practice of inserting inspection tubes into natural orifices goes back to Greek and Roman times. Hippocrates describes a rectal examination by means of a speculum. The problem however was always one of illumination. The first true endoscopic device, pow-

ered by a wax candle, was invented in 1805 by Philipp Bozzini (1773-1809) of Frankfurt-am-Main. The familiar rigid sigmoidoscope, about 25cm long and 2cm in diameter, dates from the beginning of the 20th century. The electric sigmoidoscope, fitted with a distal light source, first appeared in 1913. Its drawback however was that the light bulb tended to produce more heat than light. Despite its limitations, the rigid sigmoidoscope was one of the most useful tools in the detection and treatment of lower bowel ailments.

Recently, an unusual sigmoidoscopy set

was brought into the College by Andrew Roberts, Clinical Director - IMG. It belonged to Andrew McLeish, who had no longer any use for it, and Mr Roberts thought it might make an interesting addition to the collection.

Mr McLeish was given it many years ago, and it probably came from the Heidelberg Repatriation Hospital. It is very complete and in excellent condition, with very little signs of use, and the rubber components are not perished. The sigmoidoscopes themselves, two in this set, are quite large, and are intended for operating under anaesthetic.

Their most unusual feature is the material they are made of, an early thermosetting resin, either Bakelite or melamine. They are dark orange in colour, with a marked pattern of stripes. The obturators are slightly darker than the sleeves. The set seems to have been made in the late 1930s or early '40s.

This set is quite unlike any of the others already in the Museum, and makes an excellent addition to the College's surgical instruments collection.

Written by Geoff Down, College Curator



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Association of
General Surgeons

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Conference Managers:
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Ian Dickinson, Chair
Professional Development
& Standards Board

Online Solution to Continuing Professional Development

CPD Online

Data collection for the 2008 Continuing Professional Development (CPD) Program is available online via www.surgeons.org. Fellows are able to access a personal CPD Online Diary using usernames and passwords to maintain CPD records in a real time format. Fellows using the CPD Online Diary for 2008 will not be required to complete the hard copy recertification data form issued at the conclusion of 2008, however Fellows are encouraged to continue keeping evidence of CPD activities for verification purposes.

2007 CPD recertification data forms

Fellows are reminded that the 2007 CPD Program recertification data forms are to be returned to the College by 31 March, 2008.

Find a Surgeon Directory linked to CPD Program

The College offers a Find a Surgeon Directory on the College website, accessed via the home page. The purpose of the directory is to provide a service to members of the public and to promote the practices of Fellows.

From January 2008, the directory only includes active Fellows who have met the requirements of the College's CPD Program (or an approved equivalent CPD Program) and have opted to be on the list. Council approved this change to ensure the community that their surgeon has met the College's minimum standards for recertification.

Are you listed?

The College has been promoting the Find a Surgeon Directory over the past two years and has encouraged Fellows to have their name and contact details on the list. If you've previously registered, your details will remain on the list, provided you've met the requirements of the College's CPD Program (or approved equivalent program). More than 1300 Fellows are currently listed.

List yourself on Find a Surgeon – You must opt in

The Find a Surgeon Directory is an opt-in listing. Privacy legislation requires Fellows must consent to their name, specialty areas and contact details being featured on a publicly available area of the website.

If you are an active Fellow and have met the requirements of the College's CPD Program for 2004 – 2006 (or an approved equivalent CPD Program), take the following steps to add your name.

Login to the College website. After you login, you will see your name in the login box, and under that the text "Update personal information".

- Click on Update personal information to view your personal details
- Select the Web Options button from the horizontal row of choices across the top of the page

- Click the Web Options link on the next page
- Tick the box for Include in Find a Surgeon
- Press Update to make the change

The website re-indexes every night so you will be able to find your listing the next day.

If you would like help contact Jeremy Lim, Web Co-ordinator, on +61 3 9276 7449 or by email: college.webadmin@surgeons.org.

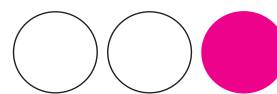
For any help with CPD online training or recertification data forms, or if you wish to confirm your current CPD Program status, please contact Maria Lynch, Recertification Officer, on +61 3 9249 1282 or by email at maria.lynch@surgeons.org.

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Successful Scholar



Sir Roy McCaughey Scholarship

Patsy Soon says the ultimate aim of the research is to allow us to know which tumours to leave and which ones need aggressive treatment

Identifying the molecular markers that could differentiate between adrenocortical carcinomas and adenomas, as well as act as therapeutic targets, was the aim of research funded through the College's Sir Roy McCaughey Scholarship.

College Fellow Patsy Soon, a breast and endocrine surgeon at the Bankstown Hospital in Sydney, received the scholarship for 2006 and 2007 to fund part of her PhD research.

Now in the process of undertaking a National Health and Medical Research Council (NHMRC) post-doctoral fellowship, Dr Soon said limitations in the current methods of differentiating benign and malignant tumours meant that some patients were dying because treatment came too late and others were having surgery unnecessarily.

She said that while adenomas were relatively common, found in seven per cent of the population aged over 50, adrenocortical carcinomas (ACCs) were quite rare but often incurable by the time of diagnosis.

"Differentiating between the two is problematic with current methods. At the moment we look at the CT scan and depending on the size of the tumour, that is if it is over 3-5cm, we operate because the chances of the tumour being malignant increases with increasing tumour size," she said.

"However, some of these tumours are found to be benign, so if we could do a fine-needle biopsy, which tells us what the nature of the tumour is, then the better the treatment we can offer. The ultimate aim of the research is to allow us to know which tumours to leave because they are benign and which ones need aggressive treatment."

Dr Soon said that while some markers had been found, the full answer was still some years away. She said there were still difficulties in differentiating between the two tumours even after they had been removed.

"We have identified a couple of molecular

"If we are able to more accurately identify the malignant from the benign tumours we can begin cancer treatment earlier, which could obviously save lives."

markers that can be used post-operatively, which is a process now being trialled by the Royal North Shore Hospital in Sydney. We haven't got there yet with pre-operative techniques, but if the post-operative identification works that will be a huge advance," Dr Soon said.

"Treatment options for ACCs are limited. A molecular marker which could act as a therapeutic target, such as HER2 for breast cancer, is desperately needed. Targeted therapy could then translate to better prognosis for patients with ACCs."

ACCs afflict only one to two persons per one million population per year and usually occur in adults, with the median age at diagnosis of 44 years. Although potentially curable at early stages, only 30 per cent of these malignancies are confined to the adrenal gland at the time of diagnosis. The most common sites of metastases are the peritoneum, lung, liver and bone. In the research, microarray gene expression profiling and loss of heterozygosity analysis were used to try to identify molecular markers as a means of differentiation.

Dr Soon conducted her initial research with funding from the College as well as NHMRC and NSW Cancer Institute support. She worked under the supervision of professor Bruce Robinson and associate professor Stan Sidhu at the Kolling Institute of Medical Research, and her PhD thesis is now under submission. She chose this field of

research after treating a young patient during her training.

"In my third year of training, I treated an 18-year-old man with adrenocortical carcinoma, which had metastasised by the time of diagnosis. He had an operation to de-bulk the tumour, but by then it was incurable and he died of the disease at age 23. That's what made me get into this field of research."

Dr Soon said she found the genetic research satisfying and rewarding, particularly given that she combines that work with her clinical practice.

"It is extremely intellectually challenging to try and find future treatment options, not only in terms of patient outcomes but also in terms of the health system. If we are able to more accurately identify the malignant from the benign tumours we can begin cancer treatment earlier, which could obviously save lives while at the same time saving the health system money by reducing unnecessary surgery.

"Even now, some patients can initially be diagnosed as having a benign tumour which then later recurs, whereas if we had a better understanding of what we were looking at, we could use surgery, chemotherapy and radiotherapy before there is a chance of metastasis."

Dr Soon has already presented some of her findings to the College's Annual Scientific Congress and also at the European Cancer Conference last September.

She was grateful for the College's support.

"One of the major problems with undertaking research, obviously, is finding the money to allow you to do it. Without the College's scholarship I would not have been able to devote my time to this," Dr Soon said.

"And I've loved it, particularly in combination with my clinical practice. It's a great mix because I enjoy the clinical work, the patient interaction and the intellectual stimulation of the research work."



Finding an interest before retirement

Surgeons need to find a hobby or interest outside of their work, and figurative painting is a natural fit because it is about the human body

Semi-retired urological surgeon Tony Taylor believes that if he had not become a surgeon he would have followed in his father's footsteps and become a carpenter or builder. It's about using his hands, he says, about fixing things, solving problems, thinking creatively.

While surgery fulfilled those needs, as he headed towards retirement Dr Taylor understood that he would need to find a replacement. He chose painting, and so good is his work that he is now a member of the quasi-professional Western Australian Watercolour Society.

Still working as the Director of Surgery at the Armadale Hospital, outside Perth, Dr Taylor also decided to share his passion by setting up an art society specifically for members of the medical profession. In 2006, he placed an advertisement in a magazine circulated to medical practitioners in WA, and he was stunned to receive 50 responses.

"I think painting, figurative painting in particular, has an appeal for surgeons and other medical professionals because clearly it is about the human body. To paint that accurately you have to understand the contraction and relaxation of the muscles, proportion, posture, the centre of gravity and the dynamics of human movement," he says.

"A surprisingly large number of surgeons dabble in art, with music the other activity, and I think it's about using our hands and about an appreciation of aesthetics because I believe medicine is an art form."

Following that response and having bought a heritage building in Fremantle, which he turned into a studio, Dr Taylor established the Western Australian Medical Art Society with a membership that now includes general practitioners, radiologists, general and specialist surgeons, paediatricians and obstetricians/gynaecologists. Each month, the group gathers at his studio to learn the finer points of mixing colours, perspective and representing shadow



Tony Taylor in his studio

and light – all accompanied with wine and cheese, of course. Dr Taylor even invites respected artists such as Robert Wade from Melbourne to lead and teach the meetings.

He says he first became interested in art – his particular love being the impressionist style – after travelling with his family around Australia for nine months with an easel and brushes. So captivated was he that in 1996 he closed up his rooms and took his family to London to undertake a three-month course at the Slade Art School, part of the University of London.

In 2002, he wound down his practice and while he now no longer consults, he assists, particularly with laparoscopic surgery. This leaves him time to not only do his own painting, but to be involved in workshops here and overseas.

"Even though I was always interested in art, always sketching, I never had time to concentrate on it as a younger man. And I also knew I had to prepare for retirement, visualise what I wanted my life to be like. Retirement can be isolating or demoralising for some surgeons who have spent their professional lives being busy, active and surrounded by people," he says.

Dr Taylor urges fellow surgeons to also find an interest before retirement arrives.

"I think there is an advantage in starting to develop new skills in a new area before retirement so that you are not starting from scratch, because otherwise it is easy to get disheartened and give it away. Painting is such great fun. It allows you to travel, to meet different people," he says.

"For example, I was recently in Venice with my wife and sitting opposite the Santa Maria church doing a sketch and pen wash and other people gathered around because they were interested.

"It's a great conversation starter."

Dr Taylor is now in the process of registering the WA Medical Art Society as a charity so that fund-raising exhibitions can soon be held, with monies raised to go, not surprisingly, toward medicine-based charities and scientific research. And he says don't worry about notions of talent.

"If people are interested, they can do it. So many people are inhibited by their own perceptions of their own limitations. There is no such thing as bad art, just different art," he says.



Congratulations on your achievements

Daryl Wall - Gordon Trinca Medal

Associate Professor Daryl Wall was awarded the Gordon Trinca Medal in 2007 in recognition for his contribution to trauma care with particular emphasis on trauma education and teaching.

Daryl Wall has been a member of the Queensland Road Trauma Committee since 1996, and Chairman since 2000. He has been on the Queensland Emergency Health Services Coordination Advisory Committee from 1991 and Chairman of the RACS Road Trauma Advisory Committee since 2003. He has also been involved with the development of the Trauma Policy of the RACS and recently through the College, the development of the national response to terrorist disaster.

Daryl Wall became an instructor with the EMST/ATLS course soon after its development in Australia and has been a Director in Queensland for more than 10 years. He continues to participate in these courses with his informative, collaborative, friendly style of teaching being legendary. Daryl has been an instructor on the Definitive Surgery for Trauma Courses since 1999. Being acknowledged as an outstanding operative surgeon has made his advice and guidance on these courses valuable to all those who attend.

Daryl has had a selfless dedication to all aspects of his surgical career. In his subsequent roles as senior lecturer and then full time surgeon / director, he has provided the backbone of the emergency surgical service and in particular the management of trauma at the Princess Alexandra Hospital.

Daryl is highly respected in Queensland and in the College in general. He has committed himself to the co-ordination and care of patients who have suffered major injuries and continues to be involved in the education of doctors involved in trauma through formal sessions with the Hospital and his College of Surgeons affiliations.



Norman Fary - The RACS Medal

Dr Norman Fary is a graduate from Melbourne University with a Bachelor degree in Commerce and Education. Following a Masters degree in education at Monash University he moved to Nebraska to complete a PHD at the University of Nebraska.

A plane crash in 1977 involving in 1977 involving an orthopaedic surgeon, James Styner and his family, caused Dr Fary to say that "When I can provide better care in the field with limited resources than what my children and I received at the primary facility --- there is something wrong with the system and the system must be changed."

This of course was the beginning of the ATLS program. The most significant next step was to turn to the Education faculty of the University of Nebraska to assist in the designing a course to provide an appropriate education envelope to teach trauma care. The more recently developed CCrISP course is modelled on this educational package. Norman's educational pedigree is therefore undoubted.

The EMST and the CCrISP programs have been undoubted success stories of the Royal Australasian College of Surgeons. Norman Fary has shared the role of educator for both the EMST and CCrISP program virtually from their launch in Australia and New Zealand. The role has included the design and delivery of Instructor Courses and the meticulous audit of course delivery.

In 1988 Norman joined the College as an Educator at the commencement of EMST and

later embraced CCrISP. Norman teaches by example and gentle persuasion and his contribution as an educator has provided a cornerstone to the EMST and CCrISP program. The so called mink glove approach.

Keith Solomon - The RACS Medal

Dr Keith Solomon has been in education most of his life. He spent eighteen years working within the Education Department in NSW then developed an interest in educational administration, which led to an overseas post in Lincoln Nebraska the home of ATLS, where he completed a PhD and developed his first association with ATLS.

Keith returned to Australia and moved to the Darwin University where he spent the next twenty years. More recently he has become the Director of AUSCOT International Pty Ltd, a consultancy firm with expertise in governance. This has given Keith the opportunity of working with such groups as AUSAid, in a wide variety of countries to the North of Australia including East Timor, Papua New Guinea, Fiji and Indonesia.

The sole criteria for a RACS Medal, is distinguished service to the affairs of the College and it has been Keith's distinguished service on the EMST Committee that is the basis of this award. Keith's contributions have been as educator, educational advisor and educational consultant, from his initial EMST Course in Bloomfield, Orange in 1988 to the present day and has coordinated over 50 instructor courses.

Like many that make significant contributions to their profession, Keith also provided major contributions to the community at large. He has contributed to Rotary, Probus, COM-ROD and was a Justice of the Peace. However, it was Keith's significant contributions to St John's Ambulance that were recognised when he was gazetted as a Commander of the Order of St John of Jerusalem in 1997.

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