SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:2 March 2009

PrimaryTrauma Care Course in Vietnam, page 26

Most injuries are from road trauma, industrial accidents and trauma at home caused by cooking fires

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

In 2009 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities will assist you to strengthen your communication, business, leadership and management abilities.

Interviewer Training

25 March 2009, Brisbane *
1 April 2009, Sydney *
29 April 2009, Melbourne *

*Video-conferenced to other centres

This evening workshop aims to equip RACS interviewers of applicants for surgical training and for International Medical Graduates with appropriate interviewing skills and an understanding of the methodology for the semi-structured interview. The workshop is designed to give participants interviewing skills and knowledge that they will then pass on to their colleague interviewers.

Mastering Intercultural Interactions

2 April 2009, Melbourne
29 July 2009, Sydney

Discover how to recognise and use the eight most common communication styles and develop effective strategies for communicating with people from different cultural backgrounds. This workshop aims to enhance your service delivery by exploring a range of cultural value systems. It is essential communication training for surgeons practising in multicultural Australia and New Zealand.

Writing Reports for Court

5 May 2009, Brisbane

This important half day workshop offers skills-based training in preparing medical reports for use in legal matters, focusing on the fundamentals of an excellent medico legal report. Gain valuable individualised feedback on your own medico legal reports as well as an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective on form and content.

Emergency Management of Severe Burns

28 March 2009, Launceston
4 July 2009, Bendigo
10 October 2009, Cairns

This course is facilitated by the Australian and New Zealand Burns Assoc. (ANZBA). You will learn how to recognise, assess, stabilise and transfer the severely burnt patient. Theoretical and practical clinical skill demonstrations enhance learning opportunities for rural medical specialists. Life-like case simulations using rural scenarios are used to consolidate and integrate the course material. This project is in partnership with the Royal Australian College of Physicians (RACP) and Australian College for Emergency Medicine (ACEM) and proudly supported by the Support Scheme for Rural Specialists (SSRS).

Australian Indigenous Health Program

This online program focuses on educating rural Fellows on the issues encountered when treating Indigenous patient such as patients taking their own leave from hospital and not showing up for appointments. Strategies for better communicating with Indigenous people will be provided. The eight modules use reading material, case studies and a discussion forum to increase the interaction. This project is in partnership with the Royal Australian College of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and proudly supported by the Support Scheme for Rural Specialists (SSRS).

Building towards Retirement

When: Saturday 13th June 2009
Where: Royal Australasian College of Surgeons offices, Melbourne

Building towards Retirement is designed for Fellows aged 55 and above who are considering retirement or who are currently in the process of winding down from surgical practice. The workshop recognises that retiring from surgical practice is an important decision and for some can be a difficult and uncertain period. The workshop seeks to provide surgeons with an overview of the various issues they will face during this period, including the role of natural ageing, health and wellness, what men really think about retirement and the role of the spouse, opportunities for the retired surgeon, medico legal aspects of winding down and ensuring financial security during retirement.

The workshop is ideal for those contemplating when to retire and those making the transition to retirement. The program will include presenters from a variety of backgrounds, including Professor Robert Moodie, Professor of Global Health at the Nossal Institute for Global Health at the University of Melbourne.

Further Information

Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development. Easy online registration is available for most workshops.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: MARCH – JULY 2009

NSW	1 April	Interviewer Training, Sydney (videoconference)
	28 April	Supervisors and Trainers (SAT SET), Sydney
	4 June	Mastering Difficult Clinical Interactions, Sydney
	19-21 June	Leadership in a Climate of Change, Sydney
	29 July	Mastering Intercultural Interactions, Sydney
QLD	19-21 March	Surgical Teachers Course, Brisbane
	25 March	Interviewer Training, Brisbane (videoconference)
	2-4 May	Younger Fellows Forum, Brisbane (pre ASC)
	5 May	Supervisors and Trainers (SAT SET), Brisbane (ASC)
	5 May	Writing Reports for Court, Brisbane (pre ASC)
SA	16 June	Supervisors and Trainers (SAT SET), Adelaide
NT	27 June	Supervisors and Trainers (SAT SET), Darwin
	29 July	Management of High Risk Diabetic Foot, Alice Springs (PSA)
WA	29 May	Risk Management: Shared Decision Making, Perth
VIC	2 April	Mastering Intercultural Interactions, Melbourne
	29 April	Interviewer Training, Melbourne (videoconference)
	26 May	Supervisors and Trainers (SAT SET), Melbourne
	27 June	Making Meetings More Effective, Melbourne
	4 July	Supervisors and Trainers (SAT SET), Ballarat
NZ	26 May	Supervisors and Trainers (SAT SET), Christchurch
	26 June	Practice Made Perfect: Successful Principles for Practice Management, Auckland

Standards in surgical practice

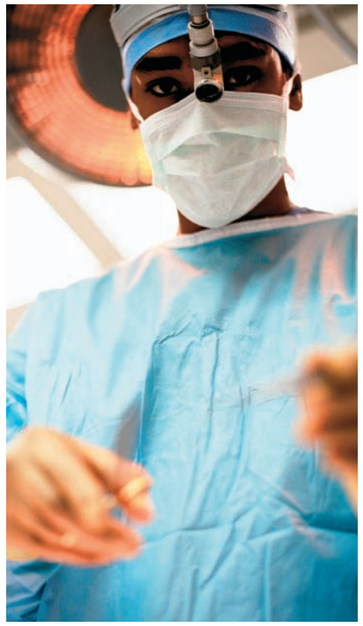
All the Medical Colleges support a National Medical Registration process

Ian Gough
President

The core of the College's various roles is to ensure standards for surgical practice are identified and that the training available in Australia and New Zealand enables a Fellow of the College to enter independent surgical practice as a safe and competent surgeon. Standards need to be determined by the profession based on the best evidence across the world. The training needs to be effective and we need to do this in a sustainable and robust manner. All of these key issues are actively being addressed by the College and the Specialty Societies and Associations.

A bureaucratic takeover of standards?

Most Fellows would have been following the National Registration and Accreditation issues. The College and indeed all the Medical Colleges are supporters of a National Medical Registration process. For too long, movements between states, even if "just over the border", have been complicated by paperwork, regulatory differences and expense. However, the various state based Departments of Health have used these concerns to perniciously progress their own agenda of dismissing and dismantling the structures that support and maintain our professional standards and their required accreditation. Having tried to work co-operatively with the taskforce for over 12 months, there is no doubt the editing and re-fashioning of the taskforce's deliberations by a faceless group of Department of Health officials is only serving the agenda of workforce reform. The proposals will subject the independent processes to support standards across all the health professionals to political manipulation.



"The College needs a sustainable model of surgical training now and into the future."

Consequently we are seeing confusion in the requirements to be designated a specialist, laxity in where workforce shortages can be declared, ministerial powers to direct rather than consult and mechanisms to enable task substitution. Having exhausted our options of co-operative dialogue, the various Colleges and the Australian Medical Association will now need to become far more politically active. Our Regional Committees and indeed all of us need to ensure that all the health ministers are aware of the substantial problems they are creating for the standards of patient care.

Why replicate the worst examples of what happens overseas?

One always hopes that improvements may be made by reviewing international experience and best practice. There are very few defenders of the Postgraduate Medical Education Training Board (PMETB) experience in the United Kingdom, where government structures tried to revolutionise the way that medical careers were developed and training provided within the National Health Service. Specialist colleges were marginalised. It is only now after the failure of PMETB that specialist training is being re-built with College input now firmly endorsed. Yet, the government officials in Australia seem determined to replicate all the problems that PMETB created by having a centralist approach that strips away the role of the various professional groups in maintaining standards. These are the key risks we as a profession and the College and Specialty Societies and Associations as your professional groups are facing.

Academy of Surgical Educators

The College needs a sustainable model of surgical training now and into the future. Our training is proudly based on a pro-bono method of training traditionally fashioned on an apprenticeship model. However, expectations, educational models and the regulatory world continue to evolve. Our training is now based on clearly defined competencies and curricula with innovative and complex methods of delivery. The regulatory bodies demand processes that are educationally valid, transparent and robust. Selection of Trainees and in-training assessment are now more rigorous and demanding of time. Counselling of Trainees for career guidance and also managing underperformance need careful and considered approaches. In a recent survey of Fellows who are involved as educators and instructors a number of key issues emerged that included ensuring there was protected time for surgeons to undertake their role, →

heightened support and recognition by the College and also the availability of more formal/structured training to be more knowledgeable about education and the College programs.

Already the College and Specialist Societies have adjusted our Hospital Post Accreditation guidelines to ensure that supervisors have protected time to spend in educational initiatives with other trainers and also the Trainees. The College is also forming the Academy of Surgical Educators to address a number of key issues but particularly to profile the importance of the educational role and provide support for those at the educational 'coal face'.

This type of initiative is also underway in the United Kingdom, Canada and the United States. The model that the College is currently proposing is one where membership of the Academy is open to all who can demonstrate they have the competencies to be an educator. This will usually be by having completed various educationally related programs, having substantial experience or by having completed formal academic courses.

"The College is also forming the Academy of Surgical Educators to address a number of key issues."

With the academy in place we aim to ensure that our Fellows who are in senior roles do have a strong educational base. We intend to provide links to the growing number of Medical Education programs that exist across Australia and New Zealand. The College now has a Memorandum of Understanding with the University of Melbourne to ensure that a specific surgical education course is developed as it is felt this will provide a niche program that is not currently available.

The development of the Academy is one of the key initiatives for the College. There is no doubt that our training programs produce well rounded, well trained and internationally comparable Fellows. However, there have been growing concerns about ensuring we have a more professional and sustainable approach are highly supportive of our Fellows and providing them with the most appropriate educational support into the future. The Academy of Surgical educators will provide this.

Note: John Aloysius Henderson was the photographer for the Colwishaw Symposium which appeared Vol 1, No1 2009.

Specialists within the new system

The Australian public doesn't deserve makeshift solutions to problems of such importance

Ian Dickinson,
Vice President

In last month's issue of *Surgical News* I outlined the College's response to the Council of Australian Governments' (COAG) proposals regarding the national registration of health professionals and the accreditation of training courses.

This response has involved a series of submissions, addressing in detail the specific proposals contained in consultation papers released over the past six months by the committee charged with implementing COAG's plan.

Over the past few weeks the College has been preparing its response to another consultation paper, issued on 21 January and relating to proposed arrangements for specialists within the new system. The release of this paper was deemed necessary by the committee to clarify the arrangements applying to specialists in the regulated professions.

Role of the Colleges

Once again, the College was disappointed to find no proposed role for the medical colleges in respect of the registration, assessment, training or continuing competence of specialist practitioners. Accordingly, we make the point that, given the colleges' proven commitment to medical excellence, it is difficult not to conclude that this entire exercise is an attempt to ease pressure on the health system by lowering the standards required to become a health professional.

Protection of title, Continuing Professional Development (CPD), area of need

Elsewhere in the College's submission we make constructive suggestions on a range of issues. These include a call for the protection of the specialist titles "surgeon" and "surgical specialist", and the rejection of the committee's assertion that "Minimum standards for continuing competence requirements for specialist endorsement must not be discipline specific". To have any credibility, continuing competence standards, or CPD, must be specialty specific and involve the specialist medical colleges where relevant. The College also opposes a proposal that boards be empowered to judge applications for area of need registration against whatever standard they themselves have developed. As our response notes: "If the standard to apply to area of need applications is completely flexible, it represents no standard at all."

Specialist register

The College also strongly opposes the proposal to define specialist practice as a form of limited registration. Currently, and quite appropriately, specialist practice is viewed as an extension of expertise, enabling a practitioner to practice specialist medicine in addition to that medicine which can be practiced under general registration.The point is made that many surgeons, particularly those practicing in rural Australia, also work across the breadth of clinical practice at some stage of their careers. It would be a severe blow to rural communities if new registration arrangements discouraged this practice. New registration arrangements should serve to expand rather than limit a clinician's options.

The College reiterated its belief that there should be a separate register for specialists and that this should confer rights of practice in addition to those conferred by general registration. There should also be a formal distinction between specialist endorsement for College Fellows and the endorsement of those with overseas qualifications who are not members of the relevant college.

Areas and scopes of practice

It is further proposed that boards and the Ministerial Council have the power to establish separate "areas of practice" which will be substantially more limited than either general or specialist registration. Whilst this may assist in those cases where an International Medical Graduate (IMG) is specialised in, say, hand surgery or foot surgery, but does not have sufficient qualifications or experience to qualify fully as an orthopaedic surgeon, the College is concerned that this clause could allow other non-surgeons to carry out surgical work on the basis of this limited "area of practice" endorsement.

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Under the gaze of our forebears

A re-write of the Council's principal document prompts reflection on why our organisation functions the way it does

I.M.A New Fellow

"It is of course quite illogical to suggest that eyes on canvass influence our current thoughts and actions. However... our forbearers do influence our actions and decisions."

It's the eyes, you know, the eyes. They're the reason. They're always there, watching, observing, noting, looking disapprovingly; always there. They think that I have not noticed them. I have – last Council meeting I saw them, all 10 sets, all 20 eyes all watching. They are the reason, I am sure. No-one else noticed them but I did – all around the walls looking down on us. They are the reason.

Before you all think that I am more off beat than usual (or worse) let me explain. During last Council meeting I was wondering why the College was such a conservative organisation. No, I really mean Conservative with a capital "C". The Council was discussing a change in the Articles of Association. As this is not the most riveting of topics I was gazing at the portraits around the Council chamber (with an intense expression of concentration, of course, so that no-one could see that I was day-dreaming). I then saw the stern faces of 10 of our past Presidents looking down on us as we contemplated a complete re-write in the rules that govern the College – the first major re-write in nearly 80 years.

The Presidential portraits are all magnificent. My favourite is that one of Sir Henry Simpson Newland (President 1929-1935). He does not look to me like a surgeon; big hands, craggy face – a farmer not a surgeon. His portrait always has a slight caricature appearance. Its significance (other than being that of the longest serving President – six years) is that it won the Archibald Prize in 1951. Mr. Historic Trivia tells me that it was painted by Sir Ivor Hele who won five Archibalds.

It seems that the portrait of Sir Henry has always been to the left of the President's Chair but he has been displaced by D'Arcy Sutherland (1978-1979). The other tradition is that the portrait of the immediate past President is to the right of the Chair. That is of course Andrew Sutherland (2007-2008) so with this temporary placement we have the father-son duopoly facing the Council chamber. The Sutherland portraits are marvellous, not only as they are both fine portraits and the family likeness is apparent but because they are the bookends of the great portrait artist Robert Hannaford who has painted eight of the presidents.

Mr Historic Trivia, a South Australian, also told me proudly that all of them are South Australian (the Sutherlands, Robert Hannaford, Sir Ivor Hele and Sir Henry Newland). He was muttering something about Port Power winning the AFL championship this year before I turned away from his parochial chants.

Now I have certainly wandered far from the point of this article. What I was trying to say is that surgeons learn from the past – from books, articles and experience. That which works we continue to use; that which does not, we discard. We are reluctant to change for the sake of change so that makes us more on the conservative side. If the College functions well we see no reason to change the rules of governance (other than nibbling at the edges) but we are doing it now under the watchful eyes of our predecessors.

The changes being considered include changes to the wording of the Articles of Association (which will be called the Constitution) and to some of the rules. After much discussion there was unanimous agreement that the College must be an umbrella organisation for all surgeons and so the current mechanism of specialty elected Council members must remain. So that they may put the view of the various surgical specialties to the Council. Curiously, the antiquated name of the Censor-in-Chief is to remain. Considering his powerful position in all things educational I was nearly going to suggest Lord High Executioner but thought better of it.

It is of course quite illogical to suggest that eyes on canvass influence our current thoughts and actions. However as I have pointed out our forbearers do influence our actions and decisions.

But on the other hand there are the ears; 10 sets, 20 ears. I noticed them last Council meeting – listening, listening, always listening.

Making a recommendation

Understanding the requirements of informed consent

Michael Gorton
Partner Russell Kennedy Solicitors

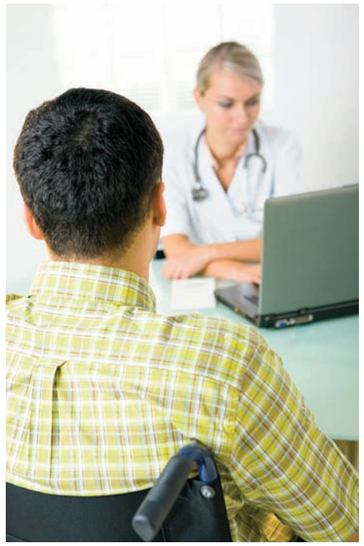
I know I must warn patients of the risks of treatment, but must I make a clear recommendation on which course of treatment I prefer?

This question examines a doctor's obligation to provide a recommendation during the course of treatment to a patient as an extension of the doctor's obligation to ensure a patient's informed consent.

There are essentially two concerns in the medical community about informed consent. The first is whether providing a recommendation to a patient (instead of just the actual facts) in the course of advice will leave the medical practitioner open to liability. The second, and what can only be described as a balancing conundrum, is whether the failure to provide that recommendation will be adequate to ensure the patient's informed consent to a course of treatment is sufficient.

Failure to Warn of Risks & Informed Consent

Rogers v Whittaker (1992) 175 CLR 479 (the leading Australian High Court case on informed consent) establishes the principle that a medical practitioner must outline all possible risks, alternatives, consequences and adverse effects of an operation or a course of treatment to a patient. This is to enable the patient to have informed consent as to the nature of their treatment and to make their own decision on treatment. If done adequately, this normally means that the patient will have no cause of action in negligence against the doctor for failure to warn because they are



accepting the risks involved, of which they have informed knowledge.

The Court said that there are four factors that should be taken into consideration so as to ensure the informed consent of the patient:

- the patient's personality, temperament and attitude;
- the patient's level of understanding;
- the nature of the treatment (major or more complicated procedures will require a more detailed explanation); and
- the likelihood of adverse effects resulting from the treatment.

These considerations alone do not impose a positive duty on the doctor to provide a recommendation to the patient, it provides an obligation to fully inform them of the consequences, the alternatives and all the material facts of each method of treatment. The patient then makes a decision as to whether or not to accept treatment.

Obligation to Provide a Recommendation

A doctor's legal obligation during the diagnosis and treatment of a patient is to provide them with a reasonable standard of care. A reasonable standard of care is established in the Wrongs Act 1958 (Vic) as 59(1):

"A professional is not negligent in providing a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by a significant number of respected practitioners in the field (peer professional opinion) as competent professional practice in the circumstances."

Similar provisions exist in legislation in most other Australian States. Whilst many doctors may provide a recommendation to their patients in the course of providing them with treatment, it is not clear that the law extends this to a legal obligation. Rogers v Whittaker, as the leading authority on the issue, does not extend the standard of care to providing recommendations to the patient. The obligation merely extends to providing the patient with all the appropriate information relevant to the patient's treatment, outlining all the potential consequences and allowing the patient to make their own informed decision.

Dr Mark Lawrence of Bayside Women's Health defined informed consent as:

"... the process by which a patient having been informed by the doctor of material risks ... In practice 'Informed Consent' will arise as a result of as full a discussion as possible between patient (or guardian) and doctor with regard to indications, benefits, risks, costs of, and alternatives (if any) to the particular treatment ..."

There is no intimation in this statement of an obligation to provide a recommendation.

The National Health and Medical Research Council has published guidelines on providing information to patients. Its purpose is to inform doctors as to their medico-legal obligations in providing information to patients.

The publication stresses that doctors should make known all the facts available and to provide advice:

"The guidelines are based on the general principle that patients are entitled to make their own decisions about medical treatments ... doctors should give advice. There should be no coercion, and the patient is free to accept or reject the advice. Patients should be encouraged to make their own decisions."

Whilst these guidelines do stipulate that doctors should give advice to patients, it should be done in the context of providing all the facts available to the patient. It also stresses (and this is a symptom of the entire publication) that the patient should be making their own decision.

The force of the words in the guidelines do not extend this to an obligation to recommend a course of treatment.

The Health Professions Act 2005, the Medical Practice Act 1992 and Medical Practice Act 2005 whilst regulating some standards of the profession, do not provide any additional information or guidance concerning informed consent and do not cause further confusion.

Therefore:

- a doctor will not be negligent simply for providing a recommendation so long as they do so with a reasonable standard of care;
- it does not necessarily extend to the creation of a positive obligation to provide a recommendation to the patient.

There is some basis to suggest that, nonetheless, doctors have a professional obligation, if not a legal obligation, to make a recommendation when they believe that a particular course of action, or particular treatment is highly recommended. Whilst patients have the autonomy to choose their own decisions of treatment, it is the doctors who have the information, the awareness and the experience to determine which course of treatment is likely to be the most effective. Accordingly, most practitioners would accept that, as part of their professional obligations, there is nonetheless a duty to make recommendations. Many patients will ask for a recommendation in any event. Some recommendations will be obvious, because they will be life saving. However, just as we go to financial advisers because they are the experts (or at least until recently we thought so!), and on legal issues we would go to a lawyer as the expert, so too, most patients go to a doctor for advice. This involves the doctor considering the various ranges of

"Doctors have a professional obligation, if not a legal obligation, to make a recommendation when they believe that a particular course of action, or particular treatment is highly recommended."

alternative treatments, discussing them with patients and, at the end of the day, making a recommendation.

If all doctors treated all alternatives as equally valid or equally appropriate, then the medical profession loses one of the qualities which makes it an expert profession.

For legal reasons, given that negligence is judged by the conduct and expectation of a "significant number of respected practitioners in the field", it might be assumed that a significant number of respected practitioners would also agree that a professional opinion involves a recommendation. There is therefore some risk that a failure to make an obvious recommendation might involve some breach of professional conduct which might be considered by a medical board or medical registration authority. There is also the possibility, although not yet determined in law, that it may represent negligence as such.

Accordingly, whilst there is some legal uncertainty as to whether there is an obligation to make a recommendation, it can be assumed that there would be a professional obligation to do so, especially when a recommendation involves a course of treatment which is life saving, or which is clearly superior to other courses of action.

1. CCH Online Tort Law Library Commentary
2. http://www.baysidewomenshealth.com.au/index.php?option=com_content&task=view&id=33&Itemid=999999
3. http://www.nhmrc.gov.au/publications/synopses/_files/e57.pdf

Need to learn more?
The 'Shared Decision Making' workshop focuses on these issues. Contact the Professional Development Department at the College on +61 3 92491106

Brisbane beckons – the finalised ASC

Convocation: 4.30 Tuesday 5 May. Scientific Program: Wednesday 6 May to Saturday 9 May

Mark Smithers
Congress Convener &
Andrew Stevenson
Congress Scientific Convener


The South bank view
PHOTO COURTESY BRISBANE MARKETING

The program for the Annual Scientific Congress (ASC) in Brisbane is complete and at the printer, the Brisbane Convention Centre has been spruced up and the weather will be welcoming to delegates for the 78th College conference.

Over 430 research abstracts were received by conveners. These have been sorted and the very best selected for oral presentation. Many have been chosen for presentation in the RACS Research Prize sessions for Trainees, which are being offered in eight programs.

It is unfortunate that time constraints mean many quality abstracts will appear in the program as posters. All accepted poster abstracts will be listed in the relevant section program, in the Supplement to the *ANZ Journal of Surgery*. The posters will be available for viewing on the screens in the exhibition area and all posters and presentations will also be available for viewing on the Virtual Congress. We encourage delegates to take a look at these during the conference.

Head and Neck Surgery program

The Head and Neck surgery program is being convened by Maurice Stevens. The RACS Visitor is Professor Randall Weber, Chief of Head & Neck Cancer Surgery at MD Anderson Hospital and a world authority on the management of head and neck cancer. Professor Weber is an avid contributor to the literature with a broad knowledge base and experience in all aspects of head and neck cancer treatment.

Professor Michael Gleeson is attending the meeting to receive an honorary Fellowship of the College. A frequent participant and contributor at previous ASCs and a mentor to many head and neck and skull base surgeons in Australia and New Zealand, he has agreed to contribute to our program on parapharyngeal tumours.

Other invited speakers are eminent head and neck surgeons in Australia who regularly produce original material from their own units. From Brisbane, we have invited a number of plastic surgeons with extensive experience in the field of reconstruction to present their experience to delegates and to address specific issues.

The themes of the section program are the management of difficult salivary gland tumours, reconstruction under difficult circumstances, particularly in patients with osteoradionecrosis with an emphasis on reconstruction of the maxilla and mandible; and the topical subject of salvage surgery following chemoradiotherapy.

Pain medicine

Professor Leigh Atkinson is convening the Pain medicine program. Leigh notes that in times of increasing specialisation in surgery, the management of the patient in pain – acute, chronic and cancer – can be neglected. The Access Economics 2007 Report identified a prevalence of 20 per cent of the population suffering from chronic pain. The Research Surgical Professor, Henrik Kehlet (Pain medicine Visitor, ASC 2007), found a significant occurrence of post-operative neuropathic pain following hernia repair, thoracotomy and amputation.

The Pain Medicine program provides an opportunity to review these problems across all specialties.

Professor Andrew Rice, from Imperial College, London, will be the 2009 RACS Visitor. He will discuss neuropathic pain and peripheral nerve injury whilst Dr Michael Turner, the Medtronic Visitor from Indianapolis, will discuss the indications and outcome from neuro-stimulation in chronic pain.

In the program, there will be sessions on craniofacial pain, peripheral nerve injury and neuropathic pain, pain in the osteoporotic spine and the outcome of treatment with neuro-stimulation. In addition, there will be a debate regarding the place of surgery for back pain.

Late changes to the program

Plastic surgery

We have been notified that Mr Brent Tanner FRCS is not able to attend the Plastic & Reconstructive Surgery program. The convener, Gerard Bayley, has appointed Professor Hisham Fansa MD PhD from the Department of Plastic Surgery, Bielefeld, Germany to replace Mr Tanner in the program. Professor Fansa has particular expertise in hand surgery and the full range of cosmetic surgery procedures.

Workshop program

Please note that due to unforeseen circumstances the Cleft Palate and Lip Workshop on Tuesday has had to be cancelled.

Online registration: asc.surgeons.org


Brisbane beckons – we look forward to welcoming you.
PHOTO COURTESY BRISBANE MARKETING

Invitation to Apply

Scholarships, Fellowships and Grant Opportunities for 2010

The Board of Surgical Research invites Fellows and Trainees to apply for the following Scholarships, Fellowships and Grants for 2010.

RESEARCH SCHOLARSHIPS AND FELLOWSHIPS

Please note:

- The availability of the advertised scholarships and fellowships is subject to funding.
- *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 4.00pm on Monday 27th April 2009.
- 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 three 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
*Foundation for Surgery Scholarship in Surgical Ethics	Open to Fellows and 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. Lay applicants must be sponsored by a Fellow of the College.	$60,000 $55,000 stipend plus $5,000 departmental maintenance	Up to three years

Bequest, Donation And Sponsor Funded Research Scholarships And Fellowships

AWARD	ELIGIBILITY CRITERIA	VALUE	TENURE
*Paul Mackay Bolton Scholarship for Cancer Research	Research topic must focus on the prevention, causes, effects treatment and/or care of cancer. Applicants must be working in Queensland or Tasmania. Young researchers, who are relatively early in their careers and show promise, will be given preference over more senior established researchers. Preference will also be given to projects which are likely to have clinical relevance within a relatively short period of time.	$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 Phyliss 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
*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

John Mitchell Crouch Fellowship

John Mitchell Crouch

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 College 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 College 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 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.

***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 prostate cancer. Applications for the Scholarship are open to Fellows and 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.

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, 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 2010. 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.
NB: The availability of this scholarship is yet to be confirmed. Please email scholarships@surgeons.org prior to application to confirm that this scholarship is being offered in 2010.

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 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 six 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.

Ramsay Fellowship - Provincial Surgeons - 2009

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 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 $12,000); a period of four weeks (two Fellowships each of $6,000); a period of two weeks (four Fellowships each of $3,000); a period of one week (eight Fellowships each of $1,500);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;
- The locations to be visited in order to achieve your aim;
- A written confirmation from the institution where you are to gain your skill or experience.
- A brief outline of the costs associated with acquiring the skills and experience.
- Two written supporting references.

Applications close Monday 27 April 2009. NB: This Scholarship is open for travel in 2009.

Important General Information

These advertisements are to be used as an initial guide only. Please consult the College website from 2nd March 2009 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.
Applications close 4:00pm Monday 27 April 2009.

Younger Fellows Forum

Issues affecting the newer generation of surgeons will be discussed at this pre-ASC event

Christopher Que Hee
QLD Representative, RACS YFC

Welcome to the first article in a regular series concerning the College Younger Fellows Committee (YFC). This initial article will give a short introduction to the YFC and its roles, activities and why it plays an important part in the College.

A younger Fellow is defined as a Fellow who is within ten years of obtaining the Fellow of the Royal Australasian College of Surgeones (FRACS). The term "younger" Fellow can be misleading as this group of Fellows may include surgeons in their forties and fifties, often being surgeons who have migrated to Australia and New Zealand.

The committee is made up of a Chair and a representative from all the regions of Australia and a representative from New Zealand. The YFC representative from each state attends the monthly State Committee meeting to represent the views of younger fellows on those committees.

You may ask, "Why bother to have a committee representing younger Fellows?" While younger Fellows share many of the attributes and problems of their more senior colleagues, they face different issues and a forum is needed to address these. Some of these issues include the transition to consultant practice, the stresses of starting a private practice and the balance between family and work. More diverse topics that have been investigated by the YFC include burnout and relationships between surgeons and industry. Many of these issues are discussed at regular YFC meetings and feedback is provided to the College at various committees and Council. The YFC Chair

"Topics investigated by the FYC include burnout and relationships between surgeons and industry"

is an observer at College council and is able to introduce agenda items.

The issues of younger Fellows are discussed at the annual Younger Fellows Forum which precedes the ASC. Younger Fellows from a range of specialties and geographical regions come together to develop ways the College can assist and guide Fellows in the early, challenging years.

The YFC hopes that you find the future articles helpful. Please do not hesitate to contact your local member of the YFC. Contact details can be found on the College website (www.surgeons.org_under Interest Groups and Sections).

Continued from page 5

The College strongly advocates that there should at least be a requirement that the Ministerial Council and the relevant board consult with the relevant specialist medical college before developing any guidelines for any approvals in this area.

We also indicated that the College could not support the registration as specialist surgeons of those who perform surgery but who do not have an appropriate surgical qualification. For example, we could not support the registration of specialist podiatric surgeons who do not have the experience and training signified by Fellowship of the College. The College would not support surgery being performed by podiatrists who have had their practice of surgery endorsed under the new scheme without review of their training and qualifications by the Podiatry board and by the College – the body accredited by the Australian Medical Council and recognised by the Australian community as the standard setter in surgical practice. In order to ensure public safety there must be cross discipline review of qualifications to practice surgery.

Conclusion

As I indicated last month, the College is keeping a very close eye on developments in the area of registration and accreditation, and stands ready to oppose any legislation which seeks to exclude the specialist colleges from the crucial task of continuing to ensure Australian medical practitioners are the world's best.

The College remains convinced that pressure on our health system should be eased by the greater investment of resources by governments, not by the lowering of educational and training standards. The Australian public doesn't deserve makeshift solutions to problems of such importance.

As I write, Australians are reeling from the greatest peacetime disaster in our nation's history. Bushfires of astonishing strength and speed swept through several regions of Victoria, notably Melbourne's northern fringes, Gippsland and Bendigo. It seems likely that the fires have claimed more than 200 lives and it is confirmed that several thousand Victorians have lost their homes. In the midst of such agony, it is heartening to note the efficiency and humanity with which Fellows of the College have responded to the emergency. In particular, and once again, the Burns Unit at The Alfred has risen magnificently to an appalling challenge. Next month's edition will include coverage of the response of Fellows to these terrible events.

Audit and performance evaluation

A meaningful opportunity for Continuing Professional Development at the ASC

Tony Green
Chair, Surgical Audit Committee

The Surgical Audit Committee is conducting a workshop on "Surgical Audit and the Evaluation of Surgical Performance" at the 2009 Annual Scientific Congress, being held in Brisbane. The workshop will take place on Thursday 7 May, from 2.00pm – 3.00pm.

As part of the Continuing Professional Development (CPD) Program, all Fellows in operative practice are required to undertake a peer-reviewed surgical audit annually and it is important that the College provides the support and resources to assist Fellows to meet this requirement. The workshop will cover a number of themes relating to audit and performance.

Dr Tony Green, Chair of the College's Surgical Audit Committee, will open the workshop with a presentation on "Audit in difficult situations". This will focus on audit activities carried out in rural settings and those conducted in private and solo situations.

Professor David Watters, member of the Surgical Audit Committee, will address the topic of "Responding to adverse events and incident reporting". These activities are detailed in the *Surgical Audit and Peer Review Guide* (third edition, 2008) and are critical to the surgical audit cycle.

Dr John Quinn, Executive Director of Surgical Affairs - Australia, will conclude the workshop with a presentation on "Reviewing a surgeon's performance". The presentation will provide an update on the mechanisms available to assist when the performance of a surgeon is questioned and the process of review. This follows promulgation of the *College Surgical Competence and Performance Guide* in late 2008.

The workshop is open to all ASC registrants and no prior registration is required. For further information on the Surgical Audit workshop, please contact Kylie Mahoney, Manager Professional Standards on +61 3 9249 1274 or via email at kylie.mahoney@surgeons.org

Leadership and Management

This popular workshop is now being offered as a formal business qualification specially tailored to surgeons

Cliff Hughes
Co-facilitator

For several years, the College has offered the successful "Surgeons as Managers" workshop, which is designed to support Fellows in their roles as leaders and managers. Over two-and-a-half days, specialist facilitators give presentations on a wide range of topics including leadership and communication styles, teamwork, managing staff, finance and business skills as well as current legal issues in health.

In response to Fellows' feedback, the College has been exploring ways to provide management training that can articulate into a formal business qualification for those who wish to pursue further study. To this end the College has partnered with the University of New England (UNE) Partnerships to offer an Advanced Diploma in Management in 2009 tailored to the needs of surgeons.

The Diploma combines distance learning modules with three face-to-face workshops. The two-and-a-half day workshops will focus on the challenges of leadership and management facing surgeons in their own business and in the broader health management context. The program will be presented by highly skilled facilitators and health management subject matter experts.

The College is very pleased to announce that Professor Cliff Hughes AO, FRACS, CEO Clinical Excellence Commission, will act as a co-facilitator with UNE staff at the workshops and is also involved with contextualising the Diploma program through a series of case studies relevant to surgeons. Many of you will know that Professor Hughes has had a long and distinguished career in surgery and has undertaken a number of significant roles with the College. Professor Hughes served as a College Councillor from 1997-2003 and was a member of the Professional Development and Standards Board in 2003-2004 as well as a Senior Examiner and Chair of the College Ethics Committee. In 1998, he was awarded the Order of Australia for service to cardiac surgery, international relations and the community.

Professor Hughes is very committed to developing the skills of surgeons in their role as managers and leaders and believes that "to be successful leaders, surgeons must spend as much effort on their practice, unit and team as they do in it."

This program provides an opportunity to interactively explore and reflect on relevant issues with your peers through discussion of the theoretical concepts in leadership and management. Fellows may choose to

- Register and attend any (or all) of the three workshops; or
- Enrol in the Advanced Diploma of Management, attend the three workshops and complete assessment for the full qualification.

Workshop 1: Leadership in a climate of change, 19-21 June, Sydney, 2009

Consistent change provides an ongoing challenge to today's leaders. Using the appropriate style of leadership is highly relevant to the situation and personalities of others in the workplace.

The first workshop focuses on leadership styles, establishing and maintaining effective working relationships, managing the performance of others and managing issues effectively in a dynamic work environment. The workshop will present activities, case studies and opportunities for interactive discussion and dialogue on each of the topics over the three days.

Prior to the workshop, participants will complete an online behavioural inventory, called a DiSC profile, which will generate a specialised report on individual leadership attributes. An interactive debrief session will be incorporated into the workshop. It will explore behavioural preferences for a range of leadership styles and offer challenging insights about leadership behaviour in relation to perceptions of the environment.

Workshop 2: Providing strategic direction, 13-15 November, Melbourne, 2009

Planning and communicating direction and strategy is integral to achieving outcomes. Participants will gain the skills and knowledge to produce and implement an organisational strategy. The workshop will focus on how to establish a strategic direction through an effective planning process. Learn how to conduct an organisational/market analysis, sustain a competitive advantage and develop strategic measurement systems. To maximise your learning, professional reading material will be distributed prior to the workshop.

Workshop 3: Sustaining your Business, April 2010

This workshop provides the foundation for developing business plans and the various approaches to implementation to sustain business growth and performance. The workshop is relevant to individuals who have experience in determining the effective functioning and success of a practice or as clinical managers within health systems.

It also explores financial management; from the preparation and analysis of responsible budgetary plans, decision making, management and reporting, to the development of estimates and capital investment proposals. It will address both perspectives of health practice management and the broader health service delivery environment.

Advanced Diploma of Management

The Advanced Diploma of Management is a nationally recognised qualification that provides a broad and practical qualification focussing on leadership and management. This qualification develops dynamic leaders looking at broadening their business perspective, enhancing management capability and strengthening leadership behaviour. It provides practical workplace focused learning to effectively manage the strategic direction of a business through leadership, financial management and comprehensive business operations.

It is composed of units from the nine subject areas of the workshop program. Each unit has a set of action learning activities and practical work-based assessments that are submitted at intervals throughout the candidature. Course material includes a comprehensive study package – course guide, study notes, online resources, activities, readings, assessment items – plus full administrative and academic support.

The Diploma's core units include:

- Providing leadership across the organisation
- Managing people performance
- Managing employee relations
- Managing organisational change
- Managing innovation and continuous improvement
- Developing and implementing strategic plans
- Managing risk
- Developing and implementing a business plan
- Managing finances

"This program provides an opportunity to interactively explore and reflect on relevant issues with your peers"

Completion of the course will require participants to attend the workshops and invest in eight – 10 hours per week over 12 months in reading, reflection and completion of assessments. Candidature is current for up to 18 months.

Learning Pathways

Pathways are available into undergraduate and postgraduate programs at the University of New England, including the Masters of Business Management, Graduate Certificate of Health Management, Graduate Diploma of Health Management and several masters and doctoral programs. Credit arrangements are currently under review by the university.

For more information, contact the Professional Development Department at +61 3 9249 1106 and PDactivities@surgeons.org or visit the UNE website www.unep.edu.au/racs

Doctors' poor health – still an issue?

Older doctors in general and hospital practice are seeming to achieve better work-life balance

Geoffrey Robinson
Physician, Addiction Medicine

There is an ongoing number of doctors with illness at the more severe end of the spectrum

Last week I attended an end–of–year social function for fourth–year medical students, and wondered if they will still be afflicted by the doctors' health issues of the past. These particular issues are what I have termed the "Four Ds" – depression, drugs (including alcohol), dimming (burn–out), and disruptive behaviour (personality problems like narcissism).

Well, it seems not too much has changed, other than a predominance of woman students, who were drinking wine, despite my tutorials. These students will have the same industrious, obsessive–compulsive, altruistic, ambitious and self–critical traits that may predispose them to psychological problems, particularly depression, that one study showed to affect as many as one in three medical students.

Perhaps these traits are compounded by a medical school culture that used to imbue students with elitism and individualism, prioritising strength and being in control, including over emotions. There was an expectation of coping, which carried over to the junior doctor years – the "baptism of fire", a fire doused by the then–normalised culture of heavy alcohol use by males, now probably by women as well.

This background of what I see as vulnerability needs to be acknowledged, as does the stress of the junior doctor years. This stress includes fatigue; professional isolation, such as night duties; limited control over work; postgraduate examinations; geographical relocation during training; intrusion of work on young families and relationships; routine interaction with fear, illnesses, uncertainty and death; and varying supervisor support.

These factors have also contributed to high rates of depression, suicide and substance abuse in junior doctors; although I am pleased to say that I do not hear nowadays of suicide by junior doctors, which was once a common tragedy in New Zealand.

Perhaps it is timely to acknowledge the Resident Doctors Association and its world–leading initiatives to reduce hours and improve conditions. Indeed, what will be different about the medical students of this generation is their clear desire and ability to put boundaries around the job, even medicine. So our health may improve, and indeed I am impressed that many older doctors in both hospital practice and general practice are seemingly achieving better work–life balance, heeding the advice of many bodies including the Medical Council, Colleges (particularly the RNZCGP) and the Doctors' Health Advisory Service (DHAS). In fact, a high point in medical preventive health was a 1997 publication, In Sickness and in Health, edited by John O'Hagan and John Richards. At the time, no other country had such a manual that covered a comprehensive range of issues affecting the health of doctors and other health professionals. It would be timely also to acknowledge Dr Edwin Whiteside, who has chaired the DHAS over two decades.

So we can be encouraged; and indeed, if we can get past the "Four Ds", doctors' general health and life expectancy is better than most occupational groups. The high rates of cirrhosis in the profession reported in United Kingdom studies of 30 years ago have much improved in recent years. A spectrum of psychological illness will continue to beset us as a profession, but we should be better armed to detect warning signs in ourselves and our colleagues. It is not difficult to answer: "Are we our brothers' keepers?" There have been too many tragedies when colleagues have clearly shown major changes in behaviour and no one has taken action. Most doctors now have their own GPs, and risky "corridor consultations" are seemingly less prevalent and acceptable.

Nevertheless, there is an ongoing number of doctors with illnesses at the more severe end of the spectrum who regularly come to the attention of the Medical Council of New Zealand (Health Committee). These illnesses include depression, bipolar disorder, alcoholism and opiate dependency, complicated at

"This stress includes fatigue; professional isolation, such as night duties; limited control over work; postgraduate examinations..."

times by personality disorders.

The Medical Council is commended on its recent guidelines on how to help deal with the "disruptive doctor".

I note the wording in the Health Practitioners Competence Assurance Act 2003, which carries a legal requirement to notify a health practitioner to the Medical Council of New Zealand (Health Committee) if they are "unable to perform" because of some mental or physical condition. This sets the bar high, and the former phrase of "may be/is impaired" should be reconsidered in the Act revision. As an assessor of the Medical Council of New Zealand (Health Committee) for nearly 30 years, I am pleased to report that this committee has operated consistently in an exemplary way to assist the profession and its more profoundly ill. Manager Lynne Urquhart and recent chairs Dr Kate O'Connor and Dr Joanna MacDonald have been fastidious in developing management plans and monitoring health–impaired doctors over many years. They have fostered a culture of rehabilitation in getting these doctors back into the workforce (usually with "conditions") as soon as practicable.

There are risks, as addiction and psychological disorders have a propensity to relapse; and this risk must be successfully balanced against the predictable intolerance of some of the public and media. Interestingly, a recent United States anaesthesiology editorial promoted a "one strike and you're out" default position for opiate–dependent anaesthetists. The writers suggested such doctors should be elsewhere in medicine because of the risk of relapse (drug "availability"), and risk of fatal doctor overdose upon relapse (nine to 31 percent). I doubt this view will prevail, but anaesthetists are the medical subgroup most recognised as being at risk of drug abuse and in need of special consideration. This is an example of the difficult issues the Medical Council of New Zealand (Health Committee) encounters.

Geoffrey Robinson MB ChB, FRACP
Physician, addiction medicine
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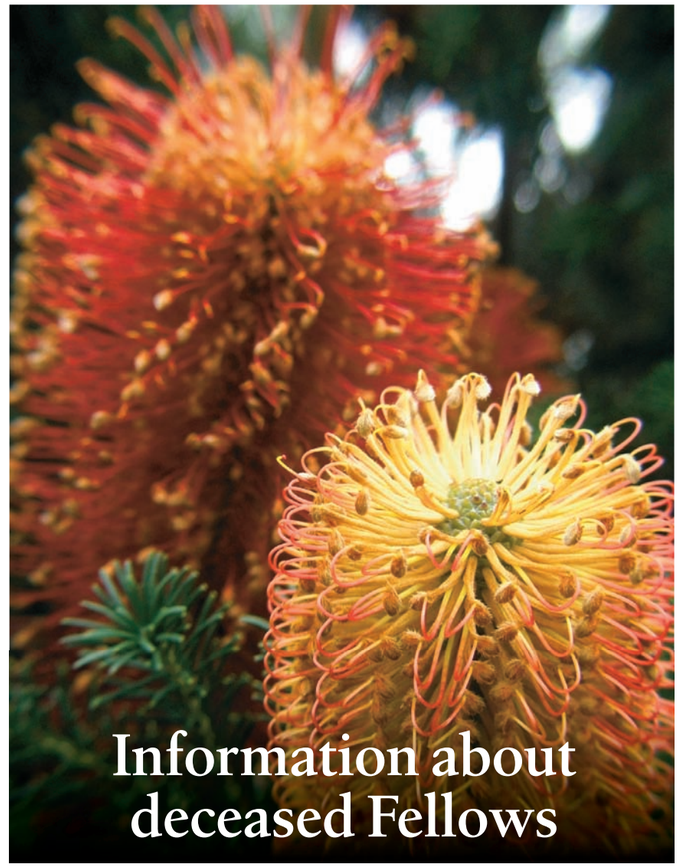


Information about deceased Fellows

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

- Harley Kilgour Baxter VIC
- Stanley Rowland Duke QLD
- Philip Henry Griffin VIC
- James Webster Mewett CANADA
- John Neophyton NSW

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

Informing the college

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

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

Rural medicine in Australia

The SSRS provides financial support for CPD projects for medical specialists

Rob Atkinson
Chair, Professional Development Committee

Good news for Australian rural surgeons, Trainees and International Medical Graduates (IMGs)! The College has again been successful in obtaining funding through the Department of Health and Ageing's Support Scheme for Rural Specialists (SSRS). The SSRS provides financial support for Continuing Professional Development (CPD) projects for medical specialists working in regional, rural and remote Australia. The projects provide an opportunity for surgeons, Trainees and IMGs to engage with peers who share an appreciation of the unique nature of rural medicine in Australia.

The College has been involved in delivering workshops and support programs to rural and remote surgeons since the scheme's inception in 2002 and this year has received funding to deliver six projects:

Rural Craft Group Audit

Project leader: Professor David Watters

The Rural Craft Group Audit will again be carried out in five major rural centres. Smaller centres and individual surgeons are also welcome to participate. Each participant receives a confidential report benchmarking their surgical outcomes for five procedures against predetermined rural standards established during previous projects.

Management of Diabetic Foot

Project leader: Dr Ollapallil Jacob

This workshop demonstrates how to effectively recognise, assess and treat diabetic patients with "high risk" foot complications.

Management of Severe Burns

Project leader: Mr Graeme Campbell

This workshop is conducted by the Australian and New Zealand Burn Association (ANZBA) and targets medical specialists who may come in contact with a severe burn shortly after it is sustained.

Northern Australia Surgeons Network (NASN)

Project leader: A/Professor Richard Turner

This program supports the professional development of the surgical community in northern Australia. It explores a diverse range of topics through monthly, breakfast videoconference sessions as well as the annual Northern Australia Surgeons Conference.

Neurotrauma Workshop

Project leader: Ms Marianne Vonau

This workshop aims to equip rural participants with the skills to deal with cases of acute neurotrauma; where the urgency of a case or difficulties in transporting a patient demand rapid, surgically-applied relief of pressure on the brain. Importantly, the workshop teaches these skills using equipment typically available in smaller hospitals, primarily the Hudson Brace.

Australian Indigenous Online Health Program

Project leader: Mr Kelvin Kong

Consisting of eight online learning modules, participants explore issues encountered when treating indigenous patients. Topics focus on indigenous culture and its impact on health decisions.

Surgeons involved in previous projects have said how much they value these learning opportunities. For instance, a participant in the Northern Australia Surgeons Network found video links to be an effective way of communicating with peers, commenting that videoconferences are "... regular, require minimal effort, informal and friendly and enable learning in a non-threatening environment"[1]. The Rural Craft Group Audit also provides rural surgeons with a means to set up an on-going audit within their hospital, an important element of CPD for all Fellows.

I would like to thank the rural Fellows who have volunteered to be project leaders as it is their enthusiasm, hard work and commitment that drive these projects. The level of assistance for remote and rural Fellows is a litmus test of the College's effectiveness in negating distance and supporting the delivery of high standard rural surgery. If we get this right the rest should be easy!

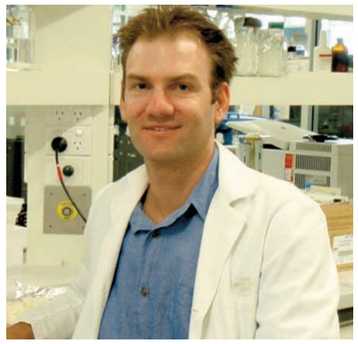
I encourage all rural and remote surgeons, Trainees and IMGs to consider these learning opportunities when planning their professional development in 2009. Please contact the Professional Development Dept at +61 3 9249 1106 or PDactivities@surgeons.org or visit www.surgeons.org for more information.

1. Northern Australia Surgeons Network Report, August 2008

This project is a joint initiative of the Committee of Presidents of Medical Colleges & Department of Health and Ageing and is funded by the Australian Government. Please note that the Royal Australasian College of Surgeons is solely responsible for the content of, and views expressed in, any material associated with this project unless otherwise agreed to in writing with the Commonwealth.

The Surgeon Scientist Scholarship

Thanks to this generous scholarship important cancer research with broad potential is being pursued



Goswin Meyer-Rochow

While the cancer known as phaeochromocytoma is uncommon with an estimated incidence of approximately one in 100,000, an improved understanding of the molecular markers and genetic triggers associated with it may assist scientists investigating the cause of a range of more common cancers, according to Dr Goswin Meyer-Rochow.

Dr Meyer-Rochow, a general surgeon with a special interest in endocrine surgery, is the current recipient of the Surgeon Scientist Scholarship, as well as the prestigious National Health and Medical Research Council and Cancer Institute of New South Wales scholarships. With the funding from the College, he is now researching the role of microRNA in the development of the disease.

Phaeochromocytomas are neuroendocrine tumours which develop in the adrenal medulla and, less commonly, from extra-adrenal sympathetic paraganglia within the abdomen, thorax and neck. Dr Meyer-Rochow said current research suggested that up to 30 per cent of patients who develop phaeochromocytomas carry a familial germ line mutation, while the remaining 70 per cent are sporadic without any known genetic predisposition.

Although the majority are benign, they are all potentially lethal due to the episodic secretion of large quantities of the catecholamines, adrenaline and noradrenaline.

"These tumours cause severe headaches, high blood pressure and may result in strokes or even cardiac arrest. Patients with benign phaeochromocytomas are generally cured by surgical excision of the tumour, however, 10 per cent of patients will develop malignant disease with metastases commonly to the bone, liver or lungs," Dr Meyer-Rochow said.

"There are currently no reliable prognostic diagnostic tests to determine the presence of malignant disease, therefore, patients with malignant disease are usually only diagnosed in retrospect once metastases have occurred. These patients have a poor outlook as current treatment options are relatively ineffective and remain palliative."

Working at the Kolling Institute of Medical Research, which is linked with the University of Sydney, Dr Meyer-Rochow is collaborating with international institutions from the United States, New Zealand and Sweden for his project. Through these collaborations, the number of malignant tumours that have been obtained make the project one of the largest such studies in the world and the first to look at the role of microRNA in phaeochromocytoma.

"Our knowledge of the workings of microRNA is still limited as this is still a new area of scientific discovery, though one which has opened vast new areas of cancer research. MicroRNAs are much smaller than messenger RNAs and don't code for genes or protein. They are generally found within noncoding regions of the genome, which until recently was considered to be just 'junk' DNA," he said.

"But recent studies are now indicating they have a role in the development of disease and a range of human cancers by binding to and inhibiting the translation of target messenger RNA to protein.

"We want to determine whether microRNAs are likely to be involved in the development of pheochromocytoma. We then want to use that knowledge to develop a diagnostic test so that patients with potentially malignant tumours can be diagnosed and treated before the tumours become malignant. This work may also lead to the identification of potential molecular therapeutic targets for future development of targeted gene therapies.

"At the same time I believe this work will have a flow-on affect into other areas of cancer research and understandings of the development of other tumour types."

He has presented aspects of his PhD work at several Australasian and international meetings, the highlight being the 2nd International Phaeochromocytoma Symposium, which was held at Cambridge in the United Kingdom last year.

Dr Meyer-Rochow's research is being undertaken as a PhD under the supervision of Professor Bruce Robinson, Associate Professor Stan Sidhu and Senior Scientist Dr Dianna Benn. He said he was also particularly grateful for the support of his key New Zealand mentor Professor John Windsor.

"He is a dedicated surgeon scientist and is very keen to encourage young surgeons into scientific research. I hope to return to New Zealand at the beginning of next year and follow his example of successfully balancing a clinical with an academic career, to continue my own research and encourage other trainees and young surgeons into surgical research," he said.

The Surgeon Scientist Scholarship is open to Fellows and Trainees enrolled in or intending to enrol in a PhD and is worth up to $70,000 per annum for up to three years.

Dr Meyer-Rochow said he was honoured to receive the Scholarship and such endorsement from the College. "This is a very generous scholarship and it is to the credit of the College to provide such funding as it sends a strong message that research is respected and encouraged and helps attract younger surgeons into the field of research to contribute and expand surgical and scientific knowledge."

Sculptor, painter and ceramicist

The combination of fixing things and the aesthetics of the human form was always appealing to Tony Emmett

Infinity

Wings of love, painted steel yellow

Retired plastic and reconstructive surgeon Tony Emmett could be described in many different ways outside of his former profession. He is the co-author of two books, one of which, the practically titled *Malignant Skin Tumours*, was once a standard text on the treatment of melanomas and other skin cancers while the other, *The Bare Facts,* is a resource book for teachers about sun effects. He was a lecturer at the University of Queensland and was made a Professor of Surgery there for his contributionto the prevention and treatment of skin cancer.

Now, he and his wife Ann have a garden complete with summerhouse and rounded arches in the style of Monet and Goldsworthy that was once featured on the television program *Burke's Backyard* (Ann is the gardener-in-chief).

He is a sculptor, painter and ceramicist with many of his structural pieces dotted throughout that lovely garden and also provides the funds for an annual art sculpture prize in his town of Bowral in the beautiful NSW highlands. It is, you could say, a life being very well lived.

"All surgeons require a three-dimensional conception and capacity to reshape the current form into something new," Emmett says in explaining his most recent life focus.

"That was the attraction of sculpture to me, the fact that I had been working with shapes all my life. Painting came later. Even when repairing a bi-lateral cleft lip and palate, for example, we'd have a three-dimensional conception of the shape we were looking for.

"A great part of my career was spent treating skin cancers, so that often meant repairing an ear or eyelid or nose. For children's reconstructions, making an ear using cartilage from the rib, or shaping skin flaps to repair hand deformities or facial deformities. That was about aesthetics, all about form and it is just a part of how the mind works. Also, of course, it was about being good with the hands as all surgeons need to be."

The son of a General Practitioner and surgeon in North Queensland in the 1930s and 1940s, Emmett said he had no childhood crisis forcing him to choose between medicine and art, although he had a great passion for both.

He says having been born with fair hair and fair skin in Queensland he was often forced to spend time indoors while the other children ran around in the baking sunshine. Stuck indoors, he became absorbed in his father's medical books.

"I decided to become a surgeon at nine years of age," Emmett laughs.

"My father was a general surgeon when they did everything and during World War II we lived in Ayr where he was the only doctor. It was difficult to send cases away. Since I'd been a small child, I had had the ability to repair things, and that actually was my first job in the world, as the family repair man. So that combination of fixing things and the aesthetics of the human form were both extremely appealing to me."

No surprise, then, that Emmett chose the thendevelopingfieldofplasticandreconstructive surgery after spending a rotation in plastics with the only plastic surgeon then working in Queensland.

Later, he travelled to the UK to work at the Mount Vernon Hospital in Northwood – then one of the world leaders in the new field – and came under the influence of renowned surgical pioneers Rainsford Mowlem and John Barron. Upon his return to Australia, he took up positions at both the children's and adult hospitals in Brisbane.

Eternal Warrior, bronze on marble

Supplication, clear resin

"All surgeons require a three-dimensional conception and capacity to reshape the current form into something new."

With health issues of his own to face, Emmett decided to retire at age 60 and, having finished his career in Brisbane, moved down south with Ann.

In the spirit of his nine-year-old boy former self, he chose not to dabble with art as a gentle retirement hobby but to study it seriously, becoming a full-time art student in 1996. Attending the West Wollongong sculpture school he turned from ceramics to steel and later went on to embrace the full range of media including bronze, marble and sandstone.

Now his works range from the delicate to the monumental, with some of his sculptures up to three-metres tall.

"I enjoy using a range of materials. Plaster-of-Paris is versatile and we can add various things to it, like shredded paper and fibre which gives interesting textures, and there is outdoor plaster also," he says.

"Ialsopaintusingacrylicsandwatercolour, it all depends on the idea. Some of the pieces can take a week, starting from a basic sketch, others take months. Our grandchildren love to come and create sculpture and painting in the studio with us, and other friends regularly come, some on sculpture days and some on painting days."

While he sells some work, holds exhibitions and works closely with the local art society, monetary appreciation has never been Emmett's focus.

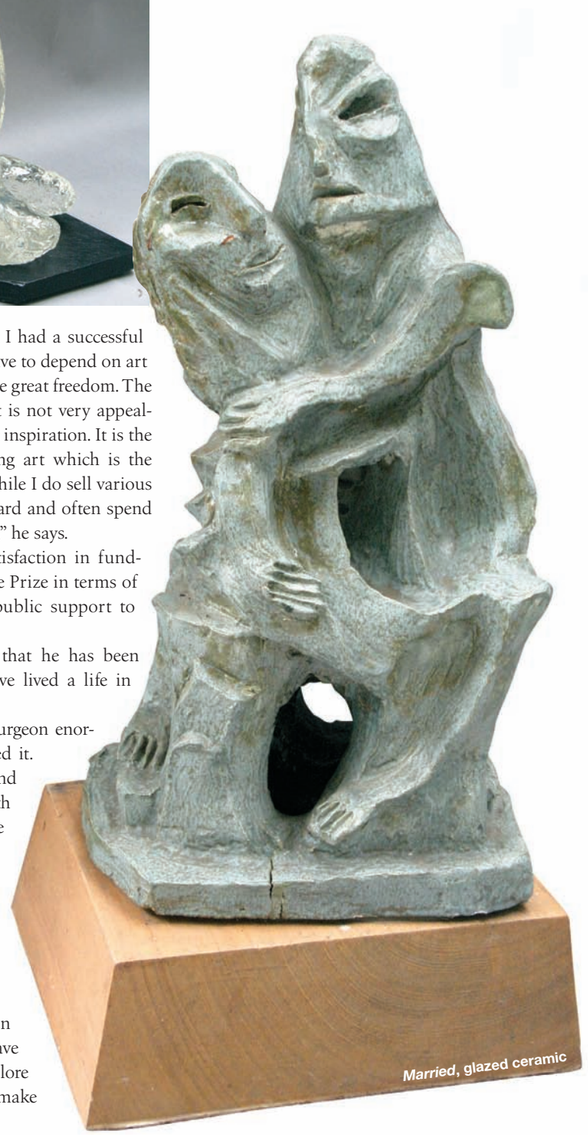
"I am fortunate that I had a successful working life so I don't have to depend on art for money which gives me great freedom. The commercialisation of art is not very appealing and tends to confuse inspiration. It is the creative aspect of making art which is the part that I like so that while I do sell various pieces, I don't try very hard and often spend more time giving it away," he says.

"I also get great satisfaction in funding the Bowral Sculpture Prize in terms of offering financial and public support to other artists."

Now, Emmett feels that he has been fortunate enough to have lived a life in two parts.

"I enjoyed being a surgeon enormously. I absolutely loved it. It is incredibly creative and I enjoyed the contact with patients and those people I worked alongside. There comes a time when physically you just can't do what you once did and you need to hand the reins over to the next generation," he says.

"I have just been extremely fortunate to have another passion to explore when the time came to make that shift."



Married, glazed ceramic

Trauma care in Vietnam

The standard of surgery has improved but there is still a great need in terms of trauma care

The in-coming New Zealand Executive Director of Surgical Affairs, Mr Allan Panting, said he had taken on the role because it offered him the opportunity to assist Fellows across New Zealand. Mr Panting is commencing in the new position somewhat faster than he had anticipated because of the recent retirement of his predecessor John Simpson and is currently in the process of reducing his clinical commitments and winding up his role as Deputy Chairman of the Court of Examiners.

"I had no intention of taking on the position of Executive Director of Surgical Affairs but once I gave it some thought I could see that the role had value – separate from the surgeon's focus on the individual patient – in terms of assisting Fellows which would in turn have a positive impact on the broader public," he said.

He said he saw a role in ensuring that surgery was promoted to government, to make sure that funding was available to meet the needs of surgical patients and addressing training and workforce needs. One of four orthopaedic surgeons in the South Island town of Nelson, he said he would continue with some clinical work during his tenure as a way of keeping in touch with the needs of Fellows. Mr Panting described himself as a generalist with a strong interest in trauma but that he had now reduced his spinal and paediatric work.

Mr Panting completed Fellowships in Melbourne and Edinburgh before returning to Christchurch. He said he decided on the move to Nelson after realising the family sacrifices required by an "impossible" workload expectation in Christchurch. After moving there, he became involved in the New Zealand Orthopaedic Association and was later appointed to the Court of Examiners.

"I thought that maybe there was a place and a need for an ordinary surgeon to fulfil this role rather than someone from the higher end of academia. I believed there could be value in someone asking what should be expected of ordinary surgeons by the community and then working with them and for them to meet those expectations," he said.

"It's probably at a stage now where I can step back a bit which is great, but I will probably continue to visit off and on. I think I get more out of Vietnam than I could ever contribute."

For the past four years he has been Deputy Chair of the Court assisting in the administration of the Final Fellowship examination. "I was interested in the exercise of how to create the best exams, how to make them as fair as possible and how to combine both of these aspects to ensure the most competent surgeons possible," he said.

The twin challenges of an expanded work force and aging population were increasingly important issues. Mr Panting was for a number of years the convenor of the Workforce Committee of the New Zealand Orthopaedic Association and said the issue was of great interest to him.

"I have always found this an interesting issue because it's not just about having an adequate supply of surgeons it's also about getting them where they are needed. I'm keen to investigate how to make regional positions, in particular, attractive to younger surgeons even just for a defined period of time rather than a lifetime as a way of meeting the different aspirations of a new generation of surgeons. John Simpson and Antony Raymont had recently completed an extensive analysis of New Zealand surgical workforce issues but there is still some work to be done on that," he said.

"There is a lot of effort now going into how to address both the health care needs associated with an ageing population and the recent training bulge. So much of surgical training is like an apprenticeship and while we now have more Trainees we only have a limited supply of surgeons able to train them," he said.

"This means we constantly face the risk of over-burdening the very people the system depends on so there is quite a lot of careful balancing that needs to be done as we seek to expand the workforce."

Allan Panting on a biking holiday in Costa Rica

Demonstrating primary assessment for PTC course

Throughout this most recent part of his career, he has also used his trauma skills during multiple visits to Vietnam. Those visits, supported by NZAid and the NZ Vietnam Health Trust, are focussed on the town of Quy Nhon, located approximately 600 km north of Saigon. With a local population of 400,000 and a regional population of two million, the town is now becoming one of Vietnam's major ports.

He said that when he first visited more than ten years ago, the main need was access to equipment, the skills to use it and guidance while doing new procedures.

"I did some surgery then but my role was more about assisting by guiding the local surgeons through procedures they had not done before. Since then the standard of surgery has improved but there is still a great need in terms of trauma care," Mr Panting said.

"Most of the trauma injuries we see there follow road trauma, industrial accidents and trauma in the home caused by cooking fires for example. Yet the initial care for patents is still very poor, they have no ambulance service and so the patients often arrive by car or truck and are not treated as trauma patients when they do arrive. Having been an Early Management of Severe Trauma (EMST) instructor for some years I was able to commence a program of basic courses in pre-hospital and emergency care based on that model (Primary Trauma Care).

"These have been very enthusiastically supported because the medical staff see the need and are always so keen to learn. Better outcomes for such patients will result over the next few years as a consequence of improved knowledge and the increasing availability of better resources," he said.

Mr Panting said the courses are developed so that local people can acquire the skills to successfully run them and that he hoped to visit Vietnam again later this year to help maintain the momentum and to guide the trainers during courses.

"It's probably at a stage now where I can step back a bit which is great, but I will probably continue to visit off and on. I think I get more out of Vietnam than I could ever contribute," he said.

"I saw it as a challenge at the time I was first approached and chose to rise to it but I never thought how much it would give to me. They are wonderful people and I learn more from them every time I visit."

Injury in Indigenous Populations

It is estimated that 25 per cent of the health gap between Indigenous people and other Australians is due to injury

Danny Cass
Chair, Trauma Committee

In January 2009 Elsevier published a supplement to *Injury*. *Injury* is an International peer-reviewed journal dealing with all aspects of trauma care and injury control.

The supplement, entitled *Injury in Indigenous Populations: Towards a Safer Future*, contains background briefing, supporting papers and recommendations of a symposium held at the College in November 2007.

In 2007, the Trauma Committee hosted its annual workshop on *Injury in Indigenous Populations* to investigate and explore possible resolutions and recommendations to this health challenge. There was growing evidence that the gap between Indigenous and non-Indigenous populations was widening in Australia whereas in other regions, such as America, there was evidence to show that the gap had been narrowing.

The symposium aimed to promote the well-being of the Indigenous people on injury-related matters. It is estimated that 25 per cent of the health gap between Indigenous people and other Australians is due to injury. Therefore efforts in injury prevention could result in a rapid improvement in Indigenous health.

The publication is an important source of information and has already been used as reference material in parliamentary submissions including the Senate Enquiry into Men's Health. The supplement highlights that injury in the Indigenous population of Australasia, in particular the male population, is an area of great need.

I feel immensely proud to be associated with this publication and would like to extend thanks to my fellow members of the Trauma Committee for their initiative in undertaking the forum.

I congratulate, and thank, Russell Gruen for the energy and skill he brought to organising such a successful and informative symposium and for the great leadership he showed by raising awareness of this issue both within the College and in the wider community.

I am also grateful to the many members of Council who have supported and commended the work of the Trauma Committee.

"I am especially grateful to the Foundation for Surgery who contributed funds to publish the supplement."

And last but not least, I am especially grateful to the Foundation for Surgery who contributed funds to publish the supplement.

I commend this publication to all Fellows and encourage you to bring it to the attention of your colleagues.

Copies are available from the College. Contact Lyn Journeaux, Executive Officer, Trauma Committee on +61 3 9276 7448 or email lyn.journeaux@surgeons.org

Need to learn more?
The Australian Indigenous Health online learning program focuses on indigenous culture and it's impact on health decisions. Contact the Professional Development Department on +61 3 9249 1106 for more information.

Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2010

Applications are invited for this two year Program and the three year academic Notaras Fellowship for 2010.
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.

For details please see website.

Information and Enquires:
http://www.cssanz.org
Professor Michael Solomon:
msolomon@med.usyd.edu.au

Applications:
Applications are to be made by letter, including Curriculum Vitae and the names and addresses (inc email) of three referees.

Closing Date:
Friday 15th May 2009

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

Home just a call away

Armed with a mobile phone, computer or calling card, calling home has never been easier for the frequent traveller. With such a range of choices available, here's what to consider when deciding what's best for you.

Mobile roaming

For full global coverage, you need a quad-band mobile phone (or at least tri-band) that uses GSM (Global System for Mobile communications) networks. While easily available from most providers, international roaming is the most expensive choice overall.

- PROS: The convenience of keeping your existing number and using a familiar phone.
- CONS: The cost, as unchecked roaming is expensive. Voicemail can multiply costs dramatically.

Swapping SIM cards

It's easy to replace your existing SIM (Subscriber Identity Module) card with a new one; however, this means your number will change. Before leaving home, you'll need to confirm that your mobile isn't locked, which it may be if you purchased it on contract. Ask your local provider to unlock your phone before you go overseas. Or do it yourself by following instructions in your phone's manual.

A multi-country SIM card is ideal for multi-country travelling. TravelSIM International Roaming offers a pre-paid SIM card, available online, that can be used in more than 150 countries. It can be topped-up via credit card and includes a freecall 1800 number for family and friends.

- PROS: You keep the same number and avoid swapping cards in each destination you visit.
- CONS: You need to advise people of your new number, and you may need to transfer your address book to your phone before switching SIM cards.

Single-country SIM card

Handy for a one-country trip. For UK-bound travellers, 0044 offers cheap UK and international calls. The SIM card is available online (international delivery costs AU$8.5), can be activated ahead of arrival in the UK and may be topped-up via credit card or at any UK post office.

The SIM provides coverage for England, Wales, Scotland and Northern Ireland. Virgin Mobile's UK PAYG SIM Pack also offers great local pricing with the advantage of cheaper international rates.

- PROS: You pay local rates.
- CONS: You need to advise people of your new number. If you do roam to another country, expect increased costs.

Call from your computer

Voice over Internet Protocol (VoIP) services such as Skype, Google Talk or Yahoo Messenger, support phone calls over the Internet. Simply download the free software, get signed-up and you can talk via your computer's built-in speakers and microphone, or through an operator-type headset, to any other computer running the same program.

Calling a traditional telephone number (or vice versa) is also possible for a very small charge. VoIP calls also work on the iPhone, iPod touch and some BlackBerrys.

- PROS: This is definitely the cheapest option overall: PC-to-PC calls are free, calls to a mobile phone or landline cost a minimal fee and best of all, your computer's internal camera allows visual contact – perfect for chatting with your spouse and children. An added benefit is that your computer-savvy kids are probably already au fait with this system and can set things up for you before you leave home.
- CONS: You need a computer and high-speed internet connection. Some hotels block Skype and other VoIP services or impose a surcharge. Ask your hotel about its policies.

Local phone Card

This is an inexpensive solution.

- PROS: Prepaid and easily available from local stores.
- CONS: Making and receiving calls can be inconvenient. You need to find a landline phone.

Renting a local phone

These are easy to hire from airport phone rental stores and even some car rental agencies. London-based Adam Phones offer short-term mobile phone hire worldwide for around AU$2 per day with a choice of local networks and phones, including BlackBerry (AU$11 per day), with delivery to your hotel.

- PROS: 24-hour care and easy billing records.
- CONS: Charges can be high depending on which network is used. To avoid surprises, get a full online quote before leaving home.

International calling card

This is an inexpensive option. Telstra's Telecard Australia Direct, is available online, operates in more than 65 countries and is charged in Australian dollars to your home or business account.

- PROS: Rechargeable by credit card; any left over credit can be used to call overseas from Australia.
- CONS: You need a landline phone to make a call. Ask your hotel about their policy and how to dial from your room.

Hotel phones

Avoid like the plague due to the high costs!

Websites

- www.0044.co.uk
- www.virginmobile.com
- www.skype.com
- www.telstra.com.au
- www.travelsim.net.au
- www.adamphones.com

Why iPhone? Redefining the mobile phone

Apart from looking really cool, Apple's iconic iPhone redefines what a mobile phone can do by offering superior specs, revolutionary multi-tasking capabilities and a wealth of easily downloadable applications to satisfy everyone from the company founder to the graduate recruit.

The revolutionary iPhone 3G operates with fast 3G cellular and Wi-Fi networks around the world making it possible to surf the web, download email, see your family while chatting on VoIP, get directions around town on a GPS map, watch video on a widescreen iPod – even while you're on a call – listen to cool tunes and take family snaps. iPhone 3G delivers GSM, Wi-Fi, EDGE, GPS and Bluetooth 2.0 + EDR in one compact device – and works practically anywhere on earth. This is all possible by using a technology protocol called HSDPA (High-Speed Downlink Packet Access) to download data fast over UMTS (Universal Mobile Telecommunications System) networks.

Designed much like a hand-held computer, iPhone offers a growing range of self-help and stress-busting applications, easily downloaded from Apple's App Store or from iTunes. Here's a sample:

Absolute Fitness Lets you log data on calorie intake, exercise and weight. Provides a database of more than 10,000 different kinds of food.

Ovulation Calendar Helps you determine your fertile days of the month so you can either achieve or avoid pregnancy.

Platinum Sudoku Choose from 20 million Sudoku and Kakuro grids with five levels of difficulty to tease your brain. iPhone-specific features include a touch interface that lets you write your answers directly on the screen with your finger.

Scrabble Word Gurus, get ready with this iPhone-sized Scrabble board in your pocket. iPhone capabilities include drag-and-drop tiles and accelerometer-enabled title shuffling.

Texas Hold'em Play like a pro against realistic opponents or with your friends over a Wi-Fi network.

Asphalt 4 Elite Racing Race against your friends through the streets of New York, Shanghai, Dubai or Paris in the exclusive Wi-Fi multi-player mode.

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The Fiji School of Medicine

For 10 years now, a postgraduate program at the Fiji School of Medicine has been working to keep graduates in the region

Gordon Clunie
Victorian Fellow

Professor Emeritus Gordon Clunie (former Director of the FSM Project) and Mrs Clunie with the surgical postraduate trainees at the anniversary dinner.

The Fiji School of Medicine (FSM) and its predecessors, the Suva Medical School and the Central Medical School, have provided medical training for the islands of the Pacific since 1885.

Until recently, formal postgraduate training and continuing professional development have not been available for graduates from the school, so that many practitioners have been lost to the islands following experience of practice in other countries, particularly Australia and New Zealand.

To correct this deficiency, a postgraduate training program was developed at FSM with the assistance of funding provided by the Australian Agency for International Development (AusAID) and managed by the College. The program provided training for a one-year diploma which was followed by a three-year masters program in the five disciplines of Surgery, Internal Medicine, Anaesthesia, Paediatrics and Obstetrics and Gynaecology.

Additional staff members were appointed in each discipline, supported by expatriate long-term advisors. Teaching commenced formally in 1998.

Thus, 2008 marked the 10th anniversary of the program, which was celebrated following the completion of both undergraduate and postgraduate examinations by a dinner in Suva attended by FSM staff, external examiners and trainees. The success of the program in training specialists for the Pacific by the Pacific was emphasised by the Acting Dean of FSM, Professor Robert Moulds, although problems of retention of graduates in the Pacific Region remain.

Continued support from specialists for training in the Pacific and from aid agencies in countries such as Australia and New Zealand is essential if the initial successes of the program are to be maintained.

For further reading, see

- Clunie GJ, McCaig E, Baravilala W. The Fiji School of Medicine postgraduate training project. Med J Aust 2003; 179:631-632
- Baravilala W, Moulds RF. A Fijian perspective on providing a medical workforce. Med J Aust 2004; 181:602.

HOMESTAY ACCOMMODATION FOR VISITING SCHOLARS

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

Due to the short term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. The International Scholarships Department and Project China are seeking expressions of interest from those willing and able to provide homestay accommodation for our visiting scholars. If you have a spare room, and are interested in learning about another culture and language, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a nominal stipend.

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

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

The challenge of placing Trainees

Clinical placements across Australia
I expect that the College is aware of the problems that this national training ASP approach causes in a regional hospital such as the Launceston General Hospital.

The selection of Trainees has been forced to be completely transparent without any bias or possibility of discrimination. This, however, has significantly disrupted the obvious local career pathway, which has served us well for many years. Some of our best interns or residents have been sent interstate and replaced by a similar person from yet another state. This may be fulfilling the need of the bureaucrats, but is not conducive to the smooth running of our Department of Surgery.

At the Launceston General Hospital the most serious problems are as follows:

1. For the Trainees:
It is clear to the residents and junior registrars that it is no longer an option to stay at the Launceston General Hospital for unaccredited surgical training in the expectation that more experience is both practically useful and likely to enhance their chances of gaining admission to accredited training. Our figures indicate that admission to training programs is unequivocally less likely under the new system.

The obvious result of this is that talented junior Tasmanian surgical Trainees leave for the mainland as soon as they can in the knowledge that not to do so will compromise their chances of admission to accredited training.

2. For the Hospital:

a) The loss of our brightest surgical prospects would be acceptable if they were replaced by equally well-trained, experienced and enthusiastic Trainees. Unfortunately this has proven not to be the case. It is increasingly common for our Australian-trained young doctors, who would spend many junior years training in Tasmania and often return to the state when fully trained specialists, to be replaced by non-Australian or non-Tasmanian doctors who have little short-term and definitely no-long term wish to be in the state.

b) Directors of specialist training at the Launceston General Hospital have lost control of junior staffing. The previous well-proven and reliable system where juniors would be nurtured and mentored in an environment where competence, commitment and enthusiasm are noticed and flourish (and incompetence and lack of enthusiasm cannot go unnoticed) has been lost. It is no longer possible to retain our best prospects for a few years with the expectation that entry to formal training is very likely (subject to acceptable performance in a very well-monitored system). The pathway has been lost to the individual, the hospital and the state.

These serious problems are apparent in all major specialties and in all the teaching hospitals in Tasmania, including the Royal Hobart. It is likely that the same applies in other states. The system requires urgent modification. One simple modification would be to allocate numbers of training positions proportional to the relative needs of states according to (say) their populations.

My surgical colleagues and I are in favour of a nationwide database which includes all the people who intend to become Trainees, as Set 1, Set 2, and Set 3 etc. We believe that there should be more local input and a significant ability for each hospital to manage and educate their own junior doctors until they have demonstrated that they are good enough to progress to the Set 2 level.

The current deficiency in Australian trained medical graduates may not be obvious in the metropolitan hospitals but has seriously affected the Launceston General Hospital. Of 21 interns, six are Tasmanian trained and 15 are overseas graduates, half of them are still in the process of becoming registered or are obtaining a work visa.

The inability of the Launceston General Hospital to provide the students with a structured career pathway and preparing them to apply for specialist training has significantly affected the ability of the Launceston General Hospital to attract Australian trained interns and residents to cope with our ever increasing clinical workload.

Professor Berni Einoder
Director of Surgery
Launceston General Hospital

"Some of our best interns or residents have been sent interstate and replaced by a similar person from yet another state"

Re: Clinical placements across Australia
Professor Einoder raises a number of important considerations related to the complex challenge of placing surgical trainees into appropriate clinical positions across Australia.

Selection and allocation of successful applicants for surgical education and training by the Specialty Boards and their subsequent appointment by the jurisdictions depends on a number of factors.

The College and its partner specialties seek to select the best candidates available using selection processes and criteria which are transparent, fair, valid, reliable and efficient. Applicants must first meet a number of generic and specialty specific eligibility requirements and there are no parameters assessed in the CV, referees' reports or the interview which disadvantage applicants based on their geographical location.

Selection takes place in a competitive environment and candidates will always seek to give themselves an advantage, whatever they perceive this to be.

Clinical placement of successful applicants and of Trainees already in the system seeks to provide a wide spectrum of career aligned experience in a range of different jurisdictions and geographical areas.

The College Trainees' Association has raised on a number of occasions the financial and domestic costs faced by those who contemplate moving between different areas and the need for greater support from the jurisdictions for Trainees and their families considering such a move. Although the final decision on allocation rests with each board the Trainees can and do nominate personal preferences.

The number of posts available each year is dictated by the number that become vacant as Trainees graduate from the nine programs and also on how many new posts are put forward by the jurisdictions and receive accreditation. This involves access to a range and volume of clinical and operative experience under appropriate supervision.

For several years the College has requested the jurisdictions nominate new positions for accreditation in order to educate and train the increasing number of surgeons required to meet the expanding needs of the community. Unfortunately a shortage of suitable posts continues.

The College and the Specialty Boards will continue to work with jurisdictions, local Fellows and Trainees to ensure those in training can experience a range of working and living environments in order to help tomorrow'ssurgeons consider long term careers in the different locations available.

Professor John P Collins
Dean of Education
Royal Australasian College of Surgeons

2009 Brisbane Annual Scientific Congress

TUESDAY 5 MAY

WRITING COURT REPORTS (9:00am to 2:30pm)

Facilitated by 'Leo Cussen Institute' barristers and members of RACS Medico-legal Section, this workshop provides unique one-on-one training in the preparation of medical reports for use in legal cases. Participants receive individualised feedback on their medico-legal reports and gain an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective.

9:00am	**Session 1**: "The role of the medico-legal surgeon"
10:30am	Morning tea
10:50am	**Session 2**: Working with legal counsel
12:20pm	Lunch
1:00pm	**Session 3**: Individual report assessment

Register for this Workshop Masterclass when you register online for the 2009 Brisbane Annual Scientific Congress: **asc.surgeons.org**

Further details may be obtained from Merrilyn Smith at the College (merrilyn.smith@surgeons.org).

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 Australasiana College of Surgeons,
College of Surgeons Gardens,
240 Spring Street, Melbourne 3000.

Lorne Peers to Pub

Swim, run, paddle or ride

But Don't Miss

The Lorne Victorian Annual General Scientific and Fellowship Meeting

at the Cumberland Resort,
October 23 -25, 2009

Photo courtesy: Gavin Hansford & Tourism Victoria

Post Fellowship Training in HPB Surgery

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

Applications are invited from eligible Post Fellowship Trainees for training in HPB Surgery.

The ANZHPBA are introducing a Post Fellowship Training Program to start in February 2010 for Hepatic-Pancreatic and Biliary surgeons. The program will consist of a minimum twenty four months continuous education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in HPB surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit.

For further information please contact the Executive Officer at anzhpba@gmail.com

Applicants should submit a CV, an outline of career plans and nominate three references, to Leanne Rogers, Executive Officer ANZHPBA, P.O. Box 374, Belair S.A. 5052, or email anzhpba@gmail.com.

Applicants will need to be able to attend interviews which will be held in the week beginning May 4th, during the ASC in Brisbane.

***** Applications close 5pm, Friday April 3rd 2009 *****

Post Fellowship Training in Upper GI Surgery

Applications are invited from eligible Post Fellowship Trainees for training in Upper GI Surgery.

ANZGOSA are introducing a Post Fellowship Training Program to start in February 2010 for Upper GI surgeons. The program will consist of a minimum twenty four months continuous education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in Upper GI surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit.

For further information please contact the Executive Officer at anzgosa@gmail.com

Applicants should submit a CV, an outline of career plans and nominate three references, to Leanne Rogers, Executive Officer ANZGOSA, P.O. Box 374, Belair S.A. 5052, or email anzgosa@gmail.com.

Applicants will need to be able to attend interviews which will be held in the week beginning May 4th, during the ASC in Brisbane.

ANZGOSA

***** Applications close 5pm, Friday April 3rd 2009 *****

Surgery and study

A new course has been established to inspire and promote surgical research and education

John Windsor
Section of Academic Surgery,
Executive Committee

The delivery of high quality surgical care requires expert surgeons. But better surgical care in the future requires surgeons committed to the discovery and dissemination of new surgical knowledge. Most would admit that as a Fellowship we could do more to identify and nurture Trainees who want to make research and/or education a vital part of their surgical career.

The Section of Academic Surgeons (from the College) and the Association of Academic Surgery (AAS) from the US have joined forces to develop an exciting course. The inaugural course will be held on May 5, immediately preceding the College's ASC in Brisbane. A distinguished faculty has been assembled from both sides of the Pacific to deliver a relevant and carefully designed one-day course. The range of presentations are listed in the program and many of them are already "crowd favourites" at the popular courses offered by the Association of Academic Surgeons. The course builds on the foundational CLEAR (critical literature evaluation and research) course currently offered by the College.

The AAS (see *Surgical News* January/February, Vol:10, Issue:1) aims to:

- Provide a forum for medical students, senior surgical residents, fellows and junior faculty members to present and discuss their current educational, clinical or basic science research.
- Promote the career development of young surgical faculty by providing workshops designed to enhance professional and personal growth
- Encourage the interchange of ideas between medical students, senior surgical residents, Fellows, junior faculty and established academic surgeons
- Facilitate communication among academic surgeons in all surgical fields.

Benefits for the participants include helping them better understand the avenues for academic practice; teaching them how to prepare scientific abstracts, papers and research applications; bringing balance to their clinical, research and family responsibilities; finding effective mentors; and learning how to build their own peer networks.

There is a difference between academic surgery as a discipline and academic surgery as a career. This course not exclusively for Trainees who want to become academic surgeons, but for all those who have an interest in developing their skills and interest in surgical research and education.

It is hoped that this course will become an annual fixture course. Please register for it and encourage others to attend.

The course is possible because of a generous unrestricted educational grant from Johnson & Johnson Medical. This has meant that a number of AAS faculty members are able to travel to Brisbane to contribute to this course. They are all passionate in promoting the rewards of academic surgery. This has kept the course fee at a low $120. A limited number of places are available. You can register through the College ASC registration (online asc.surgeons.org or by hard copy). Enquires: dcas@surgeons.org or telephone +61 3 9249 1273.

Program for 'Developing a Career in Academic Surgery'

0700-0720 - Breakfast and coffee
0720-0730 - Welcome and Introduction by College President, Ian Gough

The Surgeon Scientist
Chairs - Andre van Rij, and Kevin Staveley-O'Carroll
0730-0750 - The Surgeon-Scientist - Scott LeMaire
0750-0805 - Why not just go into private practice? - Noel Tait
0805-0945 - Types of Surgical Research
- Basic Science Research - Kimberly Kirkwood
- Clinical and Translational Research - Mark Smithers
- Outcomes Research - Michael Solomon
- Educational Research - John Collins

0945-1000 - Panel Discussion (including funding research)
1000-1015 - Morning Tea

Surgical Research
Chairs - Chris Christophi / Melina Kibbe
1015-1040 - Developing a Research Program - Peter Nelson
1040-1110 - Design, Power and Statistics - Lillian Kao
1110-1135 - Running Clinical Trials - John Fletcher
1135-1150 - Panel Discussion
1150-1230 - Lunch

Writing and Presenting Research
Chairs - Susan Neuhaus / Kimberly Kirkwood
1230-1310 - The nuts and bolts of Scientific Writing - Melina Kibbe
1310-1335 - Writing a successful grant application - David Watson
1335-1400 - Effective research presentations - Kevin Staveley-O'Carroll
1400-1415 - Panel Discussion
1415-1430 - Afternoon Tea

Building a Successful Career in Academic Surgery
Chairs - Andrew Hill / Scott LeMaire
1430-1450 - Becoming an Effective Teacher - John Collins
1450-1510 - Life-Work Balance - Max Schmidt
1510-1530 - Academic Surgery and the RACS - Ian Civil
1530-1550 - A career in academic surgery - John Windsor
1550-1600 - Discussion and concluding remarks
1630-1800 - Convocation (academic gown preferred)
1800-1930 - ASC Welcome Cocktail

Fellows and Trainees can now choose not to receive the paper version of the ANZ Journal of Surgery – note that all Fellows and Trainees will continue to have access to the ANZ Journal of Surgery via the College website at www.surgeons.org

The College has agreed on a new contract with Wiley-Blackwell to publish the ANZ Journal of Surgery between 2009 and 2013. We are aware that some Fellows and Trainees prefer to access journals online rather than receive paper copies of journals. Also, the College is committed to reducing its carbon footprint. We are therefore pleased to announce that the new contract with Wiley-Blackwell allows the College to vary the number of printed copies of the Journal according to the requirements of our Fellows and Trainees.

If you would like to stop receiving the paper version of the ANZ Journal of Surgery please email your request to anz.journal@surgeons.org

Complaint resolutions

Inappropriate behaviour in the workplace can often be dealt with by informal processes

The Victoria Equal Opportunity & Human Rights Commission

The options available to a person needing to make a complaint will depend on the situation, personnel and resources available in the organisation. However, you can summarise the options available to complainants under four categories:

1. Self-management
2. Informal internal process
3. Formal internal process
4. External resolution options

1. Self-management

It is remarkable how often inappropriate behaviour at work can be stopped simply by saying "no" firmly but politely when it occurs.

To assist this is it worthwhile asking:

"What did you do when this incident occurred?"

"Do you think the other person knows how you feel?"

"Do you feel you could raise the matter directly with the person involved? Why not?"

Five steps to effective self-management

The most effective way to protest inappropriate behaviour can be summarised in five steps.

1. Stay **calm** and polite.
2. Describe the **behaviour** not the person.
3. Indicate the **effect** of the behaviour on you and your feelings.
4. Include a clear **request** that the behaviour not happen again.
5. Ask for **agreement** (or at least acknowledgement that you have been heard).

1. By staying calm and polite, you are more likely to communicate clearly and be heard. It will also avoid making the other person feel that they are being attacked personally.
2. By focusing on the behaviour rather than the person, the respondent can change their behaviour without having to lose face or admit they were "wrong" .
3. Indicating the effect on you of the respondent's behaviour avoids any implied accusation that the respondent knew they were being offensive. It avoids escalating the dispute.

4 & 5. Making a clear request and then seeking acknowledgement is a simple form of contract, a contract that can be referred to later if the offensive behaviour re-occurs.

If you need to emphasise the message, raising your hand, palm outward toward the person (the "stop" sign used by traffic police) sends a clear and immediate message that you want them to stop. This works well if:

- it is a noisy environment;
- the other person is very emotional;
- unwanted physical contact seems to be about to happen; or
- the other person has limited language skills.

At the very least, self-management of complaints prevents a respondent from claiming later that "I didn't know you were offended." It helps sort out "accidental" sexual harassment or bullying from deliberate.

Other forms of self-management include changed work practice, improved workplace communication style, research into rights at work, accessing personal support, debriefing or training, or a discussion between the person and their manager or someone else within the organisation.

"I don't think I can do that"

Not all matters can be self-managed. Self-management may not be appropriate if:

- it is very likely to put the person who made the complaint at risk of victimisation;
- it has already been tried with no success;
- the problem is more about the behaviour of a group than about a specific individual.

EXAMPLES: HOW TO SAY "NO!"

A simple and effective way to self-manage inappropriate workplace behaviour is to protest immediately it occurs. Eg:

- "I know you think it's normal, but when you shout at me like that, I feel humiliated and upset. This is a serious request. Please do not shout at me that way again. Can we agree on that?"
- "I know you're just being friendly, but touching me like that makes me very uncomfortable. Please don't touch me again. Okay?"
- "I find jokes like that really offensive. Could you save that for when I am not around?"

Rehearsing or role-playing a preferred response can assist individuals to resolve their complaints at this level.

The success of self-management relies upon:

- the capacity of the complainant to raise their issues in a constructive fashion and with a clear focus on reaching an agreed solution; and
- the capacity of the respondent to listen to the complainant, take responsibility for their behaviour and engage meaningfully in reaching a resolution.

2. Informal resolution of complaints

"Informal' resolution refers to any way of solving a complaint without a formal complaint, investigation or discipline. It's where the complainant asks a third party within the workplace to assist in resolving the problem without formal investigation or discipline being taken against the respondent.

Some people will not feel confident to raise or discuss inappropriate behaviour directly with the person involved. They may prefer to raise the matter with another person in the workplace first, such as:

- their supervisor or manager
- the respondent's supervisor or manager
- someone from human resources

The person with the complaint can invite a colleague to such a meeting to provide them with support. However, this person must remain impartial and not speak on their behalf.

Informal complaint resolution focuses on solving the problem rather than proving something bad actually happened. The emphasis is on the future, for example:

"How will we work together in the future?"

"What practices will we put in place in the future to avoid this sort of problem?"

"What lack of awareness led to this problem and how can we promote better awareness of our policies?"

This means that a matter can be resolved without any formal findings of misconduct.

Examples of informal resolution

Informal complaints resolutions processes include:

- Mediation – a manager (or someone else with appropriate skills and authority) mediates a discussion between the parties. The outcome is in the hands of the parties, but the mediator controls the process.
- Negotiation / discussion – a manager (or someone else with appropriate skills and authority) negotiates individually between the parties to reach an agreement that is acceptable to both.
- Training – a complainant raises their concerns (for example, racism in the workplace) with their manager or with human resources personnel who then deal with the issues in some indirect way such as to organise staff training on racism, workplace diversity or the organisation's policies on workplace bullying and harassment.
- Observation and intervention – a complainant raises their concerns with their manager so that the manager can put themselves in a position to observe any future inappropriate behaviour and then step in if they see a breach of policy. If it is a serious breach of policy, the manager might decide that discipline is appropriate, but (importantly) the respondent won't know the complainant has talked to the manager, because preventing breaches of policy is part of a manager's role.

Effective informal resolution relies on managers and supervisors being clear about their responsibilities in preventing and dealing with discrimination and harassment. This is one of the reasons why skills-based training for managers on equal opportunity, dispute resolution and performance management is so important.

SAYING "NO!" AGAIN

Sometimes a request needs to be repeated with greater force. It can be helpful to let the other person know that there will be consequences if their poor behaviour continues. Eg:

- "Look, I asked you before not to do that. This is a serious matter for me. It is making me seriously offended. I believe it is a breach of our policy, and if it happens again, I may need to take up the matter elsewhere in the organisation. Do you think you can lay off from now on?"

"Informal complaint resolution focuses on solving the problem rather than proving something bad actually happened."

Advantages of informal resolution

Self-management and informal complaint resolution options are:

- the best way to achieve non-disciplinary outcomes;
- adaptable to a wide variety of complaints and can deal with most workplace issues;
- usually less intimidating or emotionally damaging for complainants and respondents;
- quicker and involves less work than a formal complaint investigation;
- often appropriate for situations where the respondent may be "ignorant" of workplace policies or unaware of the effect of their behaviour on others;
- more likely to encourage open communication and a better working relationship between the complainant and respondent;
- an effective way to reveal whether a formal procedure is required.

Disadvantages of informal resolution

Handling a complaint through informal internal procedures may not completely or effectively resolve a complaint if:

- it is done in a way that makes the respondent feel they are being judged as "guilty" or "a bad person";
- power dynamics between the people involved unfairly influences the outcome;
- the alleged bad behaviour is so serious that formal discipline would be appropriate;
- the agreement reached is not enforceable; for example, because the people involved don't have sufficient authority to monitor or enforce it;p
- informal resolution of past complaints in the workplace has produced wildly different and inconsistent decisions and outcomes.

Next month, Surgical News will explore formal internal processes and external resolution options.

The Online Library

There are full-text journals available through the College's Online Library

Graeme Campbell
Chair, Fellowship Services

One of the benefits of being a Fellow, Trainee or International Medical Graduate of the College is access to the Online Library which has over 300 journal titles, as well as e-books, image libraries and medical databases. For many Fellows, Trainees and IMGs, these resources provide real value for their subscription or training fees. If you're not currently using the Online Library and would like to find out more, please email the Library staff at College.Library@ surgeons.org

An alphabetic list of the Library's journal subscriptions is available below. For convenience, the Online Library also has resource lists organised by surgical specialty.

In addition to the titles available online, Fellows and Trainees can request reprints of any journal articles required. These are sourced from other libraries, and be posted, faxed or emailed. Please use a journal article request form, available online or from the Library, as the forms include the requisite copyright declaration.

The next issue of Surgical News will highlight the full-text books and databases available through the Library.

A

Abdominal Imaging
Academic Medicine
Acta Neurochirurgica
Acta Orthopaedica
Acta Orthopaedica Belgica
Aesthetic Plastic Surgery
Ambulatory Surgery
American Heart Journal
American Journal of Gastroenterology
American Journal of Nephrology
American Journal of Neuroradiology
American Journal of Sports Medicine
American Journal of Surgery
American Journal of Transplantation
American Surgeon
Anaesthesia and Intensive Care
Anesthesiology Clinics of North America
Annals of Internal Medicine
Annals of Otology, Rhinology & Laryngology
Annals of Plastic Surgery
Annals of Surgery
Annals of Surgery
Annals of Surgical Oncology
Annals of Thoracic Surgery
Annals of Vascular Surgery
ANZ Journal of Surgery
ANZ Journal of Obstetrics and Gynaecology
Archives of Otolaryngology Head & Neck Surgery
Archives of Surgery
Arthroscopy
Atlas of the Hand Clinics
Atlas of the Oral and Maxillofacial Surgery Clinics
Australasian Journal of Dermatology
Australasian Radiology
Australian and New Zealand Journal of Obstetrics and Gynaecology

B

BJS (British Journal of Surgery)
BJU International and Supplement
BMC Surgery
BMJ
Breast Cancer Research and Treatment
The Breast Journal
British Journal of Anaesthesia
British Journal of Plastic Surgery
Bulletin of the Royal College of Surgeons of England

C

Canadian Journal of Surgery
Cancer
Cancer and Metastasis Reviews
Cancer Chemotherapy and Pharmacology
Cardiology Clinics
CardioVascular and Interventional Radiology
Chest
Chest Surgery Clinics of North America
Child's Nervous System
Clinical and Experimental Ophthalmology
Clinical Orthopaedics & Related Research
Clinics in Chest Medicine
Clinics in Plastic Surgery
Clinics in Sports Medicine
Critical Care Clinics
Current Opinion in Otolaryngology & Head and Neck Surgery
Current Orthopaedics

D

Dermatologic Clinics
Digestive Diseases and Sciences
Digestive Surgery
Diseases of the Colon & Rectum

E

Ear, Nose and Throat Journal
Emergency Medicine Australasia
Emergency Medicine Clinics of North America
Emergency Radiology
European Archives of Psychiatry and Clinical Neuroscience
European Journal of Clinical Microbiology and Infectious Diseases
European Journal of Nuclear Medicine and Molecular Imaging
European Journal of Pediatrics
European Journal of Trauma
European Journal of Vascular and Endovascular Surgery
EJVES Extra
European Radiology

F

Facial Plastic Surgery Clinics of North America
Familial Cancer
Foot and Ankle Clinics
Foot & Ankle International

G

Gastroenterology Clinics of North America
Gastrointestinal Endoscopy Clinics of North America

H

Hand Clinics
Head and Neck

I

Immunology and Allergy Clinics of North America
Infection
Infectious Disease Clinics of North America
Injury
Intensive Care Medicine
Internal Medicine Journal
International Journal of Clinical Oncology
International Journal of Radiation Oncology*Biology*Physics
International Orthopaedics
International Urogynecology Journal
International Urology and Nephrology
Internet Journal of Thoracic and Cardiovascular Surgery

J

JAAOS: Journal of the American Academy of Orthopaedic Surgeons
JAMA
Journal of the American College of Surgeons
Journal of the American Society for Surgery of the Hand
Journal of Anatomy
Journal of Anesthesia
Journal of Arthroplasty
Journal of Bone & Joint Surgery (UK)
Journal of Bone & Joint Surgery (USA)
Journal of Cardiovascular Surgery
Journal of Clinical Immunology
Journal of Clinical Monitoring and Computing
Journal of Digital Imaging
Journal of Gastroenterology
Journal of Hand Surgery : European volume
Journal of Hand Surgery (British Volume)
Journal of Hand Surgery (USA)
Journal of Hand Therapy
Journal of Hepato-Biliary-Pancreatic Surgery
Journal of Knee Surgery
Journal of Laryngology and Otology
Journal of Medical Ethics
Journal of Medical Imaging and Radiation Oncology
Journal of the National Cancer Institute
Journal of Neuro-Oncology
Journal of Neurology
Journal of Neurology, Neurosurgery and Psychiatry
Journal of Neurosurgery
Journal of Neurosurgery : Pediatrics
Journal of Neurosurgery : Spine
Journal of Orthopaedic Research
Journal of Orthopaedic Surgery
Journal of Orthopaedic Trauma
Journal of Paediatrics and Child Health
Journal of Pediatric Ophthalmology and Strabismus
Journal of Pediatric Orthopaedics
Journal of Pediatric Surgery
Journal of Pediatric Urology

Journal of Pediatrics
Journal of Shoulder and Elbow Surgery
Journal of Thoracic & Cardiovascular Surgery
Journal of Trauma - Injury Infection and Critical Care
Journal of Urology
Journal of Vascular and Interventional Radiology JVIR
Journal of Vascular Research
Journal of Vascular Surgery
JPRAS : an international journal of surgical reconstruction

L

Lancet
Laryngoscope

M

Mayo Clinic Proceedings
Medical Clinics of North America
Medical Education
Medical Journal of Australia
Military Medicine

N

Navy Medicine
Neuroimaging Clinics of North America
Neuroradiology
Neurosurgery
Neurosurgery Clinics of North America
Neurosurgical Focus
New England Journal of Medicine
New Zealand Medical Journal

O

Obesity Surgery
Oncology
Oral and Maxillofacial Surgery Clinics of North America
Orthopedic Clinics of North America
Orthopedics
Orthopedics and Trauma
Osteoporosis International
Otolaryngologic Clinics of North America
Otolaryngology Head & Neck Surgery

P

Pediatric Cardiology
Pediatric Clinics of North America
Pediatric Nephrology
Pediatric Neurosurgery
Pediatric Radiology
Pediatric Surgery International
Plastic & Reconstructive Surgery

R

Radiographics
Radiologic Clinics of North America
Radiology

S

Skeletal Radiology
Spine
Supportive Care in Cancer
Surgery
Surgical Clinics of North America
Surgical Endoscopy
Surgical Laparoscopy & Endoscopy & Percutaneous Techniques
Surgical Oncology Clinics of North America

T

Thoracic Surgery Clinics

U

Urologic Clinics of North America
Urology

V

Vascular and Endovascular Surgery

W

World Journal of Surgery
World Journal of Urology
Wound Repair and Regeneration

War Surgery in Afghanistan and Iraq

Edited by LTC. Shawn Nessen, Col. Dave Lounsbury and Col. Stephen Hetz

John Wright
NSW Fellow

It is difficult to believe that this work could be superseded in the quality of its content, currency, detail, demonstrations and style. It represents a meticulous and highly confronting analysis of what is abhorrent but, inevitably and indefinitely, relevant to the combative world of today.

If Hippocrates was correct when he taught that a surgeon needs experience of war surgery to be ideally informed, this book demonstrates that fact. Whether or not a surgeon believes that war surgery has relevance to the whole of surgery, this publication encompasses principles and details that cannot be ignored in any type of significant trauma care. Obviously, penetrating and perforating injuries from improvised and other explosive devices are almost unique to military settings, but multiple extrapolations are possible to civilian practice, including elective surgery.

Similarly, while no single surgeon, medic, nurse, anaesthetist or other specialist could ever be expected to apply much of what this book demonstrates to their particular area of interest, it is filled with a myriad of insights into current surgical attitudes gained by the US Army in Iraq and Afghanistan. They range from measures used at the site of injury through to the various stages of care up to convalescence and rehabilitation, while recognising that many desperate injuries can only be managed by compromises and failure may be inevitable. Control of haemorrhage and its most appropriate replacement components are recognised as paramount issues in survival if definitive surgery can be accessed.

The present availability of hand-held digital cameras at almost all levels of care contributes full-colour, close-up images of presenting problems and their evaluation, evolution and treatment in astonishing detail. The sophisticated style of presentation is characteristically American. Although similar techniques have been employed elsewhere, few can equal the teaching devices included. In their comprehensiveness, they are reminiscent of Hamilton Bailey's publications of 70 years ago, Grant's Atlas of Anatomy and the Ciba Foundation publications. I venture to say that no medically interested person could fail to be affected and

"Not surprisingly, the US Army was reluctant to have this work published with its assault on the sensitivities of civilians and governments..."

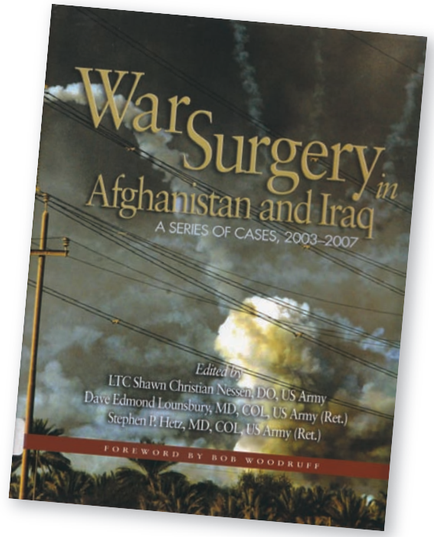
instructed by the text, tables and illustrations of this book. They include demonstrations of injuries inflicted on "host nation" victims [constituting a majority of all those treated by military forces] and soldiers of both sexes and on both sides of the conflict, as well as on injured pregnancies, infants and children. Great care is taken to address the triage of injuries as well as that of injured individuals.

This does not purport to be a textbook of surgery. It assumes much basic clinical awareness. It is much more than a brilliant colour atlas of the nature and care of acute battle trauma. It includes detailed, expertly presented analyses of some 80 cases that are exemplary of injuries in various body regions. The format sequentially focuses on the organisation of trauma systems and their subdivisions, instructional techniques, crucial aspects of intensive care and resuscitation of patients of all ages, systematic consideration of regional injuries of all sorts, computerised patient-tracking, phased repair programs, tourniquets, damage control, laboratory and other diagnostic modalities, transfusion, the management of an impacted, submerged live grenade, an injured foetus and the inadvertent transfer of human parts and infections between individuals as a result of proximate blast.

It sensitively acknowledges the differences between management of those who can be evacuated distantly [American and Allied forces to staging posts such as in Germany and, later the Americans to the US mainland] and the indigenous wounded whose care beyond maximum initial care must be left to possibly inferior and discontinuous, domestic, medical resources. Similarly, it confronts the logistical issue of protracted involvement with injuries, such as extensive burns combined with other injury types, where salvage is well nigh impossible under any circumstances – let alone close by a combat area.

But it is even more than that: it is crammed with remarkable know-how, tricks of the trade and hints about latest materials and methods, the means of exploiting rare resources, staging of multiple, frequently close interventions [a great tribute to anaesthetic services], the urgent management of compartment syndromes, the utility of vascular shunting and external fixation in acute injuries to enable comfortable, stable transportation to higher and more leisurely levels of resources. There is repeated emphasis on damage control, retaining maximum limb length for prosthetic fitting, airway management and, especially, the interruption of the mortal spiral of heat loss, acidosis and clotting failure which defeats the ambitions of all specific regions of care.

Each section is illustrated by a case history, an analysis of procedures and effects, a detailed consideration of teaching points, clinical implications and suggested reading. Much of the last was provided by the 3rd US Revision of "Emergency War Surgery", 2004. In many sections, there is mention of the history, place and rationale of a particular or "classic" surgical procedure. Each section is followed by an expert "commentary" on the cases reviewed in that section, the major principles involved, safe management essentials and lessons to be "taken home" by the reader.



Not surprisingly, the US Army was reluctant to have this work published with its assault on the sensitivities of civilians and governments by images and descriptions of such stark realities of the direly wounded. The authors are to be congratulated for accomplishing a change of attitude of those initially reluctant to approve the exposure of gut-churning details. The facts have won out.

The value of the book is self-evident. It is an educational resource of superlative quality. The fact that there is no reference to clostridial infections, apart from one late indigenous presentation with tetanus, reflects the advances possible by the very rapid evacuation and wound attention of the modern era with meticulous and repeated debridement, broad antibiotic cover, loose if any closure of contaminated wounds and frequent, expert re-evaluations. Apart from unattributed case descriptions, there are 80 contributors, including the three distinguished editors. Each commentary deserves close reading, if only for one's education and orientation.

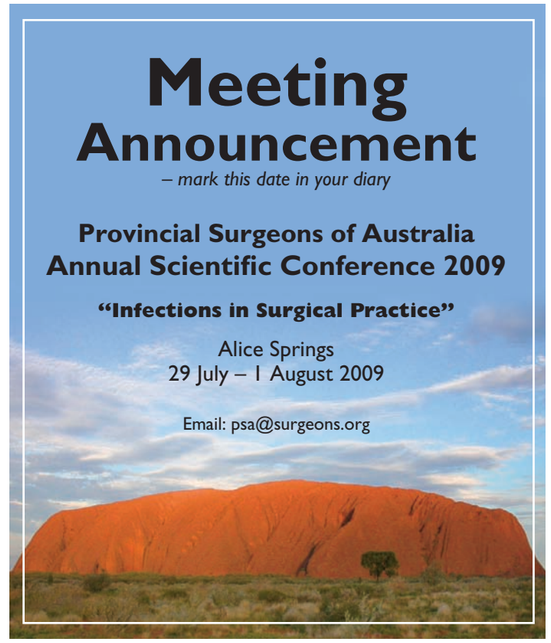
All those with an interest in emergency first aid, rapid evacuation, informed salvage and, particularly, those who might contribute

"The value of the book is self-evident. It is an educational resource of superlative quality."

at some time in remote trauma zones on land or sea, will find this relatively inexpensive work an irreplaceable, lifelong reference source. Those who would seek such experience should read this book before travelling, because their learning curves will be almost vertical once involved on site. None will return to civilian life unchanged. All medical libraries should hold at least one copy. Medical colleges of all sorts might well consider acute war surgery a major and much favoured training option, essential to answering the eternal need for such expertise worldwide. It is customary to review such works from the perspective of suggesting improvements. This book needs none. It is an exceptional document derived from exceptional experience and people.

War Surgery in Afghanistan and Iraq a series of cases, 2003-2007 *is published by the Office of The Surgeon General, Department of the Army, USA; the US Army Medical Department Center and School; US Army Telemedicine and Advanced Technology Research Center. The Editor in Chief is : Col. Martha Lenhart, Director, Borden Institute, Uniformed Services University of the Health Sciences.*

War Surgery: A Partnership of Heroes, *by John Wright, will be published by The War Book Shop in early 2009.*



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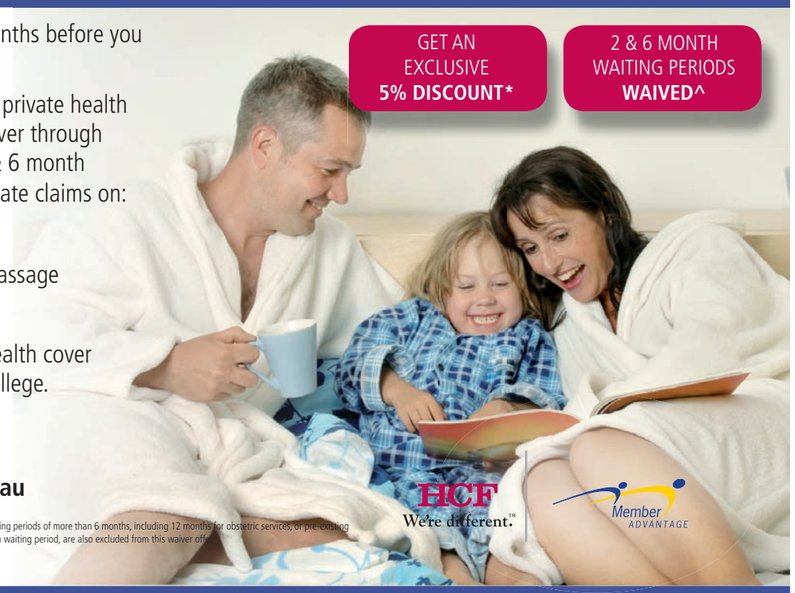

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More on Gui de Chauliac

Gui's procedure for trepanation was a traditional one based on Avicenna

Keith Mutimer
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Abbé de la Chaise-Dieu

An article on Gui de Chauliac's *Cyrurgia Magna* appeared in *Surgical News* Vol.6 No.7. In it mention was made that Gui performed a trepanation on Pope Clement VI. This elicited a response from Graham Martin FRACS, a neurosurgeon in Auckland with an interest in researching the health of the Popes. So began a research project which is not yet finished, but so far has revealed some very interesting information.

Pope Clement VI was born Pierre Roger at the *château* of Maumont (Limousin) in 1291/2. At the age of 10 he entered the monastery of Saint-Robert de la Chaise-Dieu (Haut-Loire) as a novice, and followed the religious life. In 1307 he was sent to study at the Sorbonne in Paris and achieved high academic distinction, and was known for his skill in oratory.

After being introduced to Pope John XXII, he began a meteoric rise through the Church hierarchy. His first appointments were to the priories of Saint Panteléon (Limoges) and Savigneax (Lyon), and then in 1324 to the priory of Saint-Baudile near Nîmes. He was next appointed Abbot of the influential monastery of Fécamp in Normandy. In 1328 he was appointed Bishop of Arras, and in 1334 became Chancellor to Philippe VI de Valois, King of France. A year later he was promoted to the Bishopric of Sens, and a year after that to the Archbishopric of Rouen. He was created Cardinal in 1338 by Pope Benedict XII, whom he succeeded on 7 May 1342.

His reign as Pope was characterised by munificence, success in politics, tolerance, charity and intellectual endeavour, but also by nepotism and bias towards the interests of France. In 1348 Clement bought the sovereignty of Avignon from Queen Johanna of Naples and established the Papal court there, in return for 80,000 florins and the absolution of Johanna from complicity in the murder of her husband.

Clement suffered from continuous ill health, probably derived from a heavy blow to the head which he received in an attack by bandits on the road from Paris to La Chaise-Dieu. He had severe episodes in 1343 and again in 1351. It was during one of the 1343 bouts that his surgeon took the drastic step of opening his skull. This provided only temporary relief, for in 1345, in a letter to Queen Jeanne of France, Clement confided that that he had been "gravely ill from a tertian fever, with a rheum descending from face to jaw". In a later letter, written in 1351, he described "a swelling from a gathering of humours, which causes a febrile condition, has seriously distorted our face, and has afflicted us".

As a result of this chronic condition, Pope Clement VI died in his palace at Avignon on 6 December 1352. He was buried in his old monastery La Chaise-Dieu, where his tomb still stands in the choir before the high altar.

The Pope's remains were examined on 19 March 1709 when his tomb was opened during renovation works in the choir of the abbey church, which had been badly damaged by rioting Huguenots. The examiner was a surgeon with the memorable name of Barthelémi Pissavin, who noted "in the left parietal region there is a light exfoliation of the outer table... There is a trepanation a finger's breadth from the coronal suture and a large finger's breadth from the sagittal suture".

In 1958 the remains were exposed again when one side of the tomb collapsed due to subsidence of the floor. Canon Fayard had the bones examined by two surgeons, Lois Kaepilin and Jean Barrès, who found the skull just as it had been described.

The surgeon who performed the trepanation is never named, and Gui in his writings makes no mention of this event. This is not hard to understand, for matters to do with the Papal health were virtually state secrets. The Pope's body caused considerable difficulty for mediæval theologians, for there was an inherent paradox in its position. The Pope was after all human, born of the flesh and doomed to decay, death and corruption, but his body was also the corporeal representation of Christ and the Church, and therefore incorruptible. To admit that the Pope was suffering from illness was tantamount to heresy, but his physical ailments had to be attended to nevertheless. To treat the sacrosanct body of the Pope with violence was scandalous, but the procedures of those times always involved some physical force. This is why the renowned early Renaissance writer Petrarch attacked Gui in his censorious *Invective contra Medicum* ("Invectives against a Doctor") of 1353, and also in the smaller *Invectiva contra quendam magni status hominem sed nullius scientie aut virtutis* ("Invective against a certain man of high standing but of no knowledge or virtue"). Again, Gui is never mentioned by name, but there is no doubt as to his identity.

Gui's procedure for trepanation was a traditional one based on Avicenna, starting with a favourable alignment of the stars, and avoiding the time of the full moon, when the brain was believed to swell. Then it went thus:

Day 1: Shave the head. Make two cuts in the scalp in the form of a cross or an L. Cut away the skin from the corners of the wound.

Pack the wound with rags soaked in water and vinegar, or white of egg. Bandage the wound.

Day 2: Seat the patient comfortably. Keep the room and the patient warm. Stuff the patient's ears with wool or cotton. Undo the bandage, remove the packing, examine the wound.

Begin removing bone: the actual method of exfoliation depends on the type of wound.Pack the wound, but leave it open to allow drainage.

Recovery: Change dressings regularly, at least once a day: dressings should be soaked in oil of roses or honey.

Allow the patient to rest in the most comfortable position: when the wound begins to discharge, the patient should be turned to a position that allows dependent drainage.

Gui's work on Clement gave the pontiff some relief. The operation was a success, but the patient in the end succumbed to his chronic condition. Despite the limitations of his time, Gui was a careful and thoughtful practitioner who showed the way for future generations.

Written by Geoff Down


Chaise-Dieu Entrance

The Destiny of Day Surgery

Brisbane will play host to the eighth International Congress on ambulatory Surgery

PHOTO COURTESY OF BRISBANE MARKETING

Hugh Bartholomeusz
Convener & President, Local Organising Committee

What is the IAAS?

IAAS stands for International Association for Ambulatory Surgery. IAAS is dedicated to the global exchange of information and advancement of ambulatory surgery, encouraging the development and expansion of high quality ambulatory surgery across the world. It acts as an advisory body for the development and maintenance of high standards of patient care in ambulatory surgery facilities (www.iaas-med.com).

The first international congress was held in Brussels in 1995 followed successfully by London, Venice, Geneva, Boston, Seville and Amsterdam. This year's Congress is being hosted and organised by members of the Australian Day Surgery Council and is the first time the event will be hosted in the Southern Hemisphere. It represents an exciting opportunity for Australasian professionals involved in day surgery to enjoy the benefits of an internationally recognised event right on our doorstep. The theme of the Congress is "The Destiny of Day Surgery" and the program is designed by and for surgeons, anaesthetists, nurses, managers and other health professionals working in day surgery centres/units throughout the world.

The Congress opens with the prestigious Nicoll Lecture. Named after James H. Nicoll, MB, a pioneer of modern day surgery, who first described paediatric day case surgery in 1909 and performed 8988 operations as day cases at the Royal Glasgow Hospital in Scotland. This year's Nicoll Lecturer is Jill Solly, past President of the British Association of Day Surgery.

Plenary topics cover the themes of "Ambulatory surgery in the future – models and controversies", "Risk management in day surgery centres", "Worldwide expansion of day surgery", "How will medical practitioners and nurses be trained in the future" and the "Horizons of day surgery". On Monday morning a stimulating open forum will be conducted with representatives from our local and international faculty discussing "The challenge of bureaucracy – a global perspective".

Concurrent sessions will focus on surgical, anaesthetic, nursing and management streams with free paper sessions allocated to cover the full spectrum of day surgery issues. The surgical concurrent session themes are "Major abdominal and pelvic operations", "Orthopaedic, hand and plastic surgery", "Ophthalmology, ENT and facio-maxillary" and "Surgery and interventional radiology".

With an invited faculty of over 60 international and local speakers, we will hear of the challenges, developments and initiatives in day surgery across the globe. From Europe, we will learn of the "Acceptance of Dutch standards for ambulatory surgery centres in the Netherlands" presented by Dr Dick de Jong, a General Surgeon and Past President of the IAAS. Dr Naresh Row, from The Indian Association of Day Surgery, will deliver a presentation about the "Progress of ambulatory surgery in India" and from Australia Mr Peter Sutherland will present on "The use of the ambulatory care unit 23 hour ward at The Royal Adelaide Hospital for patients undergoing Robotically Assisted Total Prostatectomy".

We are also excited to welcome the contribution of the Society For Ambulatory Anesthesia (SAMBA) who will present two sessions covering topics including "Selection challenges", "Obstructive sleep apnoea patient for laparoscopic bariatric surgery", "Post-discharge management", "Post operative nausea and vomiting consensus guidelines" and "Fast track recovery – making it really happen".

These keynote presentations represent only a small picture of the extensive program. We invite all surgeons and other health professionals interested and involved in the future of day surgery to attend this important Congress.

8th IAAS International Congress on Ambulatory Surgery 'The Destiny of Day Surgery'
3 – 6 July 2009, Brisbane Convention and Exhibition Centre

Important Dates:
Early-Bird Registration Closes: Friday 3 April 2009

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