Surgical news

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2010

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The College of Surgeons of Australia and New Zealand

A new study in East Timor will demonstrate the emotional effects of surgery on patients

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"Surgeon" – is the title protected?

The medical profession lost "protection" of the title "Doctor" many decades ago

Ian Gough
President

With the establishment of the Australian Health Practitioner Regulation Agency (AHPRA) and more clarity about how the ten national professional boards will report to the Agency structure, there is much truth in the old maxim "the devil is in the detail".

The medical profession lost "protection" of the title "Doctor" many decades ago. The proliferation of the uses of the title is substantial. Not only for academic degrees that are appropriate, but also other health professionals and even alternative health practitioners are routinely labelling themselves as "Doctor", much to the confusion of the public. The only time when there appears to be no contest for the title is when airline staff call urgently for a "Doctor" at 30,000 feet. It is strange how few naturopaths or chiropractors volunteer at this point. However, whatever we may feel, the title of "Doctor" is now part of the vernacular, a title with limited focus and broad application.

The College has been petitioning both the newly created Medical Board of Australia and AHPRA about the use of the word "Surgeon". However, this title is also going the way of the word "Doctor". Perhaps the writing was "on the van" as the local tree-surgeon comes to remove that unwanted and dangerous tree. The term Dental Surgeon is now well accepted. Despite the risks to public safety and despite our protests, it appears that "Podiatric Surgeon" will also be recognised. The College has made clear our concerns about the training and standards that are achieved in the United Kingdom/Australian schools of chiropody as compared to the American schools of podiatric medicine. However, the autonomy of the Board of Podiatry remains an obstacle to informed debate about proper standards of training and clinical care.

Within the Medical Board of Australia there is still substantial tension on how to appropriately recognise and title surgeons who have been trained to a recognised standard and practice in all areas. Using orthopaedics as an example, are we "Specialist Orthopaedic Surgeons" or "Orthopaedic Surgeons"? If a Fellow of the Royal Australasian College of Surgeons (FRACS) equates with a "Specialist Surgeon" descriptor then what about "Surgeons" who are restricted to Area of Need positions or Deemed Specialist positions? Most of these medical practitioners are either working towards achieving a FRACS or are restricted in scope of practice or region of practice. Are they entitled to use any title apart from medical practitioner with a specified area of clinical interest? Are they entitled to use the title Orthopaedic Surgeon or should this be annotated by the additional descriptor of "limited"?

Medical Boards are in place to protect the public and maintain standards. Surely they should take a perspective of having as much clarity for the public as possible. If a surgeon is not fully qualified then it needs to be self-evident, not given a political spin. We are advo-

The College was formed to protect the public from poorly trained and poorly regulated surgeons

"If a surgeon is not fully qualified then it needs to be self-evident, not given a political spin."

cating that surgeons on the specialist register (for practical purposes those with a FRACS) may be described, as is the current practice, by the relevant one of our nine specialties e.g. Orthopaedic Surgeon with the option of the additional prefix "specialist". There are four categories of limited registration (including Area of Need) and these practitioners should be described as, for example, Orthopaedic Surgeon (limited registration).

And then within the medical ranks we have non existent specialties being created by alliances between the media and ambitious medical practitioners. Fellows would be aware that cosmetic surgery is an area of clinical practice of non-specialist medical practitioners in desperate search of a specialty identity. The curriculum, training and assessment of cosmetic surgery is already fully covered within our surgical specialty of plastic and reconstructive surgery. However, this has not stopped the application to the Australian Medical Council (AMC) for the recognition of Cosmetic Medical Practice. Despite the lack of substance in the application, the AMC itself struggles with the political and media spin in this area. There is some way yet to go in the regulation of self-applied titles that so easily mislead the public.

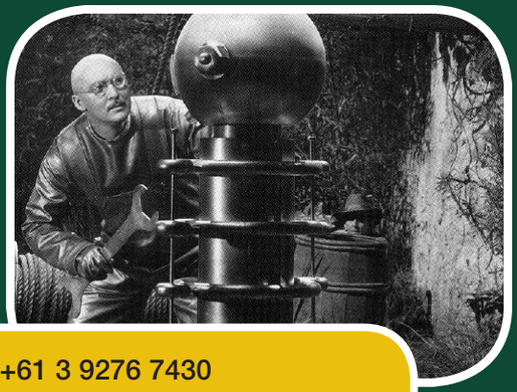
Are these abstract concerns? We believe not. There are issues of standards and costs. Access to prescription level pharmaceuticals is now broadly available to podiatrists, nurse practitioners and dentists well beyond what is required for "one-off" or "urgent" treatment. Poly-pharmacy is a potent cause of morbidity in our community. Surgery is an invasive area of medical practice that has risks of complications, sometimes very serious. There is a requirement for a high level of training, ongoing peer review and audit with continuing professional development. We need to always strive to reduce the complications, the inappropriate surgery and the exposure of risk to the public.

All of these issues are being clearly stated to the Medical Board of Australia. They are equally pertinent in New Zealand. One can only reflect on why the College was formed. It was to protect the public from poorly trained and poorly regulated surgeons. It was to establish standards and maintain them. It was to clarify what was required from training and to ensure that the community had access to good quality health care. It was to put measure and significance into the word "Surgeon".

We work within a complex world with multiple competing interests. What is self-evident to us is not shared by others and our standards and training are being buffeted by "political imperatives". The College will continue to work with all stake-holders to ensure these concerns are understood. There is still much for us to do.

INVENTORS STORIES WANTED!

If you or someone you know has invented the self retaining abdominal retractor or something like that we would like to hear from you. It can be a successful or not so successful invention in surgery. We are interested in the ideas.



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

We need stories

The need for a new College Constitution

The new constitution provides Trainees with a voice on Council for the first time

Ian Dickinson
Vice President

Time to vote

Last year I wrote in the August Surgical News of the need for a new College Constitution. While the College's existing arrangements, a Memorandum and Articles of Association dating from 1930, have served the College well, I observed that they have deficiencies with regard to compliance with modern corporations law, with the modern operations of the College and are, to some extent, a patchwork of amendments which have been required over the years.

Fellows now have the opportunity to vote on the new Constitution, so I thought it appropriate to revisit the arguments I made last August and encourage you to support the proposed changes.

The Governance and Advocacy Committee (GAC) has had carriage of the process by which the memorandum and articles were reviewed and a modern constitution developed. GAC's initial step was to approach Mr Michael Gorton of Russell Kennedy solicitors to undertake a legal review and supply GAC with a first draft of a document which complied with current corporations law and provided the College with a sound platform for the future.

Over the next several months, GAC revised this draft, working on the principles that it should be written in plain English and with a minimum of "legalese". GAC also consulted widely during this time, seeking feedback from Council, the surgical specialties, the Court of Honour and all Regional Committees.

The draft constitution was approved by Council at its June 2009 meeting and has for several months been available on the College website for Fellows to review.

What's changed?

The first thing Fellows will notice is that the language has been thoroughly modernised and that the proposed constitution is written in plain English. Terms belonging to an earlier era such as "thereupon" and "forthwith" have been removed from the new version.

The proposed constitution has also been reduced in scope. Operations of the College will be underpinned by a set of strong regulations dealing with many day to day matters while still ensuring that sufficient protections are built into the document to care for the overall College and ensure the rights of Fellows.

This has been done to ensure the College has the flexibility to deal with altered circumstances without having to refer frequently to Fellows through referenda to change the constitution. Fellows can be assured, however, that such fundamental matters as the composition of Council and the rights and privileges of Fellowship are enshrined in the constitution and can only be changed by a referendum of the Fellowship.

Regarding alterations to the constitution, the document proposes that the number of Fellows required to change the constitution be reduced from three quarters of those voting to two thirds. A further protection of only allowing change to the constitution by a vote of the whole Fellowship has however been added. This is an important protection as the existing articles allow for alteration of the articles by a vote of those present at an annual general meeting or special meeting. So while it is proposed to reduce the number of Fellows required to change the constitution, we do ensure that it will always be at a ballot of all the Fellowship.

Fellows will note that the proposed constitution commences with a series of clauses outlining the purpose of the College and the

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manner in which the College will effect this purpose. This was largely covered by Clause 2 of the Memorandum of Association. This section however, also contained a number of mechanistic clauses relating to the land and property of the College and the College finances. These are now contained elsewhere within the body of the new constitution.

The new constitution expands on the concept of the College purpose and how to effect it, focussing more on surgical standards, education and training and various forms of advocacy. This is a conscious decision by GAC to separate the ambitions of our College from the more routine operational aspects.

Articles 19 and 21 have been removed from the proposed constitution and will be handled by regulation. This proposed arrangement will allow Council to make the necessary alterations to the regulations without the requirement of a constitutional referendum.

The new constitution provides Trainees with a voice on Council for the first time. It is proposed that there would be a Trainee Co-opted Councillor who will have the same rights and privileges (excepting the right to vote for office bearers and other Council positions) as other Councillors. This elevates the standing of the Trainee representative from an observer to a co-opted Councillor and will give Trainees a greater say in the decision making process of Council. After all, for most Trainees this will be their College in the future.

There have been two small, but significant, changes to the terms of Councillors and the President. The new constitution caps the number of terms a Councillor may serve as President to two and ends the practice of a potential 10th year on Council. In future, no Councillor will be able to serve more than nine years. GAC and Council viewed this as an important step in ensuring new blood and fresh ideas were regularly being injected into Council.

> *"The new constitution expands on the concept of the College purpose and how to effect it, focussing more on surgical standards, education and training and various forms of advocacy."*

What's stayed the same?

While the elements outlined above are some of the more significant changes, a number of fundamentals have been retained from the articles and are reflected in the proposed constitution.

For example, the balance between Council and the Executive has been retained. It was viewed as important that a Council which fully represents the specialties and Fellowship should retain the fiduciary responsibility for the College. Therefore, there will be 16 Fellowship elected Councillors (formerly known as generally elected) and nine specialty elected Councillors.

Executive will remain as a committee of eight Councillors (the five office bearers and three Councillors elected by Council) with the full powers of Council delegated to it.

The current names of all office bearers: President, Vice President, Treasurer, Censor-in-Chief and Chair of the Professional Development and Standards Board have been retained.

The proposed constitution also ensures that there will continue to be a minimum of two New Zealand resident Councillors, however, this Clause has been expanded to ensure that there will also be a minimum of two Australian resident Councillors.

Regulations

GAC, in conjunction with College staff will conduct a thorough audit to ensure that sufficient regulations exist to cover any gaps which may arise should Fellows vote to adopt this new constitution. While the College already has over 600 policies, these may require slight modification or more substantial redrafting to reflect the new arrangements. In some cases whole new policies/regulations will require drafting.

For example, Clause 7 of the articles defines the manner in which Councillors are elected. No College policy exists to mirror this clause and therefore one will need to be written.

The College needs YOU!!

I would like to thank my colleagues on GAC and those College staff who have worked very hard to develop the proposed constitution. I would also like to thank the many Fellows I have met and spoken with about these matters. Both the President and I have seized every opportunity in recent months to speak at College events about the need to update the College's governance arrangements.

It's now over to you, the Fellowship. I urge you to support the new constitution, and help make the business of training the next generation of surgeons, and ensuring the preservation of surgical standards, even more efficient and effective.

Doctors need Doctors

It is important for all doctors even Professors of Surgery, to have a GP

I.M.A Newfellow

Last month I wrote about retirement of surgeons and mentioned that Mr. Nit Picker had recently turned 65. Sometimes events take a strange course – he developed an acute illness that required surgery and he finished up on the wrong side of the sheets. As he lives in my town I wondered if I should visit him in hospital. Eventually I decided to do so as he was, after all, a fellow Councillor. I have never felt close to him at all. Now the whole meeting was somewhat unusual (other than the pattern on his pajamas and his dressing gown colour).

He looked different in bed and was so compliant with the nursing requests. However, it was what he talked about that was interesting. His condition (and I dare not reveal what it was as this would reveal who Mr. Nit Picker really is – and me for that matter!) was detected by his General Practitioner (GP) during a routine visit. Now Mr. Nit Picker gave me a diatribe on how important it was for all doctors, even Professors of Surgery, to have a GP. He talked about blood pressure monitoring, prostate specific antigen (PSA) checks, health advice and stress management and what a vital role a family doctor has in this equation. He was so vocal that I thought that Mrs. Newfellow had been talking to him as she has been saying the same thing recently.

In any event he had done some research on the issue and found that fewer than 40 per cent of registered doctors have their own GP. He also found that doctors suffer from drug addiction, alcoholism and stress related mental health issues at a higher rate that the population as a whole. Some Medical Boards take a very strong line on doctors' health, self-prescribing and self diagnosis.

He also told me how to find a GP. Ask friends and colleagues and choose someone who is "old enough to know and young enough to see you out". His GP was actually someone that he had recommended to his wife who (wisely?) refused to take his advice regarding such matters as flu vaccinations, skin lumps and secret women's business. Eventually Mrs. Nit Picker, whom I believe is a strong personality, pushed him into seeing her GP also. There is a sting in the tail of this tale. Mrs. Nit Picker and Mrs. Newfellow play bridge together so I think that my days of "no GP" are very limited.

I was also pleased to hear that when Mr. Nit Picker was wheeled into the operating theatre, dopey with drugs and no doubt a little apprehensive, he was able to point out to the theatre staff that his name on the whiteboard was spelt wrongly – it was not "Not Picker". It is good to hear that even mind altering drugs did not dull his ability to pick nits.

YOUR COMMUNICATIONS NEEDS SURVEY

iPhones / Social networking / e-Learning / Web conferencing ...

Modern communication technologies are bringing a world of new possibilities to us all. The College has set up a working party to drive the new communications agenda and make recommendations on the way forward. This issue of Surgical News contains a short survey (less than five minutes to complete) seeking your views and priorities for allocating resources in the next 12-18 months.

The communication needs survey is available online, making it quick and easy to complete. The link to the survey is on the front page of the website **www.surgeons.org**
Print responses should be faxed to +61 3 9249 1275 or posted to the Royal Australasian College of Surgeons at 250- 290 Spring Sreet, East Melbourne VIC 3002 Australia
Please call the Library on +61 3 9249 1272 if you would like to discuss any aspect of the survey.

THANKYOU FOR YOUR TIME!

Employers' Rights to Employees' Inventions

A recent court case has cast doubts on the ownership of intellectual property

Paul Gleeson & Craig Subocz
Russell Kennedy Solicitors

Key Points

- Patent ownership may depend on whether employees are under a "duty to invent"
- Employers should review their employment contracts to determine whether their employees are under a "duty to invent"
- Third parties will need to exercise due diligence in any agreement with institutions to commercialise inventions

Introduction

In University of Western Australia v Gray (September 2009), the full Federal Court of Australia confirmed that universities and other non-commercial research institutes (institutes) are not necessarily entitled by law (in the absence of an express agreement) to own the patents derived from their employees' inventions. Institutes will only be entitled by law to own such patents where their employees are under a positive "duty to invent" for the institute's benefit.

Institutes should examine their employment contracts and review the ownership of their current patents portfolios. Collaborators should be careful when entering into commercialisation arrangements with institutes. Even private sector companies which earn revenue from their employees' inventions should carefully review their employment contracts.

History and background

For 15 years, University of Western Australia (UWA) employed Gray to research and teach. His employment contract never expressly addressed intellectual property (IP) ownership. During his employment, Gray developed certain liver cancer treatments and offered UWA the opportunity to commercialise them, which UWA declined. Gray established Sirtex Medical Ltd (Sirtex) and assigned his IP to Sirtex. Sirtex successfully commercialised the new treatments.

UWA claimed that the patents and Gray's shares in Sirtex belonged to UWA on three separate grounds – regulations made pursuant to the legislation establishing UWA, a term implied by law into Gray's employment contract and Gray's fiduciary duties owed to UWA. This article concentrates on the second ground.

The Court's decision

In rejecting UWA's claim, the Court emphasised that a term will only be implied into a contract where that term is "necessary for the effective operation of that type of contract". When Gray developed the new treatments, the Court found that he was not obliged to advance UWA's commercial purposes and that he was not employed to exercise his "inventive faculty" for the benefit of UWA. Further, Gray had considerable academic freedom (which included the right to publish his research, regardless of whether publication prejudiced patent applications).

Accordingly, Gray was under a duty to research but not under a duty to invent for the benefit of UWA. Therefore, it was not necessary to imply a term that would vest in UWA Gray's IP in his inventions. UWA was not entitled to own patents derived from Gray's inventions and Gray had not breached any fiduciary duties owed to UWA.

Aftermath

On 1 October 2009, UWA issued a press release announcing that it will seek special leave to appeal to the High Court of Australia.

Implications for institutes and their collaborators

The Court's decision may create unce tainty as to whether institutes hold the rights to inventions derived from their employees' research. To minimise this uncertainty, institutes should:

- promptly review employment contracts with their researchers to identify failure to adequately vest their employees' IP in the institute and to identify their researchers' specific duties
- negotiate with the researcher to resolve the inadequacies (including, where appropriate, deeds of assignment of intellectual property in favour of the institute and to specifically oblige the researcher to use his/her inventive faculty for the institute's benefit)
- promptly review its IP policies and procedures to ensure that they are effective in all circumstances; and
- use appropriate means to promulgate its IP policies to ensure that they can be incorporated into employment contracts

Collaborators and institutes should agree on:

- the nature and extent of the collaborator's right to conduct due diligence on the institute's ownership of the patents before entering into the proposed agreement with the institute to commercialise the patents
- the nature and extent of the warranties and indemnities concerning the ownership of patents the institute provides to the collaborator; and
- whether the collaborator should obtain assignments or licences of the patents directly from the relevant employee inventor

Implications for private sector

Companies which commercialise their employees' inventions may also be affected by the Court's decision. The Court did not restrict their decision to the circumstances of the dispute. Future courts will examine patent ownership in view of the full Federal Court's decision.

Accordingly, private sector companies should also have their employment arrangements reviewed to determine whether their employees are under a duty to use their inventive faculties for their employers' benefits and act to resolve any uncertainty highlighted by such reviews.

College Conferences and Events Management

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GSA ANNUAL SCIENTIFIC MEETING AND TRAINEES' DAY

Emergency Surgery: The Cutting Edge

17-19 September 2010

Hyatt Regency Sanctuary Cove, Gold Coast, QLD

Invited Speakers:
Associate Professor Daryl Wall
Professor Michael Cox
Dr Michael Von Papen
Dr Ian Martin

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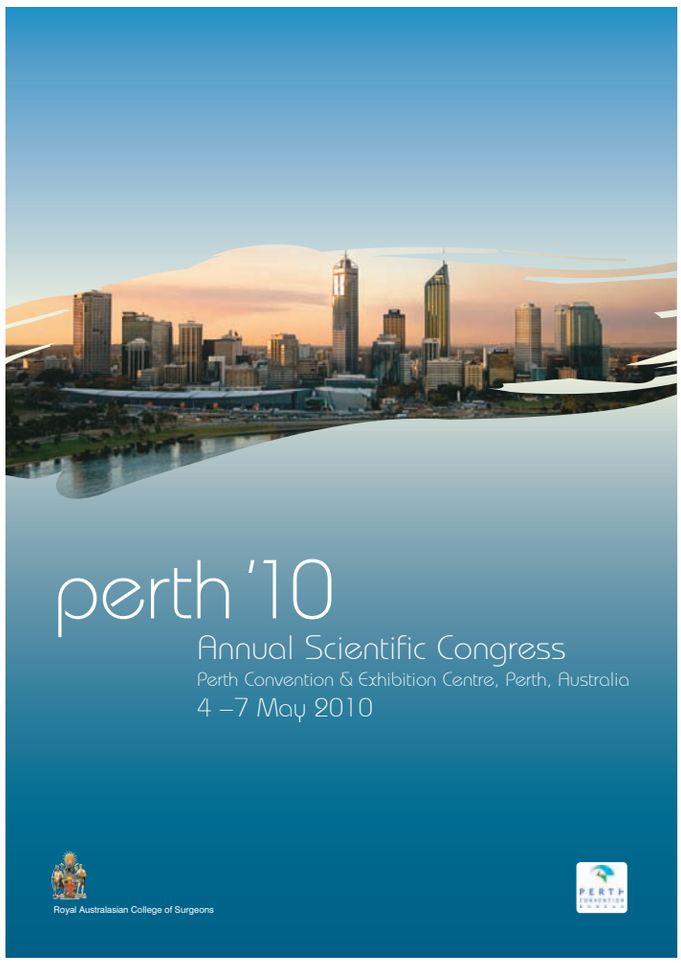
General Surgeons Australia



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Photograph courtesy of Campbell Miles

The 2010 Perth Annual Scientific Congress

The Bariatric surgery program promises to be a stimulating two day sectional meeting

Campbell Miles
ASC Co-ordinator

In May, Perth is warm, dry and inviting. Perth is the outstanding destination for the 79th Annual Scientific Congress and an outstanding starting point for a holiday before or after the conference. If you have not registered yet, you may do so via the Congress website, asc.surgeons.org.

The venue is the scenically sited, Perth Convention and Exhibition Centre overlooking the Swan River estuary. The Convocation will be held in the Riverside Theatre and the Congress dinner in the Bellevue Ballroom, both at the Conference Centre.

The scientific programs are complete, the research papers are scheduled and the conference awaits you. This year the majority of the section programs are offering a Trainee Research Prize and we expect these will be strongly contested. Posters will be displayed as electronic posters on the plasma screens in the Exhibition area.

Convocation Monday 3 May

At the Convocation at 4.30pm, the Syme oration will be delivered by Professor Jorge Imberger AM PhD, Director of the Centre for Water Research and Professor of Environmental Engineering at the University of Western Australia. At the award ceremony, an Honorary Fellowship will be conferred upon Professor Erwin Thal from Dallas and Professor John Collins, the College's inaugural Dean of Education will be presented with the Louis Barnett medal for exemplary services to education. Professor Russell Stitz, an erstwhile President of the College, will receive the Hugh Devine medal in recognition of his outstanding contributions to surgery over many years. The Devine medal is inscribed 'the highest honour that the College can bestow upon a Fellow during his lifetime'.

The Welcome Cocktail Reception follows the Convocation, at 5.30pm. Except for members of the Stage Party at the Convocation, dress for the Convocation is lounge suit and the College gown is optional.

Bariatric surgery program

Jeff Hamdorf (left) is convening the Bariatric Surgery program and he has invited as the international speakers, Dr Paul Cirangle from San Francisco and Dr Michel Gagner from New York. These names are well known in Australian and New Zealand bariatric surgery circles.

A number of themes will be explored during what promises to be a stimulating two day sectional meeting. Both visitors will fuel the fire, which has followed the sleeve gastrectomy finding its place as a primary procedure. The surgical management of Type 2 diabetes will also stimulate discussion. Trainees will be delighted to see how an expert Australasian Faculty deals with the most challenging of bariatric surgical complications during a breakfast Masterclass. Issues such as Fellowship positions in

“Perth is the outstanding destination for the 79th Annual Scientific Congress and an outstanding starting point for a holiday before or after the conference”

Bariatric Surgery and the development of International Centres of Excellence are sure to promote lively debate.

The section dinner is combined with the Hepatopancreatobiliary (HPB), the Upper Gastrointestinal and the Transplantation Sections and will be held at ‘Acqua Viva on the Swan’, a restaurant on the Swan River with an outstanding reputation for excellent cuisine.

The Section is most grateful to Johnson and Johnson Medical and Allergan Australia for their generous support for the bariatric program at the 2010 ASC.

Senior Surgeons Program

The Senior Surgeons program involves those surgeons approaching retirement and those who have already reached this milestone regardless of age. The program has now been part of the ASC since 2007. Spouses are particularly invited to attend and participate in the sessions which Gordon Baron-Hay (above) has convened. Likewise, partners are very welcome to attend the Surgical History program.

Gordon’s emphasis in his program is on retirees and their lifestyles pursued with social issues, interests and hobbies. These are factors recognised as contributing to longevity and good health. What do we owe the College after retirement is stressed by the keynote speaker Professor Paul McMenamin from the University of Western Australia Medical School. He will talk on modern anatomy teaching, a program that is enhanced by clinical personnel adding practical experience whilst the students have hands-on dissection.

There will be two talks on aspects of a more political beat, presented by Dr Rosanna Capolingua, a GP and immediate past President of the Australian Medical Association and Professor Kingsley Faulkner, past president of the College. Speakers will demonstrate that life after surgery still provides goals to achieve. Invited speakers include Bill Castleden, Tom Reeve and Stan Wisniewski amongst many others.

Congress dinner

The Congress dinner will be held in the BelleVue Ballroom on Thursday evening, 6 May. Delegates at this dinner at the 2005 meeting will remember the excellent standard of the catering for the event. This year, the outstanding West Australian soprano with an international reputation, Fiona Campbell will thrill us during the evening.

Plastic and Reconstructive Surgery dinner Delegates are asked to note that the section dinner is on Wednesday night, not Tuesday night as incorrectly recorded in the Provisional Program. The venue and time is not changed.

Medicolegal and Pain Medicine dinner Please note that this dinner is on the last night of the conference, Friday 7 May

The Congress Convener, Michael Levitt and the Congress Scientific Convener, David Oliver and their colleagues on the organising committees look forward to welcoming you to Perth and to Western Australia for the 79th Congress. Visit the website for the latest news: www.asc.surgeons.org

The Board of Surgical Research invites Fellows and Trainees to apply for the following Scholarships Fellowships and Grants for 2011.

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 Friday 30 April 2010.**
- 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 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 & FELLOWSHIPS

Award	Eligibility Criteria	Gross value $AUD	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 Research Fellowship	Open to Fellows of the College. Preference will be given to academic surgeons early in their career.	$60,000 $55,000 stipend plus $5,000 departmental maintenance.	Up to three years
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 incl: • 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 & SPONSOR FUNDED RESEARCH SCHOLARSHIPS & FELLOWSHIPS

Award	Eligibility Criteria	Gross value $AUD	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 SET 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
Sir Roy McCaughey Surgical Research Fellowship	Open to Fellows and surgical trainees enrolled in, or intending to enrol in a PhD. The research must be conducted in NSW.	$60,000 $55,000 stipend plus $5,000 departmental maintenance.	Up to three years

SPORTING CHANCE
CANCER FOUNDATION

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 **AUD$60,000** comprising AUD$55,000 in stipend and AUD$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 surgical Trainees enrolled in, or intending to enrol in, a higher degree. Applicants to surgical training are also eligible to apply for a scholarship in anticipation of their acceptance into the SET Program. They must be accepted into the SET Program by 1 August in the year prior to the commencement of the scholarship in order to take up the award.

The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department.

John Mitchell Crouch Fellowship

The John Mitchell Crouch Fellowship of AUD$150,000 is awarded to an individual, who in the opinion of the Council, is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in the field. The grantee must be working actively in his/her field and the award must be used to assist continuation of this work.

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

Criteria:

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

Applications:

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

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

NB: There is no formal application form for this Fellowship and a new application must be made for each year of application.

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 **AUD$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 AUD$50,000 will normally be awarded but more than one Fellowship may be made to a total of AUD$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 Royal Australasian College of Surgeons 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 **AUD$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 **AUD$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.

NB: 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 2011. 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 **USD$40,000**.

To be eligible, applicants must hold Australian or New Zealand citizenship and to have fulfilled all the requirements for entry into SET. Pre SET applicants and applicants to surgical training will be considered.

Preference will be given to SET Level 2-5 Trainees, Post-Fellowship Trainees, to Fellows and to serving members of the Australian Defence Force.

Travel scholarships, fellowships and grants

BEQUEST & DONATION FUNDED TRAVEL SCHOLARSHIPS, FELLOWSHIPS & 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 **AUD$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 Fellowship is open for 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 **AUD$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.

Travel scholarships, fellowships and grants cont...

BEQUEST & DONATION FUNDED TRAVEL SCHOLARSHIPS, FELLOWSHIPS & GRANTS

Hugh Johnston Travel Grants

The Hugh Johnston Travel Grants arose from a bequest of the late Eugenie Johnston. These Grants for **AUD$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.

Hugh Johnston ANZ ACS Travelling Fellowship

The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship has been established to support an Australian or New Zealand Fellow of the College to attend the annual American College of Surgeons (ACS) Congress in October 2011. It forms part of a bi-lateral exchange with the ACS and is open to Fellows who have gained their College Fellowship in the past 10 years. Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America. While there, they must:

- Attend and participate in the American College of Surgeons Annual Clinical Congress
- Participate in the formal convocation ceremony of that congress
- Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications.

This Fellowship is valued at **AUD$8,000.**

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 Royal Australasian College of Surgeons 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 **AUD$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 **AUD$10,000.**

Lumley Surgical Research Fellowship

The funding for the Lumley Surgical Research Fellowship incorporates the Edward Lumley Fellowship Fund and is supported by the Henry Lumley Charitable Trust and Lumley General Insurance Ltd, The Fellowship is designed to enable a surgical Trainee or Fellow to spend a year undertaking research in the United Kingdom. The Fellowship is valued at **AUD$60,000** plus a return economy airfare up to the value of AUS$3,000. The Fellowship is for 12 months.

Ramsay Fellowship - Provincial Surgeons - 2010

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 **AUD$20,000**); a period of four weeks (two Fellowships each of AUD$10,000); a period of two weeks (four Fellowships each of AUD$5,000); a period of one week (eight Fellowships each of AUD$2,500);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 should be forwarded to the Scholarship Coordinator, including the following details:

- 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.

NB: This Scholarship is open for travel in 2010.

IMPORTANT GENERAL INFORMATION

These advertisements are to be used as an initial guide only. Please consult the College website from 1 March 2010 at http://www.surgeons.org/scholarships.htm for detailed information about the scholarships, fellowships and grants offered by the College, relevant application forms and scholarship conditions. Scholarships 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 Sue Pleass, Scholarship Coordinator, Royal Australasian College of Surgeons PO Box 553, Stepney SA 5069. T: +61 8 8363 7513; F: +61 8 8363 3371; E: scholarships@surgeons.org for further information. **Applications close 4:00pm Friday 30 April 2010.**

Chalice Poison'd

Will I be a King Henry, a King Richard or a King Lear?

Professor U.R Kidding

Well, there it was..... As an esteemed Director of Surgical Services, I was part of the next Round Table discussion with the Minister of Health. Really, he is not too bad, but the best thing I could ever say about his advisors is "wet". But back to the Minister; he said it.... "We need the clinical leaders to show leadership."

My first response was to choke on part of the muffin I had been enjoying. It had tasted quite nice. Red and going blue in the face, I stumbled out of the room before the willing around me demonstrated their cardiopulmonary resuscitation skills (or lack thereof!). Outside, in the ante room, I self administered a Heimlick Manoeuvre to the detriment of the carpet

With composure, I regained my seat. I thought I had been demonstrating leadership when I was overhead saying some very truthful comments about Government waiting list policy. The Minister's advice at that time was best summarised by Shakespeare, being **"Men of few words are the best men".** (King Henry V, Act III, Scene II). However, I would never have put the Minister's words directly into print.

Leadership is a difficult concept to explain, let alone define. It means different things to different people. The Minister's concept, however, is clear - **"Once more unto the breach, dear friends, once more…"** with a good dose of **"We few, we happy few, we band of brothers"** (King Henry Act IV, Scene III).

One thing for sure, when I go back to the Heads of my Units meeting, leadership is always a good discussion point. Everyone is in agreement - there needs to be a lot more of it. There needs to be effective clinical leadership of the health sector. But defining what this means and how it is to be enacted is more difficult. Maybe the politicians and career bureaucrats may be able to decide on exactly what needs to be achieved, but I am not holding my breath. Where is the vision? We believe it is high quality patient care. Yes, we do acknowledge that resources need to be thought about and made to last the distance. But good quality patient care would be nice to get into all those "vision statements". And then there is the issue of control. Is control an essential element of leadership? Or is control, in fact, an impediment to leadership? Does leadership require an identifiable enemy and not the nebulous inertial cloud that is healthcare?

However, the systems are really suspect. I must admit that the College has shown a bit of leadership in encouraging surgeons and hospitals to think of different emergency surgery models. Somewhat amazingly, the College showed leadership... Somewhat amazing that the dead hand of the bureaucracy in New South Wales empowered surgeons to think through and actually implement better models... Maybe they have something going on there after all. Now the College got in on the act and encouraged the review of models from across the country. Certainly emergency surgery needs a better approach. Doing cases at midnight, which should have been done eight hours earlier, is always a recipe for complicated outcomes. I still feel tired from two nights ago...

Then there was that workshop designed to encourage communication between surgeons and medical administrators. Thought it was a plot, myself. One thing to be a Director of Surgical Services and talk with lots of surgeons; totally different when you need to form cohesive teams with the administrator teams. Now that is worthy of a Shakespearean tragedy. Makes all the political innuendo of Julius Caesar look tame. However, the point of leadership is that it needs to be done and done repeatedly. Mind you our administrators do not stay in their role all that long, so you can always change the rules of the game...

What else was the Minister saying? My mind had drifted off. Fixing emergency surgery, working cohesively with management... He was talking about cafes? What was that again...Vamp? No, he was into the culture of the health sector and using the tragedy of the suicide from that café to highlight the dilemmas of bullying and harassment... And again those words of "we want the clinical leaders to show leadership..." Amazing how everyone had gone a bit quiet. Was it the reflection of the tragedy within the hospitality sector? Was it reflection that we have surgical Trainees who also commit suicide? Was it that last discussion on the ward where I was a bit cranky? I really need to go back and apologise. I was tired, I had been up all night and even my better half had said I was like a bear with a headache. Still as they say "no excuse". I had better go back and apologise. I do not want to be viewed as a Hamlet being unstable and a dangerous loose cannon. That role should be reserved for politicians.

Yes, leadership. So many things to address in services, standards and culture... Will I be a King Henry, a King Richard or a King Lear? So many options the bard presents. One thing for sure, we need to get into it....

Medical professionals carry a burden of significant exposures to blood-borne viruses and this is on the increase.[1]

NEW Biogel PI Indicator is the only patented non-latex, double-glove indicator system that provides an immediate and clear visual warning that gives the protection surgeons and theatre staff need from the consequences of cross-infection.

It is a reflection of our commitment to your safety. But it is nothing less than you would expect from the maker of the world's finest surgical gloves.

Reference:
1. Eye of the Needle. UK Surveillance of Significant Occupational Exposures to Bloodborne Viruses in Healthcare Workers, Health Protection Agency, November 2006; p4 http://www.hpa.org.uk/infections

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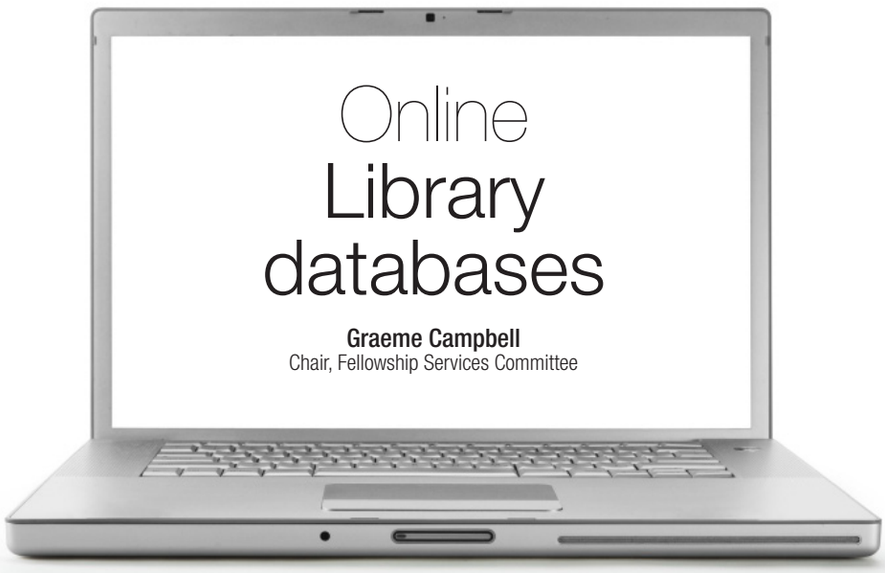


Graeme Campbell
Chair, Fellowship Services Committee

Medline

Medline is a key research tool for conducting literature searches in medicine and surgery. When you type in your keywords or phrase, a list of citations will be returned with the most recent articles first in the list. In many cases there will be a link straight through to the full text articles.

EBMR - Evidence Based Medicine Reviews

EMBR works in the same way as Medline, but results are limited to articles which are part of the Cochrane Database of Systematic Reviews and Central register of Controlled Trials, covered by the American College of Physicians Journal Club, or indexed in the United Kingdom Database of Abstracts of Reviews of Effects (DARE)

ProQuest

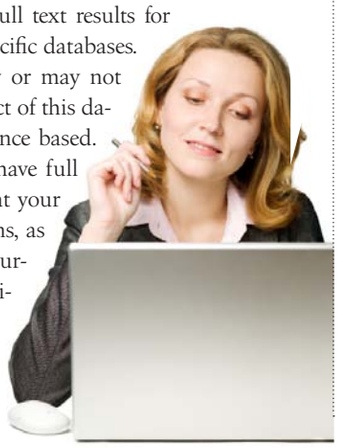
ProQuest is a database of over 1200 full text medical journals which you can search by subject. The screen prompts and search tips make ProQuest a very user-friendly tool.

MD Consult Australia

Most of the Library's online books come from MD Consult which also includes the Clinics and other key surgery journals. MD Consult includes Australian drug information and patient education tools. You can search across the entire MD Consult books and journals collection via a single search engine. Search results provide links through to the full text. MD Consult is available with an iPhone application.

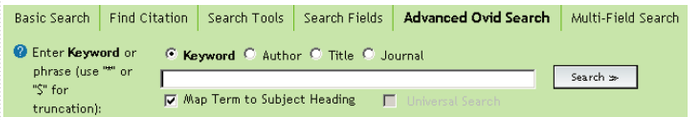
Summary

MD Consult and Proquest provide full text results for searches within the scope of those specific databases. EMBR provides citations which may or may not have full text links - the defining aspect of this database is that all results will be evidence based. Medline references may or may not have full text links, but you can be assured that your search won't miss any key publications, as all reputable medical and surgery journals are indexed by Medline. Any articles that don't have full text links can be requested from the Library.



Search tips

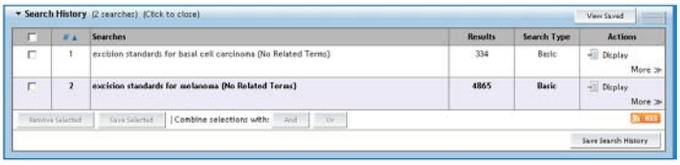
When you click on the Medline link in the Online Library, it will open with the Advanced search interface. This allows you to enter and combine multiple search terms. You can also use Map Term to Subject Heading (tick or untick the box) to use official medical subject headings and sub categories, if you wish to.



The alternative is Basic search which uses natural language, meaning you can put in a phrase like "excision standards for melanoma" and get relevant results without needing subject headings. The results are ranked by relevance and the first 10 will be the most relevant.

Too many results?

You need to be more specific.



When using advanced search you can add in another search term and then combine them. A recommended approach is to enter one search term at a time and then try different ways of combining them. Ten to 30 of the results is usually the right number to get a good match of relevant results.

No results or too few?

Try a less specific term. Look through the broader results until you find one that you like, Display it and check the Complete reference to see what subject headings are used. You can then click on and use these subject headings to get further relevant results.

You can always click on the Ask a Librarian if you'd like advice on your search.

Findings from VASM audit

Our objective is to review if the treatment provided to individual deceased patients might have been improved and changed the outcome

Colin Russell
Clinical Director, VASM

The Victorian Audit of Surgical Mortality (VASM) commenced auditing surgical mortality in Victorian public hospitals in January 2008. This report represents data collected to the end of June 2009. Our initial focus was to gain the support and participation of our surgeons and hospitals. This has been successful with all but a very few hospitals signing up and 679 (71 per cent) of 955 Victorian Fellows agreeing to participate, with more than half wishing to be assessors. Actual participation of surgeons, as measured by timely completion of the necessary audit forms, is approaching that in other states. However, compliance in completing all necessary fields in the various forms can still improve. In the critical care section, one field was left blank in 189 case reports. This has prompted a proposal to review that question.

Over the 18 months to the end of June, hospitals have notified VASM of 1,458 surgical deaths. The many rate-limiting steps in the audit process mean we have only completed the audit process in half of these cases. The clinical information on which we base our review was generally provided by the treating consultant themselves and not junior medical staff. The quality of the data provided has sometimes been disappointing, with assessors commenting on the inadequacy of the information provided in one quarter of the audited cases. This precipitated a second-line assessment in 35 (4.9 per cent) instances, to ensure clarity of events around the death.

The majority of surgical deaths occurred in elderly patients with underlying health problems, admitted as an emergency with an acute life threatening condition often requiring surgery. The actual cause of death was often linked to their pre-existing health status in that the cause of death frequently mirrored the pre-existing illness. Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved, not the treatment provided.

"The majority of surgical deaths occurred in elderly patients with underlying health problems."

This audit would suggest that venous thromboembolism prophylaxis is still not provided to all patients who might benefit. Provision of critical care support to patients was not always perceived to be ideal. The information provided does not tell us the reasons.

A consultant surgeon performed the majority 475 (63.5 per cent) of operative procedures. This bias to senior operators is appropriate for this high risk group of patients. However, consultant presence at subsequent and unplanned returns to the operating room was perhaps lower than desirable.

There were no criticisms of patient management in 518 (71.1 per cent) of audited cases. The peer-review process did find faults in the management of 200 (27.9 per cent) of the audited cases. In the majority of these instances (58 per cent), the comments were mild (areas of consideration). However, we must acknowledge that in 33 (4.6 per cent) patients, the peer-review process concluded significant errors (adverse events) in management had occurred. The individual criticisms have been directed to the treating surgeons for their reflection. In two instances, the treating surgeon successfully appealed what was seen to have been an inappropriate interpretation of what actually occurred.

Delays in referral to a surgical unit were frequently commented on. This indicates there is an opportunity to improve the timeliness of referrals to surgical units. It is surely better to consult early, even if in error, than to delay and miss the opportunity for an optimal outcome. Adequacy of preoperative investigations and postoperative care were also frequently cited.

Our objective is to review surgical deaths and assess if the treatment provided to individual deceased patients might have been improved and changed the outcome. Where treatment was adjudged to be less than optimal, feedback is provided directly to the treating surgeon. This achieves another objective, that of being educative rather than punitive. Another primary objective is identification of systemic issues and adverse trends in surgical care. Identifying issues like VTE prophylaxis is an example where improvement can perhaps improve outcomes.

Mortality reviews such as VASM employ the 'accidental death construct' as a window into quality in surgery. We must remember that there are many pitfalls in interpreting the outcome of such audits. Paramount among these is the risk of over-interpretation and creating false expectation of potential gains. I would draw your attention to the excellent review on this topic by Brennan et al (1).

We will, however, require some 'tincture of time' to achieve meaningful analysis of trends in surgical mortality. Overall it is our perception that we are slowly attaining our goals.

REFERENCES
1. Brennan TA, Gawande A, Thomas E, Studdert D. Accidental deaths, saved lives, and improved quality. New England Journal of Medicine 2005; 353(13):1405-9.

The 2009 Graham Coupland

"The Ups and Downs During the Establishment of the Sydney Cochlear Implant Centre"

The following completes the speech delivered by Professor William Gibson, New South Wales Fellow, in 2009. The first part of the speech was published in last month's Surgical News.

In 1987, I performed my first implants on young children in gross contradiction to the wishes of The Profound Deafness Study Group. The first three were children deafened by meningitis and included Holly who went on to get honours at the University of Sydney and is now a lawyer.

The first congenitally deaf child aged five years was called Pia Jeffery. Her switch on was enchanting and was published in papers all around the world, but I received a barrage of mail condemning me for what I had done.

The Profound Deafness Study group was disbanded by Professor John Yu. The publicity however was excellent from the fund raising viewpoint. The Hon. Peter Anderson as the Minister of Health gave the Royal Prince Alfred Hospital (RPAH) funding so we could do 10 public adults each year. The Yenebis family donated money to The Children's Hospital at Camperdown to build a cochlear implant centre and Dr Yu agreed to build this on the third floor of Wade House. Together with the research fellow, Christopher Game and the engineer, Halit Sanli, the centre was designed specially for cochlear implant use.

However, the opposition from within the hospital from the audiologist, paediatricians and a social worker was overwhelming and Dr Yu decided after the centre had been completed that it could not be used as a cochlear implant centre and that the area should be used for audiology. I found out later that the Yenebis family discovered that cochlear implants were not to be included and had withdrawn their donation. The hospital administration was not amused.

In New South Wales at this time, there was only one state school teaching deaf children orally; this was Chatswood public school which had an OD unit run by Maggie Loaney and Sylvia Romanik. The other oral institutions were The Shepherd Centre and St Gabriel's School, but these were all under political pressure to support Deaf culture and to teach the children sign.

As we had several pupils at Chatswood, we began by using a cupboard outside one of the classrooms to keep the equipment and during the lunch hour we used a classroom to program and teach the children. After the first four children, I went ahead and rented a nearby house in Anderson Street. The Honorary Peter Collins was the Minister for Health and he visited and gave us a grant to staff the house and to provide devices for 10 children each year.

At this stage two major 'downs' occurred. The senior teacher of the deaf decided to take control of the program and to stop increasing the number of implants, but to research in detail the children already implanted. After a power struggle, I persuaded her to resign and take a non-clinical research role.

About one month later, I was summoned to Dr Yu's office as she claimed I had wrongly dismissed her and illegally changed her job description. Her claim was overruled after an inquiry and she resigned from the program. Two months later, I received two auditors in my office and I found out I had been accused of misappropriating The EAR Foundation funds.

A major committee of inquiry was set up under Professor James McLeod. For four months, I had to reveal everything I had done to the committee and every dollar spent was checked. I felt fairly secure as I had never even claimed a bus fare from The EAR Foundation, but I knew if I had inadvertently made an error I could lose my job and I would probably have to return to England. Eventually, after several stressful months, it was determined that every dollar was spent properly and the inquiry even found some funds which had been misplaced and put in other department's funds.

The other crisis was that I was accused of running a brothel in Anderson Street. The neighbours had seen the young women going to and fro from the house and had reached a conclusion that there was a brothel in their midst. Gregory Bartels was the mayor of Willoughby, he is also the father of Kerry Chicarovsky. He came to the rescue and guided me through the council meeting, but told me that we needed to gain proper council approval for our activities in the future. The house in Anderson Street became too small so we moved to a house in Narabeen and Gregory Bartels made sure that everything was done properly.

Soon, the house in Narabeen became too small. We had increased the number of staff to eight, and we were even forced to use one of the bathrooms as a temporary office. I managed to get The Variety Club of Australia to commit to building a centre for us, which was to be in the Concord Hospital grounds.

Our Chair Bert Healy was a retired architect and designed a suitable centre, but at the last moment we were both summoned to Dr Horvath's office where her deputy Michael Wallace told us that the Concord Hospital grounds were unsuitable for such a venture. It was obviously a political decision because at the time there was an attempt to close down Concord Hospital. Poor Bert Healy was disappointed and resigned as the chair.

In 1996 two significant 'ups' occurred. Firstly the New South Wales (NSW) health department granted us the use of part of the old Gladesville Hospital. At the same time,

> *"I never imagined how rapidly everything would progress as now there are over 2,000 recipients. The success of the cochlear implant has become apparent. It is now accepted that the congenitally deaf children who receive a cochlear implant at an early age will learn to communicate so well using speech alone that they can be educated in mainstream schools."*

Right: William Gibson receiving Graham Coupland Medal from Peter Holman

Christopher Rehn was appointed as the general manager. Without his help and superb management skills, I do not believe we could have advanced. I owe him an immense debt of gratitude.

My wife and Doug Herridge spent countless hours over several weeks decorating and refurbishing the bleak old rooms and the Hon Andrew Refshauge came and opened the centre. We finally had a home for children's cochlear implants.

The RPAH cochlear implant centre had been in the basement of the residency building and became homeless due to redevelopments. After a bit of persuasion, I was able to move The RPF Cochlear Implant Centre to the Gladesville site. For a while the children's and the adult's programs remained separate, but I was very pleased when finally the programs were merged as The Sydney Cochlear Implant Centre (SCIC). By 1998 we had about 500 recipients of cochlear implants.

I never imagined how rapidly everything would progress as now there are over 2,000 recipients. The success of the cochlear implant has become apparent. It is now accepted that the congenitally deaf children who receive a cochlear implant at an early age will learn to communicate so well using speech alone that they can be educated in mainstream schools. In NSW, signed English has been totally abandoned for younger children. Every school in NSW teaches the children orally except for one school at North Rocks which offers Auslan (Australian Sign Language). This is mainly for the children born to Deaf parents, although many Deaf parents now ask for their deaf children to receive a cochlear implant.

Furthermore many more deafened adults are requesting cochlear implants so they can return to work, socialise and enjoy family life. The oldest recipient was 93 years old.

How things have changed from the early days of struggle!

Today, Sydney Cochlear Implant Centre (SCIC) at Gladesville has 40 staff members including four surgeons, another SCIC centre in Newcastle has been established with eight staff members and four surgeons, and there is a new SCIC centre in Canberra with three staff members with one surgeon. SCIC has recently opened another centre in Gosford and we are associated with a very special centre in Bronte, The Matilda Rose Centre, which caters for children with other significant disabilities. SCIC also outreaches every major town in NSW as well as Darwin and offers services to nearby developing countries.

To state that I am proud of this development and grateful for all the help I have received is obvious. It will be very sad for me when I do eventually retire, but I now know that the struggles of the early days were worthwhile and SCIC will continue long after I have left.

Community interest in the survey and eye testing is high, with all these community members coming to watch the survey team in action in Oecussi.

East Timor Eye Program

The new study will demonstrate the emotional effects of surgery on patients and their families

With age-related cataracts now the greatest contributor to blindness in East Timor, the College sponsored East Timor Eye Program (ETEP) has designed and implemented a study to assess the impact of its ophthalmic surgery service upon both individual patients and the broader community. Having now conducted more than 3,300 cataract surgeries and as the only major organisation providing surgical eye care services in East Timor, ETEP surgeons both there and in Australia have designed the study to allow them to see beyond the clinical effects of the surgery to the wider social and economic impact of the program.

The study is being conducted as a joint initiative of ETEP, the AusAid-funded Australia Timor Leste Program of Assistance for Specialist Services (ATLASS) and the Prasad Eye Institute in India. Throughout 2010, the study aims to recruit more than 250 age-related cataract operated patients through the ETEP programmes at Dili, Maliana, Baucau and Oecussi to not only determine the success of the surgery in relation to sight restoration, but also to determine quality-of-life improvements related to the surgery.

As such, patients will not only undergo follow-up examinations to determine visual acuity after cataract surgery, but will be asked to respond to a detailed questionnaire to determine if the quality of their lives have improved since the surgery. Participants will complete the survey questions both before and after surgery to determine the severity of cataract blindness and the degree of improvement following surgery in relation to everyday life matters such as, among other things, handling money, being able to conduct their usual work, to differentiate colours or to see sufficiently to walk safely.

Patients will be selected based on such criteria as being aged over 40 years, having an age-related and operable cataract and having had no previous cataract surgery. At the outset of their involvement in the study, each patient will be seen by a qualified Australian optometrist or eye care nurse who will conduct an examination to determine visual acuity, how to best correct visual acuity (spectacles or surgery) and to determine the extent and type of lens opacity (cataract) and operability as well as the presence of ocular co-morbidities. Then locally-recruited interviewers will lead the chosen study participants through the questionnaire.

Ophthalmologist Dr Nitin Verma, who started the program with a group of volunteers shortly after the country's hard-won independence in 2000, said the study was vital in determining if the program was achieving the best outcomes for the most people.

"When you first go into a country in need you sort out the problems as best you can as they present, you do the cases, you help as many people as possible as quickly as possible. Then after a few years you hopefully get into a position where you can analyse the delivery of the service," he said.

"This is a Beneficiary Study to look at the extent of the impact in the community of the East Timor Eye Program, to ask if there are ways we can improve the service, to find out if there are groups of people who need a different approach or are missing out."

Dr Verma, who is based in Hobart, but who visits East Timor up to three times a year, said that the study could show a need for more information to be given to patients or more follow-up provided. For example, some people believed the surgery to have failed if they suffered a deterioration in their eyesight over following years due to other eye diseases without understanding the fact that the deterioration could again be treated.

He said that the personal impact of age-related cataract surgery went beyond the ability to recognise more numbers on a chart following that surgery and that the study, the first

sgocsdgop

Left top: Testing visual acuity one month after surgery in Community health centre Oecussi.

Left bottom: Eye care nurse from Oecussi hospital (Mr Lazaro) and beneficiary study interviewer (Mr Jose) administering a survey questionnaire in a remote village in Oecussi as part of the follow up questionnaire.

Below: Interviewer Jose, gives pre-surgery questionnaire to cataract patient in Maliana Hospital. The young boy pictured has been this man's guide as his sight deteriorated. Following the surgery he will be able to walk home unassisted.

of its kind in East Timor, would measure that broader impact. In particular, the study could measure the emotional and functional effect of the surgery both on patients and their families.

"Quite obviously the blind can become depressed which is obvious in the change brought about in them when they get their vision back. And while elders are honoured in East Timor, many can be left alone all day simply because everyone is so busy working to sustain the family which makes them feel a burden because they cannot contribute, " Dr Verma said.

"At the same time this surgery has broader implications outside a clinical setting in that some patients work outside and others do close work, some may need glasses while others may not. There is little point, for example, giving someone back long vision if they need to sew or they are a fishermen who needs to thread hooks so the questions we are asking seek to answer whether the patient is able post surgery to do what they need to do.

"Cataract surgery is not much good to older people if they can see more numbers on a chart, but they are still unable to make a living or contribute to their families in the way they would wish."

Dr Verma said such studies as this were rarely done giving it great value and said program co-ordinators and surgeons hoped to have it completed later this year with results published in a medical journal.

"We have conducted so many cataract operations that we have enough information to look back on what we have done and this survey will help us know what more can be done. We have conducted clinical analyses over past years so that while we know all about the spectacular successes and the failures we don't know how the program affects the average patient, but this study will give us that crucial information," he said.

Ophthalmic surgeon Dr Girish Naidu, one of three eye surgeons based at the Hospital Nacional Guido Valadares in Dili, will be supervising the study as it rolls out over the course of this year, working alongside Dr Marcelino, the national ophthalmic surgeon whose training was supported by the College, Foresight Australia and Royal Australian and New Zealand Opthalmologists at the University of Sydney.

They plan to recruit patients not only in Dili, but through their outreach services located in the four other districts of East Timor. He said 65 patients had already been recruited with age-related cataract patients showing great enthusiasm to become involved.

Dr Naidu, who has worked for the College's East Timor Eye Program since January last year said he was delighted that funding had been made available, not just for the vital cataract surgery, but for the study to allow improved understanding of the impact of the surgery on the people of East Timor.

"There is still a huge backlog of cataract patients needing surgeries in East Timor especially in the subdistricts and surrounding villages. We still see patients with mature cataracts with very poor vision restricting their routine activities, but while we work to get through that backlog we still want to know if we could improve how we offer the service," he said.

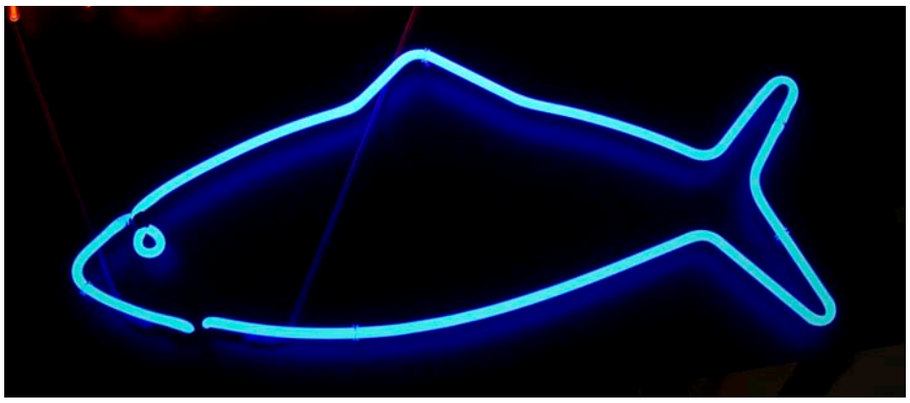
"The study should throw some light, for example, on the difficulties faced by local people in accessing our services – whether there are transport or economic difficulties or social hindrances that we are not aware of, but that could be addressed. It will also help us to know exactly what the patients feel about our services.

"The College supports (along with other supporters) the East Timor Eye Program which is the principal organisation which provides surgical eye care services in East Timor and I am very pleased the College is funding both the program and this current study which is the first of its kind here and I am proud to be working for such a program."

Preparation for Practice — Help is at Hand

Running a practice makes you a small business owner, no different to your local fish and chip shop

Jason Chuen
Deputy Chair, Younger Fellows Committee



It has always amused me that we train for so many years, only to find that at the end of all of this training we are allowed to start 'practising'! It is an honour shared amongst doctors, lawyers and accountants and probably reflects the fact that we work in professions where there is always more to learn.

For a young surgeon who has never set foot in a private consulting suite or private hospital, entering into 'practice' as a fully-fledged surgeon is daunting enough, let alone venturing into the dark and murky world of private practice and dealing with the vagaries of private health insurers!

Furthermore, many young surgeons forget that independent practice means exactly that - you are no longer sheltered by your hospital or your College. Annual leave, regular patient exposure and a take-home salary are things that can not be taken for granted. Just as a junior registrar must learn to trust their clinical judgement, an independent specialist must stand on their own two feet. Running a practice makes you a small business owner, no different to your local fish and chip shop, so you need to learn the skills to run your business successfully. If only there was a chapter in Last's Anatomy on small business book-keeping!

For many years, learning how to make your way post-Fellowship has been referred to as the 'Third Part' (and learning the intricacies of the Medicare Schedule the 'Fourth Part'). In 2007, the College's Younger Fellows Committee sought to make this process a little easier by publishing the Preparation for Practice Guide, which is accessible via the College website in the 'College Resources' section under 'Publications'. A new and updated version of this guide is currently in the works and will be published later this year, packed with tips and checklists of things you need to do in setting up a practice.

Preparation for Practice courses have also been held throughout the country, including Brisbane and Sydney in 2009, thanks to hard-working Younger Fellows who have volunteered their time. These workshops will continue to be offered on a regular basis; one is planned in Melbourne, September 4-5 2010. Topics covered include financial management and accounting concepts, medical marketing, dealing with health funds, setting up an office and managing staff as well as many others issues that you never knew were part of running a practice.

These workshops are a valuable way of seeing how other colleagues do things and learning essential tips and business practices from experts. The local fish and chip shop owner does not have the luxury of a College full of helpful Fellows so make sure you attend a workshop and consider yourself one step ahead of every other small business out there!

Part of the Younger Fellows Committee agenda is to help members develop their practice and careers as a whole and this includes focusing on those non-technical competencies that can be under-represented during formal training. A range of workshops are available (see a list under 'Professional Development' in the 'Fellows' section of the website), but we are always on the lookout for areas that are useful for Younger Fellows - so forward your ideas to PDactivities@surgeons.org

2010 professional development workshops

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

Sustaining Your Business

26 - 28 March 2010, Sydney

Effective business and financial planning is more important than ever for both private clinical practices and the broader health service delivery environment. This 2½ day workshop provides the foundation for the development and implementation of business plans to sustain business growth and performance. It 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. *This workshop is one of three entry points for the Advanced Diploma of Management*

Leadership in a Climate of Change

18 June 2010, Melbourne

This 2½ day workshop aims to develop your understanding of how to be an effective leader in the 21st century. It focuses on leadership styles, establishing and maintaining effective working relationships, managing the performance of others and managing issues effectively in a vibrant work environment. Prior to the workshop, you will complete an online behavioural inventory called the DiSC profile that will generate a specialised report on your leadership attributes. An interactive debrief session will be incorporated into the workshop. In addition, the workshop will present activities, case studies and opportunities for dynamic discussion and dialogue on each of the topics. You will also explore behavioural preferences for a range of leadership styles and be offered challenging insights about leader behaviour in relation to perceptions of the environment.

Surgical Teachers Course

25 - 27 March 2010, Melbourne / 12 - 14 August 2010, Newcastle
21 - 23 October 2010, Adelaide

The Surgical Teachers Course builds upon the concepts and skills introduced in the Supervisors and Trainers (SAT SET) course. An educational framework provides an effective guide to planning teaching episodes; from needs assessment and goal setting to the instructional methodology. The comprehensive curriculum is delivered over 2½ day and aims to enhance the educational skills of those with a keen interest in the teaching and assessment of surgical Trainees. Participants are also encouraged attend a Supervisors and Trainers Course (SAT SET), a forerunner to the Surgical Teachers Course.

SAT SET Course

20 April Melbourne / 3 May Perth / 24 May Wellington / 3 June Adelaide

This course has attracted very positive feedback from the 1000 Fellows who have attended. It clarifies the roles and responsibilities within the Surgical Education and Training (SET) program and teaches you how to use workplace assessment tools, specifically the Mini-Clinical Evaluation Exercise (Mini-CEX) and the Directly Observed Procedural Skills (DOPS). You also explore strategies for management of Trainees, especially in areas of underperformance. In addition, there is an opportunity to discuss the legal issues associated with surgical training.

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

professional development workshops

DATES: MARCH – JUNE 2010

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

NSW
24 March, Sydney Wollongong
Getting Patients Back to Work.
26-28 March, Sydney
Sustaining Your Business.

SA
3 June, Adelaide
Supervisors and Trainers (SAT SET).
23 June, Adelaide
Practice Made Perfect.

VIC
20 March, Melbourne
SET Selection Interviewer Training (Facilitator)
25-27 March, Melbourne
Surgical Teachers Course (STC).
20 April, Melbourne
Supervisors and Trainers (SAT SET).
27 May, Melbourne
Risk Management: Drafting a Consent.
18 June, Melbourne
Leadership in a Climate of Change.
26 June, Melbourne
Making Meetings More Effective.

WA
30 April, Perth (YFF)
Younger Fellows Forum.
3 May, Perth (ASC)
Polishing Presentation Skills.
3 May, Perth (ASC)
Understanding Your Patients: Become Culturally Competent.
3 May, Perth
Understanding Your Patients.

NZ
24 May, Wellington
Supervisors and Trainers (SAT SET).

Emeritus Professor Tom Reeve AC, CBE, Australian Cancer Network

More than 20 years after most people retire, this medical leader still inspires others

Reprinted with kind permission from The Australian Financial Review Magazine, February 2010.

By the time you're deep into old age, your body is no more than carcass carrying your brain around, says Tom Reeve, one of the oldest and most eminent medical figures in Australia.

Reeve believes the only way to keep yourself functioning at an acceptable level in old age is by keeping your mind alive. At 86, emeritus professor Reeve AC, CBE, is still honing his mind and still working. He doesn't do much physical exercise anymore, but cognitive aerobics keep him going. His endorphin rush comes from being intellectually stretched, challenged by younger brains and exposed to fresh ideas.

When he puts on a jacket and tie in the morning and walks 10 minutes up the hill to the train station, with a book under his arm, he feels as purposeful as ever. As he passes by the shops, he often sees contemporaries keeping their own company.

Casually dressed, they are comfortable, relaxed and involved in their own interests. But Reeve is chasing something else and he walks on. During the 45 minute trip into Sydney's CBD, he usually reads a biography unless he has to digest a scientific paper.

From Central Station, he crosses the road to his office, where he continues to make what has been described as an outstanding contribution to cancer control in Australia. Trained in general and thoracic surgery, Reeve always thought he would retire at 65 but, when that time arrived, he felt he was competent. He asked his colleagues for an opinion and they agreed he should continue. He resolved, however, to stop by 70 and, on his 70th birthday, he performed his last operation. Then he started a new career.

Reeve's father always used to say "hard work is not lethal", but the son found hard

Mary Jo and Tom Reeve

"I came to regard spending half your life in bed as being not necessary. So, during my working life, I rarely had more than four or five hours sleep. But I remember people used to get angry with me, saying I had more hours in the day than they had. The extra time was useful."

is much more than that – it is life giving. Although he had stepped back from the frontline at 60, he continued to assist a surgeon colleague for another decade or so, so he could keep up to date in his specialties of thyroid and breast surgery.

Simultaneously, he began a demanding and important day job as head of the Australian Cancer Network, based at Cancer Council Australia. His mission was to improve cancer control by creating clinical guidelines for the treatment and management of various forms of the disease. These draw on the best evidence available and constitute an immense task because thousands of published papers on each cancer need to be evaluated and graded and have their principles extracted. Strict rules of evidence must be observed and many people with different agendas and skills are involved. Consensus is essential and each set of guidelines can take years to develop.

Reeve recalls that his first attempt at his

project was a nightmare. It was like building the Tower of Babel and he doubted it could be achieved. Since then, he has driven through more than a dozen sets of guidelines with more to come. He exerts a quiet, but firm authority and has been called "the guardian of the guidelines". His age, his standing and his wisdom enable him to enter a conflict, calm all parties and resolve the issue with reason.

Personally, he has a reasoned attitude towards his own health. In his profession, he's never at a loss for medical advice and, when he needs it, he doesn't do what powerful laypeople do and look for the best name in the business. The fashionable are not necessarily the best practitioners; they are just the most fashionable. He seeks out people he knows are the most competent and experienced.

He also religiously sees his doctor every three months for a check-up. "To know I can put out my arm and have it confirmed that the medication I am taking for hypertension is working is a comfort.

"I need to know I've not gained any weight and that the pulse in my legs still work, so I can walk hands-free, as far and as fast as I like. My only problem is that I forget to drink enough water.

"My health is good, but I had a blip about four years ago. My heart rate was slowing and became tired. I was not very pleased with myself and one day I took a bit of a tumble. My pulse rate was 20 and remained between 20 and 30 for the next 24 hours. They put in a pacemaker, which changed my life. It's been a great boon because it regulates my heart and doesn't let me go below 60."

Having been a professional all his life, Reeve had never had to worry about where his next meal is coming from. He has always been comfortable, although never extraordinarily wealthy. Certainly, wealth hasn't bought him the functional longevity he so enjoys. Being happily married, socially secure and well connected within his family and profession have helped.

So has his innate rebelliousness. It puts a spring in his step. Reeve has always felt some resistance to regulation. It drives him mad to this day and he holds the view that only the weak over-regulate.

Even as a schoolboy, he didn't take too kindly to discipline. He liked to think for himself and was already labelled something of a rebel. Years later, when his medical peers went to England for further training and were accredited by Britain's august royal medical colleges, Reeve flew to the United States. When he returned years later, with his bride Mary Jo and without conventional accreditation, he had to carve his own way. Independence has kept him going, along with some good genes and a healthy upbringing.

"My mother reached 84 and her mother 89. They were Scots. On my father's side, there is a mix of French, English and Irish stock, and his mother lived to 98. She was a suffragette."

Born and bred in country Canberra, which was then a village, Reeve grew up "with plenty of space, fresh air and things to do". Always active, he has made a point of never following the dictum about a good night's rest.

"I came to regard spending half your life in bed as being not necessary. So, during my working life, I rarely had more than four or five hours sleep. But I remember people used to get angry with me, saying I had more hours in the day than they had. The extra time was useful."

Discipline and activity have kept him lean and, while he enjoys a drink, he rarely overindulges. He says Mary Jo "claims all the credit in the way she feeds me and looks after me. She's not terribly fussed about the new cuisines. She believes in vegetables and meat and ample greens."

Reeve keeps his body as healthy as he can, purely to support his capacity to think, and it's this capacity that is his biggest concern. Will he know when it's going off? Younger friends have told him not to worry and have promised that when he 'goes off the boil', they will tell him.

"Ronald Reagan knew what was happening to him and described it clearly," Reeve says. "Others have no sign or they cover it up or do a bit of both. Many older people try to delay the realisation, but, if you go back and analyse things, there were often indicators that were overlooked. This is the only thing that bothers me. When you get to my age, of course you wonder about being able to do the next thing and those around you have to realise that tomorrow you might not be here."

Nowadays, Reeve does work less. Midway though this year, he will step back from formal appointments. In the meantime, he is spending two days at the office and two in his study at home. Finally, Mary Jo has more of him and together they work in the large garden of their Beecroft home.

"Mary Jo is now 81 and we have an understanding," Reeve says. "Every night when we go to bed, we wish each other 'goodnight' knowing that if we wake up in the morning it's a bonus."

NOTICE TO RETIRED FELLOWS

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

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve. We will acknowledge your donations and place your name on the gown if you approve.

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

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

Referral to public waiting lists

There is an issue of liability for surgeons who refer patients to the public waiting list

Michael Gorton
College Solicitor

In recent years, public waiting lists, particularly for elective surgery, have significantly increased and the waiting time for some patients is extending.

There is an issue of liability for surgeons who refer patients to a public waiting list. Where a surgeon refers a patient, as a public patient to a public hospital, knowing that a waiting list will apply, the surgeon will have a responsibility to properly and fully advise the patient of the ramifications.

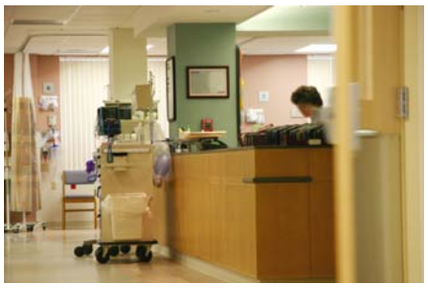
A "referral for admission" or "recommendation to admit" implies a transfer of the patient from the care of the surgeon to the care of the hospital. This transfer of care needs to be made explicit to the patient, so they understand that the surgeon is no longer immediately responsible for the care of the patient.

However, in order for the "transfer" to be fully effective, and for the surgeon to avoid liability, the patient needs to be advised of all significant and relevant information, such as:

- the current waiting time on the list,
- the possibility of waiting times expanding further,
- the possibility of deterioration in the condition of the patient,
- the risks of waiting,
- the conditions or changes which, if they occur, require the patient to immediately return to their GP or the hospital for attention,
- the options available for alternative treatment (including the possibility of private treatment).

It is generally unlikely that the surgeon will be liable and negligent if a patient's condition deteriorates whilst on a public waiting list, through no error on the part of the referring surgeon. This assumes, however, that the surgeon has fully advised the patient of the ramifications of waiting, the alternative treatments available and the need to seek immediate attention in the event of any deterioration.

Some States and Territories have extended insurance cover, or indemnity arrangements, to Visiting Medical Officers (VMO's) who arrange for referral of patients to a public patient waiting list. However, coverage will be strictly on the basis that they have an existing arrangement with the hospital, that the patient's informed consent for referral has been obtained, and the policies of the receiving hospital/health service have been observed.



Each surgeon in New South Wales should be aware of these requirements and ensure that they are fully aware of the requirements of the current health service to which they refer public patients. In New South Wales, the VMO Scheme requires indemnified surgeons to have signed the VMO standard form of contract, under which indemnity arrangements are available.

Of course, in urgent cases, it would be a requirement of good health care and quality practice that the hospital be advised of any urgent or pressing needs of the patient, as part of the transfer of the patient to the public system. In these cases, the nature of the urgency and the gravity of the situation needs to also be communicated to the patient. This is part of the process of ensuring that the patient is fully informed of the implications and ramifications of being referred to a public waiting list.

Notwithstanding access to public indemnity arrangements, surgeons should maintain their own private medical defence insurance arrangements. In extraordinary situations, advice of your insurer or legal adviser should be obtained.

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get your savings and overdraft to join forces, why wouldn't you?

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Malaysia joins the ATLS Family

The first Malaysian Student and Instructor Advanced Trauma Life Support (ATLS) and Early Management of Severe Trauma (EMST) courses were launched in January 2010 after many years of negotiation with the ATLS Sub-committee of the American College of Surgeons and College of Surgeons, Academy of Medicine of Malaysia.

Mike Hollands
Director, Malaysia ATLS EMST courses

Left: Mike Hollands and Siew Kheong Lum
Above: Trauma Malaysian trainee ATLS Coordinators

As a former chair of the EMST Committee, member of Council and American College of Surgeons Region 16 Chair for Australasia and Asia, it was an honour to direct the courses. Dr Siew Kheong Lum, Chair of ATLS - Malaysia also played a pivotal role, ensuring that an ATLS footprint would be left in Malaysia. Dr. Lum started the process of promulgation on becoming President of the Malaysian College of Surgeons. Negotiations took many years and the College played a significant role in easing the way. As Chair of Region 16, I was able to substantially reduce the costs associated with promulgation, on the way ensuring new precedents for the promulgation of ATLS.

Firstly I was able to utilise some existing Malaysian Instructors who had previously been trained in Singapore. Next the initial provider course was also held in Singapore instead of the initial Malaysian faculty travelling to Australia or the US. Finally, a multinational faculty was selected from nearby nations. Faculty came from Thailand, Singapore, Australia, and the United States. Karen Brasel, Chair of the ATLS sub-committee, was the sole American of the faculty.

Mary Lawson, Medical Educator, EMST/Care of the Critically Ill Surgical Patient (CCrISP) programs in Australasia, was invited to be the Educator. Mary worked closely with Malaysia's Educator Candidate, Professor Moses Samuel. Lesley Dunstall, National Coordinator for EMST/ATLS Australasia was involved in the training and mentoring of a team of coordinators chosen to coordinate Malaysia's future ATLS courses.

The inaugural courses took place in a facility at Sungai Buloh Hospital, just north of Kuala Lumpur, built specifically for the conduct of ATLS courses.

Sixteen students, mostly senior clinicians and leaders of the profession, participated in the provider course and represented a number of hospitals in the western peninsula of Malaysia. Nine of the 16 participants were invited to attend the inaugural Malaysian ATLS Instructor course.

International & Malaysian Faculty

At the completion of the course, certificates were handed out to successful candidates by the Senior Deputy Director of Medical Development, Dr Rohaizak. On behalf of the EMST program in Australia and New Zealand, and in recognition of EMST's assistance, I was presented with a plaque by Dr. Rohiazak. I later presented EMST Instructor T-shirts to the successful Instructor candidates. Later the Director General of Health Tan Sri Dato Ismail Merican spoke to the audience, promising on-going support for the program in Malaysia.

There is an increasing bond between surgeons in Australia and New Zealand and our regional neighbors. Courses such as EMST and initiatives such as the Weary Dunlop Boon Pong Scholarship will continue to strengthen these ties. As a consequence it is very likely that increasing numbers of Australian and New Zealand Trainees will seek further experience in our local region especially as traditional avenues such as the United Kingdom become more difficult to arrange.

The inaugural Malaysian ATLS course was well run, and I feel it will maintain the high standard associated with ATLS courses throughout the world... The present leadership has in place a succession planning, and the course has been enthusiastically embraced by the medical community at large.

"From an educational perspective, the inaugural ATLS course in Malaysia was vibrant, with many examples of active student-centred learning. The instructor candidates were among the most enthusiastic and committed that I have met. Their collective commitment to adopting interactive learning methods was inspiring and highly commendable."
Mary Lawson, ATLS Educator.

Techniques in Endocrine Surgery

Third Postgraduate Course in Endocrine Surgery

Sat 19 – Sun 20 June, 2010
The Langham, Southbank, Melbourne, Victoria

The Postgraduate course in endocrine surgery presented by Australian and New Zealand Endocrine Surgeons in conjunction with the section of endocrine surgery RACS is once again offering an exciting and informative 1½ day course focussing on the latest developments and techniques in endocrine surgery.

An outstanding faculty of local leaders in endocrine surgery and related fields is being complemented by Professor Janice Pasieka (left) from the University of Calgary, Canada. Prof. Pasieka is the current president of the American Association of Endocrine Surgeons and a world leader in endocrine surgery.

The Postgraduate course in endocrine surgery is now a biennial event for Australian Endocrine Surgeons. The course covers a broad range of topics including the latest developments and future directions in endocrine surgery. The course will provide an interactive format with presentation of interesting cases, ample question time and discussion in each session.

For registration details visit
www.endocrinesurgeons.org.au/registration

Meeting sponsored exclusively by

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63609 Staff Specialist in Orthopaedic Trauma

Division of Surgery, John Hunter Hospital

John Hunter is the principal referral centre, teaching hospital and a community hospital for Newcastle, Lake Macquarie and beyond. The hospital is affiliated with the University of Newcastle, providing training opportunities to students studying through the faculty of Nursing and the Faculty of Medicine and Health Sciences. It opened in 1991 and is the largest hospital in the region with 640 beds and is set in 132 hectares of native bushland. It incorporates the latest technology in all areas of hospital design and equipment.

John Hunter is the only Major Trauma Service (Level 1 Trauma Centre) in NSW outside metropolitan Sydney and is the busiest service of its kind in the state. There are 4500 admissions annually, more than 400 of which have an Injury Severity Score (ISS)>15. John Hunter is the only combined adult and paediatric trauma centre in NSW and provides primary and tertiary trauma services for an extended area of the Hunter, Mid North Coast and New England areas. A wide range of trauma-related specialty surgical services are available.

Co-located onsite is the $100m state of the art Royal Newcastle Centre. Opened in April 2006, this facility caters for a wide range of clinical conditions and ambulatory care (outpatient) services and includes operating rooms, overnight and day wards. Representing the future of health care, the use of technological advances and less intrusive procedures reduces the need to admit patients to the hospital.

The Staff Specialist's role includes the development, implementation and evaluation of trauma system protocols which meet the needs of the patient from pre-hospital through to rehabilitation. The successful applicant will be eligible to apply for a conjoint appointment with the internationally renowned University of Newcastle School of Medicine.

Applicants must have a medical degree registrable in NSW and possess Fellowship (RACS in Orthopaedics, General Surgery or Traumatology) or specialist recognition as provided for in the Salaried Senior Medical Practitioner's (State) Award or the Health Insurance Act 1973.

For a confidential discussion about this challenging & exciting opportunity contact:
Prof Zsolt Balogh, Trauma Director, Division of Surgery, John Hunter Hospital
ph: 02 4921 4259
e: zsolt.balogh@hnehealth.nsw.gov.au
Mr Damien Barrett, Senior Consultant, Medical recruitment
ph: 02 4922 3363
e:damien.barrett@hnehealth.nsw.gov.au

Closing Date:
30 April 2010

HUNTER NEW ENGLAND
NSW HEALTH

A new Chair for the Committee

The Annual Scientific Meeting held in November was a success for the ACT

Carolyn Cho
Chair, ACT Regional Committee

In July 2009 I was pleased to take over the Chair position of the College Australian Capital Territory (ACT) Regional Committee from Mr Chandra Patel. I thank Chandra for his work during his time as Chair and his ongoing contribution to the ACT Regional Committee. During my time as Chair, there have been several developments and significant events in the ACT.

National Registration and Accreditation

As with other states, there was ongoing debate last year in the ACT between relevant stakeholders and the ACT Government regarding National Registration and Accreditation and "draft bill B". The ACT along with other states and territories will await with interest the result of the bill, which is before two state parliaments at present.

Surgical Safety Checklist

On the 19 August 2009, Professor Ian Gough with Nicola Roxon, the Federal Minister for Health and Ageing launched the Surgical Safety Checklist at Parliament House. This event was attended by several members of College Council as well as members of the ACT Regional Committee. Of note, the Surgical Safety Checklist has already been implemented successfully in ACT private and public hospitals for approximately two years and ACT Health is continuing to incorporate this checklist into existing policies and procedures.

Surgical Audit

Good progress has been made in the development of the ACT Audit of Surgical Mortality (ACTASM). This has involved collaboration between the College and ACT Health. To date, a part-time data manager has been appointed, who will work three days per week. This data manager is based at the ACT regional office, where the secure database will be stored. The Director of ACTASM is yet to be appointed. This appointment will be through an interview process and nominations for the role will be advertised among local Fellows.

Negotiations are also continuing regarding the implementation of the National Vascular Audit, with the three vascular surgeons in the ACT committed in principle to the Audit.

ACT Annual Scientific Meeting, November 2009

The Annual Scientific Meeting of the ACT Region was held in November 2009 and was a great success. It was convened by Dr David Rangiah, with attendance of Fellows from the ACT as well as regional NSW. Mr Ian Dickinson, the College Vice-President was also present and spoke on the College Constitution. There were varied presentations from 11 surgical trainees, residents and three medical students.

The ACT Regional Committee particularly encourages attendance and participation of medical students from the recently established Australia's National University (ANU) Medical School in order to promote surgery as a career. It also has a dedicated medical student prize and in 2009 this prize was won by Sarah Stephens with a presentation entitled "Why eyeballing X-rays is not good enough". The surgical Trainee prize was won by Dr Manjuka Raj with a simple, but useful analysis of the role of temporal artery biopsy, "The true value of the temporal artery biopsy in the management of giant cell arteritis".

Sale of Calvary Public Hosptial

The ACT Government has been in ongoing negotiations with the Little Company of Mary (LCM) to purchase Calvary Public Hospital, of the two public hospitals in the ACT, which is currently run by LCM. LCM has stated that it would then build a stand-alone private hospital, to replace the private hospital currently co-located with Calvary Public Hospital. The main area of controversy and community debate is that the ACT Government is considering the sale of Clare Holland House Hospice to LCM. There is strong community feeling that this hospice should remain as a non-denominational facility in Canberra.

It is important that, in the formal separation of Calvary Public and Private Hospitals, surgical standards are maintained and there is no detrimental effect on surgical training and Trainee positions. It is also important that surgical waiting lists in the public hospital are not affected.

Research

Finally, a significant research publication will soon be launched in Canberra by the Breast Cancer Treatment Group of the ACT and SE NSW. This is a comprehensive 10 year report on the treatment of breast cancer in the ACT and region. It has a voluntary participation rate of clinicians and patients of over 96 per cent. Outcome analysis has shown that results from the region in terms of survival and recurrences are excellent and above national and internationally reported figures. It is believed to be the first such extensive regional report with follow-up data up to nine years and highlights the success of the ACT multidisciplinary team in the management of breast cancer.

Why can't we protect hearing during surgery?

Professor Stephen O'Leary tells why receiving the John Mitchell Crouch Fellowship means so much to him

Internationally renowned ear surgeon Professor Stephen O'Leary (pictured right) said being awarded the College's most prestigious funded Fellowship - the John Mitchell Crouch Fellowship – had been a highlight of his career for two reasons. The first, he said, was the endorsement of his peers that the Fellowship signifies meant that his years of research and surgical innovation had value beyond his immediate interests and second, that the untied funding had allowed him greater freedom to pursue his current fields of interest.

"If you want to end up as a surgeon scientist, you have to decide years before arriving here and you have to work extremely hard to receive the recognition you need to attract the funding you need to pursue your work. It can take years to find your voice as a scientist, a bit like artists, and much of that time is spent within your own small world of endeavour so to receive the John Mitchell Crouch Fellowship actually provides great encouragement," Professor O'Leary said.

"It says that your colleagues believe your work to have significant social value - which means that it is of value beyond the interests of my own field - and that allows you to feel that all that time has been well spent.

"It is also rather amazing how the John Mitchell Crouch Fellowship funding helps because so many of the research grants are so tightly tied down that you often don't get the chance to say: 'I just want to push this button and see what happens next,' which many scientists long to do.

"It is a wonderful honour and a wonderful Fellowship."

Professor O'Leary said he had used the funding to support his work on designing a new technique to protect hearing from damage during surgery to the inner ear and the design of virtual technology to increase the skills of trainees before they head into theatre.

"The inner ear is extremely delicate and most surgery has the potential to compromise hearing. This is particularly the situation for cochlear implantation where people can expect improved speech understanding, but this comes with a loss of natural hearing," he said.

"We started to ask five years ago: Why can't we protect hearing during surgery? Why can't we do cochlear implant surgery and retain hearing?"

Professor O'Leary said he had a hunch that drug therapy could be useful, pursued it and after years in the laboratory is on the cusp of finding out whether hearing will be protected in patients, by giving anti-inflammatory medications prior to surgery.

He said that clinical trials were now underway at the Eye and Ear Hospital in Melbourne to determine the right dose and the right time of application.

"I have been passionate about this research for many years now because protecting the ear during surgery has the potential to affect so many people and though you don't want to say you've won before the game is over, I expect this work to change what surgeons do every time they enter the theatre for ear surgery," he said.

Professor O'Leary said his other passion was the use of virtual immersion technology to help boost the skills of Trainees in an era when they have less exposure to certain procedures and less time in theatre, yet are still expected to have the same skills as surgeons trained in previous times.

As such, his team has developed 3D equipment that allows Trainees to conduct ear surgery in a virtual reality environment through a research group called the Melbourne University Virtual Environments for Simulation.

"Trainees get less time at the coal face now, less exposure to certain cases and we wanted to design a method to allow them exposure to potential situations that they may face in theatre," he said.

"The 3D mouse looks like a surgical drill in the virtual world and we can program it to offer resistance as if the trainee is actually touching their 'virtual patient'; not just seeing them. We have been able to show that people who train in this way do better when they then go onto cadavers.

"And while the simulator is designed and well suited for ear surgery it has implications for other surgical training."

The John Mitchell Crouch Fellowship is a legacy to the College from the late Mrs Elisabeth Unsworth who created and funded the Fellowship in memory of her son John, a promising young neurosurgeon who died of a brain tumour.

In a decision that even now is still considered "visionary", Mrs Unsworth chose to establish the Fellowship to reward younger surgeons who are making an outstanding contribution to the advancement of surgery or anaesthesia or to fundamental scientific research in the field.

Since its inception more than 30 years ago, those outstanding candidates have used the financial support – now up to $150,000 – to advance medical knowledge in such fields as transplant immunology, microsurgery, colorectal cancer surgery, gene therapy and post-operative healing and has been given to some of the most notable surgeon scientists in Australasia including orthopaedic surgeon Professor Peter Choong and transplantation pioneer Professor Robert Burton.

Letter to the Editor ...

Dear Editor,
I noticed some discussion in your medico legal section (Vol 10, No10, page 10) about how to 'inform' patients. In the Rogers versus Whitaker case the odds of complication were quoted 1 in 14,000. This means that if the doctor were to do the same operation every working day (say 250 days per year) the complication could be expected to occur once in 56 years. I am not sure whether the patients or lawyers appreciate the magnitude of this figure.

Regarding discussion of other methods of treatment. I think doctors should discuss other orthdox medical treatments. Most doctors are not aware of 'alternative' medical treatment. If patients raise this question they should be told to make their own enquiries elsewhere. Much information is of course now available on most websites.

Yours sincerely
John Walker, Otolaryngologist,

Editors response ...

Dear Sir,
The correspondence from Dr John B Walker in relation to informed consent has highlighted the practical difficulty faced by surgeons in complying with their legal obligations. The Australian High Court decision of Rogers v Whitaker in the early 1990's set out the legal obligations of doctors in relation to informed consent. The particular complication in that case was quoted as arising in 1 in 14,000 cases. Better evidence now suggests that the complication rate may be even rarer, at 1 in 40,000 cases. Nonetheless, the principle adopted by the High Court was not whether the risk was likely or not, but whether the risk may be such that, if disclosed to the patient, the patient would attach significance to it (ie. the patient may change their mind about having the procedure). The magnitude of the risk and the rate of complication is not the critical issue.
The legal obligation, when considering the need to inform a patient of a particular risk, requires two separate considerations:

1. Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?
2. Is the doctor aware, or should the doctor be reasonably aware, that this particular patient would be likely to attach significance to that risk?

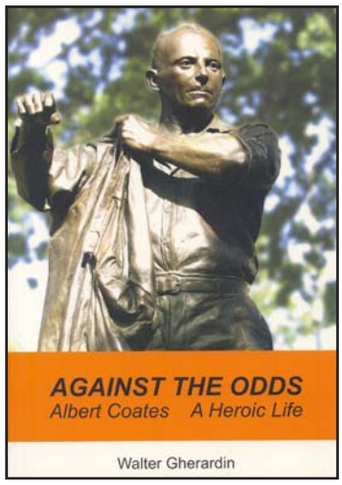
The duty arises because of the legal and ethical position that patients choose whether or not they will undergo a procedure, or have a particular treatment. They are entitled to be informed of all appropriate risks which may influence their decision to proceed or not. In other words, the information is necessary so that the patient can decide whether they wish to take the risk or not. There will be many occasions where patients may decide not to undergo a procedure, even though the risks of complication are extremely low. In the case of Mrs Whitaker, the complication, although rare, affected her sight in her sole remaining good eye, which clearly had critical and unfortunate consequences for her, when the complication in fact occurred. Even though the complication was rare, as Dr Walker points out, it nonetheless can have extraordinarily adverse consequences for the patient if it does occur.
Both the College and the NHMRC have policies and guidelines to assist surgeons in relation to informed consent. "Surgical News" has previously printed other articles providing more detailed information in relation to this important legal obligation.

Yours sincerely,
Michael Gorton, College Solicitor

Book Review

Walter Gherardin has written a biography on an inspiring Australian whose work serves as an example for succeeding generations called *Against the Odds, Albert Coates, A Heroic Life*

Scotty Macleish
Victorian Fellow



With efflux of time, the number of those who came directly under the influence and charisma of Sir Albert Coates is decreasing. Those familiar with the excellent entry in the Australian Dictionary of Biography will know the bare bones of his stellar career. This biography by his son-in-law, Walter Gherardin puts the meat on the skeleton.

Like most of his colleagues who fought in World Wars One and Two, or who became prisoners of war on the Thai-Burma Railway, Sir Albert spoke little about his experiences. But the author, assisted by his wife Winifred (nee Coates), has had access to private letters and confidential reports, and so had been able to provide an authoritative and comprehensive account of what was achieved under almost unsurmountable odds. Forty-three doctors cared for prisoners of the Japanese during World War Two, and were greatly admired by their patients. Whilst it contains no hint of odious comparison, this account clearly establishes the leading role which Coates played in a situation where raw courage, innovation, and indomitable determination saved more lives than most of us would have thought possible.

What could prepare an individual for such service? Gherardin's account of Coates' Spartan upbringing gives a clue as to what led him to achieve all that he did, although his parents clearly had premier protoplasm on which to work. The world at large will remember him most for his role as a medical commander of Prisoner of War camps and a post war reconstructionist devoid of bitterness and hatred which he regarded as the "enemy of peace and a destroyer of mankind". His medical students and surgical trainees will recall an astute diagnostician, the trace of buccaneering surgeon, a brilliant lecturer and a man of great compassion. They will delight in remembering his witty aphorisms and unforgettable teaching. Universities will be grateful for his efforts to forward the scientific and scholarly aspects of medicine, whilst preserving the art and compassion which are its "sine qua non". Men of State will acknowledge that Coates was one of their leading personalities.

This book is an important documentation of Coates and his times. It is engagingly written and will appeal to wide circles of readers, to whom it is warmly recommended.

Against the Odds, Albert Coates, A Heroic Life is published by the Albert Coates Memorial Trust, www.albertcoates.com The cost of the book is AUS $25.00 plus postage AUS $8.00.
Available for loan at College library.

Nurse Catherine Gorr volunteers her time on an Interplast program in Mt Hagen, PNG

Interplast in Papua New Guinea

It's a joy to see the enthusiasm of the registrars and interns in PNG and their great desire to see and learn as much as they possible can while a team is there

It takes a lot to shock a plastic and reconstructive surgeon when it comes to physical deformities or the effects of accident or disease, but plastic surgeon Mr Simon Donahoe admitted that some of the children waiting for his Interplast team visit to the highlands of Papua New Guinea (PNG) last month took his breath away. Two children in particular, aged four years and six years, presented at the Mount Hagen Hospital with the worst burns contractures the Melbourne-based surgeon had ever seen.

"Burns contractures are a relatively common problem in the highlands of PNG because of the climate, in that it gets quite cold up there, so people often have open fires outside or in their houses. Then kids being kids, playing around or running, can fall into the fires or roll in or put their hands out to stop their fall causing some very serious injuries that often don't get treated because the people are so remote, so removed from accessible health care," Mr Donahoe said.

"Yet the particular problem for kids with such burns is that their bodies keep growing, but their scars do not. So two children we treated during our week in Mount Hagen virtually had mittens for hands, their fingers buried in the scar, their hands fused either forward or backward into the forearm.

"One child had suffered the burn at one-month old, the other at two and I was shaken to see them. I have to say though it was hugely rewarding to be able to help."

Mr Donahoe, who works out of the Peter MacCallum Cancer Centre, was one member of two Interplast teams that visited Papua New Guinea in January/ February, funded by the AusAID Health Education & Clinical Services Project.

The team, also included fellow plastic surgeon Mr James Savundra, from Perth who spent two weeks operating in the regional centres of Mount Hagen and Alotau, the first such Interplast visits to the towns in seven years and 14 years respectively.

A second team, headed by plastic and reconstructive hand surgeon Mr James Masson from Wagga Wagga, New South Wales, worked out of the Port Moresby General Hospital. His team's work was divided between treating the

"Many Australian & New Zealand plastic surgeons have done international aid work and there are enough volunteers available to do more work in the more remote areas of PNG if funding for visits was available."

effects of burn contractures and conducting tendon repair surgery.

Both teams worked with PNG-based surgeons with Dr Morath Maire working alongside Mr Donahoe, and Dr John Maihua working with Mr Masson.

Mr Donahoe said that with news of the Interplast visit having been spread by community outreach programs in the weeks preceding, so many people turned up for treatment in both Mount Hagen and Alotau that it was necessary, but very difficult to prioritise. During the initial consultation clinic held in Mount Hagen, 103 patients presented with 33 patients chosen for surgery, while in Alotau, 83 patients attended the initial clinic with 41 operations conducted.

Yet even though Mr Donahoe has undertaken seven trips to areas of need within the Pacific Islands region through Interplast, he said choosing those to be treated when faced with such pressing need, remained difficult.

"Many of these people who arrived at the clinic had received no treatment at all for their injuries and seeing all the children with desperate problems was difficult because we knew we could not treat them all. We therefore had to prioritise, so we put the children first and then the adults who had such extensive injuries or burns contractures that their ability to work or farm or support themselves was severely compromised," he said.

"So we did what we could with two surgeons working in two theatres almost all day, every day throughout the two weeks and I was most impressed by the hospital authorities in both Mount Hagen and Alotau who provided us with access to their theatres, except in cases of emergency.

"All of us thought we could spend up to three weeks, particularly in Mount Hagen, to make a real difference and I've told Interplast that I'd like to get back there to treat more patients and I know that other plastic surgeons would do the same. Many Australian and New Zealand plastic surgeons have done international aid work and there are enough volunteers available to do more work in the more remote areas of PNG if funding for visits was available."

Founded in 1983 as a joint project of the Royal Australasian College of Surgeons and Rotary District 9800, Interplast Australia and New Zealand is an organisation that sends teams of plastic and reconstructive surgeons, anaesthetists, nurses and allied therapists to developing countries in the Asia Pacific Region.

Elizabeth Bashford, Anaesthetist volunteers her time on an Interplast program in Mt Hagen, PNG

Since its inception, Interplast had sent 600 volunteers on nearly 500 programs to 24 countries, performed more than 30,000 consultations and provided 18,000 operations.

Mr Masson and his Interplast team, which comprised anaesthetist Dr Steve Cook and theatre nurse Jeremy Moles, arrived in Port Moresby on 31 January. He too had to make some difficult choices about which patients to treat, but said he was guided in that choice by PNG surgeon Dr John Maihua's desire to see and learn certain procedures as a way of transferring skills and knowledge.

He said the team treated tiny patients aged from 17-months to adults in their 40s and said that even though he had been to PNG through Interplast on previous occasions, he still found some of the injuries confronting.

"Unfortunately in PNG, there is still a high incidence of people attacking each other with knives and machetes, which leave some appalling injures. We treated one fellow on this visit, for instance, who was training to become a pilot before he was attacked by a raskol gang who cut off one of his thumbs and slashed his hand," Mr Masson said.

"He had the wound repaired at the time, but there are not many post-surgical therapies available in PNG, which means that he was left with limited hand function, which in turn meant that he could not pass the medical test needed to get his pilot's license.

"We operated to free up the stuck tendons and hopefully he will regain good use of his hand. We also did a number of tendon transfer and tendon repair procedures so that John can start doing that surgery now, which is a great step forward."

Mr Masson, who relocated from Sydney to the New South Wales regional centre of Wagga Wagga a few years ago, has been on ten international aid trips throughout his career to countries including Fiji, Vietnam and the Dominican Republic. Yet he seems to retain a special feeling for the people of Papua New Guinea.

"PNG is so close to us yet so deprived so that when word goes out that a team is to arrive, the people start coming in to the hospital, often walking for miles or sailing to the mainland on little boats from remote islands as if they were following the pied piper and that strength and determination makes it very tough to choose," he said.

"They often have devastating injuries, but they are such wonderful people they appreciate whatever we can do and sometimes even smile when we explain that there is nothing we can do.

"Then it is confronting to come back to Australia and hear patients complaining of negligible injuries and it is difficult not to express frustration and say: 'I've just been dealing with people with no arms who find a way to manage'.

"I also greatly enjoy the enthusiasm of the registrars and interns in PNG and their great desire to see and learn as much as they possibly can while a team is there."

Mr Masson said he plans to return to Port Moresby and Madang early next year.

For more information on Interplast Australia and New Zealand visit www.interplast.com.au

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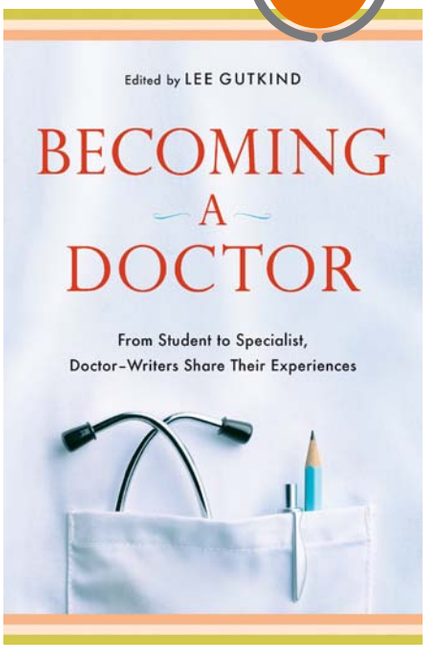

Becoming a Doctor – From Student to Specialist, Doctor-Writers Share their Experiences
Lee Gutkind
9780393071566 | Hbk | 228 pages | March 2010
~~AU$37.95~~ / **AU$30.36**

Physicians recount true, personal stories from their professional lives in this inspired anthology by new and known writers. In this poignant collection, doctors who are writers (and vice versa) relate their real-life journeys from intern to specialist, student to teacher, reflecting on the rewards, disillusionments, and triumphs encountered along the way. Featuring a wide array of distinguished voices, including Peter Kramer, Kay Redfield Jamison, Robert Coles, Lauren Slater, Sandeep Jauhar, and Perri Klass, these original stories create a vivid mural of the medical world and provide invaluable insight for both doctors in training and longtime physicians. Becoming a Doctor portrays the broad arc of a doctor's life, from a medical student's uneasy first encounter with a cadaver and her realization that the experience's redemption will lie ahead in the lives saved, to a resident's reliance on dance during her grueling year in an inner-city hospital, and a veteran doctor's profound ruminations on what it means to really listen to a patient's story

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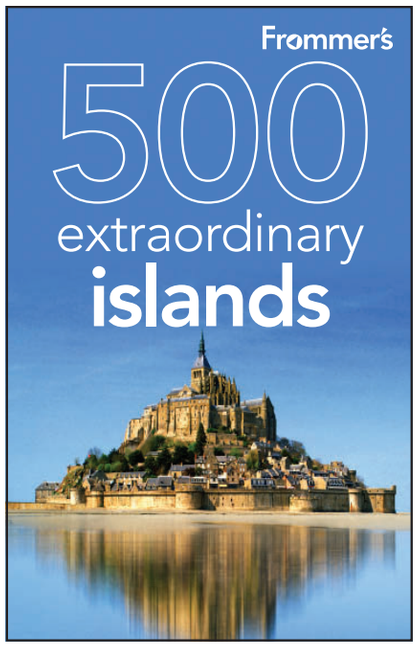

Frommer's 500 Extraordinary Islands
Holly Hughes, Sylvie Murphy, Alexis Lipsitz Flippin and Julie Duchaine
9780470500705 | Pbk | 544 pages | Jan 2010
~~AUD $27.95~~ / **AU$23.76**

Escape to the World's Most Spectacular Islands This guidebook leads you on an irresistible tour of some of the most magnificent islands around the globe—from tiny isles to island nations, and from the well-trod to the totally uninhabited. Whether it's the history and charm of islands like Mont-Saint-Michel (France) and Ocracoke (United States) or the unspoiled vistas of far-flung places like Antarctica and Polynesia's Tuvalu, you'll discover a host of islands you'd love to visit—or stay on forever.

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Andy Ihnatko
9780470542132 | Pbk | 288 pages | Nov 2009
~~AU$27.95~~ / **AU$23.76**

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- Covers using the new built-in video features, the search tool, the App Store, and all the newest applications
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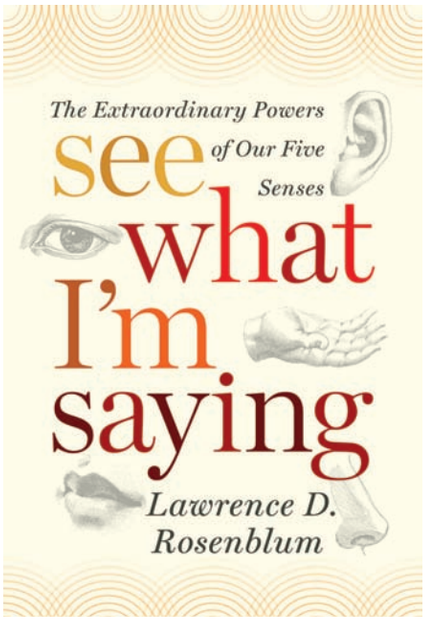

See What I'm Saying: The Extraordinary Powers of Our Five Senses

Lawrence D. Rosenblum

9780393067606 | Hbk | 288 pages | Feb 2010

~~AU$37.95~~ / AU$32.26

An in-depth look at the science that explains the hidden powers of the five senses and how to harness their potential. University of California psychologist and researcher Lawrence D. Rosenblum explores the astonishing abilities of the five senses, abilities few of us even know we have. Drawing on groundbreaking insights into the brain's neuroplasticity and integrative powers, including findings from his own research, Rosenblum examines how the brain uses the subtlest information to apprehend the world. A blind person, for example, can "see" through batlike echolocation; wine connoisseurs can actually taste the vintage of an obscure wine; pheromones can signal a lover's compatibility; and an undetected odor can influence our behavior. Rosenblum takes us from the "beep" baseball fields where blind players swing at buzzing balls to a pitch-black restaurant where diners experience taste without the aid of sight, not only illuminating the science behind our sensory powers but also demonstrating how awareness of our sensory skills can enhance and hone their power.

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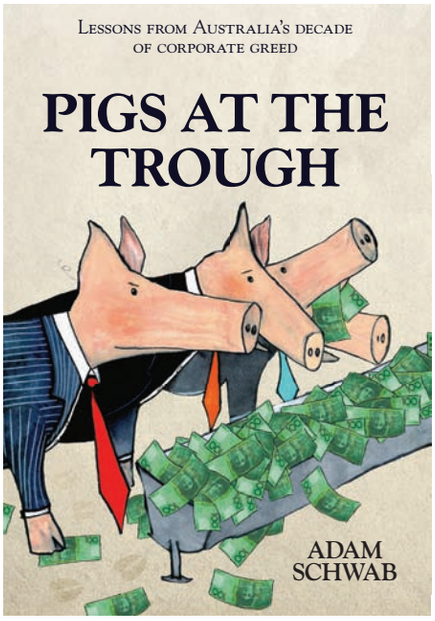

Pigs at the Trough: Lessons from Australia's Decade of Corporate Greed

Adam Schwab

9781742169903 | Pbk | 256 pages | Jan 2010

~~AUD $32.95~~ / AU$28.00

The past decade has seen a period of unparalleled growth in executive remuneration. But while CEO pay exploded, shareholders looked on helplessly as some of Australia's best-known companies self-destructed. When the fall eventually came, executives were well protected. Shareholders and creditors were not so lucky. From Telstra's enriching of Sol Trujillo to the toppling of Eddy Groves's ABC Learning Centres and the untold accounts of the billions lost by the collapsed Babcock & Brown, Allco Finance Group and MFS, Pigs at the Trough tells the story of how a generation of executives, under the supervision of well-known and respected non-executive directors, pushed all the boundaries and sometimes sailed right over them ... and got away with it. A pacey, irreverent read but with a devastatingly serious message, Pigs at the Trough gives investors invaluable insights into how to spot the telltale signs of impending corporate collapse, and how to avoid being another victim.

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