Surgical news

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THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The College's **$1.4 million** worth of scholarships

see inside p35

The College of Surgeons of Australia and New Zealand

contents

Passing the skills on

Contributing to the next generation of surgeons can be extremely rewarding

Mr Ian Civil
President

The Academy of Surgical Educators is now taking membership applications from Fellows and Trainees who have a strong interest in educational issues and wish to see this supported and developed within the College structures.

From our own discussions, formal surveys and ongoing advocacy with governments and other educational bodies there is both a need and requirement to better support and recognise the contribution that surgeons make to our health and educational sectors.

Particularly within the public hospital sector, but progressively within the private hospital sector, there is an expectation as professionals that we will commit to the ongoing training of medical students, junior medical staff and surgical trainees. This is as it should be – there is a reason why the word Doctor is based on the Latin meaning teacher.

However, it is increasingly appreciated that the capacity to teach and educate well requires skills and aptitudes that are not necessarily intrinsic. Sure, we can all recall the outstanding teachers that inspired us to greater academic achievements or the significant mentors who had outstanding surgical careers.

Equally some educators are starting to be supported and recognised by their peers and also by the systems in which they work. However, much remains to be done and this is the reason for the formation of the Academy of Surgical Educators.

The Academy Board and Advisory Committee have now been in place over the past 12 months. Having finalised the ▶

> *"There is now a significant requirement to ensure that College programs are integrated effectively and can relate to external courses run through universities and other providers"*

criteria for membership, this is now open and has been advertised on the College's website at www.surgeons.org

The Academy is providing guidance to a number of key activities being undertaken through the College. These can be broadly grouped into four areas.

The first is the educational programs that should be provided to our instructors, trainers, supervisors and examiners. Traditionally the College has undertaken this through courses such as EMST Instructor courses, Surgeons as Teachers courses, SATSET courses and the like.

They have all been enthusiastically delivered and embraced, but there is now a significant requirement to ensure that College programs are integrated effectively and can relate to external courses run through universities and other providers that deliver formal qualifications such as graduate certificates through to master programs.

The second is to review the College Educational and Training programs that are delivered within the nine specialties. Fellows and Trainees are aware of the nine competencies in which we provide our program. There is no doubt that we provide high calibre delivery of programs focusing on our technical and medical expertise as well as clinical decision making and clinical judgement.

However, the other competencies are critical for surgeons to be competent and perform at a high level through their professional careers. Surgeons rarely get into trouble because they do not competently perform certain procedures, but the ability to work within teams, communicate effectively and understand the demands of our complex health system are skills that do need better understanding and better education.

The third is the development of training within the e-learning environment. There have been substantial developments in e-learning delivery over the past 10 years. Combining this more advanced type of delivery for surgical education with the requirements for delivering reliable surgically related material over the internet is becoming a priority for the College and also for the Academy where the strategy and direction needs to be correct.

The fourth key area is that the College needs to properly address all aspects of professionalism into the future. In a world where surgeons can often be viewed and treated as expensively paid technicians, it is critical we understand the differences that our profession does stand for.

This has been previously explained within the RACS Competence and Performance booklet. The booklet is now being updated and importantly following from this we will be creating multi-source feedback tools as well as improving the assessment process for Trainees.

There is similar work being undertaken internationally. Members of the Board and the Advisory Committee of the Academy are very aware of these developments and our ambition is to ensure the program gains from this international knowledge and distinctly progresses its delivery within the surgical areas.

The College strategic direction in education is very important. We need to aspire to train highly competent surgeons and provide them with the ongoing support throughout their professional careers.

The world in which this is undertaken is changing at a rapid pace and the role of the Academy is to provide us with the breadth of understanding and the depth of knowledge to make that meaningful and supportive. It is a very significant ambition to provide a unified approach for surgical educators to be recognised, skilled and supported throughout their career.

I ask you to consider joining the Academy. Under the Chairmanship of Professor Vince Cousins, the key support of Professor Barraclough as the Dean and a number of external experts, we are well-positioned to progress this bold agenda. Please contact ase@surgeons.org for further details.

Involvement in your College

College Council and the NSW elections bring important issues to the fore

Dr Keith Mutimer
Vice President

At the time of writing, nominations for College Council have closed and the election is about to commence.

It has been said that the health of a voluntary organisation such as ours can be measured by the vibrancy of its democracy. For this reason, Council has incorporated into the College's Strategic Plan requirements to increase engagement by Fellows with the College Council election process. This is to be measured both through increasing nominations for Council positions and increasing numbers of Fellows voting in the Council elections.

It is essential that we have committed Fellows prepared to serve on College Council (and regional boards and other committees). This ensures that the College remains responsive to the needs of Fellows and reflects the views of Fellows in the decision making process.

I can personally attest to finding involvement in Council (and other committees) very fulfilling. It gives Fellows the opportunity to have a say directly in the governance of the College and to contribute to its overall strategic direction.

It is also satisfying to know that you can make a difference to our profession through your involvement. Whether it is involvement in developing surgical standards, improving the delivery of training or helping to shape our respective governments' health policies, there are roles within the College that can fit most Fellows' interests or concerns.

While nominations have closed for College Council in 2011, there are myriad other committees and activities in which Fellows can be involved, have their views considered and make a difference. And right now, your vote in the Council elections will help shape the future of our College and our profession.

So, if you haven't already, I would encourage all Fellows to take an active interest in their College and vote in the Council elections. Voting closes on Wednesday, 6 April, 2011.

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Elections in 2011

While on the subject of elections, shortly after you receive this issue of Surgical News, voters in New South Wales will be heading to the polls (Saturday, 26 March).

As has been the College's approach in recent elections, the College has written to the major political parties seeking their views on a range of issues central to NSW based Fellows.

In particular, at this election the College is focusing on issues relating to training and supervision, following up on recommendations from the Garling Inquiry and surgery funding concerns.

For example, the College has identified the inadequacy of funding for training and supervision of trainee surgeons – which was a key finding in the Garling Report – and has asked the parties to identify the provisions they will be making for the funding of this core activity.

Allied to this, are questions regarding the adequacy of specialist orthopaedic positions in NSW hospitals to support a growing number of trainees. In addition the College contends that the creation of new specialist positions in public hospitals should require newly trained orthopaedic surgeons to provide care for patients in the patients' local area, where they have access to both medical and non-medical support (such as from family).

The College challenges the expectation that orthopaedic surgeons will provide emergency services without adequate local infrastructure for elective services as this acts as a continuing disincentive to provide public hospital services across the board. This in itself represents a considerable waste of training resources.

In its letter to the parties, the NSW Regional Committee questions the parties' commitment to addressing the obesity epidemic through bariatric surgery in the public system as well as calling for clear and specific funding for trauma care and to ensure adequate resources for the recruitment of trauma staff.

Finally, the NSW Regional Committee seeks information regarding what support the parties would be prepared to commit to establish acute surgical services in public hospitals, thereby allowing elective surgery to be carried out without interruption. This is an important issue in the College more broadly and will be addressed in a discussion paper to be released in the next month or two.

The College's letters to the parties and their responses will be placed on the NSW Region's page of the College website prior to polling day.

Earlier this year the New Zealand government announced that New Zealand

will go to the polls on 26 November, 2011. The College will be preparing an "election manifesto" for New Zealand and I will have more information about that later in the year.

Bullying and Harassment

Issues relating to bullying and harassment are a challenge that many industries and professions must face, and the medical profession is no exception.

As part of the College's ongoing commitment to addressing this issue, bullying and harassment was discussed at the November meeting of College Executive, prompted in part by recent media interest.

While heightened media attention is always challenging, it serves to remind us of the importance of addressing this issue.

The College has developed an outstanding publication entitled Bullying and Harassment: Recognition, avoidance & management.

Developed and published in 2009, the booklet has been mailed to all Fellows and Trainees of the College and is available for download from the publications page of the College website.

It contains important information on what does and does not constitute bullying behaviour and tips and strategies for ensuring that interactions between colleagues, trainees and allied medical staff are positive and productive.

It provides essential reading on positive behaviours in teaching, supervision and assessment, supporting others, documenting and exchanging information, communicating effectively and awareness and insight. It also deals with addressing the problem should it arise and includes advice on effective dispute resolution.

If you haven't already, please read this booklet.

Poison'd Chalice

Shakespeare's new language

Professor U.R. Kidding

What does my registrar – almost a Fellow, have in common with the Victorian Police Force, Lady Gaga, Shane Warne and numerous UK based politicians? No prizes for this one, but for those of you who are still in the dark, it is a growing addiction to Twitter.

Twitter is defined in the dictionary as chirping in a small high-pitched voice. So what do we call someone who tweets – a "twitterer" (or just a twit?). But in today's electronic communication age, it is social media in action.

It is the never-ending connection to all those who want to learn of your most inane inner thoughts within a nano-second of them being created. And it is creating a new language as we speak.

Mind you an evolving language is not too bad a thing. Up until this time in human evolution, language reflected thought and ideas; for example Eskimos have more than 80 different words to describe ice.

I was reviewing the contributions of Shakespeare to the English language just last week and I discovered that he created hundreds of words including bedazzle (which was not the film that starred Liz Hurley as the Devil, although apparently she is a twit as well), shooting star, uneducated, spectacled, gossip and even zany.

Quite an incredible list really. But would Shakespeare have approved of the evolving Twitter language – does it reflect a richness of ideas or is it merely a reflection of expediency? Inescapably, I realise that I am yoked in a generational time warp.

I was trying to get the adverse event meeting underway. It was a struggle; the iPhones were competing with the BlackBerrys. One of the consultants out to impress had cursed as he dropped his iPad on the floor instead of onto the table.

In the 'good old days' we had struggled to listen to the overhead paging system of the hospital. These days they were all texting, checking the share-market, filling in electronic time sheets, arranging that essential after work social catch-up while I was trying to raise the level of intellectual input into the care of our patients.

Even in the operating theatre, the formerly quiet, solemn environment is now regularly punctuated with the various ringtones – each more inane than the previous, each attempting to reflect the individuality and personality of the owner.

I had read somewhere that some management groups were now making it compulsory to put all the electronic devices into a bucket next to the door before they entered the meeting. Now that would be an interesting one to try. Imagine if you picked up someone else's phone on the way out.

I often wonder what was in the SMS that brought such smiles to some of my colleagues. Even my golf club had banned mobile phones on the course, except for doctors on-call. I had thought that a good idea until I realised that I could download an 'app' onto my iphone, which utilising the GPS, could tell me how far to the pin for my next shot (there I have done it – used new language – app, iphone, GPS – words that didn't exist in my childhood!).

But the meeting degenerated one step further, when our medical student started on the presentation of one of our patients. I had always thought I had kept up with the medical acronyms. However, gone are the old days when we got confused between SOB and SOOB.

Our mature age medical student apologised for being the nOOb and said that he has some EBKAC moments. He then started the presentation by indicating the patient was a 41-year-old DWM and then rapidly got to his IMNSHO conclusion.

I put my head in my hands. Bewildered, I turned to my registrar who with a pitying look took over the meeting having understood all. The iPhones kept texting, the applications rapidly providing diagnostic opportunities and suggested treatments. I listened for the overhead page that could summon me away.

Oh Shakespeare, even you would cry.

GLOSSARY
SOB: Short of Breath
SOOB: Sit Out Of Bed
nOOb: Newbie, i.e. new person in the unit
EBKAC: Error between keyboard and chair
DWM: Divorced white male
IMNSHO: In my not so humble opinion

Pioneering liver surgeon knighted

After years of performing life saving liver transplants, Professor Russell Strong, along with his wife were given the royal treatment in Malaysia recently

Datuk Russell Strong & Datin Judith Strong in front of the King's Throne.

Picture the times. It is the 1970s. There are an increasing number of larger, faster cars on Australian roads, yet, while the requirement to wear seat belts was introduced a decade earlier, there is still little, if any, policing of speed limits or drink-driving.

Consequently, the road toll is soaring with more than 3,500 fatalities each year.

At the Princess Alexandra Hospital in Brisbane, one of the largest and busiest hospitals in Australia, the then Surgical Supervisor Russell Strong is in despair at the carnage.

Now semi-retired and reflecting on the catastrophic injuries occurring in that era which, in due course, sparked his revolutionary work in liver transplantation, Professor Strong said: "We were facing a road trauma epidemic, which seemed to get worse each year.

"One of the most significant aspects of this was the number of people bleeding to death from a ruptured liver, bearing in mind that a quarter of the circulating blood volume passes through the liver.

"At that time, surgeons in America had satisfactory results from operating on penetrating knife and gunshot wounds, but they were also struggling with the management of blunt liver injuries.

"There was, however, evidence that there was a proportionately greater number of blunt liver injuries in Australia because the driver, seated on the right-hand side of the car and subjected to a side impact, often suffered injuries to the liver."

Yet while most surgeons then feared having to deal with such injuries, Russell Strong took up the challenge in striving to save many of these previously doomed patients.

He went to the post-mortem room to learn how to get in, how to get at it, how to mobilise it and stem the bleeding as rapidly as possible.

"To begin with, this was all about access and anatomy," he said.

Then to add to his understanding of the liver, Professor Strong made himself available to treat critically injured patients from all over Queensland and, whenever feasible, would travel to other hospitals. He became prominent both nationally and internationally with the results achieved.

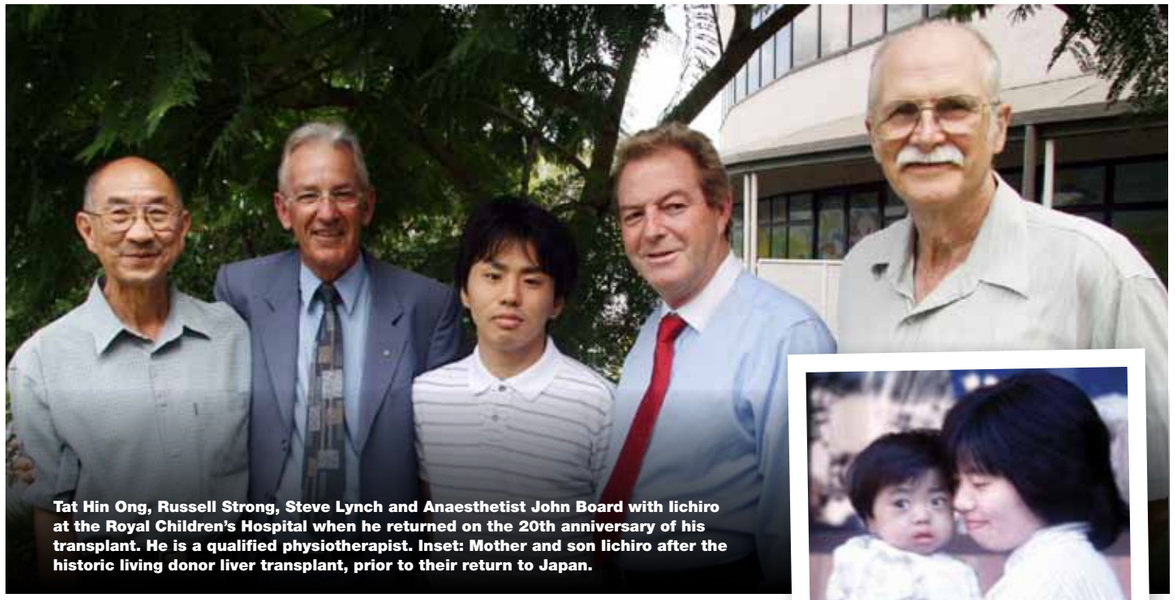
The knowledge and experience gained from the management of liver injuries led to the commencement of elective liver resections for secondary cancer and other pathologic processes in the late 1970s, a time when most surgeons regarded the organ as almost sacrosanct and to be avoided at all costs and when diagnostic imaging was not available.

Professor Strong's special interest and experience in liver surgery, together with a decade of performing renal transplants and the introduction of a new, superior immune-suppressive drug, Cyclosporine, was to lead to the commencement of the first liver transplant program in Australia in 1985.

A number of significant innovations emanated from the program.

"Early in the program, we realised that thankfully, there would never be enough children dying from brain death to provide sufficient livers for children in need, most of whom are born with biliary atresia, a disease which inevitably leads to liver failure and death," Professor Strong said.

"The challenge was to figure out how we could use an adult donor liver, reduced in size to fit into a little bub's tummy and adapt and join the adult-sized blood vessels to those of the baby.



Tat Hin Ong, Russell Strong, Steve Lynch, Anaesthetist John Board with Iichiro at the Royal Children's Hospital when he returned on the 20th anniversary of his transplant. He is a qualified physiotherapist. Inset: Mother and son Iichiro after the historic living donor liver transplant, prior to their return to Japan.

"I still have the drawings that I did when working on the method and well remember the scepticism expressed by many back in 1984.

"But sometimes an idea or innovation is premature for all except the one who made it.

"The success and subsequent publication of the procedure was to result in around 75 per cent of children's liver transplants around the world being performed by this technique over the past several decades and more than 90 per cent in children less than two years of age. It is named the Brisbane Technique in many countries."

The first successful living-donor liver transplant in the world, from a parent to child, was also performed in Brisbane in 1989 and both mother and son are alive and well 22 years later.

These revolutionary advances gained great international acclaim, but only after considerable local opprobrium. Russell Strong was called a "bushranger" on national television by a State Minister of Health and was publicly lambasted in the Australian Medical Journal, while a leading ethicist accused him of turning children into "stunted monsters".

"When commencing the liver transplant program in Australia, it was in some ways revolutionary and understandable that some people found it threatening," Professor Strong said.

"They were clearly inferring that we were pushing the boundaries and there were times when I found this reaction disappointing, that people didn't see it as amazing life-saving surgery.

"Still to be fair, it was somewhat experimental then, it was expensive so there was a fear that money would be diverted from other specialties and before the development of new immune-suppressive drugs, children didn't grow as well because of the high dose of steroids they needed to take.

"In every moment of evolution and revolution there can be opposition and you just have to believe in your work to get you through."

In the years following, the hospital gained an international reputation in liver surgery and liver transplantation as a result of the publications and lectures given and more than 80 surgeons from around the world came to Brisbane for training.

Professor Strong has now been a Visiting Professor/Guest Lecturer on 88 occasions in 22 countries and has delivered 16 named lectures around the world, including the prestigious Moynihan Lecture, Royal College of Surgeons of England in 1995 and the RACS' George Adlington Syme Oration in 2003.

He has receive innumerable honours and awards for his work including Queenslander of the Year (1986), Companion of the Most Distinguished Order of St Michael and St George (1987) and Companion of the Order of Australia (2001).

He is the recipient of an Honorary Fellowship of many Surgical Colleges and Associations and received the Centenary Prize of the Societe Internationale de Chirurgie – the oldest Surgical Society in the world.

He, along with members of the Queensland Liver Transplant team, received the inaugural RACS Award for Excellence in Surgery in 1993.

During the previous several decades, Professor Strong visited Malaysia on 30 occasions to lecture, run workshops and to operate. Following his retirement as Professor and Director of Surgery at the end of 2003, he was persuaded by the then Minister for Health in Malaysia to help them commence a liver transplant program.

With his wife Judith, he moved to Kuala Lumpur from 2004 to 2005 where he performed a huge amount of HPB surgery and helped establish their liver transplant service. This contribution led to his most recent honour.

In conjunction with the birthday of His Majesty, King Mizan Zainal Abidin, Professor Strong was awarded the title Knight Commander of the Most Distinguished Order of Malaysia in a lush, regal palace ceremony.

Professor Strong described the honour as having particular meaning for him given that it was bestowed not just upon him, but also upon his wife Judith, with the Knighthood carrying the titles of Datuk (Sir) and Datin (Lady).

"I was most delighted by this because my wife was honoured too and for us both to be there at the ceremony was very special because she has sacrificed much along the way, thereby allowing me to do the work that I did," he said.

"I also feel huge gratitude to the members of the wonderful team we put together, without whom none of the achievements would have been possible or accomplished – the anaesthetists, intensivists, nursing staff and most prominently the surgical team – Daryl Wall, Tat Hin Ong, Tony Griffin, Praga Pillay, Jonathan Fawcett and especially Steve Lynch, whose contributions have been above and beyond.

"It takes the colours of many poppies to make a tall one stand out."

With Karen Murphy

A congress of world standard

80th Annual Scientific Congress, Adelaide, 2-6 May, Adelaide Convention Centre, asc.surgeons.org

Mr Campbell Miles
Annual Scientific Congress
Co-ordinator

To have achieved 80 years, the 2011 Annual Scientific Congress represents a milestone in the surgical education activities of our College. Over these 80 years, thousands of Australia and New Zealand surgeons and trainees have contributed to the establishment of this meeting as being of an outstanding standard on a world scale. Certainly within our region it is the largest and best funded surgical scientific congress presented in English, a testament to the funding provided by the College from Fellows' registration fees. This funding, generously supplemented by our industry partners means an outstanding local, regional and international faculty can be invited.

The virtual congress

The RACS was one of the earliest adopters on a web-based copy of the presentations at the ASC. Funding for The Virtual Congress is provided by our long-standing partner, Ansell. It has been updated and this year most of the presentations, including the plenary sessions are available for viewing with both the Power Point slides and the sound track. A complaint from delegates has been that there is 'too much' presented at the Congress since there is overlap of desirable programs to attend. This has been more of a problem since the program was reduced to four days – at the recurring request of delegates. The solution is to view the sessions you missed on the Virtual Congress. This can be accessed readily from the Congress website.

Craniomaxillofacial surgery

The Craniomaxillofacial Surgery program is now offered as a free-standing program within the Congress. The convener is the Adelaide surgeon, Peter Anderson. He advises that the aim of the first day of the conference is to develop discussion on the contemporary management of craniosynostosis, utilising members of the multidisciplinary team.

Professor David David is our Congress Visitor Speaker who will share the wealth of his clinical experience. In addition there is an opportunity to attend a joint session with neurosurgeons to review the management strategies for patients with craniosynostosis and those with plagiocephaly.

The day will also include a scientific update into different aspects of the laboratory-based studies with invited speakers including two internationally respected authorities; Dr Michael Buckley from Sydney discussing genetics and Associate Professor Barry Powell from Adelaide who will discuss molecular biology.

The morning of the second day will focus on facial trauma with speakers from different disciplines. The highlight in the afternoon is a lecture by Dr Swee Tan on his vast experience of vascular malformations management.

Overall, this program should be of interest to both established surgeons wishing to update their knowledge in this fast moving field and also to CMF trainees preparing for higher examinations.

Endocrine surgery

James Kollias is convening the Endocrine Surgery program. He writes that the Endocrine Section is fortunate to have two invited American visitors, Professor Herb Chen and Professor Fiemu Nwariaku, to present on a range of topics including:

- current treatments for recurrent hyperparathyroidism
- phaeochromocytoma
- medullary thyroid cancer.

Professor Carmen Solorzano, American International Visitor for the Surgical Education Section and an internationally renowned endocrine surgeon, has accepted our invitation to present to the section.

A combined Masterclass with the Head and Neck Section will address difficult thyroid cases and be followed by a comprehensive session on voice changes after thyroid surgery. This year will also see the introduction of a 'How I do it" video session including minimally

invasive techniques and lateral/ central cervical lymph node dissection. The combined Breast and Endocrine Dinner will take place at the historical Adelaide Club where delegates and associates will savour a selection of South Australia's finest food and wine. We look forward to your attendance.

Surgical oncology

This year, the Surgical Oncology program extends across Wednesday to Friday. The convener, Brendon Coventry notes that this year we are very fortunate to have several visitors for our program to help mark the Surgical Oncology Section's 12th year within our College. Professor Clifford Ko, a colorectal surgeon and Head of the National Surgical Quality Improvement Program (NSQIP) of the American College of Surgeons; Professor Mohamed Khadra, an inspiring author and surgeon and Professor Steve Libutti, Director of Montefiore-Einstein Centre for Cancer Care and Surgery at Montefiore Medical Centre/Albert Einstein College of Medicine in New York, are our principle speakers. The program will include sessions Exciting New Advances, Improving Surgical Quality, and the True History of Surgical Oncology in Australasia.

All surgeons and trainees can register for the meeting online at the conference website, asc.surgeons.org where you can also find an updated program.

Scholarship leads to research breakthrough

Dr Zoe Wainer has been a key researcher in the latest breakthrough for lung cancer

One of the most significant advances in the treatment of lung cancer – made via an international collaboration between oncologists, surgeons and researchers across 15 institutions including Melbourne and based at the Max Planck Institute in Cologne – could have been long delayed without the support of the Australian surgical community, according to team member Dr Zoe Wainer.

Dr Wainer has spent the past two years collecting clinical data and tumour tissue to add to those collected by researchers at the Max Planck Institute, an opportunity made available to her through two scholarships provided by the College.

A cardiothoracic trainee, Dr Wainer received the RACS Research Foundation Scholarship in 2009 and the Raelene Boyle Scholarship for 2010.

In the absence of either State or Federal funding, the scholarships allowed Dr Wainer to become the only member of the five-person Melbourne team able to work full-time on the project, which now holds the prospect of a drug treatment capable of shrinking certain lung tumours.

"The support of the College and therefore the wider surgical community has been absolutely vital in advancing this research given that we have been working on a shoe-string budget in the absence of government funding," she said.

"Yet our work has contributed enormously to the collaboration and could result in an effective drug treatment for certain types of lung cancers, a development made even more important given that lung cancer has the highest mortality rates of any cancer.

"Even the initial seed money to begin the Australian research, which allowed the director of Surgical Oncology at St Vincent's Hospital, Associate Professor Gavin Wright, to conduct preliminary molecular genomic work, was provided by the Australasian Society of Cardiac and Thoracic Surgeons.

"This support from our colleagues and the College has therefore directly contributed to this advance.

"It allowed the Australian team to add detailed clinical data to sit alongside the tissue samples now held in Cologne, enabled me to both organise the delivery of our tissue specimens from Melbourne to the Max Planck Institute and to work there to contribute to our understanding of disease progression and the genetic growth factor driving tumour cell multiplication."

The breakthrough, announced in December last year, relates to the discovery that patients with squamous cell lung cancers have an over-expression of the FGFR-1 gene (Fibroblastic Growth Factor-1) which makes tumour cells continuously multiply.

While most people have two copies of this gene, patients with squamous cell lung cancer typically have 10 – 15 copies.

Two drugs, already in existence but until recently not identified as useful, have now been shown in mice trials to block the FGFR-1 receptor on the cancer cell causing the tumours to disappear.

Phase One human trials are expected to begin in Victoria and at the Max Planck Institute later this year.

St Vincent's Hospital began collecting lung cancer samples from patients in 2002 yet, given the high cost of DNA sequencing, researchers there and at the Peter MacCallum Cancer Institute could only test 60 tumours for gene abnormalities of the more than 300 tissue samples collected.

With researchers undertaking the same work in Cologne, a collaboration was designed that saw the Melbourne team contribute the second largest number of samples to the international collection stored and studied there which now stands at 1,800.

"I think we have provided some of the best clinical data of any collected for this project which is why we have become such highly valued partners in this research," Dr Wainer said.

"With every tissue sample we provided, we also gave detailed de-identified clinical data which then allowed the molecular researchers in Cologne to provide a premium genetic analysis.

"Lung cancer kills more people in Australia than any other cancer even though it is only the fifth most common cancer behind prostate, bowel and breast cancer and melanoma.

"While this drug therapy to block the FGFR-1 gene is being looked at as a treatment, not a cure, we have great hope that it could dramatically increase both the quality and quantity of life for patients with squamous cell lung cancer.

"It has also been found that there is an altered expression of the FGFR-1 gene in pancreatic, ovarian, testicular, breast and certain head and neck cancers and an over-expression found in particular gastric and prostate cancers, so the ramifications of this work in our understanding of the drivers of tumour cell multiplication could be considerable."

Once in a lifetime research

Dr Wainer is undertaking her research as part of a PhD through the Department of Surgery at St Vincent's Hospital and the University of Melbourne under the supervision of Associate Professor Gavin Wright and Medical Oncologist Dr Ben Solomon from the Peter MacCallum Institute.

"This work is not the research I set out to do, which was initially aimed at understanding the pattern of lung cancer to see if we could identify which tumours were more or less aggressive, this could then allow us to better apply optimal treatment options between surgery, chemotherapy and radiotherapy," she said.

"However, the opportunity arose to work on the FGFR-1 gene analysis which seemed both then, and now, a once-in-a-lifetime, profoundly-rewarding experience.

"The collaboration with the Max Planck Institute made it very exciting work. They have a dynamic research team which provided a great intellectual environment and the opportunity to work there was wonderful."

Dr Wainer said she planned to return to Cologne later this year to study the molecular data collected since her last visit, with a particular focus on understanding the differing patterns of lung cancers now showing up between men and women.

She said that while smoking trends could explain the increase in the incidence of lung cancer in women, there may be significant biological differences in the disease process between the two sexes.

"Women began smoking later than men, only a few decades ago, and that is now showing up in the development of certain lung cancers but we are also seeing an increasing incidence of women developing lung cancer who haven't smoked at all," Dr Wainer said.

"At the same time, women are still living longer than men, even when we control for smoking and age-related diseases, this points to an interesting anomaly which I plan to investigate this year."

Alongside all her research and cardiothoracic studies, Dr Wainer has continued to privately assist Associate Professor Wright while also contributing her surgical skills to international aid projects.

She has participated in three cardiothoracic team visits organised through the College to East Timor as well as travelling to Tonga twice and Fiji as part of the Operation Open Heart aid program run through the Sydney Adventist Hospital.

The daughter of public health reformers the late Dr Bertram Wainer and his wife Jo, Dr Zoe Wainer also has a strong commitment to public health.

For the past three years she has been a Director on the board of the Victorian Branch of the AMA with a particular interest in public health and the health and well-being of junior doctors.

"My parents have always been an inspiration to me and informed my values in medicine and I think the AMA plays an important role in matters of public health," she said.

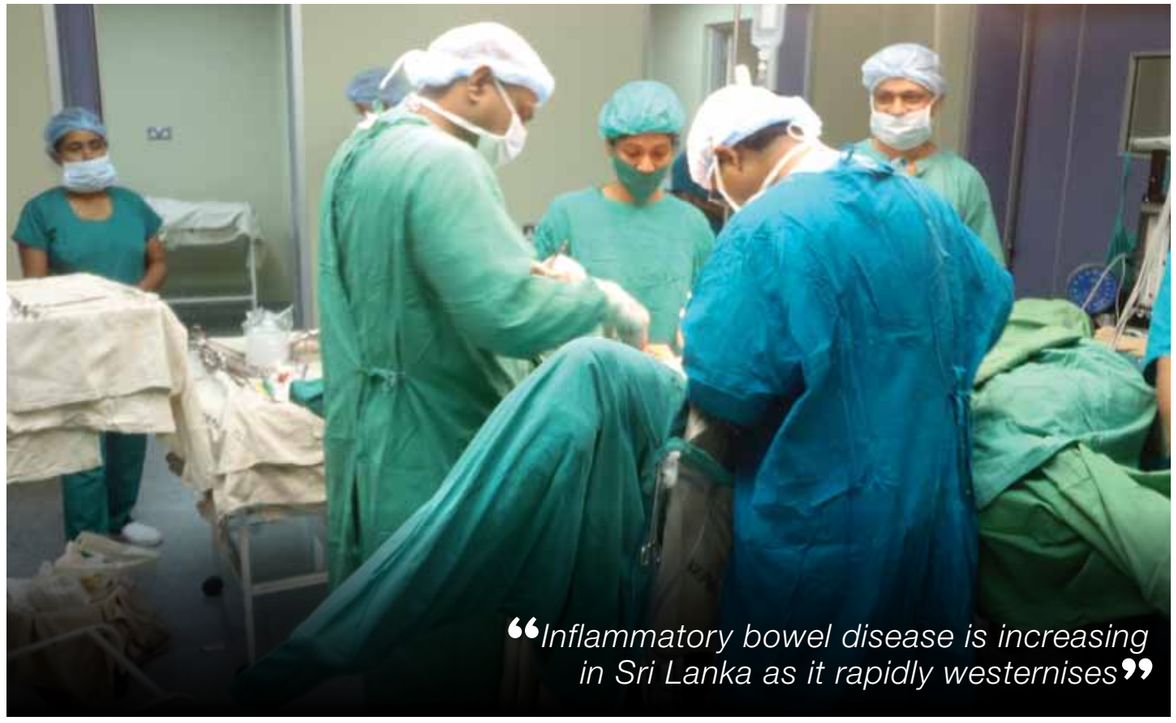
"I believe that happy and healthy doctors make for better patient outcomes and have been looking into the workforce factors that can cause junior doctors both stress and distress so that we can help redesign the workplace to take doctor safety into account."

With Karen Murphy

> *"The support of the College and therefore the wider surgical community has been absolutely vital in advancing this research."*

College support in Sri Lanka

Fellow Dr Nimalan Pathma-Nathan recently travelled to Sri Lanka to teach and assist in operations for inflammatory bowel disease



Fellow Dr Nimalan Pathma-Nathan took part in a trip to Sri Lanka recently, organised and funded by the College's International Development program as well as the Gastroenterological Surgical Society and College of Surgeons in that region.

Sri Lanka has an increasing incidence of inflammatory bowel disease. Sri Lankan Gastrointestinal surgeon Dr Amal Priyantha, who operates a practice that covers both upper and lower GIT surgery, requested assistance in teaching and performing pouch surgery at Kandy General Hospital.

Kandy General Hospital is the second largest hospital in Sri Lanka and services the central region. It has 3,000 beds with a full host of modern medical facilities and specialties.

Dr Pathma-Nathan from Westmead, helped Dr Priyantha manage several patients with chronic ulcerative colitis requiring proctocolectomy and ileal J pouches. Patients were selected over the previous few months and Dr Pathma-Nathan was able to see them all preoperatively and discussed appropriate management.

He performed several open and laparoscopic proctocolectomy and ileal J pouch procedures, all with the assistance of Dr Priyantha and his team of registrars.

Johnson and Johnson provided all staplers for the procedures as well as a harmonic scalpel. The theatre had state of the art laparoscopic equipment as well, which also assisted in performing some of the operations.

After his work, Dr Pathma-Nathan was treated to a formal reception at Kandy Hospital. The chief minister for the Central Province attended and Dr Pathma-Nathan was presented with a plaque. Families of the patients operated upon also made presentations.

"I was surprised and very honoured by this gesture and the plaque will take pride of place on my mantelpiece."

At the conclusion of the trip to Sri Lanka, Dr Pathma-Nathan visited College of Surgeons in Colombo, and was hosted by the Sri Lankan College President Dr K. Fernando. Here, he gave a lecture to surgeons and trainees on surgical management of inflammatory bowel disease.

"The trip was a great success and I was very well looked after. I was invited to join the International Chapter of their College, which I graciously accepted. I encourage other Fellows to visit this wonderful country."

Skills needed in a state of emergency

MSF Surgical Advisor Dr Patrick Herard talks about the work that goes into an emergency program and the range of skills needed in their volunteers

In January last year, when a level seven earthquake hit Haiti devastating the capital Port-au-Prince, killing more than 230,000 people and leaving more than a million homeless, Medecins Sans Frontieres (MSF) was already there in the midst of the catastrophe.

For the previous five years, MSF had been treating the impoverished people of the capital and surrounding regions at an emergency health centre.

Yet while the earthquake destroyed both the obstetrical and trauma hospitals with the health centre quickly overwhelmed, the fact that staff were on the ground meant that MSF was able to launch one of its fastest and largest emergency aid programs ever delivered since its establishment in 1971.

While surgeons, anaesthetists and nursing staff began treating hundreds of wounded, the MSF emergency desk began a massive logistical exercise from Paris to find and hire the enormous Russian cargo planes needed to transport tonnes of equipment.

Over the following two days, 17 planes equipped with supplies to fit out an entire hospital arrived in neighbouring Santo Domingo and trucked to Port-au-Prince.

From Paris, MSF Surgical Advisor Dr Patrick Herard provided advice on the set-up and daily operations. Two months later, in March, he joined the team in Haiti.

In Australia in February to address the Austrauma Conference in Sydney, Dr Herard, an orthopaedic surgeon, said the aid intervention worked in two phases.

"In the immediate aftermath, the conditions themselves created a natural though tragic triage in that most of the buildings were made of concrete and so collapsed like cards, meaning that people in or near them were dead rather than injured," he said.

"Most of the wounded were limb wounded and so we concentrated our efforts on debriding wounds and dealing with open fractures and crush syndrome.

"While expatriate surgeons began to arrive, our local staff already there did most of this initial work which is a testimony to their courage and dedication, given that many had dead or injured victims of the earthquake within their own families.

Dr Herard said the second phase moved the main MSF operations into nine inflatable tents where surgery began on Day 13. Within a month, this hospital complex grew to 40 tents including 230 beds, three operating theatres and multiple specialised facilities.

While 12 surgeons operated on the wounded in the first weeks, constant rotations of volunteer surgeons have since meant that more than 16,578 surgeries have now been conducted with more than 358,000 patients treated.

"While MSF does not really concentrate on the surgical specialties of volunteers, we do need surgeons who have training for such situations, surgeons who are familiar with war surgery, or working in other catastrophes," Dr Herard said.

"We try to send only surgeons who are familiar with MSF protocols and who have experience in such settings because they have to manage a huge number of wounded,

"They need to understand various cultural and local issues because in some countries you cannot amputate for religious reasons, and they have to have the skills and emotional strength to be able to work quickly in substandard conditions.

"However, while this has been our practice since we first began offering surgery as part of our interventions, the increase in surgical specialisation means that we now have a clear and on-going need for surgeons to cope with various surgical procedures."

Dr Herard said this was the first aid mission undertaken by MSF that specifically asked for the assistance of plastic surgeons.

"I think plastic surgery training is a real added value in this kind of catastrophe, whether in a general or an orthopaedic surgeon," he said.

Dr Herard said that the problems associated with modern subspecialisation – in that an increasing number of surgeons did not feel confident stepping outside their areas of expertise – had led MSF to establish a dedicated facility in Germany to train volunteer surgeons.

The three-day course held in Cologne is open to any surgeon who has previously volunteered with MSF.

"Haiti was one of the biggest surgical responses ever launched by MSF and cost us all the money that had been donated for the emergency response," Dr Herard said.

"The most valuable lessons we learned from this catastrophe were how effectively we could respond, thanks to those already working in Haiti; the need for lighter infrastructure, prior to a fuller build-up based on need; and the quality of care unprecedented in MSF's disaster response."

The 11th Annual Trauma, Critical Care and Emergency Surgery Conference was held at the Sydney Convention and Exhibition Centre from 17 – 19 February.

With Karen Murphy

Are you interested in sharing your skills to support the medical humanitarian work of Medecins Sans Frontieres? learn more at www.msf.org.au/join-our-team

Fear of rising dog attacks – a call for action?

The College Trauma Committee has had its attention drawn to the seemingly growing trend of dog bites in the community. However, there first needs to be good data analysis and feedback from Fellows on the topic.

A/Professor Daryl Wall,
Chair, College Trauma Committee and
A/Professor Rob Atkinson,
Chair, SA Trauma Committee

Several Fellows have raised concerns regarding an apparent rise in dog attacks. They also ask can the College lend its support to a call for action. No doubt we are all aware of the many serious injuries inflicted by dogs in Australia and New Zealand.

Our Fellowship is in a good position to influence policy makers regarding animal management practices to reduce this often devastating injury. There is a need however, to review some of the research that has been done in this area.

While injury rates and patterns of injury have been reasonably well documented, data related to the epidemiology of dog-related injury (e.g. the circumstances and breed of dogs associated with attacks) is not as strong. It is feasible therefore that our first calls for action may relate to encouraging the updating of data and further research on the epidemiology of dog-related injury.

A National Injury Surveillance Unit (NISU) paper indicated that between 2000 and 2003, the equivalent of 11.3 cases per 100,000 were hospitalised for dog related injury. In New Zealand between 5 and 7 per 100,000 were hospitalised for dog related injury between 1990 and 2001. Since 2002, a new classification enables separation of dog-related cases due to bites from those due to being struck by a dog.

It seems that over 75-year-olds are particularly vulnerable to orthopaedic injury as a result of being struck by a dog. The 0 to 9-year-old group experience the highest rate of dog-related injury – mostly bites – particularly open wounds to the head. Among older children and adults under 75 years, the injury rates are lower and are largely to the hand and forearm.

Of great concern is that, in Victoria at least, while an average of one death and 482 hospital admissions occur each year due to dog bites, more than three times that many present to the ED, are treated and sent home. Furthermore, there are no statistics on the number of dog bite injuries treated by general practitioners. The extent of the issue is therefore potentially enormous.

An early South Australian study (1990) identified the breeds involved in attacks – six breeds, which accounted for 21.5 per cent of dog population, were involved in close to three-quarters of the attacks. Bull Terriers, German Shepherds, Dobermans, Rottweilers and Blue Heelers were particularly over-represented. Further studies concluded that the relative risk of attack by a German Shepherd was five times greater than a Collie.

These sorts of studies however, are reliant on having reliable identification of dog breeds and reliable estimates of population size of all breeds – which is dependent of the level of compliance of populations with local licensing laws. Also in these sorts of studies no comparison has been made in regards to demographic, psychographic or personality data of dog owners.

What is known, however, is that in the majority of dog attacks, particularly in children, the dog is familiar to the victim. Using Victorian emergency department data – the majority of dog attacks occurred outdoors at a private home. This trend is also reflected in some overseas jurisdictions.

The injury rates and the circumstances in which injury occurs are vastly different in Australia's remote areas, particularly in indigenous communities. The number of patients admitted to Alice Springs Hospital for dog bite injuries between 2000 and 2007 is trending upward. Similar to Victoria, Dr Jacob Jacob (Alice Springs Hospital) estimates that three times as many injuries are seen in the ED, are treated and sent home. The extent of the issue is significant. The age distribution graphs in Alice Springs peak at aged 30 to 44 years, whereas nationally the peak injury age group is 0 to 9 years. Most injuries occur in town camps where many of the dogs congregate.

A National Animal Management Workshop in Alice Springs in February, 2010, helped to produce a new Alice Springs dog management policy of two dogs per household, requirements for dog registration, de-sexing and micro-chipping and ranger removal of strays and is reported to be working well.

The level of conformity with local by-laws, however, in other remote and rural communities varies significantly such that in some communities, such a program would be difficult to enforce. The workshop highlighted that dogs are an important part of Indigenous life and that dog health is very closely linked with human health. There needs to be a considered view on linking animal management and human wellbeing into the broader policy environment.

Research and statistics aside, any policies and recommendations regarding dog management need to be mindful of the significance of the roles that dogs have played in society for nearly 15,000 years. Dogs have had significant roles in hunting, herding, protection, war, policing, companionship and, more recently, assisting people with a disability.

The over-representation of children in injury statistics and the involvement of dogs familiar to the victim suggest an emphasis on policies and programs on dog owner education and breed suitability targeting both adults and children.

The College Trauma Committee is considering the research and views of various stakeholders and would like to hear the opinions of College Fellows and Trainees to help formulate a College position which can be taken to policy makers to ensure a decline in the rate of this devastating injury.

Any feedback can emailed to trauma@surgeons.org

RACS SA, NT & WA ANNUAL SCIENTIFIC MEETING

11 - 13 AUGUST 2011

VOYAGES AYRES ROCK RESORT (ULURU)

Save the date in your diary!!

The setting of one of Australia's iconic landscapes will form the backdrop for the combined RACS WA, SA and NT Annual Scientific Meeting for 2011.

The Voyages Ayres Rock Resort is located at the gateway to the worlds heritage listed Uluru – Kata Tjuta National Park, a perfect base for exploring one of the worlds national wonders.

A focus on the common issues of workforce and training will complement interesting clinical conversations with a reflective session on 'Surgical Success Stories' with some recognisable and less celebrated but equally successful surgeons.

Be sure not to miss on the commune with the Outback in The Sounds of Silence Dinner – a special cultural experience in the Red Centre, to be held on the evening of Friday 12 August.

Call for abstracts are now open.
Please contact the RACS SA and WA Regional Offices for a copy of the call for abstracts:

RACS SA 08 8239 1000
college.sa@surgeons.org
RACS WA 08 6389 8699
college.wa@surgeons.org
See you at 'The Rock' in August!
Mr Peter Subramaniam
2011 ASM SA, NT & WA Convener

Is your course accredited by the College?

If you run a course or workshop and are interested in having it recognised for its educational value, you may apply to have it approved by the College as an accredited course.

Mr Phil Truskett,
Chair, Skills Education Committee

The Royal Australasian College of Surgeons invites applications for accreditation of educational courses or activities. The College accredits activities that will support trainees and surgeons to obtain, maintain and extend their professional skills.

What is accreditation?

Course accreditation recognises that a course or educational activity meets College quality assurance requirements. Through gaining accreditation, course providers can be assured that their curriculum is aligned to and consistent with College standards, to the benefit of both the provider and participant.

Who can apply?

Accredited courses and educational activities may be:

- short courses
- university courses for medical students / modules as an adjunct to training
- postgraduate level courses
- online learning activities
- practice visit programs
- conferences and workshops

Activities not on this list will also be considered. Applications will be accepted from the course developer or governance group.

Cost

In 2011, the application fee is:
Australia: $1,100 including GST, **New Zealand:** $1,360 including GST

This fee is waived for courses that are a requirement of surgical training where no course fee is charged.

How to apply

Visit www.surgeons.org > Education & Trainees > Course Accreditation for information and the application form.

You can also contact the Accreditation Officer at course.accreditation@surgeons.org. Applications must be submitted electronically, with all attachments.

What happens to my application?

Course accreditation takes approximately three months. Complete applications are assessed by the College for educational content and then by the Course Accreditation Approval Subcommittee (CAASC) for medical and/or clinical content.

Applicants receive written notification of the outcome of their application. Successful courses and activities are approved by the Education Board, are advertised on the College's website and are accredited for a specified period of time.

Please note that the Course Accreditation process does not confer CME/CPD points.

Mind your own business

Socialising is not what it used to be

Surgical trainees should be aware of the sometimes hidden pitfalls posed by the use of social media such as Facebook and Twitter and are now being invited to read the recently released guidelines for use of such platforms designed by the AMA, according to the Chairman of the RACS Trainees Association (RACSTA), Dr Greg O'Grady.

Dr O'Grady said that while surgical trainees now comprise the first generation of surgeons to grow up in the electronic age, such networking forums may seem a natural part of the social environment, yet they do remain a risk to privacy and professional status.

He said it was essential for surgeons and trainees using such social media platforms to learn the mechanisms that allow them to limit and manage their own privacy and access settings as well as understanding how images and information can be placed on social media pages by other people and potentially accessed by others.

Dr O'Grady said that while the AMA guidelines listed examples of doctors sharing patient information on such platforms, as well as patients seeking to cross professional boundaries to become online friends with their doctor, such issues regarding surgical trainees had not yet come to the attention of RACSTA. However, one issue that has been of particular concern to trainees was media accessing private information.

"In the last two weeks alone we have become aware of two cases, both of which related to members of the media plucking content from a Facebook page to use alongside a story relating to surgery and two particular trainees," he said.

"They were unprofessional images that were not even posted by the individuals in question but placed on Facebook by other people and found by the media.

"This means that we are advising all trainees and surgeons to constantly monitor their online social presence including tagged images or information and to keep their own privacy settings well controlled.

"We are keen to remind everyone that whatever is on the public record can be used against them aggressively and perhaps unethically by the media who sometimes seem to have an ability to circumvent privacy settings."

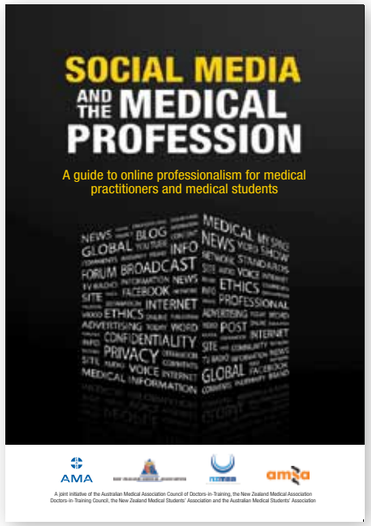
The AMA released its Social Media guidelines late last year after a range of studies indicated the growing use of such user-generated platforms such as blogging, personal websites and online networking by the medical profession.

According to its guideline document, a 2009 US study showed that 60 per cent of responding deans of medical schools reported that medical students had posted unprofessional content online, including violations of patient confidentiality, use of profanity, discriminatory language, depiction of intoxication and sexually suggestive material.

Yet, while such behaviour in the past may have stayed in the past, now if posted online such information can stay online to become a haunting electronic reminder of youthful indiscretions.

The key aspects of the AMA guidelines include:

- **Confidentiality –** all doctors must ensure that any patient or situation cannot be identified by the sum of information available online;
- **Defamation –** ensure that no defamatory content about a patient, colleague or even workplaces is accessible;
- **Setting and maintaining doctor-patient boundaries –** avoid online relationships with current or former patients, politely refuse requests to become a "friend" or establish a professional page with suitable content for them to access;
- **Consider the destiny of your data –** some of which can remain online for years and can therefore be accessed by potential employers. Think about what you are writing, what may be considered offensive and which organisations you are joining;
- **Take control of your privacy –** understand the controls, settings and regulations of your chosen social media platform including default settings, the effects of adding an application to a profile and read the privacy policy.



Dr O'Grady said that while there were risks associated with the use of social media, most trainees would not choose to avoid such media, but rather would use them with appropriate controls.

He said trainees simply needed to remember that professionalism remained one of the key competencies for being a surgeon.

"Everyone is entitled to relax and let their guard down in social situations, but now we also need to understand that information and images can turn up anywhere," he said.

"It is extremely common for trainees to use such social media platforms as Facebook now with considerable social activity conducted through these means, but our recent experience shows they are clearly not free of risk and it is important that is understood.

"At the same time, they can be very useful tools in a professional sense.

"Many doctors and surgeons now have professional practice pages on such platforms, engage in professional discussions and forums while Twitter, for example, can be of use in reminding people of such matters as exam dates and registration deadlines for seminars and courses.

"The use of such platforms therefore is about finding the balance between professionalism and private social engagement."

With Karen Murphy

The AMA guidelines were released in November and are a joint initiative of the AMA Council of Doctors-in-Training, the New Zealand Medical Association Doctors-in-Training, the New Zealand Medical Students' Association and the Australian Medical Students' Association. They can be found on the AMA website, ama.com.au

The Echinococcosis miasma

The recordings of the occurrence of these cysts form an important part of the College's research history

Mr Mike Hollands
Treasurer

Hippocrates identified the presence of hydatid cysts in humans and animals in the 4th century BC, but it was not until 1766 that Pierre Pallas suggested that hydatid cysts were the laval stages of tapeworms. And by the late 19th century when the clinical features of hydatid disease were fully understood, the disease was rife in Australia and New Zealand.

In 1986 Barrie Aarons, creator of the Aarons hydatid cone, which is now part of the College collection, wrote:

...of interest, may be the fact that hydatid disease has practically disappeared from our region after having the dubious title of the 'Hydatid Centre of Australia'. This is largely due to the efforts of a number of people with education programmes for the prevention of hydatiadosis and modern methods of surgical treatment.

Aarons worked in Hamilton and the region he was talking about was Victoria's sheep farming capital, the Western Districts.

Despite elimination of hydatids in some areas, education campaigns, government legislation and research into a sheep vaccine, the disease has not been eradicated in either Australia or New Zealand.

In Australia's case, apart from the vastness of the landscape, which hinders the effectiveness of eradication programs, hydatids is now carried by the wildlife population as well as the traditional dogs and foxes, thus giving more scope for transmission of the disease.

Surgery, now augmented by chemotherapy, was and still is the main method of dealing with hydatid cysts. In the early years, diagnosis was problematic.

In 1935 Sir Louis Barnett elucidated the advances in diagnosis – from clinical examination and X-Ray, which was faulty in more than half the cases to the Complement Fixation and Casoni (skin) tests, which increased the diagnostic success to more than 80 per cent. However, none of these methods were infallible and diagnosis continued to be difficult.

And as the following story told by Archibald Watson to J.O (Orm) Smith indicates, hydatid cysts could be discovered by accident. In the 1920s, a mugger who had accosted a woman near St Vincent's Hospital was shot in the back by police and taken to hospital. The bullet was extracted and three days later daughter cysts were oozing from the wound. Watson used the story to reinforce his view that a posterior approach (without opening the pleural or peritoneal cavity) should be used when draining liver cysts.

In 1926, Sir Louis Barnett visited the man he called the 'doyen of hydatid parasitologists', Professor Félix Dévé. Although hydatids were not common around Rouen where Dévé practised, he had accumulated data from over 200 cases in nearby regions.

Barnett was very impressed by Dévé and in 1935 he stated that "To Dévé we owe the technique of preliminary formalisation and other precautions against post-operative recurrences..." He also mentions Dévé's practical invention of a "3 way trocar to facilitate removal of hydatid fluid and the subsequent flushing of the cyst cavity with formalin solution."

Soon after his encounter with Dévé, Barnett, aided by New Zealand and Australian surgeons, set up the Hydatid Registry. Covering the period 1927-1950, the Registry was originally housed in the College Library.

In 1939, Sir Louis Barnett as the Registrar-in-Chief reported that "the accumulated records now number over 1300, together with card index and précis..." The records were grouped under the tissue names constituting the main location in the body and filed numerically. Both records and index differentiated between Australian and New Zealand cases.

The Hydatid Registry of 2,058 cases and their associated documents now reside in the College Archive – an extraordinary record of medical and surgical practice in the first half of the 20th century.

With Elizabeth Milford, College Archivist

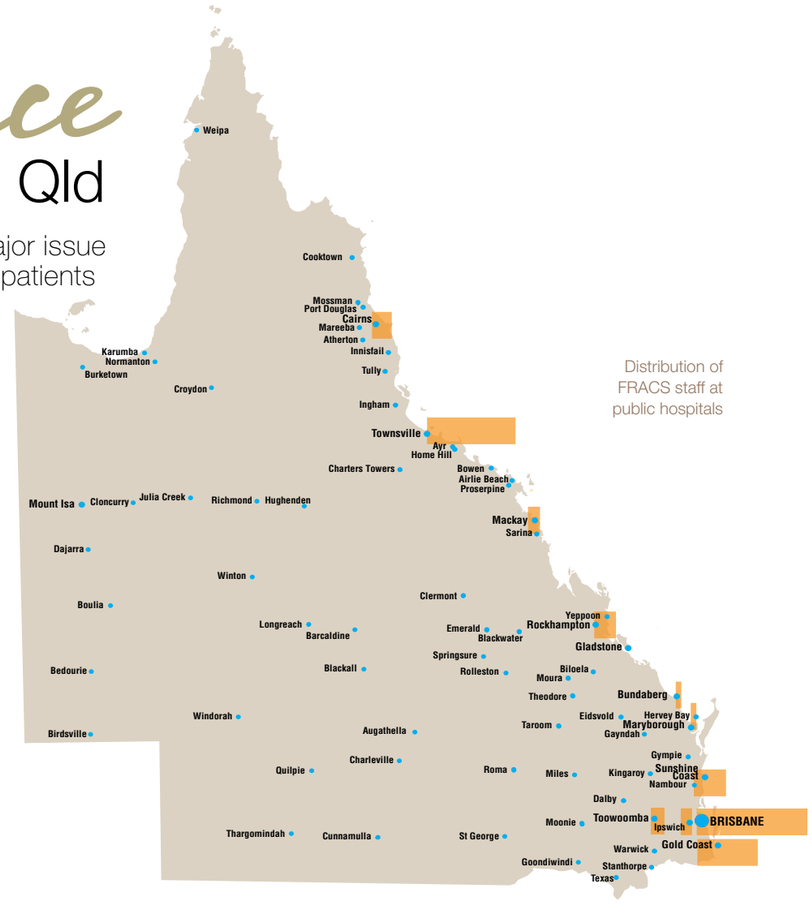
> *"To Dévé we owe the technique of preliminary formalisation and other precautions against post-operative recurrences..."*

Top: the Aarons cone is held by the College museum; bottom: a case of hydatid cysts.

Distance
a fact of death in Qld

Queensland's breadth can be a major issue when considering the treatment of patients

Dr John North
QASM Clinical Director



Distribution of FRACS staff at public hospitals

Queensland is a geographically large and decentralised state. In fact, it is the most decentralised state in Australia. Distance issues are paramount for all industries and services within Queensland, and are particularly important to consider in the health sector.

The Queensland population (4.6 million) is 20 per cent of Australia's population, and inhabits 22 per cent of Australia's geographical area. Compare this to Victoria, where 25 per cent of Australia's population inhabits 3 per cent of Australia's geographical area.

In Queensland, surgical services are situated mostly along the state's coastal fringe. Twenty-one Queensland Health hospitals (mostly located along the state's coastal fringe) have Fellows of the Royal Australasian College of Surgeons (FRACS) as visiting or full-time staff. Considering the non-coastal cities and towns, only Toowoomba and Atherton have FRACS specialist surgical services. Other non-coastal cities and towns have limited surgical services. For example,

- Mt Isa (city) has one visiting surgeon
- Longreach (town) has three visiting surgeons
- Collinsvale, Bowen and Theodore (all central coal-basin towns) have one visiting surgeon who sees outpatients but refers for surgery to a larger centre

(Note: Not all of these surgeons see public hospital patients on their visits.)

This prompted us to ask, can we remove the distance factor from surgical practice? When reviewing this issue, the Queensland Audit of Surgical Mortality (QASM) data (2007-2011) shows that because of distance issues:

- Thirty-five per cent (748/2,168) of QASM cases were transferred from a smaller to a larger hospital
- Some of the clinical reasons for transfer were: bowel pathology – eight per cent (54/637); neurosurgery – eight per cent (54/637); sepsis – eight per cent (56/637)
- Fifteen per cent (98/637) of those transferred had delays (for various reasons) in the transfer. Note: not all surgeons gave all details about the transfers.
- Eighty-six per cent (548/637) of patients who died had multiple co-morbidities
- The mean distance for transfer was 213 km
- Approximately 100 smaller hospitals transferred to the 21 coastal tertiary referral hospitals

Looking deeper at the QASM data, a further question can be asked; is the need to transfer a predictor of death?

Because there are fewer surgeons located more than 100 km from the coastal cities and towns than surgeons located in coastal cities and towns, and because there are limited visits by surgeons to non-coastal cities and towns, then the need to transfer patients may be considered appropriate.

For instance, in certain circumstances where surgery is required for acute bowel pathology; fractured neck of femur; severe sepsis; and multi-trauma, the 'need to transfer' may, in fact, 'foretell' an end-of-life situation.

There is no doubt that dead bowel, severe sepsis, and fractured neck of femur (with or without multiple co-morbidities) can be, and often are, terminal events.

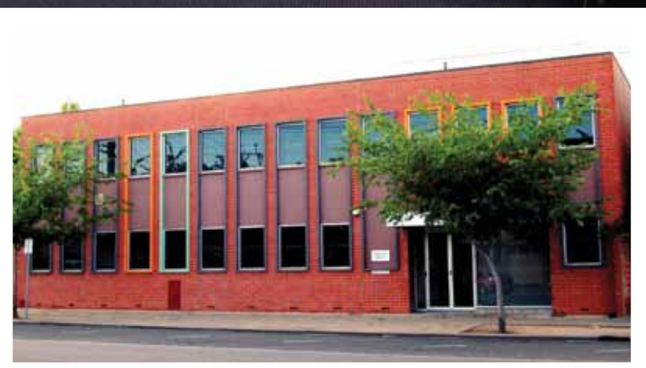
With these facts in mind, should there be a change in the decision-making process when it comes to the long-distance transfers of seriously ill patients who may require surgery?

For many surgical referrals, the distance factor will remain. However, what needs to be considered is the collaboration between the referring doctor and the receiving consultant surgeon (who may be on call at the tertiary referral hospital). Unfortunately, this collaboration is not always straight forward. Referrals that end with patients dying quickly after admission at the receiving hospital are relatively common.

Continuing data analysis will certainly expose more questions that will need to be addressed. It is anticipated that analysis of this information may eventually improve the management of transferred patients through the difficult corridors of delay, of transfer, and of treatment for serious surgical conditions that would normally lead to death.

College hub in South Australia

The uniting of three important parts of the College in SA will help the RAAS Division strive for surgical excellence



The new premises at 199 Ward St

The Research, Audit and Academic Surgery (RAAS) Division in South Australia has moved from three separate offices at Stepney into one building at 199 Ward Street, North Adelaide, directly behind the South Australian Regional Office of the College on Palmer Place.

A number of College projects will now be based under the same roof, namely the Australian Safety and Efficacy Register of New Interventional Procedures- Surgical (ASERNIP-S), the Simulated Surgical Skills Program, the National Breast Cancer Audit, the Australian and New Zealand Gastric and Oesophageal Surgical Association Audit, the Scholarships Program, the Logbooks Project, the national office of the Australian and New Zealand Audit of Surgical Mortality and the South Australian Audit of Peri-operative Mortality.

A feature of the new premises is the dry Surgical Skills Centre, which should continue to operate as an education centre after Commonwealth funding for the Simulated Surgical Skills Program ends in September 2011.

Following the successful trial of the Mobile Simulation Unit, a second surgical simulation van is being built to give trainees located outside city centres in South Australia and Victoria access to this valuable training program.

With the RAAS Division now just a few steps from the South Australian Regional Office, Fellows will have easy access to all College-related activities. In addition, staff from both offices will have the opportunity to forge closer ties and collaborate on related activities. The provision of consolidated information technology and telecommunication systems will provide both logistical and significant financial benefits to the College in the future.

What does the Fellowship examination assess?

The Fellowship examination is the final, exhaustive summative assessment, the definitive 'exit' exam

Spencer Beasley
Chair, Court of Examiners

The SET programs of all nine specialties are designed to produce surgeons of a high calibre. We expect they should be capable of practicing safely at consultant level without direct supervision.

The competencies that all surgeons would be expected to have acquired by the completion of training are well described and publicised http://www.surgeons.org/racs/education--trainees/training/standards-and-protocols/competencies and form the basis of each speciality's curriculum.

But how do we assess whether a trainee surgeon has achieved the required level of surgical competence? SET training is peppered with assessments, including the generic and specialty-specific surgical science examinations, and regular in-training reports. But of the various assessments employed, arguably the most important – given that it is the final and exhaustive summative assessment, the definitive "exit" examination – is the Fellowship examination.

It is worth remembering that in earlier years the final Fellowship examination was really the only formal assessment undertaken during advanced surgical training; nowadays, it is only one of an array of assessments employed by the specialty training boards during the course of SET training. But it is the one on which most reliance is placed.

Nevertheless, it must be acknowledged that reliable and valid assessment of competence still remains a challenge, and the tools we use are widely recognised as having their limitations.

Any one of the seven components of the Fellowship examination may cover one or more of the surgical competencies, but it is not expected that all need be evaluated. This is because many competencies (including several non-technical skills) should be acquired and are better tested earlier on in training.

Also, for many of these competencies, the Fellowship examination does not have at its disposal the best assessment tools. For example, technical expertise and operative experience are better assessed through DOPS (Direct Observation of Procedural Skills), In-Training Assessments and the operative logbook.

In contrast, the Fellowship examination itself is more suited to assessing operative decision-making and judgement.

Anything in the syllabus is considered fair game. To ensure reasonable and representative coverage of the syllabus, a process called 'blueprinting' is used. Blueprinting applies not just to the scope of topics covered, but also relates each question to specific competencies, and considers the level of cognitive function that each entails.

Bloom's taxonomy is one model for the classification of level of cognitive function, with knowledge recall being at the lower end, and complex evaluation of knowledge at the high end. The lower levels can be attained with superficial learning, such as rote memorisation.

The old BST exams were an example of this, with almost all questions requiring recall of knowledge only. It is interesting to observe that in recent refinements to the Surgical Science examinations, the taxonomy level at which the surgical sciences are being tested is being lifted, and increasingly places the questions in a clinical context.

Obviously, as an exit examination, the Fellowship examination is focused on the higher levels of cognitive function, such as clinical evaluation, and justification of management plans. Questions are carefully framed to get the candidate to demonstrate these higher levels of thinking, the very skills that they would use to be safe and competent in clinical practice.

This is one of the ways we can ensure that our Fellowship examination remains a valid way of demonstrating that a candidate has reached the expected standard of surgical competence to be let loose on the community.

Events in the ACT

An active past year at the ACT regional office

Dr Carolyn Cho

Within the last year the ACT Regional Committee has seen some Fellows step down from the committee and new Fellows commencing. One of the aims of the Committee is to have representation from a wide range of craft groups, so that the ACT surgical committee can be well represented. The current committee includes:

Mr Hodo Haxhimolla (Secretary/Treasurer), Mr Sivakumar Gananadha, Mr Wendell Neilson, Mr Damian Smith, Mr Peter Subramaniam and Mr John Tharion with me Dr Carolyn Cho as Chair. Co-opted members include: Professor David Hardman, Mr Damian McMahon and Mr David Rangiah.

In March 2010, a Registrars' Cocktail party was held at the ACT Regional Office. This is a function intended to welcome new trainees to the ACT and is always an informal way of meeting fellow trainees and surgeons from all specialties. It has been held on an annual basis and will be held again in 2011.

The ACT Regional Annual Scientific Meeting was held on 18 September, 2010. This year's ASM was convened by Mr Charles Mosse with the theme of the meeting being Surgical Safety. Mr Rob Padbury, Director, Flinders Medical Centre in Adelaide was the guest speaker and his presentation on "Delivering quality surgical care in 2010" generated considerable local interest.

In order to strengthen our ties with regional centres in NSW, Fellows from around South-East NSW were also included in the invitations to attend. A closer relationship with centres such as Wagga Wagga, Albury and Bega will also benefit our SET trainees and perhaps provide further training opportunities in the region.

The ACT regional committee also invited interested medical students from the ANU Medical School to present papers. As a further incentive, there are also separate prizes for the best registrar paper as well as the best student paper.

At the 2010 ASM, the best Registrar's paper was awarded to Dr Ramanujan Ganesalingam for his paper on "Radiological Predictors of Recurrent Primary Spontaneous Pneumothorax following Non-Surgical Management". Congratulations to all who presented for their work and effort.

College matters

The Surgical Safety Checklist was launched in Canberra last year and the Regional Committee has once again emphasised the importance of surgeons initiating and implementing the checklist in public and private hospitals.

It is vital that surgical safety issues are run and 'owned' by the surgeons and not by nursing staff or administrators. Since the launch, the checklist has been trialled and implemented in all ACT hospitals, both Public and Private.

Mr John Tharion, thoracic surgeon, was appointed Clinical Director of the ACT Audit of Surgical Mortality in 2010 following an interview process. The Audit Office is located at secure premises at the ACT Regional Office and started data collection on 1 October, 2010.

In the ACT, so far three hospitals have agreed to participate. As the ACT Surgical Community has smaller numbers in some specialties, this has made the process of appointing surgeons as first or second line assessors more delicate, and a proportion of cases will need to be reviewed interstate.

From 2010 onward the ACT Regional Newsletter and notification of other events such as the annual scientific meeting will be via email in the first instance.

Hopefully e-news will facilitate communication between the committee and local Fellows and encourage and motivate Fellows and Trainees to participate in regional events. Email is being used more commonly and should hopefully facilitate feedback from Fellows to the ACT Committee.

I will be stepping down from the role of Chair of the ACT Regional Committee in June, 2011. It has been an instructive and enjoyable experience which has provided a useful insight into the workings of the RACS as a whole. As a Younger Fellow, I would encourage other young surgeons to consider participating in the College either through their local committee or in another way.

INTERNATIONAL SOCIETY OF SURGERY (ISS/SIC) AUSTRALIAN CHAPTER

AUSTRALIAN TRAVEL AWARDS
ISW2011 will be held in Yokahoma, Japan from 28 August-1 September 2011. The Australian Chapter of the International Society of Surgery is offering two Travelling Fellowship Awards of AUD$3,000 each, for trainees and young surgeons.

If you have had an abstract for a paper or poster accepted by ISW2011 and you fit the criteria below, you may apply for an ISS/SIC Australian Travelling Fellowship award.

ELIGIBILITY
>Trainees who are Australian citizens or working in Australia on an Australian working visa.
>Surgeons under 40 years of age or who are within ten years of obtaining FRACS.

REQUIREMENTS
>Documentation from ISW2011 indicating that an abstract has been received and accepted.
>A copy of the abstract.
>A current curriculum vitae.

DEADLINE
A letter of application, abstract, and curriculum vitae must be received Saturday 30 April, 2011. Applications to Mr Peter Malycha at email: peter.malycha@adelaide.edu.au

WEBSITE
www.isw2011.com

QUESTIONS
Mr Peter Malycha, 333 South Terrace, Adelaide, +61 8 8223 5106. The recipients of the travelling scholarship will be notified via electronic mail no later than Tuesday 31 May, 2011.

Doctors' fear of being sued

How litigation can affect the wider professional community

Mr Michael Gorton
College Solicitor

Results of a study recently published in the *Medical Journal of Australia*, suggest that doctors' concerns about medico-legal issues exert a significant influence on their everyday practices. The study reflects international evidence, (Summerton N. 'Positive and Negative factors in defensive medicine: a questionnaire study of General Practitioners') and concludes that doctors' perceived fear of legal action alters "the way they would normally practice medicine."

This has clear ramifications for patient care and treatment, as well as health system costs.

Medico-legal concerns

The effects of this fear are felt in a variety of ways. The study reveals that doctors are increasingly making referrals to specialist practitioners, ordering further tests – at the expense of the patient; while some doctors are unnecessarily prescribing expensive medication. Beyond these immediate effects on patients, doctors concerns about medical negligence claims cause many medical practitioners to consider giving up the practice of medicine, reducing their hours of work, contemplate early retirement and has, for some, contributed to a developing emotional distance with patients.

Whether it is doctors adopting a more negative attitude to work or the potential fracturing of the doctor-patient relationship, the negative consequences associated with this approach to medical practice can be readily perceived. Despite this, the study also indicates that an increased concern for medico-legal issues has contributed to a number of positive outcomes; in the form of better communication between doctors and patients and the development and implementation of improved quality and safety measures.

Putting to one side the potential benefits associated with this approach, the fact that these medico-legal concerns have the potential to compromise clinical judgment and burden the health care system with unnecessary costs and constraints means that the legitimacy of these concerns needs to be addressed.

The Law of Negligence

The study suggests that a majority of doctors who participated in the survey believe that the law requires them to make perfect decisions. The upshot of such an approach is that many, if not most doctors, appear to approach a consultation with the concern of a potential negligence claim being made against them at the forefront of their mind and with the belief that if they fail to discharge their duty to deliver a perfect diagnosis, then such a claim is likely to be prosecuted.

Such an approach to medical practice, while understandable, is grounded in a misconception of the law of negligence and an exaggerated view as to the number and frequency of medical negligence claims that are made by patients against practitioners.

Undoubtedly, a respect for and a conscious adherence to the law is to be encouraged among doctors, but just as importantly and to that end, an accurate conception of the law of negligence must be fostered. As such, despite the prevailing view of doctors, at law, doctors are only responsible for their own want of care, or the failure to apply the proper standard of skill and attention that might be expected in the circumstances.

In "Rogers v Whitaker", the Australian High Court confirmed the existing obligations of doctors to exercise reasonable care and skill in providing advice and treatment to patients. The standard of care and skill required is that of the ordinary skilled person exercising the particular specialist skills involved.

From a practical point of view, this means that a specialist practitioner in a certain field is required to have the skill "of the ordinary skilled person exercising and professing to have that skill." The law recognises the variability of individual practitioner's skills and does not, unlike many patients, demand perfection, nor does it demand that doctors always perform at the highest standard of their peers.

The standard of care is that which a "reasonable person" would have taken in the circumstances. The courts will determine whether that standard has been met. While the court may have regard to the practices and procedures of other doctors in similar circumstances, the court will ultimately determine whether the standard has been met, having regard, not to some subjective utopian conception of perfection, but to the skills of the doctor, general practices in the profession, the level of knowledge and research available and other relevant factors.

Significantly, patients are only entitled to claim compensation for loss or damage that they suffer as a consequence of the negligence of the doctor. A patient must show that the loss or damage would not otherwise have arisen if the doctor had not been negligent. Critically, there is an important distinction between negligence and merely an "adverse outcome". Patients, in proving their claim, are held to a higher standard than merely establishing that a less than optimal outcome was achieved. On a fundamental level, negligence is different from a mistake or an error of judgment. The fact that a risk of treatment eventuated, or that a desired medical outcome was not achieved, does not necessarily establish a claim of negligence.

The perception that the law demands perfection of doctors remains a fallacy and whilst many doctors may believe that they are at a constant and imminent risk of facing a claim, this perception is not supported factually.

Number and frequency of claims

The most recent report of the Medical Indemnity Industry Association of Australia (July 2008), suggests that in the financial year 2001/02 approximately six per cent of doctors faced a negligence compensation claim. However, in the final year of the study, financial year 2006/07, the percentage of doctors who faced a claim had fallen to approximately three per cent. The data suggests a trend that is continuing to evolve, whereby a decreasing number of doctors are facing claims for compensation, and more broadly, it becomes apparent, as these numbers are dissected further by area of speciality, that the total number of claims made appear to be decreasing.

"The perception that the law demands perfection of doctors remains a fallacy and while many doctors may believe that they are at a constant and imminent risk of facing a claim, this perception is not supported factually"

While it is apparent that the clinical practices of doctors are influenced by a perceived threat of legal liability, the reality is that few doctors are faced with claims for compensation throughout their career, and, if the current trend continues, the number of doctors that are faced with a claim may continue to decline.

Furthermore, where claims are made, in a further encouraging sign for doctors, the impact of tort reform and changing clinical and incident management practices, has contributed to a reduction in the average cost of claims on a per practitioner basis. Irrespective of this decline in the average cost of a claim, the successful prosecution of large claims, exceeding $500,000, appears to have an outsized influence on the medico-legal concerns of doctors. The threat of facing such a large claim for compensation is a scary proposition. However, as the study suggests, the chance of facing such a claim is remote and doctors should take solace from the decline in the cost of an average claim.

Despite the presence of large claims facing some practitioners, doctors generally appear to be operating in an environment where claims for compensation are fewer, the threat of litigation is diminished and the financial costs of claims are decreasing, all of which should serve to allay some of the concerns of doctors.

Encouraging though the reality may be, doctors should "remain alert, but not alarmed", and adopt best practices to avoid any potential litigation.

Avoiding and dealing with claims

The way doctors and hospitals communicate with their patients after an adverse event will substantially influence whether the patient considers making a formal claim or even suing for negligence. Best practice communication occurs at all stages in the provision of health care; both before any procedure in the form of informing the patient in relation to realistic outcomes, risks, side effects and costs; and after, in dealing with adverse outcomes.

Ultimately maintaining detailed and appropriate communication remains a doctor's best defence and a doctor who is attentive, responsive and sympathetic after an adverse outcome is less likely to be sued than the doctor who is dismissive, distant or less empathetic.

Good record keeping is also important in maintaining a defence to claims. The lack of records or notes can be a significant hurdle in disproving a patient's allegations against a doctor. To minimise legal risks and the effect of any potential litigation, doctors should ensure that appropriate insurance is maintained and all relevant standards, protocols and guidelines are followed. In addition doctors must ensure that they have good "informed consent" procedures; maintain detailed notes and records; respond to an adverse incident promptly and if in doubt, consult their insurer or legal adviser.

That doctors have a difficult job and face a challenging environment in which to practice is beyond question. However, it is a job made more difficult by exaggerated concerns about medico-legal issues. What can assist to alleviate some of the medico-legal concerns many doctors have is a greater understanding of the risks posed by, and potential likelihood of, a claim for compensation, and strategies available to mitigate those risks.

(I am grateful for the work of Esmond Prowse in the preparation of this article)

AAS Leadership Exchange

A meeting of minds came together between the Association for Academic Surgery and the Society of University Surgeons.

A/Professor Susan Neuhaus
AAS Leadership Exchange recipient

Dr Melina Kibbe, Dr Arman Kahokehr and Prof Scott LeMaire.

In February 2011, I had the great privilege of being the Younger Fellow's Visitor to the Academic Surgeons Congress in the US.

The Academic Surgical Congress is the combined meeting of the Association for Academic Surgery (AAS) and the Society of University Surgeons (SUS). They conducted a very diverse program with strong sessions on laboratory research, health outcomes research, surgical education and the impacts of diversity.

The meeting is truly integrated with papers presented by faculty, residents and medical students. 'Hot topics sessions' and 'State of the Art' lectures proved very popular as did the Presidents' Session on 'Unconscious Bias in Academia'.

The AAS is very much the 'formative core' of US academic surgery, representing surgeons who are in their early years of establishing academic careers. Their mission is to support and encourage young surgical scientists and faculty both in their research programs and their teaching and training roles.

It was refreshing to see the extent to which they both value and practice mentoring in very practical and formalised ways. The relaxed nature of the meeting, clear focus on developing skills and experience, inclusivity of medical students and an overriding sense of peer support, rather than competition, were highlights.

This award was fundamentally a leadership exchange, designed at providing insights into the mechanisms and opportunities of academic surgery in the US. As part of the leadership exchange, I was afforded the opportunity to sit in on both the AAS Council and Business meetings.

This year has been the most successful meeting to date for the AAS with more than 960 accepted abstracts, most of which have also been reviewed for publication in the Journal of Surgical Research. The insight into the running of such a large and diverse society, coordination of program and awards review processes was extremely valuable. I thank the outgoing President, Daniel Albo and his office bearers for this opportunity.

I was also deeply honoured to be afforded a position on the Plenary session to discuss the South Australian experience of part-time training in General Surgery. Clearly the issue of working hours restriction is very topical in the US with the relatively new introduction of an 80 hour working week.

Despite differences in our training systems and organisational work practices, the challenges we share are common; to break the nexus between 'hours' and 'competency' and to develop innovative ways to deliver training outcomes in a time effective manner, that meet the needs of our regulatory bodies, the trainees and the units on which they work.

Several members of the AAS Executive Group have visited Australia as part of the faculty of the Developing a Career in Academic Surgery (DCAS) program. This innovative program has provided the College with exceptional quality faculty, many of whom presented at the College ASC in 2010. The RACS Section of Academic Surgery, led by Professor John Windsor and ably facilitated by the inimitable Richard Hanney has made deep inroads into developing a strong, reciprocal and growing relationship with the AAS.

In May this year we will be privileged to host some of these immensely talented individuals; Justin Dimick, Lillian Kao and Tim Pawlik among others, when they visit Adelaide to participate in the 2011 DCAS program. Dr Carmel Solórzano will be the AAS Exchange visitor to the Younger Fellows Forum. This is a tremendous opportunity to continue to develop relationships and opportunities between the US and Australia, particularly with the future leadership group of academic surgery.

A developing relationship with the Surgical Research Society (SRS) has also been beneficial. Dr Arman Kahokehr, from Auckland, presented the Surgical Research Society of Australasia presentation on "The use of intraperitoneal local anaesthetic in colon resection". This paper demonstrated the high standard of clinical research emanating from Australasia.

Perhaps more impressively, however, Arman was elected from the floor as the newest member of the AAS Global Affairs Committee. This is a tremendous testament to the strength of the relationship that has been developed over the last few years and a very valuable opportunity for New Zealand.

The American Academic Surgical Congress was an inspiring meeting to have attended. The program provided me with some fabulous opportunities to reflect and focus on new areas, to develop relationships with my US peers as well as providing valuable insights into the leadership issues of developing academic surgical practice.

I highly commend this program and thank the faculty and council of the ASS for their very generous hospitality and the RACS Younger Fellows for the opportunity.

For more information about the Younger Fellows Leadership Exchange, please call +61 3 9249 1122 or email younger.fellows@surgeons.org

NSW Merit Award

Presented at the NSW Regional Committee End of Year Dinner, 19 November 2010

"Professor Gibson has undertaken cochlear implant surgery on over 1,800 ears and redesigned the skin incision."

Professor William P.R. Gibson AM

William P.R. Gibson was born shortly after D Day in Totnes, Devon as the first of identical twins. He studied medicine at The Middlesex Hospital and qualified in 1967. He gained his Surgical Fellowship at the tender age of 24.

He held various appointments in teaching hospitals in London before becoming a consultant surgeon at the National Hospital for Nervous Disease and the Royal National Throat Nose and Ear Hospital. In 1973, he was inducted to the International Collegium of Oto-rhinolaryngology as its youngest member.

In 1983, Professor Gibson migrated to Australia with his family to become the inaugural professor of the Chair of otolaryngology (ENT) at the University of Sydney following a bequest from Sir William Tyree. His major interest is otology and he has pioneered methods of examining the ear electrophysiologically. In particular, in developing electrocochleography as a robust means of early diagnosis of deafness in young children, and as a method of diagnosis of Meniere's disease.

Other interests are the auditory neuropathy spectrum of disorders and the use of electric auditory brainstem responses. In 1987, he performed the first Cochlear Implant in two congenitally deaf children. Although controversial at the time, this is now gold standard management.

He has undertaken cochlear implant surgery on over 1,800 ears and redesigned the skin incision. He has also suggested the "drainage theory" in Meniere's disease as the cause of attacks and has championed the removal of the endolymphatic sac in ears affected by the disease. He has written a book, contributed 20 chapters in textbooks and 184 scientific articles. He is on the editorial board of five international journals.

Professor Gibson is the head of the Ear, Nose and Throat Unit within the Department of Surgery at The University of Sydney. He was until recently the head of the ENT Department at The Royal Prince Alfred Hospital and works also at the Children's Hospital at Westmead and at The Mater Hospital, Crows Nest. He is the founder and director of the Sydney Cochlear Implant Centres at Gladesville, Newcastle, Gosford and Canberra.

In his spare time he is an active member of Rotary International and is proud to have received a Paul Harris Fellowship with a Sapphire pin and a Vocational Excellence Award. Other honours were The Humanitarian Award from The Variety Club of Australia (NSW) in 1994, a gold medal from The Prosper Meniere Society in 1998, and a clinical award from The Society for Promotion of International Otolaryngology in 1999.

He was given honorary membership of ENT UK in 2009 and received a gold medal from the British Academic Conference in Otolaryngology in 2009. In 1995, he became a member of The Order of Australia. Last year he was invited to give the Graham Coupland Memorial Lecture by the College of Surgeons.

Despite retirement looming, Bill's energetic interest in research into Menieres Disease continues with the recent approval of laboratory space and research scientists at the Brain and Mind Institute to investigate novel methods of diagnosis of Menieres Disease.

He enjoys boating on Sydney Harbour, fishing, eating curry and the company of five grandsons and one grand daughter.

Written by David Pohl

The mental health of doctors

Good physical and mental health for surgeons and other medical practitioners is vitally important

A/Professor Marianne Vonau
Chair, Professional Development Committee

Research and the media have highlighted higher rates of suicide, depression and anxiety among Australian medical students and practitioners than for the general population.

Previous studies have also demonstrated that medical professionals, including surgeons, may be particularly vulnerable to the experience of burnout. Burnout is a unique form of prolonged physical, emotional, and psychological exhaustion characteristic of individuals working in human service occupations.

In 2007, the College undertook a survey of Younger Fellows in which almost 27 per cent of Younger Fellows reported high levels of general burnout; significantly higher levels of general and work-related burnout than other human service workers.

More recently beyondblue has launched the Doctors' Mental Health Program and published a report 'The Mental Health of Doctors – A systematic literature review'1, which assesses the extent of the impact of mental illness in the medical profession, key barriers to help-seeking and gaps in current knowledge in this area. These are the key findings:

1. Prevalence of anxiety and depression. The rate of depression in medical practitioners varied from 14-60 per cent. These depression rates do not appear to be higher in medical professionals than in other professions, but the rate of depression appears higher in male medical professionals when compared with the general population.

Depression was frequently observed in medical practitioners at all stages of their training. The rate of anxiety among medical practitioners is also high, about 18-55 per cent. However, there is no evidence to suggest that anxiety is more prevalent in medical practitioners than in other professions. A major limitation of the studies was the range of methods used to assess anxiety and depression.

2. Risk factors for anxiety & depression. Studies generally reported that factors associated with improved well-being e.g. adequate sleep, job satisfaction, higher income, lower stress at work, were negatively correlated with depression. Conversely, risk factors associated with poorer well-being were positively correlated with depression.

3. Suicide rates. Suicide rates in medical practitioners were higher than the rates in the general population; in males this was 26 per cent higher and in females 146 per cent higher. The suicide rate varied between medical specialties; psychiatrists were found to be at highest risk.

4. Prevalence of substance misuse and self-medication. There was no indication that abuse of alcohol and other drugs was more common in medical students and practitioners than the rest of the population. However, a distinct pattern of drug use was observed among medical practitioners; prescription drugs such as benzodiazepines were used more, presumably due to the relative ease of access and self-prescription was also common.

5. Help-seeking for rates for mental health care. A significant proportion of medical students and practitioners are unwilling to seek help for depression despite their awareness and understanding of the effects of depression.

6. Barriers to help-seeking behaviour for mental health care. Concerns about issues such as stigma, career development, the impact on colleagues and patients, confidentiality, embarrassment and professional integrity are barriers to medical practitioners seeking help.

7. Attitudes of medical colleagues. One publication was identified in the review which reported that many medical practitioners had a negative attitude towards colleagues with depression.

8. Impact on patient care, work and family. There was little evidence to suggest that depression can lead to poor patient care and only one publication reported that medical practitioners with depression had experienced a negative impact on their work and family life as a result of their depression. However, it is difficult to assess the impact of depression on patient care, work and family due to the lack of quantitative data.

The report concluded that depression and anxiety were commonly identified in medical students and practitioners, although there was no evidence that these rates were higher than in the general population or other professions. However, medical practitioners do have a higher rate of suicide compared to the general population with suicide being higher among female practitioners.

Beyondblue has indicated that future research specific to the Australian context needs to be undertaken. This research should determine the prevalence of depression, anxiety and other issues associated with mental health. Further work also needs to be done to raise levels of awareness of anxiety and depression and develop effective interventions for improving the mental health of medical practitioners.

More information and resources about preventing and managing depression and anxiety are available:

www.surgeons.org/racs/fellows/resources-for-surgeons#alive
www.surgeons.org/racs/fellows/resources-for-surgeons/support-for-surgeons
www.beyondblue.org.au or by calling +61 3 9810 6100.

Reference: 'The Mental Health of Doctors: A systematic literature review' by Lisa Elliott, Jonathon Tan, Sarah Norris, July 2010 available online www.beyondblue.org.au

Professional Development WORKSHOPS

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

>Supervisors and Trainers for SET (SAT SET)

23 March 2011, Perth, 5 April 2011, Melbourne, 2 May 2011, Adelaide (pre ASC)

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

>Keeping Trainees on Track (KToT)

2 May 2011, Adelaide (pre ASC) ***NEW***

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

>Occupational Medicine

8 April 2011, Melbourne, 2 May 2011, Adelaide (pre ASC)

Doctors are increasingly expected to participate in the process of helping patients return to work. Understanding a patient's working environment, restrictions and the alternative work roles available can improve communication and assist doctors to better advise patients about the timing of operations and their return to work. Each one day course includes a guided tour of the operations for one or more factories, case study presentations of successful return to work events by recovering workers and treating doctor plus information about the sites' Return to Work programs.
Proudly supported by an educational grant from Worksafe Victoria

>Polishing Presentation Skills

2 May 2011, Adelaide (pre ASC)

This whole day workshop helps to enhance your presentation skills and provide you with a step-by-step presentation planning process and practical tips for delivering your message. It is equally applicable to presentation sessions in hospitals, conferences and international meetings. Participants receive a video of their presentations for self-reflection.

>Practice Made Perfect

2 May 2011, Adelaide (pre ASC)

This new whole day workshop focuses on the unique challenges of running a surgical practice. Learn more about the six principles of running a surgical practice. Practice managers and practice staff are encouraged to join these workshops for a valuable learning experience. Fellows are also welcome.

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

2011 DATES:
MAR – JULY

NSW

>TBA, Sydney
Providing Strategic Direction

>26 March, Sydney
Keeping Trainees on Track (KToT), (Facilitator)

>11 June, Sydney ***NEW***
Keeping Trainees on Track (KToT)

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

QLD

>31 March – 2 April, Gold Coast
Surgical Teachers Course

>27-29 May, Brisbane
Sustaining Your Business

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

SA

>29 April – 1 May, Adelaide
Younger Fellows Forum,

>2 May, Adelaide (pre ASC) ***NEW***
Keeping Trainees on Track (KToT),

>2 May, Adelaide (pre ASC)
–Occupational Medicine, Elizabeth

>2 May, Adelaide (pre ASC)
–Polishing Presentation Skills,

>2 May, Adelaide (pre ASC)
–Practice Made Perfect,

>2 May, Adelaide (pre ASC)
–Supervisors and Trainers (SAT SET)

VIC

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

>22-24 July, Melbourne
Process Communication Model

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

WA

>23 March, Perth
Supervisors and Trainers (SAT SET)

>11 June, Perth ***NEW***
Keeping Trainees on Track (KToT)

Expanding opportunities in medicine: a new medical school in Western Sydney

The following is a copy of a speech delivered at the NSW Regional Committee End of Year Dinner on 19 November, 2010

A/Professor Peter Zelas
Clinical Dean

BLACKTOWN/MT DRUITT HOSPITAL
School of Medicine, University of Western Sydney

My thanks to the New South Wales Committee of the College for honouring me with the opportunity to deliver the 2010 Graham Coupland Oration.

Graham Coupland was appointed as Associate Professor in Surgery at Royal North Shore Hospital in 1976 and developed an interest in gastric surgery and published numerous papers on ulcer disease and vagotomy. I gained an introduction to Graham and he invited me to join him on teaching ward rounds.

I remember Graham fondly for his generosity of time, ability to teach, judgement, and his engaging approach to patients. He had an abiding interest in medical students as evinced to this day by the Graham Coupland Memorial Prize for the best Year 2/3 medical student at North Shore Hospital.

The University of Western Sydney (UWS) began operating in its present structure in 2001 as a single multi-campus university following amalgamation of several Colleges of Higher Education. UWS comprises six campuses with 37,500 students, 23,000 being from Greater Western Sydney. Twenty one per cent of the students come from low socio-economic backgrounds and half are the first in their family to attend university.

Greater Western Sydney (GWS) encompasses 10 per cent of Australia's population in which there are rapidly growing communities, many areas of socio-economic and educational disadvantage and a disproportionate burden of disease, especially cardiovascular, cigarette related lung disease, drug and alcohol. In addition, there are not enough doctors, both GPs and specialists, when compared with the rest of Sydney.

In March 2004, the then Premier of NSW Bob Carr challenged the Federal Government to provide funding to train more doctors to address this inequality. The Federal Government under John Howard, subsequently responded by announcing funding of $18 million to establish a medical school in Western Sydney with students mandated to commence in 2007.

Tim Wills was the first person appointed in June 2004. He was seconded from Sydney South West Area Health Service, as Project Officer to bridge the link between Health and the University.

Appointments that followed were Neville Yeomans, Foundation Dean; Ian Wilson, Professor of Medical Education and to provide advice on planning, Bruce Barraclough and Alex Bune, who had had considerable previous experience in setting up medical schools at Flinders, ANU and Griffiths. A Medical Expert Advisory Group was established to provide strategic advice, be a sounding board for the Dean, put people together with people and advise on recruitment.

The Campbelltown campus was agreed to be the site of the Medical School with Blacktown/Mt Druitt (one hospital on two campuses) and Campbelltown/Camden as the Teaching Hospitals.

Undergraduate or graduate program?

An undergraduate program was the favoured option as it presented the best opportunity to correct for social and educational disadvantage for high school students from GWS; that school leavers with UAI of 95 were just as likely to make good doctors as those with UAI of 99.9 and students would have to leave GWS to achieve the basic science education to qualify them a chance to be successful in the Graduate Australian Medical Schools Admission test (GAMSAT) and then were less likely to return to UWS. A blended intake was agreed to, with 85 per cent undergraduate and 15 per cent graduate enrolment.

NSW State Committee chair Joseph Lizzio with Associate Professor Peter Zelas.

Admission criteria and enrolments

An underlying principle has been to provide students in GWS the opportunity to aspire to a career in Medicine and hence, to correct for educational disadvantage, a positive loading for students from GWS was, and continues to be applied.

This loading extends to both the Undergraduate Medicine & Health Sciences Admission Test (UMAT) and the Australian Tertiary Admission Rank provided by High Schools. On the basis of these criteria, of more than 3,000 applicants, 300 are chosen for an interview.

In 2007, of the initial cohort of 103 students, 60 per cent were from GWS and this ratio has continued in subsequent years. In 2011 there are 100 Commonwealth supported and 20 international places.

Academic appointments

Alison Jones was appointed as Dean in 2008 following the retirement of Neville Yeomans.

During 2005/06, professorial appointments included basic scientists (anatomy, molecular physiology, and biochemistry), medicine, surgery and clinical education. The academic base has now increased with appointments in pharmacology, pathology, general practice, infectious diseases, surgery, oncology, paediatrics, mental health, population health and obstetrics and gynaecology.

Teaching hospitals

Campbelltown/Camden and Blacktown/Mt Druitt (BMDH) Hospitals proposed an alternative model to the traditional teaching hospital, with student placements at medium sized metropolitan hospitals. Was there the experience, the infrastructure, the breadth of clinical material, the teachers and what about research?

So far the answer has been a resounding "Yes", but with an acknowledged shortcoming of no exposure to quaternary medicine or surgery. This latter has been addressed by agreement with the University of Sydney and the University of NSW for Year Five student placements.

Student placements this year will also include Fairfield, Westmead Private, Liverpool and Bankstown Hospitals.

The curriculum

With the Federal Government mandating that the School of Medicine (SOM) begin its program in 2007, there was no time to develop a curriculum, and a licensing agreement was negotiated with the University of Melbourne to purchase their Curriculum of the first two years with the SOM developing the curriculum for the clinical years. Government funding has allowed Bathurst and Lismore to be the rural clinical schools.

Additional options include an Honours program in Year Four, a Bachelor of Medical Science and, in 2011, a combined Arts/MBBS degree.

Some reflections on the curriculum

In developing the curriculum, clinicians have had the opportunity to translate their clinical and teaching experience into making significant contributions.

"Greater Western Sydney encompasses 10 per cent of Australia's population in which there are rapidly growing communities, many areas of socio-economic and educational disadvantage and a disproportionate burden of disease."

Surgery

John Morley is the Professor of Anatomy. Anatomy is taught in lectures, prosected specimens and relating MRI and ultrasound to the specimens with surgical trainees from Liverpool Hospital as tutors.

There is a 12 week clinical attachment in Year Three and 10 weeks in Year Five (five of which are in a quaternary hospital).

Reg Lord was the first Professor of Surgery at Campbelltown Hospital and was followed by Neil Merrett as the Foundation Chair of Surgery at UWS. Les Bokey was appointed to the Chair of Surgery at Liverpool Hospital and Marc Gladman to the Chair at Blacktown/Mt Druitt Hospital

There is considerable interest among the students in considering a career in surgery and a vibrant Student Surgical Society wanting to achieve advanced clinical skills and opportunities in research. There is the obvious opportunity here of linking the Society with the College.

A Community Participation Strategy and focus on disadvantage are at the core of the UWS School of Medicine philosophy. A Community Council advises on guiding principles and a representative is on the Curriculum Committee. There are more than 100 community partners varying from migrant centres, women's health, disabilities and aged care.

The objectives rely on developing mutually beneficial relationships that will deepen the student's awareness and understanding of the diverse communities in Greater Western Sydney and the reality of the social determinants of health and provide a forum for the community to indicate their views. Students are attached to one of the community partners for 12 weeks in Year Three.

In Year Four there is a research project on disadvantaged in society. One of the attachments is at the Compulsory Drug Treatment Correctional Centre at Parklea in which inmates are offered a rehabilitation program.

A student reflection includes:

"Our work at the facility involved familiarising ourselves with some specific inmate case histories, and to our surprise, this in itself proved an extremely confronting experience. To some degree I had prepared myself for stories of extreme disadvantage and childhood trauma, but the reality of the experience I read about was so much more complex and disturbing than I ever could have imagined.

"It became clear very quickly that for most of these men, drug-taking was simply a coping mechanism."

At BMDH the challenge is to manage and sustain the transition of a metropolitan hospital largely staffed by Visiting Medical Officers with no students, to a Teaching Hospital with this year, 200 students attending at some time each week.

The construction of a Clinical School and Simulation Centre, enhanced by a $21.6 million contribution by the Federal Government, has ensured the establishment of BMDH as a Teaching Hospital and the presence of UWS on the campus.

In September 2007, NSW Minister for Health, Reba Meagher, announced funding for four academic Chairs at BMDH. Mark McLean, an endocrinologist has been appointed to the Chair of Medicine and Marc Gladman to the Chair of Surgery. The two Chairs provide exciting future possibilities.

The year 2011 will be momentous, with our first full cohort of nearly 600 students, with the graduation of the first students in December and the completion of construction of the Clinical School, Research Centre and Simulation Centre at Blacktown Hospital. An exciting future lies ahead for the School of Medicine at UWS.

2011 Scholarship and Grant Recipients

The Board of Surgical Research invites Fellows and Trainees to apply for the following Scholarships, Fellowships and Grants for 2012.

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 comprising $60,000 stipend plus $10,000 departmental maintenance.	Up to 3.5 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 3.5 years
Foundation for Surgery New Zealand Research Fellowship	Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Applicants must be a New Zealand citizen currently residing in New Zealand.	$60,000 $55,000 stipend plus $5,000 departmental maintenance.	12 months
Foundation for Surgery Scholarships including: •Research Scholarships •Catherine Marie Enright Kelly Scholarship •Reg Worcester Research Fellowship •ANZ Journal of Surgery Scholarship	Open to Fellows and 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 Peter King Scholarship	Open to Fellows and SET 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. Lay applicants 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, SET 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 3.5 years

Please note:

- *The availability of the advertised scholarships and fellowships is subject to funding.*
- *The successful applicant will be required to procure 25% 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 29th April 2011*
- *Where applications are open to all SET Trainees, then applicants to surgical training are also eligible to apply 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.*

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 SET Trainees, resident in South Australia and enrolled in, or intending to enrol in a higher degree. The research must be based in South Australia and the 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 SET 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 3.5 years
Francis & Phyllis Thornell-Shore 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

“...who in the opinion of the Council, is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area.”

Foundation for Surgery Funded Research Scholarships and Fellowships

RAELENE BOYLE SCHOLARSHIP
Proudly Sponsored By
The Sporting Chance Cancer Foundation

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

The scholarship is expected to draw interest from Fellows or SET 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 SET 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% of the value of the scholarship from his/her research department.

REHABILITATION MEDICINE
CONROD – RACS TRAUMA FELLOWSHIP

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

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

JOHN MITCHELL CROUCH FELLOWSHIP

The John Mitchell Crouch Fellowship of $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 this area.

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

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.

PLASTIC AND RECONSTRUCTIVE SURGICAL RESEARCH AWARD

Applications are invited for the Plastic and Reconstructive Surgical Research Award which is open to recent Plastic and Reconstructive Fellows or SET Trainees accepted into the Plastic and Reconstructive Surgery Specialty. They should be enrolled in or intending to enrol in a higher degree.

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

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

Travel scholarships, Fellowships And Grants

Bequest And Donation Funded Travel Scholarships, Fellowships And Grants

MURRAY AND UNITY PHEILS TRAVEL FELLOWSHIP

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

HUGH JOHNSTON TRAVEL GRANTS

The Hugh Johnston Travel Grants arose from a bequest of the late Eugenie Johnston in memory of her late husband, Hugh Johnston. These Grants for $10,000 are designed to assist needy and deserving Fellows and Trainees of the College to gain specialist training overseas in a field to benefit the Fellow/Trainee, the College and the Community. 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 September/October 2012, which will be held in Chicago this time. 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 AU$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 reside temporarily outside the State of South Australia, either elsewhere in Australia or overseas, in order to undertake postgraduate studies. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the surgical community of South Australia. Preference will be given to the latter. This scholarship is for 12 months. The stipend is $65,000 and there is provision for accommodation and travel expenses upon application. ▶

Applications for scholarships and fellowships below must be received by 4.00pm on Friday 29th April 2011

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 5 years. The scholarship is open to a Fellow from any specialty. The scholarship must be the only College funding secured by the Fellow but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The duration of the scholarship is 12 months. The value of the scholarship is $10,000. Applicants must not have commenced travels prior to closing date.

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 $20,000); a period of four weeks (two Fellowships each of $10,000); a period of two weeks (four Fellowships each of $5,000); a period of one week (eight Fellowships each of $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 (03) 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 Program 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 2011.

IAN AND RUTH GOUGH SURGICAL EDUCATION SCHOLARSHIP

The Ian and Ruth Gough Surgical Education Scholarship, valued at $10,000, was established by Ian and Ruth Gough to encourage surgeons to become expert surgical educators. Applicants must be Fellows or Trainees of the College, with permanent residency of Australia or New Zealand. Tenure is for one year.

Please read the important general information and the scholarship conditions prior to submitting your application. This information together with the scholarship conditions are available on our website by following the prompts to the Travel Scholarships at www.surgeons.org. Alternatively contact our Scholarship Coordinator at scholarships@surgeons.org.

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 the educational activities involved in the Masters program. The Fellowship is for a period of up to two years subject to satisfactory performance. It is valued at AU$70,000 stipend per annum with the University of Toronto providing $C45,000 per annum comprising tuition and ancillary expenses. Applicants are encouraged to apply for other external funding as well.

IMPORTANT GENERAL INFORMATION

These advertisements are to be used as an initial guide only. Please consult the College website from 1st March 2011 at http://www.surgeons.org/scholarships.htm for detailed information about the scholarships, fellowship and grants offered by the College, relevant application forms and scholarship conditions. Scholarships 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 Program Coordinator, Royal Australasian College of Surgeons, 199 Ward Street, North Adelaide SA 5006. Tel: +61 8 8219 0900; Fax: +61 8 8219 0999; Email: scholarships@surgeons.org for further information. Applications close 4:00pm Friday 29th April 2010.

CPD Program 2010-2012

Some important activities for professional development

Professor Michael Grigg
Chair, Professional Standards Committee

For the 2009 CPD year, 99 per cent of Fellows who made a return have complied with the annual requirements. As a professional group, we as surgeons can be rightly proud of this achievement.

CPD is not in itself a measure of competence or performance, but it is tangible evidence of our commitment to personal improvement for the benefit of our patients. Although it can be a 'chore', it is a vital component of our argument for ongoing professional independence.

The challenge is to continue this high level of involvement in the program in the 2010-2012 triennium. Participation in the CPD Program is now more important than ever. In Australia, participation and compliance in an approved CPD Program is part of the National Registration and Accreditation Scheme for Health Professionals introduced in mid 2010.

The College is pleased (and relieved) that its efforts and positioning with respect to CPD have been recognised by this authority. In New Zealand, Fellows of the College have been required to provide evidence of CPD participation in order to maintain vocational registration administered by the New Zealand Medical Council for some time.

You will have received the 2010 CPD Recertification Data Form in early January. This form must be returned to the Department of Professional Standards by 31 March 2011.

Australian and New Zealand Audit of Surgical Mortality (ANZASM)

The 2010-2012 CPD Program includes a requirement to participate in the Australian and New Zealand Audit of Mortality if a surgeon is in operative based practice, has a surgical death and an audit of surgical mortality is available in the surgeon's region.

ANZASM is available in all regions with the exception of New Zealand and it is expected that ANZASM will be fully bi-national by the conclusion of the 2010-2012 CPD Program.

2010 CPD recertification data forms

Recertification data for 2010 is now being collected. Details of your continuing professional development activities during 2010 should be returned to the College by 31 March, 2011. Please contact the Department of Professional Standards at cpd.college@surgeons.org if you require assistance completing yourdata form.

CPD Online 2010

Fellows using CPD Online for 2010 are requested to finalise their 2010 CPD Online data by 31 March 2011, to enable the issue of the 2010 annual CPD Statement of Participation.

Verification

From 2010, verification should be less arduous than before. Three and a half per cent of Fellows will be randomly selected to verify one section of the information contained in their recertification data form/online diary rather than all the data.

If you have been selected to verify for 2010, you will have been notified in January. Verification is crucially important to maintain the credibility of the College CPD Program.

CPD Online 2011

Data collection for the 2011 CPD Program is available online via the College website www.surgeons.org Fellows can access a personal CPD Online Diary using a username and password to maintain CPD records in a real time format.

If you use the CPD Online Diary for 2011, you will not be required to complete the hard copy recertification data form issued at the conclusion of 2011. However, you must retain evidence of your CPD activities in case you are one of the 3.5 per cent of Fellows who are randomly selected for verification.

Hot Tubbing with the best!

Being a part of legal proceedings has its complexities

A/Professor Marianne Vonau
Chair, Professional Development

When your friendly lawyer invites you to come hot-tubbing, it may not be the experience you had in mind. The courts have developed a process, used in cases where the expert evidence is central to the issues in dispute, whereby experts from both sides of a dispute gather to discuss their expert evidence, in an attempt to develop a consensus view to help the courts.

A new experience for the medical expert involved in medico-legal proceedings is the invitation, or more accurately, the direction, to participate in a, lawyer free, joint conference with the other experts involved in the same matter.

Such a joint conference, otherwise termed concurrent evidence or expert conference is sometimes identified by the legal slang term 'hot tubbing'. The purpose of the hot tub is to resolve the issues in contention between the medical experts.

The actual 'hot tub' process is that the experts, that is, those medical experts who have submitted reports for the plaintiff and the defendant, are required to meet, as a sworn panel, without lawyers, and discuss the medical issues from their own viewpoint and form a consensus understanding of the issues in contention.

The experts, in good faith, should be willing to consider alternative factual premises and opinions. The joint conference can only work if the witnesses are genuinely prepared to shift their ground.

The hot tubbing experience gives back to the experts a proper role in the court room. It enables the experts to ask questions of each other, and to respond to those questions. The experts can ask, and answer, each other questions in the same way they would interact in their hospital environment, discussing any issue of clinical concern. The outcome of this meeting is a document that identifies the matters upon which they agree, and those matters upon which they disagree.

Any matters upon which they disagree then become the agenda for a discussion in the court room. The judge is responsible for chairing that courtroom discussion, and asking questions as the judge believes to be appropriate, in order to assist the judge to understand what the witnesses are saying.

The introduction of the joint conference has occurred in response to some concerns about the manner in which expert evidence is presented to the courts. There is a frequent perception of bias. Lord Woolf in the interim report, Access to Justice said:

"Expert witnesses used to be genuinely independent experts; men of outstanding eminence in their field. Today they are in practice hired guns. There is a new breed of litigation hangers-on, whose main expertise is to craft reports which will conceal anything that might be to the disadvantage of their clients."

In response to these types of concerns, the court rules changed. These rules evolve in an attempt to balance concepts of justice against the real constraints of administrative efficiency and fiscal accountability. In 1998, the Federal Court Rules were amended to facilitate the use of 'hot tubs'. About this time, similar guidelines were introduced in other jurisdictions.

The Federal Court issued guidelines for expert witnesses, essentially a code of conduct. The principal purpose of those guidelines was to outline the responsibilities of the expert witness to the Court:

(i) 'An expert witness has an overriding duty to assist the Court on matters relevant to the expert's area of expertise';
(ii) 'An expert witness is not an advocate for a party'; and
(iii) 'The expert witness' paramount duty is to the Court and not to the person retaining the expert'.

> *"The outcome of this meeting is a document that identifies the matters upon which (the experts) agree, and those matters upon which they disagree."*

With a decade of experience with the joint conference approach, the courts have reported on the effect of the changes. The Federal Court's experience is that the 'hot tub' narrows the issues in dispute; it is beneficial for all of the expert evidence to be presented while fresh in the mind of the decision maker (the judge); reduces the level of partisanship of experts; and results in a saving in hearing time.

Another concern about the legal process that fostered the development of the joint conference is the view that the adversarial trial may discourage the leading experts from advising the courts.

There is a view that the expert is often paid to promote a position that supports one side or the other. The experts did not see the process as fair; they didn't see it as aimed at identifying in any genuine way, what it was that the expert had to contribute to the case. Rather it was a contest with winners and losers.

Should you get involved?

Consequently, some experts are reluctant to get involved as court witnesses, but this view is to the detriment of the legal system. "The justice system must ensure that the leading experts on relevant issues accept a role in the dispute resolution process. Second rate experts will result in inferior justice and an erosion of confidence in the entire system."

Although the joint conference process has many supporters and judicial proponents, the support is not unanimous within the legal profession. Lawyers, especially plaintiff lawyers, have very real concerns about the gradual erosion of the traditional bulwarks that protect the interests and legal rights of the plaintiff.

There is some concern within legal circles that the use of joint conferences is part of the emerging role of the judicial activist. In some circumstances there is a concern that judicial decision making may be beyond the powers given by legislation or precedent. This concern was foreseen by H.V. Evatt, "The sooner we get back to the ideals that justice should be administrated according to the law and not according to claptrap the better it will be for all."

There are a variety of concerns about joint conference arrangements. These concerns include:

(i) [Hot tubbing] may change expert performances, but to the extent that experts conform to judicial expectations and engage in a more collegial discussion, this does not make the evidence or any consensus reliable or even more reliable.
(ii) The Joint conference or expert conference is part of the trial that is conducted away from the view of the plaintiff, defendant and their legal representatives. This denies the process of justice.
(iii) If there is a difference in the professional positions of the experts (e.g. young surgeon and the professor who taught him), the junior may be intimidated by the imbalance in position. The more articulate expert may have more influence than his professional opinion deserves. Experts may assume the role of advocate and influence the outcome.
(iv) A clinician with a particular atypical or bizarre theory can dominate the discussions and contribute little to the appropriate resolution of the issue in question.
(v) The lawyer spends a lot of money on the reports, and should have the right to present those reports, at a time and in a manner, to the court that allows the lawyers to best put their clients' case.

There is no doubt that the lawyers will continue to argue about the development of the trial process, but from the view point of the medico-legal expert the joint conference is likely to continue. So when you are asked to jump into the hot tub, remember you are there for the court, not the lawyer. Try not to muddy the water!

An extended version of this essay with references is available by contacting MedicoLegalSection@surgeons.org or calling +61 3 9276 7433

–With David Hardman
Medico Legal Executive

Dual antiplatelet therapy

In defence of surgeons who continue antiplatelet therapy during the peri-operative period

Professor Michael Grigg
Chair, Professional Standards

Dual antiplatelet therapy (aspirin and Clopidogrel) is one of the hazards of modern surgical practice. Possibly compounding the difficulties are the increasing number of guidelines appearing in the literature, one of which is referenced at the end of this article.

Most, if not all, of these guidelines are written by the instigators of dual antiplatelet therapy, not by those who have to contend with the consequences on a regular basis.

The usual reason that patients are on dual antiplatelet medication is that they have had a coronary stent placed. Surgeons undertaking interventions on patients taking dual antiplatelet medication are thus faced with a difficult choice – if they cease the antiplatelet medication, there is a real risk of stent related complications and if they continue them there is a significant risk of increased haemorrhage, haematoma and subsequent infection.

It is not an easy choice. One can only hope that the stent was absolutely necessary in the first place. The primary purpose of this paper is to provide some defence for, and empowerment of, surgeons who feel 'forced' to continue antiplatelet therapy during the peri-operative period. Indeed this is already what many surgeons are doing.

One thing is now clear – the routine 'knee-jerk' cessation of antiplatelet prior to operative intervention is no longer acceptable. In fact the complications associated with dual antiplatelet therapy and surgery are more related to cessation of therapy rather than complications associated with continuance of therapy.

Thus the accepted surgical doctrine that a good operative outcome is best for the patient may no longer be true. No-one would argue that incurring a stroke or myocardial infarct is preferable to avoiding a wound haematoma for example. And yet surgeons still rightly fear criticism if bleeding complications do occur operatively after they have made a decision to continue dual antiplatelet therapy.

Every surgeon knows that every patient is different and every operation is different. Less well known is that the physiological stress of operation induces a pro-thrombotic state and that stents are different. In broad terms there are two types – bare metal stents and drug eluting stents.

The problem with the former relates to the development of "in-stent stenosis" – a reaction of the artery to the presence of the stent. However, the advantage of these stents is that they develop an endothelial covering – thought to occur over a 6-12 week period – at which time they are more resistant to stent thrombosis.

Drug eluting stents release an agent that inhibits adjacent cellular proliferation thus reducing "in-stent stenosis" but also inhibiting endothelial covering of the stent. They therefore remain at risk of thrombosis for much longer and dual antiplatelet therapy is required for 12 months.

So is it possible to distill the guidelines into some simple recommendations palatable to surgeons? I think it is –

1. If a patient on dual antiplatelet therapy requires operative intervention, consultation with the initiating specialist should be obtained.
2. If possible, operative intervention should be deferred for six weeks after insertion of a bare metal coronary stent and 12 months after a drug eluting stent.
3. If dual antiplatelet therapy has to be stopped prematurely for operation, operation should be performed in an institution capable of responding to the possible complications e.g. coronary thrombolysis.
4. Emergency operations should not be avoided solely for the reason that the patient is on dual antiplatelet therapy.
5. Surgeons should not be criticised for choosing to continue dual antiplatelet therapy through the peri-operative period and audits of surgical complications should allow for this.

Antiplatelet Therapy Guidelines

Cardiac Society of Australia and New Zealand (CSANZ), Guidelines For The Use Of Antiplatelet Therapy In Patients With Coronary Stents Undergoing Non-Cardiac Surgery, available at: http://www.csanz.edu.au under Education/ Guidelines/ Clinical Practice.

Therapeutic use of self and the relief of suffering

This is the second half of an article that originally appeared in the July issue of Cancer Forum, and has been reproduced with permission from the Cancer Council Australia and Prof Kearsley.

The first half appeared in the Jan/Feb issue of Surgical News.

Professor John H. Kearsley

In the beginning was the word, then came the stories. While it has been said that 'everyone has his or her own story', it is equally true that 'everyone is a story'. Each story is unique. I particularly enjoy Allen's opinion that "a human being is nothing but a story with skin around it".[30]

Our own stories define who we are. Human experience is framed and interpreted in terms of our life stories. Amato has said that "with no story to tell, we are no people at all".[31] It has been said that we live in stories not in statistics; we "continually author our own life stories as we reflect, interpret and re-interpret what happens in our lives, and tell and re-tell our stories to other people and to ourselves".[5] Stories help us to make sense of the insensible, to explain our view of the world. Storytelling can be regarded as one of the oldest healing arts.

Stories also allow us to tap into the state of suffering. Suffering arises from the meaning ascribed to events and is commonly expressed as a personal narrative – the only things about ourselves that cannot be taken away, the only things that remain coherent and intact. And from our stories, hope may gently trickle into our pools of pain. The poet Lesley Marmon Silko wrote: "I will tell you something about stories, they aren't just entertainment. Don't be fooled. They are all we have, you see, all we have to fight off illness and death".[32] Stories, according to Mount et al, are one conduit through which "healing connections" may be created, so that patients may be able to move from suffering to a sense of wellbeing.[33]

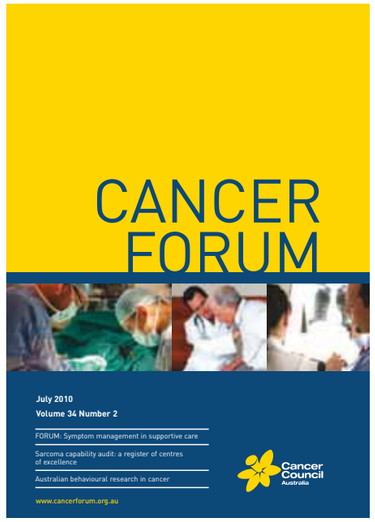
How can we as health care professionals assess and relieve suffering of our patients and their families?

In the health system, there are a large number of parameters and outcomes which are assessed – outcomes such as length of stay, infection rates, waiting times, responses to treatment, survival times and treatment-related toxicity. However, if it is accepted that a core activity of the health care system is about the relief of suffering, what is really known about the prevalence of suffering in our health system?

More than a quarter of a century ago, Cassell argued that physicians do, in fact, have a professional responsibility to understand and to treat suffering at an existential level.[1] In addition to attending meticulously to physical symptoms and seeking other sources of suffering, listening to the stories of patients is one conduit by which clinicians can tap into that state of suffering; the telling of stories is the conduit by which patients endure, reflect on, redefine and may finally transcend their state of suffering.[34,35] There is no agony like bearing an untold story inside of you; health care professionals can increase or prolong the state of suffering by ignoring it, by walking away and by ignoring the stories that need to be told. The cartoonist Leunig encourages "teach us to embrace sadness lest it turn to despair".[36] Of course, many clinicians do not even get past the standard medical history; unwittingly, we may imprison our patients within the confines of the medical history. The direct question: "Do you feel that you are suffering?" does not yet appear to have found its way into our routine assessment of patients. A recent Consensus Conference provided strong recommendations for the implementation of a spiritual history and spiritual care in patients with life threatening illness.[37]

To be a witness to a person's story is a validating and re-personalising activity. Yes, this is really happening to you – no, it is not a dream. And I am a witness to your story. And, I will tell your story. "Besides talking himself", Broyard suggested, "the doctor ought to bleed the patient of talk".[38] The physician-healer, according to Egnew, becomes a therapeutic instrument by drawing out the patient's narrative experience, and then "helps the patient to create or discover a healing narrative with new meanings that transcend suffering".[35] As observed by Frankl, "suffering ceases to be suffering in some way at the moment it finds a meaning".[39]

Stories have healing power – not only in the content, but in the telling comes healing.



Unlike the predictability of many clinical outcomes in medicine, the outcomes resulting from interpersonal communion may be neither predictable nor understandable. When we do listen to people's stories, we make room for mystery and healing to occur. A healing effect on the teller, as well as a healing effect on the listener (see Wal's story).

Remen makes the common observation that "dying people often have the power to heal the rest of us in powerful ways. Years afterwards, many people can remember what a dying person has said to them, and carry it with them, woven into the fabric of their being".[40]

Finally, stories may represent a patient's quest for 'immortality', and they remain a legacy for others.[34] Our patients may therefore say, as if in the words of Byron: "But I have lived, and have not lived in vain; My mind may lose its force, my blood its fire, and my frame perish, Even in conquering pain; But, there is that within me which shall tire torture and time, and breathe when I expire".[41]

In the end, the value of our patients' lives may not be measured so much by what they knew, nor by their possessions, but by what they have to tell in their stories, enabling them to know at last who they are and how to come to peace with life and death. Our patients live on in their stories; our story becomes woven with theirs – two, but also one. We then, become custodians of what we have heard and witnessed.

In his letter of 1549, Michaelangelo Buonarotti suggested that sculpting is a process of 'taking away', in contrast to painting which was seen as 'adding on'.[42] It is up to the sculptor to reveal the soul imprisoned within the stone. Michaelangelo carved in order to liberate, to set free, the figure imprisoned within the marble. We see this effect most powerfully in some of the unfinished statues of Slaves. The figures seem to explode from the stone. In fact, the power of the figures is enhanced by the very fact that the statues are unfinished on purpose. Complete, though unfinished; whole, though imperfect.

Wal's story

Wal came in to see me the other week. Wal is 79 years in the shade. He lives on his own in Sans Souci in the sun. I treated Wal eight years ago for prostate cancer. I think he is cured. Wal shuffles in; his fair skin makes him look anaemic. Wal has a problem with his weight, but he doesn't care. What he lacks in teeth he compensates with a big thirst for his favourite VB stubbies. Wal wears old faded fawn shorts and green thongs. Wal has good knees. In my honour, Wal has not shaven for a week. I sit with my two students; it is 11.30 am on a Friday, the end of a long follow-up clinic. And so close to lunch.

"How are you doc?" "How are you mate, what's news?" Wal and I are friends. We talk. He reaches back into the half-full pockets of his colourful past. The stories come, they start to flow. His stories about the war, his stories about life in the tropics, his work as an engineer, Mr Fixit; how he could make things work when others couldn't. A cheeky smile breaks across his ancient seafarer face; a toothless grin.

The students shuffle their feet. One looks at her watch, the other at the floor. They look at me (how much longer?). We finish – I thank Wal for his stories and for coming. "Your prostate cancer is under good control Wal, and your PSA is normal. See you in another six months time".

Wal stands, we shake hands, he turns to leave – and dissolves in tears. "All I wanted was someone to listen". No one speaks. He hugs me. None of us can speak.

Wal left. We were no longer hungry. There was silence. We have communed over the broken bread of Wal's life stories. And we were sustained. We sensed a healing had occurred for all of us.

Conclusion

In conclusion, three recommendations appear appropriate. Firstly, understand and appreciate suffering. As a result, you will learn more about yourself. Secondly, understand and appreciate the stories that your patients need to tell you. As a result, you may become healers. Finally, never underestimate the therapeutic potential of who you are, whether student, intern or senior consultant. In the words of Remen, "who you are may affect your patients as deeply as what you know. You will often heal with your understanding and your presence things you cannot cure with your scientific knowledge".[43]

Acknowledgement

This paper was written to reflect some of the key themes of the inaugural Whole Person Care Symposium, held in Sydney, October 2009.

> *"Stories help us to make sense of the insensible, to explain our view of the world. Storytelling can be regarded as one of the oldest healing arts"*

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Conference Diary Dates 2011

Here are some dates for some of the surgical conferences coming up. If you are aware of any other meetings that you would like to see added to the College website Conferences page, please let us know by email to College.library@surgeons.org. Links to the Conference websites or further information can be found on the Conference listing on the College website (under Fellows, Resources for Surgeons)

Surgery conferences
Australia/NZ

>Royal Australasian College of Surgeons Annual Scientific Congress 3 - 6 May 2011 / Adelaide SA AUSTRALIA

>International Surgical Congress of the Association of Surgeons of Great Britain and Ireland. 11 - 13 May 2011 / Bournemouth England UK

>Provincial Surgeons of Australia 47th Annual Scientific Conference. 20 - 23 July 2011 / Bendigo VIC AUSTRALIA

>11th Rural Critical Care Conference. 19 - 20 August 2011 / Port Macquarie NSW AUSTRALIA

>SimHEALTH Simulation Conference. 12 - 15 September 2011 / Sydney NSW AUSTRALIA

>American College of Surgeons 97th Annual Clinical Congress. 23 - 27 October 2011 / San Francisco CA USA

Overseas

>International Association for Ambulatory Surgery (IAAS) Congress. 8 - 11 May 2011 / Copenhagen DENMARK

>18th Asian Congress of Surgery. 12 - 14 May 2011 / Cebu Philippines

American College of Surgeons 97th Annual Clinical Congress. 23 - 27 October 2011 / San Francisco CA USA

>International Surgery Week ISW 2011. 28 August - 1 September 2011 / Yokohama JAPAN

Cardiothoracic Surgery
Australia/NZ

>Tongariro Cardiac Surgery Meeting 25 - 27 March 2011 / Queenstown NEW ZEALAND

>Asia Pacific Heart Valve Forum - Beyond the Basics 31 March - 1 April 2011 / Brisbane QLD AUSTRALIA

>Annual Scientific Meeting of the Thoracic Society of Australia & New Zealand. 2 - 6 April 2011 / Perth WA AUSTRALIA

>Winter Meeting Perfusion Downunder. 4 - 6 August 2011 / Hayman Island QLD AUSTRALIA

>CSANZ 2011. 11 - 14 August 2011 / Perth WA AUSTRALIA

Overseas

>World Society of Cardio-Thoracic Surgeons 21st World Congress. 12 - 15 June 2011 / Berlin GERMANY

>16th Congress of the Asian Pacific Society of Respirology. 3 - 6 November 2011 / Shanghai CHINA

>World Congress of Cardiology. 18 - 21 April 2012 / Dubai UAE

General Surgery
Australia/NZ

>Epworth HealthCare Breast Symposium. 18 February 2011 / Melbourne VIC AUSTRALIA

>8th Breast Interest Group of the Royal Australian & New Zealand College of Radiology meeting. 28 February - 4 March 2011 / Hobart TAS AUSTRALIA

>'Modern Era of Hernia Surgery' Conference. 3 - 5 March 2011 / Adelaide SA AUSTRALIA

>Colorectal Cancer - A Multidisciplinary Approach Conference. 24 - 25 March 2011 / Melbourne VIC AUSTRALIA

>Biennial Breast Cancer Surgical Update Meeting. 25 - 26 March 2011 / Melbourne VIC AUSTRALIA

>New Zealand Association of General Surgeons Annual Meeting. 25 - 27 March 2011 / New Plymouth NEW ZEALAND

>Tripartite Colorectal Meeting. 3 - 7 July 2011 / Cairns QLD AUSTRALIA

> 3rd International Trauma Conference. 13 - 17 July 2011 / Queenstown NEW ZEALAND

>SWAN XIX Trauma Conference. 29 - 30 July 2011 / Liverpool NSW AUSTRALIA

>11th Rural Critical Care Conference. 19 - 20 August 2011 / Port Macquarie NSW AUSTRALIA

>Endocrine Society of Australia (ESA) and APEG Combined Annual Scientific Meeting. 28 - 31 August 2011 / Sydney NSW AUSTRALIA

>General Surgeons Australia Annual Scientific Meeting. 16 - 18 September 2011 / Darwin NT AUSTRALIA

>Asian Pacific HBPA Congress. 27 - 30 September 2011 / Melbourne VIC AUSTRALIA

>Australian and New Zealand Burns Association (ANZBA) Annual Scientific Meeting. 4 - 7 October 2011 / Brisbane QLD AUSTRALIA

>Clinical Oncological Society of Australia (COSA) Annual Scientific Meeting. 14 - 17 November 2011 / Perth WA AUSTRALIA

Overseas

>Annual Meeting of the Society of Surgical Oncology (SSO). 2 - 5 March 2011 / San Antonio TX USA

>Insight (International Society for Gastrointestinal Hereditary Tumours) 4th Biennial Conference. 30 March - 2 April 2011 / San Antonio Texas USA

>Trauma Association of Canada Annual Scientific Meeting. 7 - 8 April 2011 / Banff AB CANADA

>Trauma, Critical Care and Acute Care Surgery. 11 - 13 April 2011 / Las Vegas NV USA

>12th European Congress of Trauma and Emergency Surgery. 27 - 30 April 2011 / Milano ITALY

>American Society of Breast Surgeons Annual Meeting. 27 April - 1 May 2011 / Washington DC USA

>American Transplant Congress. 30 April - 4 May 2011 / Philadelphia PA USA

>American College of Colon and Rectal Surgeons Annual Meeting. 14 - 18 May 2011 / Vancouver BC CANADA

>TraumaCare 2011 International Conference. 16 - 19 May 2011 / Telford UK

>17th World Congress on Disaster and Emergency Medicine. 31 May - 3 June 2011 / Beijing CHINA

>28th Annual Meeting of the American Society for Metabolic and Bariatric Surgery. 12 - 17 June 2011 / Orlando FL USA

>19th International Congress of the European Association for Endoscopic Surgery (EAES). 15 - 18 June 2011 / Turino ITALY

>Society of Laparoendoscopic Surgeons Annual Meeting and Endo Expo. 14 - 17 September 2011 / Los Angeles CA USA

>American Association for the Surgery of Trauma Annual Meeting. 14 - 17 September 2011 / Chicago IL USA

>Melanoma 2011 Congress. 9 - 12 November 2011 / Tampa FL USA

>European Colorectal Congress. 30 November - 2 December 2011 / St Gallen SWITZERLAND

Neurosurgery
Australia/NZ

>Spine Society of Australia Conference. 15 - 17 April 2011 / Melbourne VIC AUSTRALIA

>Neurosurgical Society of Australasia Annual Scientific Meeting. 22 - 24 September 2011 / FIJI

Overseas

>American Association of Neurological Surgeons Annual Meeting. 9 - 13 April 2011 / Denver CO USA

Annual Meeting of the International Society for the Study of the Lumbar Spine. 14 - 18 June 2011 / Gothenburg SWEDEN

>15th Conference of the European Federation of Neurosurgical Societies. 10 - 13 September 2010 / Budapest HUNGARY

Orthopaedic Surgery
Australia/NZ

>Australian Hand Surgery Society Annual Scientific Meeting. 16 - 20 March 2011 / Bunker Bay WA AUSTRALIA

>ANZORS 2011. 1 - 2 September 2011 / Brisbane QLD AUSTRALIA

>Combined Australian Orthopaedic Association and New Zealand Orthopaedic Association Annual Scientific Meeting. 9 - 14 October 2011 / Rotorua NEW ZEALAND

>Australian Sarcoma Group Conference. 15 - 16 October 2011 / Melbourne VIC AUSTRALIA

Overseas

>11th Annual AAOS / OTA Orthopaedic Trauma Update. 31 March - 2 April / Lake Buena Vista FL USA

>Annual Meeting of the International Society for the Study of the Lumbar Spine. 14 - 18 June 2011 / Gothenburg SWEDEN

>AOA 124th Annual Meeting. 22 - 25 June 2011 / Boston MA USA

>Canadian Orthopaedic Association Annual Scientific Meeting. 7 - 9 July 2011 / St John's Newfoundland CANADA

>27th Annual AOFAS Summer Meeting. 13 - 16 July 2011 / Keystone CO USA

>ASSH Annual Meeting. 8 - 10 September 2011 / Las Vegas NV USA

Otolaryngology Head and Neck Surgery
Australia/NZ

>12th Asia-Oceania ORL Head & Neck Congress. 1 - 4 March 2011 / Auckland NEW ZEALAND

>Australasian Cleft Lip and Palate Association and Asian Pacific Cleft Lip and Palate/Craniofacial Congress. 13 - 16 March 2011 / Perth WA AUSTRALIA

>ASOHNS 2011. 4 - 7 April 2011 / Melbourne VIC AUSTRALIA

Overseas

>Combined Otolaryngology Spring Meetings COSM. 27 April - 1 May 2011 / Chicago IL USA

>Canadian Society of Otolaryngology to Head and Neck Surgery Annual Meeting. 22 - 24 May 2011 / Victoria BC CANADA

>Tri Society Head and Neck Oncology Meeting. 1 - 3 September 2011 / Sands SINGAPORE

Paediatric Surgery
Australia/NZ

>5th Annual Update in Paediatric Emergencies. 6 - 18 April 2011 / Noosa QLD AUSTRALIA

>ANZAPS/SPANZA Combined Conference. 20 - 23 October 2011 / Brisbane QLD AUSTRALIA

>63rd Annual Meeting of the Paediatric Society of New Zealand. 22 - 25 November 2011 / Auckland NEW ZEALAND

Overseas

>44th Annual Meeting of Pacific Association of Paediatric Surgeons. 10 - 14 April 2011 / Cancun MEXICO

>American Paediatric Surgical Association 42nd Annual Meeting. 22 - 25 May 2011 / Palm Desert CA USA

>British Association of Paediatric Surgeons (BAPS) Annual Conference 19 - 22 July 2011 / Belfast NORTHERN IRELAND

>Excellence in Paediatrics. 1 - 3 December 2011 / Istanbul TURKEY

Plastic and Reconstructive Surgery
Australia/NZ

>Australasian Cleft Lip and Palate Association and Asian Pacific Cleft Lip and Palate/Craniofacial Congress. 13 - 16 March 2011 / Perth WA AUSTRALIA

>Australian Hand Surgery Society Annual Scientific Meeting. 16 - 20 March 2011 / Bunker Bay WA AUSTRALIA

>2011 Plastic Surgery Congress (ASPS and NZAPS). 6 - 10 July 2011 / Gold Coast QLD AUSTRALIA

>Australian and New Zealand Burns Association Annual Scientific Meeting. 4 - 7 October 2011 / Brisbane QLD AUSTRALIA

Overseas

> American Burn Association 43rd Annual Meeting. 29 March - 3 April 2011 / Chicago IL USA

> Canadian Society of Plastic Surgeons Annual Meeting. 21 - 22 May 2011 / Vancouver BC CANADA

>IPRAS 2011. 22 - 27 May 2011 / Vancouver BC CANADA

>EURAPS 22nd Annual Meeting. 2 - 4 June 2011 / Mykonos GREECE

>BAPRAS Summer Scientific Meeting. 6 - 8 July 2011 / Oxford ENGLAND

>ASSH Annual Meeting. 8 - 10 September 2011 / Las Vegas NV USA

>Canadian Society for Aesthetic Plastic Surgery 37th Annual Meeting. 16 - 17 September / Calgary Alberta CANADA

>Plastic Surgery 2011. 23 - 27 September 2011 / Denver CO USA

>16th Congress of the International Society for Burn Injuries. 9 - 13 September 2012 / Edinburgh SCOTLAND

Urology
Australia/NZ

> Urological Society of Australia and New Zealand 64th Annual Scientific Meeting. 21 - 24 February 2011 / Christchurch NEW ZEALAND

>Renal Society of Australasia National Conference. 8 - 11 June 2011 / Adelaide SA AUSTRALIA

>ANZSN Annual Scientific Meeting. 17 - 21 September 2011 / Adelaide SA AUSTRALIA

Overseas

>26th Annual EAU Congress. 18 - 22 March 2011 / Vienna AUSTRIA

>43rd Annual Duke Urologic Assembly. 8 - 10 April 2011 / Durham NC USA

>The American Urological Association Annual Meeting. 14 - 19 May 2011 / Washington DC USA

>British Association of Urological Surgeons Annual Meeting. 20 - 23 June 2011 / Liverpool ENGLAND

Vascular Surgery
Australia/NZ

>Vascular Interventions 2011. 4 - 5 March 2011 / Newcastle NSW AUSTRALIA

>Australasian College of Phlebology 14th Annual Scientific Meeting. 29 March - 3 April 2011 / Melbourne VIC AUSTRALIA

>Vascular 2011. 12 - 15 November 2011 / Christchurch NEW ZEALAND

Overseas

>Vascular Annual Meeting. 16 - 18 June 2011 / Chicago IL USA

Welcome to the Surgeons' BOOKCLUB

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

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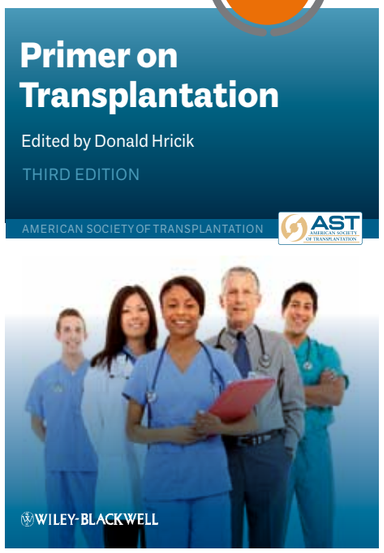

Primer on Transplantation, 3rd Edition

Donald Hricik (Editor), American Society of Transplantation
9781405142670 | Hbk | 320 pages | Mar 2011
~~AU$190.00~~ **/ AU$152.00**

Produced in association with the American Society of Transplantation, this new edition is full of practical advice for the next generation of transplant professionals. It includes essential information on:

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Paul McFedries
9781118004128 | Pbk | 336 pages | April 2011
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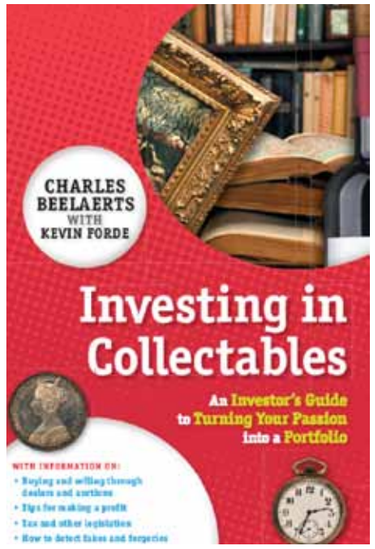

Investing in Collectables: An Investor's Guide to Turning Your Passion Into a Portfolio

Charles Beelaerts
9781742468198 | Pbk | 248 pages | January 2011
~~AU$34.95~~ **/ AU$29.71**

Ever wanted to make money from investing in something you love? From the bestselling author of *Understanding Investments* comes a comprehensive guide to collecting, investing in and making money from, collectables. Aimed at everyday investors looking to make money from their hobbies or collections and serious investors looking to profit from their passions or diversify their portfolio, *Investing in Collectables* covers:

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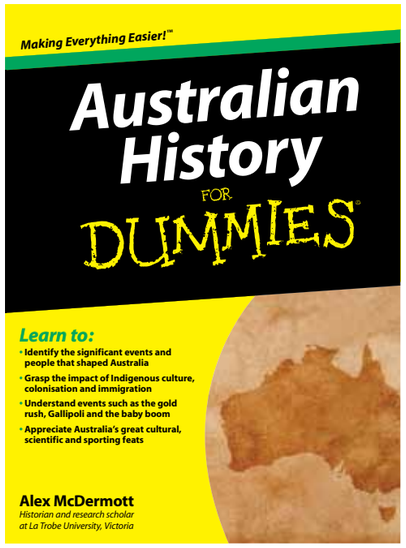

Australian History for Dummies

McDermott
9781742169996 | Pbk | 448 pages | January 2011
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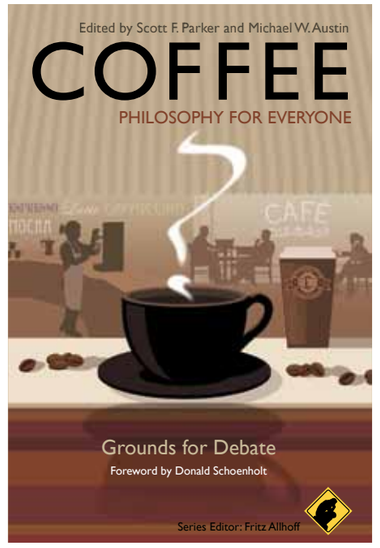

Coffee - Philosophy for Everyone: Grounds for Debate

Fritz Allhoff, Scott F. Parker, Michael W. Austin
9781444337129 | Pbk | 264 pages | March 2011
~~AU$27.95~~ **/ AU$23.76**

Offering philosophical insights into the popular morning brew, *Coffee – Philosophy for Everyone* kick starts the day with an entertaining but critical discussion of the ethics, aesthetics, metaphysics, and culture of coffee.

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In Memoriam

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

>Gordon Baron-Hay,
WA Paediatric surgeon

>Robert Marshall,
VIC General surgeon

>Samuel Philip Wrightson,
NZ Neurosurgeon

>Kerry Edgar Clark,
NZ General surgeon

>Jeff Watson,
QLD Urology surgeon

>Morgan Windsor,
QLD surgeon

CORRECTION: In the Jan/Feb issue of Surgical News, the following In Memoriam should have been:

Alastair Robson, NSW Neurosurgeon

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

Informing the College

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

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


Letters to the Editor ...

Good faith and reporting

Nylon shirt to the rescue

More nylon shirt memories

Dear Sir,

I read with interest Emeritus Professor Hughes' letter (*Surgical News*, Vol 12, No 1, 2011, page 49) describing his experience with the nylon shirt used as a replacement for an aneurysm of the abdominal aorta.

My experience with the nylon shirt goes back to the time when I was a fourth year medical student at St Vincent's Hospital Melbourne in 1955. Students had to 'live in' for three weeks every year, a time eagerly looked forward to as the experience acquired was invaluable, especially the time spent in the Accident and Emergency Department, then called Casualty.

The students were encouraged to follow patients taken to the operating theatre. One night an elderly man was admitted to Casualty in severe abdominal pain and a diagnosis of a ruptured abdominal aneurysm was made and the patient taken rapidly to the OR.

The surgeon was the late Fred Connaughton, who I came to admire greatly. At laparotomy, he found a ruptured aneurysm. After resuscitating the patient and controlling the aorta proximinally and the common iliacs distally, the aneurysm was expeditiously resected. The Y graft was cut from a nylon shirt; its edges heat-sealed using a spirit lamp and the graft sewn proximinally to the transected neck of the aneurysm and distally to the common iliacs. The patient survived the operation, but died soon after in the ward (no intensive care unit had commenced until 1961).

The first successful resection of an aneurysm also occurred in 1955 at the hands of the late John Connell. He had been recently appointed to the honorary surgical staff at St Vincent's and was the emergency surgeon that day when an elderly woman was admitted with the diagnosis of leaking abdominal aneurysm.

During his surgical training in England, Connell had visited the vascular surgeons at St Mary's Hospital London, particularly Professor Charles Rob and his assistant Mr Eastcott, and had seen them at work thereby commencing his interest in vascular surgery.

The patient was taken to the theatre and at laparotomy the aneurysm was found with a retro peritoneal haematoma, but no blood in the peritoneal cavity. The aneurysm was resected and a nylon shirt Y graft cut out, its edges united and the graft sewn to the transected neck proximally, and distally to the common iliac on one side and to the external iliac on the opposite side.

The patient recovered and was discharged well. She was known to be alive 10 years after the operation. It was the first successful operation on an abdominal aneurysm recorded at St Vincent's Hospital. Surgical success attending frank rupture of an aneurysm took much longer to achieve.

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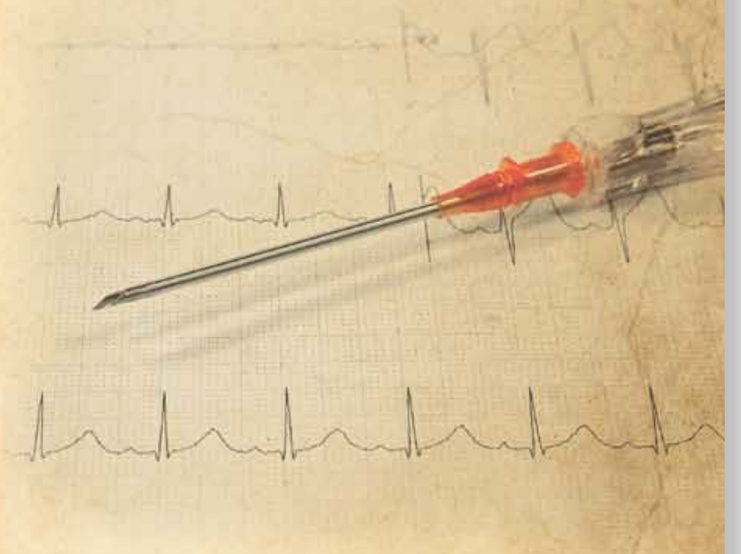
Memoirs of a *surgical investigator*

Research was done a lot differently in times past

Professor Bernard N. Catchpole,
WA Fellow



When I came out of the army to a University appointment of Surgical Tutor, I was worked on by colleagues to acquire the Fellowship of the Royal College of Surgeons of England. I achieved this in 1950 on my 27th birthday. The surgical department I was in had a main interest in vascular disease. Many patients with swollen legs and gross varicose veins crowded the outpatient clinics. "My legs do ache, doctor" was the common cry.

Why the aching? Were distended veins the cause? Who knew? No one!

Anatomists did know that blood vessels were innervated by tiny fibres running through their layers in both veins and arteries. Patients having arteriograms at that time complained of a sensation of liquid fire being injected to them. Those having organic iodide venograms did not seem to notice anything however. We had already developed the technique of measuring static and exercise venous pressure by cannulating a vein on the dorsum of the foot and recording it while the patient stood still or marked time. Normally, static venous pressure is equivalent to a column of blood to heart level – almost 100 mm of mercury, but it should fall to 20 mm or less on exercise. I wanted to know if local distension of veins with varicosities caused discomfort. I needed some little balloon catheters.

One day, an old school friend who worked for the Research Department of the Dunlop Rubber Company visited us. I asked him if he could make me a little balloon at the end of a catheter. Yes, that was quite possible. Now, I just needed some money for them. Shortly afterwards, the hospital offered small sums to finance projects within its walls. So, I applied, and soon I was off for an interview. Sitting on the panel was the Vice Chancellor of the university and two physicians. The VC had been an anatomist, a specialist in formalinised specimens. I explained what I wanted to do. A look of horror came on his face!

"You want to push balloons into the veins of sick patients to induce pain?" "Well, not exactly...," but the die was cast. I left without any money, but with a tarnished reputation – if I ever had one!

Well, I made a mercury manometer which would register 600 mm pressure – five times average systolic blood pressure. By local pressure, I isolated a segment of vein on the back of my hand and got a colleague to insert a needle into it. We injected saline at pressure until the manometer was at its peak. The vein became as hard as bone. But pain? – not a vestige!

From arteriography experience, perhaps there was a chemical method of inducing discomfort. The hospital made up many sterile solutions and I picked a bottle of Sodium Citrate which would fix Calcium ions in vessel walls. Dripping this into a vein on the back of my hand might be interesting. It was! It produced almost immediate intense ache which became agonisingly severe as it spread up my arm, until I tore the needle out! Later I discovered that this pain is mediated by somatic nerves and that sympathectomy does not modify it at all. Was this the elusive pain I was trying to track down?

But alas, I had to leave further studies. Doubtless vascular surgeons now know all about the genesis of vascular pain – 55 years after my efforts – and it is too late to tell that Vice Chancellor that balloon catheters are now frequently passed into blood vessels, even those of the heart.

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