SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:4 May 2009

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"All surgical Trainees contribute to the education of junior staff."

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Finding the time to volunteer your surgical services is a worthwhile experience.

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"It was a wonderful and life-changing time for me."

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

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Post Fellowship Education and Training

The progressive development of specialisation in surgery

Ian Gough
President

"Independent groups and the specialty societies can still approve other programs as they see fit."

Post Fellowship Education and Training

A key issue for broader professional practice and medical and surgical practice in particular over the past 50 years has been the progressive development of specialisation. This has undoubtedly led to advances and improved standards that are then more broadly available to the various professions and also to the community.

The critical issue of formally accrediting education and training in sub-specialty areas has been under discussion at senior levels of the College and Specialty Societies and Associations for the past two years. At February Council there was agreement to formally establish the Post Fellowship Education and Training Committee and to start the assessment/accreditation process for surgical subspecialty areas.

The guidelines that have now been approved will assist proponents to plan for the creation of new training programs. Importantly this process has been developed to approve programs that seek College accreditation and this will need to be done in association with the Specialty Societies and Associations. Accreditation is considered important due to the central role that the College has in maintaining surgical education and training standards. However, it is important to understand that it is not exclusive. Independent groups and the specialty societies can still approve other programs as they see fit. As an example a number of universities are now profiling courses and degrees that provide formal structures in this post-fellowship training area.

A thorough consultative process is vital to the success of this accreditation, as is the ownership by the Specialty Societies that are active in the area of clinical activity. Sponsorship by at least one of the Specialty Societies is essential to the start of the accreditation process. The assessment process must then involve all relevant Specialty Societies and they will be formally involved with the Assessment subcommittee.

The key criteria for the Assessment subcommittee are

1. Demonstrated need based on public benefit
2. Justification on the basis of a specific and unique knowledge base
3. Evidence that the proposed program provides education and training that is significantly more specialised than that provided at a generalist level in one or more of the College's nine specialty training programs
4. A defined curriculum based on College competencies
5. In-training formative assessments
6. A mechanism to certify satisfactory completion of training
7. A faculty of surgical supervisors and educators
8. Continuing professional development.

The full Post Fellowship Education and Training committee will consider the report of the Assessment Subcommittee and will make a recommendation formally to Education Board and then to Council. →

If the recommendation is for approval and is accepted then the mechanisms of its delivery, administration, funding and commitment to education, research and scientific activities will be detailed in a Memorandum of Understanding and a Service Agreement.

With this approach now accepted by Council, the Post Fellowship Education and Training Committee is being formed and no doubt applications will be received in the near future as a number of groups such as colo-rectal, hand and craniofacial surgery to name but a few, have been requesting this over recent years.

Historical and Current Context

It is important to understand the historical context of this development as changes always produce some anxiety. The College's key role is to ensure that surgical standards are being maintained and to ensure the structure and common standards for education and training of future surgeons exists. It was the lack of these common and acceptable standards that led to the formation of the College in 1927. Since then much of the direct responsibility has moved to the Specialist Societies and Associations. However they act in partnership with the College and there are agreed models for delivery of the program across all specialities. The standards of this are verified by the College's formal involvement with the accreditation process of the Australian Medical Council.

Within our current accreditation there are nine specialities. There is no current proposal to change this and the requirements to develop any new specialty are set at a high level. This is deliberate as any proliferation beyond our present nine specialties would not necessarily be in the best interest of our patients and the community.

However, there are many areas of specialisation where Fellows can and do confine their practice. This is particularly the case for Fellows who are based in metropolitan practice and are associated with larger hospitals. There is little advantage in holding back the ambitions of groups who wish to practice predominantly in a sub-specialty or cross-disciplinary area. With the formation of the Post Fellowship Education and Training Committee there is now a mechanism to formally accredit and recognise training in these sub-specialty areas.

While the present discussion is on sub-specialisation, the community requires generalists, particularly in regional, remote and outer metropolitan areas. Surgeons in all disciplines and locations deserve encouragement and professional satisfaction. The College of course supports all Fellows in establishing and maintaining high levels of surgical practice for the benefit of our patients.

Dean of Education

Applications are invited for the position of Dean of Education. The position is nominally 0.8 EFT to encourage both a significant commitment to the role and also the flexibility to maintain some external responsibilities. Although predominantly located at the College headquarters in Melbourne consideration will be given to applicants who need to be based in other cities of Australia or New Zealand.

The College is associated with a number of Surgical Societies and Associations and is the Australian Medical Council accredited provider of Surgical Education and Training to over 7,000 Fellows and Trainees. Importantly the College is now developing an Academy of Surgical Educators who are the key faculty delivering our courses and training programs. The appointee will be in the key leadership role to develop and promote a strong and collaborative educational ethos throughout and beyond the College.

The appointee will be a Fellow of a medical college, ideally possessing a postgraduate qualification in education or research. They will be experienced in managing within a complex environment requiring substantial consultation. An understanding of adult learning and a demonstrated record in the development, implementation and evaluation of innovative education programs are essential. Importantly they will have demonstrated leadership within complex professional environments.

The appointment is available as an initial three year contract, renewable by mutual agreement. Salary package is negotiable depending on qualifications and experience.

The position description and statement are available on the College's web-site at www.surgeons.org Further information is available from Dr David Hillis, Chief Executive Officer by telephoning + 61 3 9249 1205 or email david.hillis@surgeons.org

Applications in writing to the Chief Executive Officer, Royal Australasian College of Surgeons, 250 - 290 Spring Street, EAST MELBOURNE VIC 3002 by June 30 2009

Trauma care in our hospitals

Surgical leaders in our major hospitals need to continue to advocate for better trauma care

Ian Dickinson
Vice President

In last month's issue of *Surgical News* I addressed several of the issues relating to optimal trauma management in our public hospitals. While hospital administrations need to put in place trauma management systems which ensure a patient's access to the various surgical specialties, surgeons need to ensure that the drift towards surgical super-specialisation does not give rise to a situation where a broad range of surgical skills is not available for the benefit of the patient. Surgeons need to stay up to date with areas in which they do not regularly practice but where they can be called upon to practice in an emergency or trauma situation. And it is crucial that we recognise the importance of teamwork and leadership in the care of the injured patient.

Advocacy

It is imperative that surgical leaders within our major hospitals continue to advocate for better trauma care. The evidence is compelling that the best trauma management systems involve a limited number of high level surgical trauma centres, and some states have already taken this on board. Other jurisdictions, however, will need to follow suit if they are to obtain the best surgical outcomes.

While we need to advocate for major trauma centres and effective trauma systems, we must also recognise that sometimes patients can be adequately treated at a level 2 or level 3 centre. We need to adopt the benefits to be gained from "hub and spoke" arrangements, where there are sound and supportive professional relationships between the central hospital and more peripheral centres.

A brief survey of the major trauma services in Australia reveals considerable uncertainty as to the best arrangements and, it must be said, the inevitable play of political considerations.

In New South Wales the State Government chose not to embrace the Garling Report's recommendation that there be three or four major trauma centres. Victoria has two, and one major paediatric trauma service. In South Australia it has been suggested there be one. In Western Australia it has been suggested there be one. In Brisbane it has been suggested two, with a third to follow in Townsville in due course.

If major centres are created, the issue arises as to whether smaller hospitals will lose their influence. It is clear that there will always be a need for smaller emergency centres which, while not offering the full range of surgical procedures, can effectively manage such things as single or two bone orthopaedic care, and similar scopes of injury within other specialties such as eye, ear, hand, etc.

System Management

The best way to ensure surgeons are most usefully engaged is to encourage them to practice within their chosen area of specialty and subspecialty. Nowadays, credentialing procedures require them to practice within a defined scope of practice. →

Cover photograph: Ian Civil, Andrew Cochrane & Peter Choong

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Often, however, this scope of practice does not include a broader range of trauma or emergency skills. So the care of acute or trauma patients falls on a smaller group of surgeons. It is not unreasonable for the employing authority, as part of its appointment conditions, to require surgeons to participate in acute care, and to stay current in the delivery of such care. On its part, the employing authority should enable its surgeons to stay current by periodically providing and supporting opportunities to attend courses and maintain their skills.

Lessons from elsewhere

There have been significant developments in the management of trauma, both in continental Europe, particularly the German speaking countries, and in North America. While these systems have become very sophisticated and have been shown to improve patient outcomes, they are also very expensive. And they do not necessarily translate easily to the Australian and New Zealand environments.

In Australia and New Zealand the early management of trauma is usually provided by the emergency medicine physician, and only subsequently does the orthopaedic or general surgeon become involved. This leads to fragmentation of care and often it is not clear who is in charge of the overall care of the patient.

Many hospitals and orthopaedic and surgical departments have encouraged the employment of surgeons particularly from the German speaking countries who have high level qualifications in surgical trauma care. These surgeons do not fit perfectly into the category of either general surgeon or orthopaedic surgeon. This has on occasion given rise to situations in which surgeons with considerable leadership potential to offer Australian or New Zealand hospitals have not been able to progress in a way that would be of great value to our systems.

"There have been significant developments in the management of trauma, both in continental Europe... and in North America"

It is important that all surgeons who are employed here have qualifications that are substantially comparable, and that the Fellowship of the Royal Australasian College of Surgeons (FRACS) is obtained. However the incorporation of these surgeons, with their experience and expertise, can produce immeasurable benefits for a system which can at times struggle.

Recruitment of orthopaedic surgeons and general surgeons into trauma care requires appropriate consideration of lifestyle and remuneration. While surgeons can be paid more money to provide the appropriate leadership and care, this is not enough if fellow surgeons and the employing hospitals are not supportive. The surgeon left alone to perform miracles is not going to survive the extraordinary stress involved, and we have seen a number of surgeons leave their hospitals or return to their countries of origin because they were not adequately supported, either by their colleagues or their hospitals.

Teamwork

We should continue to advocate for surgeons across the specialties to participate in courses such as Definitive Surgical Trauma Care Course (DSTC) so that they can have a clearer understanding of what their colleagues are doing. This will foster a system in which surgeons on the spot, irrespective of their specialty, can assume a leadership role, directing surgical patients to the appropriate surgeon or, if necessary, performing surgery on the acutely injured patient as part of their scope of practice. It would be a measure of the sophistication of our trauma management systems if more surgeons could exercise such leadership, significantly broadening their capacity to care of the injured patient.

Results of the 2009 elections to Council

The results of the 2009 elections to Council were tabled at the Annual General Meeting in Brisbane on 8 May 2009
Congratulations to all successful candidates and sincere thanks to all candidates who nominated.
The pro bono contribution of Fellows has been, and continues to be the College's most valuable asset and resource.
We are grateful for their commitment.

General Elected Councillors

There were three General Elected Councillor positions to be filled.
Re-elected to Council are
Ian Donald Civil,
New Zealand Vascular Surgeon
Michael John Hollands,
New South Wales General Surgeon.

Newly elected to Council is
Vincent Charles Cousins, Victoria
Otolaryngology Head and Neck Surgeon.

Specialty Elected Councillors

Neurosurgery – re-elected
Glenn Anthony McCulloch, South Australia
Plastic and Reconstructive Surgery – re-elected
Keith Louis Mutimer, Victoria

Thank you to the scrutineers Andrew Roberts and Colin Russell.

Who is the Vice President?

Why do we have a Vice President and what does he do within the College?

I.M.A Newfellow

I would be willing to bet that not many of you can name the Vice President of the USA or the Deputy Premier of your state or, in the case of the New Zealanders, the Deputy Prime Minister of your country, let alone tell me a bit about him or her. Now I would hope that you can however tell me who the Vice President of the College is, where he is from and what are his functions. Where he is from is easy as everyone of any importance in the College in recent years seems to be from Queensland (the President, Ian Gough and the Vice President).

Who is he? Ian Dickinson, an orthopaedic surgeon from Brisbane. What does he do in the College structure? Now therein lies "a riddle wrapped in a mystery inside an enigma", to quote Winston Churchill (of course he was talking about post-war communist Russia and I am not implying that Ian is a dictator). One would assume, quite reasonably, that his job was to deputise for the President – and he does on the rare occasions that the President's super-human powers do not allow him to be in two places at once.

One of the responsibilities of the Vice President is to look after the Regional Committees of the College. Now that is where he does need to be a dictator. All states of Australia, the Australian Capital Territory and New Zealand have Regional Committees that deal with regional issues relating to surgery. Even the humble and diminutive Northern Territory had a small regional office to deal with local issues. Now as I understand it the Vice President's job in part is to communicate with them and keep them happy that the decisions made at Spring Street have their best interests at heart. Easy! Just pretend that you are Josef Stalin and tell them what to do and how to think. Alternatively you could take cat herding lessons.

On a serious note the strength of the College lies in its Specialty Societies and its Regional Committees. Many Regional Chairs go on to the larger scene and become College Councillors and contribute greatly to College affairs. Mike Holland, a current Councillor, is an example. Every month there is a teleconference of the Chairs of Regional Committees so that there can be a two way dialogue regarding what is happening in the College. Each Council meeting the Regional Committee put in reports so that the Councillors can read them (I note that they are always at the end of the papers so perhaps not a lot of reading takes place; I have never heard a question arising from these end papers!).

Now the other major area of the Vice President's responsibilities is advocacy and relationships. What does he advocate? In general, it is for improvements in surgery to anyone who will listen or should listen. He advocates to governments, to consumer groups, to the Australian Medical Council, to the Australian Competition and Consumer Commission, to Council of Australian Governments, to the Productivity Commission and to the numerous government bodies that are expanding like my waistline. He has relationships with all of these groups, indecent as some of the relationships might be. He tries to influence government decisions and suggest reason where there is insanity.

As you can see the Vice President needs to be a politician, a diplomat, an educator, a listener, a pragmatist, a protagonist and agonist. Of course when all else fails he can learn Russian and follow Uncle Jo's example; I am sure that I heard a vote of "Nyet" in the last Council meeting.

College Online Library books

The Library has full text online reference books in all the surgical specialties.

Graeme Campbell
Chair, Fellowship Services

The books can be searched by subject or keywords and pages can be easily printed off as required. You can access resources in your specialty or via the following list of titles –

AAFP conditions A to Z
Ropper: Adams and Victor's principles of neurology
Gillenwater: Adult and Pediatric Urology

Libby: Braunwald's heart disease : a textbook of cardiovascular medicine
Bland: The breast : comprehensive management of benign and malignant disorders
Brenner: Brenner and Rector's the kidney

Canale & Beaty: Campbell's operative orthopaedics
Wein: Campbell-Walsh urology
Goldman: Cecil medicine
Habif: Clinical dermatology
Goldberger: Clinical electrocardiography
Abeloff: Clinical oncology
Roberts: Clinical procedures in emergency medicine
Ford: Clinical toxicology
Katz: Comprehensive gynecology
Rakel & Bope: Conn's current therapy
Lalwani: Current diagnosis and treatment in otolaryngology - head and neck surgery
Cameron: Current surgical therapy

DeLee: DeLee & Drez's orthopaedic sports medicine: principles and practice
Frontera: Essentials of physical medicine and rehabilitation
Mettler: Essentials of radiology

Dolan: Facial plastic, reconstructive and trauma surgery
Ferri: Ferri's clinical advisor : instant diagnosis and treatment

Thorne: Grabb and Smith's plastic surgery
Adam: Grainger & Allison's diagnostic radiology: a textbook of medical imaging
Guide to the assessment of the degree of permanent impairment 2nd edition

Johns Hopkins: The Harriet Lane handbook: a manual for pediatric house officers
Harrison's principles of internal medicine
Hoffman: Hematology : basic principles and practice
McPherson & Pincus: Henry's clinical diagnosis and management by laboratory methods

Cohen & Powderly: Infectious diseases
Rakel: Integrative medicine

Firestein: Kelley's textbook of rheumatology
Gershon: Krugman's infectious diseases of children

Medcalc 3000
Miller: Miller's Anesthesia
MIMS
Launois & Jamieson: Modern operative techniques in liver surgery
Mason: Murray and Nadel's textbook of respiratory medicine

Kliegman: Nelson textbook of pediatrics

Gabbe: Obstetrics : normal and problem pregnancies
Khatri: Operative surgery manual
Yanoff & Duker: Ophthalmology
Piccini & Nilsson: The Osler medical handbook
Cummings: Otolaryngology—head & neck surgery
Oxford Textbook of Surgery
Park: Pediatric cardiology for practitioners
Grosfeld: Pediatric surgery

Ferri: Practical guide to the care of the medical patient
Duthie: Practice of geriatrics
Mandell, Bennett & Dolin: Principles and practice of infectious diseases
Long: Principles and practice of pediatric infectious diseases
Gordon & Nivatvongs: Principles and practice of surgery for the colon, rectum and anus

Roitt: Really Essential Medical Immunology
Ganong: Review of medical physiology
Kumar: Robbins and Cotran pathologic basis of disease
Marx: Rosen's emergency medicine: concepts and clinical practice

Townsend: Sabiston textbook of surgery : the biological basis of modern surgical practice
Sellke: Sabiston & Spencer surgery of the chest
Yeo: Shackelford's surgery of the alimentary tract
Browner: Skeletal trauma: basic science, management, and reconstruction
Green & Swiontkowski: Skeletal trauma in children
Feldman: Sleisenger & Fordtran's gastrointestinal and liver disease : pathophysiology, diagnosis,management
Stedman's medical dictionary

Goetz: Textbook of clinical neurology
Rakel: Textbook of family medicine
Gill: Textbook of laparoscopic urology
Noble: Textbook of primary care medicine
Feliciano: Trauma

Rutherford: Vascular surgery

Auerbach: Wilderness medicine
Kronenberg: Williams textbook of endocrinology

For further information contact Anne Casey, Manager, Library & Website
anne.casey@surgeons.org

College Conferences and Events Management

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

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Annual Scientific Conference 2009

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29 July – 1 August 2009

Email: psa@surgeons.org

Medical images and privacy

Surgeons need patient permission before using photographs and other images

Michael Gorton
College Solicitor

Contrary to popular belief, there is no general right for medical practitioners to use patient photographs, x-rays or other visual images, whether for education, research or otherwise. The introduction of privacy and health record legislation throughout Australia and New Zealand has made it clear that use of such material can only occur with the consent of the patient.

A number of recent cases amplify this warning:

- An investigation has been carried out in Western Australia in relation to breach of patient confidentiality after a newspaper published a photograph obtained from a hospital's internal website of a patient being treated at that hospital.
- A chief resident of general surgery at a USA hospital faces disciplinary proceedings after taking photos of a patient's tattoo, using his mobile phone.
- An apocryphal story tells the tale of a surgeon who objected, when his colleague included his x-rays in a powerpoint presentation at an education conference, without his consent. The surgeon giving the presentation was the treating surgeon.

We know that photographs, videos and other visual images are usefully used by medical practitioners for many purposes. They are obviously placed in patient records as an adjunct to clinical care. They may be displayed to colleagues, trainees and others for treatment purposes. However, they can also be used in educational settings, published in medical journals or other media, as part of ongoing education and research. Any use beyond the treatment of the patient runs the risk of a breach of privacy. Accordingly, careful management is required ensuring that each patient expressly consents to such use, so there can be no allegation of breach of privacy legislation or breach of general confidentiality obligations of doctors.

Consent

A patient can obviously explicitly consent to the use of their images for a range of purposes.

It is also acceptable, under privacy legislation, for the doctor to have a privacy statement or privacy consent document (either signed by the patient or given to the patient) which indicates that images and materials may be used for research and education purposes – and allowing the patient to "opt out" by making it clear to the medical practitioner that such permission is not given. This places the onus on the patient to object, and enables the doctor to utilise the images in the absence of such objection.

Doctors operating within hospital environments should check their hospital's privacy statement or consent form to determine the extent of consent encompassed within those documents. Many hospitals will generally have statements indicating that patients agree to use of their images for research and education purposes unless they "opt out".

These obligations are not necessarily new. Doctors have always had an obligation to maintain confidentiality in relation to patients and patient information. A breach of privacy or confidentiality can also lead to a complaint of professional misconduct, and potential disciplinary proceedings before medical boards and authorities.

Remember, the onus to show that a patient has either explicitly or implicitly consented rests with the medical practitioner. Before using photographs, x-rays and other images, particularly if they may be identifying, ensure that you have consent.

HOMESTAY ACCOMMODATION FOR VISITING SCHOLARS

Through the College International Scholarships Program and Project China, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to 12 months.
Due to the short term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. The International Scholarships Department and Project China are seeking expressions of interest from those willing and able to provide homestay accommodation for our visiting scholars. If you have a spare room, and are interested in learning about another culture and language, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a nominal stipend.

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

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

PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

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

BUILDING TOWARDS RETIREMENT

13 June 2009, Melbourne

Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. The program covers key issues including maintaining health and well being, job opportunities after surgery, superannuation and legal advice, community involvement and building relationships and networks. Learn from surgeons and other experts who can motivate you to start planning and making decisions about the next phase of your life.

LEADERSHIP IN A TIME OF CHANGE (NEW)

19-21 June 2009, Sydney

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

PROVIDING STRATEGIC DIRECTION (NEW)

13-15 November, Melbourne

Want a solid understanding of the strategic planning process? Over 2½ days you can gain the skills and knowledge to produce and implement an organisational strategy. Focus will be on how to establish a strategic direction through an effective planning process. You will also learn more about conducting an organisational/market analysis, sustaining a competitive advantage and developing strategic measurement systems.

SURGICAL TEACHERS COURSE

30 July - 1 August 2009, Canberra & 17-19 September 2009, Auckland

The Surgical Teachers Course, consisting of 2½ days of challenging and interactive activities, enhances the educational skills of surgeons responsible for the teaching and assessment of surgical trainees. Experienced faculty members employ a range of teaching techniques and presentations to deliver the curriculum including Adult Learning, Teaching Technical Skills, Feedback & Assessment and Change & Leadership.

PRACTICE MADE PERFECT

26 June 2009, Auckland & 28 August 2009, Brisbane

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, practice staff and surgeons are encouraged to join these workshops for a valuable learning experience.

BEATING BURNOUT

1 September, Sydney

Tired? Stressed? Overworked? Sometimes the demands of clinical life appear to be ever increasing and unavoidable. Not surprisingly, clinicians are at a higher risk of depression and substance abuse. This evening workshop offers advice and practical strategies for achieving a better work/life balance given the competing priorities surgeons face. You will be able to discuss important stress management issues with your peers and be introduced to proven techniques to manage the effects of burnout.

DATES, MAY - SEPTEMBER 2009

ACT

30 July - 1 August	Surgical Teachers Course, Canberra

NSW

4 June	Mastering Difficult Clinical Interactions, Sydney
19-21 June	Leadership in a Climate of Change, Sydney
29 July	Mastering Intercultural Interactions, Sydney
15 August	Supervisors and Trainers (SAT SET), Sydney
21 August	Making Meeting More Effective, Sydney
1 September	Beating Burnout, Sydney

QLD

2-4 May	Younger Fellows Forum, Brisbane (pre ASC)
5 May	Supervisors & Trainers (SAT SET), Brisbane (ASC)
5 May	Writing Reports for Court, Brisbane (pre ASC)
28 August	Practice Made Perfect: Successful Principles for Practice Management, Brisbane

SA

16 June	Supervisors and Trainers (SAT SET), Adelaide
31 August	Mastering Professional Interactions, Adelaide
11 September	Acute Neurotrauma Management (Rural), Adelaide

NT

30 May	Management of High Risk Diabetic Foot, Alice Springs
27 June	Supervisors and Trainers (SAT SET), Darwin
29 July	Management of High Risk Diabetic Foot, Alice Springs (PSA)
16 September	Supervisors and Trainers (SAT SET), Alice Springs

WA

29 May	Risk Management: Shared Decision Making, Perth
16 September	Practice Made Perfect: Successful Principles for Practice Management, Perth

VIC

26 May	Supervisors and Trainers (SAT SET), Melbourne
13 June	Building towards Retirement, Melbourne
27 June	Making Meetings More Effective, Melbourne
4 July	Supervisors and Trainers (SAT SET), Ballarat
4 July	Emergency Management of Severe Burns, Bendigo
8-9 August	From the Flight Deck, Melbourne
14 August	Polishing Presentation Skills, Melbourne
22 August	Expert Witness, Melbourne

NZ

26 May	Supervisors and Trainers (SAT SET), Christchurch
26 June	Practice Made Perfect: Successful Principles for Practice Management, Auckland
17-19 September	Surgical Teachers Course

FURTHER INFORMATION

Please contact the Professional Development Department on +61 3 9249 1106

by email PDactivities@surgeons.org

or visit the website at www.surgeons.org select Fellows then click on Professional Development

The John Mitchell Crouch Fellowship

Professor Peter Choong has used the Fellowship to focus on his research into sarcomas

Peter Choong and the team performing limb sparing surgery on a young patient with a sarcoma of his arm

According to Professor Peter Choong, the form of cancer known as sarcoma, which predominantly affects adolescents and young adults, at times can mimic the behaviour of the young people itself. Professor Choong said that like adolescents the world over, sarcomas can be irrational, they can refuse to do what is expected, some respond to treatment, some don't, some grow slowly, some show sudden growth spurts.

Believed to affect the young through a derangement of hormonal processes, sarcomas are divided between tumours which arise from bone (bone sarcomas) and others which originate from soft tissue such as muscle, fat and ligaments (soft tissue sarcomas). Both are potentially life-threatening.

Yet until now, the combination of the erratic nature of the disease and its comparative rarity has meant that treatment options have remained focussed within the matrix of surgical excision, high-toxicity chemotherapy and radiotherapy but all, again, with varying results.

Since taking on the position in 1996 as Director of Orthopaedic Surgery at St Vincent's Hospital and at the same time establishing the Sarcoma Service at Peter MacCallum Cancer Centre, Professor Choong has devoted himself to finding alternatives to amputation surgery, in particular, and to improving both the survival rates and the quality of life of the young people in his care. Now he and his team at St Vincent's have identified a protein found in cartilage that could inhibit the growth of osteosarcomas.

"It has long been known that when an osteosarcoma reaches the end of the bone it stops when it meets the growth plate cartilage. That has been known for decades and it has always been an observation of great interest to me yet no-one really had posed the question: Why is this so?" Professor Choong said.

"I encouraged a research student to have a look and we found that the growth plate had a very poor blood supply and that the cartilage had very few cells. We then hypothesised that it may have been those characteristics that stopped the tumours from growing - that is, poor blood-supply to feed the tumour and something molecular that inhibited growth.

"We looked for a molecule within the cartilage and identified for the first time the presence of pigment epithelium derived factor or PEDF which is now known to be the most potent antiangiogenic molecule in the human body.

"PEDF is known to exist in the retina and controls a variety of physiologic functions in the eye including the regulation of vascularity to prevent blindness. Then, in further research, we proved that wherever PEDF met the tumour, the tumour stopped."

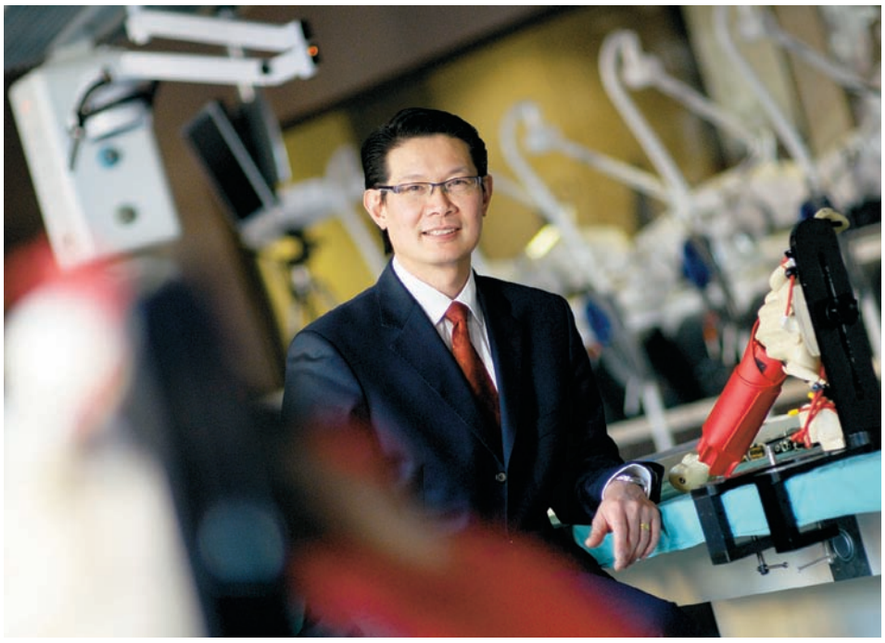
Professor Choong said that following that initial discovery his team, in collaboration with a number of hospitals, health institutes and universities, collected PEDF samples to use in in-vitro and in-vivo studies. They found it had the ability to stop the tumour growing, migrating and invading and also to stop blood cells forming. It was a good moment.

"It seemed to be able to stop all the things that tumours do. Then having confirmed that it did what we thought it did in test tubes we used it in mice models and the results were the same," Professor Choong said.

This work has now placed the Melbourne research unit at the forefront of global efforts in the field of sarcoma treatment with collaborations now extending across Melbourne universities and the University of Sydney to as far away as the University of Tokyo and the National Institutes of Health in the USA.

Professor Choong was the 2008 recipient of the John Mitchell Crouch Fellowship - the most prestigious honour offered by the College

"All of our focus has been trying to find treatment options that not only save lives but limit morbidity."



- and chose to use the funding attached and the recognition offered to focus on his research into PEDF.

However, the Fellowship not only recognised this recent work, but also Professor Choong's contribution to orthopaedic oncology surgery since his return to Melbourne in 1996 following his appointments as Tumour Fellow, Department of Orthopaedics, University Hospital, Lund, Sweden, and as the Special Fellow in Orthopaedic Oncology, Mayo Clinic, Rochester, USA.

Since his appointment at St Vincent's, the department has expanded from six surgeons to 12 surgeons, a team which performs almost 2000 procedures each year. In addition, the conjoint appointment across St Vincent's and Peter MacCallum has facilitated the development of one of the most prominent musculoskeletal oncology services in Australia and Asia.

As Chair of the Sarcoma Service, Professor Choong leads a team comprising three medical oncologists, two radiation oncologists and two surgical oncologists, all of whom are supported by a musculoskeletal imaging specialist, pathologists, geneticists, psychologists, social workers and nurses.

While the clinic began in 1996 with two consultants seeing five patients per week, it now has seven consultants and may see up to 50 patients a week. Almost all the patients in Victoria with osteosarcomas are referred to Professor Choong's department with limb sparing surgery now practiced in more than 90 per cent of cases.

Now, his team is in the process of determining how best to deliver PEDF, either through the use of nanoparticles or via a hydrogel which could be packed around the tumour. Given that such tumour cells also often invade the lungs, there is now work being conducted to look at the possible use of an aerosol delivery system.

"All of our focus has been trying to find treatment options that not only save lives but limit morbidity. Developing this greater understanding of the role of PEDF means that we have so many areas to look at now, to understand and hopefully perfect, much of which could attract the sharp minds of research students," Professor Choong said.

Professor Choong called sarcomas the "intellectual tumour" because they exhibit complex cytogenetic behaviour moving from one chromosome to another. He said they were thus poorly understood not only because of their complex behaviour characteristics but because they are only present in one out of 1000 cancers.

"Yet, though comparatively rare their impact is huge because they affect the young. If you consider sarcomas in terms of life years lost it is three times greater than bowel, breast or lung cancer and is the sixth most expensive cancer to treat," he said.

"If we can find a therapy that reduces the toxicity of the chemotherapy now needed, if we can limit the need for surgery and spare patients the pain and psychological distress of amputation then we will feel all the work, all the collaborations are a great achievement. Right now we are up to the stage of still working out if we have found the right key to the right lock."

Professor Choong's research has been financially supported not only by the College but also through the National Health and Medical Research Council, Cancer Council of Victoria, Cancer Australia and the Australian Orthopaedic Association. He said the work being done in Melbourne was now attracting international research Fellows wishing to work alongside the team.

"Both the research unit at St Vincent's and the Sarcoma Service, I believe, have been such a success because the combined focus has attracted the support of fine minds and people with great expertise, both of which means that we are now at the forefront of research efforts in Australia and also a big player on the international scene," he said.

"In the past, the default position in relation to osteosarcomas was amputation surgery which often caused great emotional distress to young people because it is not surgery that simply leaves a scar.

"So we have turned that around yet the survival rate has increased markedly because of the expertise of the multidisciplinary team in that we know how far to push to spare the young people as much as we possibly can."

Trainees as Educators

Trainees play a vital role in the education of future medical practitioners and allied health staff

Brett McClelland
RACSTA, Orthopaedic Representative

Over recent years there has been an increasing recognition of the role of surgical Trainees as educators of registrars, junior medical staff, medical students, and allied health professionals. The impending increase in the number of medical graduates, and the pressures associated with the greater volume of patients will increase the uneasy tensions between service and education for consultants, making the importance of Trainees providing high-quality teaching even greater. In addressing this issue, three questions arise: Who does this teaching? Why do they do it? And how can they do it better?

It is acknowledged that all surgical Trainees contribute to the education of junior staff. This is facilitated via face-to-face contact with residents, interns and medical students, but also by the presence of Trainees in the common teaching environments such as ward rounds, theatre lists and hospital clinics. Aside from this base-line level of teaching, Trainees with an interest in the area may seek out greater teaching roles such as organised tutorials for junior staff or allied health, or even formal appointments through any of the University Medical Schools. The College is now taking increasing steps to recognise the importance of teaching and education throughout training, and is very supportive of Trainees seeking to advance their educational qualifications through Diplomas or Masters of Education. This is in keeping with 'Scholar/Teacher' being one of the nine core competencies of the Surgical Education and Training (SET) program.

Why Trainees do this is more of a challenge answer. The Hippocratic Oath written in the 4th century BC describes 'teaching the art to the children of my teachers'. Like any form of teaching, the passing on of skills and knowledge to future colleagues is a very rewarding practice. All Trainees remember those moments in their more junior years where they found themselves in situations they were not prepared for, and are keen to help others to avoid this. Another well recognised benefit is the reinforcement of our own knowledge. One of the best ways to assess how well one knows a topic is to try to explain it to others, and teaching throughout your SET training is an excellent form of study and revision leading up to the fellowship examination.

"All Trainees remember those moments in their more junior years where they found themselves in situations they were not prepared for..."

How to improve one's teaching skills is the most important issue. Several studies have shown that the attendance of Trainees at formal teaching courses can significantly improve both educational skills, as well as subsequent student ratings. Courses are available for Trainees or junior doctors that will better equip them for their role as educators. Studies have demonstrated that the effectiveness of workshops on teaching can be short lived and that for maximum effect, the educators should have their skills reinforced with refresher courses at regular intervals. However it can be equally stated that all who participate in such courses will improve their role as teachers throughout their careers.

In summary, SET Trainees play a pivotal role in the education of future generations of medical practitioners and allied health staff. There is a growing appreciation of the importance of educational skills by the College and its partner specialties, and strong encouragement for Trainees to embrace education as part of their daily practice. However, a very large challenge lies ahead with increasing student numbers and decreasing time available for education. As such it is important that Trainees are equipped through teaching skills courses to provide the most effective education in a time-scarce setting, and, given the increasing teaching responsibilities of Trainees and Fellows, should these courses be a mandatory requirement of surgical training?

Practice Visits

Do practice visits have a role in the context of surgery?

Jean-Claude Theis
Chair, New Zealand National Committee

The New Zealand Medical Council is considering introducing regular practice visits as a requirement of Continuing Professional Development (CPD) and Recertification. They believe that the current CPD requirements of audit and peer review cannot give assurance that doctors are competent and they seek to introduce practice visits to identify poorly performing practitioners early before public harm occurs. Such practice visits have already been introduced in New Zealand by the College of Obstetrics and Gynaecology but no formal evaluation has been carried out so far and the New Zealand Orthopaedic Association is planning a pilot next year.

I recently had a conversation with the Health and Disability Commissioner and he felt that this is really like having a regular warrant of fitness on your car to make sure that it is safe to drive on the road. Although the public should expect, and rightly so, that doctors are competent, the process of assessing competence of medical practitioners is much more complex and currently there is no one process which has been demonstrated as consistently reliable.

Currently the New Zealand Medical Council issues an Annual Practising Certificate, an equivalent of a warrant of fitness, based on participation in an approved recertification program for a minimum of 50 hours per year which must include the following:

1. Audit, peer review and team based assessment
2. Educational conferences, courses and workshops
3. Cultural competence

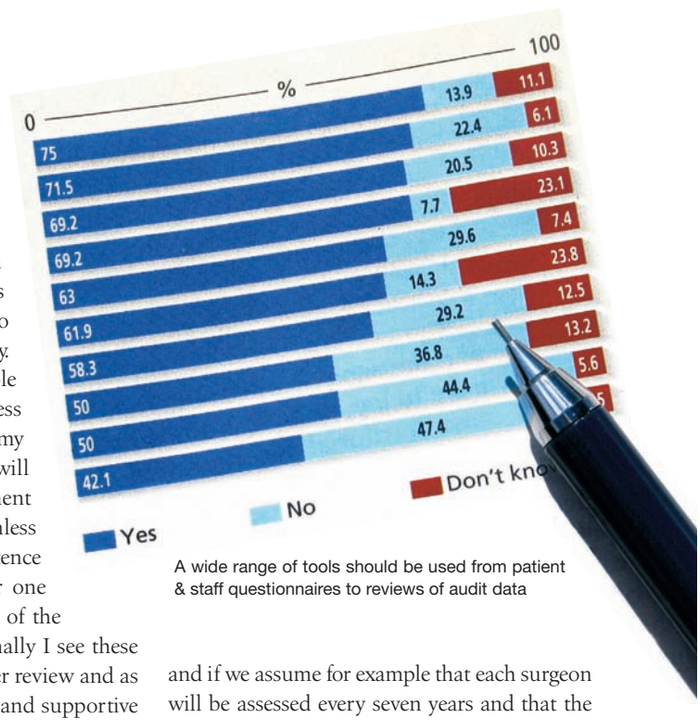
Practice visits have been evaluated in the context of primary care and have shown to enhance quality of prescribing but there is no evidence that they identify underperforming doctors. There is no literature on the value of regular practice visits in surgery and I believe it is up to us to properly assess their validity.

There are currently a whole range of methods used to assess the competence of doctors and my concern is that practice visits will become yet another measurement stick used by the regulators unless the various aspects of competence assessment are brought under one umbrella, possibly in the form of the proposed practice visits. Personally I see these visits as enhancing external peer review and as long as it is done in a collegial and supportive manner, rather than as a compulsory requirement of the Medical Council, it will enhance quality and safety of surgery in our hospitals.

However the assessment tools which are proposed to be used during these visits have to be validated and be shown to measure performance in a reliable fashion against standards established through bench marking. Assessors must be properly trained and inter-assessor variability kept to a minimum through regular auditing of practice review reports.

A practice visit is only a snap shot of a surgeon's practice and might not be a true reflection of that practitioner's everyday work. Therefore a wide range of tools should be used to enhance the validity of the assessment, from patient and staff questionnaires, review of audit data, CPD participation, and complaints to observation of consultations and operative procedures.

One of the major concerns is the resources required to run such a programme. In New Zealand there are currently around 800 surgeons and if we assume for example that each surgeon will be assessed every seven years and that the visit will take two days then this would require two assessors for a total of 220 working days to complete the task. More regular visits could well double this estimate. There will be significant costs associated with this process and the question of who will be responsible to pick up the bill is unclear at this stage.



A wide range of tools should be used from patient & staff questionnaires to reviews of audit data

Overall I believe that we should be supportive of a formal evaluation of the use of practice visits for surgeons keeping in mind the cost effectiveness of such a program in the context of other competence assessment methods.

The New Zealand Orthopaedic Association is to be congratulated for embracing this new concept as an extension of their CPD Program and I am looking forward to hearing more about the outcome of their proposed pilot.

Want to learn more about the business side of your practice?
See page 18 for more information

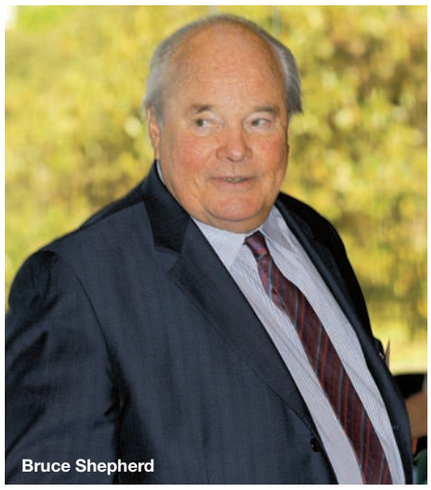
Liberating deaf children

Pioneer medico and Shepherd Centre founder, Bruce Shepherd retires after 40 years, with a celebration and fundraiser planned in Sydney to mark the event

Former AMA president and Shepherd Centre founder Dr Bruce Shepherd AM has retired as Chairman of the Shepherd Centre after dedicating more than 40 years to the development and education of hearing impaired children in Australia.

Bruce Shepherd was a pioneer in hip and knee replacements in Australia and was well-known for his passionate and at times controversial lobbying as the influential head of the AMA during the early 90s.

His wide-reaching endeavor to educate and liberate his own profoundly deaf children, Penny and Daniel, was possibly his greatest achievement and led to the establishment of the Shepherd Centre in 1970.


Bruce Shepherd

"My wife and I wanted to integrate our children into mainstream society by teaching them how to lip-read, speak, read and write. That's been the philosophy of the Shepherd Centre ever since," said Dr Shepherd.

Now 90 per cent of hearing impaired children who undergo the auditory-verbal programs at the Shepherd Centre go on to attend mainstream schools. Only 30 per cent of those students have hearing aids.

"I will always have a close connection with the Shepherd Centre but it's time for me to hang up my boots. Since my time here we have farewelled over 1000 families who've graduated from the early intervention program onto mainstream schooling, it's a great achievement and one that I know the staff will carry on following my departure," said Dr Shepherd.

Dr Shepherd's younger brother Michael has taken over as Chairman and is enthusiastic about the ability of the organisation to maintain high quality auditory verbal therapy for hearing impaired children and their families.

"The centre will continue to work towards its goal of one day sending 100% of its students into mainstreams schools having developed the spoken language," said Michael Shepherd.

The Shepherd Centre is holding a "Retirement Roast" to fundraise and celebrate Dr Shepherd's commitment and dedication to hearing impaired children and their families.

The fundraising event will be held at the Four Seasons Hotel in Sydney on Friday 12 June from 7pm.

To purchase tickets for this event or to make a donation please call 1800 020 030 or email events@shepherdcentre.usyd.edu

TRAUMA COMMITTEE REGISTRARS' PAPERS' COMPETITION –9 September 2009

The College Trauma Committee is hosting the third 'Registrars' Papers Competition' in Adelaide on Wednesday 9 September 2009 as part of the Trauma Committee program at the IATSIC/ISS meeting. Registrars are invited to submit abstracts of trauma research projects (deadline for abstracts 22 July 2009). A select group, of around 6 registrars, will be asked to present their paper at this competition on 9 September. Candidates will need to cover their own travel expenses, and registration to attend the IATSIC/ISS meeting. The winner will receive a certificate and may have the opportunity to present their paper at the Annual Meeting of the American College of Surgeons Committee on Trauma – in Las Vegas in March 2010. Last year's winner, Alexios Adamides, Surgical Trainee – Neurosurgery, presented his paper at the US Residents' Trauma Paper Competition. He won that competition too – well done Alex!

Further information – www.surgeons.org/trauma - or contact Lyn Journeaux, Executive Officer, Trauma Committee – Tel: 03 9276 7448; fax: 03 9276 7432 or email: lyn.journeaux@surgeons.org

Princess Alexandra Hospital
Metro South Health Service District

POST FELLOWSHIP TRAINING IN COLORECTAL SURGERY

Princess Alexandra Hospital, Brisbane.

Applications and enquiries are invited for:
- **2nd six months of 2009 (6 month fellowship)**
- **2010 (full year fellowship)**

The fellowship offers exposure to most aspects of colorectal surgery, including laparoscopic colon and rectal resections, functional and oncological procedures. The position does involve on call for General Surgery and Trauma.

Applications:
Applicants should submit a CV, and nominate three referees (including addresses and email).

Closing Date:
29th May 2009 (for both jobs)

Please send to:
Dr Brian Meade
4th Floor Surgical Offices,
Department of Surgery,
Princess Alexandra Hospital,
199 Ipswich Road, Woolloongabba
4102, Brisbane

Fax: 07 33972599
brian_meade@health.qld.gov.au

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

The Paul McMaster Fellowship

Applications from interested surgeons are invited for the Paul McMaster Fellowship.

It is available from February 1st 2010 to January 31st 2011. The attachment is to the Liver Unit at The Queen Elizabeth Hospital in Birmingham, UK and offers a comprehensive training in HPB surgery and Liver transplantation. It is available to post fellowship Australian or New Zealand trainees.

The closing date for applications is Friday June 12th 2009.

Applicants should submit a CV, an outline of career plans and three written references to:

Dr Robert Padbury
President ANZHPBA
c/- Leanne Rogers
Executive Officer ANZHPBA
PO Box 374, Belair S.A. 5052
or email anzhpba@gmail.com

AFL INJURIES CONFERENCE

MELBOURNE, VICTORIA

23-25 SEPTEMBER 2009

At the Melbourne Cricket Ground immediately preceding the 2009 ALF Football Grand Final

- The conference will cover aspects of sports injuries, assessment and management through a series of rigorous academic sessions.
- Plenary sessions are coupled to discussion groups.
- Practical workshops will extend participants' knowledge and practice of sports medicine.

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THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Research Opportunities For Surgical Trainees

Lecturer Positions

Contemplating research to further your surgical career? The Department of Surgery together with the Surgical Research Network at The University of Auckland offers surgical trainees excellent opportunities to undertake fulltime research in 2010.

- Research can be done before, during or after surgical (SET) training
- Expert supervision in internationally competitive laboratories
- Research can be towards a PhD, MD or Masters degree

Three positions will be offered in 2010. Applications required by 30 June 2009.

To discuss this world class opportunity at New Zealand's leading university, please contact: Scott Aitken, Manager, Surgical Research Network, s.aitken@auckland.ac.nz
+64 9 373 7599 ext 86929

Practice Made Perfect

A one-day program aims to give surgeons a better understanding of key business principles

Rob Atkinson
Chair, Professional Development Committee

Principles of Successful Practice Management

Want to know how to have a positive impact on your practice? This year the College has developed an extended, interactive format for its practice management workshops in response to participant feedback. The new look, one-day program aims to give surgeons and their practice managers a better understanding of the key principles of sound business. The first part of the workshop explores the six principles of practice management; purpose, planning, promotion/marketing, people, performance and problem solving. The second part covers one or two of these principles in more in depth. The focus is on practicality and using the checklists and tools provided to undertake a basic assessment of your practice in each of the key areas. By the end of the day, each participant will have developed an action plan as the basis for applying what has been learnt to the real world.

What are the six 'P's?

Purpose
Understanding a practice's purpose and vision is critical to the overall success of the business. These need to be clearly communicated to the practice team so that everyone understands and supports the practice's strategic direction.

Planning
Planning tools help to ensure the goals of the practice are achieved. The types of plans that are relevant to the business of health care include strategic or big picture plans, business plans (one year plan) and operational plans.

Promotion/Marketing
Promoting and marketing a practice is important for attracting and keeping a strong patient base. This involves communicating services and information to patients and attracting and retaining a strong workforce including clinical, nursing, management and administration staff.

People
Identifying and implementing the key steps to recruit, develop and keep the right people to ensure a team-focused approach to the delivery of high quality care is a cost effective strategy and essential for a successful practice.

Performance
It is important to establish a sound framework to report on how the practice is performing in each area. The core areas for performance management include patient service, people performance, business development and financial management.

Problem solving
Developing problem solving skills is an important first step in identifying opportunities for improvement. Defining why a problem exists is a great starting point for creatively thinking about challenges within a practice.

You and your practice staff are invited to attend a Practice Made Perfect workshop on:

26 June, Auckland
28 August, Brisbane
6 Sept, Perth

Another opportunity for surgeons and their practice managers to explore risk management reduction strategies is the 'Shared Decision Making' workshop on 29 May, Perth.

This workshop will address the reasons 'shared decision-making' is being advanced as an effective model and provides an opportunity to rehearse some of the most important communication skills. It will also encourage participants to reflect on their current attitudes and practice regarding patient decision making.

For further information, please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit www.surgeons.org and select 'Fellows' then click on Professional Development.

BLUE CHIP

Definitive Surgical Trauma Care Course (DSTC)

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) is pleased to announce the courses for 2009.

The DSTC course is an invigorating and exciting opportunity to focus on surgical decision-making and operative technique in critically ill trauma patients. You will have hands on practical experience with experienced instructors (both national and international).

The DSTC course has been widely acclaimed and is recommended by the Royal Australasian College of Surgeons for all surgeons and Trainees.

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel. Please register early to ensure a place!

To obtain a registration form, please contact Sonia Gagliardi on 02 9828 3928 or email: sonia.gagliardi@sswahs.nsw.gov.au

2008 COURSES

Sydney
Military Module
21 July 2009

Sydney
22 & 23 July 2009

Adelaide
3 & 4 September 2009

The Interplast Black & White Ball

The night was a success with $45,000 raised through the generosity of the attendees at the ball

Over 250 people enjoyed an incredible night at Ivy in Sydney for the inaugural Interplast Black & White Ball. Everyone went to great effort on the night to look extra special in their finest black and white couture.

Pre dinner drinks were served over three levels before guests entered the Ivy room which features striking zebra print carpet, beautiful floor to ceiling white curtains with stunning black detail and six huge white chandeliers. The room was made complete with a black and white dance floor and life size inflatable zebra known as Zeb — just for a bit of fun! Mouths were agape as guests entered the room to the live music of 10-piece band Superstitious.

Wendy Harmer, passionate Interplast Ambassador, opened the evening with her usual flair, setting the tone for a fun night ahead for a great cause. Delicious meals excited the tastebuds while the raffle and auction prizes excited the guests. Donations were received from a wide range of people and organisations so items could be auctioned on the night to raise funds for Interplast volunteers.

Some of the auction items included:

- Time in the Qantas Flight Simulator
- A round of golf with Craig Parry at the exclusive Elanora Country Club
- A mounted and framed Sir Donald Bradman signed cricket bat
- A cricket bat signed by the famous Chappell brothers
- Falls Creek Ski Holiday
- Cruising Sydney Harbour with surgeon Howard de Torres on ocean racer 'Nips-N-Tux'
- Artwork donated by photographer Anne Zahlaka, artists Nerryl Roper, Harold Scott and Jeanie Pitjarra from the Sydney Gallery of Art.
- Observatory Day Spa voucher
- Establishment Hotel dinner and stay
- Voucher for Maeve O'Meara's Gourmet Safaris of Sydney
- Florence Broadhurst hand stitched handbag
- Wine tours, nights away and meals at some of Sydney's acclaimed restaurants were also on offer.

A full list of the nearly 50 auction items and prizes are available on the interplast website at www.interplast.com.au/ivy_ball.

After the live auction everyone got up to dance to the fantastic sing-along tunes, with dancers spilling over the dance floor. Zeb didn't miss out on the fun either — ending the night crowd surfing!

Phone calls and emails have been filtering through the Interplast office from people saying they had a great night and have already got a table of friends together for the next one!

Whilst the evening was attended by a number of Sydney's surgeons and medical personnel there were many attendees who had previously not known of Interplast and had the opportunity to hear of the incredible, often unsung, achievements of Interplast volunteers.

Top: Interplast volunteer anaesthetist Dr Lindsay McBride, his wife Robyn and Interplast Ambassador Wendy Harmer Above: Interplast Board Member Dr Ross Sutton & his wife Beverley

Considered a success by all who attended nearly $45,000 was raised through the inspiring generosity of so many people and businesses. These funds will be used so Interplast volunteers from Australia and New Zealand can continue to repair bodies and rebuild lives in the Asia Pacific region.

The selection of surgical Trainees

The cornerstone of an effective selection system is a thorough analysis of the relevant knowledge

John Collins
Dean of Education
Spencer Beasley
Chair, Board of SET


Fiona Patterson

In order to achieve best-practice selection of surgical Trainees, representatives of the nine specialty training boards and College staff came together in April 2009 for a workshop in Melbourne on Trainee selection. Facilitated by Professor Fiona Patterson (United Kingdom, UK) - an international expert on selection, including that of surgical Trainees – the group combined their expertise and experience to address the many challenges involved in this very important and high stakes process.

Set against the background of the current Australian and New Zealand regulatory and legal requirements, Professor Patterson provided an evidence-based overview of the subject, including recent efforts to improve the validity, reliability and fairness of the process. She pointed out that "the cornerstone of an effective selection system relies on a thorough analysis of the relevant knowledge, skills, attitudes and personal qualities that are needed for successful performance as a surgeon. This enables accurate identification of appropriate selection criteria and assists in the identification of the best selection tools".

The College and the Specialty Societies previously identified nine core competency domains and most specialties use these as the basis for selection. The consensus of the group was that it may be timely to review these domains, and to focus on aptitudes.

Extensive discussion took place on the three selection tools currently being used by all nine specialties, namely structured CVs, referees' reports and semi-structured interviews. Weighting of individual items within the curriculum vitae and its overall weighting were debated with recognition that the ability to score career progression was most important.

The controversies surrounding referees' reports were acknowledged and modifications that might improve their value were discussed. It was agreed that the observations of surgeons who had observed the applicants in the workplace were important, but how best to utilise this information was debated. Professor Patterson discussed the difficulties surrounding the use of this tool for ranking and suggested that its greatest benefit may be in selecting out some applicants. Information contained in reports that scored some applicants at the extremes is important in the selection process. Expert judgments should be highly valued and the challenge is to improve the methodology on the best way to capture these. The possibility of having a common referees' report across all nine specialties with different specialties allocating scores (specialty-specific weighting) according to how they view the individual items and the wisdom of reducing the overall per cent allocation for these reports will be further discussed by each board and addressed at the next meeting of the Board of Surgical Education and Training (SET).

Participants agreed that semi-structured interviews provide important information not possible to obtain with the other two tools. Professor Patterson explained the importance of interviewers being trained, the sources of error and bias and why the same question areas should be covered for all candidates applying for the same type of post. Candidates should be requested to describe previous behaviour in past situations they have faced as well as outlining how they would respond to hypothetical job-related situations or scenarios they are presented with. It was agreed that increasing the number of panels to a minimum of four and having two interviewers per panel would provide greater reliability and better use of a scarce and valuable resource.

Professor Patterson described her personal experience with the development and evaluation of a new selection system called Selec-

"The ten commandments of selection."

tion Centres (or Selection Stations). This incorporates a number of stations which may include interactive, practical and written exercises to measure different attributes. Contact time with applicants is increased and the results from pilot studies have led to their adoption by a growing number of surgical specialties in the UK. A number of specialty representatives said they were keen to consider this approach and plan to take the ideas back to their boards for further discussion.

This workshop provided an important opportunity for specialty board representatives and College staff to discuss all aspects of selection, including the principles behind selection, and up-to-date methodology and evidence of best-practice selection. It has also demonstrated the strength of the Royal Australasian College of Surgeons and its specialty training boards in being able to come together in a common forum to share their knowledge and experience as they work together to improve the various aspects of surgical training.

1. Peter Choong, Neil Vallance, David Vokes & Alan Scott **2.** Peter Poon & Michael Rowland **3.** John Collins
4. Spencer Beasley & Cathy Ferguson **5.** John Miller **6.**Fiona Patterson & Gary Duncan discussing selection
7. Dave Adams, Elizabeth Donnott & Chris Pyke **8.** Listening to Fiona Patterson **9.** Phil Morreau & John Laidlaw
10. Lachlan Dodds & Andrew Cochrane **11.** Phil Morreau & Joseph Crameri

Volunteering off the coast of Tuvalu

Finding the time to volunteer your services is a worthwhile experience

Melbourne Ear, Nose and Throat (ENT) surgeon Mr Dayan Chandrasekara must have looked a strange sight as he lunched with colleagues recently on a small island off the coast of Tuvalu. As a member of the AusAid funded Pacific Islands Project (PIP) team which visited the country in March, Mr Chandrasekara's luggage had been off-loaded during transit in Fiji leaving him with nothing to wear for the week but his scrubs. While that was obviously suitable for the hospital, he had no choice but to don them also on the one free Saturday when the team was not operating.

"Clearly, it wasn't ideal. But in the hot tropical conditions we were working in, it wasn't so bad either. I wouldn't recommend it but in some ways they felt quite appropriate for the humid climate," he laughed.

Unfortunately, Mr Chandrasekara's personal luggage was not the only item jettisoned by the pilot in Fiji because of weight concerns. The team, comprising fellow ENT surgeon Elizabeth Rose, anaesthetist Anthony Hull and theatre nurse Katie Bowley, had taken, as allowed, 15 bags of necessary equipment. More than half of these were off-loaded in Suva without notification.

"On trips such as these we get a luggage waiver of up to 160 kilograms which is crucial in terms of being able to take the equipment we need. Many of the airlines do this as a matter of course, as a good-will gesture, so we can't complain," he said.

"However, we weren't notified of the captain's decision so that when we arrived in Tuvalu we only had seven bags of equipment. The ones left behind contained both anaesthetic and essential surgical equipment including otoscopes and examination headlights which presented us with a few challenges."

The team visited Tuvalu from March 11 to March 20 earlier this year. While waiting for their equipment to arrive on the next flight five days later, Mr Chandrasekara and Dr Rose spent the first four days consulting, during which time they saw more than 180 patients, providing treatment and generating the operating list. Eight patients were selected for surgery, the most complex of which was a middle ear cholesteatoma.

However, Mr Chandrasekara said the working conditions in the one-theatre hospital were not easy. "The hospital's air-conditioning unit had been out of operation for more than a year so it was pretty hot work. We had to make sure we kept the patients from overheating so we brought in fans and didn't drape the patients extensively. We didn't have temperature probes with us which would have been useful so that might be something to consider for any future visits," he said.

"The cholesteatoma was a particular challenge. It took three hours, which is not unusual, but in the hot theatre that felt quite long and then the microscope stopped working mid-way through the operation. This may have been because it over-heated so we turned it off and used a headlight for half an hour. The light then

came back on which was a great relief.

"We did some long days in there and were exhausted by the heat but all the operations went well which is the most important thing."

Mr Chandrasekara said the majority of the 180 patients seen in the clinic were suffering from chronic ear disease, perforated eardrums and infections. He said some patients had consequently developed hearing loss and that the next team to visit could look at taking hearing aids.

"Island nations like Tuvalu don't have ENT surgeons. The local doctors are mostly GPs, though they have recently been supplied with an obstetrician and a paediatrician, both from Cuba," he said.

"But while chronic ear disease has long been a problem in developing nations, which may be related to hygiene and nutrition, it is also about having access to quality health care sooner rather than later before hearing can be affected. As such these visits are crucial.

"A proportion of the patients we saw with such disease will be cured with medication, a proportion will require ongoing non-surgical care while others will require intervention in the form of surgery and will be put on the surgical list for the next team visit."

Mr Chandrasekara said that while the visit had been designed to provide a training and education component, the constant heavy work load of local staff mitigated against the plan.

"We originally had aimed to train the local hospital staff in the treatment of basic ENT related conditions but that didn't happen as we expected. I think they are so under-resourced and over-worked that they take the opportunity of a team visit to do other work, which is understandable," he said.

Based at the Austin Hospital and Monash Medical Centre in Melbourne, Mr Chandrasekara has only recently returned to Australia after an international Fellowship in Head and Neck Surgery at St George's Hospital in London.

"There has been a tradition for Victorian surgeons to go to St George's so I was delighted to have been offered the appointment. The hospital has a large ENT unit. The work was interesting and varied and I still had time to see Europe," he said.

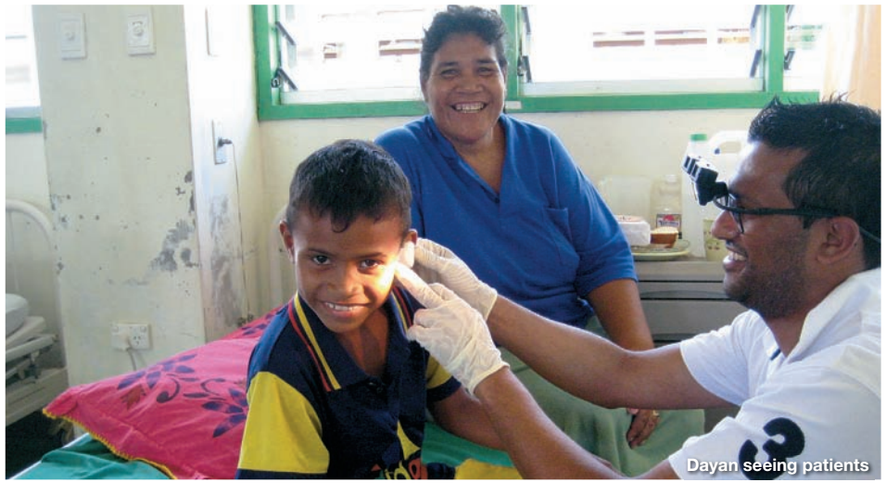
The March visit to Tuvalu was Mr Chandrasekara's first outreach visit, an opportunity he had been keenly awaiting.

He said he had long had an interest in volunteer work and some years ago had put up his hand to participate in a team visit to Guam which did not eventuate.


The narrowest part of the island


Dayan in his scrubs cleaning up


Making plates for a picnic


Dayan seeing patients

"The idea of helping people in other parts of the world has always interested me though I would make the point that there is a lot to do here in Australia as well. I would like to do trips like this at least once a year and while I know a lot of surgeons who would like to participate, many simply find it too hard to find the time. I decided, then, to try and schedule a regular volunteer component into my timetable early on, before all the pressures of private practice come into play," he said.

"I had a great time on this trip despite the challenges of the luggage, the heat and the lack of equipment. The children, in particular, were just gorgeous and had completely different reactions to the discomfort and pain related to their medical conditions. We were treated well and the local people were very appreciative of our visit. At the end of the trip we were given a huge feast by hospital staff and their families."

Closing the Gap

Improving health outcomes for indigenous Australians through more effective treatment and understanding

Robert Atkinson
Chair, Professional Development

In 2005, the Aboriginal and Torres Strait Islander Social Justice Commissioner called for Australian governments to commit to achieving Aboriginal and Torres Strait Islander health and life expectation equality within 25 years. A commitment was made to close the 17-year gap in life expectancy and the 'Close the Gap' campaign was launched.

With the Federal Government's renewed emphasis on closing the gap, the College secured funding in 2006 through the Department of Health and Ageing to develop the on-line Australian Indigenous Health Program in partnership with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). The program addresses clinical issues experienced by Fellows, Trainees and International Medical Graduates (IMGs) when treating indigenous

patients. It aims to provide more effective treatment for indigenous patients through a better understanding of:

- Communication barriers
- Reasons for patients taking own leave or 'voting with their feet'
- How to obtain informed consent
- How to manage trauma related injuries
- The role of the community and indigenous health workers

Participants access the course materials, one module at a time, by logging on to a website. Each of the eight modules has three sections to complete. The 'Knowledge Preparation' section provides access to professional readings while the 'Guided Cases' consider a clinical scenario though a series of questions. Further guidance is provided by the module facilitator. The 'Practice Issues' section is an interactive forum to discuss issues from a personal perspective and seek advice on particular situations. Feedback is provided from colleagues as well as the expert facilitator who in the first instance is an Indigenous health worker. Participants can be on-line at the same time or access the postings when they next log on.

The College is very pleased to announce that funding has been obtained from the Support Scheme for Rural Surgeons (SSRS) to offer the program again this year. Early enrolments have been strong with surgeons and Trainees across several disciplines recognising the value of the course and the flexibility of on-line learning.

The Australian Indigenous Health Program is part of the College's support strategy for surgeons who provide health care to indigenous communities. In addition, the College has created the Indigenous Health Committee, engaged the Commonwealth in this field, set challenging strategic objectives in the field of indigenous health and is actively raising funds for indigenous and rural surgical challenges.

For more information please contact the Professional Development Department on +61 3 9249 1106 or email PDactivities@surgeons.org

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

LETTERS TO THE EDITOR

Road Trauma Committees overseas

I note with great interest the recent article on *Trauma Care in Vietnam* (Vol:10, No:2). The injuries from road trauma are telling and we discovered the same situation existed in Thailand.

We have a Road Trauma Advisory Committee in the College which has been instrumental in road traffic preventative measures and its strength is the number of surgeons and its independence from Government. We are able to get good evidence and then lobby and apply it appropriately.

It would seem to me possible to have a Road Trauma Committee in Vietnam as well as Thailand. We did broach the subject with the Thai Surgeons in 2007 at our combined meeting. It may be timely for us to push this again both in Vietnam and Thailand. Food for thought.

Robert Atkinson Chair, College Road Safety Advisory Subcommittee

Send your letters to the Editor to:

letters.editor@surgeons.org or

The Editor, Surgical News
Royal Australasian College of Surgeons
College of Surgeons Gardens
250-290 Spring Street, East Melbourne,
Victoria 3002

Government of South Australia
SA Health

REPATRIATION GENERAL HOSPITAL
DAW PARK

The Repatriation General Hospital is an accredited 300 bed acute teaching hospital with close clinical and training links to Flinders Medical Centre and the Flinders University. The hospital provides urological services to veteran and community patients in the southern region of Adelaide (catchment population base 340K). Adelaide is a city of one million people and the capital of South Australia. It has a friendly Mediterranean character and is bordered by white sand beaches and Australia's premier wine growing district, the Barossa Valley, McClaren Vale and Kangaroo Island.

Urology Staff Specialist

Applications are sought from suitably qualified Urologists to provide a diverse range of urological services within the southern region of Adelaide. Current activity includes major oncology, laparoscopic and laser interventions. Medical staffing for the Urology Unit comprises 5 visiting specialists, supported by a Clinical Fellow, 2 Registrars and 2 junior staff. The hospital supports a training post accredited with the Urological Society of Australasia. Ambulatory services include a Community Continence Nursing Service. The Unit also incorporates an established clinical research program in the area of prostate cancer, benign prostate hyperplasia and voiding dysfunction.

Salary & Special Conditions: Salary and conditions of service will be in accordance with the South Australian Medical Officers Award and Enterprise Bargaining Agreement. An attractive package will include significant rights of private practice and assistance with relocation expenses.

Qualifications: Applicants must be registrable as a Specialist with the Medical Board of South Australia. Applicants must have completed advanced training in the field of Urology. A background of involvement in clinical or basic research is preferred, and preparedness to support research and teaching is essential.

Enquiries: Further information is available from Mr Mark Siddins, Unit Head Urology, telephone (08) 8275 1653. Applications, including curriculum vitae and the name, address and contact number of 3 referees, should be forwarded to:
Mr Ken Mayes, Manager Medical Administration, Repatriation General Hospital, Daws Road, Daw Park, S.A. 5041.

Applications close Friday 29 May

healthdownsouth

Otago + Southland District Health Boards New Zealand

A deliberate decision

General Surgeon

Southland Hospital, Invercargill, New Zealand

There might be any number of reasons you make a deliberate decision to relocate - gaining experience that will take your career places, building a career that won't see you pigeonholed professionally, looking for a lifestyle that offers more, for you and your family or an adventure.

Whatever the reason we'll make you welcome. How does Southland Hospital differ to some? Ours is a secondary level hospital rebuilt just five years ago. We've incredibly good facilities and equipment. We're benefiting from a strong emphasis on clinical governance – our services and working relationships across the hospital are reflective of it.

One of four general surgeons you'll appreciate the fact your work will be wide ranging – you won't be stuck in a sub specialty. That said a breast or colo-rectal sub-specialty interest would be of value. You're assured of the opportunity to combine private and public practice if you'd like to.

A deliberate decision you think may benefit you? Your welcome to contact Jan Jenkins jan.jenkins@sdhb.co.nz or on +64 3 214 8261 for more information. Otherwise see the Big Careers Section of our website.

www.healthdownsouth.co.nz

The Douglas Stephens Prize

The Prize encourages research and forwards the careers of young paediatric surgeons in Australasia

Durham Smith
Victorian Fellow

Jane Stephens, Durham Smith & Douglas Stephens enjoying the celebration of achievements

A significant new Prize has been established within the College's Foundation, to honour one of the College's most esteemed Fellows, Frank Douglas Stephens. The Prize was initiated by his family, together with professional colleagues and friends, to mark his 95th birthday. It is intended to award the Prize biennially for an original research contribution by a paediatric surgical Trainee or a Fellow within 10 years of obtaining the Fellowship in Paediatric Surgery, on the advice of the Australian and New Zealand Association of Paediatric Surgeons.

The Prize is to encourage research and to forward the careers of young paediatric surgeons. That it is a research award is very appropriate, as Douglas Stephens himself had an outstanding career in original research, and by his concern and contributions he has profoundly influenced the lives of many young surgeons.

Douglas gave unstinting service to the College, being on Council 1965-75, Honorary Treasurer 1969-75, and Editor of the Australian New Zealand Journal of Surgery for many years. Recognised nationally and internationally for his seminal contributions to the science of surgery in the field of congenital anomalies, resulting in new procedures to the benefit of thousands of children, he is a great unsung hero of Australian society in both war and peace. After secondary schooling at Melbourne Grammar School, he graduated in Medicine from the University of Melbourne in 1936. On completing Residences at the Royal Melbourne and Royal Children's Hospitals, he served Australia with great distinction in a Forward Operating Team in the AIF 6th Division, 2/3rd Field Ambulance, in the Middle East and in the SW Pacific. At El Eisa in 1942 he was awarded a DSO in the field for exceptional bravery attending wounded under heavy enemy fire, an honour he never spoke about.

After the war he returned to the Children's Hospital but his enquiring mind was recognized by the award of a Nuffield Research Fellowship for three years at the premier Hospital for Sick Children in London where he began studies of major congenital abnormalities.

On return to Melbourne he was appointed as a consultant at the Royal Children's Hospital but from the beginning he combined research with clinical practice, and as Director of Surgical Research he became recognized as the master of patho-embryology – the study of the way abnormalities develop in the foetus and newborn. These studies involved literally thousands of microscopic sections of developing organs and tissues, all meticulously drawn by him with great artistic talent, in thousands of man-hours of patient work. By unravelling the underlying processes, major advances in the treatment of abnormalities of bowel, urinary and genital organs were initiated.

More than one hundred young surgeons working directly with him, and many more indirectly, have been enormously stimulated into an enquiring and critical approach to surgical problems. Many research papers have emanated from workers in his department, but in many of these his name does not appear, even though most of the ideas came from him - such was his humility and his earnest encouragement to others.

At the age of sixty-one his international status was recognized and he was invited to a Chair in Paediatrics and Surgery of Northwestern University in Chicago and at the Children's Hospital there, and over eleven years he made further advances and trained another generation of surgeons. Notwithstanding retirement in 1986, and having published three major books and many articles, he produced a monumental book in 1996 which is the definitive world authority on developmental anomalies.

He has been honoured by many surgical societies and by the appointment as an Officer in the Order of Australia. But surgery is not the only talent of this extraordinary man. He is very loyal to his friends to whom he is utterly generous, he bears no malice or envy, and humbly brushes aside any reference to his achievements. He is an accomplished water-colour artist, an avid fly-fisherman, a mean golfer still, and until very recently a champion tennis player. This is a remarkable person of originality of thought,

prodigious output, an encourager of a host of surgeons of many nationalities, brave in war, gentle in peace, and who has enriched the lives of thousands of children.

As Douglas advances into a distinguished age, a phrase from Cicero sums him up –"the minds of such stand out of reach of the body's decay". He is of the Ciceronian elect, and it is his ever youthful outlook which enabled him to utilise his rare gifts to such great advantage.

If you would like to donate to the Douglas Stephens Prize please send your cheque payable to Royal Australasian College of Surgeons specifying that your donation is to go to this particular prize.

Above left: Anthony Douglas, Douglas Stephens, Ed Fenton, a Paediatric Surgeon from Hobart, and Richard Cook.
Above right: Douglas Stephens with Tony Sparnon

The International Society of Surgery

International Surgical Week aims to promulgate the science of surgery, with an emphasis on helping surgeons from the developing world

Peter Malycha
President, Local Organising Committee.
ISW2009 Australian Chapter Delegate,
ISS/SIC

The International Society of Surgery/ Société Internationale de Chirurgie (ISS/SIC) holds its alternate yearly scientific meeting in a different city around the world. Adelaide was chosen to host ISW 2009 nearly 10 years ago and will hold the congress in the Adelaide Convention Centre from September 6-10, 2009. For details simply Google ISW2009 to see the program and registration details.

ISS/SIC is a prestigious body with its origin dating back to 1902, when a group of European surgeons formed a scientific society to propagate ideas and advance the science of surgery. Theodore Kocher was one of these men and the Society's second president. Despite the travails of Europe, mostly through war, in the ensuing 107 years ISS/SIC expanded rapidly to become a truly international society with members on every continent and in most countries. The late Martin Allgower who was well known to many Australian and New Zealand surgeons has written the history of the Society which can be found via the ISS/SIC homepage. www.iss-sic.ch

ISW2009 covers all aspects of General Surgery including Vascular and Paediatric Surgery and the eminent internationally recognised surgeons who are on the executive committees of these international societies will present and meet at ISW2009. The Royal Australasian College of Surgeons (RACS) will co-badge ISW 2009 in recognition of the significance that ISW2090 holds for General Surgery in Australia and New Zealand. Many of the current and past RACS councillors have been involved with ISS/SIC over many years. Ian Gough was the Australian Chapter Delegate of ISS/SIC and Ian Civil is the current IATSIC representative on the executive committee of the society. General Surgeons Australia and New Zealand Association of General Surgeons will also co-badge the meeting with the former using ISW2009 as its main conference for this year.

ISS/SIC is an elite society that demands high professional standards for membership with an emphasis on standards, research and publication. Because of the high standing of the Fellow of the Royal Australasian College of Surgeons (FRACS) diploma, any Fellow is welcome to become a member for an annual subscription of 135 Euros. ISS/SIC members enjoy an association with a wide range of surgeons world wide, a subscription to *The World Journal of Surgery* and free internet access to Springer publications. ISW2009 gives me the opportunity to promote ISS/SIC and encourage fellows to join. Not only does International Surgical Week aim to promulgate the science of surgery, its emphasis is on helping surgeons from the developing world.

Please check the program for ISW 2009 to see the number and stature of participants. Indeed, it is rare that we have so many general surgeons of international repute meeting in Australia at the one time. As of mid March we have around 900 registrants and expect this number to double. Approximately one half of registrants are from Australia and New Zealand. The meeting is well priced as we need to keep the costs low to enable surgeons from poorer countries to attend. Free papers are highly vetted and in major specialties must be accompanied by a manuscript for submission to WJS before they can be presented.

The local organising committee invites and encourages you to attend ISW2009 this September. We need you to support it to ensure that our visitors enjoy themselves, to meet us and we them. We hope that they will be left with good memories of Australia and New Zealand.

The Integrated and Participating Societies meeting at ISW2009 are:

International Association of Endocrine Surgeons

International Association for Trauma Surgery and Intensive Care

Australian Trauma Society

Breast Surgery International

International Association for Surgical Metabolism and Nutrition

International Society for Digestive Surgery

The Ambroise Pare International Military Surgery Forum (APIMSF)

World Federation of Paediatric Surgeons (WOFAPS)

American Association for the Surgery of Trauma (AAST)

The Association of Women Surgeons (AWS)

European Association of Endoscopic Surgeon (EAES)

International Federation of Societies of Endoscopic Surgeons (IFSES)

International Society for Burns Injuries (ISBI)

International Society for Diseases of the Esophagus (ISDE)

The International Society of the Red Cross (ISRC)

Office bearer for ISS/SIC will be intimately involved in ISW2009 and include ISW2009 President Mike Sarr from The Mayo Clinic, John Hunter from Seattle who will run workshops on how to write scientific papers and Ken Boffard from Johannesburg who is well known for his work with trauma.

BUILDING TOWARDS RETIREMENT

Convener: Mr Andrew Roberts FRACS

A Building towards Retirement workshop will be held for Fellows of the College and their partners on Saturday 13th June at the College offices in Melbourne. The workshop offers a comprehensive program that covers some of the key issues facing retirees. The program promises to be both an informative and engaging opportunity for surgeons and their spouses. For more information or to register, please contact the Professional Development Department on +61 3 9249 1106 or PDactivities@surgeons.org

TIME	TOPIC	PRESENTER
9:30 - 9:40	Overview	Mr Andrew Roberts FRACS
9:40- 10:00	Keeping Fit & Healthy in Retirement	Prof Robert Moodie (Nossal Institute for Global Health)
10:00-10:20	Secret Confessions of a "Shoulder Tapper"	Dr Michael 'Taffy' Jones
10:20-11:05	Pilot and Surgeon – Common Issues in Retirement	Dr David Newman (Flight Medicine Systems)
11:05-11:30		**Morning Tea**
11:30-12:00	Experiences of Recent Retirees	Mr Peter Field FRACS & Mr Andrew McLeish FRACS
12:00-12:15	Retirement – The Initial Impact	Mrs Heather Anne Field & Mrs Jocelyn McLeish
12:15-1:00	Play To Your Strengths - Volunteering Throughout The World	Mr Campbell Miles FRACS Mr Sean Lynch & Ms Ann Ray (Australian Volunteers International)
1:00-2:00		**Lunch**
2:00-3:00	Finance (topic name??)	Mr Kevin Bailey (Money Managers)
3:00-3:45	Retiring From Surgical Practice - Legal & Insurance Matters	Mr David Goldberg (AMA) & Mr Bob Dickens (MIPS)
3:45- 4:30		**Drinks**

Registrars' Trauma Papers

The College Trauma Committee is hosting this years Registrars' competition on Wednesday 9 September

Danny Cass
Chair, Trauma Committee
Graeme Campbell
Chair, Fellowship Services

From left: Margaret Knudson (Competition Moderator), Reed Kuehn (Runner-up basic science research), Elizabeth Sailhamer (Winner, basic science research), Alexios Adamides (Winner, clinical research), Joseph DuBose (Runner-up clinical research), John Fildes (Chair of ACS committee on Trauma).

Congratulations to Alexios Adamides, first Australian (and first non-American) winner of the American College of Surgeons Committee on Trauma (ACS CoT) Residents' Trauma Papers Competition. Alexios presented his paper, *Patterns of brain tissue metabolites predict episodes of intracranial hypertension in patients with severe traumatic brain injury*, at the Annual Meeting of the ACS CoT held on 19 March 2009 in Chicago and was awarded first place in the clinical research category. The Trauma Committee is delighted to see this honour bestowed on Alex and grateful to the ACS CoT for their endorsement and support of this initiative.

Alexios, who is a surgical Trainee (Neurosurgery), won the College Trauma Committee Registrars' Papers Day Competition when he presented his research in Melbourne on 21 November 2008. This provided Alex with the opportunity to present his research paper at the scientific meeting in America in March this year.

Reflecting on his experience, Alex stated, "I received very useful feedback from Committee members at the Australasian meeting with practical advice on improving my presentation".

Regarding the US competition he explained that "over 100 trauma surgeons, from across USA and Canada, attended the competition and 15 papers were presented - 11 from USA, two from Canada, one from Brazil and one from Australia. Winners for each category were announced at the trauma banquet on the following evening and, as the first place winner for clinical research, I was invited to submit my paper for a fast-tracked publication by the Journal of the American College of Surgeons."

"Chicago is a fantastic city; the steaks at Chicago Chop house are highly recommended as is Kingston Mines for great live Blues! My hosts were very welcoming and kind and made my visit all the more memorable. I am very grateful to have had this experience and would like to thank both Colleges for the opportunity," said Alex.

David Dewar won the inaugural Australasian competition, held at the College in Melbourne in November 2007, for his research '*Predicting post injury multiple organ failure in Australia*'. David reflects on his experience in the inaugural competition.

"I am very thankful to the College for selecting me to present my paper at the inaugral registrars' trauma paper day. I have had an interest in surgical care for the trauma patient since my internship and I started my project in my internship year, collecting data on the physiological parameters in critically injured trauma patients. I was selected to present my two year results at the College Registrars' Papers Day and I was honoured to represent our region in Washington DC in 2008."

David went on to say, "It was exciting to present at a competitive international meeting against training surgeons from all over the world. The session was run in front of trauma surgeons from the ACS and then questions from the floor were answered. Unfortunately I did not win for our region, however I discussed trauma care with many surgeons and trainees and had the opportunity to explore some of Washington DC and New York."

"I congratulate Dr Adamides on his success at this year's meeting, and would encourage other Trainees to take the opportunity to participate in this worthwhile event."

The College Trauma Committee Registrars' Papers Competition, now in its third year, is open to all Trainees. It aims to encourage Trainees to undertake a trauma research project. The competition has built in strength, sophistication and success and confirms the intention of the Trauma Committee to hold this event on a regular, annual basis.

The College Trauma Committee is hosting this year's Registrars' Papers Competition on Wednesday 9 September 2009. It is being held in Adelaide as part of the IATSIC/ISS scientific meeting. Registrars are invited to submit abstracts of trauma research projects. The winner will receive a certificate and may have the opportunity to present their paper at the Annual Meeting of the American College of Surgeons Committee on Trauma – in Las Vegas in March 2010.

Further information – www.surgeons.org/trauma - or contact Lyn Journeaux, – Tel: +61 3 9276 7448; fax: +61 3 9276 7432; email: lyn.journeaux@surgeons.org

Standard operating systems

ISO management system standards put state-of-the-art practices within the reach of all organisations

While the College is itself going through the processes this year required to attain ISO accreditation, Fellows with surgical clinics often do the same to ensure their practices have high standards of operating systems.

ISO accreditation, offered through the International Organisation for Standardisation based in Geneva, provides a globally recognised standard of service and procedure which assists surgeons to run their practice by providing systems to cover both patient care and data management.

The clinic of the current honorary treasurer of the College, Mr Keith Mutimer, originally received ISO accreditation in 2000. With an audit required every three years, the clinic, known as the Brighton Plastic Surgery Centre recently underwent an annual assessment and has maintained its full accreditation.

The specific standard met is known as ISO 9001:2008 which has been particularly designed for organisations which need to demonstrate the ability to consistently provide a product or service that meets customer and applicable statutory and regulatory requirements and which aims to enhance customer satisfaction through the continual improvement of business management.

The Director of Nursing at the clinic, Ms Michelle Birks, said the ISO system was a very practical, useful and achievable avenue of accreditation. The plastic surgery clinic in Melbourne comprises consulting suites and a day-surgery unit with one operating theatre, two recovery trolleys and two recovery chairs with procedures conducted under both local and general anaesthetic.

"The scope of the audit and therefore the range of areas covered by ISO accreditation is quite wide but that is part of what makes it so useful. It covers clinical practices, human resources, professional development, occupational health and safety, risk management, personnel appraisals, infection control, medication management, facility management and continual improvement," Ms Birks said.

"Each full audit also covers all these areas and in addition the accreditors meet with all staff and the entire centre is assessed against all these criteria."

"It allows staff to work efficiently, it allows us to understand at a glance what has been done and what needs to be done and because the systems are in place, the patients receive an exceptional standard of service."

To maintain accreditation, the clinic is required to self-audit systems in detail and keep records available for inspection as an ongoing process. Though it may sound onerous, however, Ms Birks said it took only one staff member the equivalent of one day per week of dedicated time to fulfil the requirements in their practice but that the benefits far outweighed such cost.

"Whilst it may appear time consuming and at times confusing initially, meeting ISO standards is good business practice anyway and the majority of what you do for ISO you would do anyway in a well-run business," she said.

"It simply means that you have to check what you do and undertake constant analysis of processes and procedures. It provides extremely good traceability for practices because you have to keep records constantly up to date which offers strong protection in the case of any possible complaints or legal action. It even requires reporting on the maintenance, care, purchase and source of equipment so that everything can be followed back and having a framework within which to do this is very helpful."

The ISO has developed more than 17,000 International Standards within a variety of industries from health and hospitals, to mining, transport and construction with the standards recognised in more than 150 countries. Ms Birks said that the clinic had developed a Quality System Manual as well as a Quality Procedure Manual to maintain the ISO standard but said external consultants were also available to clinics to devise such documents if needed.

"These provide practical and useful information such as basic clinical procedures including how to admit a patient, what information is needed when, patient discharge systems right up to disaster management including fires or cardiac arrest," she said.

"Essentially they allow us to design and run the everyday management systems needed plus record and analyse anything that happens outside the expected so that we are constantly improving the services we offer."

Ms Birks said Mr Mutimer's clinic proudly displayed the ISO accreditation on all paperwork and the website. "Patients are asking more about safety and quality issues than they once did and while they may not specifically ask about accreditation, the standard of the service and care we provide here is reflected in it," she said.

"I like this system because it takes into account the resources of a small stand-alone centre which means that it works. It allows staff to work efficiently, it allows us to understand at a glance what has been done and what needs to be done and because the systems are in place, the patients receive an exceptional standard of service. However, they probably don't know that this quality of care is a direct flow-on effect of that accreditation."

Leadership for Women

Despite women making up over 50 per cent of medical graduates, few are represented at senior levels. But this project aims to open up opportunities for medical women.

Plastic surgical registrar Dr Jillian Tomlinson has been announced the winner of the Centre for Leadership for Women's 2009 national Leadership Achievement Award. The Award recognises Dr Tomlinson's pro bono work on the Bridging Leadership Barriers Project, a project she designed and implemented through the Australian Federation of Medical Women (AFMW) for the benefit of the medical and wider community.

In the course of a generation women have gone from comprising a small minority of medical graduates to making up over 50 per cent of each graduating year. Despite this women remain under-represented in senior leadership positions. Dr Tomlinson's project aimed to foster communication, networking, leadership and opportunities among medical women. Successfully gaining major funding through the Office For Women Leadership and Development Programme Grants, Dr Tomlinson awarded 22 Leadership Scholarships totalling $15,000 to assist medical women to attend the Medical Women's International Association Western Pacific Regional Congress (MWIA WPRC) in Melbourne in October 2008.

"Undertaking a major project as a surgical registrar has certainly made for a busy year, but I would recommend this type of activity to any trainee who wants to extend their management skills or pursue interests in areas complementary to surgery such as leadership, information technology, conference management, grant writing or negotiation skills."

The myriad initiatives developed from the project include:

- A negotiation skills workshop at the MWIA WPRC
- Creation of the AFMW leadership skills database to increase women's voice in public policy and service delivery
- Redevelopment of the AFMW website using the open source content management system Joomla
- Creation of a Leadership Portal at the AFMW website to promote leadership discussions and assist women in developing their leadership skills
- Website skills training sessions in Melbourne and Sydney
- The development of tools that individuals can use to develop website management skills, including a practice website and an e-Book guide to uploading and editing website information
- A quarterly national e-newsletter
- The development of resources to support administrative and communication endeavours, including the publication and national promotion of e-Books.

For more information about the 2008-09 Bridging Leadership Barriers project visit http://afmw.org.au or contact Dr Tomlinson via afmw@afmw.org.au.

Above: Chairs and presenters at the Leadership Workshop at the MWIA Western Pacific Regional Congress 2008, L-R: Dr Jillian Tomlinson, Plastic Surgical Registrar; Dr Atsuko Heshiki, President, Medical Women's International Association; Ms Shirli Kirschner, mediator and lawyer; Dr Gabrielle Casper, President Australian Women's Coalition and immediate past president Medical Women's International Association; Mr David Bryson, mediator and conflict coach.

MONASH University
Medicine, Nursing and Health Sciences

Postgraduate Course in Clinical Anatomy

The Monash University Departments of Anatomy & Developmental Biology and Surgery (MMC) are pleased to announce the Postgraduate Course in Clinical Anatomy for 2009. The Course will provide postgraduate training in anatomy for graduates wishing to advance their knowledge in anatomy. Though designed for trainees preparing for specialist college examinations, the course is open to graduates from any other health science discipline. In view of previous popularity, registrants are advised to enrol early.

The Course will be taught by anatomists from Monash University along with relevant specialist surgeons. It will involve the use of the Museum and Dissection Room facilities at the Clayton campus. The Course will consist of 16 sessions on Monday evenings from 6.30-9.30pm and will cover the gross anatomy and surgical anatomy of the entire body. Participants in the Course will have access to the Anatomy & Pathology Museums. Examiners for the College of Surgeons will give optional formative assessments if requested. The course does not involve cadaveric dissection, but will include examination of wet specimens.

Attendees will receive a CD of relevant software and a comprehensive syllabus. Each participant will receive a copy of the College approved anatomy text 'General Anatomy - Principles & Applications' (McGraw Hill 2008). Participants completing the course in 2009 will receive a Certificate of Attendance.

Further details of course are provided below:

Registration is due by Friday June 26
Dates: Monday 6 July to Monday 26 October, 2008 (including one week break)
Venue: Department of Anatomy and Developmental Biology, Building 13C, Monash University, Clayton campus.
Cost: $1,500 including GST.

If you have any questions please contact:
mira.petruzalek@med.monash.edu.au;
ph 03 9594 5500.

Further Information
Professor Julian Smith
Department of Surgery, Monash Medical Centre, Clayton, Vic 3168
julian.smith@med.monash.edu.au
ph 03 9594 5500
or
Dr Gerry Ahern
Department of Anatomy and Developmental Biology, Monash University, Clayton, Vic 3800;
gerard.ahern@med.monash.edu.au
ph 03 9905 5794

Rowan Nicks Scholar

Dr Kondwani Chalulu, a Fellow of the College of Surgeons (East Central and Southern Africa), was the 2007 recipient of the Rowan Nicks Scholarship

I was in Australia between June and October 2007 and during my stay I was under the mentorship of David Watters and Glen Guest at the Geelong Hospital. It was a whole new experience for me having to attend operations like laparoscopic banding of the stomach for treating morbid obesity when one of our biggest problems include malnutrition.

It was a wonderful and life-changing time for me. Having negotiated the problems of time difference (it took me over one week), I started enjoying life again: doing ward rounds, attending theatre sessions, x-ray sessions, multidisciplinary meetings and an occasional weekend sip of Crownies. I soon realised that my passion for the English Premier league was taking a back seat. There were no games on TV and the Australian Soccer league which had some popularity when Dwight Yorke was playing for Sydney Football Club wasn't the most popular sport.

I was attached to a firm comprising of Mr Anthony Lawler, Mr Greg Mitchell, Mr Roger White and Mr Conrad Brandt who were all ardent Australian Football League (AFL) followers. I instantly took a liking to "The Cats" who were doing brilliantly in the league at that time, eventually (after a 30-odd year wait) winning the league in 2007. I had earlier on remarked to colleagues that it was my presence in Australia that would make Geelong win. African magic, it is called. I was not in Australia in 2008 hence the loss in the grand final after again doing well the whole year. I hope to be in Australia for the surgical conference in 2009 so watch out Hawthorn and the rest, for this September "The Cats" will emerge victors again.

Since leaving Australia, I found myself thrown into the deep end of administration. The director of our hospital had been given another post at the ministry headquarters and immediately upon my arrival I was asked to fill the vacant post in an acting capacity. I had initially thought that I would do the job for a month or two while they were looking for a replacement but ended up doing the job for eight months. Queen Elizabeth Central Hospital is a 1200 bed hospital, the biggest referral hospital in Malawi (population 13 million). It also acts as a teaching hospital for the only college of medicine in Malawi which was established in 1992.

The hospital has a joint management committee with the college of medicine with the chairmanship rotating between the college principal and the hospital director. The bulk of consultants in Malawi are from the college, hence all complicated referred patients from Malawi and beyond the borders (especially from Mozambique) are referred and treated at our hospital (the only hospital with a CT scan, and recently a magnetic resonance imaging

"It was a whole new experience for me having to attend operations like laparoscopic banding of the stomach for treating morbid obesity when one of our biggest problems include malnutrition."

(MRI) scan) in Malawi. The burden of clinical work therefore is immense.

Apart from administrative duties I am also involved in teaching medical students, doing my on call duties in surgery, operating (one theatre day a week), organising audits, outpatient clinics, ward rounds, research and district outreach visits.

When I was in Australia, I was attached to a general surgical firm with interest in breast surgery. Upon my return I took over all breast work in our hospital. I started a weekly breast clinic, started auditing all breast work and dedicated one operating day to breast disease. Breast cancer patients present very late in Malawi because of various reasons and our commonest procedure is incision and drainage of abscesses from young lactating mothers.

In Geelong we were seeing very small lumps of less than two centimeter diameter with the whole multidisciplinary team of breast nurses, surgeons, oncologists, pathologists, radiologists, genetic counsellors, nutritionists, social workers being involved. In Malawi, almost all tumours that present are locally advanced breast cancers and beyond. By time of presentation there is already skin involvement and huge fixed lymph nodes (no need for sentinel nodes).

Our hospital/country has one visiting radiologist (but no mammogram), one private cytologist (most of our patients cannot afford this), no radiotherapy services at all, limited chemotherapeutic options, no histopathological service that can tell you Estrogen-Receptor-positive (ER), Progesterone-Receptor-positive (PR) or Human Epidermal growth factor Receptor 2 (HER-2) status, all these making breast cancer impossible to manage. The central medical store doesn't have Tamoxifen on its essential drug list so patients have to buy this in private pharmacies if they can afford it. Herceptin is not even known by some pharmacists and by not knowing the HER-2 status, and the expense, we don't even consider it.

With the problems highlighted (no radiological, pathological, cytological, chemoradiotherapeutical support), we cannot offer a massive screening program and we cannot treat breast cancer adequately. We do have a dedicated palliative care team already inundated by other diseases, mainly end stage HIV/AIDS and other metastatic cancers(oesophagus, cervix, Kaposi's) who take care of our advanced breast cancers.

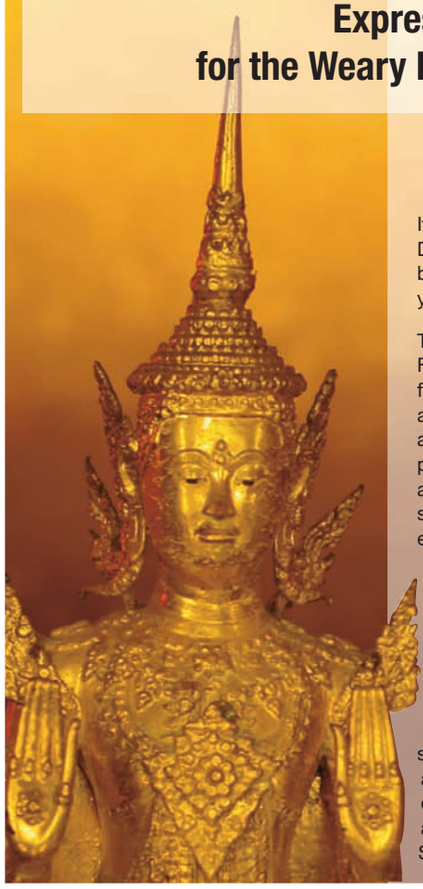
What we usually offer breast cancer patients is a modified radical mastectomy with axillary dissection and Tamoxifen 20mg daily for life. Only two patients in the past 18 months have been sent to South Africa for chemoradiotherapy post mastectomy (both nurses).

Top: The Queen Elizabeth Hospital Above: Patients waiting to be seen

The burden of work in our hospital has been compounded by the HIV/AIDS pandemic(14 per cent prevalence and up to 50 per cent in most medical wards), brain drain to greener pastures, staff attrition from HIV and the burden brought on by the ever increasing road traffic accidents. The effects of the credit crunch will have devastating consequences on our communities as well.

All in all the knowledge and experience gained in Australia has given me the opportunity to appreciate how lucky I am. Delivering a service with limited resources, limited capacity in almost all areas of health (we do get referred from the districts 300km away conditions like incarcerated hernias, bowel obstructions, insertion of drains for empyema etc, gangrenous legs for amputations, skin grafts) makes one wonder whether its worthwhile to pursue a dream of doing laparoscopic surgery or concentrate on the basics in the art of surgery. Sometimes I also wonder why I am the only Malawian surgeon in the Ministry of Health. I am sure there is a good reason. The smiles on the patients' faces after successful surgery are my main motivation to carry on.

Expressions of interest are invited from Fellows for the Weary Dunlop Boon Pong Travelling Fellowship – Thailand



This is the first invitation of a new, annual College Travelling Fellowship to Thailand funded from the Weary Dunlop Boon Pong Scholarship Fund.

It has been established to complement the Weary Dunlop Boon Pong Scholarship Fund activity that brings up to six Thai surgeons to Australia each year for four months of surgical experience.

The Weary Dunlop Boon Pong Travelling Fellowship is open to expressions of interest from Fellows who have supervised / mentored a Weary Dunlop Boon Pong Scholar in Australia and who volunteer to travel to Thailand for a period of two weeks to follow up their protégé and to help with the implementation of the skills gained in Australia in the protégé's clinical environment. This would ideally occur six to 18 months after the completion of the Australian experience of the Weary Dunlop Boon Pong scholar. Fellows interested in this Travelling Fellowship will need to include with their expression of interest a request to visit, from their Thai scholar.

The Weary Dunlop Boon Pong fund subsidises the cost of the Fellow's travel to and from Thailand by providing an economy class air-fare to Bangkok and one night's accommodation. The Royal College of Surgeons of Thailand and local Thai health institutions may, on occasion, contribute to costs of local (in country) travel and accommodation. Costs not met by RACS or Thai organisations will be met by the Fellow.

Up to three Weary Dunlop Boon Pong Travelling Fellowships may be awarded in the one year.

The Travelling Fellows are expected to act as ambassadors for the College during the Fellowship and will provide a report of their activities to the RACS International Committee and to the Royal College of Surgeons of Thailand within two weeks of their return.

Eligible fellows are encouraged to indicate their interest in this Travelling Fellowship to enhance our College's outreach activities

Bruce Barraclough AO
Australian Convener,
Weary Dunlop / Boon Pong Scholarship program.

For more information please contact International Scholarships Officer, Sunita Varlamos on +61 3 9249 1211 or sunita.varlamos@surgeons.org

ANATOMY **TUTORS** REQUIRED

The University of Technology, Sydney [UTS]and the University of Notre Dame Australia [UNDA] are seeking expressions of interest from suitably experienced medical practitioners interested in casual teaching as clinical tutors in basic and clinical anatomy in the newly established Anatomy Facility at the Broadway campus of UTS.
Please contact Assoc.Prof.Kevin Broady for details: ph: 02 9514 4101; email: Kevin.broady@uts edu.au

AGSFM

Victorian Annual General Scientific & Fellowship Meeting

Scientific Program
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150 Mountjoy Parade
Lorne VIC 3232

Information about deceased Fellows

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

Robert Leslie Hudson VIC
Graham Douglas Tracy NSW
Peter Frederick Williams VIC

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

Informing the College

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

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

Allan Hailes and Mark Gardner's lives were dedicated to the medical profession and the community

Keith Mutimer
Honorary Treasurer


Discussion on the life of Mark Gardner

On Monday 2 March a small but significant ceremony was held in the Hailes Room. On this occasion a large and comprehensive archive of papers and memorabilia of Mark Clayson Gardner (1884-1949) was presented to the College. The date marked the centenary of Mark Gardner's registration as a doctor by the Medical Board of Victoria.

In handing over this archival material, Mark Gardner's son Richard spoke of his father's life and work.

"It is an honour to meet today in the Hailes Room beneath the portrait of my father's friend and in the presence of Hailes and Gardner descendants. Allan Hailes' and Mark Gardner's lives had so many parallels: brilliant academic and sporting records, distinguished military service and lives dedicated to the medical profession and to the community," he said.

"Today not only marks the centenary of my father's registration as a doctor in 1909, but also the recent eightieth anniversary of the election of Allan Hailes and Mark Gardner to the College of Surgeons in 1928, and sadly the sixtieth anniversary of their premature deaths in 1949.

"They both shouldered huge but different burdens in the Second World War, Allan Hailes in the field as Director of Surgery of the 2nd A.I.F., Mark Gardner on the home front, part-time Director of the Ophthalmic Unit at the Heidelberg Military Hospital, but also contending with the additional workload caused both by the draining of the medical profession for war service and by the increase in wartime industrial production and consequent increase in accidents, especially in the metal trades.

"The College has accepted my father's medals, a biographical panel illustrating his life and his Registration Certificate. It has also accepted papers for the College archives based on his own records and my research in England, Turkey and Russia."

Mark Gardner graduated MB 1908, ChB 1909 and MD 1912 from the University of Melbourne. He also played football in the days when the University fielded a team in the VFL.

He then set out for London to gain further experience, and having joined the British Red Cross unit for service in the Balkan War (1912-13) was posted to Istanbul. His colleague there was (Sir) Max Page, who developed the Page Splint, also known as the Balkan Beam, which was to play an important part in fracture treatment during World War I.

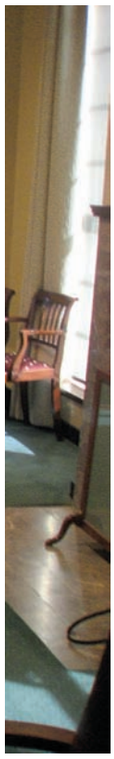
On the outbreak of war in 1914 Mark Gardner joined the RAMC and served with the Australian Voluntary Hospital in France until October 1915. He then went to St Petersburg with the British Red Cross Anglo-Russian Hospital, and in 1917 was posted to German East Africa with the 300th (Nigerian) Field Ambulance. For his service in East Africa he was awarded the Military Cross.

He served briefly on the hospital ship *Britannic* in the Mediterranean and until February 1919 was with the 25th (Wessex) Field Ambulance in the British 8th Division.

After the War he continued his studies at the Royal Eye Hospital at Moorfields in London. He returned to Melbourne in 1922, and subsequently took rooms at No.12 Collins Street.

He was admitted to Fellowship of this College by election on 26 January 1928. This was the first general admission of Fellows into the College, and the intake included many

"The College has accepted my father's medals, a biographical panel illustrating his life and his Registration Certificate."



Cass McInnes & Richard Gardner

Mildred Graham & Richard Gardner

Mildred Graham & Sarah Deasey

Tom Kay & Gary Leber

who were later to contribute to the College and shape the profession, such as C.W. Officer Brown, Edwin ('Bunny') Cato, (Sir) Harold Dew, W.A. Hailes, Henry Searby, Alfred Trinca and Hugh Trumble. Also in this group was the College's first female Fellow, Margaret McLorinan.

Mark Gardner and Alan ('Bill') Hailes were among the first tenants at No.12 and they became firm and lifelong friends. Hailes was Director of Surgery to the Australian army from 1942 to 1944 and became Censor-in-Chief of the College in 1943.

Mark Gardner was senior ophthalmic surgeon at the Eye and Ear Hospital, and consulting ophthalmologist at 115 AGH (Repatriation General) at Heidelberg. Both Hailes and Gardner died suddenly and prematurely in 1949, the former in January, the latter in November.

Richard Gardner collected, transcribed and organized a large and comprehensive archive of his father's papers, including letters and photographs, as a memorial to his father, with the intention of presenting it to the College Archives. He also preserved his father's medals, including the MC and the British Red Cross Balkan War medal, having them set in a glass case.

The amount of work and care which has gone into the preparation of the documents and objects is exceptional, setting a benchmark for biographical files which will be hard to equal.

"In the papers dealing with Mark Gardner's relatively short working life in Melbourne, from 1922 to 1949, I have endeavoured to highlight the dedication of that generation of doctors, before the days of Medicare, when a significant part of a doctor's time was taken up with honorary hospital work and a large "free list", against the background of a prolonged economic depression and six years of war," Richard Gardner said.

Those in attendance at the presentation were:
Richard Gardner, son of Mark Gardner
Mildred Graham, daughter of W.A. Hailes
Sarah Deasey, granddaughter of Mark Gardner
Tom Kay, grandson of W.A. Hailes
Patrick Deasey, grandson of Mark Gardner
Janet Michelmore, granddaughter of W.A. Hailes
Jonathan Streeton, great-nephew of Mark Gardner
I.E. ('Cas') McInnes FRACS, Chair of the Heritage & Archives Committee
Geoff Down, College Curator
Elizabeth Milford, College Archivist
Gary Leber, Honorary Librarian, RVEEH
Alan Gregory, historian of medicine

The College is most grateful to Richard Gardner for these mementoes of an early and very distinguished Fellow.

Written by Geoff Down, College Curator

External complaint resolution

Anyone can contact their State and Territory Anti-discrimination and Equal Opportunity Agencies for free and confidential advice

The Victorian Equal Opportunity & Human Rights Commission

Under Victorian law, anyone is free at any time to make an enquiry or lodge a complaint with the Victorian Equal Opportunity & Human Rights Commission (the Commission) if you feel you have been discriminated against or sexually harassed. It is against the law to punish someone for calling the Commission, or to threaten them in an attempt to stop them calling the Commission.

This option is available to people regardless of what other options may have already been attempted.

How the Commission handles enquiries and complaints

Anyone with a concern, problem or enquiry about possible discrimination, harassment, sexual harassment, victimisation or vilification can contact the Commission for free and confidential information about their rights. The Commission can give information over the telephone, by email or in person (by appointment) and can also provide a free interpreter for those whose first language is not English.

If the issue is not covered by equal opportunity laws, the Commission's Complaints Officers will usually refer an enquirer to another complaints service. If the issue is covered by equal opportunity law, the Complaints Officer will discuss the issue and then explain how the Commission may be able to help and what information they would need to include in a complaint. In this first telephone enquiry, the Commission will help the Complainant to decide the best way to get the solution they need to their problem.

Making a complaint to the Commission

If an enquirer decides to make a complaint with the Equal Opportunity Commission, they can either meet with the Complaints Officer to discuss their issue before making a complaint or write a statement of complaint, naming the grounds for alleged discrimination, sexual harassment or vilification, and send it to the Complaints Officer assisting them. There is a guide to writing a statement of complaint on the Commission's website under 'How We Can Help'.

Complainants and respondents should be aware that they can apply to have the matter handled more quickly because of a health emergency, ongoing sexual harassment or an alleged discriminatory policy decision. It is also important to note that legal representation is not necessary, that complaint details should be kept confidential to ensure easier resolution and that a complainant can withdraw the complaint at any time.

The Commission does not have the power to make orders or award compensation. It will conduct an investigation and then either refer the complaint to conciliation or decline to take further action to assist in resolving a complaint.

Investigation

Once the complaint is lodged an Investigator will inform the respondent about the details of the complaint and discuss the matter with them. Depending on the circumstances the respondent may have to provide information to the Investigator over the phone or send a written response to the Investigator addressing the complaint allegations.

The Investigator may also visit the site of the alleged discrimination, interview witnesses or convene an informal meeting, sometimes called an Enquiry Meeting, to gather information and see if the matter can be resolved.

Investigators are impartial and do not take sides or act on anyone's behalf. Investigators must keep the complaint confidential. Sometimes complaints are resolved during investigation. If they are not resolved, the Investigator will report to the Commission which may refer the matter to conciliation or decline the complaint.

Declining a complaint

After investigation, the Commission will either refer the complaint to conciliation or the Commission may decline a complaint if:

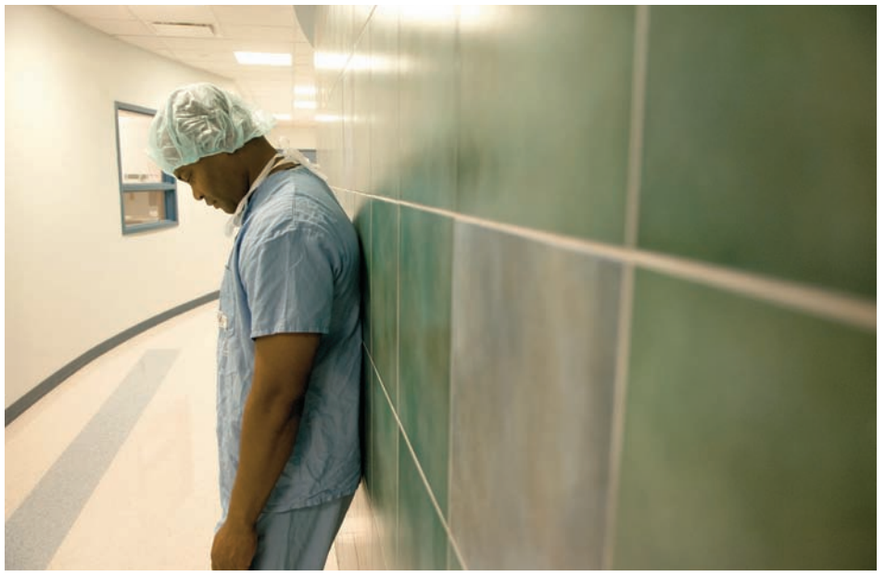
- there is little or no chance that the complaint could be resolved through conciliation
- it would be better dealt with by a tribunal or court
- it is 'frivolous, vexatious, misconceived (does not meet the legal definition of discrimination or sexual harassment) or lacking in substance'
- it is about something that happened more than 12 months ago
- a relevant 'exception' to the law applies.

If a complaint is declined, the Commission will inform everyone involved and give reasons for its decision. About one in every three complaints lodged at the Commission is declined for these reasons. A complainant whose complaint has been declined may chose to have the complaint referred to the Victorian Civil and Administrative Tribunal (VCAT) for mediation and / or a hearing.

Conciliation

About half of complaints made to the Commission are referred to conciliation. A conciliation is a structured meeting where the Commission brings to two parties together to try to negotiate a mutually satisfactory agreement on how to resolve the complaint. About half of the Commissions conciliations are successful. Common outcomes from conciliations include many of the same things complainants seek through self management and informal processes, namely:

- an apology (verbal or written, private or more public)
- changing or stopping certain behaviour
- reconsidering a decision
- providing a new or better reference, statement of service
- reinstatement



- access to a previously denied opportunity, benefit or service
- new or improved equal opportunity policies or and procedures
- training or education for staff and / or managers
- financial compensation for costs and hardship.

Taking a complaint to VCAT

The complainant may take their complaint to the Anti-discrimination List of VCAT if it remains unresolved because complaint has been declined by the Commission or if conciliation has failed. About one in three complaints lodged at the Commission end up being referred to VCAT.

A respondent may apply to VCAT to have a complaint struck-out on legal grounds, for example if it does not meet the legal definitions of discrimination or sexual harassment or if the respondent feels that they are not liable (responsible) for whatever led to the complaint. VCAT will usually attempt another mediation (like a conciliation). If mediation does not resolve the complaint, VCAT will conduct a hearing.

A hearing is similar to a court case. It is conducted by a Tribunal Member who is the equivalent of a magistrate. The Tribunal member will hear evidence under oath, consider any written evidence and then make a finding of fact and a binding order. These hearings are generally public and so not confidential. Media and members of the public can normally attend these hearings.

Lawyers and money?

No fees apply to any stage of the complaint resolution process at the Commission or at VCAT and neither complainants or respondents need to have a lawyer.

However, because VCAT sometimes orders complainants whose complaint has been dismissed to pay the legal costs of the respondent, it is often a good idea to get legal advice before going to VCAT (especially if the other side has a lawyer). In some circumstances, free legal advice can be obtained from Victoria Legal Aid, a Community Legal Centre or a specialist (eg disability or union) legal advocacy service.

Other sources of help and advice

- a counsellor can assist with providing the support through the process, eg through an Employee Assistance Program (EAP). Many organisations have an arrangement that allows employees access to a certain amount of free personal counselling with a counsellor or psychologist.
- a lawyer can explore the legal avenues and make an assessment of the likelihood of outcomes
- the commission can assist with explaining the options if a complaint was lodged at the commission and to provide information about rights and responsibilities of both employers and employees
- Other groups like WorkSafe can provide information about safe workplace practices and investigate if there has been a breach of the Occupational Health and Safety Act.

Contacting the Commission

The Australian Human Right Commission
Tel: 02 9284 9600
Complaints 1300 656 419
www.hreoc.gov.au

The Victorian Equal Opportunity & Human Rights Commission
Tel: 03 9281 7100
Toll-free country calls 1800 134 142
TTY for the hearing impaired:
03 9281 7110 or
email: complaints@veohrc.vic.gov.au
Free interpreters are available.

The Australian Capital Territory Human Rights Commission
Tel: 02 6205 2222
TTY: 02 6205 1666
Email: human.rights@act.gov.au
www.hrc.act.gov.au/

The Anti-Discrimination Board New South Wales
Tel: 02 9268 5544
Tollfree: 1800 670 812 (for rural and regional New South Wales only)
TTY: 02 9268 5522
www.lawlink.nsw.gov.au/adb

The Anti-Discrimination Commission Queensland
Tel: 1300 130 670
TTY: 1300 130 680
Email: info@adcq.qld.gov.au
www.adcq.qld.gov.au/index.html

Office of the Anti-Discrimination Commissioner Tasmania
Tel: 1300 305 062
TTY: 03 6233 3122
Email: AntiDiscrimination@justice.tas.gov.au
www.antidiscrimination.tas.gov.au

Northern Territory Anti-Discrimination Commission
Tel: 08 8999 1444
Toll free: 1800 813 846
TTY: 08 8999 1466
www.adc.nt.gov.au

The South Australian Equal Opportunity Commission
Tel: 08 8207 1977
Country callers: 1800 188 163
TTY: 8207 1911
www.eoc.sa.gov.au/site/home.jsp

The Western Australian Equal Opportunity
Tel: 08 9216 3900
Country callers: 1800 198 149
TTY: 08 9216 3936
www.equalopportunity.wa.gov.au/index.html

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