Surgical news

Vol: 11
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2010

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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Challenges for the College

We need to continue to reform the educational programs of the College

Ian Civil
President

I would like to open this article by thanking all the Fellows of the College who have provided encouragement and words of wisdom as I have assumed the position of President of the College. It is indeed an honour and I do hope that the College and Council can progress a number of key strategies and initiatives while I am in this role.

Having been Censor-in-Chief for a number of years I have been really conscious of the substantial changes coming through the educational activities of the College and the Specialty Societies. Internationally there is now much greater demand for effective in-training assessment and progressive development of more assessment tools.

A recent report on Improving Assessment[1] highlighted the challenge in the successful introduction of these into the work place. Assessments included Direct Observation of Procedural Skills (DOPS), Case Based Discussion (CBD), The Mini-Clinical Evaluation Exercise (Mini-CEX) and Multi Source Feedback (MSF). Mini CEX and DOPS are specifically outlined and taught in the Supervisors and Trainers course for Surgical Education and Training (SATSET) courses that have run through the College and Specialty Societies over the past two years. It has been a fantastic effort that over 1000 Fellows have now completed the first SATSET program.

Recently there has been a workshop co-ordinated by the CPMC (Committee of Presidents of Medical Colleges) where the challenges of being an effective supervisor were discussed at some length. Issues related to specific training for educators, expectations from Trainees and Colleges, but most importantly the availability of dedicated time for the provision of training and educational activities were highlighted frequently.

The hospital sector is now so service (and only service) focused that other important tasks of educational endeavour and research pursuits can be compromised. This is confirmed by the activities of various health authorities that openly declare their interest by funding initiatives for surgical output without necessarily considering parallel educational outputs. While a substantial funding boost has been forecast in the new National Health and Hospitals Network announced by the Rudd government recently, the specific resources that will be applied to surgical training endeavours are yet to be delineated

A key objective for CPMC and all the Colleges as a collective will be to secure adequate dedicated time for educational and supervisory activities. Somehow we need to enable the governments to grasp that by improving educational opportunities they will ensure sustainable and quality focused health services. ▶

"Internationally there is now much greater demand for effective in-training assessment and progressive development of more assessment tools."

The College has also reviewed the SET program that has been in place for over two years. This involved a workshop engaging all the various regional Health Departments and the Specialty Societies. Although there have been some challenges with the introduction of SET it has been broadly successful with the support and active enthusiasm of lots of Fellows, Training Boards and the Societies.

We should all be proud of the successes, but also very conscious of the ongoing improvements required. One of the issues again highlighted is that the success of the program is dependent on the commitment of the individual supervisor and trainer to closely monitor the Trainees, undertake in-training assessments and provide worthwhile feedback. In the past the College mechanisms could have been accused of letting people through the training program and then confronting the discipline of the Fellowship examination. This methodology is also under challenge. It is no longer tenable for Trainees to be informed they are performing satisfactorily when that is not the case. It is no longer tenable for the Trainees to be satisfactory in the purely technical components of the surgical craft if they are not able to work in surgical teams, collaborate, communicate and handle the complex issues that the health sector appears to specialise in.

So the challenges are with us. We need to continue to reform the educational programs of the College. Although the Fellowship examination is a very important component of assessment and a key element in determining that a Trainee will be a safe, competent independently practising surgeon, the emphasis on progressive assessment throughout training must increase. This does not happen without resources, without time and without commitment.

It is certainly the role of the College and Specialty Societies to understand these issues surrounding surgical education and assessment and advocate for them such that surgical education is not only maintained, but also enhanced.

In my new role as President, I look forward to meeting with you over the coming 12 months and hearing your views on surgical education and other matters affecting surgery in general.

1. Improving Assessment. London: Academy of Medical Royal Colleges 2009.

Results of 2010

elections to council and referendum on the constitution

The term of the elected Council members will commence following the Annual General Meeting of the College on 6 May 2010.

GENERAL ELECTED COUNCILLORS

There were nine vacancies to be filled. The successful candidates are:

Re-elected to Council

BEASLEY Spencer Wynyard
CAMPBELL Graeme John
SMITH Julian Anderson
VONAU Marianne
WATTERS David Allan

Newly elected to Council

BATTEN John Charles
BENNETT Ian
FERGUSON Catherine Mary
O'LOUGHLIN Barry Stephen

SPECIALTY ELECTED COUNCILLORS

The following Specialty Elected Councillors were re-elected unopposed:

Cardiothoracic Surgery
EDWARDS Mark Gordon, WA
Orthopaedic Surgery
WILLIAMS Simon Alan, VIC
Paediatric Surgery
MARTIN Hugh Charles, NSW
Vascular Surgery
GRIGG Michael John, VIC

REFERENDUM ON THE CONSTITUTION

Fellows voted overwhelmingly in favour of the new Constitution which replaces the outdated Memorandum and Articles of Association while retaining their spirit and objectives. The Constitution and its supporting regulations became effective on 6 May 2010.

Thank you to the scrutineers Campbell Miles and Colin Russell.

Threat of Litigation – *An Unavoidable Stress?*

In Australia, many surgeons will find themselves faced with a claim of malpractice

Keith Mutimer
Vice President

Fellows will recall a number of questions dealing with "soft" or subjective issues such as work/life balance or stress, in the 2009 College Census. One element of the professional stressors relates to the threat of litigation. My article this month deals with the findings of the census and compares them with some international studies in this area. I have also incorporated some of the verbatim comments received from Fellows.

....."Litigation is extremely stressful. Surgeons need early to develop strategies to switch off and to avoid using alcohol to relax" – *Respondent, College Census*

A recent Supreme Court judgement found that a general practitioner (GP) failed to properly diagnose a disorder. The court ruled that if the GP had requested further diagnostic testing the plaintiff's condition would have been identified. According to the Australian Medical Association, the Supreme Court ruling has the potential to increase negligence litigation. Negligence litigation in itself is putting pressure on medical professionals to conduct more tests than are necessary. This pressure also falls upon our shoulders.

...."There is a lot of stress in .... dealing with patient complaints and threats of litigation" – *Respondent, College Census*

Of the 3933 respondents to the 2009 Census, 3862 answered the question "Perception of the Level of Stress Experienced by Profession-Related Stressors – Threat of litigation. 11.5 per cent experienced high stress, 2.1 per cent experienced frequent stress and 20.9 per cent experienced moderate stress. Some reported stress to be inherent with the nature of the vocation, with 44.4 per cent experiencing occasional stress associated with litigation. Clearly, we are stressed by the threat of litigation. Litigation has a psychological and emotional impact on the defendant as well as their family members.

In the United States of America (USA), malpractice is prevalent. The American College of Obstetrics and Gynaecology reports that 76.5 per cent of its Fellows have been sued at least once (ACOG committee opinion, 2000).

Charles and Colleagues (1985) published findings of a survey conducted anonymously into the malpractice litigation of medical specialists in the USA, including surgeons. Of the respondents who had been successfully sued, 42.8 per cent stopped performing certain high risk procedures and 67.6 per cent ordered more diagnostic tests than their clinical judgement deemed necessary. Further, 48.9 per cent were likely to stop seeing patients with whom the litigation seemed a greater likelihood. Forty two per cent thought of retiring sooner, and 32.0 per cent actively discouraged their children from pursuing medicine as a career.

So how does this change patient/surgeon interaction?

Correia, (2002) in summary of the Levinson investigation compared videotapes of patient encounters by physicians who had been sued and those who had not. The no-claim physician used more statements of orientation, such as telling the patients what they can expect from their visit or treatment. They tended to use humour and laugh more often. They engaged and touched their patents. And they frequently checked patients' understanding and solicited their input. All these behaviours conveyed personal interest in the patient. However, those physicians who had been sued were restrained in their interaction with their patient, less likely to engage and more likely to quickly process the patient.

"....there is a lot of stress in managing unreasonable expectations of relatives... and patients" – *Respondent, College Census*

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In Australia, many surgeons will find themselves faced with a claim of malpractice. Well over half of such claims may be preventable because most are based on failures of communication and or patient selection criteria. Attention to legal principles such as a standard of care, disclosure, knowledge of patient factors and the ability to communicate effectively reduce the risk of litigation (Aziz et al., 2005). However, even if we continue to adhere to these principles, it still does not prevent unreasonable expectations from families. Further, will the fear of litigation see a shift towards the practice of defensive medicine as is currently the case in the USA?

In a study undertaken in London by Bark et al., (1997), many clinicians considered that an important step in reducing litigation was to educate patients about known risks and effects of treatment to promote more realistic expectations. In terms of delivering this information, Stanley and Colleagues demonstrated that regardless of the method of delivery of the information - whether in written form, orally or both - the patient's level of understanding remained static at 50 per cent (Stanley et al., 1998).

"....a legal system that thrives on antagonism instead of finding a solution to a problem" – *Respondent, College Census*

In the USA tort-based legal system, a patient, through litigation, can seek redress from a doctor for perceived negligence. Perceived negligence is defined as a failure to meet a professionally expected standard of practice. Most lawsuits, however, still arise following appropriate care (Bismark and Paterson, 2006). Charles et al (1985) found that of the perceived negligence cases, only 1.6 per cent resulted in an adverse finding against the defendant. Could this be symptomatic of patient and families' unrealistic expectations?

"....in New Zealand we are BLESSED to have a no fault medical system which relieves enormously the fear of litigation" – *Respondent, College Census*

The alternative to tort is a "no-fault" system where negligence does not have to be proven in court. In 1974, New Zealand (NZ) adopted a government funded system for compensating people with personal injuries, including medical injuries replacing its former tort-based system (Davis et al., 2003). Further reformed in 2005, making it a true no-fault system and thereby avoiding litigation, it can be viewed as a social gain (Bismark and Paterson, 2006). This system compensates injured patients quickly and equitably, offering accountability mechanisms focused on ensuring safer care rather than assigning individual blame (Bismark and Paterson, 2006). Further, it is funded from taxes and a compulsory payroll levy.

No-fault systems have the potential to compensate many more patients than malpractice litigation can. The NZ system does not incur large legal and administrative costs. The system has been very cost-effective, with administrative costs absorbing only 10 per cent of the Accident Compensation Commission's expenditure compared with 50-60 per cent among malpractice systems in other countries (Bismark and Paterson, 2006).

One of the benefits of a no-fault system is the reduction in heavy emotional burden of personal responsibility that clinicians have to endure (Aziz et al., 2005). New Zealand's no-fault compensation harmonises injury compensation, provider accountability and patient safety.

Given the New Zealand experience, perhaps this is one area where the College can look to further explore alternate dispute resolution mechanisms, with a view to advocating for a less expensive and less litigious system in the Australian context.

For further information please email college.vp@surgeons.org

We all need emotional and physical hugs

It is important for surgeons to look after each other and make contact after personal tragedies occur

I.M.A Newfellow

This is likely to be the only 100 per cent serious article written by me. Usually I am cheeky, provocative and trite, but this matter does not deserve such treatment so if you are looking for a bit of a giggle or snigger, look elsewhere.

It is odd how events sometimes pan out. Two months ago, I wrote about the need for surgeons to have general practitioners and how they should look after their health. I had two encounters with colleagues this last week that has caused me to write this article about how we should look after each other.

The first encounter was a bit of a shock. I ran into an old Trainee of mine, now a respected consultant. In the course of chatting he mentioned, "Did you know about X's daughter?" Now X was also a Trainee of mine and it appears that his daughter died a few years ago in tragic circumstances. Dreadful events like this do happen as we are mortal and this means death. I no longer move in the circle of these Trainees and so I was quite unaware of this sad event. The point that hit me was that the prevailing sentiment amongst colleagues after the news came out was "We should respect his privacy and leave X alone".

My former Trainee felt uneasy about this point of view and after due reflection went to see his friend. His friend wanted to talk about the tragedy and appreciated his visit. At the time he noted that at the home there were many support persons, all female, for Mrs X but no male support persons for X. Months later X told him that the only male support person that came to the home was him and that he really appreciated it.

We males are a funny bunch. We think that we are tough, and unemotional. Maybe we are most of the time, but when personal tragedy strikes we are as sad and hurt as anyone and need an emotional (and maybe physical) hug.

The other encounter was with a colleague whom I have known for many years. His wife had died a year ago after months with metastatic disease. They were very close and he was very distressed by her death. I had spoken to him several times since the funeral and he often spoke of his wife and the details (including the clinical details) of her death. It seemed to me that he almost had an obsession about talking about her.

This time when I encountered him he told me that he often spoke about her as it helped ease his pain. It seemed to help him make sense of what had happened. He also told me of a close friend who lived interstate who had visited him in his home after his wife's death. Despite pictures of her and my friend's talking of her, the deceased wife's name was not spoken by the interstate visitor. It was almost as if she did not and had not existed and had become "she who should not be named". My friend was so insulted by this avoidance behaviour that he broke contact with the interstate "friend".

So the somewhat sober message from this article is that we need to be aware of our "pastoral" responsibilities to our "flock" of surgical colleagues. Do make contact after personal tragedy and death strikes. Do talk of the deceased. Do not ignore what has happened. Don't be a male; let your feminine side out, even if for just a few hours. Give your colleague a "hug".

Now after this sober article I do promise to be back to my trite self next month.

Court determines surgeons' legal duties

A recent decision of the Supreme Court of Western Australia has provided additional insights into the duty of care expected of surgeons

Michael Gorton
College Solicitor

The allegation was made against the surgeon that he breached his duty to his patients by failing to warn of the risks of maintaining Marlex mesh in connection with bowel surgery, and then failing to remove the mesh in subsequent surgery. Expert surgical evidence was given in the case by eminent surgeons in Western Australia (WA).

At the first hearing of this case, the Court rejected the claims of several breaches of duty. However, it considered whether the continued presence of the mesh had caused an infection and fistula to develop, until subsequently rectified and removed by another surgeon some substantial time later.

The WA Supreme Court considered the appeal based on a claim that there was an alleged failure to warn the patient of the risks associated with the mesh remaining in place after surgery, together with a duty of care claim in relation to the failure to remove the mesh at an earlier stage.

The Court rejected the informed consent claim. It accepted that the patient had been sufficiently warned of the risks associated with the surgery.

The Court also rejected the second ground in relation to duty of care. The Court accepted that the use of the mesh in this particular case was in line with accepted practice, as supported by expert medical evidence. Expert evidence included that given by a former College President.

In the course of the Judgment by the Court, the following reflections were made: "The responsibility for taking the course that best serves the interests of the patient when decisions fail to be taken in the course of surgery, rests with the surgeon, to be exercised having regard to the condition of the patient and the observations made during surgery, applying the skill, training and experience of the surgeon.

That is not to say that there may not be cases where all relevant circumstances can be predicted in advance, along with the relative risks associated with different courses of action, in which there might be a duty to seek the views of the patient prior to conducting the surgery."

The Court also noted earlier decisions and accepted the statement that: "Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play ... "

It is pleasing to see that in this case the expert evidence of other surgeons was determinative in the outcome. "It reflects the fact that the law of negligence has moved substantially back to making decisions based on independent expert medical evidence, to determine whether negligence has occurred or not."

In this case, the Court accepted the expert medical evidence that the decision in relation to whether the mesh should be removed or not, and whether it justified an increase in risk to the patient arising from contracting the surgery "was a matter for clinical judgment best made by the surgeon who was able to assess the condition of the patient and the extent of the surgery required to remove the mesh".

This case will provide some comfort to surgeons who act in the best interests of the patient, based on the best available evidence, exercising their proper skill and judgment.

A 'Drafting a Consent' workshop is on offer in Melbourne, 27 May. For more information see page 15

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Advance Diploma of Management

Seven Fellows are close to completing their Advanced Diploma of Management; a nationally accredited, business qualification that the College is offering in collaboration with University of New England (UNE) Partnerships.

Marianne Vonau
Chair, Professional Development Committee

This program is customised through consultation with College and industry representatives, ensuring learning outcomes address workplace issues faced by surgeons. Its focus is on the development of health management skills by building a broader understanding of leading and managing public and private organisations.

Participants can attend any of the three, enrichment workshops described below which are stand alone or entry points into the 18-month diploma.

'Leadership in a Climate of Change' encourages a journey of self-discovery by undertaking a psychometric behavioural profiling exercise, indicating an individual's preferred leadership style. Group discussions identify alternative leadership styles, the value of emotional intelligence and a range of appropriate management styles that can enhance workplace relations.

Professor Clifford Hughes (below), CEO of the Clinical Excellence Commission in New South Wales, who enrolled in the diploma and attended this workshop said, "I was mightily impressed with the way the presenter worked with a group of clinicians, not known for their ready acceptance of some of the issues raised. It was great fun.... The informal discussions illustrate the way in which the presenter engaged each member of the group and developed their enthusiasm, including me. More importantly, I think there is still a lot to learn."

'Providing Strategic Direction', focuses on developing the skills and knowledge to create and implement an organisational strategy. A podcast from the College solicitor Michael Gorton on managing risk in litigious times provides a great springboard into applying risk management and strategic planning in a changing environment. A series of models and tools are then explored to ensure that strategic planning, whether in a hospital setting or smaller practice, addresses the needs of the internal and external environments.

'Sustaining Your Business' concentrates on operational issues associated with developing and managing a business, the financial management perspectives of a hospital and the broader health service delivery environment.

One participant said, "The biggest value for surgeons in this workshop is the exploration of the language, thoughts and priorities of hospital administrators. Surgeons learn strategies for 'selling' a new idea to a hospital administrator through the development of a business case. They are challenged to do this by telling a story about the problem; identifying the positive impact and costs of a new solution as well as the outcomes of doing nothing. The concept that people experience a predictable emotional cycle from anger through to acceptance when new initiatives are introduced into a workplace was new and created much discussion about common sources of resistance to change. It was an enriching professional development experience for all who attended."

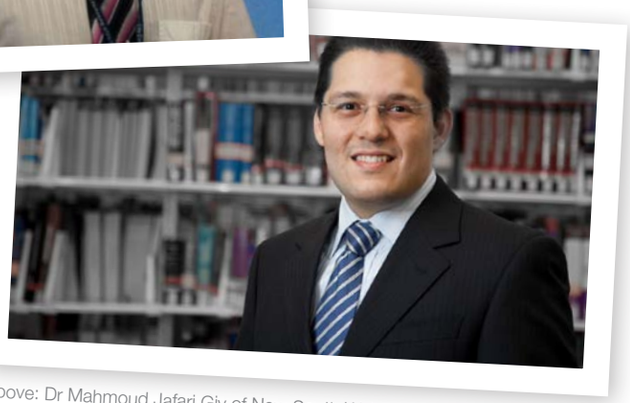
John Ross, facilitator for the workshop series, said Fellows who have undertaken the program have become more confident and capable in business to complement the incredible skills they have as surgeons.

For further information, visit the College website, call +61 9249 1212 or email PDactivities@surgeons.org

Left: Dr Andrew Macleod of Melbourne was awarded the Gordon Gordon-Taylor Medal for the SET Surgical Science Examination (Generic Paper).

Congratulations

to two Surgical Education and Training (SET) Trainees who obtained the highest score for the February 2010 SET Surgical Science (Generic) Exam and the SET Clinical Examination.



Above: Dr Mahmoud Jafari Giv of New South Wales was awarded the Clinical Examination Prize for the highest score in the Clinical Examination.

Members of the Clinical Examination Committee wish to thank the following College Fellows who examined at the February 2010 Clinical Examination.

MELBOURNE

Michael Fink (Co-ordinator)
David Macintosh
David Ying
Devan Gya
Liz McLeod
Amanda Robertson
Campbell Miles
Stephen Salerno
Ernest Lim
Chris Brown
Ian McInnes
Boon Hong
Guy Dowling
Dayan Chandrasekara
Marinis Pirpiris
Peter Scott

BRISBANE

Wendy Findlay (Co-ordinator)
Jenny Gough
Carissa Phillips
Michael Coroneos
Cliff Pollard
Boris Strekozov
Damien Peterson
Alan Gale
Trevor Gervais
Christopher Allan
Praga Pillay
Ross Bolton
Brian Miller
David McCrystal
Tony Leece
Wally Foster
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SYDNEY

Peter Cosman (Co-ordinator)
Hari Kapila
Jai Bagia
Anthony Chambers
Ke Huang
Larry Kalish
Jacqueline McMaster
Mohamad Mourad
Yuresh Naidoo
Geoffrey Workman
Nazih Assaad
Bruce French
Tushar Halder
Suchitra Paramaesvaran
Robert Piper
Adam Rapaport

AUCKLAND

Richard Wong She (Co-ordinator)
Gordon Howie
Iain Kelman
Andrew Hill
Randall Morton
Tharumenthiran Ramanathan
Alastair Hadlow
Donald Guadagni
Askar Kukkady
Erica Whinery Kelly
Udayangani Samarakkody
Li Hsee
Louis Sussman
Venkataraman Balakrishnan
John Dunn
Sivanathan Govender
Belinda Scott

Fellows interested in becoming an examiner for the Clinical Examination please contact Lorraine Jennings +61 3 9249 1245 or lorraine.jennings@surgeons.org.

What is involved? Giving up your time on two mornings per year!
What are the benefits? You help your College. You help your Trainees.
Do I get CPD points? Yes at the rate of one point per hour.
Do I get paid? Sadly not, but travel and accommodation are reimbursed by the College.
Can anyone do the job? As long as you have the FRACS you're welcome!

Topics for Younger Fellows

As always the Young Fellows Forum will be held immediately preceding the College meeting

Steven Leibman
Chair, Younger Fellows Committee

It is with great enthusiasm that I take over as Chair, Younger Fellows Committee (YFC) in 2010. It is with genuine sincerity that I give thanks to my predecessors, particularly Richard Page the immediate past Chair, who together have laid the foundation and continued the progress of a very strong committee with a loud voice and productive agenda for Younger Fellows. I recommend that all Younger Fellows become aware of their state representatives; Jason Chuen (VIC), Gowen Creamer (NZ), Richard Martin (WA) Peter Subramaniam (ACT), Darren Marchant (QLD), Raffi Qasabian (NSW), David Penn (TAS) and Christine Lai (SA/NT).

There are a number of 'hot topics' on the Younger Fellows agenda at the moment that I would like to highlight.

Firstly the YFC has a very strong association with the American Association for Academic Surgery (AAS). Credit must go to Richard Hanney and subsequently to Richard Page for their efforts and enthusiasm in the early development of this relationship and their ongoing support. It is certainly a privilege for our Committee and College to have as part of the upcoming ASC in Perth, an impressive faculty from America is visiting as part of the DCAS (Developing A Career in Academic Surgery) course. This will certainly be a very interesting day and will open the eyes of all attendees to the great rewards and benefits of an academic surgical career.

As always the Young Fellows Forum will be held immediately preceding the College meeting. Richard Martin has followed in the footsteps of previous conveners in organising what I am certain will be a very enjoyable, stimulating, educational and productive weekend in the Swan Valley. Any eligible Fellow who has not had the opportunity to attend a Forum should be placing it high up in their list of priorities in regards to valuable opportunities during their time as a Younger Fellow.

As an ongoing activity, and with great support from Covidien, the YFC has offered four Younger Fellows a Covidien Travelling Fellowship Grant. This is an annual opportunity for eligible Fellows to receive assistance with their education and training while representing the College and eventually returning to Australia with additional knowledge and expertise.

Once again the YFC is thrilled to receive an invitation from the College of Surgeons of Thailand for five Younger Fellows to attend their College meeting in Pattaya. This is a very popular meeting and as a previous attendee, I can vouch for the great value and mutual benefit in attending an international conference.

The YFC is currently undertaking a review of the 'Preparation for Practice' booklet. Credit must go to Sonja Latzel for the work she did in dramatically redrafting the previous edition. A new edition will be available in the second half of the year. 'Preparation for Practice' workshops are also being organised in some states and I encourage you to speak to your state representative or look out for advertising in *Surgical News* in regard to these informative workshops.

The General Surgeons of Australia Annual Scientific meeting will be held in Sydney late this year and the YFC has been invited to hold a special workshop to channel and stimulate discussion and interests among our group. We are currently working on a list of hot topics for this meeting.

There is currently great debate within the College and outside about registrar training in the private sector. The YFC has a strong interest in this debate and will continue to engage with Trainees and Younger Fellows about the best possible model for training.

The YFC meets regularly throughout the year and we encourage Younger Fellows to contact their state or regional representative with issues. It is also a great way for Younger Fellows to engage in College activities and develop a great understanding about how it functions.

I look forward to my term as Chair and the opportunity to engage with the wider Fellowship.

For more information please contact the YFC secretariat on +61 3 9249 1122 or email Younger.fellows@surgeons.org

The College now has a **FACEBOOK** page, we welcome you to become a fan.
www.facebook.com

Chalice Poison'd

The College program now makes it compulsory for active participation in the Audit of Surgical Mortality as well as expectation of peer audit and review

Professor U.R.Kidding

I am sure that you have noticed that increasingly our independence and freedoms are curtailed by rules and regulations instituted by others because they "are good for us"!

Of course I am thinking about Continuing Professional Development (CPD). I have been randomly selected by the College to verify my CPD return. Worse, I am now part of an institution and a system that deems CPD to be of value and I have to show leadership. Oh to be Cassius and have a Caesar to plot against and ultimately thrust a knife into. Something concrete and not nebulous.

But CPD is a reality. For those hiding out in the furthermost outpatient clinic or remote hospital outpost, mandatory continuing professional development is here with us. From July 1 this year, with the National Medical Board of Australia, the Aussies are eventually catching up with the Kiwis. They can not bat, can not bowl, have war cries without meaning, but they have had compulsory CPD for some time. And the College program now makes it compulsory for active participation in the Audit of Surgical Mortality as well as expectation of peer audit and review.....

We discussed it at the Surgical Unit Heads meeting this morning. We are all anxious to be competent and to be seen to be competent but what is the relationship between CPD and competence? And for that matter, what is the relationship between competence, what we are trained to do, and performance, what we actually do?

And then from the most unexpected source, one of the Orthopaedic Heads of Unit, this - " CPD is important in defining us as professionals and allows us to continue to argue for the value of self-regulation – a hallmark of professionalism". Well, stopped the show it did. All thought of herding cats vanished from my mind.

The meeting moved on, carried by a momentum that I wish I had injected. Scientific and educational meetings at the hospital each year that if they were attended then points would be racked up, hours completed, and evidence compiled. Adverse event meetings, clinical improvement session – the ideas flowed out – could this enthusiasm be maintained? I doubted it but pushed the negative thoughts out of my mind and basked in the energy.

That means we need someone to organise, the speakers, the venues, the compiler of attendees. The tricky bit is how I am going to persuade the trainees that they will be making this happen?

But then we came to the real issue - audit

The energy in the room dissipated. Of course the Orthopods have the easy bit in terms of CPD compliance. They already have systems in place to gather all the information about the joint replacements for the AOA Registry, and they produce reports and it shows things. Maybe not what the joint manufacturers want but it does show things. The Vascular guys are OK with their national audit rolling out. And Cardio-thoracics is easy. Tends to just be a mortality audit anyway. Of course there are more and more specialty and subspecialty national registers – breast, colorectal even the bariatric surgeons are becoming interested.

And as the discussion continues, the lead balloon is released – "if administration want us to do audit, why don't they supply the means to do it" – computers, data managers etc. But then who would own the audit? Of course this is the age-old excuse for not being active, I have to confess that I began to tune out of the conversation a little – lost in my own thoughts. Surely the time has come when we begin to view audit as something positive we as surgeons do as professionals. Isn't audit our only defence against accusations of poor performance? Isn't it important that we assess the meaning of the data and not some bureaucratic process? Surely we must seek to have complete ownership over figures capable of being monumentally misinterpreted? Why is it that some surgeons resist audit as a bureaucratic imposition rather than embracing it as a shield against an increasingly hostile environment?

The unit heads were still silent. I can see grudging acceptance.

Of course we could all progress with multisource feedback. That would be a fascinating one to challenge them with. I was looking at the system of physician achievement review (PAR) from Alberta, Canada the other day. Questionnaires for the patient, medical colleagues and co-workers. Now that will raise the temperature....

So, unlike Caesar, CPD will live on and I will have to dig out the verification required. And I find myself looking upon my insightful Orthopaedic colleagues with newfound respect.

To be continued .....

Emergency Surgery: The Cutting Edge

The 2010 GSA Annual Scientific Meeting is coming up in September

Philip Truskett
President, GSA

Planning is now complete for the 2010 General Surgeons Australia (GSA) Annual Scientific Meeting - Emergency Surgery: The Cutting Edge. The meeting will be held at the Hyatt Regency Sanctuary Cove, Queensland from 17-19 September, 2010. The meeting coincides with school holidays in many states and we encourage you and your family to attend.

An outstanding group of speakers from Australia and New Zealand has been confirmed. The meeting will include practical vignette based sessions on Upper GI, Biliary and Abdominal emergencies, addressing management of the complex conditions commonly faced by general surgeons. Other sessions will include the Surgeon and Intensive Care, focussing particularly on the ICU abdomen, the abdominal compartment syndrome and management of the open abdomen.

It is also time that GSA developed a Position Statement on Emergency General Surgery. There are significant comments general surgeons need to make that relate to workforce issues, patient care, sustainability, remuneration and value of the service provided. The meeting will include a forum dedicated to developing a public document about our position on these important issues.

The meeting will include a Trainees' Day on Friday 17 September 2010 focussing on Colorectal Surgery and Emergencies. Dr Michael von Papen has put together an excellent program, addressing issues that are considered to be core knowledge for general surgery Trainees. Fellows are welcome to attend for an update if they wish. There will be other educational activities for Fellows on the Friday, including an accredited advanced Endocrine/Breast Ultrasound Workshop, SATSET Workshop, and Selection Interviewer Training.

The meeting will include an enjoyable social program, with two dinners, sightseeing, and the GSA Trainees vs. Fellows golf tournament. Final details for the meeting and the provisional program are available on the GSA website at **www.generalsurgeons.com.au**

We look forward to seeing you in Sanctuary Cove in September.

2010 professional development workshops

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

Leadership in a Climate of Change
18-20 June 2010, Melbourne

This 2½-day workshop helps you to understand what it takes to be an effective leader. The DiSC model helps you discover more about your leadership style and behavioural preferences. In addition, the workshop covers issues of working as part of a team and gaining team commitment in the context of organisational change and management. For a more comprehensive business focus, consider attending this workshop in conjunction with 'Providing Strategic Direction' and 'Sustaining Your Business'. This workshop can also be one of three entry points for the Advanced Diploma of Management.

Making Meetings More Effective
26 June 2010, Melbourne *7 August 2010, Sydney*

Tired of meetings that never seem achieve what you want them to? This whole day workshop helps you to understand the characteristics of effective meetings. You will develop a greater awareness of the roles and responsibilities of committee members and explore the latest problem solving strategies for making your meetings more productive.

From the Flight Deck: Improving Team Performance
30-31 July 2010, Melbourne

This interactive workshop explores the lessons learnt from the aviation industry in relation to minimising errors, incidents and adverse outcomes and identifies how error analysis models can be applied to surgery. The program combines analysis of real airline accidents and medical incident case studies with group discussions. More importantly, you also have the rare opportunity to experience a full-motion training flight simulator – a chance not to be missed!

AMA Impairment Guidelines Level 4/5: Difficult Cases
5 August 2010, Brisbane *19 August 2010, Sydney*

The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This new workshop provides surgeons with a forum to discuss their difficult cases, any problems they have encountered and the steps applied to satisfactorily resolve the issues. This workshop complements the accredited AMA Guideline Training Courses.

Supervisors & Trainers for Surgical Education & Training (SAT SET) Course
24 May 2010, Wellington *3 June 2010, Adelaide*
29 June 2010, Canberra *21 July 2010, Brisbane*
7 August 2010, Hobart

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

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

professional development workshops
DATES: JUNE – AUG 2010

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

NSW
30 July, Sydney
Building Towards Retirement
7 August Sydney
Making Meetings More Effective
12-14 August, Newcastle
Surgical Teachers Course (STC)
19 August, Sydney

NT
20 August, Darwin
Polishing Presentation Skills,

QLD
21 July, Brisbane
Supervisors and Trainers for SET (SAT SET)
5 August, Brisbane
AMA Impairment Guidelines Level 4/5: Difficult Cases

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

TAS
7 August, Hobart
Supervisors and Trainers for SET (SAT SET)

VIC
27 May, Melbourne
Risk Management: Drafting a Consent
18-20 June, Melbourne
Leadership in a Climate of Change
26 June, Melbourne
Making Meetings More Effective
30-31 July, Melbourne
From the Flight Deck

NZ
24 May, Wellington
Supervisors and Trainers for SET (SAT SET)
23 July, Wellington
Mastering Difficult Clinical Interactions

Surgeon Scientist Scholar

The greatest aspect of receiving such a scholarship is that it gives your research credibility

"Scientific research is, at its core, about the pursuit of truth", according to Dr Tarik Sammour echoing the words of his research supervisor and mentor Associate Professor Andrew G Hill.

Dr Sammour, the 2009 Surgeon Scientist Scholar, has spent the past three years testing the hypothesis that warming and humidifying the carbon dioxide used to insufflate the abdomen in laparoscopic surgery improves post-operative recovery. To do so, he began by conducting a meta-analysis of all available literature on the technique, and then established a multicentre, double-blinded, randomised clinical trial comprising 82 patients undergoing laparoscopic colonic surgery in hospitals across Auckland.

"It has been known for a long time that the carbon dioxide used in laparoscopic surgery is very dry and irritates the peritoneal cavity resulting in post-operative shoulder pain, for example," Dr Sammour said.

"The next rational step was to think that if the gas could be warmed and humidified, these effects could be limited. While there was quite a lot of literature on the topic, much of the data was limited by the quality of trial design.

"So as part of my PhD research we recruited patients having laparoscopic colonic surgery at Auckland City Hospital, North Shore, and Middlemore Hospital in a rigorously designed, blinded, randomised controlled trial. This was the first study investigating humidification to directly monitor biological markers in the peritoneal fluid".

Dr Sammour, now into his second year of advanced training in General Surgery, conducted his PhD research in the Department of Surgery at the South Auckland Clinical School (SACS), University of Auckland. He worked under the supervision of Associate Professor Andrew G. Hill, Head of School and Associate Professor Roger Booth, Department of Immunology, University of Auckland.

"I've been very fortunate to have worked within the South Auckland Clinical School. The environment there is very conducive to clinical research that directly involves surgical patients." Dr Sammour said.

Tarik Sammour in San Antonio at the Academic Surgical Congress of the Association of Academic Surgery

> *"Your work is undoubtedly viewed favourably when you have the clear support of the College."*

"All the research Fellows work in close collaboration with each other, and are always keen to take on clinical research challenges. This, along with the supervision of the Assoc Prof Andrew Hill, and the assistance of the dedicated administrative staff were all instrumental in facilitating the research at SACS."

Dr Sammour said that the final trial findings have been accepted for publication by the prestigious United States publication, Annals of Surgery. The research has also already lead to multiple publications in the British Journal of Surgery, and various other international journals.

The Surgeon Scientist Scholarship is one of the College's most highly regarded, and comes valued at $70,000 stipend. Dr Sammour said the College support had been invaluable and the research experience research extremely rewarding.

"While the financial assistance is obviously useful in that it allows you to focus on the research work, I think the greatest aspect of receiving such a scholarship is that it gives your research credibility. Your work is undoubtedly viewed favourably when you have the clear support of the College," he said.

Dr Sammour is also an advocate of undertaking a period of fulltime research during training, and is candid about his personal reasons for doing so. "As surgeons we are constantly evaluating published research in order to determine the best treatment options for our patients. I thought that the best way to learn how to do this effectively was to learn research methodology first hand.

"And while it is certainly a sacrifice to take time out from your training, what you gain is a lifetime of perspective that would otherwise be difficult to attain."

With Karen Murphy

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Techniques in Endocrine Surgery

Third Postgraduate Course in Endocrine Surgery

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

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

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

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

www.endocrinesurgeons.org.au/registration

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Centre for Excellence in Teaching and Learning (CETL), Director School of Community & Health Sciences City University, London

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Dr Mary Langcake operating on a seriously ill patient at St George Hospital in Sydney

Squadron Leader Mary Langcake with a young patient in Afghanistan

Working in the military

One of my earliest memories is that I wanted to be a doctor

Steve McClelland
Flight Lieutenant

Many Reservist members of the Australian Defence Force (ADF) train for years to be ready for overseas deployment. Mary Langcake waited only a matter of months. The trauma surgeon spent six challenging weeks in Afghanistan operating on soldiers and civilians – a little less than 12 months after joining the Royal Australian Air Force (RAAF) Specialist Reserve.

"It was trauma that you don't see in civilian practice," said Dr Langcake, Director of Trauma at Sydney's St George Hospital.

"I saw blast injuries that I'd read about and talked about, but it was the first time I'd experienced them in reality. Nearly 30 per cent of the patients we treated were local children, which was a chilling reminder of the danger these people live with every day. It was also culturally rewarding – knowing that my skills and experience were of benefit to the local people.

"It was a tough gig, though, and left me with a fair bit to process and reflect on. But overall, I reckon it made me a better surgeon."

After completing a science degree and then turning to medicine, Mary Langcake graduated as a doctor in 1990. She qualified as a surgeon in 2001 and says medicine was a childhood ambition.

"One of my earliest memories is that I wanted to be a doctor. I clearly remember in Grade six while the other girls were reading 'The Pony Book', my reading of choice was 'The Heart Explorers' about Dr Christiaan Barnard and the other pioneers of heart surgery," she laughed.

"I love the practicality of surgery, using my hands to help someone, even when it leaves a sweat on your forehead."

Joining the RAAF was always on the cards for Mary Langcake – her father served in the Royal Air Force at the end of World War II.

"He was an Aircraftsman in places like Palestine and also well remembered the fierce air raids on London during the War. I picked up an interest in military history from dad and I guess by joining up myself, the family military circle is complete!

"I also joined the Reserves to give something back. The public health system trained me and joining the RAAF was a practical way for me to repay some of that benefit. One of the best things I picked up from my deployment was professional links and friendships with medical staff from other countries.

"In Afghanistan I worked alongside Dutch doctors and nurses and we shared knowledge and techniques with each other. I've stayed in touch with many of them since coming back to Australia, creating a network that wasn't there previously.

"I also had a great team of Australian colleagues, some of whom I knew from civilian practice. Led by Squadron Leader Sharon Cooper it was essential to have that support and camaraderie in the face of such a challenging experience."

But how do Dr Langcake's other colleagues in Australia respond to her work as a Reservist? It's overwhelmingly positive!

"When I joined up I was working at Westmead Hospital. Both there and at St George Hospital, my surgical colleagues are right behind what I do. When I need to be away for weeks at a time, they simply step in and take on my surgical responsibilities. I suppose it's them also doing their bit, albeit indirectly, for their country.

"At the moment my life is varied and challenging. I have a passion for educating other doctors. I do that through the College of Surgeons and also in Defence – preparing and training people to go on deployment."

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Bob teaching local intern Dr. Tama how to do a simple excision.

Teaching and treating in West Timor

It's the educational component that seems to drive Bob Sillar beyond the personal reward associated with treating people in such obvious need

New South Wales general surgeon Dr Bob Sillar first experienced the engrossing challenge of international humanitarian work when he joined a College managed program to work out of Dili hospital not long after East Timor's hard-won independence. Taking time away from his busy Newcastle-based practice, Dr Sillar worked for three months in 2002 alongside teams from the United Nations mandated to run the hospital and help restore order from the chaos of conflict.

He enjoyed it so much, that upon his return to Australia he volunteered his services to the Overseas Specialist Surgical Association of Australia (OSSAA) and the Flinders Overseas Health Group to work specifically in the impoverished areas of West Timor.

Since then, he has travelled there for two-week visits at least once each year and now, since winding back his private practice and entering semi-retirement, he has been to the region four times in the past 12 months

"Even though OSSAA has its roots in plastic and reconstructive surgery, there was a very strong need for the involvement of general surgeons," Dr Sillar said.

"Most of my work in Newcastle was broad based involving trauma, abdominal, head and neck and oncology related surgery which made me reasonably well skilled for the wide ranging demands needed in a place like West Timor."

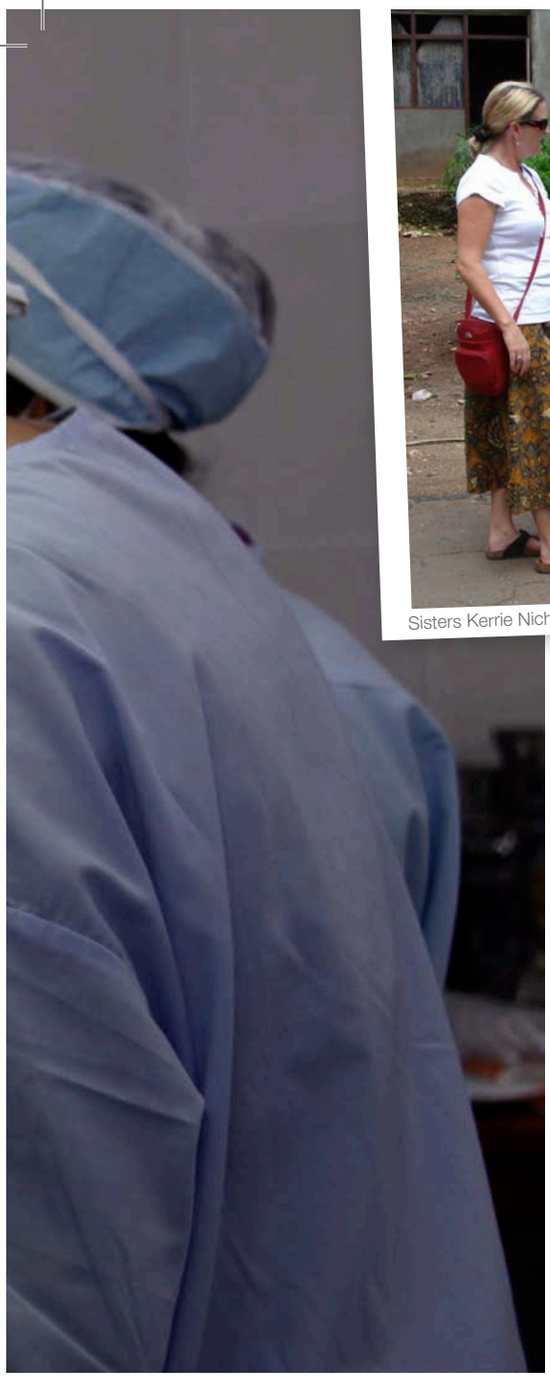
Dr Sillar has worked principally in public general hospitals in the provincial towns of Soe, Kefamananu and at the Hospital in Halilulik run by Catholic SSpS order of nuns.

Nusa Tengarra Timur is the one of the poorest provinces in Indonesia and the medical needs in many areas are essentially unmet. He said these regional areas had few specialists which meant that the visiting teams from Australia were not only warmly welcomed by the people, but seen by the health authorities as an important component of health delivery.

"In NTT, health care is not free outside that offered by the not-for-profit groups such as OSSAA," Dr Sillar said.

"The region has a population of four million people with the major referral provincial hospital located in Kupang, while the district hospitals are staffed mainly by junior resident doctors from Java doing a compulsory rotation and some regional general practitioners.

"These doctors, despite their inexperience with complex cases and their lack of resources, are of pivotal importance, some of whom provide an obstetric and basic general surgical need, so every time we go we make it a priority



Sisters Kerrie Nicholls and Penny Craig with woman who has large ovarian tumour.

Below: Bob Sillar demonstrating the value of ultrasound in the diagnosis of an intrabdominal mass.

"These are very poor communities ... and when they hear of a team visit and that the services are free there is, of course, huge excitement and hope because for some people this might be the only chance to have their problem treated."

to up-skill and further train as many as we can."

It is this educational component that seems to drive Dr Sillar beyond the personal reward associated with treating people in such obvious need.

"The educational aspect to me is the most exciting part of this work and I don't think I'd be so committed and enthusiastic if I didn't think I could make a lasting difference. Operating on 40 or 50 patients at a time is helpful, but not going to produce the long term benefit that a structured educational and training program will achieve" he said.

"We work alongside the local doctors and nurses whose enthusiasm to learn is exemplary and in recent times it's been extremely gratifying to see that real progress has been made. The capacity building programs initiated eight years ago has developed to the extent that in some hospitals the medical and nursing staff, now conduct their own agendas. In November last year I went to the regional Hospital at Kefamananu and the team didn't take a theatre sister and required only one anaesthetist for two surgeons in view of the pool of competent local staff. This seemed to me to be a small step in the ideal of making ourselves redundant.

"In an area like West Timor there are virtually no diagnostic technologies so there is much reliance on the history and physical findings. Lumps and bumps are prevalent and it is important that the local doctors are able to differentiate a simple lipoma from more serious pathology. I'm old enough to remember what surgical practice was like before the investigative facilities that we have today and I must admit I enjoy digging into the memory bank. Recently on a trip to Halilulik in the eastern part of West Timor, I took a small portable ultrasound machine and found it an invaluable diagnostic aid.

"The Udana Medical School has recently started in Kupang with a selection bias towards students from the NTT area. The initial intake of students is now in its third year and four students and a lecturer accompanied us on a trip to Kefamananu last year and I believe they benefited greatly from the teaching and liason with the visiting team. This no doubt has strengthened the ties between Udana and the Flinders Medical School. I was informed by the Dean that the Udana Faculty considers the visiting medical teams a valuable clinical resource. The output of a large number of locally trained doctors is likely to have to have a big impact on the delivery of health care in the region."

Dr Sillar said that word of an impending visit is spread through the church network and several hundred may present to the triaging clinic which can be very confronting on arrival. He said those to be treated were chosen on the basis of not only need, but the likely outcome of surgery in the environment, the availability of adequate post operative care and the distance and cost associated with their travel to the hospital.

"These are very poor communities, particularly outside Kupang, and when they hear of a team visit and that the services are free there is, of course, huge excitement and hope because for some people this might be the only chance to have their problem treated. The possible natural history of the pathology is an important consideration and for this reason it is often better, in an environment where there are few surgical services, to operate on a hernia rather than a large asymptomatic goitre. These are hard decisions and there are a lot of disappointed people, but it is important that we don't leave problems behind," Dr Sillar said.

Dr Sillar said that while infectious diseases, malnutrition and congenital abnormalities remained the major health issues affecting the people of West Timor, advanced pathology, rarely seen in Australia, present a challenge to the visiting teams particularly when the operating facilities are limited. Amongst his more memorable cases were two young women with massive ovarian tumours.

These tumours, once removed and weighed, were shown to have made up a third of the patients' body weight which was quite incredible, he said.

"They recovered quickly and as you can imagine were very happy young women."

With Karen Murphy

Medico Legal Section Newsletter

The Annual Clinical Medico Legal Meeting will be held on Friday 13 - Sunday 15 August, 2010

Neil Berry
Chair, Medico Legal Executive

Chair's report

The Medico Legal Executive held their first meeting for 2010 on Thursday, 11 March. The Executive continues to focus on the development of the Australian Medical Association Difficult Cases workshops which we expect will be of interest and value to section members. A workshop is planned for 5 August in Brisbane and 19 August in Sydney.

The first Occupational Medicine workshop for 2010 was held at the New South Wales (NSW) Coal Mine Training Facility at Woonona NSW on 24 March. The course was fully subscribed and participants reported that the meeting was informative and enjoyable. Our thanks to Dr Murray Sinclair and his team for their efforts in co-ordinating this workshop. Further Occupational Medicine workshops will be held in 2010 and details of these meetings will be highlighted in an upcoming edition of Surgical News.

At May's Annual Scientific Congress three founding members of the Medico Legal Committee, including myself, retired from the Executive. I would like to thank Kim Edwards and Malcolm Stuart for their support and wish the incoming Chair all the very best.

Combined Australian Orthopedic Association, the College and MedLaw Medico Legal Meeting

The Annual Clinical Medico Legal Meeting will be held on Friday 13 - Sunday 15 August 2010 at the Sheraton Mirage, Gold Coast. Many topics will be discussed including a session on 'Problem solving in impairment assessment' and presentations by the judiciary and legal practitioners. Further details to follow, for enquiries please contact the secretariat Mr Kevin Wickham at kevin@wickhams.com.au

Spinal Stability

The American Medical Assoc (AMA) Guidelines define loss of motion as abnormal back and forth movements (translation) between two adjacent vertebrae or abnormal angular motion of a motion segment defined as two adjacent vertebra and a disc and the vertebral facet joints.

(Fig 62, 63 AMA IV page 98).

This is defined as showing a slip of greater than 3.5mm for cervical vertebra or greater than 5mm for vertebra in the thoraco-lumbar spine or a difference of angle of motion of two adjacent motor segments greater than 11 degrees in response to spinal flexion and extension. This is validated on functional flexion extension x-rays. Loss of integrity of the lumbo-sacral junction is defined as angular motion between l5 and s1, i.e. 15 degrees greater than the motion at the l4/5 level.

The importance of careful and accurate x-rays 'cannot be over-emphasised'.

What is the assessment of spinal instability or spinal stabilisation with respect to surgical intervention and trauma?

1. DRE IV: Loss of motion segment integrity.
2. DRE IV: Radiculopathy with loss of motion segment integrity or is it DRE II or III when there is dynamic stabilisation for example, does an intervertebral disc replacement, which is meant to provide stability with motion, really fit into category IV or V?

Loss of motion segment can be:
RELATIVE

1. Dynamic stabilisation with posterior intervertebral spaces e.g. diam, xstop.
2. Intervertebral disc replacement e.g. charite
3. Cervical fracture dislocation with locked facet

ABSOLUTE

1. Arthrodesis or fusion acquired
   a) Interbody fusion or interbody fusion with spacer
   b) Posterlateral fusion or posterolateral segmental fusion with pedicle screw fixation

CONGENITAL
Fused vertebra e.g. mid cervical vertebra

Loss of motion segment integrity can be:
DEVELOPMENTAL
Spondylolisthesis: Slip does not enter into DRE because it was present years earlier

ACQUIRED
Traumatic fracture – soft tissue flexion injury – disc disruption – post discectomy - degenerative e.g. l4/5 spondylolisthesis.

The difficulty is in obtaining adequate flexion extension views. There may be difficulty with patients with pain obtaining adequate functional views and dynamic studies may not be approved as additional investigations by insurers in some circumstances. These x-ray views require adequate patient cooperation by skilled radiography and adequate interpretation by the radiologist.

With the advent of posterior intervertebral spacers and intervertebral disc replacements, a new category of dynamic stabilisation has evolved which allows motion in one plane and motion allows for limited motion therefore cannot be truly regarded as akin to surgical fusion for arthrodesis. However, it could be argued that a disc replacement is not true surgical ankylosis (fusion); disc replacement surgery has been taken to be DRE Category IV. Posterior spacers or stabilisation devices do not represent surgical ankylosis, nor do they represent spinal fusion and should not have additional whole person impairment. However, adjacent vertebral fractures, where there has been discal intrusion with subsequent autofusion, does represent loss of motion segment. The higher impairments of DRE IV (no radiculopathy) or DRE V (with radiculopathy) do apply.

References: Guides to evaluation of permanent impairment 4th Edition, August 1995 and 5th edition January 2005.

Drew Dixon
Chair, AOA Medico-Legal Society
Member, Medico Legal Executive

Industry Visit: NSW Coal Mine Training Facility at Woonona

On 24 March, 2010, some 22 Fellows experienced going underground in a mine. This is simulated with 400 metres of roadways and tunnels constructed just below the surface. The facility is used to train underground miners and for emergency service workers.

Coal Mine Health's manager Mr Peter Maher attended. Dr Murray Sinclair and physiotherapist Dale Davis described the mine structure and working including safety and response to injury and return to work. As it is not a working mine, a film showing work in progress was included.

Fellows donned safety gear including torches and were able to see and feel the physical aspects of being underground including the dark, ventilation and structures as well as much of the machinery and safety aspects, with a demonstration of how to use some of the tools.

Next we were treated to a complete three-dimensional virtual reality experience in a large auditorium in which we all stood while Geoff Buchanan, a former coalminer now trainer, took us virtually through a coalmine. We could see anything from any aspect. We could literally pass through walls and through machinery to see what it was we wished to see. It was an amazing experience.

At the conclusion David Boscoscuro explained rehabilitation return to work in mines NSW. A question and answer session assisted us in our understanding of how we could best assist workers and the mines in the return to work process.

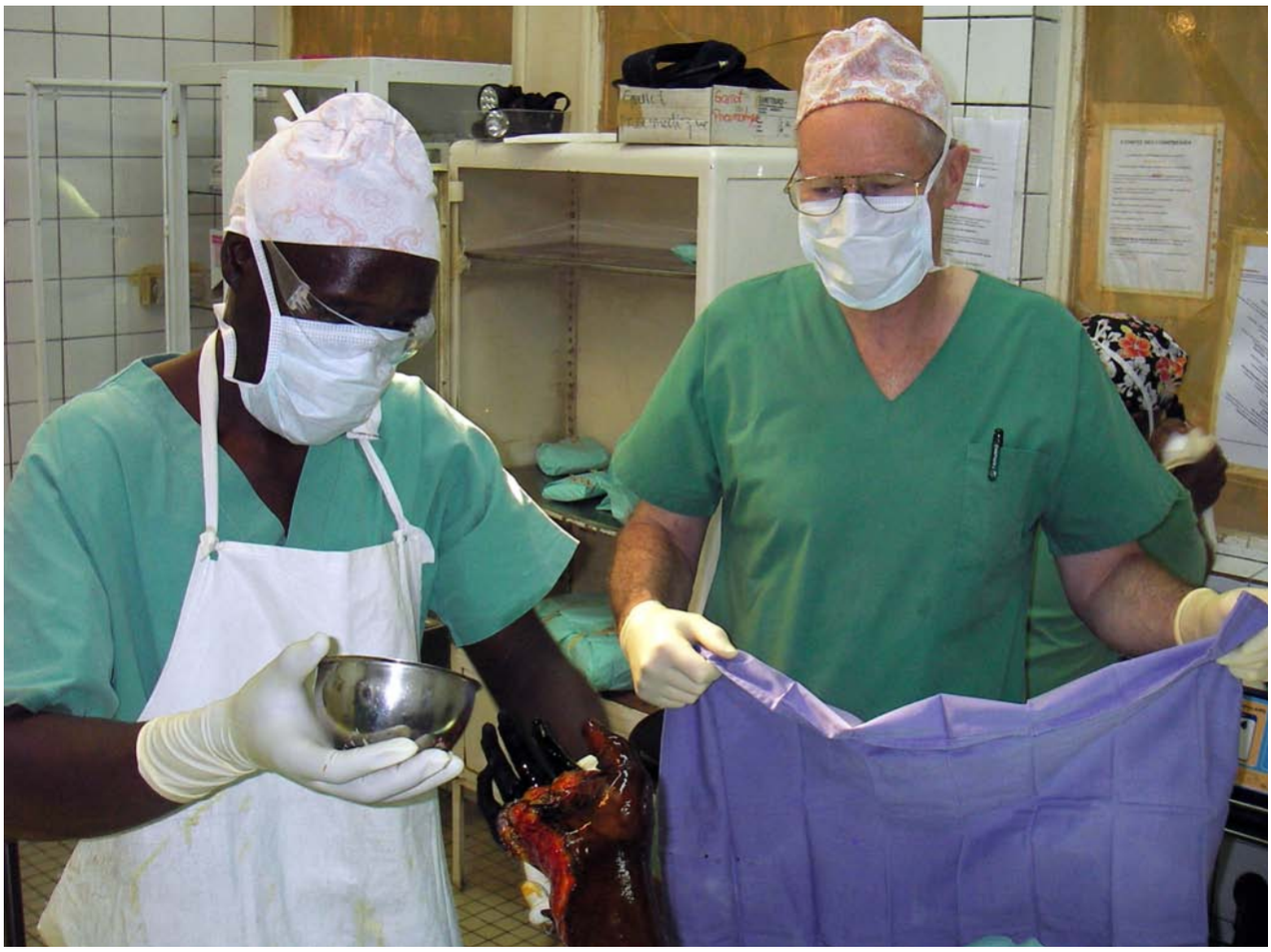
Further industry visits are in the process of being organised. If you have close contact with an industry/employer and would consider leading an industry visit, with myself and the college providing support, please contact the Medico Legal secretariat. Watch this space!

Edward (Ted) Schutz
Convenor, Industry Visit Program

For further details about these activities, please contact the Medico Legal Secretariat at MedicoLegalSection@surgeons.org or +61 3 9276 7473. Also see p.15 for more information about professional development.

Home is where the heart is

Throughout Alan Scott's surgical career he has been involved in humanitarian aid work



Gangrenous fingers as a result of a burn injury prior to amputation.

I became a surgeon in Scotland and then in 1978 I took a job at the University of Tasmania as a lecturer in Surgery. I have called Australia home ever since though go back to Scotland from time to time.

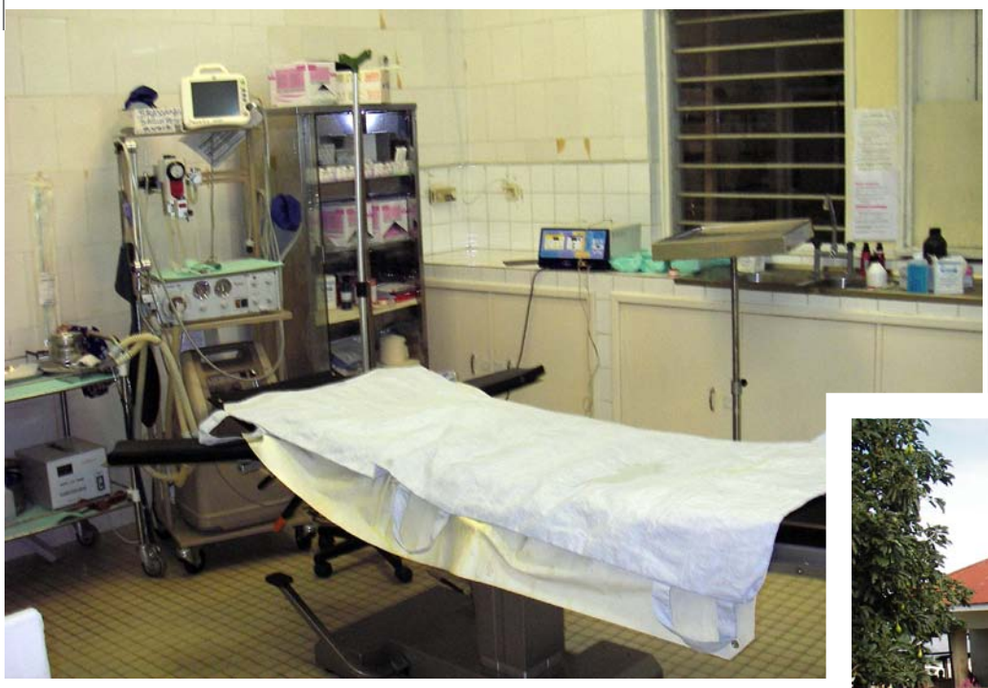
In Tasmania I was in practice in Hobart, Launceston and Burnie. I have also worked in Brisbane and towards the end of my career I spent six years in Perth. For most of my career I was a general/vascular surgeon, but during the last few years with the advent of increasing specialisation I worked mainly in the field of vascular surgery. I have been involved in work with the College as Chair of the Tasmanian State Committee Chair of the Surgical Teachers Group and Chair of the Board of Vascular Surgery.

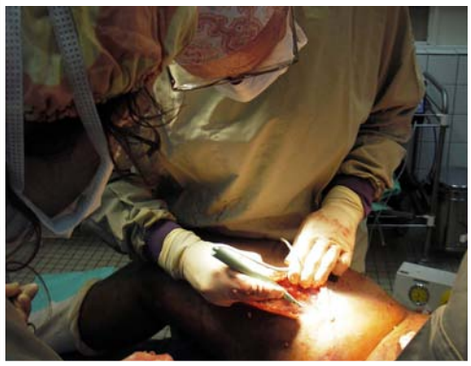
Throughout my career I have been involved in humanitarian aid work, mostly in the Pacific. I have worked in Fiji, the Solomon Islands, Papua New Guinea, East Timor and Samoa. I also spent a short time in the Yemen and Tanzania doing a few cases with the local surgeons. I find working in developing countries and places experiencing conflict surgically and emotionally challenging.

In 2007 I began working with Médecins Sans Frontières. My first placement was to Nigeria where a hospital had been set up in Port Harcourt in the Niger Delta to help people affected.

I was the only general surgeon in the Médecins Sans Frontières-run hospital in Port Harcourt along with two orthopaedic surgeons – one a national and one an expat. This hospital dealt solely with trauma, sometimes as a result of interpersonal violence, but also with road trauma. I was responsible for the chest head and abdominal trauma and was there for six weeks. Most surgical placements are for short periods as often you're the only surgeon and you work long hours. Around four to six weeks is about right as I feel the physical demands of doing it for more than six weeks would become taxing, both physically and mentally.

The following year I was asked to go to the Democratic Republic of Congo. (DRC) I accepted and was posted to the Médecins Sans Frontières hospital in Rutshuru in the east of DRC. The nearest city was Goma, but we were based in a





Above: Operating room at the MSF Hospital in Rutshuru. Above right: A case of gangrene following an illegal abortion Right: Rutshuru Hospital

country area where there was a high need for a functioning hospital because of fighting in rural areas.

You often feel out of your comfort zone, but you have to think "I have to try this because if I don't, no one else will." Sometimes you feel inadequate in these circumstances, but it's you or nobody.

From a clinical perspective you are dealing with everything, regardless of your specialisation. It seems daunting, but it can be hugely rewarding. Most of the time you're seeing very different things – things that are unusual or that you may have seen in a text book, but certainly not in real life. I was 65 when I went to the DRC and there I saw, for the first time in my career, two cases of perforated typhoid ulcers and a tragic case of gas gangrene in a young woman of 24 following an illegal abortion. Unfortunately she presented after a delay of two days and was dead within 24 hours.

At times it can be difficult. You have to be prepared for anything and make do with what you've got. You don't have sophisticated diagnostic facilities. You have your ears, eyes and stethoscope, and sometimes a portable ultrasound. In Africa and the Pacific people only go to the doctor when they are seriously ill, and there are clinical situations that you simply don't see in Australia.

The places I've been I've mostly dealt with traumas of one variety or another. In the DRC bullet wounds were the most common inflicted injury that required surgery. AK47s can do a lot of damage to the human body. Serious burns caused by intentional and accidental acts would have been the second most common injury.

I also did obstetrics in the DRC which provided a good balance, as obstetrics was an area where a small act on our behalf could make a huge difference. It wasn't rocket science, but it was very satisfying to get some good results. Caesarean Section is the most common emergency surgical procedure throughout the world and it is a procedure that any surgeon going to a remote area should master. Throughout the world approximately one woman dies every minute in obstructed labour.

Fulfilling work

The most rewarding things in these environments are the simple things. Seeing people walk out of hospital when they have been injured or very sick and knowing it would have been a different story if you hadn't been there. The hardest part is seeing people, particularly young people, dying of treatable diseases like malaria and tuberculosis. When you've got the worst combination of factors – poverty, disease and war – what hope do these people have? But perhaps even making a small difference is worthwhile.

What I like most particularly about Médecins Sans Frontières is its commitment to bearing witness. It sees an atrocity occurring and it speaks up. That is what humanitarian assistance should be about.

Working with Médecins Sans Frontières means having access to often the best facilities in that country. The organisation provides good instruments and well-trained staff who are selected very carefully. You couldn't complain about what's available to you. Their diathermy machines and ventilators are very adequate. I've worked in places that didn't have diathermy machine and it was like going back to the 1930s. Médecins Sans Frontières is also very, very efficient. They meet you at the airport, they take you to where you're going and they look after you. This hasn't been the case for other aid organisations I've worked with. Most important of all they take the security of their staff very seriously.

There's a tremendous camaraderie within Médecins Sans Frontières. In Africa I met people from France and other European countries, as well as the local staff. Many of them are half my age, but we still keep in touch. Living conditions are primitive, but you aren't there for a holiday and you keep each other going. When it gets really dangerous you're pulled out – your safety is always put first.

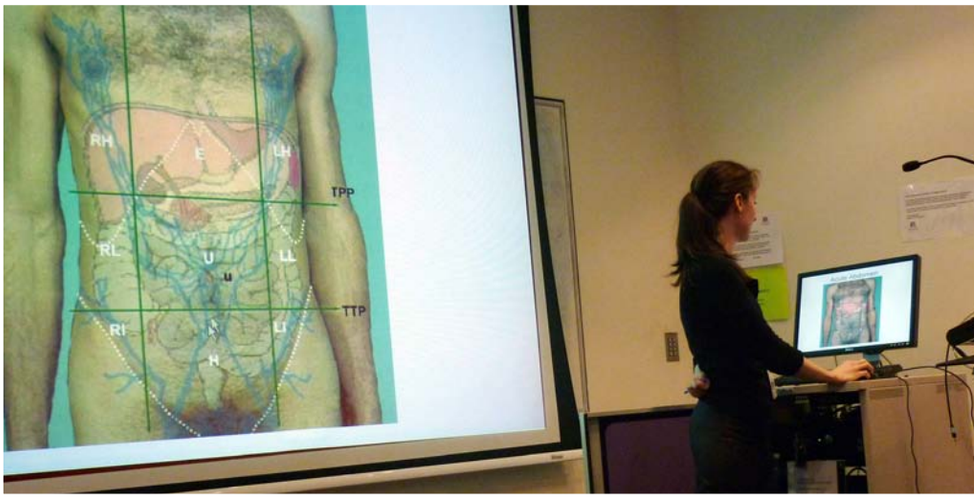
For me one of the best things is helping to teach local doctors. I have always loved teaching and the local staff are all keen to learn and are enthusiastic. Médecins Sans Frontières puts a lot of effort into training and building the skills of local staff. I am currently trying to improve my French so I can go back and do more teaching work in Africa.

When people ask why I do this work, I tell them it's for two reasons. Firstly, I like to work with sick people. I enjoy the challenge and working in these environments is certainly challenging. Secondly, you feel like you're making a contribution, however small it might be. I know I'm not changing the world, but I've made a small contribution, and for the people whose lives we've saved, it's a big difference.

Médecins Sans Frontières is always looking for experienced surgeons who would be willing to share their skills and dedicate their time to support the organisation's medical-humanitarian work around the world. Visit www.msf.org.au for more information.

With Katie Butt

As a part of this series of lectures, a number of suturing workshops were also held for students to practice their suturing skills, which proved to be very popular.



Above: One of the students giving a talk Right:The first suturing workshop

The Surgical Students Society of Melbourne

The society hopes to promote surgery as an attractive career choice for current medical students

Ran Li
President, Surgical Students Society of Melbourne, Royal Melbourne Hospital Clinical School &
Kate Drummond
Neurosurgeon, Director of Junior Surgical Training, Royal Melbourne Hospital

The Surgical Students Society of Melbourne (SSSM) is a student organisation run by medical students with a passion for surgery from The University of Melbourne. It was established in August, 2008, at the Royal Melbourne Hospital (RMH) clinical school and has grown to represent hundreds of students from not just the RMH, but also those based at St. Vincent's, Western, Sunshine and Rural Clinical Schools. Communication is via a WebPage and the social networking site Facebook. The executive committee of the SSSM consists of fifth and sixth year clinical students who run the society with the support of the Director of Junior Surgical Training at the RMH, integrating the SSSM program into other teaching and learning opportunities for surgical residents.

Many medical students are frustrated by the tendency of current undergraduate medical education to prioritise non-surgical teaching. Likewise, medical school clinical examinations focus predominantly on general medical content. Furthermore, the logistics of surgical training can be bewildering to the medical student, with an abundance of rumour, myth and disinformation circulating, particularly since the introduction of the new Surgical Education and Training (SET) program. Recent worldwide trends suggest a decline in graduates pursuing surgical careers with more and more medical graduates choosing 'lifestyle' specialties as career choices.[1] Anecdotally, the consensus amongst many University of Melbourne medical students was that there is a need to augment undergraduate surgical experiences and provide a forum by which to maintain and support medical student interest in surgery. The SSSM endeavours to generate a greater interest in surgery amongst medical students, increase undergraduate surgical exposure, as well as establish valuable professional ties with current surgeons and surgical trainees. Through these means, the society hopes to promote surgery as an attractive career choice for current medical students.

Last year, the SSSM ran a series of weekly surgical lectures held at the RMH that were given by surgical interns, residents and trainees and targeted at medical students in their clinical years. As a part of this series of lectures, a number of suturing workshops were also held for students to practice their suturing skills, which proved to be very popular. In addition, the SSSM has organised a number of surgical careers nights at the RMH, St. Vincent's hospital, and the Rural Clinical School where consultant surgeons were invited to share their experiences and give advice to prospective surgical trainees. SSSM also held a 'Women in Surgery' evening where a number of female surgeons were invited to share their perspective on life as a surgeon. For 2010, the SSSM plans to continue all the aforementioned activities and introduce new events including bedside tutorials with surgical trainees and research opportunities for students.

Currently, the SSSM is still in a phase of rapid expansion and welcomes expressions of interest from students, surgical trainees and consultants who wish to be involved in promoting surgical education.

For more information visit www.sssmelb.wordpress.com

1. Are C, Stoddard HA, Northam LC, Thompson JS, Todd GL. An experience in surgical anatomy to provide first-year medical students with an early exposure to general surgery: a pilot study. J Surg Ed 2009;66(4):186-9.

A Chinese Visit

The purpose of the visit was to study our hospital systems and health insurance policies

Pictured: President He, Gordon Low, Vince Cousins and Ms Sherry Sun and Professor Xu

The Sir Run Run Shaw Hospital presented to the College a Chinese calligraphy scroll.

The translation reads:

-Du Fu- Tang Dynasty
-A good rain knows its season,
-And comes when spring is here;
-On the heels of the wind it slips secretly into the night,
-Silent and soft, it moistens everything.

Gordon Low
Project Co-ordinator, Project China

The External Affairs division and Project China were hosts at a cocktail reception at the College for three visitors from the Sir Run Run Shaw Hospital, on Monday, 22 March. This is a teaching hospital from the east China city of Hangzhou. Our guests were Professor HE Chao, the President, Ms SUN Xiaomin, the Director of the Center for International Collaboration and Professor XU Heyun, the Professor of Cardio-thoracic Surgery, There were about 40 people at the reception, most of whom had been to this hospital or to other Project China enterprises.

In the recent five years, there has been a number of exchanges between Australia and this hospital. We have sent colleagues to establish a Pain Management Service, upgrade their Intensive Care facilities, review their anaesthetic practice, enhance their cardiac surgery practice and promote ear, nose and throat surgery exchanges. They have also sent a good number of their doctors and nurses for training in our hospitals and as observers in our EMST courses. The mission of our visitors was to study our hospital systems, our general medical administration, and our medical and health insurance policies. They also expressed the wish to increase the exchanges between our Fellows and their senior doctors. In the process, they gave us insight into the practice of medicine and surgery in China.

In Memoriam

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:

Patrick Stuart Boulter, UK
Norman Garrick Graham, UK
Ahmad Hanieh, South Australia
Geoffrey Carl Hipwell, St Leonards, NSW
George Condor Hitchcock, Auckland, NZ
Pearl Anna Inglis Macleod, UK
James Warwick Macky, Auckland, NZ
Timothy Savage Taupo, NZ

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

Informing the College

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

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

ROWAN NICKS FELLOWSHIP AUSTRALIA AND NEW ZEALAND

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of New Zealand to apply for the 2011 Rowan Nicks Australia and New Zealand Fellowship. Rowan Nicks Scholarships and Fellowships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country.

The 2011 Rowan Nicks ANZ Fellowship is offered to a surgeon from New Zealand to take up the Scholarship in Australia . The Fellowship is intended to provide an opportunity for the surgeon to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The aim is to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base. The Fellowship will be awarded for a period of between six and twelve months.

Applicants must be under 45 years of age and have completed a Fellowship of the Royal Australasian College of Surgeons at the time of application. Applicants must undertake to return to their home country on completion of the Fellowship program.

The Scholarship is valued at up to $75,000 AUD pro rata in addition to airfares, depending on the circumstances prevailing for the candidate and provided sufficient funds are available.

APPLICATIONS MUST INCLUDE THE FOLLOWING:

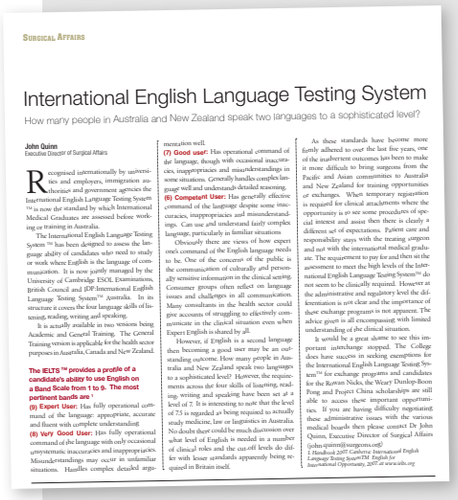
1. A covering letter that outlines the aspirations and intended program*
2. Curriculum Vitae
3. Copy of basic medical degree and Fellowship
4. The names and details of two referees who will be contacted separately

*A Sponsor in Australia is desirable (from the candidate's point of view) but is not essential and will not detract from the application.

The Rowan Nicks Committee will determine the successful applicant in November 2010. The application form and instructions are available for download via the College website: www.surgeons.org.

FORWARD APPLICATIONS BY 28 JUNE 2010 TO:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons Gardens
250 - 290 Spring Street
East Melbourne VIC 3002
E: international.scholarships@surgeons.org
T: +00 11 61 3 9249 1211
F: +00 11 61 3 9276 7431



Surgical Affairs

International English Language Testing System

How many people in Australia and New Zealand speak two languages to a sophisticated level?

John Quinn
Executive Director of Surgical Affairs

Recognised internationally by universities and employers, immigration authorities and government agencies the International English Language Testing System™ is now the standard by which International Medical Graduates are assessed before working or training in Australia.

The International English Language Testing System ™ has been designed to assess the language ability of candidates who need to study or work where English is the language of communication. It is now jointly managed by the University of Cambridge ESOL Examinations, British Council and IDP:International English Language Testing System™ Australia. In its structure it covers the four language skills of listening, reading, writing and speaking.

It is actually available in two versions being Academic and General Training. The General Training version is applicable for the health sector purposes in Australia, Canada and New Zealand.

The IELTS ™ provides a profile of a candidate's ability to use English on a Band Scale from 1 to 9. The most pertinent bands are :

(9) Expert User: Has fully operational command of the language: appropriate, accurate and fluent with complete understanding.

(8) Very Good User: Has fully operational command of the language with only occasional unsystematic inaccuracies and inappropriacies. Misunderstandings may occur in unfamiliar situations. Handles complex detailed argumentation well.

(7) Good user: Has operational command of the language, though with occasional inaccuracies, inappropriacies and misunderstandings in some situations. Generally handles complex language well and understands detailed reasoning.

(6) Competent User: Has generally effective command of the language despite some inaccuracies, inappropriacies and misunderstandings. Can use and understand fairly complex language, particularly in familiar situations.

Obviously there are views of how expert one's command of the English language needs to be. One of the concerns of the public is the communication of culturally and personally sensitive information in the clinical setting. Consumer groups often reflect on language issues and challenges in all communication. Many consultants in the health sector could give accounts of struggling to effectively communicate in the clinical situation even when Expert English is shared by all.

However, if English is a second language then becoming a good user may be an outstanding outcome. How many people in Australia and New Zealand speak two languages to a sophisticated level? However, the requirements across the four skills of listening, reading, writing and speaking have been set at a level of 7. It is interesting to note that the level of 7.5 is regarded as being required to actually study medicine, law or linguistics in Australia. No doubt there could be much discussion over what level of English is needed in a number of clinical roles and the cut-off levels do differ with lesser standards apparently being required in Britain itself.

As these standards have become more firmly adhered to over the last five years, one of the inadvertent outcomes has been to make it more difficult to bring surgeons from the Pacific and Asian communities to Australia and New Zealand for training opportunities or exchanges. When temporary registration is required for clinical attachments where the opportunity is to see some procedures of special interest and assist then there is clearly a different set of expectations. Patient care and responsibility stays with the treating surgeon and not with the international medical graduate. The requirement to pay for and then sit the assessment to meet the high levels of the International English Language Testing System™ do not seem to be clinically required. However at the administrative and regulatory level the differentiation is not clear and the importance of these exchange programs is not apparent. The advice given is all encompassing with limited understanding of the clinical situation.

It would be a great shame to see this important interchange stopped. The College does have success in seeking exemptions for the International English Language Testing System™ for exchange programs and candidates for the Rotvan Nicks, the Weary Dunlop-Boon Pong and Project China scholarships are still able to access these important opportunities. If you are having difficulty negotiating these administrative issues with the various medical boards then please contact Dr John Quinn, Executive Director of Surgical Affairs (john.quinn@surgeons.org)

1 Handbook 2007 Canberra International English Language Testing System™ English for International Opportunity, 2007 at www.ielts.org

International English Language Testing System

Dear Editor,

I echo the words of Dr John Quinn (Surgical News, Vol 11, No 3, page 12) that "It would be a shame to see this important interchange stopped." International exchanges are necessary for medical progress. It is to the credit of Dr Quinn that he had successfully argued for the exemption of this language requirement on a number of occasions.

Kind Regards
Gordon Low
General surgeon

Letters to the Editor should be sent 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

Informing patients properly

Dear Editor,

Your response (Surgical News, Vol.11, No.2, March 2010, page 35) to Dr. John Walker's query (Vol.10, No.10, page 10) defines what a "material risk" is, as expressed in Rogers v Whitaker (197),

"a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

This reply does not provide an answer to Dr. Walker's question which basically concerns 'probability'. The concerns raised in Dr. Walker's letter ring around medical "probability" and its significance in the law (of negligence). He is concerned that both professions do not understand the minitude (as opposed to magnitude) of the said complication.

Medical practitioners somehow seem to be obsessed with the idea that "probability" and "complication rates" matter in law. "Probability" is not important in negligence law. However, "foreseeability" is. In other words if a certain hereto unreported complication occurs (for the first time) with an operation, the practitioner can be held liable if the complication is 'reasonably foreseeable' (Overseas Tankship (UK) Ltd v Morts Dock and Engineering Co Ltd (No1) [1961] AC388;[1961]1 All ER 404 and Overseas Tankship (UK) Ltd v The Miller Steamship Co Pty Ltd (No 2) [1966] 2 All ER 709[1967] 1 AC 617

In Mount Isa Mines v Pusey (1970) 125 CLR 383 HCA, Barwick CJ at 389 remarked:

"But the rarity of such an injury in the circumstances does not in my opinion deny the foreseeability of an injury ....."

Windeyer J at 401 commented :

"... and reasonable foreseeability is not measured by statistical probability."

A 'reasonably foreseeable risk' was defined in Wyong Shire Council v Shirt [1980] 146 CLR 40; 29 ALR 217 as 'not insignificant' and not 'far-fetched' and 'fanciful'.

The onerosity of this task was commented on by Kirby J in Chappel v Hart (1998) 195 CLR 232:

"These standards have fairly been described as onerous. They are. But

they are the law. They are established for good reason."

Mais oui mon amis, c'est la law!

Yours sincerely
Sylvester Fernandes
Otolaryngologist

Editor's response

Dear Sir,

I have had the opportunity to review the worthwhile comments from Sylvester Fernandes, who highlights some of the intricacies of the application of the law in a medico-legal context.

Of course, in relation to whether a doctor is negligent, it is necessary to determine whether the risk was foreseeable rather than "probable".

In the context of informed consent, it is simply a question of whether the risk is known, and if known to the doctor, must be communicated to the patient, if the patient is likely to attach significance to it. That is, would the patient, if warned of the risk, possibly change their mind about having the procedure.

As Mr Fernandes notes, there is both an objective and subjective test involved in whether a risk is a "material risk", and therefore must be advised to the patient. The doctor must ask whether a reasonable person, in the context of the patient's position, might change their mind if warned of the risk. Subjectively, the doctor must also ask, based on what he knows of this particular patient, whether this particular patient might change their mind if warned of the risk.

Mr Fernandes is quite right in observing that the standards set by the High Court in Australia are onerous. He rightly notes the comment by the High Court - "But they are the law".

Yours sincerely
Michael Gorton
College Solicitor
Partner, Russell Kennedy Solicitors

Letter to the Editor ...

Dear Editor,
I noticed some discussion in your medico legal section (Vol 10, No10, page 10) about how to 'inform' patients. In the Rogers versus Whitaker case the odds of complication were quoted 1 in 14,000. This means that if the doctor were to do the same operation every working day (say 250 days per year) the complication could be expected to occur once in 56 years. I am not sure whether the patients or lawyers appreciate the magnitude of this figure.
Regarding discussion of other methods of treatment. I think doctors should discuss other orthdox medical treatments. Most doctors are not aware of 'alternative' medical treatment. If patients raise this question they should be told to make their own enquiries elsewhere. Much information is of course now available on most websites.
Yours sincerely
John Walker, Otolaryngologist,

Editors response ...

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

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

Yours sincerel
Michael G citor

Book Review

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

Scotty Macleish
Victorian Fellow

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

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

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

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

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

[Surgical News] PAGE 35 March 2010

Informed consent

Dear Editor,

I read with interest the comment by the College Solicitor Michael Gorton (Surgical News, Vol 11, No 2, March 2010) about informed consent. What interested me the most was the principal adopted by the High Court that if the risk is disclosed to the patient, the patient should attach significance to it (that is, the patient may change their mind about having the procedure). I have asked a number of medical defence organisations over the years since this decision came out what it actually means when the statement is 'the patient would attach significance' to that risk. I guess most of us felt that it meant that the patient would attach enough significance that they would change their mind about having the procedure. However, none of them ever responded in this manner. Surely the statement that 'the patient would attach significance to the risk' if discussed with them is not the same as 'the patient may change their mind about having the procedure if given that risk'. Surely the patient would attach significance to the risk of death, but that does not necessarily mean they would change their mind about having the procedure.

I hope this is clear as it appears somewhat confusing, but it is finally great to hear a lawyer state that the reason for telling them a risk is material if they may actually change their mind about the procedure and not that vague statement of the patient would attach significance.

Thank you for your consideration in this matter.

Kind Regards
Craig Johnston
Otolaryngologist

Editor's response

Dear Sir,

I have had the opportunity to review the excellent comment by Dr Craig Johnston.

It is clear that, for a patient to be successful in litigation against a doctor, they need to demonstrate that if they were informed of the risk, they would not have undergone the procedure. Hence, the reference to a patient attaching significance to a risk, can in simple English be described as a risk that would enable a patient to change their mind about having the procedure in the first place.

There are two good examples of this, where patients have been unsuccessful in their legal claims. In one case, a patient had not been told of a significant risk in connection with a life saving procedure. The court was convinced that, even if the patient had been warned of that risk, the patient would have gone ahead with the procedure, since it was for life saving purposes. In that case, other significant risks, possibly even more significant, had been advised to the patient and the patient did in fact agree to proceed on the basis of those risks.

In another case, involving cosmetic surgery, the court believed that the patient was so obsessive about having the cosmetic surgery, that had they been warned of the risk of palsy or nerve damage, they still would have gone ahead despite the risk.

I hope this helps to clarify why doctors are required to inform patients of material risks. The patient has then an informed opportunity to choose whether or not to have a procedure. Ultimately, if warned of a risk, the patient then can, in an informed sense, accept the risk (and responsibility) of the procedure.

Yours faithfully
Michael Gorton
College Solicitor
Partner, Russell Kennedy Solicitors

Referral to public waiting lists

Dear Editor,

May I make reference to the article: "Referral to public waiting lists" (Surgical News, Vol 11, No 2, March 2010, page 28) by Michael Gorton.

The writer emphasises the importance of notifying the patient all that referral to a public hospital entails. He also outlines the responsibilities of the surgeon who tranfers such a patient to a public hospital waiting list. Here I don't think he goes far enough.

In the days when peptic ulcer disease was mostly surgical, an elderly gentleman attended follow-up (I had hoped to publish 150 patients treated by Highly Selective Vagotomy (HSV) before the bubble burst!). He had a nasty raised ulcerated lesion on the skin of his right cheek. Another surgeon had simply put him on the public waiting list. That was weeks before; I expedited his admission and wasn't surprised at the histology: squamous carcinoma with perineural infiltration. He died within months of cerebral spread.

Surely it is up to the referring surgeon not only to inform the hospital of any suspicion of urgency, but also personally follow the admission up.

Yours sincerely,
Kevin Orr
General surgeon

Editor's response

Dear Sir,

I have had opportunity to review the excellent contribution by Dr Orr in relation to the article on "Referral to public waiting lists".

The purpose of the original article was to highlight the obligations of surgeons to ensure that patients are properly informed about all of the risks of them being placed on, and then waiting on public waiting lists.

Dr Orr rightly points out that some patients need urgent treatment, and a simple referral to a public waiting list may not be an adequate remedy for the patient's critical needs.

As a matter of professional service, some surgeons may wish to personally follow up on admission, where a referral has been made. That will be difficult and impractical, given the large numbers of referrals to public waiting lists for some surgeons.

The important point to make is that patients need to know all the ramifications of being placed on a public waiting list, including the likely time to wait, the period of time beyond which they should not wait, and what indicators/deterioration they should be aware of, in order to facilitate immediate access to critical care, particularly in the event of a substantial deterioration in the condition.

Referral to public waiting lists is a vexed issue. Unfortunately arrangements do vary from region to region.

Yours faithfully
Michael Gorton, College Solicitor
Partner, Russell Kennedy Solicitors

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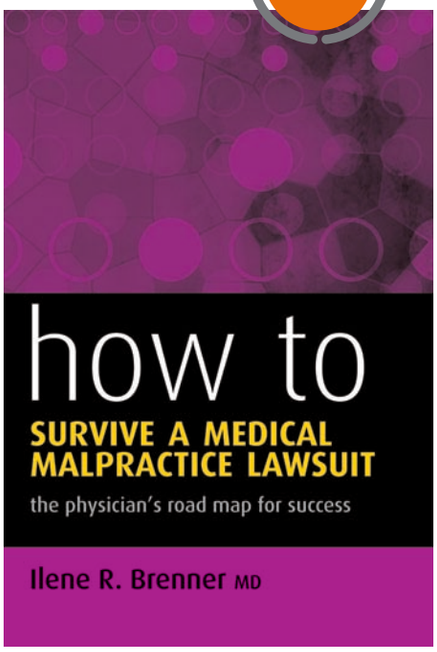

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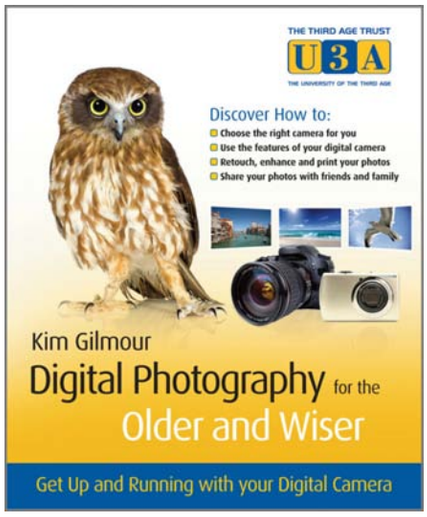

Digital Photography for the Older and Wiser: A Step-by-Step Guide

Kim Gilmour

9780470687024 | Pbk | 308 pages | Jan2010

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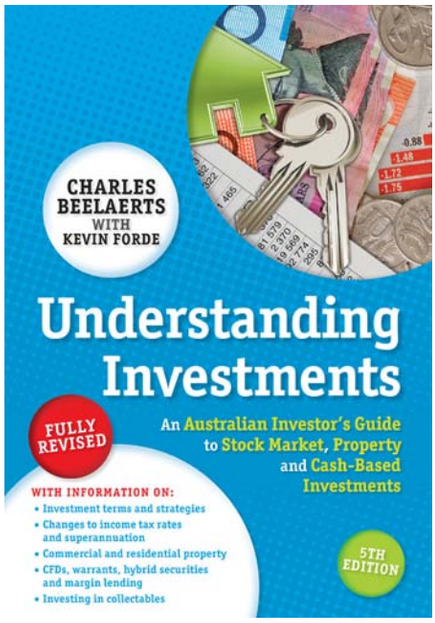

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Charles Beelaerts

9781742469508 | Pbk | 328 pages | July 2003

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