Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **MAY 2013**

The Golden Scalpel games – a test of surgical skill

Value of the Audit

Improving patient outcomes

The College of Surgeons of Australia and New Zealand

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ON THE COVER: Value of the Audit. Improving patient outcomes

President's Perspective

Global burden of surgical disease

As an active clinician, I can conceptualise the needs of the next patient, deliver a surgical service within a hospital and I have a good understanding of surgical service requirements nationally. I have introduced trauma courses to SE Asia and the Pacific and have, I think, a good understanding of differing needs in different countries. However, when it comes to the issue of the global burden of surgical disease, it is an entirely different level of interaction. College Fellows as practising surgeons should at least try to understand the issue and to do so will need to think 'outside' their usual focus of providing high quality care to the next patient.

A few figures that were highlighted at our recent symposium: of 7 billion people on the planet, 2 billion do not have access to surgical care. There are 1.2 million deaths a year from road traffic accidents – the population of Adelaide; 50 million are injured – twice the population of Australia and New Zealand. There are 2,000 childhood deaths a DAY from road accidents. There are enormous numbers of congenital anomalies with 200,000 children having club feet that would warrant surgical correction.

While Australia and New Zealand focus discussions on the rights of home births and the professional profile of midwives and obstetricians, around the world there are 1,600 obstetric deaths per day. In South Sudan, the world's newest nation, every third woman delivering a child dies. For every woman who dies in childbirth, there are 20 times that number who have complications. As an example, there are about 2 million cases of obstetric fistulae each year.

So the numbers are enormous. And where does surgical care actually occur? It is no surprise that the wealthiest 30 per cent of the world's population receives 74 per cent of the surgical procedures. The poorest one third receives only 3.5 per cent of the surgical procedures. Some countries have multiple millions within their population who would benefit from surgical care. The Global Burden of Disease is measured in terms of disability adjusted life years (DALYs) and this shows that approximately 15 per cent of the total health requirement in the Western Pacific and 12 per cent in South East Asia relates to surgical conditions.

What has now been demonstrated is that in public health terms, the best value for money spent within the surgical arena is from the following four areas:

1. Timely, good quality surgical management of trauma
2. Abdominal and other surgical emergencies
3. Comprehensive emergency obstetric and neonatal care
4. Elective conditions that have a distinct impact on the quality of life, such as cataracts, talipes, hernias.

The challenge for this College and for surgery around the world, is to ensure the profile for the surgical burden of disease is properly understood. We may understand it, and our surgical colleagues internationally also do, but to achieve action over time with the capacity for sustainable impact, means that we must convince groups like the World Health Organization that this is of vital importance. WHO has 193 member states and with their substantial 'reach' can ensure that change does occur through government and their appropriate departments of health. However, impacting their approach is a different level of interaction, a different level of sophisticated advocacy that our College is now putting its mind to.

What is our record to date, and where do we go to from here?

I remain incredibly proud of the contribution that our College has made to emerging countries like the Pacific Island Nations, Papua New Guinea, Timor Leste, and Myanmar. Between 1995 and 2012, the Pacific Island Program delivered more than 60,000 consultations, and 16,000 operations were performed. More importantly we have built capacity in the local health systems as we have undertaken these activities. In short, we have tried to leave a lasting footprint.

All enormously good work. It gives us credibility and a platform of solid contribution to take our advocacy to the higher levels of bringing the surgical burden of disease more fully to the attention of groups like the World Health Organization. This in itself is challenging; trying to interest national governments in what they may perceive as a self serving agenda is tough. This is not a short term initiative. It is a most important piece of work which our College needs to progress over the years ahead.

We have already made some headway. We have hosted two recent meetings on the Global Burden of Surgical Disease. These meetings have had representatives from across the globe and across medical specialities. Working together we have prepared a draft poster on the care of contaminated wounds at the request of surgeons in Indonesia.

At a recent meeting held in the College chaired by David Watters and Russell Gruen, we decided to progress a simple statement: "Access to Safe Surgery and Anaesthesia when needed" (an article detailing this event can be found on page 12). The Australian and New Zealand College of Anaesthetists has indicated it is keen to work with us to progress this aim.

We have consensus that WHO's metrics to assess peri-operative mortality should be collected to provide data on need and we should use that data to advocate strongly with Australia's representative on WHO to progress this issue. There is a lot more I could say about progressing advocacy in this area, as it is more sophisticated and complex than some of the work we have done thus far.

Mike Hollands
President

RESULTS OF 2013 ELECTIONS TO COUNCIL

The results of the 2013 elections to Council were tabled at the Annual General Meeting in Auckland on 9 May 2012.

Congratulations to all successful candidates and sincere thanks to all candidates who nominated.

The pro bono contribution of Fellows has been, and continues to be the College's most valuable asset and resource. We are grateful for their commitment.

FELLOWSHIP ELECTED COUNCILLORS

There were ten Fellowship Elected Councillor positions to be filled.

Re-elected to Council are

John Charles Batten, Orthopaedic, TAS
Ian Craig Bennett, General, QLD
Graeme John Campbell, General, VIC
Catherine Mary Ferguson, Otolaryngology, Head & Neck, NZ
Barry Stephen O'Loughlin, General, QLD
Julian Anderson Smith, Cardiothoracic, VIC
Marianne Vonau, Neurosurgery, QLD
David Allan Watters, General, VIC
Simon Alan Williams, Orthopaedic, VIC

Newly elected to Council is formerly co-opted Councillor

Sean Guy Hamilton, Plastic and Reconstructive, WA

SPECIALTY ELECTED COUNCILLORS

Re-elected to Council is

Michael John Grigg, Vascular Surgery, Victoria

Newly elected to Council is

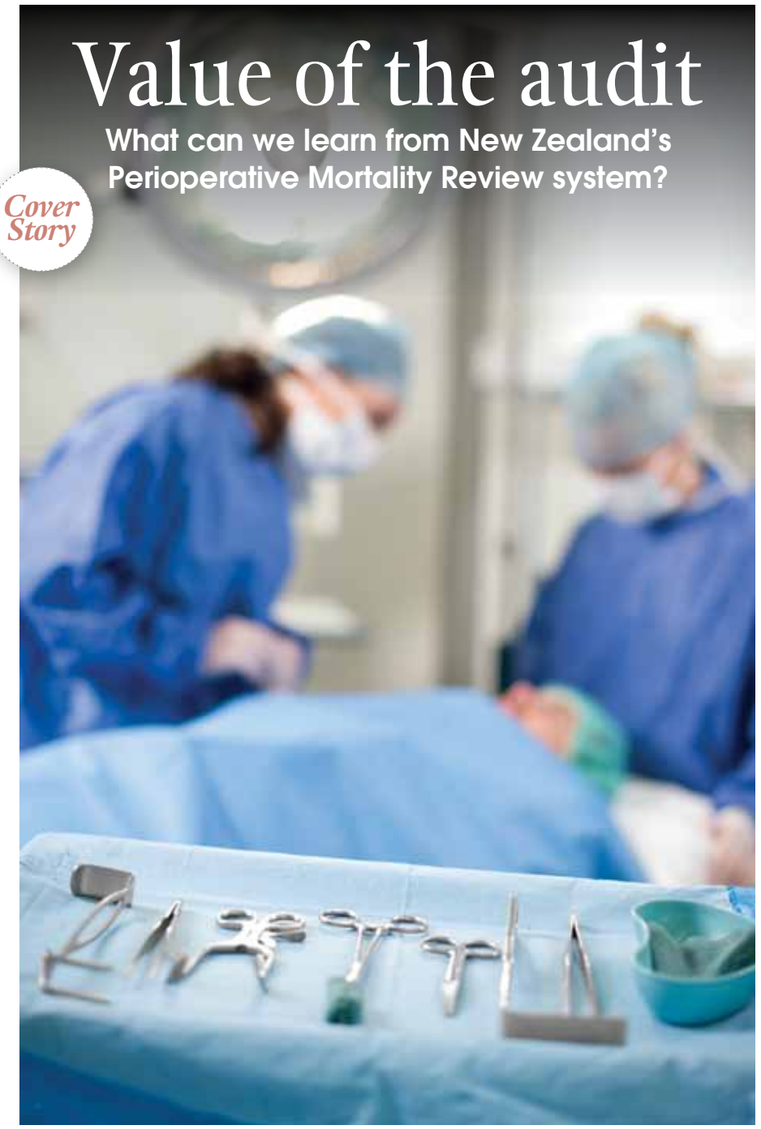
Roger Stewart Paterson, Orthopaedic Surgery, South Australia

Thank you to the scrutineers David Scott and Andrew Roberts.

Value of the audit

What can we learn from New Zealand's Perioperative Mortality Review system?

Cover Story



Surgeons have been at the forefront of championing the value of clinical audit. It is a line that I have been using, and re-using, for many years to audiences that have included health ministers, hospital administrators, journalists and others.

As a surgical profession I think we should be justifiably proud of what we do, proud that we are prepared to analyse what we do and proud that we are willing to learn from what we do in order to improve. Virtually every surgical specialty has identified audit as a key professional activity and a "raison d'etre".

I was therefore interested that the New Zealand Perioperative Mortality Review Committee (POMRC) released its second report in late March covering the period 2006-2010. The report uses information gathered from existing sources, principally the National Minimum Dataset (NMDS) and National Mortality Collection (NMC), administered by the Ministry of Health.

The POMRC's stated aim is to test the robustness of this "whole of system" view, using existing data, before planning new data collection systems as a foundation for peer review of selected cases. It is felt that "whole of system" analysis is feasible with New Zealand's population of 4.4 million.

One limitation is that not all private hospitals submit data to the NMDS; all public hospitals do and public funded procedures in private hospitals are also captured. The audit covers all deaths within 30 days of procedures (including cardiology and gastroenterology interventions) and anaesthesia (general and regional), not just deaths under the care of surgeons.

As is evident from this description, POMRC reports differ significantly from the Australia and New Zealand Audit of Surgical Mortality (ANZASM) that is supported by the College. Indeed, no New Zealand Fellow can tick the "participation in ANZASM" box on their CPD returns – ANZASM remains a goal for the future. Just as the ANZASM gained strength with the addition of each State and Territory, adding comparable data from New Zealand would add further strength when this becomes possible.

Every year, 4,000 to 5,000 patients die after procedures in New Zealand. In many cases, the procedure was only one part of a complex episode of care, often involving elderly patients. However, with any audit the challenge is to resist rationalisation and attempt to uncover valuable lessons. There are always going to be instances when care could have been better.

A brief look at the cholestectomy data shows an overall mortality rate of 0.4 per cent; 1.0 per cent in acute cases, 0.16 per cent following elective procedures. These rates are similar to those found in published North American series. Death was infrequent in ASA1-2 cases, regardless of acuity. POMRC

> ***"As a surgical profession I think we should be justifiably proud … that we are prepared to analyse what we do"***

suggests closer review of the role of acute cholecystectomy may be warranted, given the higher mortality rate.

Overall, pulmonary embolus death rates are low (0.019 per cent of all procedures, 0.05 per cent of acute admissions, and 0.008 per cent for elective admissions). As expected, mortality rises with increasing ASA status, increasing age, acute procedures (especially femoral and hip fractures) and lower limb surgery in general. Focusing on thromboprophylaxis may reduce deaths due to this postoperative complication.

Patients with an ASA score of 1 or 2 have a low rate of mortality after elective procedures (30 day mortality 0.07 per cent), but this rate rises with increasing age after the age of 50 years – 0.6 per cent mortality in the 80 – 84 year old age group and 1.4 per cent if greater than 90 years of age. Even fit, elderly patients undergoing minor procedures may face significant mortality risk.

Emergency procedures also carry a significantly greater risk, possibly magnified by age. Acute procedures in octogenarians are associated with a mortality rate of 9 per cent; elective procedures have a mortality rate of 1.2 per cent.

It is clear that while the New Zealand POMRC is not yet linked to the ANZASM, it can still provide valuable insights into deaths linked to procedures in an Australasian system. The full report (and last year's report) is available on the NZ Health Quality and Safety Commission website at http://www.hqsc.govt.nz/our-programmes/mrc/pomrc/publications-and-resources/publication/813/

Michael Grigg
Vice President

Surgery risky for ailing elderly

New Zealand's Perioperative Mortality Review Committee's second report has found that one in five unwell elderly die undergoing surgery, though Kiwis who are fit and healthy are least likely to have complications.

However, Chair of the New Zealand National Board of the College Scott Stevenson has said that the findings are an important reminder of the risks of surgery.

He also said the report is reassurance that the health system undergoes processes for continual improvements.

"The data suggests that care in our health system is as good as any first-world health system," Mr Stevenson said.

***Stuff.co.nz*, March 29.**

Life changing surgery

A young woman has had life-changing surgery to insert electrodes in her brain to control the impulses that are a result of Tourette's syndrome. Fellow Terry Coyne was part of the team with neurologist Peter Silburn to undertake the procedure that will stimulate areas of the brain. The patient, Chloe Mann said: "I'm hoping this will give me some sort of normality in life so I can go out more places and not feel anxious or judged."

***Courier Mail*, April 6.**

SA Medical School concern

Senior University of Adelaide figures have expressed concern at the lack of direction from State Government regarding the Royal Adelaide Hospital Medical School. While the government have decided to build a new hospital, there has been no indication of the shifting of the state's lead medical school. The College released a statement saying it was "dismayed over the ongoing uncertainty around the future of the state's hospital services", along with holding "grave reservations" the new hospital would deliver all the current services needed.

***Adelaide Advertiser*, March 20.**

Time heals

Eighteen years after surgery as a four-year-old, Perth woman Jasmine Teakle is thankful to then up and coming surgeon Fiona Wood (pictured) for believing she could reduce the birthmark which covered the right side of her face. Dr Wood advised that Jasmine have injections and skin grafts made from skin taken from her hip and grown in a lab. The scars are now barely visible. "Without the surgery and skin graft (the birthmark) would have affected me so much more," Ms Teakle said.

***Weekend West*, March 30.**

Alcohol-fuelled violence

An important issue for our advocacy agenda

College Councillor and NT General Surgeon Associate Professor Phillip Carson described walking into the Intensive Care Unit (ICU) at the Royal Darwin Hospital on a Monday morning as akin to walking into a war zone.

There are the young men comatose in ICU with head injuries, there are the women suffering severe facial wounds and there are the road trauma and accident victims; broken bones, broken hearts and ruined lives, patients and families filling the wards and corridors solely because of excessive alcohol consumption.

Now he has taken a proposal to the Council, building on the work of the College's Trauma Committee, to lobby for a change in public attitudes towards drinking through a campaign similar to the ground-breaking work conducted by the College to reduce road deaths and injury in the 1970s.

"I think in Australia and New Zealand we have a blind spot when it comes to drinking alcohol because it is such a central part of our society and socialising, but the situation has now become completely out of control," Professor Carson said.

"I feel angry some Monday mornings walking into the hospital and, like most of my colleagues, think this is a crazy situation and that's how we feel in a controlled environment.

"Yet the police, ambulance personnel and accident and emergency staff have it even worse when trying to deal with people who are screaming and fighting and bleeding and vomiting, most of whom will have very little memory of their behaviour when sober.

"As a society it seems we have become desensitised to the harm caused by alcohol abuse even while that harm continues to escalate leading to bashings, stabbings, domestic violence and traumatised children.

"Various reputable reports have now conservatively estimated the direct costs to Australia of alcohol misuse at $14.3 billion with total costs, including indirect costs, at $36 billion each year.

"That is a horrifying number when you consider that a massive national project like the NBN roll-out is expected to cost $37 billion or that the National Disability Insurance Scheme will begin at $16 billion per annum.

"In New Zealand the problem is similar. Half of serious crimes and a third of police apprehensions involve the misuse of alcohol with estimated costs including health care and child interventions at $16 billion."

Now Professor Carson has put a proposal forward.

In particular, he is asking the College to support:

- The application in Australia and New Zealand of a stepped volumetric tax on alcohol;
- State and Territory efforts aimed at reducing the availability of alcohol through the reduction of outlet density and trading hours; and
- The reduction of the overall volume of alcohol advertising and promotions through independent regulation, limitations on times and placement of promotions or the requirement for health advertising counter measures.

Professor Carson said that studies now showed that each week, on average, 60 Australians die and a further 1,500 were hospitalised as a direct result of excessive alcohol consumption, consumption levels that could be reduced through taxation.

"Taxation of alcohol should be based on the principle that alcohol is no ordinary commodity, but a product that is responsible for major harms in our community," he said.

"International scientific evidence consistently shows that alcohol consumption and harm are influenced by price which means that taxing alcohol on the basis of alcohol content is one of the most effective policy interventions to reduce the level of alcohol-related harm including mortality rates, crime and traffic accidents.

"However, there has not yet been the political will to introduce this change even though it was a recommendation of the Henry Tax Review."

Professor Carson is also calling for the College to ratify partnerships with the National Alliance for Action on Alcohol and other reputable independent groups and to lobby national and state governments as part of regular meetings with government representatives in support of the initiatives.

Evidence-based advocacy

The proposal to go before the College Council will also call for the College to support the collection of data pertaining to concomitant consumption of alcohol in patients presenting with injury as a mandated data field requirement in Trauma Service Verification and Emergency Department interventions.

"As surgeons we are dramatically confronted with the effects of alcohol misuse when we attend patients with injuries resulting from road traffic trauma, interpersonal violence and personal accidents along with the more direct effects such as liver failure, GI bleeding, upper GI and oropharyngeal cancer and infections related to malnutrition," Professor Carson said.

"The proportion of our patients so affected will vary with specialty and location, but overall contribute a significant proportion of the surgical workload putting us in a position which I believe requires us, as a profession, to fight for change.

"There is a substantial body of work emanating from public health researchers which provides evidence for cost effective interventions to minimise harmful drinking and the RACS can enhance the advocacy strength of this broad coalition by supporting and confirming evidence-based policies and by providing dramatic and arresting examples of the health effects of alcohol misuse as part of the public discourse."

Professor Carson said it was important for surgeons to understand that any push to limit the sale and availability of alcohol would likely be met with a fierce, professional and well-funded campaign by the increasingly well organised liquor industry.

He also said it was crucial for any surgeon entering the debate to know who was funding research and interest groups.

"The liquor industry is very rich and very powerful and increasingly organised around the world and is actively seeking to increase consumption very much like Big Tobacco," he said.

"It has its tentacles in many groups and a lot of research has been contaminated by industry backing which can only ever represent a conflict of interest so surgeons need to look very closely at where any research has come from before offering any support or endorsement."

Important position on the frontline

Professor Carson said surgeons were also in a position of offering personal interventions at the time of hospital treatment, particularly to young patients injured through binge drinking.

"Studies have shown that people are at their most open to changing their behaviours such as smoking when they first come to hospital to be treated for the consequences and there is no reason to believe the same wouldn't be true of binge drinking," he said.

"Surgeons have a certain authority and if we take the time to stress the dangers of alcohol misuse to our patients before discharge, we might save a life."

Professor Carson stressed that he and the Trauma Committee were not pursuing abstinence, but a policy of moderation and harm minimisation.

"All of these changes will require government action which may cause political pain so we need strong and conviction-led leadership to bring community opinion with us," he said.

"I believe the College is in a perfect position to help lead this social change both within general society and the political community because surgeons are now seeing the trauma and misery caused by alcohol misuse almost every day – particularly on Mondays."

With Karen Murphy

“Access to safe surgery and anaesthesia when needed”

Advancing the Agenda on the Global Burden of Surgical Disease – we need to measure the Perioperative Mortality Rate (POMR)

A meeting was held in the RACS Council room in March to reach consensus on whether and how to measure perioperative mortality. The participants included Councillors of the Royal Australasian College of Surgeons (RACS), Australian and New Zealand College of Anaesthetists (ANZCA), and Australasian Society of Anaesthetists (ASA) together with representation from the World Federation of Anaesthetists (WFSA), Tonga, the Cook Islands and Physicians active in public health.

The meeting recommended that all countries report Perioperative Mortality Rates for death on the day of surgery and death before discharge from hospital if less than 30 days postoperative.

Background

The unmet burden of surgical disease is substantial. Currently two billion of the world’s population does not have access to emergency and essential surgical care. Each year this results in an estimated 70,000 unnecessary maternal deaths (25 per cent of 280,000 per annum), 175,000 excess deaths from road traffic accidents (25 per cent of 750,000 per annum), and 35,000 avoidable anaesthetic deaths (1:500 in 35 million operations).

Trauma and non-communicable diseases (NCDs) comprise the major causes of death globally. Accidents and injuries represent the leading cause of death and disability in economically active adults aged 15-44 years, an age group that carries heavy family responsibilities. There is also a pandemic of non-communicable diseases affecting older patients, with cardiovascular and cerebrovascular disease, diabetes and cancer constituting the leading conditions, and increasing numbers likely to require surgery at some stage as their condition progresses.

Considerable improvements in maternal mortality and other maternal health outcomes have been achieved through better access to skilled birth attendants and attention to the fifth Millenium Development Goal (MDG5). However, as suggested by the estimated 70,000 deaths related to lack of maternal access to safe surgery and anaesthesia, further significant reductions in maternal mortality will only be achieved by also addressing the up to 25 per cent of pregnancies that require a procedure and/or anaesthetic to avoid injury, deformity or death of the mother and/or child.

Safe surgery and anaesthesia are not unaffordable luxuries only for rich countries. They should be seen as a basic human right, and their lack represents a significant cost in terms of life and disability to the communities that cannot access them. An increasing number of studies suggest that surgery and anaesthesia can be delivered in Low and Middle-Income Countries (LMIC) effectively and inexpensively, often at a similar cost ($11-35 per Disability-Adjusted Life Year [DALY] averted) to measles vaccination, vitamin A supplementation or bed nets to prevent malaria. The surgical management of injuries, infection, obstetric and abdominal emergencies and many deformities is, therefore, cost-effective and potentially deliverable for all.

Consensus Reached

The meeting also agreed that the one-liner “Access to safe surgery and anaesthesia when needed” embodied our message to the profession, to the public, to governments and ministries. It was originally recommended by the organising committee of the Global Burden of Surgical Disease Symposium held at the RACS September 27-28 2012, under the auspices of RACS, ASA, The Alliance for Surgery and Anaesthesia Presence (ASAP), the Harvard Humanitarian Institute (HHI) and the International Surgical Society (ISS).

The one liner’s advantages are it avoids being a slogan, is inclusive of surgery and anaesthesia, and covers the concepts of essential and emergency surgery with ‘when needed’, though this idea might sometimes require explanation. It is agnostic of whether surgery and anaesthesia are delivered by specialists or not, but highlights the right of patients to safe delivery of each.

The meeting agreed that perioperative mortality rate (POMR) is an indicator of both safety and access.

Though it might be perceived as primarily an indicator of safety, it is also a measure of access since the number of procedures performed must be known to calculate it. Lack of access resulting in delayed presentations will lead to higher mortality as well as fewer procedures. Thus POMR reflects the system’s responsiveness to primary and secondary care issues – its capacity to deliver.

There was consensus that WHO’s existing metrics on perioperative mortality should be used. These are: Death on the day of a procedure (within 24 hours/same day as procedure), and; Death after commencement of a procedure and before discharge from hospital if less than 30 days.

A procedure was defined as a procedure performed within an operating facility which requires the administration of sedation or anaesthesia whether local, regional or general.

Perioperative mortality rate requires the number of deaths and the number of procedures to be counted. In practical terms most operating rooms count the number of procedures, at least with an operation registry. It will require some form of follow up of patient progress in the wards to identify which patients die before discharge.

Although there are other measures of mortality such as death within 48 hours of a procedure and anaesthetic, death within 30 days, and death under the bedcard of a surgeon, these are more difficult to collect and would be challenging to collect in many LMICs. These metrics should be regarded as optional extras for countries with the capacity and desire to collect, analyse and report them. LMICs will not be able to follow patients up consistently after discharge for 30 days.

Risk stratification is desirable to clinically interpret perioperative mortality. Not every country would be able to collect these and the burden of recording is greater, but they are to be recommended and will be required for clinicians (surgeons, anaesthetists and public health physicians) to be convinced.

The risk stratification data recommended are simple to collect and do not require any laboratory tests to assess: age, urgency (elective or emergency), procedure and ASA status. ASA status was discussed and considered to be simple, accepted for over 50 years and quite applicable to LMICs as well as to G20 nations. Anaesthesia providers everywhere can be taught to use ASA.

A procedure should ideally be counted as the first procedure that a patient receives during an episode of care. A procedure should only count towards a death once, rather than twice or more where a patient dies after an unplanned reoperation. Ideally it should only be the first procedure that is counted.

Next steps

The workshop then turned its attention to the task ahead. This will be a sustained campaign of advocacy, persuading governments, ministries of health, hospitals and clinicians of the value of POMR as a tool to improve patient outcomes and ensure the most appropriate allocation of resources.

One of our immediate aims is to put the global burden of surgical disease and the value of POMR firmly on the agenda of the World Health Assembly.

Those in positions of authority across the world must be repeatedly reminded of the fact that timely access to safe surgery and anaesthesia will save millions of lives and avert much disability.

David Watters
Chair, Professional Development and Standards

Poison'd Chalice

"True is it that we have seen better days"

I bought a new car. This is a very unusual experience for me. I tend to buy a car, usually second hand, and then drive it until it begins to fall apart. I loved my old car – a Mercedes with many hundreds of thousands of miles on the clock, big comfortable seats, but with an unpleasant plume of greenhouse gas emissions emanating from its rear. I decided that I had better get it serviced – it had been about a decade after all.

The mechanic was kind – "I can give you $500 for it but not a cent more!"

"But I want to get it repaired" I said.

"No you don't" he said. "It is going to be at least $10,000 to get it roadworthy", muttering words like carburettor, diff etc. "and then I expect something else will go wrong." Was he heartless or just realistic? I began to realise that my car had the equivalent of inoperable cholangiocarcinoma with intractable jaundice. As the Bard did write: "True is it that we have seen better days" ('As You Like It', Act 2, Scene 4). It would be a kindness to consider its misery.

My new car is somewhat sterile in comparison, but the salesman said it would "learn" as I drove it. It would get to know my driving patterns. Imagine that – a car that can learn from observing you. If only I had Trainees like that!

But maybe the problem was not with their learning, but with my ability to teach. In the past I have been a popular lecturer and tutor – plenty of lists interspersed with witticisms. The current generation (what is the current generation – we have had "Y", are we now up to "Z"?) learn in a different way. It seems they must learn by experience, even if the experience is artificial – role-playing for example. No doubt this is the result of increasing intelligence colliding with educational deprivation through cost minimalisation strategies. Whatever, I am determined to make them think, not just rely on checklists, electronic reminders and so on.

But it is not just me that I need worry about. I have a whole department of surgical teachers that participate in undergraduate and postgraduate educational programs, mostly with no, or at best, minimal remuneration. One of the more difficult challenges for a surgical director is to get people, surgeons in particular, to do things differently, especially when the thing that they are doing is basically a gift. It is like receiving a present on one's birthday and then asking the giver if they could take it back and exchange it for something else!

New tricks

Perceived ingratitude does not lead to a cohesive environment, nor a productive working relationship. I continue to get flashbacks of awkward encounters that could be best described from 'Taming of the Shrew' (Induction, Scene 1), "I'll not budge an inch". Maybe tact should have been part of my position description. For a long time I thought "tact" was in some way dishonest involving a sacrifice or at least a disguising of principle. I have come to realise that tact is much more about appreciating other people's positions and points of view.

As I drive my new, learning-car home from the showroom I reflect on a couple of things. Firstly, will the car become confused or even dysfunctional when my wife insists on driving it? How does a car learn from two (very) different drivers? Secondly, next week's M + M meeting; maybe the Trainees can explain how they can learn from two very different surgeons? Now, there is a thought...

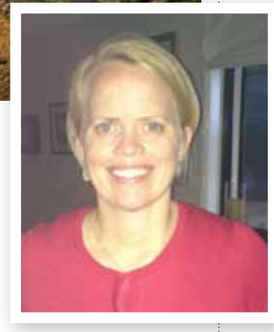
Professor U.R. Kidding

Clinical Director for Rural Coach Project


A new face is on board to move the Rural Coach project forward

Since 2011, the Rural Coach Project (RCP) has identified and supported 40 Trainees interested in a rural surgical career. This may have been by way of ongoing mentoring, advocacy and the opportunity to build their rural connections by offering financial assistance to Trainees who attend the Provincial Surgeons of Australia (PSA) conference.

A/Prof Frank Miller, a General Surgeon from Wangaratta, has been the Clinical Director of the Rural Coach Project since 2011. He has thoroughly enjoyed the role getting to know the Trainees who have sought his guidance. Due to his many extra roles within the College, he has stepped aside as Clinical Director, Rural Coach Project (RCP) to be replaced by Dr Sally Butchers.



Sally is a General Surgeon in Lismore NSW who has a special interest in Younger Fellows, Women in Surgery and Rural Surgery and is keen to make links with the Trainees. She has an interest in teaching, is an EMST instructor and is starting to instruct on the MOSES courses.

Sally started her training at Prince of Wales Hospital in Sydney. She was seconded to Lismore as an Intern and as a Registrar. She also worked in NSW at Coffs Harbour and Bega. Sally gained her Fellowship in 2005 and then spent two years working in the UK.

Sally returned to Lismore as a Consultant in 2008 and has been there for the past five years. The support from all her colleagues in all areas of medicine in the area has been the best part of working in a rural area and one of the reasons she decided to move to Lismore. The delightful surroundings and usually lovely weather were also a definite attraction. Sally has a great life outside of working including hockey, mosaics, the theatre and the arts, and lots of fine dining.

I would urge any Trainees to contact Dr Sally Butchers on sallybutchers@bigpond.com. She is keen to be of assistance to any Trainee considering working in a rural environment and will be attending the PSA conference in Queenstown NZ this year.

In 2012, General Surgeons of Australia (GSA) generously gave a Rural Surgery Grant to nine Trainees who applied to attend the Provincial Surgeons of Australia Conference in Mt Gambier. These Trainees were most grateful for the financial assistance to cover the cost of their conference registration and found the opportunities for networking very worthwhile.

GSA has generously offered to provide a Rural Surgery Grant again in 2013 for any Trainee to attend the Provincial Surgeons of Australia (PSA) conference to be held 25 – 27 July 2013, in Queenstown NZ. Applications for the Rural Surgery Registration Grant are available from the RCP Project Officer.

I would be most interested to hear of any Trainees who wish to be involved with the Rural Coach Project. The project does not offer training courses, but rather offers support for Trainees interested in a rural surgical career.

Any Trainee who is working in a rural area and would be interested in writing a short article on their experiences for publication, please contact Trish Meldrum, RCP Project Officer RACS trish.meldrum@surgeons.org

Tom Bowles
Chair, Rural Surgery Section


Burnt out or burned up?
Look after yourself

The other day C Nical consulted me. I didn't know him that well, in fact hadn't seen him for three years. I asked him how life was going – this set off a long tirade about his Surgical Directorate (not Prof U R Kidding), cuts to operating lists, nursing staff too often insisting the last case on a list was cancelled before 4.30pm just because "we might run over".

The hospital wasn't providing a good service, the waiting lists are blowing out and managers are clipboard carrying unmentionables. So what's new I thought? Hasn't it always been like this?

The diagnosis was clear within a few sentences of his frustrated complaining. C Nical was in burnout. He'd had enough and needed a break. Burnout is common amongst doctors, and at least in the US seems relatively common among surgeons.

In the US they work longer hours, carry more medical school educational debt, and have too few holidays (only 13 days a year) if comparison with the rest of the world is anything to measure by. Although surgeons aren't the worst specialists affected – top of the medical burnout charts at over 60 per cent belongs to emergency medicine, which doesn't surprise me, with urologists, general and neurosurgeons hovering around the 40-42 per cent mark while otolaryngologists and orthopaedic surgeons are 48 per cent.[1] Anaesthetists ranked in the high 40s also.

Medscape recently reported a study of burnout in general surgeons.[2] Burnout was defined as loss of enthusiasm for work (exhaustion), feelings of cynicism (cynicism), and a low sense of personal accomplishment (inefficacy).1 The clinical subtypes of burnout were classified as frenetic (involved, ambitious, overloaded), underchallenged (indifferent, bored, with lack of personal development) and worn-out (neglectful, unacknowledged, with little control).[3]

The specialists were asked on a scale of 1-7 whether it was mild (1) or so bad that they were considering leaving medicine (7). All specialties ended up with Likert scores of between 3 and 4 – i.e. middling – and they already undergo re-certification every five years!

But what did "severe" mean? Feedback identified too many bureaucratic tasks (5.4), too many hours working, financial issues (4.6), feeling like a cog in a wheel (4.2). Difficult colleagues, compassion fatigue, or a difficult employer were the lowest rated (2-3). There was no significant gender difference and it was those aged 46-55 who were most at risk.

When burnout surgeons were compared with those not suffering burnout they were less happy at work, but only slightly less happy outside work, and not much difference with regards to popular favourite pastimes – spending time with the family (84 per cent both groups), exercise (67 and 70 per cent), travel (64 and 68 per cent) and reading (60 per cent both groups).

Golf, hunting and fishing fell in the 20 per cent range without much difference between those burning and those not. Forty-four per cent of burned out surgeons took less than two weeks leave a year compared with 27 per cent of those without symptoms of burn out.

Burned out general surgeons were slightly more likely to be overweight, took less exercise and felt less confident about their health (5.3 V 5.8), but without a difference in rates of smoking or drinking alcohol. Marriage did not affect tendency to burnout, but the results favoured no burnout for those having more than one child.

Let's hope surgeons in Australia, New Zealand and the Pacific have more enthusiasm, less cynicism and a greater sense of achievement than their North American counterparts. Those of you who might want to use a standard instrument to assess your degree of burnout might consider the Maslach Burnout Inventory General Survey or the Burnout Clinical Subtype Questionnaire. But be careful what you look for – you might not like what you find.

C Nical was given the same advice as I gave Down-N-Dumped last year. First take a holiday, get away from work. Next drop some commitments, certainly those that stretch your capacity to cope – perhaps that list in the far off hospital (unless that gets you away from it all). Reduce your private patient load. Make time for regular exercise; don't drink alcohol because you are stressed, certainly not more than 1-2 drinks per evening.

But I also suggested being positive, not to dwell on the negative, on what's wrong with the system. Stop complaining, and give up the whinging. That might be difficult for C Nical, but when you are nice to people, they might even smile at you from behind their masks – and we all wear masks to work, some of which are best left where they are.

Dr BB G-Loved

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1. Peckham C. General Surgeon Lifestyles - Linking to Burnout: Medscape Survey, March 28th 2013. http://www.medscape.com/features/slideshow/lifestyle/2013/general-surgery?nlid=29829_983&src=wnl_edit_medp_surg&spon=14#1

2. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012;172:1377-1385. http://archinte.jamanetwork.com/article.aspx?articleid=1351351 Accessed February 7, 2013.

3. Montero-Marin J et al. Understanding burnout according to individual differences: ongoing explanatory power evaluation of two models for measuring burnout types. BMC Public Health 2012;12:922

A test of skill

STATION 5: TRAUMA

STATION 3: ANATOMY

STATION 2: SUTURING

STATION 3: IMAGING

Fellow Emily Granger thought it time to put some skills to the surgical test

Designed to test the knowledge, skills and nerves of junior doctors across New South Wales, the inaugural Golden Scalpel Games were held in October last year at St Vincent's Clinic in Sydney.

The brain-child of cardiothoracic heart-lung transplant surgeon Dr Emily Granger, the contest involved teams from each of the six surgical networks in NSW completing tasks at five training stations under the watchful eyes of assessors.

Dr Granger, who was the then Director of the Eastern and Greater Southern Surgical Skills Network, won the support of both the Health Education and Training Institute (HETI), which supports and promotes health education across the state, and the hospital to host the games.

On October 20 last year, surgeons, junior doctors, surgical Trainees, nurses and HETI volunteers gave up a Saturday to let the games begin, with teams competing for the Golden Scalpel Perpetual Trophy and a $2000 prize to go toward surgical training equipment.

Each network was represented by a team of five surgical skills Trainees from interns to senior resident medical officers with each team rotating through five 20-minute training stations each presenting a different challenge.

Dr Granger, a conjoint lecturer at the University of NSW, said she envisioned the games as a way of bringing the state's surgical Trainees together to both review the knowledge gained over the previous year and to showcase their skills before peers, the public and senior consultants.

"A great deal of surgical education is carried out at separate sites and I thought it might be fun for them, and interesting for us, to bring them together and see what they could do," Dr Granger said.

"Even quite junior doctors have very good skill levels and are very capable and we wanted to demonstrate that capacity and create a fun environment in which they could test themselves.

"At this stage of their surgical training they have had no formal assessment of their skills and many junior doctors are keen to receive feedback before they make decisions about further specialist or surgical training so we thought the Games offered a way to both provide that feedback while allowing them to measure themselves against each other."

THE FIVE GAMES STATIONS WERE:

STATION 1: Bowel Anastomosis at which each team member attempted a hand-sutured bowel anastomosis, being judged on selection of suturing material and suturing technique;

STATION 2: Suturing Skills in which teams were offered five suturing tasks including subcuticular suturing, excision of a subcutaneous lesion, insertion and securing of a chest drain, end-to-end vascular anastomosis and a laparotomy closure;

STATION 3: Laparoscopic Skills at which team members rotated through a range of tasks including the application of endoclips and endoloops, cutting technique, placing a suture in an artificial bowel and tying an intracorporeal knot;

STATION 4: Anatomy and Imaging where teams worked together to answer anatomical questions relating to the eye, larynx, tongue, heart, muscles of the foot and abdomen;

STATION 5: Trauma Scenario where teams role-played the simulated initial assessment of a man severely injured in an explosion who required immediate resuscitation and simultaneous identification and management of life threatening injuries.

Surgeons and nurses assessed the work conducted at each station, marked tasks, provided immediate feedback and sent scores to an electronic scoreboard which showed cumulative totals throughout the competition.

Dr Granger said the competition had been designed to enhance teamwork, test skills in a less formal environment than required at exams and provide informal tutoring as the teams progressed through the stations.

She said that such was the enthusiasm of participants, network teams arrived in team colours with mentors and supporters cheering on their endeavours.

"There was really strong enthusiasm for the event from all the Health Networks in NSW with some senior surgeons working hard with their junior doctors to get them ready," she said.

"We provided details before the day of what the stations would be, but not the tasks and

some consultant surgeons provided extra tutoring before the event as a wonderful show of support to the junior doctors."

Dr Granger said that after more than four hours of incising, suturing, laparotomy simulation, anatomy identification and trauma teamwork there were fewer than 30 points separating all six teams out of a theoretical maximum score of 250.

She said the anatomy station had been particularly included to test the knowledge of junior doctors in an era of increasing concern regarding anatomy teaching and said all judges were delighted with the results achieved by the network teams.

"The results in anatomy were extremely good and the identification was quite challenging," she said.

"They used models, radiological images, CT Scans and specimens and were very good at identifying nerves and muscles that would pose a challenge to many clinicians.

"The trauma station was another highlight in terms of seeing the junior teams work together, follow EMST principals and in some cases deal with their first emergency cricothyroidotomy.

"I have long been a believer in making surgical education more broadly available to junior doctors and so to see them embrace this opportunity so enthusiastically was wonderful.

"Some of the participants of the Games will decide not to pursue a career in surgery in favour of becoming a physician or an anaesthetist, but they still need to be proficient, in my opinion, in these basic surgical skills.

"All doctors should know how to insert and secure a chest drain, stitch up cuts, clean out dirty wounds and tie knots that will stay tied."

And so, at last, to the winners of the inaugural 2012 Golden Scalpel Games.

Unable to resist, it must be reported that the Northern Surgical Skills Network won by a knife-edge with 202.19 points over the Hunter New England Network team at 201.97.

The winners, based at the Royal North Shore Hospital in Sydney, were presented with a gold-plated scalpel encased in a trophy box along with the $2000 prize money.

Dr Granger thanked the volunteer surgeons, nurses and Games supporters including HETI, St Vincent's Hospital, Investic, the Medical Insurance Group, Leardal and Johnson & Johnson Medical and key event organiser Mr Andrew Kemp, the Education Support Officer for the Eastern and Greater Southern Health network.

The Hunter New England Surgical Skills Network has now volunteered to host the Games later this year.

With Karen Murphy

To make the Games a reality required the assistance of HETI, St Vincent's Hospital (which hosted the Games at St Vincent's Clinic), and sponsors Investec Bank, MIGA, Laerdal, Covidien and Johnson & Johnson. training network contributed staff, judges and equipment to create and manage the stations. Without our judges, officials and HETI volunteers, this day would not have been possible.

The ongoing saga of Dr Jayant Patel

Dr Patel found not guilty

On Wednesday March 13, a Queensland Supreme Court jury found the former Bundaberg surgeon Jayant Patel not guilty of the manslaughter of a former patient. This case marks the second time Dr Patel has stood trial on the charge of manslaughter relating to the death of the patient, with the High Court previously quashing his earlier convictions in 2012.

This decision does not end the Dr Patel saga; with prosecutor Michael Byrne SC saying that he intends to pursue all outstanding charges against Dr Patel including several fraud charges, two charges of causing grievous bodily harm and two other manslaughter charges. Dr Patel's defence lawyers have said they will make an application to have all future charges dropped. This recent update marks a dramatic turn in the Dr Patel saga and potentially closes the curtain on the long running medical malpractice story that has attracted worldwide attention.

The timeline – what happened?

Dr Patel first began working at the Bundaberg Base Hospital in southern Queensland in 2003. Shortly after commencing his employment, Toni Hoffman, a senior nurse at the Bundaberg Hospital, raised concerns about Dr Patel's surgical conduct. However, it was some two years later in 2005 before Queensland Health began investigating after further complaints from Toni Hoffman and a patient, Ian Fleming. Shortly following the commencement of Queensland Health's investigation, Dr Patel resigned from his position and was flown back to the United States.

There were a total of four inquiries, with multiple recommendations to charge Dr Patel with various crimes, including manslaughter and causing grievous bodily harm. Dr Patel was subsequently arrested in 2008 and extradited to Australia from the United States. In 2010, in the Queensland Supreme Court, Dr Patel was found guilty of three counts of manslaughter and one count of unlawfully causing grievously bodily harm. Dr Patel appealed that decision to the High Court of Australia on the grounds that there had been a miscarriage of justice based on the conduct of the trial and that he had been convicted on the wrong basis. The High Court unanimously upheld the appeal, saying that a "miscarriage of justice had occurred"[1] with all convictions being quashed and a new trial was ordered.

A subsequent trial was commenced against Dr Patel on the charge of manslaughter in relation to the death of one of his former patients. After a 23-day trial, a Queensland Supreme Court jury found Dr Patel not guilty of manslaughter, with the jury concluding that Dr Patel's decision to operate on the patient did not constitute criminal negligence for the purposes of a charge of manslaughter. Dr Patel's defence team successfully argued that he had an 'honest and reasonable belief' that the removal of the patient's colon, in an attempt to address rectal bleeding, was a necessary course of action.

The political inquiries

The Queensland Government commissioned four inquiries regarding the Patel circumstances. The "Bundaberg Hospital Commission of Inquiry" ("The Morris Inquiry") was led by Anthony Morris QC, and recommended that charges be brought against Dr Patel and that changes should be made to the Medical Practitioners Registration Act 2001 (Qld). The Morris Inquiry only produced an interim report and ended before any final report was produced, because lawyers for two government bureaucrats successfully argued that the Commission of Inquiry was contaminated with ostensible bias in respect of matters arising under the Inquiry's terms of reference.[2]

Following the Morris inquiry, the "Queensland Public Hospitals Commission of Inquiry" (widely known as the "Davies Inquiry") also recommended that charges be brought against Dr Patel, but also discussed how former health ministers should be apportioned with some of the blame. A further "Foster Inquiry" examined the administrative structure of Queensland Health and what administrative procedures could be put in place to ensure that the events that took place at Bundaberg Hospital would not occur again.

Lessons to be learnt

The Davies Inquiry and to a lesser degree, the Foster Inquiry, uncovered problems within the structure of Queensland Health, specifically, in respect of how it allowed Dr Patel to continue performing operations at Bundaberg Hospital after complaints were made against him. Such a failure on the part of Queensland Health highlights the importance of a thorough, detailed, transparent and adequate complaint system. Furthermore, recruitment agencies and hospitals need to ensure adequate due diligence on all potential employees; given that it became clear that, had such due diligence been done in the case of Dr Patel, it would have found that Dr Patel had previously been banned from performing surgery in New York and Oregon before his arrival in Australia – the information being available on a "Google" search.

On a larger scale, subsequent changes to the health regulatory system, such as the introduction of the Health Practitioner Regulation National Law (National Law), provides for national registration and accreditation of health practitioners, resulting in a more efficient system to check qualifications of applicants, especially in relation to overseas qualified practitioners. The National Law imposes national regulations allowing for greater consistency. Registered medical professionals now have a positive legal obligation to report to the relevant national board any health practitioner whom they believe to be placing patients at risk.[3] Failure to report in some circumstances may be considered to constitute professional misconduct ("mandatory reporting").

Where are we now – The law

Although the High Court overturned Dr Patel's conviction, it did extend the circumstances in which doctors may be charged or convicted for manslaughter arising out of negligent medical treatment. The High Court extended the concept of "surgical treatment", ultimately giving surgeons a wider duty for all of the actions, conduct and advice connected with the treatment itself and, importantly, this now includes post-operative care. In its judgement, the Court said, "Surgical treatment refers to all that is involved, from a recommendation that surgery should be performed, to its performance and the post-operative care which is necessary to be given or supervised by the person who conducted the surgery."[4] This is still good law today even after the recent decision of the Queensland Supreme Court to acquit Dr Patel. In terms of the relevant standard to be applied, it is still accepted in Australian law that, for a successful prosecution, the question to be asked is whether a competent surgeon could have decided to operate and recommend surgery, and second, whether the decision to operate was so great a departure from reasonable skill and professional expectation as to warrant criminal liability.

The Court acknowledges that there must still be a physical act of surgery, and a recommendation not to proceed with surgery would not necessarily give rise to criminal liability. However, a recommendation to proceed with surgery, which advice or opinion is formed in circumstances where the advice is grossly negligent, can certainly give rise to criminal culpability.

Such factors as the likely success of the surgery, likely impact on the life of the patient, co-morbidities affecting the outcome of the surgery and the potential for serious complications post surgery might all be relevant to the decision as to whether surgery is recommended or not.

The Court has also suggested, with that final decision, that criminal accountability could apply where a surgeon recommends and undertakes surgery "which he knew, or should have known, to be beyond his powers". That is, not simply that the surgeon may be inexperienced, but that the surgeon recklessly carries out a procedure which, on an objective basis, is clearly beyond the scope of the surgeon's experience and expertise.

Is it over?

The Patel saga raised concerns about recruitment processes and the competency of overseas medical ▶

> *This decision does not end the Dr Patel saga; with prosecutor Michael Byrne SC saying that he intends to pursue all outstanding charges*

practitioners. Furthermore whistle blowers were being ignored and internal governance procedures in hospitals failed to prevent foreseeable risks to patients. Since the first investigation in 2005, much has been done both on a legislative level and management level within healthcare facilities in an attempt to ensure that such a situation will never happen again. New national laws and registration procedures will make health practitioner registration more rigorous and ultimately make health departments more accountable for their actions.

Since being found not guilty, it has been reported that Queensland prosecutors will continue with 12 other charges against Dr Patel, including two other counts of manslaughter. Although Dr Patel's defence team have been reported as saying they will make a formal submission to the Director of Public Prosecutions to drop any new charges, there does not appear to be an immediate end in sight. There were, and are many lessons to be learnt from the Patel saga. Politicians and health department officials lost their jobs, reputations were tarnished and lives were lost. Moving forward, one can only hope that the changes made go a long way to preventing such circumstances occurring again, and help maintain the high standards of medical practice in Australia.

With Richard Laufer

Michael Gorton,
College Solicitor

References

1. Patel v The Queen [2012] HCA 29 at [130], [260].
2. v Morris & Ors; Leck v Morris & Ors [2005] QSC 243, [158-164].
3. See for example *National Practitioner Regulation Nation Law Act 2009* (Qld).
4. Above n1 at 26.

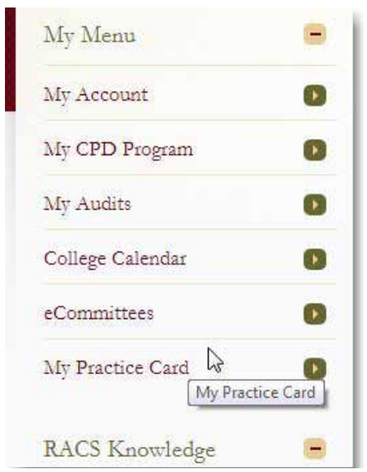
Web facility promotes your practice

Another tool for Fellows

I would like to introduce a new facility within the website to promote your practice. It's called 'Practice Card'; it's free, it's controlled by Fellows and we hope you use it. Practice Card will be of particular benefit to Fellows establishing their practice and those who don't have an existing web presence promoting their practice.

As the name suggests, Practice Card is like a business card. Practice Card provides basic information from the College website that might be of interest to prospective patients or referring clinicians and encourages contact with your practice. When a patient or clinician searches for a surgeon within Find a Surgeon, if there is a practice card associated with your listing, they can go to the Practice Card and learn more about you, your practice, your practice location and contact details.

To establish your Practice Card, log in to the College website, go to My Practice Card on the left hand menu of your 'My Page' and follow the instructions.



You can choose from different web page themes, describe your practice and detail your professional associations, load your picture and practice logo. The Practice Card facility will automatically load your name, specialty, area of practice and practice address details (which can't be different from the Find a Surgeon listing and membership database records), but you can add extra practice addresses and associate a map with your preferred practice address.

On this point it is important that the primary contact information held within the membership database is correct. Practice Card isn't a substitute or alternative to the membership records. You can change your membership record by logging in to the website, going to My Account (left hand menu of the My Page), selecting 'access your account details', and then the option 'Personal'. You can then update your personal information and opt in to Find a Surgeon. Alternatively the annual College transcript facility allows you to update your membership record.

The contact options can be controlled for times when your practice may be unattended and the entire Practice Card can be deactivated and reactivated as it suits you.

We hope you will take advantage of this facility and we welcome your feedback.

We will be promoting the Practice Card facility at the Annual Scientific Congress, and specialty society annual scientific meetings. Make sure to visit the College stand if you want a demonstration of this terrific new facility – you could win an iPAD as well.

To learn how to opt in to Find a Surgeon, see the video at http://www.surgeons.org/member-services/college-resources/website/find-a-surgeon/

To learn more about Practice Card go to http://www.surgeons.org/my-page/my-practice-card

Cathy Ferguson
Chair, Fellowship Services Committee

Dr John Kearney (right) observing Dr Padwick Gallen undertake a procedure

Continuing a vision

Dr John Kearney continues his support for the development of ophthalmology services in the Pacific

With diabetic eye disease looming as a social catastrophe in many Pacific Island nations, the discovery by an Australian eye team of a disused purpose-built optometry/ophthalmology consulting room at the Pohnpei State Hospital in Micronesia was a surprise highlight of the trip taken in January 2012.

With both a functioning slip lamp and refractor head, the room has become the focus of a campaign by team member and Queensland ophthalmologist Dr John Kearney to source the equipment to enable the suite to again become fully-operational.

Dr Kearney, an Associate Professor of Ophthalmology at Bond University and senior eye surgeon at the Gold Coast Eye Clinic, has been providing surgical eye care to the people of the Pacific, including Papua New Guinea and East Timor, for almost 20 years.

To support the delivery of eye services to people in the region, Dr Kearney is determined to restore the existing optometry/ophthalmology consulting suite at Pohnpei State Hospital and have the equipment to treat those in need.

"There had been a Micronesian ophthalmologist, but he died a few years ago and was not replaced which in turn meant that the consulting suite [in Pohnpei] was no longer in use," Dr Kearney said.

"We are working to re-equip the clinic and I have been begging companies for equipment and so far we have had offers of help from Alcon, Designs for Vision, Optimed and my mother."

Dr Kearney and a four-member team visited the two Micronesian states of Pohnpei and Kosrae for two weeks in January 2013, organised by the College as part of its AusAID-funded Pacific Islands Program.

With optometrist Mr Michael Hare, Dr Kearney and his team conducted 21 surgeries in Kosrae and 25 in Pohnpei.

During the visit, the team were able to service medical equipment that Pohnpei State Hospital already owned, but that had fallen into disrepair. Dr Kearney was pleased with the quality of the equipment that the hospital now has on hand.

So committed is Dr Kearney to the people of the region, that during an earlier visit to the Micronesian state of Yap three years ago, he not only identified and recruited a surgical resident to undertake a Diploma of Ophthalmology at the Pacific Eye Institute at Suva, but paid for it.

After completing his Post-Graduate Diploma in Ophthalmology in 2012, Dr Kearney and his team were pleased to formally present Dr Padwick Gallen with the Mrs Alison Kearney scholarship on their most recent visit to Micronesia. The scholarship, a foundation established by Dr Kearney's mother and after whom the scholarship is named, will enable Dr Gallen to undertake his Masters of Medicine in Ophthalmology at the Pacific Eye Institute in 2013.

Governor John Ehsa, Governor of Pohnpei, who attended the scholarship presentation ceremony at Pohnpei State Hospital, thanked Dr Kearney and his team for helping equip the hospital of Pohnpei to serve the needs of its people.

Dr Kearney said that his team has also identified nurses at the hospital who may benefit from further studies at the Pacific Eye Institute so that when Dr Gallen returns as a qualified eye specialist, there will be personnel available to help him provide services that Pohnpei has not previously been able to offer.

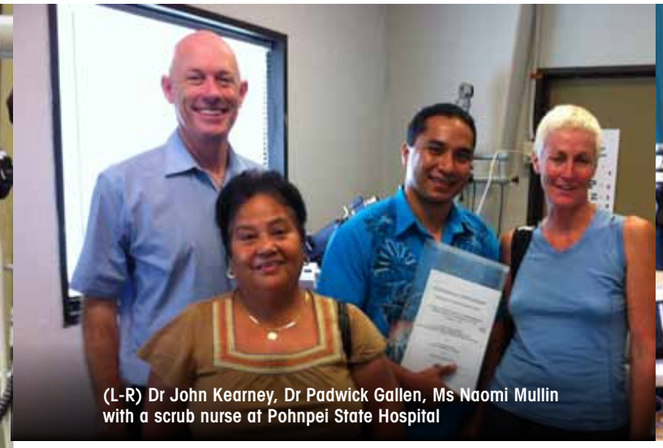
While the incidence of diabetic retinopathy was significant and consistent with the very high incidence of diabetes in the general population, most severe vision loss was directly related to cataract and to a lesser extent pteryiums.

Dr Kearney said he believed that Micronesia required regular team visits each year until they have their own in-country full-time ophthalmologist with yearly supervisory visits then made to supplement training, provide mentorship and to maintain standards.

He particularly wished to thank the staff of the College's International Development department for their skills, assistance and expert management of such teams.

"[College] staff undertaking the necessary and effective administration of these programs allows me and my team to get into these countries of need and get straight to work and that is of inestimable value," he said.

Dr Kearney also praised members of the local eye teams for their skills and enthusiasm.

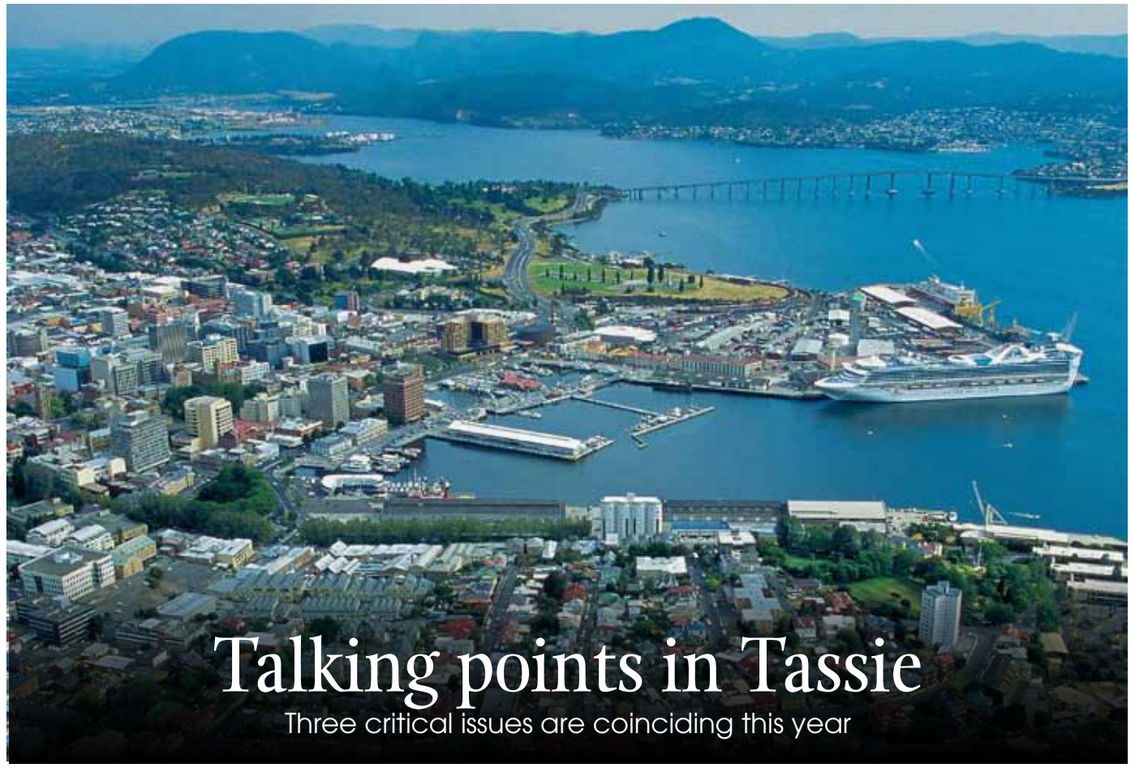


(L-R) Dr John Kearney, Dr Padwick Gallen, Ms Naomi Mullin with a scrub nurse at Pohnpei State Hospital

Dr Padwick Gallen & Dr John Kearney treating a patient

Dr Padwick Gallen pictured

Photos courtesy of Naomi Mullin



Talking points in Tassie

Three critical issues are coinciding this year

Three areas of significant concern have arisen that will have significant impact on surgical services in Tasmania. These are the Commission on Delivery of Health Services in Tasmania; the Commonwealth Funding for Elective Surgery; and the Commonwealth Funding for Education and Training Positions.

Firstly it is of concern to me as Chair that there has been no consultation with the Tasmanian Regional Committee of the College regarding our opinion on the delivery of Elective Surgical Services in Tasmania.

The Commission on Delivery of Health Service in Tasmania released their preliminary report on February 25, 2013, identifying elective surgery as a key area of Tasmania's health system that they believe would benefit from clinical and system redesign. The commission noted in their report that further analysis of the system is necessary to determine the redesign options that would most appropriately fit the Tasmanian system to the maximum benefit of patients. A project team is proposed by the commission to undertake the detailed assessment.

Secondly the National Partnership Agreement on Improving Public Hospital Services (NPA-IPHS) Schedule A: National Elective Surgery Target (NEST) is about to enter its second year. The proposals from the three major hospitals have been submitted to the DHHS who have been negotiating with the Commonwealth. Final sign off for an additional $8.3 million for the 2013/14 financial year is almost achieved. This will mean additional funding to address 623 extreme long wait patients.

The positive thing for this negotiation is that for the first time as Chair of the Tasmanian Statewide Surgical Services Committee (TSSSC), I have been actively involved in the Commonwealth negotiations. This is the first time that a practicing surgeon has been included in such negotiations as previously it was undertaken by bureaucrats from the DHHS. The important thing is for surgeons to be included in the negotiations as in the past the clinician's perspective has not been considered.

Thirdly, the initiative for training more specialist doctors in Tasmania, which is designed to support the training and retention of specialist doctors in the Tasmanian public health system. The funding available is $39.613 million over three years.

The emphasis is on consultant time for training registrars in addition to employing Fellows to give them additional experience from when they gain their qualification enabling them to undertake a broader practice in rural areas.

The other focus of the program is for additional registrars in sub specialty areas where we have trouble recruiting specialists in the state. The intention is to finalise a proposal and associated contracts between THOs/DHHS, specialist Colleges and the Commonwealth by July, 2013, in order to allow for new positions starting in 2014 to be established and accredited, if not already in place.

Brian Kirkby
Chair, Tasmanian Regional Committee

2013 Workshops & Activities

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

AMA Impairment Guidelines 5th Edition: Difficult Cases

29 May, Brisbane; 27 November, Melbourne

The American Medical Association (AMA) Impairment Guidelines inform medico-legal practitioners as to the level of impairment suffered by patients and assist with their decision as to the suitability of a patient's return to work. This activity is proudly supported by Avant (29 May and 27 November) and mlcoa (27 November).

Keeping Trainees on Track (KToT)

18 June, Adelaide; 31 July, Brisbane

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Supervisors and Trainers for SET (SAT SET)

18 June, Brisbane; 13 August, Sydney

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. This workshop is also available as an eLearning activity by logging into the RACS website.

Writing Medicolegal Reports

15 July, Sydney; 28 October, Melbourne

This 3 hour evening workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This activity is proudly supported by Avant and mlcoa.

Finance for Surgeons

19 July, Melbourne

This whole day course establishes a basic understanding of how to assess a company's performance using a range of analytical methods and financial and non-financial indicators. It reviews the three key parts of a financial statement; balance sheet, income (profit and loss) and cash flow. Participants learn how these statements are used to monitor financial performance.

Process Communication Model

2 - 4 August, Melbourne

PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach.

Preparation for Practice

24 - 25 August, Melbourne

This two day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice. This activity is proudly supported by The Bongiorno National Network and mlcoa.

Polishing Presentation Skills

12 September, Adelaide

The full-day curriculum demonstrates a step-by-step approach to planning a presentation and tips for delivering your message effectively in a range of settings, from information and teaching sessions in hospitals, to conferences and meetings.

NSW

15 July Sydney
Writing Medicolegal Reports,

13 August, Sydney
Supervisors and Trainers for SET (SAT SET)

QLD

18 June, Brisbane
Supervisors and Trainers for SET (SAT SET)

31 July, Brisbane
Keeping Trainees on Track (KToT)

SA

18 June, Adelaide
Keeping Trainees on Track (KToT)

29 - 31 August, Adelaide
Surgical Teachers Course

12 September, Adelaide
Polishing Presentation Skills

TAS

20 September, Hobart
Non-Technical Skills for Surgeons (NOTSS)

VIC

19 July, Melbourne
Finance for Surgeons

2 - 4 August, Melbourne
Process Communication Model

24 - 25 August,Melbourne
Preparation for Practice

18 September, Melbourne
Keeping Trainees on Track (KToT)

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

Research with heart

Trainee Dr Ajay Iyengar hopes to improve long-term outcomes from childhood surgery

profile

HIGHLIGHTS

2013: RACS Foundation for Surgery Eric Bishop Scholarship

2013: NHMRC Grant *"Detection of Liver and Renal Function Abnormalities in the Australian & New Zealand Population of Fontan Patients"*

2012: RACS Foundation for Surgery Catherine Marie Enright Kelly Scholarship

2011: RACS First Part Surgical Examinations (Basic Surgical Sciences/ Cardiothoracic Specialty-Specific/ Clinical Examination)

RACS Clinical Examination Committee Prize

2007: Co-Investigator and National Heart Foundation Summer Scholar: "The Australia and New Zealand Heart Research Group Fontan Database: An international, multicentric experience"

Grants provided by the College, the NHMRC and the National Heart Foundation have allowed Melbourne cardiothoracic Trainee Dr Ajay Iyengar to analyse the outcomes, failure rates and risk factors facing children in Australia and New Zealand who have undergone the Fontan Procedure to treat complex congenital heart malformations.

Only offered in New Zealand since 1975 and Australia since 1980, the Fontan Procedure is used to treat children born with only one ventricle and involves connecting the caval veins directly to the pulmonary arteries allowing blood to pass passively through the lungs without going through the heart (Figure 1).

Dr Iyengar said, however, that as the Fontan population aged, long-term risk factors and physiological effects now needed to be analysed and understood.

He is now conducting that population-based analysis of Australian and New Zealand Fontan patients using data generated through the Australia and New Zealand Fontan Registry, a multi-centre, bi-national registry established in 2008, the world's first such Fontan registry.

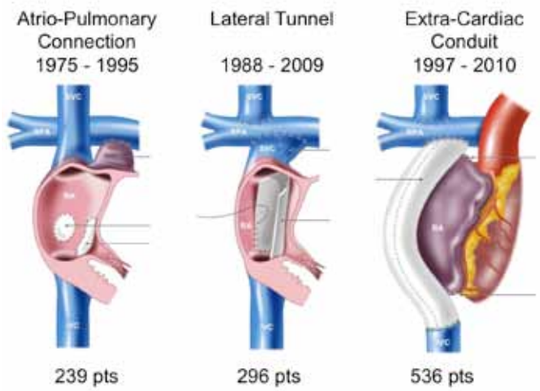


FIGURE 1

The Fontan procedure. Three modifications of the Fontan procedure have been performed in Australia and New Zealand since 1975.

In particular, Dr Iyengar is seeking to analyse early patient outcomes following the surgery, the long-term rate of failure, death, transplantation, arrhythmia and thromboembolic events and to examine the effects of warfarin and aspirin, the two main anticoagulation regimes given to Fontan patients.

"Fontan patients obviously undergo a significant physiological change and now that the population is growing steadily (Figure 2) and aging, we are in a better position to understand the long-term effects of that change," Dr Iyengar said.

"For instance, we know their veins are under much higher pressure, that the blood passing through the lungs isn't pulsatile and that cardiac output is fixed even during strenuous exercise.

"There is also enormous inter-centre variation in the practices of anticoagulation and fenestration and we need to know if there is a significant difference between regimes to determine optimal long-term treatment.

"We are also now seeking to determine the incidence of subclinical chronic liver and renal disease amongst Fontan patients, long-term complications that are only now emerging."

Dr Iyengar, who helped establish the Fontan Registry as a medical student and intern, said information was gathered from the six centres conducting the surgery and the further six centres following up adults with congenital heart disease in Australia and New Zealand.

He said that approximately 65 Fontan procedures were conducted in Australia and New Zealand per annum and said the information collected via the registry was invaluable given the heterogeneous nature of the Fontan cohort.

"Some of these children are missing the left ventricle and some the right, and while we do not know the exact cause of these defects, the usual risk factors for congenital heart disease including genetic and chromosomal abnormalities and parental exposure to environmental factors have been implicated," he said.

"These children, however, are at the worst end of the congenital heart disease spectrum, and many have already undergone multiple surgeries before having the Fontan Procedure which is now usually offered at around four to five years of age.

"We now also have a subset of patients with hypoplastic left heart syndrome, children who have only begun to survive since the development of a very large and complex operation known as the Norwood Procedure in the last decade.

"Long-term outcomes for all Fontan patients have significantly improved; however, the increase in the proportion of patients with hypoplastic left-heart syndrome has led to high rates of re-intervention and long-term failure and we need to understand this so that we can offer the best possible advice to the parents of such very sick babies."

Dr Iyengar is conducting his PhD research through the University of Melbourne, the Department of Cardiac Surgery at the Royal Children's Hospital and the Heart Research Group, Murdoch Children's Research Institute.

His work is being supervised by Associate Professor Yves d'Udekem, Department of Cardiac Surgery at the Royal Children's Hospital and Heart Research Group at the Murdoch Children's Research Institute, Professor David S Celermajer, Department of Cardiology at Royal Prince Alfred Hospital and the Sydney Heart Research Institute, University of Sydney, and Professor John Hutson, Department of General Surgery, Royal Children's Hospital and Surgical Research at the Murdoch Children's Research Institute.

A helping hand

The College has supported Dr Iyengar through the Foundation for Surgery Catherine Marie Enright Kelly Scholarship for 2012 and the Eric Bishop Scholarship in 2013, with monies provided to top up funding provided through external funding agencies.

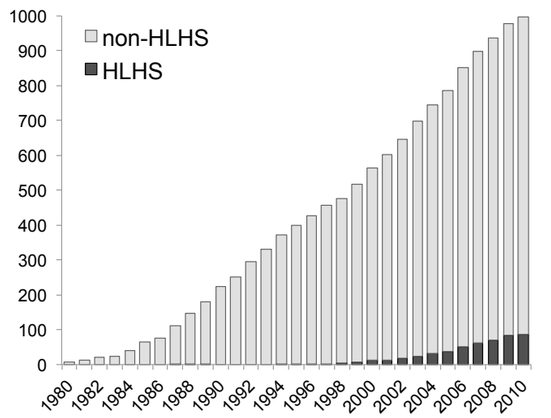


FIGURE 2

Steady growth of the Fontan population in Australia and New Zealand, with a recent exponential growth of the proportion with hypoplastic left heart syndrome (HLHS). Source: Australia and New Zealand Fontan Registry.

Dr Iyengar hopes to complete his thesis by the end of the year and believes it will be the first such population-based study of a general Fontan population published in the world.

He said Fontan patients were such a new cohort within general society, most of whom have only survived because of complex surgery, that surgeons and cardiologists felt a special duty of care toward their long-term well-being.

"These are an amazing group of patients to work with and it has been extraordinary developing an understanding of a group of people that you could say just didn't exist before," he said.

"The life expectancy of the Fontan population is not the same as the general public because of the changes made to their physiology and given that the procedure has now been conducted for 40 years in Australia and New Zealand, we are also seeing emerging evidence of increased incidences of liver disease and kidney failure and it's vital that we find out why.

"We also want to understand the differences in anticoagulation regimes that are offered through different centres and by different clinicians.

"The rate of thrombotic complications is low, but there is no way yet of knowing if that is based on one anticoagulation regime over another.

"This stream of my research will show which regime is better and even if we find no difference that will be a powerful result because aspirin is easier and safer for patients to take and we hope the information gathered will lead to an alignment of the treatment regime across Australia and New Zealand.

"Overall, I hope my work will allow clinicians to inform patients and their families about the likely long-term outcomes following the Fontan Procedure and allow clinicians to make more informed decisions about whether surgery is in the best interests of such sick kids as those with hypoplastic left heart syndrome."

Dr Iyengar, who plans to recommence his cardiac surgery training next year as a SET 3 Trainee, said he was honoured by the support provided through the RACS, particularly the opportunity given to him to expand his skills in epidemiology and bio-statistics.

Since beginning his PhD, he has also been selected to take the Graduate Certificate of Advanced Learning and Leadership offered by the University of Melbourne.

"I was already working on this research and wanted the time to concentrate on it full time so it was wonderful to receive the support of the College," he said.

"I see my future role as a surgeon and academic very broadly, as someone who facilitates change, leads research and lobbies on behalf of patients and there is no better group of patients to work with and for, in my opinion, than the Fontan population."

With Karen Murphy

Case Note Review

Mirizzi Syndrome – acute renal failure and sepsis

This can be found as a blog discussion on the website, go to: http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2013/anzasm-case-note-review-may-2013/

An elderly patient was admitted as an emergency with biliary obstruction. The patient had multiple comorbidities, including ischaemic heart disease and asthma, and developed painless obstructive jaundice. An ultrasound confirmed the presence of gallstones and the possibility of Mirizzi Syndrome was considered and subsequently confirmed on the Magnetic resonance cholangiopancreatography. Admission bilirubin was 143, renal function was normal and the patient was not anaemic.

An attempt was made to organise endoscopic retrograde cholangiopancreatography (ERCP) and stenting pending definitive treatment, but this could not be performed at the admitting hospital and was subsequently done at the private hospital in the same town.

Several days went by with no procedure being done while the patient's jaundice gradually elevated. The plan to proceed to surgery was thwarted because of the lack of an anaesthetist; eventually an ERCP was performed confirming Mirizzi Syndrome and a plastic stent was placed in the bile duct. The patient became sweaty and weak afterwards requiring intensive care and it was noted that the patient's bilirubin was elevated after ERCP and that the patient's lipase was 1400. There had been a doubling in creatinine levels from between 100 and 130 to 250. The patient required intubation, inotropic support and subsequently started haemofiltration because of anuria.

A few days later inotropes were still required and the bilirubin remained at five times normal. The decision was taken to operate to relieve the biliary obstruction because it was appreciated that the biliary stent was not working. A subtotal cholecystectomy was performed and the obstructing stone removed. The patient's postoperative course was stormy, with increasing inotropic requirements, ongoing anuria and finally torrential melaena possibly related to disseminated intravascular coagulation with bleeding from the patient's previous ERCP sphincterotomy. After a family conference the decision was taken to withdraw therapy and the patient died later that day.

Comment

Obstructive jaundice due to Mirizzi's Syndrome in an elderly patient is a very serious situation. While these patients often appear deceptively well, they are prone to developing severe complications of biliary obstruction, namely acute renal failure and sepsis. Timely relief of biliary obstruction is of paramount importance.

Due to problems with accessing anaesthetic support and accessing ERCP services, it was not possible to proceed with this patient's definitive treatment sufficiently quickly. Had biliary drainage happened sooner, it is more likely that the patient may have survived this illness. Lack of resources prevented the surgical team from being able to offer the treatment that was needed.

Guy Maddern
Chair, ANZASM

Morbidity Audit and Logbook Tool

Ongoing improvements for your logbook

It is going to be another big year for the Morbidity Audit and Logbook Tool (MALT)! Since the Web Logbook was replaced in September 2012 with the MALT system, usage by Surgical Education Training programs (SETs) has increased steadily. With the full rollout of MALT happening in 2013 the future is bright!

- Already this year, in February, a smartphone-friendly version was launched. MALT Mobile allows data entry on-the-go
- The MALT system was showcased on the College stand at the ASC in Auckland
- MALT is being configured to the specific requirements of the training boards for SETs in Otolaryngology Head and Neck Surgery, Paediatric Surgery and Urological Surgery
- MALT is being configured to the specific requirements of all International Medical Graduates (IMGs)
- Preparations are underway to launch MALT to Fellows as a personal log and audit tool
- A suite of new enhancements are being prepared

WHAT'S IT ALL ABOUT?

MALT Mobile

- Designed for any smartphone – iPhone, Android, Windows etc
- Login directly from your smartphone internet browser at malt.surgeons.org.
- No additional account setup required – if you have an active MALT account you can use MALT Mobile now.
- Linked to the main MALT system so the data automatically synchronises.

As with the main MALT system:

- Records can be referred to the supervisor in bulk
- A Dashboard shows the status of your cases in one glance
- Edit your hospital list and supervisor list
- Audit-level data can be optionally entered including diagnoses linked with SNOMED

MALT rollout to SETs and IMGs

MALT is very flexible. Training boards can customise many of the settings in MALT so it works the way they need it to. For example:

- Whether supervisors need to use MALT to approve cases or not
- The procedure list
- How many supervision levels and what they are called
- The dates of the rotation periods and when the logbook is to be closed (usually the submission deadline)
- What fields should be mandatory

MALT is currently being configured to the specific requirements of the training boards for SETs in Otolaryngology Head and Neck Surgery, Paediatric Surgery and Urological Surgery, and for IMGs of every specialty.

MALT rollout to Fellows

MALT is already being used by Fellows who are Supervisors in Cardiothoracic Surgery, General Surgery, Neurosurgery and Orthopaedics (NZ), as they need access to view/approve SET cases.

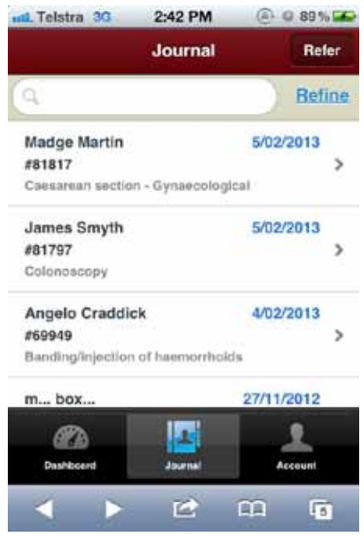
While the current focus is on rolling out the system to SETs and IMGs, MALT is ready for use by Fellows as a personal log and/or audit tool and preparations are underway to activate Fellows accounts and launch it to all Fellows for this purpose during 2013.

MALT is a free tool designed for Fellows to use in several ways:

- Personal log of cases
- Self-audit
- Fellows from a hospital surgical unit could use MALT to audit their department
- A specialty society could audit a new procedure, tracking its uptake over time
- Fellows could audit their private practice

MALT is designed to be 'ready to go' - Fellows simply record data against the standard dataset automatically assigned to them, noting that:

1. The dataset is that recommended by the College for effective surgical audit (from the Surgical Audit and Peer Review Guide).
2. Additional procedures can be added for Fellows if required. The standard procedure list is that provided for SETs.
3. The system provides five basic audit reports and a data extraction tool.
4. To enable aggregate data analyses, users can extract their own data into MS Excel and provide it to the group conducting the audit (i.e. the department of surgery).



5. The College can add a small number of procedure-specific fields on request (i.e. TNM for cancer procedures)

NEW FEATURES COMING IN 2013

Custom-reporting tool

Want to be able to easily design your own reports? Want to extract tables and graphs into presentations? Training Boards may wish to extract Trainee procedure totals into Excel for uploading into other systems? The MALT system will be able to do all this via a 'custom-reporting tool'.

Import tool

Have you years of personal case data in an Excel spreadsheet? Do you contribute to another database in a hospital or rooms? MALT will be able to import this data for you.

Apps

Need to enter data on-the-go from your smartphone where there is no network in range (i.e. some large hospitals)? Apps are being built for iPhone and Android.

One-click supervisor approval

Training boards will have the option to utilise a 'third workflow' whereby the only supervisor involvement in MALT is to view procedure totals in the Logbook Summary Report and click once to approve the whole rotation. This is useful when there is no requirement for Supervisors to review logbooks at the case level.

Better tracking of procedure totals

SETs - does your Supervisor only approve your cases at the end of the rotation? Need to know your totals more often so you can track your progress? The Logbook Summary Report will be able to be generated showing all cases, not only those approved.

Enhancements

MALT is to include a bundle of small improvements suggested by SETs and Supervisors, such as:

- UR number field being renamed to UR/NHI
- Prophylaxis and Admission Type will be multi-pick
- Ability to still add complications after case approved and rotation period closed
- Additional filters for the Journal View
- 'Today' button in date field

Ian Bennett
Chair, Logbooks and Clinical Audit Oversight Committee

To know more about MALT please contact the MALT team:
www.surgeons.org/malt
P: +61 8 8219 0900
E: malt@surgeons.org

Trainees in Difficulty

A new online resource

Surgeons have always expressed concerns about some of their Trainees. Surgeons have tried to support Trainees and positively assist them, while maintaining the quality of patient care. Being a good supervisor in this situation is difficult. More so as the approaches around training, probation, and dismissal have become more tightly regulated due to the involvement of legal and/or employment considerations.

All surgical specialty training boards have encountered one or more Trainees who experienced difficulties during their training program. Some of these difficulties have been resolved and the Trainees continued (or are continuing) to successfully complete their training program, while other Trainees had a number of terms on probation before being dismissed from the program.

Probation, dismissal and subsequent appeals are very frustrating and time consuming for all involved. Specialty training boards have invested a considerable amount of time in ensuring that their documentation and processes for probation are transparent, clear and stand up to scrutiny. There is need for resources as there are concerns expressed about the processes.

In response to those concerns the College Education Development and Research Department has developed an online resource for all members of the College: supervisors, trainers, IMGs, and Trainees. The Trainees in Difficulty (TiD) resource contains an extensive collation of advice, templates and processes and is set up so that information relating to six key topics can be accessed according to need. The topics are:

- Diagnosis of difficulties
- Gathering of evidence
- Teaching and monitoring
- Implementation of probation
- Analysis of insight
- Move to dismissal

There are two elements that were very important in the way this online resource has been developed and presented. Firstly, to be informed about current

developments, by a wide range of research, from a variety of medical teaching environments. Secondly, to bring together as many resources as possible, both generic and specialty specific, and to make them readily accessible from the same site.

International research

Early identification and response to potential problems has been identified in international research as an important key to assisting Trainees (or IMGs) who may be experiencing difficulty. Unfortunately, supervisors have demonstrated some reluctance to talk to Trainees when a problem first arises.

This attitude is not unique to surgical supervisors. Steinert identified six common responses including: denial, avoidance, anger/ frustration, and acceptance; only the last one of these leading to a productive intervention.[1]

As you can see from the above listing of topics, the first three topics in the Trainees in Difficulty resource have been deliberately designed to provide information and support documents to encourage and facilitate early intervention.

Lack of insight has been identified as a significant underlying issue in identifying particular kinds of problems which a Trainee (or IMG) may experience. Lack of insight can require a different approach to both identify and manage. Because of supervisors' expressed concerns about the difficulty of dealing with this issue, the TiD resource has identified this as one of the six fundamental topic areas.

Easy access to, and use of, resources

In order to make the resource useful across all specialties, the templates and processes include both generic and specialty specific materials. Where specialty training boards have developed their own documentation these have been included. If a specialty does not have material for any of the topic areas, for example 'diagnosing difficulties' or 'gathering information' then generic documents can be used.

Crucial to the successful management of Trainees in Difficulty is maintenance of an up-to-date and complete file of documentation. This of course also describes the intervention that attempts to address the difficulty.

Previous experience across a number of the specialty training boards has shown that the most effective way to do this is for a training board administrator to be involved in the process from the earliest point, and to have the responsibility for keeping records of meetings and all of the relevant information.

This has been found to be effective because it relieves the Supervisor of those tasks and reduces the risk of lost information. In many situations, it will describe the intervention that proves to be successful. This approach has been incorporated into the TiD approach.

To access the Trainees in Difficulty resource, College members need to be logged in to the College website.

Once a member is logged in, 'My Page' will open and in the left menu 'RACS Knowledge' will take you to 'eLearning', which will take you to 'Courses'.

Stephen Tobin
Dean of Education

Reference

1. Steinert Y. The 'problem learner: Whose problem is it? AMEE Guide No 76. Medical Teacher, 2013, e1-e11 early Online

What's right on the big day?

Let's even the playing field

There is one thing that really annoys me and that is double standards and in particular people who display double standards. I went to a wedding recently. As is the modern way the groom and bride had been living together for three years and decided to get married. I overheard one guest saying (in jest, I suspect, or at least I hope) that the groom was making "an honest woman" of the bride.

Does this mean that an unmarried couple living together is composed of a dishonest woman and a man about whom no comment is made? This set me thinking – one never hears of a bride making the groom an honest man. He may be made a happy man, but he apparently does not need to be made 'honest'.

One also hears of young men who "sow their wild oats". This is usually accompanied by a "nudge, nudge, wink, wink" as if it is to be expected and permitted. Do young women sow wild oats? If so, I have never heard of it. Such behaviour in young women is often seen as not acceptable. "She was a bit of a girl in her younger days."

Perhaps we curmudgeons are old-fashioned or jealous of the modern young lifestyle, but this seems to me to be double-standards.

The other thing that struck me at the wedding was that the guests asked to see the bride's ring, but not the groom's. Being a romantic couple they had actually chosen the same rings (but different sizes). So there is an example of double standards in the opposite direction.

Curmudgeons do not read the social pages of the papers, but I believe that there are often detailed descriptions of the dress of the bride – "Strapless, A-line gown with sweetheart neckline and corset closure. The airy shimmer of Brescia Organza lends itself to softly billowing waves that gracefully move across the A-line skirt. An embellished lace motif adds a stunning element to the asymmetrical dropped bodice." The poor groom – "He wore a grey suit," seems the average description.

Yes, you have probably already guessed that the wedding that I attended was my own. We curmudgeons do find a Mrs Curmudgeon from time to time. Please ask me to show you my ring.

In Memoriam

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

George Stirling, Victorian Fellow

Edward Beckenham, New South Wales Fellow

Charles Swanston, New Zealand Fellow

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: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Daniela.Ciccarello@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

The changing face of the Academy of Surgical Educators

Re-focusing activities for the Academy of Surgical Educators

The Academy of Surgical Educators (ASE) was established to support, enhance and recognise surgical educators within the College. In order to do this we need to identify the changing needs of members and address those needs through the professional development activities offered. The Academy also has new developments and research in the field of surgical education as important priorities.

The ASE now boasts a membership base of 320 individuals, comprised of supervisors from the Surgical Education Training (SET) program, educators from the Skills and Professional Development programs and other surgeons and external educators with a proficiency and passion for medical education.

The Academy offers a comprehensive suite of educational activities for its members. These include both online and face to face courses such as Supervisors and Trainers for SET, SET Selection Interviewer Training, Keeping Trainees on Track, the Surgical Teachers Course as well as faculty training programs for all of the Professional Development and Skills courses.

During June, the Academy will be hosting a number of Educator Studio Sessions at the College's Melbourne office and simultaneously broadcasting to its members via a web conferencing platform.

Victorian surgeons may wish to attend or take the webcast. Each presentation will be followed by a Q and A style session with a networking opportunity following. Guest speakers will include Dr Ian Curran, Dean of Educational Excellence and Head of Innovation, London Deanery, on 'Trainees in Difficulty'. Professor Tim Dornan, Professor of Medical Education at Maastricht University will be speaking on 'Where does apprenticeship stand in the competency era?' Both are in Melbourne for the ANZAHPE conference from June 24 to 26.

In Brisbane in September we have invited Dr Sonal Arora, Clinical Lecturer in General Surgery Department of Surgery and Cancer, Royal Imperial College to speak on 'Simulation and its role in educating our educators'. Dr Arora will be in Brisbane for SIM Health from September 16 to 20. Final dates, times and venues will be announced on the College website.

One of the key functions of the Academy this year is to develop a generic surgical educator program which all faculty members and surgical educators can participate in irrespective of what educational role they occupy in the College. A recent gap analysis and surgical educator curriculum report by Assoc Prof Robert O'Brien (Director of Medical Education at St. Vincent's Hospital) will inform this. The report has been reviewed within and outside the College. This educator program will be developed during 2013, and be available in 2014.

Working together

The third successful Royal Australasian College of Surgeons, Royal Australasian College of Physicians and Royal College of Physicians and Surgeons of Canada, Conjoint Medical Education Seminar was held again at the Sofitel Sydney Wentworth on Friday, March 8, 2013. The theme was 'Serving the Community: Training Generalists and Extending Specialists'.

Presenters were from the three host Colleges and boasted eminent speakers such as Mr Andrew Connolly, Dr Jason Frank, Mrs Anne Kolbe, Mr James Birch, Dr Bryce Taylor, Dr Kevin Imrie, Prof Michael Cox, Dr John Gommans, Prof Richard Murray, Prof Linda Snell and Prof Trish Davidson. Participants included senior health educators, policy makers and advisors, regulators and others working in the area of specialist education and training.

The joint Graduate Programs in Surgical Education offered by the University of Melbourne in partnership with the College enrolled 14 surgeons this semester. This suite of programs addresses the specialised needs of teaching and learning in a modern surgical environment.

The program is a modular one, with graduates exiting with a Graduate Certificate, Graduate Diploma or Masters of Surgical Education. These graduating Fellows will be integral to enhancing the knowledge and educational leadership of the Academy.

In June, the Academy members will be invited to participate in NHET Sim, Australia's first National Simulation Health Educator training program, funded by Health Workforce Australia. Educators who currently use or intend to use simulation as an educational tool to support the education and training of others are encouraged to attend free of charge.

The program is being tailored for a surgical educator audience and will involve two online core components – 'Simulation based education: contemporary issues for the health professionals' and 'Being a simulation educator'; and a one day workshop on 'Simulated patient methodology' and 'Patient focussed simulations'. The workshop will be facilitated by Professor Debra Nestel, Monash University and will be held at the College. Further details, dates and times will be announced on the College website.

As part of the Academy's advocacy work, a number of representatives will deliver educational sessions and discuss the needs of the faculty members. Presentations about the Academy developments have been incorporated into the Victorian, Queensland and Northern Territory/ South Australia/Western Australia regional Annual Scientific Meetings; the specialist society meetings of The Australian and New Zealand Society of Cardiac and Thoracic Surgeons and General Surgeons Australia; Provincial Surgeons of Australia and a presentation to the Paediatric and Urological Surgical Boards. Depending on time commitments as well as the choice of other specialities, there may be further opportunities in 2013. The Dean would welcome consideration for involvement in state and regional meetings, as well as specialty society meetings in 2014.

At the ASC

For the recent Auckland ASC, convenor Mr Richard Perry established an impressive line-up in the Surgical Education stream. A major plenary session on Tuesday, May 7, was chaired by the previous Dean of Education, Prof Bruce Barraclough.

As the Academy develops, we wish to have an Academy meeting, which could include presentation and invited speakers as well as a forum regarding current and future surgical educator needs. Rather than simply foist another meeting with associated travel onto our busy membership, we would plan that such a meeting could be based out of Melbourne and make use of webcasting. We would be interested to hear from members of the Academy and other surgeons about such a meeting.

Membership of the Academy is open to all Fellows and Trainees committed to the role of Teacher / Scholar. External members who have strong educational interests and expertise are also welcome to join. For more information refer to: http://www.surgeons.org/for-health-professionals/academy-of-surgical-educators/ or contact Kyleigh Smith on +61 3 9249 1212 or email ase@surgeons.org

Julian Smith
Chair, Professional Development
Chair, Academy of Surgical Educators
Stephen Tobin
Dean of Education

From the SAAPM Annual Report

Seven years of fractured neck of femur cases in South Australia, 2005–06 to 2011–12

Each year, the audits of surgical mortality publish an annual report. As time goes by and more cases are accumulated, there is a developing database that allows analysis of some aspect of surgical mortality.

In each annual report, the South Australian Audit of Surgical Mortality (SAAPM) has tried to look at one aspect of the audit and see if further information can be obtained. This year, the topic of interest has been deaths from fractured neck of femur (NOF) and comparing them with international standards.

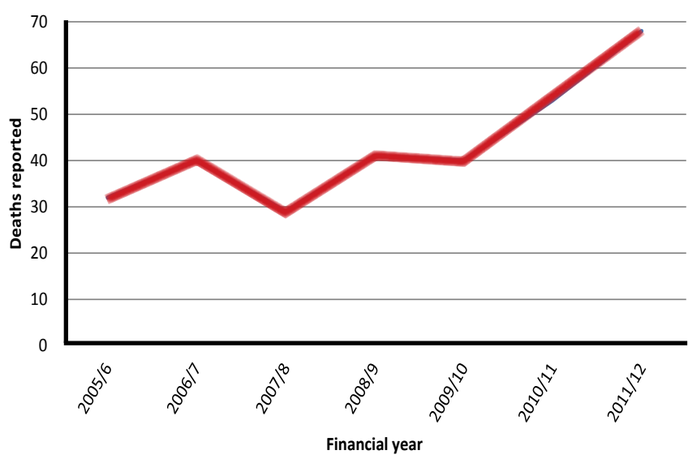


FIGURE 1

Surgical diagnosis of fracture of neck of femur

Over the first seven years of the audit, there have been 615 notifications of orthopaedic deaths. Of this group, 562 (91 per cent) have undergone the audit process of a completed surgical case form and an appropriate first – or second-line assessment, including 303 cases in which the diagnosis was fractured neck of femur.

Figure 1 (right) shows the number of surgical case forms received with the surgical diagnosis 'Fracture of NOF' for the period 2005/2006 to 2011/2012. The number of cases with this surgical diagnosis has been increasing in recent years, reflecting an increase in the number of hospitals that are involved in the audit and, therefore, the number of orthopaedic surgical deaths reported. It should be noted that surgical diagnosis data is only captured through surgical case forms (not notifications of death), so this is likely to be a slight underestimate as 9 per cent of these forms have not been returned.

Figure 1: Number of deaths with surgical diagnosis 'Fracture of NOF' (total 303)

Deficiencies of care associated with fractured neck of femur

From 1 July 2005 to 30 June 2012, there were six cases (2 per cent), out of a total of 303 deaths with the surgical diagnosis 'Fracture of Neck of Femur', for which clinical events (areas of concern, consideration or adverse events) were identified by the reporting surgeon, the first-line assessor or the second-line assessor. All of these cases were critically reviewed; the clinical events that were identified were either matters relating to hospital events (e.g. falls, delay in operating theatre access) or events that could not be prevented (e.g. sudden neurological events). There have been no events where there was a surgical or treatment error.

Considering that this population group has many serious co-morbidities, and their management is often complex and involves multiple specialties, it is a remarkable achievement that so few deficiencies of care have been identified. One could argue that the data is not complete (9 per cent of death notifications did not have their case forms filled out), but only a severe skewing of the data would alter the conclusion.

Overall mortality

It is all very well to be pleased that no serious incidents have occurred, but the question that also demands an answer is whether the mortality rate of patients with fractured NOF is comparable to other units and world standards. As SAAPM looks only at death as an outcome, one must turn to other sources of data to see how many patients have a procedure for a fractured NOF and do not die. SA Health maintains such records. Their database suggests that, in the year 2010/2011, there were 824 patients with a diagnosis of various forms of fractured NOF. Using this figure as the denominator, the 53 deaths recorded by SAAPM equates to a death rate of 6.4 per cent. The question arises whether there are any similar Australian studies that can be used as a bench-mark. Boufous et al.[1] reported on fractured NOF in NSW and noted a death rate of 4.7 per cent to 5.1 per cent over a 10 year period. The SA figures are slightly higher.

Allaf et al.[2] reported that annual fractured NOF death rates from eight NHS Trusts varied greatly, ranging from 3.9 per cent to 17.7 per cent. The purpose of their paper was to assess whether a five year average is a better indicator of the true situation. The paper presents five years of raw data for one of the Trusts, the South Manchester University Healthcare Trust, which indicates an average annual mortality rate of 7.7 per cent between 1997 and 2001, slightly higher than the SA figures.

Conclusion

The data collected by SAAPM would support the view that, in South Australia, the quality of care for patients with fractured neck of femur is similar to elsewhere in Australia and overseas. As the data collection continues, the data held by the audits in the various regions will provide a valuable source of information.

Glenn McCulloch
SAAPM Clinical Director

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1. Boufous, S., Finch, C. F., & Lord, S. R. (2004). Incidence of hip fracture in New South Wales: are our efforts having an effect? Medical Journal of Australia, 180, 623-626.

2. Allaf, N., & Lovell, M. (2004). Annual review of fractured neck of femur mortality rates: is this a true picture? Annals of the Royal College of Surgeons of England, 86(5), 347-348.

Note: Some of this data and discussion will be in the 2012 SAAPM Annual Report which is soon to be published. The article was prepared by Sasha Stewart, Project Manager, and Glenn McCulloch, Clinical Director, SAAPM.

Your Audit online

Audits improve with your feedback

I would like to thank you for your ongoing commitment to the mortality audit process. The Australian and New Zealand Audit of Surgical Mortality (ANZASM) program has been operational for more than 10 years beginning in Western Australia. It is now operating nationally, with all States and Territories contributing since 2010.

I would like to make you aware of the 'Fellows Interface', an extension to the existing in-house Web-based Mortality Audit IT system. Currently project staff enter audit information into the system to facilitate the assessment process.

However, the Fellows Interface enables Fellows with the means to enter information directly into an electronic template of the Surgical Case Form, as well as for first-line assessments. This system has been configured for both PC and Mac users. Nationally over 35 per cent of surgeons are using this interface as a means of submitting their forms.

Secure connection

The web-based Audit and Fellows Interface system ensure data security. All access to the system is controlled by username and password. Each user's access to data is limited to their own operational needs. All communication is encrypted using current industry security standards (HTTPS).

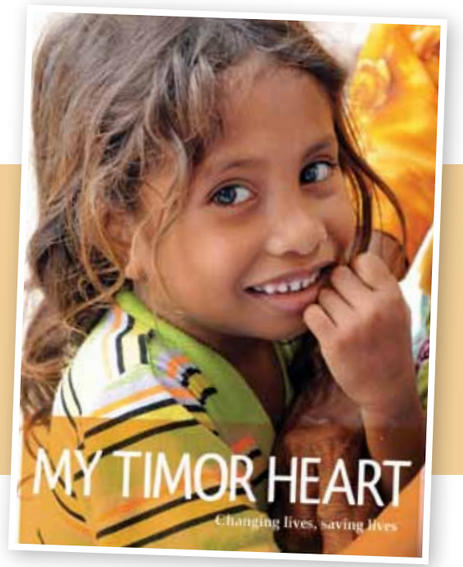
All you will require is an internet connection and preferably Internet Explorer 7 or above, Safari 4 or Mozilla Fire Fox 3.6. Directly entering data saves time; it can be completed at different times thus progressively completing all of the case information.

The system has been in use for three years now and the feedback I have received during this time has been encouraging. This initiative provides users with a dynamic, user-friendly tool to enter Surgical Case Forms and complete First-line Assessments online. Completing audit forms has been made more convenient. The process is more streamlined with less paperwork.

I am hoping that more users will try the Fellows Interface system and feedback comment, both positive and negative. Staff are available to assist you. Please contact your regional Audit office for a user ID and password.

Professor Guy Maddern
Chair, ANZASM Steering Committee

The College has produced a book, called *My Timor Heart*, to celebrate our achievements in Timor Leste. *My Timor Heart* will recognise the extraordinary efforts of the medical volunteers in Timor Leste, and the life-changing impact their work has on people living in a country that continues to struggle with the legacy of years of civil war and violence.



My Timor Heart

Written by Ellen Whinnett and Ellen Smith

Using striking photographs and volunteers' stories *My Timor Heart* illustrates the profound positive impact of the College's Timor Leste program. Written by Ellen Whinnett, a Walkley award winning journalist and the Head of News at the Herald Sun newspaper. *All proceeds from the sales of My Timor Heart go directly to Foundation for Surgery to fund the Timor Leste Program..*

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> *Not only was there satisfaction with the style of teaching and presentation of material, but a great camaraderie developed between SWB team members and local doctors and students.*

Support growing

This group is spreading its teaching further

Specialists Without Borders (SWB), established by SA Upper GI and Hepatobiliary surgeon Mr Paul Anderson in 2005 as a teaching organisation designed to increase the skills of doctors working in developing countries, has now attracted the support of more than 400 specialists from around the world.

Mr Anderson said that while there were 300 members from Australia and New Zealand, other medical and surgical specialists from Canada, the UK, South Africa, the US and Africa had now signed on to give of their time to teach in those countries that request an SWB team visit.

He said support had grown to such a degree that last year SWB was able to offer for the first time fully mixed surgical/medical seminars over two weeks in Malawi and Rwanda.

In September last year, Mr Anderson led an SWB visit comprising 20 Australasian medical and surgical consultants as well as eight medical students to the two African nations.

"While the surgical component in the seminars was dominant , consisting of the various surgical specialties including orthopaedics, ENT, neurosurgery, upper GI and vascular, we were also able to present modules around intensive care, radiology, oncology, obstetrics, paediatrics and psychiatry," he said.

"Malawi had requested a teaching visit as part of the preparation for their surgical residents who were preparing for a Master's Degree in surgery so we had the curriculum sent to us before the visit and established an association with the supervisory body in East Africa for surgical residents to ensure our teaching was relevant to their needs.

"The Malawian seminar was then constructed to assist those surgical residents by providing not only updated information, but also exam techniques over a number of days including a mixture of didactic lectures and simulated teaching modules. All the residents who attended the course passed their final exams, which was a great compliment to the teachers and the organisation.

"The second week of the trip was spent in Rwanda with the medical/surgical seminar held in Kigali attracting 100 doctors, medical students, nurses and midwives.

"Not only was there satisfaction with the style of teaching and presentation of material, but a great camaraderie developed between SWB team members and local doctors and students."

Mr Anderson said that in another first for SWB, an educationalist, Mr Don Bramwell from Flinders University, had accompanied last year's teams to oversee teaching, provide independent analysis and feedback and to help the organisation deliver the highest quality and most appropriate medical and surgical education.

"We want to provide the very best education we can by streamlining our teaching modules for qualified specialists, Trainees, interns and medical students and we believe Mr Bramwell will help us achieve that," he said.

"We have therefore invited him onto the SWB executive and are now in the process of raising additional funds to allow him to travel with us on future team visits."

Support for the future

Mr Anderson also said a recent Australia Taxation Office decision to grant SWB full gift deductibility was also a milestone in the organisation's development, allowing SWB supporters to claim a full tax rebate on their donations.

"The costs of running SWB are amongst the lowest of any not-for-profit in Australia given that our dedicated specialists pay their own travel costs and accommodation while we pay for teaching materials and local seminar venues," he said.

"This decision will hopefully have a huge impact on us because it could mean that we attract not only more personal donations, but the support of the medical industry," he said.

"The more funding we attract, the more work we can do on curriculum development and the more countries we can visit.

"In September of this year we will be going to Malawi again and to Zimbabwe, but ideally we would love to undertake four trips a year, two to Africa and two to our Asian and Pacific neighbours."

Mr Anderson said SWB was now actively seeking the participation and support, in particular, of urologists and plastic surgeons, but all surgeons and specialists with an interest in teaching are welcome.

"To be able to deliver a seminar on burns, maxillofacial and plastics, while having renal physicians conducting some training, would be wonderful in these countries."

For more information visit the website at www.specialistswithoutborders.org.au

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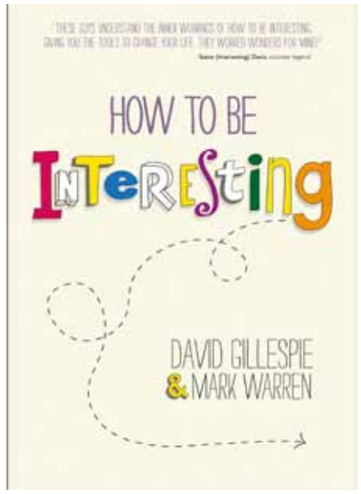

How To Be Interesting: Simple Ways to Increase Your Personal Appeal

David Gillespie, Mark Warren
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An irreverent, colourful guide to becoming more interesting and successful by gaining self-knowledge and building your confidence and charisma. Actor David Gillespie and writer Mark Warren draw upon their professional expertise to teach clients — including businesspeople, sports stars, politicians, actors, writers and celebrities — the skills they need to communicate more effectively, to impress others with charisma and find greater success at work and in life. In this wildly funny, irreverent and practical guide they share their proprietary formula for achieving a heightened and sustained level of interestingness. This book features practical tips for achieving everyday interestingness, along with personality tests to aid self-knowledge, tonnes of fascinating quotes, outrageous humour and vibrant visual material including mindmaps and infographics.

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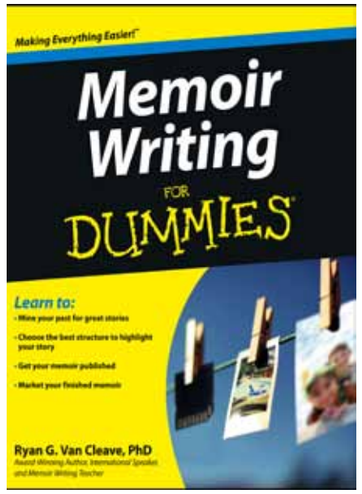

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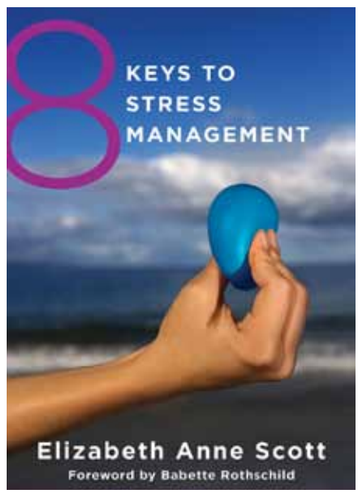

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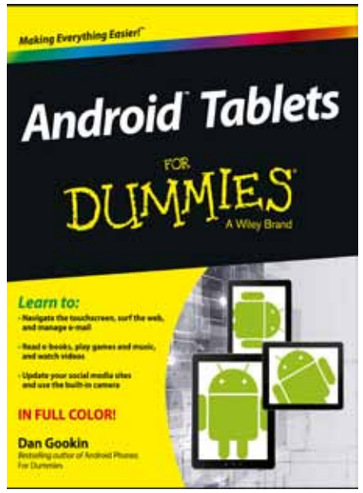

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9781118543191 | Pbk | 320 pages
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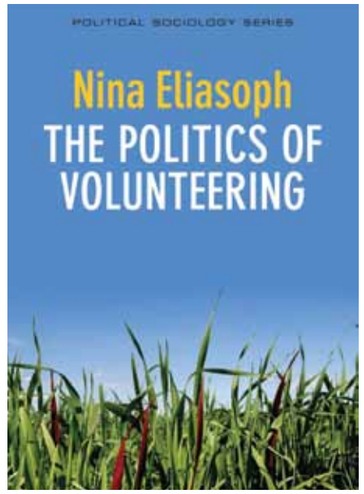

The Politics of Volunteering

Nina Eliasoph
9780745650043 | Pbk | 200 pages
March 2013, Polity

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Many of us may have participated in grassroots groups, changing the world in small and big ways, from building playgrounds and feeding the homeless, to protesting wars and ending legal segregation. In this engaging new book, Nina Eliasoph encourages readers to reflect on their own experiences in civic associations as an entry point into bigger sociological, political, and philosophical issues, such as class inequality, how organisations work, differences in political systems around the globe, and the sources of moral selfhood.

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Was Graham Coupland ahead of his time?

The second part of a lecture presented at the NSW Regional Committee End of Year Dinner, 14 December 2012

As surgeons, our concern is the person, suffering from illness, who is likely to be lost in the strange world of their own illness and the hospital or institution in which they find themselves.

The elements of suffering, varying in intensity and proportion in any single situation, are loss, isolation, helplessness and hopelessness. Looking at these four, one can immediately see that we can do something to alleviate three of the four; we can offer hope, we can offer help, and we can minimise isolation, but doing this is not easy.

A patient's suffering becomes part of their story. All of us have a story. We are our story. Indeed, it has been said that a human being is nothing, but a story with skin around it.[3] Our story defines who we are. As we go through life our experiences get interpreted then redefined and reinforced by recollection and retelling, so becoming our story. When we suffer, this becomes part of our story. How, then, are we surgeons to deal with this aspect of our patients?

Like all medical encounters we must start with diagnosis. There is no blood test or imaging that will give us this. Indeed, patients are often mute about their true suffering, tending to express only some definable concerns such as pain, malaise, weakness, nausea or loss of appetite. This is not to say that these are unimportant – in a recent study Wilson found these physical symptoms played a major role in patients' suffering.[4] The same study found that there were non-physical causes of suffering in different domains such as social in which were concerns about isolation and the welfare of others, psychological involving depression and anxiety, and more nebulous, existential concerns to do with loss of dignity, loss of control and spiritual crises.

To find out about this aspect of our patients' suffering is difficult. I suspect that a blunt question: "Are you suffering?" would be met with denial as patients would hesitate to lay bare their innermost fears in the same way that they would tell us about their appetite or their bowel habits. To know about their suffering we must listen to their story for this gives us the information but, more importantly, goes a long way to relieving their suffering – but more about that in a moment.

To enable a patient to tell their story we must first make it clear to them that we want to listen, and to listen we must empty our own minds of the day to day preoccupations that tend to clutter our heads – is this patient's mild fever significant? How am I going to get last night's urgent case into theatre? I must remember to tell the registrar to get started on time tomorrow as I'm going to be late – and so on. I found doing rounds in the evening, slowly, and without junior staff a good way to start the process. Silence can be helpful as it is an invitation for the patient to talk, as well as being important therapeutically.

> *"Silence can be helpful as it is an invitation for the patient to talk, as well as being important therapeutically"*

Some of you may feel that this aspect of patient care is being addressed by students being taught communication skills, but without true underlying compassion and a receptive, empty mind open to the patient's story, patients will quickly perceive that these techniques are superficial and thus demeaning.

The good news is that alleviation of the patient's suffering goes hand in hand with finding out about it. By being receptive to the person and connecting with them we give them the clear message that we are there for them, sharing their suffering. Just "being there" tells them that they are not alone. As they tell their stories, patients can redefine their meaning and by doing so, transcend their suffering. As I just mentioned, silence can be valuable as it gives the patient the message that we are physically present in their time of suffering, that they are not alone on their journey. Sackett, one of the founders of Evidence Based Medicine, said "the most powerful therapeutic tool you'll ever have is your own personality.[5]"

So what are the dangers of this approach? Both parties can be damaged. If you are not aware at the critical moment when the patient is ready to tell his or her story you may increase or prolong their suffering. To have an untold or rejected story of suffering is the worst of agony. How many times have you, as the "second opinion" surgeon, heard a patient say, "they didn't listen to me"?

As far as the clinician is concerned, we may get too close and so be overwhelmed by the patient's pain and loneliness, or we may expose our own vulnerabilities. I think it is this risk that is behind the tradition that doctors shouldn't engage emotionally with their patients, a view that I thoroughly reject. A middle course of engaging, listening and being there benefits both parties: it benefits the patient in the way I've described, and it benefits the clinician.

Yes, it benefits us. I'm sure we all remember some of our chronic or terminally ill patients: what they've said or how they've coped. When a patient tells us their story, and we listen correctly, it has a healing effect on us as well as on the patient. In this way the stories, theirs and ours, get interwoven. That's what our memorable patients give us and it's a wonderful gift.

Surgeons who excel also make us a gift, an example to follow, a standard to aspire to. Graham was such a person and it is for that reason that we honour his life in this oration.

To finish, let me try to answer the question in the title: 'Was he ahead of his time?' I believe the answer is both "yes" and "no".

"Yes," because his professional and personal life encompassed the attributes that we now codify as our nine competencies and all aspire to well before anybody thought of writing them down.

"No," because he was a surgeon and a healer, as so many have been before him, probably intuitively using the methods I've briefly described.

Our challenge is to resist the forces that mitigate against us practising in this way and to follow him in becoming surgeon healers, as well as teaching the next generation to be surgeon healers.

Hugh Martin,
NSW Fellow

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5. Smith: Thoughts for new medical students at a new medical school. *BMJ* 2003;327:143

CONGRATULATIONS on your achievements

This presentation took place at the USANZ ASM on 13 April 2013

award winner

Anthony Richard Mundy MS FRCP FRCS
Honorary Fellowship

Anthony Richard Mundy has an international reputation in surgery in the field of urology. He is particularly well known to urological surgeons of Australia and New Zealand.

He was born in London, educated as a classics scholar and trained in surgery and urology at St Guy's hospital in London.

His work in reconstructive urological surgery has made a great contribution to this particular field and distinguished him in urological surgery.

He has made 456 presentations to learned societies, written 160 original papers in peer-reviewed journals, 60 book chapters and authored 10 books.

He has had 36 visiting professorships, presented 192 invited lectures, and 87 times travelled as visiting surgeon in Europe, America, South Africa, South East Asia and New Zealand.

He holds a personal chair as the Professor of Urology in the University of London at the Institute of Urology, Royal Free and University College London School of Medicine.

He is also the Director of the Institute of Urology at that institution.

He is also a Visiting Consultant Urologist, St Luke's Hospital, Malta and an Honorary Civilian Consultant Urologist to the Royal Navy

He is a Member of Council, Royal College of Surgeons of England 2000 and a Past President of the British Association of Urological Surgeons.

He is an Honorary Member, Urological Society of Australia and New Zealand.

Professor Mundy has made a great contribution to urological surgery in Australia and New Zealand both through generous support to Fellows in London and through visits to both our countries.

He has been a supportive educator and mentor to many of our Trainees who have worked with him in London. Among them, I include our current President Michael Hollands.

His first visit was to Annual Scientific Meeting of the Urological Society of Australia and New Zealand in 1986. Since then he has been an invited guest at many further scientific meetings. He has delivered many papers, chaired sessions and given honest and candid opinions on many topics. He has encouraged rigor in scientific presentations and helped improved the standard of presentations at scientific meetings and as a visiting Professor undertaken surgical teaching sessions particularly in New Zealand. He has conducted workshops, demonstrated his surgical technique in complicated reconstructive operations and taught a local contingent his skills. He has made a valuable contribution to urological surgery in Australia and New Zealand over the past 25 years and this honorary Fellowship is granted to acknowledge this.

Citation kindly provided by Andrew Brooks

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