

# SURGICAL NEWS

THE ROYAL AUSTRALASIAN  
COLLEGE OF SURGEONS  
VOL 15 / NO 4 MAY 2014

## Myths of Surgical Training

### BUILDING SKILLS

Australian trained Fellow  
helping their birth country

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### MAKING SURGERY SAFER

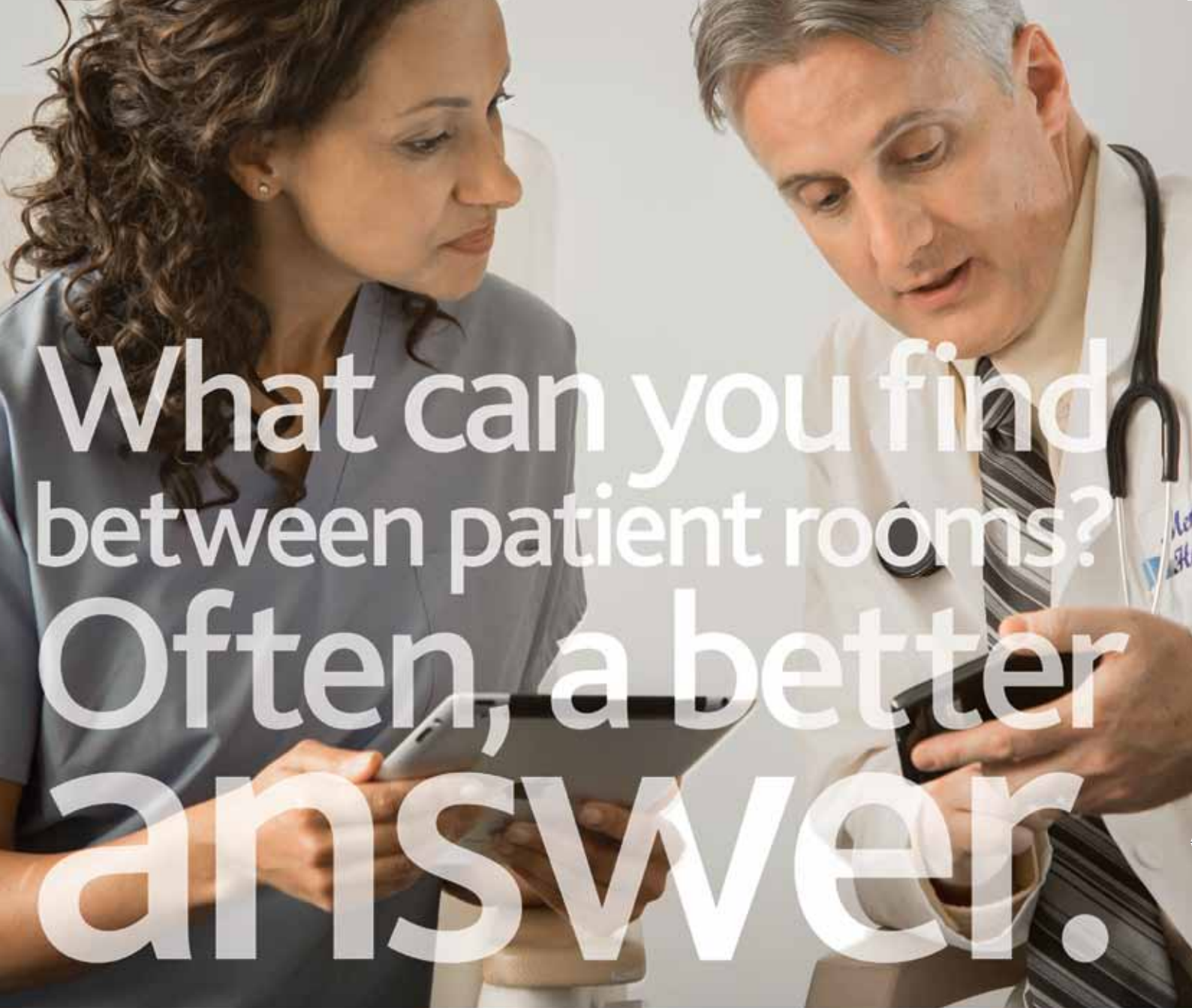
Russell Gruen on the important John Mitchell  
Crouch Scholarship he received in 2013

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**Keeping Trainees on Track (KTOT)**

**24 June, Adelaide; 29 July, Brisbane; 16 August, Perth**

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.

**Writing Medico Legal Reports**

**24 July, Brisbane**

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 ability is one of the most important roles of an expert adviser. This activity is proudly supported by mlcoa.

**Non-Technical Skills for Surgeons (NOTSS)**

**5 August, Sydney; 23 September, Auckland; 24 October, Launceston**

This workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues. This activity is proudly supported by Avant.

**Clinical Decision Making**

**6 August, Sydney**

This three hour workshop is designed to enhance a participant's understanding of their decision making process and that of their trainees and colleagues. The workshop will provide a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling trainee or as a self improvement exercise.

**Management of Acute Neurotrauma**

**7 August, Perth (the day before the WA, SA & NT ASM)**

You can gain skills to deal with cases of acute neurotrauma in a rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, you can learn these skills using equipment typically available in smaller hospitals, including the Hudson Brace. This activity is proudly supported by RHCE.

**Supervisors and Trainers for SET (SATSET)**

**16 August, Perth**

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. It is an excellent opportunity to gain insight into legal issues. *This workshop is also available as an eLearning activity by logging into the RACS website.*

**Preparation for Practice**

**23 to 24 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, mlcoa, Rooms With Style and MDA National.

**Surgical Teachers Course**

**21 - 23 August, Auckland**

The Surgical Teachers Course builds upon the concepts and skills developed in the SAT SET and KTOT courses. The most substantial of the RACS' suite of faculty education courses, this new course replaces the previous STC course which was developed and delivered over the period 1999-2011. The two-and-a-half day intensive course covers adult learning, teaching skills, feedback and assessment as applicable to the clinical surgical workplace.

**Polishing Presentation Skills**

**25 September, Sydney**

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**

**5 August, Sydney**  
Non-Technical Skills for Surgeons (NOTSS)

**6 August, Sydney**  
Clinical Decision Making

**13 August, Sydney**  
AMA Impairment Guidelines  
5th Edition: Difficult Cases

**5 to 7 September, Sydney**  
Process Communication  
Model Part II

**25 September, Sydney**  
Polishing Presentation Skills

**18 October, Newcastle**  
Keeping Trainees on Track (KTOT)

**18 October, Newcastle**  
Supervisors and Trainers for SET (SAT SET)

**VIC**

**6 June, Melbourne**  
National Simulation Health  
Educator Training Program  
(NHET-Sim)

**23 to 24 August, Melbourne**  
Preparation for Practice

**9 September, Melbourne**  
Keeping Trainees on Track (KTOT)

**29 September, Melbourne**  
Academy Educator Studio  
Session

**SA**

**24 June, Adelaide**  
Keeping Trainees on Track (KTOT)

**1 to 3 August, Adelaide**  
Process Communication  
Model Part I

**WA**

**7 August, Perth**  
Management of Acute Neurotrauma

**16 August, Perth**  
Supervisors and Trainers for SET (SAT SET)

**16 August, Perth**  
Keeping Trainees on Track (KTOT)

**QLD**

**24 July, Brisbane**  
Writing Medico Legal Reports

**29 July, Brisbane**  
Keeping Trainees on Track (KTOT)

**7 August, Brisbane**  
Strategy and Risk  
Management for Surgeons

**25 to 26 October, Brisbane**  
Preparation for Practice

**28 October, Gold Coast**  
Non-Technical Skills for Surgeons (NOTSS)

**29 October, Brisbane**  
Clinical Decision Making

**NZ**

**21 to 23 August, Auckland**  
Surgical Teachers (STC)

**23 September, Auckland**  
Non-Technical Skills for Surgeons (NOTSS)

**21 October, Wellington**  
Supervisors and Trainers for SET (SAT SET)

**22 October, Wellington**  
Keeping Trainees on Track (KTOT)

# WHAT IS THE DIRECTION FOR THE COLLEGE?



## The new President looks at where the College sits in a surgeon's life



MICHAEL GRIGG  
PRESIDENT

**W**hat is the place of the College? and 'where should it be?' are two questions I am frequently asked. Prior to being elected to the Presidency, I had often discussed these in forums of Fellows, but also importantly at senior levels of Government where I have been involved in a large number of clinical, consultative and advisory activities. As an aside I am pleased to be able to report that our College is highly regarded and respected.

Alas, there are too many surgeons who know the College only as the body that awarded them a FRACS qualification. For a time, I was in this

category – mind, you I was grateful because the FRACS determined the course of my career and I was fully aware of the prestige attached to this qualification.

But it was through my involvement with Government, prior to my involvement with the College, that it dawned on me how important strong professional bodies, such as the College, are. These professional organisations are the interface between individual clinicians and society at large and their authority is derived from the standards they profess and uphold. This has been the 'hallmark' of professional bodies for centuries.

“

**As an aside I am pleased to be able to report that our College is highly regarded and respected.**”

Our College was formed by Australian and New Zealand surgeons 87 years ago out of concern for the “degradation of the high standards” of surgical practice. Throughout its history, the key ‘flag-bearing’ issue is that of standards. Although our key strategic documents speak of a number of ambitions relating to excellence in education and engagement and support of surgeons within the community, it is the development and maintenance of standards for surgery that I see as continuing to be the prime driver for the College.

### So, how should we do that?

The first issue for surgeons as a profession, is to acknowledge that we must self-regulate ourselves with vigour and demonstrable rigour. This is our main defence against incursions into our areas of endeavour. What response is there to the proposition that podiatrists, in order to increase competition, should be encouraged to undertake lower limb joint replacements? The only acceptable response is that the demonstrable high standards demanded and achieved by properly trained orthopaedic surgeons have no equivalent.

Irresistibly, we are currently transitioning from an era where autonomy was valued to one where accountability prevails. If we do not self-regulate effectively, then external agencies or Government will fill that void, with a “glint in their eyes and with relish”. There are external forces that do not want to see strong professional groups as their focus is entirely on healthcare reform. The impediments posed by standards are more easily overcome if we are fragmented and fighting among ourselves. Having strong professional bodies, focusing on the key task of self-regulating for high standards is the first issue – the second is having that self-regulation recognised and valued.

So what does that entail?

Well, much has been written about standards in surgery. Our College is a world leader in documenting and explaining this through our training programs that highlight the nine competencies required to be a surgeon. It is not only the importance of being technically proficient that is critical to the surgeon. We now speak about these broader skills extending into issues of Professionalism, Scholar and Teacher, Management and Leadership, Communication, Health Advocacy. These are drawn from what the community expects of us. It is now how we train, examine and undertake our professional development.

The College Code of Conduct has been created to describe who we are and what our values are. It does not mince words. It is explicit with respect to standards – it does not use words like “a surgeon should” or “a surgeon should not”, but rather “a surgeon will” or “a surgeon

will not”. Our Code has been used to provide the basis of the codes of many other professional bodies. From my perspective, the Code is one of those ties that bind the Surgical Profession together, regardless of the anatomical zones of our surgical interest or the instruments we hold in our hands.

No conversation about demonstrable standards and competence is complete without mentioning the critical concept of audit. We need to document our outcomes and commit to audit of our practice. We need to do this for four reasons. Firstly we should have pride in what we do and be able to justify this pride. Secondly, audit is a practical manifestation of our ongoing desire to learn and improve. Thirdly, audit is a surgeon's best defence.

Every surgeon is all too aware that complications can occur, but when they do occur and precipitate concerns with respect to competence, audit provides the only appropriate, indisputable response. And fourthly, audit is the archetype activity of a professional in the 21st Century. It is for this reason, together with the fact that I as a surgeon, want to “own” the data that I believe surgeons should fund their own audit activities rather than waiting for, or allowing, third parties to be involved or instigators of audit activities.

There is a strong sense of history and the importance of standards within our College. It is present in all of our activities be it education of our Trainees, assessment of international medical graduates, professional development, overseas aid etc. I am totally converted to the belief that having a strong, dynamic College is vitally important for surgeons and the communities we serve – possibly more now than ever before.

Effective professional organisations require focus, sophistication, complexity, internal support and critical mass. I have mentioned a number of times in presentations about the growth and changes of the College over the past 30 years. It is staggering and will continue but it needs to be directed and managed well. It is predictable that there will be challenges, both internal and external.

The internal ones will relate to maintaining a critical mass without creating a bureaucratic monster that is not clearly here to serve us, surgeons attempting as individuals to do the best we can for our respective patients. External forces will attempt to create division and will attempt to weaken our commitment to standards either by questioning them in the name of healthcare reform or by attempting to impose alternative standards not derived from within the profession.

I am proud to be the President of the College, but I am more proud to be a surgeon and part of our College.

I look forward to discussing these and other important issues.



# HOT TOPICS AND THE REGIONS

You regional offices are working hard for issues that effect you

DAVID WATTERS  
VICE PRESIDENT



I am looking forward to serving the Fellowship as Vice-President and regard the opportunity to do so as a great honour.

One of the responsibilities within the Vice President's portfolio is the regional offices. Our New Zealand and Australian regional offices are a terrific hub of activity and I hope that every Fellow, Trainee and IMG will lend their support to the Fellows who serve on the regional committees. Councillor, Lawrie Malisano is the incoming Chair of the Board of Regional Chairs, a committee that seeks to coordinate, learn from and address the various regional issues.

Here are some statistics you may not be aware of. In 2013, the regional offices:

- Had 82 meetings with their ministries/departments of Health
- Engaged in 33 medical student or junior doctor events, reaching an estimated 5,000 potential future surgeons
- Supported clinical and fellowship exams for over 800 Trainees
- Organised and supported professional development workshops reaching 300 attendees
- Presented 13 Outstanding Service to the Community Awards to Surgeons

Your regional committees and the New Zealand National Board play a vital role in advocating for issues important in your region and to the College. How involved are you in your local committee or bringing items of importance to their attention? Do you know someone on the committee? Have you met the Chair? This link with the College cannot be underestimated.

You can also have your say by voting in the elections in your region. This is the first year the election process has been fully electronic and the return has been very good in comparison with other member-based organisations. I'm sure next year the participation will be even greater.

## Hot issues

Some of the hot topics in the portfolio are genuinely 'HOT'. Alcohol-related harm is an issue affecting both nations and all regions. Many, including the College, have written to leading or local politicians or made submissions to address the 'HOT' issues of Hours, Outlets and Taxes. In some regions, the government has already made legislative changes that we hope will have a positive impact.

Queensland's recent employment contracts for Senior Medical Officers have been heavily discussed by the regional committee. The College at both state and head office level have written to the Premier regarding our concerns for the potential to disrupt the service provided to patients and implications for the supervision of trainees and accreditation of hospital posts. Negotiations were continuing towards the April 30 deadline at the time of writing.

The New Zealand National Board deals with many issues on a national scale such as prioritisation, vocational registration processes, scope-of-practice and access to publicly funded elective surgery. Suitable Fellows and representatives of the College meet regularly with the Medical Council of New Zealand, Health Workforce New Zealand and their district health boards to advocate for these and many other issues.

South Australia and Western Australia are trying to sort through the challenges of change and implementation that comes

with the opening of new hospitals in 2015 and 2016. The issues include transferring units (and staff), accreditation of training posts and ensuring appropriate care for paediatric patients.

Each region has an audit of surgical mortality. Recent data suggests surgical and perioperative mortality is dropping. Barry Beiles recently presented a drop of 0.4 to 0.31 per cent in Victoria over 5 years. I believe it is important that we promote the value of these mortality audits to the public and the Ministries/Departments of Health.

To achieve this will involve contextualising their contribution to the health system, and one of the ways to accomplish this is to ensure that there are both denominators (the numbers of procedures) and risk stratification (it is generally the higher risk patients that are most likely to die). New Zealand's

Perioperative Mortality Committee Review Committee (POMRC) has issued two reports in 2012 and 2013. Their recent March 2014 progress report gives a perioperative mortality rate (death in hospital after a procedure) of 0.4 per cent and 0.09% for death on the day of a procedure.

## Learn from the experts

The ASC is always a great opportunity to refresh one's thinking and learn from experts. Perioperative Mortality will be discussed in a number of forums at this year's RACS ASC and ANZCA ASM in Singapore. The Quality Assurance Keynote speaker and British Journal of Surgery lecturer at the Congress is Sir Bruce Keogh, who is Medical Director of the National Health Service in England. He is a cardiothoracic surgeon and will cover "standardised mortality

rates" of Mid-Staffordshire fame and "Raising Quality Reducing Costs". In the week after the ASC he will be visiting the Health Departments and State Committees in New South Wales and Victoria.

Regional issues are important. Our interactions with and contributions to our State, Territory and National Health Departments are essential if, as a College, we are to be champions of standards, professionalism, and service to our patients.

During my term as Vice-President, I would be delighted to hear from you with regard to hot topics that require advocacy in your region. Though we are so often pressed for time, the value of establishing a consistent, trusted voice in our hospitals and health departments should not be underestimated.

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**Ban the third man**

NSW Fellow Merv Cross has supported the view that three-man tackles becoming prevalent in the NRL are too dangerous. He said the growing speed of the game mean that such tackles can have detrimental effects such as the recent case of NRL's Alex McKinnon. "They come in late and hit hard in areas where the ball carrier isn't protected. We have to look after the players. Sometimes they send in three or four defenders in to simply crush the attacking player," Mr Cross said.

**Daily Telegraph, 3 April**



**Parkassist for Surgeons**

Surgeons in Sydney are now using a robotic system that could be described as parkassist for spinal surgery. The system uses a CT Scan as a map to determine drilling hole placement as well as correct angles. Dr Jonathon Ball says it is a leap forward for the surgery, making the surgery more precise as well as improving recovery time and reducing pain.

**Adelaide Advertiser, 10 April**

### Training concern in Qld

The College warned Premier Campbell Newman that the level of actual and impending resignations by surgeons across hospitals and specialty areas could leave the Queensland hospital system 'unworkable'. The College expressed its concern in an open letter which stated reasons including the training of the next generation of Queensland surgeons. "Specialist surgeons are highly skilled and require many years of very specific vocational training. This needs to be under the close supervision of experienced surgeons." Urging a resolution, the College said "Destroying [Fellows] commitment, and trust thus forcing them to leave your health service will only be detrimental to the health services of the people of Queensland, and most likely take many years to recover."

**13 April**



### No 24-hour pub

A proposed 24-hour pub in Casula NSW has sparked protests from the surrounding community, including Trauma surgeon John Crozier. A spokesman for College's Trauma Committee, Dr Crozier believes the pub's extended licence will only lead to injuries as a consequence of alcohol consumption. "There is a 20 per cent increase in the probability of an event at a licensed premises requiring police response or presentation to the healthcare system every hour after midnight," Dr Crozier said.

**Liverpool City Champion, 8 April**

**DARWIN CONVENTION CENTRE, DARWIN, NORTHERN TERRITORY**

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**50th Annual Scientific Conference**

**PSA Scientific Program**  
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"Rural Trauma"

**Trauma Symposium Saturday 23 August**  
"Injury in Indigenous Populations - Learning from each other"

**FURTHER INFORMATION**

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*A collaboration between Provincial Surgeons of Australia, Trauma Committee and Indigenous Health Committee*



**Tri-Society Head & Neck Oncology Meeting 2014**

Thursday 14 - Saturday 16 August 2014

Darwin Convention Centre, Darwin, Northern Territory, Australia

To register online or to submit an abstract, go to: **www.anzhncs.org**

Abstract submission deadline: 25 May 2014

Australian and New Zealand Head & Neck Cancer Society  
Hong Kong Head & Neck Society  
Head & Neck Cancer Society, Singapore

**Perth**



**2014 NSA Annual Scientific Meeting**

Thursday 2 - Saturday 4 October 2014

Crown Perth Convention Centre  
Crown Perth, Perth, Western Australia

To register online or to submit an abstract, go to: **www.nsa.org.au**

Abstract submission deadline: 25 May 2014





# BUILDING SKILLS

Australian trained  
surgeon Dr Fred  
Boseto is using his  
skills to help his  
home country

PHIL CROWE  
NSW FELLOW

For many Australian and New Zealand surgeons who volunteer their time to work in the Pacific Islands, the motivation to do so often varies. Many will enjoy the 'warm and fuzzy' that glows when we help our near neighbours who are less fortunate than we are. It is often a sense of adventure and operating outside our comfort zones that is a motivation for others, but for Dr Fred Boseto, a general surgeon based in Bathurst, NSW, the motivation is a bit different.

Fred comes from a village on the island of Choiseul, one of the many islands of the Western Province of the Solomon Islands. Fred first came to Australia in 1997 and was accepted on the Surgical Training Program in 1998 at the Prince of Wales Hospital in Sydney. As Fred approached the end of his training, civil unrest threw the Solomon Islands into turmoil. The capital, Honiara, was burnt and ransacked and the Regional Assistance Mission to the Solomon Islands (RAMSI) force of upwards of 2,000 police was sent to the Solomons in an attempt to restore order. With a young family, Fred decided to remain in Australia and after stints in Darwin and Alice Springs, he is now a successful general surgeon in the central tablelands of NSW.

Although Dr Boseto left the Solomons 15 years ago, and the RAMSI force is now down to 150 personnel, nothing much has changed in the third world nation's health services. So in 2012, Fred began regular visits back to his home in the Western Solomons to provide basic surgical services. He has been accompanied on these trips by colleagues from Bathurst, surgeon Dr Neil Meulman and

an anaesthetist, Dr Andrew Dubyk. A fourth surgical visit was recently completed by Dr Boseto, accompanied by Professor Philip Crowe and Dr Anthony Hull from Prince of Wales Hospital, and they were ably assisted by two theatre nurses from Lithgow Hospital.

The trip began with a visit to the chronically underfunded National Referral Hospital in Honiara which exemplified the difficulties of delivering surgical services in the Solomon Islands. The Solomon Islands' Government spends an average of (US) \$99 per person per year on health services, compared to Australia's \$5,000 per person per year. However, after travelling by plane then canoe to Gizo in the Western Province, the perception dramatically changes.

The Japanese Government recently completed a superbly designed and well-built hospital with excellent surgical facilities. Unfortunately, there are no surgeons or anaesthetists based at the 100-bed hospital and surgical care is delivered intermittently by in-country specialists visiting from Honiara or Munda or overseas teams.

## Important visits

During the recent visit in September/October last year, the visiting surgical team performed 100 consultations and operated on 50 patients during the 10-day visit. The range of procedures done was broad: hernia repair, hysterectomy, repair of wound from crocodile attack, open prostatectomy, parotidectomy, laparoscopic cholecystectomy and laparoscopic appendicectomy to name a few. The local surgical Trainee from Honiara was present for all the major procedures performed by the visiting team, and this capacity building has been an important part of these trips to the Solomons. ▶

L-R: OT nurse Tammy Mackenzie, Dr Fred Boseto, Professor Philip Crowe and Dr Michael Buin (surgical trainee registrar from Honiara)





L-R: OT nurse Patricia Worth,  
Dr Andrew Soma (Gizo doctor)  
and Dr Anthony Hull



The case of Mrs Kareba illustrates the problems of managing common surgical conditions in the Solomons. Mrs Kareba gave a good history for a bowel cancer, but there were no facilities to confirm the diagnosis, (other than by abdominal ultrasound). Rather than travel a full day to Honiara for further investigations, away from her family and friends, she was quite happy to die of the consequences of her likely diagnosis.

Even in Honiara, a biopsy is of no value as there are no histopathological services in Honiara; all specimens being sent to Brisbane, where the results are returned three months later. Mrs Kareba was fortunate that the visiting team was able to operate and remove what was indeed a localised sigmoid colon cancer that was almost certainly curative.

These visits are now being held twice a year, with one visit a year supported by the Pacific Islands Program (PIP) being managed by the College on behalf of the Australian DFAT. However, if Fred Boseto has his way, there will be many more visits and not just from general surgeons, but from surgeons of any specialty that might help improve the surgical care of his people.

## Thank-you

The College extends a big thank you to Cook Medical, which donated a new StoneBreaker pneumatic lithotripter to the Pacific Islands Program in April. This equipment will enable RACS' volunteer urologists to perform kidney and bladder stone removal surgery using minimal invasive surgery techniques, for the improvement of surgical post-op recovery of patients in the Pacific region.



Helen Postma, RACS Medical Equipment Coordinator,  
Kell Jones, Cook Medical National Sales Manager and  
Justine Moran, Cook Medical Territory Manager.

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## WHEN AM I TOO OLD TO OPERATE?

How do we assess  
our older mentors and  
when do we recommend  
they retire?

**DR BB G-LOVED**

**R**ecently Mr Burt Enderleng, a surgeon in his early 70s, consulted me. I thought it was just going to be a routine meeting, but it turned out anything but.

I always like to call a patient into my consulting room personally. It gives me an opportunity to observe them walking, notice something about their posture and ease of movement. What I saw was

an ageing 70-plus year-old, and not the person I remembered as a junior doctor, and certainly no longer a dynamic individual who oozed with ability.

His gait showed the typical drop of the arthritic non weight-bearing hip; he moved slowly, but steadily without making me think he might fall. "How nice to see you again," I smiled. I had always liked him. Though he had been a patient in the practice for a number of years, I hadn't seen him myself for three or four. His case notes revealed the common comorbidities of hypertension and hyperlipidaemia, with type 2 diabetes developing in his 60s.

He had been an active sportsman in his youth, but was plagued by arthritis for which he took non-steroidal anti-inflammatories. About 10 years ago he was self medicating with celecoxib, but I persuaded him to stop when the scare about heart attacks was raised with rofecoxib in 2004. He hobbled into the room and sank into a chair. I must say I wasn't quite sure what or how much analgesia he was taking now.

"Are you still in practice, Burt?" I asked. "Oh yes," he puffed in response, still in oxygen debt from the effort of crossing the waiting room, "But that's the reason for my attending today. I wanted your opinion: should I still be operating?"

He had been a great and influential surgeon in his day. A hard-worker, he was the strong and confident type who won the respect and admiration of all his Trainees and junior staff. He'd had the occasional clash with colleagues, but was generally collaborative and supportive, graced with an instinct for diplomacy that had enabled him to put out many administrative and craft group fires. When he retired from his public hospital in his late 60s he continued in private, both consulting and operating.

Recently his cases had experienced some complications. There were whispers in the corridors (even I had heard them), but whether anyone had spoken to him I did not know. I wonder to whom he presented an audit of his practice for peer

review. That would be a matter for the College CPD department.

I asked if he had considered using a multisource feedback tool to have his performance assessed by those he worked with. I'm not sure he understood what this was, so I explained that the College does have such a tool and even if he only asked six other surgeons to rate his performance across the College competency framework this would be worthwhile – an important reassurance or otherwise. He had recently had his vision checked and though there was an early cataract, his optometrist had cleared him to operate.

In assessing and advising him I had to consider my own bias. When applying the BB G-loved eyeball test (when watching him move would I want him operating on me and my family?), the answer now is definitely not! Wouldn't want to risk it, no matter how good he'd been in the past.

I needed to consider his ability to physically do an operation. I asked him how long he could stand; he admitted he preferred to sit down to operate and had a lot of pain if on his feet for longer than an hour. He did take analgesics on operating days and sometimes took endone on a bad day.

I assessed him for tremor (none); his hands were supple despite an early Dupuytren's without contracture; I watched his fingers when unbuttoning his shirt preparing for an examination of his chest (no problems), although he struggled to remove his socks (the hip).

I had him write a sentence on a piece of paper – the words were legible and normally formed; no trouble there. I had him do the spiral drawing test (normal) to exclude Parkinson's, intention tremor and dystonia. I watched his fingers message me with his smart Phone – this is not evidence based, just a personal screening test for manual dexterity.

But what of his cognitive function, decision making and judgement? Next month I will tell you how Burt Enderleng fared with a mini-mental and neuropsychological evaluation.

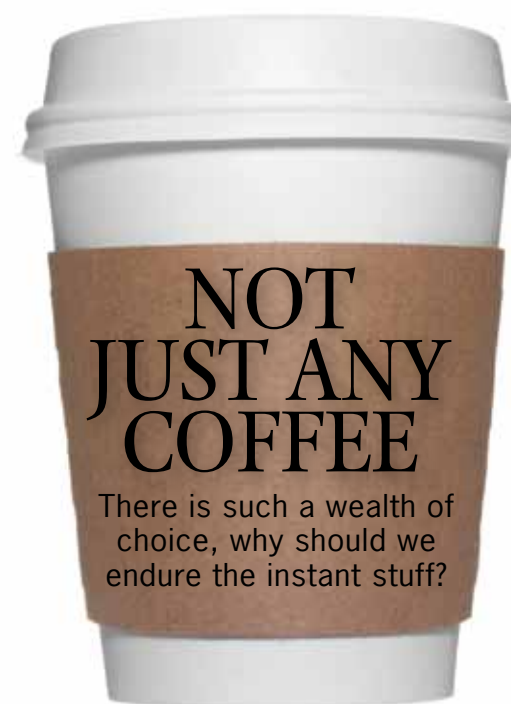


BY **PROFESSOR GRUMPY**

**T**here is one thing that really annoys me and that is coffee. Before the coffee aficionados among us protest let me explain further. I love coffee and therein lays the problem. Good coffee stimulates the senses, awakens the creativity and makes one feel human. It finalises a perfect meal and starts the day. But bad coffee – that is another story! We curmudgeons are very fussy about our coffee and will not be deceived.

So many coffee shops sell coffee that is too bitter. I know that some people like bitter coffee, but many don't. In all fairness they should offer two version of coffee – bitter and not bitter. If Indian restaurants can offer a level of hotness of the curries why shouldn't coffee shops do likewise? The airlines seem to serve very bitter coffee – I now know why. It is so that you blame the coffee for your indigestion rather than the true cause – the plastic food.

In the US I recently noticed a very unethical coffee marketing trick. This large (indeed very large) coffee franchise now sells double shot and even triple shot coffee. This is necessary as the standard shot is now so weak as to taste like water with a bit of brown sludge in it.



Of course, there is an extra charge for the extra shot. Maybe the instant stuff that seems to be so prevalent in organisations is not so bad – at least you can double or quadruple the flavour, albeit the rather unpalatable flavour.

The worst coffee, without a doubt, is that served in hospitals and, I regret to say, at the College. There must be something in medical circles that demands poor coffee. I think it goes by the name of Commercial Blend. That is a fine name, but blend of what? Barley, wood chips and corn husks? It has no aroma, a sallow taste and does not stimulate the senses.

I have spent many years on various College committees and the only thing of relevance that I have achieved was that in 2008 (with the help of a Queensland Judge who was a Council member at the time) we managed to get a brewed coffee at Council coffee breaks rather than the instant stuff. My influence was so great that as soon as my judge friend left the Council the anonymous brown stuff came back.

On a recent visit to the hallowed halls of Spring Street I was delighted to find a pod coffee machine. However, as you can imagine the College has a policy on coffee pod machines. They may only be used in the Council Room and for similarly important meetings. Curmudgeons Anonymous does not qualify.

## IN MEMORIAM

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

**Ian Farmer**  
Victorian Fellow

**Sarath Senanayake**  
ACT Fellow

**Alan Nicholls**  
NSW Fellow

**Roy Fink**  
Victorian 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](http://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



# MAKING SURGERY SAFER

## Professor Russell Gruen leads a team in the research of blood clotting and improving outcomes for trauma patients

The 2013 recipient of the College's most prestigious research fellowship, Professor Russell Gruen, is using the attached funding to further his team's work to better understand blood clotting in patients who are injured, or who are undergoing surgery, with the goals of finding effective ways of supporting coagulation in bleeding patients, and making elective and emergency surgery safer.

Professor Gruen, a general and trauma surgeon at The Alfred Hospital, Professor of Surgery and Public Health at Monash University and Director of the National Trauma Research Institute (NTRI), was awarded the John Mitchell Crouch Fellowship at the Annual Scientific Congress last year.

One of Australia's leading surgical researchers and academics, Professor Gruen has attracted research funding totalling more

than \$15 million and he is currently the lead investigator of an NHMRC-funded multicentre trial of the effects of pre-hospital tranexamic acid (TxA) given to severely injured patients (The PATCH-Trauma Study).

He is also a Lancet Commissioner in Global Surgery, has led the development of an Australian National Trauma Registry, and leads a Centre of Excellence in Traumatic Brain Injury Research for the Victorian Transport Accident Commission.

Professor Gruen said the \$150,000 stipend attached to the John Mitchell Crouch Fellowship was providing crucial support in two ways. First, it was helping to add value to the PATCH-Trauma Study by investigating injured patients for possible harmful effects of tranexamic acid such as increased rates of deep venous thrombosis. Second, it was allowing preliminary

“

*Professor Gruen said it was a great honour to receive the Fellowship, the endorsement of his surgical colleagues and the financial support of the College.”*

work to be conducted on the current peri-operative management of patients taking blood-thinners such as Warfarin or aspirin, with a view to a future trial of the optimal strategies.

“The relationship between bleeding and surgery is very complex,” he said.

“In the normal state, there is a natural balance between the formation of blood clots, and their breakdown. Without these active processes constantly at work, we would bleed to death from relatively minor injury, or we would develop harmful clots leading to strokes, myocardial infarction or pulmonary emboli.

“This balance can be affected in a variety of ways, but especially by taking medicines to ‘thin the blood’ by limiting clotting, and by significant ‘injury’, as can occur in major surgery and in severe trauma.

“We are now looking at this issue from a range of angles.”

The PATCH-Trauma Study is a major international trial examining the effects of tranexamic acid (TxA) on fibrinolysis, inflammation and neurotoxicity following trauma. TxA was found 50 years ago to competitively inhibit conversion of plasminogen to the active protease, plasmin, thereby inhibiting fibrinolysis and clot breakdown, but was little used in trauma care until the publication of the landmark 2010 CRASH-2 study (Clinical Randomisation of an Antifibrinolytic in Significant Haemorrhage). It found an almost 10 per cent reduction in trauma deaths in patients who received the drug on arrival at hospital.

Professor Gruen said that since then there had been an international push for the inclusion of TxA in trauma management protocols with first responders urged to administer the drug within three hours of injury.

However, he said there were significant knowledge gaps remaining that needed to be filled so that clinicians better understand which patients benefit from the treatment, and which may be harmed.

He said that although the CRASH-2 study was an important development in the treatment of trauma patients, 98 per cent of patients were recruited in developing countries.

“The findings of CRASH-2 have been interpreted by some as definitive evidence that all trauma patients everywhere should be given TxA within three hours of injury,” Professor Gruen said.

“However, fewer than two per cent of the patients in that study were treated in countries that routinely provide rapid access to blood products, damage-control surgery and angiography, and advanced critical care. In Australia, since the introduction of organised trauma systems with high-quality ambulance and hospital care, fewer deaths after injury are actually preventable. So we are testing whether we get mortality or other benefits from the drug alongside all the other routine treatments, and importantly, that we are not causing harm by administering the drug.

“We know that while some severely injured patients present with an early coagulopathy, many such patients go on to develop a hypercoagulable state and also that pulmonary embolism and deep vein thrombosis are common and potentially lethal problems in Australasian trauma centres, yet were reported very rarely in the CRASH 2 study.

“Another major knowledge gap concerns how TxA affects other processes, including inflammation, and other cell functions. We might find that TxA is useful in non-bleeding patients as well, or that only a subgroup of injured patients benefit. Understanding all of this could change the management of almost 10,000 severely injured patients in Australia and New Zealand every year.”

The PATCH-Trauma Study is enrolling 1200 patients in Australian and New Zealand over four years.

“It's great to work with the highly professional ambulance and helicopter services and the trauma centres in both countries to solve such important questions,” Professor Gruen said. “Australia and New Zealand have a history of successfully carrying out large multicentre trials that change practice across the world and without such expertise complex trials like PATCH-Trauma would be impossible.”

On the elective surgery front, Professor Gruen's group is interested in the best way to manage blood-thinning medications that increasing numbers of patients take to reduce their risk of stroke and heart attack. These medications can create problems around surgery, especially by increasing the risk of bleeding.

“If we can understand this process and the best way to manage or counteract anti-coagulation agents, surgeons across all specialties will be better placed to prepare patients for both elective and emergency surgery and reduce the risk of post-operative bleeding,” he said. ▶





Professor Gruen said that a variety of perioperative approaches are being used for the different anticoagulant and antiplatelet drugs, but that a significant and unacceptably high number of patients still suffered post-operative bleeding, despite these protocols. Some of these patients needed readmission to hospital or repeat surgery.

“This is a field where new drugs are emerging, many of which don’t have a simple reversing ‘antidote’, and where the risks of stopping the medication to minimise bleeding during surgery need to be balanced against the increased risks of stroke or myocardial infarction,” Professor Gruen said.

“We simply don’t yet know what is currently happening or how patients are currently being managed and what the actual rates of bleeding and thrombosis are. Our research aims to establish some baseline data across a range of specialties in both public and private hospitals to see in preparation for a future trial of optimal strategies.”

With a team of 45 scientists, trauma experts, clinical researchers and PhD students, Professor Gruen’s aim is to ensure which practices and systems of care are based on a good understanding of biology and evidence of what works.

“Where the understanding of biology is developing rapidly, as it is with coagulation, we need to be ready to change what we do as new information becomes available,” he said.

“This is a great challenge for all of us – keeping up with current knowledge and being open to doing things differently.”

The John Mitchell Crouch Fellowship was established in 1978 by Mrs Elizabeth Unsworth in memory of her son, a neurosurgeon and surgical researcher, who died at the age of only 36.

Since then, it has been awarded to some of Australia and New Zealand’s leading surgeon/academics, some of whom have undertaken world-first research to improve the care of surgical patients around the world.

Professor Gruen said it was a great honour to receive the Fellowship, the endorsement of his surgical colleagues and the financial support of the College.

He said such support was crucial to “game-changing” research.

“Conducting game-changing research, as many Fellows will know, requires a great deal of preparation, before major national grants will even be considered,” he said.

“This work includes conducting background research, designing trials and forming synergistic partnerships and much of that would be impossible without such funding as that provided by the College.

“It also represents support to do what I love to do, that is combine surgical skills with an enquiring mind to improve the outcomes for surgical patients – in this case both trauma and elective patients across all surgical specialties.

“But of course all significant projects are only possible with a large team of researchers, so while I feel proud to have received the John Mitchell Crouch Fellowship I am also humbled by the calibre of the people I work alongside.

“I also found it moving to receive this Fellowship named in honour of a surgeon who died so young and before he could fulfil his dreams to improve the care of patients within his specialty of neurosurgery.

“Conducting research under the banner of the John Mitchell Crouch Fellowship therefore means that his commitment to surgical research continues.”

**With Karen Murphy**



## DELAY IN DEFINITIVE TREATMENT

It is important to consider comorbidities in elderly patients when considering colonoscopy

Join the discussion <http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2014/anzasm-case-note-review-may-2014/>

**GUY MADDERN**  
CHAIR, ANZASM



An elderly patient with significant cardiac disease underwent gastroscopy and colonoscopy to investigate dysphagia, altered bowel habit and weight loss. A perforation was diagnosed during colonoscopy and the procedure was abandoned. Initial management was conservative with observation and antibiotics. The following day because of worsening pain, tenderness and hypotension, the patient underwent laparotomy with washout and exteriorisation of a sigmoid perforation. The patient died shortly after laparotomy from acute myocardial infarction and severe acute pulmonary oedema.

The hospital case notes document the sequence of events well. The operation findings at laparotomy were deficient in the operation report with no information on the size of the perforation, the degree of contamination by faeces or the presence of purulent peritonitis.

### Reviewer’s comments

Although there must always be concern with performing colonoscopy in elderly patients with cardiac disease, in this case the indication seemed reasonable.

The need for laparotomy versus conservative treatment is often a difficult decision. A conservative approach was adopted as the erect chest x-ray demonstrated no free gas under the diaphragm and as the surgeon appeared to have some doubts if there actually was a perforation. Perhaps a CT scan of the abdomen might have added to the clinical picture and helped formulate the treatment plan?

Junior staff faithfully recorded the overnight deterioration and abdominal signs suggesting the onset of peritonitis in the notes, but did not seem to act or inform the consultant of what was a clear indication for urgent laparotomy.

The acute mesenteric ischemia (AMI) and resulting acute pulmonary oedema may not have been preventable, but did contribute considerably to the patient’s death.

It is important to consider comorbidities in elderly patients when considering colonoscopy. If a colonoscopy is performed to look for a possible bowel cancer, but the patient is not deemed fit for major resection then colonoscopy may not be appropriate. Some may argue, however, that if polypectomy can be performed, this may prevent bowel cancer.

In patients who are being actively observed, with a provisional diagnosis of possible bowel perforation, then evidence of deterioration or progression of signs must be passed on to the senior consultant responsible. These worsening signs cannot be ignored and are often indication for laparotomy.



A change in  
government  
calls for  
renewed  
focus

# NEWS FROM THE TIP



**BRIAN KIRKBY**  
CHAIR, TASMANIAN REGIONAL COMMITTEE

Tasmania has just gone through a change of Government following the recent election. The Liberal Party has formed government with a comfortable majority having last been in government in the mid 1990s. This is a significant change from the Labor Government and most recently the Labor Greens Government.

We are currently awaiting an announcement as to who the new Health Minister will be. We hope that a good open and collegial working relationship will be able to be established with the new Health Minister along similar lines to the relationship that we had with the outgoing Health Minister Michelle O'Byrne. Despite the fiscal difficulties experienced over the past few years in Tasmania, the value of a strong relationship between the College and the Health Minister was demonstrably invaluable.

The change of Government is significant from a surgical point of view.

The incoming Liberal Government has committed \$60 million to additional elective surgery. They have also given a commitment to assist with the separation of elective and emergency surgery. This aligns with the College position in this area.

There have been a number of fatal cycling accidents in recent times in Tasmania, with a significant proportion of these involving motor vehicles. The Regional Committee of the College along with the Chair is commencing an education campaign involving both radio and print media as to the issues around the safety of cyclists and the need for motorists to give them adequate room and sufficient respect. This will involve radio interviews and newspaper articles as well as the use of social media, tapping into the current '1 metre' campaign being run by some of the cycling entities.

We plan to utilise some of the Tasmanian College Fellows who are involved in the cycling fraternity to push these educational efforts. There have also been additional discussions and support from some of the Tasmanian hospitals in terms of the cost to society both in terms

of the deaths and injuries to patients, as well as the costs of providing treatment to those injured in cycling accidents and the impact that these injuries have on other work streams of the hospital such as elective surgery and bed occupancy.

Recruitment of surgical consultants especially in the smaller sub-specialties such as Plastic and Reconstructive surgery and Ear Nose and Throat surgery remains an issue for Tasmania. It is difficult to compete with the major metropolitan centres where a significant amount of registrar training, especially when earning capacity is not as great and there is essentially a reliance on lifestyle issues as a means to entice potential surgical specialists to town.

This means that Tasmania continues to rely significantly on International Medical Graduates to fill positions such that a sustainable service is able to be offered to the patients. It is hoped that the Training More Specialists in Tasmania funding provided by the Commonwealth Government and administered as part of the STP by the College will go part of the way to addressing this situation.



## MALT AT FULL SPEED

MALT fully rolled out to Trainees, IMGs and Fellows in all nine specialties

**ASSOCIATE PROFESSOR IAN BENNETT**  
CHAIR, LOGBOOKS AND CLINICAL AUDIT OVERSIGHT COMMITTEE



The Morbidity Audit and Logbook Tool (MALT) is a system that the College has developed for all Trainees, IMGs and Fellows to use as an electronic log of procedures and/or to self-audit. MALT has been gradually rolled out to each of the surgical specialties and is now available for use in all specialties.



### MALT as a training logbook

Trainees, IMGs and Fellows subspecialising can use MALT to electronically record their logbook. For Training Boards that accept MALT reports, production of end-of-rotation reports for the Training Boards is straightforward. To confirm if your Training Board is using MALT, see your specialty page at [www.surgeons.org/malt](http://www.surgeons.org/malt)

MALT allows Supervisors to monitor the progress of their Trainees. They can access the Logbook of each of their Trainees to view cases entered and, where the specialty uses a supervisory workflow, to approve cases that have been sent to them. They can also produce logbook reports on the Trainee, including reports for a Trainee's past rotation periods which means that Supervisors can use MALT to get an idea of the previous experience a Trainee is bringing to their new rotation.

### MALT for self-audit

MALT was designed to incorporate the College-recommended minimum and expanded datasets for audit as described in the Surgical Audit and Peer Review Guide. It allows all users to optionally record data for self-audit purposes.

A series of set audit reports are available from MALT. In addition, many more reports are available in the new custom reporting tool, where users can easily determine the parameters (inclusions/exclusions) and preferred layout (graph, table, etc.) of the data they need.

The range of audit reports reflects most of those recommended in the Surgical Audit and Peer Review Guide and more will be added over time until the full list of suggested reports are available.

Users can also export their data from MALT to analyse.

### MALT for peer-reviewed audit

MALT has the potential to be set up as a peer-reviewed audit. The Morbidity Audit department has experience in setting up and managing audits for specialty groups. The team can work with you to develop a custom logbook and reports for participants and provide administration, management and user support for the audit.

Enquiries on using MALT for audit are welcomed from members of the College, but also from specialty societies, professional organisations and other clinical colleges. This additional service attracts a cost.

### J-Docs

The College is currently working on piloting use of MALT for J-Docs – junior doctors preparing for a career in surgery.

### Importing data into MALT

Already entered data on your operative experience into an alternative system? No problem. Data from existing sources can now be imported into MALT, no need to manually enter this data again.

The simple three-step process for import involves uploading the data, mapping your fields to MALT and mapping your values to MALT. MALT will even save the mapping on previous files so that when you upload a new file, you don't need to re-map every field and value.

An Import Template is now available from the MALT webpage to assist in the importing process. By formatting your data according to the template, the Import Tool will automatically know which fields match the fields in MALT, decreasing the amount of time you need to spend in mapping.

### Accessing MALT

1. Enter [malt.surgeons.org](http://malt.surgeons.org) into your browser.
2. Log in using your College username and password.

Alternatively, links to MALT can be found at [www.surgeons.org/malt](http://www.surgeons.org/malt) or on your 'My Menu'—'My Logbook' for Trainees and IMGs or 'My Audits' for Fellows.

Further information on MALT, including video guides and information specific to specialty or user group, can be found at [www.surgeons.org/malt](http://www.surgeons.org/malt). There is also a dedicated MALT HelpDesk available during CST business hours: [malt@surgeons.org](mailto:malt@surgeons.org) or +61 8 8219 0939.



Take the time to  
stop and think

and maybe call  
your loved ones

# WHAT DO I WANT? WHAT DO I NEED? HOW DO I GET IT?

**RICHARD MARTIN**  
WA FELLOW

Death is with us constantly, it's on the news, it's in our stories, it's part of our culture. Every day you are just a moment away from joining the great majority. Mostly we are barely aware of it, rarely dwelling on the inevitability of our final destination. But it is always there, much closer than you think.

My sister died in November last year. At the age of 37 with four small children; it was way too early, way too soon. Nothing prepares you for that. The grief, the disbelief, the emotional turmoil, the disequilibrium, the uncertainty; it all came so unexpectedly.

I'd often criticised her for not thinking more of the future, for not planning ahead, for not being more prepared. She lived life always in the moment, with intensity, with passion and often well beyond her means. She had the things she wanted, when she wanted, she lived life on her terms, and I believe she lived with no regrets.

"You can't change the past, but you can ruin the present by worrying about the future."

I was and always would be different, chalk to her cheese. I previously lived very much with my eyes on the future, my head in the clouds, always thinking about tomorrow. My calendar was booked 12 months in advance, safe in the knowledge that my sacrifice today would be rewarded sometime later on.

Everything changed after Louise died. I was in Melbourne at a workshop when I got the news that she had been admitted with a 5cm intra-cerebral haematoma. I had to fly back to Perth to collect my passport so I could fly all the way back east to NZ to be with her.

**Lesson 1. Always travel with your passport; it just might make a difference.**

I understand what fixed dilated pupils mean. I know what an ICP of 60 for a prolonged period of time means. I have spoken to families and loved ones about futility of treatment many times before, but I could not let my sister go.



Louise Elaine Martin  
12 May 1976 -  
19 November  
2013

**Lesson 2. Having family means not having to make all the hard decisions on your own.**

**Lesson 3. Knowing the right thing to do is very different to being able to do the right thing.**

In planning for the funeral, I had to work out how I was going to inform everyone. I didn't know any of her friends, and as I never read the obituaries I assumed they probably wouldn't either.

**Lesson 4. Facebook is an unparalleled way to inform your social network of important events.**

**Lesson 5. Your life is in your smart phone, keep it safe and use a strong password!**

It dawned on me that my family only get together at funerals and weddings these days, and as most of us have been married already, funerals are sadly by far the more common event. Our lives become too busy to think about those that mean the most to us. And time passes so very quickly. Our priorities have a way of feeding our material desires, leaving little sometimes to nourish the soul.

**Lesson 6. Keep in touch regularly and often, especially with family.**

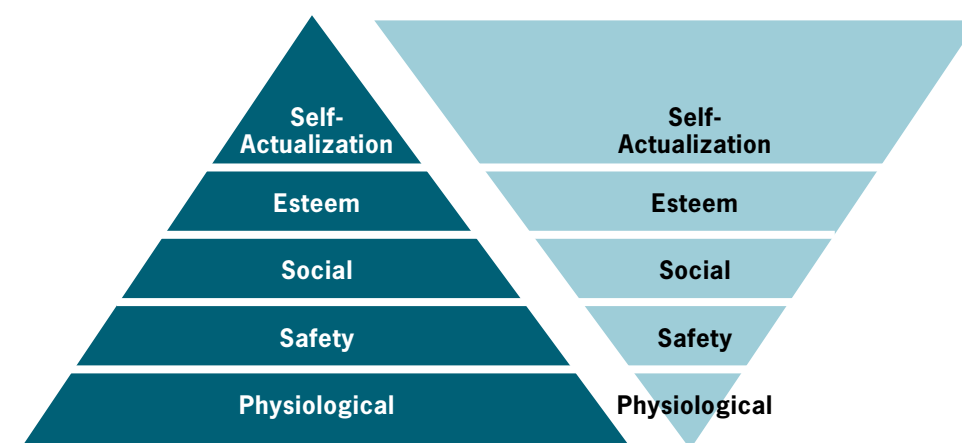
I've found it hard to plan more than a few weeks ahead since Louise passed away and I still think about her every day. I realise my life has become consumed with work, focusing on the future but sacrificing the present. Money, mortgage and bills have become all consuming pursuits.

I was struck by how little there was left after Louise died. There were some papers, some bills, some clothes and trinkets. A life encapsulated in a couple of suitcases. The thought left me empty at how little an impact we make on the world, how important we think we are, but in the end how faint the mark we leave behind, barely a whisper of our existence.

After the funeral I thought long and hard about the big questions: What is it all about? What does it all mean? What do I want from life? What do I truly need? And how was I going to get it?

Every part of my day to day existence went through the sieve. Did I want to keep working at all anymore? Was what I was doing really important to me? What did I gain from it? Did I enjoy it? Was it really necessary? Why was I doing it?

Ultimately I accepted my existence. I don't question if there is a grand plan or a greater purpose or a higher authority. Ultimately I want simply to be happy in



whatever I do, and to do the things that make me happy.

According to Csikszentmihalyi, happiness comes from becoming completely immersed in an activity, or in other words, the "flow" where temporal concerns (i.e. time, food, ego self) are all ignored.

Being intensely focused on an activity, that is of our own choosing, that is neither under nor over-challenging, that has a clear objective and that gives immediate feedback, is thus the secret to happiness.

Surgery gives me that, as does surfing, skiing, wine tasting, and many other physical pursuits. Spending time with my family is both intensely rewarding and exhausting, and getting the balance right between all those things is a challenge in itself.

There are three simple questions you can use to evaluate how happy your life is, or should be. If you can answer yes to one, you can exist, but little more, yes to two and you can be happy, yes to all three and you are in paradise.

**Question 1:** Are you mentally stimulated every day?

**Question 2:** Are you physically stimulated every day?

**Question 3:** Do you have family?

For many of us we may already be living in paradise, we may not realise

because we are constantly distracted by all the advertising telling us that we can be happy if only we bought brand X. Understanding the powerful psychology behind these lies is important in the realisation and understanding the things that you actually need, and how to find real lasting happiness.

Mostly the things we want are not actually the things we need. This is neatly demonstrated in the Maslow Pyramid.

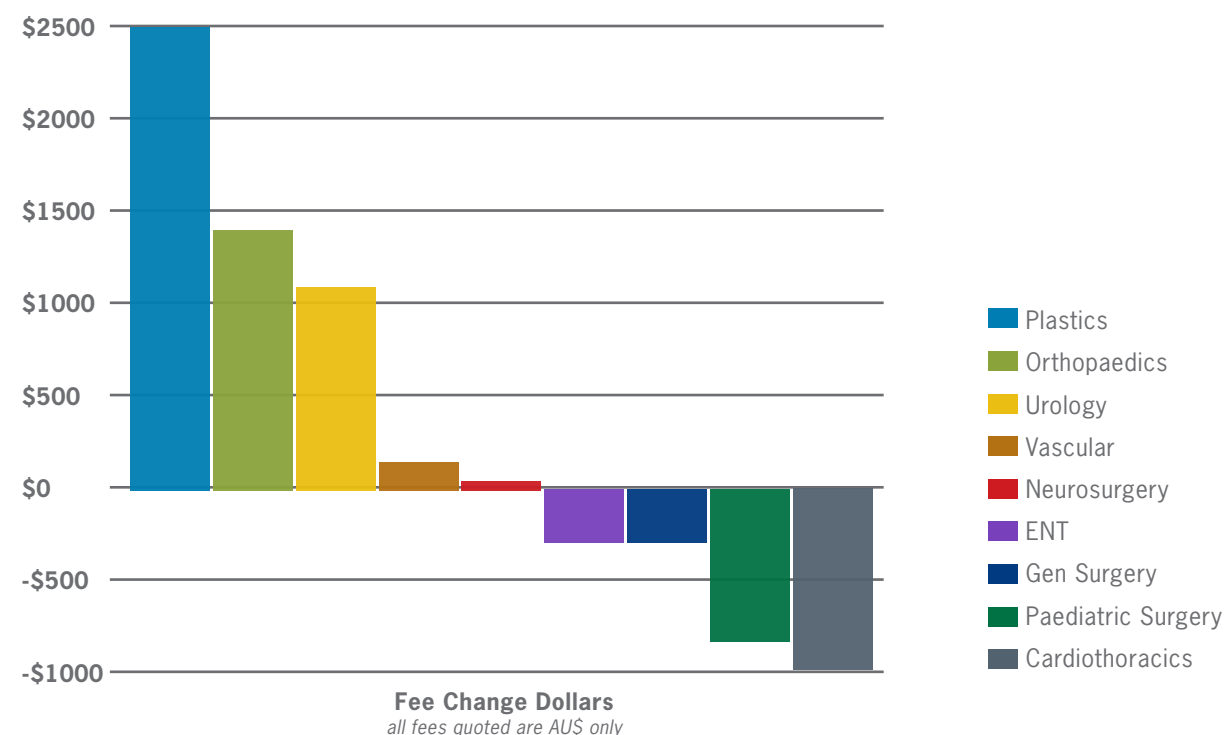
## What you need What you want

Only once you understand what it is you truly need as opposed to what you want, can you map a path to how you can achieve it. Knowing what it is that makes you truly happy is the key to unlocking that happiness. Buying material goods is an adrenaline 'hit' but like a drug, the happiness never lasts.

Family, love, charity, performing a worthwhile task to the best of your ability are the Serotonin stimulants that provide long lasting rewards.

We forget that every day is a gift, filled with precious moments that are all too easily overlooked. Each day is there to be lived with vigour, with intensity, enjoyed for all its glory. It is important to pause for a moment each day and be thankful for all you have, as you never know if it just might be your last.





# TRAINING FEES INCREASE

Nothing seems to incite a riot like increasing training fees. The last two months have seen an unprecedented demand for RACSTA's services. Never before has there been such an interest in where our money goes. So here it is: all we know.

**GRANT FRASER-KIRK**  
CHAIR, RACSTA

As you may know, every Trainee pays a College SET fee and a specialty SET fee. The College SET fee this year was AUD3000 in Australia, and NZD3800 in New Zealand. What you may not know is that the College then passes a proportion of this fee on to the specialties. All the College fees go into a pool. From that pool, \$94,500 is passed on to each specialty. What happens to that money is up to your specialty board. It may seem unfair that the smaller specialties get the same amount as the larger specialties. The reason for this is simple: our college has – and always will – opposed the charging of different fees for different specialties. Under the current system, larger specialties subsidise smaller specialties. This aims to overcome the fact that smaller training programs generally cost more to run, as they miss out of cost benefits associated with having more Trainees. (If this weren't the case, Paediatric Surgery Trainees, for example, would pay a far larger amount for their training.)

Total fees payable by each Trainee per year are available on the college website. I compared these amounts to the \$6000 we paid last year, using Australian fee data to simplify the analysis. It makes for some interesting reading.

As you can see, the majority of Trainees seem better off. There are some notable increases however. Three specialties in particular have increased their training fees significantly. If you delve deeper, it is revealed that these specialties engaged the same independent contractor to estimate the costs of their training program. It is unclear if the extra \$94,500 dollars has been factored into this costing and it remains to be seen if other specialties will follow this example. Costing explanations have been confusing and, at times, grossly inaccurate. Hopefully as real data is fed into the analysis, these inconsistencies will even out. As our specialty boards and associations adjust to their greater autonomy within the training space, we should see the duplication of services to Trainees eliminated. This may see more savings passed on to Trainees.

Is this article provocative? Perhaps. As Trainees, we appreciate that a world-class training program has certain – and often significant – costs associated with it. We are indebted to the consultants and mentors who give up their time pro bono to train us. What we can strive for, however, is transparency and accountability. I urge you to be aware of what is happening in your training sphere. Every specialty has a Trainee representative who has contact with the appropriate specialty board and the RACSTA board. Should you not be able to contact that person, I am happy to be contacted directly.

## New course for Educators

A new course provides foundation resources for a range of educators



**STEPHEN TOBIN**, DEAN OF EDUCATION  
**JULIAN SMITH**, CHAIR, ACADEMY OF SURGICAL EDUCATORS



The Foundation Skills for Surgical Educators course will be collaboratively developed between the Departments of Professional Development, Skills Training and Education Development and Research, to ensure it is relevant and applicable to the faculty training programs of each area. The development process has reviewed all of the surgical teaching and faculty development programs throughout the College and will integrate them into a progressive competency model, ensuring they are all linked together, present a consistent message and build on the knowledge and skills of the preceding courses rather than overlapping and repeating content.

The Foundation course will take the 'flipped classroom' approach whereby participants will first gain exposure to their learning needs and a small amount of new material prior to attending a one day face-to-face course. The expectation is that students will attend the face-to-face course with an established purpose, a reasonable amount of background knowledge and an understanding of the way information will be presented and organised within the course. The flipped classroom will help participants to recognise their strengths, weaknesses and impact as a teacher and think about their own growing understanding of what constitutes a surgical educator.

The course will be presented over one day and will cover such topics as:

- Understanding myself as a teacher
- Introduction to teaching
- Planning a learning process
- Understanding learners and supporting learning
- Recognising teaching and learning opportunities
- Assessment
- Feedback

It is hoped that by the end of the course, participants will be able to identify personal strengths and weaknesses that are likely to influence their learners and the learning environment. Participants will further their knowledge and skills in teaching and learning concepts and be able to apply those principles into their own teaching context.

The course will be piloted in August and September this year. If you are interested in being involved in the pilot process as a faculty member or participant, please contact Alicia Mew, Education Development Coordinator, Professional Development Department on +61 3 9276 7440 or [alicia.mew@surgeons.org](mailto:alicia.mew@surgeons.org)

A new initiative for The Academy of Surgical Educators in 2014 is to develop a generic course entitled Foundations Skills for Surgical Educators. The new course is currently in development and is targeted at senior Trainees, new supervisors and instructors. The material and principles explored throughout the course are particularly directed at facilitating the education and training of surgical Trainees; however, the course can also be applied to medical students, young doctors, Fellows and colleagues.

By developing a foundation course in surgical education, the College will establish the basic standards expected of our surgical educators within the College. It is from this base that all faculty training can emerge and be customised to the area of expertise required by the individual educator.



# CALL FOR ACTION

ENT surgeons call upon the Federal Government to take urgent action to curb ear disease and hearing loss in Indigenous children

**KELVIN KONG AND CHRIS PERRY**  
CONVENORS, INDIGENOUS EAR HEALTH  
- CLOSING THE AIR-BONE GAP WORKSHOP



ENT surgeons participating in the 'Indigenous Ear Health – Closing the Air-bone Gap' workshop held in Brisbane on March 28, called for urgent action by the Australian Federal Government to address the burden of hearing loss in Aboriginal and Torres Strait Islander children and reduce its long-term and intergenerational impact on the well-being of Indigenous communities.

The satellite meeting is an annual event of the Australian Society of Otolaryngology Head & Neck Surgery (ASOHNS) Annual Scientific Meeting, and this year welcomed speakers from the health, education and policy sectors. They included Mr Warren Mundine, Chair of the Prime Minister's Indigenous Advisory Council and A/Prof. Rae Cooper, Chair Australian Hearing. Mr Mundine outlined education, employment and community safety as the three main areas for immediate action for closing the gap in Indigenous disadvantage.

Chris Perry said, "Hearing loss in Aboriginal and Torres Strait Islander children is at pandemic proportions. If Indigenous children cannot hear or have untreated hearing impairment, it will be difficult for them to participate fully in education and employment and benefit from the measures that 'Close the Gap' intends to deliver."

Aboriginal children contract the middle ear infection Otitis Media as early as a few months after birth. It is a reoccurring disease, which left undetected, untreated and unmonitored, can result in perforated ear drums and hearing loss. Hearing impairment at such an early age affects language development, learning and socialisation, ultimately affecting education and employment opportunity outcomes in later adult years. This in turn perpetuates the cycle of disadvantage and poverty and diminished well-being. Tackling ear disease and hearing loss in Aboriginal communities, and especially in children, must go hand in hand with other measures to 'Close the Gap'.

Currently ear health screening programs vary across the nation, but experience is showing that screening is required on a regular basis. Steps need to be taken to ensure that ear health checks are routinely done as part of child health checks, from birth right through to school age.

The ASOHNS meeting showcased a number of health and education initiatives that are delivering some improvements to ear health for some Indigenous children in some areas of Australia. Overall the gains are small and being hampered by poor access to appropriate screening and treatment services. A well-funded nationally co-ordinated approach is urgently needed,

that engages all stakeholders (including the education, policy and administration sectors in addition to the medical and allied health sectors) working in partnership with Aboriginal and Torres Strait Islander communities, to design and deliver appropriate multi-disciplinary programs and services. For a full list of presenters and forthcoming workshop video please visit the ASOHNS website at <http://asohns.org.au/>

We would also like to thank Mr John Curotta, ASOHNS President and Mr Michael Griggs, College President-elect, for their interest and support for our work in Indigenous health.

The ASOHNS workshop marks the first of many activities of the College and its Fellowship in the Indigenous health sphere. On May9, 2014, in Singapore, RACS and ANZCA will jointly convene a morning session on Indigenous health. Also, on August 23, 2014, in Darwin, the Indigenous Health and Trauma committees will host the symposium 'Indigenous Injury – Learning from each other'. Both events are to promote awareness of Indigenous health issues and encourage discussion on appropriate responses among the Fellowship. For further details about these events please visit <http://www.surgeons.org/>

Thank You

## A WORD OF THANKS

From a successful Fellowship candidate to their mentor

**GRANT FRASER-KIRK**  
CHAIR, RACSTA

With Fellowship examinations around the corner, I thought it would be timely to share this. In the face of an unprecedented threat to our training in Queensland, this is a beautiful appraisal of the Trainee/Trainer relationship. I was fortunate enough to witness a speech given to a handful of consultants by a successful Fellowship candidate who will remain anonymous. The words are her own, but the sentiment is shared by us all.

"When we were medical students, my husband bought me my first stethoscope and engraved it with the phrase 'Ars Longa Vita Brevis': Short is life, but long the craft to learn. And at the end of our registrar period, I know I speak for everyone here when I say; we feel as though even now we are only beginning to understand how much there is to learn.

"Surgery is one of the few professions in which its members are expected to mentor their future competition for free.

"I always thought that this was a fairly cynical view, and although if you regard the profession as purely a business then

in some ways it is true. But the people we've invited here today have taught us that surgical leadership is so much more than simple instruction.

"It is sacrificing family time and free time to allow your registrar to finish the operation they started.

"It is remaining calm when things go wrong.

"It is late nights supervising, unscrubbed, when it would be faster to do it yourself.

"It is siding with your registrar during times of conflict or contention.

"It is time, and consistency and sacrifice.

"It is being available, and prepared and providing a sounding board for advice.

"It's giving us enough rope to hang ourselves with, but ensuring we don't fall too far.

"Seated here are the mentors who – through their own professional conduct – have moulded our idea of the surgeons we want to be. We have invited you here today to thank you for the lasting impact your tuition will have now and into the future, and for teaching us how to be a meaningful, contributory members of our profession in the future.

"I'd like to raise a toast to you all, thank you."



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SPECIALISTS ON DRUMMOND





# ADVERSE EVENTS: SYSTEMS OR SURGEONS?

Queensland Audit of Surgical Mortality (QASM) Seminar November 2013

**JOHN NORTH**  
QASM CLINICAL DIRECTOR

In November 2013, QASM held its annual one day Brisbane-based seminar: Adverse Events: Systems or Surgeons? This seminar was QASM's third and was well attended by Queensland and Northern Territory surgeons.

**Five guest speakers presented morning sessions including:**

- Defining Adverse Events: QASM data and ANZASM data (Dr John North);
- Grasping Surgeon Failure (Dr Ray Chaseling);
- Contributors to Failure (Prof Adrian Nowitzke);

- Code of Conduct and Policing the Problem (A/Prof Michael Hollands);and
- Surgeons Leading Healthcare Reform (the Hon Geoffrey Davies AO).

Younger Fellows presented afternoon sessions including challenging case studies from six surgical specialties (General, Vascular, Cardiothoracic, Paediatric, Orthopaedic Surgery and Neurosurgery). Valuable audience discussion resulted from these presentations.

As part of the QASM seminar evaluation, all attending surgeons were asked the following two questions: What are the challenges you face with systems failures? and What are the challenges you face with adverse events?

The qualitative data from this evaluation are listed in the following tables .

## What are the challenges you face with systems failures?

- Constant need to focus on just culture rather than easier route of blaming an individual
- Aim is to improve systems as there are always 'lapses'
- Funding
- Linking these with general audit statistics
- Culture of blame and its avoidance
- Collegiality, audit
- Different teams not wanting to take over care of a patient which results in delayed care. Management plans not being carried on by night team due to lack of handover, or by nursing staff due to lack of handover
- Changing of administration structures and responsibilities e.g. previously employed as Hospital Director. Now Hospital and Health Services Director
- Access to theatre to keep waiting lists down
- Information collection/collation to guide protocols: integration of international collection
- Attitudes of colleagues, maintaining patient safety
- Systems are composed of humans who are themselves in a constant state of change and a constant expanding/evolving web of relationships
- Reporting them. Effective incident analysis
- Inconsistency of care - absolutely never the same junior doctors on a daily basis things fall between the cracks on the ward
- Time constraints that preclude change
- Lack of national database
- Needs to be addressed with equal importance - I believe all links in a chain need to be strong enough to pull a load - it includes other members of team, administration as well as surgeons
- When the politicians and democracy take over
- To change inertia/resistance to change
- Re-enforced areas of concern e.g. transfer, decision making, multiple levels management, communication across hierarchy
- Making change to prevent them
- Surgery is a discipline and that must be taught 'Discipline III systems'
- We are not aware of all levels of failure especially if you can only multi-task in up to 3-4 events in theatre at one time
- Multifactorial/system/personal

## What are the challenges you face with adverse events?

- Open reporting. Query avoidance of penalties
- Data collection
- Getting everyone involved with the review
- Responsibility without control of staff or protocols
- Being attributed blame when there is a system contribution
- Change perception that surgeon is cause in all cases
- Adverse events occur in a complex "web of relationships" because they happen within this web there is not either/or to them - rather many possible outcomes preceding event involving many human stakeholders
- Having them reported
- Questioning ability and decision making. Stress and worrying about my patients
- Using the data as an education tool
- Hospital authorities "premature" decision without peer review
- Delay in diagnosis, inappropriate "conservative" management
- Support training and nurturing juniors
- Time to deal with the process adequately, ongoing distraction from other patient care duties post event - adverse patient safety effect
- Not to repeat same mistakes
- Personal challenge of poor outcome. Otherwise system works quite well at my hospital
- Anticipation and preventions and early recognition. Early consultant/specialist notification
- Ownership of the problem and fear of backlash
- Lack of confidence to get advice and help from colleagues

As QASM Clinical Director, I would like to thank all surgeons who attended and the guest speakers who presented. These collegiate activities prove to be worthwhile learning experiences for all involved.

The seminar's qualitative data listed in this article gives insight to what many other surgeons may be thinking, or commenting on to each other, regarding systems failures and adverse events in their respective work environments. These insights are worth sharing.

It was disappointing that senior public hospital and health administrators could not attend 'Adverse Events: Systems or Surgeons?'. Their input would have greatly added to the 'big picture' issues raised at this seminar and may have helped create some pathways for solutions.

To view seminar presentations, go to [www.surgeons.org/QASM](http://www.surgeons.org/QASM) and click on seminars.

If you would like to attend QASM's next Brisbane-based one day seminar, save the date: Friday, 7 November 2014.



“Both Australian and New Zealand breast cancer guidelines recommend that if a positive sentinel lymph node (SLN) is found by sentinel node biopsy, a completion axillary lymph node dissection (cALND) should be performed”

# VALUABLE DATA

BreastSurgANZ Quality Audit research in 2013

**JAMES KOLLIAS** – CHAIR, BREASTSURGANZ QUALITY AUDIT STEERING COMMITTEE  
**DAVID WALTERS** – CLINICAL DIRECTOR, BREASTSURGANZ QUALITY AUDIT



The BreastSurgANZ Quality Audit (BQA; previously known as the National Breast Cancer Audit) is the largest clinical breast cancer registry in the Southern Hemisphere, containing more than 140,000 breast cancer episodes submitted during the last 15 years. The College operates the BreastSurgANZ Quality Audit under the direction and ownership of the Breast Surgeons of Australia and New Zealand (BreastSurgANZ). College members who are also full members of BreastSurgANZ are required to submit all newly diagnosed cases of early and locally advanced invasive breast cancer to the BQA for an assessment of the quality of their practice in accordance with specific Key Performance Indicators and Minimum Standards.

This article summarises the peer-reviewed articles published in 2013.

## Treating invasive female breast cancer by mastectomy

Results from this study confirm large tumour size (40mm or more) as a predictor of increased odds of mastectomy over breast conserving surgery; however, the difference was smaller than expected. The reasons for this are not clear, but may include the use of oncoplastic techniques to extend the use of breast conserving surgery for larger cancers or the acceptance of narrow resection margins to achieve tumour clearance by breast surgeons.

The study also confirmed higher mastectomy rates for residents of more remote areas and women treated by surgeons with low caseloads (10 or less per year), although these constitute relatively small differences.

Roder, D. Taylor, C. Zorbas, H. Webster, F. Kollias, J. Pyke, C. Campbell, I. Factors predictive of treatment by Australian breast surgeons of invasive female breast cancer by mastectomy rather than breast conserving surgery. *Asian Pacific Journal of Cancer Prevention*, 2013;14 (1):539-45.

## Breast cancer in remote areas of Australia

This study aimed to better understand factors that may contribute to poorer outcomes for breast cancer patients in remote areas of Australia.

Results indicated that these patients were more likely to be:

- of lower socio-economic status
- diagnosed in earlier periods when survivals were lower
- treated at inner regional or remote centres, rather than a major city centre
- treated by low caseload surgeons
- treated with mastectomy rather than breast conserving surgery
- receiving no radiotherapy if they did have breast conserving surgery
- treated with chemotherapy.

Further monitoring of audit data will be important to determine whether the recently funded regional cancer

centres increase the utilisation of breast conserving surgery and adjuvant radiotherapy in remote areas.

Roder, D. Zorbas, H. Kollias, J. Pyke, C. Walters, D. Campbell, I. Taylor, C. Webster, F. Risk factors for poorer breast cancer outcomes in residents of remote areas of Australia. *Asian Pacific Journal of Cancer Prevention*, 2013;14 (1):547-52.

## Clinical Impact of the Z-0011 Trial

The results of the American College of Surgeons Oncology Group Z-0011 Trial, published in 2010, demonstrated equivalent regional recurrence and survival rates for certain women undergoing observation alone after sentinel lymph node biopsy compared with those undergoing subsequent axillary clearance where histological assessment demonstrated metastatic disease in the sentinel node(s). The trial was described as “practice changing”, suggesting that axillary clearance is not necessary for all women having breast conserving treatment with one or two positive sentinel lymph nodes.

Analysis of the BreastSurgANZ Quality Audit database for cases diagnosed between 2005 and 2010 showed that only 6.9 per cent fulfilled the criteria for the Z-0011 Trial, indicating that although the Trial has important implications for sentinel node positive cases undergoing breast conserving treatment the overall impact of the Trial in clinical practice is small.

It cannot be described as “practice changing”.

Ainsworth R, Kollias J, Blanc A, Silva P. The clinical impact of the American College of Surgeons Oncology Group Z-0011 trial-Results from the BreastSurgANZ National Breast Cancer Audit. *The Breast*, 2013; 22(5): 733-735.

## Subsequent axillary surgery after sentinel node biopsy

Both Australian and New Zealand breast cancer guidelines recommend that if a positive sentinel lymph node (SLN) is found by sentinel node biopsy, a completion axillary lymph node dissection (cALND) should be performed. If the sentinel node is negative, the axilla should be observed only.

According to BreastSurgANZ Quality Audit data, 79.8 per cent of SLN-positive patients had a cALND. Multivariate analysis showed that older patients (>70 years) and patients with fewer positive sentinel nodes relative to negative sentinel nodes were less likely to undergo cALND.

For 89.7 per cent of SLN-negative patients, cALND was not performed, with the proportion proceeding to cALND falling over time. Multivariate analysis showed that large tumour size (>3cm), presence of lymphovascular invasion (LVI), higher tumour grade and younger age (<40 years) were predictors of cALND.

A higher prevalence of LVI was present for patients who were initially SLN negative, but had positive nodes found through cALND.

Chong C, Walters D, de Silva P, Taylor C, Spillane A, Kollias J, Pyke C, Campbell I, Maddern G. Subsequent axillary surgery after sentinel lymph node biopsy: Results from the BreastSurgANZ Quality Audit 2006-2010. *The Breast* 2013; 22(6): 1215-9.

## Immediate breast reconstruction following mastectomy

According to BreastSurgANZ Quality Audit data, 8 per cent of patients with invasive breast cancers treated by mastectomy received immediate breast reconstruction between 1998 and 2010. This proportion increased over time and was affected by patient age (from 29 per cent in women below 30 to 1 per cent in those aged 70 or more).

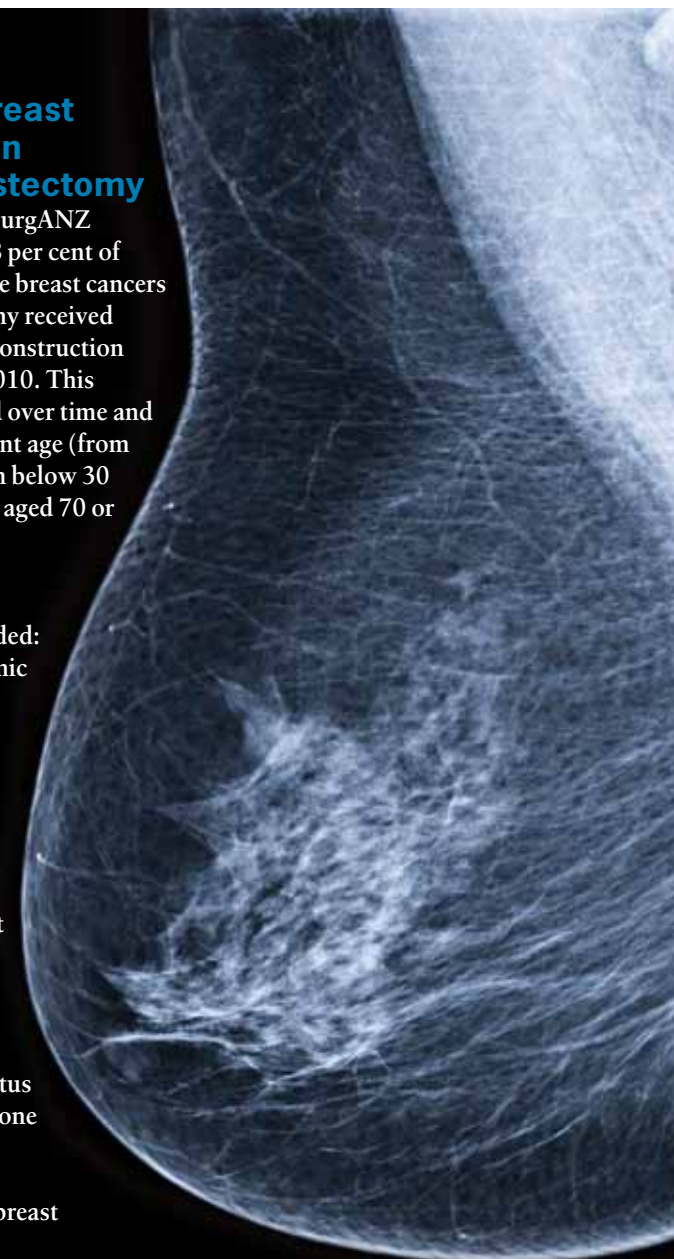
Other predictors of immediate breast reconstruction included:

- high socio-economic status
- private health insurance
- being asymptomatic
- a metropolitan rather than inner regional treatment centre
- higher surgeon caseload
- small tumour size
- negative nodal status
- positive progesterone receptor status
- more cancer foci
- multiple affected breast quadrants
- synchronous bilateral cancer
- not having neo-adjuvant chemotherapy, adjuvant radiotherapy or adjuvant hormone therapy
- receiving ovarian ablation

Roder D, Zorbas H, Kollias J, Pyke C, Walters D, Campbell I, Taylor C, Webster F. Factors predictive of immediate breast reconstruction following mastectomy for invasive breast cancer in Australia. *The Breast* 2013; 22(6): 1220-5.

The BreastSurgANZ BQA Steering Committee and Research subcommittee welcome members to pursue research projects using this valuable data resource.

For a full list of published research from the BreastSurgANZ Quality Audit, go to [www.surgeons.org/nbca](http://www.surgeons.org/nbca) and click on the Publications link.





Inge Putri - Junior HMO,  
being supervised by  
Gareth Carr, Colorectal  
Fellow, on sphincter repair  
using a pig's anus in Skills  
Centre laboratory.



James Keck, Colorectal  
Surgeon, with  
urogynaecologists,  
Lore Schierlitz and  
Alison Desouza, joint  
convenors of OASIS

## AN OASIS FOR OASIS

Think about using the excellent facilities  
at the College for your next course

**BRUCE P. WAXMAN**  
CLINICAL DIRECTOR, VICTORIAN SKILLS & EDUCATION CENTRE

**T**hough it lacks the palm trees and the spring fed lagoon in a desert setting, the Skills & Education Centre at College HQ in Melbourne, can be regarded as an oasis of opportunities with the equipment and space and trained, friendly staff for conducting a workshop that requires both a skills laboratory for working on fresh specimens or manikins, an adjacent lecture theatre and break out areas.

The organisers of OASIS (Obstetric & Sphincter Injuries) hands-on workshop decided to use the Skills & Education Centre as their chosen venue. Delegates at the workshop learn how to identify, repair and manage primary obstetric related sphincter injuries (3rd and 4th degree tears), combining a series of lectures, demonstration of endorectal ultrasound, and a hands-on repair of pig anal sphincters.

OASIS was organised as a satellite workshop of the Urogynaecological Society of Australasia's (UGSA), annual scientific and general meeting in Melbourne between Friday, 28 and Saturday 29 March 2014. The workshop was conducted at the Skills & Education Centre on Wednesday, 26 March 2014.

Random unsolicited comments from the organisers, Drs Lore Schierlitz, and Alison De Souza, Urogynaecologists and James Keck, a colorectal surgeon were: "we love this place", "it's well-organised, modern and bright; we can't fault it", and what's more, "the staff do a fantastic job".

The OASIS workshop is a good example of the utility of the Skills & Education Centre, but moreover the opportunity for a multidisciplinary approach, in this case involving colorectal surgeons, urogynaecologists and pelvic floor physiotherapists in tackling a complex obstetric problem, that often has long-term effects for the woman, particularly faecal incontinence and sexual dysfunction.

**To organise your next workshop, contact:**  
**David Lawrence, Centre Manager:** [david.lawrence@surgeons.org](mailto:david.lawrence@surgeons.org)  
**Arwen Tudor, Laboratory technician:** [arwen.tudor@surgeons.org](mailto:arwen.tudor@surgeons.org)  
**Or call the Centre on +613 9276 7455.**



Elise Fraser, Pelvic  
Floor Physiotherapist,  
in Skills Centre, Level  
1 lecture theatre

## Royal Australasian College of Surgeons 2014 WA, SA, & NT ANNUAL SCIENTIFIC MEETING



*Save the date*  
**8-10 August 2014**

**The Pullman Resort, Bunker Bay, WA**

**Theme:** The introduction of new technology in  
Surgical techniques - the do's and don'ts!

**Convener:** Mr Richard Martin

*If you would like to contribute to the  
content of the meeting, please email  
your ideas and suggestions to*  
**[college.wa@surgeons.org](mailto:college.wa@surgeons.org)**



COVER  
STORY

# THE MYTHS OF SURGICAL EDUCATION & TRAINING



In the process of new agreements some old rumours surfaced; here they are made clear

**SIMON WILLIAMS**  
CENSOR-IN-CHIEF



Over the past two years the Fellowship and College and society staff have spent a great amount of time and energy in negotiating new agreements for the support of the Surgical Education and Training program. The last of 13 agreements was signed in March, bringing the process to an end. Unfortunately, during the negotiation

process a number of myths about training have bubbled to the surface, particularly about the new fee structure. Here are some of the common myths, as well as the facts that dispel the myth.

**MYTH:** Trainees have nothing to do with the College during training, as it is all delivered by the specialty society.

**FACT:** Trainees interact with the College every day. The College is more than the bricks and mortar of the

Spring Street building, Elliott House in Wellington, ASERNIPS in Adelaide or any of the regional offices. The College is its members; the Fellows that are the surgical supervisors and trainers in the unit, that are members of the specialty training board that governs training, are examiners that test Trainee knowledge and leaders in determining the minimum standards of a competent surgeon participating in continuing professional development.

Most, if not all, specialty societies require members to first hold a FRACS. It is the recognised standard in Australia

“  
At all times however, it is Fellows who are the ultimate decision makers in the training program”

of excellence in surgery. It is the standards displayed every day by Fellows in theatres and rooms that guide Trainees to achieve competence in those same standards, and therefore to independent practice.

**MYTH:** My society gets nothing from the College fee to support training.

**FACT:** Each of the nine specialties receives \$94,500 from the fee levied by the College. Where there are two societies associated with a specialty that amount is pro-rated (by agreement between the two groups). This amount – known as the Governance Support Payment – contributes to the funding of the training infrastructure mandated by the College (training board, secretariat support, etc.). The fee charged by each specialty program is calculated to raise the funds needed to deliver training, taking into account the baseline Governance Support Payment that they receive.

**MYTH:** The College fee went up 33 per cent in 2014 from 2013, from \$2,000\* to \$3,000.

**FACT:** It is not correct to compare the money retained by the College in 2013 when a single fee was in place, with the separate fees by specialty in 2014. Prior to 2014 the College retained approx. \$2.3M from the fees paid by Trainees. This was approx. \$2,120 per Trainee. The balance of funds was allocated to each specialty to fund the direct costs of training.

The College fee charged to Trainees in 2014 is \$3,000. From those fees raised, \$850,500 is paid to the specialties for Governance Support (mentioned above). The remaining funds are retained solely by the College to support the indirect costs of conducting surgical training. Those funds, expected to be approx. \$2.5M in 2014, contribute to the costs of Council, the Education Board, College management, facilities, etc. Fellows and International Medical Graduates also contribute to these costs through their respective fees.

**MYTH:** The College and Society staff are running the training programs.

**FACT:** Fellows, through their pro bono contribution to the SET program, are the decision makers. It is unreasonable however to expect the Fellowship to organise every aspect of training. Consequently the College and societies employ specialist staff to assist them with the administration of training (meeting management, curriculum review, policy development, etc.).

At all times however, it is Fellows who are the ultimate decision makers in the training program. Documents prepared by staff – at the request of boards and committees – are ultimately approved by the Board. Where a staff-member does make a decision, it is on the basis of policies approved by Fellows that delegate to them that responsibility.

\* All amounts quoted are in Australian Dollars.

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# SAFER OPERATIVE SURGERY

Using skills learnt from NOTSS, ANTS and SPLINTS

FRANCIS LANNIGAN  
CHAIR, NOTSS WORKING PARTY



There is a growing body of evidence to suggest that poor non-technical skills in the surgical team, leads to an increased number and severity of adverse events. Non-technical skills can be defined as the cognitive, social and personal resource skills that complement technical skills, and contribute to safe and efficient task performance. These may include situational awareness, decision making and problem solving, leadership, teamwork, communication and managing stress and fatigue.

Despite the advances in surgical technique and technology, historically there has been little consideration of these 'softer' skills despite their direct correlation with technical or psychomotor skills. There are estimates from the UK and US that around 15 per cent of all surgical cases suffer from adverse events directly related to a breakdown in the non-technical skills of the surgical team and 48 per cent of these are highly preventable. There are also estimates that only five per cent of adverse events are actually reported. This burden is borne by society through escalated additional health care costs, insurances, litigious expenses, permanent disability and death. There is a less reported burden for the individual surgeons involved with recognised increased problems with stress management, anxiety and other associated issues.

The direct hospital costs of adverse events, both fatal and non-fatal, were estimated in the 1995 'Quality in Australian Health Care' study at A\$900 million per annum, a figure that would be much higher today. Medicine has therefore had to look at other high risk industries or so called high reliability organisations, such as aviation, merchant navy, fire service, oil production and nuclear energy to see how they were addressing it and adopt a similar approach in order to reduce human error in the operating room.

“

*Despite the advances in surgical technique and technology, historically there has been little consideration of these 'softer' skills despite their direct correlation with technical or psychomotor skills*”

For this reason, three assessment frameworks have been developed by The University of Aberdeen, Royal College of Surgeons of Edinburgh and the National Health Service:

- Non-Technical Skills for Surgeons (NOTSS)
- Anaesthetists' Non-Technical Skills (ANTS)
- Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS).

These frameworks have been developed by a team led by Professor Rhona Flin (keynote speaker at the Annual Scientific Congress in Kuala Lumpur 2012) after extensive consultation with subject matter experts. They use structured observation to rate behaviour that can form the basis of self-reflection and/or feedback.

Surgical training primarily focuses on the acquisition of medical knowledge, clinical expertise and technical skills. However, the NOTSS assessment categories align with the other College competencies, namely Judgement and Decision-Making, Communication, Collaboration and Teamwork plus Management and Leadership. Training in the use of a formal assessment tool for non-technical skills can increase the likelihood of these competencies being explicitly addressed in the surgical training program.

The College has been successfully delivering the NOTSS workshop to surgeons for the past three years. However, there have been multiple suggestions from participants that their experience would be enhanced by the inclusion of the other members of the intraoperative team. They felt that cross craft group professional development involving surgeons, anaesthetists and nurses would help to improve the team's 'shared mental model' of what is happening and what is the planned outcome of an operation thus leading to better communication and teamwork.

In response to this feedback, the College is excited to announce that it is partnering with the Australian and

New Zealand College of Anaesthetists (ANZCA), the Australian College of Nursing (ACN) and the Australian College of Operating Room Nurses (ACORN) to develop a workshop for surgeons, anaesthetists and operating room nurses working in rural and remote Australia. The project, entitled 'NOTSS, ANTS and SPLINTS: Working together to help intraoperative teams in rural and remote locations' is funded through the Rural Health Continuing Education (RHCE) program.

The first part of the workshop will concentrate on team work and team dynamics before exploring each of the assessment frameworks and their categories, looking at similarities and differences affecting performance and teamwork in the operating theatre.

- NOTSS – situational awareness, decision making, communication/teamwork and leadership
- ANTS – situational awareness, decision making, teamwork and task management
- SPLINTS – situational awareness, communication/teamwork, and task management

Each assessment category is described by a set of elements or behavioural markers. It is interesting to note that the concept of behavioural markers is also integral to the framework for definition of competence and performance and the associated multi-source feedback assessment tool, articulated in the RACS 'Surgical Competence and Performance Guide'.

The second part of the workshop will enable participants to practise assessing non-technical skills utilising their craft group's framework while watching operative videos and/or simulations. The cross craft collaboration will facilitate development of realistic simulation of catastrophic surgical events. This type of exercise is increasingly recognised to improve teamwork and other non-

technical skills at times of high stress, therefore the integration of this modality can only benefit patient safety.

One day workshops are currently being planned for 2014 in four Australian regional locations. If you would like more information, please contact Merrilyn Smith at [pdactivities@surgeons.org](mailto:pdactivities@surgeons.org) or call +61 3 9249 1106.

This Project has been funded by the Department of Health under the Rural Health Continuing Education Sub-Program (RHCE) Stream One, which is managed by the Committee of Presidents of Medical Colleges (CPMC). The College is solely responsible for the content and views expressed in any material associated with this Project.





## 2015 Rowan Nicks Pacific Islands Scholarship & 2015 Rowan Nicks International Scholarship 2015 Rowan Nicks Australia & New Zealand Exchange Fellowship



The Royal Australasian College of Surgeons invites suitable applicants for the 2015 Rowan Nicks Scholarships and Fellowships. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.



### The Rowan Nicks International and Pacific Islands Scholarships

provide opportunities for surgeons to develop their management, leadership, teaching, research and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand and South-East Asia.

The goal of these Scholarships is to improve the health outcomes for disadvantaged communities in the region, by providing training opportunities to promising individuals who will contribute to the development of the long-term surgical capacity in their country.

### Application Criteria:

Applicants for the both the Rowan Nicks International and Pacific Islands Scholarships must:

- commit to return to their home country on completion of their Scholarship;
- meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in Australia or 7.5 in New Zealand, in every category);
- be under 45 years of age at the closing date for applications.

### Applicants for the International Scholarship must:

- hold a relevant post-graduate qualification in Surgery;
- be a citizen of Bangladesh, Bhutan, Cambodia, Indonesia\*, Laos, Mongolia, Myanmar, Nepal or Vietnam

*\*With preference given to Indonesian applicants from outside the major capital cities of Jakarta and Surabaya who will return to practice in regional areas.*

### Applicants for the Pacific Islands Scholarship must:

- be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;
- hold a Masters of Medicine in Surgery (or equivalent). However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.

### Selection Criteria

- The Committee will consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
- The Committee must be convinced that the applicant is of high calibre in surgical ability, ethical integrity and qualities of leadership.
- Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

**Value:** Up to \$50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare from home country and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

**Tenure:** 3 - 12 months

**The Rowan Nicks Australia and New Zealand Fellowship** is intended to promote international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand and increase interaction between Australian and New Zealand surgical communities.

The Fellowship provides funding to assist a New Zealander to work in an Australian unit judged by the College to be of national excellence for a period of up to one year, or an Australian to work in a New Zealand unit using the same criteria.

### Application Criteria:

Applicants must:

- have gained Fellowship of the RACS within the previous ten years on the closing date for applications.
- provide evidence that they have passed the final exit exam to allow them to obtain a Fellowship of the Royal Australasian College of Surgeons by the time selection takes place.

### Selection Criteria:

- The Committee will consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
- assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's current position in Australia or New Zealand.

**Value:** Up to \$50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

**Tenure:** 3 - 12 months

Application forms and instructions are available from the College website:

**www.surgeons.org**

Closing date: **Monday 2 June, 2014.**

Applicants will be notified of the outcome of their application by **30 October 2014.**

**Please contact:** Secretariat, Rowan Nicks Committee, Royal Australasian College of Surgeons  
250 - 290 Spring Street, East Melbourne VIC 3002  
Email: [international.scholarships@surgeons.org](mailto:international.scholarships@surgeons.org)  
Phone: + 61 3 9249 1211 Fax: + 61 3 9276 7431

# BUTTING-OUT BEHIND BARS

Push to reduce smoking rates in prison to zero

BY KAREN MURPHY

Victoria is set to become the next jurisdiction in Australia to ban smoking in prisons, following the lead of the Northern Territory, which imposed the ban last year and Queensland which will ban smoking in prisons from May 1, 2014.

The Victorian ban, announced late last year, will make all 13 Victorian prisons smoke-free by July next year.

New Zealand became the first country to ban smoking in prisons in 2011, a move which reduced smoking rates within the prison population from around 67 per cent to zero.

In Australia, it is estimated that approximately 85 per cent of prisoners are smokers, which is almost five times the rate of smoking in the general community.

In announcing the ban, the Victorian Minister for Corrections Edward O'Donohue said that offenders coming into prison were far more likely to have serious health issues compared to the general community and that efforts must be made to improve their health during their time of incarceration as well as protecting the safety of prison staff from the effects of second-hand smoke.

He said the decision to implement the ban in 2015 would allow prison authorities to implement programs to reduce smoking

rates before its introduction with implementation teams working within prisons to ensure that all are prepared and supported, with free nicotine patches provided for defined periods for those participating in QUIT programs.

"Maintaining a safe, healthy environment for our staff and for prisoners during the transition to a smoke-free prison system is critical," Mr O'Donohue said.

## Smoking ban works

In January this year, the NT's Minister for Correctional Services, Mr John Elferink, hailed the introduction of the smoking ban in NT prisons in July 2013 as an "outstanding success" and said it had followed a comprehensive 12-month 'Smoking No Good' campaign within the prison system.

He said the keys to the smooth introduction of the ban were the training of prison staff as QUIT educators and the provision of comprehensive QUIT support to prisoners.

"There was a 12-month lead-up to the ban with educational and therapeutic measures on offer to assist staff and those in their care to kick the habit," Mr Elferink said.

"Prisoners were offered nicotine replacement therapy and unrestricted access to the QUIT line through the free inmate telephone service."

Victoria's peak health promotion agency applauded the Victorian Government's announcement.

VicHealth CEO Jerril Rechter said that current evidence indicated that while 46

per cent of prisoners in Victoria wanted to stop smoking, the stress of incarceration and prevalence of smoking meant that only eight per cent of prisoners successfully quit the habit.

She also said that the studies now being conducted following New Zealand's world-first legislation, were proving compelling.

"One study shows that air pollution in their prison facilities has halved and researchers say that a significant health hazard has been reduced for both staff and prisoners," Ms Rechter said.

"After the smoke-free policy was announced and prior to its implementation, around 2000 New Zealand prisoners started nicotine replacement therapy and the path to a healthier life.

"There is no doubt this pattern will be repeated here in Victoria.

"Quitting in prison can be difficult, because of the stressful environment and the fact that smoking is so prevalent, so this move (in Victoria) will support people who are perhaps more vulnerable to tobacco to quit."

The Quit Victoria policy Manager Ms Kylie Lindorff said the Government's decision would help stop vulnerable prisoners taking up the habit when they entered the corrections system and said the long-lead time had been found to be crucial in other jurisdictions in ensuring a smooth transition.

"We know that prisoners have extremely high smoking rates and that prisons are often an initiation point for smoking," she said.

"That is, if you didn't smoke before you entered prison, it's highly likely you will afterwards.

"Smoke-free prisons have been successfully implemented in a number of jurisdictions around the world and the lesson has really been that a long lead time, along with initiatives that support prisoners and staff to quit along with access to nicotine replacement therapies will lead to a healthier setting for everyone."

The NSW, SA and ACT governments are now in the process of considering similar bans.





# RESOURCES 'GOLD' FOR STUDY

eLearning module tailored for  
the Fellowship Examination

**JOHN BATTEN**  
CHAIR, COURT OF EXAMINERS

The Fellowship Examination is a significant event in the life of an International Medical Graduate (IMG) and Surgical Trainee. It can be daunting for Trainees, who have spent years progressing through the training program, but potentially even more daunting for IMGs, who are less familiar with the Surgical Training program, and the requirements and expectations of the exam.

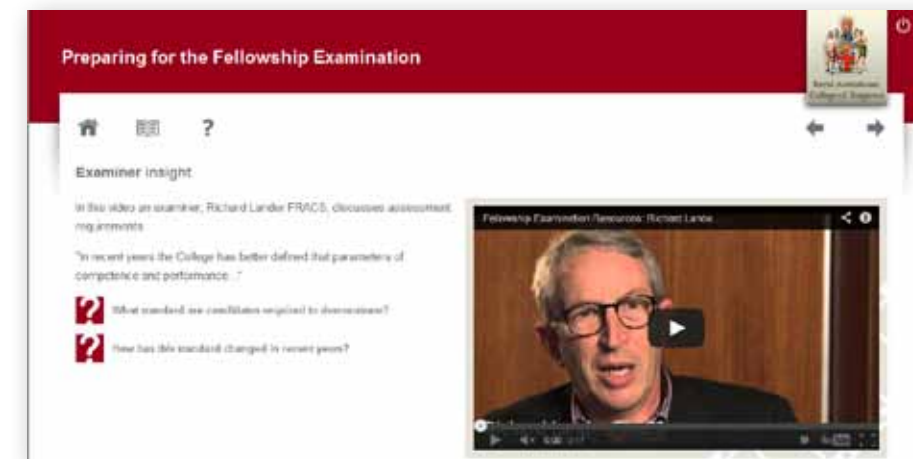
Part of good preparation for the examination is having a clear understanding of the structure and requirements of the exam. To assist candidates to properly prepare, the College recently launched four eLearning units that detail different aspect of the examination. This resource has primarily been designed to assist IMGs who are attempting the Fellowship examination for the first time; however, it is of equal relevance for all candidates. Module Four is aimed at supervisors, mentors and trainers who support candidates in preparing for the Fellowship Examination.

The eLearning modules were launched in March 2014 and have attracted a high level of interest. More than 250 candidates have undertaken the modules, and one candidate described the videos of Vivas contained in Study Tips module as 'gold'.

The resource covers four topics. It is not compulsory and modules do not need to be completed sequentially, but, rather, is designed so that candidates can refer to it whenever needed, to gain a better understanding of the examination and ways to prepare for it. While there is no formalised assessment, candidates are invited to submit feedback at the end of the resource.

## Topic 1: Introduction

The initial unit considers the examination's focus and standard in more detail. It outlines which of the surgical competencies are assessed by the examination, and also gives examples of the expected behaviours associated with each competency. Candidates can listen to advice from Richard Lander, the Deputy Chair (NZ) of the Court of Examiners, as well as the experiences of some successful candidates.



## Topic 2: Conduct of the examination

This section explains how Fellows are involved at every stage of the examination process, including the governance and administration processes for the exam. In this unit, candidates can find out more about the written and clinical sections, as well as what to expect on the day of the examination. Candidates also have the opportunity to listen to Andrew Brooks, the Deputy Chair (AUS) of the Court of Examiners, discuss issues relating to the examination's validity, reliability and fairness.

## Topic 3: Study tips

Studying for the Fellowship Examination is like learning anything else – it takes time and requires practice. This unit explores how to better prepare for the examination and provides some useful study tips, as well as some examples of how questions are framed. Candidates can:

- listen to Examiner Susan Liew's advice on how to answer questions;
- view videos of mock Vivas; and
- consider study tips.

## Topic 4: Advice for supervisors and surgical trainers

Surgical trainers and supervisors provide crucial support for examination candidates. This final section describes recent modifications to the examination, and the former Chair of the Court of Examiners, Spencer Beasley, gives an example of how the examination assesses surgical competence. Supervisors and surgical trainers have the

opportunity to hear colleagues talk about ways to help candidates prepare for issues that may arise in the examination, such as the management of clinical uncertainty, emphasising that this is not merely an examination of knowledge, but of each candidate's fitness for independent practice. The College solicitor, Michael Gorton, explores a range of legal considerations.

## Why should candidates and supervisors use this resource?

There are many benefits to using this resource, including:

- increased familiarity with the format of the Fellowship Examination and what to expect on the day
- an introduction to the examination's governance, application process, timetable, marking system, and feedback and review process
- understanding of the competencies covered and the expected behaviours associated with each
- practical suggestions of ways in which to prepare for the Fellowship Examination
- commentary from examiners and past candidates.

## How do I access it?

The Fellowship Examination preparation online resource can be accessed through the eLearning pages of the College website (login required). Should there be difficulty accessing it, please contact help.desk@surgeons.org for assistance.





## Ensure you don't miss the more comprehensive requirements on collecting information

**MICHAEL GORTON**  
COLLEGE SOLICITOR



The Privacy Act 1988 regulates how doctors, health service providers, Commonwealth government agencies and some private sector organisations may collect, use, disclose and store personal information, and how individuals may access and correct personal information held about them. It imposes certain obligations on these providers and agencies concerning the management of personal information.

The Commonwealth legislation does NOT cover State based public hospitals or public agencies, which remain subject to State law.

Health service and aged care providers, and Commonwealth government

agencies, must comply with the Privacy Act, including by adhering to the current National Privacy Principles, and by appropriately dealing with privacy complaints and possible breaches. On 12 March 2014 the National Privacy Principles were replaced by new Australian Privacy Principles (APPs), which are more comprehensive than the old regime, and impose additional requirements which providers and agencies must comply with. Under the new requirements, providers and agencies must take reasonable steps to implement practices, procedures and systems that ensure that they comply with the APPs, and are able to deal with privacy related inquiries and complaints. Providers and agencies will also be required to maintain a comprehensive privacy management policy, called an APP Privacy Policy, which must be freely available to the public e.g. on your website. Information that needs

to be covered in an APP Privacy Policy includes:

- the kinds of personal information you hold and collect;
- how personal information is collected and held;
- the purposes for which personal information is collected, held, used and disclosed;
- how an individual may access their personal information and seek its correction;
- how an individual may complain about a privacy breach, and how the complaint will be handled; and
- details about any disclosure of information to overseas recipients.

Amongst the significant changes made are those which relate to circumstances where doctors share information with others. New privacy policies need to be clear about when doctors can

share information with other treating doctors, whether through referral or otherwise. The new requirements impose additional controls on the ability to send information overseas, sharing information through "cloud computing" and storage of health information, either in the cloud or by other technology methods. The sharing of information should only occur when it is "reasonably necessary" for the purposes for which the information is provided. Accordingly, providing all of the patient's health record to a specialist may not be necessary, depending on the specific purposes of the referral. Mental health information and circumstances where it is irrelevant to the needs of the doctor to whom the referral is made, could be a breach of these requirements.

However, "privacy requirements" should not limit proper sharing of health information between treating doctors, where the health and safety of the patient is relevant.

Any current Privacy Management Policy you maintain will need to be

reviewed and updated in order to take into account the new requirements. It is particularly important that you develop and detail a complaint management process if you do not already have one in place. The current form of the Privacy Act requires that you notify individuals of certain matters at the time when you collect their personal information. This notification is generally by way of a "collection statement" included on the form used to collect personal information. The new requirements are more prescriptive regarding the matters which need to be notified in collection statements. An appropriate collection statement will usually include details of:

- the provider's or agency's identity and contact details;
- the facts and circumstances of the collection;
- whether the collection is required or authorised by law;
- the purposes of the collection;
- the consequences if personal information is not collected;

- how and to whom you usually disclose personal information;
- information about your APP Privacy Policy; and
- whether the personal information is likely to be disclosed to overseas recipients.

Your current collection statements will need to be reviewed in order to ensure compliance with the new requirements. The March 2014 changes also give certain new powers to the Office of the Australian Information Commissioner (OAIC), which regulates the handling of information privacy in Australia. The OAIC will be able to conduct assessments of your privacy management processes and systems, require you to enter enforceable undertakings, and take civil legal action in the case of serious or repeated breaches of privacy. We recommend that you review your privacy management policies and procedures, and make any necessary changes to your practices.

*With: David Littlejohn*



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## Western Health Upper GI & HPB Surgery Fellow (UGIG Unit)

Melbourne's West is one of the fastest growing and most culturally diverse areas in Australia. Western Health is investing now to meet the demands of this growing population and improve the quality of care and access to services for people in the West.

Vacancy Reference Number: 13776  
Full Time / Fixed Term Contract: 2nd  
February 2015 until 31st January 2016

The Upper GI / HPB unit at Western Health consists of 8 Surgeons who work across all three (3) campuses - Footscray, Sunshine and Williamstown. The major cases are all completed at the Footscray Campus.

The Fellow is expected to be involved in the receiving roster with the Consultants back up. The Upper GI / HPB Fellow is also expected to be involved in non-clinical duties such as education and training of Junior Medical Staff as well as representing JMS interests by acting as a representative on one or more committees such as the JMS Operations Management Committee, the JMS Post Graduate Medical Education Committee, Adverse Outcomes Committee and other relevant working parties.

The successful applicant must hold a FRACS qualification or equivalent to be eligible for this position and have obtained your General Registration with the National Medical Registration Board - AHPRA.

Please follow the direct link below to apply for this position:  
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Further Information / Enquiries:  
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03 8345 6666  
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For more information on these and other exciting employment opportunities at Western Health, please visit [www.westernhealth.org.au](http://www.westernhealth.org.au)

## COLLEGE AWARDS

# Congratulations on your achievements

**Rural Surgeons  
Award: Mr Murray  
Vincent Pfeifer MBChB  
(Otago) FRACS**

Murray Pfeifer attended The University of Otago, graduating in 1971. Through the 1970s he worked in Southland Hospital as both a house surgeon, and later as a registrar. In 1974 he came to Dunedin as an anatomy demonstrator, and returned in 1977 as a surgical registrar.

He gained his Fellowship to the Royal Australasian College of Surgeons in 1979, and then worked for a year in Preston Hospital, North Shields, England. On returning to New Zealand in 1980 he took up his current position as Consultant Surgeon at Southland Hospital.

Murray epitomises the quintessential general surgeon: providing surgical cover for subspecialty interests as wide ranging as breast and endocrine, vascular, paediatric surgery, and upper and lower GI surgery – not to mention the 'bread and butter' of general surgery. For much of his career he has worked a 1:3 acute call. This included vascular surgery, and he would often come in out of hours to help colleagues, be it a ruptured aneurysm or a challenging general surgical case.

Murray has been teaching medical students and postgraduates for

more than 30 years, and continues to do so with the same vigor and enthusiasm. He holds the post of Clinical Lecturer in Surgery, and has been the Gilmore Lecturer in Surgery.

Murray was also the Intern Supervisor for a substantial part of his career, supporting the betterment of the house surgeons as well. He is currently the supervisor of surgical training at Kew, and has mentored many surgical Trainees throughout his career.

With regards to the Royal Australasian College of Surgeons, he has been a member of the Court of Examiners, and was also on the selection committee. He has previously been chairman of the College NZ Committee, and also president of the New Zealand Association of General Surgeons. In both his College and NZAGS roles, he has always championed the General Surgeon in the rural centres.

In his role as Clinical Director for general surgery in Kew Hospital, he has been colleague and mentor to many young surgeons. He is recognised throughout the hospital for his willingness to help, his level-headed advice and his warm heart.

The term 'Rural Surgeon' is not often used in New Zealand, and we might better use the term 'Provincial Surgeon', but I cannot think of a more worthy recipient of this award.  
*Citation provided by Julian Speight  
BSC MBBS FRCS FRACS*

## Announcement of Medico Legal Meeting

The AOA/RACS/MedLaw Combined Medico Legal Meeting will be held at the Sydney Masonic Centre, 66 Goulburn St Sydney, on **Friday 21 and Saturday 22 November 2014**.

For details please contact Kevin Wickham, Conference Secretariat, at [Kevinwickham@inet.net.au](mailto:Kevinwickham@inet.net.au).



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# MANAGING BOUNDARIES

Professor Geoff Riley explores the complexities of managing boundaries

**PROFESSOR GEOFF RILEY AM**  
WINTHROP PROFESSOR OF RURAL AND REMOTE MEDICINE  
AND HEAD OF THE RURAL CLINICAL SCHOOL OF WA.

## Moral authority and the social contract

The medical profession's moral authority is in the first instance formally conferred by society through the process of licensing or registration. This is the social contract through which doctors are accorded special status in return for a particularly stringent set of behavioural expectations.

Doctors will use the best of their ability, knowledge, skills and judgement in the service of the patient. The social contract establishes an a priori assumption of trustworthiness of the profession which enables patients to reveal intimacies of mind and body. The reality of that assumption is tested in each encounter between a patient and practitioner.

In an operational sense the social contract also establishes the rules of engagement for the consultation. Doctors

are obliged to: be competent, behave ethically and professionally, have good interpersonal and communication skills, demonstrate common decency, and offer compassionate and empathic care. Patients will also deal fairly by respecting doctors' positive and negative rights, and adopting the normal expectations of the sick role: patients should know that they are ill, want to get well, seek help appropriately, and follow reasonable advice.

## The doctor-patient relationship

The doctor-patient relationship is unique among professional relationships precisely because of the nature and degree of intimacies shared. The patient's anxiety, need, dependence, and loss of control and autonomy equate to a substantial power imbalance in the doctor-patient relationship.

*This article originally ran in the Autumn 2013 issue of MDA National's publication 'Defence Update', and is reproduced here with permission*

There is potential for exploitation of the patient by the doctor. This imbalance of power imposes a great responsibility on the doctor to behave according to the highest ethical standards. Any breach of this responsibility will diminish the moral authority of the individual doctor and of the profession as a whole.

Furthermore, tribunals tend to reject the idea that patient consent for, or collusion in, boundary transgression should have any bearing on judgements of the appropriateness or reasonableness of a doctor's actions.

## Boundaries in the doctor-patient relationship

Another characteristic of this special relationship is that the doctor commits to use the encounter solely in the service of the patient. The doctor in return receives only remuneration and the

personal satisfaction of doing meaningful work. Specifically the doctor will not exploit the professional relationship for any other personal or self-serving purpose. This, for example, might include:

- improper influence, persuasion or manipulation
- improper gain, whether financial or informational
- receiving favours or gifts, including sexual favours
- selling something, literally (drugs or investment schemes) or metaphorically (religion, politics)
- role reversal, in which the doctor improperly seeks care, succour or 'therapy'.

In short, whatever transpires between the doctor and the patient in this professional relationship should address the patient's concerns and should not be about the doctor. Unlike a social relationship, it is a one-way arrangement; everything that goes on in the medical consultation is in the service of the patient and the doctor must never impose his or her needs on the patient.

An important example is that doctors should be particularly aware that self-revelation is fraught. Judicious self-revelation may occasionally be acceptable if it is genuinely in the service of the patient. It is often benignly misunderstood by doctors as good empathic sharing – the "I've been there" idea – when it is in fact often gratuitous, and indeed sometimes a product of blatant neediness on the part of the doctor.

## Boundary transgression

Boundary transgressions can be divided into boundary crossings and boundary violations.

- Boundary crossings are departures from usual practice that are not exploitative and can sometimes be helpful to the patient.
- Boundary violations are transgressions which are harmful to patients.

An example of a benign boundary crossing might be giving a young mother a lift home at the end of the day when it is raining, it is late and it is on your way home. But what if you have always found the person to whom you are giving a lift especially attractive? This may already be a boundary violation. Ask yourself why you are really doing this. And what if it starts to become routine, because you have decided to see this patient regularly in the last appointment of the day? And what if you decide after a while to stop and have a coffee or a drink on the way home? Are you telling your partner

about this? Because this is not just a boundary violation; it could be about to ruin your life and the lives of many others around you.

## Factors that increase the risk of boundary violation

We know that certain factors increase the risk of boundary violation. Doctors who are under stress, particularly relationship stress, are at increased risk of boundary violation. Those who are in solo practice, who are professionally isolated and/or emotionally unsupported, are also at greater risk. Finally, certain psychiatric states tend to increase the risk. These include dependent and narcissistic personality disorders, depression, and alcohol and substance abuse.

Patients who are more likely to violate boundaries include those with vulnerabilities of various types such as borderline and dependent personality disorders. Notably, female patients who have been sexually abused in the past are especially at risk of being abused again in professional relationships.

Borderline patients in particular may initiate inappropriate relationships and may test boundaries with active flirtation. Other demanding patients may push doctors in ways that violate professional and ethical norms, some of which may result in the doctor violating professional boundaries.

## Dual relationships

The term "dual relationships" describes situations where a professional relationship is used to establish a parallel personal relationship.

Classic examples of dual relationships are treatment of intimates including close friends, staff and associates. These situations are fraught because of the loss of objectivity. They have the potential to permanently damage personal relationships and consequent entanglements can have legal and administrative ramifications. When treating one's own family the price is potentially higher.

Treating oneself has always been recognised as stupid, but at least the main victim is you! As Osler is quoted as saying in Aphorisms, "A physician who treats himself has a fool for a patient."

The ultimate improper "dual relationship" is the sexual relationship with a patient. This topic has been well rehearsed elsewhere, but it needs to be said unequivocally that it is forbidden. Such conduct ruins lives and further degrades the perception of the profession.

## Identifying risky boundary behaviour – the checklist

**Always be prepared to check your behaviour against this list.**

- ✓ Is what I'm doing part of accepted medical practice?
- ✓ Does what I'm doing fit into any of the recognised high-risk situations that I have learnt about?
- ✓ Is what I'm doing solely in the interest of the patient?
- ✓ Is what I'm doing self-serving?
- ✓ Is what I'm doing exploiting the patient for my benefit?
- ✓ Is what I'm doing gratuitous (not what the patient has asked for)?
- ✓ Is what I'm doing secretive or covert? Would I be happy to share it with my spouse, partners or colleagues?
- ✓ Am I revealing too much about myself or my family?
- ✓ Is what I'm doing causing me stress, worry or guilt?
- ✓ Has someone already commented on my behaviour, or suggested I stop?

## Additional self-test questions for dual relationship

**Treating family, friends or colleagues**

- ✓ Am I doing this to raise my own status or in some other way gratify myself?
- ✓ Am I too close to be objective in my management of "Tom"?
- ✓ Can I perform intimate examinations of "Mary" or ask her intimate or sensitive questions?
- ✓ Can our personal relationship survive a professional error or disagreement?





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